Health Education England

HEE Workforce Planning and Strategic Framework (Framework 15)

2015/16 Call for Evidence

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

Section 1: Current and future workforce demand and supply

Section 2: Drivers of service demand change

Section 3: Patients and population

Section 4: Models of care

Section 5: Future workforce characteristics

Section 6: Any other evidence

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

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

Making your submission

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

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

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

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

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

Your contact details

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

Name	Sarah May
Job title/role in organisation	Deputy Chief Executive
Organisation (in full please)	Institute of Biomedical Science
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Contact number	020 7713 0214
Submission version)if you resubmit at any point)	V1
Date	13 July 2015

Data Protection and Freedom of Information

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

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

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

Section 1 – Current and future workforce demand and supply

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

i) the high level indicators; supply, demand, and any forecast under / over supply
or if available
ii) the more granular components of these three components e.g. retirement rates, output from education relative to attrition

1.1 Summary forecasts

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

Insert evidence here….

Current

Within Pathology diagnostic services there are supply issues in respect of experienced qualified Biomedical Scientists (Band 6) particularly Haematology (covering haematology, coagulation and blood transfusion). There is both a lack of Band 6 scientists in post and lack of movement between organisations, particularly in the south of England, which may be associated with cost of living deterring any "north to south" movement. There is also the additional influence of inner and outer London weighting that has an impact on recruitment outside of these boundaries.

The loss of experience Band 6 Biomedical Scientists is also associated with retirement reflecting the expansion of diagnostic services in the 1970's. In areas of the south east we have seen approximately 16% workforce retire in the last 3 years with possibly another 14% over the next 5 years within Haematology and Biochemistry.

The shortage of specialist band 6 Biomedical Scientists is being addressed by the recruitment and discipline specific specialist training of newly HCPC registered Band 5. However, it is worth noting that significant numbers of these scientific staff are from the EU and it is not known how long they will stay in the UK.

Pathology has provided a 24/7 service in disciplines that are needed for a urgent results service (primarily haematology, chemistry and transfusion), however, the NHS aspirations to a "true" 24/7 service with wider range of tests available will require a review and increase in workforce numbers and skill mix, with availability of senior scientist to advise and interpret diagnostic results as part of a 24/7 rota. This is different from a core out of hours emergency service and cannot be accommodated within current staffing numbvers.

1.2 Detailed / Component forecasts

Forecast Workforce Demand

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

Insert evidence here….

Drivers

- Comprehensive 24/7 clinical diagnostic service
- Diagnostic service covering more than one site
- Turn-round times to meet national performance indicators and local targets to improve quality of patient care
- Services provided closer to patient (GP or community services), either through POC diagnostics or improved phlebotomy arrangements. Overarching role in ensuring quality assurance of remote testing, QC/EQA, training and competency, IT connectivity to maintain patient care records.

Temporary Staff

- Due to scientific staff being a relatively small workforce there are rarely scientists listed on Hospital "Staff Banks" and as recruiting via agencies is prohibited or limited on the grounds of cost, most staff gaps are "covered" by existing staff. It would be helpful if there was an NHS Bank for healthcare scientist (similar to that which exists for medical staff), this would provide scope to employ additional staff to meet changes in demand e.g. "winter pressures".

Historical vacancies

- Persistent failure to recruit results in local review of workforce and scope of practice. Historically this has most frequently been resolved by appointing to a lower grade position and using "in house" training/day release/distance learning/professional qualification to enable staff development into the role. However, these sorts of posts are becoming fewer and fewer due to the way training is now commissioned and hence this route will not enable the skills gap to be bridged in the future.

Skill Mix / New Roles

- Introduction of new technology has already generated major changes in skill mix over the last few years in the support role of Bands 2 – 4 and with extended 24/7 services and potential increase in community based diagnostics increased numbers of these bands, particularly Band 4's are likely to be required.
- However, there needs to be provision to support the ongoing training and formal education of suitable Band 4's to eventually become HCPC registered biomedical scientists. This also requires the funding for and provision of accredited healthcare science or biomedical science undergraduate courses.
- Also for extended 24/7 services there needs to be available an appropriate number of Band 7 Biomedical Scientist for supervision, deliver training and provide advise and result interpretation to clinicians
- Develop IT/communication skills – diagnostics/telemedicine depend on it – frequently the "weak link"
- With respect to new roles or support extended roles across other Trusts/organisations a) development of community based biomedical scientist b) development of high level expertise in e.g. morphology, bone marrows, haemoglobinopathies c) RCPath/IBMS exams in histology for extended roles for biomedical scientist d) biomedical scientist lead clinics e.g. bleeding disorders, anticoagulant management, e) developing field of genomics and bioinformatics
- With the important role diagnostics play in >75% patient care – there is the potential for added cost and efficiency benefits 'down stream' through greater involvement of healthcare scientists in strategic planning and delivery of diagnostic services at the highest level e.g. commissioning, Trust Boards
- Involvement and support of clinical trials and PI initiated basic or translational research

Workforce Productivity

- Provision of comprehensive 24/7 service will require an increase in WTE scientist and support workers but not "double" existing workforce. This model of service would increase productivity within the 24 hour period, shortening the turn-round times of results to clinical teams/GP etc. improving quality of care to patients
- Community based services have the potential to reduce time to identifying clinical conditions and treatment availability

1.3 Forecast Supply from HEE commissioned education

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

Insert evidence here….

Biomedical scientist training is not commissioned – i.e students fund their own undergraduate degrees, which makes workforce planning challenging for a front line diagnostic healthcare science service.

With the current lack of funded “grow your own” opportunities to develop staff, the encouragement of HEIs to develop a day release model for their accredited biomedical and healthcare science degree courses would support the development of suitable associate practitioners through to HCPC registration as biomedical scientists and help bridge the pending skills gap. It would also help to develop the highly skilled and service orientated staff that the Health Service will require to meet the needs of current and future initiatives.

Current recruitment levels to the STP training programme will not provide sufficient output to meet these demands on the service, especially in the Cellular Science disciplines.

Attrition: we do not have precise numbers but retirement and loss due to diminished career progression as a consequence of pathology reconfiguration and workforce reprofiling has/will have a significant impact within NHS for significant numbers of scientists

Employment - Band 4 (support) Band 5, Band 6 healthcare scientists – secondary or future models of primary health care, in addition to filling post/roles left by retirement

1.4 Forecast Supply – Other Supply and Turnover

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

With both the current and future demands on the service and the lack of mobility of the workforce due to the current economic circumstances, there are going to be significant pressures applied to meeting future service staffing needs.

This will apply to all four nations within the UK.

Private sector providers are still a small component of the service delivery model however; they are often better placed to offer incentives to the best staff when it comes to recruitment and retention. This could over time, potentially drain a significant amount of the "talent" away from the NHS.

Staff from overseas are another important factor. It is essential that whenever overseas staff are employed, they meet the standards for registration with the HCPC to maintain patient safety at all times, especially as 24/7 and community based services become more widely established.

As far as career breaks and the increase in part time working are concerned, it must be remembered that to achieve this effectively and to introduce the levels of flexibility required to introduce 24/7 working, that there needs to be a critical mass of available staff at all levels from support worker grades to registered staff to provide a safe, effective and timely service to our patients.

Section 2 - Drivers of service demand change

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
We believe that our population is **getting older**, and that for our workforce, preferences for a change in patterns in working is increasing.		How do you think this will have an impact as a driver of **service demand**? Potential for greater demand for access to diagnostics initially more likely evenings (for non-urgent) than weekends. However, for urgent cases likely to be unacceptable to have to wait still Monday for certain investigations. Feel initial demand likely to be access to GP's/community
The influence of technology is growing in healthcare and beyond, with staff and patients using it to **increase personalisation and control** in their life. What will be its possible impact in healthcare in the years ahead? The influence of **genomics and research** will also play a vital part.	Potentially increase the number of patients with an "identified" abnormality – challenges to relate genomics to disease causation – likely to increase patient concerns and lead to more phenotype investigations	How will technology and innovation impact on **service demand** in the near future, and what education/training will the current workforce need to meet that demand? Update training of place of genomics in the patient diagnostic pathway. Understanding meaning of results and implications and place of phenotype testing
Wider factors are creating global pressures to **constrain the cost** of publicly funded healthcare, with the wider concept of wellness increasingly taking root which people will expect health service to respond to.	Depending of evidence based medicine – potentially increase in national diagnostic screening programmes (possible development for genomics) to confirm "wellness". Early detection of disease potential could increase workload but improve outcomes and reduce costs	Economics will play a part in influencing **service demand** and NHS funding will shape service demand in the near future (QIPP, funding, economics). For diagnostic use of IT to give direction to appropriate requesting at front end and review/audit and implement effect demand management to ensure "right test, right time to answer right clinical question"

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
Patients are going to want **high quality services anytime, any place, anywhere**, with a more equal (and challenging) relationship with staff, but one still based on care and a better work life balance.		What is the shorter term impact of changing patterns of expectations on **service demand**? Reduced staff retention due to requirement to work "unsociable" hours required to meet patient's needs. Potential for rostering inequality in the workplace between staff with and without dependents. Difficult to recruit to roles requiring 24/7 duties

Section 3 – Patients and population

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

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

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
Five year forward view draws attention to the NHS being committed to making **substantial progress** in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds.		How can we use our levers in the **short term** to support this commitment? Ensure all staff groups have access to a career pathway based on ability and merit with appropriate in-house and day release/distant learning knowledge/academic learning opportunity to develop for personal and NHS benefit. There should not be “glass ceilings”.

Section 4 – Models of care

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

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
Services are likely to become **increasingly integrated** in the future, enhanced through policies such as the Devolution of Local health and social care budgets, the integrated care pilots and integrated personal commissioning. Partnerships will become increasingly important, including with partners beyond NHS and social care.		How could **future service models** develop in the short term in line with these drivers, and what education/training will the current workforce need to make these models work? Identify if centrally based or local/community/clinic based diagnostic required. Education – involvement in direct patient care for healthcare scientists not currently trained in this aspect Professional/management training to influence/advise/direct/implement policies
We may increasingly see **centres of specialisation** in some specialties in some areas.		How could **future service models** develop in the short term in line with these drivers? Identify specialities, knowledge/training gaps. Develop networks of expertise with range of local and centrally delivered service, which is seamless at point of entry for patients/clinician
We will see the ongoing development of services in the area of **urgent and emergency care**	Depending of location and size of organisation, integrated diagnostics with appropriately trained staff to deliver full repertoire of investigations	How could **future service models** develop in the short term in line with these drivers? Developing diagnostic pathways for specific symptoms/suspected diagnosis to ensure right investigations and patients bleed at initial triage. Trained phlebotomists in ED to significantly reduced poor venepuncture and time delay for repeat tests. Appropriate use if required of POCT (note expensive and limited test repertoire compared to laboratory/lack knowledge interpretation abnormal results)
Five Year Forward View highlights new developments such as the **evidence based diabetes prevention service** and **encouraging new capacity in under doctored areas.**		How could such approaches affect **service models** in the near future?

Section 5 – Future workforce characteristics

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
Below are the 5 future workforce characteristics set out in Framework 15	In your evidence please highlight any or all of the following: - Are these workforce characteristics still valid? - Any evidence you are aware of work which is underway and which contributes to the achievement of the workforce characteristics - Any gaps you are aware of Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term** education and training needs required for the current workforce to meet these characteristics:
The workforce will include the informal support that helps people prevent ill health and manage their own care as appropriate.		Ability to design diagnostic reports that the patient can understand and offer advice in interpreting "normal" results to change aspects of lifestyle prior to diagnosis of a "disease state".
Have the skills, values and behaviours required to provide co-productive and traditional models of care as appropriate.		
Have adaptable skills responsive to evidence and innovation to enable 'whole person' care, with specialisation driven by patient rather than professional needs.		Including healthcare scientist within multi-discipline team training so all staff involved in the particular care pathway understand patient needs and work together
Have the skills, values, behaviours and support to provide safe, high quality care wherever and whenever the patient is, at all times and in all settings.		Appropriate qualifications/registration for role Robust competency training and standardised assessment Training courses for trainers and mentors across all workforce groups
Deliver the NHS Constitution: be able to bring the highest levels of knowledge and skill at times of basic human need when care and compassion are what matters most.		Have representation from all professions delivering care within a patient journey opportunity to attend MDT's and be aware of patient outcomes and opportunities to improve service

Section 6 – Any other evidence not included elsewhere

Insert evidence here….