Health Education England

HEE Workforce Planning and Strategic Framework (Framework 15)

2015/16 Call for Evidence

In 2015/16 we are inviting organisations for submissions which address not only immediate workforce planning and education commissioning but which look further ahead and cover wider workforce strategy. For this reason the 2015/16 form covers not only 'conventional' supply and demand concerns, but invites organisations to comment on the wider context of drivers of change and the strategic response. It is organised as follows:

Section 1: Current and future workforce demand and supply

Section 2: Drivers of service demand change

Section 3: Patients and population

Section 4: Models of care

Section 5: Future workforce characteristics

Section 6: Any other evidence

Submissions should be completed and returned to HEE, using this form, by 30th June (see below for more information).

We acknowledge that this is a bigger task than in previous years, and it may entail a higher level of internal deliberation and consultation for your organisation. This is deliberate: we want to learn as much as we can about what organisations are thinking about the long term and the big picture, while simultaneously gathering thinking about the here and now and the more immediate future which will be influenced directly by HEE's commissions in the short term.

Making your submission

- We ask that, to maximise input, your submission is completed and returned to HEE by the **end of June**
- To submit your evidence please, complete this form. You can provide extracts of reports into the free text boxes below, or submit whole reports. Where an extract is provided, please reference the source.
- In submitting evidence you are invited to take into account the following:

HEE's workforce planning guidance	HEE Planning Guidance. Due to the restrictions around the election we have not been given permission to put this on our web site. It has been widely circulated but please contact mandy.knowles1@nhs.net if you do not have a copy.
HEE's strategic framework (Framework 15)	http://hee.nhs.uk/2014/06/03/framework-15-health-education-england-strategic-framework-2014-29/
The NHS Five Year Forward view	http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

- Once you have completed the form and/or prepared your 'pack', please embed it in an email and return it to hee.workforceplanning1@nhs.net and in the subject heading please use this convention:

HEE CFE 2015/16 from [your organisation's name in full – avoid acronyms] [Sub version x]

- Please note, it is not *compulsory* to complete all sections for you to submit a response, but **in order to inform HEE's 2015/16 education commissions, section 1 must be completed and returned by the end of June**

Your contact details

Before completing the form below please submit your contact details here:

Name	Deepak Dwarakanath
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Submission version)if you resubmit at any point)	
Date	26/06/2015

Data Protection and Freedom of Information

The information you send us may be made available to wider partners, referred to in future published workforce returns or other reports and may be stored on our internal evidence database.

Any information contained in your response may be subject to publication or disclosure if requested under the Freedom of Information Act 2000. By providing personal information for this review it is understood that you consent to its disclosure and publication. If this is not the case, you should limit any personal information provided or remove it completely.

If you want the information in your response to be kept within HEE's executive processes, you should make this clear in your submission, although we cannot guarantee to be able to do this.

Section 1 – Current and future workforce demand and supply

Use this section to input evidence into the forecasting of future workforce numbers. Report here your perspectives on either;

i) the high level indicators; supply, demand, and any forecast under / over supply
or if available
ii) the more granular components of these three components e.g. retirement rates, output from education relative to attrition

1.1 Summary forecasts

- Forecast Workforce Demand
- Forecast Workforce Supply and Turnover
- Forecast Under / Over Supply

Insert evidence here….

Our Fellows report that workforce demand increases year on year, with workforce patterns unable to keep up. Despite consultant expansion, the rise in flexible working patterns and retirement rates means these changes have not impacted on overall workload and morale for those working on the front line.

GP recruitment remains a problem and, even with full recruitment, primary care working patterns would not seem to improve secondary care demands both in Emergency Medicine and Acute Medicine. There are no indications there is a problem of over supply, particularly within the physicianly specialties. There are also recruitment problems on a nationwide basis across a variety of ST3 disciplines. In addition, there are geographical differences across the UK with a clear perception of disparities across different health economies.

Evidence of medical student numbers, gender balance (insofar as this has an influence on both career choice and on the need for career breaks/part time working), career destinations (specialities) and the contributions (full-time/part-time working) are held by the GMC and Medical Schools Council. Attrition rates are low for medical students, but the medical degree gives a broad foundation and not all graduates decide to continue in medical training or practice in the UK.

Various projects explore options for changing the shape of the multi-disciplinary clinical workforce. For example, the University of Exeter Medical School has recently undertaken a scoping exercise, funded by HESW, to assess the need for extending the scope of practice of radiographers. The increased interest in Physicians Assistants is another, although we believe these roles work best in carefully defined areas of practice.

1.2 Detailed / Component forecasts

Forecast Workforce Demand

- Service Demand drivers
- Change in use of temporary staff
- Addressing historic vacancies
- Skill Mix / New Roles
- Workforce Productivity

Insert evidence here….

Fellows have not noted a change in the use of temporary staff who remain necessary across multiple rotas to keep NHS services flowing. The driver for removals of Locums, for example, lead to programmes and trusts inevitably having vacancies. New roles (eg Physician Associates), may help this with this issue when fully on stream, but at present they are not available in high enough numbers to be able to rely on.

HEE will itself hold evidence of vacancy rates for medical speciality training programmes (GP and Psychiatry), with both social/behavioural and business orientation influencing the vocational drivers of those who elect (or avoid) these areas.

The work-life balance requirements of the medical workforce will, of course, influence the lifetime contribution rates, because of the need for career breaks for maternity and carer roles. The GMC data shows that women have far fewer complaints made and by inference could be considered safer practitioners.

The complexity of multi-morbidity and an aging population will require high level experiential skills, usually from doctors, whose training requires a foundation of basic scientific principles that allow difficult problems and uncertainties to be assessed, even when there are no guidelines or algorithms. There must be scope however to increase the input from those who can deal with simple conditions (see Minute Clinic, at CVS pharmacy in the USA); or those who can deal with optimising medicines within guidelines (eg community heart failure management), with back-up from a doctor who can address complex co-morbidities when they arise.

1.3 Forecast Supply from HEE commissioned education

- Assumed training levels
- Under recruitment
- Attrition
- Employment on completion of training

Insert evidence here….

The majority of commissioned programmes within the physicianly specialties are probably still not producing enough specialists from current supply, particularly in hard to recruit to specialties.

The GMC/MSC may hold data which can relate the career destinations and in some medical schools this may reflect the curriculum (eg effect of high level of GP teaching and placement). Cultural demographics of students should also be taken into account eg some schools have a larger number of women and those from south Asian cultural back grounds.

1.4 Forecast Supply – Other Supply and Turnover

- From other education supply
- To/from the devolved administrations
- To/from private and LA health and social care employers
- To/from the international labour market
- To/from other sectors / career breaks and 'return to practice'
- To/from other professions (e.g. to HV or to management)
- Increased / decreased participation rates (more or less part time working)
- Retirement

Insert evidence here….

The RCPE has a UK and international role. There is some flow across the border from Scotland to England but less so in the other direction. This should be looked at cautiously however, as certain changes (eg Scotland continuing to appoint to LAT posts) may lead to changes in the historical levels of flow.

There is a perception that changes to immigration policy have limited the ability to use the international labour market to improve recruitment.

Return to practice is somewhat difficult across physicianly specialties, given assessment of competency across foundation, CMT and higher specialty. This is an area that could be looked at with huge benefit, but may need resource to facilitate the process as some of the necessary training and competency assessment will be looked at as "supernumerary".

Professor John Campbell has recently undertaken a study looking at career planning of GPs in the South West and this work, which includes a qualitative survey, gives some insights into the future of General Practice in the SW, and further information to influence national and regional planning may be commissioned/funded.

Section 2 - Drivers of service demand change

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
We believe that our population is **getting older**, and that for our workforce, preferences for a change in patterns in working is increasing.	Clear and ongoing increases in service demand as the population ages and becomes more complex.	How do you think this will have an impact as a driver of **service demand**? Clear and ongoing increases in service demand as the population ages and becomes more complex. These effects are felt short term as well as long term.
The influence of technology is growing in healthcare and beyond, with staff and patients using it to **increase personalisation and control** in their life. What will be its possible impact in healthcare in the years ahead? The influence of **genomics and research** will also play a vital part.	Over time we will see ongoing improvements as a result of technological changes (including genomics). At present and in reality in a variety of clinical settings this still seems far away.	How will technology and innovation impact on **service demand** in the near future, and what education/training will the current workforce need to meet that demand? Unless there are urgent changes in standardisation of IT practices and practical solutions (eg wifi provision in trusts), some potential benefits may not occur. There are likely to be myriad information sources which patients need help in negotiating.
Wider factors are creating global pressures to **constrain the cost** of publicly funded healthcare, with the wider concept of wellness increasingly taking root which people will expect health service to respond to.	Expectations of wellness/happiness are changing, due to more information being provided. Patients need help in developing resilience, and reality checks as well as self-empowerment.	Economics will play a part in influencing **service demand** and NHS funding will shape service demand in the near future (QIPP, funding, economics).

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Patients are going to want **high quality services anytime, any place, anywhere**, with a more equal (and challenging) relationship with staff, but one still based on care and a better work life balance.	This should be looked upon as a clear goal and the correct direction of travel, whilst paying reference to the significant demands already present on NHS staff and significant areas of poor morale. There are some societal changes that have led to unrealistic expectations. Patients need help in recognising urgent problems (eg a heart attack) as opposed to planned care (eg assessment of long standing back pain).	What is the shorter term impact of changing patterns of expectations on **service demand**? This is unlikely to be able to happen with current staffing levels without appropriate incentivisation.

Section 3 – Patients and population

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
With people living longer with more people living with **multiple and complex conditions** (and with our workforce being currently predominantly trained to treat distinct and different disease in isolation after a health crisis has occurred). How can we educate/train the workforce to support the prevention of ill health and, where ill health occurs, support staff to work across organisational boundaries to support high quality care for people with a range of health needs (across physical, mental health and social care)?	To be radical we should look for all primary care trainees receiving more secondary care training and vice versa. Shape of training has potential to deliver some of this; the concern is whether eg 6 months in geriatric medicine at ex CMT level is enough to truly deliver what is needed here. This highlighted area is true only for algorithm led practitioners. Teaching about health and personal responsibility could begin in early life, and as many people will be carers before they are patients, may require training for that role.	What are the possible/likely impacts on **service demand – activity and epidemiology**? There is a danger in approaching all long term conditions in the same way. Some of the principles are the same for all conditions and we support the need to change organisational boundaries to provide personalised care. However, Diabetes is very different to Parkinson's disease, for example.
Our patients and population are likely to be at different stages of being **informed, active and engaged** in their own healthcare (including using for example, data and online records), with our challenge being to support the development of a workforce which can support high quality care for all patients.	Education and provision of information, particularly across more information poor environments. As the IT savvy population ages this may become easier. It should be noted that many people will not take an interest, and peer influence could play a role.	How will needs **identified by patients and the public** affect service demand in the shorter term? Likely to show major socioeconomic and geographical differences,

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Patients will increasingly be members of a **community of health,** with the number of carers projected to rise significantly in the years ahead**.** Five Year Forward View highlights four ways in which we can engage with communities and citizens in new ways, to build on the energy and compassion that exists in communities across England, namely: • better support for carers • creating new options for health-related volunteering • designing easier ways for voluntary organisations to work alongside the NHS • using the role of the NHS as an employer to achieve wider health goals	There are conflicts within the carer's role in that more people (often women) are working and everyone will have to work for longer. It is unlikely that voluntary organisations will be able to carry the major burden. Improving the health and wellbeing of the NHS's own workforce could help influence societal shift.	How will these trends affect **service demand** in the short term and how can we support patients and communities of health through our **lever of workforce planning**?
Developing **substantial community provision** to bring about a substantial reduction in the numbers of people with learning disabilities placed inappropriately in institutional care is a central part of Sir Stephen Bubb's report in 2014 ('*Winterbourne View – time for change*).	Learning disabilities as a descriptor is poor and does not inform about the functional needs within a safe physical environment.	What will be the **service demand impact** of the changes to transform care for people with Learning Disabilities (such as those outlined in *Transforming Care for people with Learning Disabilities)*?
Parity of esteem for Mental Health will be supported through delivering improvements in areas such as integration, waiting and access targets and in the area of psychiatry liaison	Similar to primary care there is not enough mental health training at postgraduate levels in secondary care settings There is a need to consider the range of normality and recognise the changes in societal and cultural norms.	What education/training does the current workforce require to be able to make parity of esteem a reality? Similar to primary care there is not enough mental health training at postgraduate levels in secondary care settings

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Five year forward view draws attention to the NHS being committed to making **substantial progress** in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds.		How can we use our levers in the **short term** to support this commitment?

Section 4 – Models of care

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
Five Year forward View outlines a number of possible future service models including • multispecialty community providers (MCPs), which may include a number of variants • integrated primary and acute care systems (PACS) • additional approaches to creating viable smaller hospitals • models of enhanced health in care homes The **expertise to support** the piloting and introduction of these models need to be considered. Existing NHS services and areas of the healthcare workforce may work with others in new and different ways (e.g. community pharmacy).	Viable smaller hospitals should be welcomed but need not have trainees as sole methods of service provision as there are several examples where that does not work. They can be excellent learning environments if managed appropriately. Physical therapies (Physiotherapy, exercise) for residents of nursing home may keep them more mobile, easier to handle and less demanding of emergency care. Hospice/end of life care should be possible in care homes. It is essential that the starting point should be "the jobs that need to be done" and who has already or could develop the skills to do these jobs.	How could **future service models** develop in the short term in line with these developments and the learning from the Vanguard sites, and what education/training will the current workforce need to make these models work? New developments (such as PACS) need to ensure that they work with current training providers, LETBs and colleges to ensure that developments are future proofed within current regulatory frameworks. The NHS must recognise the value of focussed factories, where low risk/highly specialised activity in medical and surgical practice is carried out in relative isolation, and quality driven up and costs kept down. However, there is a need to require training and education in that environment.
Services are likely to become **increasingly integrated** in the future, enhanced through policies such as the Devolution of Local health and social care budgets, the integrated care pilots and integrated personal commissioning. Partnerships will become increasingly important, including with partners beyond NHS and social care.	As above.	How could **future service models** develop in the short term in line with these drivers, and what education/training will the current workforce need to make these models work? Integrate those with a good knowledge of social and community based care into hospital based management teams. Early review soon after hospital discharge after an emergency admission, either in the community, or in an OP setting, will reaffirm plans and progress.

Timescale/time horizon		
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	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
We may increasingly see **centres of specialisation** in some specialties in some areas.	Should be welcomed as long as training the future workforce is always considered. This concurs with the "focussed factory" approach mentioned above.	How could **future service models** develop in the short term in line with these drivers? Should be welcomed as long as training the future workforce is always considered.
We will see the ongoing development of services in the area of **urgent and emergency care**	Increasing primary care input into these areas has not made significant differences as yet. The AMUs seem to remain the place of last (or often first) resort for many patients who are sick whether they could be managed in primary care or by surgical teams. Education about expectations for non-urgent care must be used to manage resources.	How could **future service models** develop in the short term in line with these drivers? Try to scope best practice of different models of provision of urgent and emergency care and aim towards standardising where possible. There are many successful models across the country, but lack of clarity as to which works best. Many service developments are not appropriately researched or analysed.
Five Year Forward View highlights new developments such as the **evidence based diabetes prevention service** and **encouraging new capacity in under doctored areas.**	Workforce planning could be adapted to mirror local rates of diabetes. Perhaps a good example of where local workforce planning would be better than a central approach. Complex interventions including psychological and cultural inputs will be needed.	How could such approaches affect **service models** in the near future?

Section 5 – Future workforce characteristics

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
Below are the 5 future workforce characteristics set out in Framework 15	In your evidence please highlight any or all of the following: - Are these workforce characteristics still valid? - Any evidence you are aware of work which is underway and which contributes to the achievement of the workforce characteristics - Any gaps you are aware of Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term** education and training needs required for the current workforce to meet these characteristics:
The workforce will include the informal support that helps people prevent ill health and manage their own care as appropriate.	Should be encouraged.	
Have the skills, values and behaviours required to provide co-productive and traditional models of care as appropriate.	Should be encouraged and developed further via generic competency training.	
Have adaptable skills responsive to evidence and innovation to enable 'whole person' care, with specialisation driven by patient rather than professional needs.	Should be encouraged with more training in this area, which is likely to require more time than current models of training. There are many reasons that have driven people from generalisation to specialisation, but the amount of knowledge and skills required has increased over 20 years while training time has decreased.	
Have the skills, values, behaviours and support to provide safe, high quality care wherever and whenever the patient is, at all times and in all settings.	Should be encouraged and absolutely vital; and already done very well indeed by the overwhelmingly largest proportion of the NHS workforce.	
Deliver the NHS Constitution: be able to bring the highest levels of knowledge and skill at times of basic human need when care and compassion are what matters most.	Should be encouraged.	

Section 6 – Any other evidence not included elsewhere

Insert evidence here….

Our Fellows have some concerns about this document which presents a vision of the future that does not take into account the increasing reluctance of trainees to engage with front-line medicine for the acutely ill. It does not mention that the average hours worked by the consultant group according to the physician's census continues to decrease as the work life balance ethos takes a greater hold.

Most HEE local work seems to be centred in the South of England and yet the recruitment problems are most intense in the North of England.

HEE are looking to create new professions to deal with a lack of doctors rather than making the doctors who could and should be working in the front line feel valued. The emphasis that doctors receive a large share of the CPD budget seems to suggest that the share will be decreased rather than an emphasis to increase the total available.

In responding to the issues raised, it is important to recognise the challenges of long term predictions of training needs. A 15 year strategy adopted without an iterative process will not produce effective outcomes.

The response from our sister College, the Royal College of Physicians of London includes evidence from the 3 College censuses and other workforce surveys of trainees and which we have not repeated here.