

*Developing people
for health and
healthcare*

Investing in people

for health and healthcare



Workforce Plan for England

Proposed Education and Training Commissions for 2015/16

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Foreword

Health Education England (HEE) exists for one reason only: to help improve the quality of care by ensuring our workforce has the right numbers, skills, values and behaviours to meet the needs of patients.

This, our second Workforce Plan for England, sets out the £5bn worth of investments we will make in education and training programmes that typically begin in September 2015. Overall, we are commissioning more education and training than ever before, with over 50,000 doctors in training and over 37,000 new training opportunities for nurses, scientists, and therapists. It is built upon the needs of local employers, providers, commissioners and other stakeholders who, as members of our Local Education and Training Boards (LETBs), have shaped the thirteen local plans that are the bedrock of this plan for England. This plan is overwhelmingly an aggregate of our local LETBs' plans, but we have further developed it to create a final national plan with the advice and input of our clinical advisory groups and Patient Advisory Forum, as well as the Royal Colleges and other stakeholders. It is this discussion and involvement locally and nationally that makes this a plan for the whole NHS.

The medical students who start university this September may not become consultants until 2028 by which time the whole pattern of service provision could have radically changed, as well as medicine itself. That is why earlier this year we published our fifteen year Strategic Framework (*Framework 15*), which provides a strategic look at the likely needs of future patients, as a guide to our long-term investments.¹

We have tested the thirteen local plans against our *Framework 15* and the recently published *Five Year Forward View*, which sets out a new ambition and new models of care for our NHS, both of which suggest radical changes in the workforce are required.

We have made huge progress in creating and implementing a national workforce planning process during our first two years, but we are still a system in transition. We are conscious that the decisions we make today will have a direct impact on patients and staff for generations to come. We are therefore committed to a culture of transparency and openness, to ensure that the investments we make result in better care for patients today and tomorrow. To this end, the Workforce Plan for England:

- Sets out clearly the education and training commissions we intend to make in 2015/16
- Explains how these decisions were made
- Provides the aggregate number of commissions for each profession and the trend increases and decreases within and between key groups
- Provides detailed analysis for a small number of priority areas and professions, setting out what we are doing to address immediate workforce pressures, the education and training commissions we are making for the future, and the actions we are taking to support further transformation
- Through our analysis, we surface the difficult issues the wider system will need to address together if we are to deliver the *Five Year Forward View* and our own *Framework 15*.

¹ http://hee.nhs.uk/wp-content/uploads/sites/321/2014/06/HEE_StrategicFramework15_final.pdf

This plan and the analysis and issues that it exposes will now form the basis for conversations at a local level through our LETBs and with our national partners through our new Workforce Advisory Board, as we work together to understand the workforce implications of the *Five Year Forward View*. As a matter of priority, we will seek consensus on where we might best invest our funds for workforce transformation to deliver the new models of care that will achieve the greatest patient benefit at scale and pace. The outcomes of these conversations will drive our investments in the existing workforce during this year as well as next year's Workforce Plan.

The *Five Year Forward View* provides a clear service vision and it is now our responsibility to develop an appropriate workforce to make that vision a reality.



Professor Ian Cumming OBE



Sir Keith Pearson JP DL

Executive summary

We are now in our second year as HEE, providing the NHS with a single organisation with a ring fenced budget for commissioning education and training places to secure the future workforce. Our LETBs, locally based and employer led, provide an important forum for local healthcare economies to come together to ensure that we have a workforce with the right numbers, skills, values and behaviours to meet the needs of patients.

Last year, for the first time we created a workforce planning process that allowed us to bring together into one place decisions about:

- Planning the future *medical* workforce
- Planning the future *non-medical* workforce
- Investment in the education and training of *existing* staff
- *Local* needs and *national* priorities
- National workforce priorities alongside *wider system/strategic goals*.

Historically, these five decisions were made in isolation from one another, leading to an imbalance of investment between the medical and non-medical workforce and the needs of our current and future staff. National priorities were often at variance with local needs and workforce planning was disconnected from the wider system.

In 2014/15 we published the first ever Workforce Plan for England, where we highlighted the fact that without a shared vision for the future models of care, our ability to commission the right workforce was considerably hampered. Earlier this year, HEE produced *Framework 15*, a strategy based upon the needs of future patients to inform our long-term investment decisions, and more recently, we worked with the rest of the system to produce the *Five Year Forward View*.

There is still much to do: our processes are new, our data collections not yet fully comprehensive, and there is more detailed work to be done to understand the workforce implications of the *Five Year Forward View*. But now that we have a clear vision for the NHS, we are able to use our levers and resources to help transform and improve services, so that when a patient turns to the health service for help, there are enough people with the right skills, values and behaviours to meet their needs.

Our commissions for 2015/16

Overall, we are commissioning more education and training than ever before, with over 50,000 doctors in training and over 37,000 new training opportunities for nurses, scientists, and therapists. In many ways this is a good thing. But there are three reasons why we cannot and should not continue historic levels of growth in all areas indefinitely:

- Firstly, planning the future workforce is more than just a numbers game. In order to ensure that future patient needs are met, we need to make sure that we have enough people with the right skills, values and behaviours available to work in the most appropriate setting for patients. The *Five Year Forward View* sets out new models of care that span both community and hospital settings. These models will require new skills and ways of working, and increasingly, we will need to commission new types of professionals, rather than just more of the same
- Secondly, we recognise that it takes approximately 14 years to train a consultant, 10 to train a GP and three years to train a newly qualified nurse. If the new models of care are to be delivered within the next five years, then we will need to invest much more in the skills of our existing staff, rather than spending all of our resource on future staff

- Thirdly, year-on-year growth may appear reassuring, but if growth continues unchecked in all professions, this could not only lock in current patterns of supply, and/or an over-supply of trained professionals in some areas, leading to highly skilled unemployed people. This is bad for our students and bad for the taxpayer and patients, as money spent on one training post means that it cannot be spent on another. As our 2015/16 financial allocation has been largely maintained at last year's level, we have a particular responsibility this year to ensure that every proposed commission can be justified.

Our commissions for 2015/16 are based upon the forecast needs of local employers that shaped and informed the thirteen LETB investment plans. It is HEE's statutory responsibility to ensure that the aggregate of thirteen local plans add up to a coherent plan for England, and that the plans enable us to deliver our Mandate and wider strategic objectives, amending where necessary.

Three key objectives underpin the investment decisions in our Workforce Plan for England 2015/16:

1. To respond to *immediate service pressures* by supporting employers to address current gaps in priority workforce areas wherever possible
2. To *maintain and expand the future workforce in priority areas*, as set out in our Mandate or in response to service concerns
3. To *invest in service transformation*, through the education and training of our existing workforce and the creation of new roles and/or new settings as required by our Mandate and the *Five Year Forward View*.

The first objective – responding to immediate workforce pressures – is not part of our statutory responsibilities, but this year our Board, with the support of partners across the system has decided to step into this leadership space in order to protect the patient interest. Below, we summarise the key investment decisions we have made in each priority area and the work we are doing with key partners to address issues now and in the future.

Primary care

We continue to grow GP numbers and expand the wider primary care workforce. We forecast that if our planned training levels are achieved, then the number of GPs available for employment would be 36,830FTE by 2020, an increase of 14.8% from the 32,075FTE recorded as being employed in September 2013. This is based on us achieving 3,100 new trainees in 2015 and an average of 3,250 new training GP commissions each year from 2016. We are working with our partners to strengthen our ability to recruit, retain and attract people back to this vital profession.

GPs only make up 16% of the primary and community care team (67% being nurses, 14% pharmacists, and 3% allied health professionals (AHPs)). Prior to the publication of the *Five Year Forward View*, our initial analysis suggests that there is enough planned supply to support modest growth in the wider primary care workforce. Further work now needs to be done to test whether this is sufficient growth to deliver the new models of care, and to better understand the future workforce requirements in primary care. HEE has established an independent Primary Care Workforce Commission chaired by Professor Martin Roland. This will consider how we develop the wider workforce for primary care requirements and what innovative practices can tell us about supporting the future models of primary care. It will report in June 2015 and will inform our commissions for 2016/17.

Although we are training enough nurses to work in both acute and community settings, employers tell us that the post-Francis expansion in acute based nursing means that nurses are not moving from secondary to community care at the rate previously observed. We have established a Transforming Primary and Community Nursing programme with NHSE to identify what further actions we can take as a system to ensure sufficient jobs are created in the community and that individuals are incentivised and supported to choose them.

Emergency care

There have been significant successes in the development of the Emergency Care workforce: growth in the number of consultants is amongst the highest of any speciality, yet still the service has struggled to keep pace with demand. These problems are not due to insufficient commissioning of education and training places, but rather more deep-seated problems with attracting and retaining people to the professions and to the increasing demands in this part of the service.

Between 2003 and 2013, the number of emergency medicine consultants grew by 142% (776FTE more consultants). Yet until 2014, only 60% of funded posts were being filled, as doctors chose other specialities instead. In order to increase the pool of supply, last year we worked with the College of Emergency Medicine to expand the emergency medicine branch of the Acute Care Common Stem programme (ACCS) and established a 'run through' pilot for specialty training. We developed a mechanism whereby doctors working in other clinical areas can transfer into emergency medicine with their skills recognised and progress more quickly through the early years of emergency medicine training. These actions are now having a positive impact on the system, and we are now achieving a 98% fill rate.

Our analysis suggests that current provider forecasts may be underestimating the future demand for emergency medicine, but the action we have taken so far will put us back on track to fill higher training posts in EM from 2019. Meanwhile, we will continue to work with the College of Emergency Medicine and NHS England to support employers with immediate service pressures, and we are confident we will be back on track for Certificate of Completion of Training (CCT) posts in emergency medicine from 2019 and able to produce further expansion should it be required.

Paramedics play a vital role across both urgent and emergency care and are increasingly becoming employed within the primary care environment. HEE have led a major piece of work in the last 12 months stemming from the Paramedic Evidence Based Education Project

(PEEP), which recommended the introduction of a single point of education entry at degree level for paramedic training. This work is being carried out with the full support of the Ambulance Association and the College of Paramedics and we are working closely with the three devolved nations to ensure this becomes a three nation initiative. We have also made a significant investment in paramedic training – a 87% increase over two years, providing for 1,902FTE growth in available supply over the next five years.

These additional commissions, however, will not produce qualified paramedics until 2016/17, and our forecasts suggest a potential gap between demand and supply in the coming year. We have therefore recommended that paramedics are placed on the Government's Shortage Occupation List, and HEE will work with ambulance leaders and wider system partners to discuss our data (which only covers the NHS) and agree action to ensure sufficient supply in advance of our new trainees qualifying.

In addition to the more traditional elements of emergency medicine, we are committed to recognising the contribution of healthcare scientists in emergency care and improve the planning for this professional group.

Mental health and learning disabilities

HEE supports parity of practice for those with mental health and learning disabilities, and has a major programme of work covering the development and transformation of the multi-professional workforce.

This year, our forecast for the mental health workforce describes a mixed picture. There are areas where significant increases have been made, for example, following a national policy commitment by the Government, we have produced a phenomenal increase in the Improving Access to Psychological Therapies (IAPT) workforce. We will commission an additional 190 this year (25% increase) which will contribute to a 1,548FTE growth in available supply (41%) over the next three years. We will commission an additional 100 training posts for mental health

nurses in 15/16 (3% increase) contributing to a forecast growth in available supply of 2,630FTE (6.8%) over the next five years. This continued high level of training will allow for rapid growth over the next two years with more moderate growth from 2017, as a result of the ageing profile of this workforce.

Mental health service providers have forecast a reduced requirement for mental health nursing, but it is unclear to what extent this apparent reduction in 'demand' is the result of shifting employment patterns as opposed to affordability assumptions. The forecasts were collected from service providers before the recent policy announcements designed to ensure parity of esteem with physical health services. We have therefore chosen to endorse the overall rate of increase in mental health nursing proposed by our LETBs, rather than follow the more pessimistic demand line from providers.

The psychiatry workforce is divided into six specialties, and the main issue for all groups is that whilst the number of training posts should support significant growth, levels of low fill rate at Higher Specialist Training is now threatening this potential growth. Unless a different approach is taken, we will have insufficient supply to meet demand. HEE has been working with the Royal College of Psychiatrists over the past year looking at how we can both encourage UK graduates into the specialty and how we improve the transition from core training into higher training in the specialties.

The picture for learning disability nurses is more mixed. Service providers are currently forecasting a decreased requirement, so at face value, the total additional supply needed to meet this forecast need is 0.4%. Some of this decreased demand may be accounted for by a shift of activity to non-NHS providers, but we are concerned that these forecasts may be overly influenced by affordability issues, and insufficiently aligned with the recent Bubb report. We therefore plan to increase commissions by 1.7% this year. In the context of historic growth, this should be more than sufficient to meet patient needs, but we will work with NHSE to understand their future service intentions, and to what extent any apparent 'decline' actually

represents changing sectors of employment (i.e. independent and social care sectors) rather than what is needed to deliver future models of care.

Nursing

Last year, we significantly increased the number of commissions we made for adult nursing over and above local plans, representing a 9% increase on the previous year. For 2015/16, we plan to continue the growth in nursing numbers to meet safe staffing levels by commissioning 555 additional training posts, a further increase of 4.2%. This means in the two years of HEE we will have grown adult nursing training places by 13.6%. The adult nursing programme produces registered nurses in both community and acute settings, and although our plans suggest the overall level of supply should be sufficient to meet needs in both sectors, this is based upon the minimum requirements of the Transforming Primary Care strategy. We now need to work with NHSE and other partners to understand the implications of the *Five Year Forward View* for the wider primary care workforce, including nursing.

Our forecasting also indicates that unless additional action is taken by commissioners and providers, nursing in the acute sector may grow at the community's expense. The planning process for the new care models to integrate acute and community care will present an opportunity for us to further test our supply assumptions and develop processes to ensure patients receive nursing care in the most appropriate setting.

The additional nurses that we commissioned last year will not be available to the system until 2017, and we know that although National Institute for Health and Care Excellence (NICE) guidance recommends a maximum vacancy rate of 5% for nursing, Trusts are currently reporting a vacancy rate of 6.5%. Although HEE is technically only responsible for securing the future workforce, in the interests of patient safety we decided to lead a Return to Practice (RTP) campaign for nurses in partnership with the rest of the system, including NHS Employers. This campaign has been a huge success, and we have invested £1.5m in funding approximately 90 RTP courses that has already yielded an additional 779 trainees available for

employment now, at a cost of £2,000 compared to the £51,000 it takes to train a newly qualified nurse. Employers now have a responsibility to retain and develop the additional nurses we have supplied through the RTP programme, and we will work with local employers and their national representatives to understand how we might support them further.

We will increase children's nurse commissions in 2015/16 by 161 (7.4%). This training is forecast to produce 5,876FTE growth in available supply by 2019, a 35.6% increase in this workforce, which should be sufficient to meet anticipated patient need in acute settings. However, we need to do more work with NHSE and others to understand the extent to which these services are expected to shift to the community, and revisit our supply forecasts accordingly. We also need to understand why many graduating staff do not appear to be working in children's services. Providers have told us that there is a shortage of senior specialist children's nursing roles (which is currently an employer responsibility), and so we will work with NHS Employers and other partners to undertake a review of children's nursing and proposals for how the system might address this going forward.

We are also investing in a rapid expansion of key areas such as practice nurses, district and school nurses to support the shift to greater care in the community and the delivery of the wider public health agenda.

Public Health

The public health workforce underwent a radical re-organisation last year, and we have worked with Public Health England (PHE) to better understand its needs for the specialist workforce. Planning the future of this workforce and tracking its movement has become more complex following the transfer of specialists to local authorities, but we are working with the Local Government Association (LGA), PHE, and the Faculty of Public Health to ensure our training can be matched to current and future needs. This year, we plan to maintain our investment in Public Health Medicine training posts by commissioning a maximum of 421 posts.

Over the past four years we increased Health Visitor commissions by 400%, putting us on track to deliver our Mandate target of new graduates so that providers can employ 12,292FTE Health Visitors by April 2015. We also plan to commission 340 training places for school nurses, representing a 71.7% increase on last year, in order to support increased provider demand, all of whom will make important contributions to the health of the general population.

The *Five Year Forward View* makes it clear that the public's health will be a key priority for the NHS in the future, and we will work with PHE and other stakeholders to better understand the wider workforce implications of this approach. We will also look at how we can use our levers to drive improvements in health, including looking at the curricula for undergraduates and the settings in which they are trained so that our future workforce is equipped to proactively manage health rather than just respond to ill health and disease.

Service transformation

We know that in order to improve the quality of care to patients, the NHS needs to change. But the NHS is delivered by people not buildings and so if we want to transform the NHS, then we will have to transform the way we educate, employ and deploy our people. Sometimes we can drive service transformation through the rapid expansion of existing roles (such as health visitors – a 400% increase in trainees over the past four years, or school nurses – a 71% increase this year). Sometimes transformation can be achieved through encouraging commissioners and employers to create jobs for staff in different locations – such as increasing community based nursing.

But increasingly, we will need to invest in entirely new roles and professions, such as physicians associates (PAs), to help deliver more holistic care across different teams and settings. This year, we will commission 205 PAs training posts, representing a 754% increase on last year. PAs are trained to perform a number of duties, including taking medical histories, performing examinations, diagnosing illnesses, analysing test results and developing management plans. So by 2017, we expect to see real improvements

in patient care, particularly in emergency care, general adult medicine and general practice. We will also commission 108 Broad Based Training Pilots for doctors, representing a 50% increase on last year, to provide a more flexible workforce with general skills, to ensure that a proportion of doctors have a better generalist knowledge and hence are better equipped to deliver the future needs of patients.

Service innovation will be driven not just by what training posts we commission, but how our students and trainees are educated. That is why we have delivered major changes to the Foundation Programme this year, so that more trainees now spend more of their training time in the community. We will continue to increase the number of placements outside of acute settings and encourage more community and primary care based training, whilst exploring ways to support more flexible and dynamic education and training, so that, for instance, post registration programmes enable nurses to look after the whole person, including psychiatry, mental health and the physical therapies.

However, whilst it is important to create and invest in new roles, we recognise that the existing workforce will make up the majority of the future workforce. At any one time there are about 140,000 students in training, compared to the 1.3m existing staff who will still be working ten, twenty and thirty years from now. The way to drive transformation at scale and pace is through investing in our current workforce. We recognise that the education and training of our existing staff is primarily an employer responsibility, but in addition to this, £0.2bn of HEE's £5bn budget is allocated for the education and training of existing staff to support service transformation. Historically, this spend has been vulnerable to the needs of the future workforce. This year, we have taken steps to protect this vital investment to reflect the ambitions we set out in our *Framework 15*, and the challenges of the *Five Year Forward View*. We recognise the complexity and inter-connectedness of these decisions, as the junior doctors currently in training to be future consultants provide much of the care today.

Going forward, we will seek advice from our LETBs, stakeholders and the Workforce Advisory Board to ensure that we invest in those areas likely to deliver the greatest transformation, whilst continuing to provide high quality care for patients. We will explore more innovative approaches to post-registration education to enable the non-medical workforce to realise local ambitions.

This report is necessarily only concerned with the education and training commissions we will place with higher education institutions; we will set out our wider ambitions for workforce transformation later this year, as part of delivering the *Five Year Forward View*.

Investment choices

Our Workforce Plan for England for 2015/16 has three objectives: to support the service to address immediate gaps in key workforce areas; to expand the future workforce in priority areas, whilst securing our investment in the existing workforce to help drive service transformation. To achieve these three ambitions within a finite budget that has been maintained at 2014/15 levels, we have taken two clear decisions:

1. Over the past decade, the consultant medical workforce has grown by 48.1%. As always, we have had to make difficult decisions about where to invest, and in 2015/16, we have chosen to invest in our priority areas which will mean that non-priority areas will not have additional investment in new training posts. This will only affect 13 medical and dental specialties for one year whilst we undertake a thorough review of the future medical workforce requirements in the light of *Five Year Forward View* and *Shape of Training*. This decision does not represent a 'cut'; it just means no additional growth – growth that would not have produced new consultants until 2020 at the earliest. Where there is demonstrable need in a specialty, we believe HEE should act decisively and at scale rather than the current 'sticking plaster' approach evidenced by minor year-on-year increases. This is the intention and purpose of the structured reviews we will lead.

2. We have taken a pragmatic approach to areas where training posts in particular specialties have historically proved difficult to fill. Rather than simply keeping the posts open year after year and thereby implying additional growth that never actually materialises, we have accepted the proposals from some LETBs to use that resource for investing in priority areas this year. This apparent reduction in the numbers of trainees is not an actual reduction in growth: this represents greater transparency about how we can use public money to invest in our priorities. Where there are low fill-rates in parts of the profession, HEE will lead a review so that next year and beyond we can begin to understand and address the underlying root causes and ensure that patient needs are met.

Protecting our investment in our existing workforce

The benefits of creating one organisation with one workforce planning process which brings together the local and the national, the provider and the commissioner, the current and the future, and the medical and non-medical, is that we can make informed decisions based on real evidence and the views of the many.

Our planning process identified that some plans to increase the future workforce were being made at the expense of the current workforce – our initial aggregate position suggested an £11 million reduction in our £0.2bn budget to support the education and training of the existing workforce. Yet we know that only 140,000 people are in education and training at any time; if we wish to transform the workforce and thereby the models of care, then we have to invest more in the 1.3m staff who currently work in the NHS. Our Mandate, our *Framework 15* and the *Five Year Forward View*, all recognise that we need to invest more, not less, investment in our existing workforce. This was a view supported by many of our advisory groups, especially our Patients' Advisory Forum. We have therefore protected our investment in the current workforce by maintaining growth of a small number of medical specialities at last year's levels and releasing funds from historically unfilled training places.

The numbers and specialties affected may be small, but our action represents an important signal that the future shape, skills and distribution of our workforce must change. Working with partners, we will use our levers to help shape the health service around the needs of patients, rather than just roll forward what has historically been a supply driven system. We recognise that our decision will not be popular with everyone, but a failure to act now would mean that once again tough choices are placed in the 'too difficult' box, with missed opportunities to improve patient care today and tomorrow.

Next steps

The Workforce Plan for England forms the basis for the recruitment process to postgraduate medical training posts and our contracts with HEIs, who will deliver the agreed number of education places commencing in September 2015. All universities will be expected to ensure that, as a part of the selection process for NHS funded courses, successful candidates are assessed against the values of the NHS Constitution through a structured face-to-face interview, so that we can ensure that we are investing in not just numbers, but staff with the right values and behaviours to deliver care to patients. This is not just a bureaucratic requirement; it is a genuine response to the Francis Report, by ensuring that all of our staff are able to provide patients with the dignity, respect and compassion that they deserve.

During 2015, we will work with our partners to:

- Through the *Shape of Training* and *Shape of Caring* and other programmes, we will look at the structure of training, including the cause of low-fill rates in key professions such as GPs; core psychiatry training; geriatrics; learning disability and community based nursing; professional development programmes for nurses; IAPT high intensity, and consider the most appropriate actions to improve patient care
- Work with employers and commissioners and other national organisations to consider how we might use NHS Careers and other levers to attract people to work in community based and primary care settings in order to meet the changing needs of the population

- Continue to support the service to recruit trainees, retain existing staff and attract returners in key areas such as emergency medicine, nursing and GP, with a new focus on paramedics, and in primary and community care settings, in order to deliver the new care models
- Work with our LETBs, national advisory groups and the Workforce Advisory Board to understand the workforce implications of the new care models in the *Five Year Forward View*, so we can support service transformation at scale and pace through more targeted investment in our existing workforce, as well as commissioning new roles for the future
- Continue to deliver on our fifteen year ambition to build a workforce shaped around the needs of patients, as set out in our *Framework 15*. We will progress this work through our *Shape of Caring* and *Shape of Training* programmes, and through piloting a 'life cycle' approach to workforce planning, starting with children and young people's services.

In early 2015 we will publish our workforce planning guidance for education and training commissions for September 2016, where we will describe the standardised planning process we will adopt that will yield shared supply and demand assumptions and better workforce planning.

In the period to June 2015 we will develop our analysis and engage with LETBs and stakeholders in evidence based conversations in order to describe clear national priorities that we expect to see addressed in local plans, based upon the ambitions in the *Five Year Forward View* and the requirements of our Mandate. During this process we will signal those areas where we feel decommissioning may be justified, allowing greater investment in priority areas and transformation to ensure action is taken as a result.

Throughout the year we will continue to share workforce data with national bodies to support managerial intervention and action, rather than just informing our commissioning process. We will explore the use of alerts if it becomes apparent there may be a significant variance between demand and supply, so that employers can act quickly to ensure that patient needs are met.

We will take a national approach to a number of medical specialties where either the workforce or the training numbers are of a size where it is not practical to commission at LETB level, or where there is a need to drive transformation and innovation.

What we need others to do

There is increasing recognition of the importance of our workforce; the *Five Year Forward View* makes it clear that the new models of care simply won't become a reality without the people to deliver them. We now need to work with our partners through the Workforce Advisory Board to encourage:

- Employers to provide robust workforce forecasts to LETBs. These form the basic building blocks of our national plan, so the higher quality they are the better the overall plan. Every CEO needs to be engaged in this process, ensuring alignment with commissioning and provision plans and plans to implement the new care models, with workforce forecasts signed off by their medical and nursing director
- Employers and commissioners to create jobs in the right settings so that the staff we train are able to realise and deliver the policy intent of *Five Year Forward View*, rather than perpetuate an imbalance between community and acute sectors
- Employer and professional bodies to work with HEE and our LETBs on data sharing so that patients receive care from staff employed by a range of different sectors and bodies: the NHS, social care, the independent and charitable sectors. Currently, we only have access to data on staff employed in the NHS, which means we have an incomplete picture of supply
- Greater employer focus on retaining and investing in their current staff. It is our responsibility to commission education and training places to secure the supply of the future workforce, but it is becoming apparent that in some areas, requests for more commissions are due to a 'leaky bucket' effect, whereby employers are failing to retain and develop their skilled staff. Commissioning more trainees is the most time consuming and

expensive way to address shortages in supply. Attracting people back to the profession is more cost-effective, but the most effective approach of all would be to retain and develop their employees. We will work with NHS Employers and other partners to develop a more strategic and cost-effective approach to staff retention

- Patient groups, Royal Colleges and other stakeholders to work with us on reshaping the workforce. Although this plan is necessarily concerned with numbers, we know that more of the same simply won't deliver the transformed services that patients need. As set out in our *Framework 15*, we need a more flexible, adaptable workforce, able to work across professional boundaries and settings, so that they can provide high quality care wherever and whenever the patient needs help. This will require the creation and/or expansion of new roles, and active decommissioning of others, if we are to develop a workforce planning process shaped by patients' needs rather than supply
- Continued support for a shared vision and aligned planning and action. The most important development this year has been the development of a shared NHS view of the future. The *Five Year Forward View* provides a clear service vision, and it is now our responsibility to develop an appropriate workforce to make that vision a reality.



Section 1

Securing supply

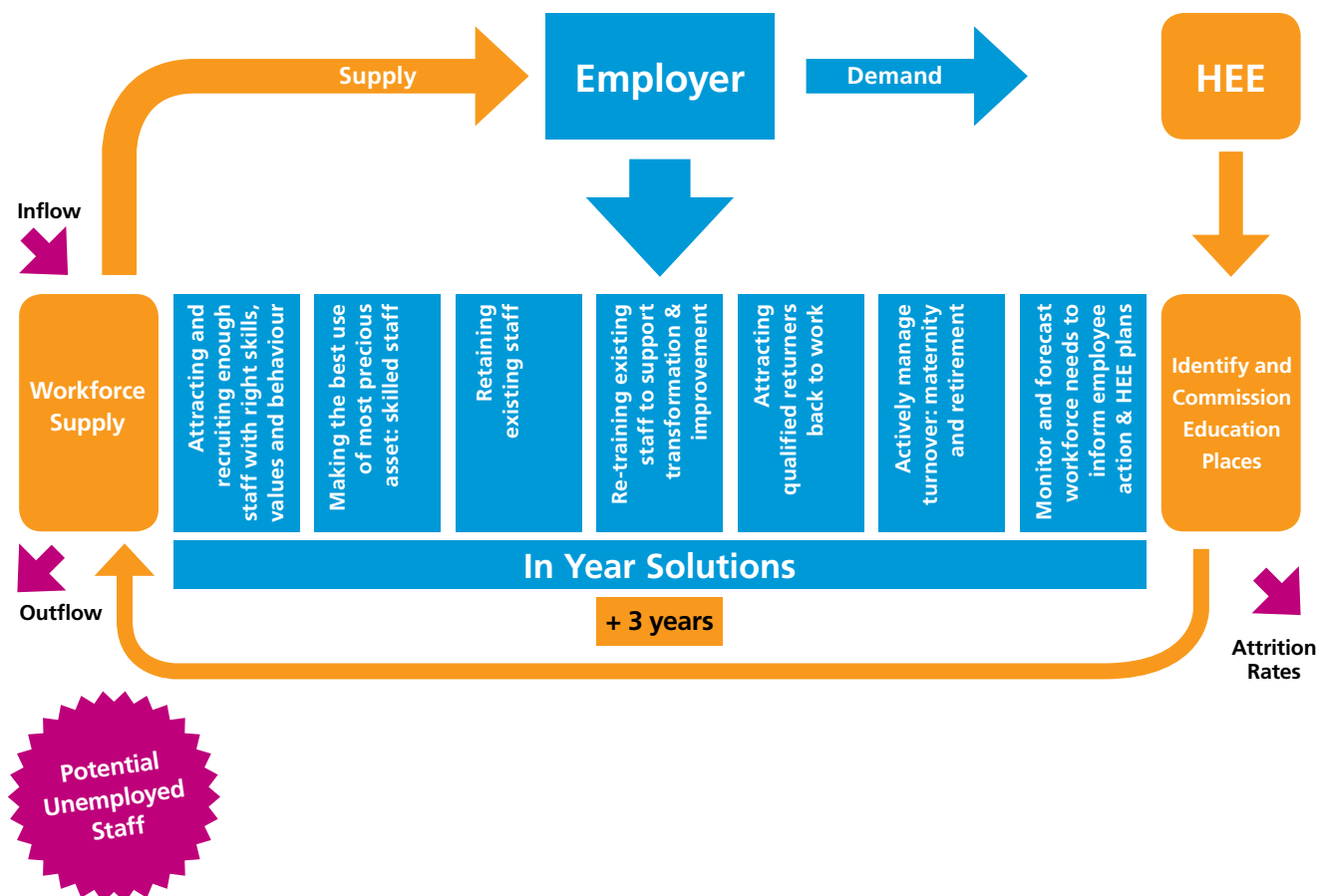
Our job at HEE is to ensure that when a patient turns to the health service for help, there is a trained person with the right skills and behaviours ready to meet their needs. Two simple actions are required to ensure that the right staff are available to patients when they need them:

1. Enough jobs must be created in the right place to deliver the care required (demand)
2. Enough staff with the right skills and behaviours must be available to fill the jobs created (supply)

Providers and commissioners are responsible for the first action. But there are two ways to meet the supply required: the existing 1.3m workforce can be re-trained (an employer responsibility) or new and additional posts can be created. In reality, both of these approaches are required to ensure adequate supply. But whilst HEE has a small budget to support the development of existing staff to help drive service transformation, it is our primary responsibility to commission education and training places to ensure sufficient future supply to fill new posts.



Securing Supply



In the diagram above, HEE’s statutory responsibilities are represented by the orange boxes. Taking nursing as an example, when there is a shortage of nurses on the wards HEE can respond to this gap by commissioning more training posts for nurses – but it takes three years to train a newly qualified nurse, at a cost of £51,000. Alternatively, employers can take steps to attract back staff who have left previously, or re-train their existing staff, which are faster, more cost-effective ways of increasing supply. Of course, the ideal situation would be to increase retention rates and reduce the gap between demand and supply in the first place.

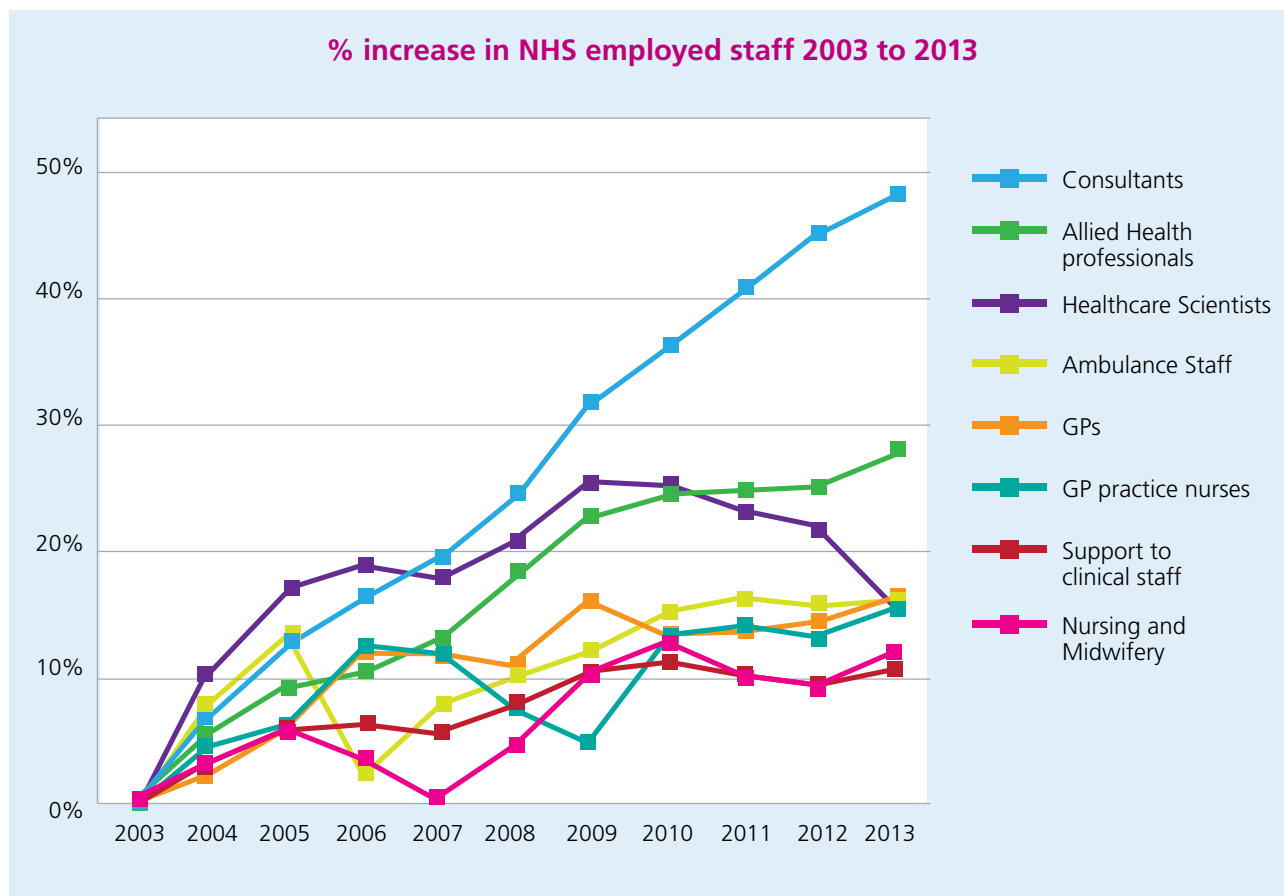
The prime focus of our workforce plan is to set out the commissions we will place with higher education institutions to provide new supply for the future workforce, but we are increasingly going beyond our statutory responsibilities to play a leadership role in the blue areas, as we recognise the importance of getting this right for patients and taxpayers. This includes work with the College of Emergency Medicine (CEM) on supporting A&E; our campaign with NHS Employers, NHS Trust Development Authority (NTDA) and Monitor and Royal College of Nursing (RCN) to encourage nurses to return to work; and more recently our work with NHS England and the Royal College of GPs to improve recruitment, retention and attract returners back to this vital profession.

Section 2

Strategic context

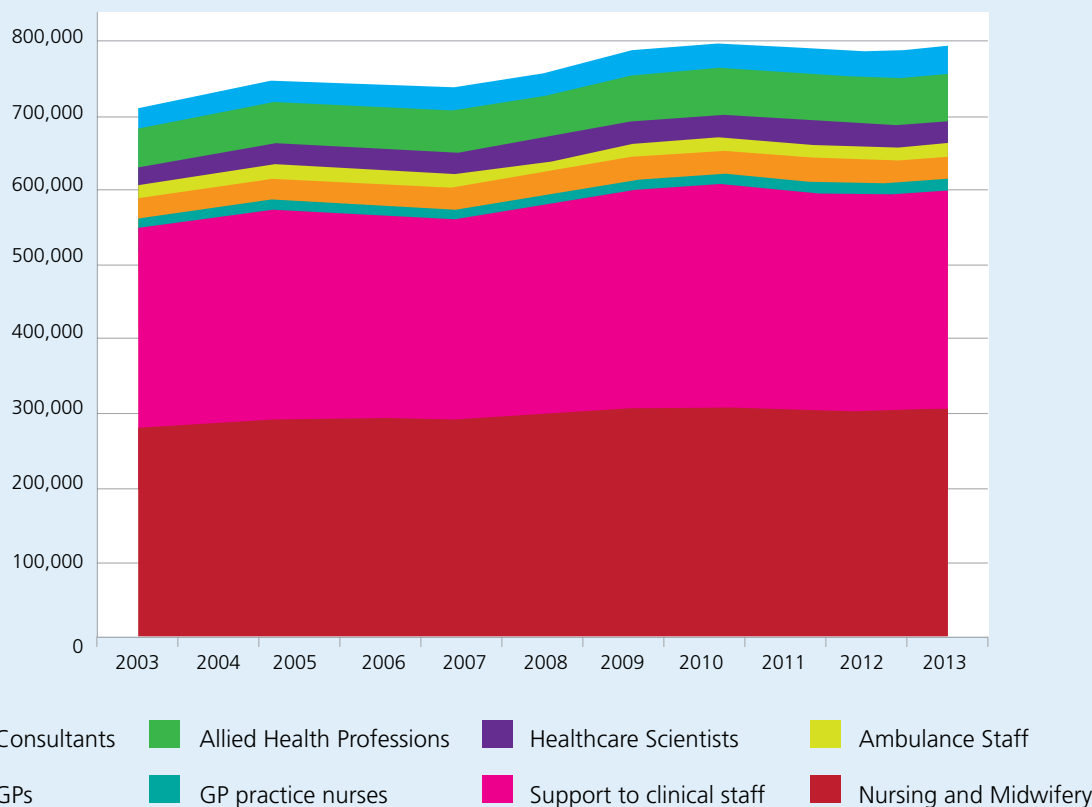
The 'bucket' may be leaking but it is far from empty. Before we set out what additional commissions we need to make for the future, we need to consider what already exists: the overall shape of the existing workforce.

There are currently over 1.3m staff working in over 300 different jobs, with over 140,000 people in education and training at any one time. The graphs below set out workforce trends between 2003 and 2013 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 and midwifery, for instance, the 11% increase represents over 29,600FTE, whereas the 48.1% increase in consultants represents 12,700FTE. The graph on page 17 shows the size of each group.

Workforce Trends 2003 to 2013 - Full Time Equivalent



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 nearly 50% (although the UK still remains below other nations in terms of number of doctors per 1,000 population)
- Until recently, qualified nursing and midwifery staff grew the least, by 11% over the period representing 29,689FTE 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.

These graphs also pose important questions for the wider health system: did we mean to do this? Whereas there may have been justified intent behind each individual decision, prior to the creation of HEE the planning system simply did not allow our workforce investments to be considered in this way.

The workforce planning process prior to 2012:

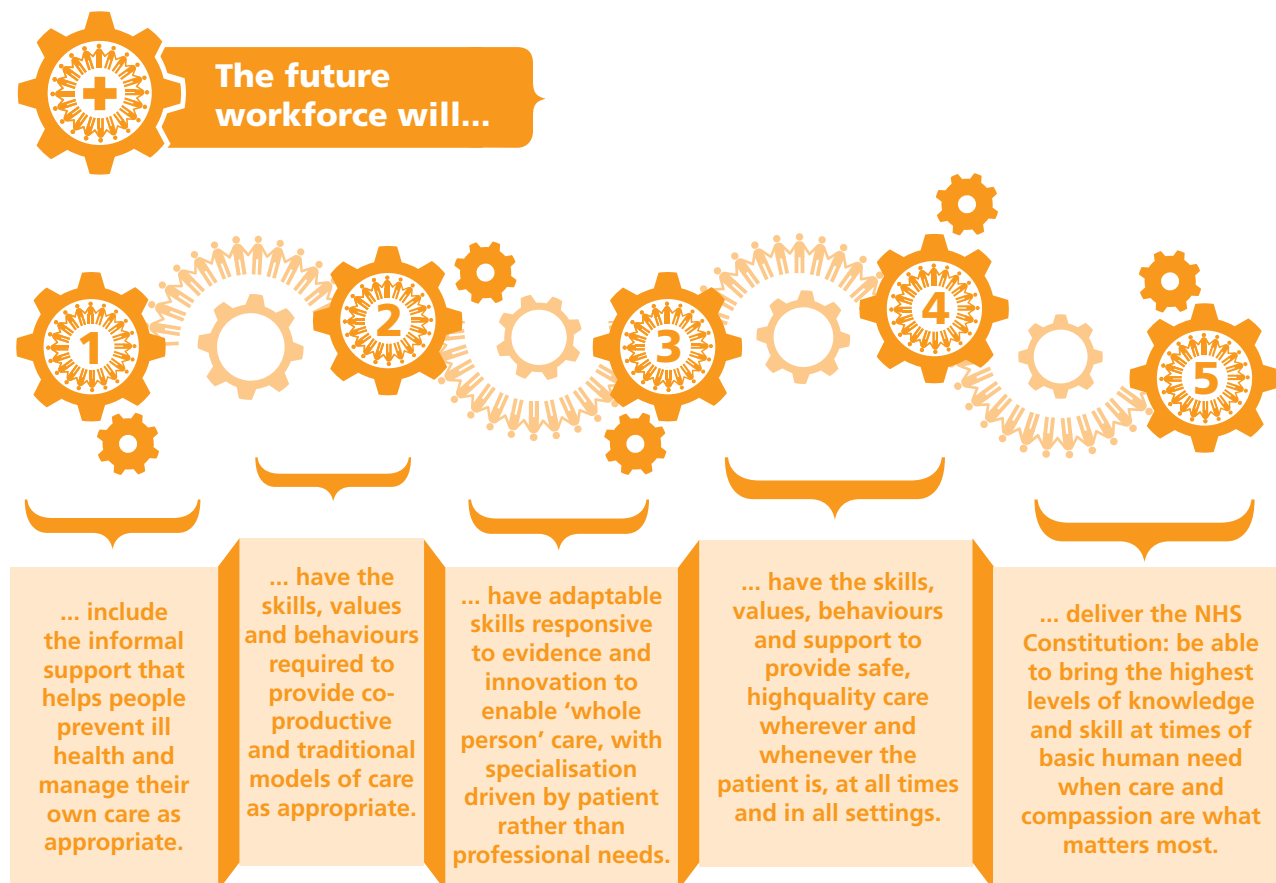
- The money for education and training was not 'ring fenced', so investments in the needs of tomorrow were vulnerable to the needs of today
- Led by ten Strategic Health Authorities, with ten different demand and supply assumptions, with no publicly available national plan for England, leading to a lack of transparency and missed opportunities for strategic alignment with wider system goals
- The planning processes for postgraduate medical (doctors) and undergraduate non-medical (e.g. nurses and AHPs) happened in isolation with the former being decided nationally and the latter locally
- Postgraduate medical numbers were decided first, reducing the opportunity to consider the relative priorities across all parts of the workforce
- Any investments in the development of existing staff was considered only after money had been committed to new medical and non-medical commissions
- Local concerns and service pressures not always aligned with national workforce priorities.

The creation of a national workforce planning process, informed by local employers and commissioners through our LETBs, has allowed us to address many of these issues. We now have a single process that connects the local with national, bringing together decisions about the medical and non-medical workforce, and the relative investment between existing and new staff in one place.

However we flagged in our first *Workforce Plan* in 2013, our ability to ensure our plans meet the needs of future patients was hampered by the absence of a clear strategy or vision for future NHS services: we had a shared process, but no shared purpose to serve. This gap has now been filled by our own *Framework 15*, which provides a clear line of sight to the likely needs of future patients over the next fifteen years, and the *Five Year Forward View*, which sets out a vision of where the NHS needs to be by the end of the next Parliamentary term. Whilst the *Five Year Forward View* was published too late to inform our local planning process this year, it provides a clear strategic direction against which our current and future plans can be assessed, and will form the basis of our planning process next year.



5 Workforce characteristics required for the future



In *Framework 15*, we identified the five characteristics of the future workforce based upon the needs of future patients. We now need to put these alongside the service vision set out in the *Five Year Forward View*, and translate them into new roles and training programmes that we can commission to help deliver the new models of care.



Section 3

HEE's workforce planning process for 2015/16

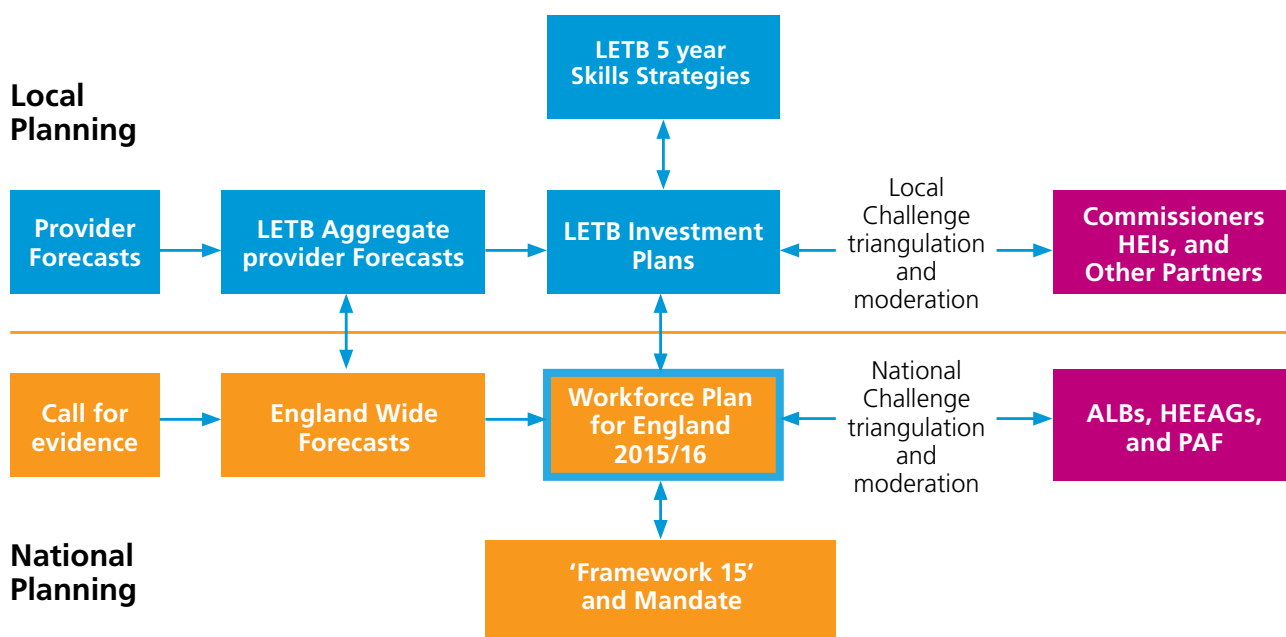
HEE now leads and coordinates the investment in the healthcare workforce in England informed by local and national expertise and intelligence with greater employer input than ever before. Our 2014/15 planning guidance for 2015/16 education commissions² built on the lessons we learned from our first planning round in respect of processes and timescales, but also in terms of roles.

The Board of HEE is accountable for signing off almost £5bn of investment in the education and development of the workforce each year. Our

executive brings together the national and local perspectives. This forum has responsibility for ensuring that the 13 LETB workforce investment plans add up to a coherent plan for England that will deliver our agreed priorities, as set out in the Mandate from the Government, and drive the service improvement and transformation required by patients.

This process rests on coherent local planning at health economy level and constructive challenge at local and national level.

HEE Workforce Planning Process 2014



²<http://hee.nhs.uk/wp-content/uploads/sites/321/2014/04/Workforce-planning-guidance-2014-15.pdf>

LETB level process

The role of LETBs – our local committees - is to diagnose what is needed on the ground and use this to develop locally assured initial investment plans. Our local presence is essential in understanding the local landscape of commissioning and provision (including providers beyond the conventional NHS ‘family’ of Foundation Trusts and Trusts) in order to triangulate, challenge and modify plans to produce LETB-level forecasts as the basis of HEE’s investment. In 2014 each NHS 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. The questions were asked in a standard format and in 2014, for the first time HEE asked providers detailed questions about the composition of and future demand for the medical workforce and healthcare science workforce at specialty level.

LETBs held local ‘Challenge and Review’ sessions with employers and commissioners to ensure that forecasts aligned 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 and in HEE’s *Framework 15*
- The workforce needs of future transformed services rather than just as currently configured and delivered.

HEE and our LETBs assess three main variables when deciding how much newly qualified training supply the system will need in future and consequently how much training to commission today. The range of variables that we consider is set out more fully at [Annex 4](#), and includes:

- The level of available supply - staff turnover versus newly qualified supply
- The level of future demand – including population need versus funded demand
- The impact of any current supply shortage - including the immediate actions of employers to address these.

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 national guidance.

National process

This local process was mirrored at national level where HEE works through the formal HEE Advisory Group structures and bilateral meetings with key system partners and stakeholders to expose, explore and test the initial plans. A key development in 2014 was the publication of NHS England’s *Five Year Forward View*³ in October – too late to influence LETB initial plans but a key consideration for HEE’s executive in planning 2016/17 commissions. *The Forward View* has exerted some influence in HEE’s final plan this year, and will be an explicit driver of the guidance HEE provides to LETBs in 2015 for 2016 commissions.



³ <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

Bringing the plans together

HEE has three national workforce planning roles:

- 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
- to lead national workforce planning for a small number of areas where the current characteristics warrant a nationwide approach
- 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.

In producing our second Workforce Plan for England HEE has:

- Assessed each LETB plan and sought assurances on the degree of local engagement and alignment
- Discussed the aggregate position within our new executive and with the HEE Board
- Sought advice and input from stakeholders through a national 'call for evidence'
- Discussed emerging trends and themes with national stakeholders
- Sought ongoing advice from key professional groups through HEE Advisory Groups
- Held bilateral meetings with stakeholders to discuss key emerging issues.

The year ahead

During the next planning round HEE will:

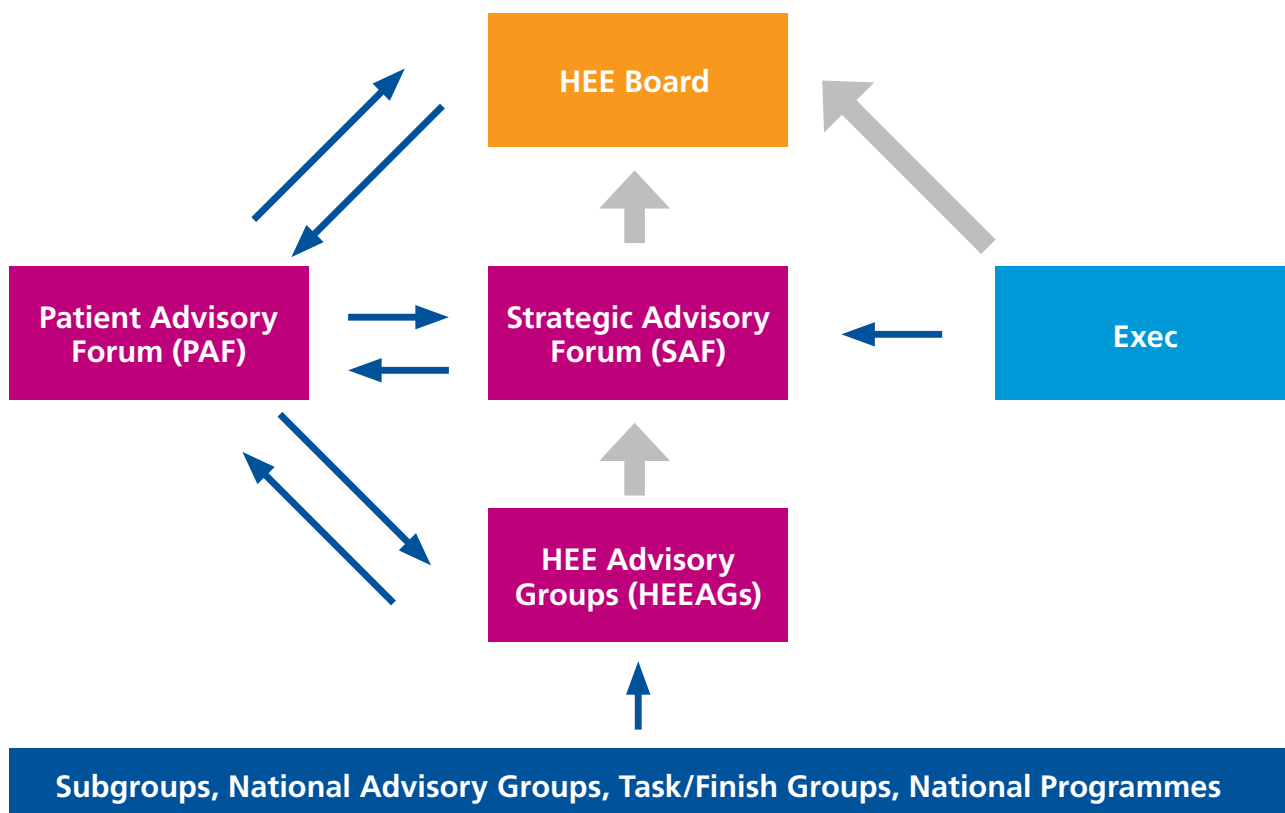
- develop and publish on our website summary positions for the workforces covered by each of the 130 programmes HEE commissions
- strengthen the way we use our advisory structures by engaging them throughout the planning cycle, taking the issues we have exposed in this plan as the starting point for discussion
- invest further in comprehensive and systematic standardised data analyses
- with our LETBs develop more explicitly national multi-year investment plans for smaller staff groups and smaller medical specialities.



National level engagement

Health Education Advisory Groups (HEEAGs)

Over the last 12 months we have revised and simplified our strategic advisory landscape which in 2014 included eight HEE Advisory Groups (HEEAGs), a Strategic Advisory Forum (SAF) and a Patients Advisory Forum (PAF).



We have eight HEEAGS

- Allied Health Professions
- Dental
- Healthcare Science
- Medical
- Nursing and Midwifery
- Pharmacy
- Mental Health
- Public Health

Other standing groups and programme structures support the work of the HEEAGs. For example:

- Medical Workforce Advisory Group
- Emergency Medicine Working Group
- Paramedic Education and Training Steering Group
- Shape of Caring Review Board

In addition to the formal structures HEE engages routinely in bilateral and multilateral meetings with a range of stakeholders at national level including NHS statutory ALBs.

- NHS England
- Public Health England
- Care Quality Commission (CQC)
- Monitor
- Trust Development Authority

In preparation for the 2015 plan HEE received over 100 responses to our 'Call for Evidence', met with all medical Royal Colleges and with representatives of most individual medical specialties.

Section 4

Providing a sufficient supply of the future workforce

Overview

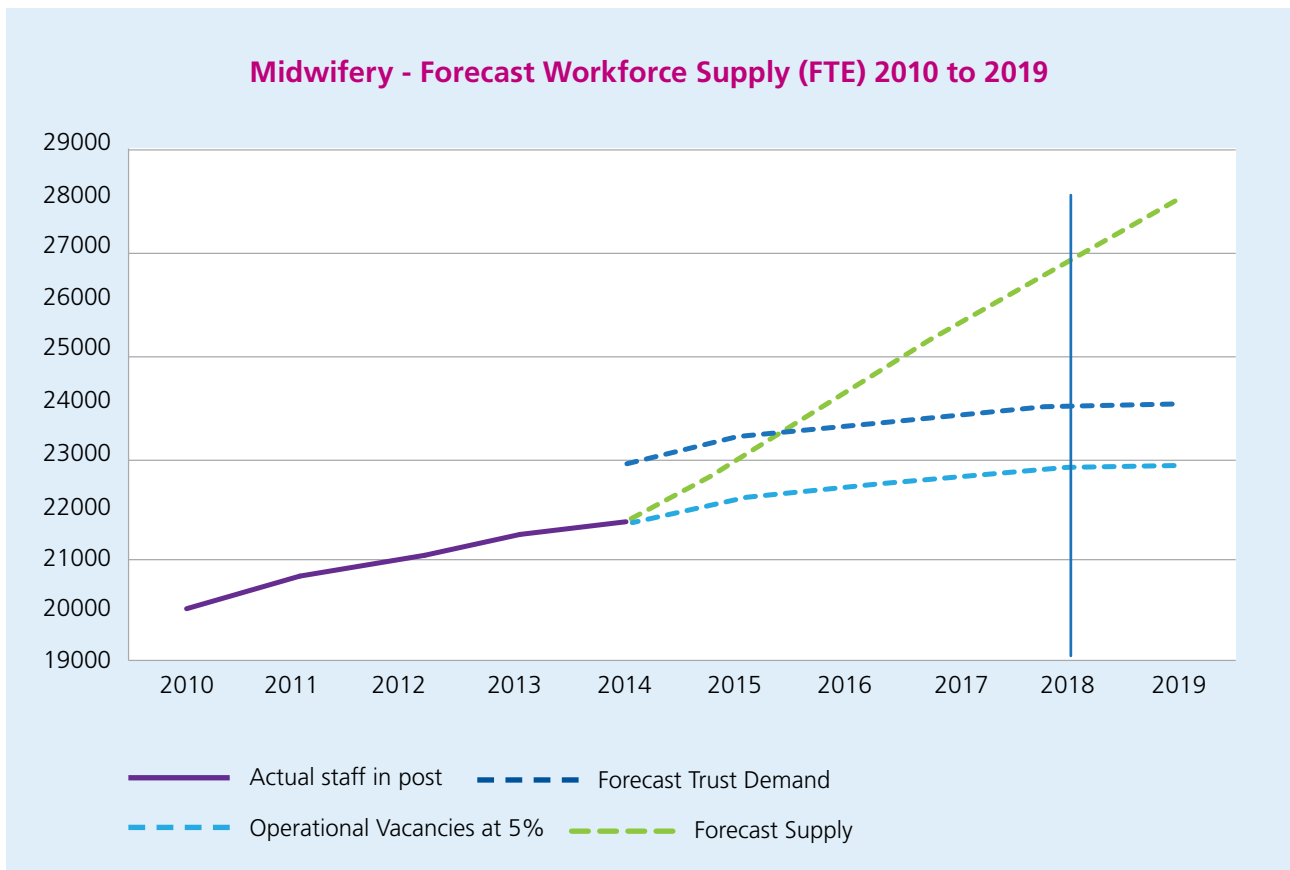
Understandably, there is a lot of focus on the volumes of training we commission and whether this number has gone up or down, but the question we are actually trying to address is ‘will there be sufficient available workforce supply in the future to meet patient needs’?

Throughout this section we describe the prognosis for each workforce in terms of the forecast supply, perspectives on demand, and consequently our view on the appropriateness of the commissioning plans of our LETBs from an aggregate national position. We also highlight where our analysis indicates partners will need

to take parallel actions to alleviate current or impending shortages.

In last year’s plan, we had limited understanding of the national supply position. We have now made a number of significant data improvements during the year, and crucially can now aggregate LETB supply assumptions alongside continued development of national supply forecasting.

We show these variables in a standard graph, which is used throughout this section to illustrate the position for each profession. Outlined below, using midwifery as an example, is a guide to what each line represents.



- The purple line represents the actual staff in post recorded over the past few years and allows us to see the recent trend in this workforce
- The dotted green line is our forecast of future available supply, and is the product of forecast output from our training less forecast staff turnover (retirements and other migration in and out of employment). It is not a forecast of the actual size of the workforce as, if sufficient jobs are not created by employers or service commissioners, then this available supply may not be utilised by the system
- The dotted dark blue line is a forecast of current and future demand. The basis on which this line is shown is specific to each profession and there may be a number of different scenarios or perspectives to consider
- A second parallel line (light blue) is shown to reflect the extent to which some level of operational or planned vacancies are anticipated. No system can or wants to operate with nil vacancies, but clearly these must be controlled to a level that only supports operational flexibility
- The vertical line simply serves to illustrate the point at which supply from this year's commissioning decisions will become available to employers. The key point of this line is that any supply issues to the left of this line can only be resolved through other shorter term supply actions.

HEE and its partners aim to ensure supply exceeds the lower demand line but does not excessively exceed the upper demand line, although modest over supply appears to be an appropriate preference of the system in terms of balance of risk.

These graphs are never used to indicate a single numeric 'truth' about the position in a future year, rather HEE and LETBs use them to stimulate discussion about the nature of future demand and the balance of risks represented by the forecast supply. Judgement must then be applied as to what actions the system should take in order to ensure patients have access to the right staff, with the right skills, at the right time.

In midwifery, for instance, the adoption of birthrate plus staffing standards would result in far higher demand than that currently forecast by service providers. The level of supply forecast would not represent over supply if this additional demand materialises.

Further detail of how HEE approaches planning for different components of these variables, such as an aging workforce, or emigration of trained staff, is included in [Annex 4](#).

Workforces considered in this report

Each year, we commission 130 education and training programmes. It is not feasible to set out this information for each profession in this report. In the following section, we have focussed on: areas of national priority (as set out in our Mandate), areas of local concern (as expressed by service commissioners and providers), or areas where we feel substantial change is required. Our full commissioning plans are set out in [Annex 1](#) and more detail in respect of other professions will be made available on our website.

The areas that we will focus on in the following section are:

- **Primary and community care**
- **Emergency care**
- **Mental health**
- **Nursing**
- **Public health workforce**
- **Diagnostic and scientists workforce**

Rather than just reflect each profession in isolation, this year we have attempted to focus on areas such as service pathways or settings, whose activity will be delivered by teams made up of different professionals.

Primary and community care

Overview

The development of a primary and community care workforce to support delivery of the care models set out in the *Five Year Forward View* at scale, whilst tackling current service pressures, is a clear system wide priority. But shifting the location of care – and therefore the workforce

– is easier said than done. Between 2005 and 2012 the proportion of medical and nursing staff working in primary and community settings as compared to hospital settings actually decreased in percentage terms, with significant increases in community nursing being more than offset by the increases in secondary care consultants.

Qualified Nurses, Consultants and GPs in Health and Care Workforce

	2012		2005	
	FTE	%	FTE	%
Hospital Based	275590	62.8%	267007	62.1%
Primary & Community Based	163280	37.2%	162883	37.9%
All Medical & Nursing	438870		429890	

Prior to the *Five Year Forward View*, the Government's policy of Transforming Primary Care created the opportunity for NHS England and HEE to begin to work together to craft a joint vision of the scale and type of services the system was looking to create and the workforce needed to deliver this vision. The high level conclusion of the work was that the GP workforce should be expanded as quickly as possible, within known constraints to the numbers that can be trained, whilst significantly expanding the members of the multi-professional primary and community care teams.

The figures that follow represent a starting point, ahead of the more detailed modelling required to implement the *Five Year Forward View* and new models of care, which has an even greater emphasis on prevention, the role of the wider workforce and care based outside of hospital than previously envisaged when this initial modelling was done.

The *Five Year Forward View* sets out an ambition to expand primary care and 'out of hospital care', calling for more community nurses and other primary care staff. It also called for a 'new deal' for primary care, to stabilise and strengthen general practice (p27). We will now work with NHSE and our Independent Primary Care Workforce Commission led by Professor Martin Roland to understand the workforce implications of the new models of care, which will form the basis of our future planning assumptions.

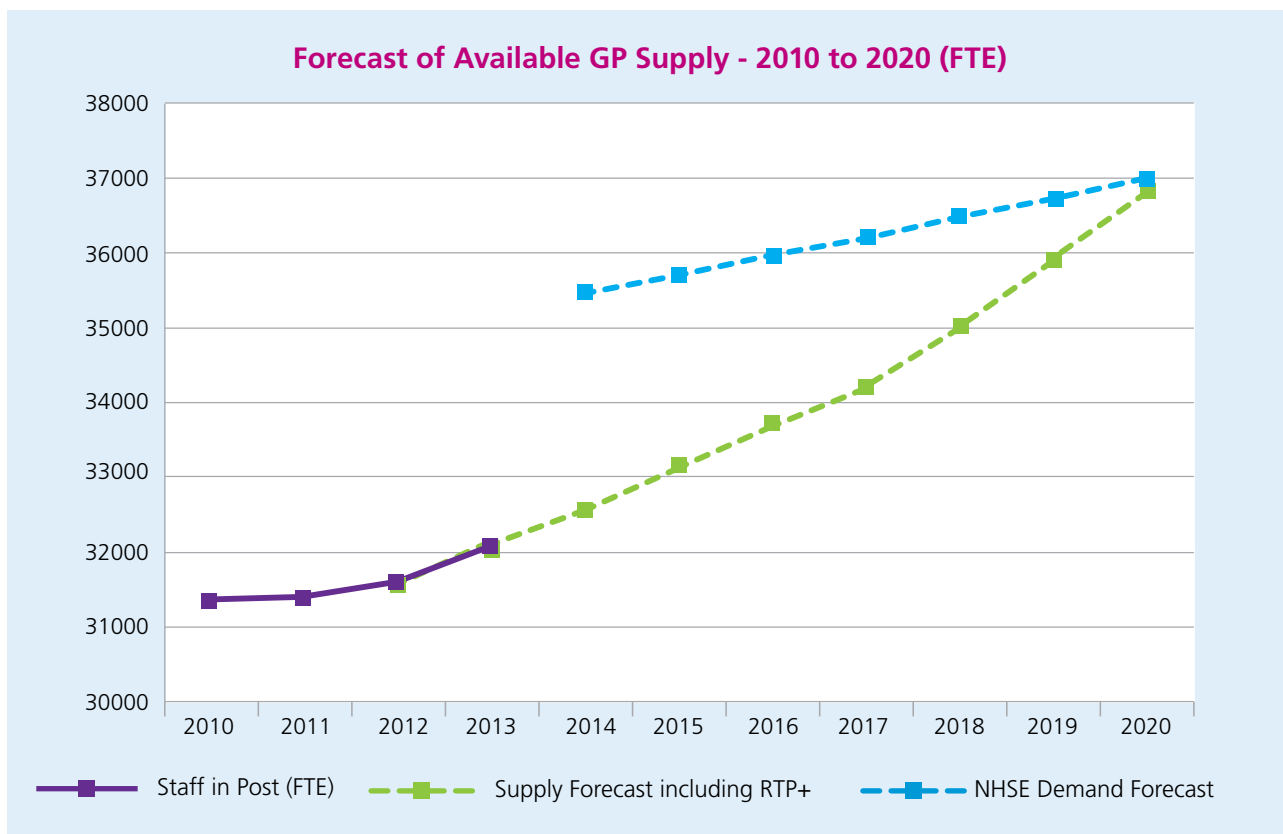
The following sections set out our existing planning assumptions and the commissions we intend to make in 2015/2016 for GPs and community based nurses.

General practitioners

England’s GPs occupy a unique and pivotal position in our health system. The first point of contact for most people concerned for their health or the health of a loved one, their status as trusted advocate or source of immediate care, has made them the person that the public are most likely to think of as their doctor.

Yet as the needs and expectations of the public have grown, and as the wider system has asked GPs to undertake new roles, such as commissioning, the growth in their numbers has failed to keep pace.

Elsewhere in this section we discuss the role the wider primary and community care teams can play to share this load, however whilst these professionals can meet some of the workload they are not substitutes for the GP themselves. The need to meet patients’ expectations about access to their doctor, in terms of both immediacy, and length and quality of the consultation, means there is no doubt that we need a more rapid expansion of this workforce than has been previously planned for.



1. Forecast supply

We are forecasting that if our planned training levels are achieved then the amount of GPs available would be 36,830FTE by 2020, an increase of 4,755FTE (14.8%) from the 32,075FTE recorded as being employed in September 2013.

This is based on achieving 3100 new trainees in 2015 and an average of 3250 new GP training commissions each year from 2016.

Potential risks to supply

In order to ensure that when a patient needs to see a GP, there are sufficient numbers of trained professionals with the right skills, values and behaviours in the right place, several things need to happen, often many years before:

1. The overall strategy or care model for primary and community care needs to be clearly set out
2. Enough training and education posts need to be identified and funded to provide a sufficient potential supply of GPs to provide the agreed care model
3. Individual doctors need to apply for the education and training posts available
4. Candidates must be assessed and appointed (or not) to the training posts
5. Upon qualification, enough jobs that are attractive to newly qualified GPs must be created for them to be employed as GPs
6. For patients' needs to be equally met, those jobs needs to be in the right geography
7. Qualified GPs must remain in service, with active campaigns and support to enable people to return after time out for family or travel.

Responsibility for these seven steps is split across many different organisations. Whilst HEE has a key role to play in supporting our partners in all of these areas, it is our statutory responsibility to undertake the second of these actions, creating the available training posts, and then to work with key partners on the third and fourth points.

The primary risk to the supply forecasts shown above is our ability to fill all the training opportunities we have created. In 2014 we had

3049 training posts available but were only able to fill 2688 of them (88%). HEE has been working closely with the RCGP and other partners to explore how we can maximise fill across all training and incentivise and encourage trainees to take the fantastic training opportunities available to become a GP in what will be a transformed primary and community care landscape.

The supply forecast is also dependant on the other variables being managed such as ensuring newly qualified GPs are attracted into substantive posts. This will require a significant expansion in the number of GP jobs commissioned under the new co-commissioning arrangements between NHSE and Clinical Commissioning Groups (CCGs) and for these positions to be attractive to new qualifiers. For instance over the past 10 years we have seen a large shift in the basis on which GPs are employed with significantly more being employed on a salaried basis. Understanding whether this is due to the preference of newly qualified staff, or a function of what has been available to them will be crucial.

2. Forecast demand

Provider/commissioner demand

Earlier in the year, NHS England undertook modelling of the activity required to meet the needs of patients under the Government's 'Transforming Primary Care' policy. This was then translated into the number of GPs required if all of this activity were to be delivered by GPs rather than by them and practice and community staff. This planning scenario is shown as the blue line on page 27 and indicates that even the lowest policy aspirations of Transforming Primary Care could not be met by GPs alone until 2020. There are also merits in expanding the wider multi-professional team in primary care settings. Consequently HEE is committed to growing the GP workforce at the fastest rate possible within known constraints, and in parallel ensure there is a sufficient supply of other members of the multi-professional primary and community care teams (see page 30).

HEE call for evidence and other perspectives

In addition to the modelling outlined previously, HEE has been in regular dialogue with the RCGP and also had the output from the DH commissioned Centre for Workforce Intelligence (CfWI) study *In Depth Review of the General Practitioner Workforce*.

<http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce>

There is a broad consensus that the GP workforce must grow and as quickly as possible. The challenge for HEE and partners will be to establish the overall scale of this ambition to ensure future service commissioning and parallel workforce development ambitions are met.

4. HEE's Commissioning Plans 2015/16

Post graduate Medical & Dental Education:	Number of Training Posts	Increase/ Decrease	%
General Practice	8,311	209	2.5%

HEE's investment plan shows our intention to commission and fund a further 209 GP training posts in 2015/16 in addition to the 222 we added in 2014/15. This will create sufficient training opportunities for between 3,177 and 3,216 new GP trainees to commence their training from August 2015. If achieved this would exceed the 3100 assumed for 2015 within the supply forecast.

5. Further actions HEE and partners will take

As well as securing future supply of GPs, HEE has worked with NHSE and RCGP to improve levels of recruitment to the training posts we commission, improve retention of employed GPs and encourage the return of qualified GPs who have left the profession. Our ten point action plan will set out the steps we will take to address these issues in the short term. Next year, we will work with CCGs and NHSE to develop a better understanding of the demand line for the primary care workforce, based upon the needs of patients in a primary care setting.

3. Demand and supply summary

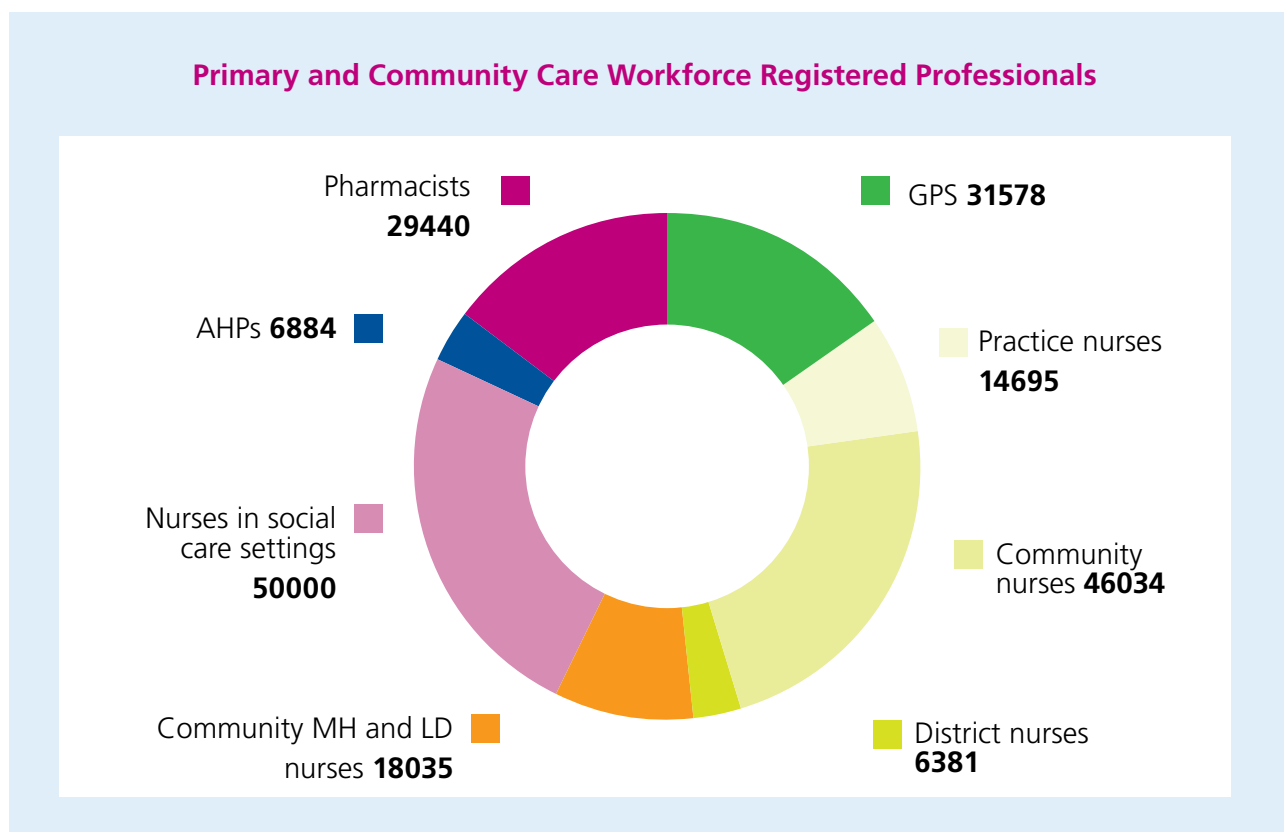
HEE's proposed training levels will provide for significant growth to the GP workforce, that can meet what appear to be the minimum aspirations of the system.

If partners require the GP workforce to grow more quickly than is achievable through newly trained supply, or at a greater scale, then they would have to consider alternate sources of supply such as retention schemes, more return to practice than is currently planned, and international recruitment of qualified GPs. Much will depend upon the development of the new care models set out in the *Five Year Forward View*.

The Primary Care Workforce Commission, chaired by Professor Martin will build upon the *Five Year Forward View* to identify models of primary care that will meet the needs of the future NHS. This will inform priorities for HEE investment in education and training to deliver a primary care workforce that is fit for purpose, flexible and able to respond to new models of primary care. The Commission will highlight good examples of integrated, patient focussed, out of hospital care which will influence service commissioners and regulators and will report at the end of June 2015.

Other primary and community team members

The needs of patients are met by a wide range of clinical professionals and support staff in both primary care teams and community care services. The diagram below shows that GPs make up approximately 16% of the total primary and community workforce team, with nurses being 67%, pharmacists 14% and AHPs 3%.

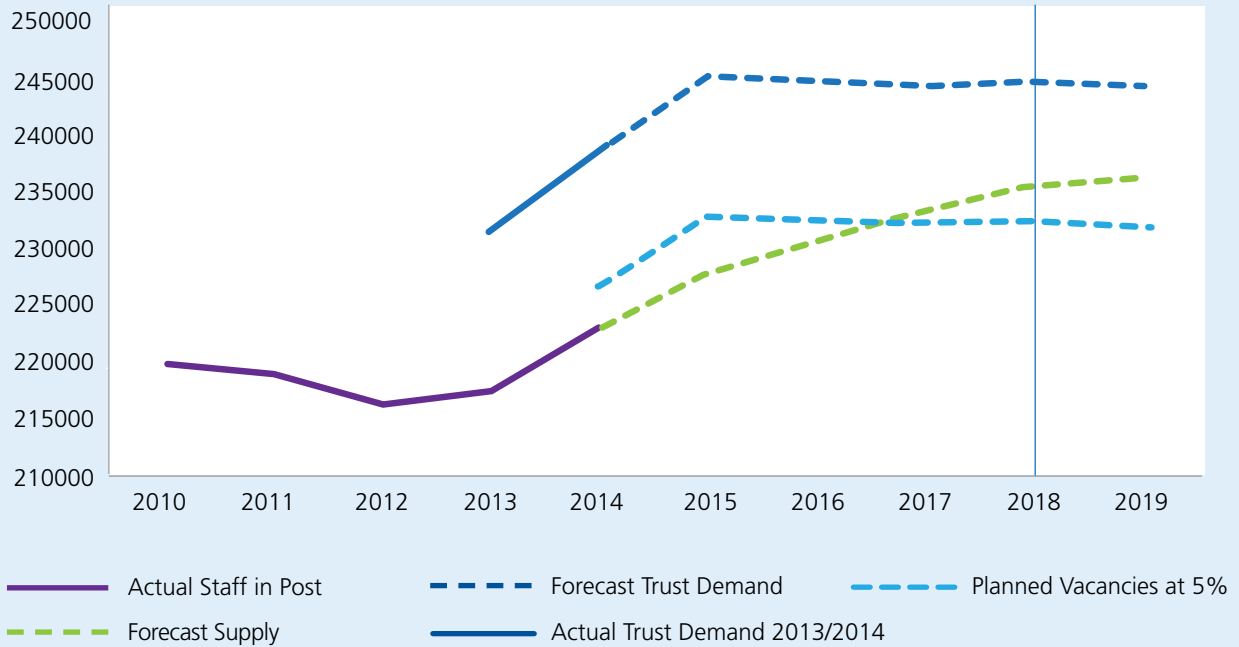


An expansion in GPs may need to be accompanied by an expansion in the wider primary care workforce, to both support them to do what only they can do and, where appropriate, provide a wider range of care and better access for patients. However, the specific make up of this primary and community care team will depend upon the model of care and so we should not simply think about this in terms of ratios of different staff groups to each other, but about the skills that are required to meet the needs of patients in primary and community settings.

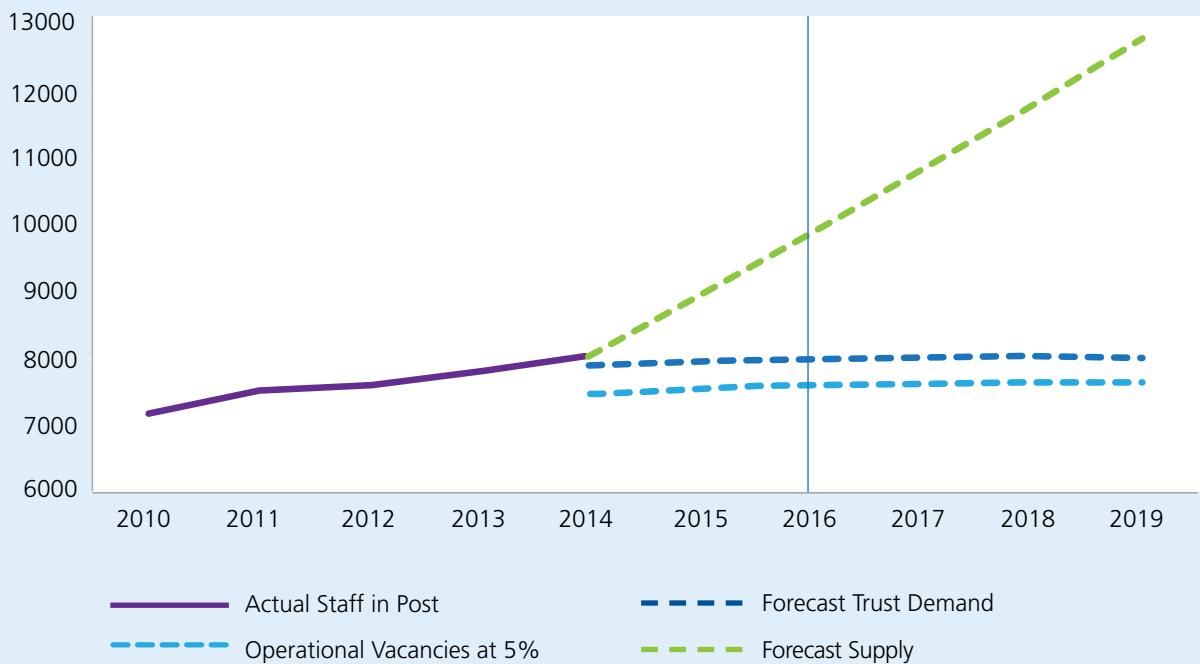
1. Available supply

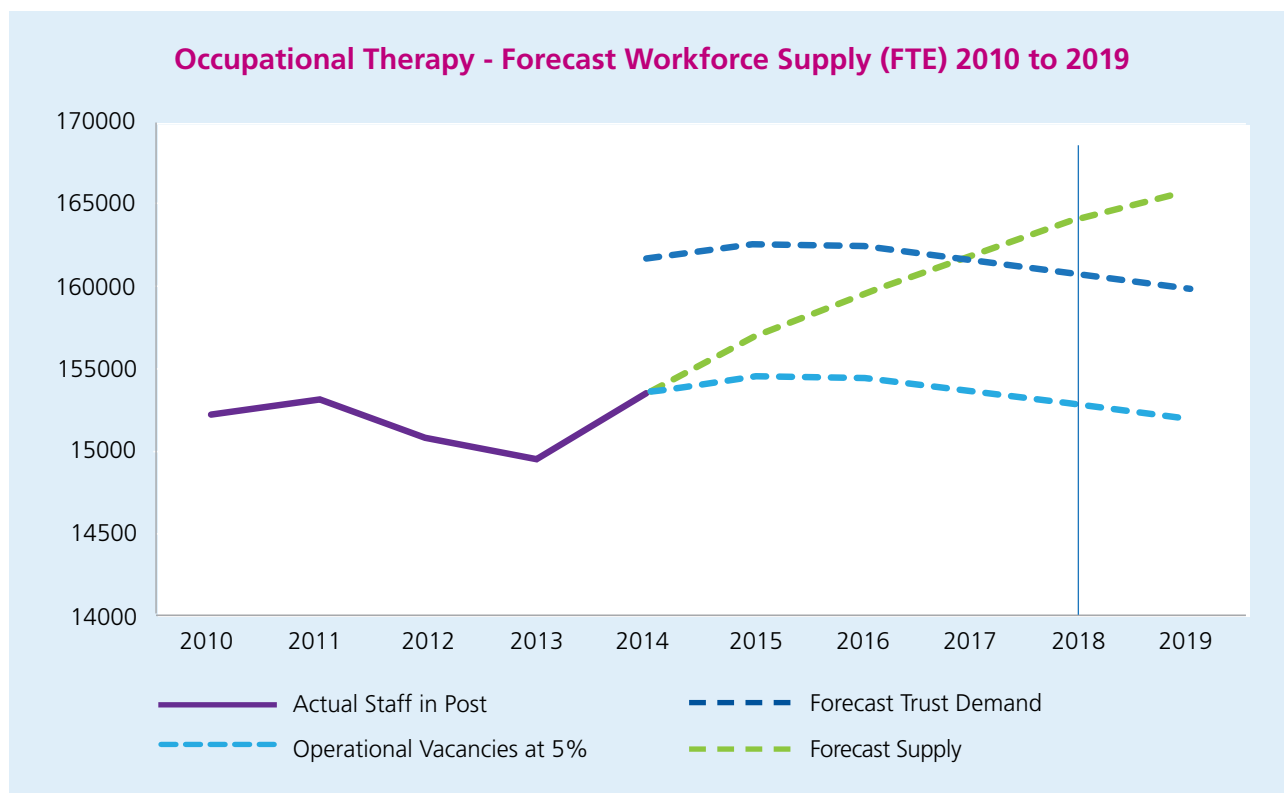
Our analysis shows that significant additional supply is forecast to be produced across a wide range of professions that could be used to expand multi-professional primary care teams. These include adult nursing, pharmacy, and a range of AHPs.

Acute and Community Nursing - Forecast Workforce Supply (FTE) 2010 to 2019



Pharmacists - Forecast Workforce Supply (FTE) 2010 to 2019



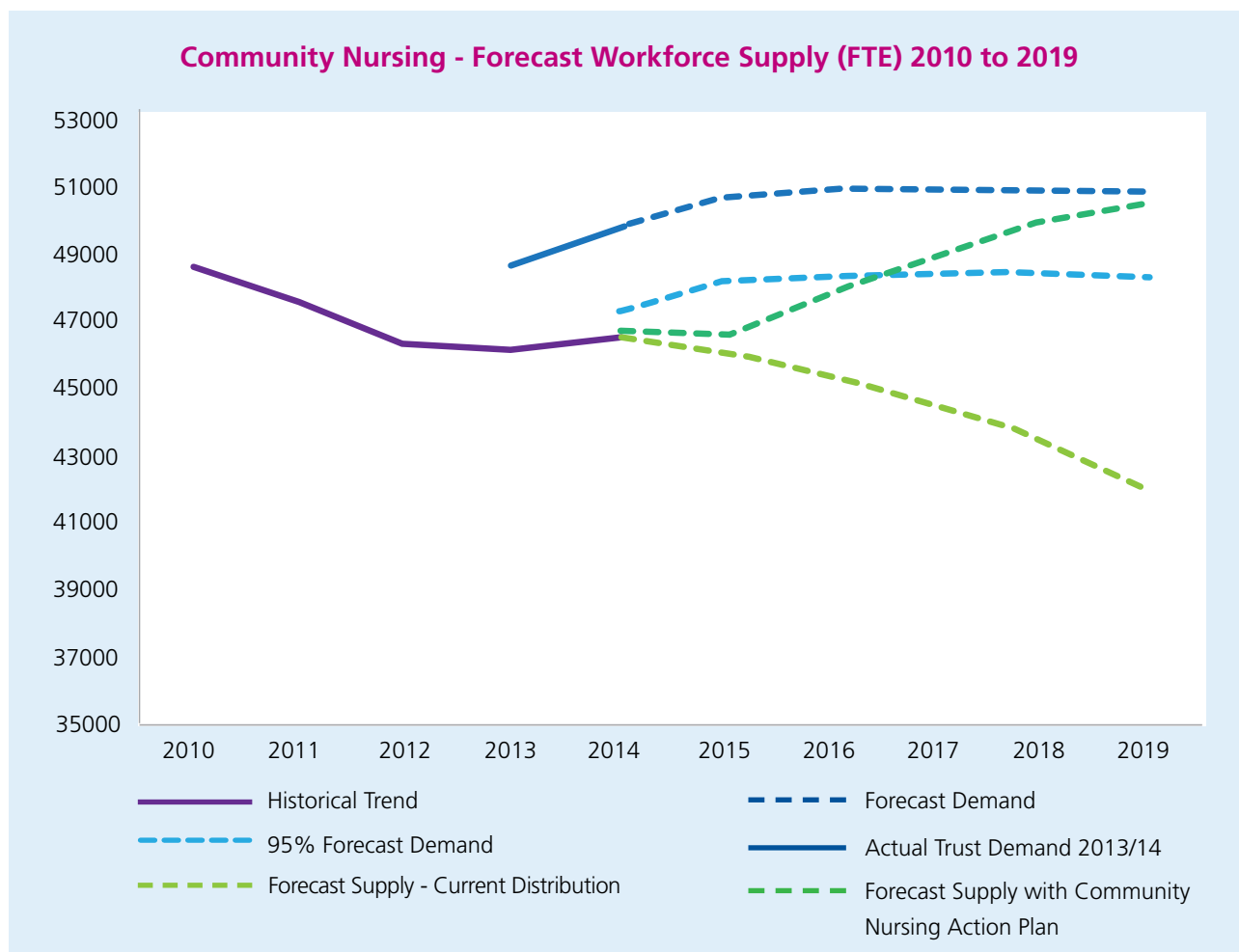


The graphs above show the forecast available supply for three professions but similar patterns are forecast for groups such as physiotherapists, dieticians, and speech and language therapists, all of whom can play a significant role in wider primary and community teams.

Risks to supply

However, this overall level of available supply does not necessarily mean that staff will make themselves available to work in primary and community care. The solution to this does not lie with simply training more numbers (although we will keep these under close scrutiny), we need to take other actions to equip staff with the skills and confidence to do these roles and to make them attractive as an option for career progression. The exposure of trainee nurses to primary and community services through high quality clinical placements in these settings is one way in which HEE is acting to address this issue. It is clear however, that we, along with other partners, must do more.

In nursing, we are seeing that the increased demand from hospital providers as a consequence of the Francis Review and NICE guidance, means that nurses are not moving from secondary care to community care at the rate previously observed and that therefore, without a specific action plan to ensure both sectors attract the appropriate share of their common supply there is a risk that the primary and community workforce will not grow at the rate the system is indicating is needed.



The graph above shows that there was a welcome increase in 2013/14 (reversing a three year trend of reductions) and that with appropriate action there is sufficient supply to support a significant growth in the community workforce over the next five years. However the second green line shows LETB's forecasts of what may happen if the system simply continues with the current pattern of staff movement between sectors.

We are also aware that the drive for staffing in the hospital sector appears to be impacting on the supply of staff to the independent and care home sectors. The CQC report *Shape of Caring – 2013/14* highlights that care homes are suffering over 8% vacancies for registered nurses and turnover rates of 32%. HEE is not responsible for resolving all workforce issues, but we do need to take account of the impact of actions on the whole health and social care workforce, especially where the performance of the whole system is so inherently interlinked.

2. Forecast demand

Commissioner/provider demand forecasts

In order to get some indication of the scale of expansion required in these other primary and community workforces, HEE and NHS England used the same modelling of additional primary care activity as used for GP planning, and made estimates of the number of other clinical professionals that would be required if they undertook some of this activity on behalf of GPs.

The analysis showed approximately 5,000 additional clinical professionals would be required to deliver this activity. In recognition of the fact that the modelling was based on NHSE's lower scenarios and that it was feasible to expand this workforce more rapidly it was decided that this growth should be pursued in addition to the expansion in the GP workforce to meet the needs of patients under the 'transforming primary care' policy. This would therefore require a total of approximately

10,000 additional primary and community care professionals including GPs by 2020.

NHS providers of community services are reporting that they had 3,234fte community nursing vacancies (6.5%) as at 1 April 2014. Trusts indicate that they expect to increase their requirements by 1,088fte (2.2%) by 2019, however this is comprised of an increase of 924 (1.9%) in 2014/15 and a much lower rate of subsequent increase between 2015 and 2019 of 165fte only 0.3%.

This indicates that sufficient funded posts will exist by 2015/16 to accommodate our initial objectives for growth and that incentivising people to fill these positions remains the critical action for the system to take.

HEE call for evidence and other perspectives

We have received numerous submissions in respect of professions that make up the primary and community workforce. In particular submissions from the Royal College of Nursing, the Royal Pharmaceutical Society, and the Chartered Society of Physiotherapists, all describe the kinds of significant and innovative contribution that their members could contribute if service models were designed to accommodate their skills and knowledge. In addition the CfWI produced one of

its ‘workforce matters’ series addressing a range of issues associated with this workforce.

<http://www.cfw.org.uk/publications/how-could-the-community-workforce-alleviate-some-of-the-pressure-on-general-practitioners-and-improve-joint-working-across-primary-and-community-care>

3. Demand and supply summary

The proposed levels of training will allow for significant growth to the primary and community nursing workforce and would allow the minimum ambition outlined in Transforming Primary Care to be met. However such growth will only materialise if staff are appropriately supported and incentivised to join primary and community services. There is a significant role to be played by the providers of these services, supported by their LETBs.

4. HEE commissioning plans 2015/16

HEE’s investment plan shows further increased commissioning in adult nursing, the main feeder branch into the community nursing workforce, as well as significant increases to specific supply routes i.e. practice nurse training and district nurse training. In addition, there is a significant increase in proposed training of physicians associates (albeit from a low baseline) although these will serve a range of service settings including emergency care, not just primary and community care.

Clinical Professional Education Programmes:	2014/15 Commissions	Planned 2015/16 Commissions	Increase/Decrease	%
Adult Nurse	13,228	13,783	555	4.2%
District Nursing	431	502	71	16.5%
Practise Nursing	218	359	141	64.7%
Pharmacist pre-registration year	600	657	57	9.5%
Physicians Associates	24	205	181	754.2%

5. Further actions HEE and partners will take

HEE will work with NHSE and the wider system through our Workforce Advisory Board to better understand the wider primary care workforce needs of the *Five Year Forward View*, to ensure that we are growing the wider workforce – such as community and district based nursing

– sufficiently to keep pace with the growth of GPs and to deliver the new models of care. This will align and connect with our Independent Commission on Primary Care and the Chief Nursing Officer’s (CNO) programme to transform community nursing.

Dentistry

The vast majority of dental staff working in primary care are not directly employed by the NHS but we still need to create a workforce which supports providers in most efficiently delivering the outcomes for patients set out in the *Five Year Forward View*.

We have commissioned and published two reports from the Centre for Workforce Intelligence (CfWI), one on dental undergraduate numbers. As reported last year, this study concluded that the rapidly changing oral health of the population is likely to reduce the demand for dental interventions in the future. The review advised that unless action was taken, there was likely to be a significant oversupply of dentists. HEE therefore agreed to reduce the number of commissions for undergraduate dental places by 10%.

Commissioning dental care professionals (DCPs) have an increasingly important part to play in

meeting the changing needs of the population but this workforce has historically had little or no strategic national workforce planning. We have recently commissioned and published a report from CfWI on DCPs and Health Education England's Dental Advisory Group will work to implement the recommendations, working with our LETBs at a local level to move this agenda forward.

We will also look at the commissioning of dental specialty training, in order to align our training commissioners with the changing oral health needs of the population and the requirements of NHS England commissioners.

HEE Commissioning plans 2015/16

HEE's investment plans show the implementation of the planned reduction in undergraduate training* and the start of increased investment in other dental care professionals, albeit at a small scale in this initial year. Post graduate specialty training has remained broadly static.

Clinical Professional Education Programmes:	2014/15 Commissions	Planned 2015/16 Commissions	Increase/Decrease	%
Dental Nurses	455	442	-13	-2.9%
Dental Technicians	69	69	0	0.0%
Dental Hygienists	116	128	12	10.3%
Dental Therapists	118	134	16	13.6%
Total Dental Care Professionals	758	773	15	2.0%
Undergraduate Dental	899	809	-90	-10.0%

*NB – UG Dental reductions were eventually actually implemented in 2014/15 but at the time the 2013 Workforce Plan for England was published this had not been confirmed and so the Plan showed no reduction. Hence the figures shown compare the 2014/15 and 2015/16 **planned** commissions at the time of publication of the respective reports but as this has already happened there will be no further reductions in 15/16 and we will review the situation in 2017.

Post Graduate Medical & Dental Education:	Number of Training Posts	Increase/Decrease	%
Total Dental Specialty Training	399	-1	-0.3%

Emergency care

Overview

There have been significant successes in the development of the emergency care workforce. Growth in the number of consultants is amongst the highest of any specialty, however even these necessary and welcome changes have only allowed services to keep pace with increased demand.

In last year's plan we described how this consistent pressure had begun to result in some potentially critical stresses. The number of young doctors choosing to train as our future Emergency medicine (EM) consultants had continued to reduce. In post graduate medical training such vacancies are not only a threat to the future growth of the consultant workforce, but also a clear and present risk to today's service delivery. Whilst we recognise that service delivery is not the primary purpose of doctors in training, the workload that these trainees carry is vital to their training and remains a critical component of meeting the needs of today's patients.

Working in close partnership with the College of Emergency Medicine, HEE developed practical solutions based on both current need and longer term sustainable solutions. These proposals covered a wide range of initiatives; however a small number of key immediate actions are already beginning to make significant contributions.

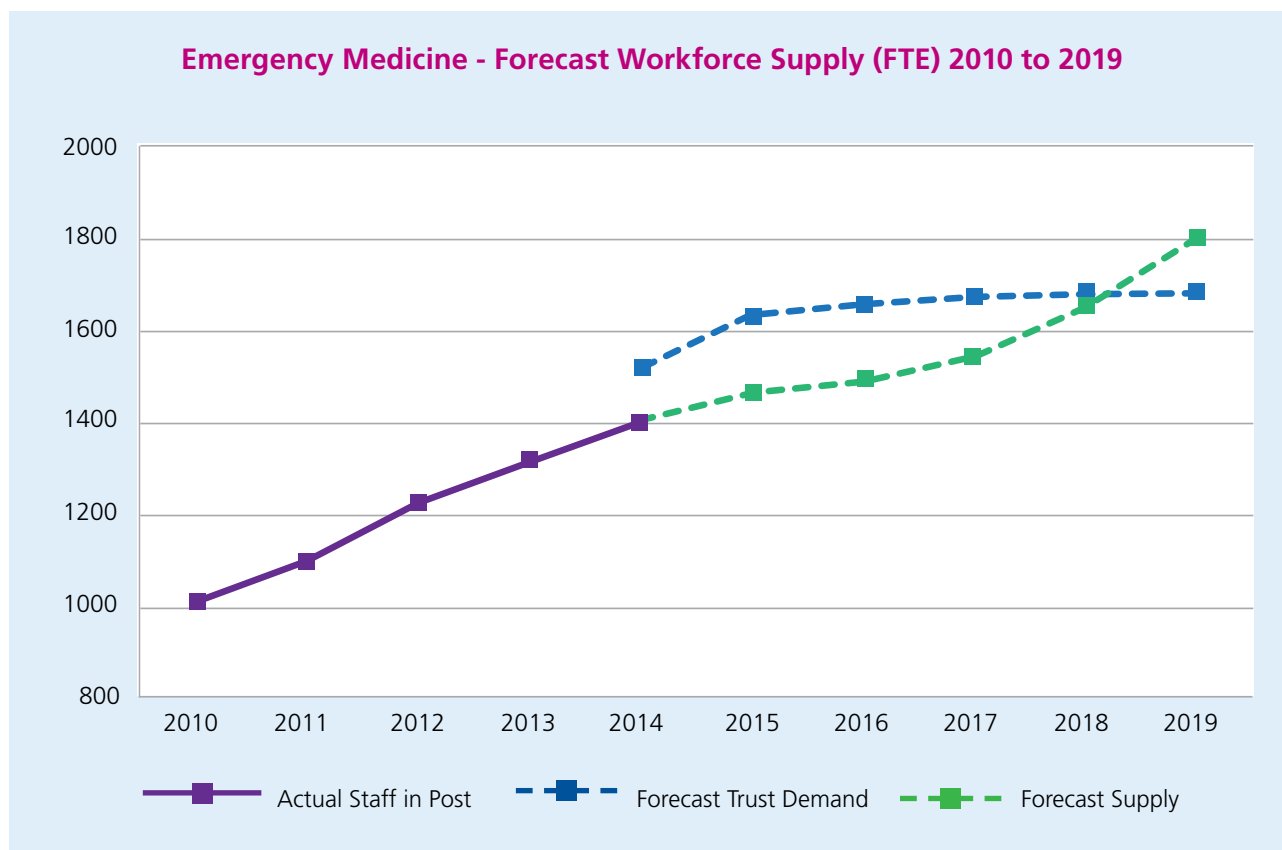
- Additional ACCS – EM posts (95 in 2014 and 95 more in 2015)
- Piloting and subsequent full adoption of a 'run through' training option
- Creation of the innovative Direct Route of Entry Emergency Medicine (DREEM) training pathway
- The work, learn, and return initiative
- Rapid expansion of physician associates

The analysis shows the impact these initiatives are already having on both staffing of today's service delivery and the likelihood of improving numbers of doctors in their final stages of training to be future consultants.

Emergency medicine consultant workforce

The College of Emergency Medicine describes emergency physicians as 'the only professional group with sufficient flexibility in our clinical skills to be able to initially assess and manage the broad range of acute presentations that present to emergency departments, across the age and acuity spectrum.' These key leaders of emergency departments, whilst supported by highly skilled teams, are at the forefront of perhaps the health systems most pressurised care setting. Ensuring that there are sufficient numbers of these key staff is critical to ensuring that they can deploy their skills effectively and to ensure we do not enter a spiral where the pressure of work results in staff leaving in unsustainable numbers.





1. Forecast supply

The emergency medicine consultant workforce has grown by 776FTE over the ten years 2003 to 2013, an increase of 142%, the largest of any professional group in the NHS.

The proposed levels of training, when allied to the actions HEE has taken with the College of Emergency Medicine (CEM) to ensure these posts filled, are forecast to deliver 398fte growth in available supply by 2019 an increase of 28.4% over the five year period.

The graph above shows the impact of poor fill of higher specialty training posts in recent years with fill rates of only 60%. As a consequence of these problems growth in new consultant supply from 2015 to 2017 will be at a much lower rate than the historic norms and if allowed to continue would have created a widening gap between the needs of the service and the number of consultants available. The actions we took last year, in our first year of existence, and the positive impact they are having means we are now forecasting the return to more rapid growth from 2017/18 onwards.

In the meantime, initiatives to maximise the number of training grade doctors in today's workforce and expand the capacity of the wider emergency care team will be needed alongside other employer actions to meet any shorter term supply challenges.

2. Forecast demand

Provider demand forecasts

Service providers report that there are currently 121FTE consultant vacancies (8.6%) in emergency medicine. They are forecasting that they will increase their workforce requirements by a further 166FTE consultant posts (10.9% increase) by 2019. The majority of this increase, (111FTE – 7.3%) is shown as being required in 2014/15.

HEE call for evidence and other perspectives

Evidence from the College of Emergency Medicine submitted as part of our call for evidence and our own observation of recent trends in activity and workforce growth leads us to assume these provider forecasts understate future demand and that until alternate services have proven their impact we should plan on

the basis that although the pace of growth may reduce slightly we cannot assume it will only increase by 3% over four years as indicated in trust returns.

The extent to which complementary increases in other roles within the wider emergency care team may obviate this demand for doctors is a valid question, however the system's experience over the past few years, suggesting the mitigating impact of any initiative must prove its impact before any assumed lessening of growth can be acted upon.

We will continue to work with the College of Emergency Medicine and NHSE to support employers with immediate service pressures and we are confident we will be back on track for CCT posts in emergency medicine from 2019 and therefore able to produce further expansion should it be required.

2. Demand and supply summary

Forecast supply will return to necessary levels from 2017 as a result of the interventions in the HEE and CEM action plan. The volume of training is in itself sufficient to generate this growth as long as posts continue to be filled.

In the shorter term there will remain a level of consultant vacancies which increased numbers of training grade doctors will help ameliorate but which employers will need to consider complementary shorter term responses to.

In the longer term, alternatives in terms of the wider workforce or in terms of the impact of complementary services must be critical to a sustainable future but will need to prove their impact before any lessening of growth in this workforce could be considered.

3. HEE commissioning plans 2015/16

Post Graduate Medical & Dental Education:	Number of Training Posts	Increase/Decrease	%
Emergency Medicine	634	6	0.9%
Emergency Medicine - DREEM	37	10	27.0%
Acute Care Common Stem - Emergency Medicine (Including Run Through)	681	95	14.0%

HEE's investment plans show a further increase of 95 ACCS-EM posts (14% increase), most of which will be 'run through' and 16 additional posts between higher speciality and DREEM training scheme. These investments will contribute to a return to appropriate consultant growth whilst also increasing the number of training grade doctors supporting services.

4. Further actions HEE and Partners will take

HEE is leading the workforce stream of NHS England's Urgent and Emergency care review and has established a programme of work to oversee

the developments including doctors, paramedics, advanced practitioners, clinical pharmacists and physician associates (PA). As a direct result of this work the number of active PA courses went from one to five this year and a further seven programmes are opening next year. This has been achieved with the close support and partnership of the College of Emergency Medicine and the College of Paramedics. It is recognised that this work is pivotal in the success of the wider national programme's success and we will continue to develop this further.

Other emergency care medical staff

It is no longer sufficient simply to plan for consultants and then assume the number of training grade doctors is merely a function of this requirement. Nowhere is this plainer than in emergency medicine where in simple numbers' terms over 70% of the workforce is represented by doctors other than consultants and where vacancies in these groups contribute to the challenging service delivery situation.

The table below represents the position submitted by NHS provider organisations at 1 April 2014.

	Current Staff in Post	Trust Requirement	Vacancies	
	FTE	FTE	FTE	%
Consultants	1401	1522	-121	-8.6%
Doctors in Training	2201	2368	-137	-7.6%
Staff Grade Doctors & Other Medical Staff	1571	1731	-160	-10.2%
Total Emergency Medicine Workforce	5173	5621	-448	-8.7%

The initiatives referred to above were designed to alleviate the impact of vacancies today as well as to ensure increased consultant growth in the future.

It is encouraging to report that the outcome of the 2014 recruitment round shows four specific improvements which are resulting in a 243FTE increase in the number of training grade doctors in service as at August 2014 compared to August 2013, these improvements are;

- Recruitment to 304 ACCS emergency medicine posts out of 311 available representing the highest ever intake into emergency medicine training (including the 97 additional posts commissioned in last year's plan)
- Recruitment to 58 DREEM posts at ST3
- Progression of 126 CT3 trainees directly into ST4 training as part of the new run through scheme, which in addition to 67 direct entry recruits means 193 new ST4s reversing years of decline at this critical level for future consultant supply

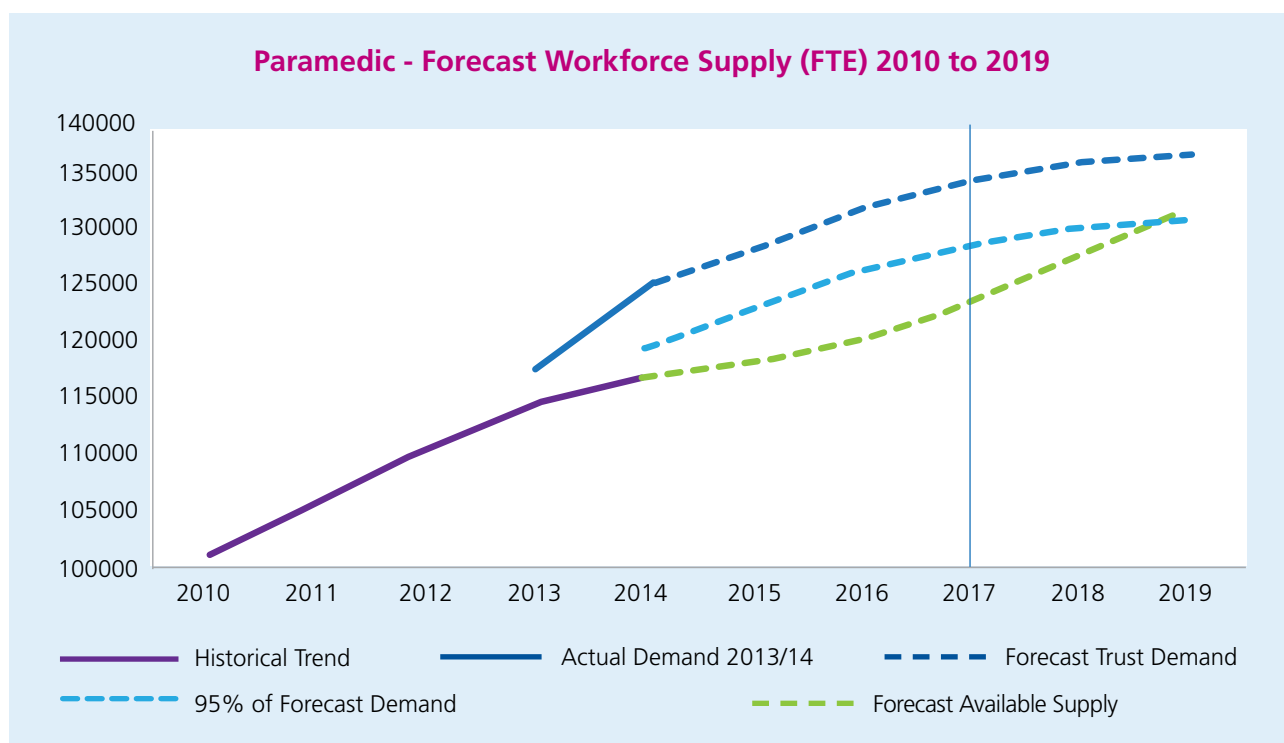
These doctors in training and doctors who are not consultants or in structured training (referred to variously as speciality and associate specialist doctors (SAS), staff grade, specialty doctors) must be taken account of and their supply actively considered.



Paramedics

Paramedics play a vital role across both urgent and emergency care and are increasingly becoming employed within the primary care environment. England's ambulance services are reporting increased pressure on their paramedic workforce. At the start of the year these trusts reported that there were 1002FTE vacancies (7.6%) and a subsequent survey of ambulance trusts reported this had risen to 1,251FTE in July (9.5%).

In 2013/14, ambulance trusts increased their requirements by almost a thousand posts (in excess of 8%) and this rapid growth in establishment coincided with a year in which the rate of supply, which had been running at about 600 per year, dipped to only 300. The combined impact of this lower growth and increased demand is the rapidly widening gap between demand and supply.



1. Forecast supply

We are forecasting that the proposed levels of paramedic training will provide for 1,902FTE growth in available supply over the next five years (15.6%).

However, the impact of HEE's significant increase in paramedic training (a 70% increase over two years) will not begin to take effect until 2016/17. A period of slower growth than recent years is forecast for 2013 to 2016 and the combination of this lower growth combined with rapidly increasing demand maybe creating the current shortages, which will continue without other short-term supply measures being taken.

The reasons for this lower growth are not yet clear, as there is no reliable data on the components of supply. This period overlapped with a radical shift of training from in-house ambulance service training to a mix of degree, diploma, and foundation degree courses, with varying course lengths and funding models. Prior to 2009, paramedic training was funded by ambulance trusts.

Recent staff turnover data also indicates a worrying trend in the rate at which existing staff are leaving the NHS has increased from 5.5% to 7.4% and in some areas, such as London, the change is even more pronounced.

HEE will ensure that the proposals for rationalising the training of paramedics to an all bachelor degree profession with its attendant three year programme, supported by all Ambulance Services, is undertaken in a carefully phased manner so that it does not create any future supply shortage. HEE would intend to adjust the volume of its commissions to account for any effect our models may indicate.

2. Forecast demand

Provider demand forecasts

Ambulance service providers (including LAS) and other NHS employers of paramedics indicated that they had 1002FTE vacancies as at 1 April 2014 (7.9%). They further forecast that their requirement for additional paramedics would increase by 1078FTE by 2019 (8.8%) of which 436FTE (3.6%) would be needed in 2014/15. This is on top of the 2013/14 increased requirements of 920FTE (7.5%).

NHS Trusts' forecasts for paramedics are one of the few areas where there is a consistent indication of additional demand being required beyond 2015.

4. HEE's commissioning plans 2015/16

HEE has responded decisively to the call from ambulance services for increased paramedic training with an increase of over 87% in our first two years of operation.

Clinical Professional Education Programmes:	2014/15 Commissions	Planned 2015/16 Commissions	Increase/Decrease	%
Paramedics	853	1,231	378	44.3%
Physicians Associates	24	205	181	754.2%

HEE's investment plan shows our intention to increase paramedic training commissions by 378 places in 2015 to 1,231, an increase of 44.3%. This will mean HEE has increased commissions by 576 over two years (87%).

The rapid increase in the aggregate requirement of ambulance services in 2013/14 always threatened to outstrip available supply which had been increasing at approximately 600 per annum. Unfortunately, the required expansion has coincided with a year in which growth reduced to only 300, so 600 additional vacancies were created when trusts increased establishments without securing additional collective supply.

HEE call for evidence and other perspectives

HEE's emergency care action plan indicates exploring roles for paramedics within emergency departments as well as their traditional role as 1st responders, however the current provider demand line above does not yet reflect this and therefore could represent even greater demand than shown.

3. Demand and supply summary

HEE's proposed training levels will provide significant growth to the paramedic workforce from 2016/17 onwards. The rapid level of increased demand, however, from Ambulance Services, means that shorter term supply solutions must be found if growing vacancy rates are not to deteriorate further until this newly trained supply becomes available.

5. Further actions HEE and partners will take

The full impact of the additional commissions for paramedics will not be felt until 2017, so ambulance services will need to explore other short-term supply measures to ensure the number of paramedics in service grows at the rate they forecast and vacancy rates in the immediate future are controlled.

The rate at which trained staff are currently leaving the profession compared to only 1 or 2 years ago is of real concern. It means the impact of our significant volumes of new training simply allows us to return to rates of growth seen between 2010 and 2014, rather than the anticipated higher rates of growth we would have anticipated if these turnover rates were controlled. Employers will also need to consider the impact of NHSE's and HEE's Emergency Care Action Plan, and what this means for the future demand for paramedics.

HEE has supported the recommendation that the paramedic workforce be added to the Government's shortage occupation list to help reduce current workforce gaps, and HEE will meet in the new year with ambulance service CEOs to better understand the data and root causes and identify further actions the wider system might take.

HEE have led a major piece of work in the last 12 months stemming from the Paramedic Evidence Based Education Project (PEEP), which recommended the introduction of a single point of education entry at degree level for paramedic training. This work is being carried out with the full support of the Ambulance Association and the College of Paramedics and we are working closely with the 3 devolved nations to ensure this becomes a UK wide initiative.



Mental health workforce

Overview

Our forecast for the mental health workforce describes a mixed picture. There are areas where significant improvements have been made (IAPT), areas where available supply is strong but use of this supply is uncertain (nursing) and other areas where planned investment should support patient needs but where issues about filling these training opportunities may indicate both current and future pressures (medical).

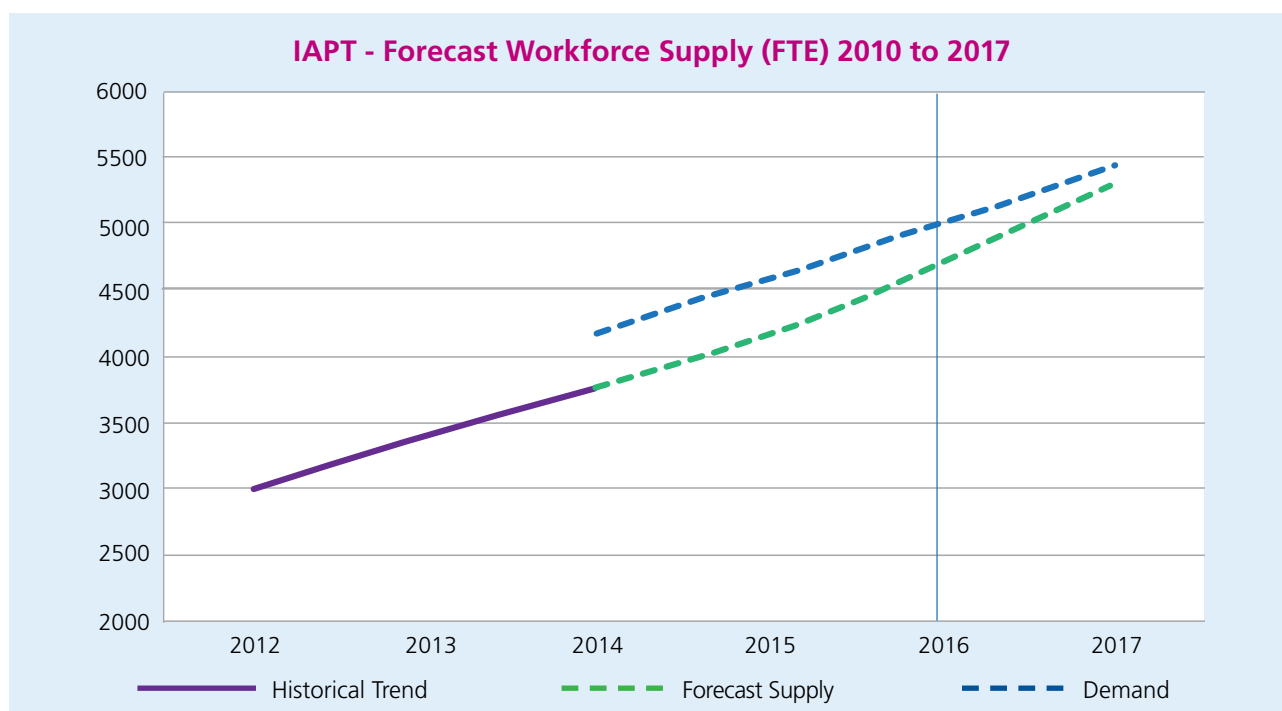
Mental health professionals have frequently demonstrated flexibility and innovation in designing and operating teams where

complementary roles act flexibly to support each other, including providing resilience to specific workforce shortages. HEE has established a Mental Health Advisory Group to help explore how we might plan for complementary workforces rather than solely looking through a uni-professional lens.

In this section we outline the separate components of the mental health workforce, and in so doing recognise this is not 'planning for teams', It does, however allow us to look at the workforce that serves this critical patient group and make explicit choices about the relative priority and value of complementary investments in different professions.

The improving access to psychological therapies (IAPT) workforce

There can be little doubt that the expansion of IAPT services and the phenomenal growth of the specialised workforce that delivers these services has had a significant impact on the lives of hundreds of thousands of people.



1. Forecast supply

We are forecasting that the proposed levels of training will provide for 1,548FTE growth in available supply over the next three years (41.1%)

This forecast is based on information collected in the 2012 and 2014 IAPT workforce surveys as there is currently no systematic data collection for the IAPT workforce.

The latest census was undertaken as at 1 April 2014 and showed the workforce had grown by 977FTE (25.1%) over the last two years. Our forecasts indicate that this very rapid expansion of the IAPT workforce will continue as long as turnover is controlled and posts are made available.

Table 1: Staff in post as per 2014 census

	Establishment	Staff in Post	Vacancies	Vacancy
As at 30/4/2014	FTE	FTE	FTE	%
High Intensity	2521	2348	173	6.9%
PWP	1646	1414	232	14.1%
Total Qualified	4167	3762	405	9.7%

Table 2: Increased staff in post 2012 to 2014

	2014 Staff in Post (Headcount)	2012 Staff in Post (Headcount)	Increase	Increase %
High Intensity	2743	2019	724	24.8%
PWP	1565	1312	253	25.4%
Total Qualified	4167	3331	977	25.1%

2. Forecast demand

The initial ambition for the IAPT workforce was established by the Government. A target for 6000 additional IAPT practitioners was established and initial training targets to deliver this growth were established. By 2014/15 HEE will have exceeded the (then) SHA's target of 6000 additional training commissions and based on current proposals will have created 7379 training opportunities by the end of 2015/16.

As at the 2014 census providers had only established 4,167FTE funded posts, but this appears to be sufficient given the level of

reported vacancies. We must be clear, however, that available supply will only translate into increased staff if posts continue to grow towards the demand target.

3. Demand and supply summary

HEE will continue to work with our NHS England partners to establish more robust and routine data on the IAPT workforce so that we can track issues such as staff turnover and progression from training into employment. The continuing high level of investment in IAPT training will ensure the target level of staffing should be achieved in 2017/18.

4. HEE's commissioning plans 2015/16

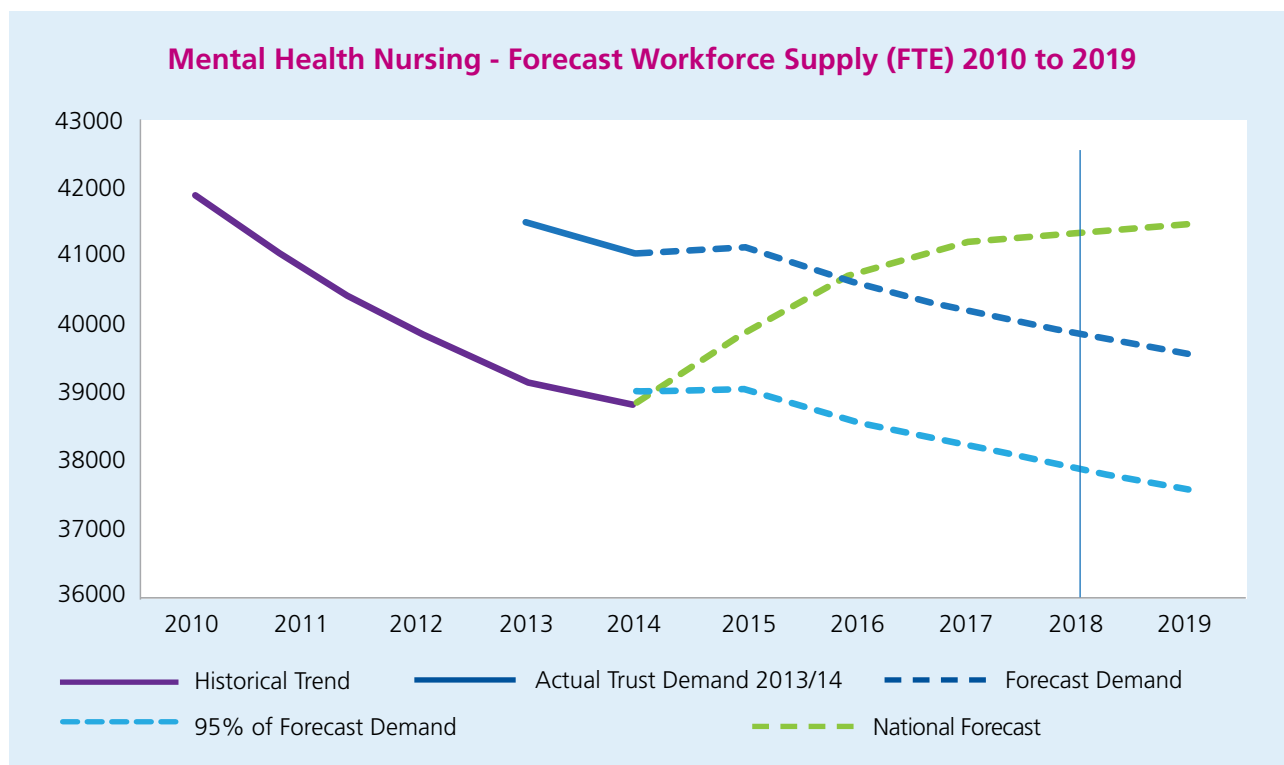
Clinical Professional Education Programmes:	2014/15 Commissions	Planned 2015/16 Commissions	Increase/Decrease	%
IAPT - Psychological Wellbeing Practitioner (Low intensity)	436	579	143	32.8%
IAPT - High intensity practitioner	320	367	47	14.7%
Total IAPT	756	946	190	25.1%

HEE's investment plan shows our intention to increase IAPT training commissions by 190 places in 2015 to 946, an increase of 25.1%.

Mental health nursing

The mental health nursing workforce plays a critical role in integrated multi disciplinary workforce teams. The number of nurses practicing in community settings is already over 40% of the workforce, demonstrating that

progress has been made in developing community based mental health services. Membership of specialised services such as early intervention teams, demonstrates that it is not just the volume of staff we should focus on, but their continuing development and career progression.



1. Forecast supply

We are forecasting that the proposed levels of training will provide for 2,630FTE growth in available supply over the next five years (6.8%).

HEE's continuation of the high levels of training will allow for rapid growth over the next two years with more moderate growth from 2017 as a result of rising forecast rates of retirement due to the aging profile of this workforce. HEE will continue to monitor levels of actual turnover and demand when assessing if further adjustments are required in future years to account for this issue.

The actual number of staff in NHS employment has fallen consistently over the past four years (by 3,062FTE – 7.3%). Our advisory group and stakeholder partners indicate that much of this change represents the shift of activity and consequently workforce to non-NHS providers, rather than a reduction in care available to patients.

We are unable to quantify this shift however and there remains some concern that this could reflect a historic pattern of differential service funding.

2. Forecast demand

NHS provider forecasts

Mental health service providers indicate that they currently have 2,330FTE vacancies (5.7%). They are forecasting that their requirement for mental health nurses will decrease further by 1,473FTE (3.6%) by 2019, although they are forecasting a very modest increase in 2014/15 of 79FTE (0.2%).

Some elements of these forecasts represent further assumptions about shifts in care delivery to non-NHS providers but we are concerned that some of it may be driven by assumptions of funding and affordability.

HEE call for evidence and other perspectives

Our stakeholders and advisory groups do not believe provider forecasts reflect the actual need for mental health nursing nor the impact of policies designed to ensure parity with physical health services. HEE will seek clarity about future commissioning intentions from NHSE nationally and CCGs and area teams locally to confirm these perspectives but in the meantime will plan on the basis that modest growth is likely to be necessary to meet patient need.

3. Demand and supply summary

The proposed increases in commissions reflect the importance placed on mental health services and an assumption that any recent imbalances in relative investment will need to be addressed.

Our actions in increasing commissions are a clear indication that it is HEE’s role to ensure supply of staff for all NHS commissioned services regardless of where delivered. It is likely that some element of the growth we are making available may end up being employed in non-NHS providers of services to NHS patients.

4. HEE’s commissioning plans 2015/16

Education & Training Commissions for 2015/16

Clinical Professional Education Programmes:	2014/15 Commissions	Planned 2015/16 Commissions	Increase/ Decrease	%
Mental Health Nurse	3143	3243	100	3.2%

HEE’s investment plan shows our intention to increase commissions by 100 places in 2015 to 3,243, an increase of 3.2%

Psychiatry workforce

The psychiatry workforce is divided into six specialties. Postgraduate medical training in psychiatry uses a ‘core and higher’ training model. Every trainee undertakes core psychiatric training (CPT) before choosing which area to specialise in as a higher specialty trainee (HST) and ultimately as a consultant.

The analyses shows the forecast position for two of the six specialties, general psychiatry and forensic psychiatry, as they illustrate the common themes for all. The main issue for all groups is that whilst the number of training posts should support significant growth (as is demonstrated by the 40% consultant growth over the past 10 years) the recent low levels of fill at HST is now threatening delivery of this additional supply.

Four of the specialties indicate that failing to fill existing training posts will result in static supply and a rapidly growing gap between supply and patient need:

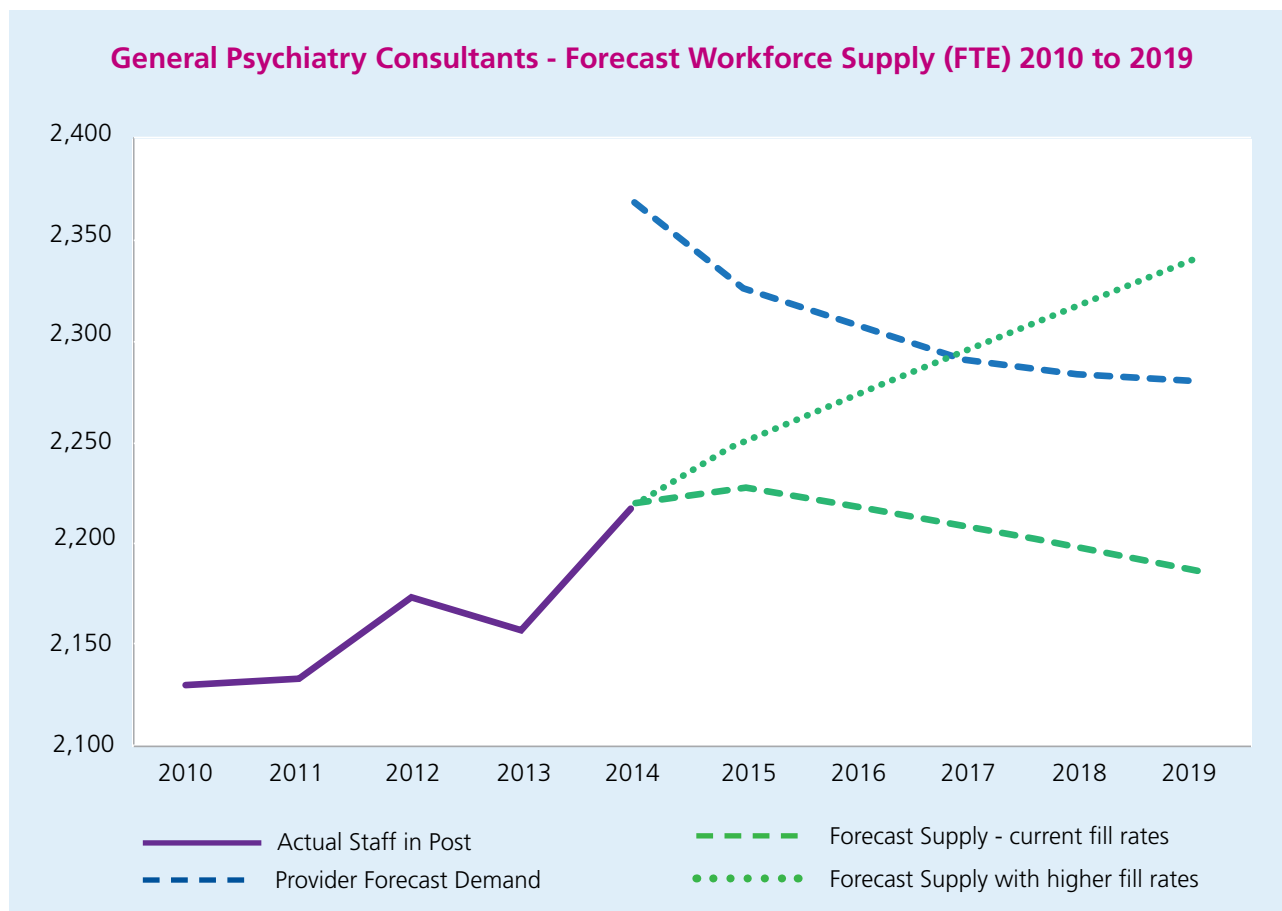
- General psychiatry
- Child and adolescent psychiatry
- Old age psychiatry
- Psychiatry of learning disabilities

For the two other specialties we are forecasting continued growth in the available supply to the consultant workforce albeit at lower rates than if all posts were filled

- Forensic psychiatry
- Medical psychotherapy

Our analysis for general psychiatry and forensic psychiatry which demonstrates the issues and characteristics common to these two groups (the full analysis of all six specialties will be available on our website).

General psychiatry



1. Forecast supply

Forecasts of available supply will depend upon our ability to fill the training posts funded. If the current pattern for lower fill rates continues for general psychiatry, then our forecast is for a decrease in available consultant supply of 32FTE by 2019, a 1.4% reduction.

Resolving current problems with filling higher specialty training could deliver growth in supply of up to 122FTE by 2019 a 5.5% increase. The importance of addressing this issue now, rather than waiting for it to become a crisis (as happened with emergency medicine) is clear.

2. Forecast demand

Provider demand forecasts

NHS general psychiatry service providers indicate that they have 150FTE general psychiatry consultant vacancies (6.3%). They are forecasting a reduction in their workforce requirements of 88FTE (3.7%) over the five years to 2019.

HEE call for evidence and other perspectives

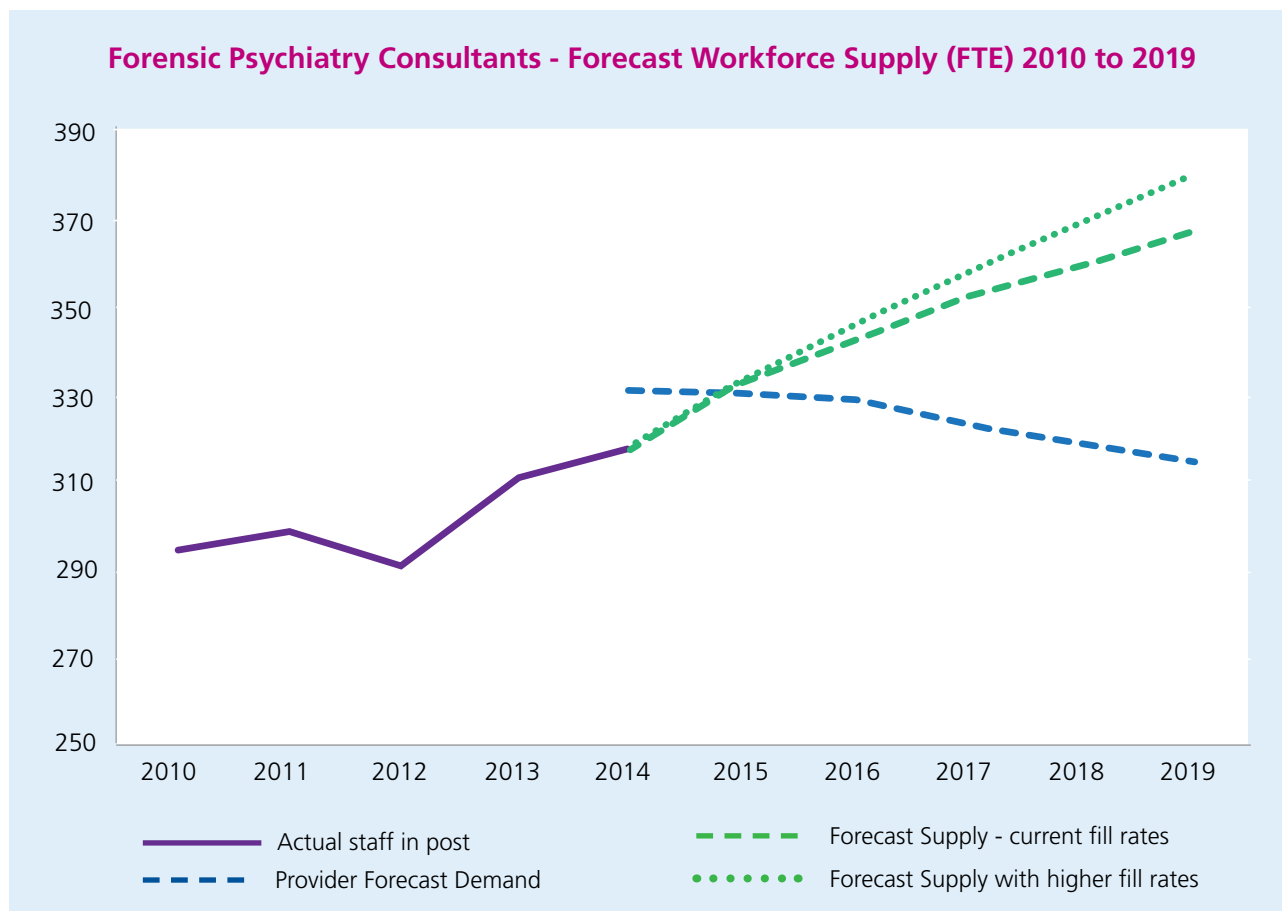
As described earlier in this section and on the advice of various stakeholders HEE is assuming that policies in respect of parity of esteem mean that some moderate growth in mental health services is likely and that NHS providers may also be reflecting the shift of some services to non-NHS providers when showing reductions.

Specific evidence was provided by the Eating Disorders Clinical Reference Group, and the Royal College of Psychiatrists.

3. Demand and supply summary

The volume of training commissioned by HEE is adequate to provide growth for the general psychiatry consultant workforce. Such growth is appropriate despite NHS service provider forecasts as we anticipate some degree of adjustment in funding linked to the policy of parity of esteem and level of patient need.

Forensic psychiatry



1. Forecast supply

Proposed training levels for forensic psychiatry are forecast to provide growth in available consultant supply of 49FTE by 2019, a 15.5% increase, despite low fill rates in specialty training. Resolving these current problems could deliver growth in supply of up to 63FTE by 2019 a 19.8% increase.

2. Forecast demand

Provider demand forecasts

NHS forensic psychiatry service providers indicate that they have 14FTE forensic psychiatry consultant vacancies (4.1%). They are forecasting a reduction in their workforce requirements of 17FTE (5.2%) over the five years to 2019.

HEE call for evidence and other perspectives

As described earlier in this section and on the advice of various stakeholders HEE is assuming that policies in respect of parity of esteem mean that some moderate growth in mental health services is likely and that NHS providers may also be reflecting the shift of some services to non-NHS providers when showing reductions.

3. Demand and supply summary

The volume of training commissioned by HEE should be adequate to provide growth for the forensic psychiatry consultant workforce. Such growth appears appropriate for the reasons previously discussed.

Clearly the priority for addressing fill rates must be in those specialties where the forecast problem is greatest; however we should not simply shift the problem between specialties, but should instead seek an overall increase in trainees joining psychiatry.

4. HEE's commissioning plans 2015/16

Post Graduate Medical & Dental Education:	Number of Training Posts	Increase/Decrease	%
Psychiatry of Learning Disability	95	0	0.0%
General Psychiatry	618	1	0.2%
Child and Adolescent Psychiatry	223	1	
Forensic Psychiatry	120	0	
Medical Psychotherapy	45	0	0.0%
Old Age Psychiatry	214	0	0.0%
Sub Total - Psychiatry Specialties Group	1,315	2	0.2%
Core Psychiatry Training	1,450	-20	-1.4%

HEE's investment plan shows our intention to transfer 20 core psychiatry posts to become GP training posts but based within mental health services. Whilst this is shown as a 1.3% reduction in posts the reality behind this local decision is that these posts have remained vacant for over five years with the consequence that temporary workforce has had to be employed where possible. By making these GP training posts within the mental health services the local deanery is ensuring that these posts are filled and consequently that;

- a) the patients within this service actually have more not less staff available (they have a good record of GP fill)
- b) Our aim of expanding the GP workforce is supported
- c) These future GPs will have valuable experience of mental health patients and services.

5. Further actions HEE and partners will take

The action we are taking on filling higher specialty posts will inevitably include action on filling core posts, at this time decisions on the volume of core psychiatry training posts are likely to be reviewed, as this rationale of long standing vacancies is resolved.

The plan also shows small net increases in two other specialties, however as discussed above the main issue in respect of future supply is not the number of training posts but rather one of ensuring they are filled.

We will take this forward as part of our wider programme to understand and improve low-fill rates.

Nursing

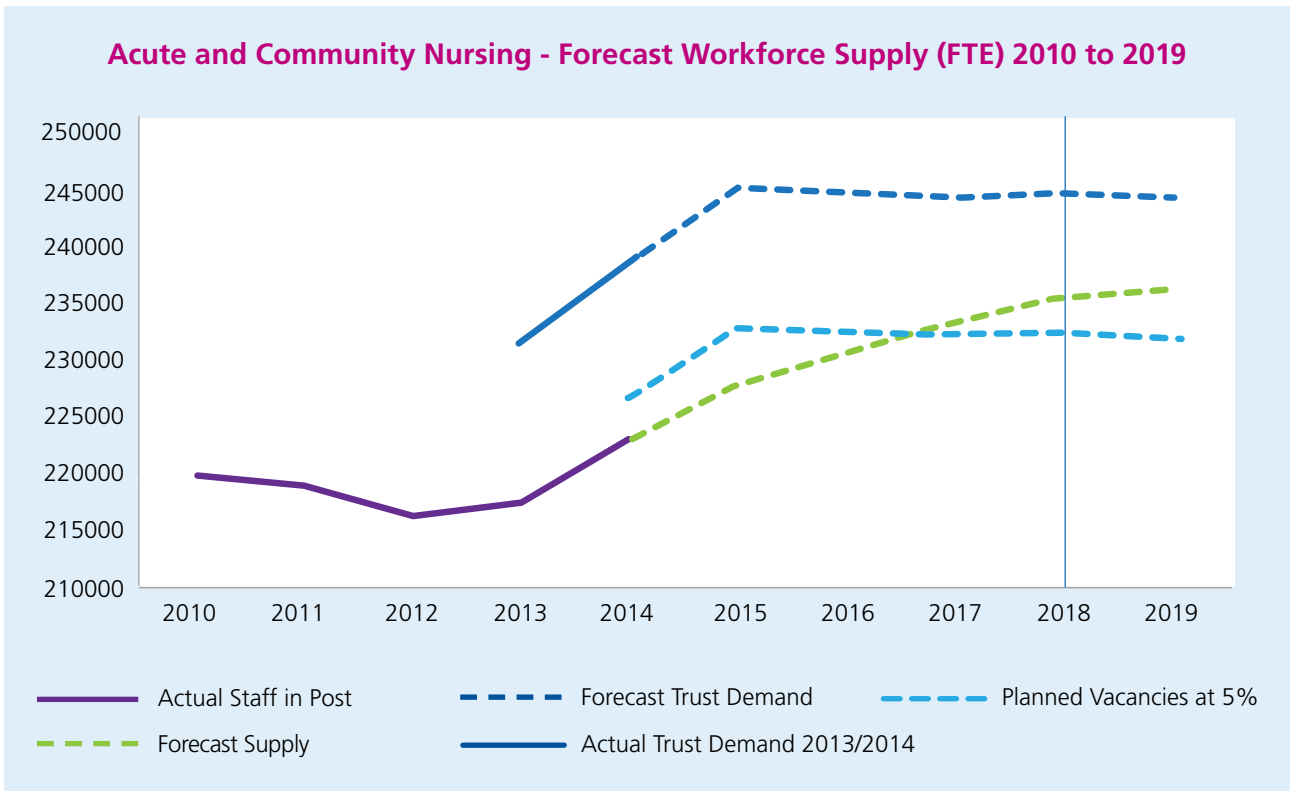
Overview

Whilst we may aspire to ensure our future workforce planning focusses on our patients and the teams that serve them, we cannot escape the fact that nurses as the single biggest professional group in the healthcare system, span all of these services and represent the key element of these teams. There are over 325,000 nurses in NHS employment in August 2014.

Combined with the focus on safe staffing levels as a result of the Francis report and the rapid expansion of provider demand for nurses that this created, means that HEE and partners continue to place significant focus and effort on ensuring we can deliver the supply for patients that this new demand requires.

Acute and community nursing

Nurses on the adult branch of the NMC register and who have undertaken the associated pre-registration training, provide services across both hospital and community settings. The fact that one of our commissioned programmes provides supply to both settings makes consideration of the impact on each specific setting something that goes beyond simple numbers. The analysis below shows how our supply can, in aggregate, meet the needs of both settings, although we will continue to assure ourselves that this is the case, as there continues to be no indication at all of excess supply.



1. Forecast supply

Proposed training levels within the adult nursing branch, which serves both acute and community workforces, are forecast to deliver 13,048FTE growth in available supply by 2019, this would represent an increase of 5.8% over this five year period.

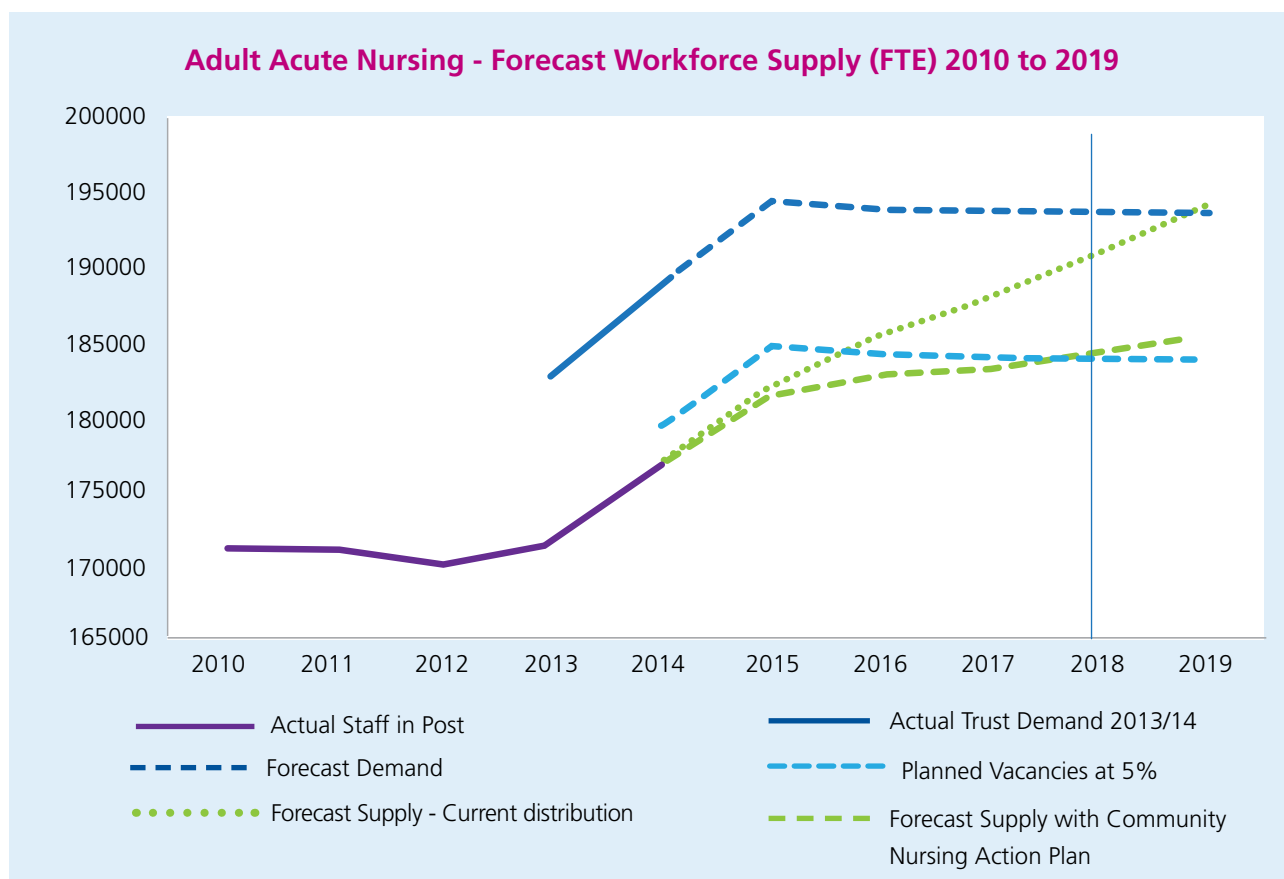
This growth will arise from a total of 62,437 commissions placed with HEIs over the period 2011 to 2015, which are forecast to produce 49,921 graduates which if employed at current participation rates would deliver 44,230FTE of service contribution. This will replace the 23,200FTE forecast retirements along with a net movement of other joiners and leavers of 8,000FTE including international migration of both UK and EU staff, and net movement between NHS and independent sector providers.

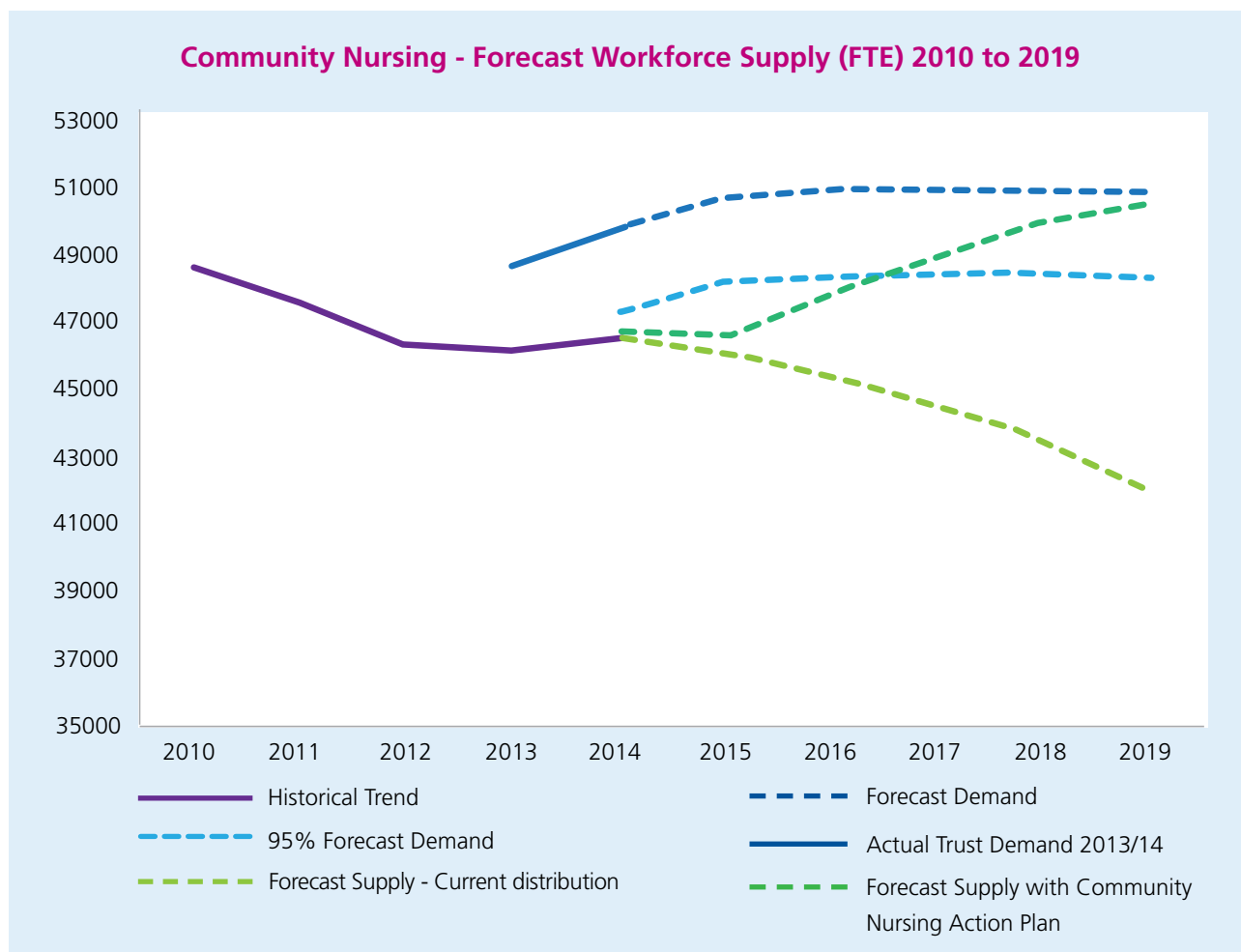
In addition to the increased training commissions the supply forecast assumes a continuation of the HEE co-ordinated Return to Practice (RTP) scheme in 2015 and 2016 with likely reductions to this effort in 2017 when the increases from the 2014 increased training commissions come on stream.

The critical issue for HEE and its partners is how this total available supply is incentivised to work in the community service settings that both HEE's *Framework 15* and the *Five Year Forward View* indicate are what patients and the system require. Transforming Primary Care indicates a minimum requirement for 5,000 clinical professionals to join the community and primary care workforce by 2020 in addition to the planned expansion in GPs.

As described in the primary care section if this expansion includes significant numbers of community nursing then, when compared to current patterns of staff movement this would require a significant effort on behalf of community service providers and their commissioners to attract staff from hospital settings and into their community teams.

The graphs below show that with the current distribution of future supply the acute sector would grow at the community sector's expense. The alternate supply lines assume specific action plans are developed to persuade an additional 2000 staff a year to take up posts in community services.





Under this second scenario growth in the acute sector is modest and we must therefore keep under constant review whether even the new levels of adult nurse training are adequate for the system’s needs.

HEE also continues to focus on the quality and volume of outputs from our training as well as commissioned inputs. 2014/15 represents the first year in which there will be more graduates with degrees than diplomas and 2015/16 will be the year in which the first all degree cohort will complete their studies. HEE has developed both its pre-degree care programme and its value based recruitment initiative to ensure patients get the best of both worlds in terms of high calibre entrants with appropriate values and motivation for undertaking this NHS funded graduate training.

2. Forecast demand

Provider demand forecasts

As at 1 April 2014 acute and community NHS Trusts were reporting that they had 15,489FTE vacancies (6.5%). All trusts hold some level of planned vacancies recognising the need for operational flexibility, but NICE guidance indicates that organisations should aim for a maximum of 5% vacancies to accommodate these needs.

The additional supply required to meet this guidance on vacancy levels would be 3,555FTE. This is before any new requirement for staff that trusts may have during 2014/15. Many organisations are indicating they are aiming for lower rates of ‘operational vacancies’ which would increase this need.

Trusts indicate that they expect to increase their requirements by 5,641FTE (2.4%) by 2019. This is comprised of an increase of 6,389 (2.7%) in 2014/15 and subsequent reductions between 2015 and 2019 of 748FTE (-0.3%).

Adult Nursing	FTE	% increase	
Current Vacancies	15,489		6.5%
Supply required to achieve 95%	3,555	1.6%	
2014/15 Increased Demand	6,389	2.9%	
Immediate Supply Requirements	9,943	4.5%	
2015-2019 Demand	-748	-0.3%	
Total Additional Supply Needed 2014-2019	9,195	4.1%	0.8%

This means that Trusts would require an increase of 9,943FTE in 2014/15 if they were to achieve, on average, NICE guidance about levels of acceptable vacancies. Our supply forecasts indicate that this will not be delivered by the normal pattern of supply and this year's output from education. Trusts will need to continue the range of additional measures they used to grow the workforce in 2013/14, such as international recruitment and return to practice.

Trust forecast reductions after 2014/15 appear to be mainly driven by affordability, however there are indications from trusts reporting of ward level staffing information that much of the structural deficit exposed by the Francis report and subsequent NICE guidance may have been met in terms of funded posts, if not in terms of substantive supply.

HEE's call for evidence and other perspectives

Whilst accepting the significant increases in provider demand have gone a long way to delivering acceptable funded staffing levels, other stakeholders and our advisory groups advise that we should still anticipate some level of further growth in acute settings in parallel to the more rapid growth in community settings. Clearly achievement of the expansion of the primary and community workforce is a necessary precursor for this more moderate growth in the acute sector being acceptable. HEE and partners will need to rigorously monitor that the anticipated shifts in activity are materialising otherwise we would risk future shortages in secondary care settings.

Specific evidence was submitted by the Royal College of Nursing.

3. Demand and supply summary

Supply to the acute sector is forecast to grow rapidly over the next two to three years. The challenge for the system is to make sure that acute and community services can each access an appropriate share of this common supply such that the goals of the system as a whole are met in order to deliver patient care in the most appropriate setting.

HEE's LETBs continue to support this agenda both in terms of significant increases to the overall level of supply, which appears sufficient to meet all needs, and in terms of significant increases to practice and district nursing training volumes. However, such specialised training cannot be the primary driver for attracting staff into community roles, there are clear indications that such training acts to increase the skills of existing community and primary as much if not more than attracting the new staff required to increase the size of the nursing workforce in these care settings.

HEE's judgement in endorsing the commissioning proposals of our LETBs is also based on the recognition that some of the recent supply into acute care may not be sustainable in the longer term with people returning to home nations as domestic economies recover and as staff move back into private and voluntary sector roles.

The combination of these factors means we believe additional growth proposed by our LETBs remains a priority area for investment and that we should continue to monitor the overall level of supply to this critical group when considering the balance of future years' commissions between professions.

4. HEE's commissioning plans 2015/16

HEE Education & Training Commissions for 2015/16

Clinical Professional Education Programmes:	2014/15 Commissions	Planned 2015/16 Commissions	Increase/Decrease	%
Adult Nurse	13228	13783	555	4.2%
District Nursing	431	502	71	16.5%
Practice Nursing	218	359	141	64.7%

HEE's investment plan shows our LETBs' intention to increase commissions by 555 to 13,738 a further increase of 4.2%. Over the past two years this will mean there has been an increase of 1,649 training places (13.6%). By 2017, when the effects of these increases are fully implemented, this will represent an increased investment in nurse training of over £60m.

5. Further actions HEE and partners will take

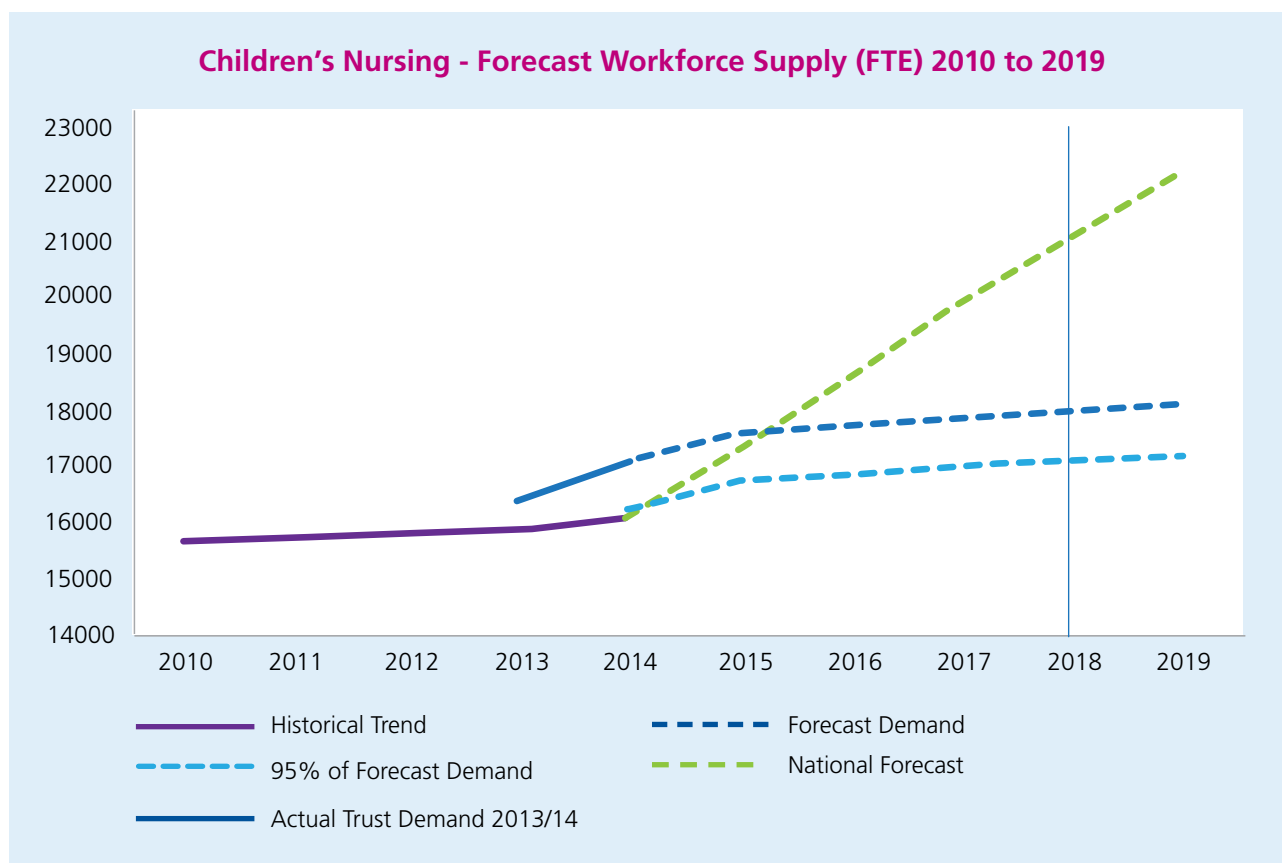
Although HEE is technically only responsible for securing the future workforce, in the interests of patient safety we decided to lead a Return to Practice campaign for nurses this year, to help Trusts fill their immediate vacancies. We have invested £1.5m in funding approximately 90 RTP courses which has already yielded 600 returning nurses currently registered on return to practice programmes, with at least 700 more expected by the end of March at £2,000 per re-trained nurse as opposed to £51,000 per newly qualified nurse.

Our forecasting indicates that unless further action is taken, this could result in a significant imbalance between supply in the acute sector and that in primary and community settings. The role of integrated care organisations, of whatever model, appears to be a significant opportunity for careful and structured operational planning to help address these key issues. HEE will continue to explore solutions through the Programme to Transform Community Nursing with NHSE, in the light of the *Five Year Forward View*.



Children's nursing

The children's nursing workforce represents a key workforce trained to address the very specific and unique challenges of caring for sick children. Operating in all settings from community team through to major tertiary centres for our sickest and neediest children, they are a scarce and valuable resource. Our analysis below indicates that some of this specifically trained resource may be being employed in general adult services, and whilst the care they provide is clearly necessary, it is concerning that the system may not be fully utilising their specialist skills and knowledge.



1. Forecast supply

Proposed training levels are forecast to deliver 5,876FTE growth in available supply by 2019, this would represent an increase of 36.5% over this five year period.

However the recent pattern of growth in the children's nursing workforce strongly indicates that newly qualified children's nurse graduates are not becoming employed in paediatric nursing services.

Low growth between 2010 and 2012 could be due to the number of funded posts available, however in 2013/14 employers grew their establishments but the number of staff employed failed to grow in line with these new

opportunities despite the very large volume of newly qualifying children's nursing graduates.

HEE rapidly needs to understand what is happening with this graduate workforce as the volume of training undertaken should be resulting in significantly higher growth to this workforce.

Both the drive for significant growth in the nursing workforce for adult acute services, and the rapid expansion of the health visiting workforce may be components of the answer and if so we may see greater growth in paediatric nursing as these two areas return to a degree of more normal growth.

2. Forecast demand

Provider demand forecasts

As at 1 April 2014 NHS Trusts indicated that they have 1,012FTE vacancies (5.9%) in the Paediatric nursing workforce.

Trusts indicate that they expect to increase their requirements by 988FTE (5.8%) by 2019, this is comprised of an increase of 523FTE (3.1%) in 2014/15 and further smaller increases between 2015 and 2019 of 465FTE (2.7%).

This means that Trusts would require an increase of 679FTE in 2014/15 if they were, on average, to achieve NICE guidance in respect of maximum acceptable vacancy levels.

Children's Nursing	FTE	% increase	
Current Vacancies	1,012		5.9%
Supply required to achieve 95%	155	1.0%	
2014/15 Increased Demand	523	3.2%	
Immediate Supply Requirements	679	4.2%	
2015-2019 Demand	464	2.9%	
Total Additional Supply Needed 2014-2019	1,143	7.1%	1.4%

The fact that NHS trusts are indicating continuing growth after 2015 is a clear signal that staffing in this area is likely to continue increasing.

HEE's call for evidence and other perspectives

The work of the children and young people's programme continues to indicate a number of areas of unmet need for children including where they have to access generalist or adult services rather than people trained in the particular needs of our young people.

In this context, the wide consensus that further growth in this workforce remains a priority seems clear. In addition to the evidence of the RCN above HEE also received evidence from the Royal College of Paediatrics and Child Health (RCPCH) in relation to children's service workforce in its wider sense.

3. Demand and supply summary

The volume of training proposed by HEE's LETBs should be more than adequate to ensure the needs of children and young people can be met by registered nurses specifically trained to meet their unique needs.

The volume of supply forecast may also create opportunities for the role of children's nurses in community teams to be explored as a component of the drive to expand this workforce.

4. HEE's commissioning plans 2015/16

HEE Education & Training Commissions for 2015/16

Clinical Professional Education Programmes:	2014/15 Commissions	Planned 2015/16 Commissions	Increase/Decrease	%
Children's Nurse	2182	2343	161	7.4%

HEE's investment plan shows our intention to increase children's nurse commissions in 2015/16 by 161 (7.4%). HEE will have increased children's nurse commissions by 192 over the past two years.

5. Further actions HEE and partners will take

We will work with our partners to understand why the large volumes of graduating staff do not appear to be ending up employed in children's services. There are no indications of widespread under employment and as such it would appear graduates are finding opportunities elsewhere or otherwise children's services are suffering exceptional levels of turnover, which again is not supported by available evidence.

HEE is also aware that the general shortage of specialist nurses is particularly acute within specialist paediatric services and indeed has resulted in threats of bed closures.

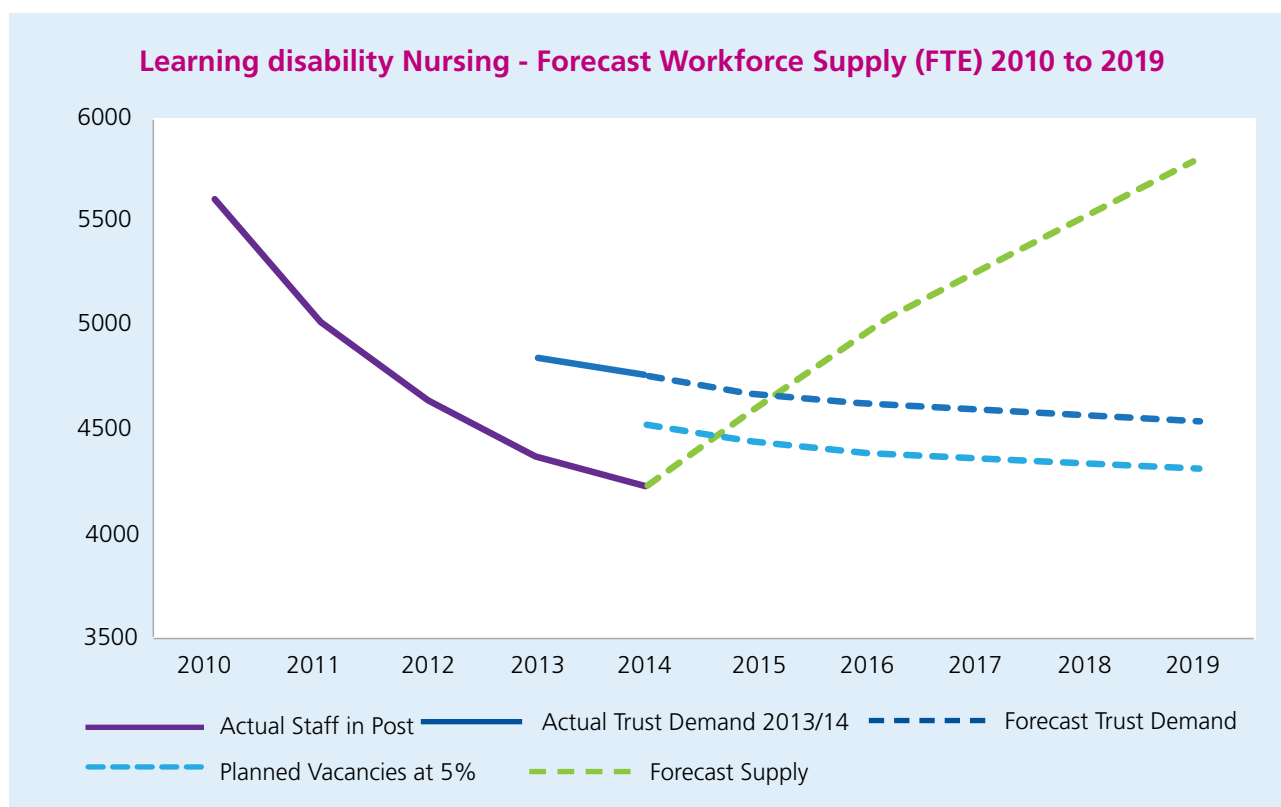
Along with the challenge described above about understanding and resolving how children's nurse graduates become part of the children and young people's services has led HEE to set up a specific work stream with ACCN with the aim of producing practical solutions that will solve both challenges.

NHS Trusts report high levels of vacancy and unmet need for specialist nursing roles, but responsibility for developing current staff formally lies with employers themselves. A combination of tight budgetary positions and the fact that training your own nurses does not guarantee that they will stay and work in your unit means there is little incentive for individual Trusts to make this investment. HEE will lead a conversation with the service and employers on whether we should take a greater role in developing the specialist nursing workforce on behalf of the system.



Learning disability nursing

The specialist skills and knowledge of learning disability nursing workforce, allied to their professional leadership, means this small workforce continues to play a critical role in delivering and leading services to some of our most vulnerable citizens. The events at Winterbourne View and the findings of the Bubb report strongly emphasise how vital having dedicated registered professionals leading care can be.



1. Forecast supply

Proposed training levels are forecast to deliver 1,567FTE growth in available supply by 2019, this would represent an increase of 37.0% over this five year period.

The actual number of staff in NHS employment has fallen consistently over the past four years (by 1,386FTE – 24.7%) however our advisory group and stakeholder partners indicate that much of this change represents the shift of activity and consequently workforce to non-NHS providers.

HEE is responsible for ensuring secure supply for all NHS commissioned services, consequently the supply line described above will act to meet the workforce needs of both NHS and non-NHS providers of these services.

Learning disability services are a priority area for us in terms of understanding the scale of requirement of non-NHS providers so our investment decisions are fully informed by this need, not least in light of the recommendations of the Bubb report.

2. Forecast demand

NHS learning disability service providers indicate that they currently have 529FTE vacancies (11.1%). They are forecasting that their requirement for learning disability nurses will decrease further by 216FTE (4.5%) by 2019, comprised of a reduction of 85FTE (1.8%) in 2014/15 and a further 131FTE (3.1%) reduction between 2015 and 2019.

Learning Disability Nursing	FTE	% increase	
Current Vacancies	529		11.1%
Supply required to achieve 95%	291	6.9%	
2014/15 Increased Demand	-85	-2.0%	
Immediate Supply Requirements	206	4.9%	
2015-2019 Demand	-131	-3.1%	
Total Additional Supply Needed 2014-2019	75	1.8%	0.4%

Some element of these forecasts will represent assumptions about further shifts in care delivery to non-NHS providers but much of it appears to be driven by assumptions of funding and affordability.

Our stakeholders and advisory groups do not believe this reflects the actual need for learning disability nursing nor the impact of policies designed to ensure parity with physical health services.

3. Demand and supply summary

The forecast supply would appear more adequate to meet both NHS and non-NHS provider requirements based upon current service models. HEE needs a clearer steer from commissioners of these services as to future intentions, and to understand the workforce implications of the recent report from Stephen Bubb. In the mean time we will take a conservative approach to our commissioning intention by endorsing the proposed increases within LETB plans.

4. HEE's commissioning plans 2015/16

HEE Education & Training Commissions for 2015/16

Clinical Professional Education Programmes:	2014/15 Commissions	Planned 2015/16 Commissions	Increase/ Decrease	%
Learning Disability Nurses	653	664	11	1.7%

HEE's investment plan shows our intention to increase learning disability nurse commissions in 2015/16 by 11 (1.7%). HEE will have increased children's nurse commissions by 36 (5.7%) over the past two years.

Public Health workforce

Overview

HEE is fully supportive of the drive to prioritise health prevention and promotion outlined within the *Five Year Forward View*. Outlined below are the actions we are taking in respect of the small number of specific public health professions for which we are responsible for ensuring future supply.

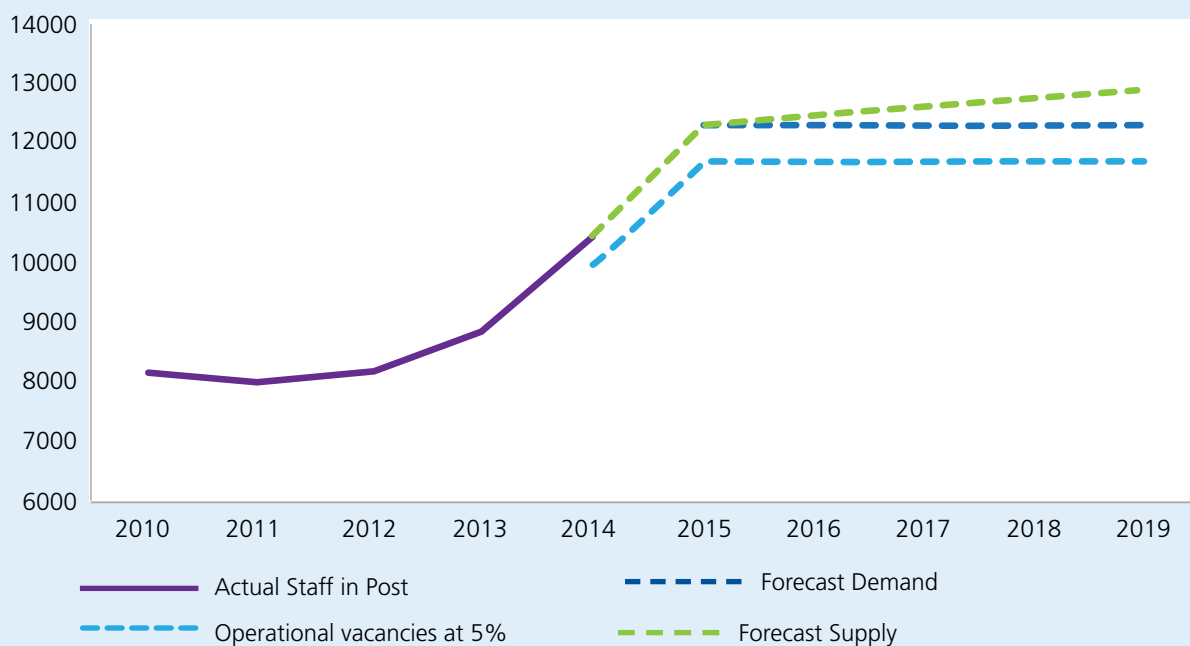
Our wider role will be to support the whole health and social care workforce in making every contact count and in putting population health at the centre of the work they do. We will continue to work with our partners to ensure curricula and programmes of education, as well as development of the current workforce, focusses appropriately on this critical area.

Health visitors

As part of its strategy to ensure families and children have the best start in life the coalition government committed to expanding the health visitor workforce by 4,200FTE and transforming the health visiting service, by 2015.

The Health Visitor Implementation Plan 2011–15 made the case for health visiting services, setting out a vision and providing a roadmap for delivery. Recent revisions to the plan take into account the progress made, changes in the health and care landscape, and the need for sustainable health visiting services beyond 2015. <https://www.gov.uk/government/publications/health-visitor-vision>

Health Visitors - Forecast Workforce Supply (FTE) 2010 to 2019



1. Forecast supply

Training levels for health visitors are forecast to deliver 2474FTE growth in available supply by 2019, however 1838FTE of this growth will be made available in 2014/15 alone, as part of the Government’s programme to deliver 4,200FTE more health visitors by April 2015 compared to May 2010.

2,363FTE of this planned growth had been achieved by 1st April 2014 an increase of 29.2% in just four years. HEE will produce over 2,500 more health visitor graduates in 2014/15 as the critical contributing factor to delivering the additional supply required. Available supply is forecast to continue to grow after 2014/15 with a further 636FTE by 2019 from proposed commissioning levels.

2. Forecast demand

Provider forecast demand

The current level of provider demand has effectively been mandated by the Government's policy at 12,292FTE. HEE has already begun liaising with local government representatives to understand their future commissioning intentions as well as continuing to directly collect provider forecasts of their future requirements.

3. Demand and supply summary

HEE is on track to deliver the volume of additional health visiting graduates required by providers to allow them to meet their need for 12,292FTE health visitors by April 2015.

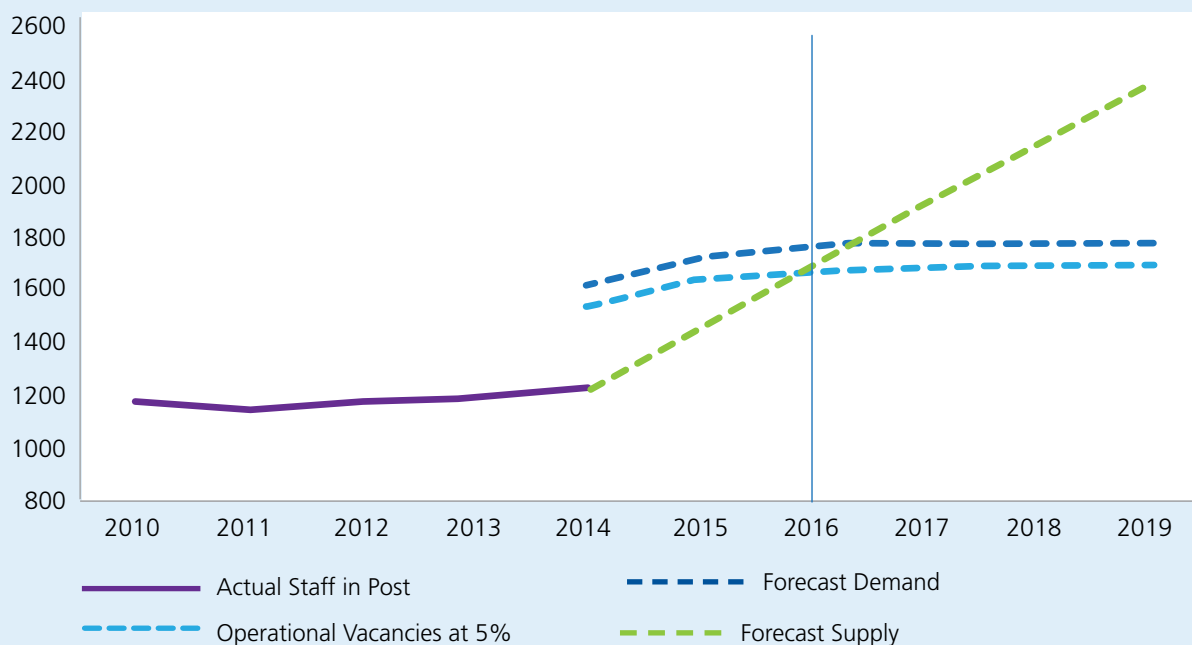
Proposed levels of future training should allow maintenance and some further growth to this workforce if required as long as employers continue to manage staff turnover to the levels they planned for in 2014/15 planning.

School nurses

In April this year Public Health England and the Department of Health published guidance to commissioners for services to school aged children, *Maximising the school nursing team contribution to the public health of school-aged children*.

The guidance highlights that the workforce is relatively small and cannot deliver the extensive healthy child programme agenda in isolation. It is clear however that the focus of prevention early in life is resulting in service providers identifying new and significant demand for this staff group.

School Nurses - Forecast Workforce Supply (FTE) 2010 to 2019



1. Forecast supply

The proposed training levels for school nurses outlined below are forecast, if sustained at this level, to deliver 1167FTE growth in available supply by 2019. This would represent an increase of 95.1% over this five year period.

2. Forecast demand

Provider forecast demand

NHS employers of school nurses indicate that they currently have extremely high levels of vacancies, with 404FTE posts not filled by substantive staff (24.7%).

They are also forecasting that they will increase their workforce requirements by a further 157FTE (9.6%) by 2019, comprised of an increase of 103FTE (6.3%) in 2014/15 and a further 54FTE (3.3%) increase between 2015 and 2019.

School Nurses	FTE	% increase	
Current Vacancies	404		24.7%
Supply required to achieve 95%	322	26.2%	
2014/15 Increased Demand	103	8.4%	
Immediate Supply Requirements	425	34.7%	
2015-2019 Demand	53	4.3%	
Total Additional Supply Needed 2014-2019	479	39.0%	7.8%

To achieve a maximum level of vacancies of 5% by the end of 2014/15 service providers would require an additional supply of 425FTE.

3. Demand and supply summary

The rapid expansion in planned training is forecast to close the existing vacancy gap and meet provider requirements for expansion by 2016. Over half of the current shortfall is predicted to

be met during 2014/15, before the impact of any parallel employer initiatives are accounted for.

HEE will then need to establish what level of training is required to maintain this workforce and/or meet new demand. This training programme is only one year in length so commissioning decisions are able to be made flexibly in response to prevailing need.

4. HEE's commissioning plans 2015/16

HEE Education & Training Commissions for 2015/16

Clinical Professional Education Programmes:	2014/15 Commissions	Planned 2015/16 Commissions	Increase/Decrease	%
Health Visiting	1041	1193	152	14.6%
School Nursing	198	340	142	71.7%

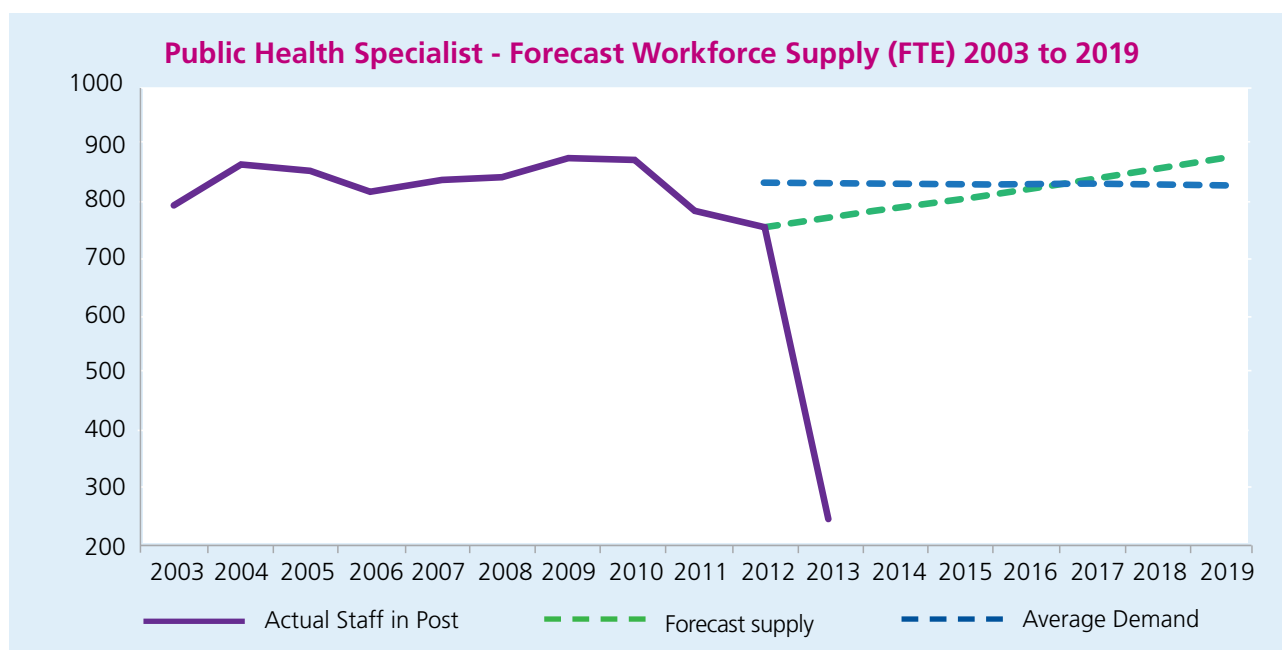
HEE's investment plan shows our intention to increase both health visitor and school nursing commissions in 2015/16 by 152 places (14.6%) and 142 places (71.7%) respectively.

Public Health specialist workforce

The public health specialist workforce has undergone radical changes over the past two years with the movement of many practitioners into local authority employment to support the leadership of this locally delivered health improvement agenda, and in parallel the establishment of Public Health England.

The graph below, which records NHS employed staff shows the point at which the majority of public health specialists transferred to local government employment.

Planning the future of this workforce and tracking its movement has certainly become more complex but certainly not insurmountably so. We are working closely with PHE, the LGA and other key stakeholders such as the Faculty of Public Health to ensure our training, which continues at full historic levels, can be matched to current and future needs.



1. Forecast supply

In many ways future supply remains a more readily identifiable factor. HEE remains in control of training volumes and outputs and the age profile of the workforce is known so retirements can be predicted. The area of uncertainty is whether the change in employment status has had any material impact on the pattern of other staff turnover.

The forecast shown on the graph comes from earlier work CfWI undertook and will need to be adjusted once our understanding of any new pattern of staff movement is known. However education supply remains strong and was based on an average of over 60 new fully qualified specialists completing every year.

2. Forecast demand

Ascertaining future demand is where HEE and the local authorities need to work closely together. Our standard approach to triangulating demand will not work in this instance, as bespoke approaches to establishing future need will need to be developed. The line above simply shows the average level of staff over the past decade as an indicator of what the status quo looks like compared to forecast supply.

The context for this work is critical. The *Five Year Forward View* places prevention at the heart of the system's response to the challenges it faces and as such we can anticipate that future requirement for such specialists is likely to grow.

3. Demand and supply summary

Maintaining the current level of training will ensure there continues to be a strong supply of new public health specialists available to grow the workforce.

HEE needs to work closely with local authorities and PHE to understand both future demand and to track the movement and progression of the current workforce so that any supply challenges can be identified and acted upon.

4. HEE's commissioning plans 2015/16

	Number of Training Posts	Increase/Decrease	%
Public Health Specialists	421	0	0.0%

HEE's investment plan indicates that we are maintaining our investment in 421 training posts for public health specialists. Depending on the number of final year trainees completing their studies we expect to recruit between 57 and 84 new trainees in August 2015.

The *Five Year Forward View* makes clear that the public's health will be a key priority for the NHS in the future, and we will work with PHE to better understand the workforce implications of this approach, and how we can use our levers to drive improvements in health.

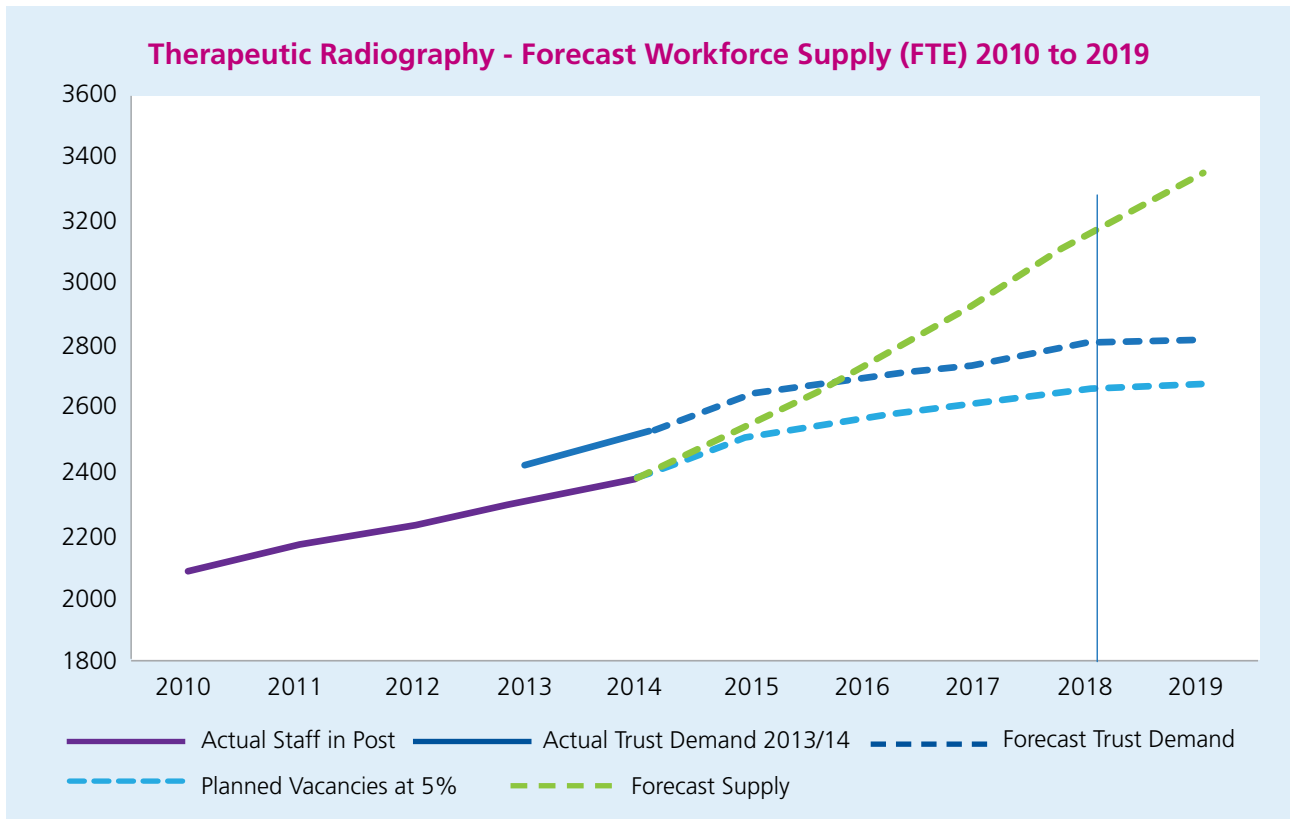


Diagnostic and scientific workforce

The professions included in this section represent a diverse range of roles which a 'catch all' description would fail to do justice. The range of diagnostic, therapeutic, and support roles centres on high levels of expertise and scientific knowledge, that these staff provide.

Therapeutic radiography

Therapeutic radiographers are a key part of oncology teams treating patients with cancer. Their role in ensuring that accurate doses of X-rays and other ionising radiation are delivered to the tumour/cancer whilst minimising the dose received by the surrounding tissues, form a critical part of cancer services. The rapid demand for growth for this workforce reflects the significant progress that has been made in using these techniques.



1. Forecast supply

Proposed training levels for therapeutic radiography are forecast to deliver 973FTE growth in available supply by 2019, this would represent an increase of 40.9% over this five year period.

This workforce grew by 903FTE over the 10 year period to 2013, a 61.4% increase, the highest of any single non-medical professional group. We need to be aware that despite new demands such as Proton Beam Therapy (PBT), current training has and is providing significant new supply and we must assess at what point a more moderate growth may be justified.

2. Forecast demand

Provider demand forecasts

NHS Therapeutic Radiography providers indicate that they currently have 138FTE vacancies (5.5%). They are forecasting that they will increase their workforce requirements by a further 307FTE (12.2%) by 2019, comprised of an increase of 131FTE (5.2%) in 2014/15 and a further 176FTE (7.0%) increase between 2015 and 2019.

Therapeutic Radiography	FTE	% increase	
Current Vacancies	138		5.5%
Supply required to achieve 95%	12	0.5%	
2014/15 Increased Demand	131	5.5%	
Immediate Supply Requirements	143	6.0%	
2015-2019 Demand	176	7.4%	
Total Additional Supply Needed 2014-2019	319	13.4%	2.7%

Available supply in 2014/15 is forecast to exceed immediate requirements and exceed future requirements as forecast by NHS trusts including planned PBT provision at The Christie NHS Foundation Trust and University College London Hospitals.

3. Demand and supply summary

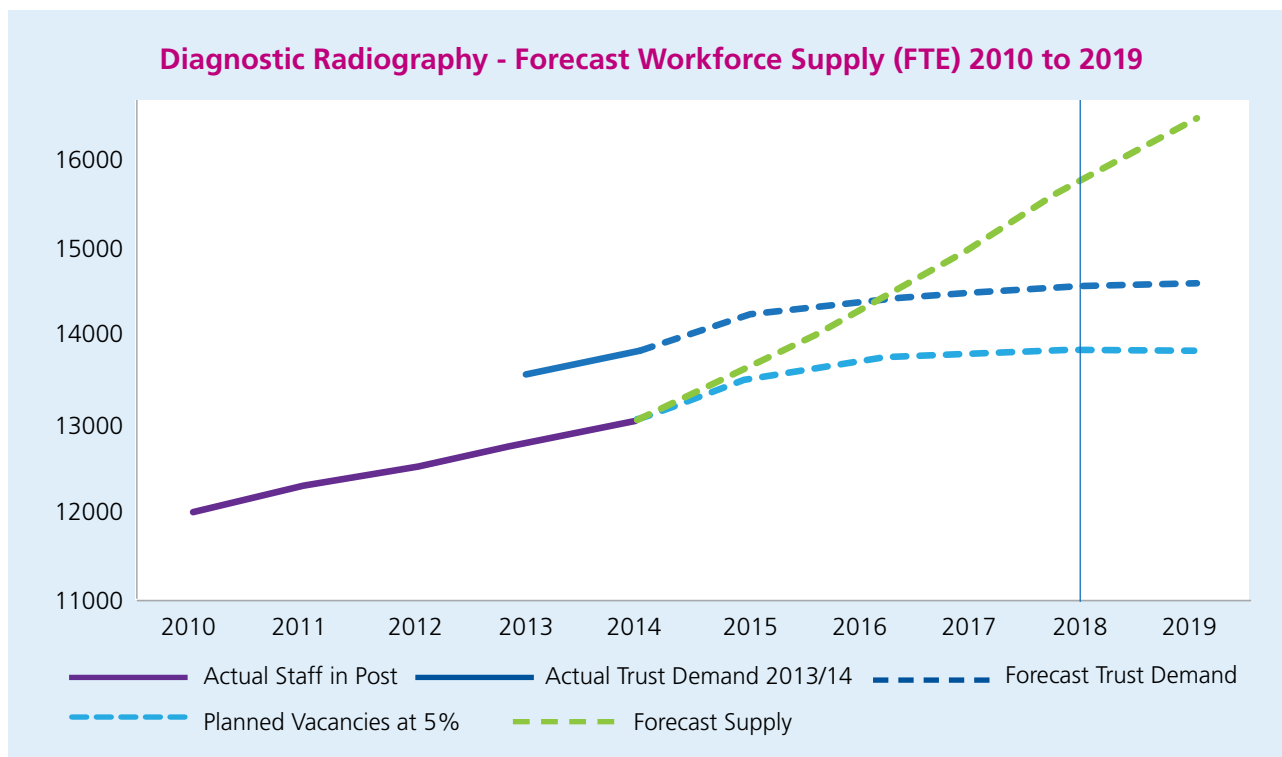
Service providers report that there remains current unmet need and an ongoing expectation of further growth including specific developments such as PBT. However the current level of training provision is forecast to exceed these needs over

the next few years, despite high levels of course attrition. It is accepted that provider forecast of demand may be moderately understated. We will need to keep these investments under close review to ensure we do not continue this growth to the point where oversupply materialises.



Diagnostic radiography

This rapid growth in demand for this workforce, operating within radiology and imaging teams, mirrors the significant increases in the volume of different modalities of imaging and scans that the NHS has observed over the past decade. The significant investment made in developing this workforce continues, however we must ensure the growth this training generates continues to represent the right balance of priorities within the wider diagnostic team.



1. Forecast supply

Proposed training levels for diagnostic radiography are forecast to deliver 3,429FTE growth in available supply by 2019, this would represent an increase of 26.4% over this five year period.

This workforce grew by 3,447FTE over the 10 year period to 2013, a 35.8% increase.

2. Forecast demand

Provider forecast demand

NHS diagnostic radiography providers indicate that they currently have 807FTE vacancies (5.8%). They are forecasting that they will increase further by 824FTE (6.0%) by 2019, comprised of an increase of 430FTE (3.1%) in 2014/15 and a further 393FTE (2.9%) increase between 2015 and 2019.

Diagnostic Radiography	FTE	% increase	
Current Vacancies	807		5.8%
Supply required to achieve 95%	117	0.9%	
2014/15 Increased Demand	430	3.3%	
Immediate Supply Requirements	547	4.2%	
2015-2019 Demand	393	3.0%	
Total Additional Supply Needed 2014-2019	941	7.2%	1.4%

3. Demand and supply summary

The forecast supply would appear more adequate to meet both NHS provider requirements despite the expectation of continued growth in this service area. There appears to be some risk of excess over supply unless demand changes radically or supply conditions alter compared to those forecast.

4. HEE's commissioning plans 2015/16

Clinical Professional Education Programmes:	2014/15 Commissions	Planned 2015/16 Commissions	Increase/ Decrease	%
Diagnostic Radiography	1,059	1,115	56	5.3%
Therapeutic Radiography	371	414	43	11.6%

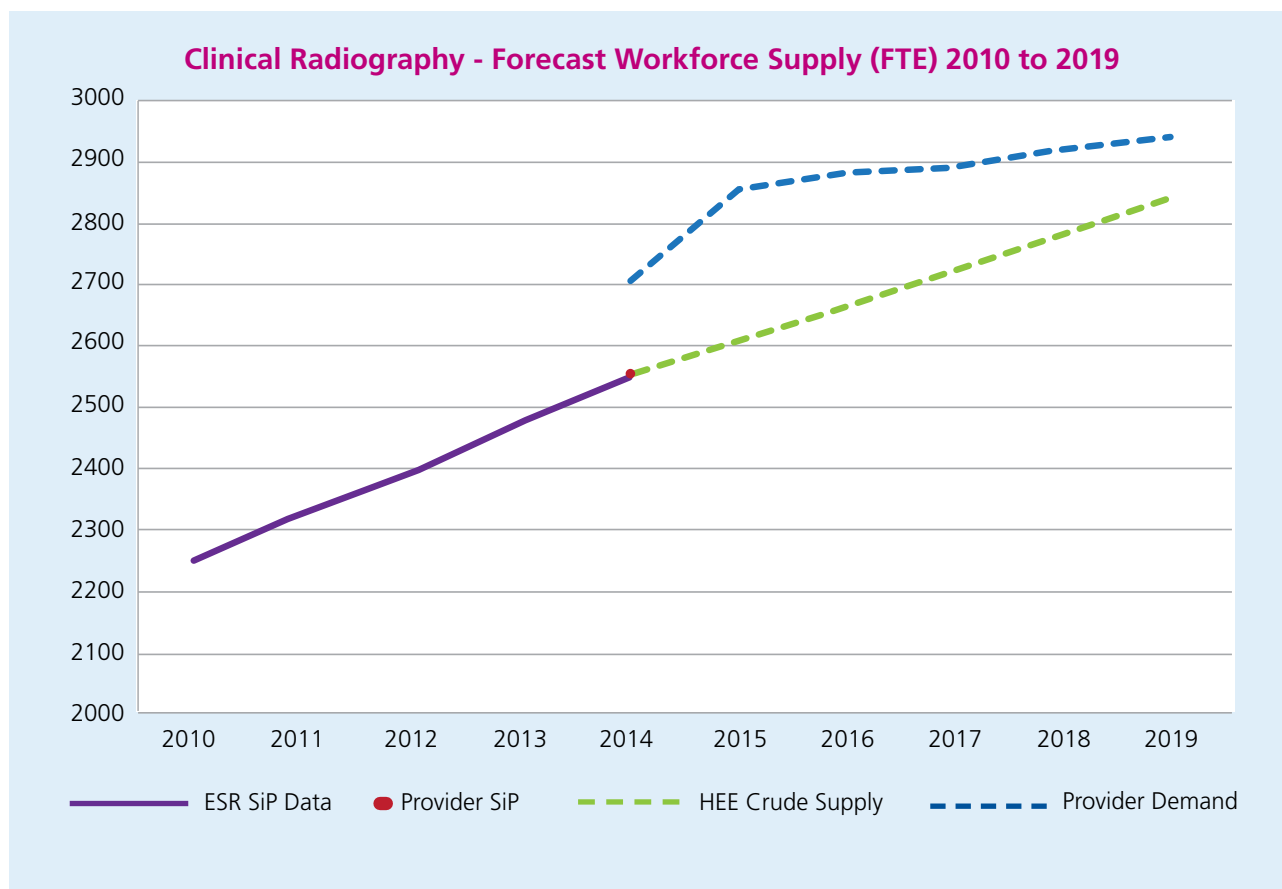
HEE's investment plan shows our intention to increase both diagnostic and therapeutic radiography commissions in 2015/16 by 56 places (5.3%) and 43 places (11.6%) respectively.

5. Further actions HEE and partners will take

Despite the ongoing priority nature of diagnostic services, a review of when it may be appropriate to moderate current training levels will be required before commencement of the 2015 HEE planning round. Resources currently used for these staff groups may be better deployed on areas such as endoscopy or sonography training that at present are supported from our limited investment in the current workforce.



Clinical radiology



1. Forecast supply

Clinical radiology is a 'run through' specialty with a five year minimum training period. The output from decisions made for 2015/16 will not materialise until 2020 at the earliest. The supply line above shows the forecast supply based on existing doctors in training who were recruited between 2009 and 2014.

This training activity is forecast to deliver 287FTE growth in available supply by 2019, this would represent an increase of 11.2% over this five year period.

2. Forecast demand

NHS providers of clinical radiology are currently indicating that they have 150FTE consultant vacancies (5.9%). They are forecasting that they will increase further by 234FTE (8.7%) by 2019, comprised of an increase of 148FTE (5.5%) in 2014/15 and a further 86FTE (3.2%) increase between 2015 and 2019.

3. Demand and supply summary

There are some moderate existing levels of vacancy that threaten to be compounded by the intentions of NHS provider to grow their establishment in 2014/15 by 5.5% which will outstrip the forecast supply in this year.

Overall supply will trend towards demand over the next 5 years but providers will need to take shorter term measures to ensure substantive vacancies in this period do not effect service delivery.

In the longer term HEE is increasing training volumes so that any structural shortfall can be closed in future years.

4. HEE's commissioning plans 2015/16

Post Graduate Medical & Dental Education:	Number of Training Posts	Increase/Decrease	%
Clinical Radiology	1,081	16	1.5%

HEE's investment plan shows our intention to increase clinical radiology training posts in 2015/16 by 16 (1.4%). This continues to build on the 14 additional posts commissioned in 2014/15.

Other diagnostic workforce groups

A number of other key diagnostic groups, such as nurse endoscopists or sonographers are formally the responsibility of providers to develop as they represent the post graduate development of existing staff. HEE has been mandated to work with partners to ensure a comprehensive response to these needs is developed within our respective responsibilities. Initial action plans in both areas have been developed by HEE with partners.

Healthcare scientists

The healthcare scientist workforce covers over 50 different scientific specialities and are the specialist workforce in the health system that respond directly and uniquely to advancing scientific and technological change. 80% of all diagnoses are associated with the work of healthcare scientists but they also have roles and functions that extend far beyond routine and highly specialised diagnostics to specialised treatment interventions and ongoing specialist monitoring, and, in the clinical engineering specialties, their expertise is applied to ensuring the advanced technology available to clinicians supports and delivers patient care safely and effectively.

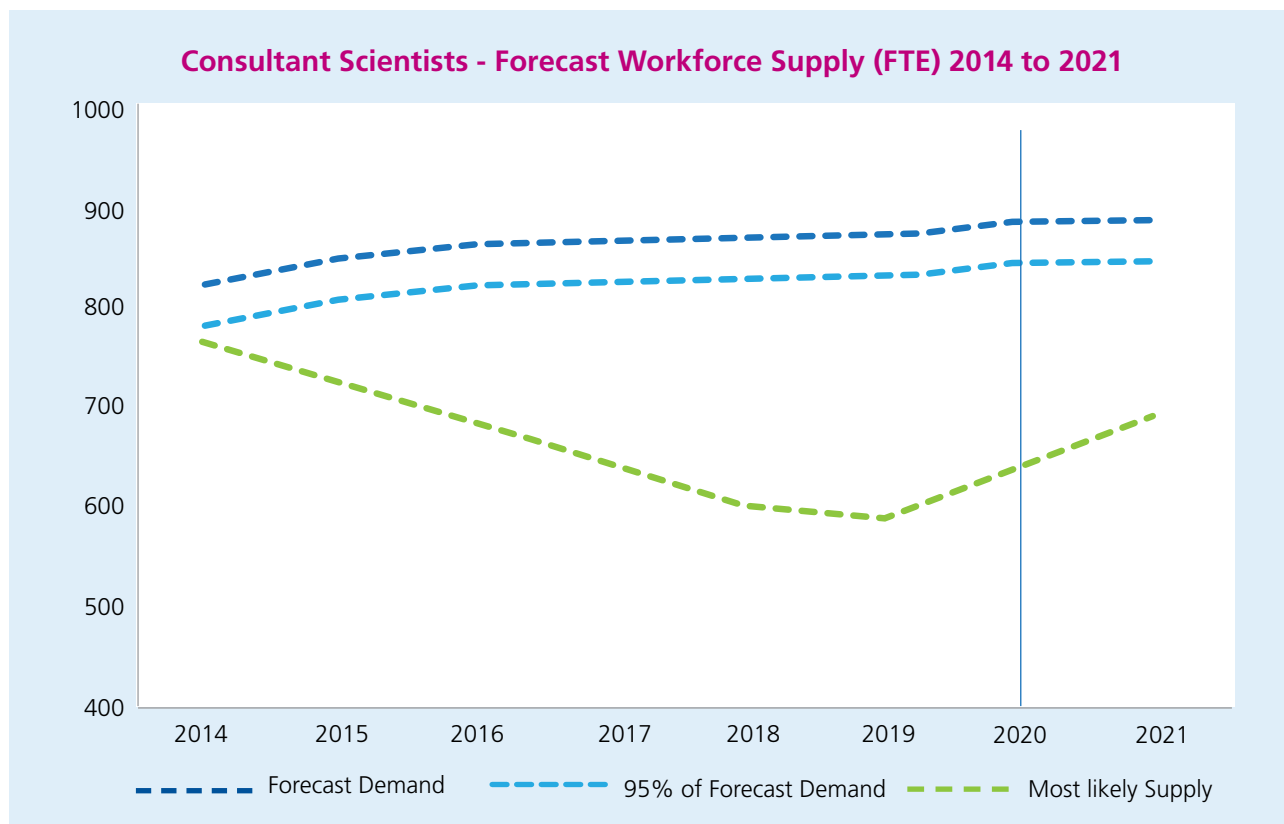
Developments in the area of genetics, genomics and clinical bioinformatics will underpin the transformation of service design and healthcare delivery. As such, we have continued to support the implementation of the modernising scientific careers (MSC) programme, and invested in the expansion of scientists recognising the key role they will play in the future of our health service.

We recognise that current modelling indicates that we may need to further expand investment in this professional group in the future, and we will build on the work started this year to increase our understanding of factors affecting the demand and supply forecasts for this professional group, including but not limited to addressing some of the inherited data limitations and training placement constraints.

The MSC programme aimed to ensure that despite the diverse number of specialties, that a common career pathway was developed alongside a consistent approach to the education and training of staff along this pathway. This structured career pathway has allowed us to observe collective trends across specialties in relation to the different senior role types, including consultant scientists and healthcare scientists, that the system is indicating it needs.

We must not, however, ignore the fact that these specialist scientific roles are supported by over 20,000 qualified healthcare scientist practitioners educated to graduate level, and 14,000 healthcare science support staff. These groups are formalised by education and training requirements defined by MSC but not all are only formally commissioned by HEE and as such do not form part of our standard supply and demand assessment, however their ongoing development is clearly critical to the overall success of the service and must be addressed in employer and our LETB's development plans for the current workforce.

Consultant clinical scientists



1. Forecast supply

The existing cadre of consultant clinical scientists achieved the knowledge and expertise they require to undertake these roles through a wide variety of development activities which did not generally follow a defined or structured pathway.

Future consultant scientists will all have completed a five year higher specialist scientific training (HSST) programme developed and introduced under modernising scientific careers, commissioned by HEE. However the programmes only commenced in 2014 and as such the first supply will only become available during 2019/20. Unless action is taken to ensure current senior healthcare scientists are further developed, there is a risk of significant undersupply over the next 5-7 years.

Our forecasting indicates that without such compensating activity that the number of consultant scientists could fall by 177FTE by 2019

(23% reduction) with a potentially significant impact on service delivery. The volume of training commissioned in 2015/16 can have no impact on this shorter term supply challenge.

HEE will rapidly work with employers and our advisory group to understand what actions and by whom are required to avoid this forecast becoming realised. As described in Annex 4, our future commissioning will be shaped by the success and sustainability of these shorter term interventions.

Note - A description of the recent trend for this workforce cannot be provided. As part of MSC all healthcare scientist posts were re-categorised and given new occupational codes, and whilst this will provide the basis for much clearer future monitoring and management, it does mean the system has foregone any direct comparability with historic movements to this workforce.

2. Forecast demand

Provider forecast demand

NHS service providers indicate that they have a current shortfall of 56FTE (6.8%). Trusts are also indicating an intention to grow the consultant scientist workforce by 65FTE (7.8%) by 2019. This aggregate growth masks increases and decreases in specific specialties and in different geographical areas. There is however some value in describing this aggregate position as it allows partners to understand the general scale of the challenge and what resources may be required to address these challenges, to allow comparison with other priorities.

3. Demand and supply summary

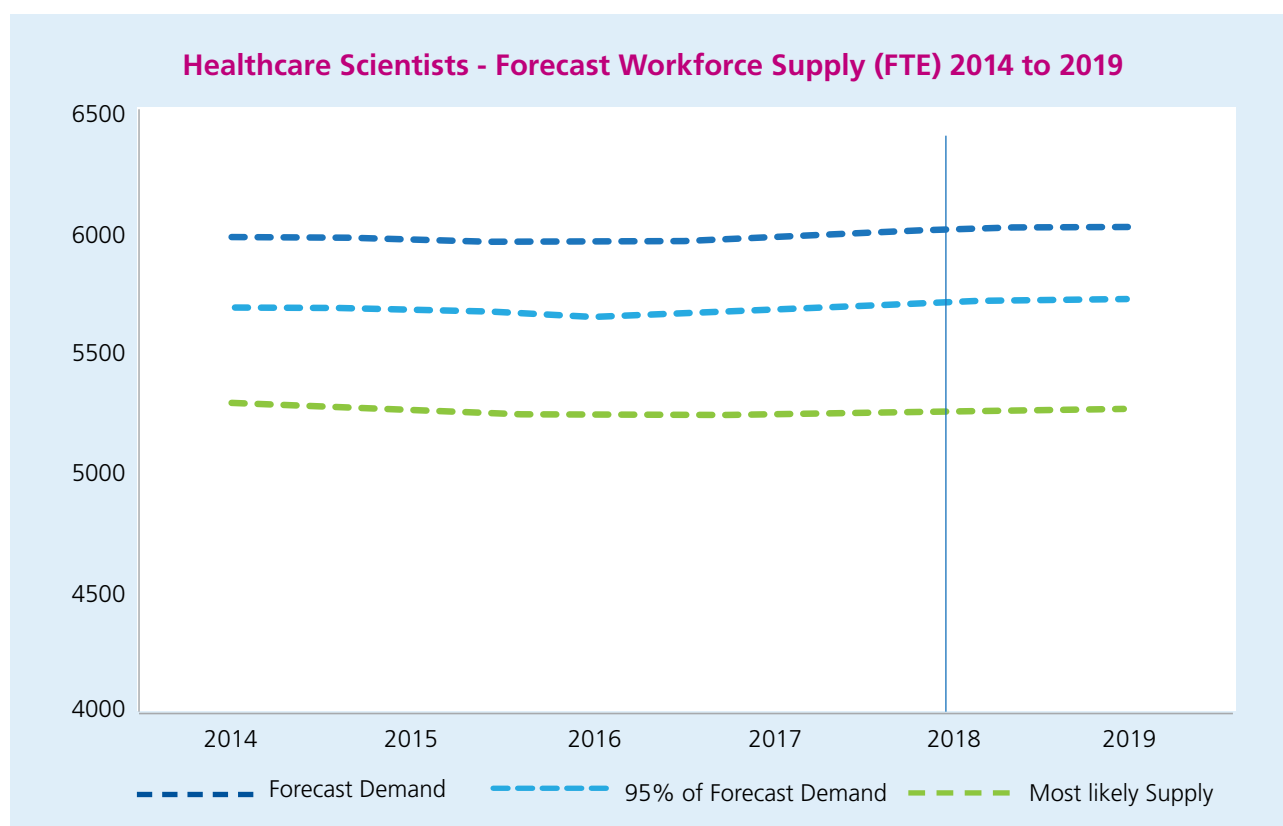
The proposed level of training will allow for growth of the Consultant scientist workforce

from 2019 onwards. HEE will need to carefully monitor the extent to which this growth is required to close any emergent shortfall caused by the fallow period of supply from 2014-2019 compared with growth to meet the increasing demand for new posts by the service.

There appear to be potential supply risks for this particular workforce if scientists are not sufficiently engaged in the planning process locally. The actual movement of staff into and out of this group will require careful monitoring, as will the providers' response in terms of numbers of funded posts especially if vacancies became long standing.

HEE and partners need to develop clear plans to ensure continuing supply through other means until the first graduates of the HSST programmes become available in 2019.

Healthcare scientists



1. Forecast supply

Current training activity and proposed commissioning levels are forecast to broadly maintain the numbers in this workforce at current levels (a reduction of just 28FTE (0.5%) over five years).

Healthcare scientists have also moved over the past 3 years onto a new structured education and training pathway, the three years scientific training programme (STP). There will be an uninterrupted transition from any remaining graduates coming off the old scheme in 2016/17 to the first graduates from STP in 2017/18.

2. Forecast demand

Provider forecast demand

NHS service providers indicate that they had (11.5%) vacancies as at the start of 2014/15. They are also indicating a very modest intention to increase their requirement for this group by (0.7%) by 2019

HEE call for evidence and other perspectives

It is the view of the Chief Scientific Officer and our HEE Advisory Group that these forecasts do not reflect the anticipated requirements for this workforce as set out in the 5 Year Forward View and HEE's *Framework 15* especially in areas such as bioinformatics, genomics, cardiac physiology and medical physics.

4. HEE's commissioning plans 2015/16

HEE Education & Training Commissions for 2015/16

Clinical Professional Education Programmes:	2014/15 Commissions	Planned 2015/16 Commissions	Increase/Decrease	%
HCS Higher Specialist Training (HSST)	94	103	9	9.6%
HCS Scientist Training Programme (STP)	271	282	11	4.1%
HCS Practitioner Training Programme (PTP)	246	473	227	92.3%

HEE's investment plan shows our intention for small increases in commissions for both HSST (consultants) following last year's large expansion, and for STP (Healthcare scientists) programmes with increases of 9 and 11 respectively.

3. Demand and supply summary

The NHS has commissioned consistent volumes of training over the past few years which will act to broadly maintain the numbers of this group available. HEE's proposed commissions appear to continue this trend but without closing the current shortfall nor meeting any demand that might emerge in excess of that expressed by service providers and that which is required to meet the future scientific and technological changes in healthcare.

This aggregate analysis simply allows the overall pattern to be observed; ideally each group should be considered within their own individual specialities. In genomics and bioinformatics for instance, HEE's genomic programme is finalising proposals to increase training in these specialities over and above that put forward by our LETBs in anticipation of future demand that is consistent with longer term perspectives of the system but which may not be captured by service provider forecasts. HEE is intending to commission up to 40 additional places over and above the commissions shown below and in [Annex 1](#).

HEE will continue to develop our understanding of all specialities, but will focus attention on areas where current shortage or rapid growth in demand, such as medical physicists and cardiac physiologists, warrant additional action.

HEE is increasing its support to the number of NHS clinical placements used in support of the modernising scientific careers approved practitioner training programme (PTP) degree courses (Higher Education Funding Council for England (HEFCE) and student loan funded which provide the graduate supply to the practitioner workforce.

Section 5

Investing in innovation and service transformation

The previous 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.

We know from our own *Framework 15* and the *Five Year Forward View* that simply commissioning more of the same will not meet the future needs of the NHS and the patients we serve. Both documents talk of the need to provide more care in the community, with greater flexibility of roles, more generalist skills and an increased focus on supporting people to prevent ill health, whilst enabling patients to be more active in the management of their own care.

There are four ways that the NHS can transform the workforce to deliver new models of care:

1. Re-train and re-skill our existing workforce
2. Create and commission new roles and professions
3. Significantly expand existing roles required to deliver the new care models
4. Innovative education and commissioning programmes

Employers are responsible for 1, whereas HEE is responsible for 2, 3 and 4. The healthcare workforce is the engine of the future. They are the source of innovative and radical ideas that can save and transform lives. We will therefore work with employers to lead local conversations with staff about what support they need in order to deliver service transformation in general, and what HEE can do to help in particular.

However, we cannot just create new roles out of thin air. HEE has a statutory duty to avoid excessive under and over supply, which means we require

evidence of demand from commissioners and employers for any new roles that we may create, and currently, we are also constrained by the requirement to achieve agreement across the four countries for the regulation of new roles. When we published our first Workforce Plan for England last year, the system lacked a clear and compelling vision for the NHS, which hampered our ability to define and commission the workforce required to deliver future care. The recent publication of the *Five Year Forward View* is a welcome development, as it makes clear – albeit at a high level – that we will need a new type of workforce to deliver the new models of care.

The *Five Year Forward View* was published at the end of this year's workforce planning process, but even so, the plans from our LETBs demonstrate local ambition for change and transformation, drawing upon our *Framework 15* and local strategies. There is more work to be done with our LETBs and local employers and commissioners to consider and discuss the workforce implications of the *Five Year Forward View* at scale and pace, which will form the basis of next year's planning process. Meanwhile, we will start to lay the foundations for transformation through our 15/16 education and training commissions:

Example of creating new roles: Physician associates (PA)

A PA is defined as someone who is: *a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.* The role is therefore designed to supplement the medical workforce, thereby improving patient access.⁴

Most commonly found in hospital settings, a small number of general practices in England have employed PAs.⁵ PAs are trained to perform a number of duties, including taking medical histories, performing examinations, diagnosing illnesses, analysing test results, and developing management plans.⁶

The role was developed in the USA in the mid-1960s and was introduced into the UK in early 2003 in a GP practice in the West Midlands.⁷ Currently around 200 PAs are working across the United Kingdom. Most of these are based in Bristol, Edinburgh, Glasgow, Weston-Super-Mare, the East and West Midlands, and parts of London.⁸ Many PAs come from a background where they were already trained health professionals, such as nurses, paramedics, and physiotherapists.⁹

PA training lasts two years, and although it involves many aspects of an undergraduate or post graduate medical degree, it focuses principally on general adult medicine in hospital and general practice, rather than specialty care. We have discussed the role the wider primary and community care teams can play to share this load, however whilst these professionals can meet some

of the workload they are not substitutes for the GP themselves. However, at two years, the training is much shorter than a qualified doctor which allows us to respond to current pressures more quickly.

Recent studies have reported high levels of patient satisfaction with PAs, and other clinicians in studies based in primary and mental health settings have been positive, concluding that PAs are competent and safe, as well as being productive in terms of handling appointments and cost.

The Royal College of Physicians (RCP) says that the number of PAs in the UK has so far been limited owing to lack of regulation for those taking on these roles. The college has been pushing for regulation of PAs since 2005. The Royal College and the UK Association of Physician Associates said that statutory regulation would allow PAs to make a “more effective contribution to the health service and the health economy as well as offering better protection to the public.” Others agree, arguing that in order to maximise the contribution of PAs, potential needs to be given to the appropriate level of regulation and the potential for allowing them to prescribe medicines.

Physicians Associates

Start year	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	Increase since 2014/15
Education Commissions	30	0	0	40	0	24	24	24	205	754%

In response to the desire for a more flexible, generic workforce and improved patient access, HEE will commission 205 PAs in 2015/16, representing an increase of 754% upon last year. In the coming year we will work with our stakeholders to identify further new roles that could support service transformation, including women’s surgeons, prescribing pharmacists and orthopaedic physicians. We are keen in particular to explore innovation in the non-medical workforce, which can be enacted more swiftly and at scale, to support the delivery of the *Five Year Forward View*.

⁴ Competence and Curriculum Framework for the Physician Assistant, UKAPA, 2012

⁵ <http://www.journalslibrary.nihr.ac.uk/hsdr/volume-2/issue-16#abstract>

⁶ www.nhs.uk/explore-by-career/doctors/careers-in-medicine/physician-associate/

⁷ Can physician associates be effective in the UK?, Antony Stewart and Rachel Catanzaro - Clin Med 2005;5:344-8

⁸ <http://careers.bmj.com/careers/advice/view-article.html?id=20019162>

⁹ <http://careers.bmj.com/careers/advice/view-article.html?id=20019162>

Expanding existing workforce roles to support transformation

Whilst new roles are important, some radical changes in service delivery and the quality of care can be delivered by the expansion of existing roles, and/or shifting the location in which they work. This has occurred most notably in this year's plan in the following settings:

- School nursing (an increase of 71.7% on last year)
- Practice based nursing (an increase of 64.7% on last year)
- Health Visitors (an increase of 500% over 4 years)
- Dental support staff

These large increases (albeit in some instances from a low base) start to create the conditions in which we can provide more care in the community, with our staff playing a key role in not just responding to incidences of disease, but working proactively with others to promote and protect health. Working with our stakeholders, we will seek to take a more strategic approach to our overall assessment of growth next year, to ensure that we place our investments where we think they have the greatest effect for patients.

More flexible education and training courses to support transformation

As well as creating or expanding roles, the way in which we educate and train our staff offers a real opportunity to support and drive service transformation. Instead of just commissioning traditional uni-professional trainee courses, we will seek to innovate in how we educate and train our staff more flexibly, for example by exploring how post-registration education can enable nurses and other parts of the non-medical workforce to look after the whole person appropriately, which could include psychiatry, mental health and the physical therapies. We will continue to expand the amount of time that our trainees spend in community and non-acute settings, so that they are incentivised and equipped to work wherever the patient is. These issues are currently being taken forward as part of our Shape of Caring and Shape of Training Reviews for the nursing and medical professions respectively.

In addition, we are leading on the Talent for Care work which forms part of HEE's Strategic Framework. Talent for Care seeks to improve the development opportunities available for healthcare support staff, typically those in roles banded 1-4, who make a vital contribution to patient care and service delivery. Those in Bands 1-4 roles make up approximately 40% of the non-medical workforce and provide up to 60% of direct patient contact, and yet traditionally receive very little investment in their training and development. HEE recognises the fundamental role support staff play in providing quality care and the necessity of ensuring this workforce receives high quality training to perform their role to the highest standard.

HEE are therefore supporting greater innovation in the way Bands 1-4 roles are utilised and encouraging suitable opportunities for staff to progress into registered roles. The additional investment and development for support staff and new roles within this banding range can make an important contribution toward future supply challenges.

In our *Framework 15*, we recognised that the workforce will include the informal support that helps prevent and manage ill health, such as patients themselves and their carers. To this end, we committed to commissioning education and training programmes for patients and their carers in order to support them in this role, and we are currently undertaking a literature review to consider the evidence as to the most effective way to invest in this approach.

Taking it forward

There is no shortage of projects across the country to help support local pockets of service transformation and change. What we lack is a coherent and concerted strategy to ensure that we drive these changes at scale and pace, drawing on expertise and experience across the country to ensure that we invest in programmes that will yield the greatest benefit.

We will lead local and national conversations about the workforce implications of the *Five Year Forward View*, and these will inform our Strategy for Investing in Workforce Transformation to be published later in the year.

Section 6

Challenges for the future

The analysis we have carried out for this year's Workforce Plan for England has exposed a number of issues that will need addressing if we are truly to transform the workforce of the future. Many of these issues are beyond the remit of any one organisation; they will require honest debate with the system and the patients we serve. In no particular order, the questions we need to consider are:

- At the heart of workforce planning is the tension between the needs of the current service and our future patients and workforce. Trainee doctors represent both the consultants of tomorrow and the service provision of today. How can we reshape the workforce of the future without jeopardising the quality of care for patients today? How can we invest more in the education and training of our existing 1.3m staff without cutting the 140,000 training posts required for the future?
- In areas where there is a gap between demand and supply, the reason is often not due to insufficient training posts, but an inability to attract sufficient applicants to the posts we believe we need. In all areas we will do more work to understand the root causes and seek to address them, but we may need to consider the extent to which we continue to allow the aggregate effect of individual choices shape the future pattern of our workforce, and whether the current balance between foundation places and post graduate places is right.
- But even if we create sufficient training posts, and encourage enough people to fill them, how can we ensure that there are sufficient jobs in the right locations to employ them in ways that meet patient needs?
- How can we support and incentivise a safe transition of our workforce from the secondary to the primary sector, with an appropriate balance between maintaining the quality of care for today's patients whilst driving forward new models of care that will improve the quality of care in the future?
- How can we equip our trainees to work within not just new settings, but a whole new paradigm of healthcare, where their role will increasingly be to predict and prevent ill health, rather than diagnose and cure disease?
- And if we succeed in creating the right jobs in the right place, for trainees with the right skills, values and behaviours, how can we improve our ability to retain and develop our most precious and expensive resource? The workforce accounts for 65% of the NHS budget, and yet we do not have a national or strategic approach to the effective management of this finite resource.
- Next year we will embark upon more detailed work on the workforce implications of the *Five Year Forward View*, but how can we maintain a line of sight to the future needs of patients, whom the new care models should be designed to serve?
- An additional challenge for us will be to move away from a model of workforce planning based upon the definition of the different registered professions (supply driven model) towards one based upon the needs of patients and their families (needs driven).

Section 7

Next steps

The Workforce Plan for England forms the basis for the recruitment process to medical training posts and our contracts with higher education institutions, who will deliver the agreed number of education places commencing in September 2015. All universities will be expected to ensure that, as a part of the selection process for NHS funded courses, successful candidates are assessed against the values of the NHS Constitution through a structured face-to-face interview, so that we can ensure that we are investing in not just numbers, but staff with the right values and behaviours to deliver care to patients.

During 2015, we will work with our partners to:

- Through the Shape of Training and Shape of Caring and other programmes, we will look at the structure of training, including the cause of low-fill rates in key professions such as GPs, core psychiatry training, geriatrics, learning disability and community based nursing, professional development programmes for nurses, IAPT high intensity, and consider the most appropriate actions to improve patient care
- Review the root causes of low-fill rates in key professions such as GPs, core psychiatry training and geriatrics and develop action plans to ensure patient needs can be met
- Work with employers and commissioners and other national organisations to consider how we might use NHS Careers and other levers to attract people to work in community based and primary care settings in order to meet the changing needs of the population
- Continue to support the service to retain existing staff and attract returners in key areas such as emergency medicine, nursing and GP and paramedics, and in primary and community care settings, in order to deliver the new care models

- Work with our local LETBs and the national Workforce Advisory Board to understand the workforce implications of the new care models in the *Five Year Forward View*, so we can support service transformation at scale and pace through more targeted investment in our existing workforce, as well as commissioning new roles for the future
- Continue to deliver on our fifteen-year ambition to build a workforce shaped around the needs of patients, as set out in our *Framework 15*. We will progress this work through our Shape of Caring and Shape of Training Programmes, and through piloting a 'life cycle' approach to workforce planning, starting with children and young people

In early 2015 we will publish our workforce planning guidance for education and training commissions for September 2016, where we will describe the standardised planning process we will adopt that will yield shared supply and demand assumptions and better workforce planning.

In the period to June 2015 we will develop our analysis and engage with LETBs and stakeholders in evidence based conversations in order to describe clear national priorities that we expect to see addressed in local plans, based upon the ambitions in the *Five Year Forward View* and the requirements of our Mandate. During this process we will signal those areas where we feel decommissioning maybe justified, allowing greater investment in priority areas and transformation to ensure action is taken as a result.

Throughout the year we will continue to share workforce data with national bodies to support managerial intervention and action, rather than just informing our commissioning process. We will explore the use of alerts if it becomes apparent there may be a significant variance between demand and supply, so that employers can act to ensure that patient needs are met.

We will take a national approach to a number of medical specialities where either the workforce or the training numbers are of a size where it is not practical to commission at LETB level.

What we need others to do

The *Five Year Forward View* makes it clear that the new models of care simply won't become a reality without the people to deliver them. We now need to work with our partners through the national Workforce Advisory Board to encourage:

- *Employers to provide robust workforce forecasts to LETBs. These form the basic building blocks of our national plan, so the higher quality they are the better the overall plan. Every CEO needs to be engaged in this process, ensuring alignment with commissioning and provision plans and plans to implement the New care models, with workforce forecasts signed off by their Medical and Nursing Director*
- *Employers and commissioners to create jobs in the right settings so that the staff we train are able to realise and deliver the policy intent of Five Year Forward View, rather than perpetuate an imbalance between community and acute sectors*
- *Employer and professional bodies to work with HEE and LETBs on data sharing so that patients receive care from staff employed by a range of different sectors and bodies: the NHS, social care, the independent and charitable sectors. Currently we only have access to data on staff employed in the NHS, which means we have an incomplete picture of supply*
- *Greater employer focus on retaining and investing in their current staff. It is our responsibility to commission education and training places to secure the supply of the future workforce, but it is becoming apparent that in some areas, requests for more commissions are due to a 'leaky bucket' effect, whereby employers are failing to retain and develop their skilled staff. Commissioning more trainees is the most time consuming and expensive way to address shortages in supply; attracting people back to the profession is more cost-effective, but the most effective approach of all would be to retain and develop their employees. We will work with NHS Employers and other partners to develop a more strategic and cost-effective approach to staff retention*
- *Patient groups, Royal Colleges and other stakeholders to work with us on reshaping the workforce. Although this plan is necessarily concerned with numbers, we know that more of the same simply won't deliver the transformed services that patients need. As set out in our Framework 15, we need a more flexible, adaptable workforce, able to work across professional boundaries and settings, so that they can provide high quality care wherever and whenever the patient is. This will require the creation and/or expansion of new roles, and active decommissioning of others, if we are to develop a workforce planning process shaped by patients' needs rather than supply*
- *Continued support for a shared vision and aligned planning and action. The most important development this year has been the development of a shared NHS view of the future. The Five Year Forward View provides a clear service vision, and it is now our responsibility to develop an appropriate workforce to make that vision a reality.*

Annex 1

Education & Training Commissions for 2015/16

Clinical Professional Education Programmes*:	2014/15 commissions	Planned 2015/16 Commissions	Increase/Decrease	%
Pre-registration Nursing & Midwifery				
Adult Nurses	13,228	13,783	555	4.2%
Children's Nurses	2,182	2,343	161	7.4%
Learning Disabilities Nurses	653	664	11	1.7%
Mental Health Nurses	3,143	3,243	100	3.2%
Midwives	2,563	2,605	42	1.6%
Total - Pre-registration Nursing & Midwifery	21769	22638	869	4.0%
Allied Health Professions				
Dietetics	336	343	7	2.1%
Occupational Therapy	1,523	1,541	18	1.2%
Physiotherapy	1,490	1,543	53	3.6%
Podiatry	362	362	0	0.0%
Speech & Language Therapy	644	668	24	3.7%
Diagnostic Radiography	1,059	1,115	56	5.3%
Therapeutic Radiography	371	414	43	11.6%
Paramedics	853	1,231	378	44.3%
Orthoptics	77	77	0	0.0%
Orthotics/Prosthetics	30	30	0	0.0%
Total - Allied Health Professions	6745	7324	579	8.6%
Other Scientific, Technical & Therapeutic				
Operating Dept. Practitioner	842	957	115	13.7%
Pharmacist pre-registration year	600	657	57	9.5%
Pharmacy Technician	300	363	63	21.0%
Clinical Psychologist	532	526	-6	-1.1%
IAPT - Psychological Wellbeing Practitioner (Low intensity)	436	579	143	32.8%
IAPT - High intensity practitioner	320	367	47	14.7%
Child Psychotherapist	41	43	2	4.9%
HCS Higher Specialist Scientific Training (HSST)	94	103	9	9.6%
HCS Scientist Training Programme (STP)	271	282	11	4.1%
HCS Practitioner Training Programme (PTP)	246	473	227	92.3%
Physicians Associates	24	205	181	754.2%
Dental Nurses	455	442	-13	-2.9%
Dental Technicians	69	69	0	0.0%
Dental Hygienists	116	128	12	10.3%
Dental Therapists	118	134	16	13.6%
Total - Other Scientific, Technical & Therapeutic	4464	5328	864	19.4%
Specialist Nurse - Post Registration				
District Nurses	431	502	71	16.5%
School Nurses	198	340	142	71.7%
Practice Nurses	218	359	141	64.7%
Health Visitors	1,041	1,193	152	14.6%
Total - Specialist Nurse - Post Registration	1888	2394	506	26.8%
TOTAL Clinical Professional Education	34866	37684	2818	8.1%

Education & Training Commissions for 2015/16

Undergraduate Medical & Dental Education:	2014/15 commissions	Planned 2015/16 Commissions	Increase/ Decrease	%
Undergraduate Medical & Dental				
Undergraduate Medical	6,071	6,071	0	0.0%
Undergraduate Dental	899	809	-90	-10.0%
Total - Undergraduate Medical & Dental	6,970	6,970	-90	-1.3%
Post Graduate Medical & Dental Education:	Number of Training Posts		Increase/Decrease	%
Foundation Training				
Medical Foundation Programme	12,567		-12	-0.1%
Dental Foundation Programme	881		7	0.8%
Total - Medical & Dental Foundation Programmes	13,448		-5	0.0%
Core Training				
Acute Care Common Stem - Acute Medicine	212		0	
Acute Care Common Stem - Anaesthesia	322		35	10.9%
Acute Care Common Stem - Emergency Medicine (including RunThrough)	681		95	14.0%
Core Anaesthetics Training	901		-20	-2.2%
Core Medical Training	2,510		107	4.3%
Core Psychiatry Training	1,450		-20	-1.4%
Core Surgical Training	1,197		-65	-5.4%
Broad Based Training (PILOT)	69		36	52.2%
Broad Based Training (PILOT)	45		24	53.3%
Total - Core Training	7,342		168	2.3%
Run Through Training				
Paediatrics	2,859		0	
Ophthalmology	547		-3	-0.5%
Neurosurgery	229		-5	-2.2%
Obstetrics and Gynaecology	1,779		-1	-0.1%
Community Sexual and Reproductive Health	25		0	
Histopathology	492		-1	-0.2%
Chemical Pathology - Including Metabolic Medicine	70		-3	-4.3%
Diagnostic Neuropathology	8		0	
Paediatric and Perinatal Pathology	9		0	
Forensic Histopathology	2		0	
Medical Microbiology	198		0	
Medical Virology	13		0	
Clinical Radiology	1,081		16	1.5%
General Practice	8,311		209	2.5%
Public Health Specialists	421		0	
Total - Run Through Training	16,044		212	1.3%
Post Graduate Dental Training				
Dental Core Training	506		2	0.4%
Dental Specialty Training				
Dental and Maxillofacial Radiology	4		0	
Oral and Maxillofacial Pathology	7		0	
Oral Microbiology	2		0	
Oral Medicine	14		-1	-7.1%
Orthodontics	175		0	
Restorative Dentistry	44		0	
Paediatric Dentistry	39		0	
Additional Dental Specialties	14		0	
Oral Surgery	22		0	
Endodontics	12		0	
Periodontics	13		0	
Prosthodontics	9		0	
Special Care Dentistry	22		0	
Dental Public Health	22		0	
Total - Dental Specialty Training	399		-1	-0.3%

Education & Training Commissions for 2015/16

Post Graduate Medical & Dental Education:	Number of Training Posts	Increase/Decrease	%
Higher Specialty Training			
Infectious Diseases	77	0	
Respiratory Medicine	490	-3	-0.6%
Dermatology	171	-1	-0.6%
Neurology	217	-2	-0.9%
Cardiology	539	-2	-0.4%
Rheumatology	211	0	
Genito-urinary Medicine	131	-1	-0.8%
Clinical Pharmacology and Therapeutics	35	0	
Geriatric Medicine	617	-3	-0.5%
Medical Oncology	132	1	0.8%
Clinical Neurophysiology	32	-1	-3.1%
Renal Medicine	243	-1	-0.4%
Nuclear Medicine	19	-1	-5.3%
Endocrinology and Diabetes Mellitus	332	0	
Gastroenterology	431	0	
Audio Vestibular Medicine	18	0	
Clinical Genetics	53	0	
Clinical Oncology	260	4	1.5%
Tropical Medicine	0	0	
Allergy	11	0	
Acute Internal Medicine	360	0	
Haematology	317	0	
Immunology	33	-1	-3.0%
Rehabilitation Medicine	63	0	
Sport and Exercise Medicine	43	0	
Occupational Medicine	46	0	
Palliative Medicine	160	0	
Medical Ophthalmology	9	0	
Paediatric Cardiology	41	0	
Stroke Medicine	30	0	
Sub Total - Medical Specialties Group	5,121	-11	-0.2%
General Surgery	1,016	-8	-0.8%
Paediatric Surgery	97	-2	
Otolaryngology	295	0	
Trauma and Orthopaedic Surgery	929	-5	-0.5%
Urology	265	-3	
Plastic Surgery	256	-4	
Cardio-thoracic surgery	123	1	0.8%
Vascular Surgery	11	9	81.8%
Oral and Maxillo-facial Surgery	138	-1	
Sub Total - Surgical Specialties Group	3,130	-13	-0.4%
Psychiatry of Learning Disability	95	0	0.0%
General Psychiatry	618	1	0.2%
Child and Adolescent Psychiatry	223	1	
Forensic Psychiatry	120	0	
Medical Psychotherapy	45	0	0.0%
Old Age Psychiatry	214	0	0.0%
Sub Total - Psychiatry Specialties Group	1,315	2	0.2%
Anaesthetics	2,130	-16	-0.8%
Intensive Care Medicine	224	16	7.1%
Emergency Medicine	634	6	0.9%
Emergency Medicine - DREEM	37	10	27.0%
Total Higher Specialty Training	12,564	-6	0.0%
TOTAL Medical And Dental Education	57,273	280	0.5%

Annex 2

Organisations who responded to HEE's workforce planning call for evidence

- Association of Neurophysiological Scientists
- British Association/College of Occupational Therapists
- British Geriatrics Society
- British Society of Neurophysiology
- Royal College of Pathologists
- Society and College of Radiographers
- Academy of Medical Scientists
- Association of Clinical Embryologists and Association of Biomedical Andrologists
- Association for Clinical Genetic Science
- Association of Directors of Public Health
- Association of Palliative Medicine Physicians
- British and Irish Orthoptists Society
- British Association of Plastic and Reconstructive Surgery (BAPRAS)
- British Association of Audiovestibular Medicine
- British Association for Sexual Health and HIV and the Faculty of Sexual Health
- British Association of Dermatology
- British Association of Paediatricians in Audiology
- British Association of Urological Surgeons
- British Cardiovascular Society
- British Dietetic Association
- British Pharmacological Society
- British Society for Clinical Neurophysiology
- British Society for Histocompatibility and Immunogenetics (BSHI)
- Cardiothoracic Surgery Speciality Advisory Committee
- Centre for Workforce Intelligence
- Chartered Society of Physiotherapy
- College of Emergency Medicine
- College of Podiatry
- Eating Disorders Clinical Reference Group

- ENT UK and Otolaryngology SAC
- Faculty of Intensive Care Medicine
- Faculty of Occupational Medicine
- Faculty of Sexual and Reproductive Health
- Great Western Hospitals NHS Foundation Trust Cardiac Centre
- Guys & St Thomas Pharmacy Department
- Health and Social Care Information Centre - Informatics
- Heart of England NHS Trust
- Joint Committee for Post-Graduate Dentistry
- Medical and Dental Schools Council
- National Council for Palliative Care
- National Institute for Clinical Excellence
- NHS Education for Scotland
- NHS England - Psychiatry Liaison and Diversion Services
- NHS England Increasing Access to Psychological Therapies Team
- NHS England Primary Care Commissioning - Optometry
- North Devon Pathology
- North West Public Health Workforce Team
- Nuclear Medicine SAC
- PHE South West Laboratory
- Plymouth Hospitals NHS Trust Medical Physics Department
- Poole Hospitals Theatre Services
- Public Health England
- Public Health England Mental Health Services
- Royal College of Physicians - Joint Specialty Committee on Sexual Health
- Royal College of Physicians - Joint Specialty Committee on Stroke
- Royal College of Physicians/JRCBPTB
- Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland
- Royal College of Midwives
- Royal College of Nursing
- Royal College of Obstetrics and Gynaecology
- Royal College of Ophthalmologists
- Royal College of Paediatrics and Child Health and British Association of Community Child Health

- **Royal College of Pathology**
- **Royal College of Physicians Renal SAC & Association**
- **Royal College of Physicians - Allergy Workforce Representatives**
- **Royal College of Physicians Genetics SAC, lead clinicians group & clinical genetics society**
- **Royal College of Psychiatrists**
- **Royal College of Radiologists**
- **Royal College of Speech and Language Therapy**
- **Royal College of Surgeons**
- **Royal College of Surgeons of Edinburgh**
- **Royal Pharmaceutical Society**
- **Secure CAMHS clinical reference group**
- **Sheffield Teaching Hospitals**
- **St Helens Clinical Commissioning Group**
- **UK Committee of Postgraduate Dental Deans and Directors**
- **University of East Anglia Physiotherapy Programmes**
- **Vascular Society**
- **Yorkshire and Humber Directors of Public Health Network**

Annex 3

HEE Advisory groups consulted on England wide workforce forecasts and initial workforce investment plan for England

HEE Advisory Group	Date:
Allied Health Professionals	4 September
Dental	11 September
Healthcare Science	30 September
Strategic Advisory Forum	4 November
Patient Advisory Forum	5 November
Medical	17 November
Nursing & Midwifery	12 November
Public Health	1 December
Mental Health	3 December
Pharmacy	17 December

Annex 4

How HEE assesses the level of education commissions needed

Planning for future workforce supply

HEE including our LETBs need to assess three main variables when assessing how much newly qualified training supply the system will need in future and consequently how much training to commission today.

- The level of available supply - staff turnover versus newly qualified supply
- The level of future demand – including population need versus funded demand
- The impact of any current supply shortage - including the immediate actions of employers to address these

Future Supply

The forecasts of future supply, which we transparently show in the graphs in section 5, are based on our explicit assessment of a wide range of variables however these variables belong to one of four groups:

- Supply from training
- Retirement
- Other Leavers
- Other Joiners

Supply from training

HEE is able to accurately forecast the amount of newly qualified staff that will become available to employers in each year.

HEE's planners assess variables such as;

- Under recruitment
- Attrition from the course

These define the supply available to employers from HEE's commissioning activity, however our planning will also make assumptions about how this supply subsequently joins the workforce.

- The number of people not choosing to take up employment, and
- Participation rate – whether new staff want to work full time or part time

These factors are predominately down to employers having sufficient posts with the right incentives to ensure this available supply becomes actual 'staff in post'.

HEE does have a part to play and is acting to ensure;

- a) people joining courses do so for the right reasons and intend to join the workforce on completion
- b) the quality of graduates produced meets patients and employers' expectations not just the minimum level required for registration or achieving the relevant award (degree, ARCP, CCT, etc.)

Our supply forecasting will reflect known patterns of employment and will be adjusted where partners make assumptions about the impact of specific initiatives such as improved course attrition or local recruitment initiatives.

Retirements

We could include this with other forms of leavers but it is such a significant variable in its own right, and partners consistently express concerns about the aging workforce that we think it is valuable to explain HEE's approach to forecasting this variable.

All HEE forecasting (and that undertaken by partners in CfWI, DH, and elsewhere) ALL use age profile adjusted forecasts for retirements. These are based on the known current and future age profiles for different staff groups and the observed patterns of retirement for people of each age.

If a group has an 'aging workforce' the supply forecast we produce will fully reflect this fact in our assumptions about the number of people leaving due to retirement in each year.

We also explore factors which may change the current rates at which people retire at each age, including the mandatory movement of staff onto the 2015 pension scheme and changes to state pensions, with delayed access to benefits, the impact of Lifetime Allowance limits on groups such as GPs and consultants, versus other issues like changing preferences and the nature of work people are willing / able to do at different ages.

Retirements and new supply are the two single largest elements of staff supply however the remaining elements are still significant in terms of size, and more importantly exhibit more variability and are capable of being directly effected in the short term by employer and other actions.

Other leavers & other joiners

There is a long list of individual variables which can make up forecasts of 'other leavers' and 'other joiners'. Our systems are not yet sophisticated enough, nor is it probably of sufficient value, to assess and monitor each individual variable. However we do have evidence of the pattern of staff turnover both from HSCIC published data, from specific ESR joiner / leaver records, and also by tracking whether staff in aggregate appear on the ESR data base in different periods.

Our consideration of these specific variables seeks to anticipate changes to current patterns. Is there a specific trigger, such as Obamacare (for leavers), austerity measures laying off staff in southern Europe (for joiners), or any impact of the feminisation of the workforce, that leads to us amending our assumptions about how many people will leave or join the workforce in future years.

The list shows the kind of variables we actively consider and ask for evidence on from stakeholders in our 'call for evidence'. This is in respect of leavers but it can be seen that joiners are often the other side of this coin, one country's emigration is another's international recruitment; one sector's turnover is another's recruitment.

- Leave the health & social care workforce – career break
- Leave the health & social care workforce – permanent (non-retirement)
- Leave the English NHS to a devolved nation
- Leave the English NHS to abroad – returning foreign national
- Leave the English NHS to abroad – English national emigration
- Leave the English NHS to other health and social Care
- Work more part time.

And from a profession perspective

- Leave profession or setting x to join profession or setting y (e.g. nursing to health visiting)

And from a LETB perspective

- Leave the LETB area to another LETB area

And from a trust perspective

- Leave our trust for another

The key activity not covered above is Return to Practice which can be a significant short term action to increase the number of 'other joiners' from people who already have the requisite knowledge and skills but need support in returning and to be incentivised to do so.

These variables and the employer actions in employing the available supply from education demonstrate the critical role of our employer partners, alongside HEE, in ensuring there is sufficient supply of staff employed to meet the needs of patients and employers as defined by the number of posts the plan funds.

This in turn leads us to the second area that HEE must consider in making its investment decisions – future demand.

Future demand

HEE is faced with a difficult challenge in relation to future workforce demand, should we plan for a workforce assessed against the needs of the population or should we respond to the signals about what workforce will be funded by employers?

We believe it is necessary to do both so that we can have open discussions about the choices the system is making between priorities within resources that are understandably finite.

We therefore seek to ask and answer two questions

- How many staff of what type is needed by the population to meet their needs?
- How many staff will be commissioned/employed to meet commissioned services?

Our planning process has been established explicitly to answer these two questions and thereby enable an open conversation about where the system thinks we should act as a consequence.

Commissioned/Funded Demand

- HEE's annual planning process ensures the future perspective of all NHS employers is captured for all professional groups. These forecasts aggregated at LETB and National level then become one view against which other perspectives about future demand can be contrasted and discussed.

All of the graphs in [section 4](#), show these employer perspectives, but these must not be considered 'plans', they simply allow us to assess

Patient/population demand

- HEE makes a call for evidence, engages with wider stakeholders, and commissions primary analysis to try and establish demand driven by the factors we outline in HEE's *Framework 15*. This then acts as a comparison point to provider perspectives.

HEE was set up to be provider led to allow the system to better reflect the needs of employers, however there is wide acceptance that better decisions are made by discussing these provider perspectives with the partners of those providers and not least with the patients they serve.

There are also critical workforces where the provider landscape is complex or diffuse, in these areas, such as primary care, we must find another way of identifying the future intentions of commissioners and the providers involved.

The final area we need to consider is the impact of any current shortages and the actions that

employers may take to address those shortages by the time HEE's education decisions materialise in 4 to 7 years' time.

Current supply shortages

The third of these variables is perhaps the most difficult for HEE to manage within our processes of triangulation, challenge, and stakeholder engagement. People's intuitive assessment of whether we need to train more is coloured by the situation that they experience in their everyday working lives. The impact that shortages have on their patients, their teams and themselves are understandably central to their immediate perspective.

However the reality is that the outcome of our decisions will not materialise for at least four years and that (with the exception of Post graduate medical trainees) current decisions in respect of future output cannot change the current supply situation.

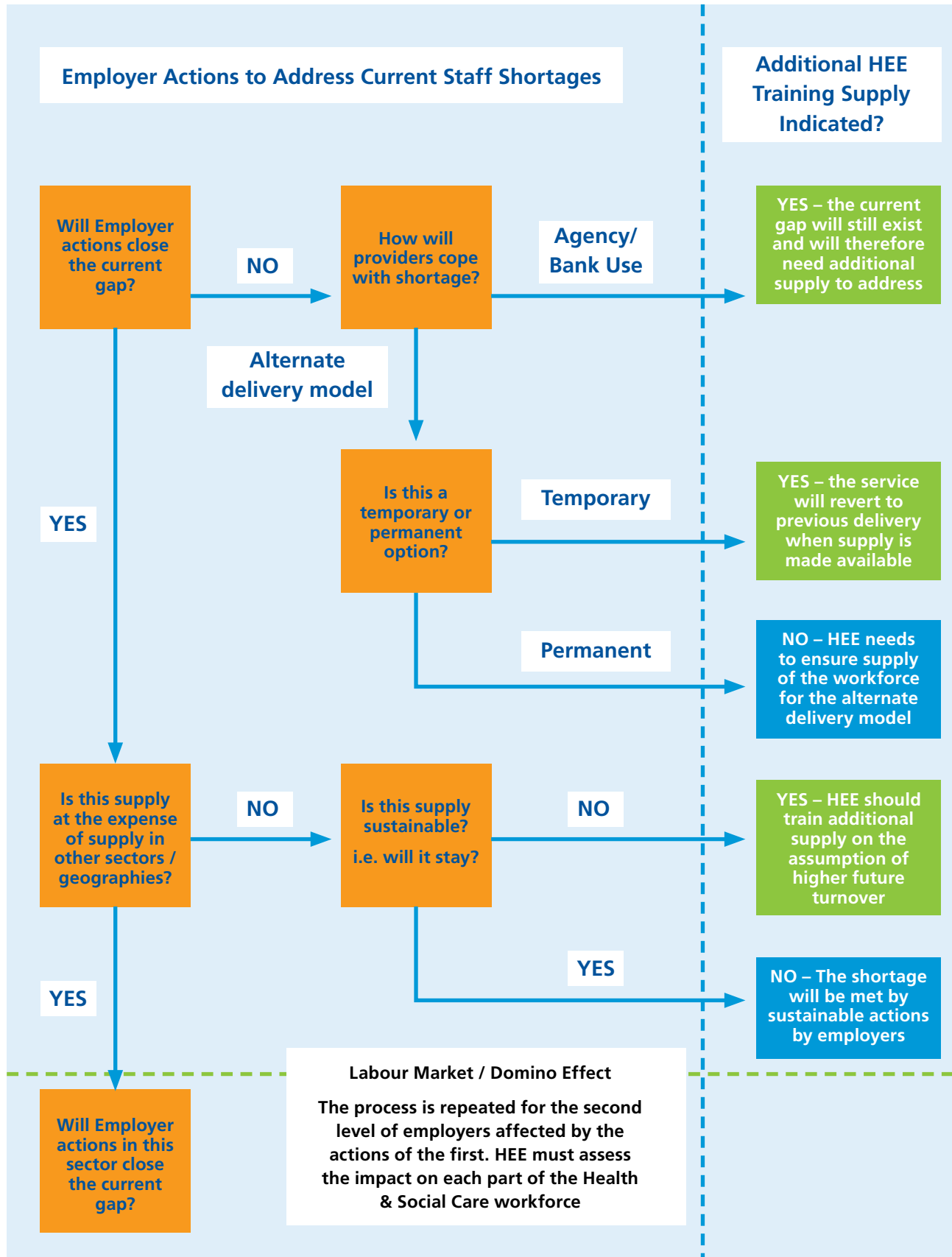
HEE is committed to playing whatever role it can, within its mandate and directions, to alleviating current shortages, but this does not automatically mean increased training is a necessary parallel response.

There is a real risk that if we always respond intuitively to current shortages, by increasing training, then we risk condemning ourselves to a system in which we use all our resources on the future workforce rather than the current. This would be compounded if we never reverse such increases once the immediate gap has closed, which also appears to be a feature of current decisions.

We understand that workforce planning has a weak history and that a system that seeks to promote analysis over intuition must prove itself and build trust in the recommendations it produces.

This does not mean we do not account for current shortages. If there is a current gap then our training might be part of ensuring it is closed sustainably. The algorithm on the following page demonstrates the questions HEE and partners need to answer when deciding if additional training is the appropriate response to current shortage.

Planning for current staff shortages within future training supply decisions



The system's response to any shortage will be a mix of all of the above. HEE's challenge is to assess the overall impact of these provider responses in terms of genuine additional supply and its sustainability such that any increase in training meets that need.

We also need to ensure that any response in terms of increased training is appropriate in context of what the system might reasonably expect from employers in terms of issues such as staff retention by meeting their obligations under the NHS Constitution.



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