Agenda Item 13

Enclosure 7

Paper ETC 23/02

Education and Training Committee

THE REPORT OF THE DoH's REVIEW OF WORKFORCE INFORMATION NEEDS

From DoH via the Secretary

FOR INFORMATION

Executive Summary

The DoH report is a public but not published document. DoH is, however, happy to share it with ETC.

It puts the education and training work at DoH into the context of workforce planning policy. The information presented here is also consistent with the background data used by Health work UK (the National Training Organisation) to inform policy development in its area.

REVIEW OF WORKFORCE INFORMATION NEEDS

EIGHTH DRAFT

EXECUTIVE SUMMARY

Background. This Review of Workforce Information Needs was undertaken following a recommendation in the earlier review of workforce development "A Health Service of All the Talents". This suggested far-reaching changes in the processes and planning systems for workforce development. It recommended that, once agreement had been reached on these new processes and systems, there should be a comprehensive review of existing information about the workforce in order to develop a robust dataset to support the new arrangements.

Scope of Review. The review covers the information required to support all aspects of workforce development:

- workforce planning;
- planning and commissioning education, training and development;
- professional regulation;
- new ways of working and changes in skills and skill mix;
- recruitment, retention and return;
- changes in employment practices such as greater diversity in recruitment, more emphasis on equal opportunities or more flexible career paths.

Although concentrating on the NHS, the review has ranged more widely. In workforce development, it is not possible to isolate the NHS or to ignore the UK dimension. For example, NHS-based Workforce Development Confederations plan the workforce for the whole health care sector and, insofar as health professionals are employed in other sectors, such as social care, for those other sectors also. Professional regulation covers practitioners regardless of their employment setting. People move into and out of the NHS and around the UK. The review has examined data from a number of sources in addition to NHS data. These include:

- further and higher education;
- professional regulatory bodies;
- labour market information;
- data from the independent and voluntary sectors;
- data from sectors other than health care where health professionals are employed.

Responsibilities and Functions Supported by Workforce Information. The review took as its starting point the responsibilities and functions of

Workforce Development Confederations and Postgraduate Deaneries and looked at the information required to support these. The main types of information required include:

- personal information (anonymised) about current staff, inside and outside the NHS – such as age, gender, length of service, qualifications and skills, employer (or self-employment/contractor status), occupation code, care area, etc.;
- information on joiners and leavers (origin of joiners, destination on and reasons for leaving);
- vacancy rates;
- information on the pool of non-working professional staff;
- local and national labour market information;
- employers' future staffing requirements;
- database of available education and training programmes;
- data on students and trainees;
- database of practice placements;
- information for financial monitoring and management;
- qualitative information on changing ways of working, likely future trends and the impact of technology;
- information related to educational quality assurance;
- wherever possible, benchmark/comparator information.

Current Situation. There are a number of deficiencies in the current availability of information. The main problems are:

- lack of connectivity between the three main datasets – the NHS national censuses; workforce information collected by confederations and deaneries from employers; and regulatory body data;
- difficulty of accessing data. The census data is available only in aggregated form; there are said to be difficulties accessing regulatory body data; information held by the Higher Education Statistics Agency is little known or used in the NHS. But the main problem is that the sheer variety of data sources makes it difficult for confederations or deaneries to access properly – there is a consistent call for, so far as possible, a single point of access to information;
- poor information from non-NHS employers/self-employment/the contractor professions;
- lack of agreed frameworks for describing skills and competencies;
- poor supporting information for decision-making on education, training and development (see the recent Audit Commission and National Audit Office reports);
- lack of technical modelling skills in workforce planning.

Structure of Future Workforce Information Requirements. The review concludes that future information requirements should be structured around such major themes as patient safety, quality, risk management, lifelong learning, equal opportunities and diversity, and partnership working, rather

than be confined to the needs of conventional workforce planning and education commissioning.

At the heart of the vision of future information needs is an **electronic staff record** (ESR), which should in part be realised through the new NHS human resources/payroll system. This would have the following key characteristics:

- there would be "shared ownership" between employers and staff of the information in the record, with the possibility of Smartcard technology access. Those who are not employed or are self-employed would maintain the record themselves;
- the record would follow the individual from employment to employment;
- it would be based on a unique identifier;
- there should be full coverage of directly employed NHS staff; the contractor professions (and their employed staff); and, for regulated professional staff, those working in the non-NHS sector or outside health care;
- it would contain all relevant information for workforce planning and equal opportunities and diversity monitoring;
- it would contain a learning portfolio, preferably based on occupational standards, serving multiple purposes:
    - (i) for employers, a basis for skills inventories, training needs analyses, checks on registration status, clinical governance and risk management (by ensuring up to date knowledge of staff skills and competencies), checks on locum and agency staff;
    - (ii) for regulatory bodies, to provide information for revalidation/relicensing purposes;
    - (iii) for the individual, to provide evidence for NVQ assessment or HE/FE APL or CATS systems, or as support for employment applications.

There is a pressing need for a **national workforce dataset and dictionary**. This would enable the use of common definitions and terms across the sector.

There needs to be a **national centre of responsibility for future developments in workforce information**. This would be responsible for maintaining national datasets and definitions; providing a framework and control system for ad hoc data requests; maintaining and managing a national list of data sources; and promoting partnerships with non-NHS data providers.

A **major internet portal for "Health Care Workforce Development"** should be developed that can be used by all stakeholders to support the full range of workforce planning and development activity. These include all workforce development confederations and their constituent organisations and the national workforce development structures of Care Group Workforce Teams and Workforce Numbers Advisory Board and it's sub-groups. The portal will support the emerging communication requirements being defined by the Workforce Development Framework group and the national structures as they develop. It should be maintained by the same national centre of

responsibility that will promote the sharing of information. Main functions of the portal would include:

- access to all electronic databases relevant to workforce development (including non-NHS sources);
- guide to other information sources;
- information on workforce development processes, skills and modelling tools;
- research database;
- online newspaper and discussion fora;
- education database;
- contact database.

The Review makes other recommendations about interim action that can be taken to improve the current situation while the major recommendations are considered or acted upon.

The review's summary conclusions are as follows:

1. **Develop an electronic staff record (ESR) to cover all health care staff. As far as possible, this should be sector-wide and UK-wide. see paras 43-45)**

2. **Develop a national workforce dataset and data dictionary. (See paras 46/47)**

3. **Establish responsibility for:**
   - **promoting and managing the information sharing interfaces in the workforce field;**
   - **monitoring the ongoing issues related to the use of workforce information; and**
   - **maintaining national datasets, definitions and dictionaries. (See paras 48/49)**

4. **Develop a single "Health Care Workforce Development" internet portal. (See para 50)**

5. **The workforce information dataset and information required for the ESR should be contained within the national HR/payroll system. (See para 51)**

6. **Improve information sharing between regulatory bodies and the rest of the health care system. (See para 53)**

7. **Improve the accessibility of medical and non-medical census data. (See para 54)**

8. **Develop integrated planning links and databases for Deaneries and WDCs. (See para 55)**

9. **Workforce information needs and requirements should aligned with SAFFs and the general and HR performance management frameworks. (See para 56)**

10. **There should be better access to the internet and NHSNet at all levels. (See para 57)**

11. **A formal agreement should be established with HESA to cover systematic access to information on students, HE staff and other relevant data. (See para 58)**

To: WDC Chief Executives
WDC Directors of Workforce Development
Postgraduate Deans

Copy: RoWIN Workshop/Reference Group members
Planning Framework for Workforce Development Steering Group Members

Date: 19 March 2002

Dear Colleagues

REVIEW OF WORKFORCE INFORMATION NEEDS (RoWIN)

I am writing to inform you of the status of the Review of Workforce Information Needs which was undertaken during spring 2001. A report and recommendations for action were put to ministers during autumn 2001. Attached is a copy of the RoWIN report and an update note setting out action taken since autumn 2001 to take forward the recommendations contained in the report. Will you please note that since the report was produced significant changes to some of the organisations mentioned have been agreed e.g a new Healthcare Sector Skills Council (probably called Skills for Health) will replace Healthwork UK.

As some of you are aware a Steering Group has been established to oversee the taking forward of the recommendations and its membership is at annex 1. The Steering Group has recently recommended that WDCs be consulted on the need for a common Workforce Planning tool that will build on the information that will become available through the Electronic Staff Record (ESR) project. The updating note also indicates that we will be forming a separate reference group whose role will be to manage the following initiatives:

- development of Strategic Outline Cases (SOCs) in respect the Healthcare Workforce Development Internet Portal and the Healthcare Sector Electronic Staff Record;
- considering issues around the placement of a national centre responsible for maintaining the WMD and Healthcare Workforce Development Internet Portal;
- to consult WDCs on the need for a common workforce planning tool and help determine what functionality might be required of such a potential workforce planning tool.

In order to ensure consistency and shared thinking of current developments the members of this reference group will be drawn from the existing RoWIN and Planning Framework for Workforce Development (see annex 2) Steering Groups. Although we will be endeavouring to keep this reference group small and focussed we recognise the need for input from a wider range of individuals and organisations. We will therefore seek additional WDC and Deanery input and also seek further nominations to the reference group via the WDC CE group and CoPMED.

I would also like to remind you of the importance to WDCs future information requirements of the development of the ESR, a £350m project which is being taken forward as part of the NHS Shared Services Strategy. As a result WDCs need to be mindful of the functionality which will become available through the ESR and should not be considering making long term IT development commitments which will duplicate this functionality.

I will be issuing a separate note in due course giving greater detail and background to the ESR project.

Yours sincerely

John Cain
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Workforce Development Branch
0113 254 6274
e-mail john.cain@doh.gsi.gov.uk

Annex 1

Membership of Review of Information Needs Steering Group

Name	Post	Organisation
Chair		
Tim Sands	Head of Workforce Development	DH Workforce Development Branch
Deaneries		
Professor Peter Hill	Chair of COPMeD	Northern Deanery
Dr Michael Bannon	Associate Postgraduate Dean	London Deanery
WDC's		
Maggie Deacon	CE, Member of the Workforce Taskforce Group	Kent, East Surrey & Sussex
Denis Gibson	CE Hampshire	Hampshire and Isle of Wight
Trish Knight	Workforce Development Manager	Thames Valley
Terry Smith	Director of Workforce Planning	West Midlands Central
Rachel Charlton	Director of Workforce Development	Greater Manchester
Clare Armour	Director of Workforce Development	Cornwall & Devon
Simon Thompson	Director of Finance	Merseyside and Cheshire
Regional Offices		
Lillian Richardson	Assistant Director of Workforce Development	South East
DH		
Gillian Hyde	Project Manager, Workforce Minimum Dataset	HRD-Workforce Development Branch
Paul Loveland	Acting Branch Head (Medical	HRD- Learning and Personal Development Division
Helen Fields	Acting Branch Head (Nursing and Other Professions)	HRD- Learning and Personal Development Division
Susan Peak	Section Head	Finance Directorate
Claire Armstrong	Care Group Workforce Teams Project Manager	HRD-Workforce Development Branch
John Bates	Head of Medical and Dental Statistics	STATS(Workforce)

Chris Pearson		IPU & Healthwork UK
Mike Wren	Head of Workforce Quantification and Analysis	HRD-Workforce Development Branch
Keith Derbyshire	Economic Advisor	Economic & Operational Research
Jim O'Connell	HR Director, ESR Project	Shared Services Initiative
NHS		
?		
Dentistry		
Jim Stokoe	Chief Statistician	DH Dental Workforce Statistics
Devolved Administrations		
Sue Cromack	Head of Workforce Planning	National Assembly for Wales
Secretariat		
John Cain	Head of Workforce Information Systems	Workforce Information Systems Team
Ian Mallett	Workforce Development Manager	Workforce Information Systems Team
Mary Newsome	Information Systems Policy Officer	Workforce Information Systems Team

Annex 2

Membership of the Planning Framework Steering group

Name	Post	Organisation
WDC's		
Terry Smith	Director of Workforce Development	West Midlands Central
Rachel Charlton	Director of Workforce Development	Greater Manchester
Paul Holmes	Chief Executive	South West London
John Sargent	Chief Executive	Greater Manchester
Catherine Tinston	Chief Executive	Merseyside and Cheshire
Amanda Hulme	Project Manager Workforce Development	Durham and Teeside
Adam Wardle	Chief Executive	North and East Yorkshire & North Lincolnshire
Trish Knight	Director of Workforce Planning and Information	Thames Valley
Deaneries		
Judy Curson	Associate Dean - Medical Workforce Review Team	Wessex Deanery
Shelly Heard	Postgraduate Dean	London Deanery
DH		
Michael Wren	Head of Quantification and Analysis	HRD-Workforce Development Branch
Colin Day	Head of Education Policy, Planning and Development	HRD-Learning and Personal Development Division
John Cain	Head of Workforce Information Systems	HRD- Workforce Development Branch
Jenny Stevenson	Project Manager, Planning Framework for Workforce Development	North and East Yorkshire & North Lincolnshire WDC
Prue Kiddie	Project Manager, Care Group Workforce Team	HRD- Workforce Development Branch
Nigel Zaman	Project Manager, Modernising Workforce Planning	HRD- Workforce Development Branch
Regional Offices		
Joe Furness	Head of Education & Training	Northern & Yorkshire
Glenis Freeman	Assistant Director of Workforce Development	South West

March 2002

What is the Review of Workforce Information Needs (RoWIN) and what is the status of it's recommendations?

Purpose of this document

1) The purpose of this document is threefold:

- To describe the background to why the Review of Workforce Information Needs (RoWIN) was conducted
- To provide an executive summary of it's findings and recommendations.
- To describe the activities that are currently underway in taking forward the RoWIN recommendations.

Background

2) In March 1999 the House of Commons Health Select Committee report into future NHS staffing requirements recommended that there should be a major review of workforce planning in the NHS. As a result a 'Review of Workforce Planning was carried out during autumn 1999. In April 2000 the government published the Review's Report, " A Health Service of all the Talents: Developing the NHS Workforce" which contained the following recommendations:

- *We believe that there should be a single agreed dataset for all clinical staff for use by the new Care Group Workforce Development Boards, by the successor body to SWAG, by the group considering annual requirements for undergraduate training and by Workforce Development Confederations.*

- *We are conscious of the cost to the NHS of collecting information and particularly of changes to information collected. We are also aware that there have been a number of abortive attempts to agree data requirements for workforce planning, the most recent of which has been put on hold by our review. However we believe that change in the workforce information area is vital if the changes we propose are to be effective. We therefore recommend that, once agreement has been reached on the new planning systems which we have proposed, and particularly the care groups, there should be an urgent and comprehensive review of existing workforce information with the aim of developing a robust dataset to support new planning arrangements and making it widely and readily available to all users.*

Review of Workforce Information Needs (RoWIN)

3) The RoWIN exercise was initiated in spring 2001 and consulted with a diverse range of stakeholder: It comprised of:

- A series of Workshops that engaged with major stakeholders (see Annex 1) on the main issues and factors driving the requirements for workforce information.
- A series of interviews conducted with key stakeholders
- A detailed questionnaire distributed to all Workforce Development Confederations and Postgraduate Medical Deaneries.

4) The stakeholders consulted included: medical Postgraduate Deans; Workforce Development Confederations; medical Royal Colleges; Professional Associations/Trade Unions; Regulatory Bodies; Allied Health Professionals (ANPs); NHS Trusts; Health Authorities; Primary Care; Higher Education Bodies; Training Bodies; Independent Sector; Regional Offices; and Social Care.

5) As a result of this series of workshops and consultations a report entitled "a Review of Information Needs" was compiled in Autumn 2001. The executive summary of this report is attached at annex 2, with the recommendations in annex 3.

6) The report and it's main recommendations were submitted to the Minister of State for Health, John Hutton, for consideration with a proposal to establish a steering group to oversee the development of the recommendations. We have received approval to develop the key recommendations more fully via business cases and a Steering Group has been established to oversee this work. We have also been allowed to proceed with developing the Workforce Minimum Dataset and Data Dictionary and a sub-group has been set up to take this forward that reports to the steering group.

RoWIN Steering Group

7) The Steering Group has been established with the remit of overseeing the development of the recommendations made in the report 'A Review of Information Needs'. The group first met in November 2001 and will meet quarterly. Members of the steering group have discussed the recommendations currently being taken forward as follows:

- The Workforce Minimum Dataset and Data Dictionary;
- The Electronic Staff Record (ESR) project previously known as the Integrated HR and Payroll Project;
- The development of a Strategic Outline Case (SOC) for both the Healthcare Workforce Development Internet Portal and the Healthcare Sector Electronic Staff Record.
- The agreement with HESA to enable access to information on health and social care students; HE staff involved in delivering such courses; and other relevant data;
- A reference group to oversee the development of the SOCs and the placement of a national centre of responsible for maintaining the WMD and Internet Portal.

Workforce Minimum Dataset (WMD) Group

8) The WMD group is a sub-group of RoWIN which meets every 4-6 weeks and has been working on the development of the Workforce Minimum Dataset and Data

Dictionary since October 2001.

9) The main purpose of the WMD group is to define a common set of data items and definitions that are required to underpin the new workforce development structures. The output from this strand of work will be a National Workforce Minimum Dataset and Data Dictionary which will be used by all the key players in the workforce development process which includes:

- NHS organisations;
- The WDCs and Deaneries; and
- The national workforce development structures – ie Care Group Workforce Teams, Workforce Numbers Advisory Board, and the National Workforce Development Board.

The workforce minimum dataset will describe the workforce information which will need to be shared between these major stakeholders to make the workforce planning and development process a success.

Also as far as possible the WMD will describe information requirements of social care, and the independent and voluntary sectors.

10) The WMD group has established links with the following projects and related areas of work:

- ESR project;
- Healthwork UK who are developing National Occupational Standards in the healthcare sector;
- The team developing the Knowledge and Skills Framework (KSF) as part of Agenda for Change.

11) The WMD reference group produced it's 'first cut dataset' at the end of February to feed into the ESR project and it's development will continue to produce the National Workforce Minimum Dataset and Data Dictionary. The timetable for this is:

Stage 1 –	draft data standards –	End Feb 02
Stage 2 -	consultation -	To start March 02
Stage 3 -	revise data standards	To start April 02
Stage 4 -	implementation	To start autumn 02, formal collection from April 03.

The RoWIN Steering Group expanded the remit of this work in March to include finance information that will support the WDC business planning process.

A project board is currently being set up to more directly manage this strand of work under the guidance of the RoWIN steering group. The project board will consist of representatives of the lead WDCs of Greater Manchester and Devon & Cornwall, Deaneries, and the Dept of Health.

Higher Education Statistics Agency (HESA)

12) HESA and the Department of Health are negotiating a contract for the exchange of information about all healthcare students studying in the HE sector. HESA and the DH have agreed new codes and fields to contain information relevant to the Departments requirements relating to students. These requirements have already been issued to the HE sector by HESA as an outcome of the student record review process.

Healthcare Workforce Development Internet Portal

13) Work on the development of a Strategic Outline Case (SOC) for the Healthcare Workforce Development Internet Portal will be taken forward in spring 2002. The Northern Deanery in conjunction with the University of Newcastle Faculty of Medicine Computing Centre have begun a pilot project to help establish the feasibility, benefits, and scope of requirements for the portal.

14) This pilot project will establish a working version the internet portal. This prototype will test some of the concepts highlighted in the RoWIN report and also provide some of the "quick win" functionality required of Deaneries and Confederations in the very short term (i.e. within a few months)

15) The prototype functionality will be determined by a reference group that will establish priorities. Early discussions have identified the following areas:

(a) Skills development resources and Planning Framework information
(b) Discussion Board
(c) Current Examples of Practice in Workforce Planning/Development.
(d) Database of Care Group Workforce Team related projects
(e) News Items
(f) Links to other related internet sites
(g) Data sources related to workforce development – e.g. HESA, Census, etc
(h) SAFF Workforce database – quarterly feedback of data.

The development of the internet portal will need to consider other related areas of work such as that of the WDC Communications group.

Electronic Staff Record.

16) The Electronic Staff Record project (formerly known as the Integrated HR & Payroll Project) has received ministerial approval and the consortium led by McKessonHBOC that includes Price Waterhouse Coopers (PWC), IBM and Oracle obtained the authority to proceed with the project in December 2001. This is a significant development costing more than £300m over a 10-year period and amongst many other benefits, will improve the quality, consistency and provision of workforce planning information across the NHS.

17) One of the key priorities of the RoWIN work is to ensure that the development of this ESR will underpin the workforce planning function for NHS Employers, WDCs, Deaneries, and organisations at a national level such as Care Group Workforce Teams, Workforce Numbers Advisory Board, and the National Workforce Development Board.

Areas of activity include:

- Definition of the Workforce Minimum Dataset to be included in the ESR – first draft version of this was made available at the end of February.

- Formation of an ESR/DH interface group to ensure that ongoing issues arising from the RoWIN and RoBIN work are discussed and addressed. RoBIN – the Review of Business Information Needs – is focusing on the DH requirements of the ESR that extend wider than just workforce planning and development. The initial focus of this interface group has been around the ESR reporting strategy.

- ESR Reference Group to ensure direct consultation with WDCs and Deaneries. This group has met once to debate issues around Skills & Competencies.

- ESR Reporting Strategy Workshop – this will be held in April and whose main objective is to define the "supra-employer" reporting requirements (i.e. DH, Strategic Health Authorities, Regional Offices , WDCs, and Deaneries). This will be followed by a Quality Assurance process that will ensure wider consultation and confirmation/refinement of the requirements.

18) WDCs will be consulted on the need for a common Workforce Planning tool which may cover functionality required but not available in the Electronic Staff Record project. Also it will be important that existing software development activities take account of the fact that a national ESR system will become available by early 2005. A reference group will need to help determine what functionality might be required of a potential workforce planning tool.

Health Sector Electronic Staff Record (Working Title)

19) The Electronic Staff Record project whilst being the largest project of it's kind anywhere in the world, still excludes certain categories of staff for which information is required to perform effective workforce planning and development. These staff groups include:

- Independent Contractors – e.g. GMS GPs and directly employed practice staff,
- Social Care
- Independent & Voluntary sector – e.g. Palliative Care Homes (hospices), Nursing Homes, Private Hospitals

Work on the development a SOC for the Health Sector Electronic Staff Record will

start once the main priorities for the existing ESR project have been adequately addressed.

Reference Group for Healthcare Workforce Development Internet Portal and Health Sector Electronic Staff Record

20) A reference group will be formed which will help define the content of the SOC's for the Healthcare Workforce Development Internet Portal and the Health Sector Electronic Staff Record group in the near future. This reference group will comprise mainly representatives of the WDCs and Deaneries with the aim of organising a meeting in mid April.

21) The first priority of the reference group will be to establish the scope and functionality of the Internet Portal.

22) The reference group will also advise on the functions expected of the "centre of responsibility for future developments in workforce information" as described in para 49 of the RoWIN report and the functionality required of any workforce planning tool.

Department of Health
Workforce Development Branch
March 2002

Annex 1

Key Stakeholders involved in the RoWIN process

Medical Postgraduate Deans
Workforce Development Confederations
Medical Royal Colleges
Professional Associations/Trade Unions
Regulatory Bodies
Allied Health Professionals
NHS Trusts
Health Authorities
Primary Care
Higher Education Bodies
Training Bodies
Independent Sector
Regional Offices
Social Care

REVIEW OF WORKFORCE INFORMATION NEEDS Report
(November 2001)

EXECUTIVE SUMMARY

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- personal information (anonymised) about current staff, inside and outside the NHS – such as age, gender, length of service, qualifications and skills, employer (or self-employment/contractor status), occupation code, care area, etc.;
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- vacancy rates;
- information on the pool of non-working professional staff;
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- lack of agreed frameworks for describing skills and competencies;
- poor supporting information for decision-making on education, training and development (see the recent Audit Commission and National Audit Office reports);
- lack of technical modelling skills in workforce planning.

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At the heart of the vision of future information needs is an **electronic staff record** (ESR), which should in part be realised through the new NHS human resources/payroll system. This would have the following key characteristics:

- there would be "shared ownership" between employers and staff of the information in the record, with the possibility of Smartcard technology access. Those who are not employed or are self-employed would maintain the record themselves;
- the record would follow the individual from employment to employment;
- it would be based on a unique identifier;
- there should be full coverage of directly employed NHS staff; the contractor professions (and their employed staff); and, for regulated professional staff, those working in the non-NHS sector or outside health care;
- it would contain all relevant information for workforce planning and equal opportunities and diversity monitoring;
- it would contain a learning portfolio, preferably based on occupational standards, serving multiple purposes:
    (i) for employers, a basis for skills inventories, training needs analyses, checks on registration status, clinical governance and risk management (by ensuring up to date knowledge of staff skills and competencies), checks on locum and agency staff;
    (ii) for regulatory bodies, to provide information for revalidation/relicensing purposes;
    (iii)for the individual, to provide evidence for NVQ assessment or HE/FE APL or CATS systems, or as support for employment applications.

There is a pressing need for a **national workforce dataset and dictionary**. This would enable the use of common definitions and terms across the sector.

There needs to be a **national centre of responsibility for future developments in workforce information**. This would be responsible for maintaining national datasets and definitions; providing a framework and control system for ad hoc data requests; maintaining and managing a national list of data sources; and promoting partnerships with non-NHS data providers.

A **major internet portal for "Health Care Workforce Development"** should be developed that can be used by all stakeholders to support the full range of workforce planning and development activity. These include all workforce development confederations and their constituent organisations and the national workforce development structures of Care Group Workforce Teams and Workforce Numbers Advisory Board and it's sub-groups. The portal will support the emerging communication requirements being defined by the Workforce Development Framework group and the national structures as they develop. It should be maintained by the same national centre of responsibility that will promote the sharing of information. Main functions of the portal would include:

- access to all electronic databases relevant to workforce development (including non-NHS sources);
- guide to other information sources;
- information on workforce development processes, skills and modelling tools;
- research database;
- online newspaper and discussion fora;
- education database;
- contact database.

Recommendations of the Review of Workforce Information Needs

The main ones being to develop:

1. an Electronic Staff Record (ESR) for all healthcare staff. For the majority, but not all, NHS staff this aspect will be covered by the HR Payroll project which is to be procured imminently.

2. a National workforce minimum dataset;

3. a National centre of responsibility for future developments in workforce information;

4. a "Health Care Workforce Development" internet portal to support all stakeholders involved in workforce development.

The Review makes other recommendations about interim actions that can be taken to improve the current situation while the major recommendations are considered or acted upon. These include:

5. The workforce information dataset and information required for the ESR should be contained within the national HR/payroll system.

6. Improve information sharing between regulatory bodies and the rest of the health care system.

7. Improve the accessibility of medical and non-medical census data.

8. Develop integrated planning links and databases for Deaneries and WDCs.

9. Workforce information needs and requirements should aligned with SAFFs and the general and HR performance management frameworks.

10. There should be better access to the internet and NHSNet at all levels.

11. A formal agreement should be established with the Higher Education Statistics Agency to cover systematic access to information on students.

Introduction

1. "A Health Service of All the Talents"[1] identified a number of problems with existing systems for workforce development. These included:

   - lack of integration of workforce, service and financial planning at national and local level;
   - lack of integration between medical and non-medical planning;
   - fragmented funding streams for education and training;
   - weaknesses in workforce information;
   - fragmented approaches to skill-mix issues.

   The document recommended that, following agreement on the new planning systems suggested, there should be a comprehensive review of existing workforce information with the aim of developing a robust dataset to support the new planning arrangements and making it widely and readily available to all users. This report summarises the first stages of that review and makes a number of recommendations.

2. **Conduct of review.** The review was conducted largely through a series of seminars – an initial large-scale seminar to undertake some initial scoping and a series of smaller meetings to consider specific aspects of workforce information. These meetings involved as many of the stakeholders as possible. In addition, a questionnaire was sent to all Workforce Development Confederations (WDCs) and Postgraduate Medical and Dental Education Deaneries (Deaneries), the answers to which have enabled us to map current sources of workforce information and gaps, together with some useful pointers to the future. The recommendations in this report have a strong measure of support from those engaged in the review process; this should not, however, be taken to imply that the organisations represented at the seminars are necessarily committed to this as the way forward in every detail. There will be a period of consultation on these recommendations. In many cases, of course, there will be much further detailed work to be done to give effect to some of the recommendations.

Focus of review

3. The review has concentrated on the information required for effective workforce development. Workforce development, for the purposes of the review, covers:

   - workforce planning;
   - planning and commissioning education, training and development;
   - professional regulation;
   - new ways of working and changes in skill-mix;

[1] *A Health Service of all the talents: Developing the NHS workforce* Consultation Document on the Review of Workforce Planning, Department of Health, 2000.

- recruitment, retention and return;
- changes in employment practices such as greater diversity in recruitment, more emphasis on equal opportunities policies or more flexible career paths.

We have not attempted to cover **all** the information about the workforce required for all purposes. For example, paybill information is required for financial planning or pay negotiations, but we have not covered this aspect in detail. The forthcoming HR/payroll system should ensure that linkages can be made where necessary. However, some workforce information is required for both workforce development and pay purposes, such as information on vacancies. Where this is the case, we have attempted to take this dimension into account. We have tried to ensure that the information requirements to support the full range of Government policies on workforce development have been taken into account.

This review covers England and, within that, focuses on the needs of the NHS. However, it is evident that the NHS health care workforce cannot be treated in isolation. There is movement between the four countries of the UK; between the NHS and other parts of the health care sector; and flows between the UK and the rest of the world. There are a number of non-NHS bodies that have a significant impact on workforce development. Although any formal information requirements stemming from this review can only be binding on the NHS in England, there are cases where significant benefit gains are possible by mutual involvement of other key stakeholders. Where this is the case these stakeholders have been identified, and their involvement should be sought at the earliest opportunity.

4. In any case, the review is not just about information that the Department of Health needs from the NHS – it is a far wider exercise covering all the information required by NHS organisations and the Department to make workforce development a success. In that respect, this review is very different from the last formal review of workforce information requirements – the Korner review of manpower information in the 1980s. That concentrated on NHS data; it is a measure of how far the concept of workforce development has changed that it would be unthinkable today to adopt such a narrow focus. Information about labour markets, information from further and higher education (FE/HE), regulatory body data, are all key to successful workforce development.

5. The review is concerned with both qualitative and quantitative data. However, the range of qualitative data affecting workforce development is so great that we cannot hope to have covered it all. We have merely attempted to capture the most significant requirements for and flows of qualitative data.

6. This review is, by its very nature, general in scope. Workforce information needs relevant to particular parts of the health service or

specific care groups should, so far as possible, be sub-sets of the overall information requirements recommended in this document. These issues will be addressed in the detailed Reviews of Business Information Needs now underway.

7. This review needs to be set in the context of the emphasis given in the NHS Plan and elsewhere to workforce development issues. An effective information base is necessary to underpin:

   - increases in staff and student numbers;
   - more investment in staff development;
   - more diversity in recruitment;
   - better retention and more return to practice;
   - more flexible ways of working and more flexible career progression;
   - modernisation of professional regulation and regulation of health support workers;
   - changes in primary care, with the advent of PCTs and care trusts, and growth of Personal Medical Services;
   - clinical governance.

Workforce Development Structures and Processes

8. This section outlines the main stakeholders, structures and processes for workforce development in the health care sector in England.

9. **Workforce Planning.** Workforce planning is about anticipating the future and is bound, therefore, to be an inexact science. However, the consequences of getting the numbers wrong are too serious to allow inexactitude to inhibit efforts to get it right. There have been a number of instances in the last few years of past failings in workforce planning, partly attributable to a poor information base, resulting in over- or under-supply of key staff groups. Sufficient information to enable people to model various scenarios of how staff will enter, flow through and leave the system is essential to any serious attempt to manage workforce issues.

10. "A Health Service of All the Talents" outlined new arrangements for this function. At local level, Education and Training Consortia have been replaced by Workforce Development Confederations (WDCs). These will continue to represent all employers of health care staff within a geographical area. The employers that need to be involved include NHS organisations, the independent and voluntary sectors, the armed services, the prison service, social care organisations and occupational health departments. The primary functions of WDCs are to:

    - aggregate workforce plans from employers to ensure consistency (information about requirements for staff is needed from all employers because the NHS or the Higher Education Funding Council for England (HEFCE) funds the initial education of all

professional health care staff, not just those required for NHS purposes);

- commission non-medical education and training;
- inform decisions on undergraduate/postgraduate medical and dental education;
- undertake, by agreement, supra-employer action in other aspects of HR management.

11. Individual NHS organisations need to prepare strategic workforce plans within the context of the Health Authority's Health Improvement and Modernisation Plan (HIMP). Other employers need to prepare local workforce plans, covering future staffing requirements, skill-mix changes, and recruitment/retention issues.

12. At national level, there is a National Workforce Development Board (NWDB) to oversee all aspects of workforce development. On workforce planning, this Board receives advice from a Workforce Numbers Advisory Board (WoNAB) on the numbers of undergraduate education places required, based on the aggregate forecasts and requirements of WDCs and NHS Plan commitments. It will also receive advice from the Care Group Workforce Teams (e.g. cancer or mental health) on workforce trends and requirements within specific areas of care. Any relevant National Service Framework (NSF) for the area of care concerned will influence this advice. In time the role of the CGWTs will cover all areas of care and not just those with NSFs. This will help to address one of the weaknesses of the previous system, which was that much workforce planning was based on more of the same, without taking sufficiently into account likely future changes in the pattern of delivery of health care.

13. Workforce planning requires information in a number of areas:

- quantitative information about stocks and flows within the workforce – wastage rates, vacancies, movement between different parts of the healthcare system, immigration/emigration, retirements, etc. Given that, for many professions, the NHS commissions education for the whole health care sector, and not just the NHS, this information is required for the whole sector. Even if workforce planning were to be confined to the NHS, information about the rest of the sector would still be needed to understand flows into and out of the NHS. Similarly, given the flows between the different countries of the UK, information is needed on a UK basis;
- quantitative information about participation rates – that is, the proportion of the total pool of qualified professional staff of working age who are working within health care. Relevant information can come from the professional regulatory bodies, the Labour Force Survey, the national population census;
- labour market and school-leaver information – what proportion of school-leavers or suitably qualified people in the working population does the health sector need to recruit and train, locally or

nationally? What strategies can it adopt to increase its share of the available labour market?

- Information on workforce trends which may in part be available through cohort studies such as that researched by the Medical Careers Research Group (MCRG) covering medical graduates. The BMA also funds a cohort study of a particular set of graduates and RPSG is planning to commission a similar study of pharmacy graduates. These long-term longitudinal studies tend to yield more qualitative information on, for example reasons for leaving (these are relatively rare among the non-medical professions, particularly the smaller ones)
- information from HE on student progress, attrition rates, first destination on leaving etc.;
- information from within the sector on future demand for staff;
- Information on individual training and development needs and progress against targets to increase our ability to plan personal and professional development to address the ever-evolving need for the DoH/NHS to manage it's workforce using a skill centric approach.

14. Workforce planning must, of course, take place in the context of changes of direction in the world at large. Scenario planning can help to model the possible impact of external changes, such as changing attitudes to retirement ages, greater social and geographical mobility, gender shifts within the workforce, technological change and so on. What impact will more specific policy changes have – such as the introduction of PMS pilots, the European Working Time Directive, clinical governance, revalidation requirements? At this level, there is an almost infinitely large number of information sources that could be taken into account. What workforce planners must do is to make clear the assumptions, reflecting these wider information streams, that underpin their plans.

15. A further dimension to workforce planning is the likely growing need to work closely with social care. For many years, Social Services Departments have employed small, but significant numbers of, in particular, occupational therapists and nurses. In the wider social care sector, doctors and nurses are often proprietors or managers of residential homes. At the non-professional level, there is thought to be considerable movement of care assistants between health and social care and vice versa, although this is unquantified. In workforce planning terms, however, the needs of the social care sector have often been treated as a form of wastage from the health sector that needs to be replaced. With the advent of care trusts, and increasing joint planning of services between health and social care, there will be an increasing need to practice proactive joint workforce planning with WDCs working closely with the regional arms of the Training Organisation for the Personal Social Services (TOPSS). This will stimulate additional information requirements and require a common language.

16. **Education, Training and Development.** WDCs commission much non-medical education from Higher Education Institutions (HEIs). This process includes nursing, midwifery and health visiting, the allied health professions, and much of the education of health care scientists. WDCs need to monitor these contracts, both from the financial point of view and in terms of quality. Other initial professional education (for example, for doctors, dentists, pharmacists, opticians) is funded through HEFCE, but in the case of doctors and dentists within the framework of Government decisions on student numbers. Postgraduate medical and dental education (PGMDE) is arranged through Postgraduate Medical and Dental Deans and deanery staff. It is planned that Deaneries and WDCs will work increasingly closely together in future. The potential role Strategic Health Authorities will have in liaison with relevant WDCs is currently under consideration. Other forms of education, training and development are largely the responsibility of individual employers, although the new NHS Leadership Centre will have an increasing influence on leadership and management development and WDCs do commission some post-qualification education, particularly in the nursing field.

17. Education and training are quality assured in a variety of different ways. Statutory regulatory bodies specify the knowledge, skills and competencies required for initial professional qualification. Where these are linked to a degree or higher education diploma, as is generally the case, the Quality Assurance Agency for Higher Education in England (QAA) has a role in assuring academic standards. As the commissioner of much education, the NHS also has a role in quality assurance. Efforts are currently being made to bring these QA processes together, both for HEFCE and NHS funded education. Greater integration is sought in terms of QA processes and the information requirements supporting them. At post-qualifying level, postgraduate medical education is quality assured through a combination of the Deaneries, the Specialist Training Authority, the Joint Committee on Postgraduate Training of General Practitioners and the medical Royal Colleges. For nursing, midwifery and health visiting, the statutory regulatory bodies specify the standard and content and monitor quality to some extent for much post-registration education. With the imminent restructuring of the regulatory bodies, it is expected that many of these QA functions will be streamlined and rationalised through closer partnership working with key stakeholders, co-ordinated by the Department of Health. Regulatory bodies will, however, remain accountable for assuring fitness for practice where qualifications and awards lead to registration, or recording on the register. Arrangements in the other professions vary, with some regulatory bodies currently having no statutory role in post-registration education. But with the modernisation of professional regulation, it is likely there will be greater convergence in the way QA is approached.

18. National Vocational Qualifications (NVQs) are the main qualifications at non-professional level. The National Occupational Standards (NOSs)

that underpin NVQs are developed by National Training Organisations, (NTOs) for their sector. In the healthcare sector this is predominantly Healthwork UK (the Health Care NTO, covering the whole of the UK healthcare sector, not just the NHS), and in the social care sector TOPPS England, the Training Organisation for Personal Social Services. NVQs are approved by the Qualifications and Curriculum Authority (England) (QCA). A review of NTO functions has recently been conducted by the Department for Education and Skills. This is likely to result in changes to current sectoral NTO arrangements.

19. NHS funding of education is, as of April 2001, via the Multi-Professional Education and Training Levy (MPET) which will increasingly integrate three earlier levies designed to fund education and training for non-medical health care professionals, to fund the additional costs to the NHS of training undergraduate medical and dental students and to support the costs of doctors and dentists undertaking postgraduate training. The value of the combined levies is £2.5 billion in 2001/2.

20. The Government is shortly due to publish a strategic framework for lifelong learning in the NHS. This will embrace all forms of learning, including links to the University for Industry Ltd (UfI), individual learning accounts (ILAs) and NVQs for staff without a professional qualification, relationships with Learning and Skills Councils, funding for continuing professional development (CPD), the need for staff to have personal development plans, the development of the University of the NHS and a greater emphasis on e-learning. It will also describe how the NHS will play its part in meeting DfES targets to address deficits in adult basic skills. Workforce information requirements need to reflect what is required to make lifelong learning a reality in the NHS.

21. **Professional regulation.** A feature of the health care and social care workforce is the high proportion of its staff who are subject to professional regulation. This covers maintenance of a professional register (to provide public protection in ensuring that those who claim to hold professional qualifications really do so); setting educational standards; establishing codes of professional conduct; and imposing sanctions in the event of professional misconduct and dealing with those who are too ill to practice. Increasingly, and in varied ways, the professions are taking steps to deal with continued competence to practice – by linking re-registration or revalidation to evidence of continued competence and by ensuring their professional conduct machinery increasingly takes competence into account. The regulatory bodies hold a significant amount of information about the health care workforce.

22. The Government is currently considering the need for some form of regulation of non-professional support staff who deal directly with patients and clients. In the closely-related field of social care, the General Social Care Council to be established later this year will have

regulatory powers over the whole social care workforce. Should regulation be extended to the health care field on a similar basis, some information requirements relating to registration, conduct and education will apply to support staff as to professionals.

23. **New ways of working.** One of the most difficult aspects of workforce development in the health care field is the need to take account of changed and changing patterns of health care delivery that are being developed to deliver better patient care. Other factors which significantly influence the new ways of working include:

    - technological change;
    - modernised education and training- this includes more varied routes into and through professional training;
    - staff shortages leading to innovative ways of working;
    - changes in role boundaries between the health care professions and between professionals and non-professionals;
    - greater use of patient-centred clinical pathways and protocols;
    - research evidence;
    - patient/client expectations;
    - more varied routes into and through professional training and more satisfying roles for staff.

    What is obvious is that there have been significant changes over the last decade in the way staff are deployed and the roles they fulfil. But the NHS Plan[2] made it clear that further change was required.

24. As a consequence, the Changing Workforce Programme has been set up to lead the change process, through working with pilot sites, building up a database of new job roles for sharing good practice and working with WDCs to help them lead local work on new ways of working. Changing professional and other roles have profound implications for workforce planning, education and training and professional regulation. Better information about what is happening now, toolkits and guidance to help NHS organisations to think about flexible use of staff skills and redesigning systems through protocols and care pathways and a greater clarity about likely future changes will all help to support workforce development.

25. **Recruitment, retention and return.** An important part of workforce development is optimising recruitment, retention and return to practice. This involves:

    - promoting diversity in recruitment, to education or employment;
    - providing more open career pathways between professions and from non-professional status into the professions;

[2] *The NHS Plan – a plan for investment, a plan for action.* Cm 4818, The Stationery Office, London, 2000.

- establishing more flexible employment practices to encourage recruitment and retention;
- enabling those who have been away from the workplace, or from health care employment, to return, through providing updating and financial support.

Information is needed on school-leavers, local and national labour markets, the pool of potential returnees, and the effectiveness of various measures to encourage recruitment and retention. The Improving Working Lives standard is an important component of this aspect of workforce development, with, for example, its emphasis on personal development plans and access to education and training.

26. **Key stakeholders.** It will be evident that there are a large number of stakeholders involved in workforce development, most of whom both hold and require information. In addition to the Workforce Development Confederations and Deaneries that have already been covered, the other stakeholders include

- ***Government Departments***

The Department of Health is responsible for overall education and training strategy for the NHS. It directly funds much non-medical professional pre-registration education, through a devolved system using NHS organisations for commissioning, and some non-professional training (either directly or through a devolved system). It funds postgraduate medical and dental education; post-registration education for other healthcare professions is largely a matter for individual employers, although there is significant funding of post-registration education in nursing in England through the levy system. The Department of Health, with the other UK health departments, is responsible for the legislation governing regulatory bodies. The departments are also the sponsors, in government terms, of the non-statutory health sector. The Department for Education and Skills is the other department with a major interest in the health field, by virtue of the significant size of the health sector within HE and in vocational training, and the size of the NHS in employment terms.

- ***Regulatory Bodies***

There are a number of these. All have functions relating to determining the professional competencies and academic awards required for admission to their register; most also have, or will shortly have, functions relating to post-qualifying training, CPD and requirements for revalidation or re-registration. Their responsibility for specifying competencies and educational requirements is justified by their overall duty to protect the public by ensuring fitness to practise. In conventional health care, most are statutory bodies dealing with those who offer direct patient care. Operating Department Assistants/Practitioners have a voluntary register.

In the NHS Plan, the government announced its intention to reform regulatory bodies which should change so that they:

- are smaller, with much greater patient and public representation in their membership;
- have faster more transparent procedures; and
- develop meaningful accountability to the public and the health service.

Two new councils – the Nurses and Midwives Council and the Health Professions Council are planned to replace the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and the Council for the Professions Supplementary to Medicine from Spring 2002. The General Medical Council is discussing proposals for reform, as are the General Dental Council and the Royal Pharmaceutical Society of Great Britain.

In order to secure greater co-ordination between the health regulatory bodies, a UK Council of Health Regulators will be established. There will also be a need for collaboration with the new regulatory body in social care, the General Social Care Council (England).

- ***Higher Education***

Most HEIs in the UK have some interest in teaching and research in the health field. In some cases, this is a major interest, with up to a third of some HEIs' income related to health (including research funding). These organisations employ substantial numbers of clinicians and well as academic staff and therefore have to be regarded as employers as well as providers of education. The Quality Assurance Agency for Higher Education (QAA) is a significant player, as efforts are made to align the QA processes of the agency, the regulatory bodies and (for those professions where it is the funding agent) the NHS/health departments. There is substantial interaction between the health care sector and Universities UK, the Council of Deans of Faculties of Nursing, Midwifery and Health Visiting (CoD), Council of Heads of Medical Schools and Faculties of Medicine (CHMS) and Council of Deans of Dental Schools (CDDS).

- ***Other Training Providers***

Further education (FE) is an important provider in the technical field and to some extent in the training of health care assistants, although some of this latter training is provided in-house in the NHS or independent sectors or by university nursing departments. These organisations provide management and personal development training, but, perhaps more importantly they also process numbers of potential pre-registration students through access courses. GNVQs in health-related fields are provided in schools and FE colleges. There is a small amount of commercially provided training.

- ***National Training Organisations***

Healthwork UK is the NTO for the sector. Its activities are being more closely aligned with those of the UK Health Departments to develop a more coherent approach to education and training for the sector. There are significant links to the work of other NTOs, particularly the Training Organisation for the Personal Social Services (TOPSS) and the Voluntary Sector National Training Organisation (VSNTO). Links with training in social work and social care may become closer with the development of Care Trusts in England, providing both health and social care. There has been work in the health care science and technology field with the Science, Technology and Mathematics NTO. NTOs have a close relationship with the Qualifications and Curriculum Authority, which is the body that oversees the development of National Occupational Standards and National Vocational Qualifications.

- ***Professional Organisations/Trade Unions***

Some bodies in the health field are professional educational bodies and trade unions that have statutory (chartered) status. Examples include the Royal Colleges of Nursing and Midwifery, the medical Royal Colleges and the Chartered Society of Physiotherapy. These are to some extent education providers in their own right, mostly in respect of CPD. Some also have a joint validation role for approval of qualifying courses together with the statutory regulatory body. Other trade unions are also heavily involved in providing or organising training, for example UNISON (with the Workers' Education Association) in respect of access and return to learning courses. There are signs of increased collaboration between employers and trade unions on education and training issues in the workplace.

- ***Employers***

As explained above, employers of health care staff form WDCs, succeeding education and training consortia. WDCs will be the key link between the health sector and Regional Development Agencies and local Learning and Skills Councils. At a more local level liaison with the local employer population through organisations such as Chambers of Commerce etc may help WDCs understand the local and regional workforce market in which they are operating. In addition to direct employers, external contractors employ substantial numbers of staff. It is estimated that 50-60,000 staff are employed by external contractors in the health care sector. Agencies also supply significant numbers of locums, nurses and other staff (e.g. temporary clerical staff). There are increased linkages between health and social care employers, through WDCs, care trusts and other forms of partnership.

- ***Volunteers and Carers***

The contribution of volunteers and carers in the sector should not be overlooked. Both groups make a significant contribution to the total delivery of health care and both have training needs that may not always be fully met. An increasingly important part of the role of professional health care staff is advising and training volunteers and carers.

- ***Post-16 Learning Frameworks***

From April 2001, the new national Learning and Skills Council (LSC) and its local councils (LSCs), the Regional Development Agencies (RDAs), the Small Business Service and Connexions (the new youth support service) will take on responsibilities for the framework for post-16 learning set out in the *Learning to Succeed*[3] White Paper. Links between the health sector and Training and Enterprise Councils (TECs) (which LSCs have replaced) in the past have been patchy; the new more inclusive arrangements should make relationships closer in future.

Future Information Requirements

27. Against this background, what is the broad shape of future information requirements? To give this question controllable shape, it is necessary to concentrate on information requirements at a particular level. We have chosen the perspective of a WDC or Deanery. Although the role of WDCs is still developing, a broad mapping of functions and information might look like this:

[3] *Learning to Succeed a new framework for post-16 learning*, Cm 4392, The Stationery Office, London, 1999.

Table 1

	Workforce Development Confederation Function	Sources of information needed by WDCs
1.	**Develop integrated workforce planning for healthcare communities based on assessment of future requirements for skills and competencies**	Integrated personnel data collection and planning system with analytical capabilities
		Ideally, personnel data held on a single NHS HR system, capable of being interrogated at different levels
		Information from social care and other non-NHS stakeholders (eg primary care contractors), preferably through electronic access/transfer
		NHS organisations' staff in post forecasts based on Business Plans/SAFF plans, HImPs and NSFs
		NHS organisations' longer term forecasts (5-6 years +) for newly qualified requirements
		OR if these are to be determined centrally, timely access to these figures to enable commissioning arrangements with HEIs
		Vacancy data (based on national, standard definitions)
		▪ PG Deans' database ▪ information on national vacancies for all doctors, all grades
		▪ access to national medical and non-medical census electronically (not aggregated paper format as presently) ▪ census to have a flexible reporting facility to turn the data into responsive information
		Qualitative information on recruitment and retention issues, changing roles etc.
		Skills and competencies data attached to staff records
		National guidelines on core competencies
2.	**Create a structure to reflect the needs of NHS and non-NHS organisations**	Shared (and locally supplemented) WDC contacts database to cater for all the stakeholder organisations' names and representatives
		Centrally suggested and supported stakeholder representation, with participation encouraged through the national 'concordats'
		Information and examples of how to set up joint funding arrangements with social care and other

		stakeholders to encourage joint commissioning of education
3.	**Develop the existing and future workforce**	Assessing impact of Changing Workforce programmes
		Clear and transparent strategy for life long learning and development of all staff working in the healthcare sector through ILAs, UfI etc.
4.	**Negotiate and manage education contracts for the NHS with local education and training providers and those parts of the NHS who provide practice placements for pre and post registration students**	Database containing all available education and training programmes (divided where relevant into registrable, recordable and non-recordable), preferably with inbuilt process for registering staff requests and for tracking students on programmes (via data link with Higher Education Statistics Agency (HESA). Close liaison with the Deans' database is also required.
		System for monitoring uptake, completion/attrition and credit value of pre and post-registration programmes (could be the same system as above)
		Local information: shared database containing names/posts of all NHS staff on HEI Curriculum Management Boards and other committees as well as names of key NHS service managers and directors including Practice placement Co-ordinators. Also to include details of joint NHS/HEI appointments and link tutors
		▪ contracts database including actual and potential capacity for commissioned and validated places that a HEI has been QA approved to run. ▪ to feed into a national database
		Standard national benchmark pricing for core elements of HEI provision with sub-sets to benchmark staff costs, libraries, accommodation etc.
		▪ national and/or regional database on contracts for small/specialist staff groups. ▪ process for feeding through information on own future need for these staff
		Standardised definitions of student attrition for national reporting/benchmarking (allowing for new step on and off programmes)
		HESA database for reasons for student attrition
		HESA database for numbers and quality

		monitoring data, with feedback into own monitoring systems
5.	**Ensure the provision of high quality practice placements for all students on NHS funded training**	▪ information on location/duration of available and occupied practice placements in NHS and outside NHS *(to be shared with trusts/PCGs and linked with HEI systems)* ▪ to include information on number of qualified staff certificated to supervise and assess ▪ contact names and numbers of qualified supervisors/assessors to be available
		HESA database - first and second employment destinations (and preferably long term tracking mechanism by linking student identifier to other form of NHS or health care worker identifier)
6.	**Ensure effective systems and procedures are in place for financial management of MPET**	▪ host organisation standing orders to be available, including all audit requirements/formats ▪ special section on preparation of WDC accounts?
		Recommended example spreadsheets and databases for financial monitoring and financial management *WDC finance staff should be encouraged to share spreadsheets used by former consortia and the best examples should be developed*
		Spreadsheets for effective and efficient preparation of FWIR (or successor) bids
		Clear guidance notes on new funding and projects should be issued by centre or regional office to ensure understanding and efficiency around distribution and spend of new monies
		Spreadsheets for management of bursary spend and attrition information to assist in bursary under/overspend predictions. As above, share best practice
		Managing the SIFT and MADEL levies will need special consideration and these should be devolved with full accompanying systems, guidance and training
7.	**Develop a consistent approach to HR policy and practice among constituent employers**	Information (preferably up to date actual copies of) policies and procedures
		National database to contain best practice examples for access by all HRDs and WDCs
		Regular local network groups and/or 'internet

		chat line' to exchange information and to use action research approach for learning (not just for HR Directors but also other practitioners)
8.	**Strengthen NHS staff recruitment, retention and return**	National HR database as in 1. above capable of analysing wastage/loss
		National statistics to be available on wastage, turnover, stability and vacancy rates for comparisons
		Regular, standardised and 'open' collection and publication of vacancies
		National database to contain best practice examples for access by all WDCs
9.	**Collect and analyse high quality workforce and local labour market data**	Database as 1. above capable of analysing rates, trends in staff flows and characteristics
		▪ access to national databases on population and employment information (NOMIS etc) ▪ more use to be made of National Population Census, especially, to help with demographic modelling
		▪ access to data/information used by Health Authorities when assessing population health needs (e.g. Jarman deprivation indicators) as these give clues to the potential workforce supply. ▪ HESA occupation and social indicators for Diploma and Degree students, but also need information for the non-professional workforce
		National shared information resource for benchmark/comparator information
		Local capability and national framework needed for preparing and interpreting labour market information
		Joint labour market research and recruitment to be explored with social care including unqualified staff
10.	**Co-ordinate the strategic management of local learning and education facilities**	National/Regional standards and per capita spend to be developed and publicised for learning facilities
		Information on specialist and new forms of learning provision, in order to assess local provision Investment in knowledge base of WDCs around

		new forms of e-learning and skills of staff to access and use new technology eg EDCL (Euro Computer Driving Licence) etc.
11.	**Establish robust working relationships with the NHS learning infrastructure**	Internet connections to the Ufl Sector Hub and Learning Centres, University of the NHS, NeLH (National Electronic Library for Health) etc.
		Database of projects and learning tools available
12.	**Promote wider involvement in delivery of education and health care**	Database of education providers
		Critically evaluated information on alternative forms of learning
		Frameworks for exploring new ways of working and new role development and the accompanying education needs
13.	**Promote the development of local Quality Assurance and Performance programmes**	QAA work on quality in NHS funded programmes to be supported by centre and disseminated to WDCs – including practice placements/experiences.
		Central guidance on the factors to be assessed through quality monitoring reviews to ensure there is some consistency in quality
		WDCs to share approaches to regular and major reviews that have already taken place
14.	**Vision the future health care work force**	National database of developing roles and re-engineered processes to be available via Changing Workforce programme
		Access needed to key R & D projects including critical evaluations of these
		National Workforce Development Board to explore future developments (medical, technical, legal/ethical etc.) and likely impact on the workforce. Results to be disseminated and accessible by WDCs

28. This table gives a flavour of the variety and source of information required by WDCs. Much of the same information will be needed by individual NHS organisations; some will be needed at national level.

Current Information Sources

29. If the previous section is a reasonably accurate indicator of future information requirements and sources, how does this compare with the current position? The main current information sources are as follows.

30. **NHS Sources.** These include:

- the medical and non-medical census carried out annually by the Department of Health. The medical workforce census includes professional registration numbers and these are used to track doctors through their careers;
- the medical, dental, ophthalmic and pharmaceutical lists maintained by health authorities (work is underway on establishing HA lists for locum and PMS doctors);
- trust/PCT staffing data/future projections, as collected by WDCs – in effect, collection of data on existing staff numbers overlaps with census data, although the latter is not accessible in disaggregated form, hence WDCs need to collect similar data;
- the Deans' databases; These hold information on postgraduate medical trainees (doctors in training) for whom the Postgraduate Dean is responsible for providing and monitoring higher specialist training utilising a common data set. The information currently only covers Specialist Registrars;
- the workforce models maintained by the Medical Workforce Review Team – has information on doctors in training and future number of consultants required. This function is part of the national workforce numbers advisory board remit;
- information collected by the NHS on nursing staff in registered homes;
- the Department's annual recruitment, retention and vacancy survey;
- HIMPs/NSFs;
- educational contract monitoring information (e.g. attrition data);
- educational contract price database;
- Student Grant Unit information;
- return to practice data collected by the Department for monitoring policies on return;
- the Department of Health earnings survey contains some information – e.g. nurses by grade – not available from the census;
- the Improving Working Lives/Human Resources Performance Framework monitoring data – for example, number of staff with Personal Development Plans (PDPs); and who have accessed ILAs and other training and development opportunities;
- the NHS Pensions Agency has information on retirement intentions.

31. **Other health sector data.** Other data sources within the health sector include:

- information on current and future staffing collected by WDCs from non-NHS employers – the independent and voluntary sectors within health, the armed forces, prisons, social care organisations, occupational health departments, education and housing; Primary care contractors;
- Pay Review Body reports (OME annual surveys);
- regulatory body data, typically covering registration status (i.e. whether on the "live" register or not), some information on qualifications, and information on immigration/emigration;
- the medical Royal Colleges and the UK competent authorities have information on doctors in training;
- Healthwork UK (penetration of various DfES initiatives, NVQ take-up, etc.). Other relevant NTOs, such as TOPSS or the Science, Mathematics and Technology Council (which deals with health scientists);
- professional organisations/trade unions data (e.g. the Royal College of Nursing's annual labour market surveys);
- research studies;
- English National Board data, typically covering information on nursing students undertaking a programme of study that may lead to a registration or other post registration qualification. Following legislative changes, the Board will be wound down in March 2002 and this data source may not be available beyond that date.

32. **Education sector information.** The education sector holds the following information:

- the Higher Education Statistical Agency (HESA) holds information on students, such as first and second destinations on leaving, and on staff in HE (in health-related education, a large proportion of teaching and research staff hold a relevant health professional qualification);
- the Universities Central Admissions Service and the Nurses and Midwives Admissions Service hold information on applicants for university programmes;
- individual HEIs hold information on their own students, databases of practice placements (sometimes shared with WDCs) and information on feedback from students/trainees;
- local education authority data (e.g. on school-leavers);
- the QAA hold information on academic and institutional review results, and subject benchmarking statements;
- NVQ awarding bodies and the QCA hold (some) information on NVQ take-up;
- DfES periodic surveys of students, covering, for example, student income and expenditure.

33. **Other information sources** include:

- the National Population Census, which asks questions about medical and nursing qualifications;
- DfES data – NOMIS, Labour Force Survey etc. – the Labour Force Survey asks questions about qualifications;
- local Learning and Skills Councils have information on local labour markets;
- local Chambers of Commerce who have views about and understandings of local labour markets;
- charities and pressure groups sometimes hold information or undertake surveys on staff groups of particular concern to their interests;
- Audit Commission/National Audit Office reports – often these include the results of special surveys undertaken for the report.

Major gaps and disconnections

34. There is, as can be seen, a wide range of information potentially available. However, looked at from a WDC/Deanery perspective (or any other, for that matter), there are major deficiencies.

35. Perhaps the most significant gap is the difficulty in obtaining information that adequately describes the skills of the workforce to allow for a care group based approach to workforce development. Workforce planning is increasingly moving towards planning on the basis of skills and competencies, rather than job titles, and on a care group, rather than profession-specific, basis. It may be some time before the NHS is fully capable of planning in this way, but information systems need to anticipate these requirements.

36. There is the lack of connectivity between three of the major datasets - the NHS national censuses, information collected by WDCs/ Deaneries themselves and regulatory body information. As mentioned above, the census data is only accessible in aggregated form, but even if it could be disaggregated, the absence of any unique identifier would make it impossible to link the three datasets. This makes analysis at all but a fairly superficial level impossible.

37. Another major problem is the difficulty of accessing existing data. For example, and fairly or not, there is a perception that it is very difficult to obtain data from some of the regulatory bodies. In some cases, the structure of regulatory bodies' information systems does make it difficult to provide useful information for workforce development, but, as public bodies, we believe this should be more readily available. The plans that some regulatory bodies have for making information more available to the general public and employers – for example, by placing some information from their registers on the internet – will have the spin-off that the information is also more accessible for workforce development. HESA data is not widely available – not because of technical or other difficulties but because the nature and usefulness of the data is not well known. Some WDCs say it is difficult to access

Specialty workforce review data, although a website has been created by the Medical Workforce Review Team which should address this issue. The main problem seems to be that the sheer variety of potential information sources makes it very difficult for an individual WDC to find the time or expertise to access all available information. There is a consistent plea for, so far as possible, a single point of access to information.

38. Obtaining good quality data on non-directly NHS employed staff is very difficult. This includes data on staff in general medical and dental practice, community pharmacy, the independent and voluntary sectors in the health field, and those employed in other sectors. As pointed out earlier, since the taxpayer, whether via HEFCE or the NHS, supports the training of health care staff for work in all settings, there is a mutual interest in all employers of such staff collaborating in supplying information for workforce planning and education commissioning purposes. This is not to imply that there is unwillingness on the part of non-NHS employers to supply information – for the most part, there is not. But there may be problems of resources, a lack of understanding about the relevance of information sought, failure to specify what is required with sufficient clarity, or different degrees of engagement on the part of former consortia with the non-NHS sector. A clear national statement of what information is expected would, we believe, improve response rates.

39. Finally, relating to information deficiencies , the recent National Audit Office report[4] reported concerns about the quality, accuracy and timeliness of information used for forecasting education and training needs at employer level. It reported on the slow pace of integrating medical and other health professional workforce planning, including difficulties integrating IT systems, databases and planning cycles into a coherent whole. The report also drew attention to the variety of planning methodologies in use and deficiencies in the training and experience of some of those using them. The Audit Commission report *Hidden Talents*[5] also drew attention to the need to improve information systems to support in-service training and development.

40. There are a number of specific information deficiencies:
    - information on agency and locum staff is sparse;
    - little or nothing is known about non-clinical staff in the independent and voluntary sectors. It could be argued that such staff do lie largely outside the workforce development systems described earlier;
    - little is known about contractor ancillary staff (again, arguably, outside the scope of this review – except that their training and

[4] *Educating and Training the Future Health Professional Workforce for England: Report by the Comptroller and Auditor General,* The Stationery Office, London, 2001.
[5] *Hidden Talents – education, training and development for healthcare staff in NHS trusts,* Audit Commission, London, 2001.

competence may well be an issue in terms of clinical governance, and doing something about it might be one of a WDC's activities);

- NHS national census data is very time-consuming to verify – information for this and other requests for information is often supplied from a very low level in organisations;
- commercial in confidence constraints – e.g. information on education contract prices is not shared by HEIs with the outside world, although WDCs do share price information among themselves;
- relatively little is known about joiners and leavers (origins, destinations, reasons);
- the pool of potential returners is difficult to estimate;
- difficulties in determining the true nature of someone's job due to past evasion of/compliance with management costs exercises;
- current occupation codes are out of date/too inflexible;
- little data on extent of changed job roles;
- little known about true extent of NVQ penetration;
- little known about why people leave professional registers;
- the true extent of immigration is not known (e.g. overseas nurses can register with the UKCC without necessarily working or residing in this country);
- insufficient longitudinal studies;
- differences in data held/collected between the four UK countries;
- a new dimension will be the need to gather data on Individual Learning Account uptake and usage –and possibly adult literacy and numeracy skills training.

Structure of Future Information Requirements

41. We were struck by how often the responses to our questionnaire to WDCs and Deaneries had common themes:

    - making little use of some data sources because of inaccessibility or lack of resources or time;
    - poor data on some basics, such as information on leavers (destination, reason);
    - lack of technical modelling and analytical skills;
    - a strong belief that a national dataset and better sharing of information were key to making progress.

42. We also recognised that it was important to structure future information systems as much around themes such as lifelong learning, equal opportunities and diversity, and partnership working as it was to base them on the requirements for conventional workforce planning. Taking this wider agenda into account means basing information on real people, not anonymous units for modelling purposes.

43. At the heart of our vision of the future structure of information requirements, therefore, is an individual staff record. We envisage this

not as a passive record that the individual may occasionally check for accuracy and more or less willingly accepts their employer will keep, but rather as an interactive record that contains the member of staff's learning portfolio or record of achievement in addition to more routine personnel details. Because of the opportunity provided to put this record on a solid foundation through the new NHS human resources/payroll system, we have christened this the **electronic staff record** (ESR).

44. The ESR should have the following features:

- the record would have "shared ownership". That is, the individual would be able to update the record, perhaps through a Smartcard facility to enable the individual to interface with the system, although employers, regulatory bodies and others would be responsible for validating changes. A start has already been made with Smartcard technology in the shape of the occupational health system for doctors in training that is being developed;
- the record would follow the individual from employment to employment. It would be necessary for those not employed or in self-employment to maintain a core record on either an electronic or paper basis. Clearly, such individuals could not be required to do this, although for professionals there could, in effect, be a requirement if the record was linked to registration/revalidation requirements;
- it would be based on a unique identifier that remains with the individual throughout their career. Ideally, this should be assigned at student stage for professional staff. This will allow long-term tracking of students and staff to inform workforce development in such critical areas as workforce planning and recruitment, retention and return;
- there should be full coverage of directly employed NHS staff, together with the contractor professions to the NHS (and their employed staff), and, for qualified professional staff (i.e. regulated), those working in other parts of the health care sector or other sectors;
- it would contain all relevant information for workforce planning purposes, with direct access to relevant data fields for Deaneries, WDCs and employers;
- it would contain all relevant information for equal opportunities monitoring;
- the learning portfolio could serve multiple purposes:
    - for employers, provide a basis for skills inventories and training needs analyses, to provide a check on individuals' registration status and to contribute to the clinical governance and patient safety agendas by ensuring an up-to-date knowledge of staff skills and competencies. It would significantly strengthen employers' ability to satisfy themselves about the credentials and field of expertise of, for example, locum or agency staff;

- for regulatory bodies, to provide evidence in whatever form they require for initial registration and revalidation/relicensing purposes;
- for the individual, to provide evidence required for NVQ assessment or FE/HE assessment of prior learning or credit accumulation and transfer systems and reference point for career decisions/development and employment moves;

• in the long term, it may be possible for regulatory bodies to rely on access to this record (or relevant parts of it) rather than maintain separate registers (although they would still have to do this in respect of, for example, those working abroad). This link to regulatory requirements is the surest way of securing adoption of the record throughout the health sector for those subject to regulation (who may, in future, include support staff).

Of crucial importance for Workforce Development will be the level of coverage of the ESR and what percentage of the workforce it will cover in the initial stages. How it is rolled out across the different staff groupings and sectors in percentage coverage terms will affect it's usefulness and this will need to be considered very carefully.

The national HR/payroll project provides a golden opportunity to realise the vision of an ESR, although the scope of the project may need to be revisited to ensure ease of transfer of the record into and out of the NHS. Adoption of the ESR would meet the recommendations made in the recent Audit Commission report, *Hidden Talents*, for identifying and meeting training needs and monitoring the outcome of training interventions more effectively. Appendix 1 contains more detail on the possible content of the ESR.

45. We recognise that there will be legitimate fears about privacy and security around this proposal. There will be a need to ensure that the ESR complies with NHS information governance requirements – the arrangements for the individual's digital identity and how this is managed and maintained will need to be robust. This will underpin security, authentication and authenticity.

46. Our second main conclusion is that there is a pressing need for a **national workforce dataset and dictionary.** This should be centred on the workforce information requirements of WDCs and Deaneries. We assume (although this will need detailed testing during development work) that the Department of Health's information requirements can be aggregated from this dataset and that individual employing organisations' requirements will be covered by a combination of this dataset and the information supplied by the new NHS HR/payroll system. Links will need to be made between this dataset and other systems – e.g. the FE/HE sector, the national medical and non-medical censuses (in the long term, the ESR/national payroll system may make aspects of the censuses redundant, but, in the meantime, maximum integration needs to be pursued). A common

dictionary of definitions is also needed so that terms are used consistently and appropriately across the NHS and, so far as possible, the wider health care sector. This would be developed in two main parts::

- current workforce data (includes forecast data); and
- work on definitions of future demand, competencies, qualifications, achievements – this will include devising new data definitions to support care group skill sets and evaluating whether National Occupational Standards (NOSs)can form the basis of competency definitions for **all** staff. This work needs to link to work on competency definitions for the purpose of competency-based pay progression.

It is suggested that the earliest start date for the NHS to implement and use a minimum workforce dataset is April 2003. This leaves approximately 18 months to form a workforce minimum dataset working group and to establish the dataset and definitions.

47. The significance of the point about NOSs is that, to have its full effect, the record needs to describe all competencies – from NVQs to professional qualifications to post-registration achievements and qualifications. We accept that the need to structure information requirements is an inadequate reason on its own for adopting NOSs as the currency and common language for the whole sector, but believe that, taken with the contribution universal adoption of NOSs would make to the Government's objectives of more flexible routes into and between professions, with stepping on and stepping off points and more diverse career pathways, the argument for addressing this fundamental issue is compelling. Nevertheless, we recognise the need for a debate on this issue.

48. Our third major conclusion is that there needs to be an identifiable **centre of responsibility for future developments in workforce information**, given the very wide range of organisations and information sources involved. Without a more structured point of access to the information available, now or in the future, we believe the work of Deaneries and WDCs will be hamstrung. Key functions would include:
    - managing and maintaining a national list of data sources to ensure that information is made more systematically available;
    - providing a framework for data requests and making information expertise available along the lines of the current ROCR. This would help to prevent the time-consuming duplication of data requests;
    - establish the need for, and frequency of, reviews of national datasets and systems - this includes responding quickly to changes required of information to support the workforce development and planning processes ;
    - support the enhancement of analytical capability in respect of workforce issues in the NHS and elsewhere;

- promote two-way information sharing between the many organisations involved – Department of Health, NHS, independent and voluntary sectors, regulatory bodies, FE/HE (including UCAS/NMAS/HESA/HEFCE), DfES, Learning and Skills Councils, professional and staff bodies; developing agreements with non-NHS parts of the sector to promote adoption of common information systems and sharing as far as possible. Wherever possible, information should be shared on a (usually anonymised) disaggregated basis. Protocols for sharing information should be developed;
- (possibly) information collection insofar as this may be required as an interim measure or to the extent that separate information collection may still be required after the adoption of an ESR/national payroll system.

49. There are a number of organisational options for the fulfilment of this function. We identify the main ones as being:

- the Department of Health. The Department is familiar with the vast majority of the information sources that need to be brought together and has considerable statistical expertise. Against this, in terms of workforce development, the Department's major priority is the NHS. Other stakeholders may feel uncomfortable that the function might become distorted by the needs of the NHS;
- NHS Information Authority. - The NHSIA is currently responsible for managing the national dataset development programme and maintaining the national NHS Data Manual and Data Dictionary. They have, therefore, the expertise and processes and procedures to develop and manage national NHS data standards. On the other hand, they do not currently have particular expertise in workforce and staffing information requirements;
- Workforce Development Confederation – a WDC would inherently understand the business process of workforce requirements and have the linkages on the ground to ensure the work is informed directly by the needs of the service. A possible disadvantage is that the function would require a significant amount of technical expertise to develop the information systems which otherwise would not be a major part of a WDCs makeup.
- an "independent" agency – this could be set up specifically for the purpose, could be a function contracted to, say, an academic department, or could form part of the functions of the National Training Organisation, Healthwork UK (which would need to be resourced to carry out the function). The advantage of this option is that it would be most likely to carry the confidence of all the stakeholders. A possible disadvantage is that it would be more remote from decision-making processes than the two previous options and could become less relevant over time.

We would welcome views as part of the consultation process.

50. A linked major recommendation is that the area of responsibility described above should develop a **major internet portal** that may be used by all stakeholders to support the full range of workforce planning and development activities with support for communications at local and national levels. Ideally, this should have a number of different "floors" to give support and access to information to staff, employers, WDCs, Deaneries, HEIs, regulatory bodies, etc. (including restrictions on access to "commercial in confidence" information on, for example, contract prices). Appropriate security measures will need to be built into the portal to ensure confidentiality of the data. Functions and content of the portal could include:
    - point of access to all electronic databases relevant to workforce development (including those external to the health care sector – e.g. HESA, Labour Force Survey);
    - guide to what other information sources exist;
    - guidance on workforce development processes;
    - workforce planning guides and modelling tools;
    - self-audit tools for workforce development skills;
    - an online newspaper;
    - discussion fora – to help with sharing of best practice;
    - e-learning relevant to workforce development (e.g. European Computer Driving Licence);
    - research database;
    - database of the Changing Workforce programme;
    - database of education providers;
    - monitoring system for uptake of educational programmes, completion and attrition rates;
    - contact database across sector;
    - contract database, including information on capacity and costs.
    - Issuing of Unique identification numbers to support the Electronic Staff Record;
    - Issuing of essential registration numbers - eg the DI7 number, which is issued to GP's required to carry out the referral and prescribing process.

    It is also possible that it could be linked to the emerging e-learning strategy and the University of the NHS to become a (or even the) point of access to e-learning, or a central database for managing continuing professional development.

51. The workforce information dataset and information required for the ESR should be contained with the **national HR/Payroll system.** This will contain additional information (most obviously in respect of payroll) and there is information relevant to workforce development that is external to the NHS. But there should be maximum integration of the information requirements discussed in this report and the HR/Payroll system. WDCs and Deaneries will require comprehensive access to the system.

52. Our other conclusions are mostly interim, where action to improve the current situation could be taken while our principal conclusions are being considered or acted upon.

53. There is a need to improve **information sharing between regulatory bodies and the rest of the health sector.** Some regulatory bodies have plans to make their data more accessible, e.g. through the internet, in order to enhance their public protection function. Access to the data available through the regulatory bodies is important for employers, Deaneries and WDCs by making it easier to check registration status and to incorporate regulatory body data in their planning processes. The work of producing a dataset and data dictionary should also consider what data is required of the regulatory bodies to support the workforce development agenda. The regulatory bodies should be encouraged to press ahead with their plans for more open access to the data as fast as possible

54. The **usefulness and accessibility of NHS census data** could be improved by:

- enabling electronic feedback of disaggregated data to WDCs, Deaneries and others, possibly via the internet;
- involve professional staff (e.g. professional heads of service) more in validation to improve data quality;
- extend the census (by agreement) to non-NHS parts of the health care sector;
- include professional registration numbers in the census to enable linkages to be made with regulatory body data and other data sets.

We recommend that these possibilities should be explored as a matter of urgency, perhaps as part of the ongoing work within the Health Care Information Strategy.

55. There are some practical steps that could be taken in advance of our principal recommendations to **improve information for Deaneries and WDCs** - these may ultimately also be part of the internet portal:

- ensure full access for WDCs to the Postgraduate Deans' database and reciprocal access for Deaneries to WDC information – many have achieved this or are working towards it, but the practice needs to be universal;
- create databases of locum doctors (a recommendation already made by CHI and accepted by Ministers) and bank and agency staff with NHS Professionals;
- create databases of staff who have the qualifications and status to teach, supervise and assess;
- share practice placement information with each other and with HEIs – some argue for a national practice placement database, although others would say that the fluid nature of practice placement/training post environments is such that this would be difficult to maintain. At the very least, sharing should ensure that potential providers of practice

placements do not get uncoordinated approaches from different professions, WDCs or HEIs.

However, it is suggested that, pending the establishment of national systems, once there are firm project plan commitments with definite development timescales then a moratorium on duplicating local developments should be implemented.

56. Workforce information needs and requirements should be aligned with **SAFFs and performance management in general and in particular the HR performance management framework.** This entails analysing the information requirements and timetable in each process in great detail and aligning them wherever possible. Information flowing from the ESR could, of course, be accessed at any time, so issues such as the different timetables for collecting workforce and other information would cease to be an issue. If the recommendations in this review are accepted, it will be necessary to review how workforce development issues are covered in the performance management framework.

57. The need for information sharing emphasised so often in this report would be assisted if there could be faster progress to enabling **net access** – for example, it can often take several days to deliver e-mails over the NHSNet, if they arrive at all. There should be better access to the internet and NHSNet at all levels.

58. A formal agreement should be established as quickly as possible with **HESA** to cover systematic access of information on students, HE staff and other relevant data. It is crucial to the workforce planning process to know how many students are training to become healthcare professionals. Although some information is currently available on the annual intakes to particular healthcare disciplines or concerning the total number of students training in a particular healthcare discipline there is no commonality of information across the range of health care courses. The information currently available also makes it very difficult to calculate attrition rates from either particular disciplines or courses.

    The information already currently collected by HESA on students studying at HEIs should produce significant benefits to workforce planners. It will enable them to identify the number of students actually in each year of training for the various healthcare professions, thus enabling them to project how many new entrants to the labour market there will be at given points in the future.

The next steps

59. A complex range of recommendations have been put forward by this review and these will need careful consideration in terms of development and further scoping. It is suggested that a sensible approach will be to establish a steering group to oversee the necessary programme of work

and consider changes which may emerge as a result of any formal consultation process.

60. The work of the minimum workforce dataset underpins the information requirements of the new workforce development structures, and therefore this activity should move forward with some urgency.

APPENDIX 1

The ESR might contain:

	Unique identifier	▪ ensure single counting ▪ provide links between record systems ▪ facilitate individual password/log-on for employee input
	Family name	▪ needed at local employer level ▪ needed to link students to placements and courses
	Forenames	part of identification process above
	Date of birth	Age analysis for: ▪ supply forecasting ▪ retirement planning ▪ equal opportunity monitoring
	Age (calculated)	As date of birth but sometimes easier for quick analysis and reporting
	Gender	▪ supply forecasting, linked with age ▪ workforce planning ▪ participation rate modelling ▪ understanding the labour market factors ▪ equal opportunities monitoring and intervention
	Disability status	▪
	Ethnic origin	▪ supply forecasting ▪ recruitment activity ▪ workforce planning ▪ demographic modelling ▪ understanding the labour market factors ▪ equal opportunities monitoring and intervention
	New field – country where primary qualification was gained?	▪
	Nature of contract	▪ supply forecasting – contracts of different length and status ▪ understanding reasons for turnover and wastage
	Whole time equivalent	▪ base for forecasting numbers ▪ links with establishment planning and finance
	Part/full time indicator	▪ factor used in determining education commissioning levels ▪ to ensure number of training places is based on actual bodies rather than whole time equivalents (WTEs)

		▪ (ratio of p/t to f/t is used to increase the wte) ▪ used in labour market analysis to check competition for staff ▪ links to age in supply planning ▪ used for planning flexible working options
	Date of joining NHS	▪ used in supply planning to analyse trends in length of time in organisation ▪ Indicates likely duration of careers ▪ Indicates stability/wastage
	Date of rejoining NHS (may be multiple)	▪ NHS is notable for number of times people leave and re-join ▪ supply planning ▪ understanding flows in and out of NHS/healthcare ▪ understanding career patterns ▪ *NB difficult data to verify for non-pensionable staff*
	Date of current contract start	▪ used in analysis of stability, turnover, wastage ▪ supply planning ▪ equal opportunities analysis ▪ HR management issues ▪ allows flows to be analysed at points in time
	Date of starting current post	▪ used in analysis of stability, turnover, wastage ▪ career planning ▪ equal opportunities analysis ▪ supply planning ▪ HR management issues ▪ allows flows to be analysed at points in time
	(Calculations on 'time in ...' expressed as number of years to be derived from all these date fields)	
	Grade level indicator	▪ understanding the 'HR system' and how people move through the organisation, especially linked to age or time in post ▪ career planning ▪ equal opportunities analysis ▪ supply planning ▪ skill mix review
	Payscale (national, where available or when re-introduced)	Grade identifier for doctors under current coding systems (specialty codes do not indicate level)
	NHS sector indicator (primary, secondary, intermediate etc)	▪ allows cross cutting analysis on databases ▪ allows comparisons and benchmarks to be drawn

		▪ aids understanding of rates and stats to have a quick identification of the sector
	Occupation code/s	▪ key code for analysing the staff groups and areas of work
	Second specialty code	▪ code for identifying doctors' real specialisation(s) ▪ needed to link to care group planning ▪ *consider using this for non-medical clinical staff also, to identify multi-disciplinary specialist teams*
	GMC/GDC number/doctors' index number (the D17) (plus any conditions on registration)	▪ link for identifying doctors and dentists across systems (Royal Colleges, Deaneries, trusts) ▪ indicates length of stay of overseas doctors *(through the different formats used)* Should this and the field below be just one field?
	Professional Registration numbers/identifiers (plus any conditions on registration)	▪ as doctors above, but for other clinical staff ▪ to provide links to or replacement of the separate professional body databases held on the same staff
	Main care group/disease group code NB: new codes to be devised	▪ new codes needed to link staff to care groups or disease groups for service/NSF/HImP planning (may need to indicate work in two or more care groups – would this need to indicate approximate time split also? Views welcome) ▪ occupation codes are too wide/non-specific ▪ *consider use of sub-specialty codes for non-medical staff?*
	Residency status	▪ supply planning for medical staff ▪ needs to be recorded for all staff?
	Post code of home address	▪ used in labour market analysis – travel to work indicators ▪ for service planning e.g. closure/ relocation planning ▪ to understand reasons for wastage ▪ to match to socio-economic factors in participation rate modelling
	Source of recruitment	▪ to understand flows in and out of the workforce (categories suggested in attached definitions paper) ▪ wastage, turnover and stability analysis ▪ to assess the success of initiatives such as Return to Practice ▪ to assist in scenario/policy modelling for changing the variables ▪ benchmarking recruitment and retention

		between organisations ▪ *needs consistent core categories across country*
	Destination on leaving	▪ to understand flows in and out of the workforce ▪ wastage, turnover and stability analysis ▪ to assess the success of initiatives such as Return to Practice ▪ to assist in scenario / policy modelling for changing the variables ▪ benchmarking recruitment and retention between organisations ▪ *needs consistent core categories across country*
	Reason for Leaving	▪ understanding of reasons for loss of staff ▪ helps with HRM intervention
	HESA student identifier (when appropriate)	▪ links with other systems ▪ learning records link ▪ identifies number of current students
	Qualified practice placement assessor/NVQ assessor indicator	▪ identifies potential for numbers of students/trainees ▪ link to practice placement system
	Highest job-related qualification indicator (non-teaching subjects)	▪ high level education and training analysis and audit
	Highest qualification (teaching)	▪ identifies potential for numbers of students and in-house training
	Highest qualification (research)	▪ will create database of those qualified to teach research methodology
	Subject of highest qualification	▪ identifies area of expertise
	NB details of all health academics to be available at WDC and central levels, taken from HESA staff database	▪ completes picture of NHS trained health staff ▪ assists in quality monitoring exercises
	Competence level indicator (to match new clinical staff pay structure levels – e.g. novice, experienced, specialist)	▪ provide high level analysis of competence levels linked to subjects and specialities ▪ to identify areas of concentrated expertise ***or*** of experience gaps ▪ to assist in modelling for service change ▪ to assist in planning for education commissioning
	Organisation and Location codes	▪ reinstate the NHS organisation codes at the second and third levels ▪ allows more detailed geographical planning

		▪ includes or could include a 'service type' indicator ▪ NHS organisation codes to be added to the HESA data sets
	Service area (internal to organisation)	▪ internal analysis and planning ▪ reporting and validation aid ▪ understanding management structures on systems ▪ especially needed when different systems are downloaded and then fed back into the information providers, so that they can have the added value of internal analysis
	Service type code	▪ if not included in organisation code, need a new service type code to map across to the NSF and HImP development/ improvement etc. ▪ e.g. to be able to identify members of multi-agency assertive outreach teams ▪ these should also map to standard activity coding, so that staffing to workload analysis can take place
	New sector code	▪ code to identify and link non-NHS employers if/when data is consolidated ▪ allows cross cutting analysis on databases ▪ allows comparisons and benchmarks to be drawn ▪ aids understanding of rates and stats to have a quick identification of the sector
	Personal Learning Portfolio/Record of Achievement	▪ to serve professional re-registration/revalidation purposes ▪ to feed FE/HE APEL and CATS schemes ▪ to satisfy NVQ assessment procedures ▪ to monitor Individual Learning Accounts ▪ to help with training needs analyses ▪ includes country of professional qualification
	(for junior doctors and some other staff – e.g. nurses undertaking second registrations) Time to completion of training/membership of rotations	▪ workforce planning ▪ links to other systems – Deans database, Royal Colleges/UK Competent Authorities