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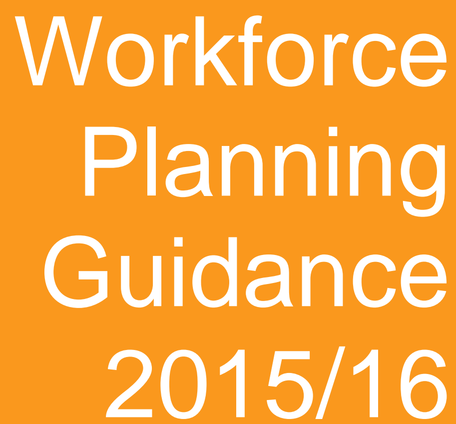

For 2016/17 Education Commissions

WORKFORCE PLANNING GUIDANCE FOR THE 2015/16 ROUND FOR 2016/17 EDUCATION COMMISSIONS

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Foreword

The £5bn Health Education England (HEE) invests annually on behalf of taxpayers funds the training and development of the health care workforce in England. The NHS employs 1.4m staff in over 300 different professions across more than 1,000 different organisations who meet the needs of 1m patients every 36 hours.

This is a complex business with labour markets cutting across health, social and independent sectors and operating at all levels from local to international. The National Health Service needs a workforce plan that delivers locally and for the sum of the parts. HEE is the single accountable national body which leads and co-ordinates investment in the development of the health and public health workforce. Local Education and Training Boards (LETBs) are the regional presence of HEE, charged with ensuring that local commissioners and employers, informed by the needs of patients, are at the forefront of the planning and forecasting process.

This is the third set of annual guidance HEE has published. Our challenge remains to use our local and national processes to deliver on our Mandate requirements, whilst ensuring our investments help drive the service transformation that will improve the quality of health and care for patients in the longer term.

But the context is fundamentally altered. In June of last year (2014) we published Framework 15, our strategic view of how the workforce of the future must be assessed by reference to the needs of the future patient. Then in October the Five Year Forward View[1], reflecting a coherent holistic vision for the future health and care system, shared across the bodies that lead the NHS was published. The Forward View is unequivocal about the need for change. Hence HEE will no longer simply roll forward what has historically been a supply driven system. More specifically HEE will work with our LETBs, national advisory groups and the new Workforce Advisory Board[2] to understand the workforce implications of the new care models in the Five Year Forward View, so we can support service transformation at **scale and pace** through more targeted investment in our existing workforce, as well as commissioning new roles for the future.

Bold and difficult choices are now a pre-requisite. In the policy context of the *Forward View* HEE will actively redirect investment into new models and settings of care, rebalance investment between the future and the current workforce, and support promotion of wellbeing / prevention of ill health, including the pivotal role of self-care and management. If funding remains static this would mean that the need to ensure every commission for a future worker, whether pre-registration clinical training or post graduate doctors in training represents an absolute priority when compared to these emergent needs.

[1] The Five Year Forward View published by NHS England in October 2014 was produced jointly by NHS England, The Trust Development Authority, Monitor, Public Health England, the Care Quality Commission and Health Education England. http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2] The Forward View into action : Planning for 2015/16 Para 5.11
http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf

We are not yet convinced that current investment proposals for the training of future professional groups do represent such absolute needs. In the 2015/16 planning round partners should expect to challenge and be challenged on the levels of training commissioned so that the development needs of the current workforce arising from service and workforce transformation can be met.

In 2014 LETBs and local providers began to have challenging conversations about the likely needs of future patients, and about where investments (and disinvestments) should be made, not just in the numbers of staff, but the skills, values and behaviours of both our existing and future workforce. 2015/16 is the year when these must begin to translate into new patterns of investment.

As a consequence of this 'burning platform' this year our guidance is simultaneously both more expansive and more focused. We know the radical change cannot happen in one singe year, and we know that in the case of medical trainees, providers need adequate notice. But the intention is clear and the work has to start now.

Our Workforce Planning Guidance for 2015/16 sets out not only the 'technical' process but also clarifies that there is just one planning process covering all professional groups, and identifies those parts of the workforce where HEE and our LETBs will focus effort in 2015/16, and the ways in which HEE will work as one organisation to develop plans which are both locally responsive but also genuinely nationwide.

1. Introduction

Workforce planning is about ensuring that the NHS has the people we need when we need them. With so many employees occupying so many varied job roles in so many employers spanning multiple sectors workforce planning cannot be the sole responsibility of individual organisations. It is only through a collective approach that we can hope to deliver what patients need both now and in the future. HEE is now established as the single national body which leads and co-ordinates investment in the development of the health and public health workforce, accountable annually for almost five billion pounds of public expenditure on behalf of NHS patients. LETBs are similarly now established as the geographical presence of HEE. LETBs have devolved budgets and are charged with ensuring that employers, informed by staff and patients, are at the forefront of the planning and forecasting process.

It is through these national and local arrangements that we will ensure that the workforce meets the needs of today's patients whilst delivering the future workforce in a way that not only maintains safe staffing levels, but supports the service transformation necessary to improve quality of care. The responsibility for planning to employ safe numbers of staff to deliver *current* services sits ultimately with providers and their boards. But through LETBs providers will influence the investments HEE makes in educating and training the *future* workforce. The engagement of providers will result in better decisions, but we recognise there will always be limitations in our individual and collective ability to predict the future.

The HEE approach in 2015

This is the third year in which HEE has published comprehensive Workforce Planning Guidance for healthcare. In 2013 our guidance signalled a radical departure from what had gone before, tackling some of the historical systemic barriers to effective workforce planning. We pulled together the medical and non-medical planning decisions, providing an opportunity for relative priorities to be assessed across the entire workforce. In 2014 our Guidance set out clearly the roles and responsibilities of each part of the system, and the milestones to ensure that the local planning processes add up to a coherent and consistent whole.

In the year ahead HEE will consolidate the NHS workforce planning process and harness it to serve the needs of the *Forward View* and meet the commitments set out in our Mandate with the Government. In 2015/16 HEE will

(i) drive *standardisation* of:

- the planning process for all commissioned groups;
- definitions of workforce 'sets' (for example when the system talks about adult nurses, everyone is talking about the same occupational groups);
- definitions of and calculation of key terms (e.g. attrition, turnover);
- planning inputs, analyses and modelling at LETB and national level;

- the presentation of outputs so the system as a whole becomes used to seeing and interpreting tables and charts in the same way so that we enable system 'literacy' in workforce planning.

(ii) Focus effort and resource on between two and four of the largest medical specialties to develop:

- A standard nation-wide analytical framework for assessing risk to inform commissioning decisions about the number and geographical distribution of training posts. This framework will consider the supply of the medical workforce alongside the supply of other relevant staff. This framework will then be applied to other groups in future years.
- A set of processes and procedures for changing the number of medical training posts, acknowledging the complexities and implications for service associated with this.

(iii) Similarly focus effort and resource on a number of the very smallest specialties and the smallest Allied Health professionals and health care science groups, in recognition of the reality that individual LETBs cannot each commission for such groups, and that these groups vary from each other in terms of important characteristics that influence education commissioning and education delivery.

(iv) Review, *with system partners*, the intake to undergraduate medicine. We know already that there is no longer a clear linkage from student intake to workforce demand. The question – for the system as a whole – is what should be done about this?

(v) Continue the exploration of how planning can evolve to become more rooted in developing characteristics of the future workforce based on the needs of patients and carers as set out in Framework 15, recognising that a key element of the future workforce will need to be flexibility. HEE will continue to develop a 'life-cycle' approach to workforce planning that initially focusses on the needs of children and young people, working alongside planners at a local and national level. A further piece of work will link with patients and stakeholders to develop a set of design principles to ensure that staff can better support self-care and the needs of carers.

Delivering an in-year plan while planning for the longer term

The results of our *annual* planning process are published each December in the *Workforce Plan for England.* Our 2013/14 Workforce Plan for England (for 2014/15 education commissions) was a significant step forward for the system, but recognised that 2013/14 was a year of transition, and that we had to be more ambitious: to be not just more open and transparent about the numbers of staff that we commission, but to start to use our investments to drive the service transformation that future patients will require. Our 2014/15 Plan (for 2015/16 commissions) went further – signalling that the future shape, skills and distribution of

the workforce must change and that HEE will use our levers to help shape the health service around the needs of patients.

This year the challenge is clear: HEE can no longer simply roll forward what has historically been a supply driven system. More specifically HEE will work through our LETBs and with our national advisory groups and the new Workforce Advisory Board to understand the workforce implications of the new care models in the Five Year Forward View, so we can support service transformation at **scale and pace** through more targeted investment in our existing workforce, as well as commissioning new roles for the future. This will also feed into the refresh of our Strategic Framework in September.

However, the radical change required cannot all happen in one single year, and decommissioning medical training posts, if required, cannot happen without the implications for service delivery being assessed and addressed. So this guidance for the 2015/16 planning round (for 2016/17 commissions) builds once again on previous guidance in respect of processes, timescales, and the roles of providers, commissioners, and HEE. The guidance again sets out whom in the system needs to do what and by when to deliver the annual plan. It offers the opportunity for all partners in the service to decide the relative importance and priority for different kinds of workforce intervention and investment. The deadlines are clear[3]. But in a significant respect our guidance this year goes further than its predecessors: it is concerned not only with 'technical' process but also describes those parts of the workforce where HEE and our LETBs will focus effort in 2015/16, and the ways in which HEE will work as one organisation to develop plans which are both locally responsive but also genuinely nationwide. It also signals our intent to develop specific proposals for medical education commissions to take effect from *2017,* to be set out *next* March (2016).

Our guidance this year is structured as follows:

- Section 2 establishes the importance of planning the workforce based on current and future patient need, and outlines the high level process for developing plans this year;
- Section 3 describes in more detail the roles of HEE and our partners in the workforce planning process;
- Section 4 describes the key changes to our approach to specific workforce groups;

[3] Unlike the rest of the NHS, our annual planning process is driven by the academic sector, and so will always run between April and November. It is vital that our partners are aware of this so they can play their full part in ensuring we make the best decisions possible. How we meet the deadlines is as important as what we produce by when. For it is the conversations between providers and commissioners, between the health and education sectors at local and national level that will create the environment within which we can identify the workforce issues that need to be addressed. This requires a culture of transparency and openness, where we can share and challenge each other's assumptions, to ensure that the decisions we make result in better care for patients.

- Section 5 sets out the timetable for delivery of components of the planning process.

This guidance will be supplemented in April as follows

- more comprehensive guidance expanding on Section 4 will be developed with LETBs;
- the two to four large medical specialties upon which HEE intends to focus will be agreed and announced and we will initiate stakeholder engagement;
- the small specialties which HEE will focus on will be agreed with LETBs, leads within LETBs will be identified, and stakeholders informed; and
- similarly the professional groups for which planning will be led at national and at cluster level will be agreed and stakeholders informed.

During the year our national strategy team colleagues will work with the planning community to clarify how different approaches to planning (such a 'life cycle' based planning approach) can be developed in practice. We will be developing guidance and best practice in this area to explore the feasibility of an approach to meeting patient need across professional boundaries. Workforce planners are asked to contribute their knowledge and skills to this work, including identifying areas where examples of this approach are already available and where further pilot work could be undertaken.

As the 2015/16 planning round for 2016/17 education commissions unfolds HEE will develop further more specific analyses to support workforce planning for the groups identified as focal points in the year ahead.

2. A national framework for workforce planning

This section

- establishes why workforce planning is an important component of the planning of service commissioning and service delivery which must be rooted in the needs of patients;
- summarises the governance framework through which HEE discharges its accountability for investing in the current and future workforce;
- outlines the process for developing HEE's investment plan; and
- sets the scene for the more detailed articulation of the roles of different parts of the system.

2.1 Workforce : everybody's business

Discussions about staffing levels, skills, values and behaviours, and how staff are trained and developed are centre stage. While the NHS transitioned to new structures, including the creation of HEE as the single national body to lead and co-ordinate investment in the development of the healthcare and public health workforce, a number of key reports were published with workforce at their centre. The Francis Report[4], and the Governments' response[5], the Berwick review of patient safety[6], the NHSE review of Urgent and Emergency Care[7], the Cavendish Review of Healthcare Assistants and Support Workers[8] and the Shape of Training review[9] were all published within a 12 month period.

The system has responded:

- the numbers of clinical staff employed in the NHS has risen;
- the National Institute for Health and Care Excellence is developing a collection of guidelines on safe staffing levels;
- HEE has increased nursing commissions to ensure sustained workforce growth;
- Health Education England has developed 'Framework 15' - a reference point for the system and the conceptual framework for how HEE approaches problems and identifies solutions, ensuring our focus remains on the patient;[10]

[4] www.midstaffspublicinquiry.com/report
[5] www.gov.uk/government/news/francis-report-on-mid-staffs-government-accepts-recommendations
[6] www.gov.uk/government/publications/berwick-review-into-patient-safety
[7] www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf
[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf
[9] www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf
[10] http://hee.nhs.uk/2014/06/03/framework-15-health-education-england-strategic-framework-2014-29/

- The combined leadership of the NHS has signalled that the NHS must develop a workforce able to work across acute and community boundaries and beyond traditional professional demarcations, with flexible skills and with the ability to adapt and innovate. The NHS leadership has also established a new Workforce Advisory Board with senior membership from across the system to develop a health and care workforce with the skills to support the implementation of new models of care[11] and 29 'vanguard' sites have been selected to pioneer new models of care delivery;
- the 'Bubb' review on the future of services for people with learning disabilities has reported;[12]
- in March the 'Shape of Caring' review published its initial report.[13]

HEE has *specific* responsibilities. But all parts of the system have parts to play in ensuring the adequate supply of staff with the right skills, values and behaviours in the right numbers to deliver safe, effective high quality care.

2.2 Clear governance

The Board of HEE is accountable for signing off almost five billion pounds of investment in the education and development of the workforce each year.

The HEE Executive has the key collective responsibility for ensuring that the 13 LETB workforce investment plans add up to a coherent plan for England that will deliver our agreed priorities as set out in the Mandate **and** drive the service improvement and transformation required by patients and mandated by the NHS Leadership in the Forward View.

The role of each LETB – the regional committees of HEE - is to provide assurance that the local plans which comprise the aggregate plan are, in turn, robust and evidence based, rooted in the plans of providers reflective of the intentions of commissioners. This is achieved by ensuring that LETB plans are the result of robust local and/or national processes of aggregation, confirmation and challenge.

In order to support this work there are national and regional advisory structures through which stakeholders contribute. The Figures at the end of this section summarise the arrangements that govern HEE's local and national investment.

2.3 Evidence based prioritisation of workforce investment

LETBs, representing *all* local service providers (that is, NHS Foundation Trusts, NHS Trusts, primary care, social care, local authorities and public heath) and with links to commissioners and other stakeholders, create the forum wherein providers and commissioners can develop coherent plans to directly shape HEE's investment by

[11] The Forward View into action : Planning for 2015/16 Para 5.11 http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf
[12] https://www.acevo.org.uk/news/winterbourne-view
[13] http://hee.nhs.uk/wp-content/blogs.dir/321/files/2015/03/2348-Shape-of-caring-review-FINAL.pdf

collectively identifying the future staffing requirements in terms of skills, values and behaviours, as well as numbers.

The key benefit that HEE aims to achieve through this robust workforce planning process is the ability to compare the relative importance, priority and risk, for different activities and investments so that we are able to actively respond to the service's workforce needs.

Our approach relies on the following processes:

- Development of LETB investment plans based on local stakeholder engagement, data analyses, data collection, confirmation and challenge;
- Development of a nation-wide investment plan through systematic analyses of available national data from official and other sources, and aggregation, challenge and if necessary review of LETB plans;
- National triangulation between Health Education England and the other system leaders and stakeholders including NHS England, Public Health England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, the National Institute for Health and Clinical Excellence, NHS Employers and the Local Government Association
- Systematic engagement with national stakeholders throughout the course of the planning cycle, including with Royal Colleges, professional representative organisations and trade unions.

This year we are introducing a number of changes to our planning process:

- HEE collectively will focus resources and planning effort on particular staff groups and particular specialties
- For small groups and small specialities HEE will develop explicitly nationwide workforce plans to inform education commissions. For some groups and specialties individual LETBs will lead this process for identified groups for the country as a whole. For other groups and specialties the HEE national planning team will play a leading role.

This approach is described further in Section 4.

Figure 1:

HEE Workforce Planning Process

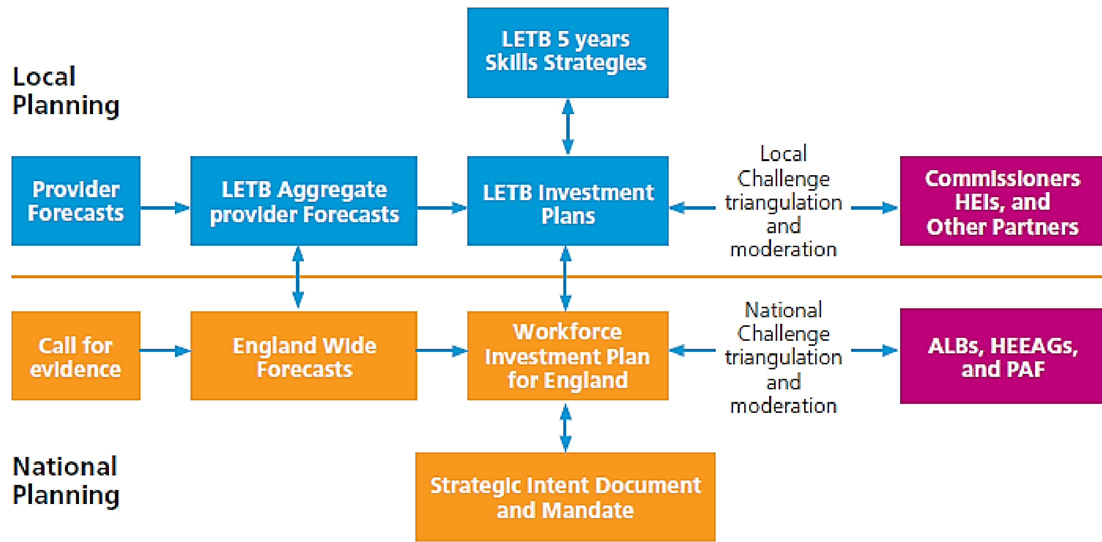
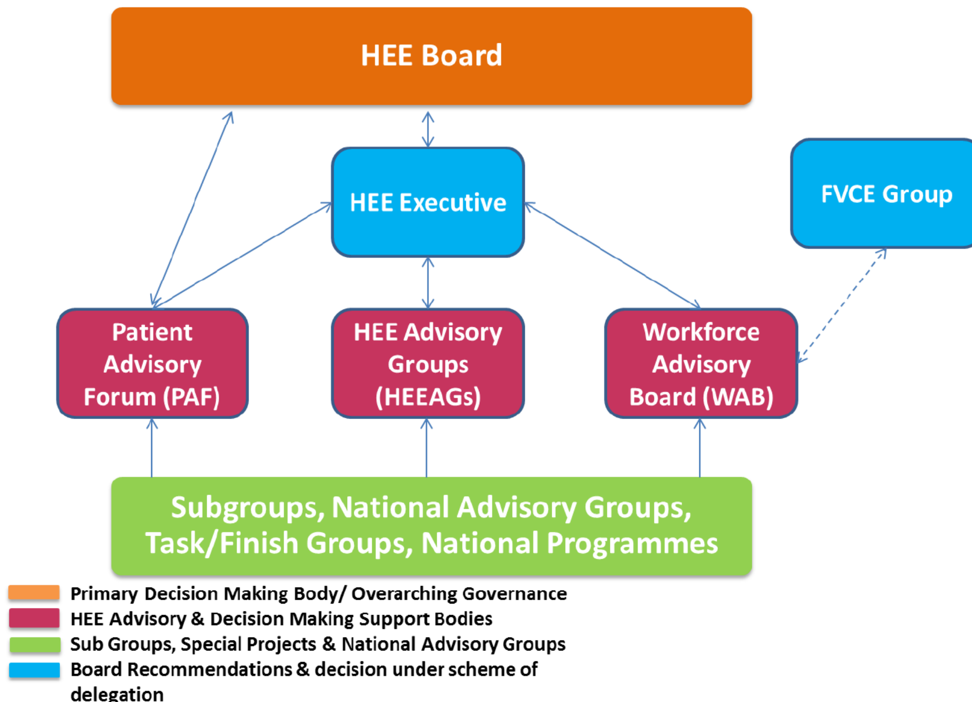


Figure 2 :

HEE Advisory Structures



3. Roles and responsibilities

This section sets out the specific roles of partners in the health care system under the following headings:

- Service providers
- Service commissioners
- LETBs
- The role of the HEE Planning team; and
- Other Stakeholders.

3.1 The role of service providers

The Health and Social Care Act places a duty on *all* service providers (including NHS Trusts, primary care, local authorities, and providers from the independent and third sector) to support the collective planning of future workforce supply. This means that they need to:

- share information on their current workforce and trends,
- share annual plans with their local LETB,
- ensure that LETBs are able to have a full understanding of the current key areas of under or over supply.

Effective planning depends upon HEE nationally and locally understanding the *full* supply and demand picture.

For General Practices, the development of a locality-level demand forecast covering General Practitioners, and clinical and non-clinical support, should be informed by General Practices as employers. In recognition of this as a new requirement and the differing maturity levels across the country relating to workforce planning in General Practice, as a transitional arrangement General Practices, Area Teams and LETBs are encouraged to develop their local systems and processes to produce a locality plan, while recognising that the planning guidance may be revised to be more prescriptive following the publication of the Primary Care Workforce Commission report.

Individual service providers, and in particular senior clinical leads, should also play an active role in assessing, challenging, moderating, and agreeing the aggregate forecast for their area through their LETB and associated stakeholder events. Hitherto HEE required that Medical and Nursing Directors sign off provider forecasts and workforce plans, in line with the agreed process for signing off Cost Improvement Plans (CIPs). This year HEE expects further that in NHS Trusts the healthcare science leads sign off the provider forecasts and workforce plans for scientists.

These forecasts will form the basis for:

- Trust Boards, primary care providers and public health providers, to develop and deliver an effective workforce strategy to meet patients' needs, including shorter term supply initiatives and effective operational deployment; and
- the workforce plans and education commissions that HEE will make, through its' LETBs, to secure future supply and drive longer term service transformation.

Access to NHS provider service plans is not the only way that LETBs will assess workforce needs of local providers. LETBs will have on-going dialogue with providers including other healthcare providers, commissioners, and networks, to identify existing gaps or emerging needs. This process of confirmation and challenge informs LETB education investment plans.

3.2 The role of commissioners with providers

In formal *joint*[14] guidance to the system Monitor and the Trust Development Authority (TDA) require NHS Trusts and NHS Foundation Trusts to refresh their operational plans for 2015/16 only noting that the Mandate from the government to the NHS is broadly stable, apart from the introduction of new and important access standards for mental health. The guidance notes specifically the expectation of aligned, realistic activity and financial assumptions between commissioners of *all* NHS and public health services and providers, right across the country and that providers and commissioners will work with LETBs to ensure that they can secure the right staff to meet future service needs and their workforce plans are affordable and reflect local strategies for transformation.

Hence commissioners – CCGs, Area Teams and Local Authorities – will need to be actively engaged in LETB led processes, and most notably, in the 'confirmation and challenge' process that results in the demand forecasts and the investment plan proposals.

3.3 The role of LETBs

<u>System convenors</u>

LETBs are local 'system convenors' for workforce discussions and the bodies that develop the thirteen local investment plans which form the basis for the National Workforce Plan for England. NHS England require commissioners to work with providers and partners in local government to develop strong, robust and ambitious plans, and in turn HEE's LETBs will engage with commissioners to ensure that education commissioning plans are rooted in both provider and commissioner forecasts of future need, and therefore reflect the workforce required for a

[14] See The Forward View into action : Planning for 2015/16 http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf and also individual guidance from TDA http://www.ntda.nhs.uk/blog/2014/12/19/planning-guidance-201516/ and Monitor https://www.gov.uk/government/publications/annual-planning-review-201516-guidance-for-foundation-trusts

transformational change in quality, outcomes and sustainability linked to the Five Year Forward View.

LETBs can only do this if *all* commissioners engage in these discussions. This year LETBs will continue to develop their understanding of supply and demand in the independent and third sector where this is relevant to their local health care economy. LETBs will also engage with local authorities to understand demand from this sector for relevant groups, including Public Health Consultants.

LETBs are encouraged to develop their local systems and processes to produce a locality plan for the General Practice workforce. There is an expectation that progress towards developing the forums for stakeholder engagement (where they do not already exist) and information flows to and from Practices (recognising the introduction of the workforce Minimum Data Set) will be taken forward through the 2015 planning round.

Accessing provider plans and forecasting demand

All LETBs should have the opportunity to access locally the plans providers submit to the NHSTDA and Monitor so that they understand the current workforce position and the future intentions of their partners. Precise arrangements may vary locally. However, LETBs should be fully aware of any current or anticipated gaps (skills, values and behaviours as well as numbers), in the current workforce. All LETBs will require future workforce forecasts from ***all*** of their main providers of NHS services (including public health), as in aggregate, these will form the basis for their own plans.

HEE has developed a standard electronic tool to collect and aggregate provider workforce demand forecasts. These forecasts will highlight the direction of travel and potential risks. Of equal importance, but less easily quantified, is the identification of current and future needs in respect of skills, values and behaviours. HEE and its' LETBs have a key role to play on behalf of the service, to work alongside professional regulators to specify the skills and behaviours required of our future workforce as identified by the service itself. Specifying and commissioning these requirements from education providers is as central to our mission as defining the volumes of training we invest in. We will also work alongside service providers to explore how our joint role in respect of Continuing Personal and Professional Development (CPPD) operates to ensure that skills and behaviour gaps within the current workforce can be addressed.

It is for each LETB to agree with their service provider members how these forecasts are generated and shared (including different arrangements given the differing characteristics and capability of providers).

LETB plans are shared with the HEE national team allowing the creation of a meaningful forecast at an England level.

Forecasting supply

Workforce planning is not an exact science. Future forecasts are inherently uncertain and factors other than the outcome of supply and demand forecasting will influence investment decisions. Such factors include programme viability, placement capacity, prioritisation of 'acceptable' risk, and availability of funding. It is within HEE's remit to provide assurance that proposed education commissions are credible, based in part on a proportionate investigation of likely futures and relative risk of over and under-supply. Hence each LETB will be asked to participate in a nationwide approach to supply forecasting.

The aspiration is to understand the General Practice and independent sector supply (through gathering intelligence on the workforce stocks and flows to the same level of detail as NHS employers in 2016), supported by the workforce Minimum Data Set. Supply modelling should be developed to incorporate this data set as it becomes available.

Local confirmation and challenge

Each LETB will hold local confirmation and challenge sessions with their partners, including representatives of education provision, on future forecasts. It is for each LETB to determine how such processes are managed but the approach will involve feeding back aggregated intelligence alongside triangulation analysis and challenge on areas of perceived risk, in order to ensure that forecasts align with:

- Robust supply and demand analysis;
- LETB 5 year Workforce Development strategies;
- Local Commissioning intentions;
- National Priorities as set out in HEE's Mandate; and
- National intelligence, generated through the 'call for evidence' instigated by HEE, including from professional and representative bodies such as patient organisations, Royal Colleges, employer groups, education provider groups, and sector skills councils.

LETBs should also ensure that these forecasts actively reflect the workforce needs of future transformed services as well as representing the needs of services as currently configured and delivered.

Such transparent challenge processes are vital to ensure assumptions are triangulated between individual organisations, are able to be compared to local commissioning intentions, create the opportunity for senior clinical input, and thereby generate stakeholder ownership and acceptance of any scenario (and tolerances) developed for the LETB area.

Following these local processes, each LETB should provide regional workforce forecasts linked to the outcomes of local discussion, as these will form the basis of the agreed Investment Plan Summary Template submission to HEE.

LETB workforce forecasts and development plans should be shared with LETB stakeholders and formally adopted by the LETB Governing Body to indicate they represent the consensus perspective of the service providers within the LETB.

Note: *It is important that we continue to stress the nature of these forecasts in the context of their purpose. Any specific numbers generated do not and cannot represent what the sum of the local providers are planning to do by a date five years into the future. The purpose of this forecasting is to identify the general direction and scale of demand and supply, such that the best possible decisions can be made about how this need is met through our education and training investment.*

Investment plans

LETBs will subsequently use their agreed LETB workforce demand and supply forecasts and the nearer term workforce needs identified in annual service plans to develop their **LETB workforce investment plan.** These plans will be developed within the context of, and with reference to, the LETBs' overarching five year workforce development strategies and HEE's fifteen year Strategic Framework.

The future forecasts and assessment of need in annual service plans represent a 'needs analysis' or *'diagnostic'* process. Investment plans represent the *action* HEE intends to take, and money that will be invested in response to these identified needs.

These plans must therefore:

- demonstrate how service transformation will be driven through a combined set of actions with regard to the numbers, skills, values and behaviours of their workforce;
- show the local component of any activity and investment agreed collectively at a national level; and
- explain how any barriers to implementation, e.g. placement capacity or sustainability of education provision, have been fully identified, discussed, and an approach to overcoming any such barriers has been agreed.

A key objective of the HEE planning cycle is to create the opportunity to consider priorities across professional groups, between the needs of the current and future workforce, and between capacity priorities and capability priorities.

Leadership for planning defined groups and professions

This year LETBs will be asked to lead on developing a national plan for one, or at most two, medical specialties, and for developing 'cluster level' plans for some professional groups. This is discussed further in section 4.

The various proposals for investment need to be brought together to enable stakeholders and LETB Boards to consider the relative workforce risks and priorities of these proposals.

Section 5 sets out the timetable for the staged development of LETB workforce investment plans and the aggregate Workforce Plan for England.

Narrative

In general LETBs are not required to supply detailed narrative to HEE nationally within the context of the planning process, although clearly locally LETBs will need assurance that investment plans balance local priorities appropriately and align with the strategic intent. However the Board of HEE will require assurance that mandate priorities have been actively considered at all levels. Hence the HEE national function will require from each LETB a concise narrative in relation to each Mandate priority where there is a planning aspect (for example endoscopy, sonography, proton beam therapy, IAPT and early interventions in psychosis and the treatment of eating disorders and local perspectives on staff groups on the Shortage Occupation list).

These Narrative returns may be generated through on-going project groups but will need to be summarised and submitted at the same time as the first LETB Investment Plan (27th September).

Note also that HEE is working with the Centre for Workforce Intelligence to develop methodologies to support planning processes for 'specialist' workforces where post-registration skills sets, rather than registration or education, are the requirement (see 4.2 below).

3.4 The role of the HEE national planning team

HEE nationally has three roles in respect of workforce planning;

(i) The Workforce Plan for England

HEE is legally required to produce a national Workforce Plan for England each year. As part of this process, HEE will produce an **England workforce forecast** based on the aggregate of the final moderated LETB workforce forecasts that have been adopted by LETB Governing Bodies. This collective England wide forecast will be owned by the HEE Executive and shared with the HEE Board, and wider stakeholders and be subject to processes including confirmation and challenge.

These confirmation and challenge processes will be conducted through the Health Education England advisory structure, including the National Workforce Board. This provides the opportunity for key professional, employer, and other national groups to influence the thinking of HEE nationally and LETBs and their partners locally. Other parts of the wider NHS system will also be invited to reflect on how these forecasts fit with their strategies.

At a national level, this will be particularly relevant to HEE's responsibility for assuring national security of supply and ensuring possible tensions between shorter and longer term priorities are exposed, discussed, and resolved, with reference to formal assessments of risk. This will also allow HEE to share and discuss supply issues between England and the devolved administrations.

The final moderated England workforce forecasts will be published in the 2015 NHS Workforce Plan for England following HEE Board approval on 15th December 2015.

(ii) Lead on collective planning

HEE will lead on collective workforce planning for an identified set of medical specialties and non-medical groups (see Section 4).

(iii) Accountable body

HEE will sign off **LETB workforce investment plans** in line with our statutory directions, and aggregate these investment plans alongside any planned national programmes of work to produce the **workforce investment plan for England.**

Sign off of LETB plans will be undertaken in the context of:

- assurance that LETB plans represent, in aggregate, secure national supply (including supporting service transformation);
- engagement with national bodies (i.e. the ALBs, PHE and the Local Government Association, but also bodies such as the national Blood and Transplant Authority);
- LETBs continued compliance with authorisation standards; and
- the formal requirement set out in HEE's Statutory Directions.

3.5 The roles of other stakeholders

HEE is committed to making the best decisions possible informed by the best available evidence, that is openly and transparently considered. The role of key stakeholders in making this commitment a reality is critical. HEE has comprehensive advisory structures at national and local level, and it is vital that partners ensure that their expert input is heard in both our 'call for evidence' phase and during confirmation and challenge phases of our process.

HEE's call for evidence

Providers and Commissioners of NHS services will be engaged locally through LETB processes. However in order to help us to fulfil our role HEE draws upon the experience and views of other key stakeholders. We recognise that many stakeholders generate important perspectives about the future workforce. We continue to seek their support and professional judgement in identifying key issues, perspectives and evidence, which we can use to shape our final plans through our formal 'Call for Evidence'. Submissions must be evidence based, and must address the core components of numbers, skills, values and behaviours, to ensure that our future workforce can deliver high quality care. The call for evidence is accessible and open to stakeholders all year round. However, to influence discussions between HEE and NHS England over the summer and autumn and to be considered in

triangulation with aggregate forecasts and other evidence, submissions should be made to HEE **by 30th June 2015**[15].

<u>Alignment with other NHS ALB plans</u>

HEE will work through the Workforce Advisory Board to assess and ensure consistency with major strategic and policy drivers.

Figure 3 summarises the roles of HEE and system partners. Section 4 sets out further detail on HEE's approach to specific groups in 2015.

Figure 3 - System roles : summary

<table>
<tr>
<td>HEE national team
• National level system convenor for workforce planning and education investment
• Develop, with LETBs, workforce plans and education commissions for those areas where collective approach is warranted as directed by HEE Executive
• Produce Workforce Plan for England based on aggregation of LETB demand, supply and Investment Plan submissions and national confirmation and challenge process
• Sign off LETB investment plans</td>
<td rowspan="5">LETBs
• Local level system convenor for workforce investment and development
• Work with Providers and commissioners to assess overarching implications of service plans
• Supply Medical Training Stocktake to HEE national team in agreed format
• Work with providers to develop aggregate demand forecasts and supply forecasts to HEE national team in agreed format
• Run local confirmation and challenge process
• Work with HEE national team on standardising supply forecasting
• Work with providers on service implications of potential changes to numbers of medical training posts
• Develop Investment Plan and supply to HEE national TEAM in agreed format
• Follow change control and plan variation procedures
• Commission pre-registration education and manage delivery and quality
• Commission post-graduate medical education and manage delivery and quality
• Commission CPD, access and other relevant education and manage delivery and quality
• Develop, with HEE central planning team workforce plans and education commissions for those areas where collective approach is warranted
• Lead on national plans for specific groups / specialties as directed by HEE Executive.</td>
</tr>
<tr>
<td>Service Provider
• Make available to LETBs workforce information relating to planning submissions to Monitor/TDA
• Develop and supply signed-off workforce demand forecasts and workforce strategy to LETBs in agreed local format</td>
</tr>
<tr>
<td>Service commissioners (CCGs, ATs, LAs)
• Develop strong robust ambitious 5-year plans
• Work with providers and LETBs to develop education commissioning plans consistent with future service plans</td>
</tr>
<tr>
<td>ALBs
• Work with HEE at national level to assess and ensure consistency between workforce plans and major strategic and policy drivers</td>
</tr>
<tr>
<td>Stakeholders
• Contribute to HEE's formal 'Call For Evidence'
• Participate in wider stakeholder forums and opportunities</td>
</tr>
</table>

[15] More details on how to respond to our Call for Evidence can be found at http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/04/Call-for-evidence_Template-2014_15-2.doc.

4 Group specific guidance and notes

4.1 A differentiated approach

This section begins with a clarification of HEE's role in investing in the current and future workforce, and then sets out how HEE will work with the wider system to develop workforce plans and education commissions for each of the major commissioned groups. In 2015 HEE will move explicitly towards a differentiated approach based on the specific characteristics of the workforce concerned.

4.2 Planning the future workforce and supporting workforce development

HEE invests on behalf of the healthcare system in two principal ways:

<u>Production of newly qualified professionals/registrants</u>

The bulk of HEE's *investment* is deployed in the creation of the 'raw stock' of professional staff who train through recognised curricula to recognised standards – the Future Workforce. HEE plays a central role in helping shape these curricula and ensuring in-service components of training (e.g. placements) have the right elements and are of the correct standard. HEE invests in these groups in the context of a locally driven but nation-wide planning process. Once staff are qualified it is for providers to employ and deploy these staff to deliver services in their particular environment and to ensure they receive necessary additional training.

In order for HEE to develop a workforce plan which supports rational investment in education commissioning for the future workforce (as opposed to developing specific interventions to address specific skills shortages), there needs to be information as follows:

- how many of any given group there are currently (stock), and where they are;
- the demographic characteristics of that stock and how these influence labour market behaviour (so HEE can model flows);
- forecast demand for the group concerned; and
- how they are currently or might in future be trained, and how long it takes / will take.

It then becomes tenable to construct a supply/demand model and advise on commissions.

The wider system then needs:

- training programmes with entry criteria and defined outcomes;
- structured placements, and placement capacity;
- a commissioning plan;
- funding streams.

Developing the current workforce

HEE also invests in the development of skills and competences of the current workforce in order to support the development of new services, and/or the acquisition of further particular skills and competences. This responsibility is shared with the wider system and most notably with employers.

The examples below demonstrate that the distinction is not always clear cut.

Practice nurses

Registered can work as nurses in practice settings, with or without a practice nurse qualification. But there are established programmes to support nurses in achieving practice nurse skills, and HEE commissions directly practice nurse training places in response to locally expressed demand for such programmes.

Endoscopy

There is a growing demand for endoscopy services. But endoscopy is a specific intervention. HEE funds the training of gastroenterologists (medical staff with the relevant qualification to join the specialist register), nurses and health care scientists, all of whom may be deployed in endoscopy services. Education commissions for these specific groups are determined by LETBs working with providers in the context of the nationwide planning process as above.

Thus those who can in principle undertake endoscopy emerge through a variety of backgrounds and require post-registration training to do so. So endoscopy is a role rather than a profession or an occupation and, currently, neither the 'stock' nor the flows can be observed centrally as there is no source of such data. There is no clearly identified demand for 'endoscopists', no readily quantifiable measure of current supply and no clear training route.

So currently HEE works with the service to develop curricula for endoscopy training to support service delivery. At some point the training may become standardised and the supply of and demand for the group clearly identifiable. But currently it is for employers, not HEE, to commission directly from their own funds the training *volumes* they require based on their local needs[16].

4.3 The groups HEE commissions and the multi-disciplinary workforce

In principle workforce plans flow from the services providers are commissioned to deliver. Services are always provided by a range of staff with particular competences, skills sets, aptitudes and approaches. Hence workforce plans are intrinsically 'multidisciplinary'.

However, the professional groups that embody particular clusters of competences, skill sets, aptitudes and approaches that provide services have emerged through a variety of sometimes discrete educational routes that lead to registration to practice

[16] Note: that endoscopy is a mandate priority and so LETBs will be required to submit a narrative report -see Section 3.3 above.

in a particular discipline or speciality. These training routes and regulatory frameworks have developed historically. They change slowly.

Hence workforce plans which underpin HEE's educational commissions are ultimately expressed in terms of professional and other groups, and then translated into educational commissions for these groups based on analysis of forecast supply and forecast demand[17].

For the purposes of this guidance there are specific characteristics of key groups which determine the level at which planning, analysis and modelling will be focussed in the 2015/16 round.

These are summarised here, with **further material to follow in April**.

4.3.1 Pre-registration 'non-medical' training.

HEE commissions large volumes of training for most nursing groups and several of the Allied Health Professions. Trainees are supernumerary while on placements, and once qualified tend to operate predominantly in relatively local labour markets. The volume, nature of training, and labour market behaviour means these are suited to local supply and demand planning, and local education commissioning, with HEE nationally providing an assurance role.

For most of the high-volume non-medical groups the focus of planning remains local. For smaller groups there will be a regional approach, whereby LETBs work together to develop regional plans. For the smallest groups HEE nationally will convene a single planning process.

Nurses

A Nursing Workforce Programme is being developed by NHS England's Chief Nursing Officer and HEE's Director of Nursing. This programme has four work streams, including one focussed on workforce planning. The Workforce Planning work stream will add value to HEE's mainstream workforce planning cycle by extending the scope of stakeholder engagement and adding structure and clarity to a collection of hypotheses and potential solutions about the 'nursing position'. The evidence gathering phase will establish:

- Are there still 'demand shortages' (i.e. areas where it is believed funded establishments are insufficient to provide safe care)?
- What is the actual level of current supply shortage (i.e. real vacancies)?
- Understanding and agreement of the current components of supply and throughput (including working patterns – staff in post, flexible staff usage, career progression)

[17] There are some groups on the fringes of this: there is no specific registration for child psychotherapists or IAPT practitioners and the training of Physicians' Assistants/Associates is not standardised and does not currently lead to registration. But the vast majority of HEE investment is in essentially standardised programmes leading to nationally recognised outcomes.

- The full range of solutions to across demand and supply variables we might pursue depending on the agreed diagnosis.

As this work stream produces results, LETBs and HEE will be able to make use of the findings to support their local and nationwide processes.

Allied Health Professions

For medium-sized AHP professional groups in 2015 proposed commissioning volumes will be developed through regionally-coordinated approaches.

For smaller AHP professional groups (Orthoptics and Orthotics/Prosthetics) proposed commissioning volumes will be developed through national-level analysis and stakeholder engagement.

Paramedics

Paramedic commissions will be influenced by results of the HEE-led project responding to the findings of the Paramedics Evidence Based Education Programme (PEEP) report. The model agreed by the steering group will take the Paramedic profession to an all graduate profession by 2019.

Health Care Science (HCS)

The HCS workforce numbers about 48,000, of which around 32,000 are qualified at undergraduate, masters, or doctoral level. There are approximately 50 scientific disciplines. While the entire HCS workforce makes up only about 5% of the total NHS staff, they are key in diagnostic decision making. The fragmented nature of this workforce means quite minor variations in workforce capacity may jeopardise patient pathways reliant on specialist services. Not all of the specialist services within HCS are necessarily represented in any great number in every Trust. Whilst it is important to retain local decision-making in the planning and shaping of services and investment in training, it would be difficult for an individual Trust or LETB to commission sufficient HCS training numbers from their local HEI to make such a provision viable. It is for this reason that a joint commissioning approach will be adopted for HCS and a number of new processes are being introduced:

- ‘Sign off’ of demand forecasts by Lead Scientist within establishments where this role exists at employer level
- Review of demand forecasts by NHS England regional HCS Leads at the locality level
- Nationally co-ordinated supply modelling and proposal of education commissions (at nationwide and local levels), also subject to national and local confirmation and challenge.

Pharmacists

The commissions for pre-registration pharmacists are determined outwith the main planning timeframe and HEE is currently undertaking a consultation on reforms to pharmacist education and pre-registration training[18].

4.3.2 Post graduate medical education

HEE funds

- undergraduate placement costs
- the bursaries of medical students in their final year
- the costs of foundation training
- the training costs and partial salary costs of core, higher and run-through trainees.

The intended final outcome of this training is the production of new specialists (CCT holders). However doctors in training make a contribution to service which grows over the course of their lengthy pre-CCT training (notionally up to 10 years for some specialties but often longer once career breaks and 'out of programme' activities are factored in). The volumes in particular specialties vary markedly - from over 1,000 to under 10. The labour markets in which medical staff operate vary from comparatively local (regional) to national, and genuinely international. For these reasons, and the sheer complexity of planning the medical workforce, the national perspective is far more significant than for other groups.

In 2015/16 planning will operate at two levels:

Nationwide processes

- HEE nationally will co-ordinate, with the 13 LETBs, planning for between two and four of the largest specialties. However, because of the long timescale required to implement significant change in medical education commissions, and the need to undertake thorough review, significant recommendations will be confirmed in March *2016* and implementation will commence in recruitment to *2017* intakes.
- Individual LETBs will coordinate, on behalf of HEE as a whole, the planning process for a number of the *smallest* specialties, supported by centrally co-ordinated analysis. This process will operate to the same timetable as the above.

LETB led processes

- For the remainder of the medical specialties it is assumed that in most cases the overall numbers will remain broadly unchanged (as they have done for a number of years), pending detailed reviews of each of these in subsequent

years. LETBs will use local discretion in determining the number of underlying posts.

4.3.3 The Dental Workforce

HEE’s Dental Health Advisory Group has proposed that HEE review the Dental workforce as a whole (i.e. including the future role of Dental Care Practitioners) in order to develop informed dental education commissioning. HEE Executive has agreed to this and is establishing a ‘limited life’ group to develop a strategic approach to planning the dental workforce, including a review of dental specialities and the role of Dental Care Professionals. Stakeholders are invited to contribute formally to the review via HEE's Call for Evidence.

5. Processes and timetable

5.1 HEE's Call for Evidence

The Call for Evidence, described in section 3.5 above is accessible and open to stakeholders all year round. However, to influence discussions between HEE and NHS England over the summer and autumn and to be considered in triangulation against numbers and other evidence, submissions should be made to HEE **by 30th June 2015**.

5.2 Staged development of plans

LETBs will agree local processes for the collection, analysis, confirmation and challenge of workforce forecasts with their local stakeholders and partners. The key milestones are set out in figure 6 overleaf.

LETB's will be expected to have their forecasts formally adopted by their local governing body through their local processes.

> ***NB**: that, the first submission (25th September) is crucial*. *The national report developed from this will form the basis for HEE's conversations with the other NHS Arm's Length Bodies (ALBs) and is the report HEE will take to HEE's Advisory Groups.*

5.3 Change control and variation from plan

The Workforce Plan for England published in December will set out HEE's intentions. This is the aggregate of the agreed investment intentions of the 13 LETBs, moderated by HEE Executive where relevant. **The expectation is that the plan as agreed will be delivered.** However it is accepted that in some **exceptional isolated** cases there may be a justification for revision to the December plan prior to final 'lock down' at end February. LETBs seeking a *change to* the education commissioning plan as submitted on 30th October will complete the Change Control documentation (see Appendix). The closing date for any such proposal (either local or national) is **12th February 2016**. HEE Executive will communicate its decision by 4th March 2016 after which the plan is handed over to the Performance team who will monitor subsequent *variations from* plan.

It is understood that there is a degree of uncertainty about medical *recruitment* numbers as the process begins before the number of vacant posts can be entirely known. It is understood further that the actual number of posts available may itself change. But there must be no uncertainty about how HEE, and thus LETBs *plan* to spend the £5bn of public money over which HEE has stewardship. Nor must there be any uncertainty about changes to the plan. HEE Executive needs a full audit trail.

Hence the investment plan submitted on the 30th October 2015 must be the actual LETB's plan, not an interim plan pending confirmation. Any doubt or uncertainty must either be managed using the subsequent change control process or left out of the plan.

It is for LETBs to assess the delivery risk (e.g. trusts indicating conversion of posts to training posts but subsequently not doing so) and make a judgement call on what to put in their plan.

There is no scope within the plan to reflect uncertainty, other than that which arises from recycling. The min-max range must only be used to reflect this issue and not more general planning uncertainty.

The intention is not to drive LETBs to adopt conservative positions, nor for the change process to be regarded as routine – it is to cover exceptions only. Hence conversations with providers and other stakeholders about risk should take place within the context of the planning round and the associated timetable.

Figure 4–timetable of key inputs to planning process

	2015								2016
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Feb
Stocktake of medical training posts & trainees from LETBs to HEE		X						X	
Call for evidence 'soft close' (wider stakeholders)			30th						
Collective Forecast Demand 'cut' from electronic tool (1)			30th		14th				
Planning Round Exceptions report to Exec		X	X	X	X				
Investment Plan Summary Template from LETBs to HEE to include narrative on mandate priorities						25th	30th		
Proposals for ***exceptional*** changes to plan		`							12th

Note 1 : The HEE national team will take a 'cut' from the electronic tool at 30th June. It is understood that this initial cut is un-moderated and will almost certainly change as LETBs continue to engage with providers and commissioners in discussions about aggregate demand. However it is important that these data are available nationally as (i) they will capture *current* shortfall and (ii) will be used to frame the same conversations nationally about 'direction of travel' and prospective future demand as are taking place locally.

Figure 5 : Planning round submission and deadlines

1	LETBs will work with providers to populate the Collective Forecast Demand Tool. The HEE national team will take a 'cut' from the electronic tool at **30th June**. The HEE national team will take a second and final cut on **14th** August. LETBs will submit their initial supply forecasts and under-pinning assumptions on **14th** August. This timetable allows LETBs to collate and 'sense check' plans and undertake local confirmation and challenge processes between the two deadlines. Over the same period HEE will be working with NHS England to distil the key expectations from the service 'direction of travel' that workforce plans will be expected to exhibit. LETB aggregate demand forecasts will provide an overview of the workforce 'direction of travel' at national level as at early July and mid-August which will be discussed with the planners' network, HEE Executive, the Workforce Advisory Board, the Patients Advisory Forum, HEE advisory groups and wider stakeholders. This aggregate England position will be used as just one element of local and national confirmation and challenge processes. In particular HEE will compare and contrast this position with national intelligence provided through the 'Call for Evidence' exercise.
2	HEE working with LETBs will provide initial planning assumptions in respect of financial allocations to be used in producing initial investment plans. LETB Investment Plans will contain agreed contingent actions for differing funding scenarios such that final plans can be rapidly produced once final allocations are confirmed.
3	LETB Geographical Directors will share progress on the development of their investment plans with the Executive throughout the planning round.
4	LETB investment plans will be summarised in a standard Investment Plan Summary Template to be submitted by **25th September.** This submission will support assessment of priorities alongside each other. The template will summarise the number of commissions the LETB proposes and the associated investment, and capture how commissions might vary under defined financial scenarios (that is percentage changes in overall allocation). The Template will capture summary narrative underpinning each proposed volume for every group rather than the full narrative LETBs will record in their full written investment plan that the local governing body signs off. However the Investment Plan itself, and thus the summary data captured on the template, will be the product of the LETBs' extensive local engagement on forecasts and priorities over the preceding six months. LETBs will submit their final supply forecasts and under-pinning assumptions and a short narrative on *identified mandate priorities* at this date. HEE will aggregate this intelligence to produce the initial view of the potential England wide position in respect of the level of financial investment in different activity types of activity and the education commissioning volumes associated with this prioritised investment. Working with LETBs this will be made available to stakeholders during early to mid-October.
6	During the course of October HEE and LETBs will refine investment proposals as necessary. A revised Investment Plan Summary Template submission will be required from each LETB a month later – by **30th October**. This will be a final update: the expectation is that changes between the two versions will result only from significant new information, significant local developments, or advice flowing from the national oversight of the aggregate plans. HEE will aggregate these LETB templates into a revised England wide position and develop further commentary and analysis on national stakeholder feedback. HEE's Executive will then consider this revised position and commentary in November. One of the key outcomes will be assurance that the post graduate medical proposals within this position can be supported within the context of any wider priorities. This will enable HEE to signal ST1/CT1 recruitment ranges to the system.
7	In November the HEE Executive will make any final amendments to investment plans to create the **Workforce Plan for England** which will go to the Board of HEE on 15th December and then be published.

Figure 6 :Process timeline

Month	Local (LETB) processes		National Processes
April	Local LETB processes for establishing future workforce requirements through engagement with CCGs and providers.	<----->	Early engagement with national stakeholders Final development of process and submission templates
	LETBs set out approach for the small medical specialties they are leading on		Further detail on process for the 4 medical specialties
	Medical Training Stocktake submission	----->	
May		<-----	Collation, review and analysis and feedback of Medical Training Stocktake
June	Engagement with commisioners (CCGs, ATs, LAs)		Guidance on priorities & allocation assumptions
	Demand aggregation tool populated (30/6)	----->	National team take 1st cut demand 'Soft Close' of Call for Evidence
July	Review and moderation of aggregate volume forecasts LETB estimate of future workforce demand		Continuing engagement with national stakeholders National supply modelling
	Report progress on medical specialties (LETB led)	<----->	Report progress on medical specialties (nationally led) Review Call for Evidence submissions
Aug	Demand aggregation tool updated (14/8)	----->	National team take 2nd cut demand
	Submit supply forecasts and underpinning calcualtions	----->	
	Ongoing stakeholder review of proposals		
	Goeg progress report to Exec	----->	
	Medical specialty commissioning proposals		Medical specialty commissioning proposals Aggregation and review of Demand and Supply Templates
Sept	Development of education commissioning and other workforce development proposals	<----- <-----	Feedback aggregate demand Feedback aggregate supply for high priority groups
	Report progress on medical specialties (LETB led)	<----->	Report progress on medical specialties (nationally led)
	Submission of Investment Plan Template (25th Sept)	----->	Triangulation and review of Investment plans
Oct	LETB workforce forecast formally adopted by LETB Governing Body		HEE national level engagement with ALBs
		<-----	Aggregation to form initial England-wide investment position.
		<----->	Collectively agreed revisions to local plans in light of national supply and priority considerations
	Submit any changes to Investment Plan Template (30th Oct)	----->	Drafting Workforce Plan for England
Nov			
Dec	LETB plans disseminated	<-----	HEE Board approve Workforce Plan for England Publication
Jan	Local confirmation with HEIs		
Feb Mar	Deadline for proposed variation from agreed Investment Plan (12th Feb)	-----> <-----	Exec response to Change Control requests (4th March) Handover to Performance and Delivery
Mar	Recommendations for 2017 medical specialties (LETB led)	<----->	Recommendations for 2017 medical specialties (nationally led)

2015/16 Workforce Planning Round for 2016/16 Education Commissions - Change Control Process

The Investment Plans' Summary Templates submitted on 30th October 2015 will set out final proposals from LETBs for investment in education (commissioning volumes and medical post numbers) in 2016/17.

These plans, where relevant modified by the HEE Executive, will represent the final plan put forward to the HEE Board on 15th December 2015. The plan will be published on the HEE web site soon after.

This published plan can then only be varied through either

i. the formal change control process described below.
ii. by reporting an *operational* variance to plan after 01/04/2016 (to be managed by the performance function).

Submission

- This process is to be used to propose ***any*** changes to the figures as per the two associated workbooks.
- Proposals are to be submitted no later than 12th February 2016.
- Proposals are to be submitted using the pro-forma below via the workforce planning inbox at HEE.workforceplanning1@nhs.net
- A separate form should be submitted, using a separate email, for **each** proposed change to the volume of commissions or the number of medical posts.
- Please use this convention in the email subject line: CR_HEXX_GROUP/SPECIALTY

Recruitment range/number (medical)

The change control is not required for changes to medical recruitment numbers *per se* as these must be driven by the number of underlying posts which in turn are either vacant or not thus necessitating recruitment or not. However if planned recruitment numbers now fall outside the range specified in the workbook (above or below) please complete sections 1 to 10 of the pro-forma and return to HEE.workforceplanning1@nhs.net. This will enable the recruitment team to keep an up-to-date record in order to respond to PQS etc. and to monitor those specialities where there is a specific recruitment target (e.g. GPs).

Financial model

Numbers of commissions in the investment plan must be consistent with the financial model. Hence any changes, once authorised, need to be reflected in the financial model as well would be helpful.

Response

Proposals will be considered in the first instance by the planning team who will contact the named lead in the LETB if necessary.

The final authorisation to formally change the plan will be granted by the HEE executive.

All proposed changes will be confirmed by 31 March 2015 at which point the plan becomes final and is handed over to the Performance function for monitoring. Any subsequent changes are thus a variation from plan.

2015/16 Workforce Planning Round for 2016/17 Education Commissions
Change Control Pro-forma

1	LETB (eg HENE)	
2	Contact name	
3	Contact role	
4	Contact email	
5	Contact tel no	
6	Date of submission	
7	Group/Specialty for which change is proposed	
8	Current number of commissions/posts (medical) as per IP workbook and current recruitment range (medical)	
9	Proposed new number of commissions/posts and proposed new recruitment range (medical)	
10	Rationale for proposed change	
11	Financial impact (brief description)	
12	Risk assessment of taking this action	
13	Risk assessment of not taking this action	
14	Confirmation that LETB Director has signed off this proposed change (yes/no)	
15	Outcome (to be completed by HEE planning team)	

Glossary

Term	Definition
Arms Length Bodies ('ALBs')	Executive agencies with particular responsibilities for business areas, accountable to, the Department of Health, Special health authorities and non-departmental public bodies which have a role in the process of national government, but are not part of government departments. Full list of NHS ALBs at https://www.gov.uk/government/publications/arms-ength-bodies/our-arms-length-bodies
Establishment	Sometimes referred to as 'Authorised' or 'Planned' or 'Budgeted' resource. Generally expressed as 'WTE' (see below)
Headcount	See WTE/FTE
Non-medical education Commissions	The number of student/training places invested in/planned to deliver newly qualified 'non-medical' staff to contribute to forecast workforce supply
Staff in post	The total number of employed (usually of a given group) available, or forecast to be employed at a given point in time
Workforce demand	The total number of staff (usually of a given group) required or forecast to be to required deliver a given (level of) service at a given point in time
Workforce Supply	The total number of staff available (usually of a given group) available, or forecast to be available to deliver a given (level of) service at a given point in time
WTE/FTE	Whole Time Equivalent or Fill Time Equivalent. The two terms are used interchangeably. This distinguishes the resourced required / in a post from the number of individuals ('headcount').