



Cynulliad National  
Cenedlaethol Assembly for  
Cymru Wales

## Health, Wellbeing and Local Government Committee

Inquiry into Workforce Planning in the  
Health Service and in Social Care

March 2008

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# Health, Wellbeing and Local Government Committee



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## Chair's Foreword

This is the first inquiry report by the Health, Wellbeing and Local Government Scrutiny Committee.

It is a measure of the importance that the Committee attaches to workforce planning in the NHS and Social Care that at our very first meeting as a Committee we agreed to look at this area as the subject of our first inquiry. In deciding to do so, I know Committee Members listened carefully and took into account concerns expressed to them by a range of organisations representing professionals working in the field about potential shortcomings in the workforce planning system.

Workforce planning may not be an issue that excites as much debate as some others in health and social care. Effective workforce planning needs to take account of a wide range of complex and variable factors where the effects of decisions taken today may not become clear sometimes for many years.

It is of fundamental importance, therefore, that the system for planning the staff needs of our health and social care services is as rigorous and robust as possible. We entrust the care of some of our most vulnerable people to these services and all of us depend on them when we are at our most vulnerable.

On behalf of the Committee, I should like to express my gratitude to all those who have contributed to this inquiry. I would also like to thank the Members of the Health, Wellbeing and Local Government Committee for their work in producing this report.

This report contains a range of recommendations that we believe will help improve workforce planning in the NHS and Social Care. I commend it to the Minister for Health and Social Services and to the Assembly.



**Jonathan Morgan AM**  
Chair, Health, Wellbeing and Local Government Committee

March 2008



## Summary and Recommendations

### Summary

We are extremely fortunate to have highly committed, hard working and professional staff running our health and social care services in Wales. These services rely on high quality, well trained staff and making sure the right staff, with the right skills, in the right numbers are employed is the essential foundation to any drive to improve services to the public. Getting it wrong means that improvements are more difficult to achieve and, at worst, can lead to failing or poor services.

The NHS in Wales employs around 70,000 whole time equivalent staff and a further 70,000 are employed in Social Care. This represents over 10% of all those in work in Wales and a huge investment of public money and resources.

Ensuring that we have the right people and skills in place, when they are needed, requires a clear planning framework, expert skills in workforce planning, the active contribution of all those with relevant professional and vocational expertise and the resources to do the job properly.

We have been reassured to find that the need for effective workforce planning has been recognised by the Welsh Assembly Government and that there is also a recognition that there needs to be improvement. We recognise that workforce planning is not an exact science and that even the best plans can be thrown off target by wider economic and social trends.

Despite this, we have found that planning is too often based on historic patterns rather than on future needs, particularly the need to develop more community based services. Those with relevant expertise, particularly Allied Health Professionals and the Voluntary Sector, are not as closely involved in workforce planning as they should be. In the NHS, further consideration needs to be given to integrating medical workforce planning with workforce planning for other health staff. Local Health Boards do not have the staff resources or the strategic perspective to contribute meaningfully to workforce planning. In Social Care, planning is often diffuse with insufficient attention paid to wider regional and strategic goals.

We are also concerned at the capacity of the organisation with central responsibility for workforce planning in the NHS. The Workforce Development Unit of NLIH (the National Leadership and Innovation Agency for Healthcare) employs nine people. Of these, only one is a fully trained workforce planner. Given that workforce planning is its main and central function this seems worryingly under-powered.

We have no criticism of the abilities or commitment of the individuals concerned, but we are concerned at the real possibility that illness or other unfortunate circumstances could leave the organisation with no-one available who has specialist training in this field. More than that, an organisation of the size and importance of the NHS in Wales surely needs

much greater central capacity to provide trained, professional advice on the staffing needs of such a significant employer and important public institution.

We are pleased that the Minister for Health and Social Services has recognised that the lack of skills in this area needs to be addressed. We hope that this will be done as a matter of some urgency.

Set out below are our recommendations. In later sections of this report we expand on our reasons for them and offer further background to our conclusions.

## Recommendations

### Health Service

*We recommend that the Welsh Assembly Government takes steps to improve the worrying lack of capacity that Local Health Boards have for contributing effectively to workforce planning. [1]*

*We recommend that the Welsh Assembly Government takes urgent action to employ or train additional workforce planners in the Workforce Development Unit of NLI AH. [2]*

*We recommend that the Welsh Assembly Government should consider how regional planning mechanisms might be strengthened particularly by bringing together Local Health Boards at a regional level. [3]*

*We recommend that the Welsh Assembly Government review the arrangements for the involvement of Allied Health Professionals (AHPs) in the workforce planning system to ensure that there is an identified person responsible for AHPs at local, regional and national level. This should include a representative of the Wales Therapy Advisory Committee on the NLI AH Workforce Development Unit stakeholder board. [4]*

*We recommend that NLI AH takes steps to ensure that the voluntary sector, patients' groups and the Trades Unions have a meaningful input into the new integrated workforce planning system [5]*

*We recommend that the Welsh Assembly Government reviews whether funding arrangements for post and pre-registration medical and dental training can be simplified to allow more coherent workforce planning. [6]*

*We recommend continuing close co-operation between the Welsh Assembly Government and the Health Departments of the other UK administrations on workforce planning issues. [7]*

*We recommend that the Welsh Assembly Government increases the number of undergraduate dental training places in Wales significantly and makes any consequential increases necessary to the numbers of those trained in professions allied to dentistry. [8]*

*We recommend that the Welsh Assembly Government investigates whether offering additional bursaries or other financial incentives could encourage more undergraduate applications from students in Wales. [9]*

*We recommend that the Welsh Assembly Government investigates whether offering additional bursaries or other financial incentives could encourage more newly qualified doctors to complete their postgraduate training in areas of shortage in Wales. [10]*

*We recommend that the Welsh Assembly Government further encourages Local Health Boards to employ more salaried GPs and Dentists. [11]*

*We recommend that investment to increase the numbers of community nurses and to train them for the enhanced role envisaged in “Designed for Life” should be a priority for the Welsh Assembly Government. [12]*

*We recommend that the Welsh Assembly Government looks at the practicalities of introducing a guaranteed employment or “internship” scheme for newly qualified nurses and for allied health professionals similar to the scheme that has been introduced in Scotland for nurses. [13]*

*We recommend that NLIAH as part of its implementation of the new integrated workforce planning system reviews the data it uses for workforce planning to ensure that it is as robust, relevant and complete as possible, particularly in the context of future service delivery needs. [14]*

*We recommend that the GP contract is amended as soon as possible so that GPs are required to provide basic information on the numbers and types of staff they employ. [15]*

*We recommend that the Welsh Assembly Government should introduce arrangements to allow training places in higher education to be commissioned over a 5 year cycle. [16]*

*We recommend that NLIAH works closely with the Welsh Language Board to develop suitable approaches to ensure that sufficient Welsh-speaking staff are employed in the NHS in Wales to meet patient needs. [17]*

### Social Care

*We recommend that as part of its review of regional workforce partnerships the Care Council for Wales (CCW) strengthens the links between them and the local workforce partnerships and develops the contribution they make to workforce planning. [18]*

*We recommend that the Welsh Assembly Government provides further support to voluntary and independent sector social care providers and service user groups to enhance their ability to engage with workforce planning processes. [19]*

*We recommend that the Welsh Assembly Government provides further guidance to local authorities to ensure that the commissioning practices of local authorities are fully interlinked with the workforce planning process. [20]*

*We recommend that the Welsh Assembly Government works with the Welsh Local Government Association (WLGA) to develop support and training for local authority workforce planning staff to enable local authorities to increase their capacity for workforce planning. [21]*

*We recommend that, subject to an evaluation of the English model the Welsh Assembly Government, through the Care Council for Wales should introduce a National Minimum Dataset to collect workforce information for the whole social care sector in Wales. [22]*

*We recommend that the Welsh Assembly Government, through the Care Council for Wales, reviews the post-qualifying arrangements for social workers with a view to improving clarity and consistency across Wales. [23]*

*We recommend that the Welsh Assembly Government undertakes work with partners in local government to harmonise the terms and conditions of employment of social workers. [24]*

*We recommend that the Care Council for Wales reviews its induction framework to ensure that local authorities take account of the needs of migrant workers, and that it renews efforts to ensure that the framework forms part of standard procedures for local authorities. [25]*

*We recommend that the remit of the current task force on the Welsh language in the health service be extended to include social care services. [26]*

### Health and Social Care

*We recommend that the Welsh Assembly Government reviews its health workforce planning strategy timetable to secure greater co-ordination with the social care sector at the earliest possible time. [27]*

*We recommend that the Welsh Assembly Government reviews the mechanisms for commissioning the training of occupational therapists and other therapy professions with a view to centralising these arrangements. [28]*

## Section 1 - Introduction

### Background

1.1 In our first meeting after the Committee was set up we agreed to carry out an inquiry into Workforce Planning in the Health Service and in Social Care. The inquiry started in September 2007 and we concluded taking evidence in January this year.

### Terms of Reference

1.2 We agreed the following terms of reference for the inquiry:

*To examine the effectiveness of the current arrangements for workforce planning in the health and social care sectors in Wales and to make recommendations about future arrangements, with reference to:*

- *The division of responsibility amongst organisations charged with workforce planning and the mechanisms they use*
- *The availability and quality of intelligence to inform workforce planning*
- *The involvement of all relevant stakeholders in the planning process*
- *Changing patterns of demand (including an ageing population) and service provision in the health and social care sectors, (including reconfiguration of services, use of new technology, new public service delivery arrangements)*
- *Cross border arrangements with the NHS in England*
- *Changing professional roles and training programmes*
- *Joint working between health and social care agencies*
- *The workforce needs of the public, voluntary and private sectors*
- *The recruitment of a workforce that reflects the diversity of the Welsh communities, including Welsh speaking staff and those from BME groups, and general equality issues with particular reference to the retention of staff*
- *Examples of good and innovative practice.*

### The Review

1.3 We conducted ten oral evidence sessions between September 2007 and January 2008 during which we took direct evidence from 48 individuals representing 19 organisations. We issued a call for written evidence to a wide range of organisations and via the media to which 17 organisations responded

1.4A list of those organisations and individuals who gave evidence in person is at Annex A, a schedule of the papers we considered and a link to transcripts of meetings is at Annex B. Those responding to the call for written evidence are shown at Annex C. These papers and the

transcripts of our public meetings are available in full on the Committee's pages on the National Assembly's Website [www.assemblywales.org](http://www.assemblywales.org). A glossary of terms used in this report is at Annex E.

## Section 2 - Background Information

### Statistics

#### NHS Wales

2.1 In 2001 the NHS employed 57,595 staff (whole time equivalent). This has grown to 70,620 staff in 2006<sup>1</sup> made up of the following categories of staff<sup>2</sup>:

- Hospital, medical and dental staff - 5,332
- nursing, midwifery and health visiting staff - 27,901
- scientific, therapeutic and technical staff - 10,242
- healthcare assistants and other support staff - 9,094
- ambulance staff - 1,444
- cleaning, portering, administration, estates and other staff - 16,607

#### Social Care

2.2 In social care, over 70,000 people are employed in a range of roles covering public, private and voluntary care but the picture is more complicated. The majority of staff provide direct care in domiciliary, residential or day care settings. The 22 local authorities in Wales together employ just under 30% of social care workers but only 5% of their workforce is employed in core social work services. Proportionately, the largest numbers of staff are employed in direct care settings and by private employers. Around 7% of staff are registered with a social work qualification with the Care Council for Wales<sup>3&4</sup>.

### Workforce Planning Arrangements

#### The Health Sector - Background

2.3 Central Workforce Planning in the NHS in Wales was first introduced in 1988 to address shortages in some professional staff groups. It comprised an annual circular, with an associated spreadsheet template sent to primary and secondary care organisations. In addition, every two years, the private and independent sector and social care workforce were surveyed. Information was aggregated and analysed to produce an all-Wales Plan, primarily to inform the commissioning of training places.

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<sup>1</sup> Provisional data

<sup>2</sup> Assembly Government written evidence - ref HWLG(3)-02-07p2 & HWLG(3)-06-07p4

<sup>3</sup> Chief Inspector of Care and Social Services Inspectorate Wales (CSSIW) written evidence - ref HWLG(3)-03-07p1 & HWLG(3)-06-07p4

<sup>4</sup> Care Council for Wales written evidence - ref HWLG(3)-05-07p2

- 2.4 In 1993, budgets for pre-registration medical training and some post-registration training were centralised in the Welsh Office with final decisions on education commissioning numbers made by Ministers. In 2001, the then Assembly Minister changed the process to one based primarily on assessed need rather than affordability.
- 2.5 In 2003, the Wanless Review<sup>5</sup> of Health and Social Care in Wales recommended<sup>6</sup> that the Welsh Assembly Government should “*review workforce planning mechanisms and put in place alternative methodologies which will ensure that the services are able to deliver the ambitious service strategy*”.
- 2.6 In response, in April 2006 the Welsh Assembly Government established the Workforce Development Unit (WDU) as part of the National Leadership and Innovation Agency for Healthcare (NLIAH). The WDU aims to provide the central workforce planning to support *Designed for Life*,<sup>7</sup> the Welsh Assembly Government’s strategy for Health and Social Care.
- 2.7 A WDU led group has now developed a new workforce planning system for the healthcare workforce in Wales which seeks to integrate workforce planning with strategic and financial planning at national, local and employer levels. This system is currently being implemented and it is too early to make a judgement on it. However, we are pleased to note the progress that is being made. A summary of the proposed new arrangements is set out at Annex D.

### The Health Sector – Current Arrangements

- 2.8 As noted above, new workforce planning arrangements are currently being implemented. A summary of the current arrangements<sup>8</sup> is as follows:

*“The Welsh Assembly Government provides guidance on the workforce planning arrangements each year to the NHS which includes the process and timescale for the submission of workforce plans.*

*The guidance from the Welsh Assembly Government requires all NHS Trusts in Wales to produce an annual workforce plan which is submitted to the Workforce Development team in NLIAH.*

*Local Health Boards (LHBs) are required to submit information on the staff they employ directly and also on local contractor staff and the staff the contractors employ, e.g. General Practitioners, Practice*

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<sup>5</sup> Review of Health and Social Care in Wales - Report of the Project Team advised by Derek Wanless - Assembly Government (June 2003)

<sup>6</sup> Wanless Report - para 4.56

<sup>7</sup> Designed for Life - Creating World-class Health and Social Care for Wales in the 21st Century - Assembly Government (May 2005)

<sup>8</sup> NLIAH written evidence - ref HWLG(3)-05-07p1

*Nurses and their staff and for this to be submitted to the Workforce Development team.*

*The workforce plans submitted to the Workforce Development Team in August one year will inform the number of students taken onto an academic programme thirteen months later.*

*The Workforce Development team provides advice and recommendations on education and training priorities to the Workforce Development Stakeholder Board and to the Welsh Assembly Government Commissioning Board. This is achieved through the analysis of the workforce plans submitted from the NHS, keeping up to date with other workforce planning issues such as the supply and demand for health service staff across Wales, the UK and to some extent globally.*

*The Workforce Development Stakeholder Board has representation from the NHS, the Welsh Partnership Forum, and the education sector, and agrees priorities and options for education commissioning based on workforce plans from the NHS, policy initiatives and intelligence from a wide variety of sources.*

*Within the Welsh Assembly Government there is a Commissioning Board which is chaired by The Director DHSS [Department for Health and Social Services] and its membership includes senior Welsh Assembly Government advisors. The Commissioning Board considers the recommendations from the Workforce Development Stakeholder Board and makes its recommendations to the Minister for Health and Social Services to enable the Minister to make the final decision on the number of education commissions each year and how the education budget for the NHS should be utilised.*

*Professional Advisors in the Welsh Assembly Government are consulted on the results of the workforce plans and provide advice before final commissioning decisions are made."*

## Social Care

2.9 Workforce Planning in Social Care is primarily the responsibility of individual employers and is therefore more diffuse with less central direction than in the NHS. As noted earlier, only around 30% of the workforce is employed directly by local authorities. Although most social care services are commissioned by the 22 local authorities in Wales they are provided by a wide range of other bodies as well as by the local authorities themselves.

- 2.10 Despite this, there are a number of central drivers<sup>9</sup>. These include the Social Services Inspectorate for Wales issuing guidance on human resource planning and the importance of accessible, up to date accurate workforce information<sup>10</sup>. The Care and Social Services Inspectorate Wales (CSSIW) has led developments and issued guidance aimed at improving the strategic approach to workforce planning issues by local authorities as commissioners of services.
- 2.11 Local authorities have set up whole sector social care workforce partnerships. The Care Council for Wales (CCW) has also supported the development of four regional social care workforce partnerships. These partnerships bring together a range of employers and training providers and other organisations and provide a vehicle for discussing workforce issues.
- 2.12 CCW also has the role of workforce regulation and development for the social care sector and is taking forward action on implementing Welsh Assembly Government policy in this area.

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<sup>9</sup> WAG, CSSIW, & CCW written evidence - ref HWLG(3)-02-07p2, HWLG(3)-03-07p1 HWLG(3)-05-07p2

<sup>10</sup> Planning for caring - Assembly Government (March 2003)

## Section 3 - Workforce Planning in the Health Service

### Introduction

3.1 During the course of its inquiry, the Committee took evidence from a range of stakeholders both orally and in writing including the Chief Executive of the NHS in Wales, the Minister for Health and Social Services and the Deputy Minister for Social Services. A full list of those who gave evidence to the Committee is in Annexes A and C. Our main findings in relation to the Health Service are set out below.

### Resources for Planning

#### NHS Trusts and Local Health Boards (LHBs)

3.2 The resources available for workforce planning in the Health Service are generally adequate to the task. However, we were concerned that in many cases LHBs do not become meaningfully involved in workforce planning. It is worrying that many appear to be simply too small to be able to devote significant resources to workforce planning and few appear to have significant relevant expertise or resources. Although they are relatively better resourced, we are also concerned that NHS Trusts may need more expertise in this area. The new integrated planning system<sup>11</sup> currently being implemented by NLIAH is likely to require even greater input from Trusts and LHBs.

**We recommend that the Welsh Assembly Government takes steps to improve the worrying lack of capacity that Local Health Boards have for contributing effectively to workforce planning. [1]**

#### Workforce Development Unit - NLIAH

3.3 The Workforce Development Unit in NLIAH was established in 2006 by the Welsh Assembly Government as the central workforce planning agency for the NHS in Wales. It is, therefore, a relatively new organisation and appears to have done much commendable work in its relatively short existence. We hope that the new integrated planning approach that it has designed and is now implementing will lead to a significantly improved planning system in Wales. We were impressed by the professionalism and commitment of those of its staff that gave evidence to the Committee and we commend them for the progress they have made.

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<sup>11</sup> See Annex D

3.4 The Workforce Development Unit is a relatively small organisation of only nine staff. We do not believe that this number necessarily needs to be increased significantly, although we would not rule out the need for more staff overall. However, we were extremely concerned at the balance of skills that the Unit has available to it. Of the nine staff employed, only one is a trained workforce planner<sup>12</sup>. We accept that some other staff have analogous skills in workforce development but given that the WDU has the central role for workforce planning for the whole NHS in Wales, this seems worryingly under-powered.

3.5 We wish to make clear that we have no criticism of the abilities or commitment of the individuals concerned, far from it, but we are concerned at the real possibility that illness or other unfortunate circumstances could leave the organisation with no-one available who has specialist training in this field. More than that, an organisation of the size and importance of the NHS in Wales surely needs much greater central capacity to provide trained, professional advice on the staffing needs of such a significant employer and important public institution.

3.6 We are pleased that the Minister for Health and Social Services has recognised<sup>13,14</sup> that the lack of skills in this area needs to be addressed and that indeed NLIAH are themselves considering this issue as part of the implementation of the new integrated planning process. We believe that improvements in this area now need to be made as a matter of some urgency.

**We recommend that the Welsh Assembly Government takes urgent action to employ or train additional workforce planners in the Workforce Development Unit of NLIAH. [2]**

## Organisation of Workforce Planning

### New Integrated Planning System

3.7 As noted above and set out in Annex D, a new workforce planning system is being introduced by NLIAH. We believe that the model proposed is an improvement on current arrangements although only time will tell. This makes consideration of wider changes to the planning process difficult at present. However, there are some issues that can be considered now. These are set out below.

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<sup>12</sup> Oral evidence to Committee from NLIAH - 17 October 2007

<sup>13</sup> Written evidence - ref HWLG(3)-12-07p1

<sup>14</sup> Oral evidence to Committee - 12 December 2007

## Regional Planning

3.8 The new integrated system currently being introduced envisages both national and local strategic workforce planning with local plans aggregated at regional level before being passed on to national level. The precise mechanism for achieving this is not clear nor is the value of what, on the face of it, is just a simple aggregation of plans at regional level. This seems to introduce an additional step that can just as easily be done at national level.

3.9 We have, however, been told by a range of organisations that a regional planning environment is important and we understand the value of structures that bridge the gap between the local and national levels. We are not convinced that sufficient thought has as yet been given to how this regional planning level should be constructed. Encouraging LHBs to pool resources in areas where they have common commissioning patterns might offer one way forward and might also help in addressing the capacity issues that are mentioned earlier in this report.

**We recommend that the Welsh Assembly Government should consider how regional planning mechanisms might be strengthened particularly by bringing together Local Health Boards at a regional level. [3]**

## Involvement of Allied Health Professions (AHPs)

3.10 Allied health professionals such as physiotherapists, speech and language therapists and occupational therapists play an extremely valuable role in the delivery of health and social care services in Wales. They are one of the keys to ensuring that people do not stay in hospital longer than they need to and can continue to work and make wider valuable contributions to society. They also help improve educational and other outcomes for children. As the direction of Welsh Assembly Government policy is to encourage services to be delivered more at a community level, the need for adequate numbers of trained allied health professionals becomes more pressing.

3.11 We have been told of shortages of some AHPs, particularly in relation to low-incidence, high specialty posts. We have also been told of “boom and bust” in the numbers of those trained compared to available vacancies. It may be impossible to reach a position where the numbers trained match vacancies exactly (although the evidence presented to us suggests that the most recent position is one where supply and demand are broadly in line).

3.12 This is not to say that there is room for complacency nor is it to argue against doing more to ensure that those who have received training at public expense are given greater assurance of being able to use and

consolidate their newly acquired skills in the workplace. We return to the latter issue, in particular, later.

3.13 Perhaps the most consistent criticism we heard from representatives of AHPs is that they are insufficiently involved as professions in workforce planning processes. We believe that closer involvement from AHPs in the planning process will help ensure that their concerns are given greater consideration. This in turn can only lead to a better informed and more accurate planning process, particularly at a time of changing needs.

3.14 We have considered the series of recommendations made to us by organisations representing AHPs<sup>15,16,17</sup>. Many of these are aimed at increasing the voice of AHPs in the planning system. Most of their recommendations are addressed either specifically or generally elsewhere in this report. However, we believe that the recommendation to formalise greater involvement by AHPs in the workforce planning system merits specific attention here and we believe that it should be implemented as a priority.

**We recommend that the Welsh Assembly Government review the arrangements for the involvement of AHPs in the workforce planning system to ensure that there is an identified person responsible for AHPs at local, regional and national level. This should include a representative of the Wales Therapy Advisory Committee on the NLIAH Workforce Development Unit stakeholder board. [4]**

#### Involvement of the Voluntary Sector, Patients' Representatives and Trades Unions

3.15 The voluntary sector and patients' groups also have an important role to play in ensuring that workforce planning takes into account as wide a perspective as possible, as do the Trades Unions. We recognise that finding a single representative voice for the variety of organisations whose views may need be taken into account in this area poses challenges. Nevertheless, NLIAH may want to consider how best it can ensure that there is a practical input from these groups.

**We recommend that NLIAH takes steps to ensure that the voluntary sector, patients' groups and the Trades Unions have a meaningful input into the new integrated workforce planning system [5]**

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<sup>15</sup> Written Evidence - Chartered Society of Physiotherapy - ref HWLG(3)-01-08p1

<sup>16</sup> Written Evidence - Royal College of Speech & Language Therapists - ref HWLG(3)-01-08p2

<sup>17</sup> Written Evidence - College of Occupational Therapists - ref HWLG(3)-02-08p1

## Funding of Medical and Dental Training

3.16 Through NLIAH, the NHS funds the training for a wide variety of registered practitioners such as nurses and allied health professionals and others. Funding for training the pre-registration medical and dental workforce, however, is primarily funded through the Assembly's Education budget while post-registration education is funded through the Post-graduate Deanery which is funded directly by the Welsh Assembly Government<sup>18</sup>.

3.17 This means that key elements of the funding for NHS progression planning (such as dental training)<sup>19</sup> do not fall within the responsibilities of the Minister for Health and Social Services. While there may be excellent co-operation between the various agencies involved, and there may have been reasonable historical reasons for this divide, there now seems to be recognition<sup>20</sup> that the position may not be tenable in future. In our view, the current arrangements are at best anomalous if not downright confusing.

**We recommend that the Welsh Assembly Government reviews whether funding arrangements for post and pre-registration medical and dental training can be simplified to allow more coherent workforce planning. [6]**

## Planning Across the UK

3.18 In most cases the employment market for medical and other health professionals is UK-wide with Wales having particularly close links to parts of England. Officials from the various UK Health Departments meet two to three times a year to discuss common workforce issues and to share workforce information. Members of the Workforce Development Unit also attend the meetings with workforce planners in England to exchange information and best practice.

3.19 Co-operation and data sharing will continue to be important in future, particularly as each administration develops its own specific organisational responses to the divergent challenges they each face.

**We recommend continuing close co-operation between the Welsh Assembly Government and the Health Departments of the other UK administrations on workforce planning issues. [7]**

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<sup>18</sup> e.g. NLIAH written evidence - ref HWLG(3)-05-07p1

<sup>19</sup> Minister for Health & Social Services - Oral evidence to Committee - 12 December 2007

<sup>20</sup> e.g. Written Evidence - Postgraduate Deanery - ref HWLG(3)-06-07p3

## Medical Recruitment Issues

3.20 We were told that there is a need for an increase in the overall number of dentists in Wales and that undergraduate training places need to increase by around 35% a year from its 2007 level of 55<sup>21</sup>. In our view, any increase in the numbers of dentists trained will also require a consequent increase in the numbers of staff trained in the professions allied to dentistry, such as dental nurses, technicians and hygienists.

3.21 The evidence on doctors is more equivocal. In his oral evidence<sup>22</sup>, Professor Gallen, the Postgraduate Dean, suggested that while there were difficulties in recruiting to some specialities, such as psychiatry, these problems were UK-wide and not wholly specific to Wales. He went on to say that the European Working Time Directive and increased part-time working indicated that there was a need to train more doctors but he was not personally sure that this was the long term answer.

3.22 In both dentistry and medicine the problem is more acute in certain parts of Wales. Mid Wales was identified by Professor Gallen as a particular area of concern and there have been long-standing concerns about GP numbers in the south east Wales valleys.

3.23 Other issues of concern in Wales include the relatively low proportion of medical undergraduates, around 38 percent, who come from Wales and the low number of first choice applications for undergraduate places from the rest of the UK. This means that Wales is heavily reliant on overseas medical graduates who make up around 50% of the intake.

3.24 While it has been assumed that a relatively high proportion of undergraduates will stay long-term within the area in which they first graduate, this does not seem to be the case in Wales where only around 20% of postgraduates completing the foundation programme apply to stay in Wales.

3.25 We recognise the difficulties in this area. We believe that Wales needs more dentists and doctors overall to help meet shortages that exist in parts of Wales. We believe the case for training more dentists appears to be made.

**We recommend that the Welsh Assembly Government increases the number of undergraduate dental training places in Wales significantly and makes any consequential increases necessary to the numbers of those trained in professions allied to dentistry. [8]**

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<sup>21</sup> Oral evidence - Postgraduate Dean - 24 October 2007: Written evidence - BDA - ref HWLG(3)-08-07p1

<sup>22</sup> 24 October 2007

3.26 We are not, however, convinced that increasing the overall numbers of training places for doctors is the best or only way forward. Increasing the proportion of undergraduates who come from Wales in the first place and then keeping more doctors in Wales once they graduate seems to be a higher priority at this stage and might produce benefits more quickly. Financial incentives to encourage students from Wales to train in Wales might be one way forward. Another might be to offer financial incentives to newly qualified doctors to work in areas of shortage in Wales. (In both cases this would need to be subject to a commitment to remain in the NHS for an appropriate time).

**We recommend that the Welsh Assembly Government investigates whether offering additional bursaries or other financial incentives could encourage more undergraduate applications from students in Wales. [9]**

**We recommend that the Welsh Assembly Government investigates whether offering additional bursaries or other financial incentives could encourage more newly qualified doctors to complete their postgraduate training in areas of shortage in Wales. [10]**

3.27 The use of salaried GPs in parts of Wales also appears<sup>23</sup> to have been successful in encouraging doctors to work in some of our more deprived areas. We believe that greater use of salaried GPs and dentists should be encouraged as a means of addressing specific regional shortages.

**We recommend that the Welsh Assembly Government further encourages Local Health Boards to employ more salaried GPs and dentists. [11]**

## **Nursing**

3.28 There has been a very significant increase in nurse staffing levels in the NHS in recent years<sup>24</sup>. The number of whole time equivalent registered nurses has risen by almost 20% since 1999 and by 4.5% since 2003. The actual numbers of registered nurses have risen even more significantly by 40% and 18% respectively.

3.29 These increases are welcome. However, the overall increases mask a decline in the number of district nurses and specialist community public health nurses (health visitors) since 1999 of as much as 10%<sup>25</sup>. This is of some concern, given the priority accorded to community based care in the "Designed for Life" strategy.

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<sup>23</sup> Oral Evidence - Minister for Health and Social Services - 12 December

<sup>24</sup> Written evidence - Royal College of Nursing - ref HWLG(3)-08-07p2

<sup>25</sup> ref HWLG(3)-08-07p2

3.30 We understand that an Welsh Assembly Government review of community nurse training was due to be finalised in December 2007 and will inform decisions on training numbers for 2008<sup>26</sup>. It will be important, whatever the detailed findings of this review, that the increasingly important role of community based nurses is fully recognised when commissioning training places.

**We recommend that investment to increase the numbers of community nurses and to train them for the enhanced role envisaged in “Designed for Life” should be a priority for the Welsh Assembly Government. [12]**

3.31 The Royal College of Nursing (RCN) in their evidence<sup>27</sup> to us were concerned at excess hours being worked by nurses. They also advocated a statutory requirement being placed on providers of patient services to ensure appropriate staffing levels for patient care. While we are equally concerned at excess working hours, we believe this issue is best addressed through the overall workforce planning process and by individual employers in the NHS.

3.32 A statutory duty of the kind described by the RCN has its attractions. There is certainly a need to assess need as well as affordability in workforce planning and we would expect the new integrated workforce planning system to do this. However, we believe that a statutory duty would be too inflexible and cumbersome.

3.33 The RCN also argued for a guarantee of employment within the NHS in Wales for all newly qualified nurses. They offered as a model a similar scheme being run in Scotland<sup>28</sup>.

3.34 The Scottish scheme acts as a sort of clearing house for those who have been unable to find employment in the normal way. They are provided with up to date details of posts within the scheme. The guarantee lasts for 12 months by which time it is anticipated that they will have secured a permanent post of their own choice, although this is not guaranteed. We believe this scheme has much to commend it, not simply in terms of employment but as a means of ensuring that newly qualified nurses can consolidate the skills acquired in training. Such a scheme might also act as a model for other health professionals, in particular allied health professionals.

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<sup>26</sup> Written evidence - Minister for Health and Social Services - ref HWLG(3)-12-07p1

<sup>27</sup> ref HWLG(3)-08-07p2

<sup>28</sup> Additional Written evidence - Royal College of Nursing - ref HWLG(3)-12-07p3

## Allied Health Professionals

3.35 We have already recommended that allied health professionals should be more closely involved in workforce planning at local, regional and national level. However, there remain specific issues of concern. For instance, low-incidence, high specialty posts are ones that need more focus in the planning process. Although not strictly within the remit of this inquiry, there are also issues of continuing professional development and management structures that need to be addressed for AHPs. Despite the apparent broad balance<sup>29</sup> between numbers qualifying and numbers employed, shortages of key professionals, such as speech and language and occupational therapists, have been reported for many years. On the other hand there have been occasions when there are insufficient funded posts available for all those that have qualified.

3.36 There are, therefore a range of issues that need to be addressed. The closer involvement of AHP representatives in the planning process should help ensure their specific issues and concerns are made more central to the planning process and will help start the process of addressing these issues. It will also ensure that the range of thoughtful recommendations that organisations representing AHPs have made can be factored directly into the planning process by those who understand these issues best.

3.37 As with nursing, there may be occasions when there are insufficient funded posts available within the NHS or with social care providers to ensure that all AHP graduates are able to find employment. In these circumstances, a guaranteed period of employment or “internship” was suggested by the Chartered Society of Physiotherapists as one way of ensuring that those who have received expensive training at the public expense are not lost to the public service.

3.38 We also believe, as with the scheme for nurses suggested by the RCN, such a scheme would help ensure the consolidation of skills acquired in training as well as ensuring that these skills are not immediately lost to the public service. Given the similarity of some of the issues involved, we believe it would make sense for the Welsh Assembly Government to consider these issues alongside one another.

**We recommend that the Welsh Assembly Government looks at the practicalities of introducing a guaranteed employment or “internship” scheme for newly qualified nurses and for allied health professionals similar to the scheme that has been introduced in Scotland for nurses.**

**[13]**

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<sup>29</sup> For instance, see para 2.11.2 of written evidence from the Chartered Society of Physiotherapists - ref HWLG(3)-01-08p1

3.39 We are concerned, however, that a position was reached where work was not available for trained therapists, particularly as these groups of staff are very important in developing community based services. We are pleased that the Chief Executive of the NHS in Wales accepted<sup>30</sup> that, particularly in relation to physiotherapy, the assumptions which had led to a reduction in requirements may have been incorrect. To help test these assumptions, the Welsh Assembly Government has established an active model pilot scheme in Carmarthenshire. We welcome this and look forward to seeing what conclusions are reached from the pilot in due course.

### Information Requirements

3.40 A number of the organisations who provided us with evidence either criticised the data and information base available for workforce planning in the NHS or made suggestions for improvements. We are not in a position to judge the merits of the various and often detailed suggestions made but the implementation of the new workforce planning arrangements seems like a good time to also look at whether the base information available to NLIAH and others involved in workforce planning in the NHS is as relevant as possible. This would also be an opportune time to review whether the data available is capable of informing decisions on future patterns of need, such as the move to more services delivered at a community level, as well as illustrating historic or current patterns of usage and spending.

**We recommend that NLIAH, as part of its implementation of the new integrated workforce planning system, reviews the data it uses for workforce planning to ensure that it is as robust, relevant and complete as possible, particularly in the context of future service delivery needs.**  
[14]

3.41 We were very concerned to learn from NLIAH<sup>31,32</sup> that under the new general medical services contract, GPs are no longer required to provide data to Local Health Boards on the number of hours worked or on staffing levels. This has led to NLIAH having very little data available to it from primary care contractors on numbers or type of staff employed.

3.42 We were told that a project is underway which may help address this gap in information. We welcome this but we remain concerned that GPs are under no requirement to provide this information. The Minister in her evidence<sup>33</sup> indicated that amending GPs' contracts to this effect would be a more substantial issue than it might appear. Despite this, we do not believe it unreasonable or unduly onerous for GPs to be required to provide basic information on the numbers and types of staff they employ.

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<sup>30</sup> Oral Evidence - 19 September 2007

<sup>31</sup> Written evidence - ref HWLG(3)—05-07p1

<sup>32</sup> Oral evidence - 17 October 2007

<sup>33</sup> Oral evidence - 12 December

We recommend that the GP contract is amended as soon as possible so that GPs are required to provide basic information on the numbers and types of staff they employ. [15]

## Planning Cycle

3.43 The difficulty of aligning workforce planning in the NHS with an annual (or even 3 yearly) financial cycle cannot be overstated. NLIAH told us<sup>34</sup> that commissioning is currently done on an annual basis. When commissioning they did not know the budget for the following year. This in turn puts Higher Education Institutions (HEIs) in the position of having very little time to respond to changing needs. If there is a requirement to increase the numbers of a staff group, HEIs are unlikely to have the teaching infrastructure in place to be able to respond in the relatively short time scales involved. Conversely, if the financial settlement dictates a reduction in numbers it can cause HEIs significant problems in funding and managing their own established staff.

3.44 These problems exist for all professional staff groups but are particularly acute when it comes to medical school training which lasts between 5 and 6 years. Postgraduate training can take anything up to a further 8 or 9 years depending on the specialism involved.

3.45 NLIAH is currently looking at this issue to see if there is a better way of aligning the financial and workforce planning cycles. The Minister is scheduled to consider their findings shortly. We do not underestimate the difficulties of moving to a longer commissioning cycle, however we are convinced that a way must be found to commission on a longer term basis than at present. Ideally, this would be over a period of 5 years but at a minimum there should be a 3 yearly commissioning cycle.

**We recommend that the Welsh Assembly Government should introduce arrangements to allow training places in higher education to be commissioned over a 5 year cycle. [16]**

## Diversity and Language

3.46 Individual organisations are responsible for the recruitment of staff to their organisations and have specific responsibilities for ensuring that equality and diversity policies are effectively implemented. NLIAH monitors the diversity of students recruited to NHS programmes within HEIs with the overall aim of recruiting students who reflect the populations they will work in. Although there is no room for complacency, we were pleased to note that the need for service delivery to reflect and show sensitivity to diverse

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<sup>34</sup> Oral evidence - 17 October

cultural and linguistic needs in communities across Wales appears to be well recognised among those who provided evidence to us.

3.47 On the Welsh language, the Welsh Language Board in written evidence<sup>35</sup> drew our attention to the importance the Welsh Assembly Government attached in *Iaith Pawb*<sup>36</sup> to "...being able to deliver services in the service users' language of choice in key areas such as health and social care...". They went on to draw our attention to a report by the Welsh Consumer Council which concluded "that in the case of Welsh-speaking patients, there are instances where they cannot be treated effectively except in their first language or in both their languages. This is especially true in the case of those receiving speech and language therapy, and for the following key groups: people with mental health problems; people with learning disabilities and other special needs; older people and young children. (Misel 2000: 5)"

3.48 Although there are somewhat different issues involved, many of the same themes arise in relation to languages other than Welsh or English and suitable provision needs to be made to meet these needs as well.

**We recommend that NLIAH works closely with the Welsh Language Board to develop suitable approaches to ensure that sufficient Welsh-speaking staff are employed in the NHS in Wales to meet patient needs. [17]**

#### Role of Local Service Boards

3.49 The Welsh Assembly Government response<sup>37</sup> to the Beecham Report<sup>38</sup> promised the establishment of Local Service Boards (LSBs) in each local authority area in Wales. The intention is that LSBs will bring together the key contributors to local service delivery in order to improve service delivery and undertake joint action where needed.

3.50 We understand the potential benefits that lie behind the concept of LSBs. If they prove to be successful in other areas of policy they may well merit a role in Health Service and social care workforce planning. However, the current health and social care commissioning environment is already a challenging and complicated one.

3.51 At this stage, we believe LSBs' involvement in the workforce planning process might complicate the position still further. We are also conscious

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<sup>35</sup> Written evidence - ref HWLG(3)-08-08p12

<sup>36</sup> *Iaith Pawb* - A National Action Plan for a Bilingual Wales - Assembly Government February 2003

<sup>37</sup> *Making the Connections* - Delivering Beyond Boundaries: Transforming Public Services in Wales - Assembly Government November 2006.

<sup>38</sup> *Beyond Boundaries* - Citizen-Centred Local Services for Wales - Assembly Government June 2006.

that LSBs themselves are not yet in a position to take on a formal role as they are still very much at the development stage and have yet to be rolled-out fully across Wales.

## Section 4 - Social Care

### Arrangements for workforce planning in social care

4.1 The arrangements for workforce planning in social care are very different and less developed than those for health services. This reflects differences in the way social care is provided and the diverse range of providers and patterns of service delivery, at the heart of which are local authorities. From the evidence we received it is clear that much valuable work is underway to develop the social care workforce, particularly in relation to the implementation of the Welsh Assembly Government's social services strategy *Fulfilled Lives, Supportive Communities*. But what is needed is a more unified approach that brings together the numerous strands of work underpinned by a system for obtaining comprehensive and robust information on the social care workforce.

4.2 Local authorities have responsibility for producing workforce plans for the whole of the social care sector in their areas, for both the services they provide directly, and for those they commission from private and voluntary sector providers. Social Care Workforce Development Partnerships, which aim to bring together providers from all sectors operate at the local authority level, and four regional workforce partnerships provide a second tier for engagement between a wide range of stakeholders, including education and training providers, at the regional level. The Care and Social Services Inspectorate Wales (CSSIW) (formerly Social Services Inspectorate Wales (SSIW)) has produced guidance<sup>39</sup> to local authorities on workforce planning and provides funding for the Social Care Workforce Development Partnerships.

4.3 We heard evidence of the complex and fragmented nature of the social care sector in Wales. The diversity of the sector in terms of the types of providers from the statutory, voluntary and private sectors creates considerable challenges for bodies and individuals tasked with planning its future workforce. Local authorities can provide information on their own staff but obtaining the same information from other providers, particularly in the private sector where there may be commercial sensitivities, can be more problematic<sup>40</sup>.

4.4 A recurring theme in the evidence to this inquiry has been the need for workforce planning to remain focused at the local authority level but within a nationally unified system. This would promote consistency across Wales

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<sup>39</sup> SSIW (2003) *Planning for Caring*

<sup>40</sup> Oral evidence, 21 November 2007, British Association of Social Workers Cymru para 184

and enable local workforce plans to be aggregated at a regional and/or national level whilst preserving local ownership of the information<sup>41</sup>.

4.5 We believe that the focus of workforce planning for social care should remain at the local authority level since it is at this level that engagement with local service providers across all sectors is most effective. It was clear from the evidence we received that there is little support for adopting a centralised, national approach to the task and that the current emphasis on local networks needs to remain and, indeed, to be strengthened. However, stronger links are needed between local and regional partnerships, and mechanisms must be developed that bring together the systems for health and social care workforce planning.

### **Workforce Partnerships**

4.6 Efforts to develop workforce planning in social care have centred on workforce partnerships at both local authority and regional level as mechanisms for engaging the range of social care providers. Evidence to the inquiry suggests that the partnerships are the most appropriate mechanism for improving workforce planning in a diverse sector although their achievements to date have tended to be in the area of staff training and development. We acknowledge the considerable gains made by the partnerships and we believe that the two sets of partnerships at local and regional level provide a suitable infrastructure for developing workforce planning. However, further work is needed to ensure that their potential contribution to workforce planning is fully realised.

4.7 The regional partnerships have to a large extent been addressing their own agendas and with stronger central direction could make a bigger contribution to workforce planning at the regional level and to supporting joint commissioning of services at this level to reduce duplication and achieve economies of scale<sup>42</sup>. Given the small size of some Welsh local authorities such initiatives would be welcome. Workforce planning for some low demand, specialist services such as neurology, may be more effective at the regional level. The Care Council for Wales (CCW)<sup>43</sup> told us that it is in discussion with the regional partnerships about their future role and this provides an opportunity to clarify and extend their workforce planning capacity.

**We recommend that as part of its review of regional workforce partnerships the CCW strengthens the links between them and the local workforce partnerships and develops the contribution they make to workforce planning. [18]**

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<sup>41</sup> Written evidence Welsh Local Government Association, ref HWLG(3)-99-07 p1, para 2.14

<sup>42</sup> Oral evidence, 17 October 2007, Care Council for Wales para 164

<sup>43</sup> Oral evidence, 17 October 2007, para 161

4.8 Given the scale of private sector provision in social care, engagement with this sector in workforce planning is vital and there is more work to be done in this area, as was acknowledged by many witnesses, including Care Forum Wales which represents this sector.

4.9 We were therefore encouraged to hear from Care Forum Wales that local independent sector provider fora are being developed in which professional staff are employed to represent the independent sector. This enables the sector to engage with the health service and local authorities, including the regional workforce partnerships. This offers an opportunity for much better engagement between private sector and other social care providers.

4.10 Evidence from the voluntary sector<sup>44</sup> indicates that more comprehensive engagement is needed between local authority workforce planning functions and the sector, and that capacity building is required<sup>45</sup>, as was acknowledged by the Deputy Minister for Social Services<sup>46</sup>. Witnesses from the Wales Neurological Alliance<sup>47</sup> and the mental health charity Hafal<sup>48</sup> told us that they currently have little engagement with the workforce planning process. Given the increasing importance of the sector in the provision of social care services and in representing the views of service users we believe that this needs to be addressed.

**We recommend that the Welsh Assembly Government provides further support to voluntary and independent sector social care providers and service user groups to enhance their ability to engage with workforce planning processes. [19]**

4.11 In order to be effective local workforce development partnerships need to include local authority service commissioners amongst their membership. The Association of Directors of Social Services (ADSS) emphasised this in their oral evidence:

*“Workforce planning, after all, gets you nowhere if your commissioners are not informing your planners of the intentions<sup>49</sup>.”*

4.12 Improvements to the commissioning of social care services by local authorities can also make a key contribution to improving workforce planning by providing a mechanism through which engagement with the private and voluntary sectors can be improved. We are aware that

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<sup>44</sup> See written evidence from Macmillan Cancer Support, Wales Council for Voluntary Action, Age Concern Swansea, UNISON supplementary paper.

<sup>45</sup> Written evidence Age Concern Swansea

<sup>46</sup> Oral evidence 12-12-07 para 89.

<sup>47</sup> Oral evidence 21 November 2007 para 84.

<sup>48</sup> Oral evidence 16 January 2008 para 206.

<sup>49</sup> Oral evidence, 24 October, para 38

improving local authority commissioning is identified as a priority in the Assembly's social services strategy<sup>50</sup> and we would urge the Welsh Assembly Government to ensure that this work takes full account of the potential benefits for workforce planning of better commissioning practice.

**We recommend that the Welsh Assembly Government provides further guidance to local authorities to ensure that the commissioning practices of local authorities are fully interlinked with the workforce planning process. [20]**

4.13 We heard evidence that capacity for workforce planning is limited in some local authorities, particularly smaller ones<sup>51</sup> and the Welsh Local Government Association (WLGA)<sup>52</sup> pointed out that the kinds of training opportunities available to workforce planners in the NHS are not available to staff in local government. Public Service Management Wales could play a role in developing such schemes.

**We recommend that the Welsh Assembly Government works with the WLGA to develop support and training for local authority workforce planning staff to enable local authorities to increase their capacity for workforce planning. [21]**

#### Data and information collection

4.14 Workforce planning in social care cannot be made more effective until data collection is improved. There is a widespread recognition that the current data collection arrangements are not providing comprehensive and high quality data. The task confronting social care is not simple. The fragmented nature of the social care industry with a large proportion of care services being provided in the private and voluntary sectors, often by small operators, makes the collection of comprehensive and standardised workforce information difficult. The Chief Inspector of Social Services, Rob Pickford, pointed out that there are in the region of 1,000 employers in social care which, between them, employ 70,000 people in Wales<sup>53</sup>.

4.15 Currently local authorities are charged with producing workforce plans for their areas which encompass all social care sector providers but it is difficult to see how this can be undertaken successfully in the absence of good data. Indeed, if meaningful engagement in workforce planning between the health and social care sectors is to occur, as we believe it should, then social care needs to improve its data collection arrangements as a prerequisite.

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<sup>50</sup> Welsh Assembly Government (2006) *Fulfilled Lives, Supportive Communities*

<sup>51</sup> Oral evidence 5 December 2007 para 25

<sup>52</sup> Oral evidence 5 December para 9

<sup>53</sup> Written evidence, CSSIW, ref- HWLG(3)-02-07 p1, paras 15 & 20

4.16 If data is to be collected from a large number of organisations, to be used effectively at the local, regional and all-Wales levels it must conform to uniform standards and must be collected in such a way that avoids duplication of effort. Witnesses stressed the importance of ensuring that employers are not asked for the same information on more than one occasion and that local authorities collect workforce information in a unified and centralised way. According to the WLGA:

*“Local authorities routinely complete a plethora of workforce information returns but each has been developed or evolved in response to different needs. The result is duplication and a diversity of information which may be incompatible and has limited impact on workforce planning. Improved coordination is required to promote greater consistency and coherence, harmonise existing activity, reduce the burden on local authorities and maximise data use and effectiveness.”<sup>54</sup>*

4.17 Two key mechanisms were suggested that might address the data collection problem: extending the register of social care staff to include all groups; and developing a National Minimum Dataset.

4.18 A comprehensive register of all social care workers would provide accurate and comprehensive information on the social care workforce which could be used for planning purposes. Gerry Evans of the CCW<sup>55</sup> told us that registration would provide the most comprehensive information given the compulsion associated with it and the reluctance of some commercial operators to voluntarily provide workforce information. Compulsory registration has already been introduced for social workers and some groups of senior staff but the much larger task of registering all care workers would take some considerable time to complete and we believe resolving the problem of poor data is somewhat more urgent than this. Ellis Williams of the ADSS told us:

*“once we can extend the registration to other areas, it will give us better quality information, which will help us. We will get to a national minimum data set, but we will do it in a slow way. We need to be a little bit more sophisticated.”<sup>56</sup>*

Therefore, whilst we fully support the registration of all social care staff we do not believe that the sector should depend on this to improve its workforce information.

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<sup>54</sup> Written evidence, WLGA – ref HWLG(3)-11-07 p1, para 2.16

<sup>55</sup> Oral evidence, 17 October 2007 CCW paras 211-212

<sup>56</sup> Oral evidence, 24 October 2007, para 36

4.19 The creation of a National Minimum Dataset (NMDS), based on annual returns from social care providers would offer another mechanism. This would mandate all social care providers to provide workforce information and would offer consistent and detailed data on the current and predicted workforce needs of the sector. Standardised and comprehensive data would yield invaluable information on patterns and trends in the workforce.

4.20 Establishing a NMDS is a complex task in terms of the number of sources of data, the difficulties of defining roles and job titles and the potential sensitivity of the information to commercial operators, but the benefits of such an arrangement were made clear to us. A NMDS is under development in England where the task is far more complex given the much larger size of the social care sector there. This has already yielded important information about staff turnover rates which would have otherwise been unavailable, as Ellis Williams of the ADSS explained:

*"I will use the English example, as England has started to do this work. It has established that the turnover rate in adult care is 19.3 per cent, turnover for care-only homes is 18.6 per cent, turnover for care homes with nursing is 19 per cent, and turnover on domiciliary care is 24.9 per cent. Those are phenomenal figures. The vacancy levels are interestingly low in England, but the turnover rates are very high, so the churn factor is incredible. If you think about the costs of training, if you turnover over 20 per cent of your staff every year, you are losing an awful lot of money and there is something wrong. That may be happening in Wales but I would not know that, because we do not have that information available to us to assess that systematically."<sup>57</sup>*

4.21 We believe that the potential benefits of creating NMDS would outweigh the cost and effort involved. However, if such a system is to succeed it must be undertaken with the broad support and co-operation of the social care industry on the ground. We were told that the CCW is scrutinising the model being developed in England to assess its suitability for Wales and that it will draw conclusions based on this exercise<sup>58</sup>.

**We recommend that, subject to an evaluation of the English model, the Welsh Assembly Government, through the Care Council for Wales, should introduce a National Minimum Dataset to collect workforce information for the whole social care sector in Wales. [22]**

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<sup>57</sup> Oral evidence, 24 October 2007, para 34

<sup>58</sup> Oral evidence, 12 December 2007, Deputy Minister for Social Services, paras 143-4

## Recruitment and retention in social care

4.22 Evidence to the inquiry revealed a number of recruitment and retention issues in social care, some of which are long standing problems, relating to both social workers employed by local authorities and to care staff, including those employed in the private sector. Local authority services for children and young disabled people face particular problems<sup>59</sup>. The CCW written evidence states:

*“There are a range of reasons for the recruitment and retention challenges facing the sector, from low pay, lack of support and management, transport, poor image, and a lack of clear career progression.”<sup>60</sup>*

4.23 Many social workers feel under pressure from insufficient staffing levels. Penny Lloyd of the British Association of Social Workers (BASW) told us:

*“I do not think that we have enough social workers, as evidenced by most of our members who tell us they are constantly overworked, have high case loads and cannot do justice to the needs of the people they are supposed to be serving.”<sup>61</sup>*

4.24 The CCW has invested considerable time and energy in raising the profile of social care as a profession in recent years and a new social work degree has been introduced. These appear to be paying dividends. However, some social care employers are clearly struggling to fill posts. The report *Social Work in Wales: A Profession to Value* produced by the ADSS in 2005 (sometimes referred to as the ‘Garthwaite report’) made an important contribution to improving social worker recruitment and retention and vacancy levels have fallen since the publication of the report<sup>62</sup>. Whilst we welcome this, there is clearly no room for complacency.

4.25 There is now a need to shift the focus from recruitment to retention<sup>63</sup> and whilst the terms and conditions offered by employers play a role in staff retention, these are less significant than other factors<sup>64</sup>. The evidence we received suggests that staff retention can be improved by providing better support and career development to social care staff. The Chief Inspector of Social Services told us:

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<sup>59</sup> Oral evidence, 21 November 2007, BASW para 141

<sup>60</sup> Written evidence, CCW ref - HWLG(3)-05-07 : (p2), para 2.4

<sup>61</sup> Oral evidence, 21 November 2007, BASW para 141

<sup>62</sup> Oral evidence, 5 December 2007, WLGA, para 4

<sup>63</sup> Oral evidence, 17 October 2007, CCW, para 142.

<sup>64</sup> Oral evidence, 24 October 2007, ADSS, para 30.

*“... basic induction, staff supervision and those sorts of issues are not universally available across the care sector. The jobs that people do ... are difficult, challenging, interesting and exciting, but they will not be able to do those jobs unless they feel that they have support around them.”<sup>65</sup>*

4.26 We heard from the BASW that there needs to be greater coherence in the provision of a post-qualifying framework for social workers across Wales. The lack of a co-ordinated approach is prompting many local authorities to develop their own professional development programmes, leading to variation in the opportunities for progression across Wales, a source of frustration for the profession. The BASW told us:

*“Previously, the Care Council for Wales was the awarding body. It has now lost the ability to lead in the same way, which I am sorry to see. There is a degree of frustration among local authority social workers that the care council is unable to take a firm lead in this. ... There are two problems: the lack of partners and the fact that we need someone saying, ‘This is how we will do it in Wales.’ We are a small country and should be able to bring it all together so it is not piecemeal as it is at present.”<sup>66</sup>*

4.27 We were encouraged to hear that the CCW is committed to ensuring that workforce development does not mean the loss of experienced practitioners:

*“we are really keen in social care ... to move away from people either being practitioners or managers and move to a situation whereby people can be developed as practitioners, so that their practice is deepened and strengthened, and they can be effective supervisors of practice.”<sup>67</sup>*

4.28 We welcome this approach but we are nevertheless concerned that the arrangements for the professional development of social workers are not working effectively in Wales, particularly in view of the need to improve skills levels and retention rates in some key areas such as children’s services.

We recommend that the Welsh Assembly Government, through the Care Council for Wales, reviews the post-qualifying arrangements for social workers with a view to improving clarity and consistency across Wales.  
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<sup>65</sup> Oral evidence 26 September 2007, CSSIW, para 29

<sup>66</sup> Oral evidence, 21 November 2007, BASW para 167

<sup>67</sup> Oral evidence, 17 October 2007, CCW, para 220

4.29 There was an acknowledgement amongst witnesses that recruitment and retention of social workers had improved as a result of the implementation of the 'Garthwaite' recommendations and the evidence shows that vacancy rates have indeed fallen. However there is clearly some way to go until the number of vacancies reaches acceptable levels and several witnesses suggested that the introduction of uniform terms and conditions for social workers across Wales could help to improve recruitment and retention of staff between local authorities<sup>68</sup>.

4.30 The Minister for Health and Social Services told us that she is in discussions to develop a standard NHS Wales contract to iron out the differences between individual NHS employers. The Minister said:

*"That is the only fair way of dealing with these things in a country like ours, with a population of 3 million, where there should not be that much difference."*<sup>69</sup>

We would suggest that this rationale could apply equally to social workers.

4.31 However, the WLGA highlighted a number of problems in relation to the harmonisation of terms and conditions including the need for internal consistency across local authority posts as they address equality issues and the need to retain the scope for varying terms and conditions to attract staff to services that are experiencing problems<sup>70</sup>. Across Wales, social services departments vary in their structures and social work posts are therefore graded differently. The WLGA also argued that there is no single social care labour market in Wales, and that there is interaction with English labour markets, which could undermine any attempt to harmonise terms and conditions<sup>71</sup>.

4.32 Although there may be technical issues that would need to be addressed to enable this we believe that there are considerable benefits to introducing such an arrangement. Given that terms and conditions are agreed at national level for other local authority staff we cannot see why it should not be possible for social workers.

4.33 Whilst we acknowledge that the harmonisation of terms and conditions for social workers across Wales would present some challenges we believe that much would be gained from it in terms of improving staff retention rates and service stability.

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<sup>68</sup> Oral evidence, 17 October 2007, CCW para 148; 24 October 2007, ADSS, para 28

<sup>69</sup> Oral evidence, 17 October 2007, CCW para 148; 24 October 2007, ADSS, para 28

<sup>70</sup> Oral evidence, 5 December 2007, WLGA, paras 47-48

<sup>71</sup> Oral evidence, 5 December 2007, WLGA, para 50

We recommend that the Welsh Assembly Government undertakes work with partners in local government to harmonise the terms and conditions of employment of social workers. [24]

4.34 A further issue that needs to be addressed in social services departments is the lack of staff capacity at senior level which is likely to be exacerbated by the imminent retirement of many experienced social workers.<sup>72</sup> The number of social services departments in relation to the size of Wales means that recruitment of senior staff can be problematic and the Chief Inspector of Social Services highlighted the importance of addressing this:

*"We have to invest more in growing our senior managers, because many of the issues that we face in social services and social care stem from the quality of leadership and management."*<sup>73</sup>

4.35 There is recognition of this issue by the Welsh Assembly Government in *Fulfilled Lives Supportive Communities* but it is clear that more needs to be done in this area and improvements to the post-qualifying framework should help to address this. However, further work will be needed if we are to ensure that Wales has sufficient senior staff to manage social care services and we urge the Welsh Assembly Government to prioritise this aspect of the social services strategy.

4.36 The social care sector is increasingly reliant on recruiting staff from other EU countries and beyond to fill vacancies and we welcome the contribution that such workers make to social care services in Wales. However, there are issues that need to be addressed in relation to this in terms of ensuring that the induction and language needs of migrant workers are met<sup>74</sup>. Care Forum Wales highlighted the importance of migrant workers to private sector providers:

*"It is certainly the case that, at the present time, without those overseas workers, we would be in a great deal of trouble. ... It is not to say that there is anything wrong with it, but there are obviously issues around cultural diversity, language and so on."*<sup>75</sup>

4.37 There are examples of good practice in fast-tracking migrant workers into college courses to improve language skills but the effectiveness of this is dependent on the engagement of social care employers with the education and training system<sup>76</sup>. Regional workforce partnerships could play a bigger role here.

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<sup>72</sup> Oral evidence, 5 December 2007, WLGA, para 65

<sup>73</sup> Oral evidence, 26 September 2007, CSSIW, para 43

<sup>74</sup> Oral evidence 17 October 2007, CCW, para 158

<sup>75</sup> Oral evidence, 5 December 2007, Care Forum Wales, para 93

<sup>76</sup> Oral evidence, 5 December 2007, Care Forum Wales, para 95

4.38 Some local authorities are recruiting qualified social workers from abroad in an effort to fill vacant posts. Such staff bring valuable skills to social services departments but need good support and induction to enable them to contribute effectively. BASW were aware of both good and bad practice amongst local authorities in the support they offer such staff indicating that some improvements are needed<sup>77</sup>.

4.39 There is a need to improve information on the employment of migrant workers in social care and we welcome the research commissioned by the CCW into this issue and hope this will create a clearer picture<sup>78</sup>

**We recommend that the Care Council for Wales reviews its induction framework to ensure that local authorities take account of the needs of migrant workers, and that it renews efforts to ensure that the framework forms part of standard procedures for local authorities [25]**

#### **Diversity in the social care workforce**

4.40 There is a lack of comprehensive information on the composition of the social care workforce with regard to ethnic background, Welsh language skills and other communication skills such as British Sign Language. Given the fundamental importance to effective practice of good communication between care practitioners and vulnerable service users, it is vital that workforce planning provides for these needs. This can only be achieved if workforce information is comprehensive and accurate.

4.41 Evidence provided to this inquiry shows that the full range of cultural and language requirements of Welsh citizens are not being met<sup>79</sup>. The Welsh Language Board evidence cited a report by the European Council's Committee of Experts monitoring compliance with the European Charter for Regional or Minority Languages which concluded:

*"a Welsh language service continues to be a matter of chance rather than design, in general it seems to be reactive rather than proactive and it is still varied whether Welsh was used at care facilities or whether this was promoted".<sup>80</sup>*

Given the equal status afforded to the English and Welsh languages in Wales this is a serious shortcoming.

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<sup>77</sup> Oral evidence, 21 November 2007, BASW, para 150

<sup>78</sup> Oral evidence, 17 October 2007, CCW, para 158

<sup>79</sup> Written evidence, WCVA, HWLG(3)-08-07 p9

<sup>80</sup> Written evidence, Welsh Language Board ref- HWLG(3)-08-07 p12

4.42 The CSSIW evidence<sup>81</sup> shows that the proportion of Welsh speaking social care staff is 15% against the Welsh speaking population of 21% but this masks wide regional variations in the use of Welsh.

4.43 Although the CSSIW provided some encouraging figures from its annual review of trends in social work training which showed an increase in Welsh speaking social work students<sup>82</sup> and a higher proportion of ethnic minority students than the general population, there is more work to do to ensure that the needs of all service users are met.

4.44 The CCW register of social care staff has some shortcomings which need to be addressed. Rhian Huws Williams told us that:

*“The information on the register does not give us a complete picture of the language issue.”<sup>83</sup>*

4.45 We were encouraged by the comments of Rhian Huws Williams that workforce planning at the local authority level needs to take proper account of the composition and needs of local populations:

*“The wider issue is trying to get local authorities, through stronger workforce planning, to see service planning as being linked to demographic analysis, language and ethnicity profiles, and then to look at the kind of skills mix that they need, including language sensitivity.”<sup>84</sup>*

4.46 However, problems in accessing information on language and ethnicity in the social care workforce can frustrate efforts to meet the needs of service users as was highlighted in evidence from the City and County of Swansea:

*“This level of sophistication is not achievable in the current round of workforce planning. At a crude level, these needs are factored in but data is unreliable especially from the independent sector. We know that their workforce has a much greater proportion of BME staff (between 12 and 19% on returns) and are beginning to address this.”<sup>85</sup>*

4.47 The Deputy Minister for Social Services told us that a second task force has been set up to look at the use of the Welsh language in the health service and that its remit could be extended to include social care<sup>86</sup>. We

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<sup>81</sup> Written evidence, CSSIW, ref - HWLG(3)-02-07, p1 para 16

<sup>82</sup> The proportion of Welsh speakers entering social work training increased from 17 per cent to 18 per cent between 2005-06 and 2006-07. Oral evidence, 26 September 2007, CSSIW, para 99.

<sup>83</sup> Oral evidence, 17 October 2007, CCW, para 176

<sup>84</sup> Oral evidence, 12 December 2007, Deputy Minister for Social Services, para 124

<sup>85</sup> Written evidence, City and County of Swansea, ref - HWLG(3)-08-07 p5, Q8

<sup>86</sup> Oral evidence, 12 December 2007, Deputy Minister for Social Services, para125

would welcome such a development as a means of addressing the uneven provision of Welsh language services in social care.

**We recommend that the remit of the current task force on the Welsh language in the health service be extended to include social care services. [26]**

4.48 There is an increasing need to respond to the language and cultural needs of the Black and Minority Ethnic (BME) Population in Wales as the age profile of BME communities creates the need for more contact with social care services. Although responding to language needs is often a priority, an awareness of cultural needs and attitudes is important too, for example in terms of gender issues or attitudes to mental illness<sup>87</sup>.

4.49 A first principle of effective workforce planning should be that services and the people that provide them must respond to the needs of the communities they serve and that this must necessarily encompass cultural and communications requirements. The development of a National Minimum Dataset (see recommendation 22) of staff working in social care would provide better information to facilitate this, and ongoing work by the CCW and the CSSIW inspection regime must continue to encourage better practice at the local level.

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<sup>87</sup> Written evidence, Gofal Cymru, ref - HWLG(3)-07-07 p6

## Section 5 - Workforce planning across health and social care

5.1 Much has been said and written about the value of closer co-operation and joint working between health and social services, and with the current emphasis in health and social care policy on community-based provision, the need for it has never been more apparent. It is therefore somewhat disappointing to discover that workforce planning for health and social care services are undertaken as largely separate activities; there is a pressing need for better integration and co-operation. Phil Davies of the Wales Neurological Alliance told us:

*"I am rather surprised that, in the new workforce planning system that is being developed, there seems to be one stream for the NHS and a separate stream for social care. I thought that, at this stage, with health and social care working so closely together—or at least they should be working closely together—there should be one system to cover both health and social care."*<sup>88</sup>

5.2 However, given the differences in the ways in which health and social care services are funded and delivered, and the large number of providers in the social care sector, integrating workforce planning between the two sectors presents some challenges. The evidence would suggest that effective co-operation in workforce planning across the two sectors cannot be achieved until social care workforce planning is improved. The Centre for Social Carework Research in its written evidence stated:

*"We feel that to attempt an overarching centralised workforce planning system involving health and social care can only realistically be achieved by getting the social care sector up to speed first. Otherwise there is a risk that the planning will be entirely health related because social care lacks the same amount or quality of workforce information."*<sup>89</sup>

5.3 Although health and social care services are provided differently there are many examples of successful co-operation between the two sectors, particularly around staff training and operational standards. The CCW told us:

*"We are working to identify the common ground on which we can work together effectively. We can give you many examples of where that has happened—not so much on workforce planning, but, for example, NVQs and the operational standards have been developed jointly between health and social care so that people can move easily."*<sup>90</sup>

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<sup>88</sup> Oral evidence, 21 November 2007, Wales Neurological Alliance, para 105

<sup>89</sup> Written evidence, Centre for Social Carework Research, Swansea University, ref - HWLG(3)-06-07 p2, para 4.6

<sup>90</sup> Oral evidence, 17 October 2007, para 205

5.4 Joint working between health and social care appears to work best at the local level and where there is a clear and established overlap between the two sectors, for example in mental health or children's services. It is service areas like these and the development of Children and Young People's Plans and Health, Social Care and Wellbeing Strategies that are currently providing the drivers for better integration. There is a need in some cases for social services to work with other service areas such as education in the case of speech therapy. It is at this level that the opportunities for better integrated workforce planning are greatest.<sup>91</sup> However, a more consistent and co-ordinated approach is needed and the new Local Service Boards, which are, as yet unproven, could offer a mechanism that would enable workforce partnerships to engage in workforce planning across health and social care.

5.5 The new arrangements for workforce planning in health currently being introduced by the Welsh Assembly Government acknowledge the need for better engagement between the health and social care sectors but we were surprised to learn that this will be addressed in the second stage of the implementation plan which will not commence until 2009-11.<sup>92</sup> We believe, as did some witnesses to our inquiry, that this should happen much sooner.<sup>93</sup>

**We recommend that the Welsh Assembly Government reviews its health workforce planning strategy timetable to secure greater co-ordination with the social care sector at the earliest possible time. [27]**

5.6 A number of professional groups work across the health and social care boundary, for example some of the therapy professions, and occupational therapists in particular. The case of occupational therapy provides a good illustration of the kinds of workforce planning undertaken for a profession working across sectors.

5.7 Twenty five per cent of the occupational therapy workforce in the statutory sector is employed in local authority social services and others are employed in a range of non-NHS settings. Yet workforce planning for occupational therapists (OTs) takes little account of the needs of these employers. The College of Occupational Therapists (COT) told us:

*"The current workforce planning only looks at NHS needs; it only looks at trust feedback at the moment. It is not taking any information from other parts of the NHS, for example, from primary or social care. That is even before you start looking at new developments such as Pathways to Work, where, in the last four years, we have gone from no OTs to 30 OTs as well as support staff. The voluntary and independent sectors and the insurance sector are also employing OTs for occupational health schemes. None of that has been taken into account in terms of how many OTs we need."*<sup>94</sup>

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<sup>91</sup> Oral evidence, 17 October 2007, CCW, para 203.

<sup>92</sup> Oral evidence, 17 October 2007, CCW, para 203.

<sup>93</sup> Oral evidence, 23 January 2008, College of Occupational Therapists, para 69

<sup>94</sup> Oral evidence, 23 January 2008, COT, para 28

5.8 Furthermore, commissioning for occupational therapy training places is undertaken by the NHS. It is therefore little surprise that workforce planning for these professionals is something of a hit and miss affair and this illustrates the need for much better joint workforce planning across sectors. The College of Occupational Therapists suggested some alternative arrangements for funding occupational therapy training:

*“Some of the money for the social care workforce development partnership comes from the Assembly Government in the form of a grant. There is nothing to prevent that from being put together with the money that is coming via the NHS human resources department to have an all-funding process with all of the funding for OT sitting in one place and being managed nationally. ... The other option is to put it all in one place but ensure that the social care funding goes in there as well and ensure that the need for social care is also included.”<sup>95</sup>*

We recommend that the Welsh Assembly Government reviews the mechanisms for commissioning the training of occupational therapists and other therapy professions with a view to centralising these arrangements. [28]

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<sup>95</sup> Oral evidence, 23 January 2008, COT, para 79

## Section 6 - Monitoring

### Monitoring

6.1 We expect the Welsh Assembly Government to report on progress in implementing our recommendations within 12 months of their initial response to this report.

## Annex A

### Organisations and individuals who gave evidence in person to the Committee

Those giving evidence	Representing
<b>19 September 2007</b>	
<ul style="list-style-type: none"> <li>▪ Ann Lloyd, Head of Department &amp; Chief Executive, NHS Wales</li> <li>▪ Ian Stead, HR Director, NHS Wales</li> </ul>	Welsh Assembly Government
<b>26 September 2007</b>	
<ul style="list-style-type: none"> <li>▪ Rob Pickford, Chief Inspector</li> <li>▪ Margaret Provis, Inspector</li> </ul>	Care and Social Services Inspectorate Wales (Welsh Assembly Government )
<b>17<sup>th</sup> October 2007</b>	
<ul style="list-style-type: none"> <li>▪ Sue Cromack, Senior Workforce Planning Manager</li> <li>▪ Stephen Griffiths, Interim Director, Workforce Development Unit</li> </ul>	National Leadership & Innovation Agency for Healthcare
<ul style="list-style-type: none"> <li>▪ Rhian Huws Williams, Chief Executive</li> <li>▪ Gerry Evans</li> </ul>	Care Council for Wales
<b>24 October 2007</b>	
<ul style="list-style-type: none"> <li>▪ Ellis Williams</li> </ul>	Association of Directors of Social Services
<ul style="list-style-type: none"> <li>▪ Professor Peter Huxley, Head</li> <li>▪ Dr Sherrill Evans, Senior Lecturer</li> </ul>	Evidence from the Centre for Social Carework Research, Swansea University
<ul style="list-style-type: none"> <li>▪ Professor Derek Gallen, Post-graduate Dean</li> </ul>	Cardiff University
<b>14 November 2007</b>	
<ul style="list-style-type: none"> <li>▪ Dr Stuart Geddes, Director in Wales</li> </ul>	British Dental Association

<ul style="list-style-type: none"> <li>▪ Tina Donnelly, Director</li> <li>▪ Lisa Turnbull, Policy Advisor</li> </ul>	Royal College of Nursing Wales
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**21 November 2007**

<ul style="list-style-type: none"> <li>▪ Dr Tony Calland, Chair of BMA's Welsh Council</li> </ul>	British Medical Association
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**21 November 2007 (Continued)**

<ul style="list-style-type: none"> <li>▪ Phil Davies</li> <li>▪ Simon Hatch</li> <li>▪ Buddug Williams</li> </ul>	Wales Neurological Alliance
<ul style="list-style-type: none"> <li>▪ Penny Lloyd, Professional Officer, South Wales</li> <li>▪ Emyr Owen, Professional Officer, North Wales</li> </ul>	British Association of Social Workers
<ul style="list-style-type: none"> <li>▪ Dave Galligan, Head of Health</li> <li>▪ Paul Elliott, Head of Local Government</li> </ul>	UNISON

**5 December 2007**

<ul style="list-style-type: none"> <li>▪ Anna Freeman, Director of Employment</li> <li>▪ Karen Long, Skills Capacity Advisor</li> <li>▪ Chris Davies, Social Services Advisor</li> </ul>	Welsh Local Government Association
<ul style="list-style-type: none"> <li>▪ Mario Kreft, Chief Executive (Honorary)</li> <li>▪ Jan Wood, National Workforce Development Officer</li> </ul>	Care Forum Wales

**12 December 2007**

<ul style="list-style-type: none"> <li>▪ Edwina Hart AM, Minister for Health &amp; Social Services</li> <li>▪ Gwenda Thomas AM, Deputy Minister for Social Services</li> </ul>	Welsh Assembly Government
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**16 January 2007**

<ul style="list-style-type: none"> <li>▪ Peter Finch, Assistant Director of Employment Relations &amp; Union Services</li> <li>▪ Philippa Ford, Welsh Policy Officer</li> <li>▪ Phil Gray, Chief Executive</li> </ul>	The Chartered Society of Physiotherapy
<ul style="list-style-type: none"> <li>▪ Dr Alison Stroud</li> <li>▪ Sian Williamson, Head of Speech and Language Therapy, Pontypridd and Rhondda NHS Trust</li> </ul>	The Royal College of Speech & Language Therapists
<ul style="list-style-type: none"> <li>▪ Alun Thomas, Deputy Chief Executive</li> <li>▪ Helen Oseman, Hafal Client &amp; Volunteer</li> </ul>	Hafal

23 January 2007

<ul style="list-style-type: none"><li>▪ Ruth Crowder, Policy Officer for Wales</li><li>▪ Sara Forster, Chair, Welsh Board</li></ul>	College of Occupational Therapists
<ul style="list-style-type: none"><li>▪ Anne Philimore, Chair, All Wales Human Resources Directors</li><li>▪ Claire Ruxton, Associate Director of Human Resources, North Glamorgan NHS Trust</li></ul>	NHS Trusts

## Annex B

### Schedule of Committee Papers Provided to Inform Oral Evidence

Date	Name of Paper	Paper Reference Number
19 September 2007	Terms of Reference	HWLG(3) 02-07(p1)
	Evidence from Welsh Assembly Government Officials	HWLG(3)-02-07(p2)
26 September 2007	Evidence from Care & Social Services Inspectorate Wales	HWLG(3)-03-07(p1)
17 October 2007	Evidence from National Leadership and Innovation Agency for Healthcare	HWLG(3)-05-07(p1)
	Evidence from the Care Council for Wales	HWLG(3)-05-07(p2)
24 October 2007	Evidence from Association of Directors of Social Services	HWLG(3)-06-07(p1)
	Evidence from the Centre for Social Carework Research	HWLG(3)-06-07(P2)
	Evidence from the School of Postgraduate Medical & Dental Education	HWLG(3)-06-07(p3)
14 November 2007	Evidence from the British Dental Association	HWLG(3)-08-07(p1)
	Evidence from the Royal College of Nursing Wales	HWLG(3)-08-07(p2)

21 November 2007	Evidence from the British Medical Association	HWLG(3)-09-07(p1)
	Evidence from Wales Neurological Alliance	HWLG(3)-09-07(p2)
	Evidence from the British Association of Social Workers	HWLG(3)-09-07(p3)
	Evidence from UNISON	HWLG(3)-09-07(p4)
5 December 2007	Evidence from the Welsh Local Government Association	HWLG(3)-11-07(p1)
	Evidence from Care Forum Wales	HWLG(3)-11-07(p2)
16 January 2008	Evidence from the Chartered Society of Physiotherapy	HWLG(3)-01-08(p1)
	Evidence from the Royal College of Speech & Language Therapists	HWLG(3)-01-08(p2)
	Evidence from Hafal	HWLG(3)-01-08(p3)
23 January 2008	Evidence from the College of Occupational Therapists	HWLG(3)-02-08(p1)
	Evidence from NHS Trusts	HWLG(3)-02-08(p2)

## Transcripts

Copies of all papers and transcripts of meetings can be found at:

[www.assemblywales.org/bus-home/bus-committees/bus-committees-third-assem/bus-committees-third-hwlg-home.htm](http://www.assemblywales.org/bus-home/bus-committees/bus-committees-third-assem/bus-committees-third-hwlg-home.htm)

## Annex C

### List of Respondents to Call for Written Evidence

The following organisations responded to the call for written evidence

Organisation	Committee Reference
Monmouthshire Local Health Board	HWLG(3)-07-07(p5)
Gofal Cymru	HWLG(3)-07-07(p6)
Blaenau Gwent Local Health Board	HWLG(3)-07-07(p7)
Age Concern Swansea	HWLG(3)-07-07(p8)
The National Deaf Children's Society	HWLG(3)-07-07(p9)
The Board of Community Health Councils	HWLG(3)-07-07(p10)
Pontypridd & Rhondda NHS Trust	HWLG(3)-07-07(p11)
Breakthrough Breast Cancer	HWLG(3)-08-07(p4)
City and County of Swansea	HWLG(3)-08-07(p5)
Macmillan Cancer Support	HWLG(3)-08-07(p6)
The Royal Pharmaceutical Society of Great Britain	HWLG(3)-08-07(p7)
The Welsh Food Alliance	HWLG(3)-08-07(p8)
The Wales Council for Voluntary Action	HWLG(3)-08-07(p9)
The British Dietetic Association	HWLG(3)-08-07(p10)
David Smith	HWLG(3)-08-07(p11)
The Welsh Language Board	HWLG(3)-08-07(p12)
The General Medical Council	HWLG(3)-12-07(p2)
Brecknock and Radnorshire CHC	Available on Website
<b>Additional Written Evidence</b>	
Welsh Assembly Government	HWLG(3)-06-07(p4) HWLG(3)-12-07(p4)
Chief Inspector Care & Social Services Inspectorate Wales	HWLG(3)-06-07(p5)
National Leadership & Innovation Agency for Healthcare	HWLG(3)-09-07(p7)
UNISON	HWLG(3)-10-07(p5)
The Royal College of Nursing	HWLG(3)-12-07(p3)
Welsh Local Government Association	HWLG(3)-01-08(p5)

Please note that the above list does not include any organisations or individuals who indicated that they did not wish their details to be published.

## **Executive Summary**

# **A New Integrated Workforce Planning System for Wales**

## **1. Introduction**

The Task and Finish Group was set up with the remit of designing a new and integrated workforce planning system for NHS Wales. Paper summarises the main recommendations following from this work.

## **2. Proposed Approach**

### **2.1 Principles**

A review of workforce planning in Wales led by Paul Williams, Chief Executive of Bro Morgannwg Trust and the *Review of Health and Social Care in Wales*, led by Derek Wanless, both identified a range of problems with existing approaches. To address these, the Task and Finish group identified a number of principles that need to apply to the new system:

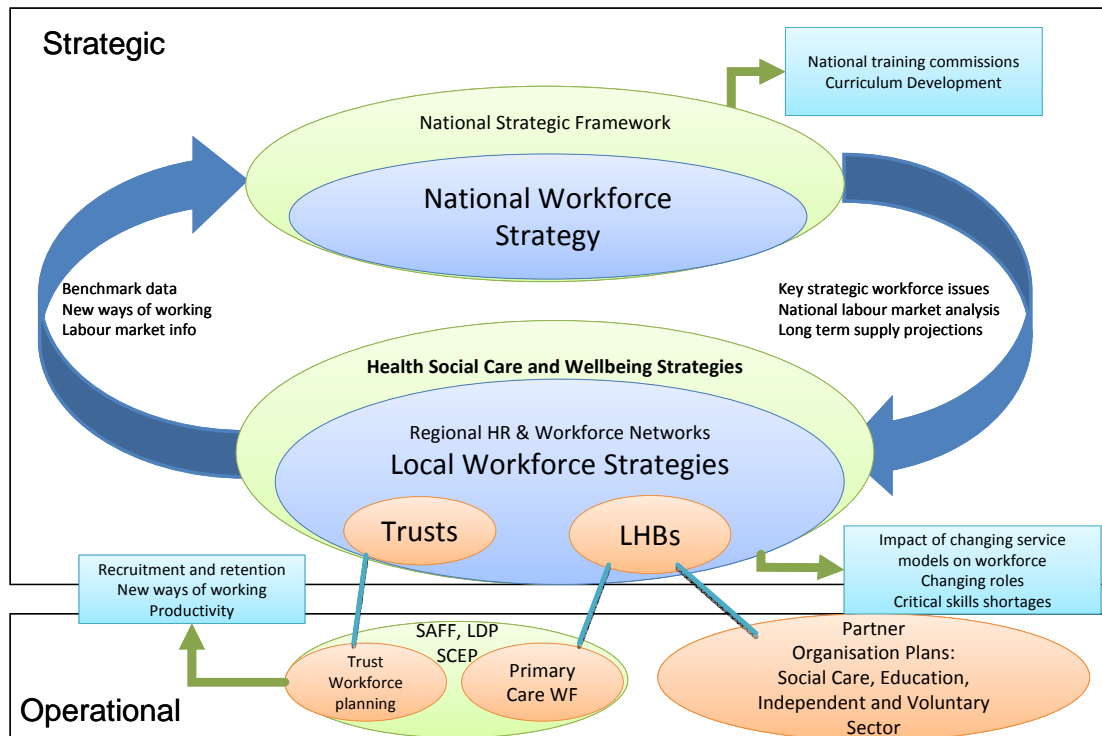
- Workforce planning needs to be fully integrated with service and financial planning so that workforce plans can reflect the major changes in service delivery that are planned and anticipated for the future.
- If workforce planning and service planning are to be fully integrated there needs to be a clear methodology for relating planned service activity and workforce demand.
- Workforce planning needs to address future workforce capability in terms of skills, roles and ways of working in teams rather than simply numbers in individual professional groups.
- Long term workforce development decisions should be made using a methodology that is appropriate to strategic planning.
- The level of expertise and resource devoted to workforce planning needs to be increased, particularly in relation to strategic planning.
- Workforce information systems need to be improved to support better workforce planning.

### **2.2 Planning Elements**

In order to apply these principles we propose that there should be three core elements to the new workforce planning arrangements each of which forms an integral part of the new arrangements for planning services.

- National Strategic Workforce Planning
- Local Strategic Workforce Planning
- Employer Operational Workforce Development Plans

This is illustrated in the diagram below:



### 2.3 National Strategic Workforce Planning

The national strategic planning will have four main functions:

- Informing recommendations to the WAG on education commissioning.
- Showing the impact of national strategies such as Designed for Life on future workforce needs.
- Informing national strategic service planning of workforce issues that could have an impact on service delivery.
- Providing a strategic framework and analysis for local workforce planning.

### 2.4 Local Strategic Workforce Planning

Building on the national strategic planning, local strategic plans will be required to reflect local circumstances and priorities such as specific plans for future service configuration, service priorities based on local needs and local labour market issues. The workforce requirements will be driven by the *Health, Social Care and Wellbeing Strategies* and *Children and Young People's Plans* and the commissioning plans drawn up by LHBs to reflect these local issues. For each of the changes planned in the delivery of services within the HSCWbS the workforce implications should be identified in terms of numbers, skills, how and where people will be working

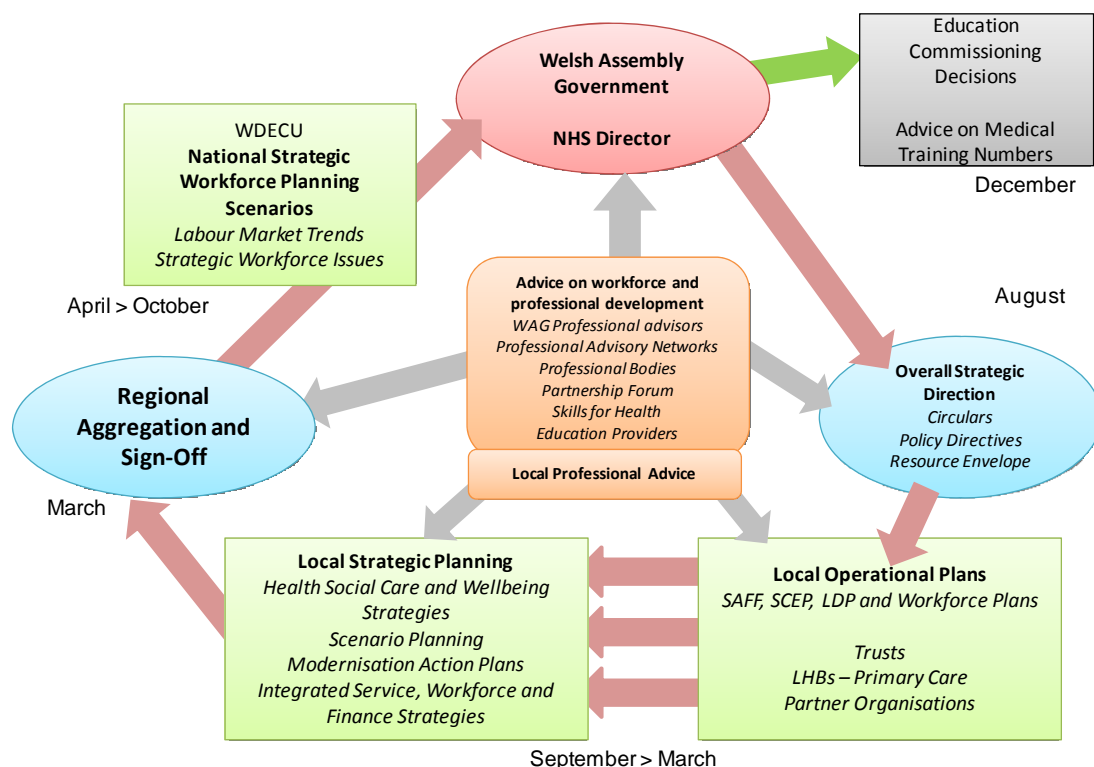
## 2.4 Employer Operational Workforce Development Plans

Workforce planning at employer level has two elements. Employers will input to the strategic planning process described above but will also need to carry out operational workforce planning which focuses delivering an effective workforce to meet their service delivery objectives.

- **Mapping service activity and workforce** – developing clear models to related planned activity to the workforce needed to deliver it.
- **Forecasting future workforce needs** – applying these models to identify how the workforce will change.
- **Skills development planning** – planning the workforce in terms of skills and roles not just numbers.
- **Service improvement** – identifying and implementing the new ways of working needed to improve service delivery.
- **Improving workforce management** – maximising the utilisation of the workforce through improved attendance, turnover and motivation.

## 2. Planning Arrangements

The workforce planning process will not only need to be integrated into service and financial planning but also to provide for input and advice from staff and professional representative bodies. It also needs to underpin the national process for commissioning education. This is quite complex. The diagram below shows some of the main elements of the cycle.



The purple arrows show the planning cycle and grey the points where professional advice will feed into the process. The cycle will feed national decisions on education commissions and the timetable for this is shown at the end of this section.

- **Overall Strategic Direction** **by August or earlier**  
 The starting point for the planning process will be the national strategic direction as set out in national policy guidance. Locally the process will need to take into account both proposals for secondary care reconfiguration and the local response to the Community Services Framework to be issued in Spring 2007. In 2007 the intention of WAG is to issue a set of priorities guidance in the Summer to support the development of the Health Social Care and Wellbeing Strategies for 2008-2011. These will contain guidance on key workforce issues.
  
- **Local Strategic Planning** **September – March**  
 A prime basis for local strategic planning will be the *Health Social Care and Wellbeing Strategies* and *Children and Young People's Plans*. The accountability for social care workforce planning rests with Social Services Directors so these strategies will also be the main focus for bringing together Health and Social Care workforce plans. The workforce strategies will identify clearly the workforce implications of planned changes in service delivery in terms of numbers, skills and ways of working. Plans for new ways of working will also form part of the *Designed for Improvement* modernisation action plans.

The longer term view will be informed by the strategies that regions are developing for future service configuration and provide a perspective across the wider health economy.
  
- **Local Operational Planning** **September – March**  
 This element comprises the planning processes which are primarily focused on delivery and may have a shorter timescale. Service plans will need to have the workforce implications and costs clearly identified. In addition organisations should have clear plans for taking forward the modernisation of their workforce.
  
- **Regional Aggregation and Sign Off** **January - March**  
 The plans for each health economy will need to be jointly agreed by the Trusts and LHBs and, where appropriate, partner organisations. The regional HR and Workforce Networks will have a key role in coordinating process and ensuring that the workforce requirements reflect the needs of the service strategies.
  
- **National Strategic Planning** **April – September**  
 The national strategic planning will have several functions. It will inform the national process for agreeing future medical and non-medical training numbers. It will also form the basis of advice to the Welsh Assembly Government to inform the future strategic direction and policy guidance.

- **Decision making by Welsh Assembly Government** **December**  
The final sign off for the workforce planning and recommendations for future education and training provision will rest with WAG. They will agree the non-medical training commissions and the number of post-graduate medical training posts by specialty.

### **3. Implementation**

The aim is to develop the new workforce planning system as part of the process for developing the next round of Health Social Care and Wellbeing Strategies and Children and Young People's Plans. This means that local strategic workforce planning will need to be completed as part of these strategies by March 2008.

Within the context of this outline planning timetable, 2007/8 will be a transition year for implementing the new arrangements. WDEC are developing an implementation project plan to support this process.

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## Annex E

### Glossary of Terms

<u>Abbreviation or Acronym</u>	<u>Explanation</u>
ADSS	Association of Directors of Social Services
AHPs	Allied Health Professionals
BASW	British Association of Social Workers
BME	Black & Minority Ethnic
CCW	Care Council for Wales
COT	College of Occupational Therapists
CSSIW	The Care & Social Services Inspectorate Wales
DHSS	(Welsh Assembly Government) Department of Health & Social Services
HEIs	Higher Education Institutions
LHBs	Local Health Boards
LSBs	Local Service Boards
NLIAH	National Leadership & Innovation Agency for Healthcare
NMD	National Minimum Dataset
OTs	Occupational Therapists
RCN	The Royal College of Nursing
SSIW	Social Services Inspectorate Wales
WAG	Welsh Assembly Government
WDU	Workforce Development Unit (of NLIAH)
WLGA	Welsh Local Government Association