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Workforce Plan for England

Proposed Education and Training Commissions for 2014/15

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Content

Foreword

Health Education England (HEE) exists for one reason alone, to help improve the quality of care delivered to patients by ensuring that our future workforce has the right numbers, skills, values and behaviours to meet their needs today and tomorrow.

This, our first ever Workforce Plan for England, sets out clearly the investments we intend to make in education and training programmes to begin in September 2014. It is built upon the needs of frontline employers, who as members of our Local Education Training Boards (LETBs) have shaped the thirteen local plans that form the basis of our plan for England.

The creation of HEE and its local committees (LETBs) has given employers a stronger voice in workforce planning so that the education and training we commission will better reflect their needs and therefore the care they deliver to patients. We recognise that there are important local variations in how services are delivered that require local knowledge and leadership if we are to meet the needs of different local communities.

But we are also a National Health Service, so for example when taxpayers spend over £500,000 on the minimum of thirteen years training it takes to become a Consultant in Emergency Medicine, that investment in an individual is made on behalf of the wider system, not a particular locality or employer. We need to reflect the fact that staff and patients move in and out of different local communities and that the needs and demands of both will change over time. Because of the long lead in times to train some health care professions HEE has a particular responsibility to ensure that our workforce plans represent not just the current needs of employers but that we are anticipating the future needs of patients. For example, medical students who take up a university place in September 2014 may not become Consultants until 2027, by which time the whole pattern of service provision, and therefore the numbers, skills and behaviours required, could have radically changed.

It is vital that we ensure our thirteen local plans also add up to a coherent plan for the country that delivers on our Mandate and offers enough flexibility and innovation for future shifts in service delivery and patient need. This is the purpose of our first Workforce Plan for England.

To this end, the Workforce Plan for England:

- Sets out clearly in one place the education and training commissions we intend to make during 2014/15
- Explains the processes by which these decisions have been made
- Provides the aggregate all England number of commissions for each profession and the trend increases and decreases within and between key groups
- Holds up a mirror to the wider and health and social care system by highlighting key trends and emerging themes from our workforce plans that may have implications for service delivery in future years
- Poses key questions and challenges that will need to be addressed if we are to make improvements in the workforce planning processes next year and beyond so that the investments that we make better reflect the future needs of patients.

We have made huge progress in creating and implementing new planning processes during our first year but we are still a system in transition. We recognise that there is no exact science or agreed methodology for predicting or responding to future patient need so we must work with other stakeholders to help us make these difficult judgements within a finite budget. This requires a culture of transparency and openness, where we can share and challenge each other's assumptions to ensure that the decisions we make result in better care for patients.

We owe a huge debt of thanks to the many individuals and organisations who worked with our LETBs on their local plans and those who responded to our national Call for Evidence as well as giving their time to participate in our various advisory bodies or bilateral meetings.

This, our first Workforce Plan for England, sets out our planned investments in people; people who as a result of the investment we make in them will be able to bring:

'the highest levels of human knowledge and skill to save lives and improve health… at times of basic human need, where care and compassion are what matters most'.

(The NHS Constitution)

Professor Ian Cumming OBE

Sir Keith Pearson JP DL

Executive Summary

Health Education England exists to help improve the quality of care delivered to patients. Each year we invest nearly £5 billion pounds of public money in education and training, so that when a patient turns to the NHS for help, the service is able to provide staff in the right numbers, with the right values, skills and behaviours to meet their needs. Whilst most NHS staff are busy meeting the patient demand that walks through the door, it is our particular responsibility to plan for the future: to ensure that we have enough supply to meet future demand, whilst avoiding excess over supply, which would result in unemployed skilled people and a waste of taxpayers' money.

For the first time ever, responsibility for all workforce planning and the commissioning of training and education for the next generation of health professionals has been placed within one organisation, Health Education England (HEE). Our plans are built upon the needs of our 13 Local Education and Training Boards (LETBs) which are employer led and informed by the professional expertise of our advisory groups and other stakeholders.

This, our first ever Workforce Plan for England, brings together our thirteen local plans, and sets out in one place the investments we will make for 2014/15 on behalf of the system.

What is workforce planning and why does it matter?

Workforce planning is about ensuring that the NHS has the people we need when we need them. With over 1000 different employers across the private, public and voluntary sectors employing 1.3 million people in over 300 different types of jobs, workforce planning cannot be left to individual organisations. It is only through a collective approach we can hope to deliver what patients need now and in the future.

It takes 13 years to train a new consultant – a new medical student who starts in September 2014 will not become a consultant until 2027, perhaps working in the NHS until 2060. Delivery of healthcare will change enormously over that period, so our commissions today need to reflect our best evidence of what patients will need tomorrow.

Our Inheritance

Between 2000 and 2012 all staff groups in the NHS grew, with over 50% more consultants and 13% more nurses which represents over 32,000 new nurses over that period. There were peaks and troughs of growth mainly based around the economic circumstances of the NHS at the time workforce investment decisions were made, and the impact of national policies can be seen on particular professions or staff groups, such as midwives.

Most of these investment decisions made sense from the perspective of individual professions: the question for workforce planners and the NHS as a whole is whether the aggregate shape of the workforce we have inherited represents the best use of public money to enable the future needs of patients to be met.

The ability to connect workforce planning with the wider strategic objectives of the NHS has been hampered by the fact that the education commissioning process is necessarily driven by the academic calendar (which runs from September to September), whereas the business cycle in the NHS runs from April to April. In addition, decisions about post graduate medical training commissions have historically happened at a national level, in advance of decisions made about non-medical training commissions which have happened at a local level. Investments in our existing workforce of over 1,358,000 people has often come a poor third place.

The creation of HEE provides, for the first time, an organisation with a ring fenced budget focussed solely on the current and future workforce. Through our LETBs, HEE offers the opportunity to connect local needs with national policies, allowing decisions about the relative investments to be made with respect to medical and non-medical commissions, as well as investment in our current workforce, increasing our ability to 'future proof' the NHS.

How we planned for 2014/15

Earlier this year we produced the first ever Workforce Planning Guidance for the NHS, setting out clearly the responsibilities of employers, HEE and our LETBs with clear timelines and milestones to deliver the Workforce Plan for England. This not only ensured we could bring together our plans in one place, ensuring transparency for the public and wider system, but offered, for the first time, the opportunity for local and national challenge as the plans developed.

At a local level each NHS employer produced their assessment of their future needs, and LETBs used these forecasts as the basis of a region wide investment plan as part of their five year strategy. Following local 'review and challenge' processes engaging with commissioners and other stakeholders, each of the 13 LETB plans were then submitted to HEE nationally.

The role of HEE nationally in regard to workforce planning is three-fold:

- to assure ourselves that a robust local process has taken place
- to ensure that the aggregate position of the 13 plans enable us to deliver our Mandate by triangulating it with other evidence
- to lead on a small number of workforce areas where it makes sense to plan nationally.

The emerging national picture was shared with our thirteen LETB MDs to discuss and agree where further collective action was required, and further tested with stakeholders through our advisory groups and a national call for evidence. We then made adjustments where necessary and produced this plan, the first ever National Workforce Plan for England.

We are proud of the open and transparent way in which we have developed this plan, and grateful to our many stakeholders for their support and advice. However, we recognise that we are still in transition, and that next year we need to use the process we have developed to drive service change and improvement through the relative investments that we make. We will have more to say about this in our Strategy to be published in spring 2014.

We have benefited from a timely indication of our financial allocation for next year from the Government which has enabled us to produce this final Workforce Plan earlier than planned. This allows our LETBs to inform Universities of the numbers of commissions we are making to allow them to begin filling them for September 2014.

Our commissions for 2014/15

HEE currently commissions 129 structured programmes of education to create the future workforce for 110 different roles. Here we highlight just some of those commissions, and the decision making process that led to those commissions in areas where we believe there will be a particularly high degree of public interest. Full details of our commissions for all programmes of education can be found in Annex 1.

In **Midwifery**, there has been significant growth in the workforce over the last five years at around 475 a year leading to an increase of 2373 since March 2008. Initial proposals from LETBs suggested that future modest growth will continue to be needed by employers, but further evidence from the Government's response to the Francis Inquiry and evidence from the Royal College of Midwives alongside evidence based tools such as Birth Rate Plus has led us to make an adjustment to the aggregate of local figures. Therefore we propose no reduction in commissions at this stage. In 2014/15 we will commission 2563 new Midwifery training places maintaining the record number of commissions from 2013/14 for at least a further year. This, allied to a concerted effort to reduce attrition rates for students who leave their courses which is currently forecast to be around 21% we believe will lead to record numbers of midwives graduating and being available to employers.

In **Nursing**, the student commissions we make this year will graduate and be available to employers in 2017. Employer forecasts in recent years have under represented the number of nurses that Trusts subsequently employed. Following the publication of the Francis inquiry, the Keogh and Berwick reviews, and a greater focus on safe staffing levels from NICE and CQC, we observed a significant change in Trusts reported employment intentions in year.

We also took into account the high attrition rate for nurse education and the need to focus more on output. Based on local plans and in the light of the new evidence outlined above HEE has therefore decided to commission 13,228 new nursing places for the coming year, an increase of 9% on 2013/14. This represents an extra 500 places on top of those identified by LETBs prior to the release of the Francis response from Government. Allied to a greater focus on reducing attrition we believe this should produce more new nurses for the NHS in 2017 than any year ever recorded before.

The Coalition Government made new **Health Visitors** a priority, setting a target to increase the numbers by 4200 by 2015. This increase of 50% in the workforce saw a huge increase in commissions from around 500 in 2010 to 2787 in 2013, an increase of over 400%. The job of HEE this year and in future years is to maintain the Health Visitor workforce at these new historically high levels. In fact we have decided to plan for further growth by commissioning 1041 new places this year, which whilst a significant decrease on last year reflects the fact that the pledge for huge expansion has now been met and maintenance is the new task.

Another national priority of the Government was **Improving Access to Psychological Therapies (IAPT)**. The plan was to create a workforce of 6000 to deliver these 'talking therapies'. Therefore we will commission 756 new places this year reflecting the 431 needed to meet the pledge with some margin and 200 needed to reflect turnover in the workforce. This will give the NHS 6125 practitioners meeting the pledge with ease.

Allied Healthcare Professions (AHPs) covers twelve separate professions ranging from paramedics to podiatrists. Between 2002 to 2012, the overall AHP workforce has grown by 31%. Despite some evidence from our providers of a risk of oversupply in the AHP workforce, we and our LETBs have elected to broadly maintain the number of AHP commissions this year, recognising that we need to better understand the non-NHS supply and demand model for AHPs, as well as the future need for their skills in the light of emerging policies. We propose a small growth of 3% in the overall AHP commissions. In two professions there are very slight reductions (Speech and Language Therapy commissions by 2% and Occupational Therapists by 1%). This small reduction in commissions still leaves the respective professions in a position of overall growth, because of the investments already made in AHPs and the anticipated rate of turnover. HEE will work with our AHP HEEAG to better understand the position for 2015/16.

Our commissions for Post Graduate Medical and Dental education are forecast to produce an average increase in the **consultant workforce** of between 3% and 4% per annum, continuing the historic trend of growth observed over the past ten years.

HEE's Mandate requires us to make significant progress towards 50% of post graduate doctor training being for **General Practice**, thereby increasing commissions for this group to 3,250 places of the 6,500 places per year by 2015. Based on forecasts from the Centre for Workforce Intelligence (CfWI) if we reach this figure by 2015 it will lead to real growth in GP numbers. These numbers will be adjusted if necessary in future years as a result of NHS England's new Primary Care Strategy and their recent Call to Action. This year HEE will be commissioning up to 3099 GP training places, an increase of 222 which will require extra GP Training Posts to be delivered by the system.

We inherited a system wide agreement that **Core Surgical Trainee** numbers should reduce to a maximum of 500 per year. The continued growth in the consultant surgeon workforce of 3% per year requires 350-400 Higher Specialist Trainees. With current numbers this means that every year between 200-250 trainees in core surgical training could not progress to the Higher Specialist Training as we recruite 600 to the core surgical programme. This is clearly not an acceptable position. We have therefore agreed with the recommendation to reduce core surgical training places by 71 this year.

Emergency Medicine remains a high profile issue for patients and the public and it is important that HEE plays its part in increasing the number of staff available to work in this area. It is clear from the evidence that the reported problems in emergency care are not due to a shortage of funded training places: the problem lies in our ability to attract trainees to select emergency medicine as a specialism. Even with these challenges, the number of Emergency Medicine consultants grew by 140% between 2002 and 2012. On average, there are between 170-190 funded 'Higher Specialty Training' opportunities to per year to train to become a Consultant in Emergency Medicine. To try and ensure these places are filled HEE is taking the following action:

- Our LETB plans propose an additional 20 (5.6%) commissions in the Acute Care Common Stem (ACCS) that feeds this specialty training
- As part of our Action Plan for Emergency Care, in addition to local plans we propose to further expand the number of ACCS posts by 75, in order to provide a larger pool of doctors able to progress into EM consultant posts.
- We will establish a 'run through' pilot, recruiting up to 173 people onto this programme, an additional 6 posts compared to 13/14
- We will recruit up to 298 people into Higher Training Posts.
- We have published a joint report with the College of Emergency Medicine that sets out a wide ranging programme around the new and existing workforce in Emergency Medicine.

In **Dentistry**, following a review in 2004, under graduate dental training was expanded. Two new dental schools were created, and dentistry student numbers increased by 29%. At the same time, oral health has been steadily improving. The proportion of 12-year-olds free from dental decay has risen from 60% in 2000/01 to 67% in 2008/09, and the latest data published by Public Health England indicates that the number of children free of tooth decay at age five rose by 9.7% between 2008 and 2012. The overall level of tooth decay fell by 15%. These welcome improvements in oral health are likely to reduce the demand for dental interventions in the future. Recent projections suggest that if no action were taken we could see a position of oversupply of dentists. We therefore propose to accept the advice of the Chief Dental Office and reduce the number of commissions for dental students, subject to urgent discussions with DH, BIS, HEFCE, and other stakeholders on how we best take this forward.

We will also commission further work into the expansion of the wider dental workforce such as dental nurses and hygenists, and keep the numbers of funded dental students under review in future years.

In **Public Health** we are working with Public Health England and the new employers in Local Government to understand their future workforce needs to meet the challenges of improving and protecting the public's health. It is expected this will lead to changes in the future as we identify the wider public health workforce including their many scientists and the role that every NHS employee can play with regard to 'Make Every Contact Count'. For this year we have commissioned training places for Consultants in Public Health, which will support a forecast increase in the Public Health Consultant workforce of 18% by 2020. We will take forward a major programme of work through our newly established HEE Public Health Advisory Group to understand better the supply and demand assumptions for this workforce and the contribution HEE can make to the wider public health agenda.

Emerging challenges and trends

HEE is part of a system that remains in transition. We have made some changes this year to our commissioning intentions based on our new processes and the better engagement of employers locally and other stakeholders nationally, but we have also identified a number of areas that we will seek to address to make next year's plan progressively better:

- We will work with employers and other regulators in the system such as NTDA and Monitor to ensure Trusts have all the skills and information they need to make workforce assessments that are both reliable and sustainable.
- There remain a number of data gaps in the system that currently impede our ability to plan effectively for the future. We will need to work closer with Trusts to understand vacancy rates and how staff move between employers, with HEIs and Trusts to better understand and reduce attrition rates, with professional regulators to understand what happens to students when they graduate, and with the primary care, independent and voluntary sectors, where our data is particularly poor.
- In order to commission a workforce that is fit for the future, we need to better understand the vision for the future. We need to work closer with our ALB partners and align our planning and information processes so that we can ensure the strategies they envisage for patients can be delivered by staff in the right numbers, with the right skills, values and behaviours available in the right place and at the right time.
- HEE will work with partners to take forward key issues within Professor Greenaway's report 'The Shape of Training'. The report gives us the opportunity for innovation and transformation of medical training. The emphasis on producing well trained doctors working in both community and hospital settings and able to manage the complexity of general care will be challenging but offers a 'once in a generation' opportunity to transform medical training for future generations of patients.

Finally, our ambition is to radically alter the way we plan the workforce of the future. Over time we will move away from a process where we are essentially planning numbers through the lens of the registered professions,towards a system that identifies the numbers, skills, values and behaviours that patients and their families need both today and tomorrow. We will seek to focus more on the quality of the output from our education and training programmes, rather than just the numbers of commissions we make. And we will work with employers to invest more in the current staff, who are also the workforce of the future.

Section 1

What is workforce planning and why does it matter?

Since the creation of the NHS, clinicians, managers and politicians have invested time and energy re-organising the structures that deliver health and healthcare. But look behind the structures of commissioning and provision; the walls of the hospital and the GP's door and you are left with the essence of the NHS: an interaction between human beings.

Our job at HEE is to ensure that when a patient turns to the NHS for help, there is a trained person with the right skills and behaviours ready to meet their needs. Two simple actions are required to ensure that the right staff are available to patients when they need them:

1. Enough jobs must be created to deliver the care required by the people of England
2. Enough staff with the right skills and behaviours must be available to fill the jobs created.

Providers and commissioners are responsible for the first action. HEE is then primarily responsible for the second using our education and training commissions to ensure balance between supply and employer demand. Sometimes demand is best met by developing the skills of existing staff, which is why HEE is as committed to developing the existing workforce as to creating the future workforce.

Why do we need a national workforce planning process?

There are at least four reasons why it is important that the NHS in England plans its workforce.

A common employment market of healthcare staff - Interdependency

No individual employer can secure the future supply of staff they require to deliver integrated care to patients which is delivered by multiple employers and teams of different professionals.

Clinicians work in a wide variety of care and academic settings. There are areas where non-NHS employment is common such as physiotherapy, podiatry, pharmacy and dentistry; areas where clinicians deliver integrated health and social care such as occupational therapy, speech therapy and nurses in care homes and in the independent sector hospitals and hospices.

Health and social care employers operate in a dynamic labour market where people move between employers for a myriad of personal and professional reasons. We also know that these labour markets are not constrained by the boundaries of the NHS or of England.

All health and social care employers share the same overall supply and virtually all of these clinicians will have been trained by and in the NHS regardless of where they end up working. For these reasons planning for the supply of future staff is a collective endeavour.

Economies of scale and expertise

The staff we train work in over 1,000 different organisations across the public, private and voluntary sector employing over 1.3 million staff in over 300 different jobs treating more than 1m patients every 36 hours. Skills for Care estimate 50,000 registered nurses are employed in care homes and there are an estimated 30-50,000 registered nurses in the private and independent sector. As previously noted by Health Select Committees this sheer scale means that workforce planning cannot be left to individual employers. There are economies of scale and expertise in workforce planning at a regional and national level with employers input which make sense for the NHS and ultimately for patients.

Meeting the needs of future patients – a long term view

It takes a minimum of three years to train a Newly Qualified Nurse, ten years to train a GP and thirteen years to train a Consultant. Given these long lead times we need to be careful that we don't lock education and training commissions

(and therefore service delivery) into current patterns of provision.

NHS England is consulting on its 'Call to Action' with proposals which could result in a major shift in service delivery from secondary to primary care. Such changes cannot be delivered unless we have a workforce with the right numbers, skills, values and behaviours. Once the vision for the future service has been agreed, we need a long term strategy for workforce planning to ensure that it happens in reality.

The consequences of failure

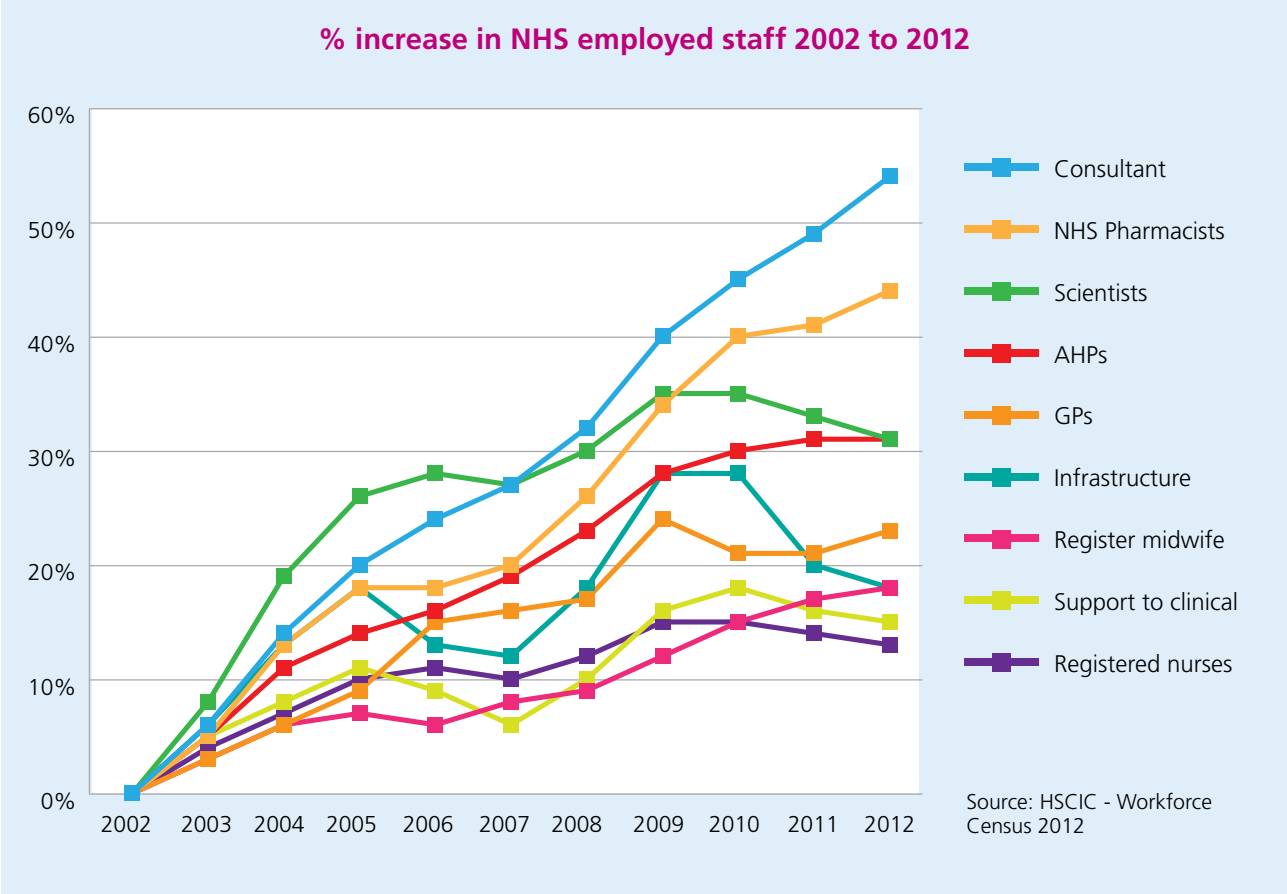
In most industries workforce planning might be sensible but it is not essential. If a supermarket does not have enough staff then the queues at the tills grow longer meaning the customer will have a bad experience and not return to that shop again. If the NHS fails to have enough qualified staff then patients and their families will suffer at a time when they are at their lowest ebb. Health care is unlike any other economic good as the consequences of failure can be catastrophic for the individual and their families. Moreover, a shortage in qualified staff is not easy for a Trust to rectify. A local supermarket can recruit from other supermarkets or train new staff in a matter of weeks but new clinicians take much longer to produce and whereas there are shorter term supply solutions in some professions, this is not true of all.

The role of HEE is therefore to 'future proof' the NHS by ensuring that we have the right numbers of clinical staff with appropriate skills trained to work in a wide range of settings.

Section 2

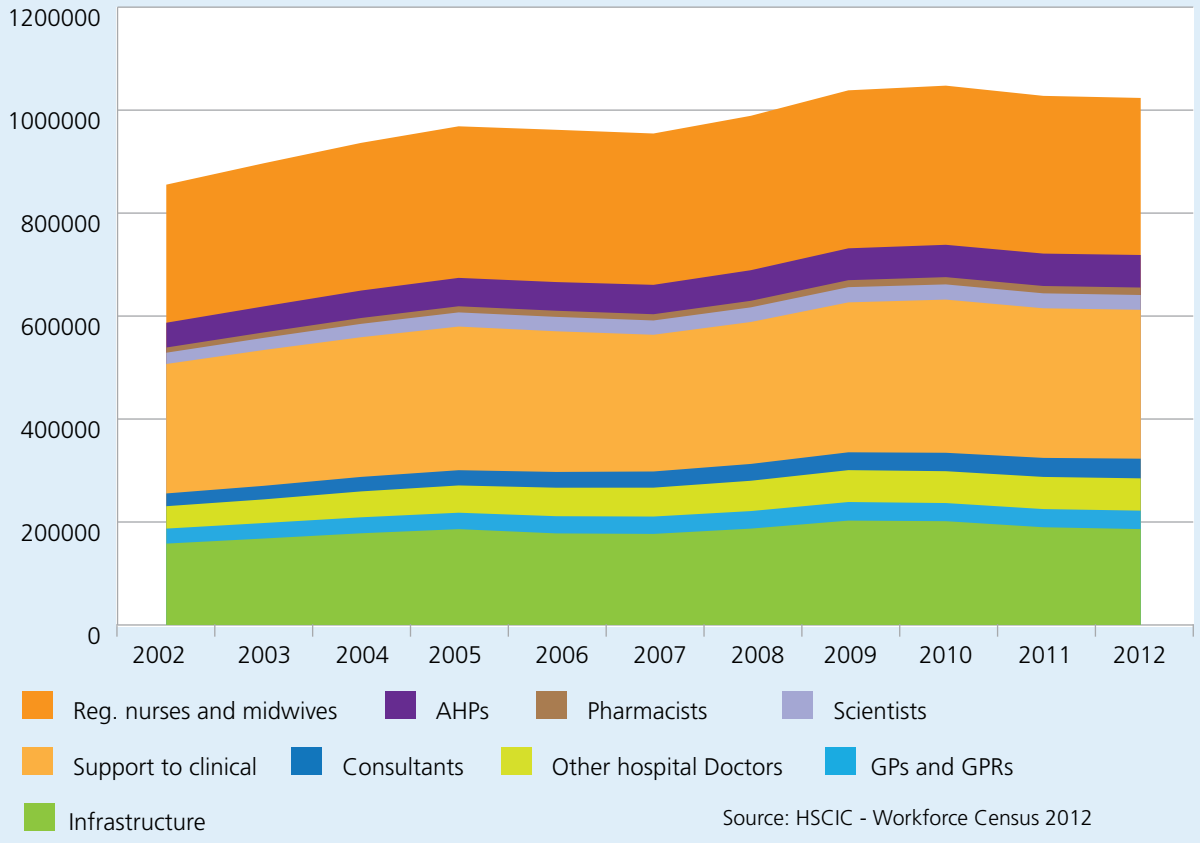
Our inheritance: workforce planning in the past

The graphs below sets out workforce trends between 2000 and 2012 for key groups of staff.



Whilst the above graph shows the relative growth between professions it does not demonstrate the overall volumes of these groups or the scale of these increases. In nursing for instance the 13% increase represents over 32,000 additional FTEs. The graph below shows the size of each group.

Increase in NHS Employed Staff 2002 to 2012 (FTE)



Source: HSCIC - Workforce Census 2012

These graphs reveal some key trends over the past decade:

- Overall, all professions experienced growth although some grew much more than others
- The Consultant workforce grew most, by over 50% (although the UK still remains below other nations in terms of number of doctors per 1,000 population)
- Registered Nurses grew the least, by 13% over the period representing 32,896fte new nurses
- Affordability has a clear impact on how the workforce grows. All professions experienced less growth in 2005 when Trusts were struggling with deficits but in 2007 returned to a position of overall growth before slowing again in 2009 as the economic downturn took effect.
- Prioritising services can result in specific professions being targeted for growth. The Midwifery workforce grew by an average of 500 per year (2.0%) after the launch of 'Maternity Matters' in 2007 and the Healthcare Commission review of maternity services, 'Towards better births' in 2008.

These graphs also pose important questions for the wider health system: did we mean to do this? Do the numbers reflect an overall NHS strategic intent? Or do they just demonstrate that one of the biggest drivers of workforce levels is the economy?

And if the economy facilitated (and inhibited) growth was the differential growth between professions driven by a clear assessment of relative priorities based upon evidence of current and future patient need? Or do these graphs illustrate the aggregate position of different decisions taken at local and national levels at different times by different organisations?

Whereas there may have been justified intent behind each individual decision (i.e. the growth in consultants and midwives) it is worth considering whether in aggregate this represents the best answer for the NHS overall. Previously the system simply did not allow our workforce investments to be considered in this way.

Prior to 2012 many SHAs (who were responsible for local workforce planning as individual statutory bodies until April 2013) made real progress in using workforce planning as a means to improve the quality of patient care, particularly through the pathway approach to service improvement as part of the Next Stage Review. However, local efforts were not always supported by national systems or processes. The planning processes for Post-Graduate medical (doctors) and Under-Graduate non-medical (e.g. nurses and Allied Health Professions) happened in isolation with the former being decided nationally and the latter locally;

Post-Graduate medical numbers were decided first to meet recruitment deadlines thereby reducing the opportunity to consider the relative priorities across all parts of the workforce, which may help explain some of the differential growth;

The decision timetable also reduced the opportunity to invest in our current workforce through Continuing Professional Development as this was only considered once money had been committed to new medical and non-medical commissions; reducing the opportunities for enhancing the skills of our existing workforce.

The ability to connect workforce planning with the wider strategy of the NHS has also been hampered by the fact that the education commissioning process is necessarily driven by the academic calendar (September to September), whereas the business cycle in the NHS runs from April to April. However, as system managers, SHAs were able to connect workforce planning with important considerations of quality and safety, as well as overall affordability. We need to ensure that the new system architecture does not prevent us from making these vital connections.

The creation of HEE provides, for the first time ever, an organisation with a budget focussed solely on the current and future workforce with both a national and local focus. Whilst the Government has committed to protect funding for the NHS we know that this is unlikely to see new money at the levels received in recent years. To get the best value out of taxpayers' money, we need a national workforce planning process, informed by local experience and knowledge and driven by current and future needs.

Section 3

Where we are now: HEE's workforce planning process for 2014/15

The creation of Health Education England and our Local Education and Training Boards (LETBs) provides an opportunity to address these systemic issues. For the first time we are able to lead and coordinate the investment in the whole health and healthcare workforce informed by local and national expertise and intelligence including greater employer input than ever before.

Our unique governance model seeks to ensure that employers, informed by staff and patients, are at the forefront of the planning and forecasting process as outlined in the first comprehensive national Workforce Planning Guidance issued by HEE earlier this year.

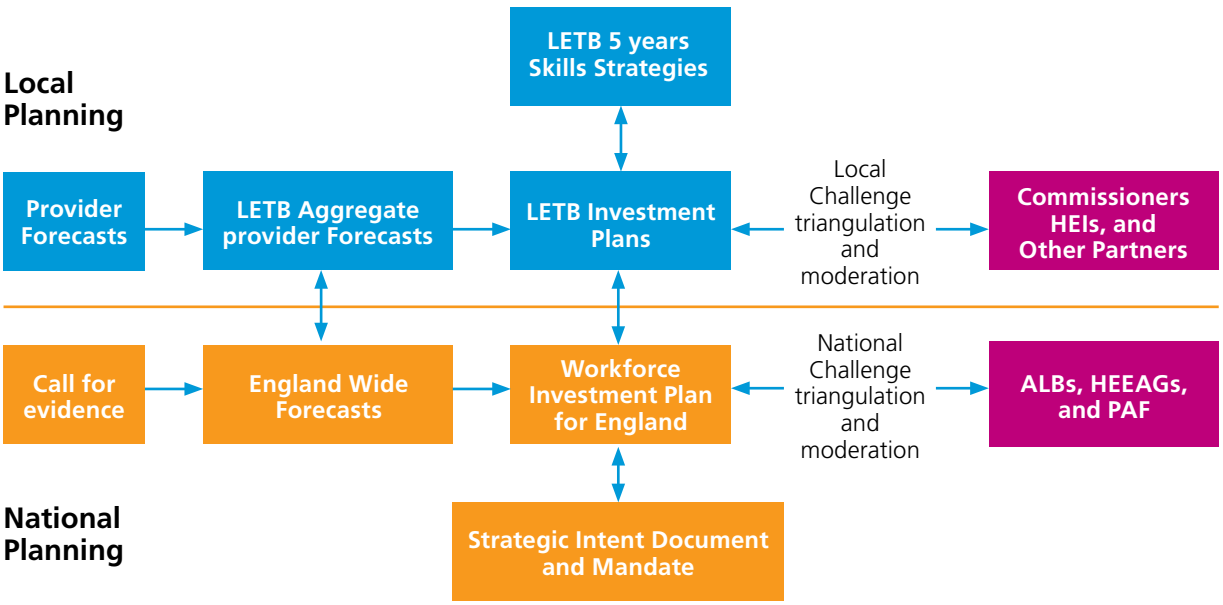
Our guidance sets out clearly the roles and responsibilities of employers, HEE and its LETBs, with clear deliverables and timelines to enable us to produce a Workforce Plan for England as required by our Mandate and it also explains the process by which these plans were produced. A brief outline is set out below:

The workforce planning and assurance process at a local level:

Each Trust was asked to provide their future workforce forecasts setting out their anticipated needs for staff numbers and skills to their LETB signed off by their Chief Executive, Nursing Director and Medical Director.

Each LETB used these individual Trust forecasts alongside an assessment of their current workforce needs to produce a forecast for their area as the basis for the LETB workforce investment plan. Forecasts provide a diagnosis of what is needed and the workforce plans show the investments we intend to make in response.

HEE Workforce Planning Process 2013



HEE's Workforce Planning Guidance required each LETB to hold local 'Challenge and Review' sessions with employers and other partners such as commissioners in order to ensure that forecasts align with:

- Robust supply and demand analysis
- LETB 5 year skills and development strategies
- Local Commissioning intentions
- National Priorities as set out in HEE's Mandate
- The workforce needs of future transformed services rather than just as currently configured and delivered.

Following a process of local discussion and engagement each LETB submitted their workforce plans to HEE nationally in line with the milestones set out in the guidance.

The workforce planning and assurance process at a national level

HEE has three national workforce planning roles:

- ➤ Firstly to sign off each LETB's workforce investment plan following assurance that a robust process has been followed in line with our guidance and after assessing whether, in aggregate, the plans alongside any national programmes enable HEE to deliver our statutory requirements and Mandate;
- ➤ Secondly, to lead national workforce planning for a small number of areas where the current characteristics warrant a nationwide approach;
- ➤ Finally, HEE is required by our Mandate to produce a National Workforce Plan for England based on the aggregate of the final moderated LETB plans and the conclusions of the national workforce planning processes.

As part of our processes to produce the Workforce Plan for England HEE has:

- Assessed each LETB plan and sought assurances to the degree of local engagement and alignment;
- Discussed the aggregate position with our Senior Leadership Team, which includes the Managing Director of each LETB, to assure ourselves collectively of the emerging national position;
- Sought continual advice and input from stakeholders through a national 'Call for Evidence': the respondents are in Annex 3. This evidence will also be available on our website.
- Discussed emerging trends and themes with other ALBs such as NHS England, NTDA and Monitor and the Department of Health to ensure alignment wherever possible;
- Sought on-going advice from key professional groups through Health Education England Advisory Groups (those HEEAGs consulted are in Annex 4);
- Held bilateral meetings with stakeholders to discuss key emerging issues

Section 4

Our ambition for the future

The creation of a new workforce planning process presents us with 3 opportunities which we will realise as we and the wider system matures:

1. to consider priorities across professional and non-professional groups and the needs of the current and future workforce, with respect to numbers, skills and behaviours, so that we can better respond to current and future patients' needs;
2. to realise the potential for staff to drive service improvement and transformation through greater investment in our current workforce and delivering transformational change through decommissioning areas of over supply or out-dated modes of delivery for investment elsewhere;
3. In the longer term our ambition is to move away from a workforce planning process that is largely driven by numbers as seen through the lens of the registered professions and move towards a process that enables us to view the workforce needs through the eyes of patients and their families, such as children and vulnerable older people. Our processes will need to reflect changes in technology, science and medicine as well as what this will mean for the 'doctor/patient relationship' and the models of care we deploy.

We will have more to say about this in our Strategy that we intend to publish in March 2014.

Section 5

The status of our plans

This Workforce Plan for England is our final plan for the next academic year. Our Workforce Planning Guidance suggested that we would publish a draft plan in December to allow us to meet our obligations to universities and Trusts to allow them to commence recruitment of students and trainees. We would then follow this with a final plan in the New Year once we received confirmation of our financial allocation from the Department of Health for the financial year ending March 2015

However, we have managed to secure information on our financial envelope early enough to allow us to publish our plan only once, increasing the stability of the system and reducing uncertainty for prospective students, universities and the health and healthcare system.

On this basis, the following section sets out HEE's final investment plans for education and training places across England commencing in 2014 and will form the basis for the contract conversations that we will now begin with universities and clinical placement providers.

Section 6

The commissions we will make on behalf of the system for 14/15

HEE currently commissions 129 structured programmes of education to create the future workforce for 110 different roles. (The rest of our workforce is developed through mainstream education opportunities in universities, colleges or through workplace education and training). There are 35 main education programmes for non-medical clinical professions, and there are 94 programmes of medical and dental education designed to deliver GPs, Dentists, 78 different types of Consultants and other Doctors.

Rather than set out the position in detail for each of these areas the following sections focus on where we plan to make material increases or decreases in our investment or where there has been a high degree of public interest.

These areas are:

- Midwifery
- Adult nursing (for both acute and community settings)
- Allied Health Professionals (AHPs)
- Health Visiting
- IAPT
- Other (non-medical) Clinical Professions
- General Practitioners
- Core Surgical Trainees
- Emergency Medicine
- Dentistry
- Public Health Workforce
- Other Medical and Dental specialties

Full details of the commissions we intend to make for each of these education programmes is included as Annex 1 and further information on each profession will be available on our website.

The annex sets out the number of commissions we intend to make in 2014/15. Any reduction may represent a decrease in the rate of growth for a particular profession rather than an actual cut to the workforce.

Factors we have taken into account when deciding our commissions

Workforce planning is not an exact science. It requires us to predict potential future levels of demand for a particular role and predict likely future levels of supply so that we can judge how many newly qualified staff might be required to balance demand and supply. Newly qualified staff are needed by employers to either replace people retiring or other leavers (turnover) or fill newly established posts or unplanned vacancies (employer requirements).

Workforce planners model these demand and supply variables and assess if the current training volume is likely to produce under or over supply if not adjusted.

Factors influencing demand include:

- Changing patterns of disease
- Developments in technology
- Introductions of new professional or regulatory standards
- Financial constraints
- New roles substituting current roles

Factors influencing supply include:

- Current workforce levels
- Rates of attrition from training courses
- Rates of staff turnover
- Retirement age
- Inflow and outflow from other countries and healthcare employers

The balance we need to achieve is that in meeting the needs of employers we do not create a situation of excess undersupply, resulting in a shortage of nurses for example, or excess oversupply, resulting in unemployed newly qualified nurses whose skills and knowledge can rapidly diminish if not used in real practice settings.

In order to help us make these judgements we have considered:

- The situation we have inherited
- 2013 Employer forecasts of future requirements (demand)
- Triangulation with other evidence
- Forecasts of the future availability of staff (supply)

By sharing the process we have gone through we hope to encourage greater transparency and highlight key data and understand gaps that we need to address more widely as a system.

We are also sharing the graphs we have used with stakeholders that represent the key variables and how they interact with each other. It is inappropriate to attach an unwarranted status to specific numbers in these graphs, as their purpose is not to infer some sort of empirical truth about the future, but to provide a general indication of trends and possible scenarios against which reasonable investment decisions can be made.

In the following section we will consider one profession, Midwifery, in some detail as the analysis and explanation in this section will then be of benefit in understanding the subsequent sections.

Midwifery

HEE's mandate requires us to 'work with NHS England and others to ensure that sufficient midwives and other maternity staff are trained and available to provide every woman with personalised care throughout pregnancy, childbirth and during the post-natal period'

The situation we have inherited

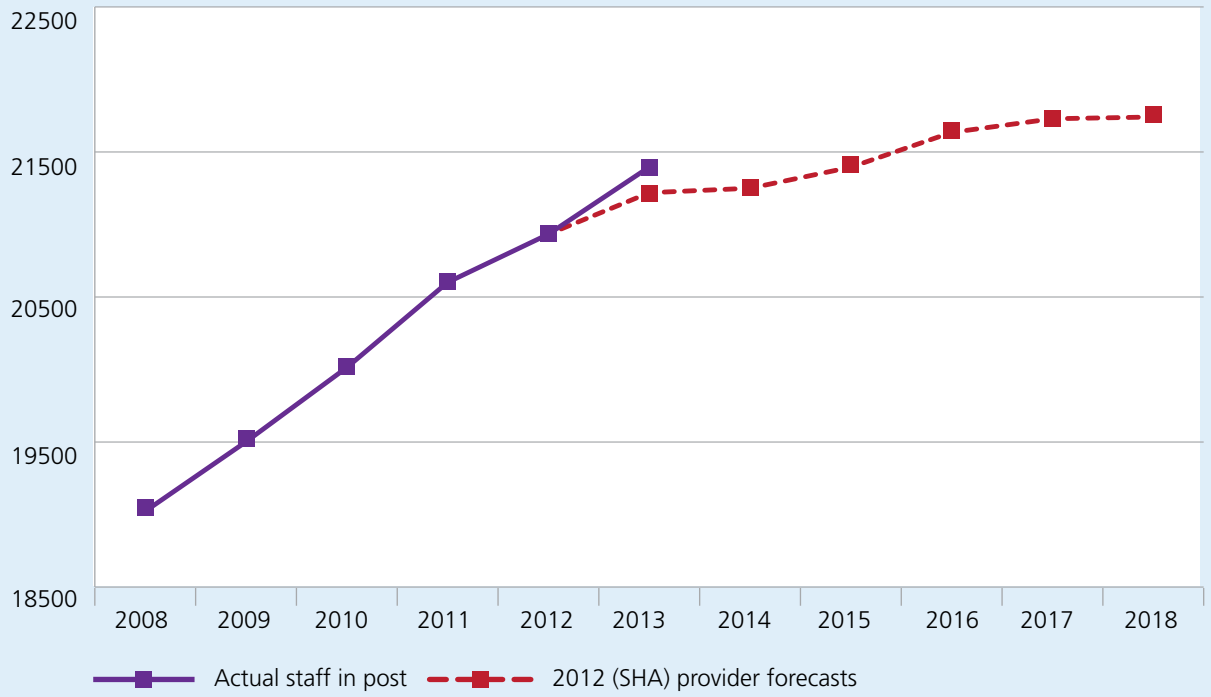
The graph below shows that the actual number of midwives in post from March 2008 to March 2013 has grown by over 10%, an average growth of nearly 500fte per year (shown by the purple line).

In 2012 the 10 SHAs asked their local employers how many midwives they believed they would need over the next five years. At the time there was no process for the 10 regional forecasts to be aggregated nationally. However HEE retrospectively produced this as part of a 'due diligence' exercise to understand the basis on which commissioning decisions taken in 2012 and now inherited by HEE were made.

The England wide aggregation is shown in the graph below (red dotted line). It shows that employers' predicted that their future requirements would continue to increase, albeit at a slower rate than between 2008 and 2012.

In 12/13 actual growth of 2.2% exceeded this employer forecast of 1.3%. We understand that a similar pattern of actual growth exceeding forecasts occurred in 2011. This probably indicates that employer forecasts include assessments of affordability, as well as likely service demand.

Midwifery growth 2008-2013 and provider's 2012 forecasts



Source: ESR Data Warehouse, SHA forecasts, LETB forecasts

The table below shows the level of education commissions and more importantly, output from education that HEE has inheritied from the SHAs. In 2013/4 we are forecasting 1,918 graduates and by 2016/17 this will rise to 2,030. Based on previous experience, unless retirement rates increase drastically, this inherited training should support significant growth in qualified staff available if required by employers.

SHA Education Commissioning levels 2009/10 to 2013/14 - Midwifery

Midwives

Start Year	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**Increase since 2012/13**
Education Commissions				2481	2393	2428	2495	2563	2.7%
Output Year	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	
Output from education	1414	1552	1651	1845	1918	1923	1976	2030	2.7%
inferred attrition				*-26%*	*-20%*	*-21%*	*-21%*	*-21%*	

2013 Employer forecasts of their future requirements (demand)

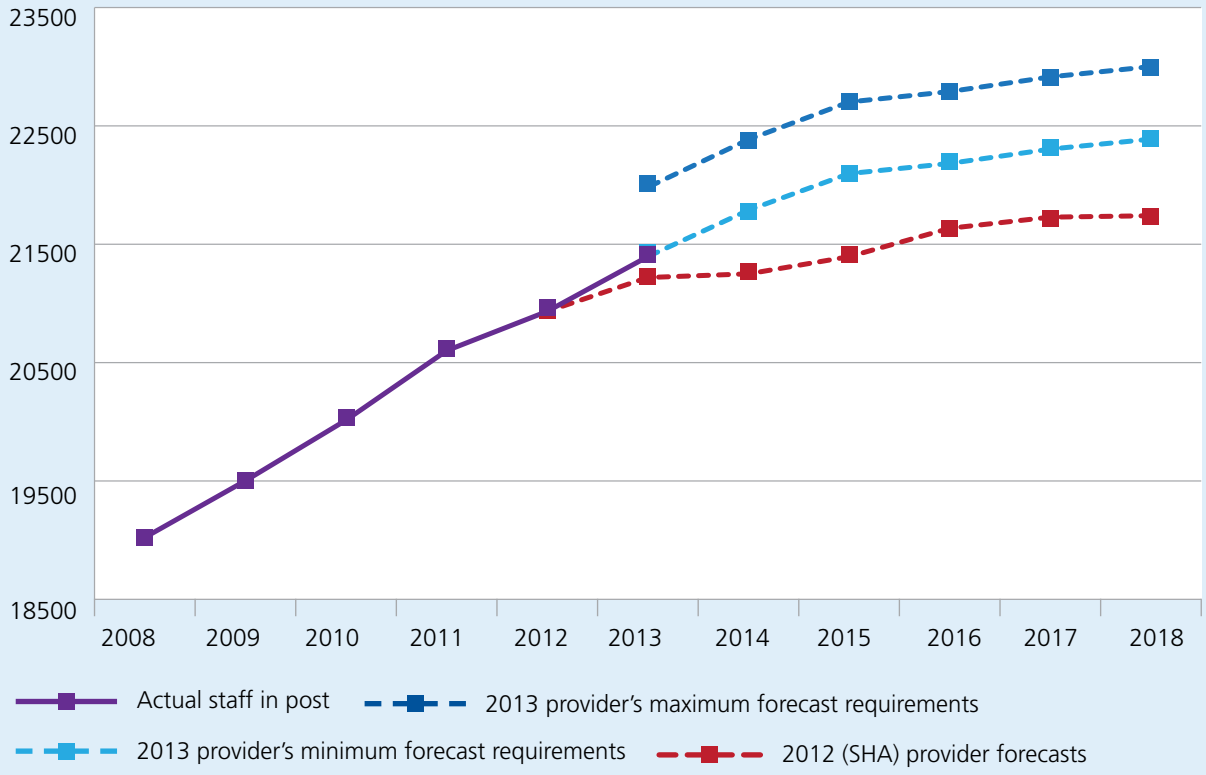
From April 2013 HEE's LETBs began to collect forecasts from employers and in parallel HEE developed the first national workforce planning guidance which described how we would ensure these 13 local processes informed an overall picture of the likelihood of there being sufficient midwives available to meet employer requirements.

The graph below shows the result of these processes. LETBs have each created a forecast for their local workforce, then HEE have applied the weighted average of these forecasts to the current level of staff in post to indicate the likely scale of future need at an England wide level.

One key component of employers future requirements is the extent to which they already have unplanned vacancies. We also asked LETBs to identify where current staff in post at March 2013 was below employer's establishment or establishment less planned vacancies. This is not a comprehensive survey of existing vacancies, and currently there is no systematic way of identifying this variable, but it does allow us to identify an additional level of potential demand if Trusts choose to replace temporary staff with substantive staff.

The graph below shows what we consider to be an estimate of provider's minimum requirement (light blue line) and their maximum requirement (dark blue line). This is the 'demand zone' with the upper limit representing no unplanned vacancies.

Midwifery growth 2008-13 and Provider forecasts in 2012 and 2013



Source: ESR Data Warehouse, SHA forecasts, LETB forecasts

These new forecasts predict a modest level of growth with a 1.8% increase being forecast for 2013/14, 1.4% for 2014/15 and then lower growth from 2015 to 2018. This is a 2.6% (500+fte) increase at March 2014 compared to the 2012 forecast.

For midwifery the employer's reported gap between current staff in post and their requirement for staff or establishment is 2.7%

Triangulation with other evidence

HEE has received evidence from the Royal College of Midwives and other interested groups. They show that applying the 'Birth Rate Plus tool' to the forecast level of births in England suggests a higher number of midwifes needed than currently employed or forecast to be employed.

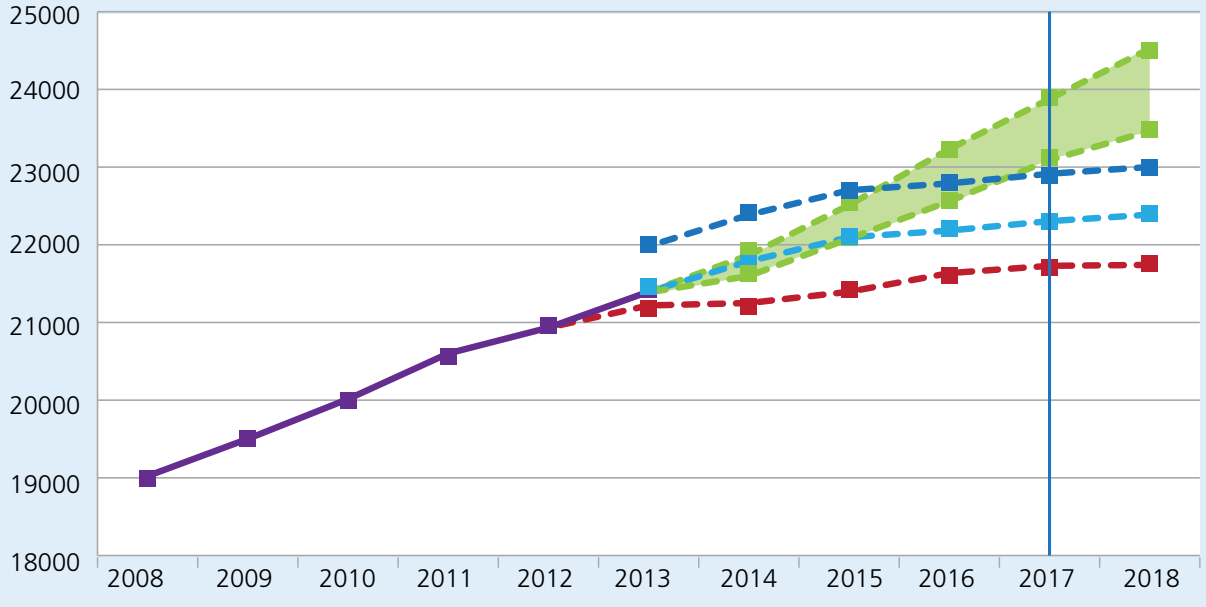
We are aware that not all service providers accept that 'Birth Rate Plus' should be used in isolation from wider intelligence on how their own maternity units operate and the use of alternative planning tools. We strongly welcome the expectations set out in the National Quality Board Safe Staffing Guidance to require all Trusts to explain what tools they use to inform staffing levels, make their rationale public and have it confirmed and adopted by their Boards. The provision of evidence based tools from NICE will also be important in building system wide confidence in establishing future employer requirements and we look forward to the outcomes of these new processes informing our planning round in 2014.

Forecasting the future number of staff available for employment (supply)

The growth in the workforce between 2008 and 2013 has been achieved by the output from education commissions made between 2005 and 2009. The forecast output from 2013 to 2017 is significantly higher and as such we are forecasting the number of midwives available to be employed will increase and at a faster rate than previously experienced.

The graph below shows this as a forecast supply zone (green) indicating the staff that we assess would be available should employers want them. This zone represents current staff plus newly qualified staff that want to work in the NHS less the effect of other leavers and joiners.

Provider forecasts of future requirements and future supply - Midwifery



Source: ESR Data Warehouse, SHA forecasts, LETB forecasts

This forecast of available staff indicates that employers should be able to accommodate both current predicted workforce growth and any needs that might arise from further assessment of safe staffing levels. Similarly, whilst there may be some element of unplanned vacancies this should not be caused by the lack of trained midwives available.

The vertical blue line on the graph at 2017, simply acts to remind users that the decisions we make today cannot affect the supply forecasts until after this date. All of the supply to the left of this line is already in training and whilst HEE can seek to maximise output from current courses and focus on quality and employability of graduates, we cannot change the training volumes until after this date. These supply projections indicate there is a risk of future over supply if employer forecasts prove to be accurate which they have not been in the last two years showing under forecast in each year.

Our commissioning intentions for Midwifery

Concerns about the high level of future workforce growth, already in the system, led to LETB proposals for a very moderate reduction of 14 places in new midwife commissions.

Although there are concerns about potential oversupply we think this does not take sufficient account of the shift towards evidence based tools and our Mandate requirement or the tendency of under forecasting.

In light of this we have chosen to moderate initial plans so that education commissions in 2014/15 will remain at the same level (2563) as 2013/14. There is an element of minor local variation but this decision ensures that future growth will be enabled if commissioners and providers require it. Our judgement is that this represents an appropriate decision in light of available data.

The table below shows both the aggregated LETB's initial proposals for 2014/15 and our final position.

HEE education commissioning 2014/15 - Midwifery

Midwives

Start Year	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**Initial proposals 2014/15**	**Moderated proposals 2014/15**	**Increase since 2013/14**
Education Commissions				2481	2393	2428	2495	2563	2549	**2563**	0%
Output Year**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**	**17/18**	
Output from education	1414	1552	1651	1845	1918	1923	1976	2030	2019	**2030**	0%
inferred attrition				*-26%*	*-20%*	*-21%*	*-21%*	*-21%*	*-21%*	***-21%****	

**HEE will be aiming to improve forecast attrition*

Adult Nursing

With the publication of the Francis report into Mid Staffordshire NHS Foundation Trust and the Government's response we have, quite rightly, witnessed an increasing focus on the issue of safe nurse staffing levels.

The under graduate adult nursing programme currently lasts a minimum of three years, and produces registered nurses trained to practice in both Acute and Community settings. Once they have their 'licence to practice', nurses need further support in the form of preceptorship and on-going CPD to enable them to function effectively within their employed environment. In establishing our commissioning intentions HEE and its LETBs need to assess the current and future demand and supply in both Acute and Community as we are responsible for commissioning education programmes to meet forecast demand from both sectors, but it is employers and commissioners who determine where nurses work.

The following section sets out the different assessments we have made of the two main settings, although as we move towards more integrated care, we recognise that this is an increasingly unhelpful distinction, which we will seek to address in future.

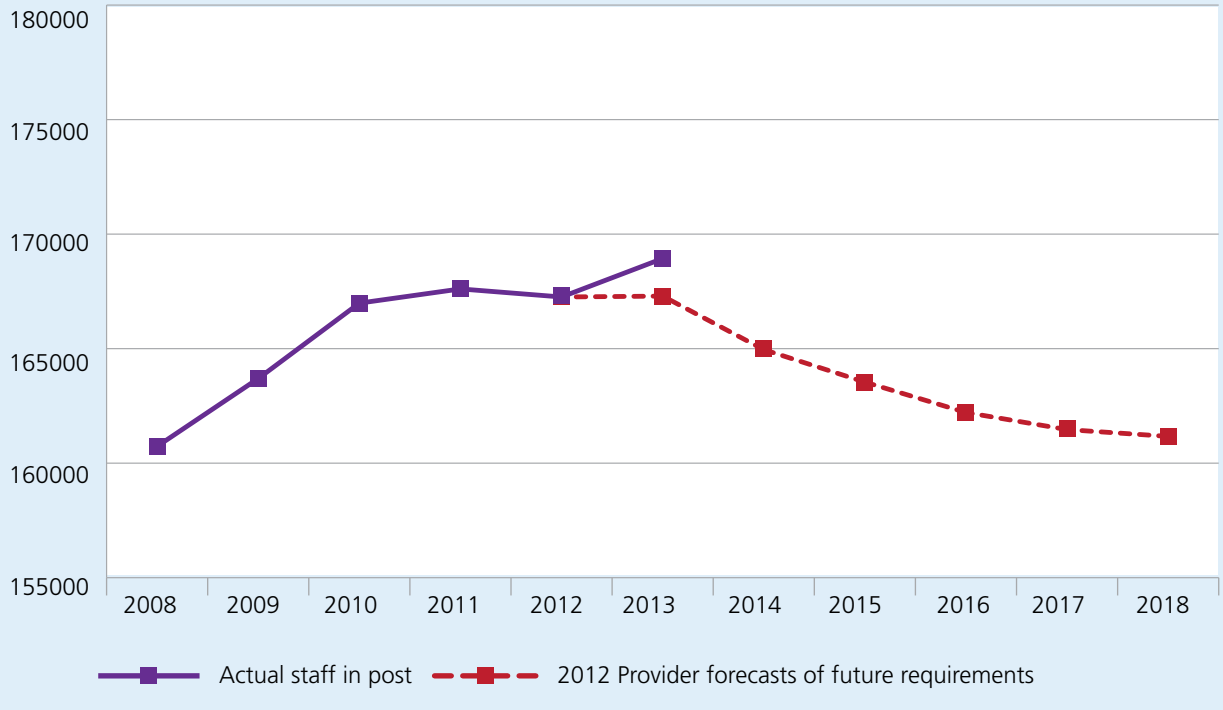
Adult nurses in acute settings

In published workforce data this group is referred to as 'Acute, Elderly and General Nurses'. It represents the largest component of the nursing workforce.

The situation we have inherited

The number of nurses employed in the 'acute, elderly, and general', workforce grew by 8199fte between March 2008 and March 2013. After growing by 268fte during 2010 to 2012 the rate of growth increased sharply in 2012/13 to 1,679fte.

Adult Nursing in Acute Settings - workforce growth 2008 to 2013 and provider's 2012 forecast of future demand



Source: ESR Data Warehouse, SHA forecasts, LETB forecasts

The 2012 employer forecasts of future demand indicated that they intended to employ the same number of nurses in 2012/13 as in 2011/12, and then less nurses from 2013/14 to 2017/18.

In 2012/13 this workforce actually grew by 1% compared to employers' forecasts of no growth. We also understand that in the equivalent 2011 process, providers forecast a material reduction in 2011/12 whereas the actual reduction was negligible. As with midwives, employer forecasts were below the number actually employed for two consecutive years. Trusts' initial plans may have been made on the basis of commissioning plans that assumed a reduction in activity that did not actually occur, and/or forecasts of affordability. In order to meet patient demand that exceeded their forecasts, Trusts have sourced additional workforce from agencies and/or overseas recruitment.

The table below shows the level of education commisisons and associated output that we have inherited. In 2013/4 we are forecasting 10,838 graduates, the highest level of output ever recorded. However during 14/15 to 16/17 the level of output may fall unless LETB efforts to improve attrition and quality of graduates offset the impact of reduced commissioning by SHAs in 2011 and 2012. To this end, HEE will work with universities and Trusts (who provide education and training places) to ensure a real reduction in attrition rates.

It should be noted however that this level of output is similar to the levels that accommodated a 3,000fte increase in staff in post in 2009/10. The increased commissioning in 2013/14 (6.3%) will support future growth in the substantive nursing workforce.

SHA Education Commissioning levels 2009/10 to 2013/14 – Adult Nursing

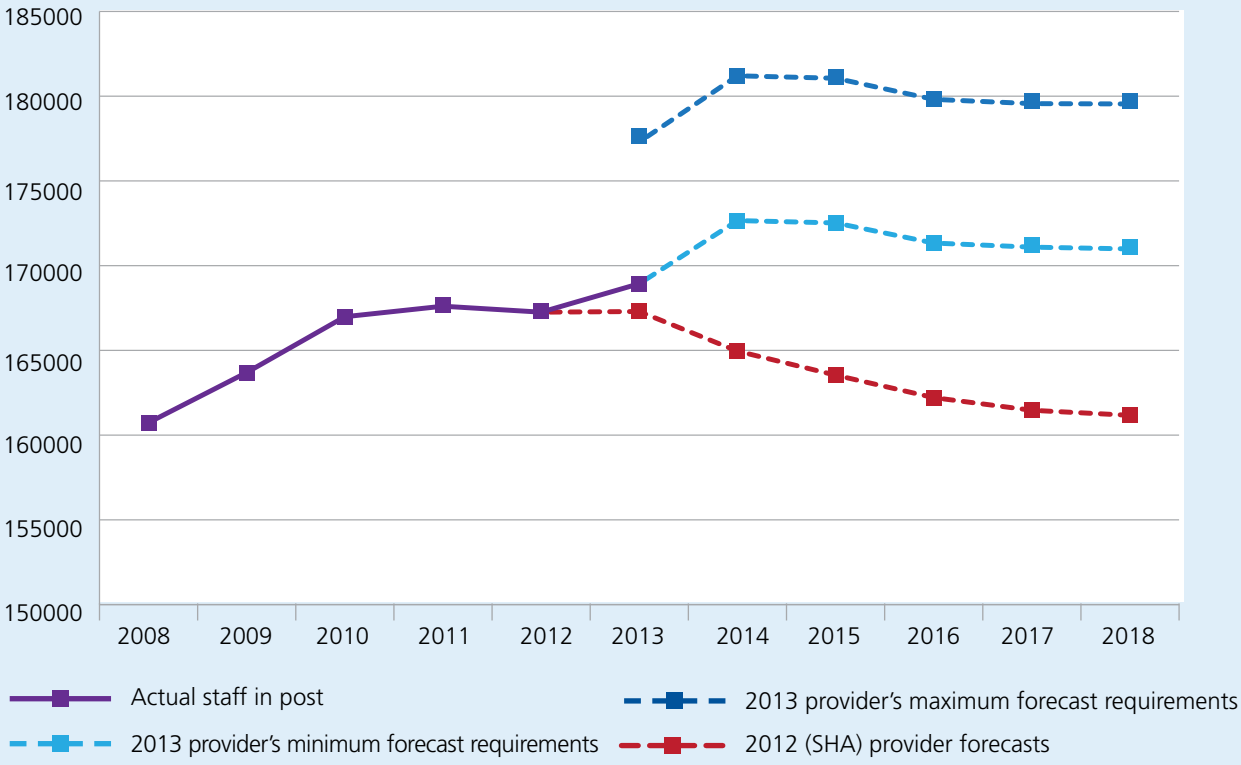
Adult Nursing

Start Year	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**Increase since 2012/13**
Education Commissions				14451	13628	11930	11416	12134	6.3%
Output Year	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	
Output from education	9465	9098	9634	10560	10383	9711	9293	9877	6.3%
inferred attrition				*-27%*	*-20%*	*-19%*	*-19%*	*-19%*	

2013 Employer forecasts of their future requirements (demand)

The graph below shows how employer forecasts have shifted over 12 months. The original (2012) forecasts showed a reduction of 1.4% between 2012 and 2014, whereas the workforce actually grew by 1%. Now employers are forecasting increased employment intentions of 2.1% staff. If Trusts acted upon their own forecasts, then this would result in an additional 3700fte nurses being employed. The difference between the 2012 forecast for March 14 and the 2013 forecast represents a 4.7% shift in the workforce required (up to 7700fte).

Provider forecasts of future demand - 2012 and 2013 forecasts



Source: ESR Data Warehouse, SHA forecasts, LETB forecasts

Employer returns suggest a gap between current staff in post and their current maximum requirement of 4.8%. However there is no comprehensive view of whether employers want to close this gap with substantive posts rather than temporary staff, or with more senior roles which may require investment in CPD to allow more junior staff to progress rather than by commissioning more Newly Qualified Nurses.

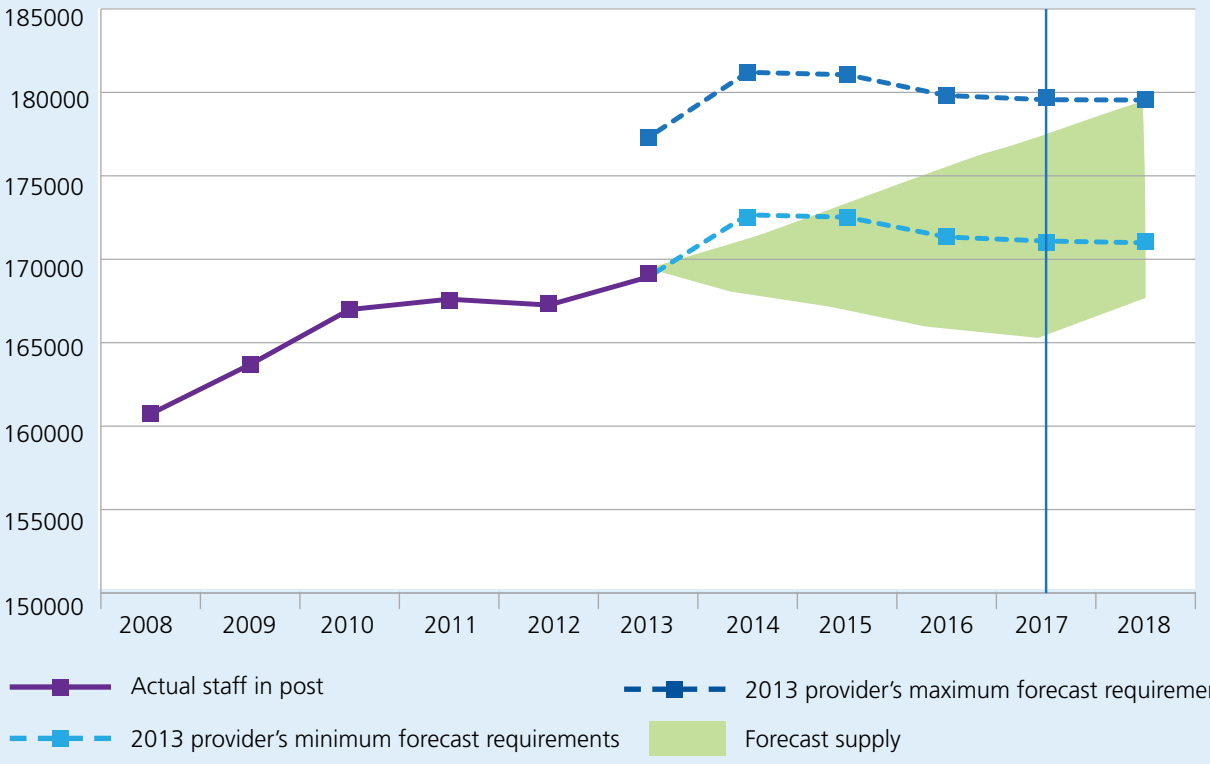
Triangulation with other evidence

As well as drawing on the evidence submitted by the Royal College of Nursing and other stakeholders we have used three key sources of data to help us make judgements about the level of commissions.

- Firstly, we have observed recent history and the extent to which employer forecasts (based, in part, upon local commissioning assumptions of affordability and activity) have been borne out in practice.
- Secondly, we have considered the likely future impact of the Francis report, the Government's response; the National Quality Board report on Safe Staffing Levels, and the anticipated regulatory practice of CQC (all of which were not published until the very end of the workforce planning process for 14/15).
- Thirdly, we have observed the changing practices of Trusts, who in response to Francis began to amend their own forecasts and in-year employment intentions.

Forecasting the future number of staff available for employment (supply)

Adult Nurses in Acute Settings
Provider forecasts of future demand and forecast of future supply



Source: ESR Data Warehouse, SHA forecasts, LETB forecasts

The green area represents a judgement about the potential future supply based upon the modelling done by our LETBs and reflecting changing forecast demand from our Trusts. HEE must aim to secure future supply within the 'demand zone' between the blue lines in order to avoid excess under or over supply. Our commissions cannot impact on this until 2017 but we need to make a judgement about whether our planned commissions for 2014/15 are sufficient to ensure the supply line (qualified nurses) ends up within the range of predicted demand.

Community Nursing

Community nursing refers to registered nurses who work in community settings, including District Nurses, Paediatric Community Nurses, Mental Health Nurses, Learning Disabilities Nurses and Health Visitors. But for the purpose of assessing demand and supply for adult nurse training we exclude mental health and learning disabilities because they are predominantly supplied by other nurse training branches.

The undergraduate programme is the same for acute and community nurses, but further specialist training and support is provided by HEIs and employers post-registration to enable work in the community. For example, Health Visitors are typically registered nurses who choose to undertake a further year's training to allow them to become a qualified Health Visitor.

The situation we have inherited

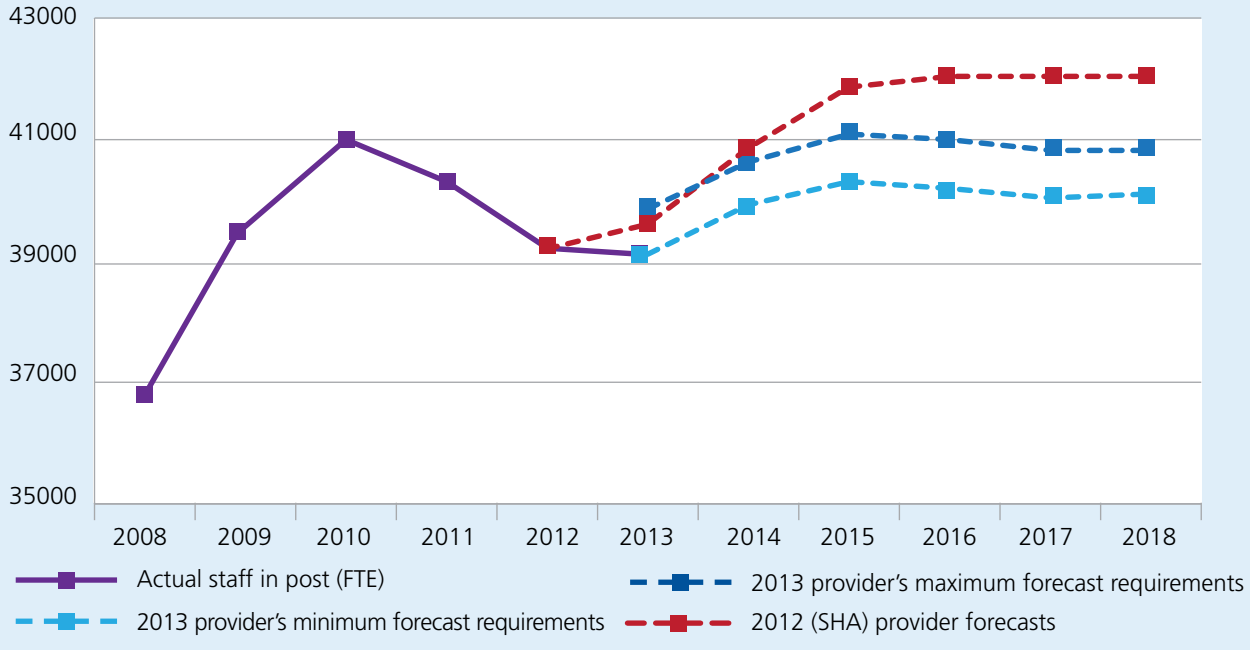
The NHS community workforce increased by 19.8% between 2002 and 2012. In the past few years the overall numbers have decreased but this is set to reverse, initially as a result of the Health Visiting expansion programme.

Community	**2002**	**2012**	**Increase/decrease**	
	FTE	FTE	FTE	%
Registered Nurses (excluding DNs & HVs)	18190	31264	13077	71.9%
District Nurses	10446	6381	-4065	-38.9%
Total Registered Nurses in Community workforce (exclHV)	**28636**	**37648**	**9012**	**31.5%**
Health Visitors	9774	8386	-1388	-14.2%
Total 'Community' Nursing	**38410**	**46034**	**7624**	**19.8%**

The community nursing workforce, excluding Health Visiting, has grown by over 30% in the past ten years, however within this there have been dramatic shifts between the number of staff formally designated as district nurses versus other Registered community nurses operating in community settings. At the same time the practice nursing workforce has also grown by over 20%.

2013 Employer forecasts of their future requirements (demand)

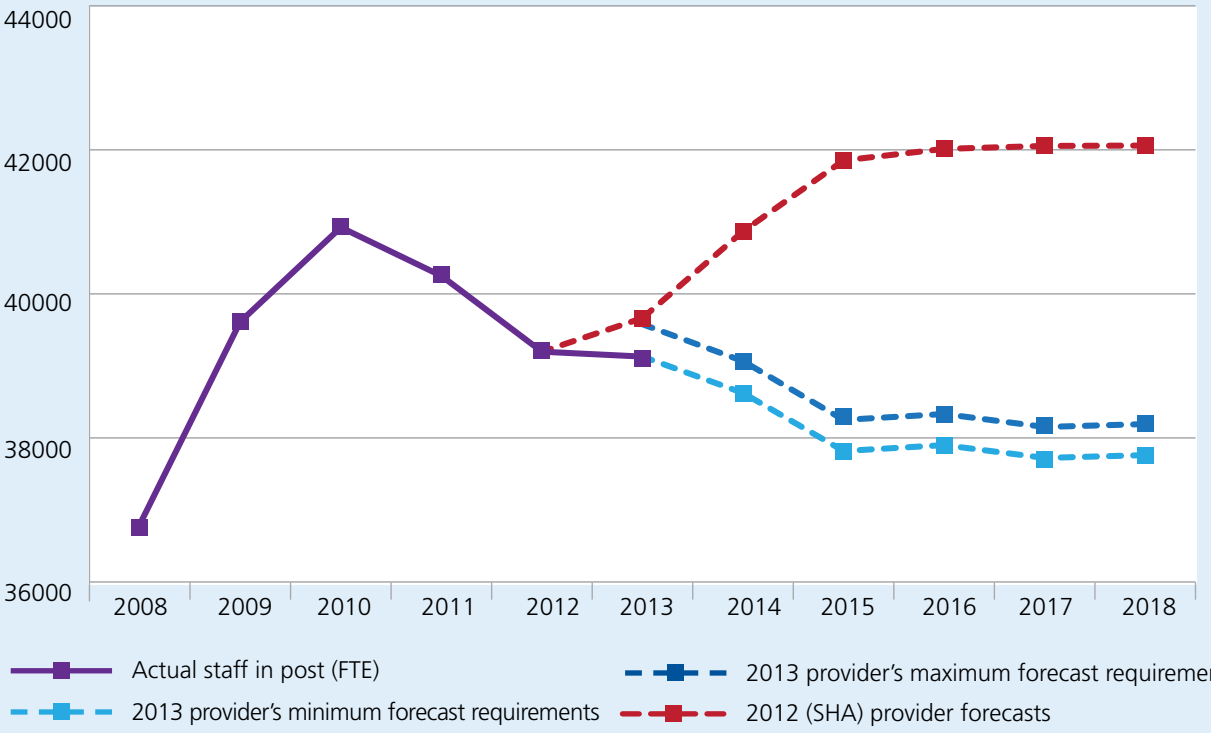
Provider forecasts of future workforce requirements
Community Nursing - including Health Visiting



Source: ESR Data Warehouse, SHA forecasts, LETB forecasts

The graph indicates providers are forecasting a 2% increase in the community workforce in 2013/14 and a further 1.1% growth in 2014/15. However the impact of the Health Visiting expansion programme masks employer forecasts about the community workforce serving adults and older people where forecasts are for a 1.5% reduction in 2013/14 followed by a 2.1% reduction in 2014/15 before demand becomes flat from 2015 to 2018.

Provider forecasts of future workforce requirements 2013 to 2018
Community Nursing - Excluding Health Visiting



Source: ESR Data Warehouse, SHA forecasts, LETB forecasts

Triangulation with other evidence

As part of our triangulation process we have considered what employers tell us their forecast need is in the light of current and anticipated policies and demographic and technological changes. We believe that the current forecast demand for nurses does not appear to sufficiently reflect the move towards more integrated care with more services provided in a community setting or the need to provide services that are more responsive to the needs of vulnerable older people and those with mental health needs. It is therefore our collective judgement that we should not take these projections of future demand at face value. Our assessment is that because of this dissonance with national policy we will assume a higher degree of demand is likely.

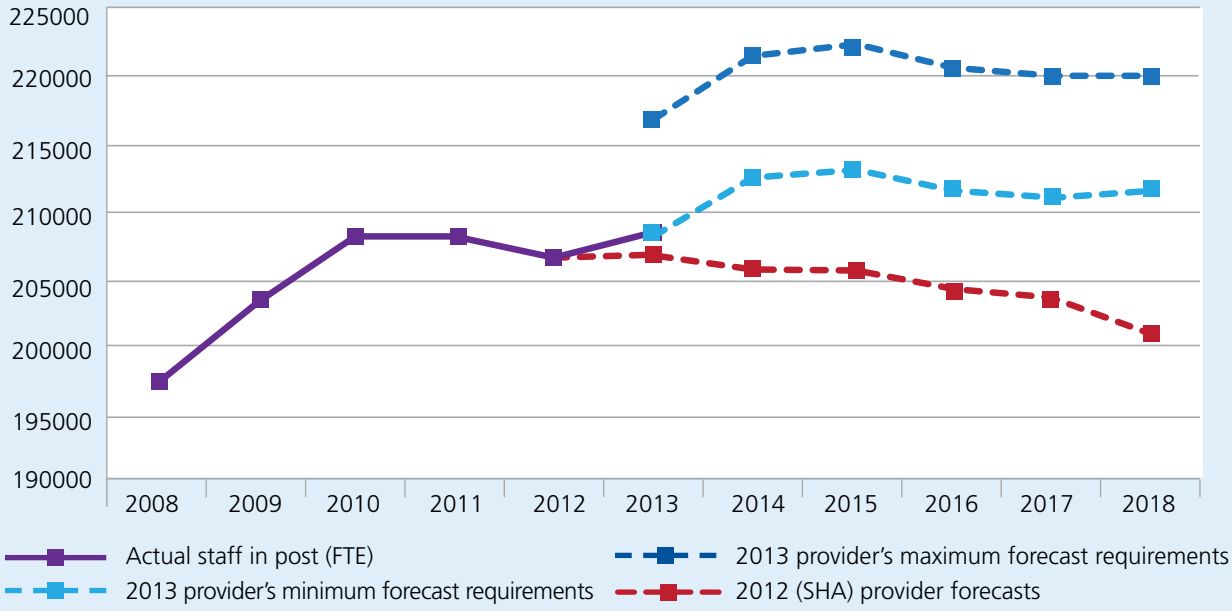
Forecasting the future number of staff available for employment (supply)

The community workforce is inter-related with acute nursing. The majority of Registered Nurses working in community roles are registered on the Adult Nursing branch of the professional register. We also need to recognise that social care (which HEE does not have responsibility for) relies on the same pool of registered nurses for local authority funded care including vital functions such as School Nurses.

Adult nursing for acute and Community settings – combined demand forecasts

These Community and Acute forecasts describes the total requirement to be met by our Adult Nursing commissions.

Combined Acute and Community Nursing
Workforce growth 2008-13 and employer forecasts 2012 and 2013



Source: ESR Data Warehouse, SHA forecasts, LETB forecasts

This combined forecast indicates providers are forecasting growth of 2.2% in 2013/14 and 0.1% in 2014/15, followed by a slight reduction from 2015 to 2018.

Our commissioning intentions for Adult nursing

Based upon their assessment of future Trust need and local supply factors, LETBs initially proposed to commission in aggregate 12, 728 adult nursing posts in 2014. This represented a 5% increase on the previous year, and reflects some increases in providers' forecasts which we believe is in response to the emerging impact of the Francis report.

This aggregate position reflects a degree of variation locally. In some areas, the LETBs are planning for a 15-20% growth in response to factors such as historic underinvestment. In other areas, there has been a sustained position of growth and a fairly high ratio of education commissions to the number of nurses within their patch. This means that despite an apparent lack of growth in commissions this year some areas have sufficient output from education to meet both future turnover and any increase in requirements from their Trusts. Other areas plan to address the need for more nurses through managing down attrition rates and service transformation.

Whilst each of these plans makes sense locally, the question for HEE collectively was whether this added up to a credible plan for England, particularly as we anticipate further guidance from NICE next year with regard to safe staffing levels.

Many Nursing Directors spoke of their experience of sudden increases in the levels of nursing following the NHS Plan and cautioned against a boom and bust approach. They warned that neither Universities nor Trusts have the capacity

to provide a significant growth in training places without compromising the quality of the trainee experience and ultimately patient care. There is also the question of whether current stated employment intentions will turn into sustainable action.

Whilst HEE needs to secure the future supply of workforce, we must take care not to inadvertently lock the NHS into a pattern of acute service provision. Nor is it right that we continue to invest in commissioning levels that simply accept and tolerate attrition rates as high as 30%. This represents far too high a level of waste of both millions of pounds of public money and the time and effort of frontline nurses and University staff.

We have therefore decided to take the following actions in addition to the initial LETB plans:

- In recognising that workforce planning involves complex judgements with many shifting variables and that the Francis report and anticipated NICE guidance has yet to take full effect, HEE will increase the commissions for nursing by a further 500 in 2014/15. This takes the total commissions to 1094 representing a 9% increase on 2013/14 commissions.
- This will enable us to deliver output in 2017 equivalent to the forecast output for 2013/14; representing the highest level ever produced according to available records.
- Focussing on output numbers will be part of our wider effort to drive down attrition rates, so that we do not reward failure through ever increasing commissions. We will work closely with our University partners and employers to set a challenging but achievable goal for reducing attrition. Blunt targets could risk unintended consequences such as pressure not to fail the minority of students who aren't capable of completing the course, but this should not prevent us from tackling this important issue.
- We will also work to ensure that the additional student nurses we commission are given increased exposure to community settings during training.

HEE education commissioning 2014/15 – Adult Nursing

Adult Nursing

Start Year	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**Initial proposals 2014/15**	**Moderated proposals 2014/15**	**Increase since 2013/14**
Education Commissions				14451	13628	11930	11416	12134	12728	13228	9%
Output Year	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**	**17/18**	
Output from education	9465	9098	9634	10560	10838	9711	9293	9877	10361	11244	14%
inferred attrition				*-27%*	*-20%*	*-19%*	*-19%*	*-19%*	*-19%*	*-15%*	

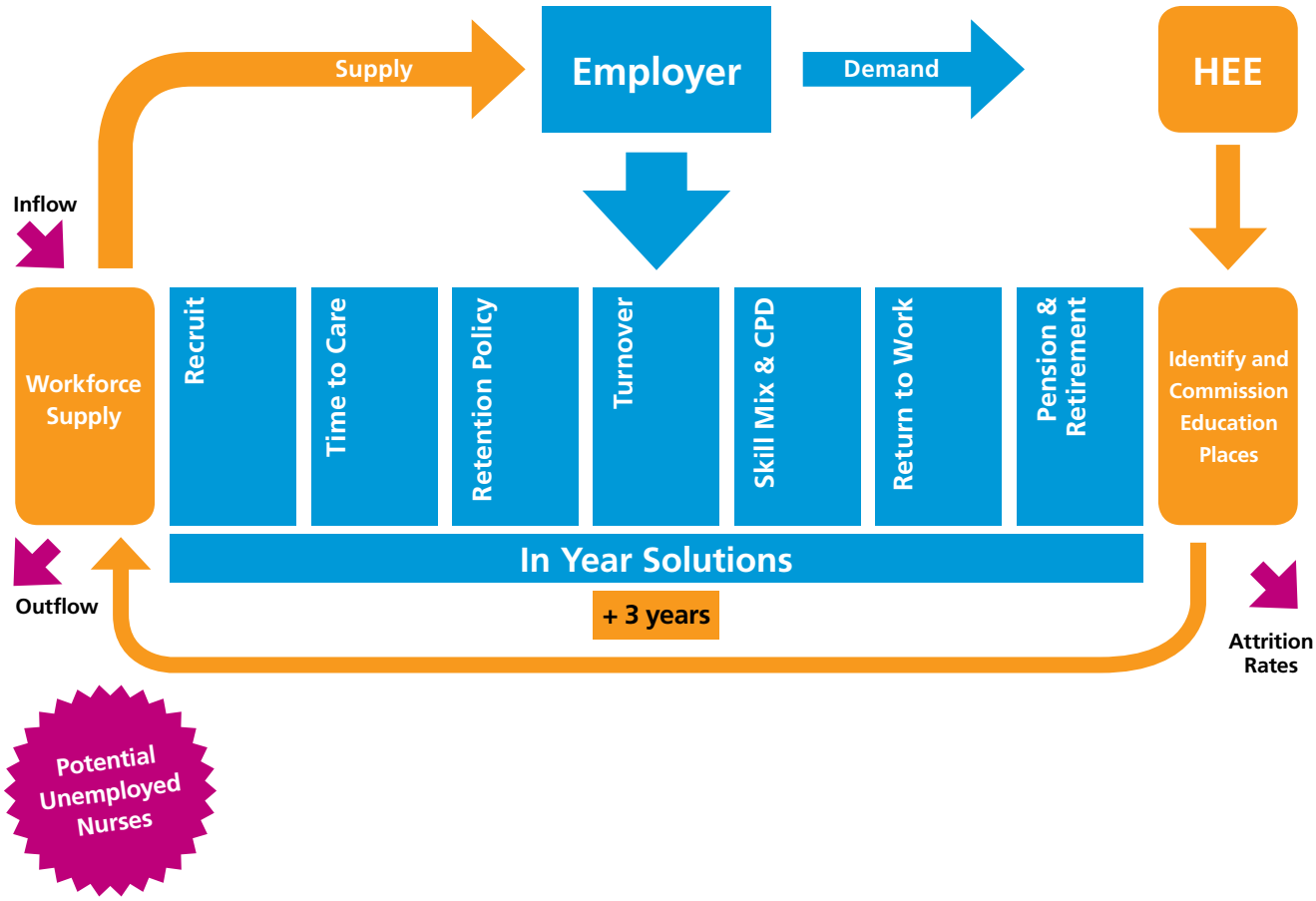
**Models the output deliverable by achieving 15% attrition*

We believe that this represents a proportionate and sensible response to a complex situation that anticipates further growth in the demand for nursing without perpetuating unacceptable attrition rates. We will keep this area under review, and take further steps if necessary during our next round of workforce planning.

Meeting patient needs today – shorter term supply

Whilst we have a statutory responsibility to secure the future workforce we recognise that the numbers we commission will not be available for employment until 2017 at the earliest. However, the workforce planning HEE and its LETBs undertake means we inherently observe potential issues with supply in the shorter term.

Ensuring a Workforce with the Right Numbers, Skills & Behaviours



This diagram illustrates that whilst HEE provides future supply it is the responsibility of employers to recruit and retain those nurses, and invest in their skills. We know from Nursing and Midwifery Council data that we currently have 649,449 Registered Nurses in England. We also know that, (according to IC Census data), approximately 490,000 are working for the NHS within the UK, of which about 390,000 are in England. We also know that 23,000 nurses have 'lapsed' in their registrations with many more registered but not employed in nursing.

As well as commissioning new nurses (at a cost of £45,000), the NHS needs to actively manage the investments we have already made in individuals and think creatively about how we might encourage qualified and registered nurses to return to work.

HEE has therefore agreed to lead a campaign on behalf of the system to provide support to employers in meeting their current nursing workforce. We see this as part of a wider shift in how we treat our investment in the workforce. We want to move to a situation where we invest not just in a three year course, but in the life-long career of a nurse. If we can use our resources to support registered nurses to return to and stay in employment then this is good for employers, tax payers, nurses, and most of all, patients.

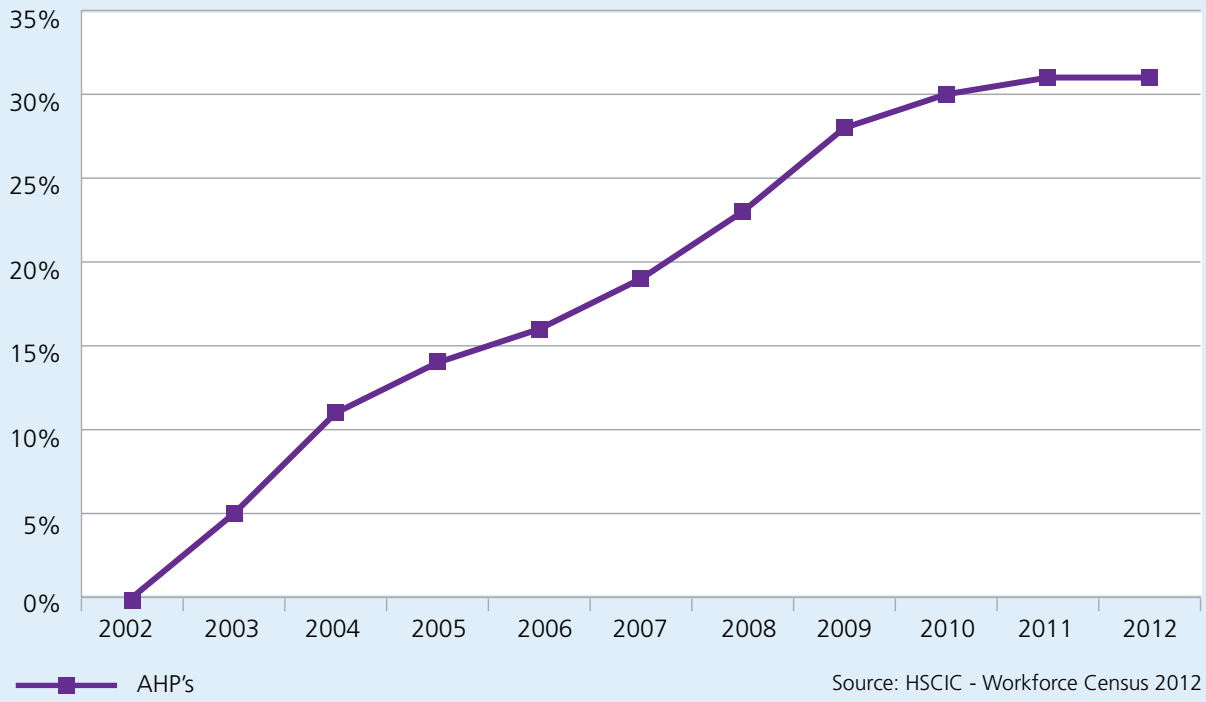
Allied Health Professionals

AHPs cover 12 separate professions of which HEE commissions pre-registration training for 11 of them as per the table below (art therapies being the exception). The individual assessment of each profession will be available on our website. Below we outline some common characteristics of the workforce and the current level of training LETBs have proposed.

The situation we have inherited

The AHP workforce has grown to 63,198fte by September 2012, an increase over the ten years 2002 to 2012 of 31.2% (over 15,000fte additional staff), with 10.4% of that growth in the last five years.

AHP Workforce Growth 2002 to 2012



Source: HSCIC - Workforce Census 2012

This workforce growth came from commissions between 2005 and 2009 with output in 2009/10 of 5551 newly qualified AHPs enabling growth in the NHS workforce of 2159fte (3.5%).

SHA Education Commissioning levels 2009/10 to 2013/14 - AHPs

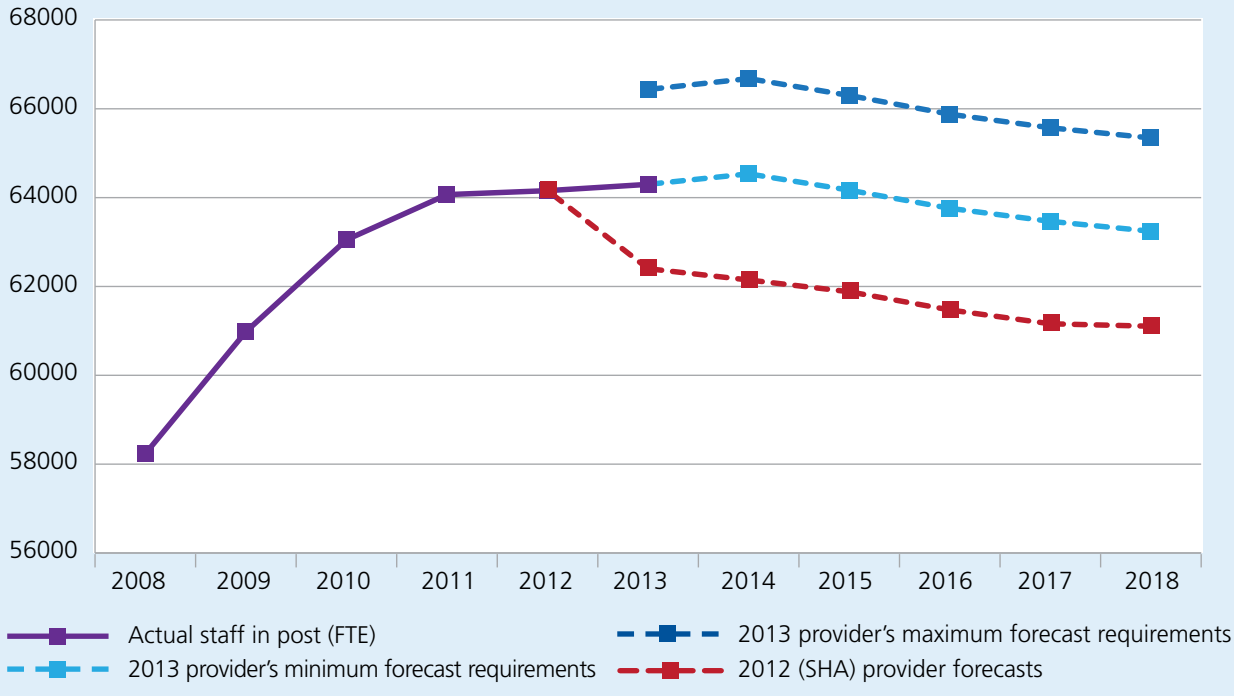
Allied Health Professionals

Start Year	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**Increase since 2012/13**
Education Commissions				7095	7049	6582	6264	6547	4.5%
Output Year	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	
Output from education	5551	5472	5452	5870	6102	5754	5476	5723	4.5%
inferred attrition				*-17%*	*-13%*	*-13%*	*-13%*	*-13%*	

Forecasts of provider's future workforce requirements collected by the SHAs in 2012 forecast a reduction in 2012/13 of 2.7% with a more moderate decline from 2013 to 2017, however in 2012/13 the workforce grew, albeit by a modest 0.2% (141fte). The last record of posts vacant for longer than 3 months across all AHPs was a record low of 0.5% (March 2010). Again this shows an under forecast from providers about their requirements.

2013 Employer forecasts of their future requirements (demand)

Allied Health Professionals
Workforce growth 2008-13 and Provider forecast 2012 and 2013



Source: ESR Data Warehouse, SHA forecasts, LETB forecasts

Current forecasts of future requirements indicate that in 2013/14 employers intend to employ 0.4% more AHPs than at March 2013 followed by a period of modest reductions from 2014 to 2018 (0.3% a year over the five year period).

Forecasting the future number of staff available for employment (supply)

The table below describes the forecast number of newly qualified staff in each Allied Health Profession in 2017 from the commissions proposed in this plan. We have then shown this output as a % of the NHS employed workforce which this new supply is designed to support. If the net number of people leaving the NHS is less than this then some of this newly qualified output would be available to allow the workforce numbers increase should employers wish it to. For example, in 2017/18, the number of newly qualified Speech and Language Therapists produced will represent 9.6% of the current workforce. If this exceeds net turnover, we would run the risk of over-supply and unemployed SLTs in 2017/18, unless there was a further expansion in the employed workforce.

Allied Health Professions	Current Workforce	Estimated Output 2017/18**	Output as % of workforce it serves
Dietitian	4116	290	7.0%
Occupational Therapist	14945	1240	8.3%
Physiotherapist	18723	1400	7.5%
Podiatrist	3065	270	8.8%
Speech & Language Therapist	6125	590	9.6%
Diagnostoc Radiographer	13147	910	6.9%
Therapeutic Radiographer	2509	290	11.6%
Paramedic	12751	770	6.0%
Total AHPs	**75381**	**5760**	**7.6%**

Triangulation with other evidence

As part of our triangulation process, we consulted with members of our professional advisory groups (although it was not possible for the full HEEAG to meet). Initial LETB proposals were challenged in terms of whether they took sufficient account of future changes in patient and service demand, such as the growth in diabetes, the need for rehabilitation services or delivering the Vulnerable Older People's agenda. We were also urged to ensure that the supply of specialist education courses were not inadvertently destabilised.

Conversely, our LETBs fed back that they were indeed considering future patient needs and that as in all areas of workforce we need to look more at the skills that we need, rather than the numbers of a particular profession. In the future we need to explore ways of equipping other parts of the workforce with some of the skills of AHPs whilst ensuring that AHPs are supported to provide the services currently offered by other professions.

We also recognise that many AHPs, although trained by and working for the NHS, are not necessarily employed by the NHS as they may work for the social or independent sectors. This makes it much more difficult to accurately assess the level of supply in the system as we do not yet have good data from non-NHS sectors.

Our commissioning intentions for Allied Health Professionals

In all AHP professions we anticipate that the level of training commissions will provide future growth to the workforce. This is despite the fact that our supply assessment indicates potential oversupply. Despite the emerging signs of potential over supply HEE has elected not to act on this indication in 2014 whilst we develop a stronger consensus on both the future requirement for these professions and skills and the extent to which practice in non-NHS settings is sufficiently accommodated for in our assessments of NHS staff turnover.

Allied Health Professions	2013/14 Commissions	Planned 2014/15 Commissions	Increase/ Decrease	%
Dietitian	329	336	7	2.1%
Occupational Therapist	1538	1523	-15	-1.0%
Physiotherapist	1488	1490	2	0.1%
Podiatrist	362	362	0	
Speech & Language Therapist	657	644	-13	-2.0%
Diagnostic Radiographer	1051	1059	8	0.8%
Therapeutic Radiographer	360	371	11	3.1%
Paramedic	655	853	198	30.2%
Orthoptist	77	77	0	
Orthoptists/Prosthetists	30	30	0	
Total Allied Health Professions	**6547**	**6745**	**198**	**3.0%**

The total number of AHP training places that LETBs will commission in 2014/15 is 6,745, representing an overall increase of 3.0% (198 places) on the level in 2013/14.

This net position is made up of an increase of 26 places over four professions, 26 decreases over two professions, and 198 additional paramedic training programmes.

The largest increase (except paramedics) is in Therapeutic Radiography (3.1%) whilst the largest decrease is Speech and Language Therapy (-2.0%). It should be noted that in workforce planning terms anything more or less than 5% is not considered to be a significant change.

However, it is also clear that the AHPs, who deploy their skills and talents work across primary and secondary care settings, offer the potential to unlock some of the current patterns of service delivery and to meet the needs of patients with long term conditions and complex needs. We will work with our Allied Health Professional Advisory Group to explore these issues further next year, to ensure that our investments reflect the changing needs of our population.

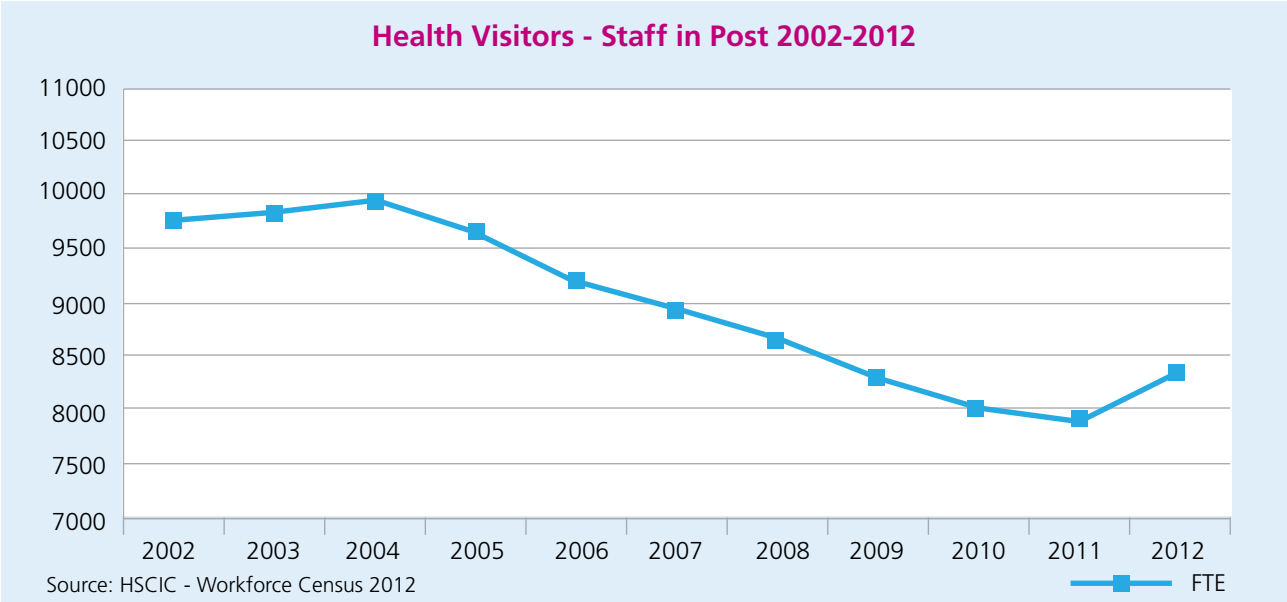
National targets

HEE was established to ensure a greater connection between the needs and demands of local employers and the education and training commissions we make. In most of our workforce modelling, the demand line is provided by local employers.

However there are currently two areas where the demand in the future has been set by national policy. These two areas are Health Visitors and IAPT.

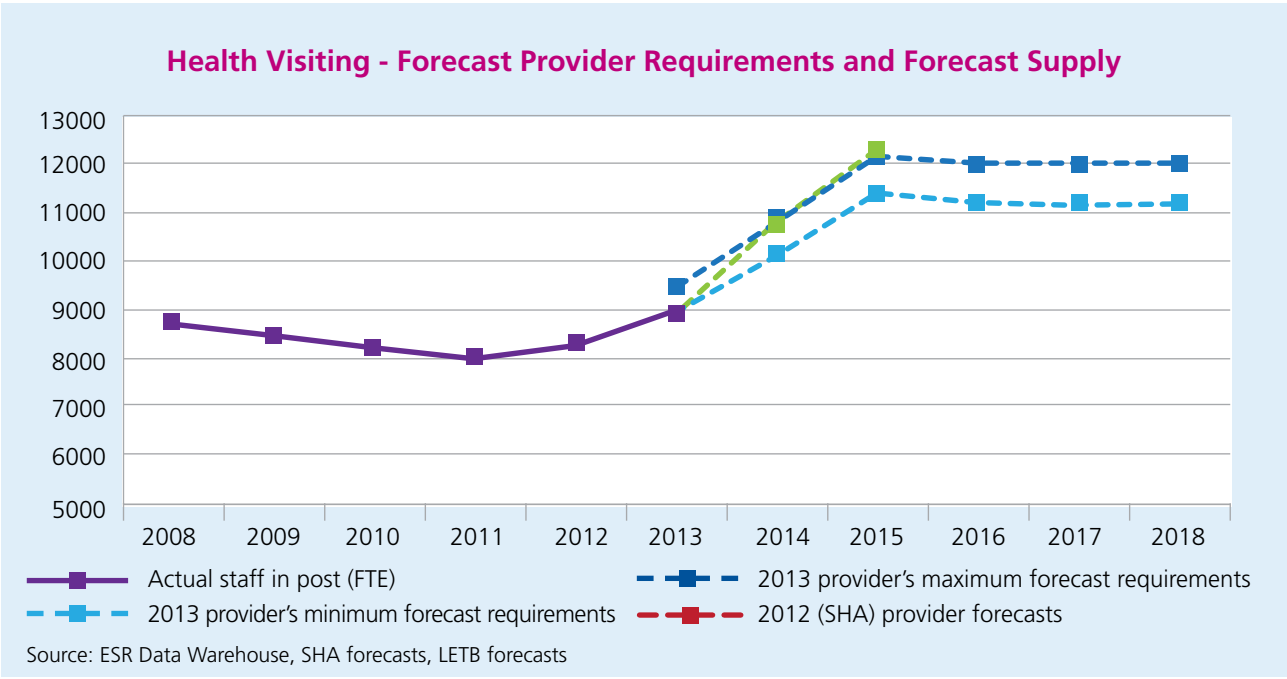
Health Visiting

The planning for the level of education commissions in Health Visiting in 2014/15 is associated with the delivery of the Government's pledge to increase the Health Visiting workforce by 4200fte between April 2010 and March 2015.



The unprecedented expansion of the HV workforce by 50% in three years required an increase in the level of education commissions from approximately 500 in 2010 to 2787 in 2013, an increase of over 400%.

The HV training programme is one year long, recruiting Registered Nurses to undertake an academic and practice placement programme to equip them to be employed in Health Visiting roles.



The rapid expansion of the workforce will be achieved by March 2015 so 2014 commissions will only be required to meet turnover plus any locally decided change to the size of the workforce which is why we show a significant reduction to 1041 new commissions. However, it is important to recognise that this remains above historical trends for the profession outside of the period of recent radical growth.

Our commissioning intentions for the Health Visiting workforce

The table below highlights our intention to commission 1041 training places in 2014, it also shows the pattern of training both in the period of expansion (2011-2013) and the original levels SHAs commissioned before the expansion programme.

HEE education commissioning 2014/15 – Health Visiting

Health Visitors

Start Year	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**14/15**	**Decrease since 2013/14**
Education Commissions	483	555	1729	2526	2787	1041	-63%
Output Year	**10/11**	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	
Output from education	372	459	1197	1891	2411	901	-63%
inferred attrition	*-23%*	*-17%*	*-31%*	*-25%*	*-13%*	*-13%*	

*2010/11 was the last time commissions were designed to provide for staff turnover and 'standard' growth

This level of education commissions will support any turnover within the expanded workforce and an element of growth if required.

Increasing Access to Psychological Therapies (IAPT)

The Increasing Access to Psychological Therapies programme has been running for six years with the aim of ensuring people have access to highly effective evidence based 'talking therapies'.

Expansion of IAPT services has been managed as a DH national programme since 2008. SHAs were tasked by the programme with creating an additional 6000 IAPT practitioners between 2008 and 2014. By March 2014 they had delivered 5,569 a shortfall of 431.

	DH Expansion Target	**Expansion Commissions**	**Turnover Commissions**	**Total Commissions**
08/09	1200	997		
09/10	1200	1731		
10/11	1200	1140		
11/12	800	538		
12/13	800	528		
13/14	800	635	196	831
Total SHAs	6000	5569		
14/15 LETBS		556	200	756
Total	**6000**	**6125**		

The future requirement for 2014/15 has been set by the national IAPT programme i.e. an additional 331 growth in the IAPT workforce.

Unlike many other programmes we plan for, the IAPT education programmes are only one year in length, therefore we only need to know future requirements one year ahead. The requirements in 2015/6 and beyond will form part of our planning process in 2014.

As we move into the period outside of the national IAPT programme LETBs will engage with service commissioners and providers locally to assess whether they have a requirement for the workforce to grow further in future years.

A significant challenge as we move beyond the nationally planned workforce expansion is that there is no systematic way of counting the size of the IAPT workforce or of observing how many staff retire or move on to other roles. IAPT practitioners come from a variety of professional backgrounds and are not currently identifiable as being an 'IAPT practitioner' on the Electronic Staff Record (our primary source of data for observing the current NHS workforce and its movement)

In the IAPT national programme's planning, they have assumed turnover of 196 in 2013/14 and 200 in 2014/15 (3% of the 6000 workforce) but we have no way of validating these assumptions

The national IAPT programme used to undertake a manual data collection from service providers but this is currently suspended. HEE is working with the HSCIC and the IAPT national programme to address how we can monitor the IAPT workforce and thereby plan for its future supply.

Our commissioning intentions for the IAPT workforce

There are two main training programmes within the IAPT programme, described as 'low intensity' which provides training for Psychological Wellbeing Practitioners and 'high intensity' training.

Allied Health Professions	2013/14 Commissions	Planned 2014/15 Commissions	Increase/ Decrease	%
IAPT - Psychological Wellbeing Practitioner (Low intensity)	474	436	-38	-8.0%
IAPT - High intensity practionner	385	320	-65	-16.9%
Total - IAPT training programmes	**859**	**756**	**-103**	**-12.0%**

As can be seen from table above HEE is intending to commission 756 training places in 2014 which the IAPT national team's modelling indicates will result in an increase of 564 in the workforce if employers choose to employ them.

The reduction in commissions compared to 2013/14 simply reflects that the amount of expansion required by the IAPT national team is far less than the 635 expansion provided for by last year's 831 commissions.

Indeed for a range of local reasons LETBs have elected to maintain training at a higher rate than would be indicated by the national team's modelling. HEE would only require 531 commissions if we were only aiming at the 431 expansion and we accepted the forecast turnover but the significant uncertainty on these variables has led LETBs to take a more prudent approach.

Other Clinical Professions (Non-Medical)

Overview

In addition to the 15 workforce groups considered in detail above, there are a further 20 programmes of education that HEE commissions for other (non-medical) clinical professions. These represent a disparate range of professions with specific characteristics and drivers both in terms of factors affecting future service demand and factors affecting turnover and the supply of new staff from education programmes. There is therefore no overall summary that can be constructed for these groups. However, our assessment of the inherited position, future forecasts of demand and supply, triangulation intelligence, and the subsequent commissioning proposals will be available for most of these groups on our website.

Forecasting the future number of staff available for employment (supply)

Each LETB has undertaken a detailed assessment of the balance between local demand for non-medical staff groups and their forecast of the factors affecting future availability of these staff. HEE has not in its 2013 planning process mandated a standard way of reporting these supply assumptions and as such a national 'supply forecast' has not been made for all professions.

We have however undertaken a 'sense check' process including generating a measure of forecast output as a % of the workforce it serves as a high level indicator of whether current training levels are likely to enable growth to the workforce if required. This indicator is shown in Annex 2.

So for example in Children's Nursing we are forecasting 1950 graduating students in 2017 (from 2182 commissions) which serves a current workforce of 15,877fte. This output is 12.3% of the workforce so if net turnover was between 5% and 7% then most of these graduates would be available for workforce growth if sufficient posts were created or vacancies existed.

Our commissioning intentions for other non-medical workforces

The full list of proposed commissions for non-medical education and training programmes is shown in Annex 1 to this report. Across all non-medical education this shows an increase of 30 commissions (0.1%). If we exclude the impact of the reduction in health visiting training the total increase across all non-medical commissioning is 1776 (5.5%)

Medical and Dental Workforce

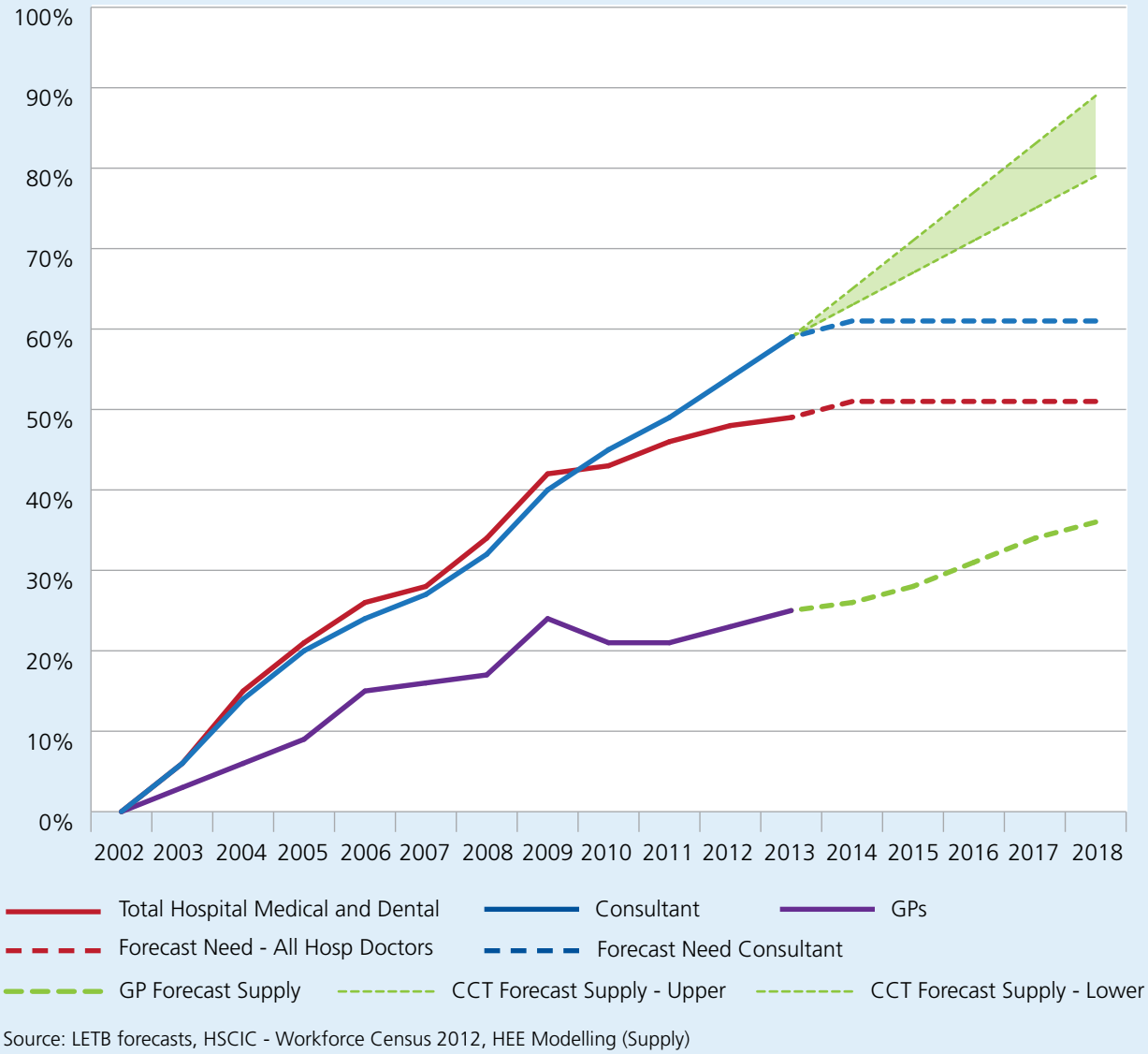
The future medical and dental workforce has historically been planned at a national level. The process has focussed on assessing the future number of Consultants the system will need in order to determine how many post graduate training posts to create. To be able to apply for a consultant post, doctors need to be on the specialist register. The normal route to entry is via training leading to the award of a Certificate of Completion of Training (CCT). The following section therefore focuses on how many post graduate medical and dental training places ultimately leading to a CCT we will commission in 2014/15.

Overview

The current level of Post Graduate Medical and Dental Education for secondary care medical specialties is forecast to produce an average increase in the consultant workforce of over 4% per annum, continuing the trend that has seen the consultant workforce grow by over 13,400fte between 2002 and 2012 (54% or 4.4% per annum)

The average forecast output of between 3,300 and 3,500 new CCT holders per year is forecast to enable an average increase in the consultant workforce of over 1800 per year if sufficient jobs are available. Regardless of what we commission in 2014/15, this future supply is already in the education system, so this level of growth is guaranteed until at least 2020.

Medical Workforce 2002 to 2018

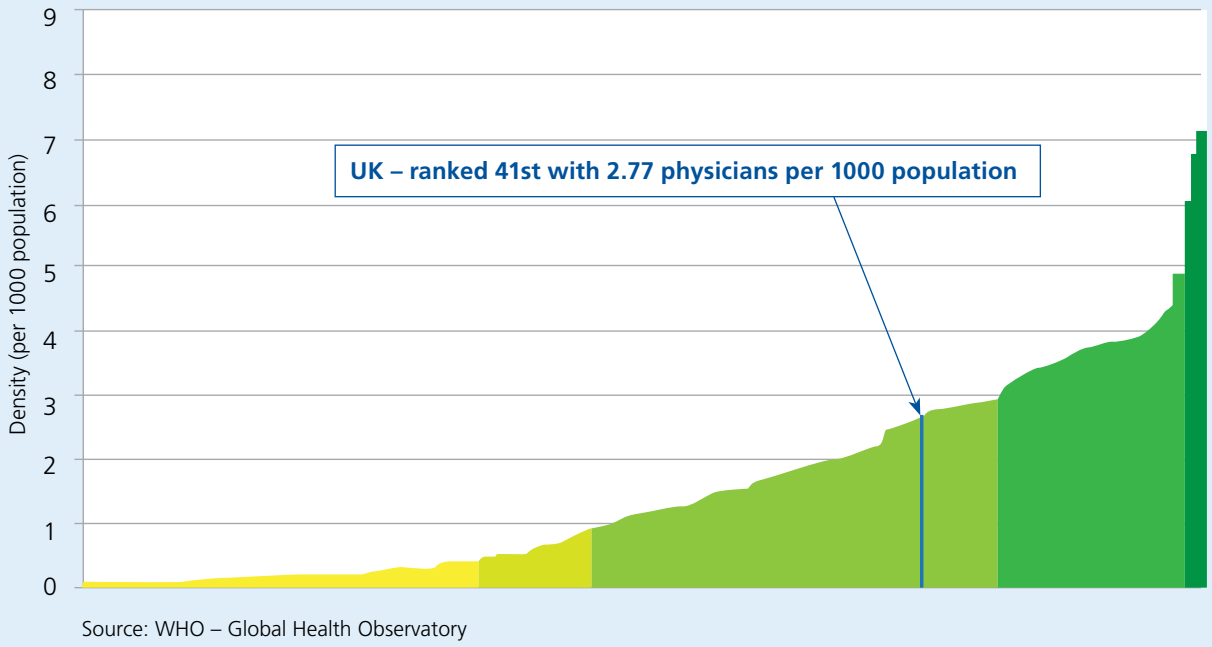


Source: LETB forecasts, HSCIC - Workforce Census 2012, HEE Modelling (Supply)

The GP workforce is discussed in more detail below, but current planned training volumes are also forecast to enable growth to the GP workforce at 2.7% per annum, compared to the average growth over the past 10 years of 2.1%

However, it should be noted that despite the growth observed over the past decade the UK still ranks significantly below a large number of countries in respect of the number of physicians per 1000 population.

Physicians per 1000 population – World Health Organisation



Source: WHO – Global Health Observatory

Forecasting future workforce requirements (demand)

The key question for HEE is whether this level of future growth (supply) is what the system and its patients require (demand). Because planning for the medical and dental workforce has historically taken place at a national level, we have less accurate demand data from local providers.

Decision makers have instead relied upon externally commissioned reports and the support, advice and challenge from the Medical Royal Colleges who have extensive understanding and expertise in relation to their own specialties (and through the Academy an oversight of the medical workforce more generally).

The last comprehensive analysis of these issues was CfWI's 'Shape of the medical workforce' report in 2011. This report made a number of recommendations for changes to the volume of Higher Specialty medical training but failed to generate sufficient consensus amongst stakeholders to drive implementation.

HEE is committed to ensuring a wider consensus on future requirements is sought with service commissioners, providers and the Medical Royal Colleges, drawing where necessary on external support and expertise. We will need to develop a shared understanding of the needs of future patients and the impact on the consultant and wider medical workforce of service transformation and reconfiguration including the implementation of the 'NHS services, seven days a week' policy.

The forecasts of future requirements in the graph above (shown as the red and blue dotted lines) are the product of the first ever attempt to canvas the views of employers themselves about the shape and size of their future medical workforce. We recognise the inherent limitations to these first forecasts, not least that these forecasts, made in April/May 2013, are unlikely to reflect key policy drivers such as seven day working. However, we do believe that engaging with the organisations that actually establish and fund consultant and other medical posts must be a component of creating consensus about the future medical workforce we should be investing in.

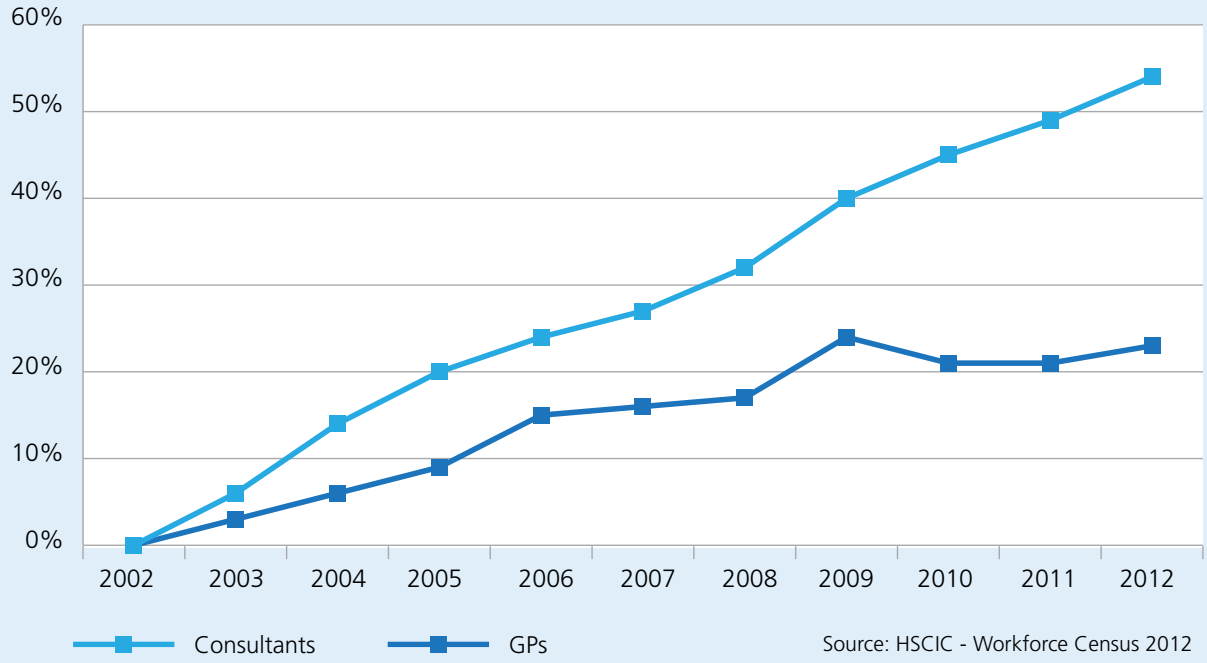
The fact that doctors in post graduate training also provide significant amounts of service whilst learning means separating the number of training posts required to deliver the future consultant workforce from the number wanted by employers to deliver today's workload. This makes an assessment of future need even more challenging. A reduction in post graduate trainees not only reduces the future number of consultants for a particular profession it can also have a real impact on patients today. This means that we need to develop a degree of evidence and consensus before initiating significant changes in such professions.

There are 78 specialties covered by the 94 programmes of Medical and Dental Education that we commission and it is not possible to set out each in detail within this document. All of our proposed commissions are set out in Annex 1 and below we describe in more detail the position in specialties where we propose to make material changes from the inherited position, and/or are subject to greater public interest. These include:

- General Practitioners
- Core Surgical Trainees
- Emergency Medicine
- Dentistry
- Public Health

General Practitioners

The position we have inherited



The GP workforce has grown to 35,871fte by September 2012 an increase of 23% (6,700fte) over the ten years 2002 to 2012.

However the rate of growth from 2002 to 2007 was over 900fte per year whilst from 2007 to 2012 it fell to 400fte per year and whilst this is still material growth the impact of lengthening the training time to be a GP has resulted in fewer GPs being produced each year, despite an overall increase in posts.

This output from training, together with the potential impact of retirement for an ageing workforce and work/life balance factors in younger GPs, means that whilst the GP workforce is still forecast to grow it may be at a slower rate than previously. The question for workforce planners is at what rate do we need to grow the GP workforce to meet forecast demand?

Forecasting future workforce requirements (demand)

There is no national target for staff in post for GPs. However, within our mandate there is an implicit expectation that demand will increase with a requirement for us to ensure that 50% of medical students become GPs. (This does not equate to a 50% increase in GPs as this is a commissioning decision for NHS England).

All analysis and policy drivers currently indicate that this supply measure is reasonable, including the CfWI in depth analysis of the GP workforce. However even this was hampered by a lack of consensus as to the future scale and shape of the GP and wider primary care workforce. We must quickly move to a position where the training we are commissioning is validated by reference to a transparent perspective of future need.

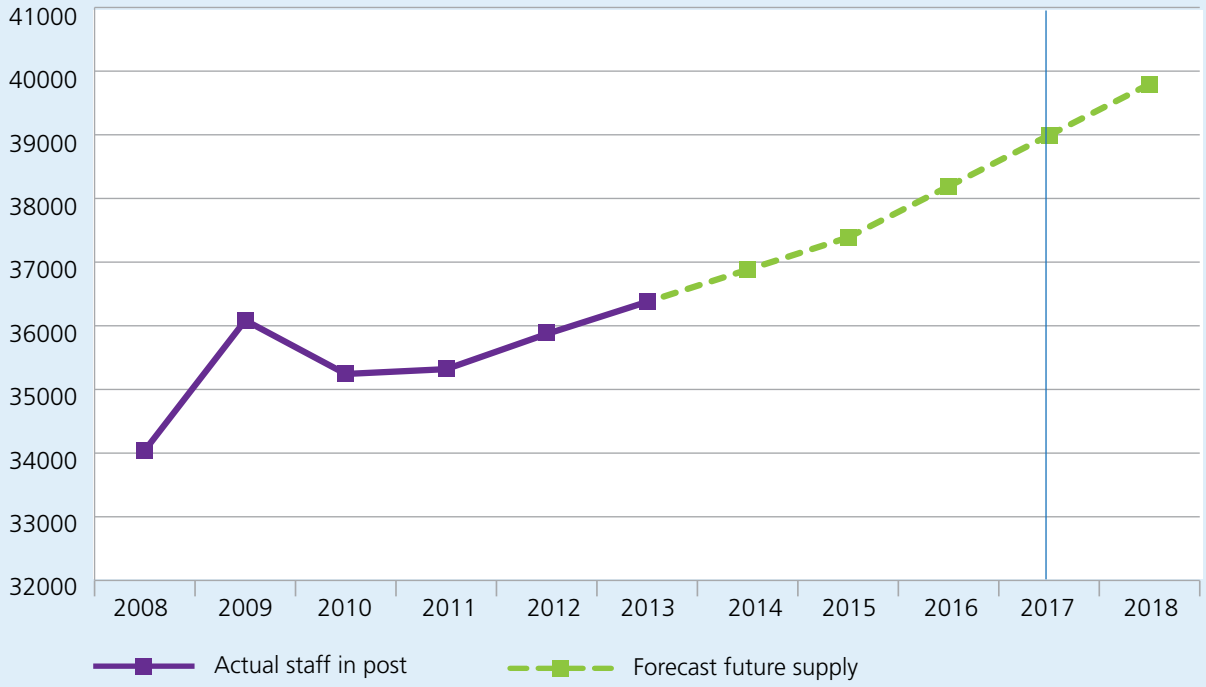
As with much of medical workforce planning this inherited recommendation is focussed on supply side analysis. What we lack is a compelling narrative on the future demand for GPs. The recent announced initiative to develop the NHS England primary care strategy is to be welcomed in this respect.

Forecasting the future number of staff available for employment (supply)

HEE's mandate requires us to make significant progress towards 50% of post graduate training being for doctors to work in General Practice. This has been defined as an increasing commissioning to 3,250 places per year.

CfWI's forecasts indicate that if we reach 3250 training places by 2015 then it would sustain moderate annual growth to the GP workforce.

GPs - Staff in Post 2008 to 2013 and forecast supply to 2018



Source: ESR Data Warehouse, HEE/CfWI

Our commissioning intentions for General Practice

Based on the recommendations we have inherited, LETBs are proposing to recruit an additional 222 new GP trainees compared to the number they would have recruited if no expansion were planned.

Education & Training Commissions for 2014/15

General Practice	Planned 2014/15 Recruitment*	Number of Training Posts	Increase/ Decrease	%
Total - General Practice	**3099**	**6423**	**222**	**3.6%**

*recruitment figures represent the maximum number of training opportunities available. Post may not be available if existing trainees do not complete there qualification to the expected timetable.

Core Surgical Trainees

HEE has inherited a number of proposals for post graduate medical education from the previous system.

One of the key inherited recommendations that we have tested through our new Medical Workforce Advisory group and with the Medical HEEAG is the proposal to reduce the volume of Core Surgical Training to 500 per annum.

The main driver behind this recommendation was that current training levels of over 600 per year were resulting in hundreds of doctors graduating from this core training being unable to progress into Higher Specialty Training as we only require 350-400 of these per year (note this level of higher specialty training provides for growth to the consultant surgeon workforce of over 3% per year.)

Education & Training Commissions for 2014/15

Core Surgical Training	Planned 2014/15 Recruitment*	Number of Training Posts	Increase/ Decrease	%
Total - Core Surgical Training	**507**	**1268**	**-71**	**-5.6%**

*recruitment figures represent the maximum number of training opportunities available. Post may not be available if existing trainees do not complete there qualification to the expected timetable.

The recommendation we inherited required a reduction in recruitment of 75 training places (15%). In their 2014 plans all LETBs have contributed at least this 15% reduction unless they were already at their target level. We considered the achievement of 71 reduction sufficient for 2014/15 however this will be kept under review with LETBs who are not yet at target levels (London, NW, SW) being expected to meet any further reductions if required.

Emergency Medicine

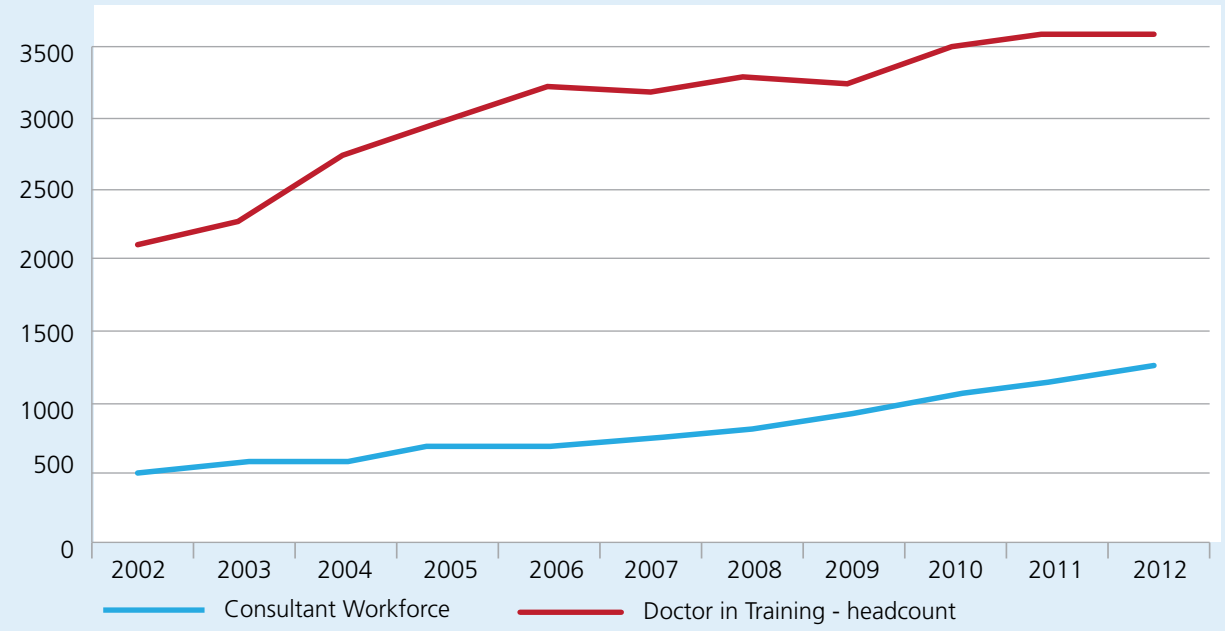
The position we have inherited

As at the September 2012 census the Emergency Medicine medical workforce was made up of the following components;

Emergency Medicine - Medical Workforce:	Headcount
Consultants	1,279
Doctors in Training Posts	3,561
Doctors in Non-Training Posts	563
Other Medical Staff	54
Total Workforce	**5,457**

Over the ten years 2002 to 2012 the number of Emergency Medicine consultants grew by 140% (746 more consultants) and doctors in training posts by 70% (1465 more doctors).

Emergency Medecine medical workforce growth 2002 to 2012

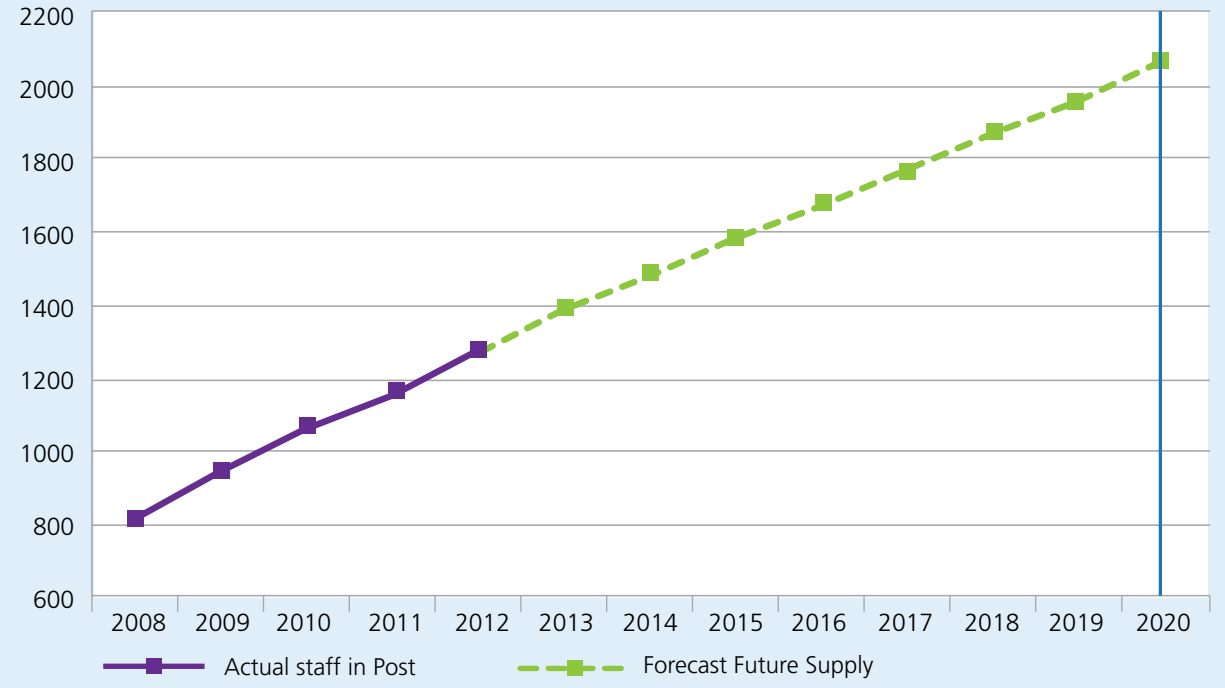


Source: HSCIC - Workforce Census 2012

Forecasting the future number of staff available for employment (supply)

In the absence of other data, the basis for our supply assumptions is the analysis behind the 'Shape of the Medical Workforce' report (2011) by CfWI. This assessed how output from current levels of training would affect the number of doctors available to be consultants up until 2020.

Emergency Medicine Consultants - Staff in Post 2008-2013 and forecast supply



Source: ESR Data Warehouse, HEE/CfWI

The green line shows the number of Consultants that could be available to employ if all the CCTs currently in training were employed. This forecast is based on current training levels and includes an assessment of the extent to which Higher Specialty Training posts are not filled and the extent to which doctors do not complete the programme.

A reliable and consistent measure of the volume of training being undertaken is one of the challenges HEE has inherited. However on average there are between 170 and 190 funded training opportunities per year to train to become a consultant in Emergency Medicine. In the CfWI modelling they have only assumed an annual output of 132 to 136, so it would appear that the current challenges in filling higher specialty posts have been accounted for in forecasting future consultant supply.

There has been much attention paid to the problems in Emergency Medicine recently but it is important to recognise that in Emergency Medicine there are sufficient training posts; the problem is encouraging enough people to undertake the training. In response to this problem, HEE has led a taskforce aimed at encouraging more people into Emergency Medicine as a career which will have an impact on our commissioning intentions.

Our commissioning intentions for Emergency Medicine

There are three main programmes of education that HEE commission to support the Emergency Medicine workforce. Our proposals for recruitment to these programmes is set out in the table below:

Education & Training Commissions for 2014/15

	Planned 2014/15 Recruitment*	Number of Training Posts	Increase/ Decrease	%
Emergency Medicine - Core Training				
Acute Care Commom Stem - Emergency Medicine**	176	359	20	5.6%
Emergency Medicine - Higher and Run Through				
Emergency Medicine (Run through pilot)	173		6	
Emergency Medicine	298	634	0	
Total - Emergency Medicine	**647**	**993**	**26**	**2.5%**

*recruitment figures represent the maximum number of training opportunities available. Post may not be available if existing trainees do not complete their qualification to the expected timetable.

** recruitment figures exclude proposals for additions ACCS trainees being considered by HEEs EM workforce taskforce.

LETBs are currently proposing an increase of 20 posts in the ACCS – Emergency Medicine training programme, which is the main 'core training' that equips doctors to apply for Higher Training opportunities.

However, given that we know we have problems recruiting to these posts, HEE has considered what further action we might take in order to increase the chance of the training posts being filled as part of our Action Plan for Emergency Care and in order to deliver our Mandate.

It is clear there are vacancies in the consultant grade and a relative lack of popularity at recruitment to middle-grade medical training. Conversely core training in Emergency Medicine through the Acute Care Common Stem (ACCS) programme is popular with a ratio of 3:1 applicants to posts this year. HEE is working with the College of Emergency Medicine to develop strategies to improve the attractiveness of the specialty but in the short term we intend to increase the number of training places in ACCS Emergency Medicine by 75 in order to provide a larger pool of doctors able to enter the middle-grade and progress to EM consultant posts. Decisions about the overall increase will be completed in time for recruitment for 2014 start dates.

In addition to our LETB commissions and the expanded ACCS programme, we will:

- Establish a 'run through' pilot, recruiting up to 173 people onto this programme, an additional 6 posts compared to 13/14
- Recruit up to 298 people into Higher Training Posts which is made up of a maximum of 193 posts made available when current trainees complete their training in 2014 and 119 posts that were unfilled in previous recruitment rounds

Dentistry

The position we have inherited

In response to the dental workforce review published in 2004, the Government agreed to a 25% expansion in dental training in England with an allocation of over 170 extra places for dentists. There was also a recruitment of an additional 1,000 dentists to the NHS including dentists returning to practice and overseas dentists. Two new dental schools were created and dentistry student numbers have actually increased by approximately 29% over the past decade.

In 2012 the Health & Education National Strategic Exchange (HENSE) reviewed the issue of medical and dental student numbers. A recommendation was made regarding medical training numbers but no recommendation was made regarding dental student numbers. It was decided that further work should be carried out on dental school intakes in 2013 and that a recommendation should be made in time to influence dental school intakes from September 2014 before being subsequently reviewed on a 3 yearly basis.

Health Education England asked the Chief Dental Officer for England to lead a review using the HEEAG for dentistry which has a broad membership, including HEFCE and the General Dental Council, as a reference group (a full list of members can be found in the Annex). The Chief Dental Officer commissioned a report from the CfWI to forecast and analyse the future supply of and demand for the English dental workforce looking between 2012 and 2040. This report can be found at http://www.cfwi.org.uk, and some of the key findings are summarised below.

Forecasts of future workforce requirements (demand)

The dental health of the population is changing, with significant improvements in oral health. Being seen according to the Adult Dental Health Survey (ADHS), the need for complete dentures in those over 65 has diminished from 28% in 1978 to just 6% in 2009. The proportion of 12-year-old children free of dental decay has risen from 60 per cent in 2000/1 to 67% in 2008/09, and

the very latest data on decay rates in 5-year-old children published in September 2013 by Public Health England, indicate that the number of children totally free of tooth decay at that age rose by 9.7% between 2008 and 2012 and that the overall level of tooth decay fell by 15%. These welcome changes in population health are likely to reduce the demand for dental interventions in the future.

The review considered the dental workforce as a whole taking account of the balance between NHS and private sector working, the rapidly changing oral health status of the population and the greater and correct focus on prevention which is at the core of proposed changes to NHS dental contractual arrangements.

Forecasting the future number of staff available for employment (supply)

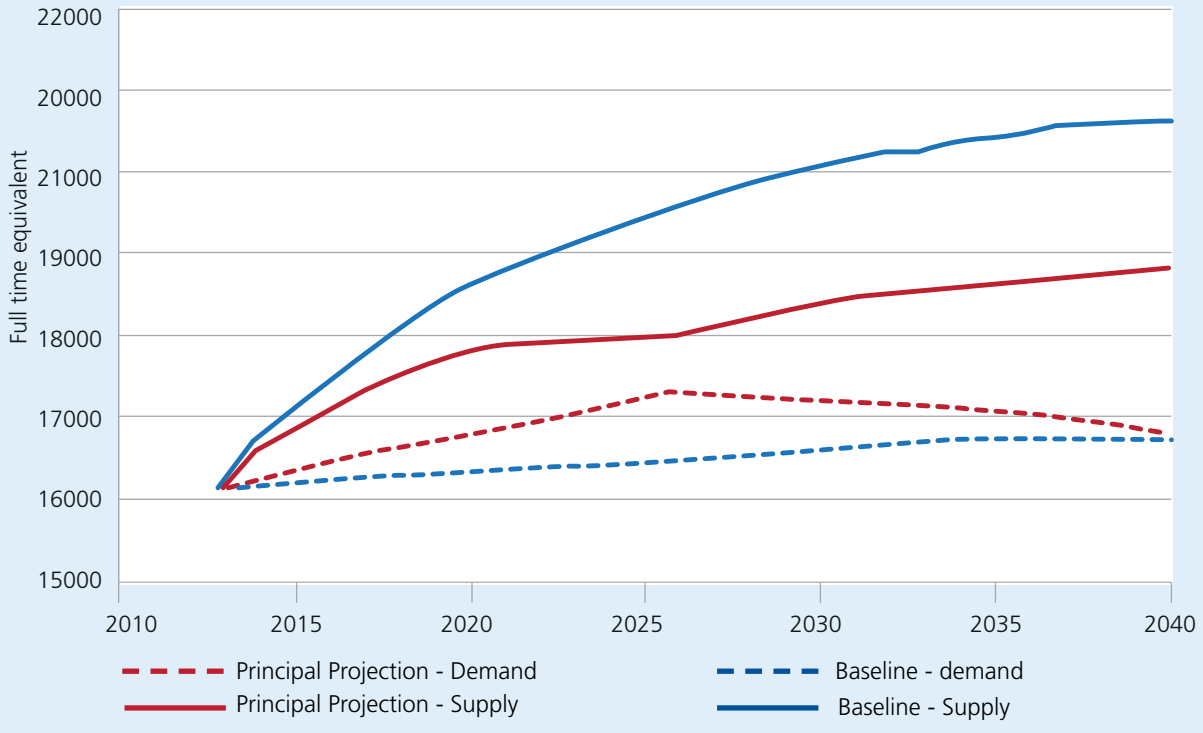
Having considered all the factors relating to supply of dental workforce and the likely future need and demand for dental services CFWI produced a baseline projection of the likely workforce situation between now and 2040 if no change were made to current training plans and the assumptions necessarily made were correct.

The baseline projection suggests that if no action is taken there would be a very significant over-supply of dentists widening to 2040.

Our commissioning intentions for dentistry

We support the professional advice of the Chief Dental Officer for England to reduce the number of commissions for dental undergraduate education. We are however aware of concerns from some universities about this and we are therefore having urgent discussions with the Department of Health, the Department for Business, Innovation and Skills and HEFCE on how to alleviate the potential oversupply of dentists identified. Updates on the outcomes of these discussions will be reported to a future HEE Board.

Total supply and demand of dentists showing supply above demand for the baseline and the principal projection



Source: CfWI

Public Health

Public health has undergone a radical re-organisation during 2013. We are working closely with Public Health England, the new expert national agency for the public's health, NHS England, the commissioner of national public health programmes, and with local authorities, the local leaders responsible for improving the public's health and wellbeing, so all of us can understand better not just the demand and supply of the existing workforce but how we can invest in the wider workforce to drive real improvements in the public's health.

The public health workforce consists of much more than the public health specialist workforce that is outlined below. In addition to key professional groups such as Health Visitors, Family Nurse Practitioners, and School Nurses, there are a wide range of other professions whose members play key roles within the Public Health arena, such as Healthcare Scientists, Dieticians, and staff working in areas such as smoking cessation and other wellbeing activities.

In its broadest sense, the 'Make Every Contact Count' model means that every health care worker is a member of the public health workforce and can help people improve their own health and wellbeing. We are currently working with Public Health England to understand how we can define and plan for the wider workforce however below we set out the results of the workforce planning process for the specialist workforce for which we have specific commissioning responsibilities.

Public Health Specialist Workforce

For more than ten years there has been a commitment within the public health community to multi-disciplinary public health teams and to opening up the profession to non-medically qualified public health specialists operating on the basis of equality with medically qualified specialists. The training we commission with the faculty of public health, and the resultant specialist workforce as described below reflect this commitment to the multi-disciplinary workforce.

The situation we have inherited

The current (September 2012) public health specialist workforce consists of the following components

Public Health Specialist Workforce	Headcount
Consultants	756
Doctors in Training Posts	315
Doctors in Non-Training Posts	374
Other Staff	372
Total Workforce	**1817**

Forecasting the future number of staff available for employment (supply)

A recent stocktake indicated that there are currently 350 Higher Specialty training posts in the system, which should provide an average of 70 new CCT holders per year from the five year programme. The Centre for Workforce Intelligence has forecast a CCT output of 53 per year to 2015 and 62 per year to 2020, indicating some element of under recruitment or attrition. They forecast that this would result in 896 consultants by 2020 if sufficient jobs were available, providing growth in the Consultant Public Health Workforce of 140 (18.5%).

Triangulation with other evidence

However we recognise that we need to do more to both understand the current public health workforce (looking beyond the Consultant workforce to pick up those in the community who commission and provide public health services and are part of the 'make every contact count' approach) and also to better understand potential future demand for their services from the two major employers, which following the reforms are Public Health England and Local Authorities.

To this end HEE and PHE have jointly commissioned a deep dive from CfWI so that we can better understand the nature of the public health workforce and the issues we will need to address in order to aid effective workforce planning. We have also established a new Public Health HEEAG which will have oversight of this work and advise us not just on matters related to the public health workforce, but how our broader strategy can better support the longer term objectives of PHE.

Our commissioning intentions for Public Health Medicine

In addition to recruiting 65 people to the specialist public health training programme, we have agreed to fund a public health fellowship programme to enhance the capacity and capability of the specialist public health workforce and provide new opportunities to fill gaps in specific areas of practice.

Other Post Graduate Medical Specialties

Overview

As is described above there has been a significant increase in the total specialty medical workforce over the past decade and similar growth is forecast until at least 2020 if required. However the medical workforce is not a single group, it is made up of numerous specialties, each with its own drivers and characteristics that should determine the system's future requirements for these specific specialties and the associated level of training.

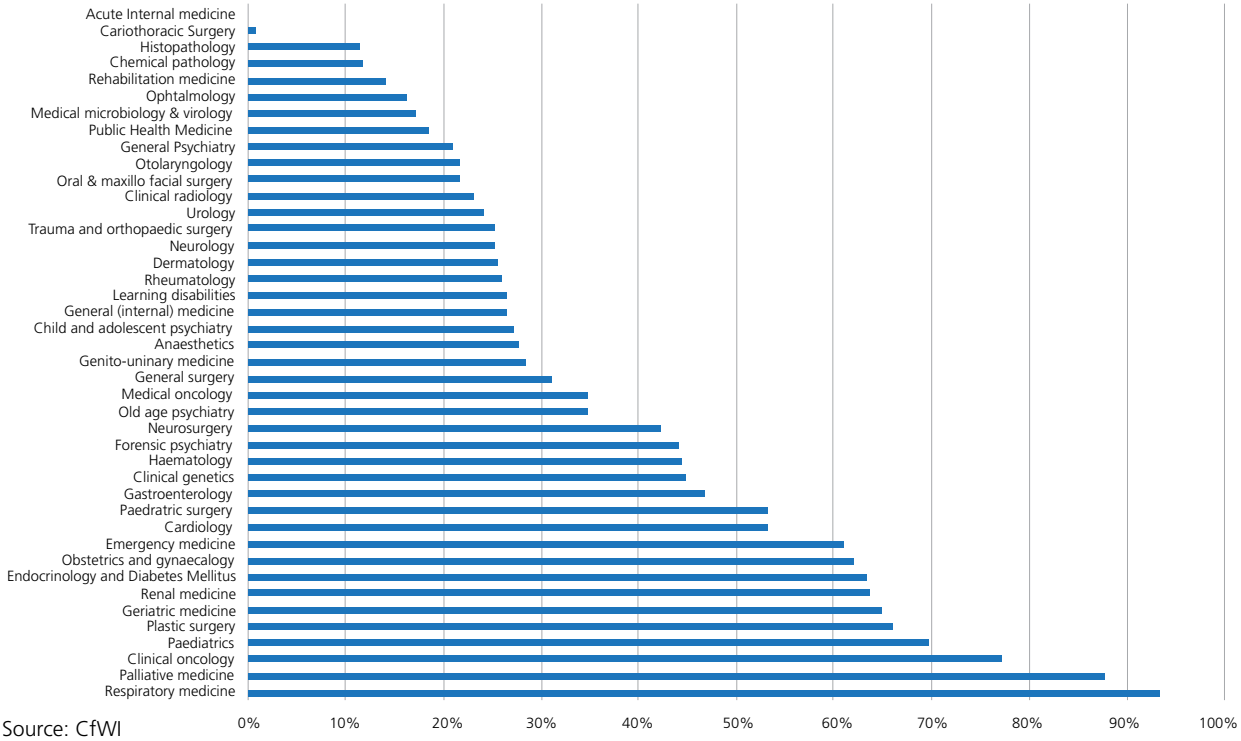
We will continue to work on a specialty by specialty basis with Royal Colleges, employers and commissioners and through work commissioned from the CfWI to establish understanding and consensus on both the drivers of turnover and supply from education and the future service and patient need.

We are already considering next steps in areas such as Trauma and Orthopaedics and Renal and in 2014 we will consider reports into areas such as Anaesthetics, Obstetrics and Gynaecology, and Acute Medicine.

In the meantime work by Royal Colleges and LETBs through their Post Graduate Deans, continue to make small local or specialty specific adjustments to training, including using the recommendations and analysis within the CfWI report 'shape of the medical workforce'.

Forecasting the future number of staff available for employment (supply)

The table below shows the level of forecast consultant growth in each specialty* to 2020.



Source: CfWI

*the table covers all specialties addressed in CfWI's 'Shape of medical training' report. It excludes small or new specialties & sub-specialties for which insufficient data on consultant turnover and training output was available.

This analysis has forecast the number of new CCT holders that will be produced from current levels of training and then compared this output with forecast levels of retirement and leavers from the consultant workforce. Again the growth in the workforce will only actually occur if sufficient consultant posts are created.

Annex 2 highlights the forecast output for each specialty and shows this output as a % of the consultant workforce it serves. This is a high level indicator of the extent to which current training represents potential future growth. This allows direct comparison with the levels of training for non-medical specialties for which we use the same high level indicator.

However, for medical training we are also able to report the forecast consultant growth that this level of output from specialty training would support, based on the modelling done in support of the 'Shape of medical workforce' report.

So for example we are forecasting an average output of new CCT holders in General Surgery of 159 per year. There are currently 1990fte consultants in general surgery so this annual output represents 8.0% of the consultant workforce. We are forecasting this would enable growth to the consultant workforce of 3.4% per year.

So roughly 90 to 100 of the newly qualified CCT holders will replace retirements and other leavers, and 60 to 70 would be available to fill any new posts created by providers to expand this workforce.

Our commissioning intentions for other medical specialties

The full list of proposed recruitment to medical and dental training programmes is shown as part of Annex 1 to this report. The main other than GP and Core Surgical training are,

- Other Higher Specialty or run through training - 17 increase (from 19 specialties)
- Other Core Training - 36 increase (from 4 specialty groups)

It is our assessment that these changes are either in line with previous national recommendations or represent local decisions which do not impact materially on the future national supply for these workforce groups

Section 7

Investing in innovation and service transformation.

The above sections necessarily focus on numbers, as in order to commission the education and training places with universities, we need to set out the investments in quantitative terms. But we are clear that workforce planning is not just about numbers. High quality care will only be delivered if we can produce a workforce with the right numbers, the right skills and the right values and behaviours to meet the needs of patients in the future.

2013 has been a year of transition with LETBs focussed on establishing themselves and their new teams whilst putting in place the foundations and processes that will support robust workforce planning. Nevertheless, we are already starting to see innovative approaches to education and training emerge as local employers have engaged with HEE, seizing the opportunity to start to make the changes they know they need to make.

Our LETBs local plans will contain detailed examples of how they are ensuring the education and training system we operate becomes increasingly responsive to the immediate service development and transformation priorities of their communities.

Of course there is more to do and the challenge will be to ensure that workforce planning becomes a means to an end (higher quality care) and not just an end in itself (producing numbers of commissions). We are committed to putting greater focus and attention on this area in future years.

HEE is committed to investing more money in the current workforce as we recognise that this is the way in which we will drive real service transformation and improvements for patients.

Section 8

Emerging trends and challenges for the system

By publishing our Workforce Plan for England we have, for the first time, brought together in one place the planned investments in medical and non-medical staff at both a local and national level. As well as supporting greater transparency and accountability, this report and the processes behind it will help us make better decisions, allowing priorities to be made between and within the respective professions rather than in isolation from one another.

It also allows us to identify some emerging trends and issues that raise key questions not just for workforce planners but for the wider healthcare system, which need addressing if we are to produce a workforce that really meets the needs of future patients.

Apart from increasing the undergraduate adult nursing commissions, our Workforce Plan for England for 2014/15 does not contain any other dramatic increases or decreases in the education and training investments we plan to make. The plans in aggregate will not deliver any fundamental service redesign or innovation at a national level. The reasons for this are four-fold:

- We are an organisation and system in transition
- We have inherited a system with gaps in data
- We do not yet have sufficient consensus or understanding about the future needs of patients and the appropriate service response
- In the absence of a clear service strategy the appropriate workforce response is not always apparent

We are an organisation and a system in transition

The creation of Health Education England and its thirteen LETBs means that we now have a ring fenced budget to deliver the investment and innovation we know we need to make in our workforce. But we recognise that quality and safety can suffer during a time of transition so we have focussed on ensuring the safe transfer of functions and staff, whilst implementing new and robust workforce planning processes. We have put in place the foundations that will enable us to make radical changes in the future whilst ensuring a safe transition this year.

We have inherited a system with gaps in data

There are longstanding gaps and weaknesses in our knowledge that we need to address as a matter of urgency. For example, on the supply side, there are different definitions and interpretations of attrition, and we do not, have any way of monitoring what happens to those students who actually complete their course. Of those students who graduate in nursing, for example, we do not know how many register with the NMC; how many will gain employment as a nurse, and five, ten, twenty years later, how many will remain within healthcare and in what capacity. We currently have incomplete data with regard to how many nurses are employed within the community, social care and independent sectors. An inadequate understanding of what the current supply is (i.e. how many qualified nurses there currently are) makes it harder to decide just how much additional supply is actually needed.

In terms of demand, whilst we have established mechanisms for capturing the employment needs of NHS Acute Trusts, this is not the case in primary and community care. We also do not have established ways of understanding the needs of the independent and third sector. This is particularly the case with GPs, where we do not have an agreed way of understanding the forecast demand in the future.

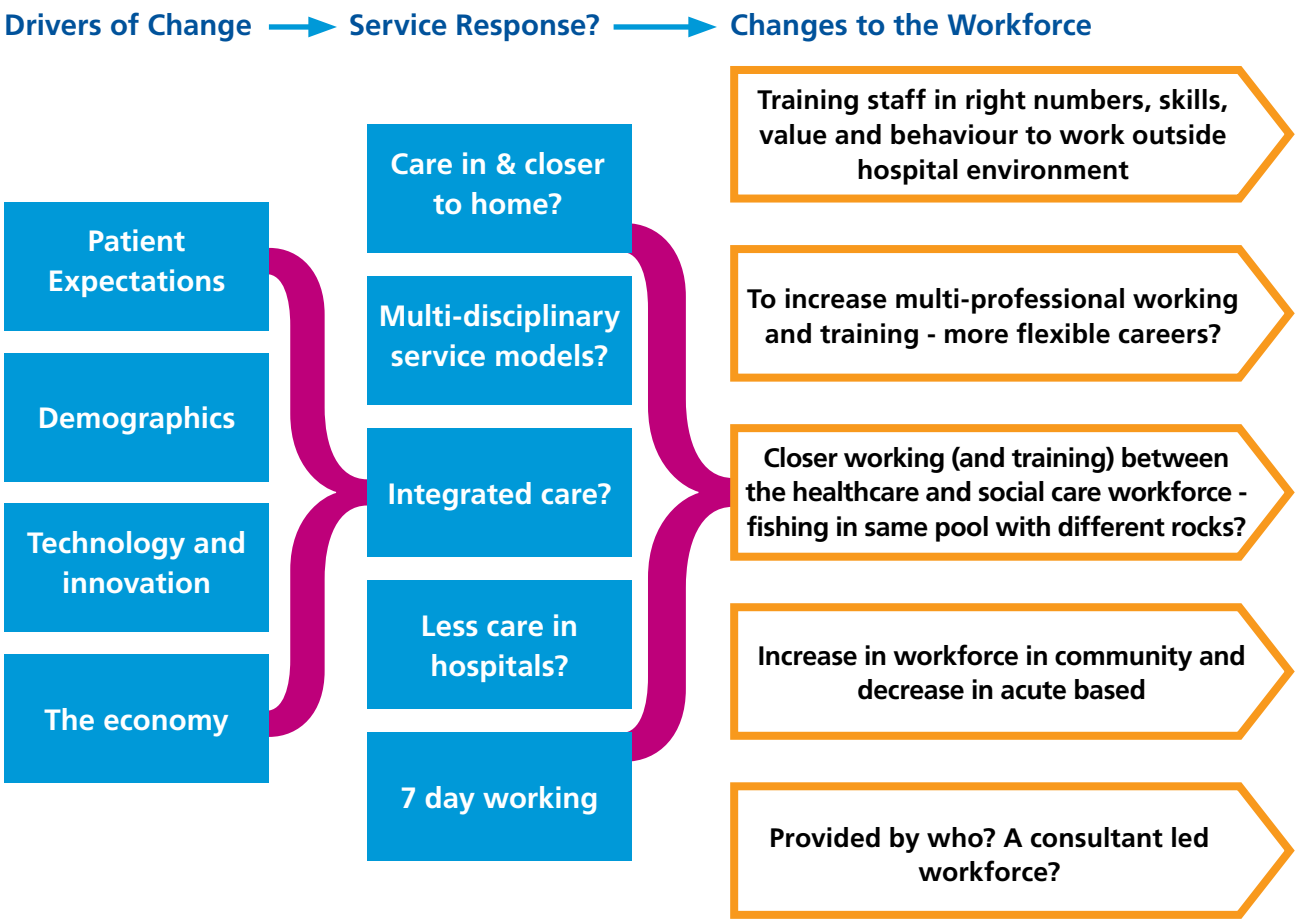
So whilst our existing workforce planning data suggests a potential over supply in some areas we did not feel the data was robust enough to justify significant decommissioning or dis-investments this year. However, as the quality of the data and our understanding of it improve we will be able to act much more confidently and radically on those areas where there is a risk of oversupply and,

conversely, undersupply. Through the Workforce Information Architecture project we are working with the Department of Health to ensure that we close these knowledge gaps urgently. In addition we will work with our LETBs and partners to explore ways of ensuring we have the data we need to make the right investments in the future.

Insufficient consensus about the future

Managers, clinicians and politicians have supported the concept of moving care from the Acute sector into the Community for many years. But health care services can only be moved into different settings if we have the staff in the right numbers, with the right skills, values and behaviours to deliver them. It is not just a case of moving staff from one building to another. The skills required to work in a busy Acute setting as part of a multi disciplinary team are very different to those required of a care giver working alone in a persons' own home as part of a networked team cutting across sectors and funding models. We will not be able to shift more care in the community if we do not have the nurses and other professionals there to provide the services.

Therefore it is critically important that we all understand what the vision for future services are, so that Health Education England can make the education and training commissions that will help deliver the stated vision.



As our diagram shows there is a general consensus around the drivers of change in health care. We need to ensure that we have the same level of understanding about the long term service response to these drivers of change. If we were clear about the service response then it would be for HEE to consider how best to invest in the workforce to ensure that that service could be delivered.

If the big questions in the second column are not answered then this encourages the tendency to roll forward last year's numbers as the safest way to avoid excess under or over supply. A failure to act radically on workforce plans, to decommission some areas so that we can invest more in others, is not just a missed opportunity, it is an obstacle to future innovation and service change meaning we are potentially locking in the service model of today, which is unlikely to be fit for tomorrow's purpose.

For example, if the current trends suggested by our existing workforce forecasts continue then we may produce a workforce that is:

- *Hospital based:* with many of the professions, particularly nursing, growing faster in hospitals than the community
- *Consultant led:* with current projections suggesting 3% to 4% growth in consultant numbers until 2020. This may be a good thing, if the service model for delivering seven day working depends upon more consultants, but others have argued for a more flexible workforce where not every doctor becomes a Consultant
- *GP led:* we are currently working to a model that assumes the majority of primary care will be delivered by GPs but there may be a need to grow the wider primary care support workforce to make community led care a reality
- *Based on a 'one size fits all':* where a medical model of care (which is absolutely right for some patients) underpins some services which might be better delivered by a more preventative approach
- *Driven by supply needs:* such as how many paediatric surgeons do we need as the driver rather than the needs of children and their carers.
- *At a national level, investing in tomorrow's staff rather than todays:* where employers continue to invest in the CPD of their staff but national workforce planning processes continue to only invest tiny amounts in the current workforce relative to those in future staff. This is a missed opportunity, as in many cases the most effective way of driving service improvement is to support our existing staff to improve their skills and progress in their areas.

Overall these issues are the result of the different business planning cycles between the NHS and workforce planning which makes it difficult to connect our investments with policy and strategy for service change.

Below we set out how we might better align this in the future.

Section 9

Working with the system to deliver a workforce fit for the future

The education and training commissions that we fund from this September will produce staff that will still be working in the NHS in 2060 and beyond. If we are to deliver a workforce that has the right numbers, skills, values and behaviours to respond to future patient needs then we need to work and plan in partnership with the rest of the system. We need to work closely with NHS England to better understand their future commissioning vision and how we can help deliver that. We need to:

- Work with the Department of Health to ensure that our planning processes align better at a local and national level where one can inform the other, triangulating the needs of employers with the commissioning intentions of CCGs.
- Continue to work closer with NTDA and Monitor to reduce duplication of data requests and ensure that our workforce plans are sustainable in the long term, and do not result in over supply and unemployed staff.
- Lift our heads up and out of the timeframes that inform current NHS planning processes, working much more closely with Public Health England and our Independent and Social Care partners to better understand how we can use our investments in staff to drive further improvements in public health and deliver integrated care.

Below we set out some of the actions that we will need to take in order to ensure that next year we can build on the solid foundations that we have put in place this year. How we can use our investments in people as a key means to drive improvements in the way that services are delivered to and experienced by patients.

Improving the data

We have well established mechanisms for collecting and analysing data in secondary care. However, our ability to make sound investments in our future staff is severely inhabited by the poor quality of data currently available in primary care and our historic disconnect with social care and the third sector. All employers are expected to provide LETBs with both their establishment figures and their future forecasts to aid our planning process. Working with DH, NTDA, Monitor, NHS England and the Independent Sector we will improve the quality of data about the current and future workforce so that we have a better understanding of supply and demand to inform our decisions. We will work with partners to reduce duplication of data submissions and produce one version of the truth. We will progress this through our Workforce Information Architecture project, with a view to addressing the major gaps for the 2015/16 planning round.

Clarifying the service vision

If we are clear about the future vision for service delivery then HEE can consider how we can help deliver this through the investments we make in education and training. NHS England's Call to Action is a welcome step forward and we will work with them to help address some of the key questions we have highlighted above. In particular, we need to understand whether we are making the right level of investments in Consultants and GPs to deliver the future model of health care. We will contribute to their thinking by leading work on the workforce implications of seven day working. We will also work with Public Health England to better understand how the workforce can support improved public health.

HEE will produce its own strategy in spring 2014 in order to inform the planning process for 2015/16 and beyond.

Financial challenge

In the future our strategy will be framed in a much more constrained environment than we have experienced historically. Resource allocations to HEE will be determined through DH processes but are unlikely to increase at the pace of our cost

increases. This will drive requirements for increased productivity from our providers of education and clinical placements, for more effective commissioning from us and substantial reductions in our running costs and activities.

If we are to commission staff in sufficient numbers with the right skills, values and behaviours to meet the needs of patients as set out by Francis and others then HEE will need to ensure we get a higher quality return on the investments we make:

For *individuals* who apply for the education and training courses that we fund there will be a values based recruitment process to ensure that applicants share the values of the NHS Constitution. In return HEE will do more to manage the investments we have made in their career starting with a Return to Practice Campaign.

For the *universities* we contract to provide our courses there will be a much greater focus on both the quality of the courses and the output that they produce, with a concerted effort to drive down attrition rates. We will work with universities to ensure stability where it is in the patients' interests and to ensure that tax payers receive value for money.

For the *Trusts* that provide training places for our students we will require a high quality training experience for our staff, identifying and rewarding best practice, and taking action (including the removal of trainees) where the environment is not safe or provides a poor training experience.

Aligning our planning processes

The NHS works on an April to April financial year whereas our workforce planning process operates on an academic cycle, September to September. Despite this, we believe we have made good progress this year on bringing the two together for the first time through the publication of our Workforce Planning Guidance for England. This sets out clearly the requirements and milestones we were working to with local review and challenge sessions with commissioners and other partners and a national 'Call for Evidence'.

We will review and revise the 2014/15 planning round and take the learning into our process for 2015/16. We will listen to the views of our LETBs and stakeholders and publish revised Workforce Planning Guidance for 2015/16. This will again set out clearly the requirements for LETBs to triangulate the views of providers with commissioners and other stakeholders. We will consider formalising this at a national level through a 'Star Chamber' event that brings together the key parts of the system to ensure that strategy, quality and affordability are appropriately aligned.

The Strategic Workforce Forum, which brings together all of the ALBs to discuss workforce issues under the auspices of the NQB will also aid further alignment.

Stepping up our ambition

We are proud of the progress we have made this year but have ambitions to achieve so much more. The people who work in HEE and who are members of our Local Education and Training Boards are driven by a belief that we can change things for the better through our investments in staff. They understand that it is the people we employ who deliver the service and that they are the key to improving quality and patient experience.

To achieve this we need to radically alter the way we plan the workforce of the future. The numbers set out in the 2014/15 plan reflect the fact that we currently plan through the lens of each registered profession: we can tell you how many paediatric surgeons we have or how many paediatric nurses but we can't say whether collectively this adds up to a high quality service that meets the needs of children and their families, both today and tomorrow

Whilst continuing to put the basic building blocks in place to ensure we have the data to make better decisions we also want to pilot new and innovative methods for developing a workforce fit for the future. This will require partnership working with the medical and non-medical leadership as we move to a system that does not judge success by the percentage a particular profession grows or contracts but the extent to which we have the right skills and behaviours to meet the needs of patients whilst exploiting the opportunities presented by developments in science and technology.

To this end we will work with CfWI to pilot a new approach to workforce planning to see whether it is possible and useful to plan through the eyes of patients rather than the lens of the professional. We will begin this work in the New Year with a view to considering such an approach across the life cycle of an individual including vulnerable and older people. Our Strategic Advisory Forum will assess the workforce implications of seven day working and what this means in terms of future numbers, skills, values and behaviours.

We will set out more detail on our strategic ambitions for workforce planning in our Strategic Framework in the spring.

Section 10

Next steps

The Workforce Plan for England sets out our commissioning intentions in aggregate for 2014/15. Following HEE Board approval of the process and the investments, these will form the basis of the contracts that each LETB places with their local universities for the academic year beginning in September.

First round Medical recruitment begins	November 2013
Universities notified of non-medical commissions	December 2013
Higher Specialty Training recruitment	January 2014 onwards
Workforce Planning Guidance for 2015/16 published	February 2014
Local planning processes and triangulation	Spring 2014*
Plans start to be aggregated and triangulated at national level	Summer 2014*
Draft English aggregate position produced	September 2014*
2nd Workforce Plan for England published	Nov/Dec 2014*

*exact dates subject to final guidance.

Annex 1

Education & Training Commissions for 2014/15

Clinical Professional Education Programmes*:	2013/14 commissions	Planned 2014/15 Commissions	Increase/ Decrease	%
Pre-registration Nursing & Midwifery				
Adult Nurse	12134	13228	1094	9.0%
Children's Nurse	2151	2182	31	1.4%
Learning Disabilities Nurse	628	653	25	4.0%
Mental Health Nurse	3096	3143	47	1.5%
Midwives	2563	2563	0	0.0%
Pre-Degree Programmes	165	250	85	51.5%
Total - Pre-registration Nursing & Midwifery	**20737**	**22019**	**1882**	**6.2%**
Allied Health Professions				
Dietitian	329	336	7	2.1%
Occupational Therapist	1538	1523	-15	-1.0%
Physiotherapist	1488	1490	2	0.1%
Podiatrist	362	362	0	0.0%
Speech & Language Therapist	657	644	-13	-2.0%
Diagnostoc Radiographer	1051	1059	8	0.8%
Therapeutic Radiographer	360	371	11	3.1%
Paramedic	655	853	198	30.2%
Orthoptist	77	77	0	
Orthotists/Prosthetists	30	30	0	
Total - Allied Health Professions	6547	6745	198	**3.0%**
Other Scientific, Technical & Therapeutic				
Operating Dept. Practitioner	811	842	31	3.8%
Pharmacist pre-registration year	604	600	-4	-0.7%
Pharmacy Technician	292	300	8	2.7%
Clinical Psychologist	531	532	1	0.2%
IAPT - Psychological Wellbeing Practitioner (Low intensity)	474	436	-38	-8.0%
IAPT - High intensity practitioner	385	320	-65	-16.9%
Child Psychotherapist	41	41	0	
HCS Higher Specialist Scientific Training (HSST)	4	94	90	
HCS Scientist Training Programme (STP)	236	271	35	14.8%
HCS Practitioner Training Programme (PTP)	215	246	31	14.4%
Physicians Assistant	24	24	0	
Dental Nurses	451	455	4	0.9%
Dental Technicians	70	69	-1	-1.4%
Dental Hygienists	119	116	-3	-2.5%
Dental Therapists	115	118	3	2.6%
Total - Other Scientific, Technical & Therapeutic	**4372**	**4464**	**92**	**2.1%**
Specialist Nurse - Post Registration				
District Nursing	402	431	29	7.2%
School Nursing	192	198	6	3.1%
Practice Nursing	49	218	169	344.9%
Health Visiting	2787	1041	-1746	-62.6%
Total - Specialist Nurse - Post Registration	**3430**	**1888**	**-1542**	**-45.0%**
TOTAL Clinical Professional Training	35086	35116	30	0.1%
Less; Health Visiting	2787	1041	-1746	-62.6%
TOTAL Clinical Professional Education (excluding HV)	**32299**	**34075**	**1776**	**5.5%**

*excluding medical and dental (see following sheets)

Education & Training Commissions for 2014/15

Undergraduate Medical & Dental Education:	2013/14 commissions	Planned 2014/15 Commissions	Increase/ Decrease	%
Undergraduate Medical & Dental				
Undergraduate Medical	6071	6071	0	
Undergraduate Dental	899	899	0	
Total - Undergraduate Medical & Dental	**6970**	**6970**	**0**	**0.0%**

Post Graduate Medical & Dental Education:	Planned 2014/15 recruitment*	Number of training Posts	Increase/ Decrease	%
Foundation Training				
Medical Foundation Programme	6207	12485	82	0.7%
Dental Foundation Programme	978		0	
Total - Medical & Dental Foundation Programmes	**7185**	**12485**	**82**	**1.2%**
Core Training				
Acute Care Common Stem - Acute Medicine	62	210	2	1.0%
Acute Care Common Stem - Anaesthesia	174	316	6	1.9%
Acute Care Common Stem - Emergency Medicine	176	359	20	5.6%
Acute Care Common Stem - Intensive Care	0	145	0	
Core Anaesthetics Training	419	914	-13	-1.4%
Core Medical Training	1348	2487	23	0.9%
Core Psychiatry Training	560	1476	-26	-1.8%
Core Surgical Training	507	1268	-71	-5.6%
Broad Based Training (PILOT)	48	45	24	53.3%
Total - Core Training	3294	7220	-35	**-1.1%**
Run Through Training				
Paediatrics	540	2861	-2	-0.1%
Ophthalmology	99	549	-2	-0.4%
Neurosurgery	64	229	0	
Obstetrics and Gynaecology	233	1779	0	
Community Sexual and Reproductive Health	7	24	1	4.2%
Histopathology	108	492	0	
Chemical Pathology	18	70	0	
Diagnostic neuropathology	5	8	0	
Paediatric and perinatal pathology	5	9	0	
Forensic histopathology	1	2	0	
Medical Microbiology	39	198	0	
Medical Virology	10	13	0	
Clinical Radiology	239	1067	14	1.3%
General Practice	3099	8089	222	2.7%
Public Health Medicine	65	421	0	
Cardiothoracic Surgery (Pilot)	6		1	
Emergency Medicine (Pilot)	173		6	
OFMS (Pilot)	6		0	
Total - Run Through Training	**4717**	**15811**	**240**	**5.4%**
Dental Specialty Training				
Dental and Maxillofacial Radiology	3	4	0	
Oral and Maxillofacial Pathology	3	7	0	
Oral Microbiology	2		0	
Oral Medicine	3		0	
Orthodontics	66	175	0	
Restorative Dentistry	13	44	0	
Paediatric Dentistry	14	39	0	
Additional Dental Specialties	3	14	0	
Oral Surgery	10	22	0	
Endodontics	13		0	
Periodontics	13		0	
Prosthodontics	17		0	
Special Care Dentistry	8	16	0	
Dental Public Health	9	15	0	
Total - Dental Specialty Training	**177**	**336**	**0**	**0.0%**

*recruitment figures represent the maximum number of training opportunities available. Post may not be available if existing trainees do not complete there qualifiacation to the expected timetable

Education & Training Commissions for 2014/15

Post Graduate Medical & Dental Education:	Planned 2014/15 recruitment*	Number of training Posts	Increase/ Decrease	%
Higher Specialty Training				
Infectious Diseases	21	77	0	
Respiratory Medicine	125	490	0	
Dermatology	57	171	0	
Neurology	57	217	0	
Cardiology	106	539	0	
Rheumatology	51	211	0	
Genito-urinary Medicine	40	131	0	
Clinical Pharmacology and Therapeutics	10	35	0	
Geriatric Medicine	195	603	14	2.3%
Medical Oncology	47	132	0	
Clinical Neurophysiology	13	32	0	
Renal Medicine	52	247	-4	-1.6%
Nuclear Medicine	13	19	0	
Endocrinology and Diabetes Mellitus	99	332	0	
Gastroenterology	106	431	0	
Audio vestibular Medicine	9	18	0	
Clinical Genetics	21	53	0	
Clinical Oncology	56	260	0	
Tropical Medicine	0	0	0	
Allergy	11	11	0	
Acute Internal Medicine	123	360	0	
Haematology	97	317	0	
Immunology	17	33	0	
Rehabilitation Medicine	27	63	0	
Sport and Exercise Medicine	21	43	0	
Occupational Medicine	18	45	1	2.2%
Palliative Medicine	41	160	0	
Medical Ophthalmology	5	7	2	28.6%
Paediatric Cardiology	8	41	0	
Stroke Medicine	43	26	4	15.4%
Chemical Pathology (Metabolic Medicine)	3	68	0	
Sub Total - Medical Specialties Group	**1492**	**5172**	**17**	**1.2%**
General Surgery	159	1024	-8	-0.8%
Paediatric Surgery	19	97	0	
Otolaryngology	57	295	0	
Trauma and Orthopaedic Surgery	194	931	-2	-0.2%
Urology	66	265	0	
Plastic Surgery	56	256	0	
Cardio-thoracic surgery	31	129	-6	-4.7%
Vascular Surgery	22	7	4	57.1%
Oral and Maxillo-facial Surgery	39	138	0	
Sub Total - Surgical Specialties Group	**643**	**3142**	**-12**	**-1.8%**
Psychiatry of Learning Disability	37	93	2	2.2%
General Psychiatry	157	616	2	0.3%
Child and Adolescent Psychiatry	52	223	0	
Forensic Psychiatry	34	120	0	
Medical Psychotherapy	6	47	-2	-4.3%
Old Age Psychiatry	84	212	2	0.9%
Sub Total - Psychiatry Specialties Group	**370**	**1311**	**4**	**1.1%**
Anaesthetics	429	2150	-20	-0.9%
Intensive Care Medicine	93	214	10	4.7%
Emergency Medicine	298	634	0	
Total Higher Specialty Training	**3325**	**12623**	**-1**	**0.0%**
TOTAL Medical And Dental Education	**25668**	**55445**	**286**	**1.1%**

*recruitment figures represent the maximum number of training opportunities available. Post may not be available if existing trainees do not complete there qualifiacation to the expected timetable

Annex 2

Education & Training Commissions for 2014/15 - Assurance Assessment

Clinical Professional Education Programmes :	Current Workforce*	Estimated Output 2017/18**	Output as % of worforce it serves
Pre-registration Nursing & Midwifery			
Adult Nurse	208063	10840	5.2%
Children's Nurse	15877	1950	12.3%
Learning Disabilities Nurse	4515	460	10.2%
Mental Health Nurse	39198	2600	6.6%
Midwives	21396	2090	9.8%
Specialist Nurse - Post Registration			
District Nursing	6381	390	6.1%
School Nursing	1202	180	15.0%
Health Visiting	8911	780	8.8%
Allied Health Professions			
Dietitian	4116	290	7.0%
Occupational Therapist	14945	1240	8.3%
Physiotherapist	18723	1400	7.5%
Podiatrist	3065	270	8.8%
Speech & Language Therapist	6125	590	9.6%
Diagnostoc Radiographer	13147	910	6.9%
Therapeutic Radiographer	2509	290	11.6%
Paramedic	12751	770	6.0%
Orthoptist	1408	60	4.3%
Other Scientific, Technical & Therapeutic			
Operating Dept. Practitioner	7748	670	8.6%
Pharmacist pre-registration year	15054	540	3.6%
Pharmacy Technician	4637	280	6.0%
Clinical Psychologist	7107	520	7.3%
Child Psychotherapist	370	40	10.8%
Dental Care Professions	3247	680	20.9%
TOTAL	**420495**	**27840**	**6.6%**

*NHS employed workforce + Community Interest Companies using ESR - as at March 13 or September 12

** Output estimated using forecast attrition from 2013/4 due diligence exercise

Education & Training Commissions for 2014/15 - Assurance Assessment

Post Graduate Medical & Dental Education:	Consultant & GP Workforce Staff in Post Sept 2012	Estimated average annual CCT Output	Output as % of consultant workforce	Average annual forecast growth	Forecast Growth in Consultant Workforce to 2020
Higher Specialty Training					
Infectious Diseases	117	18	15.4%	11.0%	131%
Respiratory Medicine	746	112	15.0%	8.6%	93%
Dermatology	562	38	6.8%	2.8%	25%
Neurology	607	20	3.3%	2.8%	25%
Cardiology	1025	101	9.9%	5.5%	53%
Rheumatology	535	40	7.5%	2.9%	26%
Genito-urinary Medicine	361	29	8.0%	3.1%	28%
Clinical Pharmacology and Therapeutics	17	7	41.2%	18.3%	284%
Geriatric Medicine	1046	120	11.5%	6.5%	65%
Medical Oncology	319	28	8.8%	3.8%	35%
Clinical Neurophysiology	88	6	6.8%	1.0%	8%
Renal Medicine	453	51	11.3%	6.4%	64%
Nuclear Medicine	52	3	5.8%	0.0%	0%
Endocrinology and Diabetes Mellitus	540	63	11.7%	6.3%	63%
Gastroenterology	892	83	9.3%	4.9%	47%
Audio vestibular Medicine	46	3	6.5%	-	-4%
Clinical Genetics	128	12	9.4%	4.8%	45%
Clinical Oncology	588	75	12.8%	7.4%	77%
Allergy	11	2	18.2%	14.0%	186%
Acute Internal Medicine	104		0.0%	0.0%	
Haematology	700	67	9.6%	4.7%	44%
Immunology	72	6	8.3%	2.1%	18%
Rehabilitation Medicine	120	10	8.3%	1.7%	14%
Sport and Exercise Medicine	5	7	140.0%	38.2%	1233%
Occupational Medicine	91	9	9.9%	3.9%	36%
Palliative Medicine	276	38	13.8%	8.2%	88%
Medical Ophthalmology	6	1	16.7%	8.6%	94%
Paediatric Cardiology	86	7	8.1%	3.1%	28%
Chemical Pathology (Metabolic Medicine)	132	11	8.3%	1.4%	12%
Sub Total - Medical Specialties Group	**9725**	**967**	**9.9%**		
General Surgery	1990	159	8.0%	3.4%	31%
Paediatric Surgery	147	15	10.2%	5.5%	53%
Otolaryngology	580	44	7.6%	2.5%	22%
Trauma and Orthopaedic Surgery	2094	146	7.0%	2.8%	25%
Urology	660	46	7.0%	2.7%	24%
Plastic Surgery	366	41	11.2%	6.5%	66%
Cardio-thoracic surgery	321	14	4.4%	0.1%	1%
Oral and Maxillo-facial Surgery	297	22	7.4%	2.5%	22%
Sub Total - Surgical Specialties Group	**6455**	**487**	**7.5%**		
Psychiatry of Learning Disability	265	19	7.2%	2.9%	26%
General Psychiatry	2416	152	6.3%	2.4%	21%
Child and Adolescent Psychiatry	751	54	7.2%	3.0%	27%
Forensic Psychiatry	309	26	8.4%	4.7%	44%
Medical Psychotherapy	76	11	14.5%	6.9%	71%
Neurosurgery	240	20	8.3%	4.5%	42%
Old Age Psychiatry	650	53	8.2%	3.8%	35%
Sub Total - Psychiatry Specialties Group	**4707**	**335**	**7.1%**		
Anaesthetics	6026	414	6.9%	10.9%	128%
Emergency Medicine	1279	136	10.6%	6.1%	61%
Total Higher Specialty Training	**28192**	**2339**	**8.3%**		
Run Through Training					
Chemical Pathology	132	11	8.3%	1.4%	12%
Clinical Radiology	2570	163	6.3%	2.6%	23%
Community Sexual and Reproductive Health	44	2	4.5%		-
General Practice	36105	2418	6.7%	1.8%	15%
Histopathology	1248	71	5.7%	1.3%	11%
Medical Microbiology & Virology	56	35	62.5%	2.0%	17%
Neurosurgery	240	20	8.3%	2.8%	25%
Obstetrics and Gynaecology	1913	220	11.5%	6.2%	62%
Ophthalmology	1074	66	6.1%	1.9%	16%
Paediatrics	2638	313	11.9%	6.9%	70%
Public Health Medicine	756	53	7.0%	2.1%	18%
Total - Run Through Training	**48376**	**3522**	**7.3%**		
Total Training for Consultant & GP Supply	**76568**	**5861**	**7.7%**		

Annex 3

Organisations who responded to HEE's Workforce Planning Call for Evidence

- **Royal College of Speech and Language Therapists**
- **Society and College of Radiographers**
- **BMA**
- **British Association/College of Occupational Therapists**
- **Care Quality Commission**
- **College of Emergency Medicine**
- **Epsom and St Helier NHS Trust**
- **Haduma Limited**
- **Health Education England**
- **Medical Schools Council and Dental Schools Council**
- **Royal College of Physicians**
- **Oxford University Hospitals NHS Trust**
- **Royal College of General Practitioners**
- **Royal College of Nursing**
- **Royal College of Paediatrics and Child Health**
- **Royal College of Pathologists**
- **Royal College of Radiologists**
- **The British Association of Stroke Physicians (BASP)**
- **Royal College of Midwives**
- **University College London**
- **Whipps Cross University Hospital**

In total 35 responses were received from these organisations and individuals.

Annex 4

HEE Advisory Groups consulted on England wide workforce forecasts and initial Workforce Investment Plan for England

Nursing & Midwifery HEEAG:

- 4th October 2013
- 8th November 2013

Medical HEEAG:

- 11th September 2013
- 27th November 2013

Healthcare Science HEEAG:

- 6th November

Dental HEEAG:

- 3th November

AHP HEEAG*:

- 25th November

The overall workforce planning position was also discussed with Strategic Advisors Forum (SAF) and the medical workforce Advisors Group (MWAG)

*note: the full AHP HEEAG has not yet been established, so a meeting with the CPO and AHP leaders was convened especially to discuss 2013 Workforce Planning.

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