


## Best Practice in Workforce Development and Management: The evidence reviewed



### MAKING INTEGRATED CARE SYSTEMS HAPPEN

Including two case studies, one led by Conrane, which illustrate how workforce pressures and shortages can be the catalyst for integrated care solutions

Best Practice – the evidence

Strategic Workforce Planning and Development

Situational analysis and scope for change

Demand and Supply

Workforce Redesign

Case Studies from the UK and US

Benefits and Outcomes

# Best Practice in Workforce Development

Based on an OECD-wide evidence review spanning 2006 to 2021 and commissioned by the World Bank.

**Download the full document here**

Focus on specifically best-practice in workforce planning and human resource management across 37 countries.

Highlight the learning from leading-edge projects and experience

Identify any scope for further improvements and make recommendations on best practice

Spotlight any further issues arising directly from responses to the Covid19 pandemic.



The review was commissioned in 2020 at the apex of a 20-year partnership with the World Bank in international workforce development projects in middle-and low income countries. It also reflects 30 years leading-edge practice across the UK and in other high-spending countries.

# A comprehensive definition from Queensland Health Board



Strategic workforce planning is a cyclical process of evidence gathering, scenario planning, strategy development, action planning and review. Aims include:

- positioning the workforce in ways which effectively support achievement of the health service organisation's strategic objectives over the medium- to long-term
- target changes in workforce characteristics such as capacity, capability, sustainability, diversity, design, culture, wellbeing and performance
- help the business to understand and enhance its workforce over time and to manage risks
- effectively position the workforce to deliver the outcomes the business is working towards, at both an individual service and health and social care system-level.

Integrated strategic planning cycles for health services, workforce, capital works, and digital and medical technology *work together* to enable delivery of the organisation's strategic and service objectives.

# Strategic Workforce Planning – overview :

“delivering service objectives through workforce”



## Enhancing Workforce....

- Capability
- Capacity
- Design
- Diversity
- Culture
- Wellbeing
- Performance

A recent Europe-wide review describes the purpose of workforce planning as ‘putting the right number people, with the right skills at the right place, with the right productivity, at the right time to fulfil the goals of the organisation’ “It is the tool which ensures the availability of people whose skills and approaches are essential to achieving and sustaining high-quality healthcare delivery.”

# Comprehensive, integrated, stage-by-stage



The most recent review of healthcare workforce planning in 18 OECD countries characterised best-practice as a comprehensive, integrated within a stage-by-stage process.

*Comprehensiveness* spans:

- A detailed understanding the starting point
- highlights key challenges and opportunities in the relation to existing healthcare delivery systems
- Forecasting requirements for staff in relation to
  - population trends,
  - changing morbidity patterns
  - future service strategy, structure and utilisation
- Sustaining staff supply through
  - recruitment,
  - entry-level training,
  - career development
  - mitigating attrition or outflow.



*Integration* has two dimensions:

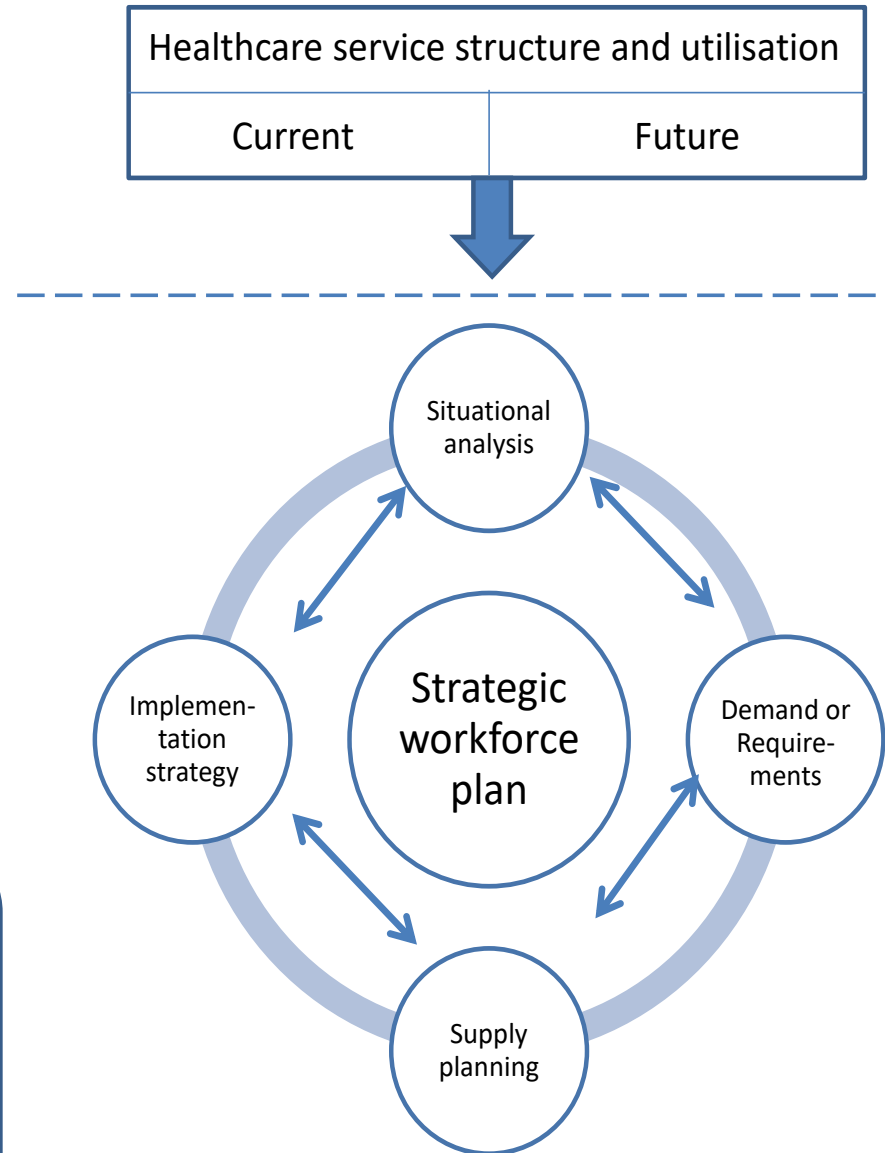
- *Horizontal Integration* focusses on:
  - the relationships within professional groups across healthcare providers
  - not only tertiary and secondary acute care, primary care
  - but out of hospital sectors including pro-active management of non-communicable diseases and community-based paediatrics and older people's care
- *Vertical integration* concerns the relative roles across staff groups within workforce redesign including task-sharing from registered professionals to mid-level staff such as physician assistants and licensed vocational nurses, as well as to support/auxiliary staff.

# Major stages in workforce development



- *Defining the specific objectives and project scope* congruent with national and local service strategies
- *Situational analysis* including understand the business and analysing the current workforce
- *Scope for process and workforce redesign*
- *Demand planning* including gap analysis, quantified to inform cost analysis and scale of the challenge
- *Supply planning* to deliver the requirements and ensure sustainability
- *Actions plans* (Implementation planning including detailed strategies, phasing, staffing supply, training capacity and resourcing).

From the outset and whether for an entire country, region or large provider, each workforce planning project should be well-designed and managed with senior executive leadership. Participants should include a senior lead from finance, HR, medical and nursing directors alongside other professional heads and senior service departmental managers. It should also be *collaborative* with key stakeholders fully involved at each stage of the process. This generates ownership and enriches the process with local expertise.



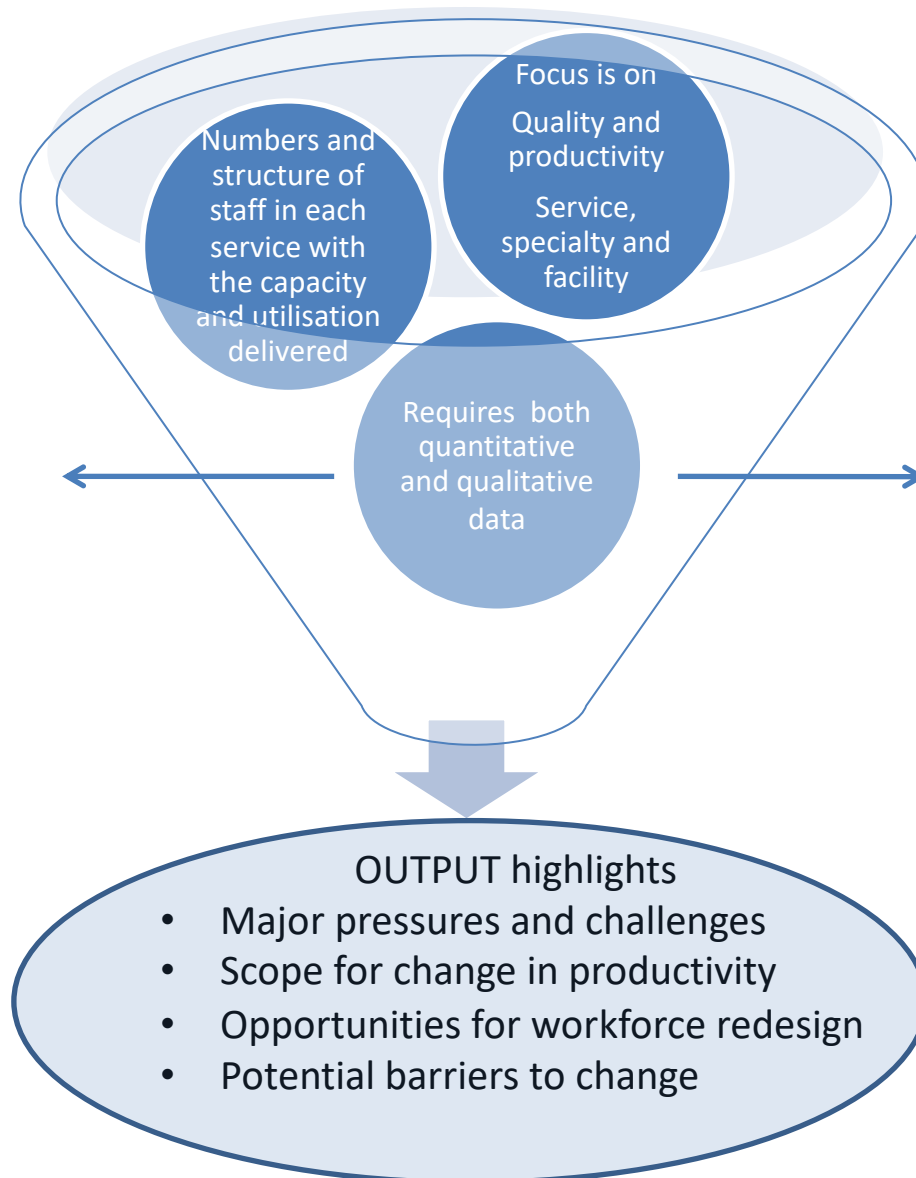
# Stage one: situational analysis and scope for change (1)



Since workforce planning is not an exact science we need to know where we are starting from.

In order to inform meaningful analytics, the data-set on current staffing should be structured in parallel with the service. It should also include all major staff groups by grade - ideally staff in-post and establishment in full-time equivalent, plus headcount. It will typically include:

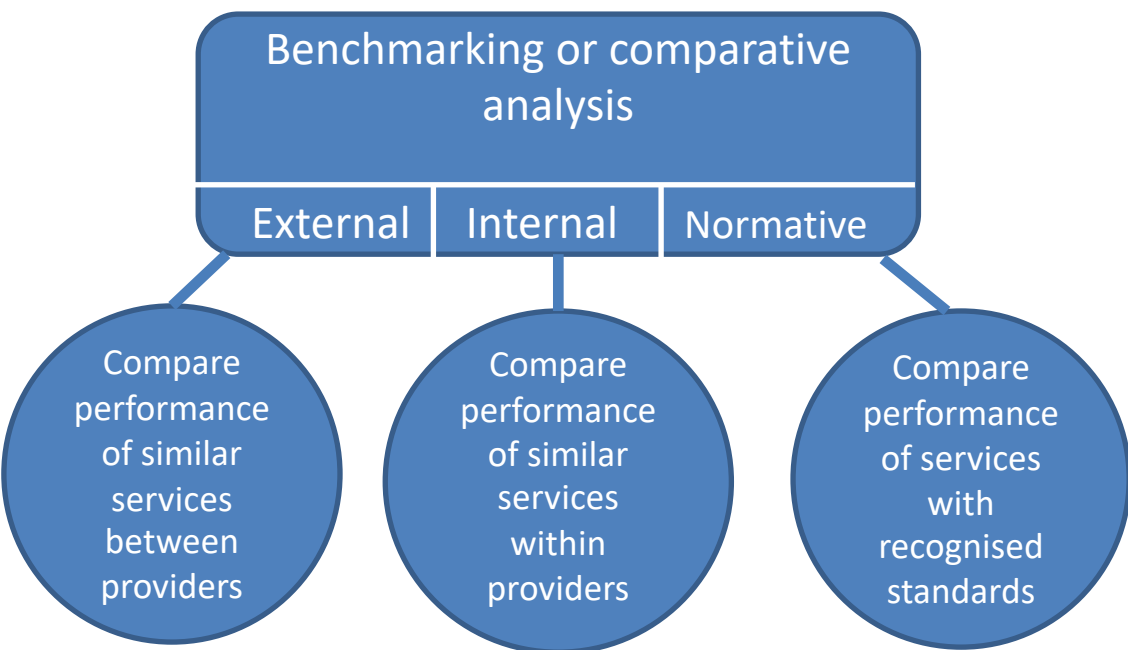
- Hospital doctors (surgeons and physicians) by major specialty and grade mix
- Primary care physicians similarly by grade mix
- Nurses by service sector ideally highlighting 'skill mix': registered nurses versus vocational/assistant staff
- Professional and technical staff including diagnostic technicians, allied health, and laboratory staff
- Support staff
- Age-structure, annual leavers or outflows and recruitment including migration in and out of country
- Capacity and output of training universities and institutes
- The ratio of registered professionals to other staff in each area.



Workforce data can prove the most contested of all health statistics. The source data should be therefore agreed with the project leadership and confirmed with service managers before analysis is undertaken. They can also be sources of qualitative information. At the provider level, staffing data derived from payrolls is the most up-to-date and reliable and thus inspires the confidence of professional and managerial stakeholders.



# Stage one: situational analysis and scope for change (2)



Recognised standards may include recommendations of professional bodies and associations, accreditation agencies at national or international level and not least payers and commissioners through contracts

## AIMS

Staffing is assessed against population, service capacity and relevant workload or activity measures depending on the staff group. Examples may include:

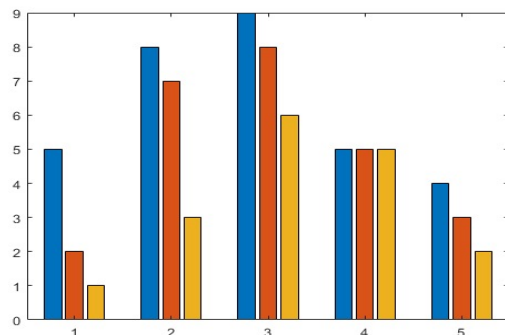
- Doctors to population, episodes, attendances - specific to speciality and case-mix
- Nurses to patients and capacity such occupied beds and attendances in ambulatory care - weighted by acuity
- Diagnostic staff to volumes procedures by type weighted for complexity

Comparison of similar services which indicate resource variations *within* an organisation can be very powerful

Benchmarking is only an indicator of variations which may need further exploration. The aim is to identify significant variations in staffing to identify any significant outliers in terms of resource deployment and seek to understand these

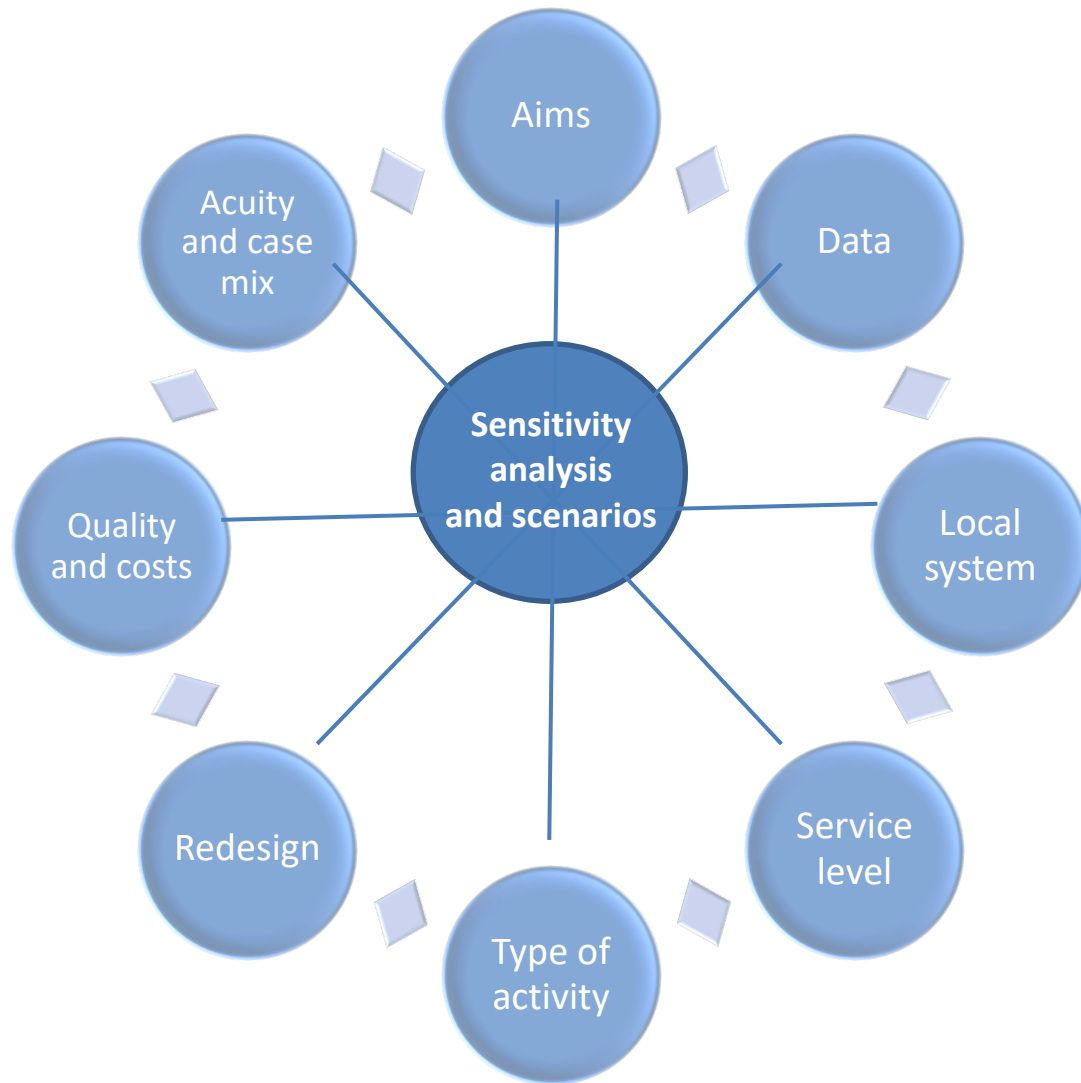
Apart informing current provision, this stage can also serve to define the parameters which connect staffing to activity and capacity which can then carry forward to projecting future requirements

The process is well-known to departmental and professional heads who may themselves contribute data to service-wide benchmarking clubs



# Demand and requirements planning

## Factors determining choice of parameters

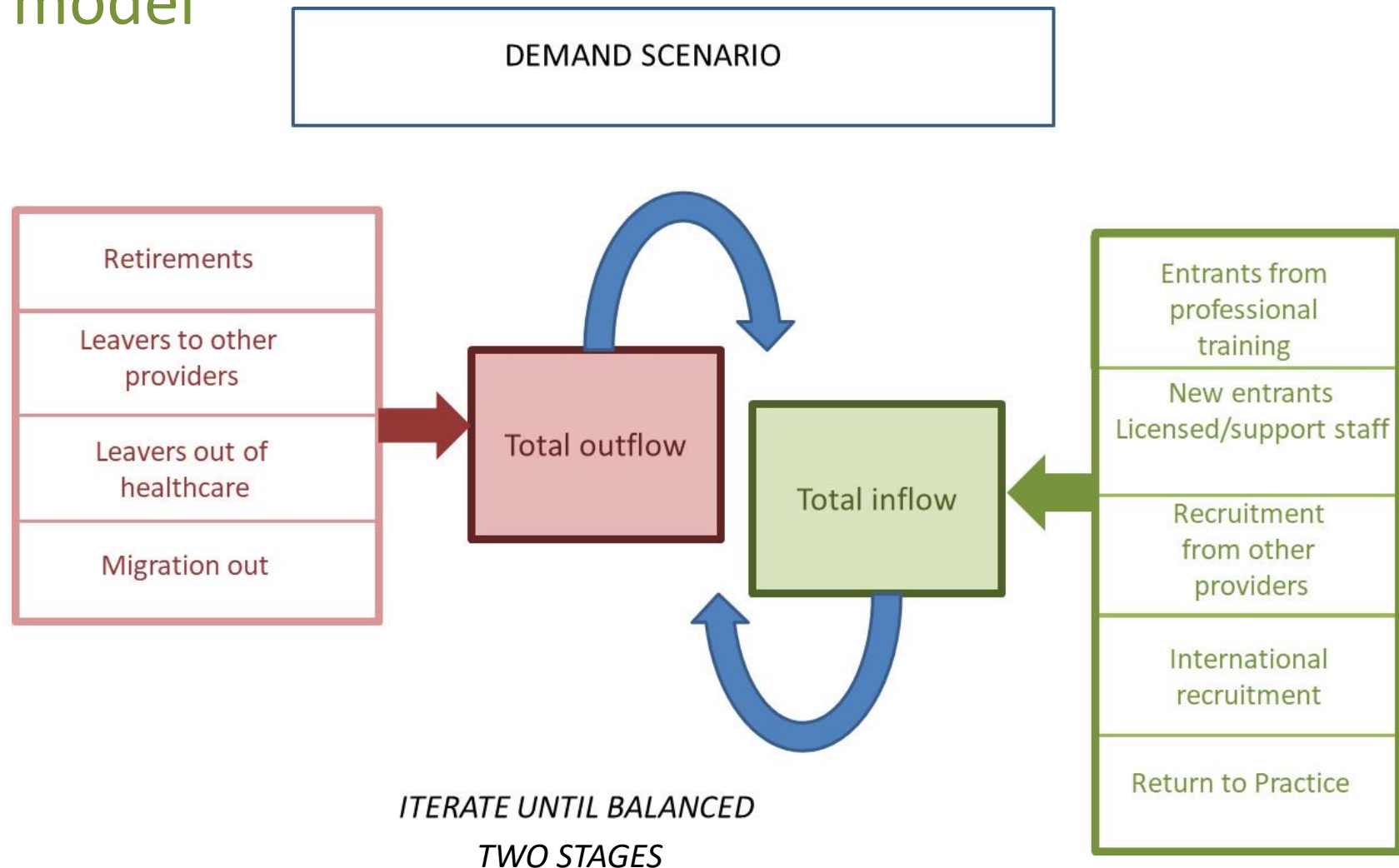


## Examples by service and staff group

- *Doctors including physicians and surgeons in tertiary and secondary care hospital networks and are planned using current, evidence-based guidelines on population served specific to each speciality.*
- *GPs or primary care physicians are planned on population and the GPs' direct patient workload, devolution to other staff groups and changing GP role as the specialist leader of the multi-disciplinary team*
- *Nurses in hospitals are planned on service capacity and utilisation by sector adjusted for varying patient acuity in different service areas. Grade mix and skill mix varying by the same considerations*
- *Nurses in primary and community care are planned in relation to the number of doctors, structure of teams and the type of services which primary care offer within any healthcare system.*
- *Other allied and professionally qualified technical staff are planned on population, and productivity ratios of staffing to activity weighted by case-mx. Scope for pathway redesign and assistant practitioner roles are reflected*

A limited range of scenarios are produced by varying key assumptions through *sensitivity analysis*. Workforce plans can then be kept under constant review and monitored against out-turn at least every 5 years and optimally bi-annually.

# Supply model

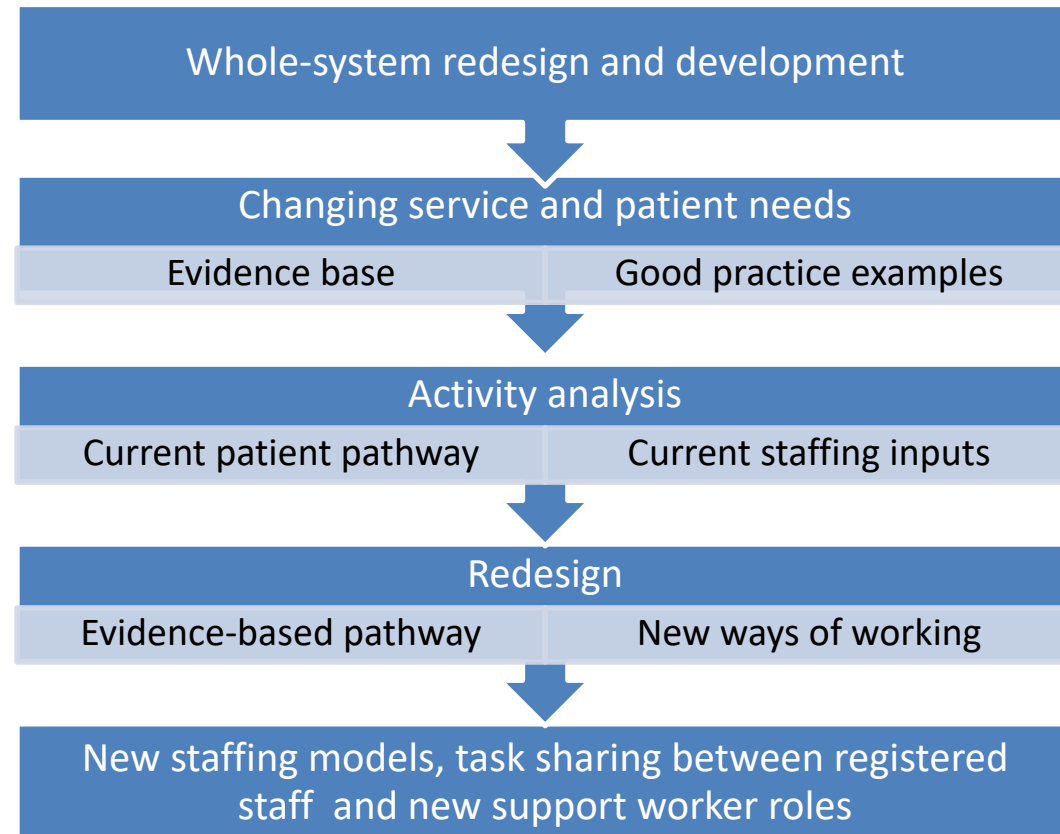


**The first stage** is to quantify current attrition rates. An analysis of the workforce age-structure indicates expected retirements. There are three categories of leavers: those who opt to work abroad, those who move internally to other providers and those who leave the health workforce altogether. Exit interviews can determine (a) the reasons for leaving and (b) destinations in terms of future employment. This data can then inform current HR management and retention strategies. Also the cost of replenishing attrition should be monitored within HR financial management.

**The second stage** is to map the flow of new entrants to the workforce. This will require an assessment of training capacity in relation to service need. Good practice is to align state-funded or -subsidised training capacity to local demand to ensure jobs for all newly qualified staff. In relation to doctors, best-practice horizon scanning should align both the capacity and incentives for post-graduate training to the changing requirements by specialty in hospitals and not least primary care. For specialist doctors, allowance is made for the timescale of 10 to 15 years for new entrants to progress to senior or consultant grade. For new support workers training can be in-service against competence frameworks linked to National Vocational Qualifications recognised in the NHS grading structure.

# Workforce redesign through task sharing

- Changing healthcare needs in the 21<sup>st</sup> century require a more creative approach to staff role design whilst workforce resilience and cost management require new labour markets.
- Too many organisations and nations still plan future services on the basis of 20<sup>th</sup> century staffing conventions.
- Recent visioning for the DoH expects that 60% of new staff entering the workforce by 2035 years should be in support roles within teams lead by professionally trained and registered staff.
- This is particularly the case in advanced primary care integrated care and the management of non-communicable, chronic diseases long-term conditions
- *In addition to formal workforce needs*, the potential of empowering patients, carers and their immediate communities as further resources remain largely untapped.



Conrane have led the development of new practitioner and assistant roles in the NHS both nationally with professional regulatory bodies and at the level of health economies, providers and primary care. Our international work has influenced developments in countries such as Australia and identified learning which we absorb into practice  
See case studies below

# Case Study 1 Catterick Integrated Care Campus – OBC led by Conrane

## How addressing a workforce planning challenge drives a major service development

### The challenge

#### *GP supply challenge and changing population needs*

- Practices in locality under pressure causing chronic shortages of GPs
- New access rights for military personnel to NHS primary care coming into force
- Large military garrison in Europe in the local catchment area
- Rural elderly population with increasing acuity, complexity
- Need for more services locally to avoid distance access to nearest acute hospitals
- Local aspirations to qualify as a Vanguard project had not come to fruition

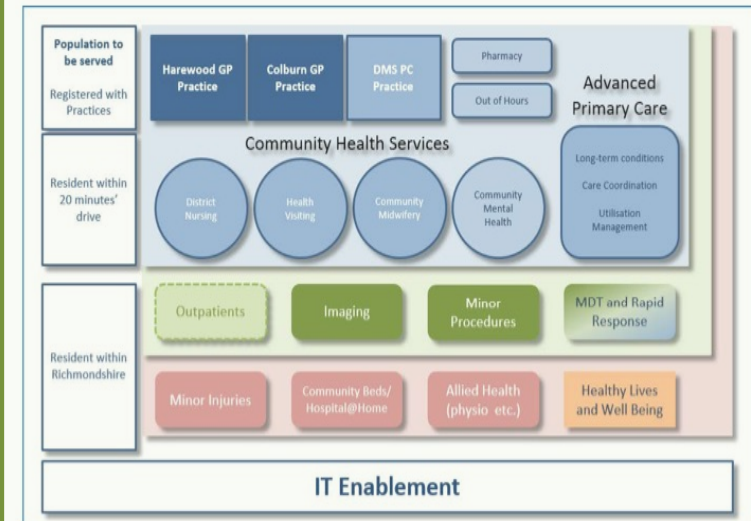
### The solution

#### *Integrated care campus for local population AND the military personnel*

- Design an integrated care service which reflected specific local needs in relation to the military base and resident populations
- Model the impact of comprehensive integrated care on local hospital activity and demonstrate scope for demand management
- Develop an outline business case for integrated care facility incorporating extended primary care teams using learning from Group Health (see next slide)
- Propose a new model in which both sets of populations would access the same services according to their needs
- Engage with CCG, GPs, NHS England and the local military personnel and the Ministry of Defence on the OBC
- Engage advice on workforce from Group Health – freely given at no cost
- Fully costed workforce plan, financial impact of redesigning current patient flows demonstrates service and financial viability

### Results

#### *Joint NHS and MoD development opening 2024 Joint funded by NHS and Ministry of Defence*



# Case Study 2 Workforce planning in integrated care – Group Health Seattle

*How addressing a workforce planning challenge drives a whole service redesign and benefits*

## The challenge

### *GP burnout, and attrition*

- Urban integrated care system serving 500,000 population. Funded as a co-operative, owned by the patients. Home of the chronic care model developed by Ed Wagner who works there
- Faced a growing challenge with recruitment and retention of GPs or Primary Care Physicians
- Particularly challenge of burn-out amongst the doctors whose resilience was draining away - exacerbating recruitment and retention challenges
- Group health of only 7 health care systems in the US that qualifies for 5 stars rating by the US DoH in older people's care (over 65s) yet one of the lowest utilizers of reactive hospital care in the US *at the beginning of the initiative*

## The solution

### *Pilot 10,000 population integrated care hub*

- Widened the multi-disciplinary teams bringing in pharmacists, paramedics and new medical assistant role (MA)
- MA provide general medical services in an extended 'primary care HCA type role'
- MAs support patients with LTCs in health coaching and monitoring
- Supporting the registered practitioners managing the more complex needs
- Introduce more remote working with patients on telephone and email with many managed by the MAs under clinical supervision and pathways
- Mas additional clinical audit requirements through data management and reporting
- Focus on whole population management – individualized, holistic care programmes
- Introduce care coordination of complex-need patients
- Focus on patient empowerment, co-production, motivational work

## Results

### *Workforce pressures resolved plus other (unexpected) benefits*

- GP morale addressed and burn-out reduced – now function as clinical team leaders,
- GPs see fewer but more challenging patients in 30 minute times slots.
- Number of GPs required unchanged
- Major change in the workforce is in the medical assistant role (MA) which becomes the 'workhorse' of the system.
- Registered nurses have lists and manage most complex patients. MAs do the more routine work.
- MAs also the least expensive staff member and quick to develop as requiring only 2 years in service training to bring up to full competence
- Patient outcomes and satisfaction increased.
- Acute hospital bed utilisation reduced by 27% from a low base in the US
- Rolled out to whole system now redefined as the Comprehensive Primary Care model and internationally innovative as incorporating whole population management.

<http://content.healthaffairs.org/content/29/5/835.full>. [http://www.ehcca.com/presentations/medhomesummit3/reid\\_1.pdf](http://www.ehcca.com/presentations/medhomesummit3/reid_1.pdf)

<http://www.annfamned.org/content/12/2/142.full> [https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/primary-care/workforce-financing/white\\_paper.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/primary-care/workforce-financing/white_paper.pdf)

## Potential Benefits and Risks of Strategic Workforce Planning

Potential Benefits	What to avoid
Helps to achieve state and organisational strategic goals	Lack of organisational commitment to the process
Provides greater agility and flexibility to deal with change	HR and business units silo-ed, restricting collaboration and not linking workforce and service outcomes
Facilitates transitions to other models of service provision	Getting caught up in the data and analytics, instead of starting with what is available and building on shortfalls
Enables more efficient and cost-effective use of resources	Focusing only on day-to-day operations, budgeting and headcount
Supports future-proofing and service sustainability	A narrow a focus on cost savings without potential broader impacts on service improvement and workforce resilience
Mitigates risks from future capability gaps and critical, hard-to-fill roles	Top down approach without sufficient stakeholder participation
Identifies and prepares pipelines for future required workforce capabilities	Insufficient participation by service managers and practitioners
Improves employee mobility and provides more job security	Workforce plans in which quantification is largely absent
Whole system approach to workforce redesign improves patient experience and opens new employment markets	Treating the strategic workforce plan as a static document and not revisiting it throughout the planning life cycle

# Outcome of effective workforce development: Benefits to patients, staff and benefits to the organisation





## TRANSFORMATION AND CHANGE

*Our knowledge and experience demonstrates that the pursuit of improved quality and patient experience in health reform will deliver whole system value for money.*

We bring together skills, experience and products that support innovative and workable solutions to 21st century healthcare challenges.

These include:

- Integrated Care at ICS and Place-levels
- Acute utilisation review and demand management
- Innovative business cases including Vanguards and other Integrated Care Hubs
- Whole system redesign
- Long-term Conditions – Care coordination, case management and Guided Care
- Population health management using the Johns Hopkins Adjusted Clinical Groups Tool
- Risk adjusted resource allocation and management
- Workforce planning in acute, community and primary care
- Workforce and process re-design
- International healthcare system reform working with the World Bank and other major donor organisations

Contact **David Cochrane**  
Phone: **07970739656**  
Email: **info@conrane.com**

