Introducing Health Education England

Our Strategic Intent
January 2013
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Foreword

‘The NHS belongs to the people. It is there to improve our health and well-being, 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.’

This is the most often quoted passage from the NHS Constitution. Not just because it’s a moving piece of prose, but because it manages to capture the human endeavour at the heart of the National Health Service. The ‘NHS’ includes over 1,000 different employers across the public, private and voluntary sector. But peel away the structures of commissioning and provision; the walls of the hospital and the GP’s door, and you are left with the essence of the NHS: a human interaction between people.

To deliver high quality care, we need staff in the right numbers, with the right skills and the right values and behaviours. Health Education England (HEE) has been created for this very purpose. In a fast changing healthcare environment, investing in our current and future workforce is the only way of ‘future proofing’ the NHS. Without doctors, nurses, dentists, physiotherapists and other roles, there is no NHS. HEE therefore needs to operate at the frontiers of existing knowledge, to secure the right numbers of people, with the right skills and behaviours, to ensure that the possibilities offered by our best researchers and scientists can become a reality.

Of course we need high quality primary and community services and hospitals with the most cutting edge treatments available to all. But without the right staff, they are just buildings with shiny machines that go beep. We need excellent commissioners to purchase care on behalf of their populations, but if we haven’t planned for and developed the right workforce, then commissioners will not be able to ensure delivery of the services that patients need. It is vital that we encourage greater innovation and research, but there’s little point investing in research and development and technology if our staff do not have the skills to use them. Most important of all, the NHS could employ hundreds of thousands of staff with the right technological skills, but without the compassion to care, then we will have failed to meet the needs of patients.
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HEE is currently in its infancy. On 28th June 2012 we were formally established to work as a shadow Special Health Authority from October 2012, and we will take on our full duties on 1st April 2013. There is much work to be done to establish HEE and our Local Education and Training Boards (LETBs) and agree with our stakeholders how we are going to work together in the interests of patients. These conversations will form the basis of our strategy going forward. In order to begin that conversation, we are publishing our Strategic Intent.

The aim of this document is two-fold. Firstly, it sets out clearly the purpose of HEE and its LETBs: that we exist to support the delivery of excellent healthcare and health improvement to the patients and public of England. We do this by ensuring that we have the right numbers of staff, with the right skills and right behaviours when and wherever they are needed. Because of the time it takes to select, educate, train, recruit and develop the healthcare workforce, the decisions we make today will need to be informed by our imperfect understanding of the future. This purpose, and our focus on the current and future workforce, will be at the heart of all that we do, and we will use it as a guide to action over the coming months and years.

Secondly, we realise that we cannot achieve our purpose alone. Our Strategic Intent Document is the beginning of that conversation, and will help us to develop our strategy as we grow. As a first step, we are seeking views on a small number of proposed strategic priorities under each of the domains of the Education Outcomes Framework. We will review the above in light of feedback and the forthcoming Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC which we anticipate will have implications for education and training.

If we are clear about what HEE is here to do, then we believe we can work together with you on how to achieve it. We hope that you will use this document to come and talk to us about how we can use the greatest resource in the NHS – our people – to achieve high quality care for all.

Sir Keith Pearson
Chairman

Professor Ian Cumming OBE
Chief Executive
Our Proposed Strategic Priorities

<table>
<thead>
<tr>
<th>EOF domain</th>
<th>HEE proposed priority</th>
</tr>
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<tbody>
<tr>
<td>Excellent education</td>
<td>Develop role models for education and training - ‘make being a trainer a badge of honour’</td>
</tr>
<tr>
<td></td>
<td>Education for life - ‘supporting and championing multi-professional CPD’</td>
</tr>
<tr>
<td>Competent and capable staff</td>
<td>Support a dementia aware workforce - ‘ensuring all staff are trained to rise to the challenge on dementia’</td>
</tr>
<tr>
<td>Widening participation</td>
<td>Making healthcare the career of choice - ‘use NHS Careers to reach out into schools for our future workforce; and open to all - encourage more part-time degrees’</td>
</tr>
<tr>
<td>Flexible workforce responsive to research and innovation</td>
<td>Making technology central to education - ‘introduce an app to allow students to access information and feedback on their experience’</td>
</tr>
<tr>
<td></td>
<td>Realise the potential of research and innovation - ‘invest in education and training in genomics’</td>
</tr>
<tr>
<td>Ensuring a workforce with the right numbers, skills and behaviours</td>
<td>Securing future supply and supporting stakeholders with current problems in ‘key areas such as emergency care workforce, primary care workforce, 24/7 services’</td>
</tr>
<tr>
<td>NHS values and behaviours</td>
<td>Roll out best practice so that healthcare workers are ‘recruited for values, trained for values, appraised for values and held to account for values’</td>
</tr>
</tbody>
</table>
1.1 Our purpose

Health Education England (HEE) exists for one reason and one reason only: to support the delivery of excellent healthcare and health improvement to the patients\(^1\) and the public of England, by ensuring that our workforce has the right numbers, skills, values and behaviours, at the right time and in the right place.

Following consultation in December 2010, the idea of an autonomous national body providing system wide leadership and oversight of workforce planning, education and training received widespread support. These ideas were built upon by the Future Forum (see Annex A), and the Government has responded by setting out a clear remit for HEE.

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\(^1\) NB: *For the purposes of this document a patient is defined as being any user or potential user of NHS services.*
HEE will provide leadership for the new education and training system. It will ensure that the shape and skills of the future health and public health workforce evolves to sustain high quality outcomes for patients in the face of demographic and technological change… HEE will ensure that the workforce has the right skills, behaviours and training and is available in the right numbers, to support the delivery of excellent healthcare and drive improvement. HEE will support healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through development of the Local Education and Training boards (LETBs) which are statutory committees of HEE.

Liberating the NHS – Developing the Healthcare Workforce: From Design to Delivery, Jan 2012.

Our remit and functions

HEE was established on 28th June 2012 to work as a shadow Special Health Authority from October 2012, and take on full responsibilities from April 2013 with five national functions:

- Providing national leadership on planning and developing the healthcare and public health workforce
- Promoting high quality education and training that is responsive to the changing needs of patients and local communities, including responsibility for ensuring the effective delivery of important national functions such as medical trainee recruitment
- Ensuring security of supply of the health and public health workforce
- Appointing and supporting the development of LETBs
- Allocating and accounting for NHS education and training resources and the outcomes achieved.
1.2 Our leadership responsibilities

The following diagram sets out the areas where HEE has a direct or a leadership responsibility.

**HEE remit and levers for change**

- **Workforce planning**
  Commissioning under and post graduate education to ensure that we have a workforce in the right numbers, with the right skills, values and behaviours to respond to the current and future needs of patients.

- **NHS Careers**
  Web based service that promotes the NHS as a place of work to potential employees.

- **Undergraduate & postgraduate education**
  Commissioning places to reflect the future needs of patients.

- **Recruiting for values and behaviours**

- **Continuing professional development (CPD)**

- **In service training for bands 1-4**

**Key:**

- All lines are the levers that exist within the system.
- Dotted lines represent areas where HEE holds a leadership responsibility and indirect influence although direct influence lies elsewhere.
- Non-dotted lines represent factors for which HEE has a direct responsibility.

HEE will use the above levers to ensure that our budget of nearly £5 billion pounds is invested in our current and future workforce, so that we can meet the needs of patients both now and in the future.
Our opportunities for influence and leadership are many, and include:

**NHS Careers:** is currently a web based service that promotes the NHS as a place of work to young people. It offers an exciting opportunity for HEE to reach out to the next generation of healthcare professionals, not just to ensure that we have the right numbers, but to attract people with the right values and behaviours, and to open up access so that the workforce of the future better reflects the communities that it serves.

**Recruiting and training for values and behaviours:** HEE will use its contractual and other levers to ensure that we not only recruit for values, but ensure that service training places are selected and funded on the basis of their ability to role model the values and behaviours that we wish to promote. This will avoid a situation whereby we recruit values driven people, reinforce this through excellent education, but erode it through training placements that do not role model the values and behaviours that we wish to promote. We will also work with employers to encourage a greater emphasis on the continual professional development of the existing workforce, particularly for the bands 1-4.

**Workforce planning:** HEE is responsible for commissioning under and postgraduate education, to ensure that we have a workforce in the right numbers, with the right skills, values and behaviours to respond to the current and future needs of patients. HEE will ensure that our local and national plans are aligned with the service planning processes of providers and commissioners, so that we can help turn service strategies and visions into a reality. The decision making points for workforce are often driven by the academic cycle rather than the financial annual planning round of the NHS, and are necessarily much longer term.

**Shaping the future:** It typically takes around three years for a nurse to go through undergraduate training and three to four years for most undergraduate Allied Health Professional degrees. The timescales of training the medical workforce vary greatly, however following completion of medical school it can often take up to 10 years for an individual to gain their Certificate of Completion of Training (CCT) status.

A medical student graduating this year will still be providing care in 2050. We know that the availability (or not) of skilled healthcare professionals can often drive service reconfiguration. HEE therefore has a key leadership role to play with regard to understanding and responding to the future. Our thinking about the future needs of patients will be dynamic and we will work with stakeholders to influence thinking on designing the shape of future service delivery to reflect this. We will provide leadership at a local and national level to encourage providers, commissioners and other stakeholders to develop long term visions for services wrapped around the needs of patients, so that we can take forward the workforce response.
Our focus on outcomes

Prior to the creation of HEE, our stakeholders worked together to develop the Education Outcomes Framework (EOF), as a means to ensure that the healthcare system is driven by and is held to account for the outcomes that matter to staff, public and patients. HEE welcomes the EOF, as it sets out a clear framework for the action that we will support and lead, and a focus for our work in the months and years ahead:

The EOF applies to the wider healthcare system, and we will be held to account for the areas for which we have responsibility. It will drive the decisions that we take within HEE and those that are made every day locally by our LETBs and their Governing Bodies.
1.3 Our values: How we will behave

Our core values at a national and regional level are aligned with the NHS Constitution and our pride, across the system, in doing what we do for current and future patients and the public in England. We fully commit to promote and uphold the values of the NHS Constitution in all that we do, which are:

- Respect and dignity
- Commitment to quality care
- Compassion
- Improving lives
- Working together for patients
- Everyone counts

HEE will set an example by being an excellent employer in our own right. As a people organisation, we will seek to promote and support the NHS Constitution pledges to staff, which are:

- to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities (pledge);
- to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed (pledge);
- to provide support and opportunities for staff to maintain their health, well-being and safety (pledge); and
- to engage staff in decisions that affect them and the services they provide individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families (pledge).

These will be supported by our 10 principles which will guide all that we do:

- **The patient comes first** – not the needs of any organisation or profession
- **We will future proof** the NHS by designing and commissioning a workforce that is flexible, technologically literate, confident in learning and innovation
- **We will work together,** across organisational and professional boundaries, to drive improvements in quality
We will base our decisions upon evidence about the needs of current and future patients.

We will be open and transparent with all of our information and decisions.

We will deliver best value for the public money we spend.

We will promote a multi-disciplinary workforce in which all voices are heard.

We will recognise and value the diversity of the NHS workforce and will seek to reflect and promote this in all that we do.

We will promote research and innovation in both culture and practice.

HEE is part of the NHS, and we will speak highly of all our stakeholders who work to meet the needs of patients.

1.4 Our ways of working

We will recognise that everyone has a responsibility for ensuring that patients are treated by staff with the right skills and behaviours. Each professionally registered member of staff has a responsibility to maintain their own Continuing Professional Development (CPD); every employer has a duty to ensure that they are planning for and recruiting the right numbers of staff with the right skills and behaviours to meet the needs of their patients, and the boards of provider organisations are responsible for assuring themselves that current staffing levels are safe and appropriate. Regulators have a particular responsibility to with regard to professional and organisational standards, and commissioners will need to make sure that they set out clearly what kind of services they wish to buy in the future, so that we can begin to educate and train the people who will turn these visions into a reality.

We will be driven by local needs and decision making, through our LETBs. LETBs are sub-committees of HEE, led by Managing Directors and informed by a governing body that brings together the providers of healthcare in each locality. This unique governance model will ensure that providers, who at the moment are the main (but not the only) employers of healthcare staff, informed by clinicians and professional leaders who have day to day contact with many patients, can inform and shape the decisions about education, training and workforce planning. Experience tells us that unless we can engage the providers in these issues, then the NHS will remain focussed on today, and fail to plan adequately for tomorrow. HEE, together with its LETBs, provides a real engine for delivery and reform.
Subject to the authorisation process, there are likely to be 13 LETBs (see Annex B). With employers and professionals as part of their governing bodies, LETBs will improve the quality of education and training outcomes so they meet the needs of service providers, patients and the public within their local footprints. They will have the flexibility to invest in education, training and ongoing professional development to support innovation and development of the wider health system. They will also be able to ensure that funding in the new system follows the student/trainee on the basis of quality and education and training outcomes.

LETBs are currently operating in shadow form with delegated authority from Strategic Health Authority (SHA) clusters. The authorisation criteria for LETBs has been agreed by the Secretary of State and published. We will implement the authorisation process to establish LETB governing bodies as committees of HEE between November 2012 and March 2013. This will create a new drive and dynamic in the system, with planning more informed by the needs of employers, and employers and clinicians more engaged in the future needs of the wider system.

Within a national accountability framework. The NHS is a National Health Service, and one of our greatest challenges is the mobility of our workforce both within and outside of our nation. Decisions about demand and supply will impact on the rest of the country. If one area does not increase education commissions for GPs, then this could affect overall national supply figures. Some specialist professions will need to be planned nationally to secure future supply. LETBs will of course reflect local needs in their planning and investment decisions, but within a national strategic framework that reflects the longer term needs of England as set out by HEE, which in turn will be informed and influenced by our LETBs’ plans and priorities. HEE will need to account for how our £5 billion of public money has been spent, and to provide assurance that investments are driven by the needs of patients.

Our work will be informed by the views of patients and professions. The establishment of Medical Education England in 2009 helped to develop strong stakeholder relationships and lay and patient representation. HEE will build upon these strong foundations as it moves forward. We know that the engagement of stakeholders is not just important for good relations – it is essential to good decision making. We are currently reviewing our advisory structures and will shortly consult with stakeholders on options for ensuring greater clarity and transparency of the decision making process, so that it is clear where governance and accountability lies, duplicative effort is reduced, and stakeholders are able to provide information and advice to the decisions which need to be made. But we are clear that the decisions will be made based upon an assessment of the impact on patients, rather than any particular profession or organisation.

We will use transparency as an accelerator for change. Education, training and workforce development will no longer be subsumed within the everyday business of SHAs but the sole purpose of a dedicated national body, with ring fenced resources. In the past a myriad of different budgets such as MPET (Multi-Professional Education and Training) and SIFT (Service Increment for Teaching) have evolved over time. In the future, there will be one budget: HEE’s budget and it will exist for one purpose: investing in the planning, education and training of our workforce. We will be open and transparent with all of our information and decisions including investment decisions which will reflect and recognise the current financial climate and challenges facing the NHS, acknowledging the need for improving efficiency and at the same time improving quality and ways of working.
Section 2: Our ambition

The Health and Social Care Act 2012 has set in train a radical programme of reform, and a number of new organisations are now being established in order to take forward these changes. All of this is taking place in a period of economic turbulence, which means that the NHS is unlikely to see the levels of investment it has enjoyed in recent years. Quite simply the NHS is going to have to deliver higher quality care with less money. Now, more than ever, it is vital that we consider the most important resource that the NHS has: its people. Without a skilled workforce there is no NHS.

The current and future healthcare workforce will be the means by which the ambitions of the NHS are realised. Therefore we should never have:

- a situation where a service cannot be delivered, or commissioned, even though it is the right thing for patients, because we have failed to get workforce planning right. Similarly we should never have to withdraw a service because of a workforce shortage as a result of our failure to secure future supply
- patients not receiving the latest treatment that evidence based research has to offer because we are too slow to train our workforce in these new skills and techniques.

The direct relationship between the workforce and the quality of patient care has never been more clearly illustrated than in the first report on the failings at Mid-Staffordshire Foundation Trust:
Never again should patients and those close to them be subjected to the experiences described in this report. Staffing must be adequate to ensure a proper level of basic care; training, support, supervision and leadership must be strong enough to mean there is no excuse for members of staff to behave as some have in this hospital.


But this is not just a case of getting the workforce numbers right. When patient care suffers, it is often because the staff who are treating them have not been recruited or supported to have the right skills, values or behaviours.

2.1 Where we are now

With over 1.3 million staff the NHS operates on a global scale and is one of the five largest employers in the world and the largest in Europe. This workforce performs over 300 different types of jobs spread across more than 1,000 separate employers delivering services on an industrial scale. On a typical day, the NHS workforce interacts with over a million patients, including:

- 836,000 people visiting their GP practice or practice nurse
- 389,000 community contacts
- over 50,000 people visiting accident and emergency departments
- 124,000 outpatient attendances
- 114,000 people in hospital as an emergency admission
- 44,000 people in hospital for planned treatment
- Approximately 200,000 patients receiving dental treatment
- 19,000 calls to NHS Direct
- Over 13,000 emergency patient journeys by ambulance
- 2.6 million prescription items dispensed.

These are huge numbers, but it is important to recognise that each one of these interactions is a personal one, each one different, each one having an impact on the life of an individual and their family, and each one driven by the professionalism, skills, values and behaviours of the individual staff member concerned. The NHS is industrial in numbers, but so very personal in practice.

That workforce, the people who deliver the care, is currently comprised of the high level groupings as seen in the pie chart on the following page.

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3 Curson et al 2008.
6 Source: based on 961 items per year in 2011 from The Health and Social Care Information Centre: Prescriptions Dispensed in the Community: England, Statistics for 2001 to 2011. This includes items dispensed by all pharmacists, whether directly employed by the NHS or not.
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Each member of this workforce is the result of extensive investment from taxpayers, in terms of their employment costs, but also as importantly for the majority of the workforce, the investment made in their education and training.

For example, on average it costs approximately:

- £70,000 to train a qualified nurse
- £60,000 to train an allied health professional
- £560,000 to train a medical consultant
- £500,000 to train a GP.  

In 2012/13, we are spending nearly £5 billion on education and training in the NHS, which is approximately £9,500 a minute. This money is being spent on:

- 91,000 non-medical pre-registration students
- 44,600 post graduate medical and dental students
- 23,000 under graduate medical and dentistry students.

This is a huge investment for the NHS and its future: nearly £5 billion supporting 160,000 students who are the next generation of doctors, nurses, healthcare scientists, physiotherapists and all the other professions. In this economic climate, we are going to have to account very clearly for every pound invested in the workforce, and to demonstrate how we can support the health and healthcare workforce to deliver higher quality care with less growth than before.

If we are to achieve our ambition of high quality care provided by the right numbers of staff, with the right skills and behaviours in the right place at the right time, then we will need a more strategic and planned approach to this investment in the future of the NHS.

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7 Personal Social Services Research Unit, Unit Costs of Health and Social Care 2012.
8 Department of Health, 2012.

Source: NHS Workforce Census Bulletin 2001-2011 produced by the Health and Social Care Information Centre. NB: The NHS Workforce census bulletin only includes pharmacy staff directly employed by the NHS and not those employed in local high street or independent pharmacies.

NB: There are a range of different professions, not all of which are differentiated in the pie-chart below. The range of difference in size of some of these can be demonstrated for example by the numbers of commissions planned for 2011/12 undergraduates for example for Adult Nurses there were 12,017, but for Orthoptists only 74.

(CWI Workforce Risks and Opportunities, Education Commissioning Risks Summary 2012, based on DH NMET Monitoring data 2011 Q4.)
2.2 Where we need to be

We live in extraordinary times. The revolution in information technology offers the potential to transform the way that patients access information, diagnosis and treatment. Developments in genomics will create a paradigm shift from a health system based upon ‘diagnose and treat’ towards a model of ‘predict and prevent’, and demographic changes are influencing the types of care and treatment people need now. These developments are having a significant impact on our healthcare services and the workforce that delivers them. The workforce will need to be flexible and adaptable enough to cope with fundamentally different ways of working. Some of these changes are highlighted in the following table, the first two columns of which are taken from the Institute of Medicine as cited in the King’s Fund report ‘Transforming the delivery of health and social care’. The third column we have added as our view on the implications and impact these changes will have for the healthcare workforce.

<table>
<thead>
<tr>
<th>Current Approach</th>
<th>New Rules for 21st Century Healthcare</th>
<th>Healthcare Workforce Implications</th>
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</thead>
<tbody>
<tr>
<td>Care is based primarily on visits</td>
<td>Care is based on continuous healing relationships</td>
<td>The workforce will need to be flexible and adaptable enough to cope not just with new care pathways, but also a fundamentally different way of working and a different dynamic to relationships with patients and other care givers across a variety of public, private and voluntary sector organisations in health and social care.</td>
</tr>
<tr>
<td>Professional autonomy drives variability</td>
<td>Care is customised according to patient needs and values</td>
<td>The workforce will need strong communication skills along with the ability to empathise with the needs of individual patients in their own context. Clinicians will need the skills to ensure that decisions are evidence based and personalised to the specific needs of the patient, with the potential use of mobile technology to support this working across integrated services.</td>
</tr>
<tr>
<td>Professionals control care</td>
<td>The patient is the source of control</td>
<td>Clinicians will need to empower patients to manage their own conditions and clinicians will need to be fully immersed in the use of new technology to deliver care and advice remotely.</td>
</tr>
<tr>
<td>Information is a record</td>
<td>Knowledge is shared and information flows freely</td>
<td>New innovations may lead to the development of new bespoke services, such as genomics in the field of tailored public health advice and support. The workforce will need the skills to understand and support the spread of innovations through continuous professional development including training on the science of implementing change.</td>
</tr>
<tr>
<td>Decision-making is based on training and experience</td>
<td>Decision-making is evidence-based</td>
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<tr>
<td>‘Do no harm’ is an individual responsibility</td>
<td>Safety is a system property</td>
<td></td>
</tr>
<tr>
<td>Secrecy is necessary</td>
<td>Transparency is necessary</td>
<td></td>
</tr>
<tr>
<td>The system reacts to needs</td>
<td>Needs are anticipated</td>
<td></td>
</tr>
<tr>
<td>Cost reduction is sought</td>
<td>Waste is continuously decreased</td>
<td></td>
</tr>
<tr>
<td>Preference is given to professional roles over the system</td>
<td>Co-operation among clinicians is a priority</td>
<td></td>
</tr>
</tbody>
</table>

Source: Committee on Quality of Health Care in America, Institute of Medicine (2001), and cited in ‘Transforming the delivery of health and social care’, King’s Fund 2012
These characteristics of our future workforce will be driven not by changes in legislation or politicians, but by wider drivers of change that affect all health care systems across the globe.

As previously mentioned, developments in genomics will fundamentally alter the way that we provide health and healthcare, creating a shift from a model based upon ‘diagnose and treat’ to a model based upon ‘predict and prevent’. Digital developments and the information revolution will drive further radical changes in the expectations of patients and their relationship with clinicians and carers.

The continuing shift from the acute sector to care closer to home will also drive further changes in the way that our workforce is educated and trained, as the skills necessary to work as part of a multi-disciplinary team in a seven-thousand strong hospital are different to those required by individuals working autonomously out in the community where the homes of patients may become their primary place of work. We need to be alert to both identifying and responding to such changes in our approach to workforce planning and through our education and training system.

2.3 Drivers for change

One way of understanding the different drivers of change is in terms of demand and supply. A primary care practice, for example, may have a demand for more nurses trained in diabetes management, but their needs can only be met if there are enough nurses with the right skills available to employ (supply).

The challenge for workforce planners is how to balance demand with supply, when demand is likely to increase given the rise in prevalence of long term conditions. In addition, all healthcare policy for diabetes is driving a shift toward primary care, multi-disciplinary teams and greater involvement of patients in their own care.

The following example illustrates the importance – and difficulty – of getting the balance between supply and demand right in a constantly changing field like health and healthcare.
The prevalence of diabetes has increased rapidly over the last 10 years and forecasts suggest that this trend is likely to continue.

- Between 2006 and 2011 the number of people diagnosed with diabetes in England has increased by 25%, from 1.9 million to 2.5 million. On top of this it is estimated that up to 850,000 people have diabetes but don’t know it.
- Another 7 million people could be at high risk of developing diabetes and numbers continue to increase dramatically each year. If current trends continue by 2025 it is estimated that 5 million people in the UK will suffer from diabetes.

Forecasts suggest that this trend is likely to continue, but predicting the number of people with Type 2 diabetes in 20 years’ time, and therefore the workforce needed to respond to this is complex. Demand may reduce due to the early identification of those at risk, intensive lifestyle interventions and drugs, such as Metformin, can prevent some people progressing to develop diabetes. Conversely, a failure to tackle the ‘tsunami’ of diabetes could lead to an increase in patients and a greater demand for diabetes services.

The prevalence of diabetes will impact on other NHS services and professions. For example, as a result of complications from diabetes, between 2006 and 2010:

- Retinopathy – increased by 118%
- Stroke – increased by 87%
- Kidney Failure – increased by 56%
- Cardiac Failure – increased by 43%
- Angina – increased by 33%
- Amputations – increased by 26%

Many of these complications are avoidable with good risk assessment and early diagnosis, patient support and good ongoing services, which is why public health strategies need to be a vital part of our workforce planning processes.

Source: State of the Nation 2012, Diabetes UK.
Workforce planning, education and training contribution to tackling the rise in diabetes and associated challenges:

**System wide strategies**

**Supported by education and training and workforce planning solutions**

**Example of the types of solutions**

- **Prevention**: CPD, under graduate and post graduate training and development of the public health workforce and all healthcare workers can make sure that ‘every contact counts’ by training all front line staff in established behaviour change techniques, if we give them the skills and knowledge to talk with people about diet, lifestyle and other factors that can reduce the risk of contracting diabetes. Educating the public so that they know how to reduce their own risk is key to prevention. Primary care staff trained and able to apply validated diabetes risk assessment tools. Staff confident in working in collaboration with patients to encourage greater self-care.

- **Diagnosis**: there is a huge variation in the levels of identification of people with diabetes across the country. In the best performing organisation 22% of people are receiving NHS Health Checks in a primary care setting whereas in the worst performing organisation the figure is 0%. Ensuring we have the right numbers of people with the right skills and the right values and behaviours in the right place could help to tackle these inequalities by increasing early diagnosis of diabetes. Primary care staff should be trained and equipped to accurately diagnose diabetes in those patients identified as having a high risk. This includes the use of Near Patient Testing equipment and an up to date knowledge of diagnostic criteria.

- **Management**: 19% of hospital inpatients at any one time have diabetes. This is not good for hospitals, and is not always best for patients and their carers. In order for people to receive the support that they need in a community or home setting, we will need a workforce trained with the right skills, in the right number with the right behaviours in primary and community care settings. As part of this, we will also need specific workforce interventions such as training more GPs with a special interest in diabetes, and increasing the number of specialist primary care nurses trained to carry out routine screening checks for patients with diabetes looking for early signs of renal disease, retinopathy and neuropathic changes in the feet.

Some more examples of the drivers of demand and supply (many of which are cited by the King’s Fund in its ‘Transforming the Delivery of Health and Social Care’ Report 2012) to ensure the delivery of a high quality service to patients are given overleaf:
Demographics

- The population of England will grow by nearly 8 million over the next 20 years.\(^9\) Boys born in 1901 were expected to live for 45 years and girls for 49 years. In 2012, boys could expect to live for 79 years and girls for 83 years.\(^10\)
- By 2032, the number of people aged over 65 is expected to grow by more than a third from 9 million to 13.5 million (39%) and the number of people aged over 85 is expected to double from 1.3 million to 2.6 million.\(^11\)
- Whilst healthy life expectancy is also increasing, trends suggest that people are living a greater proportion of their lives in ill health.\(^12\)

Disease Prevalence

- By 2018 the number of people with three or more long term conditions (LTCs) is predicted to rise from 1.9 million (2008) to 2.9 million (2018).\(^13\) Three core factors are driving the anticipated growth in the number of people with chronic disease and disability: the growing number of older people; risk factors such as obesity and inactivity; and the growing capacity to treat.
- It has been projected that the number of people in the UK with dementia will double in the next 40 years.\(^14\)
- The prevalence of obesity has risen from 15% in 1993 to 26% in 2010.\(^15\) Some predictions suggest that by 2035 46% of men and 40% of women will be obese, resulting in more than 550,000 cases of diabetes and around 400,000 additional cases of heart disease and stroke.\(^16\) If current trends continue by 2025, it is estimated that 5 million people in the UK will have diabetes.

Innovation

- Precision medicine will revolutionise our ability to predict, prevent, monitor and treat a whole range of conditions.\(^17\) Alongside low-cost genetic sequencing, genome mapping, biomarker tests and targeted drugs and treatments, this could enable professionals to build tailored health information and create personal treatments to improve patient outcomes.\(^18\)

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10 House of Commons, 1999.
12 CfWI, Big picture challenges for health and social care, p.3, 2012.
16 Wang et al 2011.
17 Couzin-Frankel 2011; Ioannidis et al 2011
18 Cho et al 2012.
Introducing Health Education England
Our Strategic Intent

Innovation in genetics, biotechnology, material sciences and bioinformatics has already brought benefits to patients with diseases such as cancer and heart disease and now holds out new hope for people with neurodegenerative diseases, such as multiple sclerosis and Parkinson’s. Six out of ten people are likely to develop a disease that is at least partly genetically determined.19

Significant growth is predicted in the use of home-based technologies that support individuals and their carers to manage their long term conditions. Robotic-based surgical procedures are also growing rapidly.20 This can be coupled with the increasing impetus to deliver care at distance through video conferencing and the digital transfer of medical information.

There is increasing impetus to deliver care at a distance through video-conferencing supported by the digital transfer of clinical information. This could include remote intensive care monitoring systems, already in use in the United States, that enable hospitals to deliver intensive care using staff observing patients across multiple intensive care units from a single remote location.21

Quality – Patient & Public Expectation

The public are becoming more demanding of health professionals and are seeking more engagement in decisions about their care.22

Dignity and respect and the relational aspects of care are core drivers of satisfaction with health and social care services.23 For example, the ‘Delivering Dignity’ report by the Commission on Improving Dignity and Care in 2012 stated that: ‘Student nurses, medical students and other trainee health professionals need to have dignity instilled into the way they think and act from their very first day.’24

Net satisfaction with the NHS has fallen recently from 70% to 58%.25

The Care Quality Commission (CQC) report into health and social care providers in 2011/12 states: ‘On 31 March 2012 most of the services (73%, 10,313 locations) that CQC had inspected across all health and social care sectors were meeting all the essential standards checked. Within this, there is much excellent care being provided. But this also means that 27% of services (3,617 locations) that CQC had inspected up to that date (including those inspected before 2011/12) were not meeting at least one standard on 31 March 2012. Any substandard care will ultimately impact on the experience of people who use services.’26

19 Hayden 2012.
20 Barbash and Glied 2010.
22 Economist Intelligence Unit 2009.
23 King’s College London and The King’s Fund 2011.
24 Delivering Dignity, Commission on Dignity in Care for Older People, page 35
Supply side drivers of change

Numbers

The situation will vary across the country at different times, but some commentators estimate:

- The predicted gap between the demand and supply for the healthcare workforce in developed countries over the next 20 years is predicted to be between 22% and 29% globally.27
- Managing a potential oversupply of 2,000 hospital consultants overall by 2020,28 against a backdrop of specific current shortages for consultants in emergency medicine, neurology, forensic, general and old age psychiatry and learning disabilities.29
- A potential shortfall of between 40,000 and 100,000 nurses by 202130 and currently shortages for specialist nurses working in operating theatres.31
- Other shortage areas include HPC registered sonographers, diagnostic and therapeutic radiographers, and operating department practitioners.32
- Increasing numbers of midwives are being employed and trained; and yet the highest birth rate in England for four decades is putting increasing pressure on the capacity of midwifery services and the numbers of midwives nearing retirement age is also increasing. The number of older mothers is growing, which will also put additional pressures on services.33

Skills

- If technology is to enable a step change in productivity the health and social care workforce will need the appropriate skills and capabilities to embrace that technology and to support new ways of working. We will need to develop new skills and careers in genomics and clinical informatics. Clinical academic training will underpin successful delivery.
- Equipping a workforce for the future is not something that can simply be left for future recruits. The majority of professional staff who will be working in health and social care in ten years' time are working in health and social care today – CPD will need to address these issues. A key element of this will be the development of staff in bands 1 to 4 who are closely involved in patient care by ensuring they have the flexibility to adapt to new innovations in service delivery.
- Communication skills will be essential for the workforce of the future. The General Medical Council in 2012 reported a significant rise in concerns about how doctors interacted with their patients. Allegations about communication rose by 69% and alleged lack of respect rose by 45%.34

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27 Source: OECD data, analysis by KPMG International 2012
28 Centre for Workforce Intelligence, 2012
29 Most recent report from the Migration Advisory Committee
30 Royal College of Nursing 2011
31 Most recent report from the Migration Advisory Committee
32 Most recent report from the Migration Advisory Committee
33 Second annual State of Maternity Services Report 2013 (Royal College of Midwives)
34 The state of medical education and practice in the UK, General Medical Council, 2012
Behaviours and Values

- 22% of all written complaints from patients received in 2011/12 related to poor attitude and/or communication. Work is ongoing to address these issues with “Developing the Culture of Compassionate Care” describing the new vision for nurses, midwives and care givers committing to action in six areas: Care; Compassion; Competence; Communication; Courage and Commitment.
- We need to develop flexible ways of working so that healthcare services can be provided around the needs of patients such as the introduction of 24/7 working. However, like the rest of society the healthcare workforce seeks a balance between work and life. Balancing these two factors will be a significant leadership challenge. For example the part time employment grew from 16% in 2000 to 19% in 2009. Average hours worked per week have dropped by 7% over the last 20 years. If current trends continue it’s estimated that the average working week will fall by 5.6% to just under 34.5 hours. The combined effect would be a reduction in healthcare workforce capacity of between 9% and 11% by 2022.
- The introduction of the Friends and Family Test (FFT) will provide a key source of information and intelligence about patient experience in the NHS. The results of this feedback will start to inform the debate about values and behaviours of the workforce and in turn possibly feed into wider discussions about training of our healthcare professionals.

Our ability to balance demand and supply has real impact on patients. There are also wider opportunity costs for the healthcare system and tax payers. The rate at which students drop out of undergraduate courses for nurses, midwives and other clinical professionals is relatively low but has significant variation. The amount of money spent by the NHS on students who do not go on to become members of the workforce is estimated to be in excess of £100 million per year in tuition fees and student support payments.

Some degree of attrition is unavoidable and even necessary, as the system must not shy away from failing people who are unable to meet the required standards, but this should be minimised to ensure this wasted resource can be used to meet other areas of workforce need that are currently unmet because of limits to available resources.

Achieving a balance between demand and supply in a way that produces a workforce with the right numbers, skills and behaviours is further complicated by the fact that different decisions are taken by different agencies at different points in time that affect the overall balance of supply and demand, as illustrated by the diagram overleaf:

35 Health and Social Care Information Centre, 2012
36 Developing the culture of compassionate care: creating a new vision for nurses, midwives and care-givers, Department of Health, November 2012
37 Source: OECD data, analysis by KPMG International 2012.
It is almost impossible to predict future demands in any industry or profession, but as a rule of thumb, forecasting aims to be “roughly right and precise about the wrong”. Activity trends can be projected forward based on demographics and the changing nature of disease and disease prevalence but this cannot be predicted accurately as there are too many variables in play. The King’s Fund report on workforce planning in 2009 recognised the technical challenge and complexity involved in planning the NHS workforce. So we will not always get it right. Indeed, although we have used the language of ‘right’ and ‘wrong’, this is for illustrative purposes only. Successful workforce planning is about accurately identifying where the gaps and risks could be in the future and making plans to mitigate these risks.

The following scenarios are imaginary, but they illustrate how decisions that different individuals and organisations make over long periods of time can have an impact on the quality of care that patients receive from the health service:

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38 NHS Workforce Planning - Limitations and Possibilities, King’s Fund 2009
Scenario 1: Matching Supply to Demand

Mrs X has a long-term condition. She lives alone and suffers a fall possibly linked to her condition. Later in his career Dave developed a number of clinical skills. He has the opportunity to continue his professional development and take on a new direction by developing links with his local university and works as a Senior Paramedic/ECP. Dave went on to study for an advanced paramedic qualification and became a clinical academic teaching the next generation of paramedics both at the university and in clinical practice.

He was able to listen to her concerns about being admitted to hospital with no relatives living close by and his compassionate and sympathetic manner combined with first class clinical skills put Mrs X at ease. Her anxiety about being admitted to hospital with no relatives living close by are allayed and she experiences excellent care.

Mrs X feels that she was treated with dignity and Dave was able to listen to her concerns about being admitted to hospital with no relatives living close by and his compassionate and sympathetic manner combined with first class clinical skills put Mrs X at ease. Her anxiety about being admitted to hospital with no relatives living close by are allayed and she experiences excellent care.

She felt that she was treated respectfully throughout and would describe this as a positive experience of care.

Mr Dave’s case is an excellent example of the right values and behaviours, and this is supported by the sense of vocation and a deep understanding of the compassionate care needed to deliver dignity and a good patient experience.

Mrs X experiences first class care and is treated with dignity.

Mrs X feels that she was treated with dignity and Dave was able to listen to her concerns about being admitted to hospital with no relatives living close by and his compassionate and sympathetic manner combined with first class clinical skills put Mrs X at ease. Her anxiety about being admitted to hospital with no relatives living close by are allayed and she experiences excellent care.

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She felt that she was treated respectfully throughout and would describe this as a positive experience of care.
Developing people for health and healthcare

The Career pathway of Vikki...

Vikki was inspired to take up nursing from a young age, and she decided to take GCSE and A level subjects which allowed her to apply for the Nursing course at the university she really wanted. On her course she took up an acute elderly pathway and her learning through lectures was really brought to life by some inspirational local nurse leaders who also made a point of regularly speaking to the nurse students. Vikki felt pride about being part of the profession as she learned about the values which underpin the NHS Constitution and her professional code of practice. She was able to see clearly how these values related to practice and she could see how she could make a difference to the lives of patients. She regarded herself as a compassionate and caring individual; and that these qualities were clearly aligned to the values required to be an excellent nurse. Her tutors were pleased with her progress and expected her to pass the course and she had never been more certain that she had made the right career choice which for her was a vocation.

However, towards the end of the course things started to go less well for Vikki. Her final two placements were at a different trust from the one she had been placed in before, and would be the base for a final acute elderly and a community placement. She noticed from the outset that there seemed to be fewer nurses on the elderly wards than on other wards where she had been placed earlier in the course. She also noticed that senior nurses were struggling on those wards and had less time for her fellow student nurses. Senior nurses appeared to be concentrating on completing ‘paperwork’ and patients seemed to wait longer than in her other placements. At times the paperwork appeared to have received more priority than the day to day needs of the patients. Vikki felt troubled and conflicted about this – whilst she didn’t feel that the values she had placed so much store by with being lived by on a day to day basis, she also felt that it might cause trouble to speak out and she didn’t feel she had anyone to speak to.

Her new mentor (her previous mentor had left), didn’t really seem to have the time to speak to her, was also clearly rushed off her feet, and was not supported in turn by her managers within the ward. There appeared to be a culture within the hospital which verged on bullying; there were no positive role models within the ward, and when Vikki made an unsupervised mistake, everything came to a head when she made a mistake on the wards, as her mentor and senior nurses on the ward did not sufficiently support her. Her sense of letting down her patients, the reason she had decided to go into nursing in the first place, was overwhelming. A culture in the organisation of not acknowledging the wider factors at work leading to the mistake left her feeling completely unsupported, and she started to become convinced that the fault was entirely hers.

On her final community placement she was placed with a senior community nurse who was clearly suffering from burnout and spent a great deal of time between home visits complaining about the workload, and told her how much she was looking forward to retiring. Finally, Vikki could take it no longer, her dreams of being a nurse were crushed, and she decided she had to get out, and leave her course.

Scenario 2
If things go wrong on placement

Even when we match the demand and supply for the workforce, ensuring the right numbers, with the right skills and values and behaviours. It is still possible for things to go wrong if the system fails to offer appropriate support:

**Individual**

- Vikki had the vocation and the right values and attitudes to make a great nurse.
- Vikki did well on the academic part of the course and does well in her early placements.
- Vikki becomes disillusioned by the lack of support that the senior nurses on her final placements are able to give.
- Vikki’s dreams of becoming a nurse, a job for which she was very well suited, are destroyed. The patients who would have benefitted from her care will never know what they missed…

**System**

- The university recognised her compassionate caring nature alongside her academic prowess and offered her a good course.
- The university supported Vikki well and gives her the skills and inspirational leadership that really motivates her.
- The service fails to support Vikki on her placement, and contributes greatly to the error she makes.
- The service then fails to recognise this and support her.

Even when the individual has the right behaviours and learns the right skills… the system still needs to offer the right support.
2.4 What success looks like

Much of the public debate about workforce tends to focus on numbers: whether the NHS has enough nurses or doctors to provide the care that we all need. This is understandable, as it is vital that we have enough staff in place to provide the high quality care that patients expect and deserve. Over stretched staff cannot provide the full range of care that they are qualified and motivated to deliver.

But it’s not just about the numbers. It is no good having the staffing ratios right, if the healthcare worker does not possess the skills or knowledge to deliver safe or appropriate care. The challenge is two-fold: we have to ensure that our education system provides our future workforce with the right knowledge and skills, but at the same time we need to ensure that our current workforce maintains and updates their skill base, so that patients can reap the benefits of the latest developments in medicine and technology. HEE is committed to ensuring not just excellent education for our future workforce, but ensuring greater investment in Continuing Professional Development (CPD) for people currently in post.

Of course, we all want to be treated by people with the skills and knowledge to ensure that we get the right diagnosis and treatment. But as users of services, when we reflect on our own care, it is often the way we are treated as people that makes the difference to our experience. Because when it comes to health, the NHS doesn’t just provide a service, it provides care.

Care (verb): “To look after and provide for the needs of” - Oxford Dictionary.

That is why ensuring we have the workforce with the right values and behaviours is absolutely vital. When we have staff with the right values and behaviours, our patients feel the benefit, as the following patient story illustrates:

“I have been given the opportunity to write about my experience at the … in October. Starting with the receptionist, a welcoming smile and a lovely helpful attitude making me feel relaxed and comfortable straight away. I then had a short wait before …, a friendly member of the team, showed me into his surgery. I have been suffering with a painful condition called plantar facia, well … examined my feet and the negatives and plusses of my feet, after 30 minutes in his company I walked out of his surgery with a better understanding of my complaint and more important a positive attitude that as long as I follow his instructions in time my pain will go. Thank you…, a very good experience- Please do not change a thing.”

39 https://www.patientopinion.org.uk/opinions/79651
Sadly, there are times when the NHS falls short of the values and behaviours we would expect from a caring profession, as the following patient story illustrates:

“My relative was taken to … Hospital by ambulance on a Saturday afternoon. After seven hours she was admitted but not until being sent to x-ray to be told she should be on a trolley and in a gown, that took one and a half hours on the wait even though it was their mistake. Sunday was just a wait, told different things would be happening but nothing. Monday much the same except was taken to outpatients and told to go home and come back on Wednesday. Vulnerable elderly lady living alone and she is told this? During my visit to the ward on the Sunday I heard a sister shouting across the ward that a patient needed a commode as she hadn’t had a bowel movement for four days. Do I need to know that and what about dignity and respect? Some staff on the ward seemed to spend most of their time chatting to each other and texting on their mobiles. Should they have them on while working? I felt it was a shameful experience of the NHS.”

The forthcoming report from the Public Inquiry into Mid Staffordshire NHS Foundation Trust will quite rightly focus attention on the values and behaviours of the workforce, and Health Education England will use all of our levers and resources to ensure that our current and future staff have the right values and behaviours to enable them to care for patients.

In fact recent evidence suggests that improving the quality of the workforce using effective appraisal and CPD, has a direct impact on the quality of care patients receive so the two go hand in hand. Happy and motivated staff equal happy patients.

Successful workforce planning is therefore not just a case of getting a balance between demand and supply, important though this is. To deliver high quality care, we will need to ensure that our current and future workforce has the right number of staff with the right skills, and the right values and behaviours. High quality care can only be provided when we have not one of these components, not two, but all three in place. This is our ambition.

40 https://www.patientopinion.org.uk/opinions/77438
We won’t always get this ‘right’ as our knowledge of the future will always be imperfect and our ability to plan for all of the variables incomplete, but if we are clear about our purpose and ambition, then we will greatly increase our chance of success.
Section 3: Proposed Strategic Priorities for 2013/14

The health and healthcare system employs over 1.3 million members of staff in over 300 roles, including the independent and third sectors and Local Authorities. If HEE is to have an impact, if we are to respond to the needs of the service and achieve the ambitions that we have set out in this document, then we will need to focus our efforts and target our resources. We will have to set priorities.

Everyone has a role to play in ensuring that we have a workforce with the right numbers, the right skills and the right values and behaviours. But there are some issues that will require national leadership and/or support, and many more that will require local leadership and local decisions by our employer led LETBs. Over the coming months we will work with our LETBs, providers and the Department of Health to agree an Operating Model that sets out a high level protocol, that makes it clear when it makes sense to take national action and when it makes sense for local bodies to drive issues forward.

We are committed to being an evidence based organisation, and over the next few months we will consult on how best to identify our strategic priorities for 2013/14 and beyond. LETBs will lead this locally. HEE will engage nationally, and together with our stakeholders and advisory forums we will develop our strategy for the next year and beyond. That is the conversation this document seeks to start.

We want to base our strategy on evidence, build on what we know works, and take people with us.
But our commitment to ‘getting it right’ should not stand in the way of ‘getting things done’. There are a number of issues currently on the local and national radar that we believe would benefit from HEE’s leadership and engagement. We have assessed the thirteen draft LETB plans which set out their key priorities, scanned the national landscape and used the Education Outcomes Framework to help us identify a proposed list of early strategic priorities.

If we can secure excellent education, at the same time as widening participation, thereby producing a capable and more diverse workforce, who are flexible in relation to how healthcare is delivered and receptive to research and innovation, who live the NHS values in their work, then the outcome we will get is excellent healthcare and health improvement.

Therefore, for the remainder of 2012/13 going into 2013/14, we are proposing a small number of strategic areas of focus and action for HEE and its LETBs, which are summarised below:

<table>
<thead>
<tr>
<th>EOF domain</th>
<th>HEE proposed priority</th>
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<tbody>
<tr>
<td>Excellent education</td>
<td>Develop role models for education and training - ‘make being a trainer a badge of honour’</td>
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<td></td>
<td>Education for life - ‘supporting and championing multi-professional CPD’</td>
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<tr>
<td>Competent and capable staff</td>
<td>Support a dementia aware workforce - ‘ensuring all staff are trained to rise to the challenge on dementia’</td>
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<tr>
<td>Widening participation</td>
<td>Making healthcare the career of choice - ‘use NHS Careers to reach out into schools for our future workforce; and open to all - encourage more part-time degrees’</td>
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<tr>
<td>Flexible workforce responsive to research and innovation</td>
<td>Making technology central to education - ‘introduce an app to allow students to access information and feedback on their experience’</td>
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<td></td>
<td>Realise the potential of research and innovation - ‘invest in education and training in genomics’</td>
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<tr>
<td>Ensuring a workforce with the right numbers, skills and behaviours</td>
<td>Securing future supply and supporting stakeholders with current problems in ‘key areas such as emergency care workforce, primary care workforce, 24/7 services’</td>
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<td>NHS values and behaviours</td>
<td>Roll out best practice so that healthcare workers are ‘recruited for values, trained for values, appraised for values and held to account for values’</td>
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The above list is not exhaustive: there is much else that HEE and its LETBs will be doing throughout the year to support and secure our current and future workforce. Neither is it set in stone. We are sharing our initial thinking with the system through this document to provoke debate and discussion, with a view to informing our strategy going forward. HEE will review them in the light of our conversations with stakeholders and in the light of the Robert Francis report.
## Proposed Strategic Priorities for 2013/14

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<tr>
<th>EOF Domain</th>
<th>Seizing the opportunity – our proposed strategic aims for the future workforce</th>
<th>Seizing the opportunity – our 2013/14 proposed key actions</th>
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<tr>
<td><strong>Excellent Education</strong></td>
<td>We will ensure education curricula are up to date with future innovations and the process of bringing new research into clinical practice is efficient and timely. We will ensure that education curricula, including practice education, take account of changes in service models, such as 7 day services, to produce newly qualified staff with the right skills and behaviours to deliver these. We will focus on improving the quality of learning experiences in practice through placing more accountability and expectation on service provider organisations to support learning in practice and champion this through role models. We recognise the need for the continuing professional development (CPD) of the whole workforce and planning and investment are needed to support this.</td>
<td><strong>Develop role models in practice education</strong> A lot of effort has quite rightly been focused on the education of our workforce in academic settings, and standards are now generally high. But a significant part of a person’s education is provided by NHS organisations who offer training placements in healthcare settings. This is a key time when role models are observed, and values and behaviours adopted. To ensure that our future workforce are exposed to the best role models who provide professional leadership and mentorship in support of practice education we propose to work with our stakeholders to develop programmes that identify, support and accredit trainers, so that only the very best are entrusted with the training of our future workforce. Being an accredited trainer will be a badge of honour reserved for the very best. This will apply to all trainers including those who provide service training to staff in their organisations <strong>What are your views?</strong></td>
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**Education for life**

Education doesn’t end when you leave academia or training. If our workforce is to continually meet the needs of patients, then they will need to be continually listening and learning. We propose to support and champion multi-professional CPD, working with our stakeholders to highlight opportunities for a more collaborative approach and celebrate the best examples through a programme of work to spread best practice. In recognition of the fact that support workers, including care workers and assistant practitioners, have most contact with patients yet the least training, we propose to agree a targeted use of CPD resources for support workers. **What are your views?**
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<td>Competent and Capable staff</td>
<td>We will work with stakeholders to identify the ‘must have’ skills for the future to meet patient needs. Many core skills will be the same no matter where, when or how care is delivered. Workforce planning is an enabler which will not only support the development of these skills but the ways in which they are deployed. We will ‘re-imagine’ the role of clinical and caring staff to ensure that patients receive the fullest possible benefit from community based GPs, nurses and other therapists.</td>
<td><strong>Support a dementia aware workforce</strong>&lt;br&gt;Demographic changes mean that the NHS needs to change its model of care to respond to the growth in long term conditions and the increasing age and complexity of patients. One of the challenges that demographic changes will bring is an increase in dementia. We will rise to the challenge on dementia and propose to create a three level programme, from awareness at least to expert level at best, to create a dementia aware workforce amongst our current staff. <strong>What are your views?</strong></td>
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<tr>
<td>Widening Participation</td>
<td>We will attract young people into the healthcare workforce, especially given the fact that the number of people approaching 16 is proportionally less than ever before. We will ensure a supply of workforce representative of local populations and communities in which they provide services.</td>
<td><strong>Making healthcare the career of choice</strong>&lt;br&gt;We need to do more to ensure that our workforce at all levels within the health service, reflects the society we serve, including race, socio-economic groups and gender. Once people join the NHS, we need to make it easier for staff to progress in their careers. We propose to:&lt;br&gt;• Build on the work taking place in higher and further education and use NHS Careers to reach out into schools to attract students from all backgrounds into a career in the health service&lt;br&gt;• Work with stakeholders to enable support workers to progress in their careers by encouraging greater vocational and academic awards and/or progression opportunities onto professional programmes such as part-time degrees, by the start of the 2014 academic year&lt;br&gt;• Support and champion existing best practice so that it can help improve the performance of areas that have been shown to be underperforming for diversity such as medicine for socio-economic groups. <strong>What are your views?</strong></td>
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| **Flexible workforce responsive to research and innovation** | We will ensure that there is the correct capacity and capability in the workforce to achieve gains in innovation and technology. Innovation, Health and Wealth referenced the need to bring about a lasting change in culture and behaviour amongst our current and future leaders, and the workforce as a whole as an enabler to help the delivery of innovation in the NHS. | **Making technology central to education** We will continue to support and build on the existing use of technology in the preparation of the future workforce including clinical skills laboratories, simulation and virtual learning environments – ‘learning about technology by using it for learning’. We propose to:  
- Ensure that relationships between Academic Health Science Networks and LETBs develop effectively so that the workforce is responsive to research and innovation. This includes joint working on a systematic approach to students and trainees learning service improvement science in the classroom and then applying it on placement  
- Introduce applications usable on mobile devices that will allow students to access information about their education and feedback on their experiences  
- Invest in education and training in genomics.  
*What are your views?* |
| **Ensure a workforce with the right numbers, skills and behaviours** | We will ensure people entering the healthcare workforce have the right values and behaviours and existing staff are retained and developed. We must ensure we value and reward staff achievements and display good HR practices underlined by the NHS constitution. *All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted and actively listened to. They must be treated with respect* | **Targeting current problems** We propose to work with stakeholders and our LETBs to secure future supply in the:  
- Emergency care workforce  
- Primary care workforce  
- 24/7 service.  
We propose to ensure that we promote effective multi-professional working through education and training to deliver these issues.  
*What are your views?* |
## EOF Domain

<table>
<thead>
<tr>
<th>Seizing the opportunity – our proposed strategic aims for the future workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>at work, have the tools, training and support to deliver care, and opportunities to develop and progress</em>.</td>
</tr>
</tbody>
</table>

## NHS values and behaviours

<table>
<thead>
<tr>
<th>We will recruit for values and behaviours. It is important that everyone who wishes to care for people at their most vulnerable should have the right values and behaviours as outlined in the NHS Constitution.</th>
<th>Recruiting for values and behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our ambition is to recruit for values, train for values, appraise on values and to hold people accountable for working to those values. In the first instance we propose to work with our stakeholders to develop and introduce best practice in the testing of values in the recruitment of staff in both education and training, but also with employers across the NHS.</td>
<td><em>What are your views?</em></td>
</tr>
</tbody>
</table>
Section 4: Taking it forward: How you can help us

In this document we have set out why workforce planning, education and training matters. We have used real stories and imaginary scenarios to illustrate the impact that both success and failure can have on individual patients and staff, whilst recognising the impossibility of always getting it ‘right’ in such a complex, changing environment with so many variables. We have set out our ambition: to ensure that we have the right numbers of staff, with the right skills, values and behaviours, in the right place at the right time to deliver high quality care to the patients and the public of England.

Clarity of purpose will increase our chances of success, but we cannot achieve this alone. For HEE and its LETBs to commission the right numbers of education places, we need to understand the long term visions that healthcare commissioners have for their local services. To ensure that our future plans are as valid as possible, we need to have access to robust employer workforce plans. To avoid destabilising the education sector or providers with a high reliance on trainees, we need to work closely with our stakeholders and to understand their needs. For our future plans to be relevant, we need to work with the professions and other experts to understand the latest developments in technology and the impact it will have on service provision. Most important of all, we need to understand and respond to the needs of current and future patients.
This document is meant to be the beginning of a conversation with our stakeholders. So please talk to us. Tell us:

- Is our purpose clear? Do you understand our role and remit, and how it fits with yours?
- How can we align our planning processes with the commissioning, provision, regulatory, professional or educational cycle to get the most benefit?
- Do you agree with our values and principles, and how we intend to work with the system?
- What are your views on our proposed priorities? Are there areas that we can work together on to amplify our efforts?
- What should be our strategy going forward beyond transition? How can we ensure alignment where appropriate with other strategies in the health and education system?

We would genuinely welcome your views on the above, and would appreciate it if you took the time to share your thoughts with us at:

HEE.StrategicIntentFeedback@nhs.net
### ANNEX A: Extract of views expressed to the NHS Future Forum

<table>
<thead>
<tr>
<th>PERCEPTIONS OF CURRENT SYSTEM</th>
<th>HOPES FOR THE NEW SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Driven by short-term needs</strong></td>
<td>‘Need a stronger commitment to long term-planning – looking at least 3-5 years ahead. Long term vision is fundamental in order for HEE and LETBs to fulfil their remit effectively’</td>
</tr>
<tr>
<td></td>
<td>‘Priorities should be set over a long time period i.e. at least 10 years, correlating to the maximum planned training duration of a doctor.’</td>
</tr>
<tr>
<td><strong>Workforce planning a low priority</strong></td>
<td>‘From our point of view, we welcome the idea that, if you put new architecture in place, you do not just get a lift and shift of the old system into the new system and say, “We have a change in NHS architecture, let us make sure we get education and training that works in there.” This is an opportunity to get a fundamental rethink about how we look at what are the needs of patients and how we plan our workforce into the future.’</td>
</tr>
<tr>
<td><strong>Supply led rather than demand driven</strong></td>
<td>‘LETBs and HEE need to focus on the quality of patient care and service delivery, not simply qualifications’</td>
</tr>
<tr>
<td></td>
<td>‘HEE’s annual priorities document must include considerations of workforce trends to deliver a sustainable workforce and guard against over/under supply’</td>
</tr>
<tr>
<td></td>
<td>‘The low involvement of providers in workforce and education historically has been a problem and so they should be leading in the new system.’</td>
</tr>
<tr>
<td><strong>Sometimes driven by politics rather than evidence</strong></td>
<td>‘Supportive of the vision behind HEE as a national, independent organisation – represents a significant new opportunity for a genuine long term perspective on workforce planning for all healthcare professions.’</td>
</tr>
<tr>
<td><strong>Not aligned with future service needs</strong></td>
<td>‘HEE has a crucial role to play in supporting the transformation of services and developing the community workforce’</td>
</tr>
<tr>
<td></td>
<td>‘Training needs to be delivered in an integrated way that works across disciplines. Training needs to take place in health and social care settings.’</td>
</tr>
<tr>
<td><strong>Not sufficiently multi-professional</strong></td>
<td>‘LETBs need to address the education and CPD needs of the whole workforce, including support workers and those working in advanced practice, management and leadership roles.’</td>
</tr>
</tbody>
</table>
ANNEX B: Local Education and Training Boards (LETBs)

Chairs and Managing Directors (MD)

East Midlands
Chair: Kaye Burnett
MD: Simone Jordan

East of England
Chair: Stuart Bloom
MD: Stephen Welfare

Kent, Surrey and Sussex
Chair: Sir David Melville
MD: Philippa Spicer

North East
Chair: Prof Oliver James
MD: Elaine Readhead

North West
Chair: Sally Cheshire
MD: Chris Jeffries (interim)

North West London
Chair: Marcia Saunders
MD: Charles Bruce

North, Central and East London
Chair: Dame Christine Beasley
MD: Prof Chris Fowler

South London
Chair: Richard Sumray
MD: Julie Screaton

South West
Chair: Jane Barrie
MD: Sarah Watson-Fisher

Thames Valley
Chair: Janice Shiner
MD: Sandra Hatton

Wessex
Chair: Jacqueline Swift
MD: Paul Holmes

West Midlands
Chair: Jenni Ord
MD: Prof Janice Stevens

Yorkshire and Humber
Chair: Kathryn Riddle
MD: Adam Wardle
ANNEX C: The Health Education England senior team

www.hee.nhs.uk/about

ANNEX D: Glossary of Abbreviations

CCT  Certificate of Completion of Training
Cert HE  Certificate of Higher Education
CfWI  Centre for Workforce Intelligence
CPD  Continuing Professional Development
CQC  Care Quality Commission
C-Section  Caesarean section
DH  Department of Health
Dip HE  Diploma of Higher Education
ECP  Emergency Care Practitioner
EOF  Education Outcomes Framework
GMC  General Medical Council
HEE  Health Education England
HEI  Higher Education Institution
HPC  The HPC has recently changed its name to the Health and Care Professions Council (HCPC)
HR  Human Resources
LETBs  Local Education and Training Boards
LTC  long term conditions
MPET  Multi Professional Education and Training
MRI  Magnetic resonance imaging
NBM  ‘nil by mouth’
NMET  Non Medical Education and Training
ONS  Office for National Statistics
R&D  Research and Development
SHA  Strategic Health Authority
SIFT  Service Increment for Teaching