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Grow Your Own

CREATING THE CONDITIONS FOR SUSTAINABLE WORKFORCE DEVELOPMENT

GROW YOUR OWN

Creating the conditions for sustainable workforce development

Gita Malhotra

King's Fund

This paper has been produced as part of a wider project looking at the issues and challenges of developing a sustainable health care workforce using local workforce solutions. This strand of work builds on previous King's Fund research into London's NHS workforce trends and international recruitment. The project was carried out by the King's Fund in partnership with the North East London Strategic Health Authority (NELSHA). NELSHA, together with the four other London strategic health authorities, ceased to exist as of 1st July 2006. They have now been replaced by a single strategic health authority – NHS London.

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Gita Malhotra
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Introduction

The NHS in London employs one-fifth of the total English NHS workforce. Since the NHS Plan was introduced in 2000 (Department of Health 2000), and as a result of extra investment, the total labour force in the capital has grown by 26 per cent – an increase of just over 30,000 full-time equivalent posts in five years (NHS HSC Information Centre 2006). Despite this expansion, London continues to experience recruitment and retention difficulties, exceptionally high staff turnover and vacancy rates, as well as an over-reliance on international recruitment. Such concerns are set within the context of a transient and increasingly diverse population (Buchan *et al* 2003, Buchan *et al* 2004).

The capital is also the setting for immense demographic change, with an anticipated population growth of 850,000 by 2016, as well as the retirement of the 'baby boomer' generation (Hollis and Hay 2005). These demographic shifts will result in a rising demand for health care – for example, there will be an even greater focus on the needs of children, young people and older people – and an increased need for skilled labour in a growing and increasingly competitive London economy. At the same time, these demographic changes will also present opportunities for developing the workforce by providing a large 'local' pool of potential employees from which the NHS can recruit.

Since 2000, NHS workforce policy has focused on increasing the size of the health care workforce, with an emphasis on meeting centrally defined national targets for occupational groups, such as nurses and allied health professionals. Much of the growth in the labour force has come from an expansion in the number of students entering health professional (pre-registration) training, as well as the development of schemes designed to encourage those staff who had left the NHS to return. However, as high financial investment in the NHS is set to slow down, and there is a move away from international recruitment – for ethical reasons – to the development of more home-grown solutions to workforce challenges, expanding capacity by simply increasing workforce numbers is no longer viable.

As a result, alternative approaches are needed to develop a workforce that can be both responsive and flexible enough in its work practices to manage the complex changes and pressures facing the NHS. These include the patient choice agenda, the establishment of an increased range of health care providers and the implementation of Payment by Results. The government's recognition of the need for different approaches to workforce development is evident from its desire to 'ensure that staff are enabled to deliver the changes in practice and culture that will underpin reforms' (Department of Health 2005a). In practice, this means a shift away from a workforce largely defined by professional

qualifications and distinct occupational groups to one that is defined by skills and competencies, and is centred on the patient. This shift will inevitably influence who carries out the work, how it is organised, and where and how it is delivered. Crucially, it will also affect the source of the future labour supply.

'Home-grown' or 'grow-your-own' workforce approaches have often been identified as strategies to support workforce development priorities and there are many examples of good practice in the capital (Hutt and Buchan 2005). However, while grow-your-own approaches are not new, their adoption and incorporation into mainstream policy have not been as effective as they could be, for reasons that are outlined later in this paper.

Grow-your-own workforce strategies are characterised by two important features. First, they look to local labour markets as a key source of workforce supply. Second, they encourage organisations to use the skills and talents of their existing unregistered – or not formally qualified – workforce more effectively. Developing and extending staff roles, especially to meet new service requirements and expectations, can achieve this. In addition, home-grown workforce approaches in the NHS may be more likely to recruit and produce staff with greater commitment and loyalty to their organisation. By offering improved development opportunities, and more interesting and varied roles, the NHS can become the employer of choice locally, which may also reduce staff turnover rates. Crucially, successful grow-your-own approaches do not exist in isolation from an organisation's overall workforce plan and strategy.

NHS recruitment from local populations has often focused on creating a workforce that is more representative of the social and ethnic background of the population it serves – usually with the aim of delivering what have been described as 'culturally competent or culturally sensitive' services (Lord Warner 2006). While this outcome may result from home-grown approaches, it is not the main concern of this paper. Instead, the focus here is on how these approaches can address the persistent recruitment and retention difficulties in London and the emerging need for new ways of working.

This paper describes the experiences and views of London NHS organisations and other partners currently engaged in the development of grow-your-own approaches. It offers some consistent insights into 'what works and what is required' in changing the workforce practice of NHS employers. The paper also considers what may be needed to influence change at a policy level to enable these types of activities to become part of mainstream NHS strategic workforce development.

Although the findings set out in this paper are discussed in the context of grow-your-own approaches, they have wider application and relevance across all aspects of strategic workforce development. For example, the need for high-quality labour market intelligence and the need to ensure that there is clear ownership of workforce development do not apply exclusively to home-grown approaches.

Methodology

Information and findings presented in this paper were gathered from a review of literature and national and regional NHS policy documents relevant to the development of local approaches to workforce development. Qualitative research was also carried out with key stakeholders, using interviews and group workshops.

Stakeholders included representatives working in:

- the Royal Colleges
- strategic health authorities
- NHS trusts – human resources and service modernisation
- the Department of Health
- NHS Employers
- higher education.

The research explored the following broad questions:

- What motivates an organisation to develop grow-your-own workforce strategies and approaches?
- What are the characteristics of and conditions present in organisations that have embedded this type of intervention in local mainstream policy and practice?

The context

This section considers the labour market and policy environments in which NHS employers operate in London. In order to recruit and retain an adequately sized workforce that possesses the necessary skills, NHS employers in the capital face a number of challenges, some unique to the city, that grow-your-own strategies can help to address.

Since 2000, NHS workforce planning has focused primarily on expanding professional staff numbers – that is, meeting targets for extra doctors, nurses and therapists. However, the Department of Health has recently stated that: 'Long-term workforce planning is important to provide a strategic view of supply and demand and to reflect the changes in the wider context of technology, resourcing patterns and demographics' (Department of Health 2005b). But what does this mean in practice? How does it relate to current government and local responses to workforce policy, and what are NHS organisations already doing to address this? To answer these questions, we need to understand the wider context within which grow-your-own workforce strategies are currently being shaped. This section examines the following areas:

- the NHS workforce in London
- the capital's labour market
- NHS policy on workforce issues.

The NHS workforce in London

Head count

The NHS in London directly employed almost 200,000 people in both medical and non-medical roles as at September 2005. This represents more than one-fifth of the total English NHS labour force. Full-time equivalent employment in the health service in London has grown by 26 per cent since 2000 (*see* Table 1, below).

TABLE 1: SIZE OF THE NON-MEDICAL WORKFORCE IN NHS HOSPITAL AND COMMUNITY HEALTH SERVICES, 2000–05 (FULL-TIME EQUIVALENTS)

	2000	2005
All non-medical staff, England	739,399	889,973
All non-medical staff, London	114,296	144,423
Clinical support workers, London	10,807	41,012
Qualified nurses, London	51,809	53,908

Source: NHS HSC Information Centre 2006

Vacancy rates

Although vacancy rates in England have fallen in recent years (there were, for example, 713 fewer unfilled nursing posts in 2005 compared with 2003), the NHS in London continues to experience vacancies at twice the national average. A third of all NHS vacancies are in the capital. In 2005, for example, there were 2,066 nursing posts (including 130 qualified midwifery jobs) vacant in London – 35 per cent of the total qualified nursing vacancies in England. For qualified allied health professionals, 6.6 per cent of posts in London are vacant (the national average is 3.4 per cent). The statistics for health care scientists are similar: vacancy rates in the capital are at 4.6 per cent, which is twice the national average (NHS HSC Information Centre 2006).

A high proportion of London's NHS staff are recruited from abroad. A Royal College of Nursing (RCN) survey found that 13 per cent of London's nurses were trained overseas, compared with 3 per cent for the United Kingdom as a whole (Ball and Pike 2004). However, the emphasis and reliance on active international recruitment is declining. One reason for this is the ethical concern that international health workers may come from countries that are experiencing their own staff shortages and challenges. Another concern is that the capital represents a gateway or 'revolving door' for international recruits who may be more likely than UK workers to move on from the United Kingdom to work in other countries that are also seeking to boost their health care workforces (Buchan *et al* 2004). It is therefore unlikely that international recruitment will provide a sustainable source of workforce supply in the future.

Turnover

Like vacancy rates, staff turnover rates in London are higher than in the rest of England. In their evidence to the Select Committee on Health's 2006 inquiry into workforce planning, the five London strategic health authorities (SHAs) pointed out that turnover in the capital can be 30 per cent higher than the national average and that vacancies can cost up to £10,000 in recruitment costs and lost productivity (Select Committee on Health 2006a). The SHAs note that this picture is unlikely to change in the future. Interviewees for this paper highlighted turnover rates of 25 per cent in some areas. They emphasised that this was a key motive for organisations to develop grow-your-own workforce strategies in an attempt to retain staff.

Hutt and Buchan (2005) have highlighted some of the reasons for poor retention in the London workforce. These include:

- large numbers of young mobile workers
- lack of access to affordable child care
- the high cost of living
- heavy workloads.

The capital's labour market

Although London's workforce is projected to grow in the next decade and is not ageing as quickly as the rest of the United Kingdom, NHS employers in the capital do face a number of challenges resulting from changing demographics – in particular, increased competition for skilled labour.

London's overall population is forecast to increase by 850,000 between 2006 and 2016, and its workforce will rise by 516,000 from its current level of around 4 million (Greater London Authority 2005). A project recently undertaken by the US-based Concours Group (Concours Group and Age Wave 2003) examined future population trends in the United States and in Europe, and their impact on workforce planning. Two findings from this research – undertaken on behalf of a number of stakeholders including the NHS – are particularly relevant to the future of London's labour market:

- There are not enough workers to replace the numbers and skills of the 1950s and 1960s 'baby boomers' as they reach retirement age during the next 20 years.
- The workforce is growing increasingly diverse in terms of gender, ethnicity, class, education and other factors.

The capital has a high level of ethnic diversity – 46.6 per cent of England's minority ethnic population live in the capital and almost a third of the city's inhabitants comprise minority ethnic groups (Association of London Government 2005). Such diversity means that the NHS needs to ensure that its workforce is equipped with the appropriate skills – such as the ability to speak different languages – to meet the needs of its distinct populations. The demography of London's population is ageing at a slower rate than the rest of the United Kingdom, with the result that the city has substantially more young adults (aged 20–44) than the rest of the country. The minority ethnic population in England is particularly young. For example, 45 per cent are under 25 years old compared with 29 per cent of white people (Ethnic Minority Employment Taskforce 2005). Eighty per cent of the growth in London's potential workforce is expected to come from black and minority ethnic groups living in the city (Roberts and McNeish 2005).

Supply and demand for staff in London

In spite of the projected growth in its population, London employers, including the NHS, will face greater competition for skilled staff in the future than they do now. A recent CBI/KPMG London Business Survey (CBI Publications 2006) revealed that a shortage of skilled staff is currently the biggest barrier to business in the capital. Sixty-one per cent of London employers face skills shortages – a rise of 12 per cent since last year. The survey also highlighted a lack of basic literacy and numeracy skills in the capital. This skill shortage is currently reflected in the NHS by the high vacancy rates for professionally registered staff.

NHS policy on workforce issues

A key tenet of the NHS Plan (Department of Health 2000) was to reform the NHS workforce. The Plan was explicit in its aim – that growing and 'modernising' the workforce was crucial if the government's ambitious policy objectives were to be realised. It was proposed that a bolstered NHS human resource (HR) function (Department of Health 2002), together with a clutch of HR and workforce policies and strategies (*see* box, below), would deliver a growth in capacity. Commissions of pre-registration professional training places would also be increased. These policies were also intended to improve working and pay conditions for staff, which would result, it was hoped, in improved recruitment and retention.

WORKFORCE TOOLS AND STRATEGIES TO SUPPORT THE NHS PLAN

- **New pay agreements** for NHS staff, including the consultants' contract and Agenda for Change (AfC). AfC covers all non-medical staff, except very senior managers. It is based on a single job evaluation scheme, a common grading system and the Knowledge and Skills Framework (KSF) (Department of Health 2004a).
- **The Knowledge and Skills Framework** (KSF) defines levels of competency for a range of skills and responsibilities (called 'dimensions') such as communications. Each job covered by AfC, including new roles, has a series of KSF dimensions, such as the level of written, verbal and non-verbal communication skills required. The KSF helps determine the learning and development that staff receive through annual appraisals.
- **The Model Career Framework** is a new NHS-wide career structure that makes it possible to develop staff and their roles and support career pathways. It is underpinned by the KSF, the appraisal system and the Skills Escalator.
- **The NHS Skills Escalator** is a mechanism by which staff can enter the NHS from any route or training qualification, and develop skills and gain promotion by using the KSF.
- **Improving Working Lives** is a benchmark set by the Department of Health to assess the extent to which NHS employers locally are following good practice in human resources. Information is gathered on, for example, provision of child care and access to training.
- **Recruitment strategies** such as Return-to-Practice schemes, provide a range of incentives for professionals, such as nurses who have left the NHS, to encourage them to return.

More staff working differently?

The title of the HR strategy that accompanied the NHS Plan was *More Staff Working Differently* (Department of Health 2002). In his review of the long-term resource requirements of the NHS, Derek Wanless noted that, in order to meet skill shortages and rising demand for health care, NHS staff needed to 'take on new and challenging roles' (Wanless 2002, p 15). While good progress has been made in recruiting more staff, as illustrated by the growth in workforce numbers in London, there has been less significant progress in staff 'working differently'. In its evidence to the Select Committee on Health inquiry into workforce planning, the Department of Health acknowledged that:

> *We are moving from a rapid expansion in staffing and investment in health care to a 'steady state' of investment and a focus on productivity. In essence, the last five years has been 80% about growth and 20% about transformation and new ways of working.*
> (Select Committee on Health 2006a, para 5.7)

The Department of Health is now placing greater emphasis on productivity to ensure the most efficient use of frontline resources during the next five years of the NHS Plan:

> *Workforce capacity (...) in the future will need to come from more efficient ways of working and through even more productive use of the workforce.*
> (Lord Warner 2005)

The financial context

The NHS in London was £168 million in deficit in 2005/6, an increase of £84 million compared with 2004/5 (Department of Health 2006). This shortfall will need to be recovered this year. Coupled with policy imperatives such as patient choice, Payment by Results and the need for primary care trusts (PCTs) in London to achieve efficiency savings, this has created an even greater need to demonstrate both improved service quality and activity. This has to be met from existing human resources and increased investment. However, current approaches to financial balance, such as cutting agency staff and freezing posts in London, could have the following consequences.

- **Increasing workload** Excess workloads were identified as a key factor behind high turnover in London (Hutt and Buchan 2005).
- **Halting innovation** During periods of uncertainty, developments such as new ways of working and skill mix may be challenged.
- **Focusing on short-term needs** This may take place at the expense of long-term strategies, including grow-your-own approaches.

The next section highlights the factors and the environment that have enabled a number of London-based NHS employers to effectively adopt home-grown strategies. It also considers how the barriers and obstacles to their effective implementation can be addressed.

What works and what is needed

This paper has described the context for grow-your-own workforce strategies in London and has explained how the development and strengthening of these approaches can contribute to mainstream workforce planning. This section, based on interviews with stakeholders, examines what works and what is needed to embed such approaches. The latter part of the section goes on to examine the challenges and barriers to developing and establishing home-grown strategies in NHS organisations.

Discussions with stakeholders revealed that there were four key conditions that needed to be in place for home-grown workforce strategies to be effective in NHS organisations:

- focused organisational motivation
- clear ownership and responsibility for workforce change
- strong leadership, champions and collaborations
- strategies for measuring and evaluating success.

Key conditions

Each of these conditions is now described in turn.

Condition 1: Focused organisational motivation

Stakeholders identified what had motivated their organisations to develop home-grown approaches to workforce development and how they had set about justifying them. The following factors were important influences:

- recognition of the organisation's wider position and role within its local community
- the impact of new building developments
- concern that a trust's workforce should reflect the diversity of its local population at all levels
- acknowledgement that 'more of the same' type of workforce does not resolve ongoing workforce challenges.

RECOGNITION OF THE ORGANISATION'S WIDER POSITION AND ROLE WITHIN ITS LOCAL COMMUNITY

Interviewees described how an awareness of their organisation's 'corporate social responsibility' (CSR) – that is, the contribution that the organisation could make to the health and sustainability of its local community (*see* box, overleaf) – had motivated them to consider implementing grow-your-own workforce strategies. As one head of learning and development put it:

> *[We have a role] in improving the health of our local communities driven by our corporate citizenship role as a good employer in what is a deprived community… a key part of our chief executive's philosophy is we drive down health inequalities through local employment.*
>
> (Head of learning and development)

CORPORATE SOCIAL RESPONSIBILITY FOR HEALTH IN THE NHS

The NHS can improve the well-being of communities through the effect of its activities on citizens' health, local economies and the environment. In many areas, particularly deprived ones, the NHS is frequently the largest employer – creating jobs for unemployed people and helping individuals with poor skills to improve them. In its role as a good corporate citizen, the NHS can also source provisions from local suppliers, improve access to health centres, particularly for those without a car, and build energy-efficient hospitals and clinical centres.

THE IMPACT OF NEW BUILDING DEVELOPMENTS

For some stakeholders, new building developments, including hospitals and health centres, had triggered them to consider grow-your-own strategies by bringing CSR-related issues to the fore. One regeneration manager described it as a question of, 'Who builds it and who fills it?' As capital investment for new buildings entered local – and frequently deprived – areas, a persistent question for some interviewees had been: 'What exactly do local people get from this?' As the same regeneration manager commented: 'Clinicians would frequently respond with "a new hospital" but we also saw that the health dividend was still missing.' This recognition had prompted some NHS employers to consider grow-your-own approaches as a way of improving engagement with the local populations – using local people not only to work in the hospital once it was constructed, but also to build it.

CONCERN THAT A TRUST'S WORKFORCE SHOULD REFLECT THE DIVERSITY OF ITS LOCAL POPULATION AT ALL LEVELS

Stakeholders cited this concern as an important motive and justification for introducing grow-your-own strategies. It was assumed that a more ethnically diverse and locally derived workforce in London would be 'more likely' to improve equity of access to health services. It was thought that this would be particularly relevant in very diverse communities where language issues might be a barrier – and would therefore improve health outcomes for those groups. As one mental health community development worker said, what is needed is: 'a diverse workforce to deliver culturally competent/sensitive services'.

In addition, interviewees frequently cited wider legislative requirements on race and ethnicity, such as The Race Relations (Amendment) Act 2000 (The Stationery Office 2000), as a key driver for the development of grow-your-own strategies. The Act gives public authorities a statutory duty to promote race equality and to monitor, by ethnic group, their existing staff and applicants for jobs, promotion and training. It also requires them to publish the results annually:

> *Without the diversity argument as a key driver there may have been some challenges and potential resistance in our organisation to our work on local recruitment.*
> (Regeneration manager)

ACKNOWLEDGEMENT THAT 'MORE OF THE SAME' TYPE OF WORKFORCE DOES NOT RESOLVE ONGOING WORKFORCE CHALLENGES

Many stakeholders had recognised that trying to meet the challenges of workforce development by simply increasing the overall size of the health care workforce was no longer a viable option: it was financially unsustainable, had failed to resolve ongoing vacancy and turnover rates and had not resulted in more flexible ways of working. As one head of learning and development commented:

> *Essentially there was a wake-up call – we couldn't carry on as we had been if we really wanted to modernise the workforce – the workforce for the future.*

Instead it was realised that a new approach to workforce development was required – one that ensured that workforce planning was integrated with service-planning activity across an organisation. For some stakeholders, this realisation had provided the most successful justification for developing and embedding grow-your-own strategies in their organisations. Drawing on a coherent understanding of recruitment and turnover patterns, local labour market trends, and new service developments, they were able to argue that grow-your-own approaches would make it possible to create a more responsive service delivered by new types of workers who would be sourced either locally or from existing staff and that this, in turn, could produce a more motivated, loyal and committed workforce.

Condition 2: Clear ownership and accountability for workforce change

Interviewees emphasised that responsibility and accountability for workforce development needed to be clearly defined and identifiable if the implementation of grow-your-own strategies in NHS organisations was to succeed. They highlighted two factors as being particularly important:

- understanding the 'business of health'
- existence of a supporting governance structure.

UNDERSTANDING THE 'BUSINESS OF HEALTH'

Stakeholders said that whoever was held responsible for workforce development within an organisation needed to understand what several called the 'business of health'. As noted by one interviewee:

> *The only way meaningful workforce modernisation and the introduction of new entry routes [to the workforce] can take place… [is if it is] based on an understanding of what the problems, issues and barriers are on the service side and how the work is organised.*
> (Head of learning and development)

In practice, this meant that whoever was responsible for workforce development – whether HR, service modernisation or learning and development leads – needed to have, not only an overview of both the business and organisational objectives, but also a detailed knowledge of service need and development. It was also important that they considered the workforce implications of any planned changes contained within these objectives.

Stakeholders explained that it was important to understand that the role of workforce development was separate from but complementary to the more traditional role of HR. If those responsible for workforce development were not HR professionals, they would need

to draw on the expertise of their HR colleagues in helping staff to understand and manage the impact of service changes through appraisals, reviewing job descriptions and applying the Knowledge and Skills Framework. Stakeholders also stressed that the expertise of the HR function was important in helping to ensure that the NHS was considered attractive as a local employer.

EXISTENCE OF A SUPPORTING GOVERNANCE STRUCTURE

According to stakeholders, the existence of a supporting governance structure linked to wider organisational and service objectives ensured that the rationale for developing grow-your-own strategies was recognised and supported at all levels of an organisation and that those responsible for developing the workforce had the authority and incentives to be able to do so:

> *However altruistic and value laden this type of work [recruitment from local populations] can be… the reality is that we work in a hierarchical and performance-based system, so targets based on a good analysis of what the organisation needs are necessary and need to be embedded into any plan.*
> (Regeneration manager)

Condition 3: Strong leadership, champions and collaborations

Stakeholders felt that the presence of the following made it easier to implement grow-your-own strategies:

- board-level leadership
- champions and collaborations.

BOARD-LEVEL LEADERSHIP

In the interviews, there was a clear consensus that effecting meaningful change in approaches to workforce development – particularly when developing your own workforce and wanting to rely less on the qualified workforce – could only take place with strong board-level leadership. As one head of learning and development commented: 'It is all about the leadership at the end.'

Stakeholders with leadership support had felt that they had permission to innovate and take risks in relation to changing workforce practices:

> *Our organisational approach to service and workforce transformation was inspired by the chief executive and an executive director – both highly motivated and engaged – so firstly you can't argue against this work – it's a good thing, but more importantly the leadership allowed for systemic change. It's the first time I have ever experienced a whole senior management team in action.*
> (Head of learning and development)

Leadership support had also enabled stakeholders to deal more effectively with resistance to change – for example, from professional groups with vested interests.

CHAMPIONS AND COLLABORATIONS

Beyond board-level leadership, stakeholders emphasised the importance of developing champions and collaborative relationships to build wider support for grow-your-own strategies. Examples included:

- engaging middle and service managers with the grow-your-own agenda
- identifying dynamic and enthusiastic individuals across the organisation who could act as a network of 'change agents' to influence others. As one modernisation lead commented: 'They [champions] are not necessarily always at the top… you might get more done with an enthusiastic matron or pharmacy lead.'
- collaborating with strategic health authority experts on workforce and service modernisation
- establishing collaborations between people at different levels of an organisation, for example, with senior managers heading up project boards:

  We had strong corporate sign up – chief executives, commissioners and link directors – to deliver a large-scale change programme across four NHS organisations in three clinical areas. The internal structures are key – when something goes awry there is a management network in place that can act.
  (Director of modernisation)

Condition 4: Strategies for measuring and evaluating success

Interviewees felt that to strengthen and reinforce the case for grow-your-own approaches it was important to be able to demonstrate their effectiveness. To do this they needed the following:

- systematic monitoring and evaluation
- access to good-quality workforce data.

SYSTEMATIC MONITORING AND EVALUATION

Although interviewees had recognised the importance of systematic monitoring and evaluation of the impact of grow-your-own interventions, generally this remained under-developed, particularly in areas such as the effect on patient experiences. However, stakeholders had started creating some indicators to test and quantify the impact of their interventions in order to determine their success and to plan for the future. The box overleaf gives examples of improvements that different organisations identified.

ACCESS TO GOOD-QUALITY WORKFORCE DATA

Interviewees pointed out that the quality of available labour market information – and its subsequent analysis – were crucial factors in ensuring that workforce changes were fit for purpose, flexible enough in a climate of changing service models and working across different care boundaries.

The sources of information most frequently referred to by stakeholders as being useful were:

- vacancy data
- turnover rates
- annual staff surveys
- intelligence about the local labour market trends from local partnerships and networks.

WORKFORCE IMPACT MEASURES

- Reductions in staff turnover of approximately 12 per cent since the introduction of an organisational lifelong learning model (skills escalator) to support staff career development.
- Acquisition of skills and career progression, particularly for support staff.
- Widened and increased entry routes to employment, particularly around starter or entry jobs.
- Performance measures with good-quality project management structures in place.
- Staff surveys and the implementation of the Improving Working Lives initiative indicated increased access to, and improved satisfaction with, learning and development opportunities.
- Success stories of staff development. For instance, this example from a head of learning and development: 'the porter who is now a team leader... existing staff such as operating department assistants, health care assistants and phlebotomists coming into new roles like the clinical assistant practitioner'.
- Improved appraisal systems and personal development plans in place, which are then acted on.
- Strengthened local partnerships with the local authority, colleges, schools and community-based organisations, which provide improved entry routes for local people into employment.

Barriers and obstacles to developing home-grown strategies

On initial examination, the four conditions described above appear to be reasonably straightforward. However, all stakeholders indicated that there are barriers and obstacles to the effective implementation of grow-your-own workforce strategies in the current context of service and organisational change. A discussion of some of these challenges and how organisations have attempted to address them now follows.

Short-term focus

Traditional approaches to workforce planning have focused on increasing the numbers within existing occupational groups, particularly by commissioning education and training places for professionally qualified students. Essentially, this has been an exercise in balancing the supply and demand of the workforce. Interviewees said that, as a consequence, there has been insufficient encouragement or incentive to consider the size and shape of the future workforce – and where it would come from – from a long-term perspective. In effect, the direction of workforce policy to date has crowded out or marginalised grow-your-own workforce strategies in favour of developing the qualified workforce.

Lack of clarity around the arguments for an ethnically diverse workforce

As the focus of this research is London, many stakeholders pointed to local diversity – and specifically ethnic diversity – as a key factor influencing the development of local workforce strategies. The primary reason they gave centred on developing a culturally competent workforce that reflected the ethnically diverse local population that the organisation served. However, there were a number of problems with using the ethnic diversity argument as the main rationale for developing grow-your-own approaches.

First, there was a lack of clarity about what was meant by the term 'a culturally competent workforce'. Second, there was scant evidence available that proved a direct correlation between a representative ethnically diverse workforce and the impact that this might have on improved health outcomes for patients. Third, it was questionable whether staff from black and minority ethnic groups should be held responsible for addressing issues of cultural competency in the delivery of health services. As one respondent pointed out:

> *Let's be clear that we don't end up thinking we solve BME [black and minority ethnic] 'problems' with BME staff – in the end, this is about the London population being our future workforce – and they happen to be from ethnic minority groups.*
> (SHA director of education and workforce development)

More work, analysis and evidence is needed on the development of impact measures and quality indicators relating to ethnic diversity if it is to be used as a sustained argument for a home-grown workforce in London.

Uncertainty about ownership and responsibility

The importance of clarity about ownership and responsibility of the workforce agenda in NHS organisations was an ongoing consideration throughout this research. Despite the Department of Health's focus on the HR function nationally in delivering workforce modernisation (Department of Health 2002, 2004b, 2005b), stakeholders persistently identified a concern about HR's current capacity and capability to carry this out in practice. It was apparent that the terms 'HR' and 'workforce' had often been used interchangeably in organisations and at times had become conflated in their meanings. This had led to a widely held assumption that workforce development was the sole responsibility of the HR function of an organisation. Yet, for many stakeholders, the reality was that HR departments had not always been fully engaged in the wider service modernisation agenda and did not necessarily always understand the 'business of health' and the delivery of health care. As a consequence, there was limited capability in HR to understand and therefore support workforce modernisation.

One director of service modernisation spoke of specific difficulties that emerged in HR when trying to implement newly designed roles: 'There is sometimes a lack of ability to understand [that] 'it' [the way health care is delivered and work practices] could be different and how that might happen'. However, stakeholders acknowledged that the

implementation of large-scale programmes driven by the Department of Health, such as Agenda for Change and Improving Working Lives, had challenged capability and capacity issues in the HR function of the NHS. As the same director commented: 'In some cases I think the corporate agenda – such as implementing Agenda for Change – has inhibited the human resource role in transformation [process redesign].'

However, in cases where HR had been able to respond to the demanding agenda for workforce change and where they had understood the need for new strategies to recruit and develop staff, including grow-your-own strategies, the results were very successful:

> *We developed what was effectively a modern approach to workforce planning, not just concerned with balancing supply and demand. For example, our [workforce] planner was really interested in workforce development and also the local labour market and its trends, and this made a real difference to how we then developed our workforce strategy.*
> (Head of learning and development)

Insufficient senior-level support

Interviewees highlighted that a central element in the successful delivery of new ways of working and innovation that supported grow-your-own strategies was the championing of these new approaches at a senior level. However, this level of support had not always been evident – for example, HR directors had often been poorly represented at board level and, as a result, the broader workforce agenda had not always been championed. Many stakeholders said they had been surprised by the frequent lack of senior-level engagement, given the significant pay bill in terms of the cost of the workforce in any single organisation. A number of interviewees also emphasised the challenges of engaging service-level managers both in new ways of working and considering the local population as a recruitment source. Such engagement – while clearly desirable – took time and effort, which needed to be factored into planning processes.

Challenges from professional interests

Grow-your-own strategies were frequently described as an important response to supporting new ways of working and service modernisation because they often offered an enhanced labour supply for new and support roles. Nevertheless, several interviewees had faced challenges from professional interests – that is, the habits, history, customs and practice of professional groups – in altering how health care work and services were organised. Stakeholders had found that change was slow as professional groups could be reluctant to break down barriers and would contest – and sometimes resist – the delegation of work. As one director of modernisation commented: 'All professionals are really good at extending their own roles but there seems to be problem with giving things up.' Ensuring the quality, authority and commitment of leadership in supporting home-grown strategies was considered an important factor in tackling some of this resistance.

Lack of patient impact measures

The intention of most recent national NHS policies and reforms (Department of Health 2005c) has increasingly been to organise services around the patient rather than professional groups. Interviewees had found that this created the potential for workforce redesign and started to unlock opportunities for developing the skills and abilities of staff:

> *We wanted to look at our sexual health services. There were gaps and issues about quality across the service – [but] looking at the optimal patient journey is the starting point, and working back from there and seeing the skills you need in your staff.*
> (Director of service modernisation)

However, the lack of impact measures – measures that could demonstrate improved patient and service outcomes as a result of workforce interventions – had provided a barrier to introducing and sustaining grow-your-own strategies. Patient experience, in particular, had been difficult to quantify. One way of helping measure the impact of workforce planning and development on patient experience is to ensure that patients have a say in the design of services. One interviewee had factored in patient involvement as part of their redesign programme and had adopted alternative approaches to test service and workforce responsiveness to individual patients. For example, a patient tested out existing services, such as the quality and type of information given, the effectiveness of signposting to services, and the amount of dignity and respect shown towards them.

Limited labour market information

Stakeholders consistently highlighted the importance of good-quality and timely labour market information. However, this research found that the use of data when shaping workforce plans was relatively limited. Buchan *et al* (2003) have emphasised the need for quality labour market data to enable effective assessment of current and future workforce supply. This is crucial in the development of home-grown approaches to workforce development because an analysis of local labour markets will highlight local unemployment rates, skills shortages and population trends, as well as enabling a more detailed understanding of trends and patterns within the existing workforce. All of these factors influence which strategies are most suitable to be used on the supply side. Elliott (2003) has stressed that local labour markets have a considerable impact on the NHS's capability to deliver services – both now and in the future. The NHS, he suggests, needs to consider:

- the composition of the local population, combined with the type and quality of training and education provision. These underpin the number and type of skills that are then produced in the local labour market
- local attitudes and perceptions of the NHS
- the degree of competition for labour. If other employers compete directly for similar types of skills as the NHS, then this is more likely to have an immediate – and potentially detrimental effect – than where the required skills are different.

Conclusion

This paper has presented the findings from a small-scale qualitative piece of research into how grow-your-own workforce strategies are currently being established by London health care organisations. The focus has been on exploring 'what works and what is required' in the establishment of these practices and the barriers and obstacles to embedding them within NHS organisations. In addition, this paper has emphasised how such practices can support wider strategic workforce development in the capital.

Capitalising on the local market

Many stakeholders acknowledged that a continued emphasis on expanding workforce numbers through traditional routes would not be effective in meeting London's anticipated labour market challenges. Nor would such an approach capitalise on the 'local' pool of potential recruits that London's growing population would create. The findings uncovered many positive and encouraging aspects in relation to the development of grow-your-own workforce strategies taking place in London NHS organisations. Nevertheless, while these approaches were clearly not new, the extent to which they might become firmly established in organisations was dependent on what could be described as an 'enabling environment'. All of the stakeholders involved in this research described at length the characteristics of what was needed to underpin the introduction and, importantly, the sustainability of home-grown strategies.

This information can be distilled into four key conditions:

- focused organisational motivation
- clear ownership and responsibility for workforce change
- strong leadership, champions and collaborations
- strategies for measuring and evaluating success.

Quantifiable success measures

Current pressures facing NHS organisations mean that workforce issues are under much scrutiny. However, there was a broad consensus in the findings that going 'local' in terms of recruiting from local populations – as well as using the talents and skills of existing staff – was increasingly making a significant contribution to workforce development. Grow-your-own approaches were having a considerable impact and organisations were beginning to identify quantifiable success measures, such as reductions in staff turnover and improved staff satisfaction as a result of structured development opportunities. While organisations were often motivated to act on the basis of value-based arguments, such as corporate social responsibility, there was a growing realisation and acknowledgment among interviewees that grow-your-own strategies could not only address these arguments but

also be successful in addressing workforce challenges. An important factor determining the success of grow-your-own strategies was the degree to which they had become part of mainstream workforce activity: thriving schemes tended to be better integrated; less successful ones tended to be operating in isolation.

Fresh approaches to workforce issues

Financial constraints, and actual and anticipated shortages of traditional workforce supply, also seemed to influence organisations. They realised that their survival was dependent on new approaches to workforce issues – in this context, looking beyond the customary labour source of professionally qualified staff. Although local workforce strategies had been identified as a potential way forward, the need to address statutory requirements, for example, on issues of race and disability, had given added weight to these approaches. There was also growing awareness of the potential impact of demographic changes in the capital – for example, age, ethnicity, skills base, educational levels or attainment – and the challenges for service delivery in London that such shifts would bring.

Strong leadership and HR capacity and capability

The very varied nature of responsibility and leadership for workforce development in NHS organisations was the greatest concern for stakeholders. Unsurprisingly, grow-your-own strategies require strong leadership but also highly developed HR capacity and capability. There is an assumption that the responsibility for transforming workforces should lie with HR. In practice, this was clearly not always the case. In order to improve and clarify the situation, there needs to be more investment in, and support for, the development of the HR function in the NHS, particularly in relation to organisational development skills and practice. Our research found that there are examples of strong leaders who have already recognised this and acted upon it.

Looking ahead

In terms of the future, the signs for regional and national policy development in this area look promising. The current Select Committee on Health inquiry (2006b) into workforce planning and how it should progress in the future reinforces the point that workforce planning and development cannot continue without due consideration of demographic and technological shifts. It has also highlighted the importance of changing and adjusting the roles of existing staff and improving their skills, as well as implementing better models for recruiting and retaining staff.

The recent creation of a single strategic health authority (SHA) for London represents a real opportunity for both workforce and organisational development across the capital. Although the workforce functions of the new SHA are still yet to be determined at the time of writing, there is the potential to develop a coherent regional policy on leading, co-ordinating and managing appropriate aspects of workforce development in London, particularly in relation to sustainability and, within this, grow-your-own approaches. This will be important as the range of stakeholders and partners in the NHS increases. Alongside London's health and social care workforce employers and planners, education providers – including those in higher and further education – must now be regarded as active partners in the planning and development of London's NHS workforce.

Above all, what is clear is that London needs to act now to develop and co-ordinate coherent approaches, such as grow-your-own workforce strategies, that are tailored towards the capital's labour market, in order to provide a sustainable, flexible and effective workforce for the future.

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