NHS
Health Education England

Heart Disease: understanding the future service and workforce need

Heart Disease Workshop - Evaluation Report

Foreword

Cardiovascular disease (CVD) affects one in ten people in the UK causing a quarter of all deaths and placing a significant burden on the NHS. It is identified as a clinical priority in the NHS Long Term Plan at a time of significant workforce challenges with efforts underway to boost NHS activity and tackle the rising backlog of care. It remains the leading cause of premature mortality in England and a major cause of health inequalities.

HEE and NHSE have been working closely through the National Clinical Director for Heart Disease Professor Nick Linker and GIRFT Joint Clinical Leads Dr Sarah Clarke and Professor Simon Ray to understand current priorities for the heart disease workforce; the pressures and challenges they face; suggest solutions to them; and identify current barriers to achieving these ambitions and changes. A joint initial workshop on 11th August 2022 was held to scope and understand the work that is currently underway across the system on workforce, identifying improvement opportunities and alignment that will help deliver national priorities for heart disease. Also, providing a forum to influence and shape future funding and resource priorities for the heart disease workforce.

This report includes initial recommendations that we aim to take forward jointly and address. This includes the following:

- Focusing on cardiovascular workforce data and supply by scoping how best we can help address uniformity in data system sources and any system data gaps.
- Looking at workforce upskilling and training through concentrating on the skills and capabilities that are required for emerging models of care, new roles and ways of working.

These will help in the delivery of a future ‘service ready’ CVD workforce with a core set of functional capabilities.

The ownership and delivery of these interventions will need to account for the cardiac delivery networks (CDNs) and integrated care systems (ICS) infrastructure through the important role they can play. These networks will provide leadership on workforce solutions, enable the sharing of best practices, harness role or career opportunities specific to the CVD specialty and consider localised workforce transformation opportunities. for example, through the ‘HEE Star’ workforce transformation lens and identify funding opportunities amongst others.

It is envisaged that oversight of these activities will be directed through the NHSE Cardiac Delivery Board and HEE will continue to support these as we transition into the merger of both organisations. Further workshops, engagement events and scoping activities may be undertaken to further understand how we can strengthen interventions for the CVD workforce.

Professor Adrian Brooke, Medical Director, Workforce Alignment Programme Senior Responsible Officer (SRO) for Long Term Conditions (LTC) Health Education England

Introduction

The NHS Long Term Plan has set out its ambitions for the NHS over the next 10 years, identifying cardiovascular disease (CVD) as a key clinical priority. This is at a time of significant workforce challenges with efforts underway to boost NHS activity and tackle the rising backlog of care.

The NHS People Plan sets out a number of priorities around (i) looking after our people (ii) belonging in the NHS (iii) new ways of working and delivering care (iv) growing for the future; with NHS England (NHSE) and Health Education England (HEE) having an important role to play in delivering this. Importantly, systems too have an important role in leading and overseeing progress on this agenda, strengthening collaboration among all health and care partners. HEE has a key role to deliver and reform education to produce the best possible future workforce; to transform the current workforce to meet tomorrow's health and care needs; and ensure the quality of our education and training system.

The NHS Long Term Workforce Plan will look at short, medium and longer term workforce plans aiming to optimise skill mixing, enabling technology, upskilling and adapting the workforce to meet the needs of the population.

It is for this reason a workshop consisting of key national stakeholders from NHSE and HEE came together to discuss how the future service should be shaped for heart disease, and what the workforce needs should be, taking into account the emerging opportunities systems can play in delivering this.

This report provides an overview of the discussions from the day, identifying what the collective short-medium and long-term actions need to be at all levels in addressing workforce challenges for heart disease aligned with emerging service priorities and needs.

Background

CVD affects around seven million people in the UK and is a significant cause of disability and death. It is responsible for one in four premature deaths in the UK and accounts for the largest gap in healthy life expectancy. Those in the most deprived 10% of the population are almost twice as likely to die as a result of CVD than those in the least deprived 10% of the population.

The pandemic has continued to drive excess non-COVID mortality and widen health inequalities for patients with CVD.
CVD is also a key driver of health inequalities. It accounts for around 25% of the life expectancy gap (27% in men and 24% in women) between rich and poor populations in England; premature death rates being three times higher in the most deprived, compared to the least deprived, and 40% of all amenable deaths in CVD are in the three most deprived deciles. People from the most socio-economically deprived groups are over 2.6 times more likely to die prematurely of respiratory problems than those in least deprived groups.

A year on year increase in mortality has continued, and there are currently 1.4 million heart attack survivors and 900,000 people living with heart failure in the UK. Heart failure is a

large burden on the NHS, accounting for 1 million bed days per year, 2% of the NHS total, and 5% of all emergency admissions to hospital, and this is likely to rise with an ageing population.

Prevention is key with a series of interventions underway, in addition to service configurations and new models of care. These aim to help ensure multi-disciplinary teams provide support as part of primary care networks, virtual wards and cardiac rehabilitation that can save lives, improve quality of life and reduce hospital readmissions. However challenges remain but there are opportunities to do more to address these.

Our Purpose

With the articulated ambitions above, service pressures and new models of working, it was felt important that the NHSE and HEE programme teams should come together and identify how as a national programme we could draw on available expertise to help shape the workforce agenda for heart disease.

From a strategic perspective, the aims are to understand current priorities for the heart disease workforce, the pressures and challenges they face, suggest solutions to them and identify current barriers to achieving these ambitions and changes. The workshop's emerging themes will develop deliverables and actions for HEE, NHSE and other stakeholders to scope and identify gaps in the workforce and align them with achieving the aims of the NHS Long Term Plan

The Workshop

The vision for this workshop was to scope and understand the work that is currently underway across the system on workforce, identifying improvement opportunities and alignment that will help deliver national priorities for heart disease. Providing a forum to influence and shape future funding and resource priorities for heart diseases workforce.

The objectives focussed on:

- Bringing together key stakeholders who are involved in steering national priorities on heart diseases, and those involved in setting priorities for individual professional groups, with an aim of establishing 'common ground' on opportunities and alignment.
- Considering priority areas on the current and future workforce needs for heart diseases, that will include any upskilling and education and training gaps that need to be considered for individual professional groups.
- Identifying potential short-, medium- and long-term solutions and opportunities that can help address heart diseases workforce challenges aligned to NHS Long Term Plan ambitions.

Methodology

The plan was to undertake a strategically focussed facilitated workshop consisting of stakeholders from NHSE and HEE, professional societies and those with a remit/vested interest in the heart disease workforce.

The first one day workshop was conducted as a hybrid workshop (most face to face with some dialling in virtually) – the agenda can be found in Appendix 1. Its aim, to engage stakeholders who can help shape workforce solutions around pre-determined current challenges focussing on (i) medical consultant staffing, (ii) nursing, (iii) allied health professionals (AHPs), (iv) advance clinical practitioners (APs) and, (v) healthcare scientists.

The facilitated discussion was framed around a strengths, weaknesses, opportunities and threats (SWOT) analysis and was underpinned by the 'HEE Star' domains.

The questions focussed on:

1. What are the identified workforce priorities for heart disease that we can identify collectively and do we have solutions to address these? *Focussing on strengths around current system planning and alignment opportunities*

- What sectors are we focussing on?
- What are the professional groups we are talking about?
- What currently works well that we need to capitalise on?
- What can participants relate to from their areas of work?

2. Where do some of the opportunities sit for specific professional groups and how can we address these? *Focussing on future opportunities around individual roles but also opportunities around multi-professional upskilling and the 'generalist' agenda*

- What are the identified numbers/roles/skills/outputs that are required and what drivers support the priorities highlighted in Q1?
- What strategic priorities/programmes/networks/groups/channels/ can be used to strengthen engagement in addressing the highlighted priorities?
- What suggestions and ideas do you have to help support the delivery of these priorities?
- What about multi-professional/agency planning and how can this be ensured?

3. What challenges and barriers do we envisage that could impact the workforce ambitions and priorities that have been highlighted today? *Focussing on weakness and threats*

- How assured are you that solutions highlighted in Q2 can be delivered effectively?
- Where do you see some of the obstacles / competing priorities when it comes to the highlighted priorities and solutions?
- Are there any regulations, policies or legislations that may threaten our objectives and ambitions?

A follow-up survey was distributed to all attendees, so respondents could feedback on the workshop content and production to help contribute to the outputs of the workshop.

The emerging themes from this can be found in Appendix 2 and the outputs will determine follow on actions and activity that will help shape a system solution for the heart disease workforce.

It is likely that workstreams will be established to progress agreed themes and deliverables. These will then be reviewed at a future meeting (format to be agreed).

Stakeholders identified by the programme teams were invited for this strategic workshop and those who agreed to participate are identified in Appendix 3.

Discussion

From the discussions it was clear that we need to build workforce capacity and capability that is aligned to system and service transformation. This will ensure the delivery of an effective future 'service ready' workforce.

Suggestions for example include:

- The need for nurses and Allied Health Professionals (AHPs) to be more community based to support virtual wards and at home programmes with targeted investment to support this.
- More professions represented to deliver a hybrid cardiac rehabilitation programme.
- Review where Advanced Clinical Practitioners (ACPs) are working and training to ensure they have been able to work across all systems.
- Exploring new models of training through undergraduate placements and multi-professional trainee exposure to varied clinical settings.
- Creating tutor and supervisor capacity and time with 'buy in' at all levels especially higher management.

This is further explored below, and emerging themes have been modelled on the 'HEE Star' (as shown in the image below) to ensure system uniformity at all levels in addressing some of the challenges we face.

Workforce Data and Supply

There are perceived workforce gaps at all levels i.e. consultant cardiologists, clinical pharmacists, cardiac physiologists, specialist nurses, physiotherapists, psychological professions, other AHPs, ACPs, physician associates, nursing associates etc.

There are opportunities to align workforce priorities through the NHSE Peoples Directorate / Plan and for example emerging workstreams on education reform, redistribution and expansion (all specialties); pharmacists in primary care (especially independent prescribing role out); cardiac physiologists expansion through the NSHCS; echo training expansion; ACP trainees in primary care alignment; nursing workforce commitments amongst others. However, it is recognised that we need to understand more fully what the current state of the CVD staffing workforce is and its perceived priority status at a local level.

Standardisation of both the demand and supply data for the whole CVD workforce aligned to workforce transformation opportunities through the 'HEE Star' is vital. Linked to this there

is a need to involve the ICS and cardiac delivery networks and look to develop a working relationship which onboards them as stakeholders enabling NHSE/HEE to utilise their local knowledge and information routes to enhance the data flow and provide more accurate workforce data.

Recommendation: Scope how best we can help develop actions to address uniformity in data system sources and any system data gaps, providing solutions to address these. This could help shape and create a national CVD workforce dashboard providing 'real-time' intelligence at all levels, aligned and modelled in conjunction with the NHSE Peoples Directorate and HEE Data Intelligence teams.

Actions:
- Creation of a core multi-professional 'CVD Data Workforce Strategy and Delivery Group'.
- Alignment of activity with the medical education reform programme (MERP) work on medical workforce distribution and expansion and others.
- Understand and articulate CVD specialist workforce supply data for other professional groups within the cardiac pathway.
- Deliver a national CVD workforce dashboard that will help align service and workforce priorities.

Workforce Upskilling and Training

A focus on prevention along the cardiac pathway should be considered to support and prepare the population, promote both self and shared care. Other key emerging priorities include heart failure management and cardiac rehabilitation (including psychology) uptake in primary care. It is felt we need to find ways to upskill health professionals for early detection of heart failure, upskill primary care for early diagnosis, and upskill non-medical professionals to be prescribers (as per GIRFT). To deliver this there will also need to be an increase in specialist nursing and AHPs underpinned by a multi-professional educator network. Further opportunities should allow graduate and undergraduate training rotation ensuring the future workforce is prepared to respond to this service need. End to end capability building a framework for student opportunities, rotational posts, career frameworks, apprenticeship models and advanced practice training need to be scoped and created. As the service increasingly works with those with complex needs, we need to understand how best we can benefit from working with the unregistered workforce and build models of care.

With the shift to digital transformation through artificial intelligence [1, 2], near patient remote testing and monitoring etc. we need to ensure the workforce is digitally capable too. Alignment to the Digital, Data and Technology (DDaT) occupational framework development framework and utilising data i.e. NICOR to drive change is vital especially with the move to heart failure at home and heart failure virtual wards.

(a) Skills and Capabilities

There are perceived gaps in formalised training and upskilling offers. Postgraduate courses are available but questions around the quality assurance and consistency have been raised. In addition to this alignment of these courses to service priorities it is felt need to be

considered to ensure once trained, the workforce can deliver NHS ambitions and service user needs. This should be underpinned by a multi-professional capabilities framework that is mapped to the patients' needs and referral pathway ensuring they have the right response and care at the right time.

The ability to prescribe should be considered when assessing service needs at the point of patient access and who they see. Therefore, expanding independent prescribing to those with specialist skills in this area for example physiologists and physician associates, will allow quicker service response reducing unnecessary pressure elsewhere. In addition to this, a capabilities framework for the unregistered workforce that uses a cross-specialty approach rather than a confined specialty could help provide flexibility in care particularly outside the hospital setting.

(b) Emerging Models of Care

There needs to be a definition on the emerging models of care, what is the spectrum for this and how the levels are defined. We need to be clear on the crossovers and how we can ensure multi-professional supervision capacity for future professions too. We need to think about advanced roles linked to service transformation across systems with accompanying skills and capabilities, and how we align to for example the breathlessness pathway. Alignment with ACP credentials being developed for primary care and long-term conditions is vital and ensuring prevention is captured within conversations for all health workers. In addition early year enhanced clinical practitioner careers should be explored allowing expansion of skills providing future specialty based career growth. There needs to be a focus on 'middle career upskilling' and thinking about how this can be linked within a capabilities-based model. The central role of physiologists in emerging pathways through community diagnostic hubs needs to be captured and consolidated.

(c) Patient training and support

With the advent of heart failure at home and heart failure virtual wards it is important to consider patients' ability to self-monitor and their education with accompanying support tools. Healthcare workers at all levels need to be equipped to provide this support and training and in-turn need to be trained and developed to provide this support. Digital readiness and transformation is key and needs to be central to work on developing the workforce in being digitally literate ensuring a digitally ready future workforce.
As the delivery of heart failure virtual wards expands across the country, this could be used as a learning opportunity to identify any training gaps and how workers can be supported better. This will also provide reflections on what could be done to support the development of further patient pathways on heart disease. Engagement with patient groups and charities is important too and the role of providing a centralised training platform for example e-learning for healthcare should be adopted.

Recommendation: Explore and develop a core set of capabilities for the CVD workforce. This will consider opportunities around emerging models of care aligned with new roles and ways of working to deliver a future 'service ready' workforce with a core set of functional capabilities.

Actions:

- Creation of a core multi-professional 'CVD Capability Framework Group'.
- Alignment of activity with the advanced clinical practice cardiovascular credentialing work and others.
- Understand and articulate core capabilities covering both the generalist and specialist workforce along the entire cardiac pathway.
- Deliver a national CVD core capabilities framework that will help align service priorities and workforce capabilities.

Recommendation: Explore further training and development opportunities for the workforce. This will require NHSE and HEE CVD teams working with national partners to align activity with emerging models of care, ensuring benefit to service users from an effectively upskilled workforce.

Actions:
- Deliver a series of stakeholder engagement events and consultations with national partners to further understand what workforce CVD training and development needs are.
- Undertake workforce training needs analysis through the cardiac delivery networks.
- Understand available postgraduate training offers and how these align with emerging service priorities and models of care.
- Address training and development gaps by delivering effective solutions. This includes making a case for budget through the annual multi-professional education and training investment plan (METIP) and comprehensive spending review (CSR).

New Roles and Ways of Working

Nationally we need to understand all current job roles within the CVD network and find how best each of these are utilised locally and share best practice back through the cardiac `networks. There was also discussion around hospital/community combined roles and the need to investigate this further at Trust level to establish the practical nature of making this happen. We also need to understand for example the current heart failure nurse specialist (and others) development needs are, and how to not only attract the additional numbers required but to also ensure they have a structured career path through which they channel their career aspirations. Roles need to be created beyond the confines of the registered workforce and we need to think of the benefits others bring for example health and wellbeing coaches, support workers, care navigators etc.

As mentioned before, we need to consider what offers are available to support career development opportunities for different professional groups. This should start form undergraduate training standards aligning student rotation opportunities with clinical placements and understanding rotation of posts when specialising once registered. These should ensure exposure to personalised care and lived patient experiences underpinned by peer leaders and support networks.

There is evidence that focus on specialisms can lead to burnout and we need to make careers and not jobs to attract the right candidates into these. Variability in roles both from a specialist perspective to flexibility in function for example aligned with the four pillars of advanced practice i.e. clinical practice, leadership and management, education and research should be considered. The service shift focussing on the needs of the patient and care outside hospital should underpin the creation of these roles and careers.

A capability driven framework that defines how one should develop a specialist interest paving the way for 'generic-specialty' and 'specialty-specialty' roles may help. We know this is currently lacking for ACPs post generic training and we need to define what further specialty training looks like. Overall, as career structures are lacking, can we do more to show what this can look like for different professional groups being clear that progression should be capability and not profession driven. We need to also think about those roles that can be further developed for example physician associates and changes to the registration process. Overall, there needs to be a clear career advancement structure underpinned by functional skills and capabilities that is aligned with pay progression.

Recommendation: Once formed, the 'CVD Multi-professional Capability Framework Group' should develop effective career pathways underpinned by a generic-specialty-based capability driven framework.

Actions:
- Undertake an analysis of available CVD career frameworks and how these align with current service needs and emerging models of care.
- Account for CVD 'specialist skills' within generic associate, generalist and advanced career pathways.
- Develop a definitive career and development pathway for those aspiring to work in CVD (using learning from work underway in cancer).
- Promote future careers along the entire cardiac pathway building future workforce capacity and capability at all levels.
- Creation of a repository that showcases career advancement opportunities linked to job roles and profiles.

Recommendation: Identify and further understand career roles within the CVD network and share best practice. These can be further embedded using the cardiac networks (CNs) infrastructure through local workforce transformation initiatives, for example using the 'HEE Star' methodology.

Actions:
- Include workforce as a core priority area for cardiac networks and ensuring alignment with local workforce transformation initiatives.
- Scope current roles identifying workforce gaps and opportunities that will help address workforce challenges across the cardiac pathway.
- Run a series of dedicated cardiac network workforce workshops and engagement events enabling sharing best practices and opportunities for collaboration.
- Implementation of 'HEE Star' workshops through cardiac networks to support local workforce transformation to drive implementation of careers at local level.

Recommendation: ICBs and cardiac networks should investigate further the prospect of a network-based workforce that can move around and overcome the current competition for posts between Trusts. The teams can relocate based on need and engender cross sector working to tackle the wider CVD challenges.

Actions:

- Understand local workforce CVD roles and careers and how these are embedded across local pathways and aligned to service priorities.
- Create 'sector fluid' roles that account for required generalist and specialist skills based on local cardiac service priorities and user needs. This should be fed-back through national networks to help shape national planning activities and service models.
- Maximise emerging transformation opportunities for cardiology ensuring a continuous improvement programme with workforce at the heart of this.

Leadership

There needs to be closer working between all parts of the system at all levels with closer national engagement between NHSE/HEE, professional societies, patient organisations and charities to help 'shape' an effective national workforce intervention. As HEE and NHSE transition into a merger, closer working between both programme teams will be of paramount importance. We need to ensure our teams are adequately equipped and skilled to address emerging workforce priorities and challenges through this transition.

(a) Infrastructure

There needs to be closer intra and inter 'knowledge and expertise sharing' between ICBs and cardiac networks at regional and local level creating a support network aligned with the LTP CVD programme team, GIRFT and HEE workforce transformation teams (using Star, CLEAR, roles explorer). This will aid the development of sources for 'local intelligence' that will provide the evidence to support further national/regional/local investment in this space. Aligning workforce transformation interventions with other opportunities for example through the Health Foundation should be considered too. This could help align commissioning and workforce priorities locally.

As the system expands and CVD ICB specific roles emerge, functions need to consider how workforce priorities will be developed and owned through these roles. There may be opportunities to develop training and support offers to further drive 'leadership' and resources and tools should be developed nationally to aid this.

(b) Finance

There will inevitably be limits to the budget available for the pursuit of the CVD agenda, but there is a clear need to have budget to achieve what is needed to advance CVD workforce priorities. This will require prioritisation of these asks with a specific costed approach to allow selection of deliverables based on allocated budget. The role of ICBs cannot be overlooked and as cardiac networks play a prominent role, it is important we reach out to these networks and look at ways to use locally available finances more effectively at scale.

Recommendation: Harnessing structural opportunities as they arise, national/regional/local workforce interventions need to be co-created and driven uniformly across systems, ensuring mutually beneficial networks emerge that create equity and support the needs of service users.

Actions:

- Create capacity and capability within system level CVD programme teams to ensure they are adequately equipped and skilled to deliver workforce CVD ambitions and priorities.
- Scope and deliver CVD 'support offers' that will help leadership development at all levels, especially around ICS and cardiac network engagement and workforce development.

Recommendation: Budget planning processes at all levels need to consider how CVD workforce agendas are supported and delivered. Commissioning arms play an important part role and leaders need to be equipped in making this happen.

Actions:
- Ensure funding prioritisation and support for the CVD workforce through annual budgetary planning cycles at ICS and national level.
- Align CVD transformation opportunities, service priorities and user needs with allocated workforce funding. This will ensure equity that aims to focus to reduce health inequalities, service pressures and mortality from CVD, that continues to be a significant cause of death in England.

Next Steps

The approval of these recommendations through the NHSE Cardiac Delivery Board.

Providing a clear plan on how these recommendations will be taken forward and by whom setting out programme activities for the next few years.

Driving system engagement at all levels using established infrastructure, and where there are gaps, identifying further solutions to mitigate these.

Creating a case for funding and investment where applicable to ensure these recommendations can be delivered.

Appendices

Appendix 1 – Agenda

Time	Agenda Item	Speaker
10:00 – 10:05	Welcome And Introductions	Prof Adrian Brooke
10:05 – 10:25	Heart Disease Workforce Priorities and Challenges	Prof Nick Linker
10:25 – 10:55	HEE Workforce Planning & Analysis - An Overview: Heart Disease	Tom Clayton
10:55 – 11:10	Heart Failure Workforce Review	Sue Piper
11:10 – 11:15	*Comfort Break (If needed)*	
11:15 – 11:25	Medical Priorities	Simon Ray
11:25 – 11:35	Funding Nurse Practice: Pilot Update	Sajel Mulji
11:35 – 11:45	Cardiac Rehabilitation Workforce	Sally Hinton, Kathryn Carver

11:45 – 11:50	*Comfort Break (If needed)*	
11:50 – 13:00	Facilitated Discussion	Orlando Hampton
13:00 – 13:15	Next Steps	Prof Adrian Brooke
13:15 – 14:00	*Lunch*	

Appendix 2 – Survey Responses and Facilitated Discussion

The following collates the context of topics, survey responses and key action notes from the day and discusses the key themes that emerge around each of the questions which shaped the topics of dialogue.

What are the identified workforce priorities for heart disease that we can identify collectively, and do we have solutions to address this? *(Focussing on strengths around current system planning and alignment opportunities)*

The key sectors which were focussed on were diagnostics with primary, secondary, and tertiary care; Cardiology (particularly heart failure) and CDCs. Doctors, nurses, ACPs, physician associates, physiologists and echocardiographers, physios, psychologists, dieticians, exercise physiologists, administrator, AHPs, HCS, support workers were the professional groups identified in discussion. This was to obtain and identify a clear understanding of the workforce and who specialises in CVD within England; informing workforce planning around skill gaps and competencies.

Currently, there is a variety of systems in place which work well and have been identified as something that is needed to be capitalised on. Examples include secondary prevention; role transformation with advanced practitioners, valuing nurse specialist roles and the wider integration of heart failure services through primary and secondary care; and increasing training through existing programmes. This in turn waves to manage patients at home rather than in hospital and helps in understanding the employment of healthcare staff from working within acute trusts to the community to support better engagement.

From their own area of work, respondents felt they could link experiences with the topics of discussion. One felt that workforce shortages and training capacity affect workforce priorities as there is no shortage of candidates wanting to be trained, however the limiting factor is the capacity to train them. In turn, another stated ‘patients with increasing multi-morbidities are more anxious due to length of time waiting for investigations/ GP appointments, due to increasing referrals, large caseloads and stressed community services’ linking again to the shortage of workforce.

Where do some of the opportunities sit for specific professional groups and how can we address these? *(Focussing on future opportunities around individual roles but also opportunities around multi-professional upskilling and generalist agenda)*

The key opportunities that can support the identified priorities, were within cardiovascular rehabilitation clinics. Through undergraduate and graduate learners to have rotational posts on training schemes for nursing and allied health professionals, and ensuring more professions are represented will help deliver a hybrid cardiac rehabilitation programme. Waiting times for Echocardiographs affects a lot of areas in terms of recovery plans as it impacts a lot of different pathways. An increase in echocardiographers over the next 3

years in both Trusts and CDCs, will address the Long-Term Plan. Heart failure nurses/ ACPs have also been identified as a need.

To strengthen engagement highlighted in these priorities, establishing better linked professional workforce planning through using ICBs, will harmonise services and reduce inequalities between secondary care providers. Another is within ACPs and increase the supervisory capacity for medical and non-medical staff to enable service transformation. It is suggested this could be achieved by reviewing where ACPs are working and training to ensure they have been enabled to work across systems. Lastly, understanding the career pathway from healthcare assistant to consultant level would be beneficial e.g. Primary Care Network Nursing Model.

What challenges and barriers do we envisage that could impact the workforce ambitions and priorities that have been highlighted*? (Focussing on weakness and threats)*

The solutions highlighted were not met with much assurance that they will be delivered effectively, due to the NHS needing more funding and having other competing priorities. It was also discussed there is an exhaustion in departments, if asked to take on more trainees, they are keen to do it, but do not have the time – more support and understanding is needed from higher management. Engagement with ICS leads was discussed, but there was no establishment of a wider strategic work view at ICS level, as there were no ICS leads on the day.

The most mentioned obstacles to addressing the priorities and achieving solutions were money/ funding and competing priorities between national programmes. Additionally, there is a need to look longer term when taking on trainees and allowing time for those to do the training, as service is impacted at beginning of training. Lastly, heart failure is linked with high hospital admission rates, Trusts are working at capacity, causing patients to be admitted late or discharged too early, increasing readmissions. Readmission rates are aggravated by the long waits to see a heart failure nurse in the community – more investment in good community services is needed.

It was identified that COVID-19 recovery targets and waitlists may threaten the solutions/ training given above. Lack of political support and recognition of how COVID-19 and treasury restrictions have damaged morale for the objectives and ambitions we have.

Appendix 3 – List of Attendees

Adrian Brooke – Deputy Medical Director Workforce Alignment and LTC Programme SRO, HEE.

Andrew Milner – Programme Lead, Medical Education Reform, HEE.

Annabella Gloster – Regional Faculty Lead for Advancing Practise, HEE.

Jane Lynch – Clinical Scientist, STP Training Programme Director, HEE.

Libby Potter – Head of Portfolio - Long term conditions, Cancer & Diagnostics and Maternity, HEE.

Mohamed Sadak – Programme Lead, Long Term Conditions, HEE.

Orlando Hampton – HEE Head of Workforce Transformation.

Paul Gledhill – Senior Project Manager for Long Term Conditions, HEE.

Rachael Moses – President, British Thoracic Society.

Rachel Newton – Head of Policy, Chartered Society of Physiotherapy.

Tom Clayton – Deputy Head of Workforce Planning & Intelligence, HEE.

Andrew Sharman – Student Placement in Long Term Conditions and Prevention, HEE.

Clementine Kellaway – Project Support Officer Long Term Conditions and Prevention, HEE.

Dr Sue Piper – British Society for Heart Failure.

Nick Linker – NHSE National Clinical Director for Heart Disease.

Richard Bellamy – Deputy Dean and Director of Specialty Training and Cardiology Lead, HEE.

Russell Smith – Regional Postgraduate Dean and Cardiology Clinical Lead, HEE.

Sajel Mulji – NHSE Senior Policy and Project Manager.

Simon Ray – NHSE Cardiology GRIFT Lead.

Martin Allen – NHSE Respiratory GIRFT Lead.

Beverly Harden – National AHP Lead, HEE.

Lisa Plotkin – Policy Manager, British Heart Foundation.

Jayne Masters – Lead Nurse, British Society for Heart Failure.

Sally Hinton, Executive Director, British Association for Cardiovascular Prevention and Rehabilitation (BACPR).

Mark Fores, Senior Nurse Workforce Delivery, HEE.

Richard Collins, Deputy Head of Workforce Planning & Intelligence, HEE.

Victoria Edbrooke-Hyson, Workforce Planning & Intelligence, HEE.

Lisa Anderson, Chair, British Society for Heart Failure.

Julia Taylor, Primary Care ACP Lead, HEE.

Appendix 4 – Post Workshop Feedback

The average consensus with the workshops aims and objectives, and overall capturing the workforces' immediate priorities was very useful. There were improvements suggested to include a broader understanding of the context of the workstream for those with no background and coming into this new, as well as breaking into smaller groups to allow synchronised planning and explore things further, as it is such a complex topic.

Regarding the context of the workshop, it is suggested that more discussion around other professions is needed as a lot was based on medical staff and nurses, and other staff who have led successful initiatives could be included. Workstreams such as staff wellbeing, access to psychological support and business cases for cardiac rehab programme, were

amongst the emerging topics attendees felt should be discussed following from the workshop.

Feedback stated the speakers were clear and articulate with what the workforce systems priorities and challenges are, although, there is room to distribute more information prior to the event and a follow up summary of action points after the event, to give people better understanding and clarity.

The format of the workshop had mixed reviews, as some felt the hybrid model felt unequal, to those who had to travel far for it, and some in-person attendees felt the discussion felt dominated by those online due to the format of gaining attention to speak. Suggestions for the next workshop to be either all online or in-person.