Health Education England

HEE Workforce Planning and Strategic Framework (Framework 15)

2015/16 Call for Evidence

In 2015/16 we are inviting organisations for submissions which address not only immediate workforce planning and education commissioning but which look further ahead and cover wider workforce strategy. For this reason the 2015/16 form covers not only 'conventional' supply and demand concerns, but invites organisations to comment on the wider context of drivers of change and the strategic response. It is organised as follows:

Section 1: Current and future workforce demand and supply

Section 2: Drivers of service demand change

Section 3: Patients and population

Section 4: Models of care

Section 5: Future workforce characteristics

Section 6: Any other evidence

Submissions should be completed and returned to HEE, using this form, by 30th June (see below for more information).

We acknowledge that this is a bigger task than in previous years, and it may entail a higher level of internal deliberation and consultation for your organisation. This is deliberate: we want to learn as much as we can about what organisations are thinking about the long term and the big picture, while simultaneously gathering thinking about the here and now and the more immediate future which will be influenced directly by HEE's commissions in the short term.

Making your submission

- We ask that, to maximise input, your submission is completed and returned to HEE by the **end of June**
- To submit your evidence please, complete this form. You can provide extracts of reports into the free text boxes below, or submit whole reports. Where an extract is provided, please reference the source.
- In submitting evidence you are invited to take into account the following:

HEE's workforce planning guidance	HEE Planning Guidance. Due to the restrictions around the election we have not been given permission to put this on our web site. It has been widely circulated but please contact mandy.knowles1@nhs.net if you do not have a copy.
HEE's strategic framework (Framework 15)	http://hee.nhs.uk/2014/06/03/framework-15-health-education-england-strategic-framework-2014-29/
The NHS Five Year Forward view	http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

- Once you have completed the form and/or prepared your 'pack', please embed it in an email and return it to hee.workforceplanning1@nhs.net and in the subject heading please use this convention:

HEE CFE 2015/16 from [your organisation's name in full – avoid acronyms] [Sub version x]

- Please note, it is not *compulsory* to complete all sections for you to submit a response, but **in order to inform HEE's 2015/16 education commissions, section 1 must be completed and returned by the end of June**

Your contact details

Before completing the form below please submit your contact details here:

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Submission version)if you resubmit at any point)	V1
Date	30th June 2015

Data Protection and Freedom of Information

The information you send us may be made available to wider partners, referred to in future published workforce returns or other reports and may be stored on our internal evidence database.

Any information contained in your response may be subject to publication or disclosure if requested under the Freedom of Information Act 2000. By providing personal information for this review it is understood that you consent to its disclosure and publication. If this is not the case, you should limit any personal information provided or remove it completely.

If you want the information in your response to be kept within HEE's executive processes, you should make this clear in your submission, although we cannot guarantee to be able to do this.

Section 1 – Current and future workforce demand and supply

Use this section to input evidence into the forecasting of future workforce numbers. Report here your perspectives on either;

i) the high level indicators; supply, demand, and any forecast under / over supply

or if available

ii) the more granular components of these three components e.g. retirement rates, output from education relative to attrition

1.1 Summary forecasts

- Forecast Workforce Demand
- Forecast Workforce Supply and Turnover
- Forecast Under / Over Supply

1) Overall national projections

- The findings from the CfWI's in-depth review indicate a doubling of the need for ICU service provision by 2033 is feasible, with the aging population being a significant part of that projected demand. The headlines from the report were:
    - HEE should continue to fill the current number of training posts for anaesthetists and intensivists in England to minimise the risk of short term undersupply. The report notes "HEE may wish to support the flexibility required to meet the needs of the future workforce by training an appropriate mix of specialists with single and dual CCTs, particularly noting that the future ICM service is likely be delivered mostly by intensivists with Dual CCTs."
    - The report recognises that anaesthetists provide a notable level of service to ICM and that any changes to this provision would need to be counteracted with an increase in the provision of ICM.
    - The report recognises, in line with ICNARC research on projected usage of Level 2 and 3 bed days, that there is **likely to be a significant increase in need over the next 18 years up to 2033**, with most scenarios indicating that it is likely to double.
- The ICNARC research indicates: "Modelling the trends in terms of age- and sex-specific bed utilisation rates and then projecting forward to 2033, if the observed trends continue, then an increase in overall bed days is estimated of approximately 4% per annum – comprising an approximate increase of 7% per annum for Level 2 bed-days and an approximate decrease of 2% per annum for Level 3 bed-days." [1]
- The FICM will begin local engagements with regions to source granular (by hospital) project data during 2015, with the first two regions likely to be West Midlands and Wales.

2) Projected undersupply

- The average number of consultant appointments with sessions in ICM is 137 pa over the last five years. Over the same period the average number of trainees reaching CCT was 81, leading to an overall average shortfall of ICM trained doctors of 56 per year. This has been filled by partner specialty trainees who train to an intermediate level in the specialty. However, this number has been steadily decreasing and cannot be relied upon in the future.. As of the current 2015 recruitment, the number of training posts has risen to 147, but is not likely to fill more than 90% of these posts.

- ICM currently operates two training programmes, a Joint CCT of 7.5 years and a Single CCT of 7 years (which most trainees undertake in a dual programme which lasts 8.5 years). Due to the GMC's mandated swift transition from the Joint to the Single/Dual CCT programmes, there is likely to be a significant drop in output between 2016-2018 and a slow return to a position of status quo from around 2020/2021.
- It has become increasingly common for AACs in ICM to be cancelled due to lack of appropriate candidates (16 interviews cancelled in 2013 and 32 in 2014).
- The increase in consultant posts and training posts is not currently at the rate to meet the predicted future requirements covered in the overall national projections covered above.

3) Transition from Joint to Single/Dual CCTs

- In 2001, the Intercollegiate Board for Training in Intensive Care Medicine (IBTICM) introduced the Joint CCT. Trainees were recruited from 'parent' specialties, usually in ST5, to complete a period of training in addition to that of their parent specialty. The Joint CCT generally took 7.5 years.
- In 2010 the GMC requested the newly formed FICM to create a single CCT for the specialty. This was approved in 2011 and recruited to for the first time in 2012.
- Trainees are recruited from Core Medical Training, Core Anaesthetic Training and all three branches of the Acute Care Common Stem. As well as training solely in the specialty, it is also possible to train in a Dual CCTs Programme with (currently) Acute Medicine, Anaesthetics, Emergency Medicine, Renal Medicine and Respiratory Medicine. Other dual programs may emerge.
- A Single CCT Programme takes a trainee 7 years from CT1 to CCT. All Dual CCT Programmes take 8.5 years from CT1 to CCT. However, these are naturally baseline timeframes and with Out of Programme Experience, maternity leave, Less Than Full Time training, sick leave, ARCP Outcome 4s and other related reasons, many trainees who take longer (sometimes considerably longer) to complete their training.
- The new Dual CCT is 12 months longer than the Joint CCT. Due to the tight transition timeframe defined by the GMC, there is likely to be a period of undersupply from 2016-2018 when output will be significantly lower than in previous years.

4) National initiatives and their impact

- FUTURE HOSPITAL COMMISSION: The effect of any centralisation of specialised services (eg vascular surgery, complex GI surgery) may have a significant impact on the ability of units within smaller hospitals to function effectively. Over half of the hospitals who responded to our census indicates they had 20 or fewer beds.
- SEVEN DAY CONSULTANT PRESENT CARE: ICM is largely a Consultant-delivered service at present but this report and its recommendations may have significant impact on the specialties with which it is intrinsically linked.

5) Middle grade cover

- Due to the historical shortfall in manpower to the specialty, a notable proportion of ICM on-call is provided by trainees and some service provision is provided by consultants in anaesthesia. Anaesthetics will experience its own increase in service demands and as ICM moves from being 90% Anaesthetic to a more even division between its medical and anaesthetic components, there is likely to be considerable pressure on this organic service configuration.
- Advanced Critical Care Practitioners (see Section 1.4) may be a solution to some of this shortfall but funding and regulation remains an issue.

1.2 Detailed / Component forecasts

Forecast Workforce Demand

- Service Demand drivers
- Change in use of temporary staff
- Addressing historic vacancies
- Skill Mix / New Roles
- Workforce Productivity

(NB: A number of areas relevant to this section were covered in 1.1 above).

Change in training landscape

- The average Direct Clinical Care PAs in ICM that a consultant undertakes is 4.5. With a shifting skill mix from non-anaesthetic ICM clinicians (from under 10% of consultants to 25% of trainees) and the slight growth in the number of consultants opting to go full time ICM (from 5% to 7%), this may change.
- The percentage of ICM trainees who are female (c.32%) is double that of the percentage of ICM consultants who are female (c.17%). ICM remains a supportive environment for LTFT working and the greater number of female doctors may have a limited impact on overall PAs worked in the specialty.

1.3 Forecast Supply from HEE commissioned education

- Assumed training levels
- Under recruitment
- Attrition
- Employment on completion of training

- Training numbers have significantly increased from 82 (2012) to 147 (2015). The fill rate has been an average of 86% across the four years of recruitment to the new programme.
- The growth conceals a variation across the country with most regions averaging one new post per 350k of the population. However in England some regions are falling notably behind that curve. West Midlands (1.135k), East of England (992k), East Midlands (920k) and KSS (746k) have a significantly higher population to post ratio. As trainees are increasingly unlikely to move between regions to find consultant posts, these regions are creating long-term workforce issues for themselves.
- Almost all funding options for the conversion of Trust posts have been fully explored. Some of the new funding for 2015 has come at the cost of Anaesthetics CT3 and ST3 posts, which is unsustainable long-term and detrimental to Anaesthetics.
- Our Regional Advisors report that there is a considerable risk that the growth in training numbers will be stalled.
- Feedback from our Regional Advisors has indicated that trainees are able to achieve consultant posts upon reaching CCT.

1.4 Forecast Supply – Other Supply and Turnover

- From other education supply
- To/from the devolved administrations
- To/from private and LA health and social care employers
- To/from the international labour market
- To/from other sectors / career breaks and 'return to practice'
- To/from other professions (e.g. to HV or to management)
- Increased / decreased participation rates (more or less part time working)
- Retirement

1) Advanced Critical Care Practitioners (ACCPs)

- An ACCP curriculum is due to be launched this summer by the FICM in conjunction with the National Association of ACCPs. ACCPs trained to this standard will be able to provide considerable support to ICU services.
- ACCPs are championed by the FICM and the specialty as a whole, but there is still considerable financial risk associated with the local funding and training of an ACCP. Units may not elect to invest the funds to train ACCPs when there is risk of that investment going unrealised if a neighbouring Trust is able to poach the newly trained practitioners.
- There is no formal body that will undertake the regulation of ACCPs.

Section 2 - Drivers of service demand change

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
We believe that our population is **getting older**, and that for our workforce, preferences for a change in patterns in working is increasing.		How do you think this will have an impact as a driver of **service demand**?
The influence of technology is growing in healthcare and beyond, with staff and patients using it to **increase personalisation and control** in their life. What will be its possible impact in healthcare in the years ahead? The influence of **genomics and research** will also play a vital part.	Aspects of ICM could benefit from telemedicine in geographically isolated units.	How will technology and innovation impact on **service demand** in the near future, and what education/training will the current workforce need to meet that demand?
Wider factors are creating global pressures to **constrain the cost** of publicly funded healthcare, with the wider concept of wellness increasingly taking root which people will expect health service to respond to.	ICM should be more closely linked to ward care and community care to ensure that the service demands are properly matched to those who will know the benefit.	Economics will play a part in influencing **service demand** and NHS funding will shape service demand in the near future (QIPP, funding, economics).
Patients are going to want **high quality services anytime, any place, anywhere**, with a more equal (and challenging) relationship with staff, but one still based on care and a better work life balance.		What is the shorter term impact of changing patterns of expectations on **service demand**?

Section 3 – Patients and population

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
With people living longer with more people living with **multiple and complex conditions** (and with our workforce being currently predominantly trained to treat distinct and different disease in isolation after a health crisis has occurred). How can we educate/train the workforce to support the prevention of ill health and, where ill health occurs, support staff to work across organisational boundaries to support high quality care for people with a range of health needs (across physical, mental health and social care)?		What are the possible/likely impacts on **service demand** – **activity and epidemiology**?
Our patients and population are likely to be at different stages of being **informed, active and engaged** in their own healthcare (including using for example, data and online records), with our challenge being to support the development of a workforce which can support high quality care for all patients.		How will needs **identified by patients and the public** affect service demand in the shorter term?

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
Patients will increasingly be members of a **community of health,** with the number of carers projected to rise significantly in the years ahead**.** Five Year Forward View highlights four ways in which we can engage with communities and citizens in new ways, to build on the energy and compassion that exists in communities across England, namely: • better support for carers • creating new options for health-related volunteering • designing easier ways for voluntary organisations to work alongside the NHS • using the role of the NHS as an employer to achieve wider health goals		How will these trends affect **service demand** in the short term and how can we support patients and communities of health through our **lever of workforce planning**?
Developing **substantial community provision** to bring about a substantial reduction in the numbers of people with learning disabilities placed inappropriately in institutional care is a central part of Sir Stephen Bubb's report in 2014 ('*Winterbourne View – time for change*).		What will be the **service demand impact** of the changes to transform care for people with Learning Disabilities (such as those outlined in *Transforming Care for people with Learning Disabilities)*?
Parity of esteem for Mental Health will be supported through delivering improvements in areas such as integration, waiting and access targets and in the area of psychiatry liaison		What education/training does the current workforce require to be able to make parity of esteem a reality?

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
Five year forward view draws attention to the NHS being committed to making **substantial progress** in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds.		How can we use our levers in the **short term** to support this commitment?

Section 4 – Models of care

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
Five Year forward View outlines a number of possible future service models including • multispecialty community providers (MCPs), which may include a number of variants • integrated primary and acute care systems (PACS) • additional approaches to creating viable smaller hospitals • models of enhanced health in care homes The **expertise to support** the piloting and introduction of these models need to be considered. Existing NHS services and areas of the healthcare workforce may work with others in new and different ways (e.g. community pharmacy).		How could **future service models** develop in the short term in line with these developments and the learning from the Vanguard sites, and what education/training will the current workforce need to make these models work?
Services are likely to become **increasingly integrated** in the future, enhanced through policies such as the Devolution of Local health and social care budgets, the integrated care pilots and integrated personal commissioning. Partnerships will become increasingly important, including with partners beyond NHS and social care.		How could **future service models** develop in the short term in line with these drivers, and what education/training will the current workforce need to make these models work?

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
We may increasingly see **centres of specialisation** in some specialties in some areas.		How could **future service models** develop in the short term in line with these drivers?
We will see the ongoing development of services in the area of **urgent and emergency care**		How could **future service models** develop in the short term in line with these drivers?
Five Year Forward View highlights new developments such as the **evidence based diabetes prevention service** and **encouraging new capacity in under doctored areas.**		How could such approaches affect **service models** in the near future?

Section 5 – Future workforce characteristics

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
Below are the 5 future workforce characteristics set out in Framework 15	In your evidence please highlight any or all of the following: - Are these workforce characteristics still valid? - Any evidence you are aware of work which is underway and which contributes to the achievement of the workforce characteristics - Any gaps you are aware of Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term** education and training needs required for the current workforce to meet these characteristics:
The workforce will include the informal support that helps people prevent ill health and manage their own care as appropriate.		
Have the skills, values and behaviours required to provide co-productive and traditional models of care as appropriate.		
Have adaptable skills responsive to evidence and innovation to enable 'whole person' care, with specialisation driven by patient rather than professional needs.		
Have the skills, values, behaviours and support to provide safe, high quality care wherever and whenever the patient is, at all times and in all settings.		
Deliver the NHS Constitution: be able to bring the highest levels of knowledge and skill at times of basic human need when care and compassion are what matters most.		

Section 6 – Any other evidence not included elsewhere

Insert evidence here….