Workforce Strategy Appendix – Workforce Information

In the detail that follows the term HSC (Health & Social Care) staff refers only to staff directly employed by one of the Department of Health's 16 health arm's length bodies (BHSCT, NHSCT, SEHSCT, SHSCT, WHSCT, NIAS HSCT, HSCB, PHA, BSO, PCC, NIMDTA, NIPEC, NIGALA, NIBTS, RQIA and NISCC). Unless otherwise specified, HSC staff statistics have been sourced from the Human Resource, Payroll, Travel & Subsistence system (HRPTS) as at 31st March 2017 and exclude staff on bank contracts and domiciliary care workers. Information from the registers of UK regulators relates to registrants with a Northern Ireland address.

Headline Information

The total size of the '*human, health and social work activities*' sector was estimated to be **122,560** jobs as at March 2017, covering public and private sectors (including those known as independent and voluntary sectors)[1].

There were over 73,000[2] individuals directly employed by the 16 Health & Social Care (HSC) organisations in Northern Ireland (defined as the Department of Health's arm's length bodies) in various roles and capacities. This is the workforce that the Department of Health knows most about, but combining this with other sources of information such as professional regulation registers, gives an overview of the majority of the health and social care sector as a whole.

Utilisation of independent/voluntary sector workers mostly occurs within social care (e.g. residential care workers, day care workers and domiciliary care workers) in the areas of older people's services, children's services, learning disability services, physical disability services and mental health services. A significant amount of people are also working in primary care as independent contractors (or employed by them) i.e. general practitioners (GPs), general dental practitioners, general ophthalmic practitioners, pharmacists and their employees.

Overview of the health and social care sector

- 31,000 registered social care workers in Northern Ireland, with the majority working in the independent sector (adult residential care, day care and domiciliary care for example). Source: NI Social Care Council, NISCC.

- 23,800 registered nurses and midwives, mostly employed by the HSC Trusts but also in the independent sector in the likes of nursing homes, hospices and GP practices. Source: Nursing & Midwifery Council, NMC.

[1] Northern Ireland Quarterly Employment Survey March 2017, NISRA. https://www.nisra.gov.uk/statistics/labour-market-and-social-welfare/quarterly-employment-survey [2] Human Resources, Payroll, Travel & Subsistence system (HRPTS), maintained by HSC organisations. This count is without any exclusions and counting each person once, at 31st March 2017.

- 6,200 registered doctors, licensed to practice (Source: General Medical Council, GMC). The majority are employed by the HSC Trusts but around 1,700 are GPs (with most working as independent contractors).

- 1,700 registered dentists (Source: General Dental Council), with around two thirds providing at least some HSC general dental services and there are about 2,200 dental nurses (Source: General Dental Council, GDC).

- 2,300 registered pharmacists in Northern Ireland (Source: Pharmaceutical Society for NI, PSNI), with a majority working in community pharmacies, around 580 working in HSC Trusts, but now also a growing number employed in General Practices.

- 600 Ophthalmic Practitioners (optometrists and dispensing opticians) working as or for independent practitioners but providing HSC services (Source: General Optical Council).

- 6,170 registered allied health professionals (1,800 physiotherapists, 1,400 occupational therapists, 1,180 radiographers, 710 speech & language therapists, 520 podiatrists, 390 dietitians, 90 art therapists, 60 orthoptists and 20 prosthetist/orthotists) [Source: Health & Care Professions Council, HCPC], with around 70% working for HSC Trusts.

- 6,500 registered social workers (Source: NI Social Care Council) with two thirds working for HSC organisations.

- 2,600 registered clinical scientists and biomedical scientists (Source: HCPC) or HSC-employed medical technical, assistant technical officers or science support staff.

- 550 registered practitioner psychologists (Source: HCPC) with over 60% working for HSC Trusts.

- 12,500 HSC administrative and clerical staff, 6,800 HSC estates and support services staff. Source: HRPTS.

- 5,000 HSC employed nurse/midwifery support staff and 800 HSC employed AHP/psychology support staff. Source: HRPTS.

- 1,120 ambulance staff (390 paramedics, 260 emergency medical technicians, 260 patient care services staff, 90 ambulance officers and 120 control assistants). Source: HRPTS.

Some of the larger staff groups not able to be quantified above include other primary care workers (e.g. admin, pharmacy support), non-HSC allied health profession support workers, non-HSC nurse support workers and non-HSC admin/estates/support services workers.

Information on directly employed HSC staff and costs

The majority of directly employed HSC staff (95%) work within the 6 HSC Trusts (Belfast, Northern, South Eastern, Southern, Western and NI Ambulance Service). The largest HSC Trust is Belfast, accounting for 31% of HSC staff, with the other main Trusts employing 14-16% of HSC staff each. NI Ambulance Service HSC Trust employed 2% of staff. The remaining HSC organisations employed a further 5% of staff.

In 2015/16, expenditure on directly employed HSC staff salaries was over £2,300 million, with an additional £92 million being spent on agency workers. (Source: 2015/16 HSC organisation accounts). Complete information on staff costs in other sectors was not available.

Of HSC Trust staff costs (including agency workers), the largest proportions were spent on nursing & midwifery staff (32%), doctors (19%) and social services/care staff (15%). Allied health professionals, scientific, psychology and pharmacy staff accounted for a further 13% of staff costs. Administrative staff providing front line, indirect front line or business support services accounted for 14% of staff costs. Ambulance workers (including paramedics, control staff, patient care services and ambulance officers) accounted for 2% of staff costs. The remaining 5% of staff costs related to support services (e.g. domestics, catering, porters) and estates services (e.g. engineers, maintenance, joiners). Source: 2015/16 Trust Finance Returns - includes BHSCT, NHSCT, SEHSCT, SHSCT, WHSCT and NIAS HSCT.

Agency worker expenditure represented 3.8% (£92 million) of total HSC staff costs in 2015/16. Given levels of agency worker expenditure during 2016/17, it was estimated that this could rise to 6% of total staff costs. Around half of agency expenditure related to doctors.

Less than 3% of direct HSC Trust staff costs (£66 million) related to expenditure on staff with bank contracts (staff utilised on an ‘as and when required’ basis usually to fill staffing shortfalls and maintain service provision). Bank expenditure consisted mainly of nursing & midwifery (include support) staff costs (71%) and social services/care staff costs (19%). Most staff with bank contracts (69%) were also employed on an HSC contract for regular contracted hours, and the vast majority of those (94%) were on permanent contracts. This figure was higher for nursing & midwifery bank staff where 76% had another contract and 97% of those were permanent contracts.

Roles

Collectively, nursing & midwifery staff (including support workers) were the largest group amongst HSC staff, accounting for 35% of the whole-time equivalent (WTE) workforce with around 19,400 WTE staff. Of this total, 41% were acute/general nurses, 22% were nursing/midwifery support staff, 8% were mental health nurses, 5% were midwives, 5% were specialist nursing staff, 4% were district nursing staff and 4% were paediatric nurses. The remainder were in roles such as learning

disability nurse, health visitor, nurse manager, school nurse, treatment room nurse and prison nurse. With a registered nurse and midwifery workforce of around 23,800 (source: NMC register) we estimated the non-HSC workforce to be around 4,500, working in areas such as in nursing homes, hospices and general practices.

In total, NISCC registration figures (at September 2017) showed that there were around 6,500 social workers registered to work in Northern Ireland. Around two thirds were directly employed by HSC organisations. NISCC registration figures showed that the total social care workforce was around 31,000, this includes care workers in areas such as adult and children's residential care, domiciliary care, day care and supported living settings. Around 25% were directly employed by HSC organisations.

Professional & technical HSC staff accounted for 14% of the WTE total (7,830 WTE). Within this group, 48% were allied health professionals [e.g. physiotherapists (1,208 WTE), occupational therapists (1,085 WTE), radiographers (913 WTE), speech & language therapists (540 WTE), podiatrists (260 WTE), orthoptists (36 WTE) and dietitians (345 WTE)] and 7% AHP support staff and 32% (2,160 WTE) were scientific staff, technicians, pharmacy support and dental nurses. A further 7% (510 WTE) were HSC pharmacists, with 5% (360 WTE) graded as clinical psychologists and assistant psychology staff.

Consultants made up 3% of directly employed HSC staff (1,665 WTE) or 41% of the medical workforce. The larger specialties were anaesthetics/intensive care medicine (14% of WTE consultants), psychiatry (9%), radiology (7%), paediatrics (6%), obstetrics & gynaecology (5%), pathology (6%). Collectively, the various surgical and general medical specialties accounted for 16% and 20% of WTE consultants. Emergency medicine consultants accounted for 4% of WTE, cancer services/oncology accounted for 3% and public health medicine 1%. (Source: HSCT returns, excludes specialty of agency staff).

Around 1,800 WTE (46% of the medical workforce) HSC staff were doctors in training, including foundation doctors, registrars, core trainees and GP trainees. The specialty doctor/associate specialist HSC workforce was 441 WTE (11% of the medical workforce).

The number of GMC licensed general practitioners (GP) was over 1,700 (Source: GMC) and around 1,300 were attached to GP practices (Source: Business Services Organisation, BSO), leaving the remainder working in areas such as GP Out of Hours, as GP hospital practitioners or as GP locums. The total number of registered pharmacists was over 2,300 (Source: PSNI) and around 580 of them worked for HSC Trusts, with the majority of the remainder working as community pharmacists (primary care) in local pharmacies. The number of general dental practitioners (primary care) providing at least some HSC dental services (as opposed to private) was just under 1,100 (Source: BSO) The NHS Digital report on UK Dental Working Hours 2014/15 and 2015/16 showed 72.4% of weekly working hours were devoted to Health Service dentistry. The specialist HSC Trust community dentist workforce was just under 100 staff. In total there were just over 1,700 dentists on the GDC register.

Analysis of demographics and other profile information

Directly employed HSC staff were predominately female (79%), though some staff groups had a majority of male employees such as the ambulance (74% male) and estates workforce (97% male). The NISCC register of all social care workers showed 87% were female and the register of all social workers showed 82% were female. Whilst the proportion of HSC staff that were female has not changed overall in the last 10 years, within the HSC doctor and dentist workforce a notable increase has been observed. Ten years ago, 43% of that workforce were female, compared to 51% currently. The general practitioner (GP) workforce has also showed a rise in females from 38% in 2007 to 50% currently (Source: BSO).

Although the HSC registered nurse workforce was just 7% male, within the areas of mental health nursing and learning disability nursing the proportion of males was greater at 14% and 22% respectively. The pharmacist workforce (HSC and community) was 68% female (Source: PSNI). The general dental practitioner workforce showed an increase in the proportion of females from 50% in 2012 to 55% in 2017 and the rise likely to continue with 66% of those aged under 40 being female (Source: BSO).

The average age of HSC staff increased slightly in the last 10 years from 40 years to 43 years as at 2017. Of HSC staff at 31st March 2017, 40% were aged under 40, 27% were 40-49 years and 33% were aged 50 years and over. Ten years ago 47% were aged under 40, 31% were 40-49 years and 22% were aged 50 years and above. Some of the HSC staff groups displaying older age profiles included HSC Trust community dentists (43% aged 50+), midwives (40%), health visitors (40%), school nurse (39%) nurse/midwifery support (37%), district nursing (36%), mental health nurses (35%), consultants (36%), social workers (33%), specialty doctor/associate specialist (31%) and paramedics (31%).

The NISCC register of social care workers showed 32% were aged 50 and over. Analysis of the age profile of GPs showed a consistently high proportion aged 50+ for at least the previous 8 years (42-45%), and the proportion in 2017 stood at 39%. The HSC allied health professional workforce showed a younger profile, with just 16% of staff aged 50+. The total pharmacist workforce (HSC and community) also showed a younger age profile with two thirds (67%) being aged 40 and under. The general dental practitioner workforce has 50% aged under 40.

The proportion of HSC staff working part-time changed little in the past ten years (39%) and indeed the participation rate (whole-time equivalent to headcount ratio) increased just slightly from 0.86 to 0.87 in terms of contracted WTE (note a participation rate of 1.00 would indicate all staff working full-time). Overall the 39% was made up of 36% part-time females and 3% part-time males. Part-time working was most prevalent within the HSC support services workforce (66% of staff worked part-time) and was least prevalent within HSC estates services (1% of staff worked part-time). The main HSC staff groups that showed a notable increase in part-time working in the past 10 years were allied health professionals (40% of staff were part-time at March 2017) and in particular their support staff (51% of staff were part-time at March 2017). Increases were also seen amongst HSC social services staff (36% of staff were part-time at March 2017).

The only workforce that showed a notable increase in the proportion of male part-time working in the last 10 years was amongst ambulance workers (mostly emergency medical technicians and patient care services), though just 3% of the overall ambulance workforce were part-time males. Part-time working was also low amongst paramedics overall, with just 6% contracted to work part-time. Of the HSC doctor & dentist workforce, 19% worked part-time (made up of 14% female and 5% males). A rise in the proportion of part-time working was seen amongst this workforce in the last 10 years, linked to the rise in the number of female workers, however this has actually had little effect on the participation rate of the workforce (0.91 at March 2017).

The participation rate for GPs is currently unknown as whole-time equivalent is not centrally available, but it stood at 0.93 before the GMS contract i.e. 2003. In the period 1995-2003, the proportion of GPs that were female increased from 27% to 34% however the overall participation rate only dropped from 0.94 in 1995 to 0.93 in 2003 (Source: BSO). NI Medical & Dental Training Agency GP appraisal records would indicate that 17% of the GPs appraised in 2015/16 were part-time partners, based on reported status (excluding Out of Hours GPs and sessional GPs).

HSC staff participation rates by age band generally showed a decreasing pattern the older the age group, ranging from 0.93 for the under 30s to 0.79 for those aged 60 years and over. The proportion of part-time working ranged from 26% for the under 35s, between 41-43% for each of the 5 year age bands up to the age of 59, then increased to 54% part-time working amongst those aged 60+.

Most HSC staff (93%) were on Agenda for Change (AfC) terms and conditions, 7% were on Medical & Dental terms and conditions, with a very small proportion (less than 1%) on other terms and conditions (usually related to TUPE protection). More than half (57%) of AfC staff were paid at Band 5 level and above (salaries above £21,693, 2016 scales) and 43% were paid at Bands 1-4 (salaries ranging from £14,437 - £22,236, 2016 scales).

The main HSC staff groups consisted of differing levels of AfC banded staff. Those containing professionally qualified staff had higher proportions of staff at AfC bands 5 and above and lower proportions at band 1-4. For example within professional & technical (AHP, scientific, pharmacy, psychology staff) and nursing & midwifery (including support) staff groups, 21-22% of staff were paid at bands 1-4, whereas support services consisted almost entirely (99%) of staff paid at these bands. Almost three quarters (71%) of administrative staff were paid at bands 1-4 also. A breakdown of pay points within AfC bands showed that 62% of AfC staff were at the top pay point within their band, reflecting high proportions of experienced staff.

Around 1 in 8 (13%) directly employed HSC doctors were on temporary contracts (excludes doctors in training on planned rotation). HSC organisations also employed 7% of administrative staff, 7% of social services staff and 6% of professional & technical staff on temporary contracts. This compared to nursing & midwifery where only 2% of staff are employed on temporary contracts.

Within HSC organisations, the percentage of scheduled hours lost in the 2016/17 year due to sickness absence was around 6.6% and accounted for over £100 million in lost productivity (meaning staff costs to HSC orgs of those off sick). Mental health related reasons accounted for 30% of hours lost (stress, grief/bereavement, depression, anxiety, work-related stress). Back problems, injuries/fractures and other musculoskeletal problems accounted for 20% of hours lost. Reasons such as general debility, post surgical debility, respiratory, gastrointestinal problems accounted for a further 5-6% of hours lost each. Pregnancy related absence accounted for 4% of hours lost. Flu/cold/cough reasons accounted for 3% of hours lost and cancer accounted for 4% of hours lost.

Within HSC staff groups, sickness absence was highest amongst nurse/midwifery support staff (over 10% hours lost), ambulance roles (paramedics, emergency medical technicians and control staff) at over 10%, support services staff at 9%, social care staff at 9% and midwives at 8%.

The overall percentage of HSC staff off on maternity/adoption/paternity/shared parental leave was 3% at March 2017. This percentage was high at 6.2% overall for allied health professionals and specifically it was high amongst dietitians (7.2%), speech & language therapists (7%), occupational therapists (6.5%), physiotherapists (6.3%) and radiographers (5.7%). The percentage amongst registered nurses was 4% overall. Within registered nursing, higher levels of such leave was seen amongst paediatric nurses (6.1%) and acute nurses (4.6%). The midwife workforce also had 4.3% of staff off on maternity/adoption/paternity/shared parental leave. The proportion of staff on such leave amongst junior doctors at the registrar level (including GP trainees) was 5%, compared to just 1.5% for consultants. For social workers, 3.5% were on maternity / adoption / paternity / shared parental leave.

HSC Recruitment and Turnover

Whilst overall staff numbers have been increasing in recent years, there is still a need for additional staff. The March 2017 vacancy rate (of posts being actively filled) was around 5% for posts currently in the system (Source: HSC organisations).

As at 31st March 2017 the largest volume of vacancies in HSC recruitment was registered nurse posts (1,262), a vacancy rate of 7%. It should be noted that there was a 10% WTE increase in this staff group in the last 10 years and the March 2017 high vacancy rate would suggest a demand for further expansion of this workforce. The number of midwife vacancies in recruitment was 71, a vacancy rate of 5% and the number of nursing/midwifery support vacancies was 286, a vacancy rate of 5%.

Registered Nurse vacancies in recruitment trend

	Current + Temp Vacancies in recruitment		Staff in Post		Vacancy Rate	
	HC	WTE	HC	WTE	HC	WTE
Mar-12	445	405.4	14,774	12,728.7	2.9%	3.1%
Mar-13	544	474.9	15,080	13,053.4	3.5%	3.5%
Mar-14	486	448.8	15,371	13,333.3	3.1%	3.3%
Mar-15	826	774.0	15,522	13,534.0	5.1%	5.4%

Source: HSC Vacancy Survey, collated by DoH

The HSC pharmacist and psychologist workforces had a vacancy rate of 11% and 12% respectively as at 31st March 2017, with 74 and 44 vacancies in recruitment.

Trend in Pharmacist vacancies in recruitment

	Current + Temp Vacancies in recruitment		Staff in Post		Vacancy Rate	
	HC	WTE	HC	WTE	HC	WTE
Mar-12	30	26.9	441	391.3	6.4%	6.4%
Mar-13	27	25.5	479	423.9	5.3%	5.7%
Mar-14	13	12.1	509	448.3	2.5%	2.6%
Mar-15	37	33.4	517	451.0	6.7%	6.9%

Trend in Psychologist vacancies in recruitment

	Current + Temp Vacancies in recruitment		Staff in Post		Vacancy Rate	
	HC	WTE	HC	WTE	HC	WTE
Mar-12	19	18.3	277	254.2	6.4%	6.7%
Mar-13	14	12.6	253	228.0	5.2%	5.2%
Mar-14	21	20.5	302	273.2	6.5%	7.0%
Mar-15	33	30.3	298	271.2	10.0%	10.0%

Collectively, HSC allied health professional vacancies in recruitment totalled 301 as at 31st March 2017, a vacancy rate of 6%.

Trend in Allied Health Professionals vacancies

	Current + Temp Vacancies in recruitment		Staff in Post		Vacancy Rate	
	HC	WTE	HC	WTE	HC	WTE
Mar-12	198	174.8	3,652	3,140.4	5.1%	5.3%
Mar-13	237	219.3	3,772	3,238.8	5.9%	6.3%
Mar-14	110	102.3	3,947	3,351.3	2.7%	3.0%
Mar-15	291	263.8	4,034	3,411.9	6.7%	7.2%

Just over 100 HSC consultant vacancies were in recruitment as at 31st March 2017, a vacancy rate of 5%. In addition, 65 specialty doctor/associate specialist vacancies were actively in recruitment which is an 11% vacancy rate. The consultant workforce experienced a 39% WTE increase in staff in the last 10 years, almost an additional 500 permanent/temporary staff. The specialty doctor/associate specialist workforce has also seen a similar level of growth in the last 10 years (37%), likely attributed to Modernising Medical Careers, but clearly demand for staff at this level is high.

Trend in Consultant vacancies

	Current + Temp Vacancies in recruitment		Staff in Post		Vacancy Rate	
	HC	WTE	HC	WTE	HC	WTE
Mar-12	103	99.7	1,494	1,411.4	6.4%	6.6%
Mar-13	99	96.7	1,542	1,455.0	6.0%	6.2%
Mar-14	155	147.1	1,625	1,528.7	8.7%	8.8%
Mar-15	161	160.6	1,666	1,569.0	8.8%	9.3%

Trend in Specialty Doctor/Associate Specialist vacancies

	Current + Temp Vacancies in recruitment		Staff in Post		Vacancy Rate	
	HC	WTE	HC	WTE	HC	WTE
Mar-12	52	51.5	439	357.5	10.6%	12.6%
Mar-13	47	45.4	494	405.9	8.7%	10.1%
Mar-14	49	47.5	504	421.3	8.9%	10.1%
Mar-15	76	73.9	522	434.8	12.7%	14.5%

Posts actively being recruited to as at 31st March 2017 – by staff group

	Post actively in recruitment
Admin & Clerical	569
Estates Services Staff	38
Support Services/User Experience	273
Registered Nurses	1,262
Registered Midwives	71
Nurse/Midwifery Support	286
Social Workers	151
Social Care Workers / Domiciliary Care Workers	210
Other Social Services staff	168
Allied Health Professionals	301
Pharmacists	74
Clinical Psychologist	44
Scientist / Scientist Support / Medical Technical Officer / Assistant Technical Officer	128
Other Professional & Technical staff	86
Consultant	101
Associate Specialist / Staff Grade / Specialty Doctor / other Doctor	69
Doctors in training (core trainees, specialty registrars, foundation doctors)	27
Paramedic / RRV Paramedic / Ambulance Officer	8
Patient Care Services	21
Total	**3,887**

Source: HSC organisations - Includes those posts that are actively being recruited to, including those posts going through pre-employment checks, up to the point of a start date being agreed.

In recent years, the HSC workforce has been increasing, meaning joining rates (6.7% overall in 2016/17) exceeded leaving rates (5.4% overall). During 2016/17 the estates services workforce decreased, with a high leaving rate at 9.3% and a joining rate of 7.5%. The nursing & midwifery workforce leaving rate was 5.9% but the

joining rate was 7.4% in 2016/17. The professional & technical workforce (AHPs, scientific, pharmacy, psychology) had the highest rate of movement of staff between HSC organisations at 3.2%. The nursing & midwifery (including support staff) and doctor workforces displayed similar levels of movement between HSC organisations at 1.8% and 2.1% respectively (not including doctors on training on planned rotation). Regional reporting on reasons for leaving was not yet robust, but around 2% of the workforce retired each year. (Source of HSC leavers, joiners and movers – comparison of HRPTS 31st March 2017 snapshot of staff with that of 31st March 2016).

Data limitations/improvements

The above analysis is only a selection of the information available. Whilst the Department holds a wide-range of data on the entirety of the health and social care sector, this data is most comprehensive for those directly employed by HSC organisations (the 16 ALBs). The size of the workforce involved in primary care services tends to be limited to the professionals contracted to deliver the service, with little known about the numbers and profile of the staff that they employ. We are also lacking in whole-time equivalent information for primary care professionals. With NISCC compulsory registration of social care workers, it is hoped that more comprehensive profile information will be available on the entirety of this workforce which depends heavily on the independent sector. However, in general, information on the independent sector workforce delivering health and social care services is not comprehensive.

Recent HSC workforce planning reviews have raised inadequacies with the categorisation of particular roles and therefore numbers being reported (e.g. within nursing specialties), with whole-time equivalent recording (e.g. domiciliary care workers and GPs), with information regarding the specialties that staff work in (e.g. medical staff) and with information on the setting that staff work in - meaning hospital, community etc or even programme of care. Whilst DoH statisticians have begun an annual collection from HSC organisations of doctor and dentist specialties, this information should be reliably reportable from the HR system (HRPTS). In addition due to the high level of agency doctors, medical specialty analysis is incomplete as only expenditure is available for agency staff. Quantifying staff by settings (e.g. hospital, community, primary care setting, programme of care), is obvious for some roles within HRPTS for HSC staff, but can be difficult to gauge for staff groups who work across settings and is inadequate for staff outside of HSC employment, particularly in primary care.

In terms of vacancies, criticism is often received on a lack of information on all unfilled posts (as opposed to posts in recruitment). The unfilled posts measure is often based on real-time status and lacks regional agreement on definition so it is difficult to collate on an HSC wide level and is resource intensive, though attempts are being made to collect such data for selected services or staff groups. Patterns in recruitment information (applicants numbers, called to interview numbers, offers, acceptances etc) tend not be widely shared or collated to a regional picture. The recent international recruitment projects, looking at Band 5 nursing and Consultant/SAS doctor vacancies, have allowed a strategic view of vacancies by specialty across the region and a forum for raising possible problems such as lack of

pool of applicants, shortfalls in numbers in training in certain specialties. Vacancies data for independent/voluntary sector staff is not centrally available and would be difficult to collect from the 500+ employers.

Regional groups do exist for HRPTS coding, workforce information reporting, absence management etc and these groups continue to tackle specific system issues as well as standardisation of recording and reporting across the region.
In terms of data required for strategising or planning for a future workforce, information on supply and demand is the overarching requirement. For supply information, improved links with education and training bodies' data are needed to gain further post-qualification employment statistics and intelligence on attrition. Recording of country, place and year of qualifications is absent from the HSC HR system and only some skills and training information is recorded. More detailed 'exit' information would also be useful for existing HSC employees. Standardised and robust information on the workforce required to meet future demands are scarce, except where professions have guidelines or other strategies to work towards (e.g. Delivering Care policy framework for Nursing & Midwifery workforce, also certain doctor specialties and Royal College recommendations). Use of local system's data such as those containing rota and job plan information are generally not exploited as a source of workforce intelligence but this is complicated by regional software variations and type/quality of data recorded.