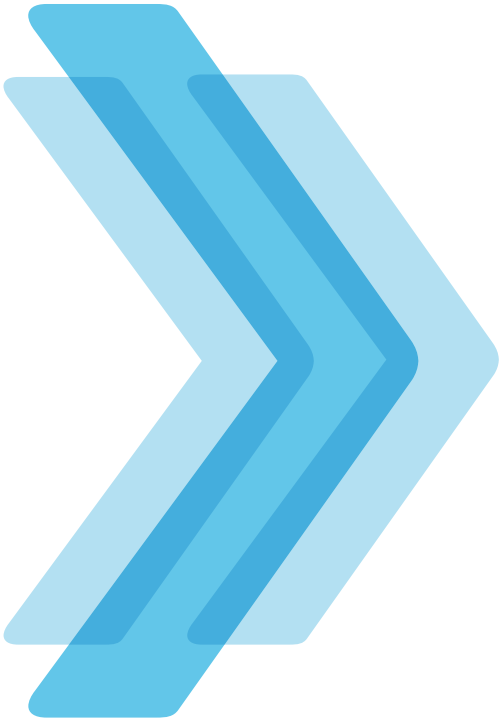
The King's Fund

Ideas that change health care

Developing a strategy for the health and care workforce in England

Summary of a roundtable discussion



September 2018

Foreword

Following publication of the draft 10-year workforce strategy *Facing the facts, shaping the future*, The King's Fund, the Health Foundation and the Nuffield Trust convened a roundtable event to facilitate discussion on the issues it raised. Attendees came from academia, Health Education England, the Department of Health and Social Care, HM Treasury, NHS Improvement, Care Quality Commission, Public Health England, NHS Employers, NHS Providers, Skills for Care, NHS provider trusts, the Office for Budget Responsibility (OBR) and the Institute for Fiscal Studies (IFS).

The event was run under Chatham House Rule and focused on two areas: reflections and opportunities to improve the current modelling underpinning the workforce strategy and how workforce planning could be improved.

The discussion sought to facilitate a diverse range of views and perspectives to inform the work of Health Education England, rather than to arrive at an agreed position or set of actions. The following write up provides an overview of the event and reflects the individual points raised and views expressed in the ensuing discussion.

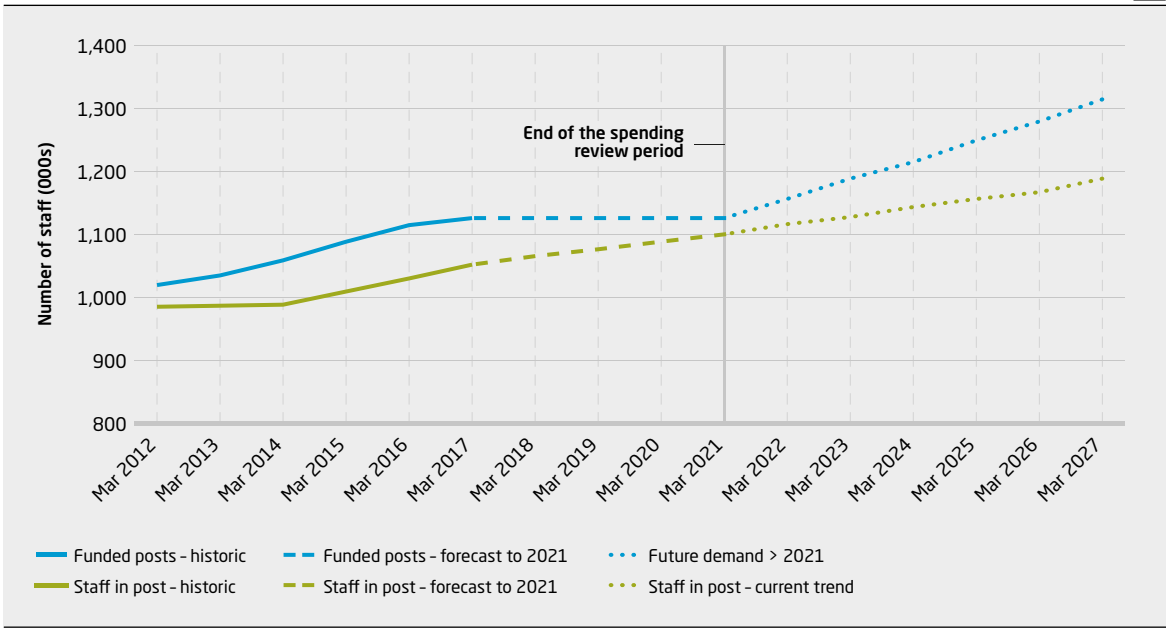
Creating a coherent narrative – the need to tackle demand and supply

Strategic workforce planning is a technical task – using data to develop projections of expected demand for care and of how that demand can be met with a sufficient number of trained and appropriately skilled staff. However, it is also about supporting, developing and valuing those staff to increase recruitment and retention, maximise productivity and provide the best quality care.

Opening the discussion, a representative from Health Education England gave an overview of the modelling they had undertaken; projections were based on:

- extrapolations of OBR and IFS projections of demand to 2030 and accounting for key drivers including demographic factors, morbidity
- an assumption of 1.7 per cent productivity – the mid-point in a range between standard economic productivity (2.2 per cent) and recent NHS performance
- extrapolation of workforce supply figures from current performance, reflecting the impact of a range of factors where known, and focused on staff employed by the NHS only.

Figure 1 Future demand for staff – beyond 2021/22



Health Education England acknowledges that the assumptions and figures on which this model is based are open to debate, but its value lay in articulating the scale of the challenge and the need for policy interventions to act on both demand and supply.

The question posed by Health Education England was: 'How effective is the model in balancing complexity and presenting sufficient information that makes the case for action, but without engendering a sense of hopelessness in the process?'

Transparency was one of the key issues raised in discussion. Although the strategy focuses on meeting future demand, participants expressed a need for candour about the current pressures that organisations are facing and the impact these pressures are having both on frontline staff and the quality of care.

Transparency is also needed in relation to the model itself; the model could be improved or adapted but the most important thing was to communicate what is going on to those who were involved in or affected by workforce planning. Health Education England's suggestion that it could develop and share some scenarios based on different assumptions was welcomed.

Demand and supply assumptions – developing scenarios

Developing scenarios based on different assumptions was seen as valuable not only in aiding transparency but also in supporting decision-making by highlighting the strengths and weaknesses of different perspectives. Combining this with sensitivity analyses would further help to identify actions that were likely to have the biggest impact and those that may appear attractive but are unlikely to make a difference.

There was broad agreement that projecting future workforce requirements on the basis of what is needed rather than what can be afforded within current spending settlements would be more valuable. That consideration of need also raised questions about the value and priority given to standards of care, targets or what patients might genuinely want, each of which will provide a different picture of workforce requirements.

Discussion also focused on the nature of the health and care system that policy aims to create and particularly on integrated care. Several participants highlighted the interdependencies between health and social care that influence demand and the impact of unpaid care. As one participant noted, people who provide unpaid care to family, relatives and neighbours represent the largest workforce – a 10 per cent reduction in the amount of unpaid care would increase the requirement for formal care by more than 10 per cent, which should be factored in when considering demand. Current projections within the draft strategy have relied entirely on staff employed by the NHS, with associated projections for the social care workforce being undertaken by Skills for Care. In addressing integration, a question was raised of whether there is an ambition to align or integrate projections for different aspects of the workforce and in particular workforces in the NHS and social care.

As well as demand, the discussion also focused on supply – on the roles and skills of the workforce, on how people work and on what makes health and social care an attractive career option.

The NHS workforce makes up more than 10 per cent of the labour market in the UK and is set to grow. So market conditions more generally – eg, rates of employment – will have an impact on projections of health and social care workforce. Current market conditions – low unemployment and high employment – are unusual, distorting future projections. Furthermore, market dynamics often vary according to skill level. Brexit is expected to affect the ability to fill low-skill roles, and if the medical workforce grows significantly this could increase the competition for high-skill roles in the labour market.

An appropriate skill-mix has to be considered in deciding what comprises an effective workforce and how to meet future demand. There was general agreement that the current skill-mix is not optimal and if this is used as the basis for modelling it risks replicating current issues in the future. In many cases, it is not clear what optimal looks like and there remain difficult conversations about whether we should be aiming for optimal or what is acceptable. Underlying that conversation are issues about skill-mix, acuity, complexity and, importantly, risk – for example, where organisations had a high proportion of newly qualified staff, leading to many providing care unsupervised and in turn to those inexperienced staff training other inexperienced staff.

Working patterns and pay also influence workforce supply. Current patterns of working are changing – eg, nurses are retiring much earlier, staff in different age groups want and need different working patterns and flexibility. This has implications for modelling and the relationship between headcount and full-time equivalent numbers, as well as for retention and training costs (per headcount).

The workforce strategy also has the potential to help reshape the workforce. For example, it could reflect support to enable staff to work at the top of their licence and use their skills most effectively; support for continuing professional development, to enable staff to gain new skills and work in new ways and respond to new technology as it emerges; greater flexibility around roles, with the ability to retrain or change professions. Developing a long-term strategy provides a unique opportunity to build in flexibility and support the changes required to meet future workforce needs.

Productivity

Current assumptions about productivity in the NHS were felt to be overly optimistic, and methods to improve productivity in the NHS were more limited than those used in industry. As one participant noted, current efficiency targets are largely being met by cuts rather than true productivity.

At the same time, there was support for a more nuanced understanding of productivity. For example, improved IT and administrative capacity could help to maximise the value of clinical time and different service models could offer opportunities for improvement. In both cases, there would be a need for support and resource implications, including the need to address capital investment.

Opportunities for greater productivity at a systems level were also highlighted – eg, whether staff should spend more time engaging patients and supporting prevention. Programmes such as Getting it Right First Time and NHS RightCare indicated a need to consider long-term productivity rather than just hitting targets. A further consideration at a systems level was relative productivity – eg, the impact of unpaid care on formal care.

Workforce planning

The model outlined in the draft strategy provides a single picture of the workforce across England. However, participants noted the need to recognise the significant geographical and regional variations in NHS workforce supply and the wider labour market that have an impact on the effectiveness of different approaches to addressing workforce supply. An example was given from Manchester where pathways and training support are being developed to support young unemployed people and those with experience of care into the NHS labour market. Increasingly Health Education England is able to generate workforce data at a regional and sustainability and transformation partnership level, but there were questions regarding what data might be valuable, the relevant structures in which this data would be useful, and what capacity there was at a local level to understand and use data to plan effectively.

Workforce planning needs to identify what can be achieved by local, regional and national planning systems. Understanding local variation as well as opportunities to influence variation was highlighted as important. Areas with a large university, for example, may be able to train more professionals, but this would not be the case elsewhere. A framework that local areas could use to support improvements in workforce planning and management by offering suggestions on what to do, where to go, and who to ask might be valuable. At the same time, participants highlighted national policies that contributed to workforce pressures, including limits to recruiting skilled overseas staff as a result of restrictions on visas and potential loss of unskilled workforce, particularly in social care, as a result of Brexit.

The role of the employer

The focus on modelling and national strategy meant that the role of individual organisations was more often implicit than explicit. However, a greater focus on employment practice and specific actions that could be taken to promote the NHS as a good employer were highlighted as important opportunities. A previous policy Improving Working Lives was identified as an example of an output that cost little but gave a welcome signal that the government cared about the workforce. Other

examples shared included an emphasis on organisations being well-managed and well-led as a marker of supporting and managing people well. The question of who leads change within individual organisations, particularly NHS trusts, was raised. It was suggested that in the majority of cases this falls to human resources (HR) directors, who do not necessarily have the time or the skills to implement a workforce productivity improvement strategy such as Getting It Right First Time.

A call to action

It was widely acknowledged that the existing timescale presented considerable limitations on what could be done, challenging the ability to develop a robust and long-term plan. Even so, participants believed that the draft workforce strategy could include more detail, and there was strong support for the idea of providing scenarios to help people understand the relative impact of different factors presented in the strategy and the options available to support workforce planning.

At the same time, while the data continues to improve, participants highlighted the need for caution about the limitations of the data and the assumptions being made. One particular issue is the focus of the strategy on NHS-employed staff. Although workforce projections for social care are being produced in parallel, there are overlaps in data with registered staff in the NHS, and substantial gaps in information about both registered and unregistered staff in private and voluntary sector providers. The importance of engaging with local authorities, public health and other sources of data (eg, NHS Partners) to support a holistic picture of the workforce was highlighted as was the potential for linking data in the medium to long term.

The biggest challenge is to create a single workforce strategy for health and social care. The NHS was described as a nationalised workforce market, with a recognisable block of employers. In contrast, social care was seen as having millions of people competing in a wider labour market with 50 per cent of employees being in small businesses. In addition, there is an even larger unqualified workforce providing care in people's homes; many of these people work part-time, have more than one job and are employed directly by an individual. Different options for what health and social care integration could look like at the workforce level were discussed, ranging from aligning processes to develop a workforce strategy in health with what is known about social care to having a single funding model and one employment contract. The interplay between health and social care being such that if there is not sufficient social care workforce, health will ultimately lose out.

Design features for future strategic workforce planning

The second half of the discussion considered the design of the strategic workforce planning model itself.

The discussion was prefaced by two presentations. The first given by Peter Smith, Emeritus Professor of Health Policy at Imperial College, explored the NHS Advisory Committee on Resource Allocation (ACRA), an alternative model of strategic resource modelling employed in the NHS.

The Advisory Committee on Resource Allocation (ACRA)

ACRA makes recommendations on the relative geographical distribution of resources for health services in England, given the set objectives of the funding formula, to the

- Secretary of State for public health allocations
- Chief Executive of NHS England for NHS allocations.

ACRA, formerly the Resource Allocation Working Party, was established in September 1997.

The formulas developed by ACRA should support equal opportunity of access for equal need and contribute to the reduction in avoidable health inequalities.

Recommendations should be based on the best evidence and be clear when judgements have been made.

www.england.nhs.uk/publication/advisory-committee-on-resource-allocation-acra-terms-of-reference/

The strengths of ACRA are:

- it has a broad membership drawn from NHS England, Department of Health and Social Care, clinical commissioning groups, some providers, other government organisations and academics; it is supported by a strong technical advisory group
- it has clear objectives and supports some clear decisions on resource allocation
- it's a scientific body and tries not to get involved in making judgements; it aims to make recommendations that are independent of spending patterns and any political interest.

It also has some weaknesses:

- there are gaps in expertise, particularly in labour economics
- the technical group does not have a permanent membership; apart from the skills within NHS England, every time there is a new round, a new group has to be commissioned
- it has a major problem with the scope of data that is available, its quality and, increasingly, access to it
- the model reinforces silos for different services whereas in principle it would want to bring these together and have a unified model.

Other countries with similar health systems do not have this type of committee, but those with a preference for a more technical approach to planning aspire to it.

The second presentation considered the ACRA model in relation to previous NHS workforce planning mechanisms and what we could learn from each. Key characteristics of the ACRA model included:

- a well-defined scope
- robust and transparent methodology
- capacity to commission specific pieces of work
- the recommendations do not challenge the overall NHS funding level
- not deciding the pace of change
- making effective use of experts from across the system.

In contrast, previous workforce planning mechanisms such as the Centre for Workforce Intelligence:

- had a loosely defined and changing scope
- used experts from across the system to a variable extent
- had perceived challenges around use of evidence, methodology and transparency
- made recommendations that directly challenged NHS funding assumptions.

In addition, while ACRA and the independent recommendations it makes to government are built into wider systems of NHS governance, the Centre for Workforce Intelligence was not. The differing characteristics of each body may have impacted on their overall success and continued existence.

Drawing reflections from participants, subsequent discussion focused on whether a dedicated body such as ACRA could be valuable in supporting strategic workforce planning, what characteristics it would need to have, and what work was needed to improve the quality of available intelligence.

Balancing technical and political decision-making

Participants recognised that in the workforce planning process there is a need to balance technical and political decision-making, the value of independence in arriving at objective decisions, as well as being able to hold government accountable, and ensuring workforce planning is both robust and sufficiently flexible to meet the requirements of future models of care.

A key value perceived of an independent body was transparency, with data and the assumptions and decisions that are applied being made available. Although transparency offered the potential for challenge, the experience of participants was that the technical nature of the data required a level of expertise to understand it. In practice transparency often precluded contestability as the basis for analyses were overt.

The potential value of an independent workforce planning body that brought people together to discuss and coalesce around a decision was framed by the question of what decisions it would make. If there was a clear remit about what the body would do and what judgements it would make, then it was felt that this could be a valuable decision-making mechanism.

A key component of defining the remit was achieving a balance between technical and political decisions, which in turn would have an impact on the relative value of the decisions and on how long such a body would last – the narrower and more technical the scope, the easier it would be for an independent body to survive and be valued by ministers or decision-makers. However, it was recognised that choices about workforce in the NHS might start as technical choices but very quickly, because they impact on either patients or staff, or because they require resources to be allocated by the government, become political choices.

As one participant noted, this raises some very fundamental issues. Constitutionally, the question about what is the right type of body to make some of these decisions does have a big impact on decisions about how much the government is spending, how much it is borrowing and how much it is raising. Should that be done by a democratic process or by a technical process?

The complexity of workforce planning may require more than one body or solution, but in each case, having clarity about what decisions they are informing, and who will be held accountable was highlighted as important.

Starting points for future modelling

One of the key features of discussion on future modelling was that there were different starting points, which in turn influence information required to support decision-making. One question was how far workforce planning is a technical task or a strategic task based on understanding the workforce market. An observation from the room was that only the medical and dental workforce was tightly managed; the levers have changed for the non-medical workforce, and the rest was subject to the market.

Alongside this was a question of whether we should continue to plan for a precise number of NHS staff or to plan for a supply-side market – ie, to make it likely that the NHS will be able to find the staff it needs. As one participant noted, planning for a supply-side market may mean that not everyone who is trained can be employed and may change the relationship between the government and the workforce – for example, whether individuals should share the cost of training in return for guaranteed employment.

As in earlier discussions, the tensions between workforce planning and funding arose as an issue. Current approaches to planning had largely focused on making the workforce affordable within allocated funding. Without raising fundamental questions about the funding model itself, future models provided the opportunity to develop scenarios to explore how the workforce could meet future demand at different funding levels or indeed how funding could be distributed.

Similarly, productivity within the current approach was described as considering how much care can be achieved with a given sum of money and designing a workforce around that. Alternative models of productivity may consider how much care could be provided for a given number of people, prompting decisions on how much care can we provide within a given workforce. This could be valuable in understanding what it is realistic for the workforce to achieve and in supporting a

policy conversation with the public on this. The rest of the demand-side modelling would flow from this choice, representing a fundamental shift in approach.

Developing data to support modelling

One of the keystones of the ACRA model is the requirement for good data. Participants acknowledged that data used for modelling workforce in the present is not suitable for modelling into the future. It was suggested that basing future modelling on trends rather than current predictions might be better. Another consideration is that we often base workforce predictions on average policies and average efficiency rather than on an optimal position so any future progress and productivity gains need to be factored in. Using demand as the basis of a workforce model was described as particularly challenging and was one area where an expert group could help to identify suitable starting points. Supply-side modelling was less challenging, but as with ACRA the advice was to start small, building up understanding and intelligence.

Perhaps most important were those contributions that focused on what a workforce strategy is trying to achieve. As one participant noted, it's hard to model a workforce based on demand when you don't know what the future service model is. This is where the discussion returns full circle, with sensitivity analysis highlighted as offering an opportunity to start small, exploring scale and scope at a high level, and then supporting policies that create the environment you want.

The world of health care is inherently uncertain. Advanced practice and extended skills are already developing faster than workforce planning, while training in many areas remains too rigid to accommodate change. In the words of one contributor – beware of creating a more sophisticated way of coming up with the wrong answer because of the nature of the assumptions (and political influence). The important thing is that we need to have a flexible workforce with capacity to change.

The King's Fund is an independent charity working to improve health and 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 health and care is available to all.

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