

ANNEX B

Facing the Facts, Shaping the Future

A draft health and care workforce strategy for England to 2027



For consultation



Public Health
England



The NHS belongs to the people.

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

Introduction

The NHS is one of our country's finest achievements. As outlined in the NHS Constitution it belongs to, and is a source of pride to, the people.

The public health staff in local authorities, those in the voluntary or independent sector providing NHS care and those in hospitals, GP surgeries and our communities as well as colleagues in social care. Social care and health together make up the largest workforce in the country, by comprising 13% of all jobs, yet we have not had a national strategy for recruiting, training and supporting them for over two decades.

That will change next year. This consultation document will lead to a workforce strategy for the health service to be published in July 2018. This document informs a conversation about what staff need; about what staff the health service needs, and how we shape the future we all want: a sustainable, free, universal healthcare system.

Production of this document was led and co-ordinated by Health Education England but it is a product of the whole national system including NHS England, NHS Improvement, Public Health England, and the Department of Health.

In this document we outline why we need a workforce strategy, before detailing the 2017 workforce and how it has changed over the last five years. Workforce growth comes from three main areas: output from education and training, retaining our current workforce, and recruitment of trained workforce from elsewhere. We describe actions to grow capacity and capability to move towards self-sustainability in our workforce and build the NHS's global reputation as a centre of excellence in healthcare education and training.

We then extend our lens to 2027, recognising that education and training and workforce reform takes time we look at how new technology, prevention and flexibility are required to meet the service's workforce requirements a decade away.

We conclude by discussing the future for each of our workforce groups, using a focus on professions to analyse need and set out actions.

Please take the time to read this document and respond to the consultation to ensure that the final strategy is a comprehensive product of the whole system.

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Setting the scene

Professor Ian Cumming OBE

Chief Executive, Health Education England

“Health is all about people. Beyond the glittering surface of modern technology, the core space of every health care system is occupied by the unique encounter between one set of people who need services and another who have been entrusted to deliver them”

Frenk, J., Chen, L., Bhutta, Z. A., Cohen, J., Crisp, N., Evans, T., Fineberg, H., et al. (2010) Professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet* 376(9756) pp. 1923-1958

Setting the Scene

A national conversation

This is the first time in almost 25 years that the health service in England has set about producing a Workforce Strategy. This document is not the final strategy but a draft, designed to present the facts and stimulate debate. It builds on the concepts discussed in Health Education England's (HEE) Framework 15, published in 2014. We describe the current state of the NHS, health and care workforce from 2012, outline recent strategic workforce interventions; describe key decisions that will impact on the future workforce through to 2027; and seek your views on what we should do next to ensure our workforce provides the best quality care to patients, service users, carers, and the public. Your responses will be used to inform the full strategy to be published in July 2018, and then updated annually. HEE has led and co-ordinated this document's production, but it is not an HEE document; it is from the whole national system with content from NHS England, NHS Improvement, Public Health England, the Care Quality Commission, NICE and the Department of Health. Each have specific responsibilities which impact on the NHS workforce, as set out in as set out on page 17.

Our current workforce

Throughout this document we draw on data from the NHS and the health and care system – where the latter is available.

The NHS spends almost 65% of its operational budget on its most valuable asset; our staff. Almost all clinical professions in the NHS have grown in the last five years. We have over 40,000 more clinicians substantively employed than in 2012, a 7.3% increase. We have 14,306 more adult general nurses (8.6%); 445 more emergency medicine consultants (37.5%); 2,130 more mental health therapists (83.7%); 2,248 more health visitors (27.4%); 1,146 more community mental health nurses (7.2%), and 1,692 more physiotherapists (9.1%). The ratio of qualified nurses to occupied NHS beds has also increased from 1.86 to 2.02. A small number of professions have however seen a fall in employed numbers including 1,674 fewer district nurses (26.1%), and 842 fewer learning disability nurses (36.5%). GP numbers have also reduced by approximately 1% since 2012. Overall, the total amount the NHS spent on pay has increased by £3.7bn in real terms from 2012/13 to 2016/17 (substantive and temporary staff).

So why doesn't it feel like that? Put simply, because of huge growth in demand and a focus on quality. Since 2012 England's population has grown by 2.1 million (around 4%), and has continued to age. The number of people with long-term conditions has grown sharply, as have advances in medical care and treatment - keeping more people alive for longer. The drive for safer staffing following the Mid-Staffordshire Trust tragedy saw over 40,000 additional posts for registered nurses created in the NHS. This enormous growth in demand for more nurses coincided with supply, the output from nurse training, being at a low point as student nurse commissions were reduced between 2009 and 2012. Action has been taken to correct these supply shortfalls, but it takes time. HEE has grown nursing commissions by over 15% in the last 3 years, and the government has recently confirmed a further increase in clinical placement funding, allowing for a further 25% increase in student nurse places from 2018. This 25% increase means an extra 26,000 nurses will be available for employment by 2027. The Secretary of State also announced a 25% increase in medical school places from 2018/19. These additional doctors will become consultants or GPs in around 2030-32.

Vacancies

So, we have more staff who are treating more people. Alongside this we have created many more additional clinical posts than we have been able to fill. Current total NHS vacancies for nurses, midwives and allied health professionals (AHPs) are almost 42,000 (9.4%), an improvement on the 2016 position of 44,000 (9.9%), but more needs to be done. The vast majority of vacant posts do not translate into vacant shifts as most are covered by bank or agency staff, but using agency staff is expensive and continuity of care can be compromised. Also, some vacant shifts (about 8%) remain uncovered, increasing pressure on existing staff and potentially impacting on quality. Vacancies also vary by region. For example, nurse vacancy rates are 8% in the North East but 15% in London. The West Midlands Ambulance Service currently has no paramedic vacancies, whilst elsewhere almost one third of paramedic posts are vacant. In some areas clinicians have also chosen to leave substantive NHS roles, returning to the same post as locums, driving up both vacancies and costs.

Whilst doctors in training provide an important service to the NHS, the prime reason for their placement is to gain education and training leading towards their Certificate of Completion of Training (CCT). The number of postgraduate trainees we have in each specialty is based on the predicted future demand for consultants in that specialty, not the number of junior doctors needed to staff rotas. Many rotas are also staffed by non-consultant, non-training grade doctors. How we look after and offer a rewarding career to these doctors is critically important, as is how we train and better utilise non-medical advanced clinical practitioners. The “blue triangle” concept described in chapter 8 sets out our thinking about how to better address these issues and ensure that our patients have the cover they need.

Workforce supply

New professional workforce comes from only three places; new graduates; returning practitioners, or recruitment from elsewhere. We have turned on all these taps, starting with the increased student numbers already outlined above. Return to practice initiatives have seen over 4,000 people commence training to return to practice in nursing and other professions, but more can be done. In line with government policy to reduce net migration our international “Earn, Learn and Return” schemes bring qualified professionals to this country for a fixed period, to enhance their knowledge and skills and contribute to our health service before returning home.

Retention

The most cost-effective way to ensure the health and care system has the staff we need is to keep the people we already employ. The percentage of nurses leaving the NHS for reasons other than retirement increased from 7.1% in 2011/12 to 8.7% in 2016/17. This means that in 2016/17, 5,000 more nurses left NHS employment than in 2011/12. Had the rate remained at 2012 levels through to 2017, we would have 16,000 more nurses working in the NHS today - that's almost half of our currently vacant nurse posts filled. Some of the increase in people leaving may be due to pressure of work, some because of lack of flexibility, some due to pay, and some because people feel they are not getting the career development they want. But, as many of these are issues affect the whole NHS, why is there such variation from employer to employer in staff turnover?

Changing expectations

There is a new factor that is affecting retention as we plan for the future. Different generations want different things in their working lives. Millennials often want non-linear careers and they see flexible working with career breaks as a right. For example, twelve hour shifts once resonated well with employers and employees but increasingly people are now wanting more flexibility. Some like twelve hour shifts, some eight hour shifts, and some 'school run shifts', all supported by web-based flexible rostering.

When considering changing expectations we need to be mindful of wider societal changes. We have to find a way to stem the rise in lifestyle related illness to take further pressure off the health service. Prevention must be the first priority. Do we currently train all our clinicians with this as a basic premise? Do we spend enough time training clinicians in population medicine? Do we ensure that all clinicians understand the benefits of exercise on both physical and mental health and wellbeing? And are we serious about parity of esteem between physical and mental health.

Patient and citizen expectations continue to change, making interactions with healthcare professionals very different from a few years ago. Many people now have as much, or more, knowledge about their condition as many of the clinicians they see. Are we training clinicians to work with this as the new reality? We also need to look at where we train healthcare professionals. If we are creating a healthcare system delivered in the community with in-reach into hospital, why do we train our staff the other way around? We also know there is a correlation between where people train and where they ultimately work so should we move more training posts to areas in which we have more vacancies or there is more unmet need?

Finally, the way we expect to work with local populations and deliver care in the future is changing. The creation of new care models, including Primary Care Homes, developments in technology that mean many more services can be offered in the home – eg blood pressure monitoring – and the changes to diagnostic approaches – eg via genomics – all have a profound effect on the way we provide and deliver health services. We need to ensure our people are prepared to work effectively in these changing situations.

Planning the workforce of the future

The current gap between workforce demand and supply has occurred partly as a result of a historic disconnect between service planning, financial planning and workforce planning. To plan for the future workforce requires adequate knowledge of service delivery models and commissioning intentions. The Five Year Forward View described service transformation plans in a number of priority areas, from which we have been able to produce service specific workforce plans, the first time the health service has produced a strategic workforce response to defined future service delivery models. One of the areas in which we are seeking your views is the introduction of a 'Workforce Impact Assessment' for new best practice or service redesign recommendations, ensuring that workforce competencies, skills and training as well as numbers are considered early in the planning phase.

As well as concentrating on training new staff, it is critically important to focus on our current workforce and their on-going development needs. More than 50% of today's workforce will still be working in the health service in 2032. If we want to transform services over this period we need to develop the current workforce. In the last few years HEE has prioritised spending on

new workforce production which has reduced our ability to invest in the transformation of our current workforce. We now collectively need to increase investment in our existing workforce and prioritise what we need to achieve with that resource.

For the first time we have looked more than five years ahead in planning our workforce – through to 2027. We have considered the likely demand for NHS staff using growth projections for the economy rather than the aggregation of employer demand as this has always under-estimated future demand. Our ten year forward look shows that if no action is taken to reduce demand through prevention or through better productivity and service transformation, the NHS will need to grow by 190,000 clinical posts by 2027 to meet demand.

We also want to ensure that we have a future workforce representative of the population we serve and to offer 'careers not jobs' to people who demonstrate the NHS Constitution's values and behaviours. We are expanding apprenticeships for both new entrants to our workforce and existing staff. The new nursing associate (NA) role has proved to be extremely popular with over 8,000 healthcare support workers applying for a place on the pilot cohorts. As well as creating a much-needed new role in its own right, NA training also offers an alternate route to becoming a registered nurse. Current projections are that we will have over 45,000 qualified nursing associates by 2027, with an expected 17,000 NAs also having completed additional training to become registered nurses by this date. We now want to consider expanding this associate concept to other professions.

Non-clinical staff

This document primarily focuses on clinical staff but our wider workforce are critical to the running of the NHS; our secretaries, porters, receptionists, managers, catering and estates staff to name but a few. The health service has over 350 different roles giving us one of the most diverse range of roles of any employer in the world. Many of this document's key points about apprentices, careers not jobs, and leadership development apply equally to all our workforce.

This is our first opportunity for a quarter of a century to ensure we have a comprehensive system-wide understanding of our workforce needs for the future; be that next year, five years away, or a decade away. This document outlines five years of action, taking on challenges as they arose, and finding solutions, but the future needs more than fixing as we go along. Agreeing what we need is the first step to planning the capacity and capability measures to deliver what we need. This document takes the first step – together we need to take the next one.

Please take the time to read this report and respond to the specific consultation points, but also any other areas you feel strongly about. We need your views, thoughts, concerns and perspectives on how to address the issues we describe and whether the collective actions we are proposing are enough, or indeed correct.

I look forward to the conversation.

Professor Ian Cumming OBE
Chief Executive, Health Education England





Have your say on the draft strategy

We want to hear views from across the country to inform the Workforce Strategy that will be published in July 2018 to coincide with the NHS's 70th birthday. We will, for example:

- Hold at least one stakeholder event in each region, in partnership with other ALBs
- Hold webinars/online discussions on specific topics
- Consult at LETB meetings in this period
- Take advantage of already scheduled stakeholder events and meetings
- Create a web-based mechanism for final responses and ongoing Q&As
- Use social media to promote the consultation

The consultation will begin with the launch of the document and will finish at 5pm on Friday March 23, 2018.

Chapter 1

Developing a workforce strategy

Chapter Summary:

- The NHS has a mixed history of workforce planning, with fragmented approaches, numerous variables and unanticipated spikes in demand.
- Currently the NHS faces workforce challenges at various levels, and the additional need to respond to the service goals set in the Five Year Forward View.
- Action has already been taken to address many of these challenges and further plans are being put in place.
- There is a complex landscape of responsibilities for workforce at all levels but structures are in place to support joint working on delivery, both nationally and locally.
- The impact of current trends on the future workforce is uncertain, even though there are likely to be new challenges as well as opportunities to reduce demand.
- A set of principles for future workforce decisions is described - designed to better manage that uncertainty.

Why have a workforce strategy?

The future of England's health and social care system relies on its staff, those providing face to face care all day, every day and those working behind the scenes to keep our NHS and care services functioning. Good health and social care relies upon easy, dependable access to staff who know what they are doing, have the time to do it and treat us with respect and compassion.

That is why health and care staff, who currently make up over 13% of all people in employment in the UK, are the single biggest investment we make in health and care. The NHS wage bill is nearly two thirds of its entire operational budget. For both patients and taxpayers getting workforce policy right is critical to the sustainability of high quality health and care services.

This document is about putting staff at the heart of a patient centred service vision.

With over four million people employed in health and social care, the shape of the workforce also impacts far beyond the confines of the services. As the largest employer in many places it is an important part of the local community impacting on social mobility, diversity and local economic growth.

This document informs a national discussion on strategic workforce issues so that by next July a workforce strategy to 2027 can be published: the first Workforce Strategy for over two decades.

Health Education England (HEE), the national health workforce planning, education, training and development body, has led this document's production in partnership with others. It represents a shared vision for the workforce.

While HEE does not have any formal responsibility for the social care workforce, the closer integration of health and social care is a long-term policy goal. We therefore include a section and a consultation question on the social care workforce, recognising that key social care issues are even now being considered across government.

While much good work has already been done, significant shortages in some groups of staff and in some parts of the country are placing real pressure on staff, the services they work in, and the financial position of employing organisations. Appendix 1 sets out examples of the wide ranging actions we are taking to help address those pressures.

The changing environment for health and social care

The health and care system is part of every community. Our country has a growing and ageing population with greater health and care needs; a growing and increasingly diverse workforce with changing work patterns; a raft of global socio-economic and political factors; and rapid technological and digital developments. In planning for the future, the NHS needs to better anticipate and understand these drivers.

Growing care needs

We celebrate that we are living longer but we need to recognise that many more of us are developing long-term health conditions with an impact on our health and care services.

- 11.6 million people in England are aged 65 and over, an increase of 21% in a decade whilst 1.5 million are aged 85 or over, an increase of 31% over the same period
- 3.8 million people live with diabetes and 2.5 million people have a cancer diagnosis
- 25% of people experience a mental health problem at some point in their lives
- 1 million additional people will have dementia by 2021
- 15 million people in England have one or more long term conditions
- The number of people with three or more long term conditions will have risen to 2.9 million by 2018

These facts highlight why health and care needs to be organised around individuals, rather than service or professional silos. We need to think innovatively, work differently and transform the way healthcare is delivered.

Changing expectations and knowledge

Patients, carers, and their families are becoming increasingly informed about their own conditions, treatment and care needs.

Shared decision-making, enabling self-care and increasing patient choice are core themes of HEE's Strategic Framework 15, whilst the Five Year Forward View (FYFV) described transforming care through 'a new relationship with patients and communities' by supporting people to better manage their own health; supporting carers to better engage with the NHS; encouraging community volunteering, including developing new roles for volunteers; and building better partnerships with the voluntary sector.

The number of people caring for a close family member or friend, who could not cope without their support, is rising. People need to be supported to develop the knowledge, skills and confidence to manage their own conditions and to care for others.

- Around 5.5 million people support a friend or family member as unpaid carers.
- 1.4 million unpaid carers care for more than 50 hours a week
- 20% of carers do not have access to any support
- Across health and care 3 million people regularly volunteer
- There are 300,000 volunteers in over one hundred different roles across the NHS

The number of carers and volunteers far outweighs the combined health and social care workforce. They are not, and cannot become, substitutes for professional staff, but they are part of the care family, so need and deserve more support.

Much preparatory work has been done; the government's 2016 call for evidence on a carers' strategy, NHS England's work on self management and HEE's consultation on a volunteering strategy. However, still more work is needed to support, enable and empower individuals, carers and volunteers through education and training.

Recognising this, HEE is announcing a series of workstreams and reviews to look at how we can better support the education and training needs of volunteers, carers and patients.

- HEE will work with Sir Tom Hughes-Hallett, chair of HelpForce, on a new independent initiative to promote high impact volunteering across the NHS.
- HEE will work with unpaid carers and their representative organisations to consider healthcare education and training needs for unpaid carers, to empower and equip them with the knowledge and skills they need.
- HEE's Patients Advisory Forum (PAF) will consider the role that HEE could play in providing education and training to patients on managing their conditions.

Generational differences across the workforce

Patterns of work are changing with more people wanting flexible careers, partly as a result of differences in generational expectations. To attract and retain staff, the NHS and social care must have an employment offer that remains attractive in this changing environment.

Reflecting society, the NHS workforce is changing. For example, around 10% more nurses were over 45 in 2015 compared to 2010 (38% to 48%).

Three generations are working in health with stark differences between them in expectations, perceptions, and motivations. These differences matter. Understanding and responding to differing motivational needs improves recruitment, retention and career development.

A changing socio-economic and political environment

The social, political, economic, environmental and regulatory world we live in presents the NHS with challenges and opportunities. These include changing notions of 'illness' and 'health'; changing economic trends and resources likely to be available for the health system; changes in climate leading to changed disease profiles; resistance to antibiotics, new or mutated pathogens, air quality and the availability of natural resources; changes to international relationships; and the reach of health and social care regulation.

The interdependence of health and social care

While the greater part of this document focuses on the NHS workforce, as with other developed economies internationally, the deep-seated interdependence of health and social care is increasingly evident and important as both sectors face the same demographic challenges and pressures. The success of each sector is dependent on the success of the other.

Chapter 5 sets out some of the key current and future challenges for the social care workforce and the consultation seeks views on which policies might best be explored to ensure the

right workforce is in place as the Government considers wider social care strategy next year. In considering those issues it will be important to recognise that the social care system is not simply a mechanism to ease pressure on health services, but is a vital system in its own right and that the framing of national and local NHS workforce policy and systems equally needs to consider how it can best contribute to the success of social care workforce policy.

Workforce planning and education and training systems will need to meet the needs of both sectors and policy makers in both parts of the health and care system will need to work together to ensure that success in recruiting and retain key staff in one sector does not drain much needed staff from the other. England needs the right staff with the right skills in both health and social care if both are to meet the needs of the population, whether they are patients, service users or both.

In framing the final workforce strategy for the NHS, it will be important to ensure that it supports the development of a thriving social care workforce at the same time. In particular, with NHS bodies acting as the key engine for growth in registered professionals who work in both systems, it will be important that any changes to workforce planning and education and training meet the needs of both sectors.

A changing world of technology and innovation

Health and healthcare will continue to benefit from research, technology and innovation, with for example precision medicine seeing rapid progress. Broader developments such as portable digital diagnostic devices may further change how patients, users and staff manage healthcare in the future. The implications of these for the 2027 NHS workforce may be hard to assess, but ready access to information, genomic medicine and advanced robotic surgery will undoubtedly affect the shape, size, and skills of the health workforce.

How the NHS is organised - roles and responsibilities for workforce

Most people who work in the NHS now and in the future are the individual and collective responsibility of all NHS organisations, nationally, regionally and locally: educating; training; recruiting; employing; supporting; managing and engaging staff at every level. Developing, improving, and transforming the workforce requires collaboration between organisations and with staff and their representatives.

The workforce related roles of the main national bodies, local structures and regulators are set out in table 1. The size and complexity of the workforce means relationships and partnerships with a whole host of other bodies are also vital. These include professional and system regulators, NHS Employers; the NHS Confederation; NHS Providers; NHS Clinical Commissioners; universities; as well as professional bodies; charities; trades unions and the Local Government Association to name just a few. Each brings perspective, expertise and authenticity to the workforce challenge.

DH, with HEE and other partners, will review organisational roles and responsibilities for the health and care workforce to ensure the system is fit for purpose to deliver the final strategy.

There are also formal structures that bring the national and local NHS leadership together around workforce issues. At a strategic level, the Minister of State for Health's Workforce Steering Group comprises all the relevant national health bodies to ensure coherent strategic system leadership. The group helps ensure the key workforce issues are identified and

coherent action is taken by the right organisations. The Arms Length Body (ALB) Chief Executive group provides strategic oversight for the national delivery of the FYFV priorities and objectives and brings together ALBs on issues of common interest.

Local governance structures

These national groups complement local governance structures for national service priority programmes including Sustainability and Transformation Partnerships (STPs) including emergent Accountable Care Organisation (ACO) and Accountable Care System (ACS) arrangements.

Local Workforce Action Boards (LWABs) serve STP areas and are effectively the workforce arm of the STPs, providing a forum for place based partners and local ALB representatives to discuss and agree consistent action on workforce issues.

We anticipate development of workforce delivery plans for both national priority programmes and place based plans in support of STPs. These are not simply numeric exercises, instead they should form the framework for consistent local and national conversations about who needs to do what and when.

The Social Partnership Forum

The Social Partnership Forum (SPF) brings together the DH, its ALBs, NHS Employers and healthcare trade unions to discuss system transformation and policy with workforce implications, and has its own local structures. Chaired by a Minister, the SPF is widely seen as one of the most advanced forms of industrial partnership in the public sector. It recognises the importance of partnership working for high quality patient care, evidencing the critical links between workforce engagement, patient experience and overall organisational performance.

The SPF Partnership Agreement includes: building trust and mutual respect for each other's roles and responsibilities; openness, honesty and transparency; top level commitment; a positive and constructive approach based on shared goals; early dialogue and a culture of no surprises; and a commitment to ensuring high quality outcomes for patients and the public.

Health and social care workforce – System responsibilities

Table 1:

The Secretary of State for Health – Department of Health <ul style="list-style-type: none"> Supporting Ministers & whole system oversight Setting strategic objectives and holding the system to account Pay Pensions Industrial relations Electronic Staff Record Professional regulation leadership Legislation ALB sponsorship 	
Health Education England <ul style="list-style-type: none"> System-wide workforce planning Workforce education and training Workforce intelligence and analysis Workforce transformation Postgraduate medical and dental education Commissioning of clinical education and training NHS apprenticeships Leadership development & whole system talent management Return to Practice International Education and training Programmes Health Careers Service 	NHS Improvement <ul style="list-style-type: none"> Shared lead for implementation of FYFV and service transformation Quality improvement Performance management of provider organisations in relation to: <ul style="list-style-type: none"> Workforce productivity Workforce retention improvement Reducing reliance on agency Organisational workforce/finance plans
	NHS England <ul style="list-style-type: none"> Shared lead of FYFV and service transformation priorities National lead for delivery of FYFV Setting service specifications/outcomes Specialised commissioning Primary care; commissioning, performance, workforce Workforce equality and diversity NHS Professional leadership (Chief Professional Officers also work for HEE and NHSI)
	Skills For Care For Adult Social Care: <ul style="list-style-type: none"> Standards, Learning, Qualifications and Apprenticeships (SLQA) Recruitment and Retention Employer Engagement Workforce Intelligence Workforce Innovation Regulated Professional Workforce in SC Leadership and Management
Sustainability and Transformation Partnerships (STPs) & Local Workforce Actions Boards (LWABs) <ul style="list-style-type: none"> STPs – support closer working of provider organisations to support implementation of the FYFV LWABs – Workforce arm of STPs (including Accountable Care Systems and Devolution areas) aligning STP intentions and working collaboratively with HEIs etc. 	
Public Health England <ul style="list-style-type: none"> National Lead for FYFV and Prevention/ Population health Leadership of the public health workforce (including public health nursing and midwifery workforce) Workforce development, equality and diversity Implementation of Fit for the Future: Public Health People 	NHS Employers <ul style="list-style-type: none"> National negotiation with health unions Support and guidance for local HR, OD and recruitment
	Professional regulators (overseen by PSA) <ul style="list-style-type: none"> Registration and continuing Fitness to practice of regulated professionals Setting professional and educational standards Approval and inspection of programmes of study
	NICE <ul style="list-style-type: none"> Evidence-based practice and technology guidance National Quality Standards Indicator development (including Quality Outcomes Framework)
	Care Quality Commission <ul style="list-style-type: none"> Inspection of standards – safe staffing levels, leadership
	Higher Education Institutions/ funding organisations <ul style="list-style-type: none"> Provision of education and training Student loans system

A set of shared principles to underpin future workforce decisions

National workforce planning is challenging for a system as large and complex as the NHS. It needs to take account of future finances and service redesign, while medical advances and changing patient needs and expectations add to the uncertainty of projections. The time it takes to train clinical professionals means we need to look for ways of building greater resilience into our future workforce plans. It is in the interests of current and future patients that we do so.

Now we have greater clarity on future service models, we have an opportunity to plan more coherently. To support this, HEE proposes a set of principles for future NHS workforce decisions, which aim to mitigate the risks associated with workforce planning. If these principles are to have real impact, they need to be agreed and adopted across the system, so we need your views on them.

The six principles are:

- 1. Securing the supply of staff** that the health and care system needs to deliver high quality care in the future. Since the NHS began patients have been well served by staff from around the world. However, maximising the self-supply of our workforce is critical. It cannot be right for the NHS to draw staff from other countries in large numbers just because we have failed to plan and invest.
- 2. Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff.** Individual NHS professions have distinct roles but there is scope for more blending of clinical responsibilities between professions. This flexibility is rewarding for staff and can provide the NHS with more choice in how we organise our services.
- 3. Providing broad pathways for careers in the NHS,** and the opportunity for staff to contribute more, and earn more, by developing their skills and experience. Structured career opportunities which enable staff to progress both within and between professions will enhance retention and make the health and care system more resilient and attractive in the face of changing demands from staff.
- 4. Widening participation in NHS jobs so that people from all backgrounds have the opportunity to contribute and benefit from public investment in our healthcare.** This enshrines the public duty to provide equal opportunity for all and will ensure the NHS workforce of the future more closely reflects the populations it serves. If delivered successfully it will increase the pool of people available to be recruited into the NHS.

5. **Ensuring the NHS and other employers in the system are inclusive modern model employers** with flexible working patterns, career structures and rewards. These need to support staff and reflect the way people live now and the changing expectations of all the generations who work in the NHS. To retain dedicated staff now and in the future requires employment models that sustain the values which drive health professionals every day whilst protecting against burnout, disillusionment or impossible choices between work and home life.
6. **Ensuring that service, financial and workforce planning are intertwined, so that every significant policy change has workforce implications thought through and tested.** This will help ensure the NHS gets the best for patients from all its resources. Aligning service and workforce planning fosters realism alongside creativity in considering what the workforce in all the relevant groups can best contribute to a new or changing service. This will also increase the resilience of workforce planning and ensure the NHS workforce is rightly seen as an enabler of improved services, not as a constraint.





Chapter 2

Facing the Facts

The NHS Workforce in 2017

Chapter Summary:

- Since 2012 there has been growth of over 40,000 additional clinical staff across the NHS.
- Growth rates differ between professions and geographies.
- The NHS needs to do more to attract newly qualified staff into substantive employment and retain its current workforce.
- The rate of growth is slower than it might have been as a higher number of staff have joined professional registers from training than joined the NHS.
- Alongside growth in staff, there has been a significant growth in vacancies. The majority of vacancies are covered by bank and/or agency staff.
- We should both increase the amount of training placements available and make the NHS the employer of choice.

Where we are now

The NHS employs more staff now than at any other time in its sixty-nine year history. There are more clinicians in nearly every profession working substantively in the NHS. Around 40,000 new professionals have been substantively employed over the last five years, a growth of over 7%.

Analysis of thirty years of public satisfaction data gave the NHS in 2016 one of its highest ever ratings, with inpatient satisfaction at its highest for two decades. In England 69% of people say they get good healthcare compared to 57% in France, 59% in Germany and only 47% of people in 22 other nations. NHS staff surveys also show increased levels of job satisfaction, growing year on year. 80% of staff say they are able to do their job to a standard they are personally pleased with.

Although we have seen growth in staff and high levels of public satisfaction and increasing staff engagement, we know this is not the full picture. Over half of NHS staff work unpaid overtime every week and a significant minority say they did not feel able to deliver the care they aspired to.

While the workforce has grown, it has still not kept up with demand. The NHS is treating a growing and ageing population that grew by 2.1 million (4%) over the last five years. There are currently 45,000 clinical vacancies across the NHS. Each vacancy represents pressure on the system.

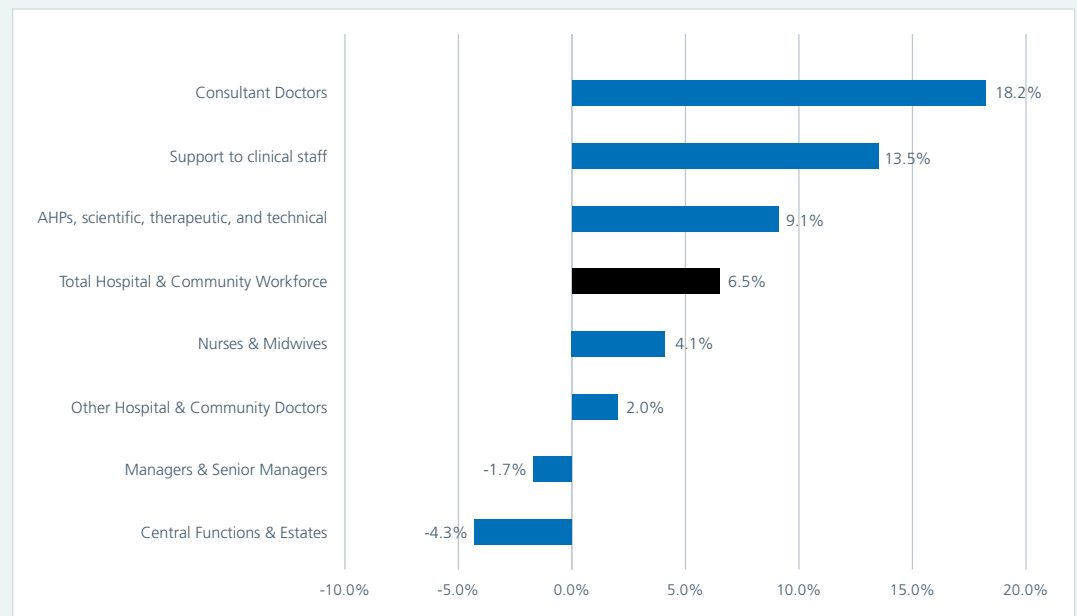
While the overwhelming majority of vacancies are covered by bank and agency staff, excessive use of agency staff is not optimal for patients or the wider system. Action by NHS Improvement and partners to reduce agency spend has already seen it fall by £1bn from its peak.



The Hospital and Community workforce

The NHS created over 67,000 new posts for frontline qualified clinical staff between 2012 and 2017, with the substantively employed workforce growing by over 40,000 to partly fill these new posts. Over the same period there are 37,000 more people providing direct clinical support – staff such as health care support workers – whilst managers and infrastructure staff fell by 8,000.

Figure 1: Percentage increase of substantively employed staff by group – 2012 to 2017



Source:
NHS Digital

The Primary Care Workforce

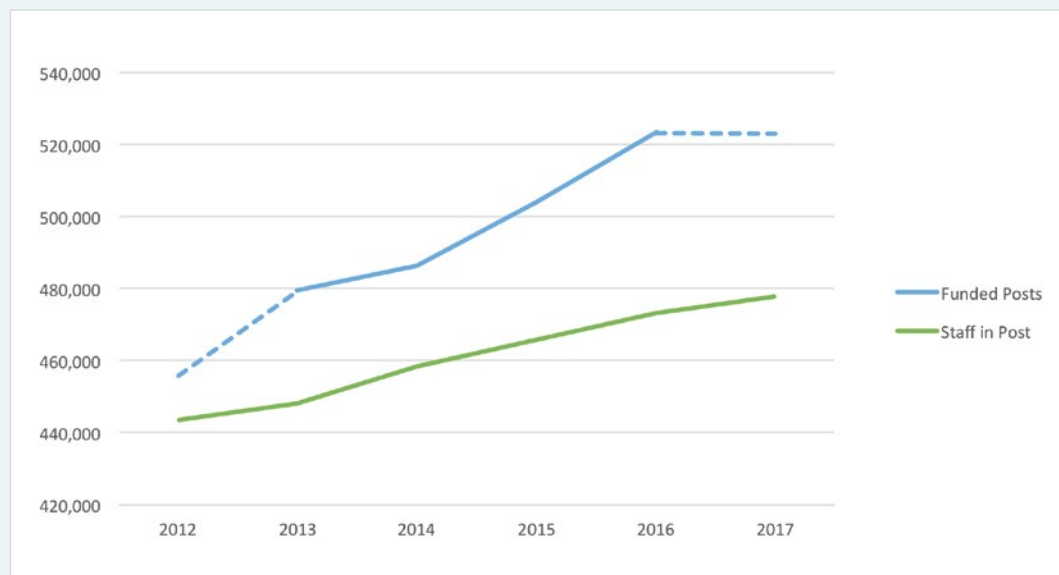
In primary care, we estimate the total number of staff grew by more than 6,000, with clinicians and other clinical support staff responsible for about 3,500 of the growth and receptionists and other staff making up the other 2,500.

However in September 2017 NHS Digital indicated that the headcount number of GPs working in general practice has fallen back to just below 2012 levels.

Vacancies and agency spend

Data collected by HEE from providers indicates around 45,000 clinical posts were not filled by a substantive member of staff in March 2017 down from 50,000 in March 2016.

Figure 2: Funded Posts v Staff in Post – NHS HCHS Employed Clinical Professionals – 2012 to 2017



Source:
HEE collection / ESR

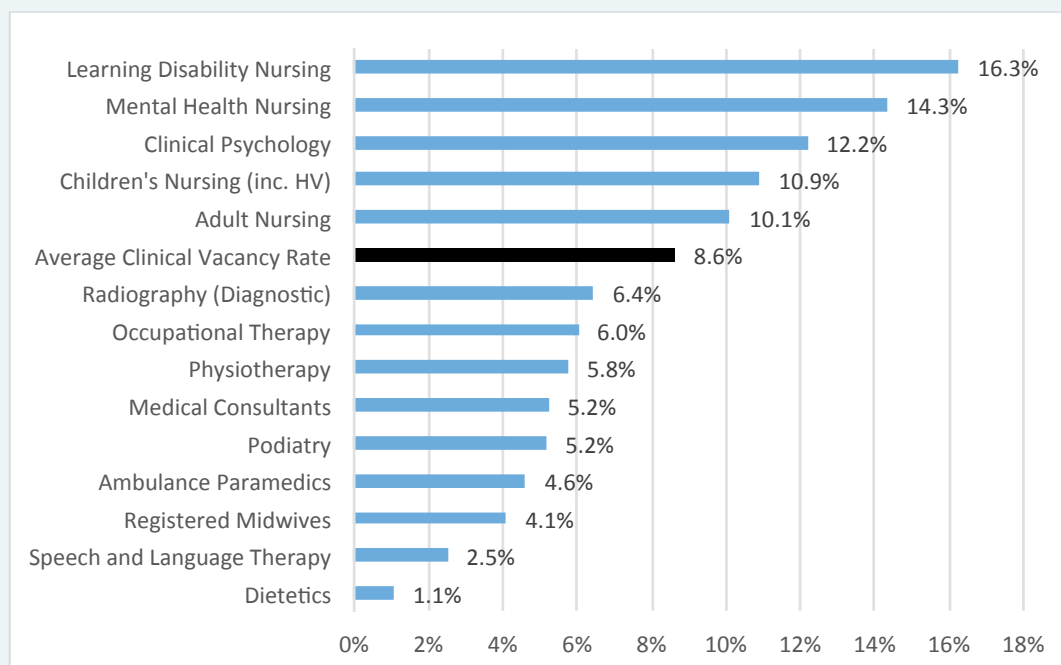
* dotted lines represent estimates due to 2012 being inconsistent SHA data and 2017 being trust reported 2016/17 operating plans, not outturn

NHSI analysis of trust returns places the September nurse vacancies at 36,000, of which around 33,000 (92%) were covered by Bank and Agency staff. Agency expenditure rose rapidly by £545m to 7.5% of providers total pay-bill by 2016. In October 2015 NHSI put in place rules to curb this rise and support trusts to improve their use of temporary staffing.

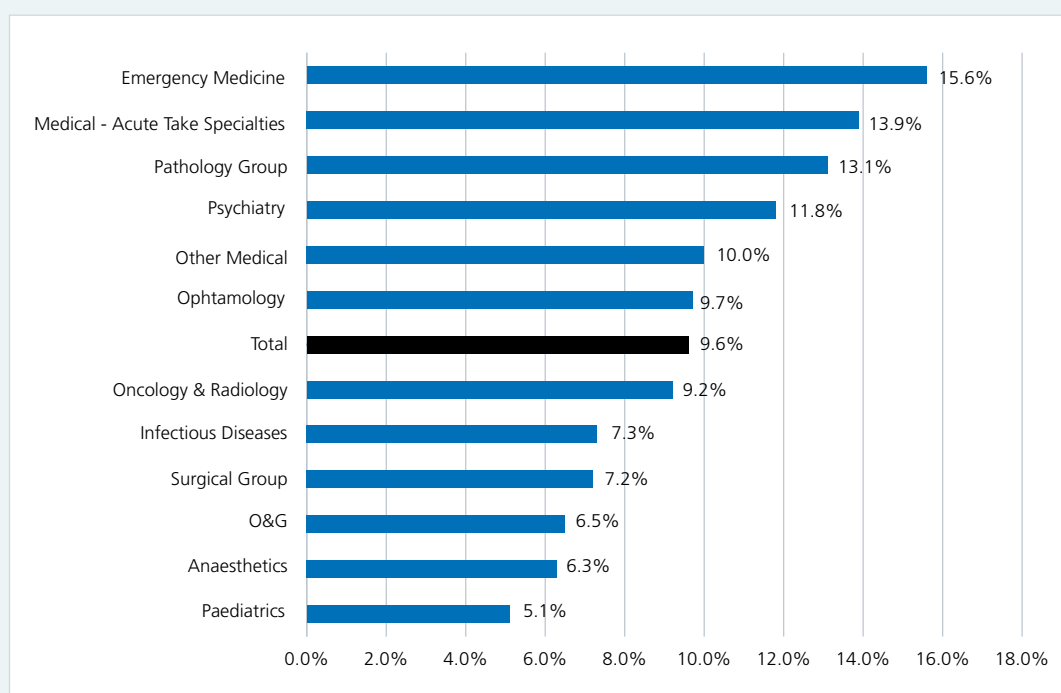
NHSI set a target for 2018 to reduce agency spend by a further £435m by monitoring compliance with the new agency rules and supporting trusts in meeting expenditure ceilings, with a particular focus on medical locum spend. This improved employer transparency, increasing scrutiny by benchmarking spend against other Trusts.

Further work was led by NHSI to assure the quality and safety of agency staff by ensuring Trusts use agencies only from a pre-approved NHSI Framework. But, by far the most important long term support is to encourage agency staff back into more cost-effective NHS Bank and substantive employment.

The aggregate vacancy position masks significant variation between professions, care settings, localities and providers. For example, vacancies are just over 12% for clinical psychologists but around 1% for dietitians. The professions requiring increased support to deal with vacancies include; mental health, adult and learning disability nursing and within medical specialties; psychiatry, emergency and acute medicine, and clinical radiology. Other priority areas may be due to localised variation (paramedics), or as a result of anticipated demand on top of current vacancies (diagnostic radiography).

Figure 3: Percentage vacancy rates as at March 2017 – By profession / branch

Source:
HEE collection / ESR

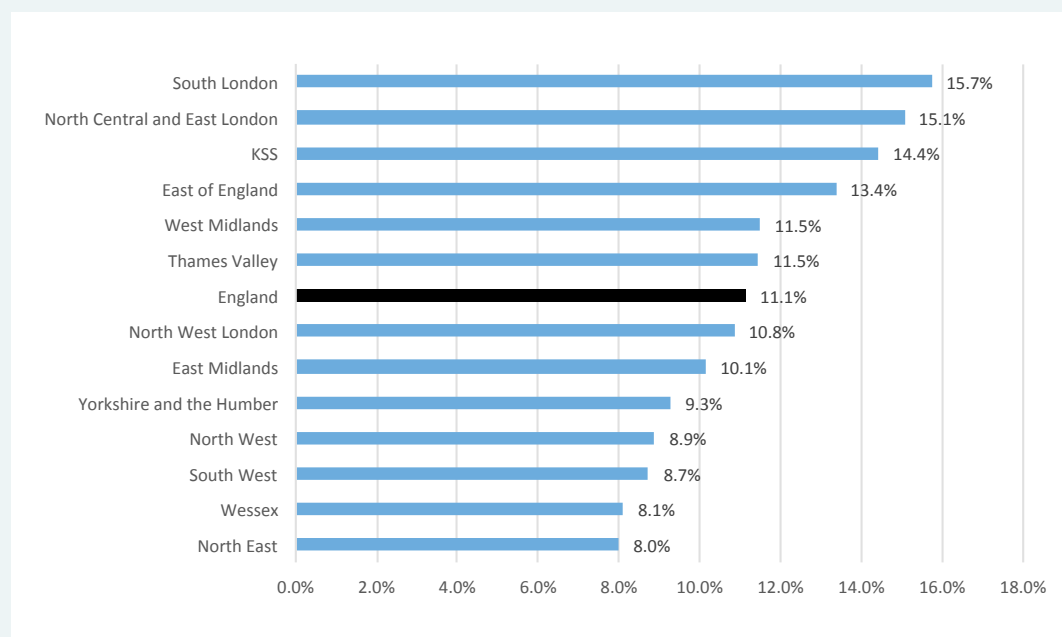
Figure 4: Percentage vacancy rates as at March 2016* – By medical specialty

Source:
HEE collection / ESR

*March 2017 demand estimates appear inconsistent with previous trends and have not been used at this time

As well as variation in the number of vacancies between professions and service specialties, there is wide variation in different areas of the country, and between different organisations within each area. In the example below adult acute nursing is showing vacancies varying from 8.0% in the North East to over 15% in parts of London.

Figure 5: Adult Acute Nursing Vacancies by Area - March 2016



Source; HEE analysis of ESR and Trust data collection

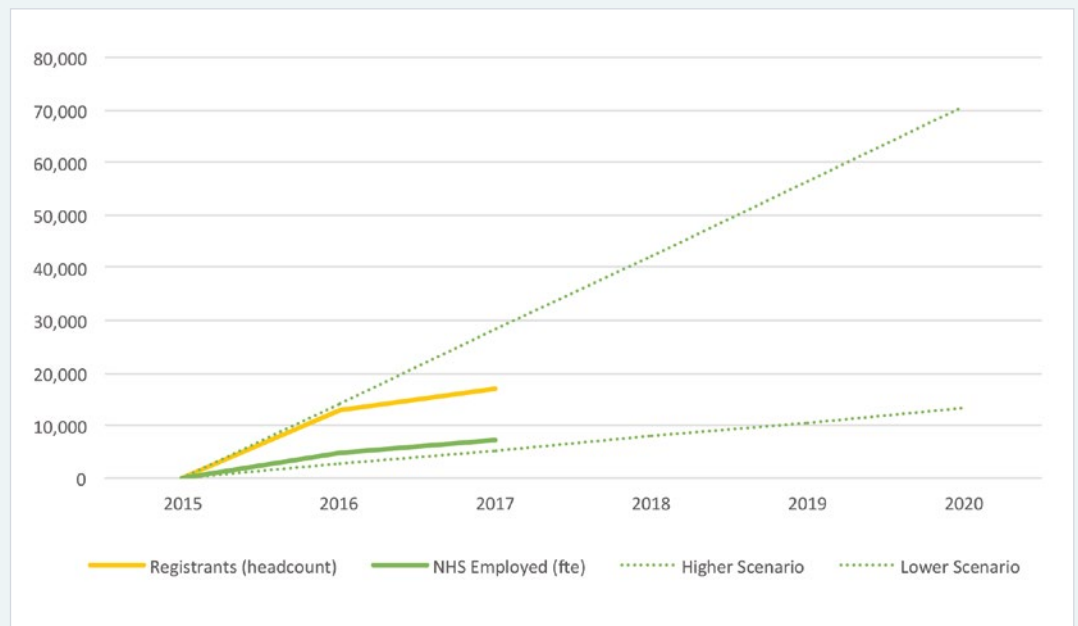
National and regional workforce intelligence can only describe broad trends and issues. To drive appropriate action targeted at specific priorities and circumstances requires workforce information to be available on a profession specific and local basis. HEE will be providing this data to STPs over the next few months.

Recent Workforce growth

HEE's workforce plan 2016 showed that health and care could see additional net employment of 13-70,000 nurses and AHPs between 2015 and 2020, dependent on employers attracting newly qualified staff, whilst retaining their existing staff. Between 2015 and 2017 the total number of nurses, midwives, and AHPs on the professional registers grew by 17,000 (headcount) whilst those employed by the NHS in England only grew by 7,000 (FTE). Some of the staff not employed by the NHS may of course be delivering NHS funded services whilst employed outside the NHS, especially AHPs.

This performance suggests growth is currently toward the lowest of HEE's scenarios, therefore the rate at which we as a system are reducing vacancies is slower than we need it to be.

Figure 6: Increase in registered and NHS clinical workforce – Actual v Forecast 2015 to 2017

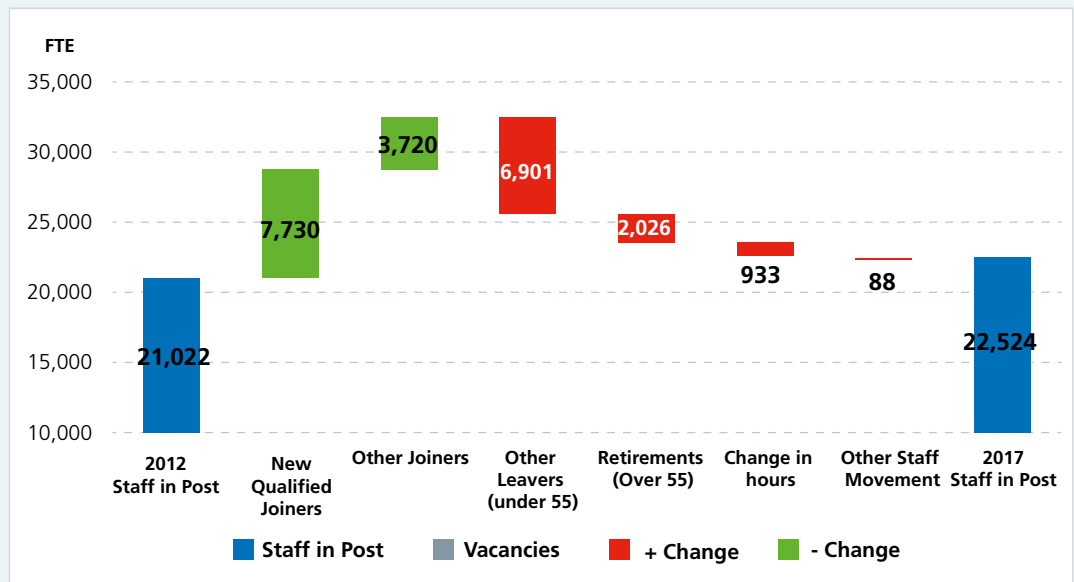


Source: HEE/ESR/NMC
& HCPC registration data

The reasons for this slower growth are multifaceted, but observing and understanding different drivers is critical to ensuring the actions we take are based on evidence and targeted on what matters.

HEE and its partners have started using 'waterfall' diagrams to describe the component parts of movement into and out of the workforce. In the example below the 1,500 increase in midwives between 2012 and 2017 is made up of inflows of almost 8,000 newly qualified staff and 4,000 joiners from non-NHS settings. These are offset by outflows of nearly 7,000 people leaving the NHS for reasons other than age retirement, over 2,000 retirees, and the equivalent of almost 1,000 FTE reduction as a result of existing staff choosing to work fewer hours.

Figure 7: Movement in Midwifery Staff in Post 2012 to 2017



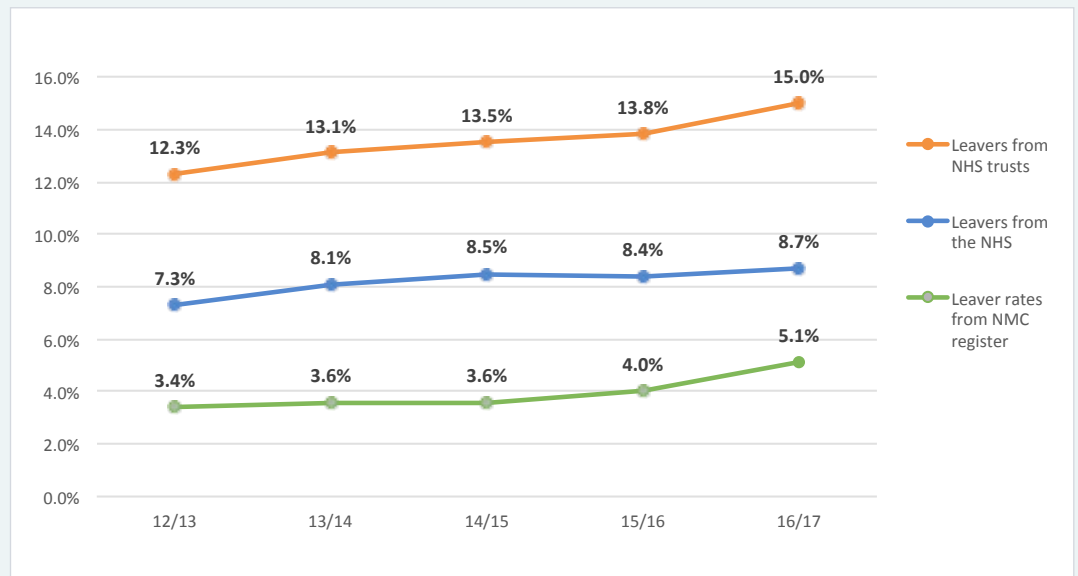
Source:
HEE analysis of ESR

The reasons for slow growth include the impact of reduced training commissions between 2009 and 2012 but we need to acknowledge two other key factors:

- the impact of worsening retention, and
- the NHS may have become a relatively less attractive employment option for some.

Figure 8 shows the steady increase in the rate at which staff left the NHS. The rate for nurses rises from 7.3% per year in 2012/13 (itself an increase from 7.1% in 2011/12) to 8.7% in 2016/17. The cumulative impact of this has been 16,000 less nurses in NHS employment than would have been the case if retention had been maintained at the level coming into 2012.

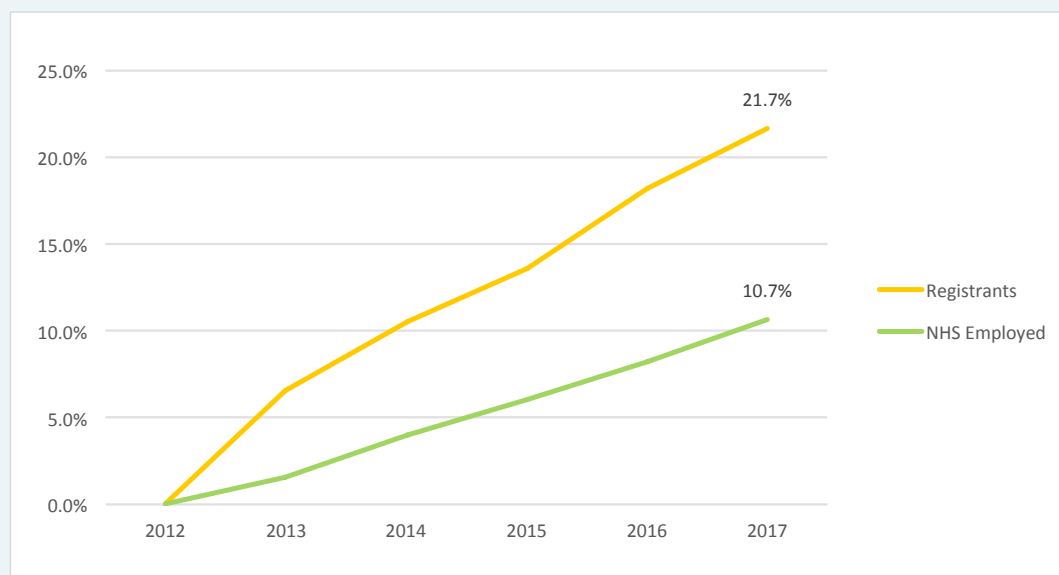
Figure 8: Nurse leaver rates from trusts, the NHS and the NMC register



Source:
NHS/DH analysis of
NMC Register
and ESR data.

In terms of the NHS's ability to attract its share of the whole clinical professional workforce there are indications, by comparing NHS growth to registrant growth, that some clinicians are choosing other employment models and settings.

Figure 9: AHP registrant v NHS Employed growth – 2012 to 2017

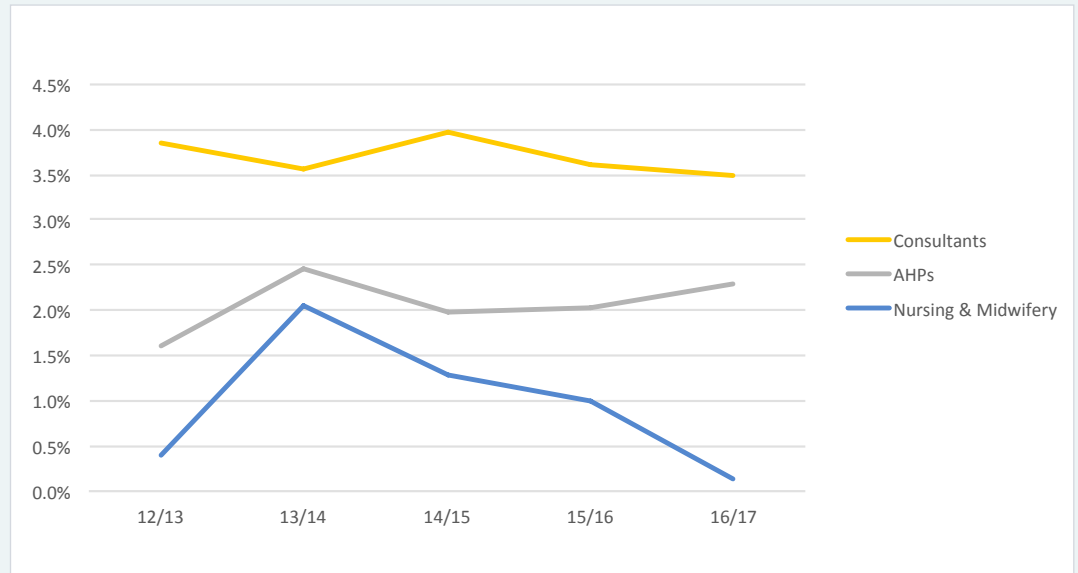


Source:
HEE analysis of HCPC
and ESR data

Figure 9 shows AHPs on the HCPC register grew by 21.7% (34,982), but over the same period the number of NHS employed AHPs only grew by 10.7%. Over 25,000 qualified AHPs effectively chose not to work for the NHS. If the NHS had attracted its 'fair share' and had therefore grown at 21.7% there would have been over 8,000 more AHPs in NHS employment. We estimate there are 4,500 AHP vacancies in the NHS as at March 2017.

These recruitment and retention challenges indicate the actions we need to take to make the NHS the employer of choice. The complex mix of issues which determine people's employment choices are explored in chapter 3.

The impact of these issues is not distributed evenly. Figure 10 shows that workforce growth rates for different staff groups has varied, with steady growth for AHPs and medical consultants but a slow-down in the rate at which the nursing profession is growing. This reinforces the need to prioritise and target actions and for this prioritisation to be informed by local versions of these indicators, as well as the national overview.

Figure 10: Annual % workforce growth – 2012/13 to 2016/17

Source:
HEE analysis of
ESR data

The workforce has been growing but more slowly than we want and need. Our improved understanding of the component drivers of workforce growth now allows us to identify the range of actions and which actions, are likely to have most impact.

We need to further enhance our understanding of the dynamics in the whole health and care labour market. In turn this understanding will require further improvements to how we collect, analyse, and share workforce information.



Chapter 3

Growing our workforce

Chapter summary:

- Workforce growth comes from; new graduates; return to practice and recruitment from outside the NHS; and retention of current staff.
- Education will deliver more medical school places, increased nursing undergraduate places and other priorities.
- New roles will play a major part of growth and increasing skill mix.
- Retaining existing staff has the most immediate impact.
- A national retention programme is in place.
- As we move to self sufficiency in staff overseas work will concentrate on England as a world-class education and training provider.

Introduction

We have expanded the number of clinical staff in training over the past three years. Specific action has been taken to expand medical, Allied Health Professionals (AHP), and nursing undergraduate places. To ensure the future supply of qualified staff meets the needs of the NHS this expansion needs to continue.

Work to support this includes encouraging more young people to consider working in healthcare through Health Careers; increasing the number of funded clinical placements; expanding undergraduate medical school places; reducing course drop out rates; developing new apprenticeships and supporting the NHS to access the apprentice levy; and developing associate roles.

Health careers

Careers in the NHS need to be attractive to everyone, especially young people. The NHS Careers service, Health Careers, is key to this by offering accurate and persuasive information using the latest communications tools, underpinned by a greater understanding of modern career aspirations.

The Health Careers website receives 700,000 visits per month with the helpline getting 20,000 calls a year, offering information on more than 350 health careers along with resources for employers and education and training providers. Health Careers also runs a number of campaigns inspiring young people to join the NHS.

The Step into the NHS campaign annually gives 10,000 12-14 year olds careers information as part of the Key Stage 3 curriculum. This year's #BeTheDifference campaign promoted nursing, midwifery and AHPs around university clearing, increasing exposure amongst key audiences by 300%. Work experience toolkits supporting employers offering NHS work experience to people from under represented communities can also be found at <https://hee.nhs.uk/workexperience>

We will build on this work by pushing even harder to get the NHS's share of the brightest and best young people. The development of a healthcare science A-level, is proposed which will ensure that individuals are able to gain a comprehensive understanding of healthcare science ahead of entering a clinical career.

Other actions include:

- A new campaign aimed at schools whose students do not traditionally go into professional NHS careers.
- Fifty primary schools will pilot a new project to promote the range of opportunities whilst challenging gender stereotypes of NHS careers.
- A new campaign to encourage nurse and AHP undergraduate growth.
- A campaign promoting NHS work experience aimed at employers and further growing our Step into the NHS campaign.

Case study: Inspiring young people to want a career in the NHS

In October, Enact Solutions delivered six performances of NHS Success!, a 40 minute drama encouraging young people to consider an NHS career, to over 500 school students in the North East.

The results were positive. Around 450 children said they would now seriously think about an NHS career. The vast majority said they knew more about the variety of roles. Around three in five knew more about different routes to a job; where to get further help, advice and support; NHS training possibilities; and how exciting NHS work can be.



Widening participation and opportunity

The NHS workforce, across all levels and all professions, should be more reflective of the communities it serves. This means ensuring careers in the NHS speak to, and are available to, everyone regardless of background, economic status or protected characteristics. We also need to ensure fair treatment and equal opportunities for current staff.

Around 20% of NHS staff are from a BAME background. The NHS Workforce Race Equality Standard (WRES) ensures fair treatment and equal access to career opportunities for BAME staff, including aspiring to see more BAME staff in the most senior posts. One requirement is that providers transparently publish data annually against nine indicators of staff experience and opportunities, enabling improvement and benchmarking of performance on these measures.

In partnership with universities we have introduced value based recruitment across health courses which complements work to support social mobility. Getting this right is fundamental to a sustainable NHS.

Undergraduate clinical supply

There are currently more than 120,000 students studying clinical courses in our universities, they are the NHS's future workforce.

Medical

In October 2016, the Health Secretary announced a historic expansion of medical students by 1,500 places, approximately a 25% increase, moving the NHS closer to self-sufficiency in doctors. The first 500 additional places have been allocated and the new students start in September 2018.

The remaining 1,000 places are subject to a competitive process to ensure this increase in supply of doctors meets the needs of the NHS. The process assesses aspirant universities against a number of key criteria, including:

- the university curricula encourages more students to choose shortage specialties, such as general practice and psychiatry
- the university produces graduates in geographical areas where there are relatively fewer doctors
- the university uses innovative educational delivery models, and
- the new students will be from a wide socio-economic background to better reflect the population

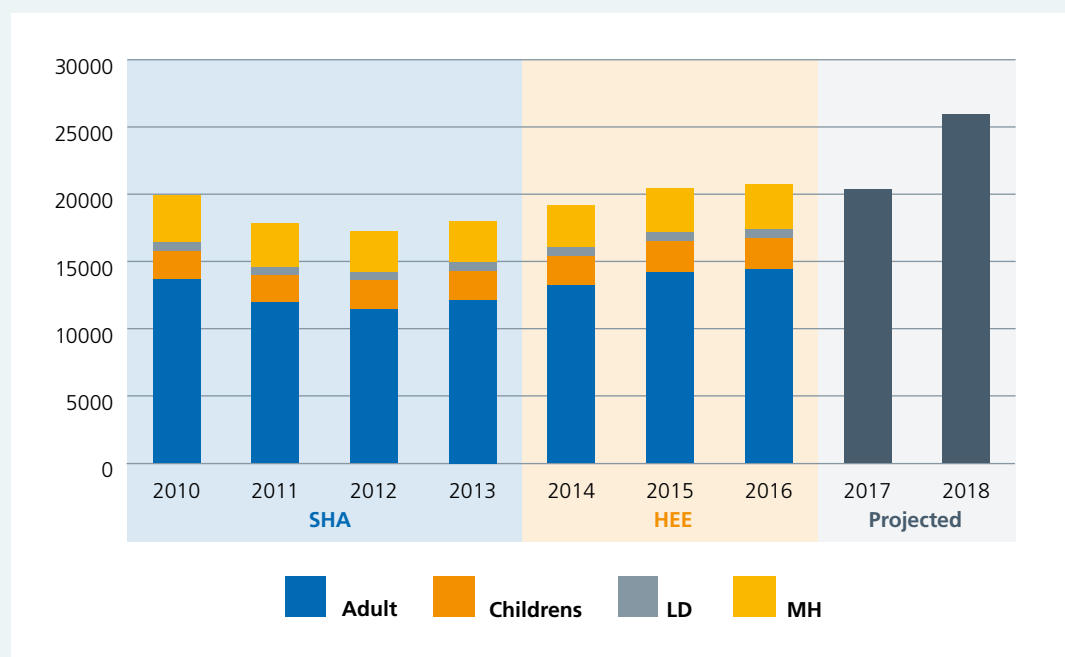
The process to allocate these additional places is ongoing and the decisions will be announced by spring 2018.

Due to the length of medical degrees, the first graduates from these cohorts will not qualify until 2023. In the meantime, the NHS continues to rely on existing staff, return to practice and the invaluable contribution of overseas trained doctors to ensure patients have the medical expertise they need.

Nursing

HEE increased nurse training places each year since its creation, delivering a 15% increase in the three years to 2016. The first expanded cohort graduated and joined the workforce this year. This expansion will result in an additional 6000 registered nurses over the next four years.

Figure 11: Undergraduate Nursing Commissions, by branch, 2010-2017



To facilitate faster expansion from the 2017 intake, the Government removed constraints on the number of undergraduate places by moving from NHS funded commissions to the student loan system. The DH is funding HEE to increase annual nurse clinical placements by over 5,000, a 25% increase in training capacity.

For the first cohort of student loan funded students in 2017, UCAS application data showed a 23% reduction. However, the number of UCAS placed acceptances has only reduced by 3%. Recent data collected by HEE directly from universities shows the number of student nurses starting this autumn will be at least equal to the number in 2016, probably because not all students join universities through UCAS.

HEE will work closely with universities and others over the next 12 months to recruit to the increased number of training places available in 2018, through Health Careers, and the additional clinical placement funding available.

Allied health professionals

Between 2012 and 2017 HEE broadly maintained the level of AHP training places, thereby supporting strong growth in the number of registered AHPs, which grew by 22%, or 35,000 professionals over the period.

Some professions saw differential investment, including paramedics where the number commissioned has more than doubled. Professions such as physiotherapy are already seeing a significant increase in student numbers since the change in undergraduate funding models and have also benefitted from the funding for extra training placements announced last August.

However, some undergraduate courses – such as podiatry, therapeutic radiography, orthoptics, and prosthetics and orthotics – are struggling to fill. HEE will work with universities and others to address this.

Reducing undergraduate attrition

Leaving education before completing the course is an individual decision but it can also be a waste of talent and investment by both the NHS and the individual. If we can do more to support students to stay in education and meet their potential we should.

HEE's Reducing Pre-registration Attrition and Improving Retention (RePAIR) programme identifies best practice in reducing attrition and has been collated into a toolkit to help education and training bodies reduce attrition.

New roles and new skills

Having the right mix of competencies and skills across a team improves outcomes for patients, improves clinical productivity, and ensures individual clinicians are empowered to showcase the full range of their talents. This is discussed in depth in chapter 6.

Developing new roles is a key part of supporting a richer skill mix in multi-disciplinary teams across health and care. HEE is supporting rapid growth in physician associates and nursing associates as part of this.

Complementing this we are supporting a range of initiatives to support advanced or extended practice in a range of professional roles. These include the introduction of clinical pharmacists into general practice and the development of a cross-profession advanced clinical practice framework.

Medical associate professions

There is widespread recognition that the shape and composition of the medical workforce needs to adapt.

As a result, the NHS has seen the emergence and increased use of new professional roles within multi-disciplinary teams. Four of these professional roles can be grouped under the heading of 'Medical Associate Professions' (MAPs). Whilst there are significant differences in their clinical scope of practice, they share similarities in their career framework and education and training. The four roles are:

- Physician associate (PA)
- Physicians' assistant (anaesthesia) (PA(A))
- Surgical care practitioner (SCP)
- Advanced critical care practitioner (ACCP)

MAP roles are trained to the medical model to augment service delivery alongside doctors. They are competent to practise in a range of specialties and can offer continuity of care, particularly in acute settings and GP practices. HEE has supported universities increasing trainee numbers: from 76 across four providers in 2014 to over 1,000 across 25 training programmes now.

As these professionals become more widely utilised in the health service, it is necessary to explore the options for professional regulation. The Department of Health is currently consulting on the regulation of the MAP roles including physician associates. This closes on 22 December 2017.

The consultation can be accessed at: www.gov.uk/government/consultations/regulating-medical-associate-professions-in-the-uk

Nursing associates

In December 2015 HEE created a new role; the nursing associate (NA). NA's work alongside healthcare support workers and registered nurses to deliver hands-on care to patients. Eleven partnerships covering care homes, acute, community, mental health trusts, and hospices are employing and training the first cohort of 1,000 NAs.

A further 24 test sites are delivering the second cohort of 1,000 who started in April 2017. The Secretary of State has announced a further expansion of 5,000 starting in 2018 and 7,500 each year from 2019. The popularity of this post in building a career path from healthcare support worker to registered nurse, as well as being a profession in its own right, was demonstrated when 8,000 current support workers applied for the first cohorts.

To support this career path HEE will develop a degree level nurse apprenticeship to facilitate transition from NA to registered nurse. This will both widen the pipeline into registered nursing and extend the career ladder to everyone working in direct NHS patient care.

To ensure the role best supports the needs of patients and is given the status it deserves, it is important it is regulated. The Government is consulting on draft legislation to ensure the role is regulated by the NMC by the time the first cohort of students graduate in December 2018. The consultation closes on 26 December 2017 and is available at:

<https://consultations.dh.gov.uk/professional-standards/regulation-of-nursing-associates-in-england>

New routes

Apprenticeships have a proud NHS history and will continue to support social mobility, widen participation and provide an important route into the modern NHS. HEE has supported NHS apprenticeships since its creation and will continue with the introduction of the new apprentice levy.

The new apprenticeship levy came into force this year and as the largest employer in England the NHS will lead the public sector in its use. The NHS' annual payment will be about £200m; to recoup this the NHS needs 27,500 apprentices each and every year.

Importantly for the NHS, smaller employers who do not make payments into the levy can still access it to pay 90% of their apprentices' training and assessment costs. The majority of GPs, dentists and other primary care providers fall into this group.

HEE is directly supporting over half the 70 healthcare specific apprenticeship trailblazers, as well as many others – such as business and administration – which have potential across the NHS.

To support this career path HEE is developing quality principles that guide employers, STPs, and LWABs. These will support development of apprenticeships to provide career pathways aligned to recruitment and retention strategies.

As well as supporting employers' apprenticeship work through diagnostic tools, setting standards, trailblazers and relationship managers, HEE will undertake a full review by the end of 2018 of the NHS's first year of accessing the levy and make recommendations as to how to best use, or amend, this new system for the future.

Medical student mental health and wellbeing

There are increasing reports of learner (students and doctors in training) distress, mental health problems, self-harm and suicides from a number of countries. Many reports focus on the individuals, their generation (they are being blamed rather than their issues understood), the learning environments or employment conditions. However, the breadth of the causes, the perspectives of those affected and the actions that can or should be taken to reverse this concerning trend have not been examined in detail.

HEE's Chair, Sir Keith Pearson, will lead a commission on the mental health and wellbeing of staff, students and those training in the NHS. This will consider the causes, international evidence, successful interventions including best practice from other sectors and make recommendations.

We recognise many other organisations have commissioned work in this area specific to their stakeholders or raised concerns about these issues recently. This commission will not seek to impose a single view but will listen to experts, bring together 'best practice' and enable read across from individual professions or organisations so that the whole NHS can benefit. The commission will report publicly via the HEE Board with a comprehensive set of recommendations to help employers, regulators, other stakeholders and staff, including those in training.

Improving quality and patient safety

Quality and safety across the NHS depends on the capacity and capability of clinicians, which is ultimately secured through their selection, training and regulation. HEE's Quality Framework describes the standards expected of providers across six domains to demonstrate high quality education and training within work-based learning environments.

HEE's responsibilities in this area include the planning, funding, quality management and organisation of post graduate medical education and clinical placements for nursing and AHP students.

Through the quality framework HEE supports providers to plan placement shape and capacity in response to changing patient needs and service models whilst maintaining high quality training. The Department of Health sets the tariff for placements but HEE will advise ministers in spring 2018 on reforming undergraduate and postgraduate tariffs to better support clinical learning environments and a larger learner population.

Training environments are a good barometer for quality of care. Failings in the quality and standards of education within a provider can be an early warning sign of emerging issues about service fragility or patient safety. Improvements to the educational environment can also be a significant part of the solution to improving quality of care within such providers.



In 2015, HEE set up a Commission to review how education and training interventions can improve patient safety. The quality framework provides the infrastructure for delivering the Patient Safety commission's recommendations set out in 'Improving Safety through Education and Training' published in March 2016.

One of the report's recommendations was the importance of embedding human factors principles across education and training. Human factors in healthcare is about understanding the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities before applying that knowledge in clinical settings. As a signatory to the Human Factors in Healthcare Concordat and in response to the commission recommendations, HEE is working on a number of initiatives to develop human factors capability and to evaluate effectiveness.

We, with professional bodies and universities, are developing a human factors career pathway for staff keen to further develop their expertise. The ambition is this will lead to masters and PhD qualifications.

Work has also commenced on implementing human factors training within curricula, with the GMC, royal colleges and other professional bodies.

Developing the multi-disciplinary team

There is a wealth of evidence that multi-disciplinary team working delivers significant improvements in safety, patient experience, team productivity and the working lives of individual clinicians. It also allows the system to blur traditional lines between services, for example by ensuring a mental health professional is part of every team.

Clinicians often, 'act down' in their day to day work in order to ensure patients receive the highest standards of care – but this should not be the norm. A broad multi-disciplinary team, well supported by non-clinical staff, should mean every professional works across their whole scope of practice and displays the full range of their capabilities, skills and knowledge. We seek to ensure everyone in the NHS is able to realise their potential both in the interests of efficacy and efficiency for patients, and the interests of the professionals themselves.

For example, the development of the nursing associate role is key in enhancing the breadth and depth of the multi-disciplinary team. Nursing associates do more clinical tasks than unregulated support workers, relieving nurses of this workload, freeing them to deliver the elements of care only nurses can do.

Aligned with apprenticeships and the newly launched ACP framework, associate roles also provide a clear career path and routes for progression. Anyone with the talent, drive and values should be able to join the NHS and, while working and earning, attain a foundation degree, a BSc and entry to a registered profession, and allow further development with postgraduate qualifications and specialisation.

To improve patient care, broaden multi-disciplinary working and develop career pathways, HEE will explore which other professions might benefit from new associate pathways and roles.

Making the NHS the employer of choice

Introduction

Frontline NHS staff say their experience at work continues to improve, with 2016's staff survey scores at a five year high. NHS staff remain respected and admired, yet more staff are leaving and increased part-time working among certain staff groups adds to the challenge of maintaining growth. NHS clinical staff grew by 40,000 over the last five years; if nurse retention had remained at the 2012 rate, there would be an additional 16,000 nurses in employment in the NHS today.

Reducing staff turnover improves working conditions, patient outcomes, and productivity. Making staff turnover reduction one of the highest workforce priority for Boards is in the interests of staff and patients.

The NHS must become the employer of choice, putting people first and focussing on the things we know are important to our staff.

Understanding turnover

If we are to deliver the growth rates the NHS needs in and reduce the number of vacancies, then we need to get retention right. One extra staff member staying means the new graduate is an additional, not replacement, member of staff.

Using the rate at which nurses are leaving trusts as an example, this has increased from 12.3% in 2012/13 to 15.0% in 2016/17 (including to move to other trusts). This suggests that insufficient growth in supply, more retirements, and increased demand for staff are leading to greater competition between trusts for nurses. This level of turnover is inefficient as well as potentially impacting on the quality and availability of services as staff move between trusts. More seriously, the rate of nursing staff leaving the NHS altogether has increased from 7.1% in 2011/12 to 8.7% in 2016/17.

Nurse leaver rates, including moves to other trusts, are also highly variable between providers and regions. The core leaver range is 9% to 25% with outliers tending to reflect structural change rather than turnover, but even within the core range the difference is nearly 3:1. Structural issues such as housing, transport and the local job market play a role in regional and some local variance. There are also sectoral differences with the community sector having turnover at 14.6%; 3% worse than acute trusts.

Analysis suggests that organisations with higher staff retention have improved staff experience, better patient outcomes, higher productivity and reduced reliance on temporary staffing. So, reducing turnover is good for the NHS, its patients and its staff.

Many trusts are able to maintain a more stable workforce, which suggests it is partly within the power of individual trusts to make a difference.

NHSI analysed the provider trust picture to develop a support plan to improve retention. The programme was launched in July 2017 and is focussed on strategies identified through analysis and fieldwork. Latest figures from NHSI show a small, but welcome reduction in nurses leaving trusts, or the NHS in the last year.

Putting people first, focussing on what works

The reasons why people leave are complex, but each organisation already has the knowledge of what make staff happy, what makes it easier to recruit and retain staff.

Most reasons are not even NHS specific, but good employer specific. A recent NHS Employers briefing summarises case studies and tool kits such as NHSI Culture Tools, crowd sourcing staff ideas, health and wellbeing plans, and the impact of improved staff engagement on better patient outcomes.

Core NHS values need to resonate in organisational culture. Leaders must be committed to doing the right thing for patients and staff within a culture of equality and diversity. When people are respected and valued, retention is easier.

The NHS must commit to careers not jobs, with development and learning core to increasing skills and capability, creating the conditions for career progression. The focus on whistleblowing, following the Mid-Staffs tragedy and other high-profile cases, has placed a premium on people feeling safe to speak up, confident they will be protected and that management will learn, not blame.

People like teams and knowing their place within them, working in an orderly job, with good line management, clear objectives and a shared sense of purpose within a clean, modern environment equipped for safe and effective care. Staff must have the support to look after their own mental and physical health, whilst being protected from violence, bullying and harassment in the workplace. And, perhaps an area where the NHS still has much to learn, people value the flexibility to manage work-life balance, ending binary choices between professional and personal commitments.

Creating organisations with these values and attributes, improves staff satisfaction and patient outcomes, thereby reducing turnover, but it isn't easy. There is no single solution to retention and turnover, it is hard work across a range of priorities but it can and must be done, organisation by organisation.

The NHS staff survey is a rich source of data which the CQC report Driving improvement: case studies from eight NHS trusts used to share what the most improved organisations have in common regarding staff engagement.

Making improvements in the quality of care the uniting goal, putting people, patients and staff first, leads to improved outcomes. The most improved organisations used evidence and worked with staff to inform solutions.

Trusts need good people management whilst focussing on specific staff interventions, such as health and wellbeing. Almost all NHS organisations have their own values, based upon the NHS Constitution and staff pledges, including now STP or system based values. The most improved develop values further and link them to behaviour. It is these areas, these models of good employee engagement, shared values and goals in a supportive and positive environment that make organisations good and make people want to work for them, an employer of choice.

Supporting local trusts, to improve retention

NHSI is now directly supporting 53 mental health providers and over 60 acute and community providers. This work involves:

- A universal offer of support and best practice for all trusts, including a series of retention masterclasses aimed at directors of nursing and HR directors. These focus on evidence-based interventions such as improving the staff offer, improving continuous professional development, careers advice and planning, and organisational culture. Four events have been run with over 500 delegates from 200 trusts.
- Rollout to all trusts of a national retention improvement programme, building on the NHS Employers programme currently working with 92 trusts.
- A specific support programme for nursing, providing targeted, clinically-led support to trusts in the top quartile of nursing leaver rates. The first cohort of 20 trusts began in July, a further cohort started in October, and a further cohort will begin in January next year to complete action in the worst quartile.
- The MH sector will be working to achieve 6,000 FTE savings by 2020. Those with above average leaver rates will receive targeted support following the same methodology as the nursing NHSI retention direct support programme and will be required to achieve larger, FTE reductions savings. All mental health trusts will be required to produce detailed improvement programmes on how they plan to address their high leaver rates and see retention improvements over the next 12 months.

Workforce transformation and continual professional development

Ensuring our staff have the opportunities to develop their skills and progress in their careers is good for the individuals, can enhance the skill mix and productivity of teams, benefits employers through better retention and flexibility, and is a key enabler of service transformation and improvement.

HEE currently spends over £350 million each year supporting workforce development. Alongside this there is investment by other national bodies on specific service areas (such as NHS England's investment in IAPT training), the investment of employers, and of staff members themselves on CPD. However, there is a growing recognition that we need to seek to align all this investment from across the system to better develop the workforce go deliver improvements in patient care.

Total reward, including pay

The total reward package offered by the NHS includes pay (basic, additional and allowances), employer pension contributions and leave entitlements, alongside service terms. The NHS Pension scheme is also a very valuable component.

Pay, whilst not the only or even main reason staff give for leaving the NHS, is a significant factor in recruitment and retention of staff. The government is adopting a flexible approach to public sector pay to address areas of skills shortages and in return for improvements to public sector productivity. However the Government has now adopted a more flexible approach to public sector pay to address areas of skills shortages and in return for improvements to public sector productivity. In the budget, the Chancellor awards provided they are part of an agreement with trade unions about reforms to boost productivity. The Chancellor also committed to provide additional NHS funding for national Agenda for

Change pay awards provided they are part of an agreement with trade unions about reforms to boost productivity.

The Government wants to reform national pay contracts. The contract enacted for junior doctors is designed to ensure fairer pay, safer working patterns and better supports training. Talks are now taking place on the consultant contract. These reformed national contracts will provide the pay and conditions framework for the whole employment offer but it is important local employers take a total reward view; considering how to maximise the recruitment, retention and motivational impact of the complete offer.

Agenda for Change already offers flexibility, allowing employers to offer local Recruitment and Retention Premia (RRPs) to address particular recruitment challenges. These are little used but perhaps could help reduce the need to employ expensive agency staff to fill gaps.

It is also possible to offer choice to employees. Some NHS organisations offer the flexibility to buy or sell annual leave. A few trusts have considered offering pension flexibility, allowing staff to rebalance pension accrual and salary. Pension flexibility is also important for retaining staff in the later stages of their career.

Total Reward Statements are available for all staff employed by NHS organisations but many staff do not access these, meaning very few trusts use them to engage staff over financial planning for retirement which may allow employers to make an offer that retains them in the workforce.

A good employment package needs to be able to flex to the needs of employees at different life stages. Different generations have different attitudes to work and reward; employing baby boomers alongside generations X and Y requires more thinking about how the employment offer might flex to meet their preferences. HEE has done work to help better understand the differing needs of the three generations who currently work in the NHS and the millennials who are next.

The number of NHS staff over 50 is increasing and the state pension age is rising but it remains a key part of most retired NHS staff's income. However the average age at which staff take the NHS pension is reducing. Staff in their 50s and 60s often want to continue working in a different way as they may have increased caring responsibilities so flexibility is key to what they need from their employer.

An ongoing commitment to treat NHS staff fairly after years of pay restraint, ensuring they have the support they need to do their job safely and compassionately, whilst making clear the vital role of EU and EEA workers, are all important steps in ensuring the NHS has the staff it needs now and in the future.

Many of those factors are in the hands of those who lead NHS organisations – directors, clinicians and managers. Whilst expecting Government to do its bit, local leaders have the freedom to exploit these flexibilities. All of these actions will support the NHS in attracting staff into substantive employment.

Return to practice

Some qualified clinical staff choose not to work in the NHS and there are others with lapsed professional registrations. These are just the sort of people the NHS should seek to attract back. Many are highly experienced and skilled and encouraging and supporting them back into substantive NHS employment is a highly cost effective way of growing the workforce.

The national return-to-practice scheme for nurses has been run by HEE since 2014 and provides experienced nurses with training and a route back into the NHS. To date more than 4,200 have commenced the practice programme and over 2,400 have completed and entered NHS employment.

This programme is being expanded with a target of 1,000 each year. This is seen as a blueprint for other professions with a new pilot scheme started to bring 300 AHPs back into the NHS before 2019. A GP return to practice scheme is covered in the primary care section of this document.

The global healthcare workforce

Introduction

The NHS has historically relied on significant numbers of staff from overseas to meet service needs. The contribution of those already working here is highly valued and will be needed, until new graduates from recent increases in domestic clinical education programmes are available.

Over 40,000 clinical professionals from other European states are part of today's NHS with recent figures from NHS Digital showing modest increases in the numbers of EU clinical staff in post since the Brexit referendum. However, the Nursing and Midwifery Council reported increased numbers of EU nationals leaving its register and fewer joining, reflected in a small reduction in the number of EU nurses and midwives working in the NHS.

EU staff working in the NHS before and after the referendum in post 30 June 16/in post 30 June 17

Doctors	9,695/ 10,136
Nurses and health visitors	20,907/ 20,618
Midwives	1,220/ 1,247
Ambulance staff	250/ 386
Scientific/therapeutic/technical	6,112/ 6,957

The Prime Minister and the Health Secretary have both shown their support for the contribution EU nationals make to the NHS and have made settling their position a priority in the negotiations with EU partners.

The Government has always maintained that there should be an early agreement on the rights of UK nationals in the EU and EU nationals in the UK, on a reciprocal basis. The deal agreed on 8 December allows for that to happen. Any EU citizen resident in the UK at a specified date with five years' continuous residence will be able to apply for UK settled status. Anyone who has less than five years' continuous residence at the specified date will be allowed to stay to enable them to secure settled status.

The deal agreed on 8 December is without prejudice to Common Travel Area arrangements between the UK and Ireland and the rights of British and Irish citizens in each others' countries. Irish citizens will not need to apply for settled status to protect these entitlements.

The Government has published proposals intended to create a service for obtaining settled status which can be found here:

<https://www.gov.uk/government/news/more-detail-provided-on-new-settled-status-for-eu-citizens>

On 27 July, the government commissioned the Migration Advisory Committee (MAC) to gather evidence on patterns of EU migration and the role of migration in the wider economy, ahead of our exit from the EU. This includes the role that EU migration plays in the health and care workforces. The MAC has been asked to report by September 2018. The government will carefully consider any recommendations made to it before finalising the details of the future immigration system for EU nationals

The World Health Organisation (WHO) estimates the world faces a global shortage of almost 4.3 million doctors, midwives, nurses and other healthcare professionals. Looking ahead, as the sixth largest economy in the world and as an ethical global citizen, England should not be relying on net inflows of healthcare professionals.

In 2017 the NHS once again ranked top of the world's best healthcare systems and was praised for its safety, efficiency, and affordability. This global recognition means the already high international demand for the NHS's knowledge, skills and services is increasing. Healthcare workers are also globally mobile, highly trained, qualified professionals and we need to better manage these flows whilst supporting clinicians moving in both directions.

All this means we need to find a balanced approach to enabling qualified overseas staff to train here. Where they fill currently vacant NHS posts in the process this provides a further benefit, alongside the professional development they receive. HEE is developing ethical overseas programmes to ensure the NHS enables these staff to return home more experienced and skilled, strengthening health systems in partner countries.

The NHS as a global centre of excellence for workforce development

To develop the NHS as a global learning hub, HEE's Global Team will promote the education and training benefits of closer relationships between the NHS and overseas partners. We will continue to create sustainable partnerships with countries to mutual benefit, underpinned by the following principles:

1. Recognise the capacity of the NHS to transform overseas health economies by co-developing educational programmes which benefit both countries.
2. Promote and develop models to support global learning for NHS staff; with the aim of improving job satisfaction, retention, capabilities and productivity.
3. Ensure value for money by coordinating global initiatives through a single structure, preventing duplication and ensuring a consistent ethical framework.
4. Create time-limited, ethical 'earn learn and return' programmes for professional groups where there is a clear educational offer to help reduce global skills shortages.
5. Use the workforce excellence of the NHS to support commercial relationships and where this is in line with wider Government policy on reducing net migration.
6. Learn from others through global partnerships.

Ethical earn, learn and return programmes

The Global Learners Programme offers a three-year work-based education experience in the UK for overseas clinicians. Each learner will return home with enhanced skills to apply into their own healthcare system.

These qualified healthcare professionals will already possess a wealth of knowledge and skills and it will benefit the NHS to share their experience from different healthcare backgrounds and systems.

While nurses remain on the shortage occupation list, HEE will continue recruitment of overseas nurses on "earn learn and return" schemes in the short term, in a way that is consistent with wider Government policy on reducing net migration.

Medical training initiative (MTI)

The MTI enables overseas doctors to access education and training opportunities in the NHS, making a valuable contribution to improving the skills and capabilities of doctors across the globe.

NHS global learners

Our global ambitions are two-way. A large number of initiatives facilitating overseas placements for NHS staff and trainees already exist across the NHS. Global learning opportunities benefit individual clinicians, overseas healthcare systems and the NHS. They are highly attractive to many NHS employees and aid recruitment and retention. HEE is working with partners to support and expand existing schemes, ensuring the right conditions are in place to provide a quality learning experience which is mutually beneficial.

Global Health Fellowships in South Africa

In partnership with the South African government HEE is facilitating opportunities for some GP trainees to have a year long overseas training experience. It gives individuals the opportunity to work in rural communities and contribute to sustainable change in resource poor healthcare settings, whilst building skills and career prospects.

“You learn things remarkably quickly. I remember my first handover... you do find confidence in your own decision making, something that I could never dream of in my five years in the NHS. The buck stops with you. You need to make those decisions. You may feel like you are in the deep end at times but it is exactly that which makes you thrive in your decision making and clinical skills and learn more in a matter of months than you ever would with years as a Foundation doctor. I never felt the system was doing the patient an injustice or was dangerous, you learn the safest way to manage a snake bite, crush injury, motor vehicle accident or inhalation burns.” *Trainee on placement 2016/17 in KwaZulu Natal, South Africa*

A global health strategy will be published by HEE in Spring 2018.



Chapter 4

The workforce response to Five Year Forward View

Chapter Summary:

- Next Steps outlined priority areas for action to deliver the overall vision of the FYFV.
- The priorities are Cancer; Mental Health; Urgent and Emergency Care; Maternity; and Primary Care.
- HEE produced workforce plans designed to deliver these service priorities.
- Learning Disabilities also requires focus.
- Integrating care will be vital in delivering the FYFV effectively.

Introduction

It is three years since the NHS Five Year Forward View (FYFV) was published, a transformative vision about why and how the NHS should change. Next Steps on the Five Year Forward View, highlighted progress and areas where acceleration remained necessary. This section summarises workforce delivery plans; outlines what has already been done; and the challenges remaining.

Locally integrated care

The golden thread running through the FYFV is better integration between professions, services and sectors.

Local partners

Next Steps wanted “to make the biggest move to integrated care of any major western country”. Organising around this principle saw FYFV Vanguard lower growth in emergency hospital admissions and emergency inpatient bed days.

The 44 STPs are building on these results. The strongest have become Accountable Care Systems (ACSs), scaling up population-health care models to whole systems. The ACSs take on additional freedoms in return for greater responsibility. Eight shadow ACSs have been announced (two devolution areas), with more to come.

How are systems integrating services?

The eight ACSs are integrating services around a single, population making it easier for staff to work across boundaries. This could be an NHS staff ‘passport’, including portable pre-employment checks, employment indemnity and DBA checks.

Delivering the workforce requirements

Integrating services means staff working in new environments, for instance more GPs working in larger networks, sharing workforce assets and building flexible careers paths.

These networks will need to employ nurses, clinical pharmacists, mental health therapists and allied health professionals in teams with GPs. Some systems also want support to ensure professional training reflects new ways of working like out of hospital rotations for junior doctors.

LWABs are the workforce arm of STPs, bringing together providers, workforce analysts and specialists, commissioners, universities and others to develop the current workforce and plan for the future. They will grow and develop as part of their health system, providing the analysis, data and intelligence to help make the best possible decisions.

Making it easy

A simpler coherent approach to workforce change will help deliver the FYFV priorities and the new local arrangements, de-risking service change. Joint work between NHSI, NHSE, HEE and PHE is focusing on maximising the opportunities to ensure we avoid duplication. This includes developing solutions to technical employment issues to enable staff to work more easily across multiple employers and professions.

To maximise local flexibility and ownership, pilots will be delivered in partnership with local organisations and trades unions. This will include testing the long term sustainability of solutions.

The Priority Workforce Plans

The FYFV identified system priorities: mental health; primary care; cancer; maternity; and urgent and emergency care. Each priority has a cross-system implementation plan. Key to delivering these services is better local integration.

Mental health services

One in four of us will at some point in our lives experience a mental health problem and it is the single biggest cause of disability. Yet, mental health services remain the poor relation to physical health services. Parity of esteem is law and we must recognise it is time to change.

The Mental Health FYFV set an ambitious vision of improvements by 2021 whilst the Mental Health Taskforce identified four key ambitions to meet the vision: service accessed at an earlier stage; accessible services at the right time; more integrated service delivery and mental health capabilities more widely embedded into the NHS. In response, HEE published *Stepping Forward to 2021: the mental health workforce plan for England*.

The full plan can be found at:

<https://www.hee.nhs.uk/our-work/planning-commissioning/workforce-planning/mental-health-workforce-plan>

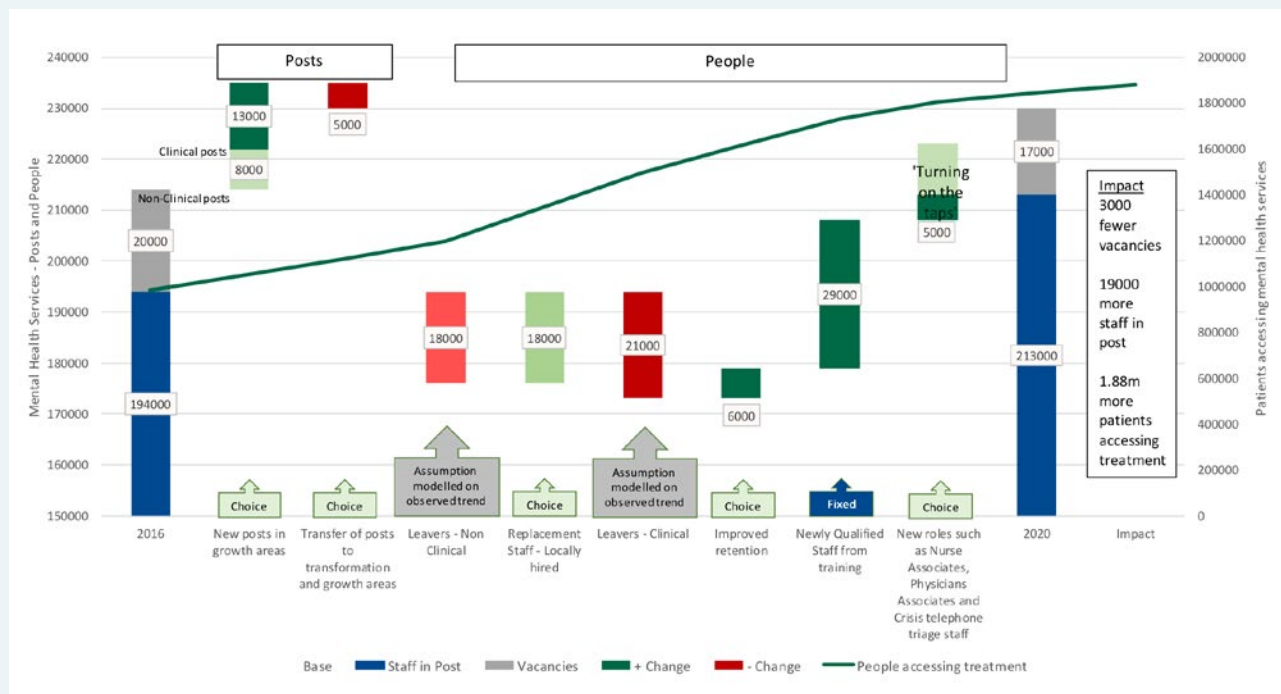
Growing the workforce

There are about 214,000 NHS mental health posts, 20,000 of these are filled by bank and agency staff, meaning the NHS has around 194,000 substantively employed members of staff working in mental health services.

The Mental Health Workforce Plan illustrated that 21,000 additional posts would be needed to deliver the specified service improvements, and laid out actions to support the NHS to employ 19,000 new staff across the system by 2020. Of these 11,000 will be core clinical professions such as nurses, occupational therapists or doctors. The other 8,000 will be new roles such as peer support workers and personal wellbeing practitioners. These new clinical support roles broaden skill mix as new service models rely on multi-disciplinary teams of qualified professionals and trained support staff. The plan requires staff growth of 47% in areas like Childrens and Young Peoples services; crisis; perinatal; liaison and intervention in psychosis; with a 9% growth across the whole workforce.

The waterfall diagram, figure 12, shows at a glance the relative impact of the main drivers behind this projected workforce growth. It helps the system focus on the key variables which can be influenced in the FYFV timescale.

Figure 12: Growth and transformation for mental health services to 2021



Attracting and retaining staff

Recruiting newly qualified staff, and keeping our existing mental health workforce is vital to success. Attrition rose 3.1% to 13.6% between 2012 and 2016, much higher than the 8.6% average in physical services.

NHSI plans to improve retention by 6,000 members of staff. HEE will create a dedicated mental health workforce development budget and lead a Return to Practice campaign for the 34,000 qualified mental health clinicians not currently in NHS employment.

Action already taken

We have expanded exposure to psychiatry in our Foundation Training programmes for doctors so 47% of junior doctors now undertake a psychiatry post; increased training to deliver more 'talking' therapists ensuring access for 60,000 additional people next year and 200,000 by 2020 – an increase of over 20%; supported 20 specialist perinatal mental health teams providing care to 2,000 more women next year and 9,000 the year after; and created 10 consultant practice fellowships for new Perinatal Mental Health units.

New roles and improving skills

Expanding the numbers of advanced practitioners; nursing and physicians associates; consultant AHPs; and peer support workers, will increase the skill mix and flexibility of teams. To support new team working models the Leadership Academy will deliver bespoke leadership courses to mental health teams.

HEE will support growth in psychiatry by running campaigns to promote the career and ensure medical student places are allocated to medical schools which encourage placements in psychiatry. HEE will also work to reduce attrition from training pathways and explore salary supplements for psychiatrists training in difficult to recruit areas.

We will also seek to better support children and young people with mental ill health, both through improving NHS delivered services, developing new roles such as the personal wellbeing practitioner, and through improved and better integrated children's social care services and schools mental health services. The government is currently consulting on how best to do this.

The consultation can be found at: <https://engage.dh.gov.uk/youngmentalhealth>

Reducing future demand is also critical. There are predicted to be two million more people with mental health conditions by 2030. PHE and HEE will improve the mental health prevention training in the public health workforce; make the NHS an exemplar employer for mentally ill staff and promote *Time To Change*.

HEE will work with partners on a longer-term strategy including making the UK a world leader in mental health research. Given the current strategy only covers the FYFV period, we will also produce a comprehensive longer-term vision for the MH workforce.

Cancer services

We are making unprecedented advances in preventing, diagnosing and treating cancer, but evidence shows that incidences are going to increase by over 60,000 per annum by 2022. Local Cancer Alliances need sufficient staff with the right skills to embed new treatments and tests quickly ensuring patients reap the full benefit.

The FYFV Cancer Workforce Plan is designed to deliver the Cancer Taskforce Strategy's four key goals by 2021:

- prevent more cancers
- increase the rates of early diagnosis
- improve the treatment and experience of cancer
- support people to live with and beyond cancer

The Workforce Plan outlines interventions to increase staff numbers and introduce new skills and productivity measures, recognising delivery is a collective effort.

The full plan can be found at: <https://www.hee.nhs.uk/our-work/planning-commissioning/workforce-planning/cancer-workforce-plan>

Actions already taken

The NHS did not wait until the cancer workforce plan before acting, investing £130m in radiotherapy and £200m in rapid diagnosis and assessment. HEE has already invested in increasing Clinical Radiology training programmes, and created a fast-track training pathway for Clinical Endoscopists.

Making the most of what we have

The answer to workforce growth is not just more newly-qualified staff. Action to improve retention, working practices and attract qualified staff back are needed to make a difference. The plan outlines the need to target clinical radiology, histopathology, oncology, diagnostic and therapeutic radiography. The cancer nurse Specialist workforce needs to grow, and a new clear training route is being developed by HEE, to be published in Spring 2018.

The medium to long term

HEE will invest in training a further 200 new clinical endoscopists and 300 reporting radiographers to increase early diagnosis capacity, as well as creating the HEE Skills Fund for Cancer. There will be continued system commitments to key cancer professions by increasing the numbers of qualified professionals who work in the NHS.

Ensuring local and national alignment

A new cancer staff forum will focus initially on best practice in seven professions: histopathology and healthcare scientists, gastroenterology, clinical radiology, diagnostic radiography, medical and clinical oncology, therapeutic radiography, and nursing, especially cancer nurse specialists.

However, the cancer workforce is broader than this. Gastroenterologists, GPs, nurses and histopathologists may not specialise in cancer but play a significant role in the treatment pathway. HEE is working Cancer Alliances through LWABs to develop plans based on an understanding of the wider workforce and analysis of the significant regional variations to support local solutions.

Nationally, HEE will work with partners on workforce plans for national programmes to develop a long term workforce strategy beyond 2021, built upon analysis of future patient need, emerging service models, and the need for continued innovation.

End of life care

Addressed as part of the cancer strategy, most people say they would like to spend as many of their last days at home as possible so it is important they receive support to be able to do so. Currently, only 23% die at home and similar numbers in care homes.

Responding to an independent review of end of life care in 2016 the government made six commitments to end variation in end of life care by 2020: honest discussions between professionals and people at the end of their lives; assisting people making informed choices about their care; personalised care plans for all; discussing personalised care plans with care professionals; the involvement of family and carers in end of life care; and a main contact .

HEE will embed how to care for the dying across settings in multi-disciplinary education and training.

Primary care

The FYFV confirmed the importance of primary care to patients, communities and the NHS's long-term sustainability; and also the need for investment and improvement. The General Practice Forward View (GPFV) outlined funding growth of £2.4 billion per annum by 2021 alongside an immediate £500 million injection. The key workforce aim is doubling the growth rate for doctors in general practice, to ensure by 2020 there would be 5,000 more doctors alongside 5,000 other clinical professionals working in primary care.

Action already taken

NHSE, HEE, the RCGP and the BMA have been working together to deliver the GP 10 Point Plan which includes growing new roles, expanding the number of primary care clinicians, incentivising returners, incentivising GP trainees to work in under doctored areas and creating training hubs for GP Practice staff.

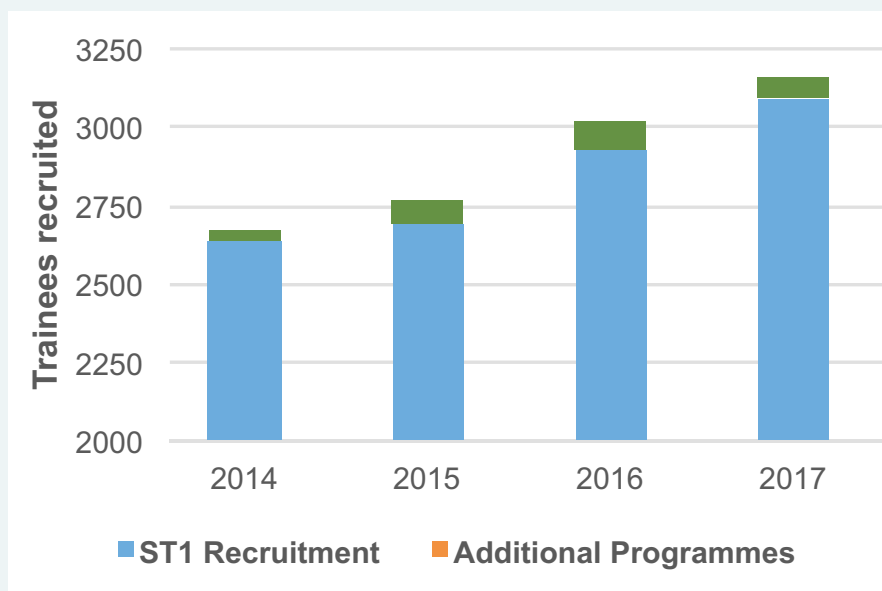
General Practitioners

HEE has invested unprecedented resource in growing GP trainee numbers, delivering year on year growth with record numbers in the last two years.

The growth to produce 5,000 additional GPs is the result of two key sets of interventions, DH and NHSE overseeing retention and overseas recruitment programmes and HEE increasing the numbers of GP trainees.

NHS England and DH are concentrating on increasing retention through reward policy and by offering incentives and flexibility to GPs nearing retirement, return to practice schemes and recruiting over GPs from abroad. HEE has implemented 21 separate initiatives to boost GP trainee recruitment to make it more attractive to trainees. These initiatives include opportunities to work for a year overseas, a one-off £20,000 salary supplement to encourage people to work in under-doctored areas, and the option of post-CCT training in subjects such as emergency medicine, leadership and research.

Figure 13: GP trainees recruited by year



The primary care multidisciplinary team

HEE's Primary Care Workforce Commission, chaired by Professor Martin Rowlands identified that a flexible multidisciplinary team, led by a GP, supported by technology delivers the best primary care.

To support this HEE has developed Community Education Provider Networks (CEPN) to deliver multidisciplinary team training and support local recruitment, retention and return to practice programmes. By March 2018 all GP practices will have access to a local CEPN.

They will also deliver the '*Recognise, Rethink, Reform*' plan for general practice nurses which calls for improved training capacity; more pre-registration training placements in the community; retention schemes and a return to work programme.

HEE has significantly increased the number of physicians associates training to deliver the 1,000 promised to primary care and is working with the DH to ensure they are regulated as a profession.

NHS England is leading the increase numbers of clinical pharmacists in primary care, with HEE and the Centre for Pharmacy Postgraduate Education providing the education pathway. We aim to have 1,500 clinical pharmacist working in general practice by 2020, so far 491 clinical pharmacists have been recruited.

HEE is also piloting the general practice assistant role and many GPs are employing paramedics and other AHPs to broaden the skill mix.

Beyond the GPFV

General Practice is currently the shortest specialty training programme and HEE believes that we should further evaluate, with partners, the case for an extra training year.

Ensuring we recognise long term locum doctors in planning is vital as some GPs want to work as locums to gain additional flexibility. They see long term locum roles as a legitimate career choice making it vital we understand that for purposes of providing care to patients and planning the future primary care workforce. NHS England are testing this, and their support needs, through its GP careers plus pilot.

NHS England and HEE will continue work with the RCGP and other partners to promote general practice as a career. HEE recently announced that 2017 was a record year for doctors choosing GP training with 3157 trainees recruited, ensuring additional supply to complement an extensive range of NHS England actions to retain current GPs and recruit new ones.

Urgent and emergency care

NHS Emergency Departments treated 23 million patients last year under increasing pressure. Since 2013, HEE and the Royal College of Emergency Medicine (RCEM) have worked in a constructive and successful partnership to change and improve the ED workforce.

Action already taken

In 2013 HEE and RCEM published a plan which expanded training posts from 225 to 300 for three years; established a 'run through' option to higher training; created an additional training pathway for doctors from other specialties; and developed an earn, learn and return programme offer to overseas doctors wanting to gain more training in this country.

This programme delivered 100% fill rate in Emergency Medicine training places for the first time ever. These actions have helped ensure more doctors providing service and establishing a strong pipeline for future consultant growth.

Developing a multi-disciplinary workforce

In October 2017 an Emergency Department Workforce Plan was published by HEE, RCEM, NHS England and NHSI. Developing multi-disciplinary teams is core to the plan with roles such as advanced clinical practitioners, pharmacist clinicians and physician associates being developed. These roles increase the skill mix, flexibility, resilience and sustainability of today's emergency care workforce.

Around 30% of physician associates work in emergency medicine and the current training pipeline will deliver a near ten-fold increase to 3,200 in 2019 giving scope for growth. Advanced clinical practitioners will also grow as part of the emergency team with 135 Paramedics applying recently to be part of the ACP in emergency departments programme and further investment doubling next year's ACP.

The plan also committed to continuing the expanded number of medical training posts with 300 doctors starting training in each of the next four years. The RCEM and HEE will further support emergency teams by recruiting a further 100 doctors per annum for up to four years into a range of other training programmes, developing emergency medicine skills at a range of levels, to ensure the best mix of junior and middle grade expertise.

Continued development

HEE is committed to reducing attrition from EM training which is considered to be one of the hardest training programmes. Initiatives include a new leadership training programme for every trainee and an evaluation of the part time training pilot to apply to future cohorts.

A range of measures including dedicated HR support, post Certificate of Completion of Training fellowships and a best practice clinical development fellows toolkit will be introduced to further reduce attrition as well as support the one third of Trusts facing the biggest training challenges.

RCEM and NHSI will encourage and share best practice on non-CCT routes to the specialist register – e.g. CESR route. A series of development events and a best practice toolkit from RCEM and HEE will support alternative routes to becoming an emergency medicine consultant.

Maternity

In February 2016 the national maternity review: Better Births set out a vision to ensure that maternity services in England are safe and personal; ensuring those services provide personalised, supportive and high quality care to each of the more than 660,000 women who give birth in England each year. It also delivers the safety ambition set by the Government to halve the rate of stillbirths, neonatal mortality, maternal death and serious brain injuries occurring during or soon after birth. In November the Government underlined its commitment to this ambition by bringing forward the date for delivery from 2030 to 2025.

The transformation of maternity services is led by 44 Local Maternity Systems (LMS) across England. Each LMS brings together commissioners, providers and services users to plan and implement improvements in maternity care. LMS's will require significant national support to deliver the improvements required. The Maternity Transformation Programme (MTP) has brought together NHS England, NHSI, and PHE to provide each area with a bespoke package of support to deliver their planned improvements.

As part of this package of support we have:

Begun to train 200 healthcare professionals from a range of relevant professions, including midwives, AHPs, operating department practitioners and healthcare scientists in third trimester obstetric ultrasound.

Implemented new supervisory arrangements for midwives, A-EQUIP (Advocating for Education and Quality Improvement Programmes), to replace the previous statutory supervision, including the creation and roll out of a national training package for professional midwifery advocates (PMAs) in every maternity unit in England to deploy the new model of supervision.

HEE distributed £8m to 136 Trusts to provide maternity safety training to staff. An independent evaluation of this investment will be completed in 2018/19, however interim outcomes suggest improved relationships between teams and across services and professional groups and a noticeable improvement in culture.

Identified Board level maternity safety champions in every maternity provider in England to lead safety improvements across midwifery and obstetrics, and will recruit new regional champions to work with other local and national champions.

Each LMS, as part of their role, will work with LWABs to provide a joint and agreed plan for the maternity workforce in each part of the country.

Currently 35,000 staff, including 22,300 registered midwives, make up the clinical teams that provide this care. We are committed to working with commissioners, providers, women and their families and staff to ensure that we create and develop the right numbers of staff, with the right skills, with the right culture to provide safe and personal maternity care across England.

HEE is working with partners, including the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, to understand the size, shape and training requirements for the future workforce in order to implement Better Births. This includes any changes needed to support key improvements we are seeking to make such as introducing continuity of carer and improving personalised care planning.

A final maternity transformation workforce action plan will be published in early 2018 and will set out how we will provide the NHS with the skilled staff it needs to deliver improved maternity care. It will:

- Identify current supply and future demand requirements including the need for up-skilling, reskilling, new roles, new ways of working, leadership and culture change to support maternity transformation.
- Address the high attrition rates for maternity support workers, registered midwives and neonatal nurses and other registered nurses and midwives who leave their organisations for non-retirement reasons each year including opportunities for return-to-practice.
- Work with the RCOG to understand and better support the 30% of obstetrics and gynaecology trainees who do not complete training, many of whom move into general practice.
- To close gaps in current workforce provision especially in midwifery, sonography and neonatal nursing including the role of advanced practitioners.

The overarching Maternity Workforce Strategy will also address educational and development issues including a review by the NMC of the Midwifery curriculum, a review of the RCOG curricula to reflect revised GMC standards and developing consistency in the role, education and career routes for maternity support workers.

Learning disabilities

The FYFV identified services for the 1.5m people with learning disabilities (LD) as requiring increased focus. The learning disability workforce programme will ensure the workforce has the education, skills, values and behaviours it needs to help service users lead better, more independent lives.

Though yet to happen everywhere LD services must be delivered through integrated, community based services. The LD workforce needs to change as more services are moved into the community to improve the quality of care. Social care is expected to employ an additional 7,500 staff with community support requiring 1,000 workers. Around 2,750 inpatient staff need to transfer their skills and knowledge to community settings. Staff in the community require competencies in positive behavioural approaches (PBS), mental, physical and forensic interventions.

The current phase is focused on aligning and developing the workforce and services with significant progress in competency frameworks, workforce planning, new roles and leadership. As provision is commissioned the effort will shift to service providers.

A new PBS alliance will find the best way of ensuring standards as steps are taken to address emerging risks such as; graduate pre-registration nursing, special interest LD GP fellows, LD children and young people Improving Access to Psychological Therapies (IAPT) and pilot media campaigns.

The next phase will ensure sustainability including the supply and development of key professionals through apprenticeships and HEE, with partners, will review the future staffing and skill mix required for the new LD services.





Chapter 5

The adult social care workforce

Chapter Summary:

- The adult social care workforce is larger than the NHS workforce but has lower average pay, fewer qualifications and more part time staff.
- Turnover is high and there are 88,000 vacancies.
- Required growth of between 14% and 31% is forecast by 2030.
- 18% of the workforce is from overseas with regional variation.
- 20,300 independent organisations provide care in England.
- The government is consulting on changing aspects of the system.

Introduction

Adult social care (ASC) provides personal, practical care and support to adults of all ages; older people and working age adults with physical disabilities, learning disabilities or physical or mental illnesses, as well as support for carers. Care designed around the individual, supporting as many as possible to live independent fulfilling lives in their own homes and communities, relies on effective working across the NHS, adult social care and other partners.

The relationship between social care and NHS capacity is highlighted in the FYFV which says NHS efficiency targets rely on “sustaining social care services”. High quality adult social care and prevention services are vital to managing NHS demand. Equally when there are frictions between how services link up in adult social care and the NHS, the optimum service is not delivered to patients and demands on both services can be seen to increase.

Service users and patients don’t necessarily distinguish between NHS care and adult social care, nor should they have to. People centred care relies on working across organisational boundaries. Health and social care also share professions such as nurses, social workers, occupational therapists and managers.

The shape of the workforce

There are around 1.45 million staff working in adult social care in England, more than work in the NHS. Adult social care has a broader employer mix with 78% of staff employed by 20,300 private and voluntary organisations and the remaining 22% in local authorities, for individuals or in the NHS. The majority, 817,000, of the ASC workforce are care workers with the remainder including social workers, therapists and registered nurses.

Figure 14: Percentage of adult social care jobs in England by employer type, 2016

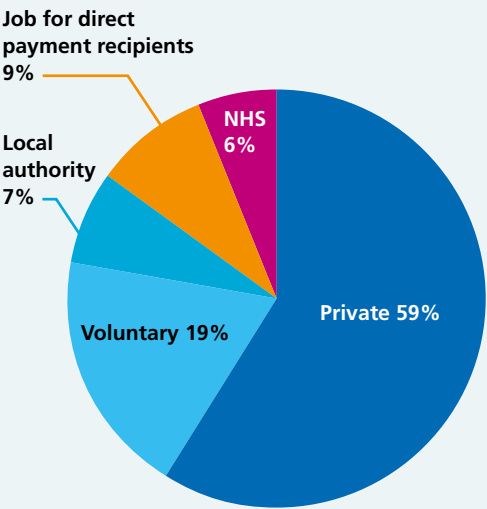
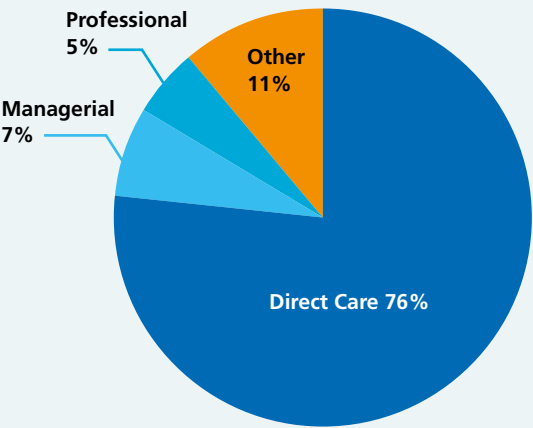


Figure 15: Percentage of adult social care jobs in England by job role, 2016



The majority of the care workforce is likely to earn at or near the National Minimum Wage. The workforce is 82% female with an average age of 43 and nearly half work part time including 54% of care workers. Zero hour contracts cover 24% of all staff and 33% of care workers. Turnover is high at over 25% with around 347,000 staff leaving roles during 2016/17, 33% of those leaving the sector altogether.

The sector faces recruitment and retention challenges at all levels, in both regulated and unregulated professions. Vacancy rates are higher than the general economy at 6.6% compared to 2.5%, with approximately 88,000 vacancies.

Workforce diversity, as with the NHS, means a combination of interventions are needed to support an adult social care workforce for the future. The government has recognised pressures on the social care system with an additional £2bn, however a number of factors such as pay, large numbers of small employers, contract status and retention and recruitment make workforce issues challenging for the sector.

Increasing demand for adult social care

Demand is growing as people live longer with more comorbidities leading to more complex health and care needs. According to “Horizon 2035: health and care workforce futures”, by 2025 unconstrained demand for lower skilled direct care staff is likely to increase by 12%, (around 120,000 more jobs), and an overall workforce demand increase of 14% (190,000 jobs). Skills for Care suggest that need might be as much as a 31% increase or 500,000 jobs by 2030.

Factoring in vacancies approaching 90,000 and the challenge of the current staffing model to meet these demand projections is clear. It also has implications for the wider economy, with labour used to meet this increase not being available to other sectors.

There are interventions that can alleviate some of this increasing demand whilst meeting peoples’ desire to remain independent and well at home for longer. These include social care staff supporting prevention and public health interventions; better join up between health and care; more support for carers; and new technology. Local initiatives, like ESTHER in Kent, encourage greater participation from the workforce in the care and wellbeing of the individual, making more rewarding roles. The forthcoming Government Green Paper will build on action to address demand and set out a long term plan for addressing the challenges facing ASC.

Maximising recruitment

There are two focus areas for ASC recruitment. The first is training and skills development. Roles tend to have low entry requirements with around half the workforce having no formal social care qualifications. This is especially true of the vast majority of staff providing direct care and support. The regulated professions tend to perform more supervisory roles.

There are no standard training requirements across large parts of the sector with too many staff not receiving training or professional development, despite providing direct care for vulnerable adults whose dignity and quality of life is dependent on the quality of their work. The Care Certificate, developed by HEE, Skills for Care and Skills for Health, provides a standard induction framework across social care and health. There is no mandated skills training or development across employers.

The second recruitment challenge is overseas staff. UK nationals make up 83% of the ASC workforce; 7% (around 90,000), are non-UK EEA nationals and 11% (about 140,000) are from the rest of the world. Direct care staff form the biggest group of EEA staff with about 67,000 workers.

Actions to deal with workforce challenges

Skills for Care, which is funded by DH, aims to improve the skills of the ASC workforce and support employer's recruitment and retention through the £12m Workforce Development Fund. Skills for Care are also working to widen ASC recruitment to non-traditional workforces.

Strong, compassionate leadership builds high performing teams so Skills for Care has produced new leadership visions which cover a range of development, including registered manager networks, registered manager membership offer and leadership programmes.

Health and care has more apprentices than any other sector, with 420,000 starts in the last six years, with social care apprentices up 37,300 or 42% from 2010.

A plethora of high profile programmes to support social work in ASC include the creation of Social Work England, bursaries, teaching partnerships and the assessed and supported year in employment (ASYE), with top graduates being recruited to adult mental health social work through Think Ahead.

Employers of choice

As with the NHS, employers need to have the right offer to keep the staff they need and reduce turnover. The four key challenges to retention start with pay and reward. Relative low pay, resulting from industry structure, low productivity and funding issues, is associated with low levels of learning and development, and high turnover.

Average ASC pay increased by 4% between 2012 and 2016, largely due to the National Living Wage (NLW), but showing a divide between registered professions and NLW roles with wages increasing for independent sector nurses by 19% as opposed to 2% for support and outreach staff. Local authorities also pay higher average wages than the independent sector.

The sector faces competition from retail, catering and hospitality with high labour market participation rates meaning that ASC employers compete for a limited number of workers to posts that are more physically and emotionally demanding than those in competing sectors. Values based recruitment can help ASC employers with an evaluation by Skills for Care showing that employers using it have turnover rates 5.6% lower than the overall sector average.

Terms and conditions are the second retention challenge. Almost a quarter of ASC staff are on zero hours contracts and whilst some staff value the flexibility, for others it contributes to high turnover. More generally the overall employment offer varies substantially between employers, with some employees covering their own training, travel, and uniform costs.

The majority of roles have low entry requirements and limited career structures. The 20,300 employers separately determine job titles and structures, which makes demonstrating career pathways challenging meaning staff often seek career progression by leaving the sector. Increases in the National Living Wage have driven up pay for those on the lowest wages but also narrowed pay differentials thereby reducing the attractiveness of seeking promotion or progression in some cases.

Professional regulation supports the delivery of safe and high quality care through setting standards and ensuring continuing fitness to practise. Greater regulatory oversight of social care workers might be an option. A regulatory framework could also support the development of clearer roles linked to competencies, building on the Care Certificate.

While this is an opportunity, it would be more challenging to deliver in social care than the similar new role of nursing associates in health. There are fewer levers in social care to drive consistent changes in the workforce, not least the large number of small private or third party employers in the sector.

Future ambitions

In parallel to work already underway, the government has announced plans to publish a Green Paper presenting its proposals to reform care and support for older people alongside a parallel work strand on social care for working age adults. Over the coming months, experts, stakeholders and people using care and support services will have the opportunity to shape the long-term reform needed. When the Green Paper is published, it will then be subject to a full public consultation, providing further opportunity for interested parties to give their views.



Chapter 6

Workforce requirements beyond 2021/22

Chapter summary:

- Workforce planning must better align with service delivery and financial planning to be effective.
- Modelling shows that with no action, including increased productivity or service redesign, the NHS will need 190,000 additional posts by 2027.
- If supply continues at the rate of the last five years, 72,000 new staff could be expected to join the NHS by 2027.
- Trusts will need further support to address continuing productivity requirements.

This document has so far looked at how we address our current challenges, including delivery of FYFV priority services and system improvements. This section outlines a proposed approach to meeting our six workforce change principles in the longer term, to ensure we have a sustainable workforce which meets the needs of patients now and in the future.

Workforce consequences of funding and efficiency in the Five Year Forward View

The Five Year Forward View is a plan led by patient need. It acknowledges the full demographic, non-demographic, and pay pressures anticipated by 2020/21 and then sets out the plan for meeting this need. The possible combinations of nationally delivered productivity, NHS planned productivity, and real terms funding growth were explicitly laid out in the FYFV and associated modelling.

The actions outlined below describe how this challenge is being met through both national service priorities, greater service integration and the NHS's 10 point efficiency plan as outlined in next steps in the FYFV.

The NHS's 10 Point Efficiency Plan

1. Free up hospital bed capacity
2. Temporary staffing costs and improve productivity
3. Procurement
4. Medicines and Pharmacy
5. Reduce avoidable demand and meet demand more appropriately
 - Prevention
 - Emergency care
 - Elective care
6. Unwarranted variation in clinical quality and efficiency
7. Estates, infrastructure, capital and clinical support services
8. Corporate services and administration
9. Income
10. Financial accountability and discipline

In addition to these measures, which will fundamentally shape the system's requirement for staff, the actions described in chapter 3 will determine our success in boosting supply so that we meet our aim of supply sufficiency by 2021 as we move into the next phase of our planning.

Future Demand – beyond 2020/21

The difficulties in predicting future demand are well known. However, there is clear value in establishing the range within which future demand might fall and identifying the scale of actions on supply, service and workforce productivity that the system might need to take to ensure sufficiency of supply.

In considering the future, both affordability and patient or population demand drivers are important. It would be inappropriate to ignore constraints to service funding, but wider consideration of demand drivers can help the system prepare for the challenges it faces. In this section we present a modelling scenario which reflects a reasonable view of how workforce demand might be expected to develop without further active management.

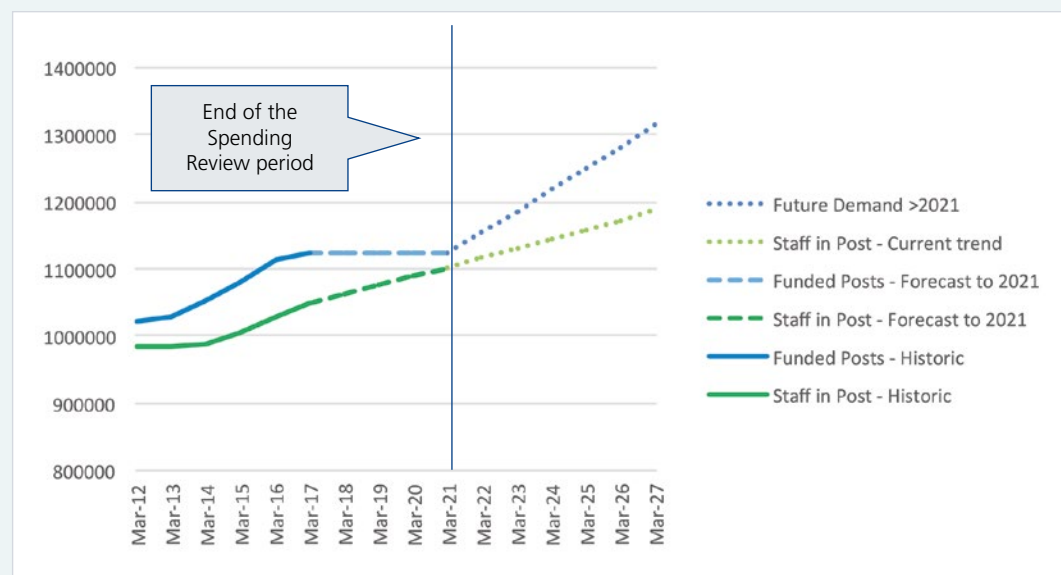
In the immediate term our modelling scenarios for workforce demand reflect current service and spending plans for this Spending Review period. Beyond this, scenarios for demand for the healthcare workforce need to consider a variety of factors including: population growth, changes in morbidity and the trend towards societies devoting an increasing share of their resources to health as income rises.

In addition, future scenarios must consider productivity gains. The NHS will always be expected to achieve appropriate productivity gains as its contribution to meeting the costs of future population health needs. How the NHS delivers this productivity and thereby reduces the level of additional posts that would otherwise be required is a key question for the system.

In the context of this document we have used a 'do nothing more' modelling scenario which, considering these factors and recent trends in NHS productivity, suggests potential for workforce demand growth of 17% between 2021/22 and 2026/27 unless action is taken to reduce this demand through prevention, service transformation and productivity growth.

This would result in approximately 190,000 additional posts being required. If additional supply were to continue at the rate that we have seen between 2012 and 2017, then an additional 72,000 staff could be expected to join the NHS.

Figure 18: Future Demand for Staff – Beyond 2021/22



As described elsewhere in this document we have already taken significant steps to increase the future supply of staff including over 5,000 more nurse training places and 1500 more medical students each year. We can therefore already anticipate significantly 'outperforming' the historic supply trend shown. However, this projection sets the context for deciding what further action the NHS needs to take on service productivity or further supply measures.

How the NHS manages this risk and reduces the number of additional posts that would otherwise be required is a key question for the system. In acknowledging this challenge now, some five to ten years ahead of the potential realisation of future risks, we are giving ourselves the opportunity to collectively agree what actions should be taken, at what scale, and in what combination to achieve our goals.

Policy options for a sustainable future workforce

In Framework 15, we outlined an approach to planning for the longer term which acknowledged this cannot just be about predicting specific service futures or workforce numbers. Instead it promoted the need to focus on the characteristics of our future workforce and development of workforce policies, structures, and systems that build in sustainability through flexibility and responsiveness. Areas we need to address to fulfil this ambition include:

- Assessing the impact of change to prioritising measures aimed at preventing ill health and promoting wellbeing, and developing the public health workforce to deliver these actions.
- Reducing unwarranted variation in the provision and quality of services delivered.
- A focus on high value, evidence-based activity and interventions.
- Reducing unwarranted variation in operational performance and productivity.
- ‘Frontier shift’ in productivity through technology and innovation.
- Future teams – addressing the barriers to creating modern agile teams.
- Future employment – exploring new models of employment to serve our future needs and our relationship with the wider domestic and international labour market for health and care staff.
- Valuing and engaging our staff and equipping them with the tools and resources to serve patients.
- A modern flexible education, training and development system and its contribution to securing supply and supporting the lifelong learning of staff.
- Integrating service and workforce planning – a coherent, co-ordinated, and actively managed system for managing the workforce.

In the next chapter we outline the measures already in train or under development that illustrate how these key issues may be addressed. We need to engage with the whole system in frank and open conversations about how we should collectively address these issues and what novel or innovative ideas we might wish to implement to address some long-standing challenges.



Chapter 7

Shaping the future

Chapter Summary:

- The NHS needs better data and intelligence to improve planning.
- A greater focus on prevention will require development of the public health workforce.
- Reducing variation and delivering productivity can only be truly successful with an engaged workforce.
- Review into impact of technology on educating and training the future workforce.
- Regulation, upskilling and advanced clinical practise vital to improving skill mix.

The previous chapter outlined the factors associated with patient need that would, without further action, result in an additional NHS workforce demand for 190,000 posts by 2027. This 'counterfactual' then becomes the context for the actions the health and care system will need to take now and in the coming years to shape the system's future requirement for staff and in turn the supply of staff required to meet our principle of sufficient supply.

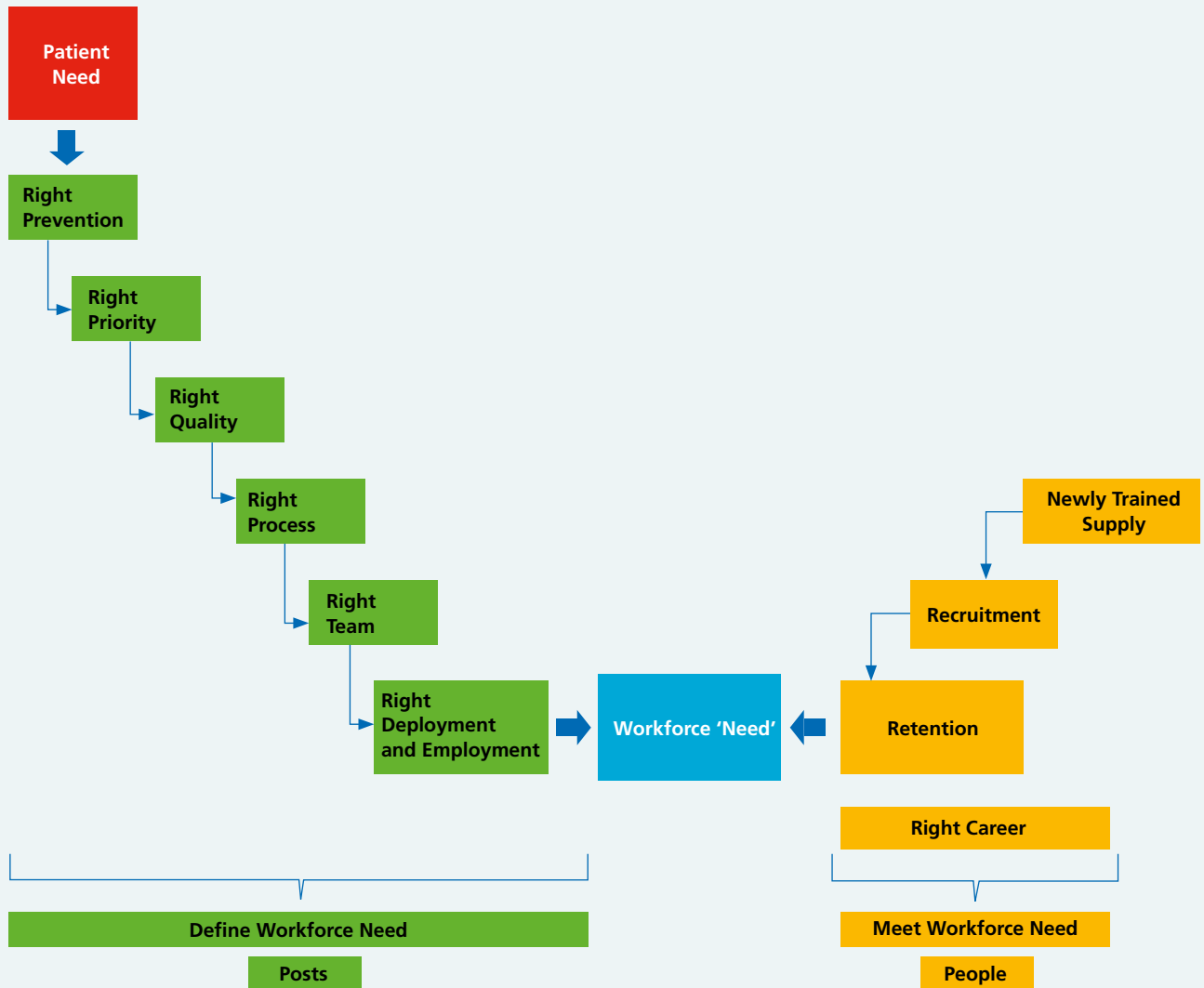
We set out below a clear workforce planning process to help the NHS deliver in this complex and changing world. The number of staff required is defined by a combination of patient or service user need and expectations, the standards of care sought and the delivery model. For too long we have talked about productivity as if it were simply a function of staff doing more with less, which may be how it has felt to staff as well.

Productivity should not just be seen as how we respond to avoidable need. It is about designing a system where our staff are supported to be more effective and efficient, building further on already world beating NHS performance identified in the Commonwealth Fund Report.

Many of the measures designed to ensure high performing teams and organisations are system planning activities which lead to people needing fewer interventions, only receiving care they need and want, effectively and efficiently. Most productivity is identified and delivered well before any interventions that would traditionally be seen as workforce related.

Following this process will allow the NHS to better achieve these patient benefits and ensure workload effectively managed and maximised around patient need:

1. **Prevention:** reducing need through prevention and population health improvement.
2. **Priorities:** for example, using Rightcare and Getting it Right First Time (GIRFT) to reduce unwanted variation across systems.
3. **Quality:** getting it right first time improves quality and better, more efficient care.
4. **Processes:** greater productivity and efficiency through initiatives like Lord Carter's review.
5. **High Performing Teams:** real teams, career paths and skills mix benefit productivity and safety.
6. **Deployment:** practices such as E-rostering to improve workload and productivity.
7. **Employment/Access:** new models such as small profession lead employer or networks.
8. **Current staff:** attracting, valuing, rewarding, retaining and developing current staff.
9. **New staff:** Attracting, valuing, and developing new staff, trainees, and students.
10. **The next generation:** designing flexible careers and promoting in schools.

Figure 19: Integrated Service and Workforce Planning

Better information for planning

Understanding, analysing and acting on NHS workforce data is complicated by the scale and breadth of the workforce, 1.3m people, in 350 different roles, moving between thousands of employers producing almost certainly the most complex and dynamic workforce picture in the world.

As more organisations beyond the NHS become involved in commissioning and delivering healthcare - local authorities and PHE in public health and NHS care delivered by independent sector organisations - some health staff groups are now employed by several different bodies. Developing a shared understanding of this across the whole system will improve planning and encourage co-ordinated action to address staffing issues.

Therefore, HEE, NHSI, NHSE and NHS Digital, working with DH, will review data requirements across the system and the collections we need to support them. We will also need to work with professional regulators to understand the dynamic of the whole workforce not just that employed by the NHS. Using this new data, HEE are committing to routinely publish profession specific monitoring reports from December 2017, to ensure more informed local and national policy. This will include the skills and resources to support local planning for Sustainability and Transformation Partnerships through Local Workforce Action Boards.

Prevention and Public Health

The Five Year Forward View called for a radical upgrade in prevention and public health to close the health and wellbeing gap, and to reduce the burden of avoidable ill health.

The system, predominately through Public Health England (PHE), has taken important action on prevention and public health including; plain packaging for cigarettes, first national diabetes prevention programme, sugar tax agreed to reduce childhood obesity, vaccinating over 1 million infants against meningitis and an additional 2 million children against flu, and public health campaigns including “Be Clear on Cancer” and “Act Fast”.

The FYFV recognised that the main impact of many of these actions would be beyond its five year timeframe, but as we develop a ten year health and care workforce strategy for England we should assess what impact these and other measures will have to reduce the burden of avoidable ill health and the extra workforce that ill health would otherwise have needed.

Developing the public health workforce

As well as reducing the demand for NHS and social care staff, we need to enable these benefits through the appropriate planning for, and investment in, the Public Health workforce.

To support this, PHE, HEE and others have taken a strategic approach to developing the public health workforce in Fit for the Future – Public Health People. This is relevant for all NHS staff, as well as those in public health, since it adopts a more preventive approach. The themes in the report mirror much of what we have seen in our principles and overall strategic approach, namely;

- Creating an attractive career
- Developing a stronger social movement for health (the informal workforce)
- Building 21st century skills
- Strengthening systems thinking and leadership
- Ensuring resilience, flexibility and mobility

Significant action has already been taken on each of these. Next year the focus will be on leadership and developing critical skills, including health economics, digital and commercial, to help transform the system.

In line with encouraging employment flexibilities elsewhere, we will also work to remove any barriers to movement between the NHS, local authorities, civil service and other sectors. This matters, because responsibility for public health is spread across different organisations, with roles for the NHS, local authorities, PHE, NICE, and HEE.

More recently, NHS England planning guidance has set out how local health and care systems will come together to deliver STPs. NHS England, PHE, HEE and other system leaders have been working together to equip the health and care workforce with the necessary tools to improve prevention and maximise wellbeing.

This has involved joint working at all levels. PHE and HEE have focussed on providing the public health specialist workforce needed, and the integration of the public health careers website (PHORCaST) into the Healthcare Careers website. This has included the continuing development of public health practitioners, especially in small but critical teams like sexual health, screening and immunisation.

We have also sought to impact on a much broader group of staff through embedding prevention into the curricula of health professionals, ensuring all staff focus on the issues around AMR, and training the current NHS and social care workforce to Make Every Contact Count.

There remains much more to do, which is why PHE and its partners are committed to a number of initiatives designed to benefit the workforce and deliver better services and outcomes for the populations we serve.

- PHE is working with HEE on producing an apprenticeship standard through a public health trailblazer
- Focussing on the difference health professionals can make to prevention by promoting the next stage development of All Our Health, and auditing midwifery interventions to reduce smoking in pregnancy
- The Leadership Academy will work with PHE on Future Public Health Leaders campaign,
- We will develop the Public Health Skills Passport, and
- We will seek to introduce a revalidation scheme for public health specialists from a non-medical background.

Together these initiatives will have a real impact on our current and future public health workforce but will also help us as a service get better at using all our health and care resources and staff to support public health and prevention.

Service and Workforce Quality and Productivity

The NHS provider sector faces a huge efficiency challenge: an historically unprecedented 2% pa efficiency improvement over the next five years. The Carter Report identified scope for improving the quality of care delivered to patients and delivering savings from associated efficiencies of around £5 billion, or 9% of operating costs, of which of 40% relates to optimal use of the clinical workforce.

Supporting and Engaging the workforce to deliver quality and efficiency

Our approach to workforce productivity continues to ensure a focus on quality and productivity and efficiency. We cannot compromise on quality and must deliver excellent services in the most productive and efficient ways.

The link between staff engagement and better quality outcomes is well understood and evidenced across high performing organisations and systems. Improving the well-being of staff will not only see more efficient service delivery but can also lead to improved clinical outcomes.

We have a much greater chance of delivering and sustaining improved workforce productivity if we focus on the people of the NHS as the solution to the productivity challenges. So the heart of our work to improve productivity is around aligning organisational and system wide people practices to fully understand where efficiencies can be made, learn from good practice and establish new operational management processes. For example, through better use of clinical staff, reducing agency spend and adapting good people management practices we believe we can unlock significant savings. There is exceptional practice already happening in the NHS but more needs to be done so that poorer performance is addressed.

Staff ill health is a key driver of absenteeism, with musculoskeletal and mental health issues resulting in the most days lost. The Carter report described how NHS sickness rates are high compared to the rest of the public sector (4% vs. 2.9%), and that there is significant variation between Trusts. There is an opportunity to improve the support offered to staff across the system and to position the NHS as a national example in the support it offers employees to stay healthy. The NHSE Healthy Workforce programme has been working with a cohort of Trusts to identify the core set of interventions that all Trusts should offer staff on health and wellbeing.

Quality & Efficiency Across the patient pathway

NHSI and NHSE, supported by NICE guidance and PHE, are leading important initiatives to ensure the work the system does is of the highest value, priority and quality

NHS Rightcare – reducing unwarranted variation in quality and activity

NHS Rightcare has been working to explore the variation around the country in activity and outcomes for patients and to understand whether this is random, warranted (i.e. true clinical variation based on geographical variation in need) or unwarranted and caused by under- or over- provision, failure to implement evidence guidelines or poor access for patients because of travelling times, socio-economic factors or poor health literacy.

Supporting commissioners and providers in reducing unwarranted variation not only supports the £4.3bn efficiencies required in the FYFV but establishes a mechanism through the Atlas of Variation to monitor this variation over time.

Getting it Right First Time (GIRFT) – addressing variation in clinical practice

NHSI's programme of work with and for organisations and systems across the NHS is focussed on whole workforce solutions with strong clinical leadership such as GIRFT. This work is based on raising the standard of clinical care delivered in 32 service areas to optimal levels (what good looks like) as defined by national specialty leads. This work will be developed to define the multi-disciplinary workforce required to deliver the desired standard of care, defined by the range of competencies needed, and the capacity to achieve the right clinical outcome.

Getting the most from the whole clinical workforce will involve matching the staff available to the demand for patient care, ensuring the right person is undertaking the right task, maximising the productive use of staff time (reallocation of non-clinical roles/responsibilities to reduce costs and improve outcomes), and mobile working using technology to work remotely within hospitals and in the community.

Unwarranted variation in operational productivity and performance

Trusts in particular will need to ensure there is effective, prospective job planning for all groups aligned with the clinical needs and budgets of identified service lines over a 7 day week. This is based upon increased understanding of the pattern of demand from data contained within the Model Hospital to identify points when demand puts capacity under most pressure. It makes it easier to deploy the right staff during these periods, using more flexible shift patterns to tailor capacity to match expected demand. The introduction of electronic rostering and job planning technology enables trusts not only to improve advance planning of their workforce (through improved leave and rota management), but also to take daily operational decisions about staff deployment to meet the care needs of patients, and minimise demand for additional temporary staffing.

The development of competence-based rostering will support further flexibility in deploying clinical skills to deliver high quality care. Better use of available digital technology will also be essential, enabling for example the typing of patient notes at the time of consultation; accessing up-to-date patient notes through Electronic Health Records (EHR) with mobile devices, reallocating staff during the day if an appointment is cancelled; matching staff members with patient requirements – including electronic ordering of equipment – and accessing real-time advice from specialists.

The effects of these interventions on improved quality of care and efficiency will be assessed at four levels depending upon the needs of trusts, based on a methodology piloted in 27 'deep dive' trusts. The success of the program will be evaluated against metrics agreed in advance. Other work streams involve re-configuring diagnostic services to improve quality, turn round times, sustainability and the introduction of new technologies. Key factors in future service design and workforce modelling will be the use of technology to connect diagnostic staff across clinical networks and to enable remote working, workload balancing, sub-specialisation and 7-day service resilience are.

NHS at the cutting edge – Technology and innovation

Digital Technology

Innovation in digital technology will increasingly change the way patients and staff perceive, understand, and manage health. In 2016, 41.8 million adults (82%) in UK accessed the internet every day compared with 16.2 million (35%) in 2006. People are adopting to new technologies more rapidly and it is changing how we relate to one another.

In a global ranking of countries best placed to take advantage of new information technologies the UK has maintained a top 10 place. As technology and innovation grows exponentially, revolutionising health and healthcare we will need to ensure;

- staff have the skills to respond to and adopt new research, technology and innovation;
- where care and training is provided facilitates the use of technology, and;
- recognise models of care can become quickly out of date as new technology emerges but care and compassion must remain constant.

People have an increasing appetite to be informed about their own health and that of their families. Technology is improving our capacity to meet that need but we are leaving some people behind.

Helping NHS staff to embrace the digital agenda is crucial for future services. HEE is leading a programme for the system to help staff to become comfortable enough with digital tools so that they can contribute to changing the way they work to carry out their roles faster, easier, and with better results.

In January 2018 we will launch the NHS Digital Academy that will train 300 Chief Information Officers and Chief Clinical Information Officers over the next three years. HEE will also support employers to encourage digital skills to become a core component of their ongoing personal development.

HEE also operates one of the most successful online health care learning systems in the world. The Technology Enhanced Learning System launched 3.3 million sessions in 2016 and currently has over 600,000 registered users. HEE will seek to grow this resource to meet the needs of the NHS and wider health and social service with an eventual target of 1 million users.

Genomics

Over 60% of us are likely to develop a disease at least partly genetically determined over the course of our lives. Sequencing an individual's genome, or that of their cancer or of an infectious agent, as one of the foundations of precision health, has the potential to fundamentally change outcomes for those people. We can now examine the whole of a person's DNA, every letter of their genetic code – their genome - quicker and cheaper than

ever before, with exponential advances in technology transforming the cost from more than £2 billion in 1990 to less than £700 in 2017, with costs set to further as newer technologies are introduced. These advances however, can only be fully realised when they are coupled with detailed clinical and phenotypic data, and integrated with the whole genome outputs through the ability to store and interrogate big datasets using complex data analytics.

The 100,000 Genomes Project, a government initiative announced in 2012, has been sequencing whole genomes in individuals with rare diseases and their family members, and in patients with cancer. A key principle of this world leading initiative, has been the recruitment of patients from the NHS to establish the mainstreaming of genomics from the end of the project in 2018. NHS England established 13 Genomic Medicine Centres as part of its commitment to the project to recruit eligible patients, provide high quality samples and clinical data and to validate the outcomes from whole genome sequences for clinical care purposes.

NHS England is introducing a new genomic medicine service into the NHS in October 2018 which will include a genomic laboratory network, a genomic testing directory, restructured clinical genetics services and updated NHS genomic medicine centres. This will be underpinned by a informatics and data infrastructure developed in conjunction with Genomics England, making us the first health service in the world to systematically introduce whole genome sequencing and other cutting edge genomic technologies into mainstream healthcare.

This enhanced genomic information will support the introduction of personalised medicine, working towards a future where the NHS will deliver a more predictive approach to healthcare meaning a more precise and earlier diagnosis, enabling more precision treatments and interventions, also enabling patients and the public to play a more participatory role in their choice of treatment.

HEE's Genomics Education Programme is developing education and training interventions to support this initiative as well as to upskill the NHS workforce to embrace genomic technologies. HEE have developed a toolkit of resources including e-modules, fact sheets and have launched the first the first Genome Sequencing Massive Open Online Course. 1.5 million research fellowships have been established and new training places and programmes for the specialist workforce have been introduced.

The need to further develop the workforce in the area of genomics as well as in gene therapy and editing and personalised medicine has been recognised and highlighted not only in the CMO annual report 'Generation Genome' but in recent Government Select Committees and in the Life Sciences Industry strategy.

Top facts

- HEE is funding training for 114 Clinical Scientists on Scientist Training Programme (STP) programmes associated with Genomic medicine
- HEE is funding training for 30 Higher Specialist Training posts in genomic medicine
- 550 Masters in Genomic Medicine commissioned across 10 universities

HEE will continue to drive innovative and robust education approaches, supporting ongoing transition to the NHS genomic medicine service, providing scrutiny and oversight of education programmes to ensure quality, whilst working with partners to integrate genomic medicine competencies into all undergraduate and postgraduate medical and non-medical curricula and training programmes.

HEE and NHS England will work closely to deliver targeted education and training resources in the joint commitment to embed genomic technologies into healthcare and to engage in a broader conversation with the public on genomics.

Technology Review

This game changing pace of development in relevant technologies such as genomics, machine learning and artificial intelligence, digitalisation and data analytics, bio-nanotechnology and robotics means they will form a key part of the future NHS. To enable NHS staff to make the most of these opportunities to improve services and help ensure a sustainable NHS, the Secretary of State for Health is commissioning a major independent review, led by Professor Eric Topol and facilitated by HEE. This will advise on

- how technological and other developments (including in genomics, pharmaceutical advances, artificial intelligence, digital and robotics) are likely to change the roles and functions of clinical staff in all professions over the next two decades to ensure safer, more productive, more effective and more personal care for patients;
- what the implications of these changes are for the skills required by the professionals filling these roles, identifying professions or sub-specialisms where these may be particularly significant;
- the consequences for the selection, curricula, education, training, development and life-long learning of current and future NHS staff.

The review will be based upon the best available UK and international evidence and views of experts in relevant fields, having regard to building on and accelerating the ongoing programme of work to respond to these changes within the United Kingdom's professional regulatory and educational bodies. It will provide interim conclusions to the Secretary of State by June 2018 and a final report by the end of 2018.

Planning for the wider workforce consequences of technology

Successful adoption of new technologies on the future requirements for workforce creates the possibility of a 'frontier shift'. The impact of technology such as robotic surgery in UCL's Urology department for prostate cancer is to enhance both patient experience and outcome's and deliver remarkable productivity. To quote the lead consultants, "using the machine we can do 500 cases with 5 surgeons where is used to take 50". This kind of technological change is here now and we must be ready to adapt and adopt.

Last week we announced the expansion of capacity to serve the increasing diagnostic needs for cancer patients between now and 2021. At the same time we acknowledge that in the near future that activity might increasingly become undertaken by technology. It is critical therefore that we acknowledge the generic skills and knowledge of professionals and make their ongoing development and adaption to new roles as easy as possible.



A modern flexible workforce – advanced practice and multidisciplinary working

Flexible and responsive multi-disciplinary teams have a profound effect on the lives of the patients they serve and the staff who work within them. They can allow the skills and ambitions of individuals to be fully realised and provide systemic resilience to the significant problems that can be created by potential over reliance on individual professionals.

Examples of high performing, highly valued teams are scattered across the health and care landscape and yet there are still areas where more traditional patterns of team design dominate even when, there is a known shortage of the profession in question.

Multi-disciplinary team working must not be simply seen as the solution to a professional supply problem. They must be seen as an appropriate response to the NHS constitution, how we respect our fellow health professionals and the wider team, and the framework within which all staff and professionals can maximise the use their valuable skills.

There have been significant concerns about these innovative and flexible responses, and unaddressed these concerns readily become barriers to adoption on a wider scale. We must therefore address these concerns head on, addressing issues where concerns are clearly valid, and challenging, through dialogue, where concerns have less substance.

Outlined below are example of where the system is already working to address these concerns and barriers to adoption. We also need to address key issues such as funding for ongoing development, scope of practice and supervision, and the interface between the modernisation of professional regulation outlined below and credentialing.

Enhancing workforce capability through advanced clinical practice

Advanced clinical practice (ACP) is an increasingly effective and attractive workforce solution to a number of issues. The offer of a new way of working in a new career allied to better understanding of workforce capabilities and supporting better senior decision making within teams is increasing the uptake of advanced clinical practice.

Given the increasing pressure on services from increased demand it is important teams have all the support they need. ACP roles enhance the skills and flexibility of clinical teams across the full range of health and care settings. These practitioners are already working across a number of key areas including placing the most appropriate clinicians earlier in pathways to maximise self-care and prevention, helping staff to work to their full trained capability and across professional boundaries and 7 day working to name but a few.

Through Shape of Training and Shape of Caring the opportunities to support the development of wider workforce roles are aligned and linked across all professions to build transformation of the workforce at the bedside, in the consulting room or community by training teams side by side. While decisions about developments in skill mix should always be evidence-based, it is essential for the future that the NHS has the right number of skilled staff operating in the right settings.

Advanced Clinical Practice Framework

HEE working with NHSI and NHSE, employers, practitioners and service users has developed an advanced clinical practice (ACP) Framework. This is a first for England and establishes a shared understanding of the roles and how they can be deployed across all clinical groups to deliver better care for patients, releasing the full potential of the concept. It also offers opportunities for mid-career development of new skills in areas such as prevention, self-care, shared decision making to help deliver the FYFV. The national recognition and the training routes also aid increased workforce flexibility. HEE, NHS Improvement and NHS England will work to ensure this framework is embedded through the system.

Future work programmes

HEE is developing further the RCEM blueprint for advanced practice by working with other Royal Colleges and NICE to help set national competencies and capabilities. These are in areas such as ward based surgical care, eye health pathways, musculoskeletal practitioners in primary care, the emergency department, and paramedics within primary and community services as well as new professional roles like the mental health ACP and the radiography ACP. These are being developed alongside a renewed focus on the consultant practitioner role to help us keep our brightest and our best.

Credentialling

HEE will explore with professional regulators and others the concept of creating 'credentials', available to all regulated healthcare professions. In this model, training would be available to appropriate registered healthcare professional allowing, once the training is completed, individuals to extend their practice in that defined area irrespective of their professional group. Examples could include endoscopy, ultrasonography or joint injection.

Case study: Eye Health whole workforce

Ophthalmology is taking a multidisciplinary workforce approach to understanding its workforce and capacity challenges. Ophthalmology faces many challenges; it has small specialist workforce and faces increasing demand placed on the Hospital Eye Services because of the demands of the increasing ageing population. One in ten of all NHS out-patient appointments are in the Hospital Eye Service and cataract surgery is the most commonly performed elective operation in the NHS. In response, all the relevant professional bodies have united to support the creation of efficient and productive teams, to realise the full potential of all staff.

Ophthalmology has a detailed programme of medical reform on going, seeking to broaden flexibility of the medical training. The Royal College of Ophthalmologists, the College of Optometrists, the British and Irish Orthoptic Society and the Royal College Nursing developed a common clinical competency framework in 2016.

This agreed the capabilities required by the multi-disciplinary workforce stepping up into roles across the four main care pathways, offering a framework for the contribution and future potential of the workforce to be better understood at three levels of practice.



Supporting upskilling of the wider workforce

To achieve upskilling of the wider workforce and support the development of multi professional teams and the 'modern firm' HEE has led a number of initiatives to support the advanced clinical practitioner approach. Advanced clinical practice is a good example of the flexibility of the apprenticeship agenda as ACP apprenticeships are created at these advanced levels. We are working with universities to support the work based learning and assessment development required.

Supporting a more flexible future workforce through regulation

The UK's model of professional regulation for healthcare professionals has become increasingly complex and outdated. It needs to change to protect the public better, to support our health services and to help the workforce meet future challenges. The UK Governments have five objectives in taking forward reform:

- Improve the protection of the public from the risk of harm from poor professional practice;
- Support the development of a flexible workforce that is better able to meet the challenges of delivering healthcare in the future;
- Deal with concerns about the performance of professionals in a more proportionate and responsive fashion;
- Provide greater support to regulated professionals in delivering high quality care; and
- Increase the efficiency of the system

The Department of Health, in collaboration with the devolved administrations, has published a consultation seeking views on proposals to reform the regulation system for healthcare professionals in the UK. The consultation presents a number of proposals that aim to address the objectives by:

- Allowing the regulation system to respond to changes in how healthcare is delivered;
- Setting clear criteria for which groups should be regulated;
- Reviewing the number of regulators, with the potential to increase the efficiency of the system;
- Updating to provide consistent, flexible powers to the regulatory bodies to deal with fitness to practise processes proportionately;
- Build on and increase the support to professionalism of all registrants; and
- Increase the joint working and shared functions of the regulatory bodies.

The key areas considered in the consultation are: who should be regulated; the case for fewer regulators and joint working between regulators; improvements in fitness to processes; and supporting professionalism. The consultation also covers the autonomy of regulators, better governance and the fees charged.

The consultation can be accessed at the link below and closes on 23 January 2018.

<https://www.gov.uk/government/consultations/promoting-professionalism-reforming-regulation>



Chapter 8

Developing the NHS workforce

Chapter Summary:

- Each workforce group has its own specific issues as well as those cross cutting across the service.
- Multi-disciplinary working is a priority, but focussing on individual professions is also important.
- Advances in technology and innovation will radically change healthcare.
- A leadership strategy for the whole NHS is being implement.
- Seven workforce groups: medical; nursing and midwifery; dental; AHPs; healthcare science; Pharmacy; and the wider workforce are covered.

Improving leadership across the NHS

Introduction

Leadership with the right skills, values and behaviours is key to successful health and care systems and to delivering better patient outcomes. In 2015 two reviews of NHS leadership by Lord Rose and Ed Smith found the NHS did not have a consistent approach to training its leaders and the environment did not always support managers focussing on service improvement.

The national bodies published a leadership strategy, *Developing People – Improving Care*, in 2016 to deal with these issues. Identifying and supporting leaders across all levels and disciplines will aid clinicians and managers to step up, lead and work together in addressing system and organisation challenges.

All leaders as a priority

The Leadership Academy (LA) supports and develops outstanding leaders across the NHS to ensure they promote a culture of compassion, inclusion and collaboration that puts patients first. Over 12,000 NHS staff undertook leadership training in 2017.

The Leadership Strategy identifies five leadership conditions from high-performing systems to improve the quality of care for patients:

- Leaders equipped to develop high-quality local health and care systems in partnership
- Compassionate, inclusive and effective leaders at all levels
- Knowledge of improvement methods and how to use them at all levels
- Support systems for learning at local, regional and national levels
- Enabling, supportive and aligned regulation and oversight

To deliver an NHS where these conditions thrive the LA has a range of programmes aimed at leaders at all levels. With partners, the NHSLA is committed to increasing the number of senior NHS clinical leaders, including a fast track currently supporting 35 staff, and work with NHSI and NHSE to develop nurse directors.

To grow the number of senior clinical leaders the LA will implement the Faculty of Medical Leadership and Management review of clinical leadership. The Academy of Medical Royal Colleges has recommended quality improvement science should underpin all doctor's training. As the FYFV requires local system leaders to work across organisations, the LA has teamed up with Yale University and PHE to deliver a new cross- boundary training programme.

To build a more inclusive system with more BAME senior leaders, the LA has quadrupled its positive action development programmes to 320 next year. Also, the award-winning Graduate Management Training Scheme (GMTS) will continue growing to an intake of 500 per annum by 2021, and 1,000 per annum beyond that.

Building on the West Midlands pilot the LA will create talent boards in every region, supporting local organisations to create talent pools. Future leaders, including from outside the NHS, will receive support and training to succeed through the High-Potential Scheme.

Primary care will be targeted with new courses delivered by a network of senior frontline leaders and HR professionals, which will help grow course attendance by 60% to 20,000 by 2021.

To deliver wider choice while maintaining quality and value for money the LA will create a digital marketplace with quality assured and 'kite-marked' suppliers. The LA is also supporting the national network of Freedom To Speak-Up Guardians to grow learning cultures locally.

NHS Improvement leadership interventions

NHSI and the Care Quality Commission (CQC) have revised the Well-Led Framework, alongside a culture and leadership toolkit, supporting providers implementing effective leadership and governance systems to oversee safe, compassionate care. Further local NHSI programmes develop directors and boards and both culture measurement and improvement.

Local leaders are also helped to deliver efficiency using the Carter review, the Model Hospital and GIRFT. NHSI and The Health Foundation also fund and develop the Q community; a growing network of over 2,000 clinicians, managers and policy specialists collaborating to improve the quality of care and drive value.

Management

Many of the challenges faced by the NHS – including staff experience, service transformation, safety, quality and financial performance – require excellent leadership but also excellent management by senior and mid-level managers. The LA will deliver skills training for management, enhancing the NHS as a place where careers are forged, rather than merely a place where jobs are done.

NHS staff groups

The previous chapters have considered the NHS workforce through a cross-system lens and through service priorities. Equally important is how the future is seen by individual staff groups. This section covers action to meet demand for numbers of staff in the NHS and to improve their education and training, enhancing the capabilities of the current and future NHS workforce.

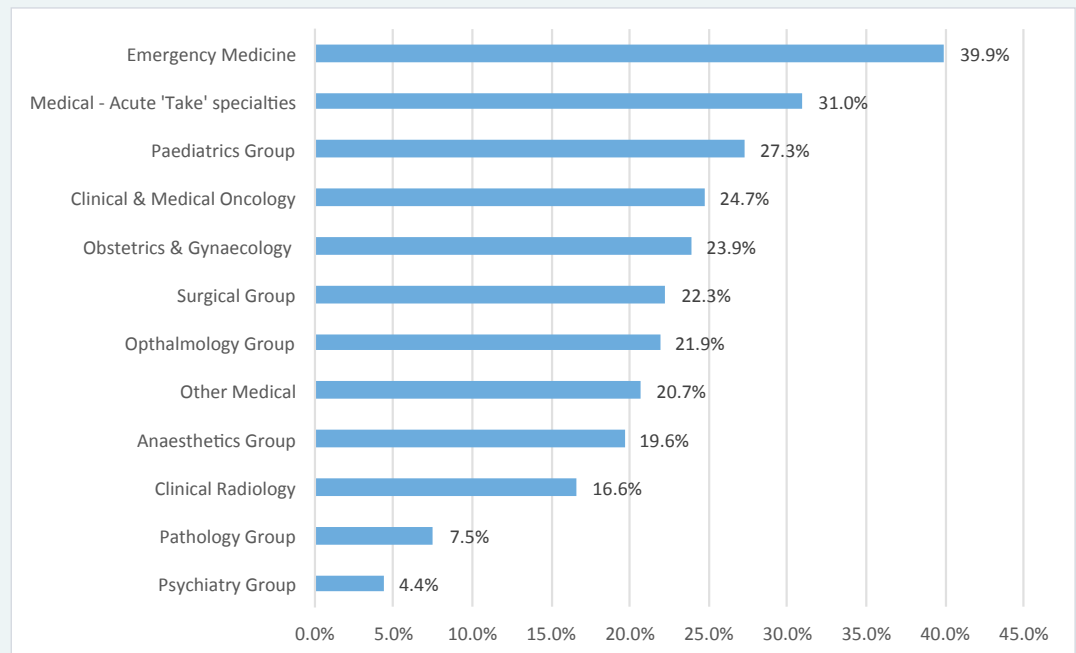
The data here includes HEE's latest and most comprehensive analysis of multiple data sources, including provider plans, the Electronic Staff Record and Regulator databases. HEE will use this new data to regularly publish profession specific reports, as well as provide the resources locally to support providers, STPs and local workforce advisory boards with bespoke content.



Medicine

Overview

Figure 20: Consultant Growth by Specialty / Group – 2012 to 2017



Introduction

The NHS medical workforce includes many different groups – GPs, consultants, academics, staff grades, associate specialists, trust grades and doctors in training. They work in multidisciplinary teams across hospitals and the community providing diagnosis, treatment and care. They are NHS leaders, academics and innovators, committed to the highest quality of care across every specialty.

Ensuring we have sufficient supply of doctors across all grades and specialties is key to excellent patient care. This chapter addresses long-term supply, improving education and training and working lives and asks what more we can do to support doctors dealing with pressures on service delivery and training. The medical profession has seen the largest and most consistent growth of any profession but this masks variations in geography and specialty.

In some areas and in some specialties employers are finding it challenging to maintain cover. The training timeframe, from undergraduate through postgraduate to consultant, means supply side actions take years to translate into middle-grade doctors and at least a decade for GPs and up to 15 years for consultants. Today's first year students will not be consultants until the early 2030s.

The way doctors make career choices is changing – for example increasing numbers step off the training ladder for a time, before returning. The NHS needs doctors with both specialist and general expertise, and in numbers which respond to new service models and changing patterns of disease. This requires ongoing reform to medical education and training.

Medical supply

The numbers of doctors in postgraduate training programmes are determined by HEE to meet the future needs of the NHS for consultants and GPs. Building on work by the GMC and HEE we will continue to improve training so that attrition is reduced, doctors can move between specialties more easily and flexibility within programmes encourages doctors to stay in the NHS. However, providing cover for rotas is also vital for patient care and to protect the quality of training. Therefore medical supply planning must not simply consider doctors in formal training programmes.

The NHS has relied heavily on overseas doctors to meet patient demand and will continue to for many years. However, in line with the principles for workforce decisions outlined in chapter one and the approach of the NHS as an ethical “global citizen” in chapter three; we will not plan for continued reliance on overseas doctors. We should train the doctors the NHS needs for the future. The government has announced 1,500 more medical school places from 2018 which we will use to target areas with the most need, widen participation from non-traditional entrants and produce more GPs and psychiatrists.

We need to keep demand and supply under regular review – the increased medical school intakes are based on 18-month-old assumptions and we know participation rates in general practice are falling. Therefore we need to start a conversation about the need for any further expansion of doctors graduating in 2026 and beyond.

HEE will also investigate, with partners, whether it would be beneficial to the NHS if a proportion of medical school places were ‘tendered’ more regularly ensuring medical school places can flex more easily to reflect NHS need.

Increasing entrants to medical school, while right to secure the future, is not a solution to current pressures. To help trusts alleviate these pressures HEE will improve support to non-training grade doctors, support better multi-professional team working, and, in the short term, ethically recruit overseas doctors into training.

Programmes giving overseas doctors a period of working and training in England before returning home can improve healthcare overseas. HEE is also running pilots involving longer staff exchanges in clinical radiology and emergency medicine.

Reforming postgraduate training

The NHS Foundation Programme is a world-leading medical education offer that supports newly-qualified doctors, developing generalist clinical skills and informing their future career choices. HEE has worked with UK partners to develop the programme since 2013, supporting service need by increasing the number of doctors completing a GP, Community or Psychiatry post.

HEE supports moving the point of medical registration to the end of medical school but recognises more discussion is required to ensure all voices are heard and agreement about the best way forward is reached. The GMC also proposes the introduction of a Medical Licensing Assessment. HEE with partners, will review the Foundation Programme in England during 2018 to assess how it can best support the development of the doctors of tomorrow.

The transition to specialist training brings a number of issues into focus.

Doctors tend to stay in the area where they trained. The geographical distribution of training programmes therefore affects the future supply of doctors so HEE will review this geographical distribution in 2018. As well as future need the review will address providing all doctors with high-quality training and the role trainees play in service delivery, especially in small or medium-sized hospitals.

The perception that postgraduate training is producing too many specialists and not enough generalists has been raised by the service and in Shape of Training so supporting the development of general skills in formal training is sensible. However, defining what a generalist doctor does in common across all specialties and therefore how one would be trained has been challenging. This has advanced following the publication of the GMC Generic Professional Capabilities in Excellence by Design. HEE will work with the GMC and colleges to increase clarity on generalist training and transferable competencies.

RCS and HEE have developed the Improving Surgical Training initiative to seek to solve this issue for general surgery training by explicitly redressing the balance in favour of generalism without impacting on future consultant career opportunities. The project is being extended to pilots in urology and vascular surgery from 2019 and HEE supports further expansion where there is specialty demand.

Increased flexibility in education and training would improve doctors' working lives and allow providers to react and implement new services quicker. HEE's Medical Education Reform Programme (MERP) is enhancing the structure and delivery of postgraduate medical training to ensure doctors are supported, valued and provided with the means to be the best they can be. This will include supporting doctors stepping out of training for whatever reason to continue developing their skills and knowledge. This will attract and retain high-quality doctors by providing the career flexibility they want and the adaptability the service needs.

Credentialing for doctors identifies key elements of training, or 'credentials', where extra training or development would allow a doctor to change specialties or increase their range of practice much quicker than starting a new specialty education programme. Partnership between the royal colleges, GMC, devolved administrations and HEE will progress credentialing.

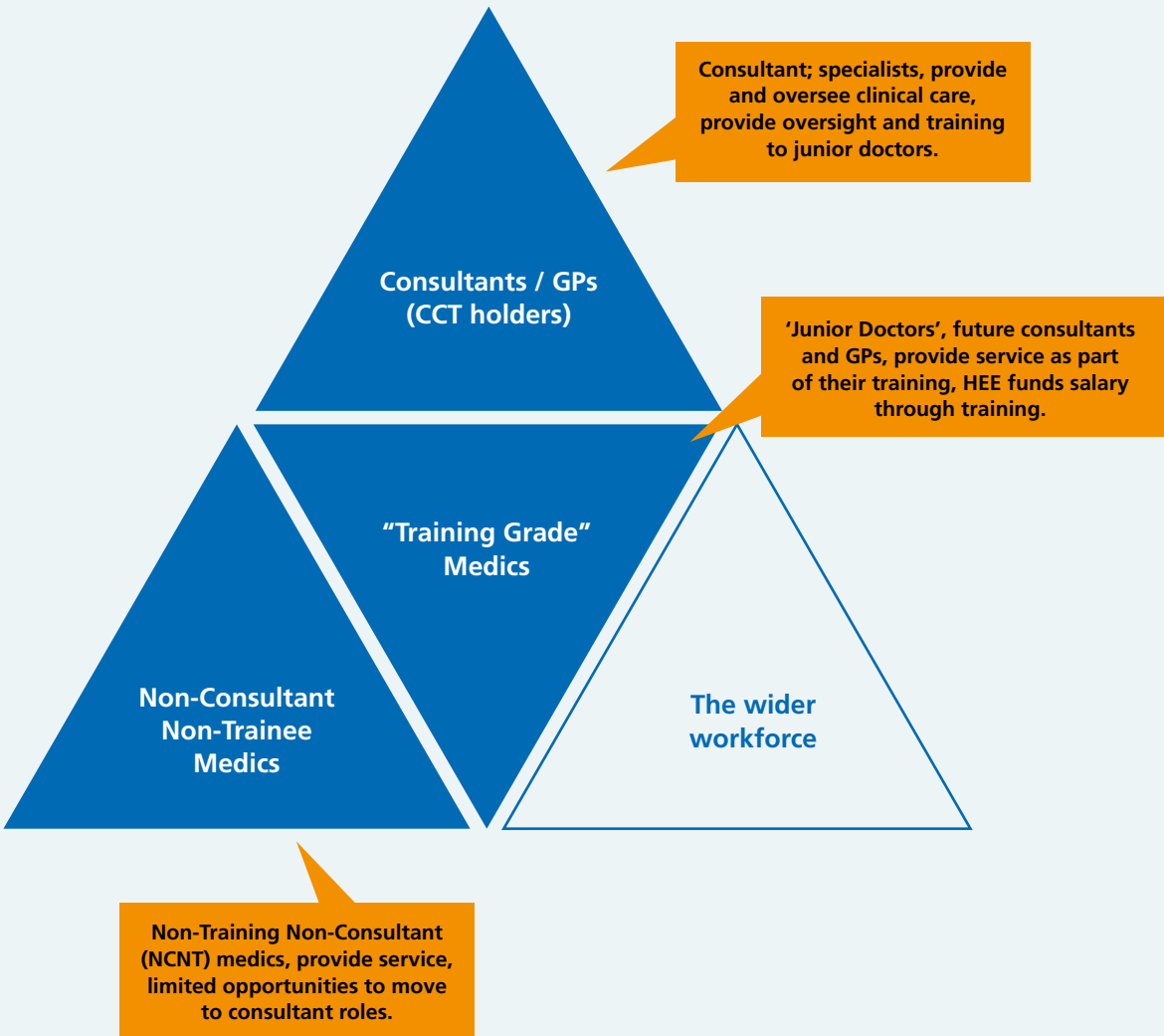
Doctors provide a huge amount of service while in postgraduate training. Every vacancy increases workload for other staff and can adversely affect the whole education and training environment. There are now several thousand 'Trust Grade' doctors often employed to fill rota gaps who are not part of postgraduate training programmes. This is often not the best option for doctors themselves nor the NHS in the longer term. HEE has been exploring how to help NHS providers overcome the challenge of meeting service needs while providing a good training experience.

There is a wealth of evidence that multi-professional teams (MPT) improve safety, patient experience, productivity and the working lives of clinicians. Building on the Annual Review of Clinical Progression (ARCP) HEE will seek opportunities for local education and training that benefit doctors not in formal training and staff stepping up into advanced clinical practice roles.

As the Blue Triangle illustrates, this blurring of professional boundaries through education and training across whole clinical workforce can reduce the impact of individual rota gaps. This improves the working lives of doctors and enables employers to improve access to education and training. This will aid retention and job satisfaction. Through our postgraduate deans, HEE will work with trusts to ensure local education and training support for clinicians development of clinicians out-with formal training programmes, such as trust grade doctors.

HEE currently invests £12m per year in the education and training of Staff and Associate Grade (SASG) doctors, who make up 9% of our medical workforce with trust doctors. A genuine focus on recruiting, investing, supporting rewarding and recognising SASG doctors can significantly help deliver medical rotas. We need more discussions and ideas about what re could be done to support and value the SASG workforce.

Figure 21: The medical workforce



HEE will continue work with royal colleges, ALBs and others, using local intelligence, to determine the numbers required for medical specialty training to produce the consultants and GPs of the future.

Improving the experience of work for postgraduate doctors

Junior doctors who leave their posts during training have identified other training opportunities, inflexible pathways and limited scope for part-time working as reasons.

HEE has led work, welcomed by junior doctors, to improve the quality and experience of training. Employers, colleges, NHSI and the GMC have all been engaged in projects to improve doctors' NHS training experience. We recognise more needs to be done to ensure consistent, full access to training opportunities, which meet their needs and the needs of the service.

Collectively, we will use the annual Enhancing Junior Doctors Working Lives update, the GMC Trainees Survey and other feedback to address issues raised. This will build on current work to improve junior doctors which includes;

- i. Revising HEE's Code of Practice with trusts so doctors know their rotations and duty rotas 12 and six weeks in advance respectively.
- ii. Local Safe Working Guardians and postgraduate deans will use the Quality Framework to factor in rostering and intensity of work if it impacts on access to, or quality of, training.
- iii. Following concerns that HEE is not an employer and therefore not covered by whistle blowing legislation, it voluntarily modified trust contracts to give junior doctors the right to take HEE to court should they believe it has acted to harm them and their training for raising service or staff concerns.
- iv. Responding to concerns about burn out and enabling more portfolio and flexible careers; HEE, employers and the GMC will pilot part-time working for higher specialty trainees in emergency medicine.
- v. The Royal College of Physicians have piloted Flexible Portfolio Careers by individualising training within medical specialties and supporting the expansion of the Chief Registrar project with support from HEE.
- vi. HEE invests £10 million per annum supporting doctors returning to training after a period of absence. The impact on these doctors will be significant and the service will benefit from more confident doctors re-entering the workforce.
- vii. Consolidating HEE's study leave budget will ensure trainees have access to the education resources required to progress through training, regardless of specialty, location or point in training. HEE, the colleges, NHS Employers and the BMA will work to reduce individual costs of training.
- viii. HEE's new specialty training recruitment process allows applicants who are primary carers, have a medical condition or disability, to be pre-allocated a programme, and provides greater opportunities for doctors to apply jointly to work in the same area of the country.
- ix. HEE has developed principles on the length of training rotations to ensure minimal geographical movement of trainees while ensuring satisfactory experience and acquisition of curricular competencies.

In addition, HEE is supporting the 'modern firm' pilots with the RCP and RCS to enhance the supportive training environment, pastoral relationships and continuity of care associated with the old 'firm' within the modern multi-professional team. The role of doctors responsible for education and training needs to be recognised and protected.

As a final reflection on how doctors in postgraduate training roles are perceived and view their own position, a recent debate has been started on the right name for doctors in post-graduate training – in particular reacting against the implications of 'junior doctors'. It is likely this issue will be raised in response to this document.

Aligning roles with new service models

Looking further into the future, and building on models like ACSs, we will need to consider how both consultants and GPs can move more readily between work across traditional organisational boundaries. More flexible employment models may be part of the answer for these groups, as they will be for other staff.



Nursing and Midwifery

Introduction

Nursing and midwifery are the two largest professional groups working across health and social care in England, both constantly evolving, adapting to challenges and opportunities to better meet the health needs of our population. The work of these professions impact across the health and care system and are reflected in every part of this document.

This section sets out a number of key areas of action that are underway and signals the start of a conversation as to what can be done to support the professions going forward.

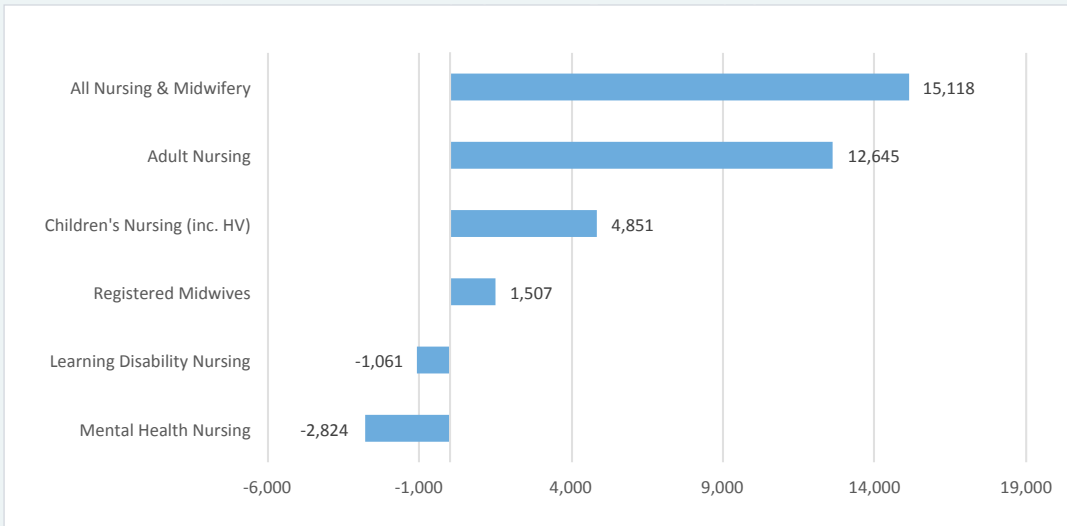
Nursing has developed significantly in the last 30 years with the development of the academic base of nursing delivering change in research, clinical practice and professional roles, as well as cementing the professions as credible and adaptable leaders. 'Leading Change, Adding Value' (LCAV) identified how nurses and midwives are vital to closing the FYFV's three gaps demonstrating leadership and impact on individual and population health and well-being. LCAV places the focus on prevention and unwarranted variation, positioning the professions to measure and quantify the significant impact of their everyday practice. An 'Atlas of Shared Learning' platform will collate and demonstrate the leadership contribution of the professions to delivering the priorities of the FYFV outlined in chapter 5.

The current workforce

A recent IPSOS/MORi poll placed nursing as one of the most trusted professions in the country, alongside doctors. In recent years public confidence in the system and professional pride in nursing has been restored following the Francis Inquiry. The publication of 'Compassion in Practice', which first introduced the concept of the '6Cs' as a value base across the profession has helped with this.

Since 2012, the number of NHS nurses in post has risen by 15,000, including 12,500 in the adult acute sector, with mental health, community and learning disabilities nursing numbers declining.

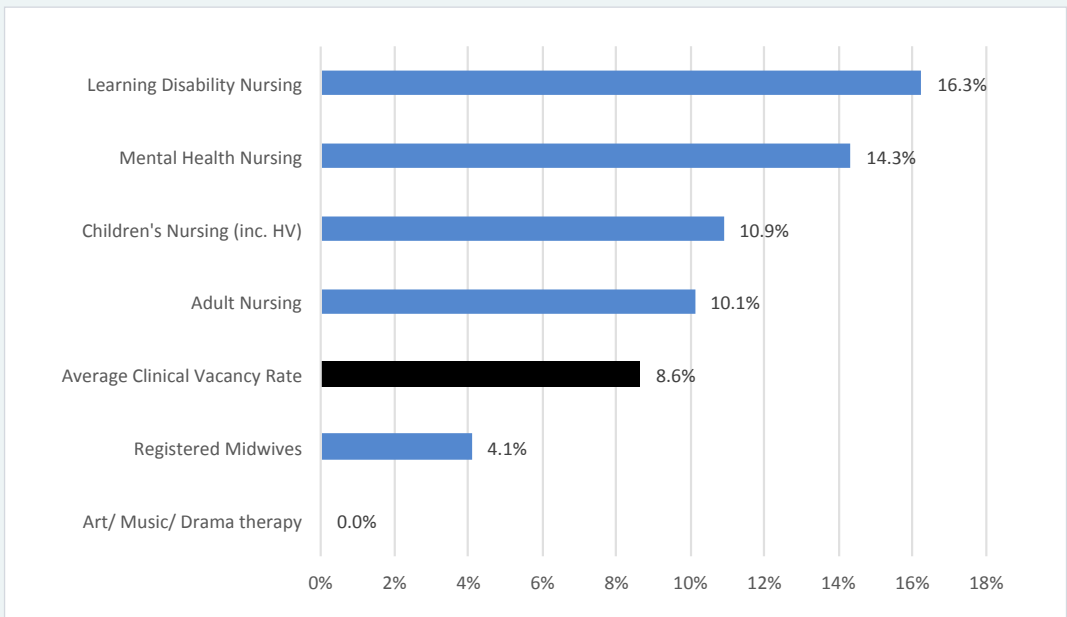
Figure 22: Growth / Reduction in NHS Employed Nursing and Midwifery by Branch – 2012 to 2017



Source: HEE analysis of ESR data

Despite the overall increase in numbers, we still need to do more to meet increased demand as we still have considerable numbers of vacancies.

Figure 23: Nursing and Midwifery vacancy rates – March 2017



Source: HEE analysis of ESR data

There are over 690,000 registrants on the UK Nursing and Midwifery Council (NMC) register, working in the NHS and other sectors. In the changing landscape of health and care, there is a huge opportunity to enhance the role of nursing and midwifery and ensure future generations are attracted to the profession in greater numbers. Modern regulation is central to protecting the public and ensuring a fit for purpose profession, which is why the DH is consulting on the reform of existing regulatory arrangements across healthcare.

Future context and opportunities

We need to focus on the future to meet our workforce challenges. Registered nurses and midwives work in many roles in different sectors, including practice, policy and academic environments. There is no single solution to workforce supply and demand so this chapter looks at the challenges we, as a system and as professions, need to face together.

The development of a comprehensive career framework will enhance efforts to attract more people to the profession by positioning nursing as a modern career, within a contemporary healthcare workforce. Importantly, HEE is also widening access through the creation of nursing associates and apprenticeships, both of which provide clear progression routes to the degree profession.

Modernising training and practice

The ongoing development of the graduate registered nurse as a member of the multidisciplinary team is vital to reducing unwarranted variation, and improving patient experience and outcomes. Therefore it is essential education, training and research are aligned with system changes and that the role of academic leaders in the shaping of evidence based practice, service delivery and leadership is recognised.

In 2015 HEE commissioned the 'Shape of Caring review', led by Lord Willis which recommended the introduction of what has become Nursing Associates as well as looking at the structure of the nursing degree.

Subsequently HEE developed 'Raising the Bar' aiming to provide a fulfilling, flexible career pathway with clear progression opportunities from entry right through to doctoral studies and beyond, welcoming a diverse range of applicants. Widening participation in healthcare professions is good for patients, communities, the NHS and individuals.

Valuing the care assistant role, HEE worked with Skills for Health and Skills for Care to develop the Care Certificate which introduced minimum training standards in health and social care. Health care assistants provide a significant amount of direct care, yet historically have had little access to funded education and development. The Care Certificate provides a firm foundation to build a career.

The new nursing associate role was announced in 2015, sitting between healthcare support workers and registered nurses to deliver hands-on care as part of the nursing team. The role also further develops prevention and health promotion skills in the workforce, helping Make Every Contact Count. Following huge interest in the role both from providers and aspirant nursing associates, some 2,000 people are now in training. HEE will work with partners to train a further 5,000 in 2018 and 7,500 a year from 2019.

Nursing associates

8003 applied for 2000 places

84% female, 16% male

Academic achievements: 3% with degrees, 4% with level two qualification

Age ranging from 18-65: main recruits in 24-35 category

End of quarter two retention – 95%

Wide diversity of applicants, representative of communities they serve



Danielle Meegan, Donna Bangham, Luke Smith and Sian Cadman – West Midlands trainee Nursing Associates

Nursing associates enable the NHS and social care to access untapped potential, widen access to nursing and develop a more diverse workforce. This NA role also acts as a model for new roles and routes in other professions.

HEE launched a pilot scheme to recruit a group of aspiring nurses with little or no previous care experience into healthcare. This Pre-degree experience programme offered the opportunity to those considering a career as a registered nurse to gain practical insights into the role, including whether it was the right career for them to pursue, and also for employers to advise on their suitability for the role.

HEE has worked with higher education institutions to embed values-based recruitment into undergraduate programmes. The public can now be confident that each newly-qualified nurse has been assessed as having the appropriate values base before starting their nurse training and this continues.

Similarly, the NMC review of pre-registration nurse education standards encompasses flexibility and places an emphasis on outcomes rather than competencies. The proposed standards should support the parity of esteem between physical and mental health and broaden career opportunities.

Finally, there is work underway to address the post-graduate level of the career framework, which includes considering the outcomes of the NIHR study into clinical academic careers. This will offer a complete and flexible pathway from Care Certificate to doctorate, while recognising not everyone will wish to follow the whole route.

Securing supply and retaining existing staff

We have more nurses and midwives in the NHS than we did five years ago, but posts have also increased by almost 43,000 to meet demand leaving a significant shortfall to be filled by bank and Agency Staff. Between 2012 and 2016 HEE increased nurse undergraduate commissions by over 15%, the first cohort of which only entered NHS employment this year.

There are 299,000 registered nurses and over 22,000 midwives currently working in the NHS and over 36,000 vacant posts, 92% of which are covered by temporary staffing. There are many actions currently being taken to improve supply, including HEE increasing and widening access to training. These programmes increase the diversity and skill mix of the workforce.

There is also work piloting post graduate pre-registration programmes which attract those from diverse backgrounds and accelerate nurse training. NHSE have funded a pilot programme for 40 post graduate students in mental health and learning disabilities, developing them as future leaders to work in areas with significant workforce challenges.

Nursing will have to compete hard for young minds to come into nursing as their choice of careers is far greater than ever. Nursing needs to be able to articulate the career offer not only to those as direct entry, but maximising the mobility of those who join the nursing profession through alternate routes.

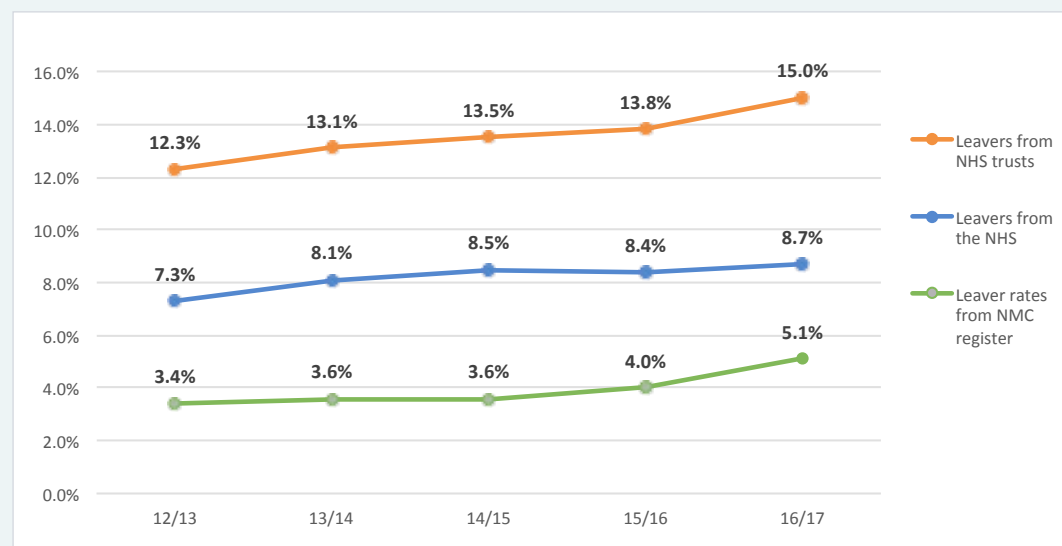
The reform of education funding and the increase of clinical placements by over 5,000 annually from 2018, an increase of 25%, will provide an important boost to the supply of nurses by the early 2020s and beyond. As discussed earlier, the number of UCAS placed acceptances for 2017 reduced by 3.0% but an HEE data collection direct from universities suggests however that the overall number of students is broadly similar to 2016 when other (non-UCAS) students are included.

The new funding system adds a challenge to planning for future numbers, but there is a clear desire for growth. The new data and analysis tools available locally and nationally will be important as nurse leaders and workforce planners identify future need, taking into account national, regional and local drivers including: population growth, changes in healthcare and technology, funding, societal needs and system integration.

There is a real appetite from the public and professions to modernise the image of nursing and midwifery to reflect that while the profession is proud of its heritage, it needs to advance the image to graduate practitioners with underpinning scientific knowledge, expertise and compassion. This will help retain the current workforce and attract the future one. This work, led by NHS England, will align to the global programme Nursing Now! led by Lord Crisp and supported by a number of stakeholders including HEE and national and international nursing organisations.

There has been an increase in nursing and midwifery 'turnover' in the NHS from 12.3% to 15%, with significant variation by region and sector. The number of staff leaving NHS employment rose from 7.1% in 2012 to 8.7% in 2017. The cumulative impact of this deterioration has been over 15,000 less nurses in NHS employment than would have been the case if retention had been maintained at the level coming into 2012.

Figure 24: Nurse leaver rates from trusts, the NHS and the NMC register



There is a large variation in turnover between different providers, sectors, and regions. The range is, 9% to 25%, but even removing outliers, the difference is nearly 3:1. Issues such as housing, transport and the local job market play a part in this variance.

As detailed in chapter 3, NHSI is leading work on improving retention. The NHSI Retention Support Programme on nursing is providing targeted, clinically-led support to organisations. Sixty acute and community providers, alongside all 53 mental health providers are part of this programme which aims to improve retention and reduce both turnover and leaver rates from the NHS.

NHSE has also developed a programme with similar aims for general practice nurses. LCAV also includes promoting and supporting the health and wellbeing of the workforce to reduce sickness absence and contribute to improved retention.

HEE continues to encourage nurses who have left practice to return through Return to Practice campaign. This provides nurses with refresher training and a route back into the NHS. 2,461 nurses have completed this program since 2014 and a further 1,777 are currently working towards re-registration.

Discussions have started on a new national recruitment campaign, aligned to the work already underway on the Image of Nursing, learning from the armed forces and teaching recruitment campaigns which were successful in attracting more people to the professions.

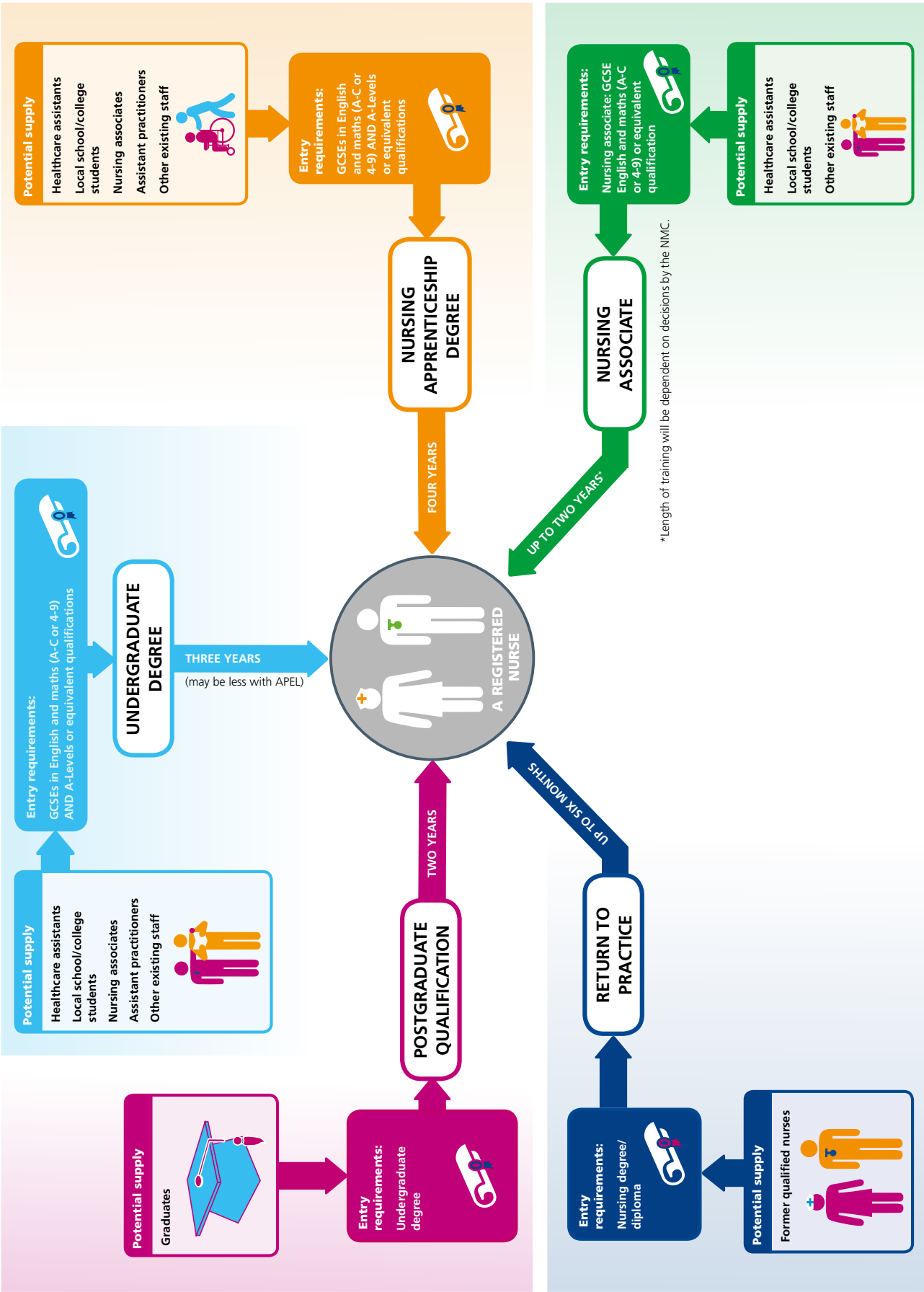


Developing flexible routes into nursing

Apprenticeships and nursing associates offer roles in their own right but also career paths from healthcare support worker to registered nurse and beyond, working towards a nursing degree while offering service to patients and earning a salary.

Degree-level nurse apprenticeships have been created to enable people to earn and learn and become a graduate registered nurse while employed, studying part-time and training in a range of placement settings. The first registered nurse apprentices began in September 2017.

Routes into nursing



Focus on the public's health and wellbeing

The future nursing and midwifery workforce will need knowledge and skills to meet public health challenges including rising levels of lifestyle related non-communicable disease (NCD) and continuing inequalities in healthy years of life. This will require:

- All nurses and midwives to have improved knowledge and skills in prevention and health promoting practice including supporting self care/management.
- Primary and community health nurses with sufficient numbers and skills to provide a full range of services from conception and birth across the life course to older adults in prevention and well-being (including community assets) maternal and child health; support for self care in NCDs; first response for minor illness; primary practitioner for NCD management; and the leadership of teams for care of older adults at home and end of life care. Increased diagnostic skills and an increased number of prescribers will be required.
- Specialist public health nurses for children and family 0-19 will be required in sufficient numbers to meet the changing birth rate. Nurse education for infectious disease management, sexual health, substance misuse (including drugs, alcohol and tobacco), occupational health will be vital to meet current and future needs.
- The needs of parts of our population currently underserved and with poorer outcomes requires specific focus including those people with poor mental health and physical and learning disabilities.
- The nursing associate role provides an excellent opportunity to focus on prevention and enhancing partnership working with individuals, communities and populations.

The Five Year Forward View acknowledged more needs to be done to transform community nursing. To meet the unprecedented demographic challenges and the complex needs of delivering care closer to and within people's homes, there is an urgent requirement to increase numbers, capability and image to transform community services. As a first step, HEE with NHSE and partners will be embarking on a comprehensive review of the current range of community-based nursing qualifications.

NHSE is coordinating an investment of £15m investment in General Practice nursing to attract, develop and retain nurses. This includes focus on; Image of GP nursing, best practice employment, increasing clinical placement, increase access to CPD, and securing flexible roles. In addition, it is important to emphasise the support to developing GP nurses as leaders.

Investing in a postgraduate nursing and midwifery

To further the career paths open to nurses HEE will consider introducing a suite of national post-graduate standards in research, education, clinical practice and leadership, building on the evidence and research on clinical academics and the work on Advanced Clinical Practice.

More recent initiatives to transform the workforce include the further development of nursing with a national advanced clinical practice framework and plans to review and support a more flexible community nursing and intellectual disability workforce. This work will complement the approaches being developed in the mental health workforce plan, recognising that nurses don't work in isolation, but in multi-professional teams across the health and care sectors.

Producing great leaders

In delivering this ambitious future for nursing and midwifery, there is a need to leverage the huge experience and expertise in the workforce to deliver this change.

Clinicians from all backgrounds make excellent leaders. Several programmes have been developed by HEE, NHSE and NHSI to support development of nurse and midwifery leaders. This is built upon foundation of recognition that leaders who are collaborative, compassionate, inclusive and often from a clinical background. The Leadership Academy are working with NHSI to deliver the next generation of nurse directors.

Creating compassionate environments

A strong message during the development of LCAV was to retain the 6Cs as a professional value base. We will continue to engage the workforce in focussing on the benefits of their expertise in improving outcomes and experience. There will be further support to nurses and midwives to demonstrate impact through measure and improve, and reduce unwarranted variation.

LCAV was developed to help nursing, midwifery and care colleagues truly consider the outcomes of their work and question whether their actions always make a measurable difference to experience, outcomes and the use of resources. By bringing this focus to achieving the 'triple aim' of improving experience, outcomes and use of resources, we will clearly demonstrate the vitally important contributions of the professions to the FYFV and the wider system going forwards.

What next for the nursing and midwifery community?

The NHS must maximise opportunities to recruit and retain the number of nurses and midwives it needs in a manner that is sustainable to ensure nursing and midwifery excellence at all levels. There is a need for all professions to position nursing and midwifery for current and future generations as a career that is flexible with diverse opportunities.

Case study: trainee nursing associate

At the age of 16 I was still unsure about a career, but when my grandparents became ill and I helped care for them, my future was decided - I knew then what I wanted to do.

I decided to apply for a healthcare assistant role in the NHS, in the hope that one day I could find a route into nursing where I could work, earn and learn at the same time. I was happy working as a healthcare assistant and part of the care team, knowing that I was working towards my end goal even if it took a long time.

I started this journey in February 2017. I now have more of an understanding of what it means to be a nurse. I am able to take on more responsibility within my new role by learning new skills, improving my core skills and living up to set values and standards, understanding what it means to be a professional. I'm learning techniques of communication, and about medication, and there's much more to come.

I worked in mental health and then transferred into children's care. I fell in love! I've worked in children's care for nearly three years now and can't imagine working anywhere else. I feel very privileged to be offered the trainee nursing associate role, I am proud of the role and the future it holds. I am also proud of the NHS!

Dentistry

Introduction

Despite improvements in adult and child oral health over the past decades, oral and dental diseases still affect a significant majority of the population. Levels of disease vary between different population groups with continuing health inequality. We will continue to deal with the consequences of disease that developed more than 50 years ago. With more people living longer and keeping their natural teeth into older age, we are faced with managing oral disease alongside co-morbidity, frailty and access issues.

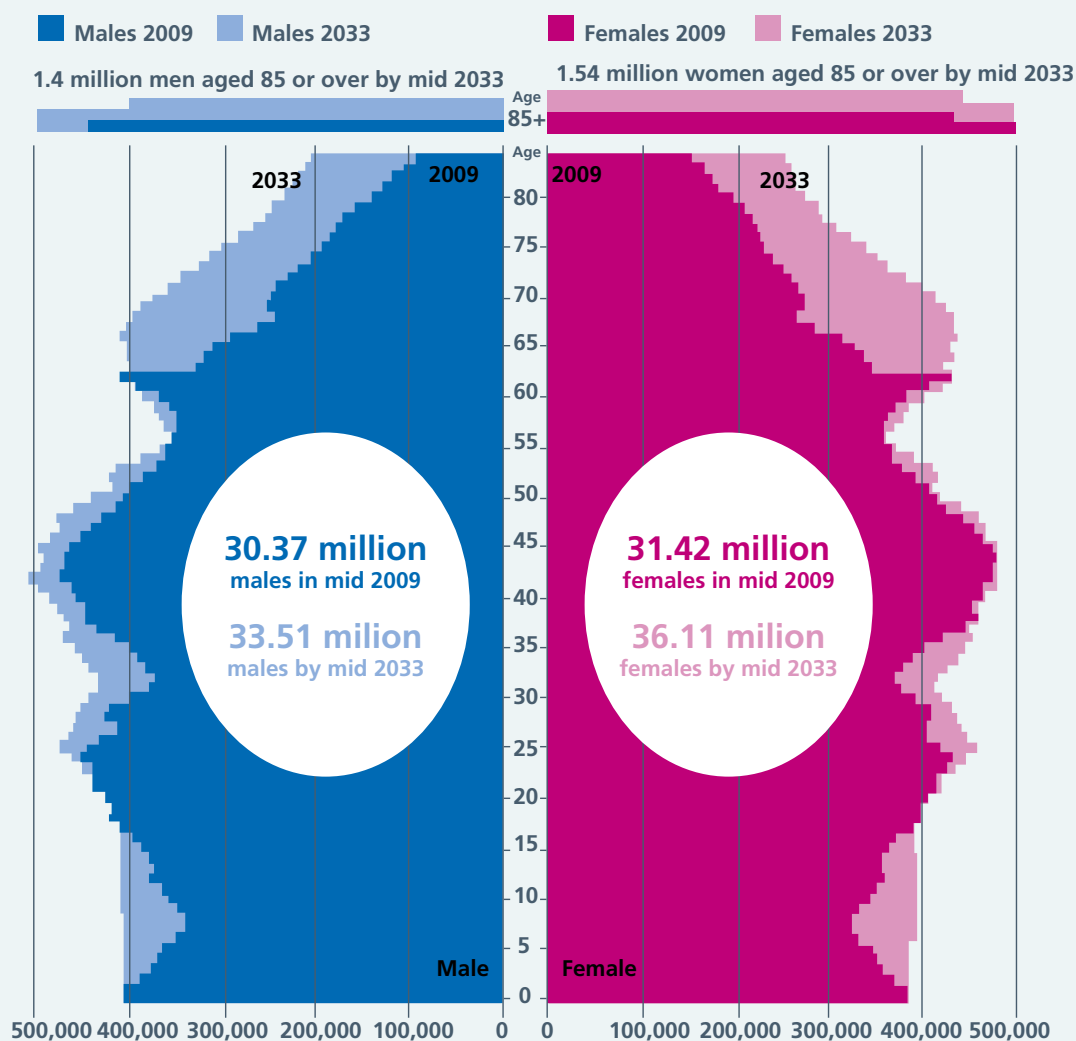
This points to the need for an agile approach to maintain a professional cadre of sufficient size; capable and motivated to deal with the future demands for care and to support the shift in focus to prevention and public health.

Background

Good oral health is important for all ages, although the increase in the number and proportion of older people means an increased focus on the challenges this age group face in obtaining and receiving appropriate dental and mouth care. By 2033, with 23% of the population over 65 and just 18% under 16, dental care for the older adult will assume greater significance and complexity.



Figure 25: Future Age structure in the UK



Aging Population

- Co-morbidity challenges
- Edentulous population decreasing
- Complex repair/replace
- Periodontal/oral cancer
- Special care/domiciliary care

Middle age longer - working life to 70yrs

Adolescents - Impact of social media & emphasis on aesthetics/image

Children - 25% of under 5s with dental caries

Another major focus will be providing for an increasing number of people with special care needs, frequently associated with co-morbidity and access challenges. These groups will require more time and expertise as well as multi-disciplinary working to manage health and quality of life.

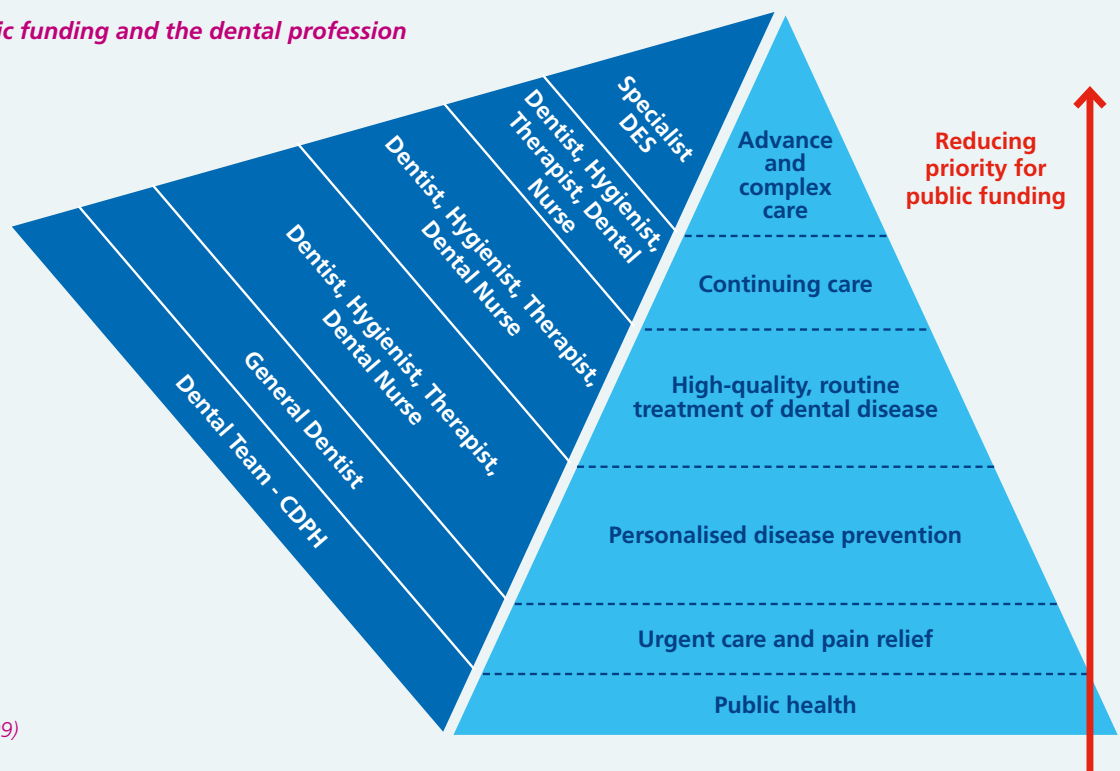
Against these treatment challenges we need to focus on preventative oral health for the younger generations. This is complex, mixing clinical activity, behaviour change and public health interventions, but success will minimise risk, discomfort and costs for future generations.

Current situation

The number of people entering dental schools was reduced in 2013 to reflect projections of workforce demand. We need to get better at developing specialists from the newly qualified groups to ensure adequate supply of the right specialty skills which are key for the future and in delivering managed clinical networks.

We must continue growth in multi-disciplinary teams by attracting students to dental hygiene and therapist training courses. This will help mitigate any workforce impact of the UK leaving the EU and aligning overseas dental practitioners to the NHS England performers list.

Figure 26: Public funding and the dental profession



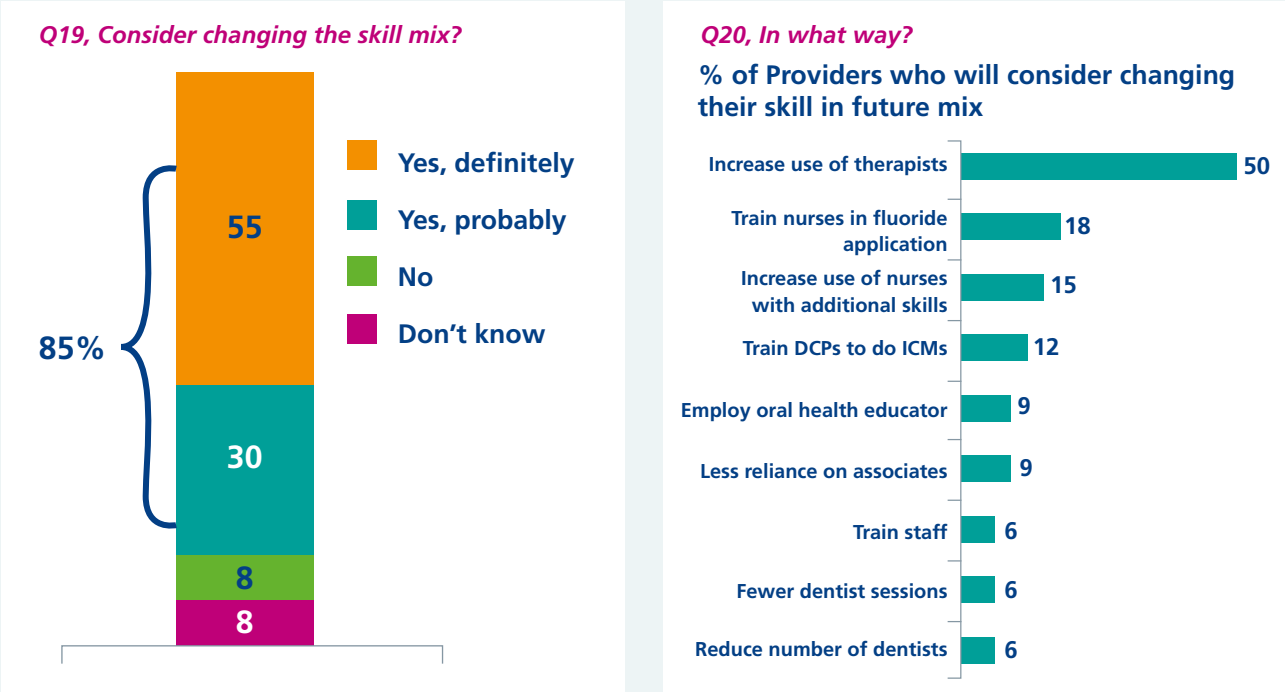
(Steele Report 2009)

Actions – workforce developments

To meet these challenges we need a dental workforce with greater breadth and depth, as dental therapists, hygienists and clinical dental technicians undertake many elements of the routine care prescribed by a dentist. This team approach to oral health is being shown in a slow but steady shift in the wider employment of dental care professionals (DCP) in both primary and secondary clinical care settings by high street dentists.

With the increased focus on prevention, this growth is expected to accelerate as it becomes more readily available and therefore acceptable to patients.

Figure 27: Changes to skill mix in the practice if Care Pathway becomes permanent (providers)



Q19: Would you consider changing the skill mix of staff at some point if the new way of working becomes permanent?
Base: All providers (40%)

Q20: How might your practice change the skill mix of staff in the future to help deliver the new way of working?
Base: All providers who say 'yes' at Q19.

Investment in the creation of multi-disciplinary teams for dental care will need to be complemented with leadership training and development opportunities for both dentists and DCPs. These skills will also be needed to support and manage local dental commissioning, and can be provided by current NHSLA programmes and developed through clinical fellowships.

Dentists will also need to continue to develop the diagnostic and operating skills to meet the more complex clinical challenges of the ageing population and vulnerable groups. A national approach to the design of specialist workforce training numbers and planning is advocated. This is a shift from the regional focus that has predominated and offers a greater opportunity to ensure a dental workforce of adequate size, capable of addressing current “pinch point” specialities and meeting the future need and geographic disposition of specialists.

This broad focus on enhanced teams, greater skills of dentists and carefully managed succession planning for senior specialists and consultants is integral to the delivery of the FYFV and ensuring timely access for patients to high quality care cost effectively.

Ambitions – understanding and planning for the future

The Chief Dental Officer for England and HEE have launched a review into whether existing models are the best way to deliver the workforce patients need for the future. The review is:

1. Exploring the appropriate mix of care shared between professionals such as dental therapists, hygienists, dental technicians and qualified dentists.

2. Exploring new training structures and pathways to increase flexibility (for trainees and the NHS) and efficient use of public funds by considering whether specialist training is meeting future patient and service need.
3. Sharing thinking and engaging with stakeholders as widely as possible to ensure all perspectives, including educational, service, quality, economic and legislative are taken into account.

The review will report in Spring 2018.

Allied health professions

Introduction

The allied health professions include a wide range of health professionals including physiotherapists; speech and language therapists; occupational therapists; paramedics; orthoptists; operating department practitioners and dietitians who, along with nurses and doctors, comprise the backbone of our health and care workforce. They, individually and collectively, play a critical role in providing care in a range of settings.

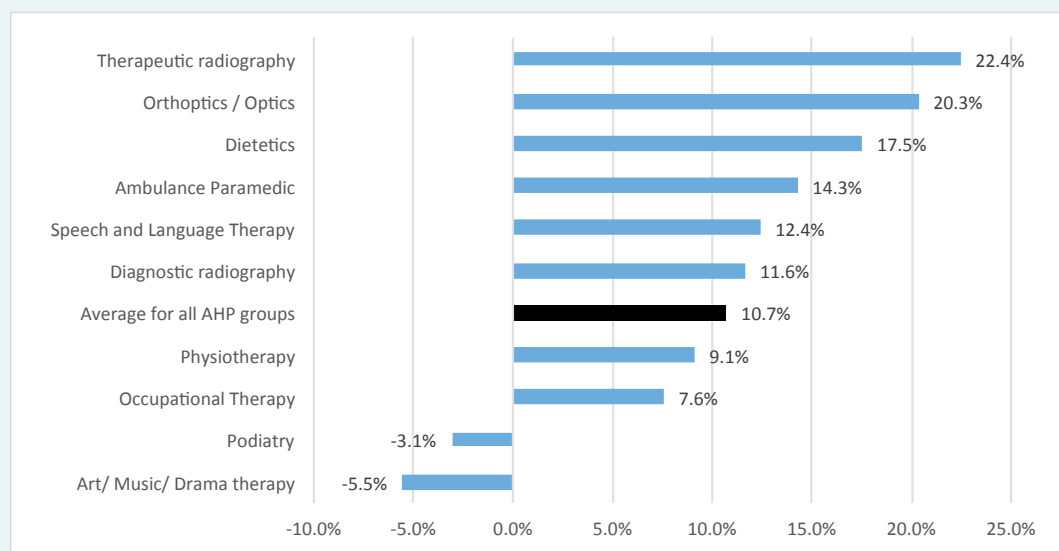
AHPs aim to prevent, diagnose, support self-care and treat a range of conditions and illnesses, normally working within multidisciplinary teams to ensure the NHS delivers the best possible patient outcomes and standards of care.

The number of initiatives already under way across this workforce demonstrates both its complex nature and the opportunities for the NHS to use their skills in delivering a sustainable future service.

The current workforce

There are over 82,000 Allied health professionals employed in the NHS, 1 in 7 of the qualified clinical workforce. This represents about 45% of the 197,000 AHPs registered with the Health and Care Professions Council, illustrating the scale of the non-NHS labour market and setting the context for the highly dynamic flow of staff between employment sectors. AHPs employed in the NHS have increased by almost 8,000 fte (10.7%) over the past five years. However over the same period the NHS created almost 12,000 posts (15.7%).

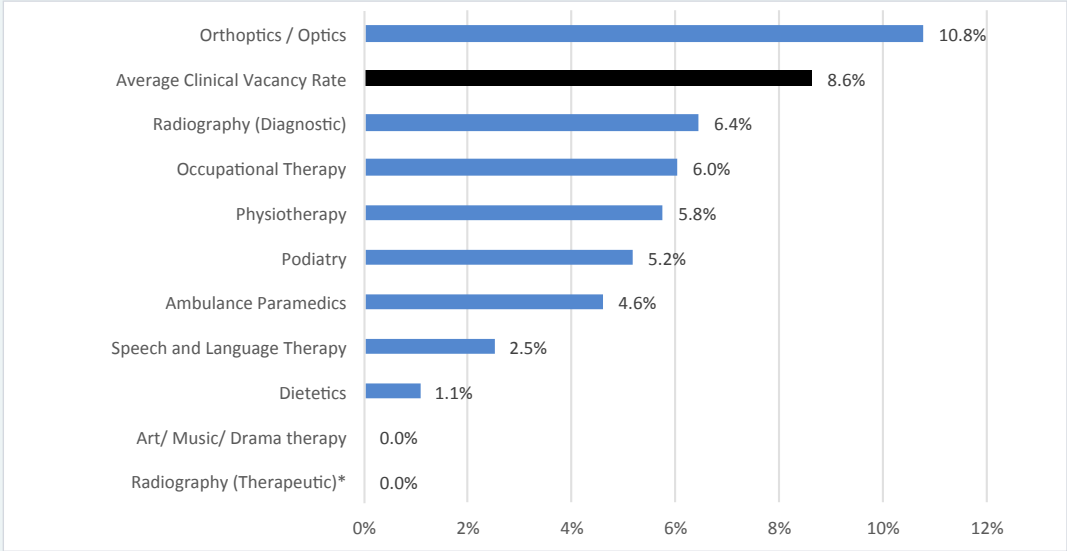
Figure 28: Growth / Reduction in NHS Employed AHPs by profession – 2012 to 2017



Source: HEE analysis of ESR data

Their growth to posts and people has resulted in an increased number of vacancies, with a total of 4,400 as at March 2017, an average of 5.1%. There is however significant variation between the 12 different professions with vacancy rates ranging from 1.1% for dietetics up to 10.8% in orthoptics. Most AHP professions have below the average vacancy rate for clinicians in general in the NHS.

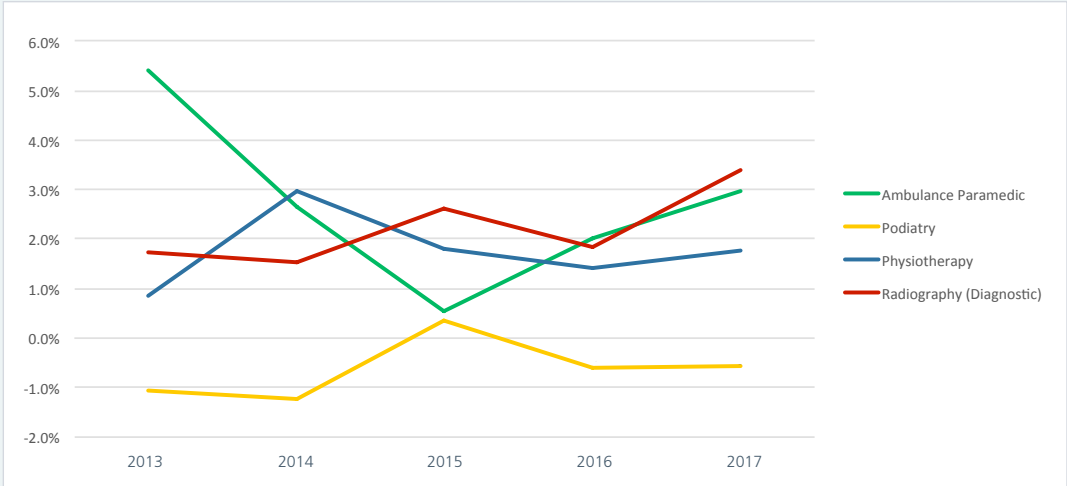
Figure 29: Allied health professionals NHS vacancy rates - March 2017



Source: HEE analysis of ESR and NHS provider data collection

AHP workforce growth has been steady, ranging between 1.6% and 2.4% per year. In 2016/17 this allowed vacancies to reduce from 7.2% to 5.1% but the NHS is still not attracting its proportionate share of the overall growth in registered AHPs.

Figure 30: % Annual Growth - Selected AHP professions



Source: HEE analysis of ESR

The situation for individual professions has been more variable. In paramedics a worrying decrease between 2012 to 2014 was arrested and then reversed by investment in additional training and active recruitment and retention initiatives. Physiotherapy has shown steady growth and is likely to be boosted by increased training numbers in future. Diagnostic radiography has risen but as the cancer plan shows demand is expected to continue to rise and therefore further supply effort is needed. Podiatry numbers have fallen in every year except 2014/15. This indicates the need to prioritise this profession, especially in light of UCAS data on the number of new students entering training in 2017.

The NHS needs to get better at recruitment and retention of AHPs by building 'place based' careers. This would enable AHPs to work to their full capacity by, for instance, using their breadth of skills and autonomy of practice as musculoskeletal practitioners in primary care, as they can in independent practice or through portfolio careers.

The NHS can also help AHPs meet their clinical, leadership, research, education and career goals through advanced clinical practice, leadership development, clinical academic careers and new ways of working. Growing the NHS AHP workforce is further supported by the expansion of a HEE pilot extending Return To Practice initiatives to AHPs and healthcare scientists.

Actions

The workforce requirements of this strategy will lead to the first AHP focussed national workforce plan for England which will connect all key areas of work, enablers and profession specific programmes to deliver the vision and shared value across the workforce.

The focus on paramedics in urgent and emergency care has resulted in this staff group becoming valued in other care settings. HEE and its partners intend to go further, with significant investment this year to support a pre-degree pilot for new routes and access for training, responding to the current HCPC consultation on entry requirements for paramedics to the register; advanced clinical practice pilots; making the case for use of mechanisms of medicines supply by paramedics and training to extend 'hear and treat' and 'see and treat' within primary and community care. Complementing this work as part of the Ambulance Improvement Programme, is the trial rotational programme of paramedics building primary care and community capacity and capability.

Deep dives into the workforce issues of small professions such as prosthetics and othotics, orthoptics, and podiatry are ongoing following work with HEFCE, the professional bodies and employers to develop a programme of support, ranging from immersive work experience to advanced clinical practice.

Within primary care both workforce and service support is being developed by NSHE and HEE to roll out first point of contact musculoskeletal practitioners. This will position professionals such as physiotherapists, podiatrists and osteopaths in the front line supporting GPs, enabling earlier access to expert advice, prevention, supported self care and return to work support. Further developments around dietician based interventions, diabetic foot protection, paramedic roles and frailty are ongoing as the multidisciplinary approach to primary care continues to develop.

To further improve cancer outcomes stakeholders are working with the diagnostic radiography workforce to develop and standardise a reporting role, and retrain those with knowledge and skills in barium enemas and gastrointestinal cancers to support endoscopy. HEE is making the case for regulation of an undergraduate pathway in sonography, agreeing the scope of practice and identifying how to grow training capacity by supporting innovative practice.

AHPs follow the clinical academic programmes through to doctoral level, increasing research output and research roles within the NHS. Providing access to these roles to aid retention is an essential next step alongside the Advanced Clinical Practice Framework which places research central to clinical delivery.

AHP leadership in developing utilisation of data, digital support to clinical interventions and education and linking services and workforce are significant and growing enablers. AHPs are increasingly represented across digital leadership and talent programmes and as coaches and mentors.

This focus on digital is evident in AHPs' work in Learning Disabilities. AHPs already promote instruments from Apps to support daily living and independence, through to switch controlled environments and communication systems for individuals with profound and multiple disabilities.

There remain many more opportunities for growth in AHPs supporting primary care such as dietetic practitioners and AHPs being at the forefront of better understanding the impact of frailty and multi-morbidity, acting as first point of contact frailty care practitioners.

AHP support to the FYFV Mental Health strategy is identified in occupational therapy, speech and language therapy and art, drama and music therapy – alongside the psychological therapies.

Ambitions

The aim for the next decade is to fully realise the potential AHPs offer the NHS and social care. This will require focussed AHP leadership in national bodies, local systems and organisations.

We want to liberate AHPs to meet the FYFV goals on population health around better prevention and care closer to home. AHPs are key to reablement and rehabilitation, supported self-care, shared decision making, care and support planning, advocacy and maintenance of independence, return to work, and skilled treatment across specialties.

Healthcare science

Introduction

Science is at the forefront of the NHS and public health. It is one of the fastest moving areas of medical practice and novel concepts around preventative and prognostic healthcare, precise diagnosis, targeted and innovative treatments, tailored patient care, and analysis of large datasets are becoming the norm and implemented at scale. These are vital to a sustainable NHS long into the future.

Healthcare scientists are employed in over 50 different scientific specialisms and in England are the largest group of scientists in any employment sector. They operate across all care pathways from health and well-being to end of life, responsible for scientific and clinical services that are both routine, highly specialised and complex. They also lead the service in the creative use of scientific and technology advances and make significant contributions to innovation and translation into practice in areas such as genomics, medical physics and novel forms of radiotherapy and multimodality imaging bioinformatics and transplantation and stem cell therapy.

Good access to high-quality scientific services delivers better patient outcomes, and vice versa which is why investment in and promotion of the healthcare science workforce is an investment in the whole of the NHS and in delivering the NHS Constitution commitment of ensuring the NHS remains at the cutting edge of science.

There is however a need to develop more robust and informative workforce supply and demand modelling. Without this there remains the challenge of predicting the workforce that is required for the future and the numbers to match this.

Achievements

The education and training of healthcare scientists was modernised as part of an initiative led by the Chief Scientific Officer which began in 2007/8. This introduced new education and training programmes from support workers to consultant level clinical scientists and established the National School of Healthcare Science (NSHCS, now part of HEE) and a series of commissioned masters-level programmes.

Since that time the NSHCS has implemented and overseen the quality and delivery of healthcare science training and education programmes across all levels of the workforce in the NHS, in PHE and in NHS Blood and Transplant. Over 1,300 clinical scientists and 1,700 biomedical scientists and scientific practitioners have been through its programmes in the past seven years.

These nationally acknowledged training programmes provide relevantly trained scientists who are leaders in system thinking and evidence based use of technology and are trained to work outside of traditional boundaries in multidisciplinary teams.

Some of the particular programmes designed to support specific system transformation as part of delivering the FYFV are: in genomics where the NSCHS works closely with the genomics education programme, in cardiac physiology which incorporates echocardiography and is pivotal to seven day NHS service provision of cardiac services, radiotherapy physics supporting the proton beam therapy programme, and in pathological sciences such as histopathology and blood sciences which are vital to delivering the Cancer strategy.

In 2014, NSHCS also implemented the pioneering new five-year doctoral training Higher Specialist Scientific Training (HSST) programme to provide the NHS with consultant level healthcare scientists. Currently there are over 230 HSST trainees in the first cohort with around 50 of these specialist scientists expected to be ready for employment in 2019.

Alongside this healthcare scientists have been support to access clinical academic career fellowships and programmes, linked to the overall modernised scientific careers framework for healthcare scientists.

Actions

There is an ongoing focus on the quality of the education and training delivery within the workplace and ensuring that trainees get the best possible outcomes from the HEE investment and in considering innovative approaches for trainees to experience all areas outlined in their training programmes. This is coupled with the ongoing work to ensure that the complimentary academic programmes are kitemarked in meeting the required quality standards and supporting the vocational elements of the programme.

The formal assessment approach within the STP and HSST programmes remains leading edge and builds upon the experience in medical education and training. The recruitment to the STP programmes continues to attract large levels of interest with innovative approaches now well embedded in selecting the next generation of healthcare science trainees.

The NSHCS also undertakes a series of bespoke programmes to support NHS priorities.

When the first cohort of HSST scientists graduate in 2019 they will be able to bring their skills and expertise to bear in supporting even more clinical transformation programmes envisaged over the coming years. These include cyto/histopathology and most of the pathological diagnostic specialties where genomic and molecular technologies will likely require specialist scientific understanding and leadership.

NSHCS is also supporting the credentialing agenda which helps employers increase the flexibility and effectiveness of the multidisciplinary approach to care. “Accredited Scientific Practice” (ASP) in certain scientific specialties, such as cardiac imaging and echocardiography, is crucial to the safety and continuation of some workforces. Courses to support this are being piloted by HEE.

The apprenticeship route into the NHS is also being embraced by the Healthcare Science professions. Three healthcare science standards are approved for training at levels two, four and six. The NSHCS holds the curriculum for level six and much of level four and acts as a national hub and support for the NHS wishing to develop scientists through the apprenticeship routes.

Ambitions

The next step is to enhance opportunities develop academic careers for scientists, placing the NHS even closer to the future of health and healthcare related innovation and technology and in working collaboratively with industry partners.

There is also a need for NHS healthcare science to continue to embrace cutting edge science and technology, so we plan to deliver education and training around two new scientific specialties including STP programmes merging molecular and genomic technologies with stem cell therapy. We will also continue to ensure we are leading the NHS in genomics, bioinformatics and computer science and in newer applications of nanotechnology and machine learning and artificial intelligence which can be applied to many areas of healthcare science and that the overall workforce remains key to innovation in many other areas including clinical engineering, immunology, microbiology and tackling AMR and in physiological sciences.

There is more work to be done to support recruitment and demand and supply planning for the practitioner level programmes that are largely delivered by the higher education sector and to have a better oversight of the quality and outcomes of these programmes to deliver fit for purpose practitioners for the future. Improving the workforce information across healthcare science is an objective, to ensure that the appropriate planning can take place. NSHCS will focus on how this can be achieved and what tools and techniques can assist in this work.



Pharmacy

Background

The pharmacy profession has a significant role to play in the delivery of new care models outlined in the Five Year Forward View. It is also vital to the delivery of the medicines value programme, which is core to the NHS finding the efficiencies it needs over the FYFV period. Both of these interventions will also improve medication safety, patient experience and patient outcomes.

Two reports are driving the transformation of the pharmacy workforce. The first is the Independent Review of Community Pharmacy Clinical Services, which sets out the opportunities to better integrate clinical pharmacy skills within NHS community, primary and urgent care teams. The second is the Carter Report, Unwarranted Variation: A review of operational productivity and performance in English NHS acute hospitals, which set out the need to enable pharmacists and clinical pharmacy technicians to spend more time on clinical pharmacy services to improve efficiency and performance.

The development and transformation of the pharmacy profession are central threads to deliver wider FYFV workforce programmes, including primary and community care, urgent and emergency care, public health, including AMR and sepsis, and mental health.

These developments will be underpinned by a robust assurance process which ensures that patient safety is at the heart of the training, assessment and ongoing development of all professionals to take on new roles. HEE will work with the General Pharmaceutical Council, employers and the Royal Pharmaceutical Society to ensure the right checks and balances are in place to underpin a sustainable approach to the provision of high quality patient care by registered pharmacy professionals.

Action

These actions are driving a raft of action across pharmacy which are outlined in the Pharmacy Integration Fund in partnership with NHS England. This strategy has already benefited from wide engagement and consultation with partners and patients so the focus is now on delivery of its recommendations, especially the workforce elements.

The Pharmacy Integration Fund aims to enable pharmacists, pharmacy technicians and their teams to spend more time delivering clinical services and health improvement; work in a variety of NHS settings as part of an integrated local primary care team and use improved technology all to improve efficiency for the NHS and outcomes for patients.

We are currently delivering the initial fund priorities which are being implemented between 2016 and 2018. These priority actions will firstly deploy clinical pharmacists and pharmacy services in community and primary care including groups of general practices, care homes and urgent care settings such as NHS 111 and, secondly, create the environment and infrastructure to accelerate digital integration and medicines optimisation for patient-centred care.

Over the coming period, the seven workforce initiatives outlined in the pharmacy Integration Fund will be the priority for engaging and transforming the pharmacy workforce:

- Independent Prescribing for Pharmacists
- Post-registration training for pharmacists
- Community Pharmacy Technician Training and Development Programme
- Care Home Training Pathway
- NHS111/Integrated Urgent Care Workforce Development Programme
- Clinical and professional leadership development
- Accuracy checking pharmacy technicians

Once this work is complete then the NHS will have transformed the current pharmacy workforce and therefore the pharmacy service. HEE is leading work to change how we educate and train the future workforce in parallel.

Case Study: pharmacist clinicians in the 21st century workforce

Today's healthcare workforce includes an ever-increasing number of different professionals, undertaking clinical work in the medical domain. The traditional, medicines-focused role of the pharmacist is being challenged by Health Education England (HEE) and its national stakeholders. The WHO argues that the clinical pharmacist of the future should be capable of confidently and competently managing patients at an advanced clinical level – with health assessment, diagnostics and clinical examination skills comparable with that of an advanced clinical practitioner.

A recent three-year programme run by HEE, evaluated the potential for pharmacists to manage patients in the emergency department and across urgent and acute care. Evidence from the 'Pharmacists in Emergency Departments' (PIED) suite of studies suggests that pharmacists with advanced training may clinically manage up to 36% of patients attending emergency departments. The study presented this data and proposed enhanced clinical development pathways for pharmacists, through access to clinically enhanced independent prescribing ("CEPIP" programme), "shop floor" clinical skills training ("CASM" clinical skills module) and access to the HEE national Advanced Clinical Practice (MSc) pathway.

The programme recommends a change in thinking around the pharmacists' role in the future integrated clinical workforce across urgent, acute and emergency care.

Ambition

The Pharmacy Reform Programmes align HEE's strategic aims to transform pre-registration and post-registration pharmacy education and training, and to equip the pharmacy profession with the skills and values required in a changing NHS landscape. This work will ensure new staff will be ready to work in the transformed system.

HEE plans to extend, a national pre-registration pharmacist recruitment scheme to ensure the system has the right number of pre-registration trainees with the appropriate skills and knowledge. The programme includes the rollout of e-portfolio access to trainee pharmacists, providing more robust trainee sign off through Pharmacy Competency Panels and allowing more flexibility in pre-registration rotations.

We will also invest in supporting pre-registration tutors and ensure trainees continue to receive high quality training support.

We will support the development of the pharmacy technician workforce through assessing and managing the impact of national policy changes on pre-registration pharmacy technician training.

Post-registration our task moves to a new phase working in partnership with professional bodies and wider stakeholders by developing common vocational foundation training for all newly qualified pharmacists.

We will also provide support to the advanced clinical practitioner roll out across the NHS by aligning existing advanced and specialist pharmacist training to HEE's national ACP framework to enable a consistent and transferable skilled ACP workforce across the NHS.

Pharmacists will also play their role in cutting edge medicine and technology by working with NHS England to develop the technical pharmacy workforce to manage advanced therapy medicinal products alongside the wider work in genomics.

We will also work with post-registration pharmacists to ensure they have the capability and capacity to lead the research and development of medicines optimisation.

Finally HEE will enhance pre and post registration pharmacy technician development to maximise the utilisation of extended roles within the wider pharmacy team, as part of building teams that make the most of each member's skills and competences.

The wider workforce

Introduction

The wider workforce in health and care includes a huge range of roles and professions ranging from administrative and clerical staff, managerial, HR, finance, IT, catering, porters, maintenance, estates, housekeeping and others. We have talked about clinical support roles earlier in the document, in this section we will focus on those mostly working in non-clinical roles.

The wider workforce plays a crucial role in the running of the NHS. Yet this part of the workforce is sometimes undervalued and seen as part of the bureaucracy rather than an essential part of the system working to deliver the highest quality of care.

While the clinical and non-clinical support workforce makes up 40% of the total NHS workforce, this group historically received less than 5% of the national training budget. HEE has worked with various national, regional and local partners to change this picture, to increase investment in the support workforce and to spread good practice and innovation.

What are we doing to support and develop this group?

Support roles – Talent for Care

HEE's Talent for Care strategy seeks to improve the education, training and development opportunities available to the healthcare support workforce. The Talent for Care national strategic framework focuses on ten strategic intentions under the primary themes of:

- **Get In** - opportunities for people to start their career in a support role
- **Get On** - support people to be the best they can be in the job they do
- **Go Further** - provide opportunities for career progression, including into registered professions

The strategy challenges employers to implement a development programme for all support staff, above and beyond annual appraisals and mandatory training, and to support talent development that identifies and nurtures people with the potential to go further. A significant number of the larger NHS employers (124) signed a pledge to commit to these intentions and the championing of the support workforce has been evident in the number of employers who now have a Talent for Care lead or coordinator role as part of their teams.

Apprenticeships

We continue to contribute to development of new apprenticeship standards, ensuring NHS involvement with apprenticeship standards developed by other sectors, for example in customer service, administration, HR, IT and Finance. In particular, we are looking to use the new leadership and management apprenticeships in conjunction with the NHS Leadership Academy to help people in or seeking to move into management roles.

NHS Graduate Management Training Scheme

The NHS is one of the top graduate management scheme recruiters, with multiple awards including Target Jobs Public Sector Employer of the Year three years running.

The NHS Graduate Management Training Scheme has six areas of specialism: finance, health analysis, health informatics, human resources, policy and strategy or general management. All of these areas help the NHS to function so that we can provide first class healthcare.

- Finance management leads the drive towards achieving the necessary efficiency savings and ensuring value for money, general management colleagues work on the front line ensuring services are managed and delivered in the best possible way for patients.
- Health analysts provide insight and evidence, and data-based products to support decision-making in the NHS for the benefit of patients.
- Health informatics is the lifeline that ensures everyone has the information they need to make informed decisions for the benefit of patients.
- Human Resources management make sure we have the best workforce to deliver the best patient care, and to tackle the unprecedented change we're going through.
- Policy and strategy create the programmes that improve patient care through evidence-based policy, systems thinking and strategy development.

During a time of unprecedented change, the NHS is continuing to attract the brightest and best candidates, supporting them to develop the skills and confidence to help lead then NHS through its transformation into an ever more efficient, successful and professional health care service.

Supporting recruitment and retention of bands one to four

Enabling and supporting employers across the NHS to support a diverse range of people from their local community into wider workforce roles is key to ensuring NHS organisations are able to establish and retain a strong and representative future workforce supply.

There are some excellent examples of good practice initiatives to support the recruitment and retention of the workforce, especially into bands one to four including in administrative, clerical and estates roles.

NHS Employers have recently been showcasing case studies on their website which highlight innovative approaches to supporting the recruitment and retention of the workforce in these areas among others.

- Sheffield Teaching Hospitals work in a local partnership to support local people who may have faced social disadvantage into admin roles within the trust specifically.
- South Tees and other trusts nationally run supported pre-employment programmes which are often focussed on training for admin and clerical roles/estates for those who may not traditionally be well represented in the NHS workforce. Such programmes ensure candidates become work ready over a number of weeks (usually between 4-12 weeks). Support of previous candidates who are employed within trusts, are often used to support the newer candidates with induction and training.
- We know that supported internships and apprenticeship programmes such as Royal United Bath's approach to Project Search often support people with learning disabilities into bands one to four roles who would not otherwise easily find employment in the NHS.

- Apprenticeships such as those run by Sandwell and West Birmingham, can specifically support those at most disadvantage (in this case those at risk of homelessness) into paid employment in the future. Central and North West London NHS Foundation trust engaged a local apprenticeship provider to advertise a clerical apprenticeship placement to a more diverse pool, and resulted in supporting an older adult into an apprenticeship via this route. North Middlesex University Hospitals Trust engaged locally with their community to recruit 19 apprentices in full time employment, including in clerical and admin roles such as business admin and accountancy.
- *Think future* offers specific opportunities to young people aged 16-24 such as work experience is an effective way for trusts to recruit the future workforce for the NHS. Guys and St Thomas re-structured their work experience to bring more local young people into the trust.

Knowledge services

The contribution of healthcare library and knowledge services is widely valued, supplying the evidence base to the service to make decisions on treatment options, patient care and safety, commissioning and policy, as well as to support lifelong learning, undertake research and drive innovation.

Library and knowledge specialists are central to the drive towards the NHS becoming the world's largest learning organisation and HEE is supporting these professionals to use their expertise to mobilise evidence obtained from research and organisational knowledge to underpin decision-making in the NHS.

Library and knowledge management staff have loaned or supplied 2.2 million items, handled 1.2 million enquiries, trained 153,000 NHS staff and supported 31,000 carry out expert literature searches.

HEE has developed the Knowledge for Healthcare Development Framework to articulate the vision for knowledge services and provide the basis for more detailed conversations with our partners about the challenges and opportunities ahead. It is a framework upon which HEE, in dialogue with stakeholders and partners, will build an action plan – with a focus on customer care and value for money, achieved through better coordination, collaboration and cooperation, including through pooling of resources and expertise.



Chapter 9

Conclusion and consultation

Chapter summary:

- Consultation will run from Wednesday 13 December 2017 to 17:00 Friday 23 March 2018.
- The consultation will revolve around eight broad questions with a number of issues addressed under each one.
- HEE will lead the consultation with the help and support of partners.

Consultation

This document is about bringing the system together to discuss the future of its workforce and inform next years workforce strategy. To enable a conversation about what staff need; about what staff the health service needs, and how we shape the future we all want: a sustainable, free at the point of need universal healthcare system.

To facilitate this conversation, we have identified a series of questions based around the proposed principles. These questions are deliberately broad as we want the fullest debate. No issue or suggestion should be excluded simply because we did not ask the right question. We also welcome specific comments on any other elements of this document.

Please take part in this consultation by visiting <https://consultation.hee.nhs.uk>

The questions we ask are:

1. Do you support the six principles proposed to support better workforce planning; and In particular will the principals lead to better alignment of financial, policy, and service planning and represent best practice in the future?

Areas to explore may include:

- What more can be done to help staff work across organisations and sectors more easily?
- What data do we need to ensure we can plan effectively, and how do we align across workforce, finance and service planning?
- For what sort of measures/plans/proposals should the Workforce Impact Assessment be used?

2. What measures are needed to secure the staff the system needs for the future; and how can actions already under way be made more effective?

Areas to explore may include:

- Are there fresh ideas for attracting more people to work in the NHS, either as new recruits or returners?
- What scope is there to extend workforce flexibility using ideas such as credentialing, transferable qualifications, scope of practice and others?

3. How can we ensure the system more effectively trains, educates and invests in the new and current workforce?

Areas to explore may include:

- Are there any specific areas of curricula change or new techniques such as gamification or new cross cutting subjects like leadership, public health or quality improvement science that should be taught to all clinicians?
- How does the system ensure it spends what is needed on individual CPD and gets the most effective outcomes from it?

4. What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?

Areas to explore may include:

- What more can be done to create careers not jobs for all staff, regardless of qualifications, entry level and current skills?

- What reforms are required to medical education and training to deliver the doctors the system needs in the future but also supports the needs of the system now?

5. How can we better ensure the health system meets the needs and aspirations of all communities in England?

Areas to explore may include:

- What more can be done to attract staff from non-traditional backgrounds, including where we train and how we train?
- How we better support carers, self carers and volunteers?

6. What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?

Areas to explore may include:

- What more would make it more attractive to work or stay in the NHS as you progress through different careers stages?
- What should the system do to ensure it is flexible and adaptable to new ways of working differing expectations of generations?

7. Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England?

Areas to explore may include:

- What opportunities are there for making a difference through skill mix changes, staff working flexibly across traditional boundaries, and enabling staff to work at the top of their professional competence?
- What more can be done to deploy staff effectively and reduce further the use of agency staff?
- What more should we do to help staff focus on the health and wellbeing of patients and their families?
- What are the most productive other areas to explore around management and leadership, technology and infrastructure?

8. What policy options could most effectively address the current and future challenges for the adult social care workforce?

Conclusion

This document is unashamedly broad in its inclusiveness, deep in its detail and long in both its length and its ambition. The strategy tells the workforce story of the last five years, lays out where we are now and looks forward, using both the immediate Five Year Forward View frame and a more aspirational decade long timescale.

It introduces both new and widely known information. And above all it seeks to engage the health care system; its staff, its users, its partners and its organisations to make their views known about the future.

It is a document that bears the hallmarks of the national system, but its ambition goes further. The final strategy, built on your responses and published around the NHS 70th birthday, will be for the whole system; local and national, all staff, patients, users and carers and all sectors including social care and public health.

The final strategy must speak to and for us all because if there is one key message from this document it is that we are better when we work together, that is when we really deliver for those who need us most.

In that spirit we look forward to the conversation over the coming months.

Appendix one

Supporting and developing the current and future NHS and workforce: a summary of key new and existing strategic actions

Objectives	Action	Leads
Increase future workforce supply from education and training	Increase numbers of GP trainees to 3,250 per annum	HEE
	Expand undergraduate medical places by 25%	HEE, HEFCE, HEIs, GMC,
	Expand nursing student places by a further 25%	HEE, HEIs
	Expand AHP student places	HEE, HEIs
	Campaign to maximise recruitment to clinical undergraduate courses	HEE, HEFCE, UUK
	Expand physician associates in training to over 1,000 per annum	HEE, HEIs
	Secure future supply of podiatrists and other shortage professions	HEFCE, HEE, HEIs
	Increase Nursing Associate training places to 7,500 per annum	HEE
	Increase Emergency Medicine trainees	HEE
	Train 400 clinical endoscopists and 300 reporting radiographers	HEE
	Deliver 19,000 new Mental Health staff	HEE, NHSI, NHSE
	Deliver 1,500 clinical pharmacists working in general practice	NHSE, HEE, CPPE
	Review tariff for undergraduate and postgraduate placements	DH, HEE
	Develop and roll out targeted Health Careers campaigns	HEE
	Introducing healthcare science A-level	HEE
Evaluate		
Increase workforce supply by recruiting experienced staff	Attract 1,000 returning nurses and 300 AHPs back into the NHS per annum	HEE
	Attract 2,000 GPs from overseas	NHSE
	Launch return to practice campaign for GPs	NHSE
Increase workforce supply through retention and help NHS become the employer of choice	National retention improvement programme	NHSI, NHS Employers, HEE
	Review reward package	DH, SPF
	Develop flexible working solutions	Trusts, NHSI, HEE
	Pearson review into health and wellbeing of NHS staff and trainees/ students	HEE, GMC, NHE Employers
	Improve working lives of BAME staff; NHS Workforce Race Equality Standard (WRES)	NHSE, NHSI, HEE
	Build on "Improving Junior Doctors Lives" programme	HEE
	Improve flexible working offers for staff nearing retirement	HEE, NHS Employers, NHSI
	Improve career pathway options within and between professions	HEE

	Consider new ring-fenced workforce development funding for priority areas	DH, ALBs
	Extend use of e-rostering and effective job planning	NHS Employers, NHSI
Review and modernise education and training	Consider periodic review of number and allocation of medical school places	HEE, HEFCE, DH, DfE
	Deliver Medical Education Reform Programme – greater flexibility in training, ARCP review, review of foundation training in England	HEE, GMC, AoMRC
	Review distribution of postgraduate medical training places by specialty and geography	HEE, NHSI, NHSE
	Review Clinical Psychologists training route and psychology degree content	HEE, HEIs, Regulator
	Accelerated route to nursing pilot programme	NHSE, HEE
	Review how technology will affect roles, functions, education and training	OH, HEE
	Explore greater use of gamification in training	HEE, Royal Colleges, GMC, HEIs
	Investigate areas, such as population health, that should be taught across curricula	HEE, Royal Colleges, GMC
	Expand distance, online, blended learning to a broader number of areas	HEE, HEIs
Widen participation in the workforce	Investigate possible changes to Point of Registration	GMC, DH, HEE
	Ensure curricula across all professional groups contain Mental Health content	HEE, Royal Colleges, Regulators, HEIs
Widen participation in the workforce	Support clinical and non-clinical apprenticeships by ensuring access to levy – review of first year use	DH, HEE
	Target non-traditional schools via Health Careers campaigns	HEE
	Improve employment opportunities for people with learning disabilities including the NHS learning disability employment programme	HEE, NHSI
Improve skill mix in workforce	Produce system wide approach to agreed investment in CPD	HEE, NHSI, Trusts
	Develop credentialing across all professions	HEE, GMC, NMC, HCPC
	Explore introduction of nationally consistent postgraduate nursing qualifications	NMC, HEE
	Development and implementation of the Advanced Clinical Practice framework	HEE, NHSI, NHSE
	Ensure Training Hubs available to all GP practices	HEE
	Ensure appropriate regulation of clinical professionals	DH, HEE

Position NHS as a centre of global excellence for health workforce, education and training	Develop, promote and facilitate innovative, ethical and mutually beneficial educational placements in the NHS and overseas	DH, HEE
	Offer ethical earn, learn, return programmes	HEE
Leadership development	Implement WRES and leadership scheme	NHSE, HEE
	Implement <i>Developing People, Improving Care</i> Framework	ALBs, DH
	Increase numbers on Leadership Academy Schemes to 20,000 per annum	HEE, NHSI
	Expand GMTS to 500 places by 2020 with an ambition to go further	HEE, NHSI
Workforce planning solutions	Review of learning disability workforce	HEE, NHSE, NHSI
	Review of community nursing qualifications	HEE, NHSI, NHSE, NMC
	Create demand modelling process for all professions post 2021	HEE, NHSI, NHSE, DH, PHE
	Explore better alignment of workforce, finance and service planning	National ALBs, DH
	Review of the workforce responsibilities of all ALBs	DH, ALBs
	Publish intelligence reports by profession and geography	HEE,
	Review data needs across system including reinstatement of vacancy data collection	NHS Digital, HEE, NHSI, NHSE, DH
Improve support for patients, carers and volunteers through education and training		
	Series of workstreams with Independent leadership to promote volunteering and consider training needs of individuals managing their own conditions, informal carers and volunteers	HEE PAF, DH, ALBs,

Appendix two

Abbreviations

ACP – advanced clinical practitioner	View	NMC – Nursing & Midwifery Council
ACS – accountable care systems	HEE – Health Education England	NSHCS – National School of Healthcare Science
AfC – Agenda for Change	HEFCE – Higher Education Funding Council for England	OD – organisational development
AHP – allied health professional	HEI – Higher Education Institute	O&G – obstetrics and gynaecology
ALB – arm's length body	HSST – Higher Specialist Scientific Training	PHE – Public Health England
AMR – antimicrobial resistance	IFA – Institute for Apprenticeships (IfA)	PIED – Pharmacists in Emergency Departments
ARCP – Annual Review of Competence Progression	LA – Leadership Academy	PMA – Professional Midwifery Advocates
ASC – adult social care	LCAV – Leading Change, Adding Value	PSA – Professional Standards Authority
BAME – black, asian and minority ethnic	LD – learning disability	RCEM – Royal College of Emergency Medicine
BMA – British Medical Association	LWAB – Local Workforce Action Board	RePAIR – Reducing Pre-registration Attrition and Improving Retention
CCT – Certificates of Completion of Training	MDT – multi-disciplinary team	RCGP – Royal College of General Practitioners
CEIP – clinically enhanced independent prescribing	MERP – Medical Education Reform Programme	RCOG – Royal College of Obstetricians and Gynaecologists
CESR – Certificate of Eligibility for Specialist Registration	MH – mental health	RCS – Royal College of Surgeons
CQC – Care Quality Commission	MSK – musculoskeletal	RRP – recruitment and retention premia
CYP – children and young people	MSTF – Maternity Safety Training Fund	SASG – staff and associate specialist grade
DH – Department of Health	MSW – maternity support worker	SPF – Social Partnership Forum
ED – emergency department	MTI – Medical Training Initiative	STP – sustainability and transformation partnerships
ESR – Electronic Staff Record	MTP – Maternity Transformation Programme	WRES – NHS Workforce Race Equality Standard
FMLM – Faculty of Medical Leadership and Management	NHS – National Health Service	6Cs – Care, Compassion, Competence, Communication, Courage, Commitment
FYFV – Five Year Forward View	NICE – National Institute for Healthcare Excellence	
GIRFT – Get it Right First Time	NHSI – NHS Improvement	
GMC – General Medical Council	NHSLA – NHS Leadership Academy	
GMTS – Graduate Management Training Scheme	NLW – national living wage	
GPFV – General Practice Forward		

Appendix three

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