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Workforce Planning Guidance 2014/15

For 2015/16 Education Commissions

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WORKFORCE PLANNING GUIDANCE FOR THE 2014/15 ROUND FOR 2015/16 EDUCATION COMMISSIONS

Owner: Jo Lenaghan, HEE Director of Strategy and Planning

Status: FINAL

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Version: 5

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Foreword

The £5bn Health Education England (HEE) invests annually on behalf of taxpayers funds the training and development of the health care workforce in England. The NHS employs 1.4m staff in over 300 different professions across more than 1,000 different organisations who meet the needs of 1m patients every 36 hours.

This is a complex business with labour markets cutting across health, social and independent sectors and operating at all levels from local to international. The National Health Service needs a workforce plan that delivers locally and for the sum of the parts. HEE is the single accountable national body which leads and co-ordinates investment in the development of the health and public health workforce. Local Education and Training Boards (LETBs) are the regional presence of HEE, charged with ensuring that local commissioners and employers, informed by the needs of patients, are at the forefront of the planning and forecasting process.

In 2013 we published the first national workforce planning guidance, ensuring that there was one process which pulled together the medical and non-medical planning decisions, culminating in our first Workforce Plan for England. However, 2013 was a year of transition, so there was still some degree of variation in timescales and planning assumptions across the country, reflecting the position we inherited from SHAs. We have spent the past year working with LETBs to agree a consistent approach to workforce planning, supported by shared tools and assumptions. Our Workforce Planning Guidance for 2014 sets out clearly the roles and responsibilities of each part of the system, and the milestones which must be adhered to so that we can ensure that the local planning processes add up to a coherent and consistent whole.

In 2014, our challenge is two-fold: we must use our local and national processes to deliver on our Mandate requirements for this year, whilst ensuring our investments help drive the service transformation that will improve the quality of health and care for patients in the longer term. Our Mandate will be published by the Secretary of State for Health in the coming weeks, and HEE's fifteen year Strategic Framework will be produced shortly after.

Both will require bold and difficult choices to be made. Our Mandate will require us to have clear nationwide plans to ensure that we can deliver on our accountabilities; our strategy will make clear that if we are to meet the needs of future patients and better reflect the current direction of health policy, then services must change and the workforce must change with them. In a policy environment which encourages redirecting investment from acute settings into other services to reduce admissions and prevent ill health, we will need to look at rebalancing investment between different parts of the workforce.

2014 must be the year where LETBs and local providers and commissioners have challenging conversations about the likely needs of future patients, and about where investments (and disinvestments) should be made, not just in the numbers of staff, but the skills, values and behaviours of both our existing and future workforce.

The Workforce Planning Guidance for 2014/15 marks the beginning of these conversations, which we recognise are as important as the plans that they will produce.

1. Introduction

Workforce planning is about ensuring that the NHS has the people we need when we need them. With over 1000 different employers across the private, public and voluntary sectors employing 1.4m people in over 300 different types of jobs, workforce planning cannot be the sole responsibility of individual organisations. It is only through a collective approach that we can hope to deliver what patients need both now and in the future. Health Education England is now established as the single national body which leads and co-ordinates investment in the development of the health and public health workforce, accountable annually for almost five billion pounds of public expenditure on behalf of NHS patients. Local Education and Training Boards (LETBs) are similarly now established as the regional presence of HEE. LETBs have devolved budgets and are charged with ensuring that employers, informed by staff and patients, are at the forefront of the planning and forecasting process.

It is through these national and local arrangements that we will ensure that the workforce meets the needs of today's patients whilst delivering the future workforce in a way that not only maintains safe staffing levels, but supports the service transformation necessary to improve quality of care. The responsibility for planning to employ safe numbers of staff to deliver *current* services sits ultimately with providers and their boards. But through LETBs providers will influence the investments HEE makes in educating and training the *future* workforce. The engagement of providers will result in better decisions, but we recognise there will always be limitations in our individual and collective ability to predict the future.

This is the second year in which HEE has published comprehensive Workforce Planning Guidance for healthcare. In 2013 our guidance signalled a radical departure from what had gone before, tackling some of the historical systemic barriers to effective workforce planning. For the first time we pulled together the medical and non-medical planning decisions, providing an opportunity for relative priorities to be assessed across the entire workforce. The results of our planning process were published in the first ever Workforce Plan for England in December 2013, where we set out the level of education commissions we planned to make, and crucially, set out the basis for our decisions. Our Workforce Plan for England represented a significant step forward for the system, but we recognised that 2013/14 was a year of transition, and that we had to be more ambitious: to be not just more open and transparent about the numbers of staff that we commission, but to start to use our investments to drive the service transformation that future patients will require.

In the longer term, our ambition is to radically alter the way we plan the workforce of the future by beginning the move away from a process where we are essentially planning numbers through the lens of the registered professions, towards a system

that identifies the numbers, skills, values and behaviours that patients and their families need both today and tomorrow.

This guidance for the 2014/15 planning round builds on the lessons we have learned in the past year in respect of processes, timescales, and the roles of providers, commissioners, HEE and its LETBs. The guidance sets out whom in the system needs to do what and by when. It offers the opportunity for all partners in the service to decide the relative importance and priority for different kinds of workforce intervention and investment.

This guidance sets out clearly the milestones and timelines for the planning process to be operated in 2014/15 to produce 2015/16 investment plans. The deadlines are clear. Unlike the rest of the NHS, our annual planning process is driven by the academic sector, and so will always run between April and November. It is vital that our partners are aware of this so they can play their full part in ensuring we make the best decisions possible. How we meet the deadlines is as important as what we produce by when. For it is the conversations between providers and commissioners, between the health and education sectors at local and national level that will create the environment within which we can identify the workforce issues that need to be addressed. This requires a culture of transparency and openness, where we can share and challenge each other's assumptions, to ensure that the decisions we make result in better care for patients.

Our guidance this year is structured as follows:

- Section 2 establishes the importance of planning the workforce based on current and future patient need, and outlines the high level process for developing plans this year;
- Section 3 describes in more detail the roles of HEE and our partners in the workforce planning process;
- Section 4 sets out the timetable for delivery of components of the planning process;
- Appendix A elaborates on the context and on systemic improvements that are in train to improve the planning process.

As the 2014/15 planning round for 2015/16 education commissions unfolds HEE will:

- develop further more specific guidance notes covering medical workforce planning and other groups where, for one reason or another, the generic planning and/or commissioning process requires adaptation, and where collective 'all England' planning may be most appropriate;
- collate and share information on 'workforce hot-spots' and areas where there are clear indications that commissioning volumes may alter significantly. As well as avoiding staff shortages HEE is committed to avoiding excess over supply, so that the opportunity to invest in other high priority staff development is not missed.

2. A national framework for workforce planning

This section

- establishes why workforce planning is an important component of the planning of service commissioning and service delivery which must be rooted in the needs of patients;
- summarises the governance framework through which HEE discharges its accountability for investing in the current and future workforce; and
- outlines the process for developing HEE's investment plan.

The section sets the scene for the more detailed articulation of the roles of different parts of the system (section 3).

2.1 Workforce : everybody's business

2013 was the year in which discussions about staffing levels, skills, values and behaviours, and how staff are trained and developed moved centre stage. During 2013 the NHS transitioned to new structures, including the creation of HEE as the single national body to lead and co-ordinate investment in the development of the healthcare and public health workforce. At the same time a number of key reports were published with workforce at their centre. The Francis Report [1], the Governments' response to Francis[2], the Berwick review of patient safety[3], the NHSE review of Urgent and Emergency Care[4], the Cavendish Review of Healthcare Assistants and Support Workers[5] and the Shape of Training review[6] were all published within a 12 month period.

As a result, ensuring the adequate supply of staff with the right skills, values and behaviours in the right numbers to deliver safe, effective high quality care is now understood to be everybody's business, although HEE has specific responsibilities in this regard. This has been recognised in system guidance from NHS England, Monitor, the Trust Development Agency (see section 3.1), and in the collective expectations outlined in the National Quality Board guidance on safe staffing levels[7].

This guidance builds on the first ever guidance in 2013 and sets out what is required by each part of the system to ensure that Health Education England has a robust set of workforce plans and forecasts in order to ensure that when patients turn to the

[1] www.midstaffspublicinquiry.com/report
[2] www.gov.uk/government/news/francis-report-on-mid-staffs-government-accepts-recommendations
[3] www.gov.uk/government/publications/berwick-review-into-patient-safety
[4] www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf
[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf
[6] www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf
[7] http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

NHS for help, we have enough staff with the right skills, values and behaviours to meet their needs.

2.2 Clear governance

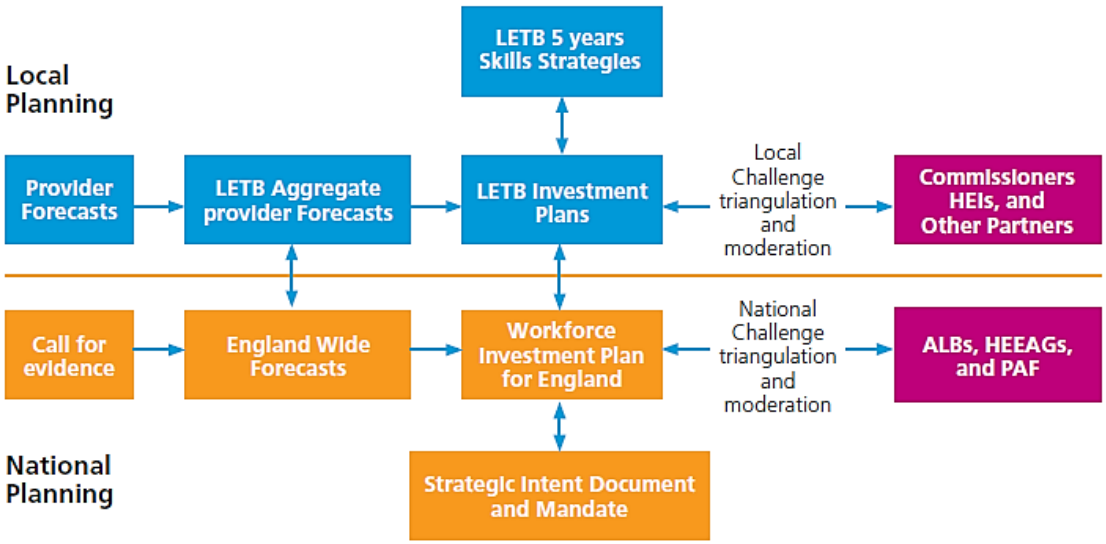
The Board of HEE is accountable for signing off almost five billion pounds of investment in the education and development of the workforce each year.

The Senior Leadership team (SLT) of HEE brings together the Executive of HEE and the Managing Directors of our LETBs, and this forum has a key collective responsibility for ensuring that the 13 LETB workforce investment plans add up to a coherent plan for England that will deliver our agreed priorities as set out in the Mandate **and** drive the service improvement and transformation required by patients.

The role of each LETB – the regional committees of HEE - is to provide assurance that the local plans which comprise the aggregate plan are, in turn, robust and evidence based, rooted in the plans of providers reflective of the intentions of commissioners. This is achieved by ensuring that LETB plans are the result of robust local and/or national processes of aggregation, triangulation, challenge and moderation.

In order to support this work there are national and regional advisory structures through which stakeholders contribute. The Figures below and overleaf summarise the arrangements that govern HEE's local and national investment.

HEE Workforce Planning Process



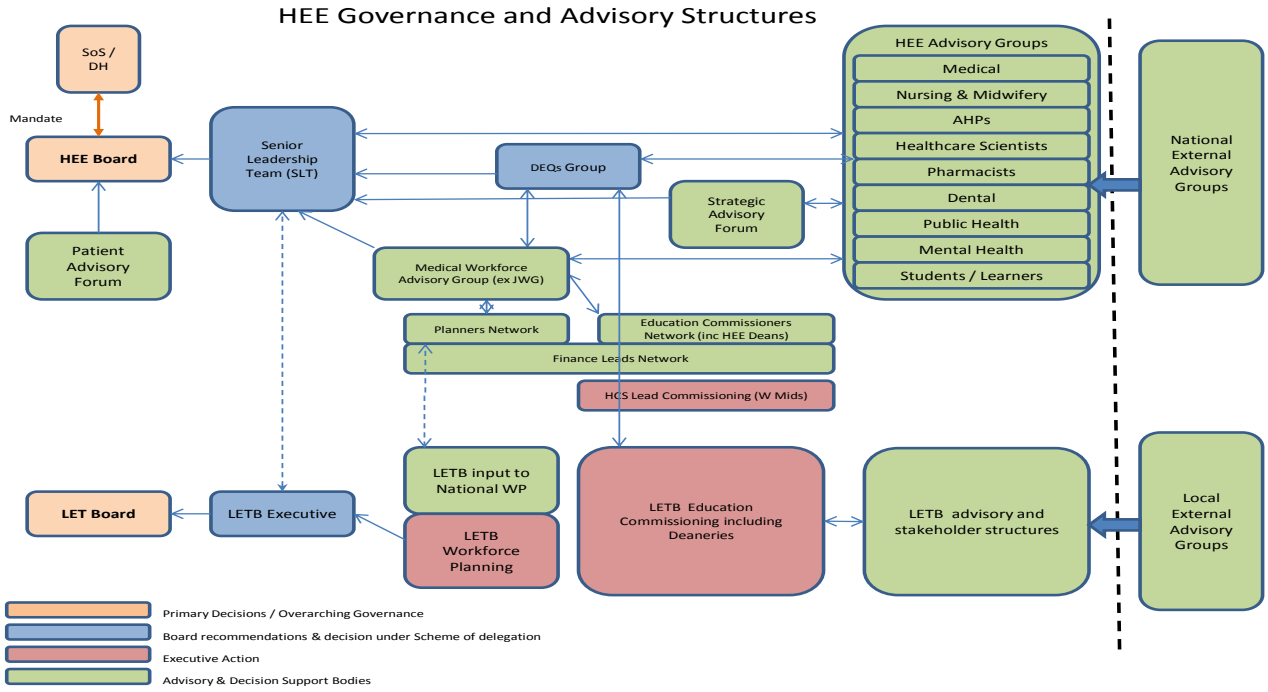
2.3 Evidence based prioritisation of workforce investment

LETBs, representing all local service providers and with links to commissioners and other stakeholders, create the forum whereby providers and commissioners can develop coherent plans to directly shape HEE's investment by collectively identifying the future staffing requirements in terms of skills, values and behaviours, as well as numbers.

The key benefit that HEE aims to achieve through this robust workforce planning process is the ability to compare the relative importance, priority and risk, for different activities and investments so that we are able to actively respond to the service's workforce needs.

Our approach relies on the following processes:

- Development of LETB workforce development and investment plans based on local stakeholder engagement, data analyses, data collection, challenge and review;
- Development of a national investment plan through systematic analyses of available national data from official and other sources, and aggregation, challenge and if necessary review of LETB plans;
- National triangulation between Health Education England and the other ALBs including NHS England, Monitor, the NHSTDA and the CQC; and
- Systematic engagement with national stakeholders throughout the course of the planning cycle, including with Royal Colleges, professional representative organisations and trade unions.



3. Roles and responsibilities

This section sets out the specific roles of partners in the health care system under the following headings:

- Service providers with service commissioners;
- LETBs;
- the HEE national team; and
- other Stakeholders

3.1 The role of service providers with service commissioners

The Health and Social Care Act places a duty on service providers to support the collective planning of future workforce supply. All Trusts are required (by the NHS Contract) to share their annual plans with their local LETB, to ensure that LETBs are able to have a full understanding of the current workforce and any key areas of under or over supply. This requirement extends also to providers from the independent and third sector. For some professions such as AHPs and nurses, effective planning depends upon us understanding the full supply and demand picture (see Appendix A).

Individual service providers, and in particular senior clinical leads, should also play an active role in assessing, challenging, moderating, and agreeing the aggregate forecast for their area through their LETB and associated stakeholder events. HEE expects Medical and Nursing Directors to sign off provider forecasts and workforce plans, in line with the agreed process for signing off Cost Improvement Plans (CIPs).

NHS Trusts and NHS Foundation Trusts are required by either Monitor or the Trust Development Authority (TDA) to produce their five year plans, including the workforce component. These plans, which will reflect commissioning intentions, should encompass workforce forecasts which are as accurate and robust as possible and should be consistent with the workforce forecasts shared with LETBs. These forecasts will form the basis for:

- the Trust Board, as an employer, to develop and deliver an effective workforce strategy to meet patients' needs, including shorter term supply initiatives and effective operational deployment; and
- the workforce plans and education commissions that HEE will make, through its' LETBs, to secure future supply and drive the longer term service transformation.

The TDA has collected workforce data in their two year plans and will be seeking five year forecasts in their June submission. The TDA in their planning guidance, make explicit their expectations:

'all Trusts need to ensure a robust approach to workforce planning, sign off, monitoring and reporting that ensures sufficient staffing capacity and capability throughout the year to support the provision of safe, high quality services'.

Access to NHS provider service plans is not the only way that LETBs will identify the workforce development needs of local providers. LETBs will have on-going dialogue with providers including other healthcare providers, commissioners, and networks, to identify existing gaps or emerging needs. This process of challenge, review and moderation informs LETB education investment plans.

NHS England requires commissioners to work with providers and partners in local government to develop strong, robust and ambitious future facing five year plans. NHS England proposes more holistic education commissioning plans, which reflect both provider and commissioner forecasts of future need, and therefore the workforce required to deliver transformational change in quality, outcomes and sustainability linked to five year strategic commissioning plans. It follows that CCG and Unit of Planning outputs need to be shared and discussed with LETBs.

The LETBs' processes of aggregation, stakeholder review and moderation of these forecasts will act to mitigate any potential weaknesses in individual forecasting.

3.2 The role of LETBs

System convenors

LETBs are local 'system convenors' for workforce discussions and the body that develops the local investment plan which forms the basis for the National Workforce Plan for England. NHS England require commissioners to work with providers and partners in local government to develop strong, robust and ambitious five year plans, and in turn HEE's LETBs will engage with commissioners to ensure that education commissioning plans are rooted in both provider and commissioner forecasts of future need, and therefore reflect the workforce required for a transformational change in quality, outcomes and sustainability linked to five year strategic commissioning plans. LETBs can only do this if commissioners share their plans with LETBs and engage in these discussions. This year, we expect LETBs to develop their understanding of supply and demand in the independent and third sector where this is relevant to their local health care economy.

Accessing provider plans and forecasting demand

All LETBs should have the opportunity to access locally the plans providers submit to the NHSTDA and Monitor so that they understand the current workforce position and the future intentions of their partners. Precise arrangements may vary locally. However, LETBs should be fully aware of any current or anticipated gaps (skills,

values and behaviours as well as numbers), in the current workforce. All LETBs will require future workforce forecasts from all of their NHS providers, as in aggregate, these will form the basis for their own plans.

These forecasts will identify future numbers of staff required and highlight direction of travel and potential risks. Of equal importance must be the identification of current and future needs in respect of skills, values and behaviours. HEE and its' LETBs have a key role to play on behalf of the service, to work alongside professional regulators to specify the skills and behaviours required of our future workforce as identified by the service itself. Specifying and commissioning these requirements from education providers is as central to our mission as defining the volumes of training we invest in. We will also work alongside service providers to explore how our joint role in respect of Continuing Personal and Professional Development (CPPD) operates to ensure that skills and behaviour gaps within the current workforce can be addressed.

It is for each LETB to agree with their service provider members how these forecasts are generated and shared (including different arrangements given the differing characteristics and capability of providers). LETB plans are shared with the HEE national team using the agreed 'Collective Forecast Demand Template', allowing the creation of a meaningful forecast at an England level.

Forecasting supply

Workforce planning is not an exact science. Future forecasts are inherently uncertain and factors other than the outcome of supply and demand forecasting will influence investment decisions. Such factors include programme viability, placement capacity, prioritisation of 'acceptable' risk, and availability of funding. It is within HEE's remit to provide assurance that proposed education commissions are credible, based in part on a proportionate investigation of likely futures and relative risk of over and under-supply. Hence each LETB will be asked to share, via an agreed Forecast Supply Template, an indicative supply forecast for each staff group for which HEE commissions pre-registration education.

Local challenge and review

Each LETB will hold local challenge and review sessions with their partners, including representatives of education provision, on future forecasts. It is for each LETB to determine how such processes are managed but the approach will involve feeding back aggregated intelligence alongside triangulation analysis and challenge on areas of perceived risk, in order to ensure that forecasts align with:

- Robust supply and demand analysis;
- LETB 5 year Workforce Development strategies;
- Local Commissioning intentions (at either CCG or Unit of Planning level);

- National Priorities as set out in HEE's Mandate; and
- National intelligence, generated through the 'call for evidence' instigated by HEE, including from professional and representative bodies such as patient organisations, Royal Colleges, employer groups, education provider groups, and sector skills councils.

LETBs should also ensure that these forecasts actively reflect the workforce needs of future transformed services as well as representing the needs of services as currently configured and delivered.

Such transparent challenge processes are vital to ensure assumptions are triangulated between individual organisations, are able to be compared to local commissioning intentions, create the opportunity for senior clinical input, and thereby generate stakeholder ownership and acceptance of any scenario (and tolerances) developed for the LETB area.

Following these local processes, each LETB should provide regional workforce forecasts linked to the outcomes of local discussion, as these will form the basis of the agreed Investment Plan Summary Template submission to HEE.

LETB workforce forecasts and development plans should be shared with LETB stakeholders and formally adopted by the LETB Governing Body to indicate they represent the consensus perspective of the service providers within the LETB.

Note: It is important that we continue to stress the nature of these forecasts in the context of their purpose. Any specific numbers generated do not and cannot represent what the sum of the local providers are planning to do by a date five years into the future. The purpose of this forecasting is to identify the general direction and scale of demand and supply, such that the best possible decisions can be made about how this need is met through our education and training investment.

Factoring in agreed priorities

LETBs' plans will be expected to pay particular attention to areas of the workforce where HEE collectively has identified potential over or under-supply. HEE will work with LETBs in April and May to gather information in order to provide early signals to the system of areas where we anticipate significant shifts of investment.

Investment plans

LETBs will subsequently use their agreed LETB workforce demand and supply forecasts and the nearer term workforce needs identified in annual service plans to develop their **LETB workforce investment plan.** These plans will be developed within the context of, and with reference to, the LETBs overarching five year workforce development strategies and HEE's fifteen year Strategic Framework.

The future forecasts and assessment of need in annual service plans represent a 'needs analysis' or *'diagnostic'* processes. Investment plans represent the *action* HEE intends to take, and money that will be invested in response to these identified needs.

These plans must therefore:

- demonstrate how service transformation will be driven through a combined set of actions with regard to the numbers, skills, values and behaviours of their workforce;
- show the local component of any activity and investment agreed collectively at a national level; and
- explain how any barriers to implementation, e.g. placement capacity or sustainability of education provision, have been fully identified, discussed, and an approach to overcoming any such barriers has been agreed.

A key objective of the HEE planning cycle is to create the opportunity to consider priorities across professional groups, between the needs of the current and future workforce, and between capacity priorities and capability priorities.

From 2014 onwards LETBs will need to develop and demonstrate further capability in planning the medical workforce based on robust analysis of demand and supply whilst working closely with providers to manage risks associated with potential decommissioning of training posts. This is far from straightforward and there are few 'quick fixes' but it is essential if HEE is to invest appropriately to deliver the workforce of the future. The Medical Workforce Advisory Group will develop further guidance.

The various proposals for investment need to be brought together to enable stakeholders and LETB Boards to consider the relative workforce risks and priorities of these proposals.

Section 4 sets out the timetable for the staged development of LETB workforce investment plans and the aggregate Workforce Plan for England.

3.3 The role of the HEE national team

HEE nationally has three roles in respect of workforce planning;

(i) <u>The Workforce Plan for England</u>

HEE is legally required to produce a national Workforce Plan for England each year. As part of this process, HEE will produce an **England workforce forecast** based on the aggregate of the final moderated LETB workforce forecasts that have been adopted by LETB Governing Bodies. This collective England wide forecast will be

shared with the SLT, HEE Board, and wider stakeholders and be subject to processes including triangulation, challenge and moderation.

These challenge and moderation processes will create the opportunity for key professional, employer, and other national groups to influence the thinking of HEE nationally and LETBs and their partners locally. Other parts of the wider NHS system will also be invited to reflect on how these forecasts fit with their strategies.

At a national level, this will be particularly relevant to HEE's responsibility for assuring national security of supply and ensuring possible tensions between shorter and longer term priorities are exposed, discussed, and resolved, with reference to formal assessments of risk. This will also allow HEE to share and discuss supply issues between England and the devolved administrations.

The final moderated England workforce forecasts will be published in the 2014 NHS Workforce Plan for England following HEE Board approval on 16th December.

(ii) Lead on collective planning

HEE will lead on collective national workforce planning for a small number of agreed areas where the current characteristics of this planning warrants a collective approach. Where appropriate, such collective planning will be driven by the consensus forecasts of service providers contained in LETB future forecasts. These processes will produce **joint commissioning proposals** for discussion at SLT and subsequent inclusion within LETB workforce investment plans.

In particular proposals in respect of post-graduate medical recruitment will be generated for collective consideration by SLT through the Medical Workforce Advisory Group.

(iii) Accountable body

HEE will sign off **LETB workforce investment plans** in line with our statutory directions, and aggregate these investment plans alongside any planned national programmes of work to produce the **workforce investment plan for England.**

Sign off of LETB plans will be undertaken in the context of:

- assuring that LETB plans represent, in aggregate, secure national supply (including supporting service transformation);
- LETBs continued compliance with authorisation standards; and
- the formal requirement set out in HEE's Statutory Directions.

3.4 The role of other stakeholders

HEE is committed to making the best decisions possible informed by the best available evidence, that is openly and transparently considered. The role of key stakeholders in making this commitment a reality is critical. HEE has comprehensive advisory structures at national and local level, and it is vital that partners ensure that their expert input is heard in both our 'call for evidence' phase and during challenge and moderation phase of our process.

HEE's call for evidence

Providers and Commissioners of NHS services will be engaged locally through LETB processes. However in order to help us to fulfil our role HEE draws upon the experience and views of other key stakeholders. We recognise that many stakeholders generate important perspectives about the future workforce. We continue to seek their support and professional judgement in identifying key issues, perspectives and evidence, which we can use to shape our final plans through our formal 'Call for Evidence'. Submissions must be evidence based, and must address the core components of numbers, skills, values and behaviours, to ensure that our future workforce can deliver high quality care. The call for evidence is accessible and open to stakeholders all year round. However, to influence discussions between HEE and NHS England over the summer and autumn and to be considered in triangulation against numbers and other evidence, submissions should be made to HEE **by 30th June 2014**[8].

Alignment with other NHS ALB plans

HEE will convene a meeting of all relevant ALB partners to share the interim outputs from its planning process to assess and ensure consistency with major strategic and policy drivers.

[8] More details on how to respond to our Call for Evidence can be found at http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/04/Call-for-evidence_Template-2014_15-2.doc.

Figure 3 - System roles : summary

<table>
<tr>
<td>HEE
National level system convenor for workforce planning and education investment
Develop, with LETBs, workforce plans and education commissions for those areas where collective approach is warranted
Produce Workforce Plan for England based on aggregation of LETB demand, supply and Investment Plan submissions and national ‘sense check’ process
Sign off LETB investment plans</td>
<td rowspan="5">LETBs
Local level system convenor for workforce investment and development
Work with Providers and commissioners at Unit of Planning level to assess overarching implications of service plans
Supply Medical Training Stocktake to HEE in agreed format
Work with providers to develop aggregate demand forecasts and supply to HEE in agreed format
Run local challenge and review process
Develop aggregate supply forecasts and supply to HEE in agreed format
Work with providers on service implications of potential changes to numbers of medical training posts
Develop Investment Plan and supply to HEE in agreed format
Follow procedure for any variation from plan post publication of Workforce Plan for England 2014
Commission pre-registration education and manage delivery and quality
Commission post-graduate medical education and manage delivery and quality
Commission CPD, access and other relevant education and manage delivery and quality
Develop, with HEE central planning team LETBs, workforce plans and education commissions for those areas where collective approach is warranted</td>
</tr>
<tr>
<td>Providers
Make available to LETBs workforce information relating to planning submissions to Monitor/TDA
Develop and supply signed-off workforce demand forecasts and workforce strategy to LETBs in agreed local format</td>
</tr>
<tr>
<td>CCGs
Develop strong robust ambitious 5-year plans
Work with providers and LETBs to develop education commissioning plans consistent with service plans at Unit of Planning level</td>
</tr>
<tr>
<td>ALBs
Work with HEE at national level to assess and ensure consistency between workforce plans and major strategic and policy drivers</td>
</tr>
<tr>
<td>Stakeholders
Contribute to HEE’s formal ‘Call For Evidence’
Participate in wider stakeholder forums and opportunities</td>
</tr>
</table>

4. Processes and timetable

4.1 Early signalling of high priority areas

LETBs have been asked to identify particular areas of the workforce where there is significant risk of over or under supply and/or where education commissioning volumes are expected to shift significantly. There will be a further iteration of this process later in the planning round.

4.2 HEE's Call for Evidence

This is described in section 3.4 above. The call for evidence is accessible and open to stakeholders all year round. However, to influence discussions between HEE and NHS England over the summer and autumn and to be considered in triangulation against numbers and other evidence, submissions should be made to HEE **by 30th June 2014**.

4.3 Staged development of plans

LETBs will agree local processes for the collection, analysis, challenge and moderation of workforce forecasts with their local stakeholders and partners. The key milestones are as follows:

1	LETBs will return the agreed aggregate Collective Forecast Demand Template to HEE by **15th August**. This timetable allows LETBs the time to collect plans from providers at the same time as Monitor and TDA require analogous service plans (early June), to collate and 'sense check' these plans and begin local challenge, review and moderation processes. At the same time HEE will be working with NHS England to distil the key expectations from the service 'direction of travel' that workforce plans will be expected to exhibit. LETB returns will be aggregated during August to provide an *initial* overview of the workforce 'direction of travel' at national level which will be shared with the HEE Senior Leadership Team (SLT), the Strategic Advisory Forum, the Patients Advisory Forum, HEE advisory groups and wider stakeholders. This aggregate England position will be used as just one element of local and national triangulation and challenge processes. In particular we will compare and contrast this position with national intelligence provided through the 'call for evidence' exercise.
2	LETBs will return aggregate supply forecasts using a common Forecast Supply Template. For groups identified as high priority these supply forecasts will

	accompany the demand forecasts above.
3	HEE working with LETBs will provide initial planning assumptions in respect of financial allocations to be used in producing initial investment plans. LETB Investment Plans will contain agreed contingent actions for differing funding scenarios such that final plans can be rapidly produced once final allocations are confirmed.
4	LETB Managing Directors will share progress on the development of their investment plans at the SLT meeting scheduled for **28th August.**
5	LETB investment plans will be summarised in a standard Investment Plan Summary Template to be submitted by **26th September.** The September submission is to be regarded as the main submission. The template will allow for submission of a 'core plan' based on initial financial assumptions and will explore how the investment might be prioritised under different financial scenarios. This submission will support assessment of priorities alongside each other. The template will summarise the number of commissions the LETB proposes and the associated investment, and capture how commissions might vary under defined financial scenarios (that is percentage changes in overall allocation). The Template will capture summary narrative underpinning each proposed volume for every group rather than the full narrative LETBs will record in their full written investment plan that the local governing body signs off. However the Investment Plan itself, and thus the summary data captured on the template, will be the product of the LETBs' extensive local engagement on forecasts and priorities over the preceding six months. HEE will aggregate this intelligence to produce the initial view of the potential England wide position in respect of the level of financial investment in different activity types of activity and the education commissioning volumes associated with this prioritised investment. Working with LETBs this will be made available to stakeholders during early to mid-October.
6	During the course of October HEE and LETBs will refine investment proposals as necessary. A revised Investment Plan Summary Template submission will be required from each LETB a month later – by **29th October**. This will be a final update: the expectation is that changes between the two versions will result only from significant new information, significant local developments, or

	advice flowing from the national oversight of the aggregate plans. HEE will aggregate these LETB templates into a revised England wide position and develop further commentary and analysis on national stakeholder feedback. HEE's SLT will then consider this revised position and commentary in November. One of the key outcomes will be assurance that the post graduate medical proposals within this position can be supported within the context of any wider priorities. This will enable HEE to signal ST1/CT1 recruitment ranges to the system.
7	In November HEE and LETBs will make any final amendments to investment plans to create the **Workforce Plan for England** which will go to the Board of HEE on 16th December and then be published.

NB: **the 26th September submission is crucial**. The national report developed from this will the form the basis for HEE's conversations with the other NHS Arm's Length Bodies (ALBs) and is the report HEE will take to HEE's Advisory Groups.

LETB's will be expected to have their forecasts formally adopted by their local governing body through their local processes.

There can be no slippage in the dates above.

4.4 Variation from plan

The Workforce Plan for England published in December will set out HEE's intentions. This is the aggregate of the agreed investment intentions of the 13 LETBs. **The expectation is that the plan as agreed will be delivered.**

However on an *exceptional* basis there may be justification for variation from plan at LETB or national level. The process for obtaining formal approval for the change is as follows:

- individuals or organisations seeking a variation from the education commissioning plan at *local* level must set out the proposal and the rationale in writing to the MD of the LETB concerned. The MD needs then to raise this directly with the HEE Head of Planning and Information who will advise on whether the change needs to go to the Executive of HEE, the Medical Workforce Advisory Group, the HEE Senior Leadership Team, or can be approved by the local LETB Governing Body.
- individuals or organisations seeking a variation from plan at *national* level must set out the proposal and rationale in writing to the HEE Head of Planning and Information who will then advise on next steps.

The closing date for any such proposal (either local or national) is 28th February 2015.

Figure 4: Planning round submission and deadlines

	2014								2015
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Feb
Early signalling of high priority areas (iterative) from LETBs to HEE (1)	X		X						
Stocktake of medical training posts & trainees from LETBs to HEE (2)		X						X	
Call for evidence 'soft close' (wider stakeholders)			**30th**						
Collective Forecast Demand Template from LETBs to HEE (3)					**15th**	(26th)			
Planning Round Update report to SLT					**28th**				
Workforce Supply Template from LETBs to HEE (4)					**15th**	26th			
Investment Plan Summary Template from LETBs to HEE (5)						**26th**	29th		
Proposals for variation from plan (6)		`							**28th**

Notes

1	First iteration of 'early signals' is complete. Dates of second iteration to be confirmed
2	Census dates for Stocktake are 1st April and 1st October. Submission dates to be confirmed in context of local and national priorities.
3	The second submission of the collective demand template (26th September) is an opportunity for LETBs to submit post-moderation version
4	The submission of the supply forecasts on 15th August will cover high priority groups.
5	The 26th September submission is to be regarded as the main submission. The 29th October submission will be a final update: the expectation is that changes between the two versions will result only from significant new information, significant local developments, or advice flowing from the national oversight of the aggregate plans

Figure 5 :Process timeline

	Local (LETB) processes		National Processes
April	Local LETB processes for establishing future workforce requirements through engagement with CCGs and providers.		Early engagement with national stakeholders
		<----->	Final development of process and submission templates
	Early review of key priority groups	<----->	Early review of key priority groups 'Launch' Planning Round
May	**Medical Training Stocktake submission**	----->	
		<-----	**Collation, review and analysis and feedback of Medical Training Stocktake**
June	Engagement with CCGs at 'Unit of Planning level'		Guidance on priorities & allocation assumptions **'Soft Close' of Call for Evidence**
July	Review and moderation of aggregate volume forecasts LETB estimate of future workforce demand		Continuing engagement with national stakeholders National supply modelling
			Review Call for Evidence submissions
Aug	**Submit Demand Template (15th Aug)**	----->	
	Submit supply forecasts for high priority groups (15th Aug) Ongoing stakeholder review of proposals	----->	
	Progress report to SLT (28th Aug)	----->	
			Aggregation and review of Demand and Supply Templates
Sept	Development of education commissioning and other workforce development proposals	<-----	**Feedback aggregate demand**
		<-----	**Feedback aggregate supply for high priority groups**
	Submission of Investment Plan Template (26th Sept)	----->	Triangulation and review of Investment plans
Oct	LETB workforce forecast formally adopted by LETB Governing Body		**HEE national level engagement with ALBs**
		<-----	Aggregation to form initial England-wide investment position.
		<----->	Collectively agreed revisions to local plans in light of national supply and priority considerations
	Submit any changes to Investment Plan Template (29th Oct)	----->	
			Draft Workforce Plan for England
Nov	Collectively agreed revisions to Investment Plan impacting on LETBs adopted by LETB Governing Body		
Dec		<-----	**HEE Board approve Workforce Plan for England**
	LETB plans disseminated		
Jan	Local confirmation with HEIs		
Feb	**Deadline for proposed variation from agreed Investment Plan (28th Feb)**	----->	**Consideration and response to proposed variation from agreed Investment Plan**
Mar		<-----	

Appendix A: The context for HEE's Planning and Commissioning Processes

This section sets out the context within which the Workforce Plan for England to be published in December 2014 will be developed. The section is set out under the following headings:

- A.1 summarises the education HEE investment to meet the needs of current and future patients;
- A.2 describes the workforce that HEE's investment fuels;
- A.3 explores planning for groups where NHS trusts are not the employer or the only employer.

This section also summarises developments in train to improve the information and intelligence which form the basis of workforce plans and thus education commissioning intentions and thereby increase confidence and assurance that HEE is investing in the right programmes and intervention:

- A.4 sets out how the timetables for commissioning education have now been harmonised through the single investment plan;
- A.5 summarises the processes NHS England, Monitor and the Trust Development Authority have now put in place to link workforce and service plans at commissioner and provider level;
- A.6 reviews ongoing developments in improving workforce data available to the system.

A.1 The education HEE commissions

Approximately £5bn of public money is invested annually in the training and development of the health care workforce in England. This pays for:

- Degree-level and diploma-level pre-registration programmes (for example, nursing, midwifery, allied health professions);
- Higher Level pre-registration programmes (for example NHS-based pharmacy, clinical psychology);
- Post-graduate education for the medical and dental workforce;
- Post-registration specialist training programmes which lead to qualifications recordable with regulatory bodies (for example Specialist Community Public **Health Nurses including** Health Visitors)[9];

[9] See RCN factsheet for explanation of regulatory framework and protected titles www.rcn.org.uk/__data/assets/pdf_file/0018/501921/4.13_RCN_Factsheet_on_Specialist_nursing_in_UK_-_2013.pdf

- Post-registration programmes which do not lead to recorded or registered qualifications or 'protected titles' but which support specialist practice (for example District nursing, Advanced Practitioners);
- Specific programmes for new roles for which regulatory arrangements have yet to be clarified (for example Assistant Practitioners); and
- Programmes to equip staff and new entrants to the workforce to develop their education or experience (for example apprenticeships, Foundation Degrees).

A.2 The workforce HEE investment fuels

While HEE adopts a common approach to planning, this needs to be flexible to accommodate a range of variation between training models, workforce and sectors.

- Some of the training above feeds a workforce almost exclusively employed in NHS settings, while some feeds more disparate provider bases tending in the main to NHS patients (in for example primary care and Improving Access to Psychological Therapies (IAPT) services), and some feed wider sectors including social care (e.g. occupational therapy) and the private health care sector (for example high-street physiotherapy). Section A.3 below explores workforce planning for groups where NHS trusts are not the employer or only employer.
- In some of the groups above the trainees are explicitly not part of the formal workforce (that is they are 'supernumerary' while training). In other groups trainees are explicitly part of the workforce delivering the service - most notably in post-graduate medical education.
- there are different labour markets in operation from the truly local to the genuinely international (for example, the majority of midwives, tend to work in the geographical area they trained in, while medical staff are generally more mobile in their early careers).
- some groups of staff are employed primarily within the NHS (e.g. midwives) while other groups of staff are found across multiple sectors (adult nurses). Others have a large private practitioner workforce (such as physiotherapists).
- HEE has access to varying levels of information of varying accuracy to support education commissioning from the well-established and detailed (ESR) to the more fragmented (for example community pharmacy).
- There are marked differences in the volume of annual commissions from over 12,000 (nursing) to tens (orthoptists) and even to single figures (some medical specialities).

It follows that the generic approach to workforce planning and education commissioning has to be adapted for different groups. The balance of planning

decisions between providers, LETBs on behalf of providers, LETBs on behalf of the system as a whole, and HEE as a whole varies.

The medical workforce provides the starkest example:

- HEE needs to ensure security of supply and avoid long-term over supply for each of nearly 70 recognised specialties plus further sub-specialties;
- LETBs needs to ensure local supply;
- Providers need to deliver services where doctors in training are a key component of the workforce and ensure a viable educational infrastructure.

These different perspectives on the same group – doctors in training – entail inherent tensions that are not easily resolved in the short term and require collaboration between the different parts of the system to effect change.

A.3 Workforce Planning for groups where NHS trusts are not the employer or only employer

Important components of the health and public health workforce are not employed by NHS trusts. It is vital therefore that our processes ensure the plans and future forecasts of other service providers and commissioners are fully considered. The three main groups for which this is true are;

- Public Health Workforce
- Primary Care Workforce
- Independent and third sector employers

In additional we fully recognise the need to understand the requirements of the social care workforce, not just because of the overlap with clinical professionals such as nurses or Occupational Therapists, but also because of the significant drive towards integrating services around individual people's needs, and the significant impact challenges in social care delivery may have on health services.

<u>Public Health</u>

HEE are working closely with Public Health England (PHE) and Local Authorities through the Public Health HEEAG to define the challenges to the public health workforce in its widest sense and to create clarity about the relative responsibilities of partners to plan and invest in workforce development. The Centre for Workforce Intelligence (CfWI)has been jointly commissioned by HEE and PHE to help us understand this disparate workforce better, including the role of all health professionals in terms of promoting public health through the 'making every contact count' policy.

In respect of public health specialist, the two main employers are Local Authorities and PHE itself. We will therefore be working with both of these stakeholders to

understand how we can gain a perspective of their future specialist workforce requirements to inform our commissioning of this key multi professional group.

Primary Care

The volume of GP training HEE plans to undertake is established in our Mandate. However this does not mean we should not seek to continually ensure that the future qualifying GPs we are about to produce are either sufficient or required by the needs of patients. Validating the amount of training we are undertaking will build confidence in, and understanding of, the investments we are making and thereby create additional support for overcoming some of the difficult implementation challenges we will face.

A number of local initiatives are underway to explore how best to secure effective forecasts of the future need for GPs. This includes exploring how individual practice plans may be accessed and aggregated, however there is a sense that the relatively small / dispersed nature of the service provider and the facet of self-employment means that securing a collective perspective is important. This could be through commissioners of primary care service and/or organisations representative of groups of GPs such as CCGs or LMCs. Clearly the work undertaken by the CfWI commissioned by the DH represents one important marker in respect of this collective perspective, but we must and will continue to refresh, communicate, and discuss this view of future need as widely as possible.

The focus on GPs must not detract from planning for the rest of the primary care and practice teams. These groups have historically been given too little focus, some of which is as a result of not being within a large employer with the capability to express future requirements. Most work has been undertaken at a local level, however HEE will now explore how we create a nationwide perspective on this potentially unmet need and ensure it is actively planned as part of an integrated primary and community workforce response especially given the likely renewed focus on services in settings other than hospitals.

To support this future forecasting work, significant progress has been made by the Health and Social Care Information Centre (HSCIC), DH, and HEE to establish a routine Minimum Workforce Data Set for primary care, which will enable stakeholders to track the current position and future impact of our investment decisions and other variables.

Independent and third sector Employers

The challenges of capturing the future needs and expectations for these providers of NHS commissioned services are different to the two groups above where key elements of the workforce represents distinct ‘professions’ such as GPs, PH specialist, or practice nurses.

The key issue for the independent and third sector is capturing their requirements for the large numbers of clinical professionals for whom we commission supply and for whom we routinely capture forecasts of future need from NHS trusts.

In part we have relied on observing the level of turnover from NHS organisations as a proxy for the degree of demand arising from these sectors. However whilst not invalid this is not as satisfactory as securing a primary perspective of any current challenges and future planned requirements.

NHS commissioned providers are required to collaborate but are not mandated to provide future plans and forecast in the way NHS trusts are through Monitor, TDA, and the NHS contracts.

We will continue to work with employers and their representatives to understand how their views on current issues and future need are systematically and actively considered. As with primary care good progress has been made in agreeing a minimum workforce data set to capture the current health commissioned workforce in these sectors. This should act as an important stimulus to ensure this key component of the overall health and public health workforce is considered alongside the NHS employed workforce.

A.4 Aligning education commissioning timetable

Prior to the establishment of HEE and its' LETBS in 2013 the planning processes for post graduate medical education, under graduate pre-registration non-medical education, and all other priorities (including the development of staff to undertake specialist roles, new roles and interventions training to support access to higher education for 'Bands 1 to 4') happened largely in isolation from one another. This was the result of several factors:

- different timelines: education commissions are driven by the academic year calendar which runs from September – September, whereas the business cycle in the NHS runs from April to April;
- different priorities: the bodies discussing and agreeing national workforce planning have been different from those developing and agreeing local workforce plans; and
- medical workforce planning in particular, but also planning for health care science tended to happen in isolation from the bulk of the 'non-medical' workforce planning.

Previous workforce investment plans risked being the sum of separate decision making processes, rather than the coherent outcome from an analysis of workforce need and relative risks and priorities. This resulted in non-alignment with the core

NHS planning processes and missed opportunities to respond to and influence service transformation.

In 2013 HEE brought the different workforce planning and education commissioning timelines together and published the plans simultaneously. The 2013 process threw into sharp relief the limitations of the pre-existing system:

- the disjoint between the processes underpinning plans were demonstrated;
- gaps in system-wide data were reinforced;
- the diversion of focussing attention solely on medical recruitment numbers rather than underlying posts needed to maintain or change the long-term supply of the medical workforce staff was clarified; and
- the complexity of the relationship between service provision and training for the trainee medical workforce, and the absolute necessity of understanding and resolving this issue at provider, health economy and national level were laid bare.

These problems will not be addressed by HEE and LETBs in isolation. This year HEE and the wider system has signalled important movements towards more integrated and evidence based workforce planning which explicitly recognises the 'trade-offs' and opportunity costs inherent but often ignored in investment decisions.

A.5 Integrating Workforce and Service Planning and Commissioning

Health Education England (HEE) exists for one reason alone: to help improve the quality of care delivered to patients by ensuring that our future workforce has the right numbers, skills, values and behaviours to meet their needs today and tomorrow. It follows that the HEE education investment must be fully aligned to the services NHS England and Clinical Commissioning Groups intend to commission.

In November 2013[10] NHS England, the Local Government Association, the Trust Development Authority and Monitor signalled in a joint letter to the health and social care sector the requirement to develop and implement transformative long-term strategies and plans for fully integrated health and social care services. The four co-signatories signalled a move away from incremental one year planning, requiring in addition plans which cover the next five years. This initial signal informed the more detailed guidance each body has since published.

[10]Joint letter from LGA, TDA, Monitor and NHSE to CCGs, Trust and FT Chief Execs, Local Authority Chief Execs, Directors of Social Services, and CSU Managing Directors, 4 Nov 2013 www.england.nhs.uk/wp-content/uploads/2013/11/jnt-plann-lett.pdf

- NHS England[11] requires commissioners to work with providers and partners in local government to develop strong, robust and ambitious five year plans. In a response to this the NHS Strategy Unit proposes more holistic education commissioning plans, which reflect both provider and commissioner forecasts of future need, and therefore the workforce required for a transformational change in quality, outcomes and sustainability linked to five year strategic commissioning plans.
- MONITOR[12] required a first phase submission (March) and will then conduct reviews (April and May) assessing the strength of foundation trusts' operational plans to address the two-year short-term challenge to 2015/16 looking at the degree to which foundation trusts have started planning for, and have already begun implementing, transformational initiatives. MONITOR then require a further submission on 30th June focussing on the robustness of foundation trusts' strategies to deliver high quality patient care on a sustainable basis. This phase covers five year financial projections and will focus particularly on the degree to which each foundation trust has developed realistic transformational schemes.
- The NHSTDA[13] requires trusts to submit two year Board-signed off plans and commissioner-aligned Operating Plans covering finance, quality, workforce and delivery followed by June five-year commissioner aligned Integrated Business Plans (20th June).

Where in the past NHS providers have produced annual workforce plans designed to ensure they are employing the right workforce to meet the needs of current patients, they are now required to provide future forecast five year plans, each including a workforce component. The new architecture has signalled explicitly that service plans have to be underpinned by workforce plans that acknowledge that staff resource cannot be turned on and off like a tap. They require commissioners and providers to take on board the practicalities of developing staff and the lead times entailed (it takes at least three years to train a nurse to be able to join the register, and longer to develop nurses to undertake more senior and specialist roles. It takes 15 years or more to fully train a consultant).

If follows that CCG plans need to inform LETB plans and that in turn LETBs need to support CCGs and area team planning. The assurance (by NHSE) of CCG plans will

[11] 'Everyone Counts : Planning for Patients 2014/15 to 2018/19. NHS England. www.england.nhs.uk/ourwork/sop/

[12] Monitor Guidance for the Annual Planning Review 2014/15 www.monitor.gov.uk/sites/default/files/publications/GuidanceAnnualPlanningReview2014-15Revised.pdf

[13] *Securing Sustainability – Planning Guidance for NHS Trust Boards 2014/15 – 2018/19* http://www.ntda.nhs.uk/blog/2013/12/23/planning-guidance/

assess levels of engagement with and input of LETBs, and how these have shaped strategic commissioning intentions. In turn HEE assessment of LETB plans will seek assurance that education commissioning plans are informed by CCGs service plans, working at the appropriate 'Unit of Planning'[14]

A.6 Improving data and intelligence

Standardising inputs

In 2013 HEE and its LETBs developed collectively agreed standard templates for the aggregation of workforce demand forecasts and education volumes and investment at LETB level. This standardisation makes it possible to develop aggregated and comparative analyses to enrich discussions within HEE and facilitated national level 'sense-checking' of aggregate commissions. In 2014 these collection tools and analysis products will be improved and augmented by a new standardised workforce supply forecast template.

The Workforce Information Architecture programme

It is not practical for each LETB to collect data and plans on the current and future workforce from every provider of services, across all sectors in their area, or every organisation that may employ healthcare professionals. For example there are approximately 8,000 Dental practices, 10,000 nursing and care homes, 11,000 GP practices and 12,000 pharmacy outlets in England. 2013 saw the formal launch of the 'WIA' programme with the publication of *'Workforce Information Architecture in the Reformed NHS Landscape'* (DH,2013), collaboratively lead by the Department of Health, HEE and the Health and Social Care Information Centre (HSCIC).

The scope of the programme is vast: designed to develop information systems to support planning across the whole system[15]. Development of the programme will continue for the years to come, providing oversight of whole system progress as well as implementing and embedding change across individual sectors. Current priorities for data, process and system development under the WIA programme are:

- Primary Care, incorporating General Practice staff, dental care, opthalmics and community pharmacy; and
- the Independent Acute Sector.

In 2014 a new workforce Minimum Dataset will be implemented across Hospital and Community Health Services (HCHS), GP & Practice and independent sector services, succeeding the previous annual census collected by the HSCIC. The outcomes of this data collection will provide the system at local, regional and national level with more granular, wider reaching and accurate data on which to base

[14] For further discussion of Units of Planning see 'Everyone Counts' www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
[15] For further details on the WIA see http://www.hscic.gov.uk/wMDS

workforce planning. However, while the HSCIC continue to work with HEE, DH, NHSE and other partners, making significant inroads into the development of processes and data collection vehicles, these will not yield new data in time to support this year's planning round for 2015 commissions.

While the WIA develops towards full capability, LETBs will inevitably seek to plug gaps in the data locally. Efforts to do so and local systems and processes must inform and be informed by the goal of implementing ultimately systems which are streamlined and collect the prescribed minimum data set in the most efficient way and which supports nationwide planning.

Collaborating in data creation

In 2014 HEE will continue to develop and enhance available data sources through:

- the full implementation of the twice yearly medical training stocktake;
- closer working with partner bodies including Skills for Care, Skills for Health and the General Medical Council, and professional representative organisations including Royal Colleges; and
- more sophisticated secondary analysis of ESR and other data sources.

Key to this will be close collaboration with the Centre for Workforce Intelligence (CfWI), for whose work HEE is now the primary commissioner.

Glossary

Arms Length Bodies (‘ALBs’)	Executive agencies with particular responsibilities for business areas, accountable to, the Department of Health, Special health authorities and non-departmental public bodies which have a role in the process of national government, but are not part of government departments. Full list of NHS ALBs at https://www.gov.uk/government/publications/arms-length-bodies/our-arms-length-bodies
Establishment	Sometimes referred to as 'Authorised' or 'Planned' or 'Budgeted’ resource. Generally expressed as ‘WTE’ (see below)
Headcount	See WTE/FTE
Non-medical education Commissions	The number of student/training places invested in/planned to deliver newly qualified ‘non-medical’ staff to contribute to forecast workforce supply
Staff in post	The total number of employed (usually of a given group) available, or forecast to be employed at a given point in time
Workforce demand	The total number of staff (usually of a given group) required or forecast to be to required deliver a given (level of) service at a given point in time
Workforce Supply	The total number of staff available (usually of a given group) available, or forecast to be available to deliver a given (level of) service at a given point in time
WTE/FTE	Whole Time Equivalent or Fill Time Equivalent. The two terms are used interchangeably. This distinguishes the resourced required / in a post from the number of individuals (‘headcount’).