Health Education England

Respiratory Disease: understanding the future service and workforce needs

Respiratory Disease Workshop - Evaluation Report

Foreword

Respiratory disease affects one in five people in England and is the third biggest cause of death. Chronic obstructive pulmonary disease (COPD) remains a constant challenge, with 2 million people diagnosed and up to three times as many people remaining undiagnosed, it has therefore been identified as a clinical priority in the NHS Long Term Plan. In addition, the pressures on the service post the coronavirus pandemic continue with many suffering from long-term symptoms of lung damage, including breathlessness, fatigue and limited ability to exercise. All these are placing significant pressures on respiratory services at a time of significant workforce challenges with efforts underway to boost NHS activity and tackle the rising backlog of care.

HEE and NHSE have been working closely through the National Clinical Director for Respiratory Disease Dr Andrew Menzies-Gow and GIRFT Clinical Lead Dr Martin Allen to understand current priorities for the respiratory disease workforce; the pressures and challenges they face; suggest solutions to them; and identify current barriers to achieving these ambitions and changes. A joint initial workshop was held on August 11th 2022 to scope and understand the work that is currently underway across the system on workforce, identifying improvement opportunities and alignment that will help deliver national priorities for respiratory disease. Also, providing a forum to influence and shape future funding and resource priorities for the respiratory disease workforce.

This report includes initial recommendations that we will aim to take forward jointly and address. We will focus on respiratory workforce data and supply by scoping how best we can help develop actions to address uniformity in data system sources and any system data gaps. At the same time, we will look at workforce upskilling and training thinking about the skills and capabilities that are required as new roles and ways of working emerge specifically for ‘out of hospital’ care. This will ensure the delivery of a future ‘service ready’ workforce with a core set of functional capabilities.

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

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

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

Introduction

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

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

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

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

Background

Why?

Respiratory disease affects one in five people in England and is the third biggest cause of death. It is felt that the quality of care is better from a specialist than a generalist at a time when chronic obstructive pulmonary disease (COPD) remains a challenge. There are 2 million people in the UK with diagnosed COPD and up to three times as many people have not yet been diagnosed. Almost 30,000 people die from COPD annually with over 1 million bed days per year are taken up by COPD patients.

The annual economic burden of asthma and COPD on the NHS in the UK is estimated as £3 billion and £1.9 billion respectively. Tackling covid-related challenges in services for patients with respiratory conditions remains a priority.

Expansion of pulmonary rehabilitation is one of the key commitments of the NHS LTP. Increasing access to pulmonary rehabilitation for people with lung conditions could save NHS England £69m every year and see a reduction of 150,924 GP appointments, and 26,633 fewer hospital admissions per year.

Our Purpose

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

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

The Workshop

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

The objectives focussed on:

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

Methodology

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

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

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

The questions focussed on:

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

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

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

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

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

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

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

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

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

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

Discussion

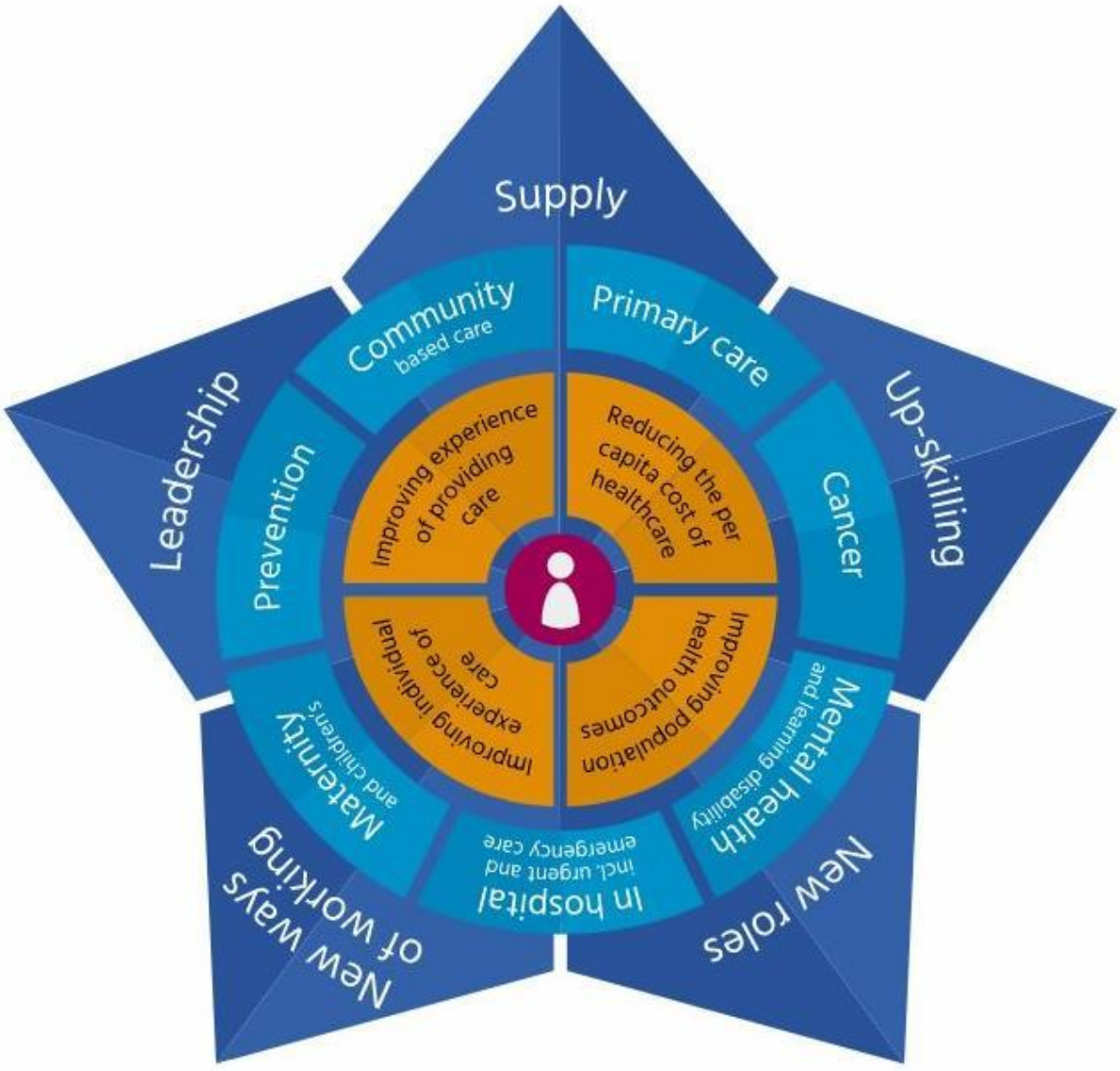
From the discussions it was clear that we need to build workforce capacity and capability that is aligned to system and service transformation. This will ensure the delivery of an effective future 'service ready' workforce.

Suggestions for example include:

- Prevention is key and need to build capability around this aligned with the ongoing work on pulmonary rehabilitation transformation. This could prevent 1 in 3 admissions leading to the service being more productive and less reactive.

- There needs to be awareness raising and education on the appropriate use of inhalers especially preventers as it is felt majority of patients are prescribed relievers. There needs to be management of acute asthma in the community aligned with the work underway to redesign pathways for outpatient services.
- There is a need to bring together system activities on workforce, for example the British Thoracic Society (BTS) work "A respiratory workforce for the future" and aligning with the lung cancer pathway too for example. And as expansion in medical schools will deliver more numbers by 2023, we need to ensure future projections are aligned.

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



Workforce Data and Supply

There are opportunities to align workforce priorities through the NHSE Peoples Directorate / Plan and for example emerging workstreams on education reform, redistribution and expansion (all specialties); pharmacists in primary care (especially independent prescribing role out);

respiratory physiologists expansion through the NSHCS; spirometry training; ACP trainees in primary care alignment; nursing workforce commitments, physician associates amongst others.

However, it is recognised that we need to understand more fully what the current state of the respiratory staffing workforce is and its perceived priority status at a local level. Standardisation of both the demand and supply data for the whole respiratory workforce aligned to workforce transformation opportunities through the 'HEE Star' is vital. Data sources to consider includes RCP; BTS; NACAP; GIRFT and the accompanying role ICBs and RDNs can play.
The starting point it is felt has to be acute and tertiary care to align service need to the workforce and modelling that can capture all the roles with defined job planning for all similar to the medical workforce.

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

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

Workforce Upskilling and Training

There is a need to scope and improve the standards of education and curriculum that aligns skills and competence with service need. This will allow a better understanding of how the capabilities and skill sets of the wider healthcare workforce who support respiratory services can be improved**.** This should happen at both undergraduate and post-graduate level, and there is a need for interprofessional education through rotational posts whilst on placement. Enhancement in learning opportunities will occur for these individuals across the wider spectrum of respiratory medicine.

Overall, there are clear gaps in formalised training and upskilling offers for the respiratory workforce. With changes in ways of working and roles highlighted below, there will need to be a process of ensuring staff are supported with the right capabilities that will enable them to perform effectively in delivering service and user needs. This should be underpinned by a multi-professional capabilities framework that is mapped to the patients' needs and referral pathway(s) ensuring they have the right response and care at the right time.

End to end capability building a framework for student opportunities, rotational posts, career frameworks, apprenticeship models and advanced practice training need to be scoped and created. As the service increasingly works with those with complex needs, we need to

understand how best we can benefit from working with the unregistered workforce and build models of care. There needs to be a focus on 'middle career upskilling' and thinking about how this can be linked within a capabilities-based model. The central role of physiologists in emerging pathways through community diagnostic hubs needs to be captured and consolidated.

The role of ACPs in respiratory medicine needs to be developed further with the creation of 'peer support' and 'peer leadership' underpinned by practice educators through a peer-trainer support network. The service shift focussing on the needs of the patient and care outside hospital should underpin the creation of these roles and careers. A multi-professional respiratory capability driven framework should act as a starting point for this clearly articulating generic and specialist capabilities. This could then also be supported with a 'framework for decision making' describing levels of care in different settings. Alignment with ACP credentials being developed for primary care and long-term conditions is key. Job plans also need to capture alignment to the four pillars of advanced practice i.e. clinical practice, leadership and management, education and research in practice.

Recommendation: Creation of a core 'Multi-professional Capability Framework Group' that will help explore and develop a core set of capabilities for the respiratory workforce. This will consider opportunities around improving standards of education and curriculum at all levels of training.

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

Recommendation: Once formed, the above group should consider how effective career pathways can be developed underpinned by a generic-specialty-based capability driven framework.

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

Recommendation: The NHSE and HEE respiratory teams working with national partners to further explore training and development opportunities for the workforce. This aligned to emerging models of care ensuring benefit to service users from an effectively upskilled workforce.

Actions:

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

New Roles and Ways of Working

There needs to be a shift in thinking with a focus on more multi-professional 'out of hospital' consultations and roles. In addition to this, the provision of diagnostics in the community will be key, for example driving spirometry testing in primary care with the added benefits it brings. With challenges in filling vacant acute posts a new paradigm into the ways of working and roles withing respiratory will need to be explored. Redesign of services focussing on the non-medical workforce with support networks enabling members of the multidisciplinary team to work on top of their license. All this will require a capability-based approach ensuring the workforce has the right skills underpinned by robust training and qualifications to deliver effective care.

There are opportunities to utilise physician associates, respiratory physiologists, physiotherapists, exercise trainers etc. where new and alterative roles can be developed and trained against specific capabilities. There may be scope to also widen diagnostic capability through the apprenticeship scheme for example through Band 4 physiologists.

(a) Opportunities in 'out of hospital' care

A solution would be to consider 'integrated care' in the community with the emergence of virtual wards where there needs to be a focus on acute respiratory infections (such as community acquired pneumonia [CAP]) and respiratory related conditions especially in the elderly. There are also significant numbers of respiratory related outpatient appointments that is placing pressure on the secondary care workforce at a time when many roles are unfilled. Service redesign for example through COVID-19 has proved successful. This however will require a workforce that is trained and has the skills and knowledge to meet the needs of the service and users.

(b) Working differently

We need to also shift the focus from the 'core' secondary respiratory workforce towards 'out of hospital' respiratory and sleep scientists, physiologists, psychologists. This can reduce focus of 'front door' and acute care services linked to a broader preventative approach in an integrated 'out of hospital' care setting reducing service pressure on acute and tertiary care.

To make this happen there is a need to understand the system of respiratory as a wider medical specialty covering from asthma to sleep medicine and breathlessness. Linking the acute services with the community preventative care and management of these long-term conditions. In addition, increasing capacity to give people rehabilitation in the community primarily through shared care facilities and the combined primary/community workforce model.

With an ageing workforce, there is an opportunity to utilise retiring specialists and flexing the workforce model where possible; allowing people to return on their own terms/ set days. This will aid succession planning and enable the passing on of vital skills and knowledge to the future flexible workforce.

(c) Training support

There is a need to also expand capabilities and skill sets of the wider workforce (including non-medical staff) for respiratory medicine training. It is traditionally done by consultants or physiotherapists in acute services but others can do this – it will alleviate exacerbation on acute services, to free up these senior colleagues to oversee other duties. The primary care respiratory society has done work in this area that can be further built upon

The service will need to be aligned to this new emerging workforce to ensure users have access to the right people at the right time of need. There needs to be a multi-professional approach to training with flexibility around supervision rather than this being from the same professional pool. This needs to be reflected in the roles too with professional autonomy and line management being multi-professional speciality based rather than profession specific line managers who are not linked to the specific specialty.

There may be opportunities in primary care and the use of primary care networks (PCNs) to create new education networks through training hubs for cross training. This through a capability framework that will enable share best practice across local, regional and national level to ensure consistent delivery of care.

Recommendation: Ongoing work on pulmonary rehabilitation transformation, spirometry commissioning, CAP should be used to understand how workforce opportunities in 'out of hospital' care can be utilised to understand multi-professional capabilities to deliver service change.

Actions:
- Ensure workforce is a core-part of national planning activities for respiratory disease commissioning understanding how this aligns with current service priorities.
- Scope and understand the multi-professional workforce required to deliver effective respiratory services at all levels.
- Identify the core multi-professional capabilities that are required to drive respiratory disease transformation.
- Embed core multi-professional respiratory disease transformation capabilities ensuring the workforce is effectively equipped to deliver service change and address user needs.

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

Actions:
- Include workforce as a core priority area for respiratory delivery networks and ensuring alignment with local workforce transformation initiatives.
- Scope current roles identifying workforce gaps and opportunities that will help address workforce challenges across the respiratory pathway.

- Running a series of dedicated respiratory-RDN workforce workshops and engagement events enabling sharing best practices and opportunities for collaboration.
- Implementation of 'HEE Star' workshops through RDNs to support local workforce transformation to drive implementation of careers at local level.

Recommendation: ICBs and RDNs should focus workforce capability and capacity in primary care with a view to addressing local priorities and delivering care outside the acute and tertiary setting.

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

Leadership

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

(a) Infrastructure

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

As the system expands and respiratory ICB specific roles emerge, functions need to consider how workforce priorities will be developed and owned through these roles. There may be opportunities to develop training and support offers to further drive 'leadership' and resources and tools should be developed nationally to aid this. Lessons need to be gained from the work already underway across ICS footprints for example Cheshire and Merseyside that can be shared across other networks. This will also help build the economic argument based on the impact and savings models that have already been worked up.

(b) Finance

There will inevitably be limits to the budget available for the pursuit of the respiratory agenda, but there is a clear need to have budget to achieve what is needed to advance respiratory workforce priorities. This will require prioritisation of these asks with a specific costed approach

to allow selection of deliverables based on allocated budget. The role of ICBs cannot be overlooked and as respiratory delivery networks play a prominent role, it is important we reach out to these networks and look at ways to use locally available finances more effectively at scale.

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

Actions:
- Creating capacity and capability within respiratory programme teams to ensure they are adequately equipped and skilled to deliver workforce respiratory ambitions and priorities.
- Scope and deliver respiratory 'support offers' that will help leadership development at all levels, especially around ICS and CDN engagement and workforce development.

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

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

Next Steps

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

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

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

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

Appendices

Appendix 1 – Agenda

Time	Agenda Item	Speaker
14:00 – 14:05	Welcome And Introductions	Prof Adrian Brooke
14:05 – 14:25	Respiratory Workforce Priorities	Prof Andrew Menzies-Gow
14:25 – 14:55	HEE Workforce Planning & Analysis - An Overview: Respiratory	Tom Clayton
14:55 – 15:15	Respiratory Workforce Challenges	Martin Allen
15:15 – 15:20	*Comfort Break (If needed)*	
15:20 – 16:35	Facilitated Discussion	Orlando Hampton
16:35 – 16:55	Next Steps	Prof Adrian Brooke
	Close	

Appendix 2 – Survey Responses and Facilitated Discussion

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

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

The main focal sectors were respiratory diagnostics, acute care, outpatients, procedures, primary, secondary, CDCs and tertiary care. With medical, nursing, physiology, physiotherapists, healthcare scientists, pharmacists and other AHPs; expanding to respiratory psychologists as the professional groups at the fore front of discussion. It was established that there are currently excellent relationships between key stake holders, but there is room to develop this through understanding the relationship between acute and respiratory medicine within secondary care and effective ICS's. Additionally, the promotion of high-quality education has created clear standards for multi-professionals, to allow development of specialist skills, however there is room for further support for this. The participants related their own work to this by expressing their work pressure, workforce shortfall and capacity to train, hinders this development towards solutions. One lesson which could be learnt from; It was positively stated by one respondent that the success of specialist commissioning for example in asthma, shows how the current joined up service planning based on patient need with data to evidence, promotes recruitment, retention and could translate effectively to other areas.

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

Respiratory networks, NSHCS, CSO, and allowing Taskforce for Lung Health to use ICS, to allow effective identification or local need and drive specific workforce planning. This was

mentioned as some systems/ channels to help strengthen engagement for addressing the highlighted priorities.

A key topic mentioned to support the priorities, was changing the nature of the training and qualifications for 'fast tracking' specialist nurses; increasing the number of specialist training places and creating more flexibility; all with more data to support and planning. Collectively this could protect current respiratory roles within acute services. Additionally, more understanding of respiratory as a wider medical specialty covering from asthma, respiratory physiologists and dedicated sleep specialists is needed.

To deliver these priorities, more support for training was the most frequently discussed as a solution. Development of curricula and higher standards of education, to increase understanding and improve the capabilities and skill sets of the wider healthcare workforce who support respiratory services. Specifically moving away from acute medicine towards raising the profile of respiratory and sleep scientists, physiologists and psychologists. One suggestion on how multi-professional planning can be ensured explained there are roles that respiratory scientists can develop into e.g. consultant respiratory scientists to take some of the workload off other healthcare professionals helping with capacity challenges and service prioritisation.

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

Some of the attendees were not assured that the solutions highlighted will be delivered effectively. The main obstacles identified were funding, lack of workforce, recruitment delays, and back log of COVID-19 and its competing priorities. Another key barrier is there is too much focus on acute care/ 'front door' service and is detrimental to overall care across the NHS as a whole. A broader preventative approach with broader skills will be able to support patients better and reduce front door pressures, instead of throwing more efforts into acute care alone. A key regulation that threatens objectives is the pensions legislation, as it leads to loss of senior clinical decision makers, limiting workforce but also ability to train future workforce.

Appendix 3 – List of Attendees

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

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

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

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

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

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

Orlando Hampton – HEE Head of Workforce Transformation.

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

Rachael Moses – President, British Thoracic Society.

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

Rose Nakibirango – NHSE Project Manager.

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

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

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

Andrew Menzies-Gow – NHSE National Clinical Director for Respiratory.

Dr Paul Walker – Chair, British Thoracic Society.

Beverly Harden – National AHP Lead, HEE.

Martin Allen – NHSE, GRIFT Clinical Lead for Respiratory.

Dr Charlotte Addy – Workforce Lead, British Thoracic Society.

Jon Hossain – Postgraduate Deputy Dean AND Respiratory Lead, HEE.

Sarah McFayden – Vice Chair at Taskforce for Lung Health.

Mark Fores, Senior Nurse Workforce Delivery, HEE.

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

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

Appendix 4 – Post Workshop Feedback

The average consensus with the workshops aims and objectives, usefulness in meeting attendees' own expectations, and overall capturing the workforces' immediate priorities was medium/ high. The key workforce workstreams that attendees feel should emerge and be part of further discussion include the development of training and qualifications for nursing to be at higher standards and having curricula and support for postgraduate learning. For future events, it is expressed that there should be exploration around other parallel workstreams and link it to the topics at hand e.g., breathlessness, rehabilitation.

Feedback stated the speakers were clear and articulate with what the workforce priorities and challenges are, but room for improvement regarding virtual attendees. A respondent to the survey, who attended virtually, felt only being invited to the discussion and not being able to hear the presentation reduced ability to contribute and gain the most out of the workshop. It was suggested that a larger face to face session, with smaller breakout sessions will reduce the number of ‘formal’ presentations discussing issues as a whole and allow more detailed in-depth conversations around specific areas.