WORKFORCE PROJECT: INITIAL ANALYSIS OF ISSUES FACING THE PROVIDER SECTOR

September 2017

- Introduction
- Supply and retention
- National level structure and accountability
- Transformation
- Key issues and questions moving forward

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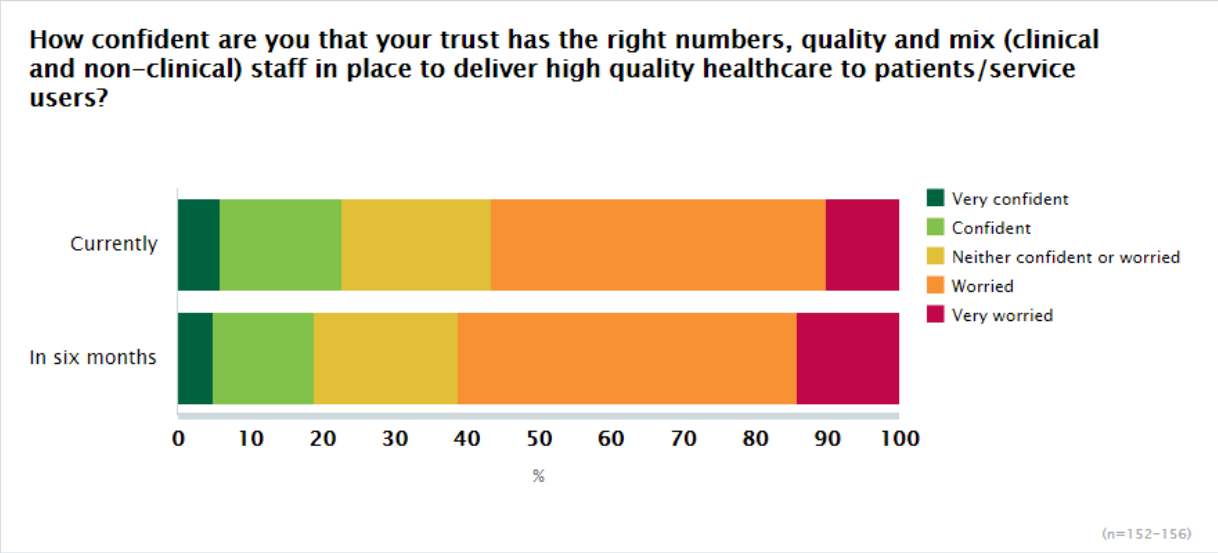
Workforce is now a top concern for trust leaders

57% of trust chairs and CEOs are 'worried' or 'very worried' about their current ability to maintain the right numbers of staff – clinical and non-clinical – to deliver high-quality care. Looking ahead six months, the figure was **61%**.



From: *State of the provider sector,* July 2017, NHS Providers

Workforce is in the news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Health

More than 86,000 NHS posts vacant, says report

By Siretha Mundasad
Health reporter, BBC News

25 July 2017 Health

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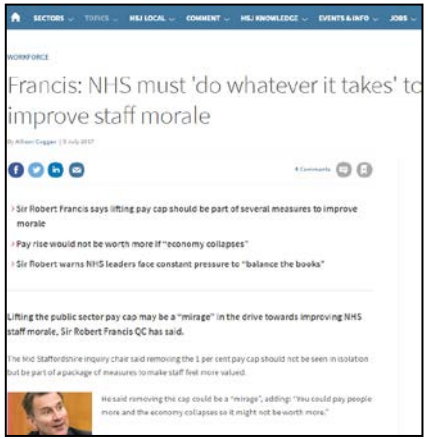
More than 86,000 NHS posts were vacant between January 2017 and March 2017, figures for England suggest.

Statistics from NHS Digital, which collates data, shows the number of vacancies climbed by almost 8,000 compared to the same period in 2016.


SECTORS TOPICS HSJ LOCAL COMMENT HSJ KNOWLEDGE EVENTS & INFO JOBS

WORKFORCE

Francis: NHS must 'do whatever it takes' to improve staff morale

By Alison Goggin | 5 July 2017

4 Comments

- Sir Robert Francis says lifting pay cap should be part of several measures to improve morale
- Pay rise would not be worth more if "economy collapses"
- Sir Robert warns NHS leaders face constant pressure to "balance the books"

Lifting the public sector pay cap may be a "mirage" in the drive towards improving NHS staff morale, Sir Robert Francis QC has said.

The ex-Staffordshire inquiry chair said removing the 1 per cent pay cap should not be seen in isolation but be part of a package of measures to make staff feel more valued.

He said removing the cap could be a "mirage", adding: "You could pay people more and the economy collapses so it might not be worth more."


Brexit staff exodus 'could plunge the NHS into crisis'

21

An exodus of staff caused by Brexit could cripple the NHS, the head of the Royal College of Nursing has warned.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workforce and training

27.07.17

Exodus of experienced nurses doubles in three years

More warnings about the nursing workforce have been issued today as it was revealed that the number of experienced nurses leaving the profession has doubled in the last three years.


Pressures on NHS are 'toughest I have ever seen', says regulator's chief nurse

One of England's most senior nurses has said the pressures facing the health service, including nurse shortages, are the worst she has ever seen.


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workforce and training

15.08.17

RCN: Not enough nurses in 90% of largest NHS hospitals

More than 90% of England's 50 biggest hospital trusts are not properly staffed and do not have enough nurses to the planned levels, a leading health group has today warned.


NHS 'afraid' to hear safety concerns, warns new chief inspector of hospitals

- NHS "does not have an embedded safety culture", Professor Ted Baker says
- Hospital safety remains CQC's "biggest concern"
- New inspection regime will "test" any disconnect between trusts' self-assessment of quality and findings of inspectors

The NHS is "still afraid of hearing the truth about problems", the Care Quality Commission's next chief inspector of hospitals said yesterday.


NHS bursary reform fails to increase student nurses

- UCAS data shows number of students on a nursing degree is down 8 per cent in 2016
- The number of placed students and those waiting to hear is lower than the total accepted on to courses last year
- Students studying medicine in England up 1 per cent

The government's plan to expand the number of nurse training places by scrapping the NHS bursary appears to have failed, the latest data suggests.

Overview of challenges – supply and retention

- Rapidly rising demand for services, constrained funding, and a set of growing workforce challenges are leading to mounting pressures across all NHS services.

- Having enough staff with the right skills is the number one workforce issue. Generally speaking, the issue is clinical staff, but this is not to say there are no difficulties for other staff.

- The NHS has more clinical staff than ever before, but numbers have not kept pace with rising demand for services and a legitimate focus on improving quality.

- Retention as well as supply of new staff is important, yet it's increasingly difficult to keep staff as the job gets harder and harder. Work-life balance is now the fastest growing reason for staff leaving the NHS, indicating the scale of the discretionary effort staff are putting in to close the demand and funding gap. This is while their real pay continues to fall.

- In terms of clinical staff, there is a particular issue with nursing, some medical specialties, and paramedics.

- There is a continued need for the NHS to recruit from the EU and the rest of the world to mitigate staff shortages, yet the outlook is uncertain in the context of Brexit and tighter immigration policy.

Overview of challenges – leadership and culture

- Effective leadership and culture are fundamental to success in the NHS – nationally, locally and institutionally.

- Staff engagement is impacted by leadership and culture within trusts, and these together, as the Care Quality Commission has recognised, are linked to care quality. The NHS has had a sustained focus on openness and transparency, against the backdrop of the Francis Inquiry and other investigations and recent developments such as freedom to speak up guardians.

- Valuing and developing the NHS' diverse workforce supports inclusive and high quality patient care and is the right thing to do. Trusts leaders need to be supported to foster positive and inclusive cultures and make the most of opportunities provided by national initiatives such as the workforce race equality standard and the upcoming workforce disability equality standard.

- Yet NHS leadership capacity and capability is being stretched thinner and thinner, just at a time when it's most needed, both to maintain and improve current performance and bring about transformation.

- Trusts are finding it more and more difficult to recruit and retain senior leaders. The leadership pipeline needs to be addressed, building on NHS England and NHS Improvement's publication of the national leadership framework "Developing people improving care" last year and the work of the NHS Leadership Academy following its incorporation within Health Education England.

Overview of challenges – national level factors and transformation

- At the national level responsibility and accountability for workforce is fragmented and this makes a credible and coherent approach to support trusts to recruit and retain the staff they need more difficult.

- There has also been a mismatch between the number of staff trusts need to employ and the funds they have been allocated.

- A lack of top level, robust, publically available information on workforce, eg vacancy rates, retention rates, means that it is difficult for there to be a single version of reality for people to debate and plan from.

- There is a significant challenge to transform the workforce to deliver care in new ways and meet the ambitions of sustainability and transformation partnerships (STPs). The workforce is a key enabler of many of the new models of care, but is also seen as a key barrier to change as trusts struggle to have the right number of staff with the right skills.

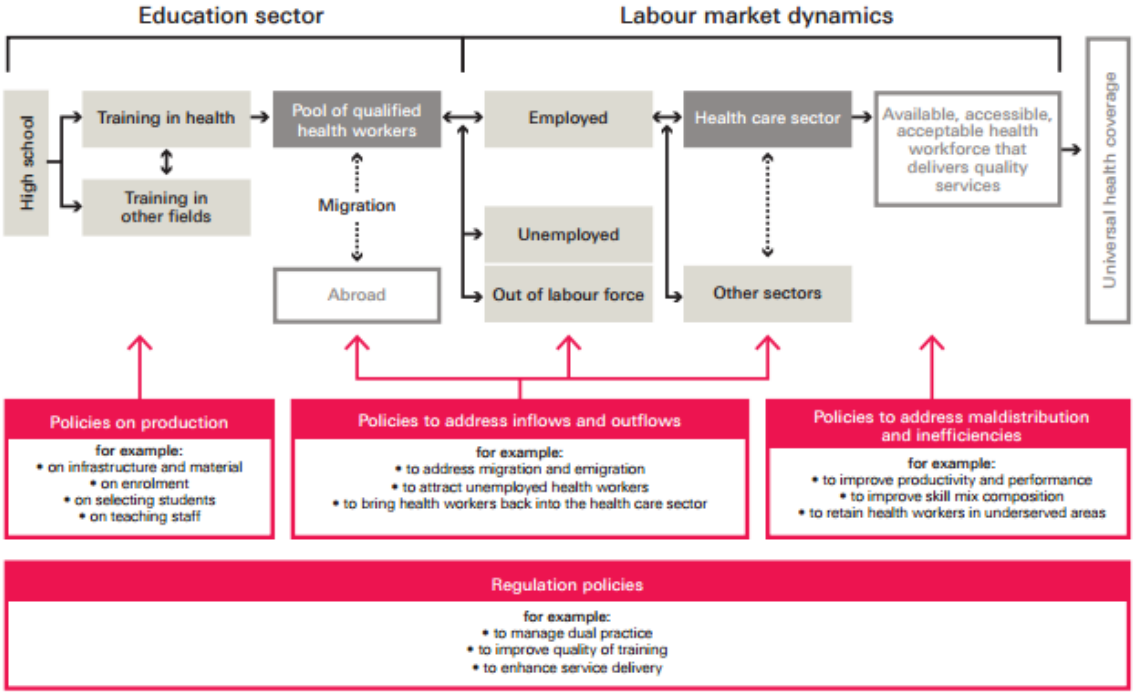
Aims of workforce policy from a provider perspective

What happens when these aims are not achieved?

- Service quality, eg waiting times, may be jeopardised.
- Safety can be at risk leading to the closure of services.
- Trusts can become financially unsustainable as they depend on expensive agency staff.
- Staff morale deteriorates under sustained pressure and burnout can occur.

A joined up approach – using a labour market framework

Figure 1: A Labour market framework for the health care workforce



Source: Adapted from Sousa et al, *Bulletin of the WHO*. 2013

From: *Staffing matters, Funding Counts,* July 2016, Health Foundation

Key elements of strategic workforce policy:

- Production
- Inflows and outflows
- Efficiency and distribution
- Regulation.

- Introduction
- **Supply and retention**
- National level structure and accountability
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- Key issues and questions moving forward

Initial diagnosis – more staff but not enough staff

- Having enough staff is the number one issue. This is where we will focus. Generally speaking, the main issue is clinical staff and there are particular issues with nursing and some medical specialties.

- Any meaningful analysis needs to look further than the “all staff, national” level. There is variation of difficulty and distinct drivers across different clinical staff groups and regions.

- The NHS in England has more clinical staff overall than ever before, but numbers have not kept pace with rising demand for labour intensive services and a focus on safe staffing.

- The pipeline of newly qualified clinical staff has not grown quickly enough. Trusts are also finding it increasingly difficult to retain existing staff as the job gets harder and pay falls in real terms, even as trusts have improved levels of staff engagement.

- When considering whether the NHS has enough clinical staff, what is key is not whether there are more or less staff today than there were 10 years ago, but rather whether or not we have the number of staff we need to meet the level of demand for services and expectations of quality we face today.

Initial diagnosis – Brexit is an aggravating risk

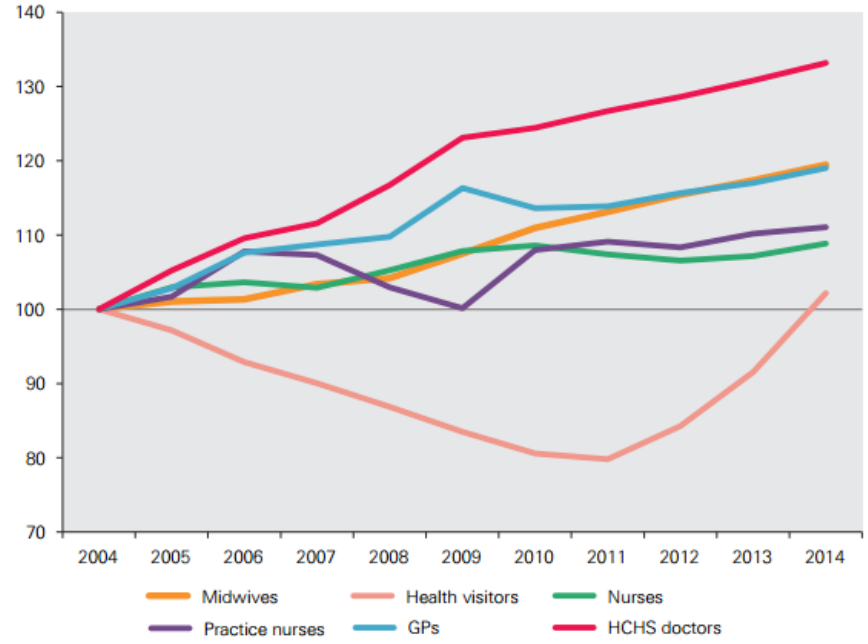
- There aren't enough clinical staff at present, but the position would be even worse if it were not for the NHS' longstanding employment of staff from overseas, notably the EEA and the English speaking world.

- Around 5% (60,000) of staff in the NHS in England are from the EU and around 7% of staff (74,000) are from the rest of the world. The NHS has one of the highest levels of reliance on overseas staff in the OECD. There is regional variation, for example in London around 11% of staff are from the EU, whereas in the North East it is less than 2%.

- Until such a time as the NHS has significantly increased the numbers of clinical staff trained domestically and successfully recruited and retained them within the NHS, then any significant reduction in the number of staff from overseas is likely to have a serious adverse impact on services. For the foreseeable future provider trusts must be supported to recruit and retain staff from overseas.

More clinical staff than ever before, but it doesn't feel like it

Figure H: Change in selected occupations, NHS in England, 2004–14 (FTE)



Note: There were changes to the data collection system between 2006 and 2009 particularly for GPs. Since 2010 the GP data collection process has changed by collecting information at individual practice level rather than at an aggregate PCT level, which makes the figures from 2010 onwards not fully comparable with previous years.

Source: HSCIC. *NHS Workforce Statistics in England, Summary of staff in the NHS - 2004-2014, Overview*

From: *Staffing matters, Funding Counts,* July 2016, Health Foundation

- There are 26k more clinicians working in the NHS than in 2012 (Ian Cumming, HEE at the 2017 NHS Confederation conference).
- But the clinical establishment – the number of funded posts – has gone up by 62k since 2012.
- So we feel like we haven't got enough staff.
- The drivers are growing demand and focus on safety and quality following scandals.

Measuring the gap – nurses and other clinicians

Table 4.4: Current provider expressed shortfall from demand for staff at March 2015

Staff group	England	North	Midlands and East	London and South East	South
Nursing and Midwifery	9.0%	6.7%	8.3%	12.4%	9.9%
Allied Health Professions	6.8%	6.0%	6.0%	9.3%	6.3%
Of which Qualified Ambulance Staff	*7.3%*	*6.3%*	*8.3%*	*9.2%*	*4.7%*
Healthcare scientists	6.1%	5.7%	3.7%	8.6%	6.9%
Other qualified staff	5.9%	5.7%	9.1%	5.4%	2.1%

Source: Health Education England

From: *National Health Service Pay Review Body 30th report: 2017,* March 2017, NHS Pay Review Body

- "Shortfall rate" is full time equivalent (FTE) demand for staff, minus FTE staff in post, divided by FTE demand for staff
- There is considerable regional variation.
- London and the South East has the highest shortfalls across all groups except other qualified staff.

Measuring the gap – medical consultants

Table 6.1: Consultant shortfall by HEE region and specialty

	Scale (Staff in Post)	England	North	East & Mids	London and SE	South
Small Specialties	508	13%	14%	9%	16%	9%
Accident and Emergency	1,509	13%	13%	15%	11%	10%
Acute Take	4,087	10%	12%	14%	8%	6%
Pathology & Lab	1,917	10%	16%	9%	6%	8%
Psychiatry	3,963	8%	13%	7%	3%	9%
Cancer Services	4,724	8%	11%	9%	6%	4%
Ophthalmology (Inc. Medical)	1,026	7%	10%	5%	10%	2%
Other Medicine	4,393	6%	8%	7%	3%	6%
Surgery	7,302	6%	8%	5%	4%	4%
Anaesthetics & ICM	6,533	5%	5%	4%	8%	1%
Obesterics & Gynaecology	2,069	4%	4%	3%	5%	1%
Paediatrics & Paed Cardio	2,977	4%	8%	4%	3%	2%
All	41,557	8%	9%	7%	6%	5%

Source: Health Education England.

Note: The shortfall rates are coloured to draw the eye. A shortfall of 6 per cent or less is coloured green, which is not to say it does not present a problem for providers. It is rather that an element of 'labour market friction' is to be expected as staff leave (for example, retire) and are recruited (from, for example, new CCT holders). Shortfalls of between over 6 and under 10 per cent are coloured amber and those of 10 per cent or more are red.

From: *Review Body on Doctors' and Dentists' Remuneration 45th Report: 2017,* March 2017, Review Body on Doctors' and Dentists' Remuneration

- There is variation by specialty and region.
- A&E notably has shortfalls across England.
- The North struggles more than other regions across several specialties.
- Shortfall rate is not comparable to vacancy rates as trusts may not be trying to fill the gap entirely due to financial constraints or decisions to use temporary staff.

Measuring the gap – junior doctor core and run through fill rates

Table 5.3: Fill rates for Core (CT1) and Run-through (ST1) posts, England

	Fill rate, two year averages 2015 and 2016					
	England	North	E. & Mids.	South	Lon/KSS	London
Clinical Radiology	100%	100%	100%	100%	100%	100%
Ophthalmology	100%	100%	100%	100%	100%	100%
Public Health Medicine	100%	100%	100%	100%	100%	100%
Neurosurgery	100%	100%	100%	100%	100%	100%
Cardiothoracic surgery	100%	100%	100%	100%	N/A	N/A
Oral and Maxillo-facial Surgery	100%	100%	N/A	100%	N/A	N/A
Community Sexual and Reproductive Health	100%	100%	100%	100%	100%	100%
ACCS Anaesthetics/Core Anaesthetics	100%	100%	100%	99%	100%	100%
Obstetrics and Gynaecology	100%	99%	99%	100%	100%	100%
Histopathology	99%	98%	100%	100%	100%	100%
Core Surgical Training	99%	99%	99%	100%	100%	99%
Acute Care Common Stem - Emergency Medicine	99%	97%	100%	98%	100%	98%
ACCS Acute Medicine/Core Medical Training	97%	92%	98%	98%	100%	100%
Paediatrics	95%	88%	94%	100%	99%	100%
General Practice	83%	70%	78%	91%	99%	99%
Core Psychiatry Training	79%	66%	73%	78%	99%	100%
All recruited at CT/ST1	90%	83%	88%	94%	99%	100%

Source: Health Education England.

From: *Review Body on Doctors' and Dentists' Remuneration 45th Report: 2017,* March 2017, Review Body on Doctors' and Dentists' Remuneration

- "Fill rate" is the proportion of available training posts filled.
- There is variation by specialty and region.
- The lowest average fill rates were for core psychiatry and general practice.
- London was able to fill almost all of its posts, while the North and East and Midlands had more difficulty.

Measuring the gap – junior doctor higher training fill rates

Table 5.4: Fill rates for 'higher' level posts, England

	Fill rate, two year averages 2015 and 2016					
	England	North	E. & Mids.	South	Lon/KSS	London
Anaesthetics	93%	83%	90%	98%	100%	100%
Surgery	98%	96%	98%	98%	100%	100%
Cancer Related	90%	82%	85%	95%	97%	97%
Acute Take	88%	90%	84%	82%	94%	96%
Intensive Care Medicine	88%	77%	92%	95%	97%	100%
Pathology	66%	55%	63%	63%	83%	85%
Psychiatry	58%	52%	48%	49%	79%	79%
Gastroenterology	99%	98%	100%	96%	100%	100%
Geriatric Medicine	93%	97%	87%	89%	96%	95%
Respiratory Medicine	87%	90%	78%	87%	100%	100%
Acute Internal Medicine	70%	75%	69%	61%	76%	84%
All	81%	76%	76%	82%	90%	91%

Source: Health Education England.

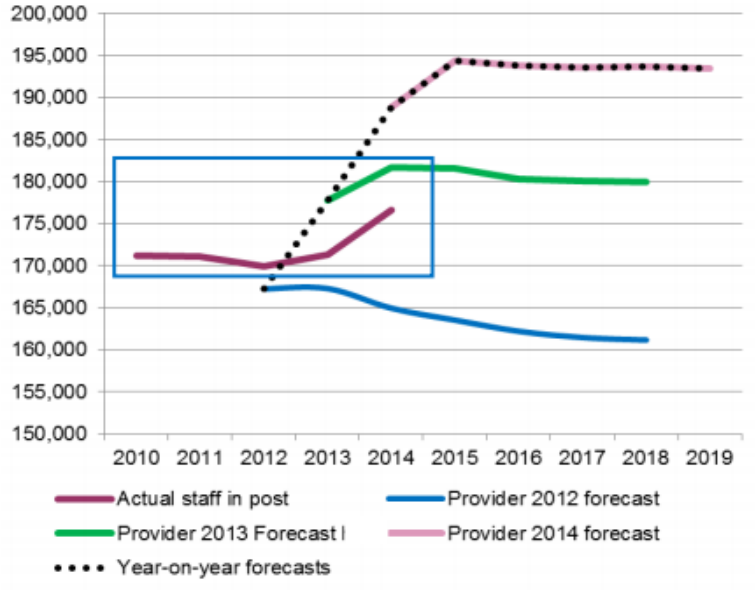
Note: Only doctors who have completed core or common stem training or can demonstrate equivalence can apply to these posts.

From: *Review Body on Doctors' and Dentists' Remuneration 45th Report: 2017,* March 2017, Review Body on Doctors' and Dentists' Remuneration

- There is variation by specialty and region.
- Psychiatry has the lowest fill rate again at 58%.
- The North and East and Midlands tend to struggle to fill posts more than London and the South.
- The average fill rate across all specialties is notably lower for higher training, 81%, than for core and run through, 90%.

Nursing gap – demand went up following Mid-Staffs…

Figure 2: Numbers employed and forecast demand for adult nurses (FTE) working in the acute sector



Source: HEE

- In 2014, trusts reported to HEE that they needed 189,000 adult nurses (acute) in total.
- Two years earlier in 2012 trusts had predicted they would need only 165,000; in 2013, this had risen to over 180,000.
- The Mid-Staffs public inquiry report was published in early 2013. Safe staffing was a big factor in increased demand for nurses. Growing admissions and acuity were also factors.

From: *Evidence from NHS Improvement on clinical staff shortages: A workforce analysis* , February 2017, NHS Improvement

… just as the number of newly qualified nurses fell…

Nursing Commissions 2010 to 2016:

	SHA Commissioning				HEE Workforce Plans		
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Adult	13628	11930	11416	12134	13228	14160	14417
Children's	2095	2045	2159	2151	2182	2343	2343
Learning Difficulty	681	599	606	628	653	664	638
Mental Health	3500	3253	3083	3096	3143	3243	3343
Total Nursing Commissions	**19904**	**17827**	**17264**	**18009**	**19206**	**20410**	**20741**
Yearly Increase					*1197*	*1204*	*331*
Cumulative increase					*1197*	*2401*	*2732*

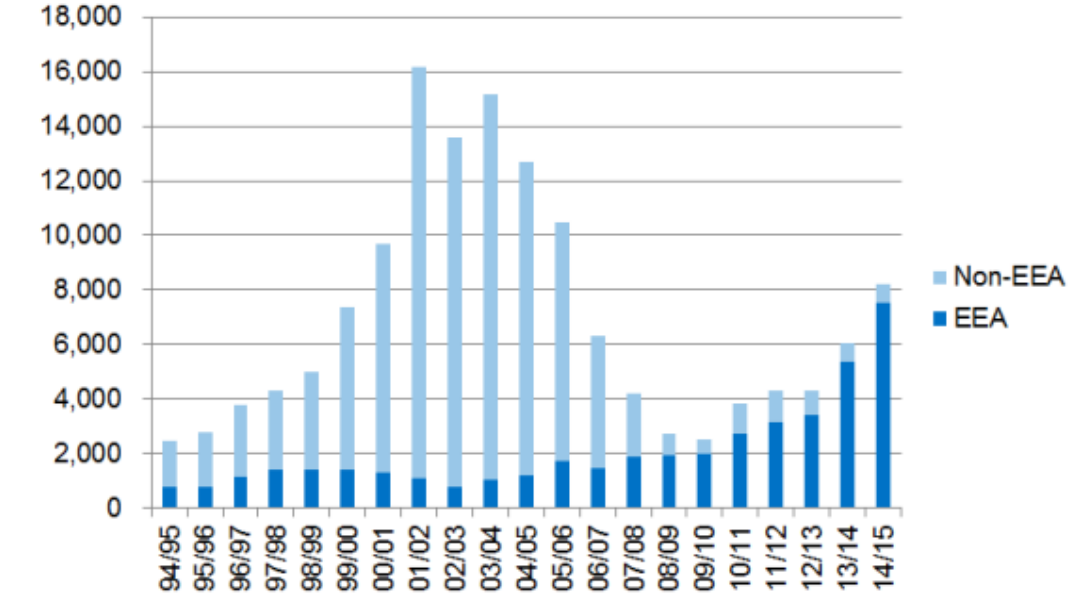
From: *Evidence from NHS Improvement on clinical staff shortages: A workforce analysis ,* February 2017, NHS Improvement

- Under the SHA commissioning system nursing commissions fell in the two years after 2010/11. While trusts have had difficulty forecasting demand for staff, this also reflects national level decisions linked to funding.

- From 2014 the number of nursing students graduating (from the three year course) was reducing, just when demand from trusts had gone up.

… and trusts were unable to recruit from overseas at past levels

Figure 3: New registrations on the Nursing and Midwifery Council register according to EEA and non-EEA origin



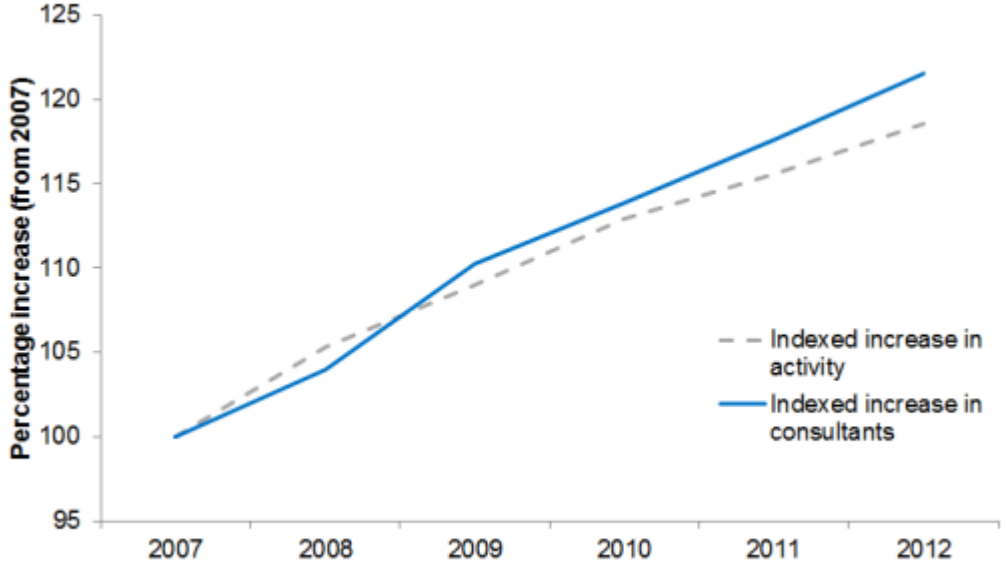
Source: RCN (2015) *International recruitment 2015*

- In the early 2000s trusts had recruited many non-EEA nurses to plug a gap between demand and supply.
- This was no longer an option to same extent due to immigration policy and language tests and although EEA nurse recruitment increased it was not enough to plug the gap.
- By April 2014 HEE reported the national nursing vacancy rate was 6.5% (15,489 FTE).

From: *Evidence from NHS Improvement on clinical staff shortages: A workforce analysis* , February 2017, NHS Improvement

Medical consultant gap – a less well understood picture

Figure 7: Comparison of increases in consultant numbers and activity



Source: Electronic Staffing Record; Centre for Health Economics, York 2007 to 2012.

From: *Evidence from NHS Improvement on clinical staff shortages: A workforce analysis* , February 2017, NHS Improvement

- The number of consultants has grown faster than consultant activity.
- Yet some specialties still have shortages.
- Possible explanations include:
  - Changes in demand due to changes in staff demographics
  - Quality standards driving demand
  - Doctors seeing some specialties as less attractive than others, eg psychiatry and general practice.

Leaving rates are up, but why…

Table 4.2: Leaving rates from the NHS by staff group and country, 2010 to 2016

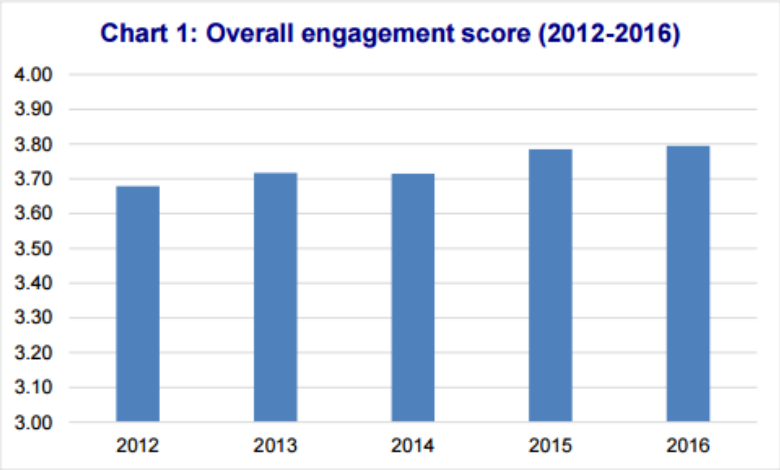
	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
England						
All NHS non-medical	**9.9%**	**11.4%**	**10.3%**	**11.7%**	**10.7%**	**10.9%**
Nurses & health visitors	8.6%	10.1%	9.7%	9.5%	10.1%	10.4%
Midwives	7.4%	8.0%	8.3%	8.7%	9.5%	10.0%
Ambulance staff	4.8%	5.0%	6.0%	6.8%	7.4%	7.6%
Scientific, therapeutic & technical staff	9.3%	11.2%	10.7%	10.3%	11.1%	11.2%
Support to clinical staff	10.6%	12.3%	10.6%	10.5%	11.1%	11.2%
NHS infrastructure support	11.7%	13.0%	11.4%	19.5%	11.3%	11.4%

Source: NHS Digital;

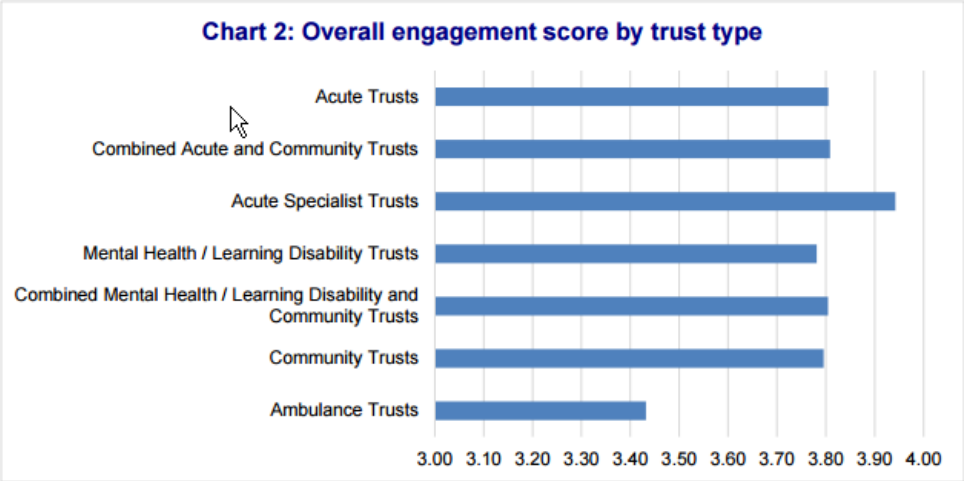
From: *National Health Service Pay Review Body 30th report: 2017,* March 2017, NHS Pay Review Body

- Nurses, midwives, ambulance staff, and scientific, therapeutic, and technical staff have seen notable increases in leaver rates since 2010-11.
- The data includes staff moving between different NHS trusts as well as those who leave the NHS altogether.

Retention and staff engagement…



- Overall engagement score continues to improve. Much of the movement driven by "involvement" indicators, reflecting efforts made by trusts. There is still much to do, notably for black and minority ethnic staff.



- Variation across trust sectors, with ambulance trusts facing the most difficulty (although they are moving in the right direction).

Both from: *Briefing note: issues highlighted by the 2016 NHS staff survey in England,* March 2017, Picker Institute Europe.

… and leadership and culture

- Staff engagement is impacted by leadership and culture within trusts, and these together, as the Care Quality Commission has highlighted, are linked to care quality.

"Many hospitals have told us that staff recruitment is one of their most difficult challenges; this often leads to too much reliance on temporary and agency staff. While many factors influence recruitment, for many of these same trusts staff report high levels of work-related stress, bullying and discrimination, which are either not recognised or not sufficiently addressed by the trust. This can vary between hospitals and departments within a trust, but we have found that the NHS staff survey is one of the most reliable predictors of the effectiveness of NHS trusts' leadership and of the quality of care they provide for patients." (From: *The state of care in NHS acute* hospitals, page 9, May 2017, Care Quality Commission.)

Surveys over the past 18 months suggest that the mean tenure of an NHS provider chief executive is just three years, and possibly less (NHS Providers 2016; Barnes 2015; Health Service Journal 2015; Janjua 2014). Significant numbers of chief executive posts are vacant or are currently filled by interims. There is a view that it is becoming more difficult to recruit directors – whether clinical, financial or operational – and in turn that it is becoming more difficult to persuade people to step up from director posts to become chief executives. (From: *The chief executive's tale, page 6,* May 2017, The King's Fund and NHS Providers.)

- Yet it's becoming more difficult for trusts to recruit and retain senior leaders, further stretching leadership capacity and capability at a time when it's most needed. This needs to be addressed.

Retention and work pressure

- The Nursing and Midwifery Council survey nurses who left its register between June 2016 and May 2017 to ask about why they left.
- Among those nurses who did not leave the register due to retirement, the top three reasons given were:
  - Working conditions, for example staffing levels, workload (44%)
  - A change in personal circumstances, for example, ill-health, childcare responsibilities (28%)
  - Disillusionment with the quality of care provided to patients (27%).

Figure 4.3

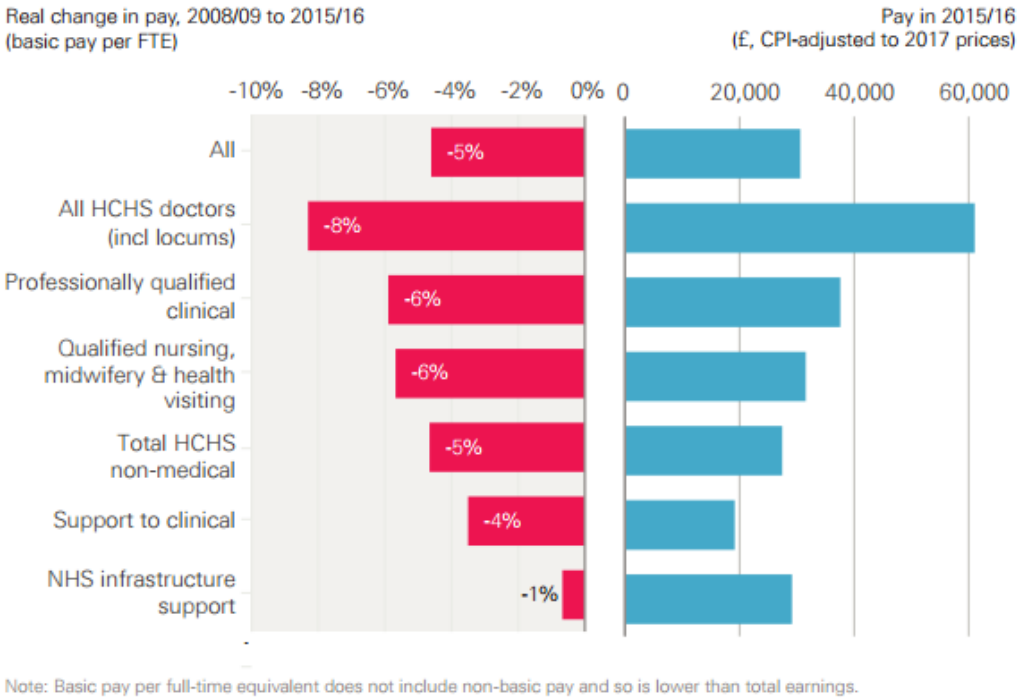
Feedback from the staff survey in 2016 reflects the pressure on staff and their continued commitment.

70%	staff working extra hours
47%	staff disagreed that there are enough staff at their organisation for them to do their job properly
37%	staff feeling unwell due to work related stress in the last 12 months
28%	staff experiencing harassment, bullying or abuse from patients, relatives and the public in the last 12 months

From: The *state of the NHS provider sector,* July 2017, NHS Providers.

Retention and pay restraint

Figure 4: Real change in basic pay per full-time equivalent by staff group, 2008/09–2015/16



Note: Basic pay per full-time equivalent does not include non-basic pay and so is lower than total earnings.

From: *In short supply: pay policy and nurse numbers,* April 2017, Health Foundation.

- "It is clear that current public sector pay policy is coming under stress. There are significant supply shortages in a number of staff groups and geographical areas. There are widespread concerns about recruitment, retention and motivation that are shared by employers and staff side alike. Inflation is set to increase during 2017 compared to what was forecast leading to bigger cuts in real pay for staff than were anticipated in 2015, when current public sector pay policy was announced by the new UK Government… **Our judgement is that we are approaching the point when the current pay policy will require some modification**, and greater flexibility within the NHS." From: *NHS Pay Review Body 2017 report*

Retention and retirements

- Some parts of the NHS workforce – particularly qualified nursing staff, nursing support staff and GPs – have an ageing profile, which raises concern about a “retirement bulge”.
- For example, one in five GPs is aged 55 or older and almost one in three qualified nurses, midwives and health visitors is aged 50 or older
- In comparison, other groups such as allied health professionals and hospital doctors have a younger profile, which suggests a less immediate policy concern about overall retirement patterns and reflects relatively large recent intakes to the profession.
- For example, OECD data highlight that the UK has the lowest proportion of hospital doctors aged 55 or older of any OECD country –13%, compared with an OECD average of 33%.

Retention and working generation types

Chart 1: An overview of the working generations

Characteristics	Maturists (pre-1945)	Baby Boomers (1945-1960)	Generation X (1961-1980)	Generation Y (1981-1995)	Generation Z (Born after 1995)
Formative experiences	Second World War Rationing Fixed-gender roles Rock 'n' Roll Nuclear families Defined gender roles — particularly for women	Cold War Post-War boom "Swinging Sixties" Apollo Moon landings Youth culture Woodstock Family-orientated Rise of the teenager	End of Cold War Fall of Berlin Wall Reagan / Gorbachev Thatcherism Live Aid Introduction of first PC Early mobile technology Latch-key kids; rising levels of divorce	9/11 terrorist attacks PlayStation Social media Invasion of Iraq Reality TV Google Earth Glastonbury	Economic downturn Global warming Global focus Mobile devices Energy crisis Arab Spring Produce own media Cloud computing Wiki-leaks
Percentage in U.K. workforce*	3%	33%	35%	29%	Currently employed in either part-time jobs or new apprenticeships
Aspiration	Home ownership	Job security	Work-life balance	Freedom and flexibility	Security and stability
Attitude toward technology	Largely disengaged	Early information technology (IT) adaptors	Digital Immigrants	Digital Natives	"Technoholics" – entirely dependent on IT; limited grasp of alternatives
Attitude toward career	Jobs are for life	Organisational — careers are defined by employers	Early "portfolio" careers — loyal to profession, not necessarily to employer	Digital entrepreneurs — work "with" organisations not "for"	Career multitaskers — will move seamlessly between organisations and "pop-up" businesses
Signature product	Automobile	Television	Personal Computer	Tablet/Smart Phone	Google glass, graphene, nano-computing, 3-D printing, driverless cars
Communication media	Formal letter	Telephone	E-mail and text message	Text or social media	Hand-held (or integrated into clothing) communication devices
Communication preference	Face-to-face	Face-to-face ideally, but telephone or e-mail if required	Text messaging or e-mail	Online and mobile (text messaging)	Facetime
Preference when making financial decisions	Face-to-face meetings	Face-to-face ideally, but increasingly will go online	Online — would prefer face-to-face if time permitting	Face-to-face	Solutions will be digitally crowd-sourced

*Percentages are approximate at the time of publication.

From: *Talking about my Generation: exploring the benefits engagement challenge,* September 2013, Barclays.

- Generations X and Y aspire to work-life balance and flexibility.
- More staff are choosing to work fewer hours and some of this seems to be generational. HEE thinks this trend will continue and grow and the NHS needs to adapt.
- GP participation rate has recently moved from 0.9 to 0.83.

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- **National level structure and accountability**
- Transformation
- Key issues and questions moving forward

Initial diagnosis – national workforce policy lacks coherence

- For too long, national strategic workforce policy decisions on how many staff to train and about issues that affect trusts' ability to recruit and retain staff, eg pay awards, immigration policy etc, have lacked coherence, reflecting the fragmentation of responsibilities and accountability for workforce.

- These decisions have too often also been swayed by unacknowledged funding considerations and this lack of transparency has resulted in a lack of credibility.

- The Ministerial workforce board and arms length bodies CEOs forum are potential spaces to allow coordination and a credible and coherent strategic approach to workforce policy. But there is no transparency and trusts have no confidence that they will receive the national level support they need, despite targeted national programmes on reducing agency spend and improving retention, and in respect of the mental health workforce.

- If demand for services continues to grow year on year, and in the absence of breakthroughs that allow provider trusts to deliver services with significantly fewer staff, then we should expect that the NHS in England will continue to need a growing number of clinical staff and funding will need to be made available to train and employ these staff.

National level fragmentation of responsibilities & accountabilities

Ministerial workforce board and Arms length bodies CEO forum to provide coordination

Health Education England ("ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place")

Department of Health (overall approach, national pay awards)

NHS Improvement (culture and leadership, reducing agency spend, safe staffing)

NHS Employers (negotiations with unions on national terms, representing employers on workforce policy, practical support for employers)

NHS England (NHS Staff survey, staff wellbeing, workforce equality standards)

Examples of tensions in workforce policy at the national level

- Number of education and training commissions for which funding is available vs number needed to meet demand for staff from trusts and, more recently, a lack of a timely plan to support the introduction of student loans for healthcare students.
- Immigration policy making it more difficult to recruit from outside the EEA (and possibly now from within the EEA) vs trusts wanting to recruit from overseas to fill nursing and other vacancies.
- Language requirements for NMC registration acting as a barrier to overseas nurses who trusts consider appointable
- Commitment to public sector pay restraint vs indications of growing impact on recruitment and retention.
- Pursuing initiatives like seven day services without fully working through workforce implications.

The role of Health Education England

- Not a single nurse commissioned by HEE has yet graduated. First cohort will graduate this year.
- Workforce planning for the NHS is a complicated and difficult job. Also changing with introduction of student loans.
- Does not target junior doctor numbers, only consultants, whereas trusts in practice rely on junior doctors to deliver services alongside their training.
- Does not look at independent healthcare or social care and demand for staff from these sectors.
- Perception not always open with data and how reaches decisions, eg funding constraints. This compounds a lack of data available publically on a timely basis, eg on vacancy rates, retention.
- Lacks the confidence of many trusts and a sense of urgency, eg 2017/18 workforce plan still not published.

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Initial diagnosis – need to support transformation

- While STPs and new care models are intended to deliver reduction in demand for some services, eg A&E, and efficiency savings, through delivering care in new ways, they can only succeed if the current workforce are equipped to work in new ways and sufficient staff with the right skills are trained.

- The Forward View update acknowledged that the NHS in England will need to continue to grow its front line workforce. At the same time, today's workforce is to a large extent tomorrow's workforce.

- In response to current workforce challenges, trusts are innovating at the local level, eg redesigning the workforce to deliver services in new ways, embracing new roles such as nursing associates and advanced care practitioners, upskilling existing staff

- The NHS will also need to respond to developments in artificial intelligence and automation.

- Trusts report mixed experiences of how effectively local workforce action boards (LWABs) are meeting their purpose of supporting and progressing collective delivery of the workforce agenda.

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Recap of key themes

- Having enough staff is the number one issue. Generally speaking, the issue is clinical staff.
- The NHS has more clinical staff than ever before, but numbers have not kept pace with rising demand for services and quality drives.
- Retention as well as supply of new staff is important.
- There is a particular issue with nursing, some medical specialties, and paramedics.
- Any meaningful analysis needs to look beyond the “all staff, national” level.
- There is variation of difficulty and distinct drivers across different staff groups and regions and between individual trusts.
- At the national level responsibility and accountability for workforce is fragmented and this makes a credible and coherent approach to support trusts to recruit and retain the staff they need more difficult
- A lack of robust, publically available information on workforce means that it is difficult for there to be a single version of reality for people to debate from.

Key workforce challenges and opportunities to be addressed

Workforce planning

- Matching supply and demand of staff in context of:
  - changes to funding of healthcare education, medical student growth
  - renewed focus on apprentices
  - retirement bulge for some staff like nursing and nursing support
  - Brexit
- Matching numbers of staff to the NHS financial envelope
- Workforce redesign, new roles, and upskilling existing staff

Pay, contracts, and staff experience

- Pay restraint and competitiveness vs other sectors
- Contract reform for doctors and other staff
- Staff experience: engagement and wellbeing, equality standards

Structure and accountability

- Need for a sense of direction from the ALBs and Department
- Ending unhelpful fragmentation of responsibility for workforce policy
- Improving timely availability of workforce data, eg vacancies, retention
- Getting the national / local relationship right eg junior doctor contract

Key questions that need to be answered

- How will the national bodies work together to adopt a coherent and credible workforce strategy, setting out what will be done, by who, and by when, to support trusts to get on with recruiting and retaining the staff they need?
- How will greater transparency be achieved about demand and supply forecasts for staff and how decisions on how many staff to train are taken?
- How will data, eg on vacancies and retention rates, be made publically available in a timely manner to inform workforce policy debate?
- When will the right to remain for EU staff working in the NHS be confirmed?
- How will government immigration policy and professional regulatory requirements support trusts to recruit staff from overseas to fill domestic gaps?
- How will the fundamental mismatch between what the NHS is being asked to do and the resources it has been given, which is placing greater and greater pressure on staff, be addressed?
- How and when will pay restraint come to an end?

Issues we've not focused on in detail here but are important

- Support and infrastructure staff (non-clinical staff)
- Board level leadership capacity and capability