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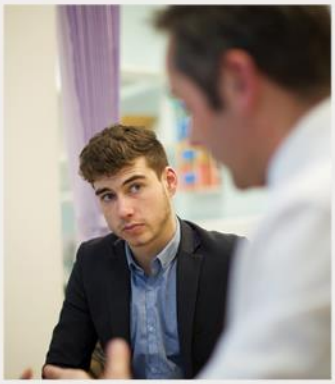

Workforce Plan for England

Proposed Education and Training Commissions for 2016/17

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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. HEE's main way of achieving this goal has been the planning and development of the future workforce supply, through the investment of our dedicated £5bn budget on high quality education and training.

HEE has previously identified a range of workforce issues beyond the provision of future supply that require the collective, collaborative, and co-ordinated action of other partners across the NHS to solve. HEE has established the Workforce Advisory Board (WAB) to act as a vehicle through which such collective action can be assured. This approach is consistent with the wider collaborative working across the NHS Arms-Length Bodies (ALBs) that has now become the norm as we move to implement the vision for the future NHS outlined by Five Year Forward View (FYFV). The WAB is able to escalate issues to the FYFV Board if ALB Chief Executive level sponsorship or agreement is required.

This, our third Workforce Plan for England, starts to address the full range of workforce issues facing the Health and Care system regardless of HEE's own specific responsibilities. In doing so it aims to address the important issues raised in both the National Audit Office and Public Accounts Committee reports on 'Managing the supply of NHS clinical staff in England, and will also reflect on the observations made in the Health Foundation's recent report on workforce policy in the English NHS. In addition to future workforce supply this report therefore considers current workforce shortages and how they may be addressed and also builds on the opportunities presented by the Shared Delivery Plan and the new Sustainability and Transformation Plans (STPs) to outline the critical service and workforce transformation agenda.

Each of these three areas is critical to the overall delivery of health and care through prevention activities and sustainable high quality services. However we also need to ensure that our actions future proof the health and care system, and to that end HEE continues to promote use of our 'Framework 15' strategic framework , to ensure the needs of future patients are at the heart of our and our partners' plans.

Future Workforce Supply

This is HEE's third annual Workforce Plan for England, and in line with the previous two versions sets out the £5bn worth of investment we will make in education and training programmes for the following year. These investments are primarily (though not exclusively) focussed on our core role of ensuring secure future supply. This year we have again increased the overall volume of education and training with in excess of 38,000 new training opportunities for nurses, scientists, and therapists, and over 50,000 doctors and dentists in training. We have targeted increases on critical areas such as adult and mental health nursing, paramedics, and physician's associates, whilst in postgraduate medicine there are increases to training posts in General Practice, Emergency Medicine and Clinical Radiology. This training supports continuing

strong growth in the number of clinical professional staff both within the NHS and the total number of registered clinical professionals in England. HEE forecasts that as result of this training between 24,000 and 82,000 additional staff could be available to the NHS or other employers by 2020, depending on the extent to which service providers act to employ output from our programmes and work to retain their existing staff.

The plan is developed using the workforce planning processes we have established over the past three years and as such is built upon the needs of local employers, providers, commissioners and other stakeholders who, as members of our Local Education Training Boards (LETBs), have shaped the thirteen local plans that are at the heart of this Workforce Plan for England. This plan is predominately an aggregate of the local LETB plans, but the final national plan is only agreed with the advice and input of our clinical advisory groups and Patients' 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.

Following the Chancellor's Spending Review announcement, some elements of this future supply will, from 2017, move to a system in which there are no specific caps on the volume of training that can be undertaken. HEE remains mandated to ensure sufficient supply for the NHS and will work closely with the Department of Health and other partners to manage the implementation of this new policy.

Current Workforce Shortages

HEE has highlighted that the investments and commissions described in our Workforce Plans for England cannot, in the main, effect the current workforce supply position, but instead act to ensure that future shortages are avoided.

The system has over the past few years relied on each individual component of the system to discharge their own responsibilities in respect of current workforce supply and demand in order to address any problems. This approach has not been sufficient to guarantee effective solutions in problem areas and it has become apparent that more active co-ordination and management of the various current supply and demand variables, including the significant workforce productivity challenge, is required.

This was a key driver of the establishment of the Workforce Advisory Board (WAB). Membership from DH, all ALBs, plus employer representatives, ensures the bodies that hold all the relevant policy levers capable of shaping the workforce are present in one place. Addressing current shortages is one of four priority programmes that the board is overseeing, and in this report we outline some of the individual work streams being undertaken including oversight of the nursing supply programme, the Paramedic Evidence Education Project (PEEP) paramedic programme, as well as the joint HEE /Royal College of Emergency Medicine (RCEM) programme on improving emergency medicine workforce supply and the wide ranging work on the primary care workforce including General Practitioners.

Such co-ordination must however be effective at a local level as well as nationally and regionally. In light of this HEE has commenced the convening of Local Workforce Action Boards (LWABs) as a mechanism through which local partners can meet to agree and discharge their

collective responsibilities in a co-ordinated manner across the full range of workforce issues outlined in this report.

Service and Workforce Transformation

The historic lack of connection between service strategy and workforce planning has been identified by HEE as one of our, and the systems, key challenges. The publication of the FYFV provided us with a clear overall vision of the radical changes to service delivery and ways of working that will be required to deliver an NHS that can deliver the triple aims of health, quality and financial sustainability.

The implementation of the FYFV vision is now beginning to add real content and context to our work. HEE has a unique offer to make both in terms of national initiatives and local capacity and capabilities to support front line change. We will work through both the national implementation of the independent reviews of Mental Health, Maternity, and Cancer as well as at a local level through the Vanguard and other transformation programmes, as well as the placed based Sustainability Transformation Plans (STPs) as the vehicle through which comprehensive system wide service and workforce transformation will be delivered.

This report represents an important step forward in the development by the NHS of a comprehensive and co-ordinated approach to the inter-related workforce challenges that we face. HEE will continue to discharge its specific responsibilities, but will also continue to act to co-ordinate and support the wider actions of partners. In 2016 HEE will also take on responsibility for the NHS Leadership Academy and will act to ensure the leadership challenges faced by the system are equally co-ordinated and integrated into this system wide workforce approach.

HEE will also continue to use our Framework 15 strategy to ensure our actions do not simply address today's problems but lead us on the path to a workforce with the key characteristics required for a genuinely patient centred future NHS in which the triple aims of the FYFV are met and the NHS Constitution remains at the heart of all our work.

Professor Ian Cumming OBE **Sir Keith Pearson JP DL**

1. The workforce system - working together

HEE's first two workforce plans had a primary focus on the future prospects for workforce supply, how this would match up against future demand as expressed by the system, and as a consequence what our specific investment priorities in educating and training the future workforce should be. This was in line with our specific mandated responsibilities.

Partners welcomed the fact that a comprehensive and transparent, local and national process had been developed, and that this created the opportunity to consider priorities between differing professional groups and between developing the current or future workforce, in a way that had previously been impossible, due to the uni professional architecture of previous planning systems.

Our reports also highlighted the range of local and national work being undertaken to support service and workforce developments, including the creation of local skills' strategies. However, it has become increasingly apparent that these developments are not in themselves sufficient to meet the full range of workforce challenges that the system faces. In this report we have gone beyond the constraints of our own mandated responsibilities, and have instead attempted to outline the fundamental NHS wide workforce challenges that we as a system need to address and crucially how we intend to act with partners to meet these challenges.

In addition to core **future workforce supply** there are two further challenges that providers and other partners are telling us need to be addressed for the system's workforce planning to be relevant and effective.

Service and workforce transformation - How to design sustainable services, and the teams that deliver them, so that the triple aims of the Five Year Forward view can be delivered?

Current workforce capacity and supply – How do we establish the mix and numbers of funded workforce posts capable of delivering the volume of services to standards required? How do we then ensure there is enough current supply, including how we value and develop existing staff, to meet this defined and funded need?

Key issues in respect of each of these individual areas are reported in sections 2 to 4 of this report however the characteristic that they have in common are:

- They are inherently inter-connected, and
- There are multiple partners with specific responsibilities and ability to act within each domain.

HEE established the WAB with the specific purpose of increasing awareness of the mutual roles that partners play in each part of the system and ensuring the actions of these partners can be co-ordinated to solve common challenges.

This collaborative approach, although not exclusively generated through WAB has begun to show benefits in areas such as the GP ten point plan, in collaboration with partners on nursing supply, including making the case for adding nursing to the Shortage Occupation List, and in the early stages of task force implementation groups, such as cancer and mental health, to ensure policy is not implemented without regard for the workforce supply available to deliver it.

We are equally clear that such co-ordination needs to happen at a local and regional level as well as nationally. Initial work with Vanguards identified that their needs in terms of workforce are in the same three domains. They have also identified the critical need for better workforce data, especially in respect of the current supply position and understanding the labour market dynamics and behaviours that shape their future supply prospects.

Learning from this experience HEE is now proposing that Local Workforce Action Boards (LWABs)be established to ensure co-ordination of the workforce actions and responsibilities of ALBs, commissioners, and service provider partners across each of the three challenges identified above, supported by common and improved workforce intelligence.

STPs are now clearly the footprint for NHS planning and as such are the natural place in which HEE will seek to support service and workforce transformation, building on our work with Vanguards and other transformation initiatives.

Acting on current supply is probably best done at the level of natural labour markets where the pool of staff from which providers / employers draw staff is known. This may be at a level greater than a single STP area and the most appropriate footprint for LWABs will need to be decided locally in context of the scale of STP footprints and the characteristics of local labour markets.

HEE's local teams and our LETBs will retain responsibility for assuring future supply (albeit within the context of new arrangements for undergraduate training of nurses, therapists, and scientists) but will clearly want to ensure this component of the three challenges is integrated with complementary work in the other areas, especially in light of the system wide consensus on future demand requirements that we should expect to emerge from STPs.

HEE will work with partner ALBs including at a regional level to agree the appropriate governance and operating models for these groups. One common feature of all three challenges has been the increased recognition of the need for better workforce data. The data required to support workforce design or to observe and understand current supply are actually more detailed and more specific than the broad and aggregate themes that can support future supply planning. In the sections below we outline some of the current data challenges and how we may address these given the system's own commitment to sponsor and support such improvements.

This closer collaborative working reflects the wider themes being seen in the NHS. ALBs came together to create a single vision for a sustainable future NHS in the FYFV. Implementation of this vision has created a number of collaborative vehicles including the FYFV Board, the WAB, and implementation programmes for key service priorities. The NHS has worked closely with the Department of Health to ensure the Shared Delivery Plan is precisely that, an agreed and

owned set of priorities. Finally within the context of Single Planning Guidance, the ALBs have asked commissioners and providers to come together with other relevant stakeholders to develop single place based STPs.

The proposed establishment of a comprehensive national and local co-ordinated approach to the whole spectrum of workforce challenges, through LWABs, is a natural extension of this new way of working.

Perhaps it is also not surprising therefore, that many of the responses to the workforce challenges being considered in service and workforce transformation initiatives focus on the role of multi-disciplinary teams within which individuals work across professional and organisational boundaries to genuinely put the patient at the heart of their health and care.

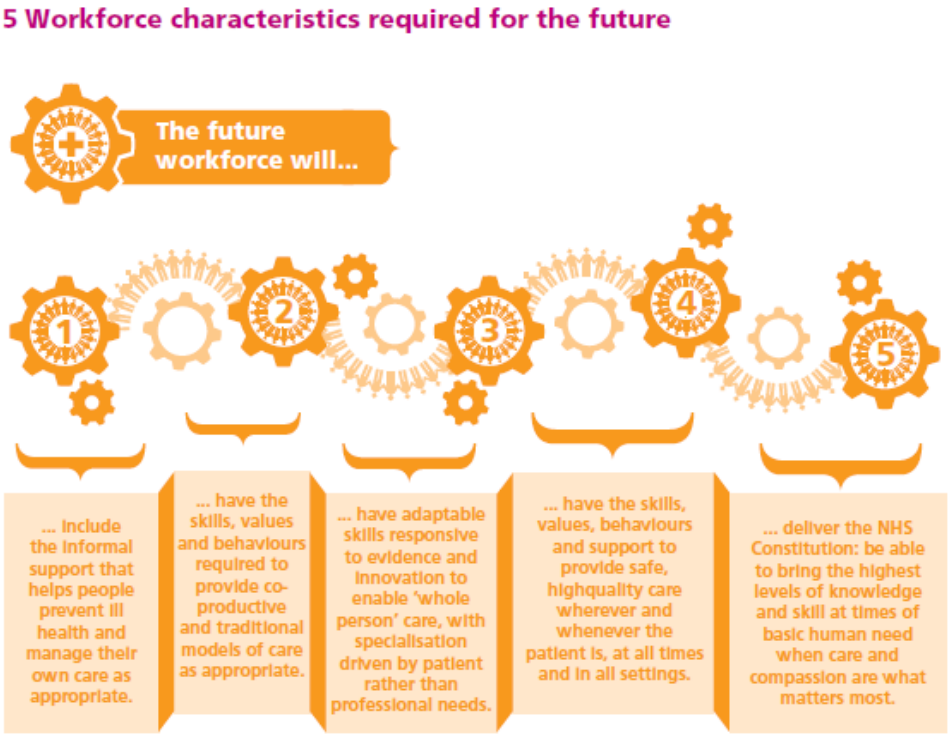
In the sections that follow we outline the specific issues under each of the three types of workforce challenge and describe the collaborative mechanisms and specific activities that are being undertaken to address these challenges.

2. Service and Workforce Transformation

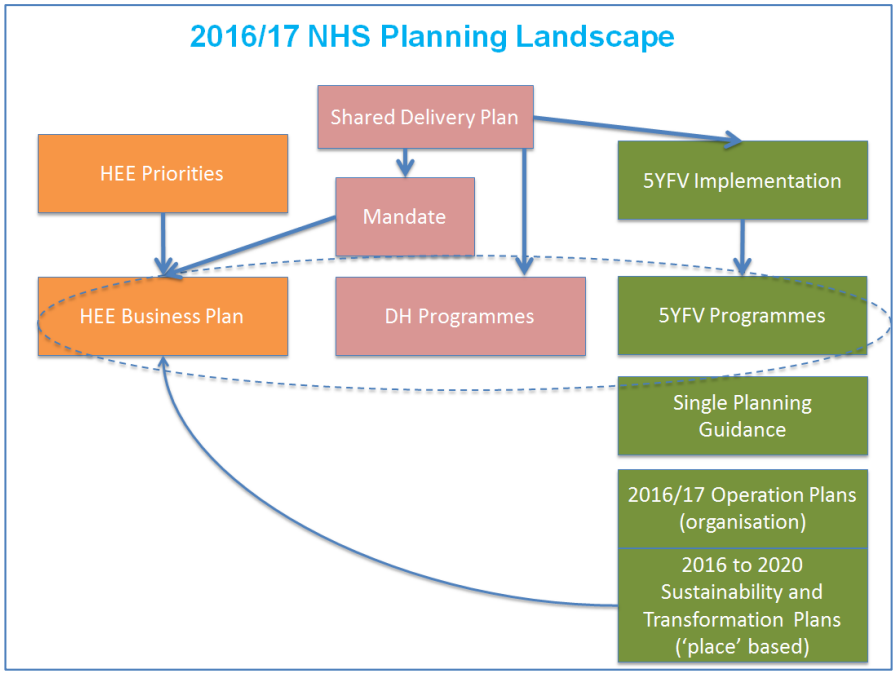
From the outset HEE has identified the lack of connection between service strategy and workforce planning as one of our, and the systems, key challenges. At a recent King's Fund event Professor Richard Bohmer of the Harvard Business School said…

> 'you can't redesign the workforce until you have redesigned the work'

It is with this principle in mind that HEE recognises that work in this area must always be about service and workforce transformation not workforce transformation in isolation. We do however add one caveat to this general principle. Framework 15 our strategic framework, has outlined the key characteristics of the future workforce that we believe will be required to meet the needs of future patients. This document was developed with patient and public input from start to finish. Work to develop these core characteristics can and must run in parallel to the more 'applied' transformation work, but is in itself critical by creating a more receptive and adaptive environment within which these and future changes can be delivered.



The publication of the FYFV provided us with a clear overall vision of the radical changes to service delivery and ways of working that will be required to deliver an NHS that can meet all three elements of the triple aim: health, quality and financial sustainability. The Shared Delivery Plan and subsequent Single Planning Guidance, with their associated work streams, national priorities and ambitions then set the specific context for the service and workforce transformation work the system intends to undertake.



In approaching this work we recognise that a transformed future healthcare workforce is only in part the product of how we design the formal training of new members of the clinical workforce. The vast majority of transformational work must be dependent on how we help the existing 1.3m people already working in the health system, the 1.6m people working in the care system, as well as supporting self-care and carers, to discharge new ways of working envisaged for them within new models of care and service innovation.

Similarly workforce transformation isn't something that is only relevant to the health and care system in 2020 at the end of FYFV period. The productivity challenges faced by the system in 2016/17 will require short term / immediate changes to the workforce that reflect opportunities for different mix of staff within teams delivering care and the mutual roles, responsibilities, and scope of practice of the members of those teams.

Our work in supporting service and workforce transformation falls into three broad categories each of which are complementary to each other and examples of which are outlined in this section:

- Working with specific national service improvement initiatives
- Transforming the workforce through education
- Working with frontline delivery partners in support of their STPs

HEE has a unique set of knowledge, capabilities, relationships, and responsibilities at both a national and local level to support the service in delivering these critical transformational activities.

2.1. National Service Improvement Priorities

The NHS, within the framework of the FYFV, has worked with the Department of Health to ensure there is maximum alignment of priorities through the development of the Shared Delivery Plan. Within this plan a number of key service areas, emerging from either the independent reviews commissioned under the FYFV programme or from government priorities, have been prioritised. Structured work programmes are now being initiated with full ALB membership and engagement. All programmes include extensive requirements for service and workforce transformation.

- Primary Care
- Mental Health
- Maternity
- Cancer
- Prevention
- Health and Care Integration
- Urgent and Emergency Care
- Seven Day Services

HEE is engaged in each of these areas and outlined below we have used the Primary Care priority to illustrate the range and types of activities being undertaken. At a national level HEE is able to mobilise senior clinical and educational leadership and deploy scarce policy expertise in support of these programmes as well as utilise key relationships with national groups such as regulators and professional bodies. These activities can be critical to developing system wide solutions to problems which then empower local solutions and practical front line implementation.

2.1.1. Primary and Community Care

HEE commissioned an independent report chaired by Professor Martin Roland 'The future of primary care – Creating teams for tomorrow'.[1]

The commission aimed to outline workforce solutions that would meet present and future needs of the NHS primary care workforce. The commission believed that many of the problems that have been identified in recent years could be addressed through the multi-professional workforce, better use of technology, and through organisational changes to the NHS primary care system.

> 'Through the submission of evidence, site visits and dialogue with local and national organisations, what we found was that exceptional people and teams had taken opportunities to create new and innovative ways of working' Martin Roland

HEE believe that, with primary care at its foundation, the NHS is in an outstanding position to fulfil its potential as a truly world-class healthcare system and to remain the number one

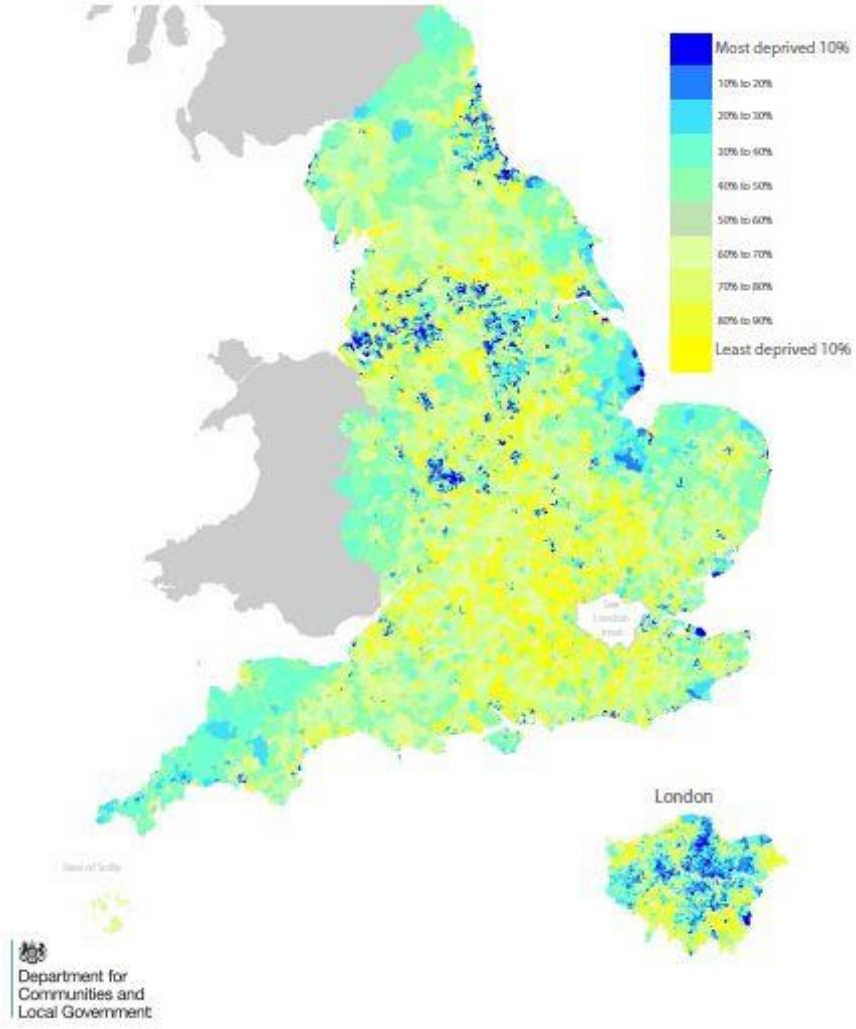
[1] https://www.hee.nhs.uk/sites/default/files/documents/WES_The-future-of-primary-care.pdf

healthcare system in the world. The shared vision looks to ensure that we will provide challenging and fulfilling careers as part of a modern, innovative primary care system, and that together we deliver a standard of care of which the NHS can continue to be truly proud.

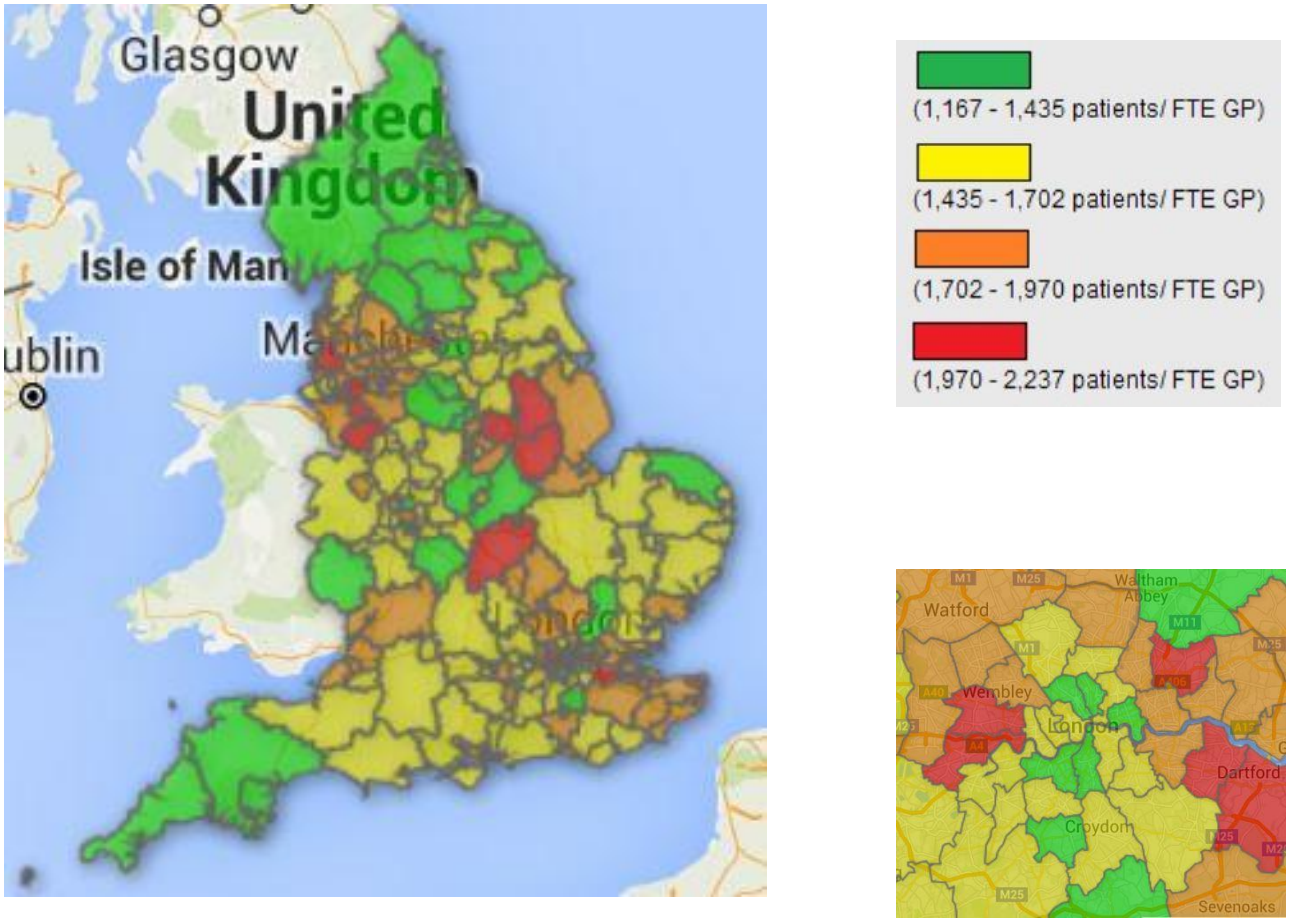
HEE have been encouraged by the fact that many of the recommendations of the report are not only achievable, but that they might be implemented quickly. We accept that the workforce need to be empowered to both evaluate their own work and to improve the systems in which they work if primary care is to remain at the heart of the NHS. We must, however, echo the views of the Commission that those requiring cultural change or the development of cross-organisational boundaries, although attainable, will take more time.

HEE will achieve this through the long term investment in more GPs together with the plans to enhance medical care in the primary care system with Physicians Associates, Clinical Pharmacists and Paramedics and the creation of the new administrative support role, Medical Assistant, will ensure an integrated, diverse workforce for the emerging service models. Proposed changes to nurse training that will ensure early exposure to practice and community settings; together with changes to the ways in which nurse training is developed will strengthen practice, community and district nursing elements of teams looking after patients in or closer to their own homes.

The role of the General Practitioner is key to the success of 5YFV plans. The geographical spread of GPs across England shows that there are areas with serious problems recruiting sufficient numbers of doctors. As is shown in the maps below, these areas show significant overlap with the areas of greatest social deprivation.



Source:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464431/English_Index_of_Multiple_Deprivation_2015_-_Infographic.pdf



Source: http://www.gponline.com/exclusive-huge-variation-gp-patient-ratio-across-england-revealed/article/1327390

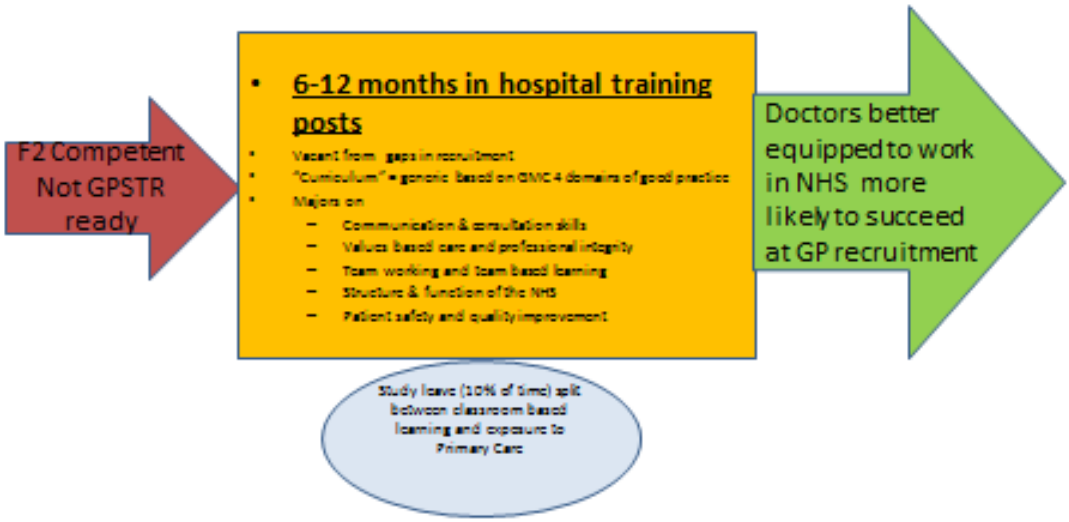
Professor Roland makes it clear that there is no one service delivery model but as we see the emerging principles from the 5YFV Vanguards we need to be able to rapidly and at scale deliver an integrated workforce.

HEE has launched a number of schemes to improve recruitment into training in ‘hard-to-fill’ regions following successful pilots. The pre-GP training programme offers doctors an opportunity to gain the skills necessary for the 3 year GP training programme.

Preparation for Specialty Training (PST)

- Doctors who have F2 competences but fail to gain entry through GP/Specialty selection
- 6-12 months in hospital training posts vacant from gaps in recruitment
- Study leave (10% of time) split between classroom based learning and exposure to Primary Care
- "Curriculum" = generic part of BBT & based on GMC 4 domains of good practice
- Majors on
  - Communication & consultation skills
  - Values based care and professional integrity
  - Team working and team based learning
  - Structure & function of the NHS
  - Patient safety and quality improvement
  - Recording and reflecting on their learning
- Aim is doctors better equipped to work in NHS more likely to succeed at recruitment.

Pre-specialty training (PST) GP themed



Providing doctors with enhanced training beyond their completion of the GP training programme is proving to be a popular incentive and HEE is offering around 200 more programmes in hard-to-fill areas. This allows doctors to enhance their clinical skills in the local environment encouraging both a professional and emotional commitment to local people and services that will improve retention into long term general practice employment.

Retention of the existing GP workforce is vital if we are to utilise the experience of more senior doctors in primary care. Although this is not the direct responsibility of HEE we are working with NHS England, the Royal College of General Practitioners (RCGP) and the British Medical Assocation (BMA) through the '10 Point Action Plan'[2] to understand the levers and the offers that will make it attractive for GPs to stay in employment. HEE is implementing the recommendations from Professor John Collins' Foundation for Excellence report[3] and all doctors in the Foundation Programme in England will spend a minimum of four months working in General Practice or Primary and Community care by 2017. The experience these young doctors have in this environment is one of the determinants of their future career and we all have a responsibility to ensure it is positive and that they see their long term future reflected through this attachment. HEE is leading work to define the levers at undergraduate level in medical schools that will ensure the appropriate supply into General Practice. The wide variation in outcomes with respect to future career choices resulting from undergraduate education is being challenged as the public investment in Universities needs to ensure that, at the very least, the basic needs of the NHS medical workforce are met.

The content of the GP training curriculum is varied and the consequences of this mixed structure have produced doctors who in some instances have very limited experience in areas of clinical practice as important as paediatrics and mental health. Increasing the length of training formally was rejected by all four UK administrations however there are mitigating options that include the increasingly common federating of GP practices, reduced barriers between secondary care specialists and primary care so that consultants are providing more direct community based support, networks of services crossing boundaries supported by better integrated workforce including the use of new or extended roles for non-medical professionals. It is important that these innovative, patient-centred developments are reflected in local workforce plans and that the focus shifts further from the existing traditional delivery dominated by secondary care providers. HEE is also offering GPs training support in Mental Health and other disciplines through e-Learning for Health programmes.

The launch of the new competency framework for Community and District Nurses will raise the quality of education by setting the core nurse competencies and skills needed for the change from acute to primary and community care in these two distinct nursing disciplines. The District Nursing and General Practice Nursing Service education and career framework will underpin the shift from acute to primary and community care by setting out for the first time standardised roles and responsibilities, as well as provide practitioners with a career pathway. The national

[2] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/building-the-workforce-new-deal-gp.pdf
[3] http://www.agcas.org.uk/assets/download?file=2053&parent=793

framework aims to ensure general practice and district nursing workforces are fit for both practice and purpose in the new care models, recognising commonalities that apply to nurses working in primary care and those working in district nursing, but also to be clear about how the roles differ. The framework gives versatility in terms of the commissioning and development of this district and practice roles, as either can be generated in isolation of each other or via a hybrid model that combines the two. It will enable practitioners to plan and develop careers; help education commissioners and providers to identify organisational learning needs, skills and educational requirements and assist employers in conjunction with workforce planners to enable the provision of high-quality primary and community care.

Without improved integration in community and primary care services, the need for either workforce transformation or new commissions will remain opaque. The flow of staff between these services and with social care is well recognised but poorly quantified and local expertise in this vital component of integrated care has an opportunity to develop through the 'Training Hubs' being launched between 2015 and 2016 as part of the joint GP Workforce 10 Point Plan.

Although Physicians' Associates are not a new role, they have had very little impact in the UK in General Practice or primary care settings. HEE is working with recognised experts in the field to commission PA courses that will result in their increased activity in General Practice by 2020.

Pharmacists in Primary Care

HEE is working closely with NHS England, as part of the 10 point plan programme, to implement at scale the recommendations to include clinical pharmacists in the general practice teams. A training and development programme will support the 400 plus pharmacists currently being recruited to work in general practices to deliver patient facing clinical consultations that focus on optimising medicines use, particularly in long term conditions. This cohort of pharmacists will also be expected to enhance the integration of community pharmacist led services and to work closely with hospital specialist pharmacists to support discharge planning. Integrating the development of this important cohort of pharmacists with the training of GP trainees is seen as critical to the long term sustainability of this model of practice.

Similar programmes to develop advanced clinical and consultation skills are being explored to enhance urgent and emergency care and the treatment of self-limiting illness outside hospital and general practice and the care of people in nursing and residential care homes.

2.2. Enabling workforce transformation through education

Whilst it is right that we cannot transform the workforce in isolation from redesigning the work, we can ensure that the structures and processes of clinical education we commission deliver professionals that are flexible, adaptable and have the generic characteristics and skills to meet future system needs.

Examples of enablers that will allow workforce transformation at scale include elements within the Shape of Caring[4], The Shape of Training[5] and Paramedic Evidence Education Project (PEEP)[6] reports with respect to the nursing, medical and paramedic workforces. However, there are other levers that will either produce new workforces such as the consultation regarding a new role to sit between a Care Assistant with a Care Certificate and a graduate Registered Nurse, and changes to education and training that will produce the 'enhanced' workforce such as Pharmacists and Paramedics.

Some of these initiatives create specific opportunities such as the reform of pharmacy education to support multi-disciplinary teams in primary care. Other initiatives, such as our work on education and training for patient safety aim to embed core characteristics which will have significant impact across the whole system and its culture, and over the whole span of a professional's career.

Future proofing clinical education

The levers available to the system to develop the skills, knowledge and attributes of the healthcare workforce in order to deliver care in new service models and to raise the quality of patient care are varied. It is important to reflect these changes – the reality of the job today and the potential role tomorrow – into undergraduate curricula as soon as possible. An example of how a nationwide approach to this can be effective is the Genomics Education Programme[7] . However, while the scope of a major scientific breakthrough for future healthcare is clearly best encompassed in a national programme there is still an important role for local development, recognising the different needs of those in healthcare roles as they and the service change.

Paramedic Education Reform

The PEEP report provides the evidence for change bringing paramedic training into line with the other Allied Health professionals that are degree level entry. The additions and changes to the degree curricula provides a greater breadth and depth of competencies for the profession thus allowing them new opportunities for managing patients over the phone through "hear and treat" and on the road and in the home, through new "see and treat" strategies. These changes will also provide new employment opportunities for the paramedic skills especially around supporting General Practitioners in managing urgent cases in the primary care settings, a potential major boost for supporting clinical pressures in General Practice at scale.

Shape of Caring and new nursing roles

Raising the Bar: Shape of Caring: a review of future education and training of Registered Nurses and Care Assistants, (2015) set out 34 recommendations which have all been accepted by the HEE Board for implementation. These fall into the following key themes:

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[4] https://hee.nhs.uk/our-work/developing-our-workforce/nursing/shape-caring-review
[5] http://www.shapeoftraining.co.uk/
[6] https://hee.nhs.uk/sites/default/files/documents/PEEP-Report.pdf
[7] https://www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents

- Valuing and developing the care assistant workforce which will include a consultation in the early 2016 into the development of a potential new role, currently referred to as a Nursing Associate.
- Establishing national standards for post registration education to ensure that we maximise skills and talent and prepare the nursing workforce to respond to changing needs and to work effectively within new care models.
- Ensuring flexibility in pre-registration education including Widening Access to enable those with the right values to work towards registration.
- Enabling excellence in nursing practice.

Medical Education and Training Reform

There is recognition that elements of postgraduate medical training need to change to reflect the future needs of the public and patients. While some of this is encapsulated in the most recent report into this area of training, The Shape of Training 2013, much of the work that HEE is supporting and leading is necessary to improve the quality of training. The RCS England is working on a proposal to develop a 'General and Acute' surgeon. While there are many challenges to be debated this is an exciting proposal and demonstrates how collaborative, innovative thinking that encompasses proposals for the whole workforce – the clinical team- can make effective inroads into the perceived rigidity of existing training models. There are other specialties where reform is actively being considered and supported by HEE and where an integrated workforce approach is being taken to ensure 'the right person is available at the right time in the right place'. The GMC Consultation on credentialing is due to report in 2016 and this, with the combined developments across specialties will allow for greater flexibility in the part of the workforce that takes the longest to train but is a vital component, particularly in acute and out of hours care, during the training period. The challenge will be to deliver these changes at a lower cost and more efficiently than at present. Engaging the whole medical workforce, not just those doctors in CCT training programmes, will be key to improving the quality of education for all, understanding effective team work, and developing the wider workforce. This will assist in reducing the impact on patients and the service of the often described 'rota gaps'.

Commission on Education and Training for Patient Safety

HEE established the Commission on Education and Training for Patient Safety to provide us with clear guidance on how education and training interventions can actively improve patient safety.

The commission's report explores a number of key themes including

- Supporting the culture and processes of learning from errors rather than blame
- Supporting learners and staff to raise concerns
- Embracing transparency
- Patient safety must be embedded in the education and training from the outset and throughout careers

Key recommendations include;

- Developing a clear evaluation framework to assess the efficacy of education and training for patient safety
- Recognising and including the important role of patients, family members, and carers in preventing safety incidents within training and education
- Support the development of a culture of openness and transparency by reviewing existing training to ensure they support the duty of candour regulations.

In each of these areas it is not some specific action on role design or team working that is important, it is that HEE is addressing issues relating to either the fundamental structure of clinical education or in respect of core competencies or beliefs, that create the environment within which specific change proposals can be more readily delivered.

2.3. Working with local partners – Vanguards, STPs, and other initiatives

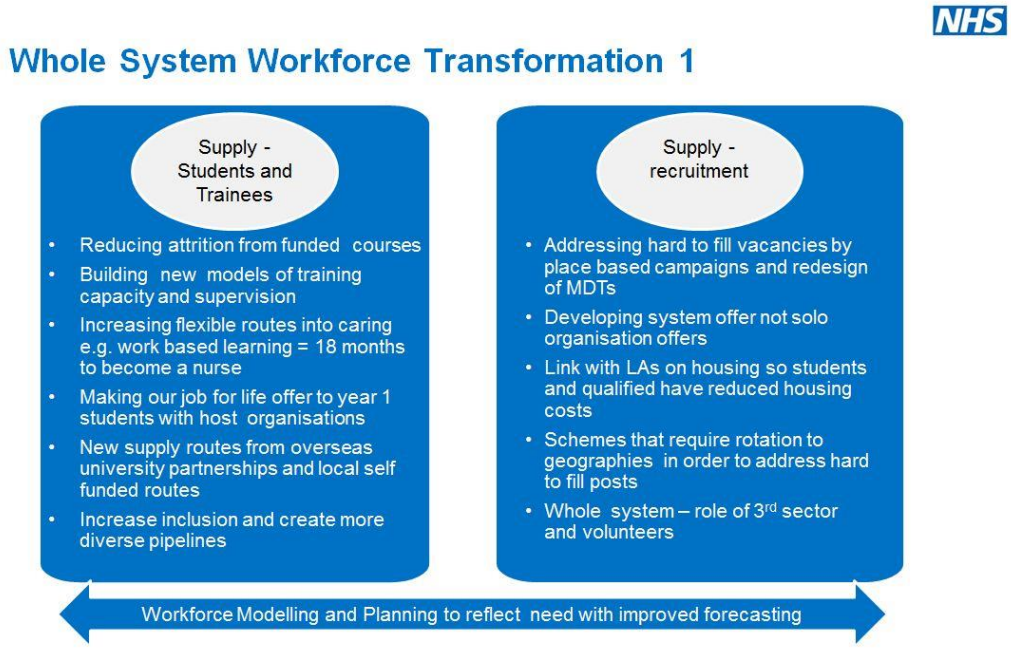
Service and workforce transformation is delivered by local organisations, teams, and partnerships designing and implementing new ways of meeting patient need and by designing and employing the workforce required to deliver these models. Such work can of course be adoption of national initiatives, for example the care certificate or new roles, but ultimately actual implementation and use must come down to local delivery.

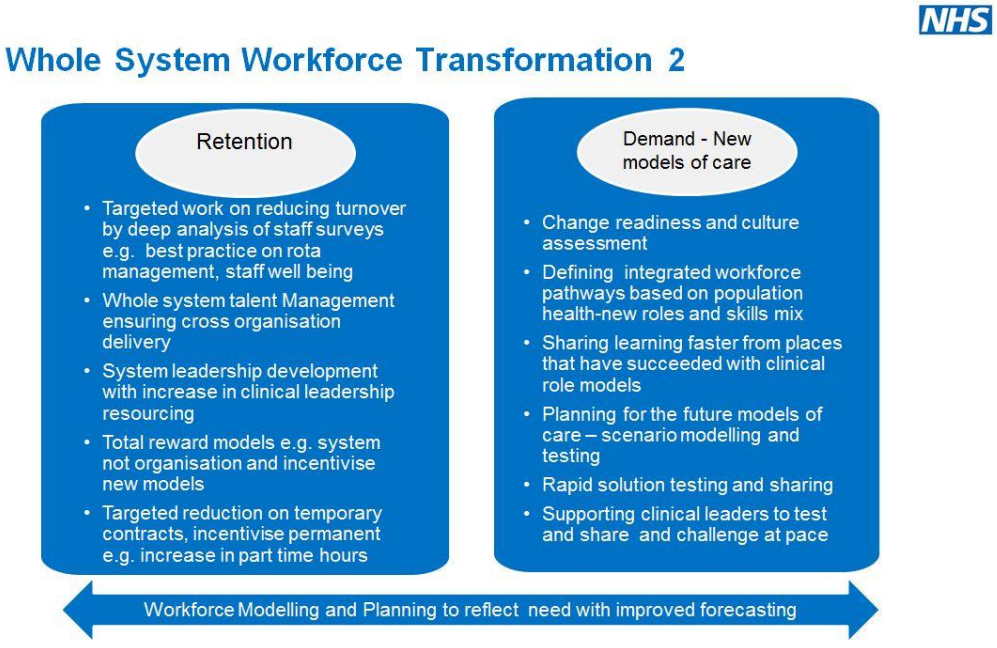
Similarly the majority of the workforce responsible for delivering the vision described in the FYFV is already in the workplace, and therefore the up skilling of this workforce and their adaption to new ways of working must be central to delivery of our vision.

HEE's local teams have worked extensively over the past three years, with provider and commissioner colleagues on a wide variety of service and workforce transformation initiatives. These have ranged from individual process re-engineering projects through to whole system programmes.

More recently HEE has been listening to the Vanguards within the New Care Models programme to understand their needs so we could shape our support offer. What was striking about this work was the consistency of themes emerging from these discussions. These local health and care systems made no distinction between their needs based on the notional workforce responsibilities of different ALBs or themselves. What they were looking for were solutions across all aspects of their workforce challenges captured in a single coherent and comprehensive workforce demand and supply strategy.

The emerging themes from the Vanguard sites are set out below.





We have also worked with each Vanguard site to:

- Through networks, continue to identify good and best practice and share that at pace
- Support and co-design fast Organisation Development interventions e.g. simulation events that bring teams and systems together to shape and test future pathways of care
- Influence national bodies by constant highlighting of the barriers and new solutions
- Use Planning Guidance processes to focus creation of system wide workforce plans

HEE is now looking to build on all this experience to shape and clearly define the contribution we can make to local transformation work in all of the 44 STP areas. It is clear however that this offer cannot be restricted to service and workforce transformation, it must be part of a comprehensive solution that solves current and future supply challenges as well.

This work is ongoing and an important part of this work will be establishing common terms, however some key components of this requirement / offer would appear to be:

- Consistent and reliable data on current supply, demand and existing gaps, plus a clear assessment of the immediate and future supply prospects – systems need to understand whether proposals they are creating are deliverable with regard to assumptions they may have made about the availability of different staff. Such analysis may lead to additional supply interventions (current or future) or in the most extreme cases lead to re-design of the care delivery model and MDT to account for this supply constraint.
- Workforce Modelling – tools and expertise to experiment with the make-up of the workforce within the context of different MDTs and delivery processes. These are fundamentally' workforce design tools'
- Workforce planning support – support in the use of proven and consistent workforce planning methodologies. Standard terminology to enhance common understanding. Training to enhance workforce planning capacity within provider and other partner organisations. Signposting to similar work and sharing of best practice. Data collections and reporting including the Workforce Repository and Planning Tool (WRaPT) (in support of reliable data above)

These 'planning' activities are then likely to lead to support with a range of actions / solutions;

- Up-Skilling
- New roles
- New ways of working
- Action on workforce supply (including retention and recruitment of existing staff and maximisation of new supply as per the Vanguard model above)

All of which will be underpinned by leadership and Organisational Development initiatives and support. Many opportunities to develop effective multidisciplinary teams will want to explore the role that effectively trained support staff can play in helping their clinical professional colleagues. HEE is working closely with NHS and other providers to ensure we maximise the opportunities presented by the new proposals for apprenticeship funding, building on our existing 'talent for care' strategy.

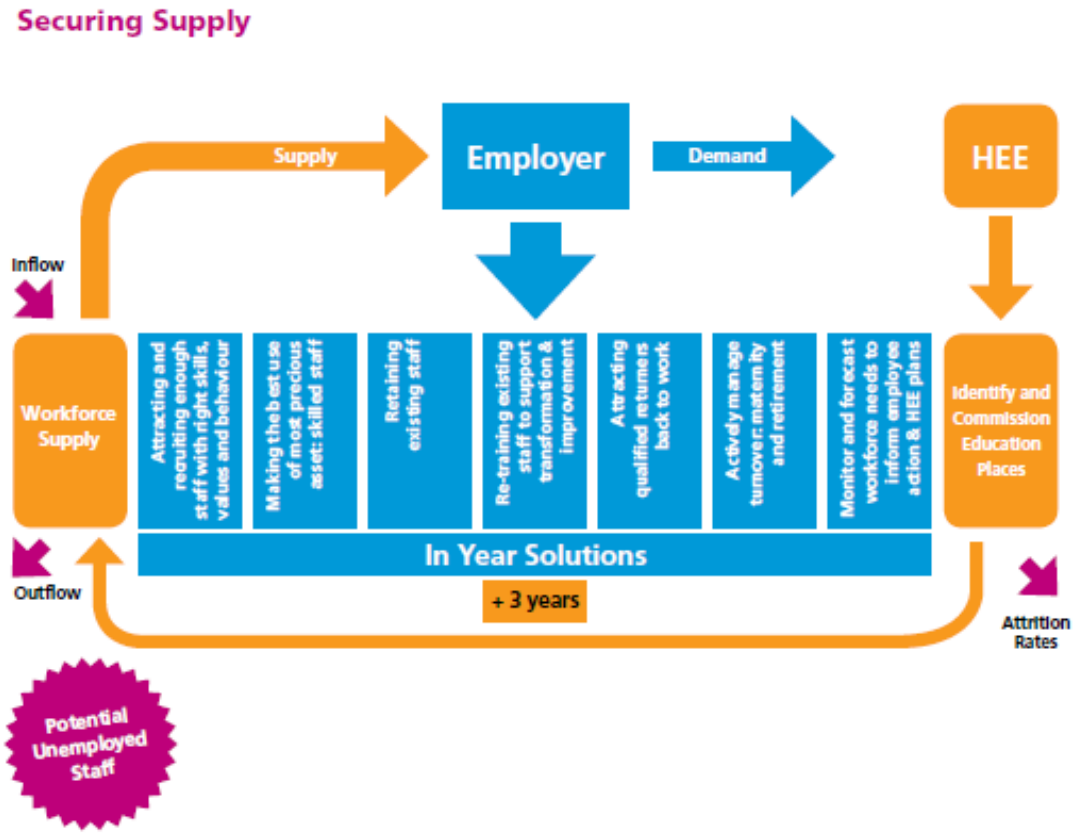
At an aggregate regional and national level partners will want to be able to extract themes about future demand from these local STPs. We are exploring what level of detail partners believe will be useful but there is general agreement that scenarios based on genuine place based consensus are likely to provide better indications of future demand than has been achievable through forecasts that have been solely generated through the lens of individual providers.

3. Current Workforce Shortages

The majority of activities and investments described in HEE's Workforce Plan for England have a four year or longer time lag until new workforce supply is created and cannot effect the current supply position. Where current shortages exist other actions must be taken if the system is to avoid the consequences of too few staff and/or avoid excessive use of agency staff. Shortages not only affect patient care directly but also, particularly in the case of postgraduate medical training affect access to and the quality of training.

The effective management of current supply and demand are also central to achieving the future supply projections and supply / demand balance outlined in Section 4 of this report. Future supply is after all simply the sum of five years' current supply actions. The higher supply projections we have made are reliant on NHS employers accessing the output from our education programmes and acting to improve staff retention.

In last year's Workforce Plan we began to outline the mutual responsibilities and actions that other partners must take in order to address any immediate shortages. HEE has also established the only NHS wide assessment of gaps between supply and trust reported demand through its annual workforce data collection. Without this data the nature and spread of any shortages (by specialty and geography) cannot be identified and targeted action taken.



In 2013 HEE established the comprehensive national future workforce supply planning processes and associated data collections. The system's newly stated requirement for a

comprehensive and co-ordinated focus on current workforce supply means that we rapidly need a similar programme of work to establish the planning processes and data requirements needed to support this task. In the meantime the work and analysis contained in this section represents early analysis of the current situation, assessment of the likely causes, and possible solutions.

Current workforce challenges appear to fall into three broad headings;

1. Priority shortage areas - There are a number of professions where a material gap between funded demand and current supply has arisen and without additional action are likely to be sustained for a number of years. Action will be required on both supply and mitigating demand in order to accelerate the rate at which shortages are addressed and consequently future agency use can be minimised.
2. Other supply shortages - There is a second group of shortages where a) the wider supply landscape indicates NHS supply should not be a problem and the cause of current vacancies needs specific investigation, or b) it is unclear whether the demand increases that have triggered current shortage are sustainably funded into 2016/17 and beyond (i.e. appear to be not aligned to SR funding or FYFV assumptions).
3. Finally there are areas where stakeholders describe 'shortage' in terms of the number of funded posts available to deliver service volumes, standards, or priorities. These may not be current supply challenges, but experience tells us that if such concerns have substance then commissioners or providers may at some point act rapidly to increase the funded workforce. If this happens, without careful proactive planning and phased implementation, then supply challenges may follow.

Outlined below are some initial observations on work being done in priority areas. As HEE develops its approach to addressing current supply issues we will explore and report on our findings within the other two shortage categories.

3.1. Priority shortage areas

The current workforce shortages work stream of the WAB identified four specific priority areas:

- Nursing
- Emergency Medicine
- Paramedics
- General Practice

In addition it recognised that individual medical specialties may have specific challenges although these were often geographically specific. Within these medical challenges are examples where there are calls for more 'junior doctors' to be made available to fill rotas. However we must be conscious that the number of doctors in training is designed to be explicitly related to the need for future CCT holders not simply to provide today's service. This is a key tension for the service and STPs should seek to address how services can be delivered through options such as use of multi-disciplinary teams or further consultant delivered services.

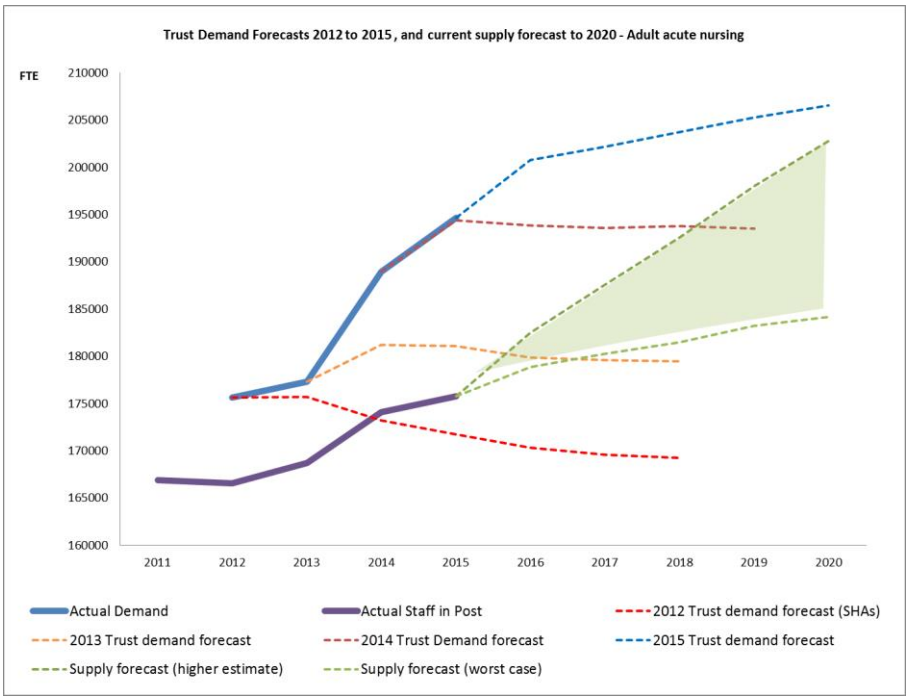
In terms of the General Practice priority there is, at the moment, no systematic measure of vacancies within General Practice. HEE has been working with the Department of Health, the Health and Social Care Information Centre (HSCIC), and NHS England to develop a workforce minimum dataset for primary care.

In order to address current vacancies and meet future demand, the GP ten point plan discussed earlier in this report is the mechanism through which partners are seeking to grow the GP workforce as fast as is possible, including seeking to address current supply actions such as improved retention and return to practice.

The examples outlined below do not represent complete coverage of the issues facing the NHS nor are they a comprehensive assessment of each area. They do however illustrate the main themes that both local and national partnerships will want to explore as we develop a more co-ordinated approach to current supply planning.

3.1.1. Nursing

It is self-evident that we are in an extremely challenging situation in respect of a mismatch between the number of funded nursing posts established by NHS providers and the supply available to meet this requirement. The primary cause of this shortage is well known and understood. In response to the Francis report into the serious service failings at Mid Staffordshire the system, in response to The National Institute for Health and Care Excellence (NICE) and National Quality Board (NQB) guidance and Care Quality Commission (CQC) inspections, undertook a fundamental review of the level of staffing it was providing. The graph below illustrates how NHS funded demand (and their forecasts of future demand) for nursing staff increased year on year between 2012 and 2015.



Across all nursing branches, the impact of these safe staffing policies and guidance has been the creation of 24,000fte new nursing posts between 2012 and 2015, an 8.1% increase. Over

the same period the number of nurses employed by the NHS grew by over 9,000fte, a 3.2% increase. The consequence of this rapid growth in demand outpacing the available supply has been the resulting 26,700 nursing vacancies as at 1/4/2015, which represents 8.5% of the funded establishment. The shortage experienced by employers will vary with gaps ranging from 5.4% in the North East to 13.8% in South London. Even these measures are simply regional averages that will mask a wider range between individual organisations, and between nursing branches and specialisms.

Trusts also indicated to HEE their intention to create a further 8000fte posts during 2015/16 but such expansion appeared to be inconsistent with the assumptions in both the Spending Review and the Five Year Forward View. The extent to which there has been any further growth in funded posts, within sustainable finances, will not be known until 2016/17 plans are submitted and analysed.

The position in adult acute nursing (as shown in the graph above) is particularly stark with the highest percentage increases in new posts 19,028fte (10.8%) and although this workforce showed net growth of 9,199fte between 2012 and 2015 this has resulted in reported vacancies of 18,899fte (9.7% of establishment). Adult acute nursing is the largest single nursing group and as such is likely to have contributed most staff to the 4000fte expansion of Health Visiting workforce achieved over this same period.

In order to address these challenges in a comprehensive and co-ordinated manner, Jane Cummings Chief Nursing Officer (CNO), established a nursing supply board with representation from all other ALBs, DH, and employer organisations. It was recognised that in addition to the additional future supply being generated by HEE's increased training commissions action would need to be undertaken across a range of areas:

- Improved recruitment and retention
- Return to Practice
- Increased training output by reduced course attrition
- Increased employment of education output
- Moderating workforce demand
- International Recruitment

Improved recruitment and retention

In order to address NHS supply shortages the system's efforts must focus on creating additional supply not competing between organisations or regions for the existing supply.

There is a natural level of movement of people within the NHS and between the NHS and other employers of healthcare professionals. Some of these employers are commissioned to provide NHS services and as such fall within our view of NHS supply. However where the NHS has an immediate unmet supply requirement it is only natural to try to minimise outflow from the NHS and to try and attract staff from other sectors back into NHS employment.

The records for the previous four years show that the rate at which the nursing and midwifery workforce are leaving the NHS has increased by over 3,700 per year. These figures represent

people who have completely left NHS employment not those who leave to join another organisation or promotion within an organisation. A component of this will be the impact of increased retirement rates but the majority describes increased staff turnover.

Table 2: Qualified nursing & midwifery – Joiners and leavers 2011 to 2014

	Leavers	Leaving Rate	Joiners	Joining Rate
2014/15	30,655	8.6%	34,617	9.7%
2013/14	28,907	8.2%	33,924	9.7%
2012/13	27,511	7.9%	27,240	7.8%
2011/12	26,916	7.7%	23,688	6.7%

Source: HSCIC

Anecdotally some of this deterioration may reflect staff moving to agency employment from substantive NHS employment, and in turn this is thought to be associated with the increases in agency rates seen during 2014/15. The price and volume controls instigated via NHSI over the past few months should go some way to reversing this reported trend.

In the same period the number of joiners increased by 11,000 (although this does not mean we should be complacent about the deteriorating retention). The 2011/12 baseline is likely to be a false comparator as with low vacancies and few new jobs the NHS appears not to have been actively looking to recruit additional staff.

If we are to manage current supply better we do need a better understanding of where staff are moving to/from and why; for example, we do not know what element of the joiners shown above represents people who have just qualified from NHS training schemes or what proportion of the total graduating class this represents.

Uniquely the NHS is able to identify these factors as it has a comprehensive Electronic Staff Record system and creates joiner and leaver records for staff moving into or out of the NHS. Unfortunately compliance with this record appears to be currently incomplete and even where records are generated the recording of source/destination and reasons for leaving are also patchy. However even in its incomplete form these records can provide useful intelligence including comprehensive data on age related retirements (as all retirees need a leaver record to trigger payment of pensions) and items such as dismissal and redundancies (surprisingly 425 nurses were made redundant in 2014/15 despite the extensive supply challenges outlined above). An example of the available data is given for Occupation therapists in section 4.5.2.

One of the reasons for establishing Local Workforce Action Boards (LWABs) is to give HR directors and colleagues an explicit purpose for collecting and collating data within their labour

market, and in respect of how their area interacts through staff migration with neighbours, other sectors, and the rest of the country.

NHS Employers continue to work on researching and sharing best practice on staff retention including in areas such as staff engagement and development, actions which also enable employers to meet their NHS Constitution obligations to staff. However to date no specific ambition has been set for what we might expect adoption of such good practice to achieve, nor how we might observe differential practice between organisations or areas and target improvement support.

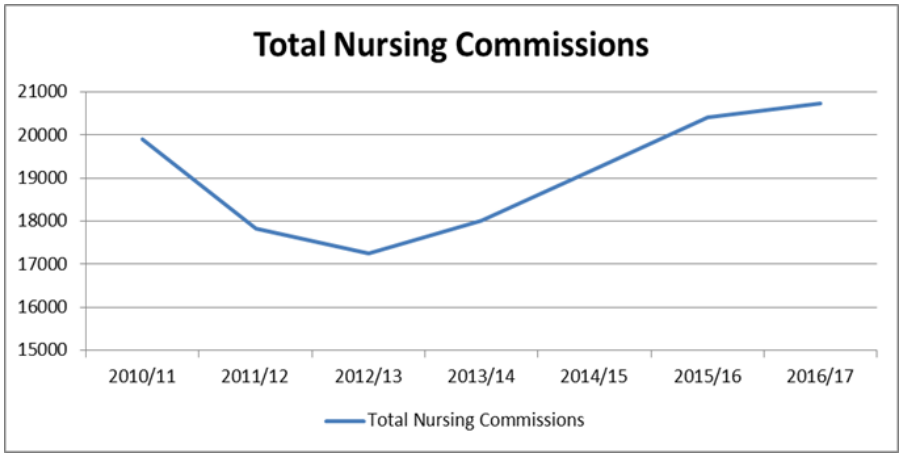
HEE is keen to work with providers to enhance the education offer more widely to, for example, trust doctors so that all staff are valued and supported as one element in reducing staff turnover rates.

Return to practice

HEE has also intervened to support employers with shorter term supply through the 'Come back to nursing' campaign and associated structured return to practice education and support. The initiative commenced during 2014/15 and by January 2016 2,083 people had been recruited onto the programme and 850 people had completed. Of these 584 had secured employment and a further 266 were seeking employment or awaiting their PIN. HEE intends (subject to agreement of our 2016 business plan) to maintain this initiative as a standing offer to the system and explore if this approach would be worthwhile in other areas of specific need (including potentially a social care version).

Education output and employment

As we have previously described increased education commissions take four years to come to fruition. However it is worth noting that the 745 increased commissions undertaken by SHAs in 2013/14, as the initial response to the emerging 'post Francis' world, will be additional supply during 2016/17, and the first tranche of HEE's increased commissions (1,197 increase) will be graduating from 2017.



	SHA Commissioning				HEE Workforce Plans		
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Adult	13628	11930	11416	12134	13228	14160	14417
Children's	2095	2045	2159	2151	2182	2343	2343
Learning Difficulty	681	599	606	628	653	664	638
Mental Health	3500	3253	3083	3096	3143	3243	3343
Total Nursing Commissions	**19904**	**17827**	**17264**	**18009**	**19206**	**20410**	**20741**
Yearly Increase					*1197*	*1204*	*331*
Cumulative increase					*1197*	*2401*	*2732*

However the system can act to maximise the immediate impact of new education supply in two ways;

i. Improved course attrition such that the same or lower inputs produce more output
ii. Improved rates of employment of the graduates produced.

Under the first heading HEE has been leading extensive work with (Higher Education Institute) HEI and placement partners to improve attrition in line with our mandated target to reduce inappropriate attrition by a third. There are good indications (although not yet confirmed by consistently observed data) that a combination of factors ranging from pre-degree experience, values based recruitment, an all degree entry, and specific initiatives within the education programmes are having the desired impact. These improvements are not yet fully reflected in HEE's supply forecasts in Section 5 and as such represent an opportunity to accelerate progress to supply / demand balance.

Understanding how the NHS attracts and retains the graduates it has just spent three years training is a critical component of addressing the supply challenge. During the early period of the current shortage we were still hearing providers who said they need experienced staff in preference to newly qualified staff and there were some indications that not all of our graduates were finding employment. Data from the Higher Education Statistical Authority (HESA) shows that a high proportion of nursing related graduates do find employment within a year of graduation. What these statistics do not show is where, or in what kind of job these graduates are working. These rates are high by comparison with other graduates and there is clearly a case for expecting the vast majority of this highly vocational course to be retained and developed by the NHS. In London the 'Capital Nurse' programme, in context of their very high vacancy rates, is actively exploring a job guarantee scheme. Whether such an idea needs to be adopted elsewhere, for as long as the supply conditions remain challenging, is worth further local consideration. However unless local partners have the data on the current take up of graduates into NHS employment such considerations will be significantly impaired.

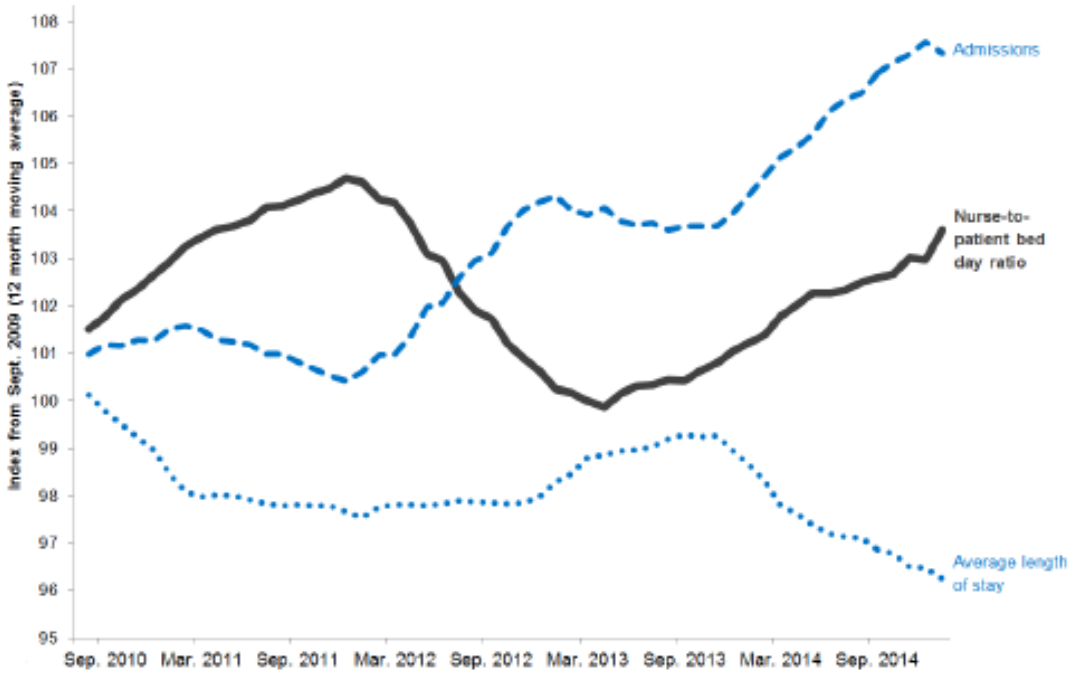
Not all vacancies can be filled by new entry level supply. There are reports of significant vacancies for senior and specialist nursing roles, although again there is currently no mechanism for counting these separately from the total. The question of how the system routinely invests in its current staff at a post graduate level to provide a consistent and secure supply of staff into these roles is one of the key challenges for the WAB. At present the official policy is that such development is an employer responsibility, however there is widespread agreement that pressures on front line delivery and resources in addition to a fear of training staff only to lose them to other employers acts to impede staff development at the scale

needed. HEE has already been asked to step in to develop the next cadre of additional non-medical endoscopists and our local teams have been asked by their Boards to prioritise areas such as sonography. As vanguards and STPs increasingly look to utilise multi-disciplinary teams with advanced skills within their future care models, it appears critical that a mechanism for developing staff with advanced skills at scale is designed, agreed, and implemented.

Moderating increases in workforce demand – Workforce consequences of productivity

It is critical that efforts to close current shortages recognise and include efforts in respect of productivity. This is both the workforce consequences of service productivity as well as productivity generated by the workforce itself in areas such as skill mix or enhanced performance through training and development or use of technology. The NHS Institute for Innovation and Improvement's (NHSI) report 'Evidence from NHS Improvement on clinical staff shortages' (Feb 2016) highlights that the impact of the Francis report was not the only driver of increased demand. Significant increases in hospital attendances, as well as increasing acuity, may also have represented driving factors. Their analysis below succinctly highlights the different elements of demand activity that the system and providers must take action on, in line with the FYFV assumptions on sustainable high quality services.

Trends in nurse-to-patient ratio, admissions and length of stay 2010 to 2015[2]

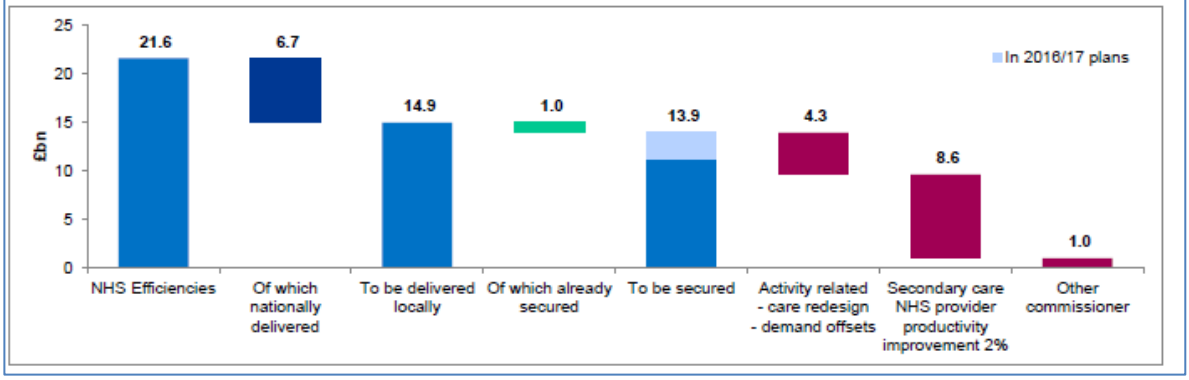


Source: NHSI - Evidence from NHS Improvement on clinical staff shortages

Systemic productivity – The graph shows the impact of increased activity, many of the proposals in respect of new models of care and service integration aim to moderate or reduce levels of hospital activity, with the attendant impact on staffing numbers without impacting on staffing levels. The analysis of the £22bn efficiency assumptions with the FYFV modelling (see

table below) shows £4.3bn of such 'activity related' efficiencies that will materially limit the number of additional staff that would otherwise have been required.

Chart 4.1 – Breakdown of the 2020 £22bn efficiency programme going into 2016/17

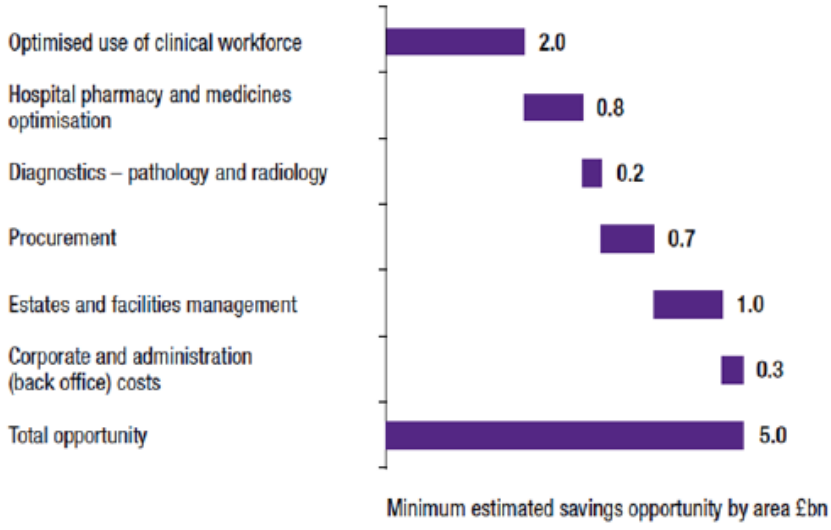


Source: NHSE - Recap briefing for the Health Select Committee on technical modelling and scenarios

Healthcare Process productivity – The graph similarly shows how providers within the context of increasing activity have mitigated the impact of this by reducing length of stay, the NHSI report points out that without this demand moderating activity the number of additional posts required could have been higher.

The final ratio shown is nurses per patient day, the recommendations in Lord Carter's report indicate that scope exists in some organisations, through activities such as better deployment and rostering of staff, to deliver the same high standards of care with fewer staffing inputs. Some £2.0bn of saving opportunities, from optimum used of clinical workforce, is identified in the Carter Review.

Chart: Carter Review estimated savings opportunities



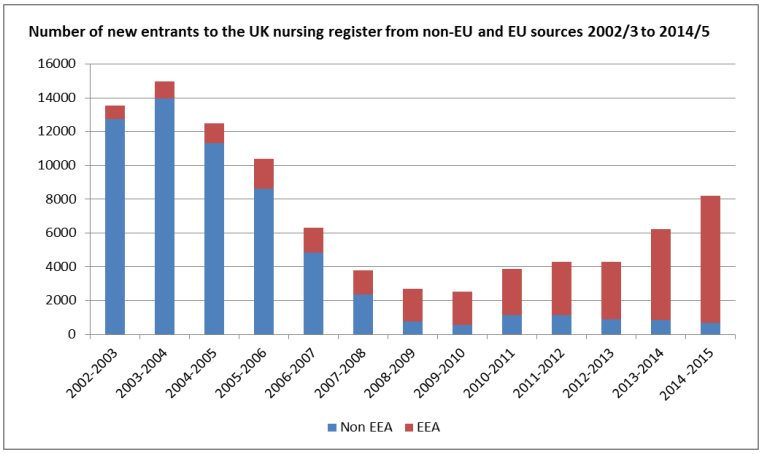
Source: NHSE - Recap briefing for the Health Select Committee on technical modelling and scenarios

The NHSI report also describes how they are committed to helping providers improve their productivity using support tools such as the 'Reference cost benchmarking tool' and their report on opportunities to improve productivity in elective care.

International Recruitment

One key piece of work undertaken this year by the WAB partners, led by DH colleagues, was the creation and submission of robust evidence to the Home Office, Cabinet Office, and Migration Advisory Committee in respect of the overall supply position with regards to nursing in England. The existence of an NHS wide multi-faceted approach to actively managing the gap between supply and demand provided confidence that the NHS was taking its responsibilities seriously, such that the temporary inclusion on the Shortage Occupation List was approved. Work is ongoing to ensure the temporary requirement for this status is retained whilst the measures described above are delivered.

It is noticeable however that although the current shortage emerged during 2013/14 and was compounded in 2014/15, there does not appear to have been the level of system wide International recruitment seen between 2002 and 2005 (at the time of the workforce expansion under the 'Wanless review' and NHS ten year plan.



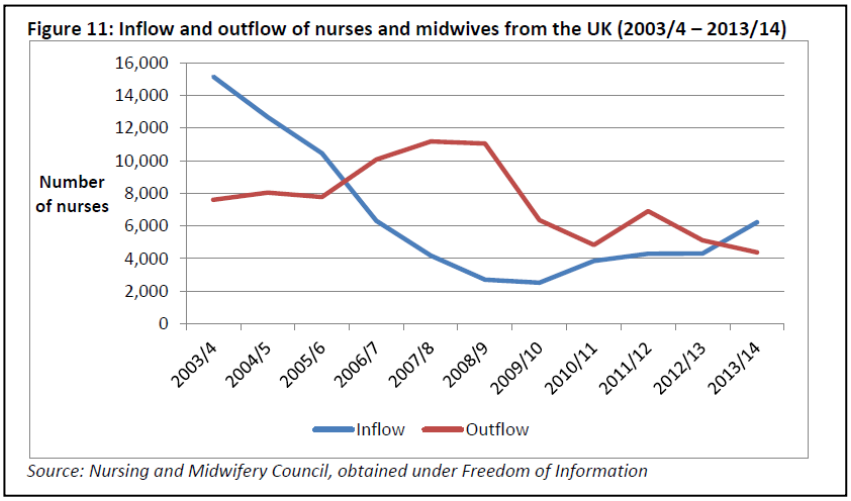
Source: Nursing and Midwifery Council

Recruitment on this scale (40,000 over three years) would have addressed virtually all of the current shortage, and whilst there have been reports of large initiatives by individual trusts, it is clear that many Directors of Nursing did not opt to go down this route and by 2015/16 began to face the cap on the number of tier 2 visas available as a result of increased competition for visas from other recovering economic sectors. The reasons for this may be varied. There are certainly reports that the high levels of international recruitment in the early 2000's were not without their challenges and certainly both the practice of nursing in England and the requirements in terms of communication and language skills have both developed significantly over the past ten years, as have international agreements on not taking skilled staff from developing nations.

The nursing supply group members and other WAB partners have discussed the merits of co-ordinated International Recruitment activity. The general consensus is that such co-ordination is

best achieved at a regional level with access to specific expert knowledge and advice at a national level. HEE is actively developing proposals for the system in this area.

It is worth noting that the increased number of leavers reported above does not appear to include increased emigration. Indeed the number of UK nurses applying to the NMC for certificates of competence has diminished since a peak in 2007/08.



Data, reporting and governance

HEE will be discussing with ALB partners what mechanisms we think are appropriate set performance expectations and to monitor progress and support improvement

3.1.2. Paramedics

In 2013/14, ambulance trusts had increased their demand for paramedics by almost a thousand posts (in excess of 8%) and that rapid growth in establishment coincided with a year in which the rate of supply increase, which had been running at about 600 per year, dipped to only 300 (mainly as the result of increased staff turnover). The combined impact of this lower growth and increased demand was the rapidly widening gap between demand and supply which has persisted ever since.

HEE sponsored commissions have increased from 655 in 2013/4 to the 1729 proposed for 2016/17, however additional supply will only come on stream from 2017 and even then providers' forecast further increases in demand.

As at 1/4/2015 trusts reported shortages totalling 1,212fte 9.3%, although as can be seen from the table below this problem is highly skewed across specific geographic areas. We have previously reported that leaver rates had increased significantly and it is clear that we need to understand at an individual local level the mechanisms through which such extreme variation in shortages have arisen and therefore what can be done in addition to future training supply to resolve these challenges.

Paramedics - Demand v Staff in Post as at 1/4/2015

HEE Area	Staff in Post	Trust Demand	Gap	
	FTE	FTE	FTE	%
East Midlands	1,112	1,139	27	2.4%
East of England	1,195	1,346	151	11.2%
Kent, Surrey, Sussex	782	806	23	2.9%
North East	551	658	107	16.3%
North West	1,712	1,789	77	4.3%
London	1,549	1,950	401	20.6%
South West	1,542	1,646	104	6.3%
Thames Valley	689	874	185	21.1%
Wessex	45	46	1	1.1%
West Midlands	1,462	1,454	-8	-0.6%
Yorkshire and Humber	1,140	1,285	145	11.3%
Total England	11,781	12,993	1,212	9.3%

London's ambulance service working with HEE has been active in both international recruitment, incentivising people into their training programmes, and retaining them into employment.

HEE will continue to work through the PEEP group with Ambulance Services to understand what role the wider ambulance team may be able to play in addressing these challenges within STPs, and to carefully manage the implementation of degree level entry so as to avoid any risk of a 'fallow' output year.

3.1.3. Emergency Medicine

In our first Workforce Plan for England (2014) we described how consistent pressure in Emergency Departments had begun to result in some potentially critical stresses. Post graduate medical training vacancies are not just 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 since inception, HEE developed practical solutions to workforce pressures based on both current need and longer term sustainable solutions. These proposals included increasing the number of posts by 95 in 2014 and a further 95 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; and the work, learn, and return initiative whereby training places are offered to overseas doctors to develop emergency medicine skills and gain valuable clinical experience. The 'learn and return' programme is up to four years, after which the doctor will return home to use their skills to care for patients and share learning with colleagues. To date this has resulted in 26 additional trainees. As a result of all of the initiatives described above, and in particular the success of the run through option in ensuring near 100% fill, the number of doctors in training has expanded, which has relieved pressure on Emergency Departments.

3.2. Next steps on current shortages

Individual employers must remain at the heart of how current supply and demand for staff is managed, including how staff are valued, supported, engaged, and retained within their obligations to these staff under the NHS constitution. It is critical that any collective action is not seen to diminish this primary responsibility and accountability.

The system has acknowledged however that co-ordinated collective action on current supply is required in addition to individual employer efforts. Work in this area at a national level has already started including the creation of the WAB, the specific work outlined above, as well as other areas such as the work on agency controls.

The establishment of LWABs will be a significant measure to ensure this approach is adopted at a local level where many interventions are best initiated and planned.

However it is crucial that we develop additional consistent and accurate workforce data to support this task. In the electronic staff record the NHS has a potentially powerful tool to assist this task, but it must be used more consistently in light of these new requirements. Similarly we must be able to observe the problem we are trying to solve. The lack of a systematic vacancy measure trusted by all partners is a fundamental barrier to identifying, diagnosing, and solving shortage problems.

If partners are serious about tackling these challenges then we need consistent, sponsorship, support and compliance in building the data needed. HEE will work with workforce colleagues in NHSI to develop proposals, including standardised outputs, for consideration at the next appropriate WAB or FYFV CEs meeting. This work will address issues in respect of workforces not in NHS employment and in particular primary care.

4. Future Supply

4.1. Overview

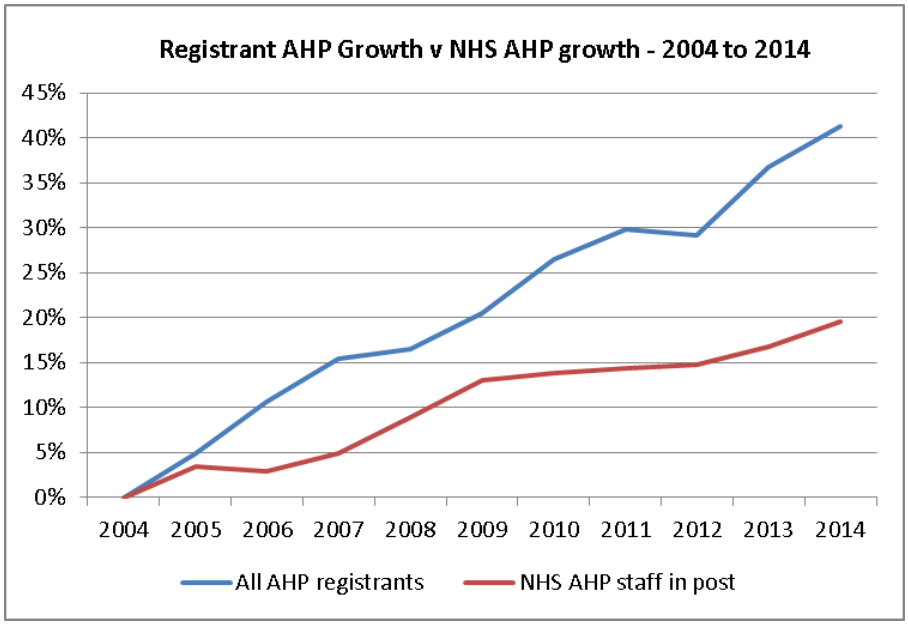
HEE's assessment of the future supply prospects for the NHS workforce was outlined in our 'Commissioning and Investment Plan – 2016/17'. This provided the basis on which we accepted the investment proposals of our thirteen local teams. The report was approved by our board and published in late December 2015 in order to allow us to meet our responsibilities to key HEI partners to notify them of our commissioning proposals in line with contractual requirements.

In that report we forecast that additional clinical workforce supply of between 24,000 and 82,000fte would be available to the NHS by 2020. The range is generated by assumptions in respect of how actively employers attract newly qualifying output from our programmes and act to value and retain their existing staff. The lower 'worst case' figure anticipates significantly lower retention of staff than recent norms. This supply would also be available to other employers of clinical staff and indeed we do not believe the NHS would utilise all the supply at the higher end of these forecasts as this would appear to be in excess of what is affordable within Spending Review assumptions.

We have been asked by partners to be more explicit as to how we assess the supply prospects for the wider labour market for health care professionals in England when assessing the investment proposals put forward to us by our local teams. This is especially relevant for professions such as the various AHP groups where the NHS does not represent the employer or commissioner of a significant majority of working clinical staff. Outlined later in this section are specific examples of how we, and colleagues such as the CfWI, have made assessments of the component parts of the labour market for different professions. We also show how we use the registrant data for each profession to give us an overview of the wider supply prospects arising from recent training levels in order to inform our judgement for the NHS. This is supported by invaluable profession specific data submitted to HEE by professional groups through our call for evidence.

In summary however these analyses show a general picture in which training volumes, broadly similar to current levels, have supported significant and consistent growth to these professional workforces. Our forecasts indicate that this trend will continue. What the analysis does show however is that the majority of this supply within many AHP groups would appear to have been accessed predominately by employers other than the NHS.

The graph below shows the overall level of growth to those elements of the UK AHP workforce that HEE commissions compared to the level of growth within the English NHS.



Source: HCPC and HSCIC (excludes paramedics, prosthetists, and art therapists)

The total growth in the AHP workforce over this ten year period was 44,880 (41.4%) whilst the NHS AHP workforce grew by 12,653 (19.5%). The NHS went from representing 60% of the total register in 2004 to only 50% in 2014. HEE's comparable forecast for the next 5 years was a range from 7,400fte to 22,300fte.

Our primary responsibility is to provide sufficient workforce for NHS commissioned services. We have a second duty to work with social care partners to address issues in the wider health and care workforce and support closer integration. We are also aware that clinical professionals work in other areas of public service such as schools and DWP and pay due regard to their needs. We also recognise the fact that all clinical professionals including those in the private sector, not delivering NHS commissioned services, are still trained by and within the NHS. It has been clearly illustrated above, that we need to understand the migration of staff between these employment settings in order to discharge our primary responsibilities properly. However, having regard to these issues is not the same as the NHS having to ensure supply for these groups and / or being expected to fund such development.

We must be clear therefore that for the NHS to achieve the higher scenario for future forecast available supply it would need to act in a way that accesses the majority of newly qualified staff, retains existing staff or attracts back into NHS employment clinicians currently employed in other settings. If the NHS does not do these things (the worst case scenario) this supply does not disappear it simply means that it would be available to other employers in the way that appears to have happened over recent years.

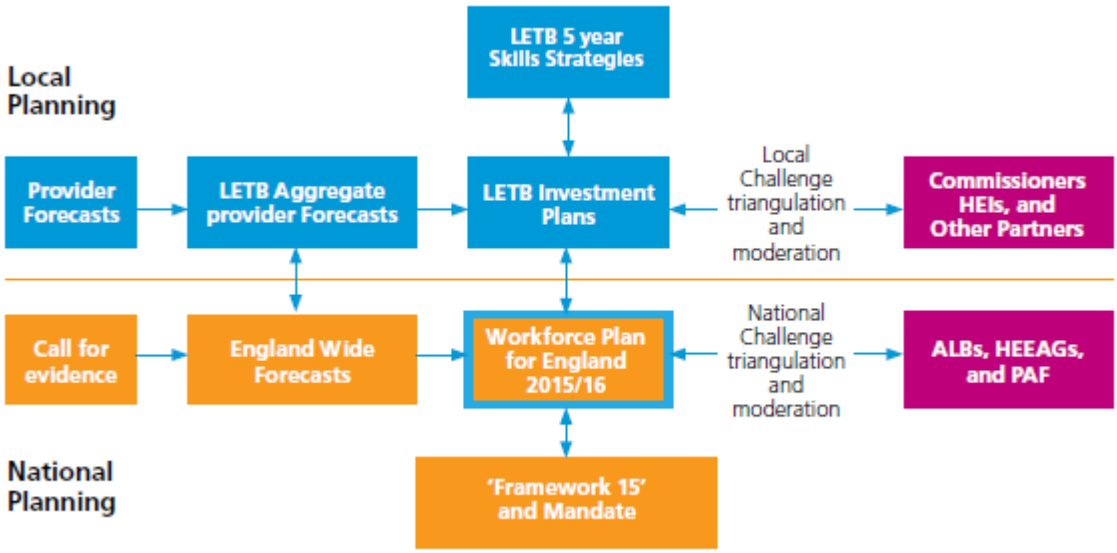
As discussed in section 3, we will want to explore, both locally and nationally, why it may be that the NHS is not accessing the supply available to it (e.g. employers' preference for experienced staff or graduates preference for flexible / portfolio working as is being seen in Speech and Language Therapy) This consideration should include the job guarantee options being explored in London's 'Capital Nurse' programme.

4.2. The HEE planning process

Health Education England is responsible for ensuring that there is sufficient future supply of staff to meet the workforce requirements of the English health system. In undertaking this role it must also work with partners to assess, but not have primary responsibility for, the workforce consequences for the wider health and care system.

Each year we provide local and national forecasts of the supply that will arise over the next five years and use these forecasts to discuss with stakeholders whether this supply will match the system's view of future demand including the extent to which any current shortages will be addressed.

HEE's Workforce Planning Process



This analysis and discussion is then used to identify whether any changes are required to the volumes of training commissioned by HEE, whilst recognising that the impact of these decisions will, for most programmes, have no impact on supply until four years' time. The 2016/17 commissions outlined in Annex 1 will not deliver new supply until 2019/20 at the earliest (later for medical commissions).

All commissioning proposals have historically been constrained by the total amount of resource available to HEE, and consequently a critical part of local and national discussions has been in respect of which investments represent the highest priority or address the highest risks. In November 2015's Spending Review the Chancellor announced that current bursary and fee arrangements for undergraduate nursing, midwifery, AHPs, and other clinical groups would be replaced by student loans for new students from 2017[8]. Whilst this clearly creates the opportunity for the future training volumes of these professions not to be constrained by the

[8] https://www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents

overall amount of funding available, HEE has not, in establishing our proposals for 2016/17 made any assumptions about the impact of this policy on future supply.

The Department of Health will be leading consultation on and implementation of this policy and HEE will be an active partner in ensuring any risks are identified and addressed. The wider system will need to continue to monitor the actual behaviour of both the education supply system and the supply 'performance' of employers / the labour market so as to assess future supply prospects and use the range of levers available to act if required.

Future Supply

HEE's forecasts of future supply indicate that we are training more people to enter the system than those leaving the system in every profession. This includes people leaving NHS employment to work in the independent and care sectors. The table below shows the forecast increase in available supply by 2020 for a range of major professional groups. This indicates that between 24,000 and 80,000 additional staff could be available to be employed in the NHS, or by other employers of clinical staff by 2020, with the levels of training proposed, if underpinning supply assumptions are achieved. The lower forecast scenario does act to highlight the importance of the system acting to improve staff retention alongside efforts to reduce course attrition and improve employment rates. If the service were to deliver performance on retention in the moddle of this range then approximately 50,000 additional staff would be avaiable to the NHS or other emplyers. It also acts to highlight the relative risks to different professions, with the greatest risk being observed in Adult Nursing and Paramedics. It is this differential future risk that has resulted in HEE's local teams prioritising commissions in these professions over others where supply prospects are stronger.

Table 3: Forecast Increases in NHS only available supply – March 2015 to March 2020*

Workforce	2015 NHS Staff in Post	2020 Forecast Supply (higher)	Forecast Supply Increase (Higher Scenario)		2020 Forecast Supply (lower)	Forecast Supply Increase (Lower Scenario)	
	FTE	FTE	FTE	% of NHS	FTE	FTE	% of NHS
Adult Nurse	216,282	237,416	21,133	9.8%	213,428	-2,854	-1.3%
Children's Nurse	36,027	44,945	8,918	24.8%	38,427	2,400	6.7%
Mental Health Nurse	37,880	46,387	8,506	22.5%	40,184	2,304	6.1%
Learning Disability Nurse	3,904	5,682	1,778	45.5%	5,030	1,126	28.8%
Midwifery	22,198	28,814	6,616	29.8%	25,505	3,307	14.9%
Total Nursing & Midwifery	**316,292**	**363,243**	**46,952**	**14.8%**	**322,574**	**6,282**	**2.0%**
Dietietics	4,042	5,556	1,514	37.5%	4,515	473	11.7%
Occupational Therapy	15,503	21,756	6,253	40.3%	17,740	2,237	14.4%
Physiotherapy	19,561	24,733	5,172	26.4%	19,863	302	1.5%
Podiatry	2,973	4,057	1,084	36.4%	3,645	672	22.6%
Speech & Language Therapy	6,347	9,816	3,469	54.6%	8,167	1,820	28.7%
Diagnostic Radiography	13,358	17,005	3,647	27.3%	14,653	1,295	9.7%
Therapeutic Radiography	2,505	3,682	1,177	47.0%	3,133	628	25.0%
Paramedics	12,272	13,671	1,398	11.4%	11,811	-461	-3.8%
Total AHP	**76,562**	**100,275**	**23,713**	**31.0%**	**83,527**	**6,965**	**9.1%**
Consultants	41,165	47,204	6,039	14.7%	47,204	6,039	14.7%
Doctors in General Practice*	36,919	42,300	5,381	14.6%	42,300	5,381	14.6%
Total Medcial	**78,084**	**89,504**	**11,420**	**14.6%**	**89,504**	**11,420**	**14.6%**
Total	**470,938**	**553,022**	**82,085**	**17.4%**	**495,605**	**24,667**	**5.2%**

*The Doctors in General Practice forecast is September 2014 to September 2020 due to the annual census date

Source: HEE analysis and modelling

It should be noted that the percentage increases are in respect of the NHS Workforce only. For professions where a large element of the workforce is employed in care, local government and private/independent sectors, then this growth will represent a smaller percentage increase of the whole profession, and would be offset by retirements from these employers not reflected in the range above.

Future Demand

HEE undertakes a comprehensive collection of NHS provider forecasts of what their future demand for staff will be. These forecasts then become, both locally and nationally, the focus of wider discussions with commissioners and professional leaders as to the likely direction of travel.

In respect of the 2015 forecasts, whilst individual professional positions may be completely valid, the aggregate of this year's forecasts do not appear to represent a position consistent with the expectations of the five year forward view including the agreed financial settlement in the Spending Review and the associated productivity assumptions that underpin it.

Table 1: NHS Provider forecast increases in workforce demand 2015 to 2020

Workforce	2015 Demand (establishments)	2020 Forecast Demand	Increase	
	FTE	FTE	FTE	%
Adult Nurse	238,141	251,198	13,057	5.5%
Children's Nurse	39,670	41,952	2,282	5.8%
Mental Health Nurse	41,669	41,896	227	0.5%
Learning Disability Nurse	4,297	4,292	-5	-0.1%
Midwifery	23,329	24,628	1,299	5.6%
Total Nursing & Midwifery	**347,105**	**363,965**	**16,860**	**4.9%**
Dietietics	4,264	4,524	260	6.1%
Occupational Therapy	18,335	18,902	566	3.1%
Physiotherapy	21,192	22,082	890	4.2%
Podiatry	3,267	3,315	49	1.5%
Speech & Language Therapy	6,860	7,004	144	2.1%
Diagnostic Radiography	14,508	15,655	1,147	7.9%
Therapeutic Radiography	2,640	3,037	396	15.0%
Paramedics	12,993	15,486	2,494	19.2%
Total AHP	**84,059**	**90,005**	**5,946**	**7.1%**

Source: HEE data collection, 2015

At the heart of the FYFV is the premise that plans must meet all three goals; health, financial, and quality. HEE is acutely aware of the risks of planning based solely on financial constraints and as such strongly welcomes the new proposals for integrated service and capacity planning being put forward collectively by all DH Arm's Length Bodies (ALB) in the 2016-17 planning guidance.

Place based multi-year plans, generated by provider and commissioner partners, within which capacity assumptions including workforce are explicit, creates a real opportunity to achieve a consensus on the size and make up of a future workforce. Such a workforce vision would be

inherently designed around transformed services and the multi-professional teams that will deliver them, and would therefore enable HEE and partners to act with greater confidence and with the system's explicit sponsorship in making potentially challenging future supply investments and interventions.

Commissions

It is not always apparent how commissioning levels in any given year relate to such future supply forecasts and that is in part because it is the total volume of training over the period, compared to the rate at which staff retire and leave that is important.

In context of our flat cash financial settlement, the priority investments above have been enabled by decommissioning in a number of areas where future supply is assessed as being more secure.

In Post Graduate medical education we have decided not to add a further year's intake to the Broad Based Training initiative. This pilot programme currently has 113 trainees on it and we will use learning from these cohorts as part of the intelligence to inform the design of future programmes.

Elsewhere we have accepted local team proposals for reductions in a range of professions. In physiotherapy for instance the reduction of 104 places still leaves a forecast increase in supply to 2020 of up to 5,100fte. The health visiting proposals must be seen in light of the previous large increases in commissioning that supported the rapid expansion of this workforce between 2011 and 2014. The proposed commissions are still 60% higher than the levels commissioned at the beginning of this initiative and will ensure the current level of staffing can be maintained.

4.3. Medical workforce

4.3.1. Historic trends

In the period 2004-2014 the medical workforce employed in Hospital and Community Health Services (HCHS) grew by approximately 26,000 WTE from 78,462 to 104,501. This represents 33% growth over the period – an average of 2.9% per year. This annual rate of growth has fluctuated over the years with very strong growth in the first half of the period and more modest growth in the second half. This is most likely to do with the steadily reducing working hours and the need to balance rotas compliant with the New Deal and the Working Time Regulations.

The medical workforce divides into more than 60 specialties, and within each of these the workforce comprises three principal components:

- the consultant workforce;
- the trainee workforce;
- the group who are neither in training nor consultants - which includes SAS and Trust doctors but which we refer to generically as Non Consultant Non-Training Doctors (NCNT)

The mix of each of the above and the extent to which trainees contribute to service delivery varies between specialties.

In 2005 the Modernising Medical Careers (MMC) framework replaced the previous system of training medial staff and the associated grading structure. From 2005 onwards the training workforce began to shift as the new system was implemented and the 'MMC' group grew year on year. Some of the longest run-through programmes are just completing their first cycle.

MMC structured and shortened training and was an explicit intervention to not only improve training but to support growth in the Consultant workforce. In this respect it has been successful: in the decade 2004-14 the Consultant workforce grew by 12,302 from 28,141 to 40,443. This represents 44% growth over the period – an average of 3.7% per year. This annual rate of growth has fluctuated markedly year on year but has been sustained over the whole period. This reflects strong investment in training places in the past as well as significant recruitment from outside the UK. Over the period the proportion of the workforce who are consultants has grown from 35.9% to 38.7%, or put another way the ratio of wider medical staff to consultants has shifted from around 1.8:1 to 1.6:1.

4.3.2. Medium term supply of new CCT holders

There are currently of the order of 21,500 higher and run-through training posts in the English training system, excluding general practice posts, from which CCT output ultimately is produced. The annual aggregate outturn from training in any one year is to some extent unpredictable, and this unpredictability increases the further out we look. Specialty programmes are of different length (from 3 to 8 iterative years), and in some specialties pre-CCT subspecialisation adds to the notional length of training. Moreover while training is structured in a series of levels broadly deemed to be equivalent to a year, trainees progress at different rates; and many trainees work part time and/or go 'out of programme' at some stage which lengthens the time between entering and completing training. Finally programmes exhibit different levels of attrition and this changes over time.

Hence for practical purposes HEE undertakes supply forecasting at the level of individual specialty. However it is possible to construct a crude estimate of how CCT supply will change over the medium term based on current numbers in training and observed workforce turnover. The key data are:

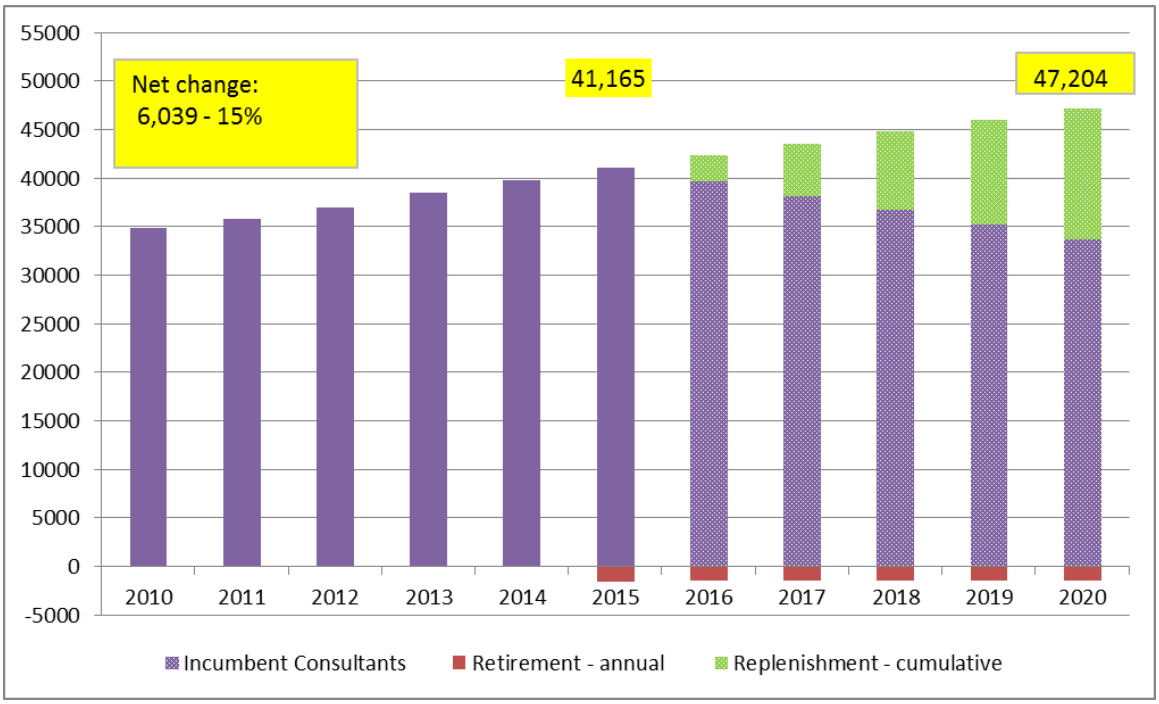
- The forecast aggregate outturn from training based on the **current number of posts** and fill is of the order of 3,000 new CCT holders per year.
- The 40,443 WTE consultant posts noted above were filled by 42,733 headcount;
- Hence annual training output represents approximately 7% of the consultant workforce.
- Annual observed retirements are 3.0 % of the workforce, and are forecast by applying age-related retirement data to the profile of existing consultant staff.

Historically the NHS in England has not been reliant exclusively on training output from the English post-graduate medical education system, and that system has not been reliant exclusively on graduates from UK medical schools. In fact far from it: at end March 2015 one third of those in consultant posts gained their Primary Medical Qualification outside the UK, one

in six trainees did so[9]. Nor do trainees flow seamlessly into consultant roles. Hence after allowing for 'leakage' at the end of training; further outflow for reasons other than retirement; current levels of post-graduate medical training coupled with net inflow from other sources are forecast to support continued growth in the Consultant workforce in the medium term (see table below).

However this will not be evenly distributed either by specialty or geographically. Some specialties and geographies will continue to exhibit high levels of unfilled consultant posts and there will be a continuing need to augment 'domestic' supply with recruitment from the EU and the wider world.

Forecast Consultant Supply 2015 to 2020:



The supply prospects shown in the charts above represent the overall position for the medical workforce. The future supply situation varies significantly by specialty, as does the current level of vacancies and forecast demand. Through 2013 and 2014 it has become apparent that local planning, whilst identifying and acting on specific local medical priorities, has not been comprehensive in identifying any changes that need to be taken on a system wide basis.

In June 2015, prior to the announcement of the NAO review, HEE established national co-ordination of comprehensive local planning for five of the largest medical training specialties – covering collectively more than 50% of medical training posts (including GPs) - with the intention of making definitive recommendations for implementation in 2017. The initial report will be available in Spring 2016 when a period of review and consultation will begin. This will provide NHS employers, supported by HEE nationally and locally, with 18 months lead in time

[9] Note that almost two thirds of those in 'Non Consultant non Training 'grades were not UK graduates

to accommodate the impact of any such changes on current service delivery. There will then follow a series of rolling reviews of other medical specialties.

As part of this planning HEE is committed to actively considering the part played in delivering services by SAS and trust grade doctors as well as doctors in training. Only by openly and explicitly acknowledging the whole medical workforce and their supporting multi professional teams will we be able to make sensible decisions on the levels of structured Post Graduate medical education to commission for future consultant and GP supply.

In the meantime we have therefore limited material changes in 2016/17 medical commissions to three known priority areas of GP, Emergency Medicine, and Clinical radiology. Other small changes observable in Annex 1 are in respect of locally agreed changes to training programmes.

4.3.3. Future demand

There is no settled view on future demand for medical staff across the NHS. HEE collects five year demand forecasts directly from providers in the context of the wider forecasting work undertaken for all staff. HEE receives responses to our 'Call for Evidence' from multiple stakeholders. Arms Lengths Bodies develop and publish strategic service frameworks. Ministers set out visions and policy commitments. The multiple sources imply quite different futures. None is adequate in isolation to drive HEE's commissioning decisions. Together they frame the ongoing discussion about the future medical workforce. One of the key questions for STP partners is to establish a common vision for the future size and make-up of the medical workforce and its supporting team members.

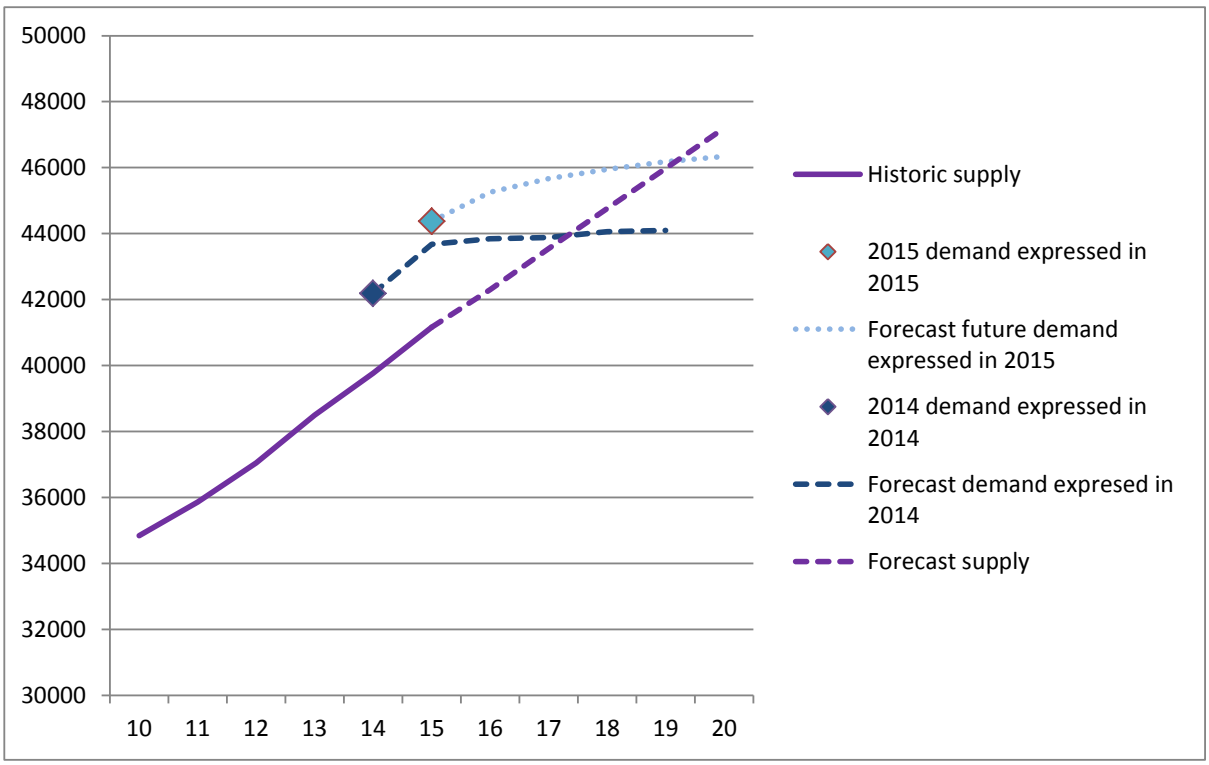
4.3.4. Provider demand forecasts

In 2014 and 2015 NHS service providers were asked for data on current staff in post, current demand, and forecast demand for the following five years. This provider data serve three purposes:

- it forms a unique source of intelligence on the extent to which current posts are filled, which enables HEE to explore relative current shortfall between geographies and specialties. There is no other systematic data collection that fills this fundamental purpose;
- the data provide one view of future demand, essentially predicated on the current financial imperatives, which providers then project forward. This then creates one scenario that wider partners can discuss through local challenge and moderation processes.
- successive data demonstrate that provider forecasts of future demand shift significantly year on year.

The next graph summarises the aggregate data provided in 2014 and 2015 together with the 'short term' supply forecast from the above.

NHS Provider forecast demand for consultants – 2014 and 2015 forecasts:



Source: HEE data collection & HSCIC

At aggregate level at end March 2014 the aggregate consultant supply was approximately 39,800, and demand approximately 42,200 WTE – a shortfall of 2,400 consultants, or around 6. Providers were forecasting growth in demand to approximately 44,300 in 2015. Hence the gap between supply in 2014 and the 2105 requirement was approximately 3,900 WTE. A year later supply had grown to 41,300, which, if forecast demand had been realised, would have resulted in a current gap of 2,500 (i.e. the under fill would have been maintained). However by this stage providers were reporting demand of 44,400 WTE. Hence despite an increase in the consultant workforce of 1,400 WTE or 3.7% the reported shortfall has grown in both numeric and percentage terms – to 3,200 WTE, and 7% of demand.

Some of the current under fill is not necessarily shortage of supply. Locums – who are available supply – may have filled some of the gap and there are time delays involved in recruiting consultants in to posts. As the NAO point out, the data available to HEE is inadequate.

But in a context where training output is of the order of 3,000 new CCT holders each year (see above) providers should in principle be able to fill the majority of funded posts in most specialities. That they cannot arises from a combination of factors including the distribution of trainees between specialties, the concentration of training posts in particular geographies, and the preferences of new CCT holders to find posts and working patterns in geographies that meet their personal requirements.

4.3.5. HEE response in 2016 and the plans for the next round

The bulk of specialty trainees commissioned through HEE's first Workforce Plan for England (the 2014 intake) will complete their training from 2020. Our 2016 commissions will be joining the CCT holder workforce from 2021 through to the mid 2020's. Nothing HEE does in terms of post graduate medical education commissions in either 2016 or 2017 will have an impact on 'hospital and community' CCT holder supply within the timeframe of the five year forward view. But HEE's investment decisions and other decisions about the duration and content of training programmes will have a profound effect on the shape of the health care workforce in the decade beyond, and these commissions, unlike all undergraduate ones, are active participants in the delivery of care as registered doctors.

Our guidance for the 2015 planning round for 2016 commissions, published in March 2015, established that HEE nationally would co-ordinate, with the 13 LETBs, planning for a small number of the very largest specialties. The guidance was clear that because of the long timescale required to implement significant change in medical education commissions, and the need to undertake thorough review, significant recommendations would be confirmed in 2016 and implementation of significant changes would commence in recruitment to 2017 intakes. The guidance established also that HEE, through its local teams, would coordinate, on behalf of HEE as a whole, the planning process for a number of the smallest specialties, supported by centrally co-ordinated analysis. This process would operate to the same timetable as the above. HEE signed off on an associated programme plan in 2015 and the work is proceeding to plan.

The guidance assumed also that for the remainder of the medical specialties in most cases the overall numbers would remain broadly unchanged (as they have done for a number of years), pending detailed reviews of each of these in subsequent years, and that LETBs would use local discretion in determining the number of underlying posts.

In 2016, in the context of tight financial constraints, HEE has chosen to act explicitly to increase supply in two particular specialties (in addition to the planned expansion in GP training): Clinical Radiology and Emergency Medicine. HEE's decisions and rationale are set out below.

4.3.6. Clinical Radiology

HEE has, for the third consecutive year, increased the number of training posts in clinical radiology. The total number of posts will increase from 1,112 to 1,144. We forecast that this change, combined with previous increases, means the number of new CCT holders will grow from the current average annual output of approximately 170 to 230 from 2021/22. This will of course not ameliorate current shortages (quantified by providers at 280 WTE or approximately 10% of all consultant posts) and, preliminary analysis suggests, will not alone be sufficient to meet future medium to long term demand. In 2016 HEE will conclude our analysis and bring forward proposals for commissions for 2017 onwards which take account of perspectives from service commissioners, Five Year Forward View vanguard sites, and the radiology and radiography professions and which are necessarily set in the context of competing priorities for limited funding, and limited numbers of trainees.

4.3.7. Emergency Medicine

Working in close partnership with the College of Emergency Medicine since inception, HEE developed practical solutions to workforce pressures based on both current need and longer term sustainable solutions. These proposals included increasing the number of posts by 95 in 2014 and a further 95 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; and the work, learn, and return initiative whereby training places are offered to overseas doctors to develop emergency medicine skills and gain valuable clinical experience[10]. As a result of the above the number of doctors in training has expanded, which has relieved pressure on Emergency Departments. Growth in the number of consultants has now been sustained at an average of 9% per year for more than a decade (compared with 3.7% for all consultants); the wider EM medical workforce (ie trainees and others) has grown at 3.7% per year compared with 2.4% for the overall wider medical workforce; in 2004 Consultants represented 15% of the EM medical workforce. In 2014 this was 23%.The most rapid growth in both numbers and skill mix were in the period 2008 to 2013. Rates of growth and skill mix change are now beginning to slow - but there was still 7.9% growth in Consultant numbers between 2013 and 2014.

The available supply of Consultants into the workforce is growing and is forecast to grow further. However forecasting the rate of production of future EM Consultants from domestic supply is complicated by additional uncertainty: the expansion of ACCS with the option to 'run through' was initiated in 2014. Hence while surveys of EM trainees at the early stages of training suggest the majority will continue it will be 2017 before HEE will *know* the extent to which the run-through option will be taken up. Hence HEE has, for the third successive year, increased the number of training posts in emergency medicine. In 2016 we will continue to monitor closely the potential of the changes described in the national Urgent and Emergency Care Review to reduce demand, developments in respect of the roles and numbers of Physician's Associates, and the intentions of the cohorts of potential run-through trainees at CT/ST1,2 and 3.

4.3.8. General Practice and Primary Care

NHS England, HEE, RCGP and the BMA GPs committee (GPC) are working closely together to ensure that we have a skilled, trained and motivated workforce in general practice. We have jointly produced a ten point action plan to address immediate issues, and to take the initial steps in building the workforce for the future and new models of care. The plan is designed to complement and support HEE in its delivery of our mandated aim of recruiting 3,250 GP trainees by 2016.

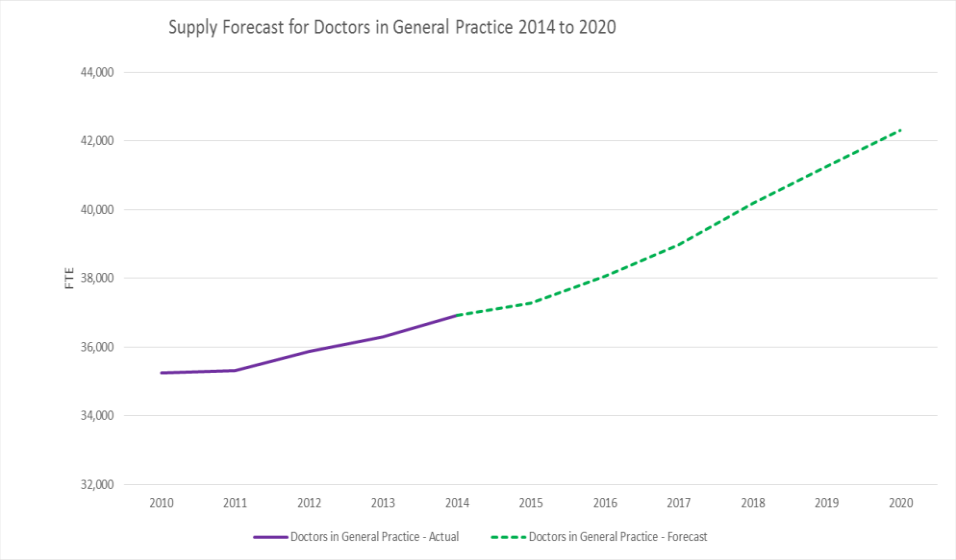
The commissioning proposals outlined in Annex 1 include the additional investment in training posts required to support this target recruitment level for General Practitioners.

[10] The programme is up to four years, after which the doctor will return home to use their skills to care for patients and share learning with colleagues. To date this has resulted in 26 additional trainees.

The forecast growth in other workforce groups should provide sufficient staff to meet the needs of expanded multi-professional primary care teams. The challenge for the NHS is to ensure such posts are available and staff are incentivised to move into primary and community settings. A number of initiatives include the increased use of pharmacists within the primary care team and as such our local teams have prioritised further increases in pre-registration pharmacy training.

GPs – 134 additional training programmes underpinned by 51 additional posts supporting the increase in recruitment to 3250

Doctors in General Practice Supply Forecast 2014 to 2020:

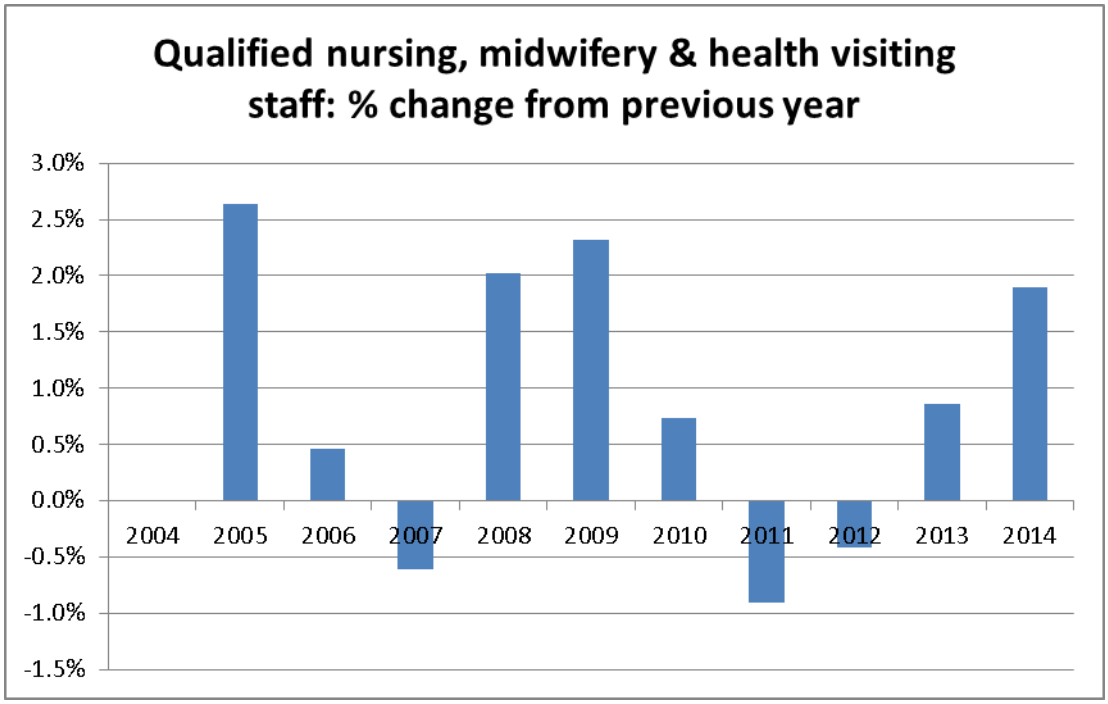


4.4. Nursing and midwifery workforce

4.4.1. Historic trends

The registered nurse workforce can be divided into its four main ‘branches’ or primary registrations: adult, children, mental health and learning disability. Nurses and midwives may go on to specialise in particular areas of work, some of which result in additional entries on the nursing and midwifery register, such as Health Visitors.

In the period 2004-2014 the registered nurse and midwifery workforce employed in Hospital and Community Health Services (HCHS) grew by approximately 26,700 WTE from 286,840 to 313,514. This represents 8.9% growth over the period – an average of 0.9% per year. This annual rate of growth has fluctuated over the years, as shown in the graph below.



Source: HSCIC http://www.hscic.gov.uk/catalogue/PUB16973/nhs-staf-2004-2014-over-tab.xls

4.4.2. Medium term supply

In 2012, the NMC introduced all-graduate registration, meaning that all new entrants to the NMC register would need to be qualified to a Bachelor's standard. This means that a typical direct-entry under-graduate training programme leading to entry on the NMC register as a nurse or midwife will take three academic years to complete. Small numbers of part-time programmes and nurse-to-midwife conversion programmes are also available.

The following table sets out the planned numbers of commissions for nursing and midwifery. Annual nursing commissions will have increased by 2,732 (15%) from 18,009 in 2014 to 20,741 proposed for 2016, representing a total of over 6,000 additional nursing students able to qualify by 2020.

	SHA Commissioning				HEE Workforce Plans		
	2010/11	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Adult	13628	11930	11416	12134	13228	14160	14417
Children's	2095	2045	2159	2151	2182	2343	2343
Learning Difficulty	681	599	606	628	653	664	638
Mental Health	3500	3253	3083	3096	3143	3243	3343
Total Nursing Commissions	**19904**	**17827**	**17264**	**18009**	**19206**	**20410**	**20741**
Yearly Increase					*1197*	*1204*	*331*
Cumulative increase					*1197*	*2401*	*2732*

In forecasting the outturn from these commissioned programmes, we model the following features:

- Fill-rate
- Attrition from training

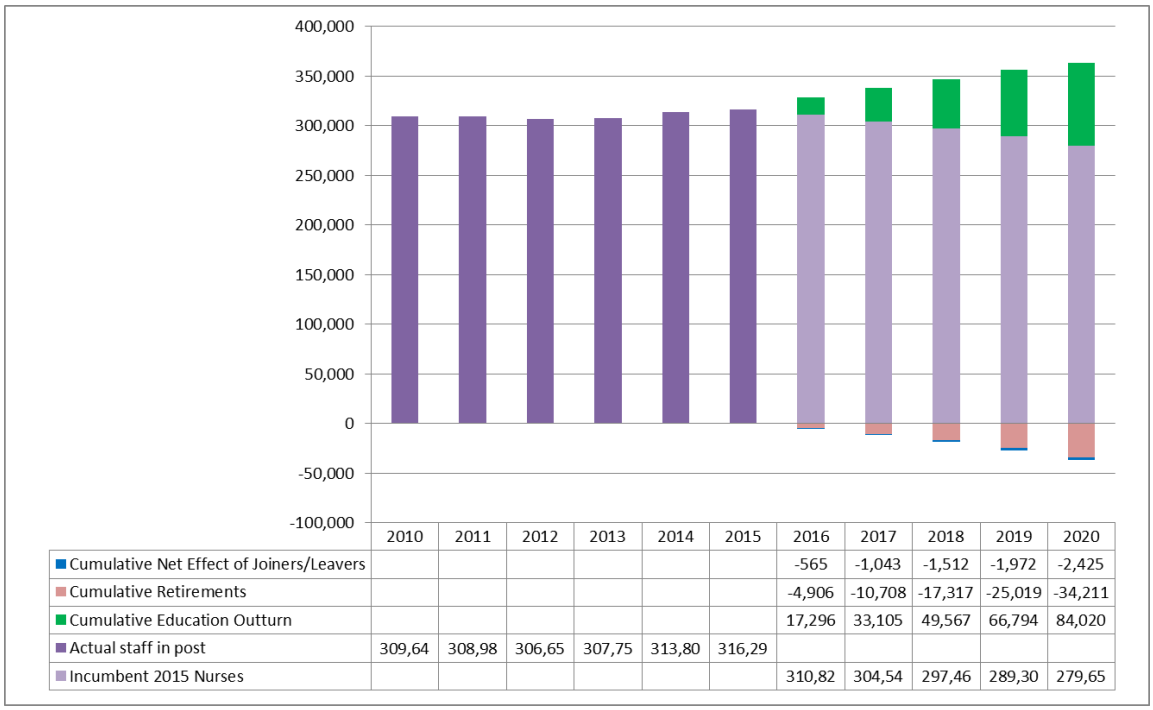
- Attrition in transfer to employment
- Participation rate (whole time equivalence).

The outturn from training programmes form part of our total forecast supply: the remainder being made from the workforce in place today that we forecast will remain in work going forwards. To forecast the total available supply, we model:

- Outturn from education
- Retirements
- Non-retiring leavers
- Other joiners.

Across nursing & midwifery over 108,000 undergraduate commissions will have been placed with universities between 2012 and 2016, which we forecast will produce 84,000 WTEs of available supply for NHS employment. This new supply is forecast to replace 36,500 WTE retirements and the net effect of other joiners and leavers, thereby producing the 47,000 additional available supply that is forecast. These forecasts include the impact of an aging workforce with significantly higher retirement rates forecast toward the end of the period than at the beginning.

Components of Supply and Turnover – All Nursing and Midwifery 2015to 2020:



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Cumulative Net Effect of Joiners/Leavers							-565	-1,043	-1,512	-1,972	-2,425
Cumulative Retirements							-4,906	-10,708	-17,317	-25,019	-34,211
Cumulative Education Outturn							17,296	33,105	49,567	66,794	84,020
Actual staff in post	309,64	308,98	306,65	307,75	313,80	316,29					
Incumbent 2015 Nurses							310,82	304,54	297,46	289,30	279,65

4.4.3. Future demand

There is no settled view on future demand for nursing and midwifery staff across the NHS. HEE collects five year demand forecasts directly from providers in the context of the wider forecasting work undertaken for all staff. HEE receives responses to our 'Call for Evidence' from multiple stakeholders. Arms Lengths Bodies develop and publish strategic service frameworks. Ministers set out visions and policy commitments. The multiple sources imply quite different

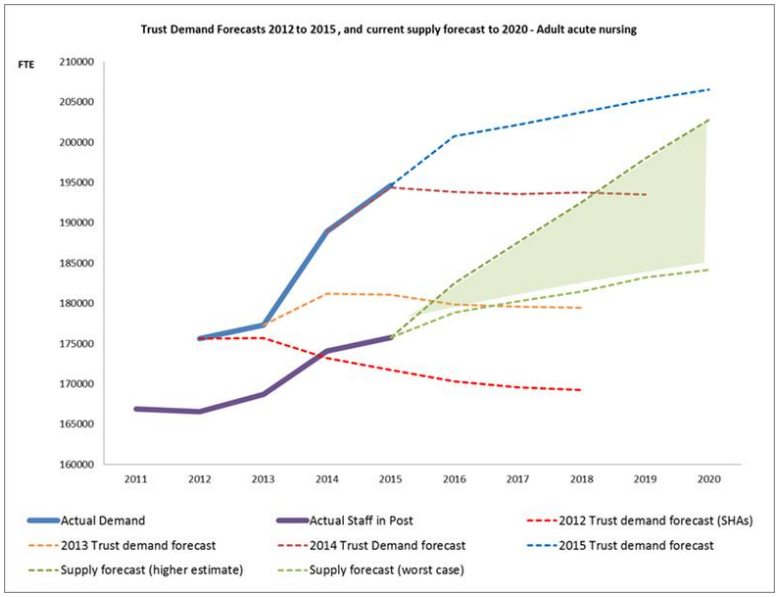
futures. None is adequate in isolation to drive HEE's commissioning decisions. Together they frame the on-going discussion about the future nursing and midwifery workforce.

4.4.4. HEE response in 2016 and the plans for the next round

The level of supply growth forecast means we are able to make modest prioritisation decisions between professional groups without risking future under supply. Consequently there has been a consistent view by our stakeholders that further expansion in a small number of areas is warranted and desirable.

4.4.5. Adult Nursing

Our planning process in 2014 forecast increases in available supply to 2019 and beyond. The 2015 planning process has shown that provider demand has continued to grow and increased turnover has resulted in slower growth than anticipated.



As discussed in section 3 partners are committed to collective action to manage both supply and demand, but the criticality of this workforce to both financial and service outcomes means further growth in commissions is warranted ahead of the fundamental changes to under-graduate supply planned for 2017.

Commissioning Intention – 257 increase

4.4.6. Mental Health Nursing

The current level of mental health nurse training is the highest of any nursing branch as a percentage of the workforce it serves and should allow for significant growth in the MH Nursing workforce (22% by 2020, over 8,000fte). However the existence of over 3,000 vacancies indicates this education supply is not translating into increased numbers in employment. HEE will work with NHSI, HEI and employer partners to understand why our high levels of training investment are not having the impact we would anticipate, and thereby identify what actions over and above additional training volumes may be taken to meet future need.

Provider forecasts of future demand growth while consistent with the general terms of the NHS's Spending Review settlement do not appear to represent the additional focus and resources we might anticipate in light of the policy around parity of esteem. Failure to anticipate a differential investment in mental health services could risk producing a future supply shortage similar to that seen in acute nursing when additional resources came on stream in the wake of the Francis review. Mental Health nursing along with Maternity is one of the areas under review by the 'safe staffing' work stream being led within NHS Improvement.

Mental Health Nursing – 100 increase

4.5. Allied Health Professions workforce

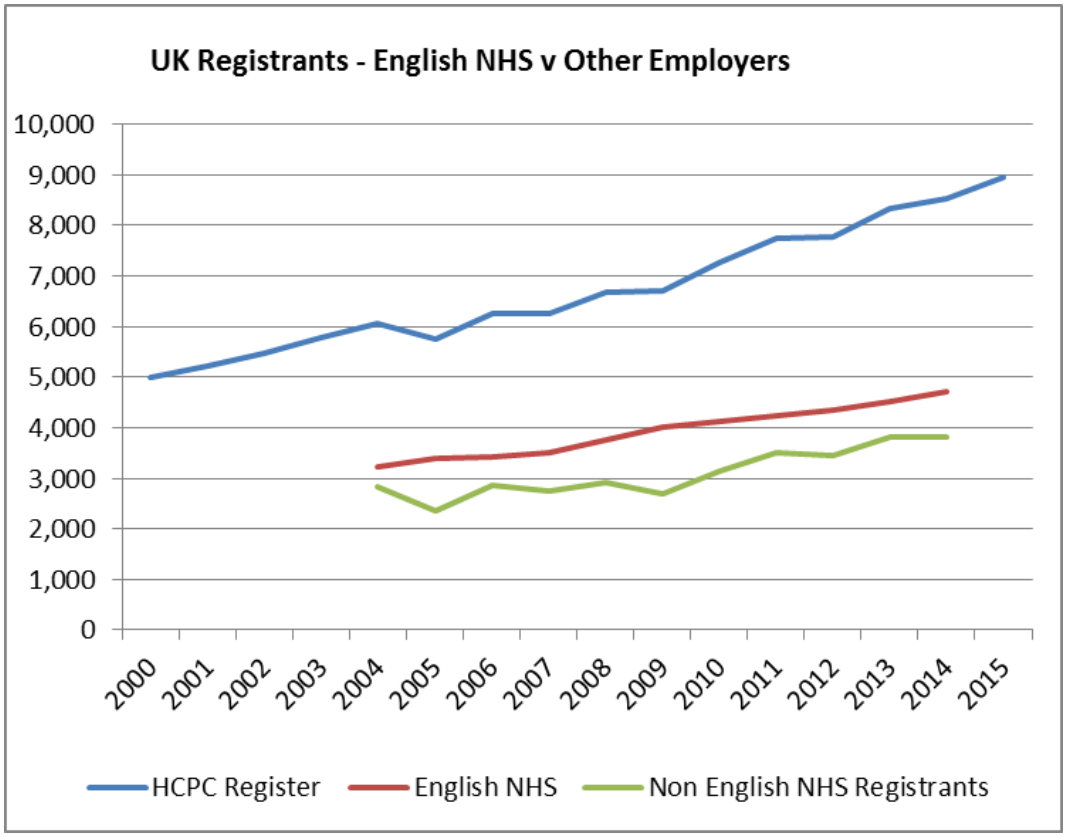
The Allied Health Professions staff grouping covers a range of distinct professions. Observing trends and making forecasts at the aggregate level masks the complexities and differences between the individual professions. Where changes in commissions are being made, the detail behind these decisions is set out below.

The level of supply growth forecast means we are able to make modest prioritisation decisions between professional groups without risking future under supply. Consequently there has been a consistent view by our stakeholders that further expansion in a small number of areas is warranted and desirable.

4.5.1. Dietitians

Growth in the registered Dietetics workforce

In terms of the total number of dietetics registrants we can see a pattern of strong growth in supply. The overall increase on the HCPC register between 2005 and 2015 was 3,202 (55.6%), and the five year rolling average shows consistent increases of 1,500 to 1,800.



Note / Sources – the 'Other' figure is calculated by taking English NHS data per HSCIC from total registrants per HCPC.

Trend in the NHS Workforce and HEE NHS supply forecasts

Over the past five years the NHS dietetics workforce has grown from 3,459fte in March 2010 to 4,402fte as at March 2015, an increase of 583fte (16.9%). Over the same period the increase in all registrants was 23.3%, indicating that the NHS may not be accessing its proportionate share of available supply.

Our NHS modelling is based on the three main sources;

- joiner / non-retirement leaver records for the NHS as recorded in the Electronic Staff Record (excluding intra NHS flows)
- Forecast newly qualified supply based on known training inputs and assumptions about course attrition, percentage available to be employed in the NHS, and their participation (FTE per person) rate.
- Modelling of retirement based on the specific age profile of the population in each year and observed pattern of retirement for each age group.

Our forecasts indicate that by 2020 the available workforce to the NHS will have increased by between 473 and 1,514 WTEs; with the differing scenarios reflecting uncertainty about the destination of leavers and the source of joiners, but are actual observed movements from and into NHS employment.

Demand Forecasts

NHS provider partners indicate that they require approximately 406fte (9.8%) growth in the dietetics workforce by 2020 to address current shortage and meet increased demand. The growth in this workforce of over 583fte over the past five years, including the years 2010 to 2012 in which the NHS may not have sought to employ all newly qualified output does, alongside the general increase in registrants and various forecasts, indicate that this requirement can be met. This does mean that providers need to act to ensure they attract the necessary proportion of future available supply into their employment.

Conclusion

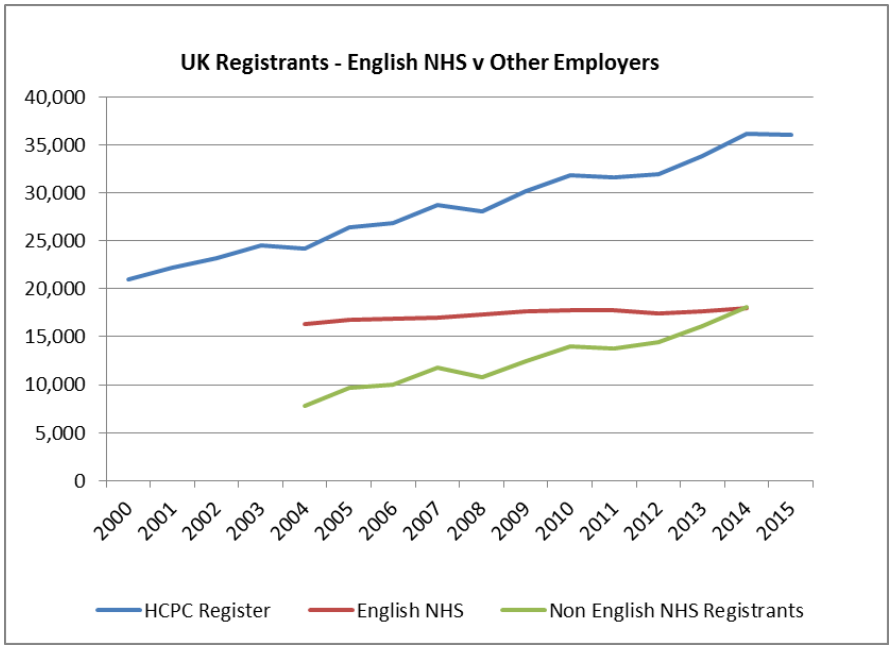
Overall our judgement was that supply prospects for Dietitians look secure when assessed through multiple lenses. This increased supply would appear capable of meeting increasing demand both within the NHS and elsewhere, although we agree scale of this is complex and higher demand would put pressure on all employers to retain staff better.

Dietitians – 29 decrease

4.5.2. Occupational Therapists

Growth in the registered Occupational Therapy workforce

In terms of the total number of occupational therapy registrants we can see a pattern of strong growth in supply. The overall increase on the HCPC register between 2004 and 2014 was 11,937 (49.3%). However of this growth 10,306 was in employers other than the English NHS, a growth of 131.8% versus 1,631 in the English NHS, growth of 10.0%. This disparity has actually increased in the past five years with total growth of 6,006 (19.9%) being split 5,702 (45.9%) in other employers and only 304 (1.7%) in the English NHS.



Note / Sources – the 'Other' figure is calculated by taking English NHS data per HSCIC from total registrants per HCPC.

Trend in the NHS Workforce and HEE NHS supply forecasts

Over the past five years the NHS occupational therapy workforce has increased from 15,222fte in March 2010 to 15,503fte as at March 2015, an increase of 282fte (1.9%). Over the same period the increase in all registrants was 13.4%, again indicating that the NHS may not be accessing its proportionate share of available supply.

Estimate of Non-NHS Workforce - per CfWI 2011

Component	HC	% NHS v Non-NHS	% England v RoUK
English NHS	17,776	72.8%	
English Non-NHS	6,634	27.2%	
England	24,410		77.3%
RoUK	7,181		22.7%
HCPC	**31,591**		

Estimate of Non-NHS Workforce - 2014

Component	HC	%	Assumption / Source
English NHS	18,002	49.8%	HSCIC
Other NHS	5,377	14.9%	77:23 england:RoUK
UK NHS	23,379	64.7%	
Non-NHS	12,749	35.3%	*2930 in SC (COT data)*
HCPC Registrants	**36,128**		HCPC register

Our NHS modelling of 'available supply' is based on the three main sources;

- joiner / non-retirement leaver records for the NHS as recorded in the Electronic Staff Record (excluding intra NHS flows)
- Forecast newly qualified supply based on known training inputs and assumptions about course attrition, percentage available to be employed in the NHS, and their participation (FTE per person) rate.
- Modelling of retirement based on the specific age profile of the population in each year and observed pattern of retirement for each age group.

Shown below is the analysis of NHS joiners and leavers for Occupational therapy that forms a component of our supply forecasting.

Occupational Therapy - NHS Supply Movements 2014/15	HC	FTE
Leavers:		
Death	6	5.0
Dismissal	29	24.2
Fixed term contract	157	128.5
Redundancy	26	18.6
	218	176.3
Blanks	4	4.0
Resignation - Unknown destination	1,312	1,119.2
Total Non-Retirement Leavers (ex NHS)	1,534	1,299.5
Retirements	216	178.2
Total Leavers / Retirement	**1,750**	**1,477.7**
Joiners:		
None	355	320.2
Private Sector / Self Employed	529	494.3
Public Sector	182	166.9
Education Sector	48	41.3
RTP / No employment	107	93.0
International Recruitment	16	14.2
Total Other Joiners (excl intra NHS)	1,237	1,129.9
Education and Training Supply	168	161.6
(NB from 1627 starters in 2011)		
Total Joiners / New Supply	**1,405**	**1,291.5**
Movement within the NHS:		
Joiners from other NHS	1,439	1,335.3
Leavers to other NHS	1,064	968.6
Joiners from NHS not identified as leavers	375	366.7
Total Joiners	1,780	1,658.2
Net Movement of Joiners / Leavers	**30**	**180.5**
Staff in Post:		
01/04/2014		15,363.5
31/03/2015		15,503.1
31/03/2016		
Actual Movement on ESR		**139.6**

Our forecasts indicate that by 2020 the available workforce to the NHS will have increased by between 3,307 and 6,253 WTEs; with the differing scenarios reflecting uncertainty about the destination of leavers and the source of joiners, but are actual observed movements from and into NHS employment.

Demand Forecasts

NHS provider partners indicate that they require approximately 1,616fte (9.3%) growth in the occupational therapy workforce by 2020 to address current shortages and meet increased demand.

Within a system in which the workforce is growing by between 4,000 and 6,000 every five years, then this demand as well as the requirements of other sectors would appear to be achievable.

Conclusion

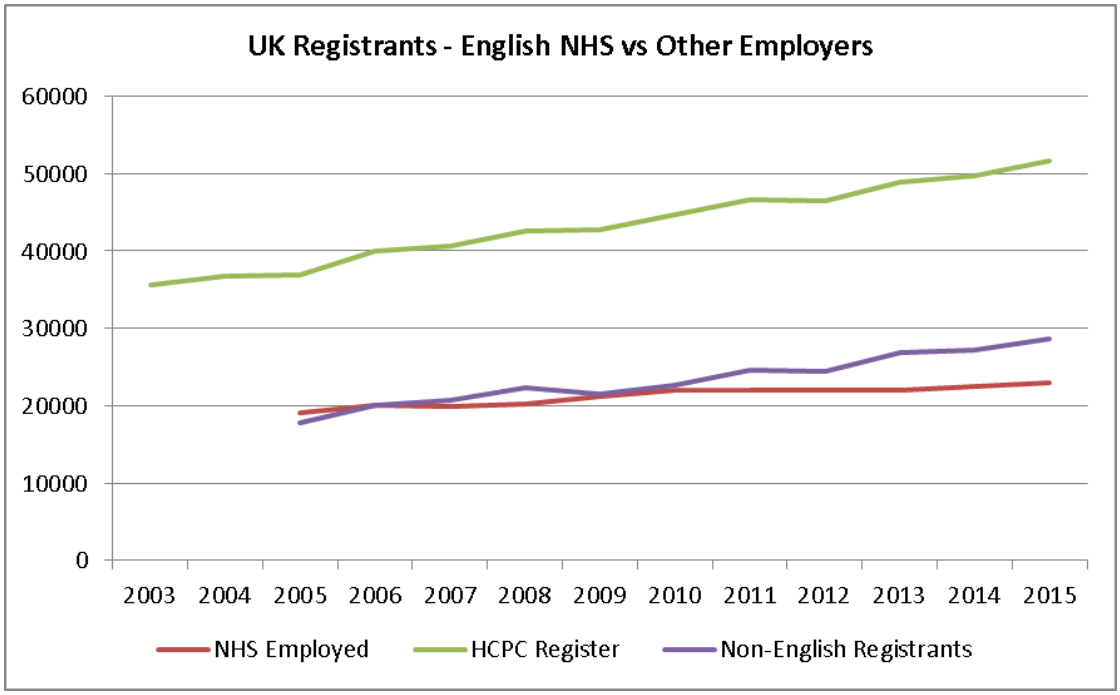
There is clear indication that current levels of training can sustain growth in supply, although there appears to be a real challenge in ensuring the NHS accesses its proportionate share of this supply. Overall our judgement was that the increased supply would appear capable of meeting increasing demand both within the NHS and elsewhere.

Occupational Therapists – 52 decrease

4.5.3. Physiotherapists

Growth in the registered Physiotherapy workforce

In terms of the total number of physiotherapy registrants we can see a pattern of strong growth in supply. The overall increase on the HCPC register between 2004 and 2014 was 14,654 (39.6%). However of this growth 10,787 was in employers other than the English NHS, a growth of 60.5% versus 3,867 in the English NHS, growth of 20.2%. This disparity has actually increased in the past five years with total growth of 6,937 (15.5%) being split 5,915 (20.6%) in other employers and only 1,022 (4.6%) in the English NHS.



Trend in the NHS Workforce and HEE NHS supply forecasts

Over the past five years the NHS physiotherapy workforce has increased from 18775.2 FTE in March 2010 to 19560.8 FTE as at March 2015, an increase of 785.6 FTE (4.1%). Over the same period the increase in all registrants was 15.5%, again indicating that the NHS may not be accessing its proportionate share of available supply.

Our forecasts indicate that by 2020 the available workforce to the NHS will have increased by between 302 and 5,172 WTEs; with the differing scenarios reflecting uncertainty about the destination of leavers and the source of joiners, but are actual observed movements from and into NHS employment.

Demand Forecasts

NHS provider partners indicate that they require approximately 2,521FTE (12.9%) growth in the physiotherapy workforce by 2020 to address current shortage and meet increased demand.

Within a system in which the workforce is growing by between 5,000 and 8,000 every five years, then this demand as well as the requirements of other sectors would appear to be achievable.

Conclusion

There is a clear indication that current levels of training can sustain growth in supply, although there appears to be a real challenge in ensuring the NHS accesses its proportionate share of this supply. Overall our judgement was that the increased supply would appear capable of meeting increasing demand both within the NHS and elsewhere.

Physiotherapists – 95 decrease

4.5.4. Speech and Language Therapists

Growth in the Registered Speech and Language Therapy (SLT) Workforce

In respect of the number of total SLT registrants we can see a pattern of strong supply growth. The overall increase on the HCPC register between 2004 and 2014 is 5,525 SLTs (58.4%), and the five year rolling average increase has ranged from 1,701 SLTs in the five years to 2012 compared to 2,823 SLTs in the five years to 2014.

Trend in the NHS Workforce and HEE NHS supply forecasts

Over the past five years the NHS speech and language therapy workforce has increased from 6117.4FTE in March 2010 to 6347.1FTE as at March 2015, an increase of 229 FTE (3.8%). Over the same period the increase in all registrants was 16.0%, again indicating that the NHS may not be accessing its proportionate share of available supply.

Our forecasts indicate that by 2020 the available workforce to the NHS will have increased by between 1,820 and 3,469 WTEs; with the differing scenarios reflecting uncertainty about the destination of leavers and the source of joiners, but are actual observed movements from and into NHS employment.

Demand Forecasts

NHS provider partners indicate that they require approximately 657FTE (10.49%) growth in the SLT workforce by 2020 to address current shortage and meet increased demand.

Within a system in which the workforce is growing by between 1,700 and 2,800 every five years, then this demand as well as the requirements of other sectors would appear to be achievable.

Conclusion

Overall our judgement was that supply prospects for SLTs look secure when assessed through multiple lenses. This increased supply would appear capable of meeting increasing demand both within the NHS and elsewhere, although we agree scale of this is complex and higher demand would put pressure on all employers to retain staff better.

Within the context of growth to the total workforce of between 1500 (CfWI) and 2800 (actual 2009 to 2014) per 5 year period, the proposals by local teams, to reduce English commissions by 60, which will only impact in 2019, did not seem unreasonable given their need to prioritise areas with clear supply challenges such as paramedics and nursing.

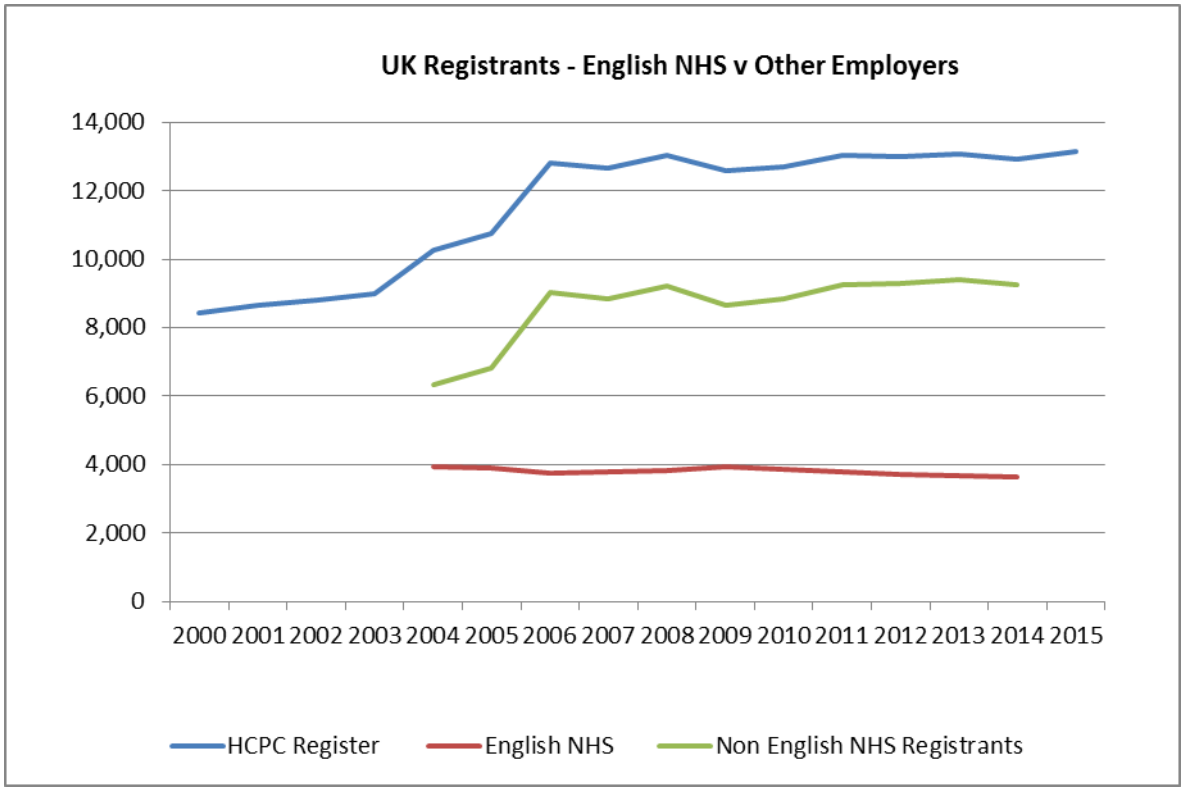
Speech and Language Therapists – 40 decrease

4.5.5. Podiatrists

Growth in the registered Podiatry workforce

In terms of the total number of Podiatry registrants we can see a pattern of growth in supply, albeit at a lower rate than some other AHP groups. The overall increase on the HCPC register

between 2005 and 2015 was 2,419 (22.5%). This growth is lower than previously recorded and it would be useful to understand the drivers of growth in previous periods which cannot be ascribed to slightly higher training levels. Similarly we would like to better understand the impact of restricted growth in NHS posts, especially at entry level band 5, may have had on registration overall.



Note / Sources – the 'Other' figure is calculated by taking English NHS data per HSCIC from total registrants per HCPC.

Trend in the NHS Workforce and HEE NHS supply forecasts

Over the past five years the NHS podiatry workforce has reduced from 3,232fte in March 2010 to 2,973fte as at March 2015, a reduction of 259fte (-8.0%). Over the same period the increase in all registrants was 3.6%, again indicating that the NHS may not be accessing its proportionate share of available supply.

Our forecasts indicate that by 2020 the available workforce to the NHS will have increased by between 672 and 1,084 WTEs; with the differing scenarios reflecting uncertainty about the destination of leavers and the source of joiners, but are actual observed movements from and into NHS employment.

Demand Forecasts

NHS provider partners indicate that they only require approximately 224fte (7.2%) growth in the podiatry workforce by 2020 to address current shortage and meet increased demand.

Clearly it is not the level of available supply which is the primary issue here but the level of demand providers believe they need to deliver services. However the two are clearly linked in

that the available supply we have identified will not be utilised unless additional posts are created.

The call for evidence submission from the profession provides extensive support for the role of Podiatrists in delivering the five year forward view. If the sustainability and transformation plans indicate there is a clear indication that the service intends to commission and use podiatrists in the manner described then this would then be the circumstances in which the NHS would utilise the supply we forecast will be available.

Conclusion

There are clear indications that current levels of training can sustain growth in supply, however this supply risks being dissipated if the NHS does not change its recent pattern of requirements. Overall our judgement was that the increased supply would appear capable of meeting any increased demand within the NHS and other employment settings.

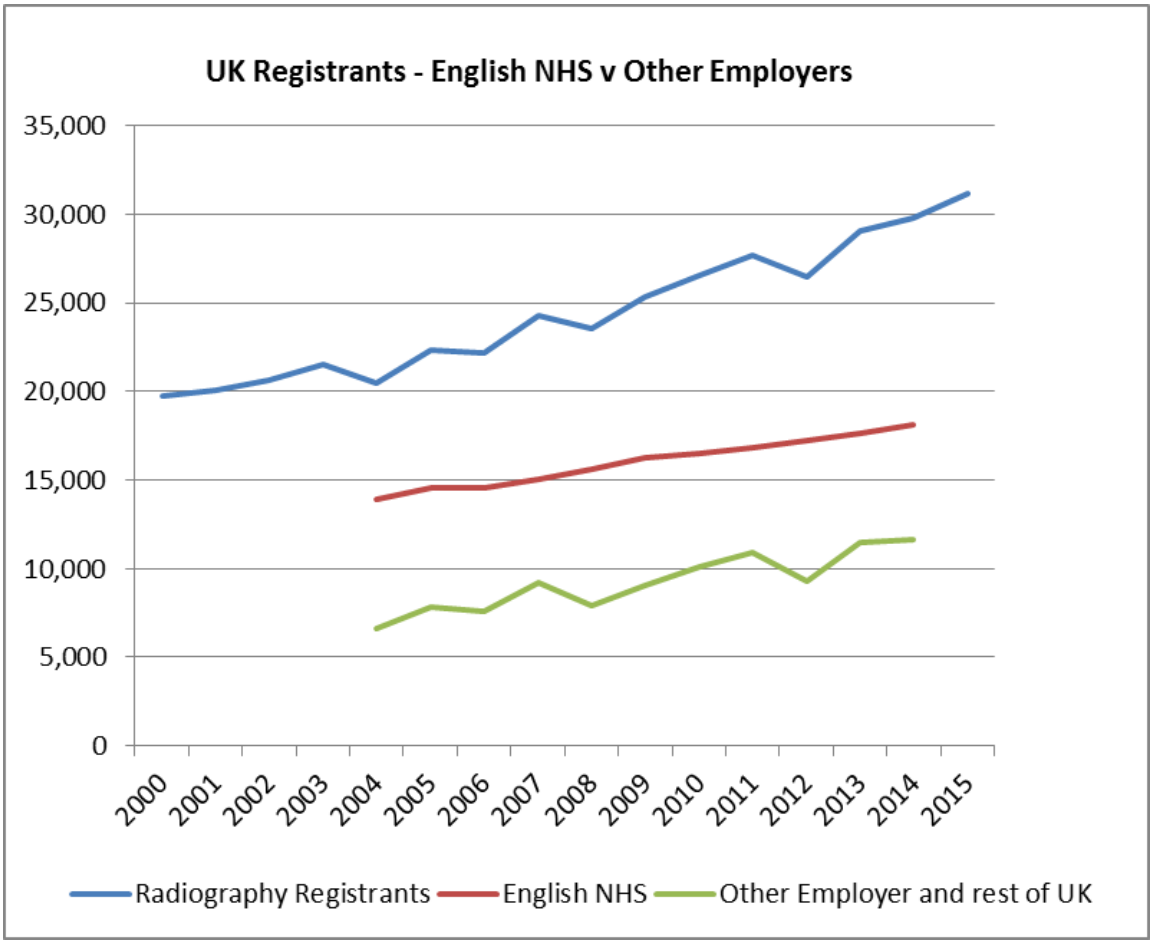
Within the context of growth to the total workforce of between 500 and 1000 per 5 year period, the proposals by local teams, to reduce English commissions by 35, which will only impact in 2019, did not seem unreasonable given their need to prioritise other areas.

Podiatry – 35 decrease

4.5.6. Radiography

Growth in the registered Radiography workforce

In terms of the total number of radiography registrants we can see a pattern of strong (and necessary) growth in supply. The overall increase on the HCPC register between 2004 and 2014 was 8,817 (39.4%), and the five year rolling average shows consistent increases of 4,000 to 5,000.



Note / Sources – the 'Other' figure is calculated by taking English NHS data per HSCIC from total registrants per HCPC.

Trend in the NHS Workforce and HEE NHS supply forecasts

Over the past five years the NHS diagnostic radiography workforce has grown from 11,942fte in March 2010 to 13,358fte as at March 2015, an increase of 1,416fte (11.9%).

Similarly the NHS therapeutic radiography workforce has grown from 2,087fte in March 2010 to 2,505fte as at March 2015, an increase of 418fte (20.0%).

The combined increase to the NHS employed workforce represents 13.1% growth, this compares to 17.4% growth across the UK wide register, again indicating that the NHS may not be attracting or retaining available supply at the rate for non-NHS employment.

Our forecasts indicate that by 2020 the available diagnostic radiography workforce to the NHS will have increased by between 1,295 and 3,647 FTEs and the therapeutic radiography workforce will have increased by between 628 and 1,177 FTE; with the differing scenarios reflecting uncertainty about the destination of leavers and the source of joiners, but are actual observed movements from and into NHS employment.

Our modelling includes the fact that total diagnostic radiography commissions will have increased by 80 (7.6%) since HEE began operations and therapeutic radiography 36 (10%) even allowing for this year's reduction.

Demand Forecasts

NHS provider partners indicate that they require approximately 2,200fte (16.5%) growth in the diagnostic radiography workforce by 2020 to address current shortage and meet increased demand. The growth in this workforce of over 1,400fte over the past five years, including the years 2010 to 2012 in which the NHS may not have sought to employ all newly qualified output, does alongside the general increase in registrants and various forecasts indicate that this requirement can be met. This does mean that providers need to act to maximise current supply now (including international recruitment as a temporary measure), and ensure they attract the necessary proportion of future available supply into their employment.

In Therapeutic Radiography NHS provider partners indicate that they require approximately 540fte (21%) growth in the workforce by 2020 to address current vacancies and meet increased demand. Both observed growth and forecast growth indicate this can be exceeded.

We appreciate the demography and activity drivers in each area are complex and real, let alone other variables such as extended roles for Radiographers in relation to work currently done by medical colleagues (and the relative supply growth / availability of these colleagues – our specialty review into clinical radiology will be reporting within the next two months). We welcome the 'diagnostics 2020' work being undertaken by CR-UK and look forward to working with them through the cancer transformation board and programme to explicitly map future activity increases and the use of the whole workforce capacity in England to meet these needs.

Conclusion

Overall our judgement was that despite strong future supply growth some further additional investment in diagnostic radiography was justified. However we must act with partners to address the current supply challenge through other measures including valuing and retaining current staff, ensuring newly qualified staff are employed by the NHS, and maximising the output from our education programmes by addressing course attrition.

A moderate reduction in Therapeutic Radiography was also justified given the rate of growth observed for this group. Because of these growth forecasts, the prospects of downward adjustments to the therapeutic radiography commissions has been consistently flagged over the past two years, not least within our published Workforce Plan for England 2015 (p65) which said;

> 'We need to be aware that despite new demands such as proton beam therapy, current training has and is providing significant new supply and we must assess at what point more moderate growth might be justified'

Within the context of growth to the total workforce of between 418fte (actual NHS only 2010 to 2015) and 1,177fte (HEE's 'most likely' scenario), the proposals by local teams, to reduce English commissions by 18, which will only impact in 2019, did not seem unreasonable.

The increased supply in both workforces would appear capable of meeting increasing future demand both within the NHS and elsewhere, although we agree the scale of this is complex and

higher demand would put pressure on all employers to retain as well as attract newly qualified staff.

Diagnostic Radiography – 16 increase

Therapeutic Radiography – 18 decrease

4.5.7. Paramedics

In the ambulance workforce HEE has worked closely with all English ambulance services through the PEEP programme, both to modernise the future training of paramedics and other ambulance service workers to be fit for future services, but also to address real supply pressures in a number of areas arising from rapid increases in funded demand and the impact of pockets of high staff turnover.

Paramedics – 617 increase

5.0 Next Steps

This report has highlighted the need for a collaborative, co-ordinated, and comprehensive approach to addressing the whole range of workforce challenges of the health and care system. Finding solutions to these workforce issues will be critical in ensuring the system can address the extremely difficult current operational positions and progress to implementation of the consensus vision in the Five Year Forward View to ensure future sustainability of the service whilst delivering all three goals; Health, Quality and financial sustainability.

Support to STPs

STPs represent a real opportunity for the creation of a consensus service vision and consequently a single local view on the shape, size, and characteristics of the workforce required to deliver these future services. This vision will inherently include consideration of the wider health and care workforce and include the role of carers, self-care, and third sector partners.

HEE is working closely with ALB partners to define the workforce element of high quality STPs, and to develop appropriate support resources to both develop plans and support their implementation.

Establishing Local Workforce Action Boards - LWABs

LWABs are designed to be the primary vehicle to support the workforce elements of both STPs and current operational challenges. The opportunity to have a single conversation on all workforce matters relevant to a health community in one place, and from those discussions generate co ordinated and effective action would appear to address concerns about the currently fragmented system voiced by numerous partners and commentators.

Current shortages through both productivity and supply measures

It is clear that LWABs cannot simply consider the route to a transformed future in 2020. They have to be relevant to addressing the very real and significant challenges facing service commissioners and providers today.

Prioritised immediate effort will therefore go into ensuring systems have clear intelligence to support their understanding of their current position and the dynamics of their particular labour markets. From this appropriate action on areas such as managing retention or productivity can be assessed and agreed.

Service and Workforce Transformation

- National priority programmes – planned implementation
- Education innovation
- Local S&WT

Future Supply/Future Proofing the NHS

HEE remains mandated by the government and our establishing statute to ensure a balance of future workforce supply and demand. We are however supportive of views expressed that appropriate oversupply is a desirable goal within the context of appropriate value for money. As described elsewhere in this report HEE will continue to generate workforce intelligence on the range of likely supply and demand scenarios the system is likely to face. The landscape within which this intelligence will be used is however changing with the new approach to medical planning described earlier and the changes to funding of some key clinical professional groups such as nursing, midwifery and AHPs. HEE will work closely with partners in light of responses to the DH consultation on this policy to ensure we can support the system by discharging our ongoing responsibility.

HEE will also continue to promote the principles in 'Framework 15' our strategic framework. This work had the explicit aim of ensuring the actions of HEE and partners support not just the latest service models but embed the key characteristics of a future workforce such as flexibility and responsiveness, and a truly patient centric approach from health professionals. This 'future proofing' activity must run in parallel to addressing the more immediate one to five year challenges of the NHS.

Improved data

It is crucial that we develop additional consistent and accurate workforce data to support LWABs and national interventions and policy. In the electronic staff record the NHS has potentially the most powerful workforce planning tool to support this work. However it must be used more consistently in light of these new requirements and a key challenge will be to demonstrate to local HR teams the value to their own systems and organisations of improved data. Similarly we must be able to observe the problem we are trying to solve. The lack of a systematic vacancy measure trusted by all partners is a fundamental barrier to identifying, diagnosing, and solving shortage problems.

HEE will work with partners, and particularly NHSI, to secure consistent sponsorship, support and compliance in building the data needed. Proposals will be developed for consideration at the next appropriate WAB or FYFV CEs meeting. This work will address issues in respect of workforces not in NHS employment and in particular primary care

These 'next steps' are all actively underway through open and constructive discussion with partners across all components of the system. Together they represent a real opportunity to ensure the health and care system can actively address the key workforce challenges for today and the future.

Annex 1: Proposed Education and Training Commissions for 2016/17

			ANNEX 1	
Proposed Education & Training Commissions for 2016/17				
Clinical Professional Education Programmes:	**2015-16 plan (post change control)**	**Proposed 2016/17 Commissions**	**Increase / Decrease**	**%**
Pre-registration Nursing & Midwifery				
Adult Nurses	14,003	14,353	350	2.5%
Children's Nurses	2,343	2,343	0	0.0%
Learning Disabilities Nurses	664	641	-23	-3.5%
Mental Health Nurses	3,243	3,343	100	3.1%
Midwives	2,605	2,605	0	0.0%
Total - Pre-registration Nursing & Midwifery	**22,858**	**23,285**	**427**	**1.9%**
Allied Health Professions				
Dietetics	343	314	-29	-8.5%
Occupational Therapy	1,536	1,496	-40	-2.6%
Physiotherapy	1,543	1,448	-95	-6.2%
Podiatry	361	326	-35	-9.7%
Speech & Language Therapy	668	631	-37	-5.5%
Diagnostic Radiography	1,115	1,131	16	1.4%
Therapeutic Radiography	414	396	-18	-4.3%
Paramedics	1,014	1,631	617	60.8%
Orthoptics	76	77	1	1.3%
Orthotics/Prosthetics	30	30	0	0.0%
Total - Allied Health Professions	**7,100**	**7,480**	**380**	**5.4%**
Other Scientific, Technical & Therapeutic				
Operating Dept. Practitioner	957	939	-18	-1.9%
Pharmacist pre-registration year	657	698	41	6.2%
Pharmacy Technician	360	354	-6	-1.7%
Clinical Psychologist	526	526	0	0.0%
IAPT - Psychological Wellbeing Practitioner (Low intensity)	579	579	0	0.0%
IAPT - High intensity practitioner	367	367	0	0.0%
HCS Higher Specialist Scientific Training (HSST)	71	71	0	0.0%
HCS Scientist Training Programme (STP)	282	294	12	4.3%
Child Psychotherapist	43	43	0	0.0%
Physicians Associates	205	657	452	220.5%
Dental Nurses	442	418	-24	-5.4%
Dental Technicians	69	69	0	0.0%
Dental Hygienists	128	137	9	7.0%
Dental Therapists	134	123	-11	-8.2%
Total - Other Scientific, Technical & Therapeutic	**4,820**	**5,275**	**455**	**9.4%**
Specialist Nurse - Post Registration				
District Nurses	502	505	3	0.6%
School Nurses	338	293	-45	-13.3%
Practice Nurses	359	359	0	0.0%
Health Visitors	1,042	817	-225	-21.6%
Total - Specialist Nurse - Post Registration	**2,241**	**1,974**	**-267**	**-11.9%**
TOTAL Clinical Professional Education	**37,019**	**38,014**	**995**	**2.7%**

ANNEX 1

Proposed Education & Training Commissions for 2016/17

	Baseline (2015)	Proposed change in 2016	Resultant number of posts	Movement from baseline
Foundation & BBT				
Foundation Programme Year 1	12693	-6	12687	-0.05%
Broad Based Training	113	0	113	0.00%
Anaesthetics and ICM				
Acute Care Common Stem - Anaesthesia	501	50	551	9.98%
Core Anaesthetics Training	944	-36	908	-3.81%
Anaesthetics	2068	-6	2062	-0.29%
Intensive Care Medicine	315	9	324	2.86%
Emergency Medicine (inc ACCS, DR-EM)	1329	58	1387	4.36%
Medicine				
Acute Care Common Stem - Acute Medicine	234	2	236	0.85%
Core Medical Training	2751	8	2759	0.29%
Acute Internal Medicine	364	8	372	2.20%
Endocrinology and Diabetes Mellitus	338	-3	335	-0.89%
Gastroenterology	449	1	450	0.22%
Geriatric Medicine	606	4	610	0.66%
Respiratory Medicine	478	-1	477	-0.21%
Allergy	12	0	12	0.00%
Audio vestibular Medicine	17	0	17	0.00%
Cardiology	553	0	553	0.00%
Clinical Genetics	57	-1	56	-1.75%
Clinical Neurophysiology	31	0	31	0.00%
Clinical Pharmacology and Therapeutics	36	0	36	0.00%
Dermatology	175	4	179	2.29%
Genito-urinary Medicine	129	0	129	0.00%
Immunology	32	0	32	0.00%
Neurology	220	-1	219	-0.45%
Nuclear Medicine	19	0	19	0.00%
Occupational Medicine	45	0	45	0.00%
Palliative Medicine	170	0	170	0.00%
Rehabilitation Medicine	64	0	64	0.00%
Renal Medicine	246	-1	245	-0.41%
Rheumatology	217	-1	216	-0.46%
Sport and Exercise Medicine	45	0	45	0.00%
Haematology	337	-1	336	-0.30%
Clinical Oncology	269	0	269	0.00%
Medical Oncology	146	1	147	0.68%
Forensic histopathology	4	0	4	0.00%
Diagnostic neuropathology	11	0	11	0.00%
Paediatric and perinatal pathology	13	1	14	7.69%
Combined Infection Training - themed Infectious Diseases	100	2	102	2.00%
Combined Infection Training - themed Medical Microbiology	185	-2	183	-1.08%
Combined Infection Training - themed Medical Virology	18	0	18	0.00%
Combined Infection Training - themed Tropiical Medicine	0	0	0	0.00%
Medical Ophthalmology	11	0	11	0.00%
Paediatric Cardiology	41	0	41	0.00%
Surgery				
Core Surgical Training	1216	-42	1174	-3.45%
Cardio-thoracic surgery (Inc. Pilot)	135	0	135	0.00%
Vascular Surgery	30	10	40	33.33%
General Surgery	1004	-14	990	-1.39%
Oral and Maxillo-facial Surgery (Inc. Pilot)	139	0	139	0.00%
Otolaryngology	298	-2	296	-0.67%
Paediatric Surgery	94	-2	92	-2.13%
Plastic Surgery	255	-3	252	-1.18%
Trauma and Orthopaedic Surgery	945	-4	941	-0.42%
Urology	269	0	269	0.00%

ANNEX 1

Proposed Education & Training Commissions for 2016/17

Psychiatry				
Core Psychiatry Training	1463	0	1463	0.00%
Child and Adolescent Psychiatry	229	3	232	1.31%
Combined psychiatry posts (eg Adult/Child etc)	13	0	13	0.00%
Forensic Psychiatry	122	0	122	0.00%
General Psychiatry	627	-7	620	-1.12%
Medical Psychotherapy	44	0	44	0.00%
Old Age Psychiatry	226	5	231	2.21%
Psychiatry of Learning Disability	94	0	94	0.00%
Run Through Specialties				
Paediatrics	2828	-2	2826	-0.07%
Obstetrics and Gynaecology	1724	-5	1719	-0.29%
Clinical Radiology	1112	32	1144	2.88%
Ophthalmology	536	0	536	0.00%
Histopathology	467	-1	466	-0.21%
Public Health Medicine	467	-7	460	-1.50%
Neurosurgery	228	0	228	0.00%
Chemical Pathology	65	-2	63	-3.08%
Community Sexual and Reproductive Health	24	-1	23	-4.17%
General Practice	9164	51	9215	0.56%
Dentistry				
Dental Foundation Programme Year 1	849	-1	848	-0.12%
Dental Core Training	563	0	563	0.00%
Additional Dental Specialties	3	0	3	0.00%
Dental and Maxillofacial Radiology	5	0	5	0.00%
Dental Public Health	25	1	26	3.97%
Endodontics	23	0	23	0.00%
Oral and Maxillofacial Pathology	10	0	10	0.00%
Oral Medicine	15	0	15	0.00%
Oral Microbiology	1	0	1	0.00%
Oral Surgery	29	0	29	0.00%
Orthodontics	164	0	164	0.00%
Paediatric Dentistry	42	0	42	0.00%
Periodontics	25	0	25	0.00%
Prosthodontics	18	0	18	0.00%
Restorative Dentistry	49	0	49	0.00%
Special Care Dentistry	21	0	21	0.00%
Totals by Main training Stages / types				
Foundation	12693	-6	12687	-0.05%
BBT, Core and ACCS (all excluding E Med and Dental)	7222	-18	7204	-0.25%
Higher Anaesthetics and ICM	2383	3	2386	0.13%
Higher medicine and pathology	5438	10	5448	0.18%
Higher surgery	3169	-15	3154	-0.47%
Higher psychiatry	1355	1	1356	0.07%
Run-through (including Emergency Medicine)	17944	123	18067	0.69%
All medical, surgical and psychiatry	50204	98	50302	0.20%
All Dental	1842	0	1842	0.00%
Grand total	**52045**	**98**	**52143**	**0.19%**