Health Education North West

Health Education North West Workforce Planning Process Guidance 2014-15

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***Please note this document should not be used in response to; FOI, PQ, media enquiries – please consult your local communications team and contact/advise HE NW Workforce Planning Team where needed**

CONTENTS

1. Purpose

This document provides detailed guidance for completion of the Workforce Forecast Demand Template which will allow regional aggregation of workforce demand forecasts into an overall North West position and future trajectory. The intended audience of this guidance is the Provider Workforce Planning Leads – some may wish and are welcome to use elements of this guidance to inform the production of locally focussed guidance.

2. Background

The Workforce Forecast Demand Template forms part of an underpinning evidence base supporting a "bottom up" approach to workforce planning in the North West, building on local expertise and practice to inform education commissioning investment decisions undertaken at regional and national level by Health Education North West (HENW) and Health Education England (HEE). Collecting future workforce demand forecasts is an important part of building the evidence base for investment in education because:

- Of the time it takes to select, educate, train and recruit the healthcare workforce.
- It allows HENW to commission education and training places based on the most robust evidence available from Providers.
- This ensures millions of pounds worth of public money is invested in mobilising a workforce fit to deliver future services and patient need informed by Provider views across the region.
- It acknowledges the future impact on workforce demand driven by local service transformation, re-design, productivity and improvement initiatives and the future "patient profile" ensure that the right people are treated appropriately in the correct settings with the right workforce.

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3. Principles

The following principles underpin the design of the Workforce Forecast Demand Template and have been set out to ensure core users are aware of its purpose, intention and limitations:

The Workforce Forecast Demand Template **IS / DOES:**

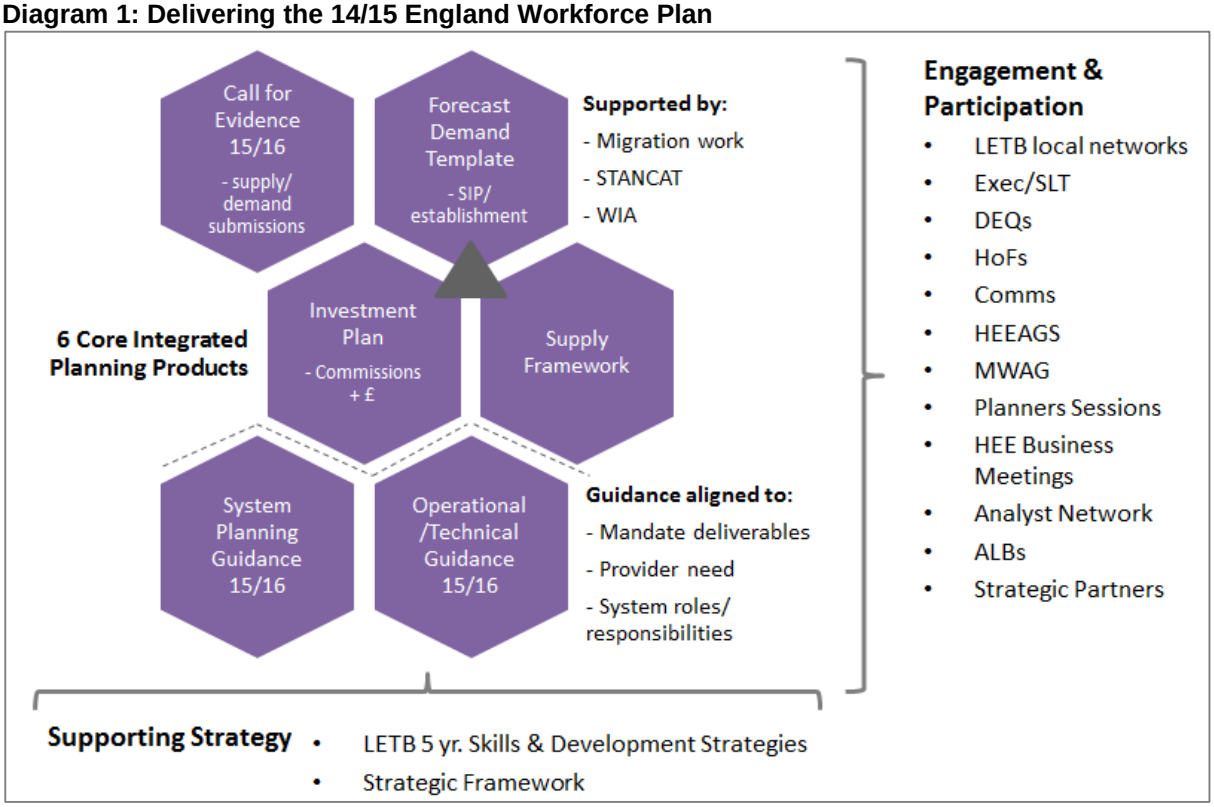
1. Support a **joint agenda**: for providers and service commissioners
2. Aims to create a **'common currency'**: so that the system as a whole can talk consistently and transparently about workforce demand and supply across the total workforce.
3. Reflect content agreed through **collective consensus**
4. Appreciative of the required **alignment** between workforce demand, supply and investment
5. Aim to highlight the direction of future demand as of **greater importance** than any scrutiny of the individual numbers
6. Only includes individual staffing categories considered as **"required"** (there are **no "desirable" elements**) to inform a whole workforce planning approach that best;
   - describes the current workforce
   - allows a forecast of future anticipated demand
   - map's back to an education commissioning route where appropriate (either **directly** i.e. Registered Health Visitor role is supplied through a Health Visiting education programme OR via an evidence based/calculated assumption i.e. Neonatal Nurse roles can be supplied through a variety of more general foundation nurse education routes, for example; adult or learning disabilities nurse education programmes)

4. England Workforce Plan

The 2013/14 planning round (which has just finished) saw the publication of the first ever Workforce Plan for England. The plan set out clearly the investments HEE intends to make in education and training programmes to begin in September 2014. The plan was built upon the needs of frontline employers, who as members of the Local Education Training Boards (LETBs) shaped the thirteen local plans that formed the basis for the England plan.

Operational delivery of the Plan this year will be subject to the consolidation of 6 core planning products, outlined below. Along with stakeholder engagement and participation these will provide the evidence based upon which education commissioning investment decisions are made for programmes to begin in September 2015.

Diagram 1: Delivering the 14/15 England Workforce Plan



5. Timetable

Please see below an indicative timetable of core activities supporting the 14/15 planning round

Provider Submission Dates

- Submission of plans to HE NW by Friday 18th July 2014.
- July 2014 – August 2014 Discussion of Plans and validation for Phase 1 with providers.
- August 2014 – September 2014 refinement of demand and supply submissions with providers / LWEG / LETB and Networks – Phase 2.

- Sub-regional discussion and challenge.
- Professional network engagements.
- Finalised North West demand and supply position.
- Inform Education Commissioning and Management.

Health Education North West submission dates to Health Education England

- 15th August 2014 – 1st Cut Submission of aggregated plans to HEE
- 26th September 2014 – 2nd Cut submission of aggregated plans to HEE
- Final challenge sessions
- Final submission for Education Commissioning Plans
- Share intelligence from Narratives across system

6. Submissions Process

Communications from HENW

All core communications out from the HENW Workforce Planning and Information Team to support the above submissions will be done via the formal HE NW communications route to CEs, Directors of Nursing, Directors of Finance, HR Directors, Workforce Planning Leads and Workforce Analysts. Communications will also go to relevant networks in the HENW regional oversight team.
All documentation and guidance will also be available on eWIN
www.ewin.nhs.uk.

Submissions into HEE

All submissions to be sent to mike.burgess@nw.hee.nhs.uk
Only one live submission will be considered at any one time – i.e. the most recently dated submission will be the one used, previous submissions will be deleted. Providers should therefore have local version control to support this.

Naming Conventions and Spread-sheet Control

Please do not amend the validation, totals or add any additional rows or columns to the worksheet as the file will be slotted in for validation and analysis
The naming convention for submitting the Workforce Forecast Demand Template is:

Naming Convention: ProviderName_Demand_dd-mm-yy
Example: CMFT_Demand_17-07-14

7. Terminology

Informed by the National Minimum Dataset definitions v2.6 & National Workforce Planners discussion
Link: http://www.hscic.gov.uk/datasets/nwd

The terms and definitions as stated below have been reached via consensus and are relevant to the completion of the Workforce Forecast Demand Template via Providers to HENW and from HENW to the HEE national team. The terms utilised in local discussion / other circumstances may mean different things to different audiences:

In alphabetical order:

- **2013/14 Planning Round** – the Planning Round that has just finished which resulted in decisions reached regarding the commissions for education programmes commencing from September 2014
- **2014/15 Planning Round** - the Planning Round that is just starting which will result in decisions reached regarding the commissions for education programmes commencing from September 2015
- **Workforce Forecast Demand Template**– the forecast demand planning template reached in joint consensus between HEE and its LETBs in terms of structure and composition in order to provide a "common currency" for the collection of data against particular staffing categories and used by Providers
- **Current NHS workforce** - essentially those staff captured on the Electronic Staff Record (ESR) working in 'core' providers and others where there is access to 'real' (not always correct) data
- **Education commissions** - the number of places invested in/planned to deliver newly qualified staff to contribute to forecast workforce demand
- ***Establishment** - this item may also be known as the 'Authorised' or 'Planned' WTE or 'Budgeted Whole time equivalent (WTE) for position'. It describes the authorised amount of time which may be contracted for a Position. This may be greater than, less than or equal to 1 (If related to funding, the WTE would probably be Paid rather than Contracted). Each grade and the amount of WTE within each grade are added to calculate the Budgeted WTE for the block.
- **Fill rate** – calculated as the FTE staff in post as a percentage of workforce demand at a particular point in time. This is included to present a high level view of what is likely to be a composition of; vacant posts across substantive and agency, bank and locum staff
- ***Full Time Equivalent (FTE)** - this item may also be known as "Whole time equivalent (WTE)". This is the standard method for defining the amount of work of an employee or in a position. It is the basis for most planning and monitoring of the workforce. The workforce is usually expressed in terms of WTE and Headcount numbers. Contracted WTE is calculated by dividing Contracted Hours or Contracted Sessions by the Standard Hours (or Sessions) for the Grade. For example: if the standard hours for a nurse are 37.5 and an individual Staff Nurse contracts to work 22 hours per week, then that employee's WTE is 22 divided by 37.5 = 0.59 WTE. If the standard hours for a full time Junior Doctor are 40 hours a week and an individual Junior Doctor contracts to work 40 hours per week, then that employee's WTE is = 1.00 WTE Note that a similar formula is used when calculating Worked WTE, Budgeted WTE or Paid WTE.
- **Forecast workforce demand** – the future estimated required workforce establishment as at a particular point in time (reflective of the replacement for leavers plus predicted change in capacity required plus vacant posts)
- **Planning Round** – term used by HEE and LETB workforce planners to describe the period of time within which core aggregate regional and national planning processes take place
- **Staff in Post** –the number of staff directly employed by the Provider organisation (exclusive of; agency, bank, locum or hosted staff) measured in terms of Full time equivalent (FTE) (for the purposes of the Workforce Forecast Demand Template– can also be measured in terms of headcount (HC)

***If clarity of any other terms would be useful, please let us know at:**
mike.burgess@nw.hee.nhs.uk

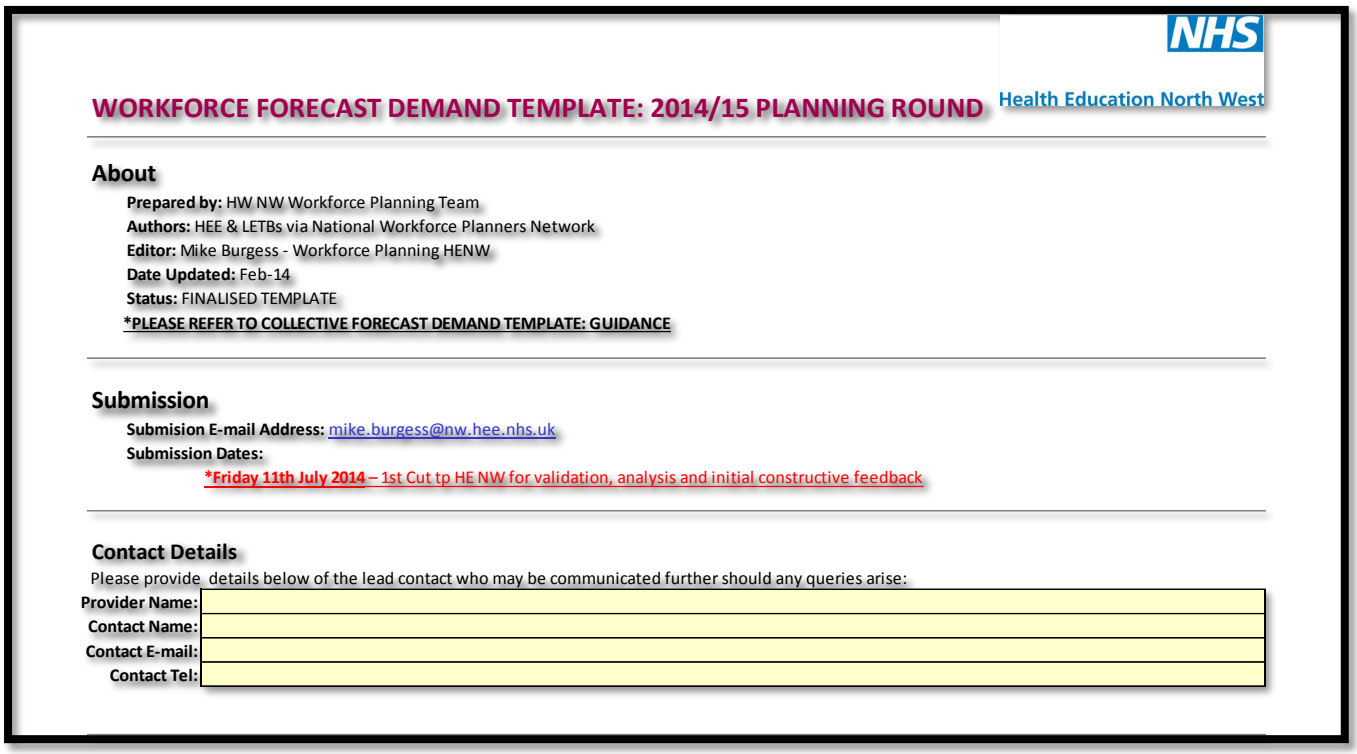
8. Completing the Workforce Forecast Demand Template

The following guidance takes you through a step by step guide of each tab in the Workforce Forecast Demand Template14/15:

8.1 Overview Tab

This tab provides overall details about the file, including key dates/route for the files submission:

Diagram 2: Workforce Demand Template: OVERVIEW Tab



WORKFORCE FORECAST DEMAND TEMPLATE: 2014/15 PLANNING ROUND

NHS
Health Education North West

About

Prepared by: HW NW Workforce Planning Team
Authors: HEE & LETBs via National Workforce Planners Network
Editor: Mike Burgess - Workforce Planning HENW
Date Updated: Feb-14
Status: FINALISED TEMPLATE
***PLEASE REFER TO COLLECTIVE FORECAST DEMAND TEMPLATE: GUIDANCE**

Submission

Submision E-mail Address: mike.burgess@nw.hee.nhs.uk
Submission Dates:
***Friday 11th July 2014** – 1st Cut tp HE NW for validation, analysis and initial constructive feedback

Contact Details

Please provide details below of the lead contact who may be communicated further should any queries arise:

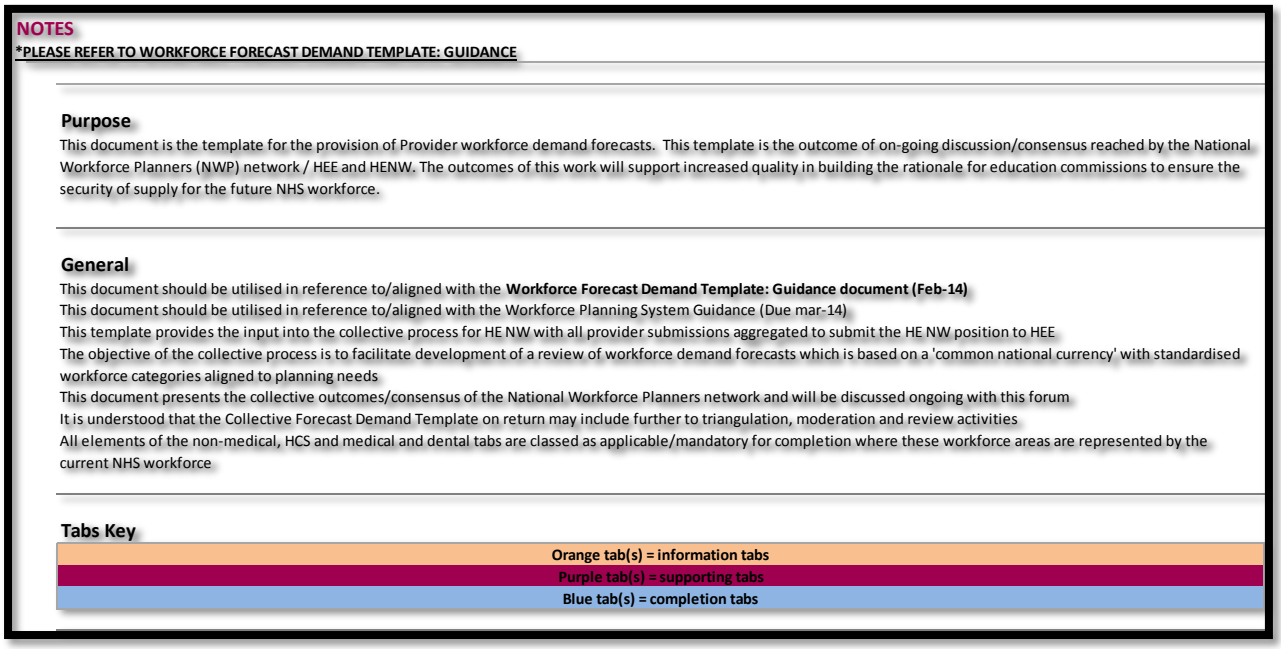
Provider Name:	
Contact Name:	
Contact E-mail:	
Contact Tel:	

In the yellow cells under the “Contact Details” section please enter the Provider name and name/e-mail and direct telephone number of the lead contact who may be contacted further should any queries arise.

8.2 Notes Tab

Provides high level guidance to completion of the template – a sub-set to the more detailed guidance offered by this document

Diagram 3: Collective Demand Template: Tab 1. Notes



NOTES

*PLEASE REFER TO WORKFORCE FORECAST DEMAND TEMPLATE: GUIDANCE

Purpose

This document is the template for the provision of Provider workforce demand forecasts. This template is the outcome of on-going discussion/consensus reached by the National Workforce Planners (NWP) network / HEE and HENW. The outcomes of this work will support increased quality in building the rationale for education commissions to ensure the security of supply for the future NHS workforce.

General

This document should be utilised in reference to/aligned with the **Workforce Forecast Demand Template: Guidance document (Feb-14)**
This document should be utilised in reference to/aligned with the Workforce Planning System Guidance (Due mar-14)
This template provides the input into the collective process for HE NW with all provider submissions aggregated to submit the HE NW position to HEE
The objective of the collective process is to facilitate development of a review of workforce demand forecasts which is based on a 'common national currency' with standardised workforce categories aligned to planning needs
This document presents the collective outcomes/consensus of the National Workforce Planners network and will be discussed ongoing with this forum
It is understood that the Collective Forecast Demand Template on return may include further to triangulation, moderation and review activities
All elements of the non-medical, HCS and medical and dental tabs are classed as applicable/mandatory for completion where these workforce areas are represented by the current NHS workforce

Tabs Key

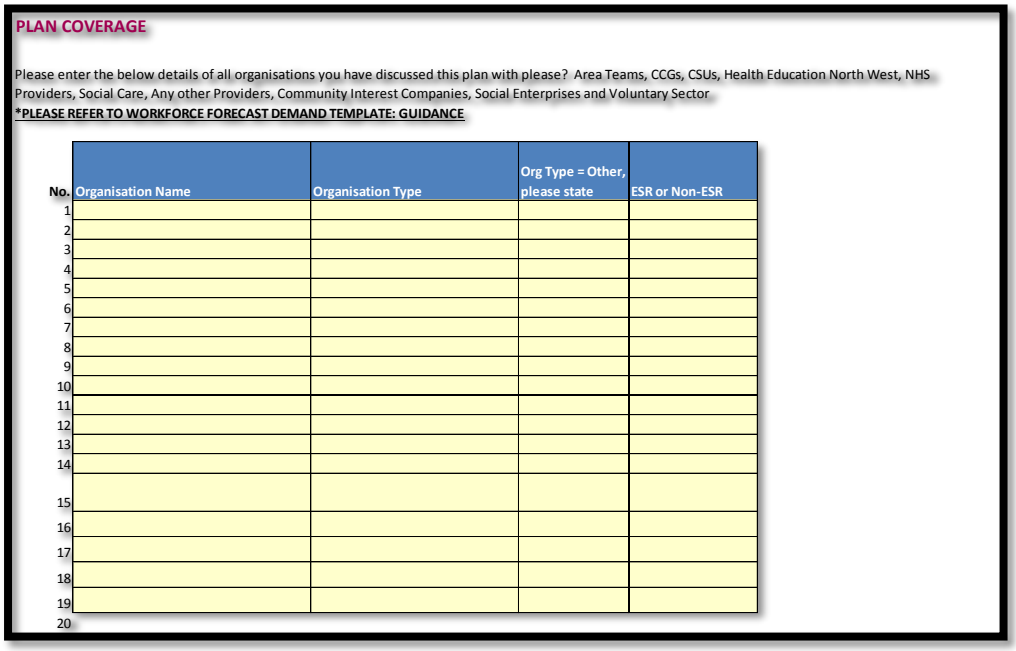
Orange tab(s) = information tabs
Purple tab(s) = supporting tabs
Blue tab(s) = completion tabs

This page provides high level notes supporting the completion of the Workforce Forecast Demand Template. The notes provide guidance as to what different; terminology, colours and symbols mean as well as contact, support details and additional references.

8.3 Plan Coverage Tab

HENW deemed it important to understand the profile or “make-up” of the provider plans in terms of the engagement with the number and type of organisations contributing to the overall workforce demand.

Diagram 4: Collective Demand Template: Tab 2. Plan Coverage



PLAN COVERAGE

Please enter the below details of all organisations you have discussed this plan with please? Area Teams, CCGs, CSUs, Health Education North West, NHS Providers, Social Care, Any other Providers, Community Interest Companies, Social Enterprises and Voluntary Sector

*PLEASE REFER TO WORKFORCE FORECAST DEMAND TEMPLATE: GUIDANCE

No.	Organisation Name	Organisation Type	Org Type = Other, please state	ESR or Non-ESR
1				
2				
3				
4				
5				
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9				
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16				
17				
18				
19				
20				

This tab therefore asks for the following information on each organisation contributing to the plan:

- **Column B-Organisation Name:** Free text, please enter the full name of the organisations that have submitted plans OR copy and paste an extract of the names as they appear in ESR.

- **Column C-Organisation Type:** Select from the drop down list the organisation type of the organisation listed on the same row in column B (which includes the below data items) OR copy and paste an extract of the organisation types as they appear in ESR.

Acute –Multi-service: Trusts comprising a district general type of acute hospital as well as significant amounts of community activity (non-acute expenditure greater than 15%).
Acute –Teaching: Trusts with an attached undergraduate medical school.
Acute –Large/Medium/Small: Trusts with an A&E department and all core acute specialties. Subdivided into three categories, based on 2011-12 ERIC data on income: • Small denotes an annual income of up to £190m • Medium -between £190m and £260m • Large -above £260m
Acute –Specialist: Trusts with very restricted specialties, such as orthopaedic and children's trusts.
Ambulance Trust: Trusts providing emergency access to health care.
Care Trust: Trusts that provide social care as well as health care.
Community Provider Trust: Trusts responsible for providing community health services for their local population, typically delivering services such as midwifery, community nursing, learning difficulties services, chiropody, community physiotherapy and occupational therapy. May be named "Community Interest Companies (CICs), operating as Social Enterprises
Mental Health and Learning Disability: Trusts with over half of their outpatient activity in mental health specialties. Some trusts concentrate solely on community services, mental health or learning disabilities. Others may have significant acute expenditure but mostly in medicine and elderly, indicating cottage and community hospitals rather than district general hospitals.
Shared Services Organisation: Organisations that provide a central administrative and/or HR function for a number of NHS Trusts.
Others: Any not listed in the above. Organisations in iView that do not fit into any of the above groups. At present, this accounts for only the Post Graduate Institute, an organisation in North East SHA hosting doctors-in-training.

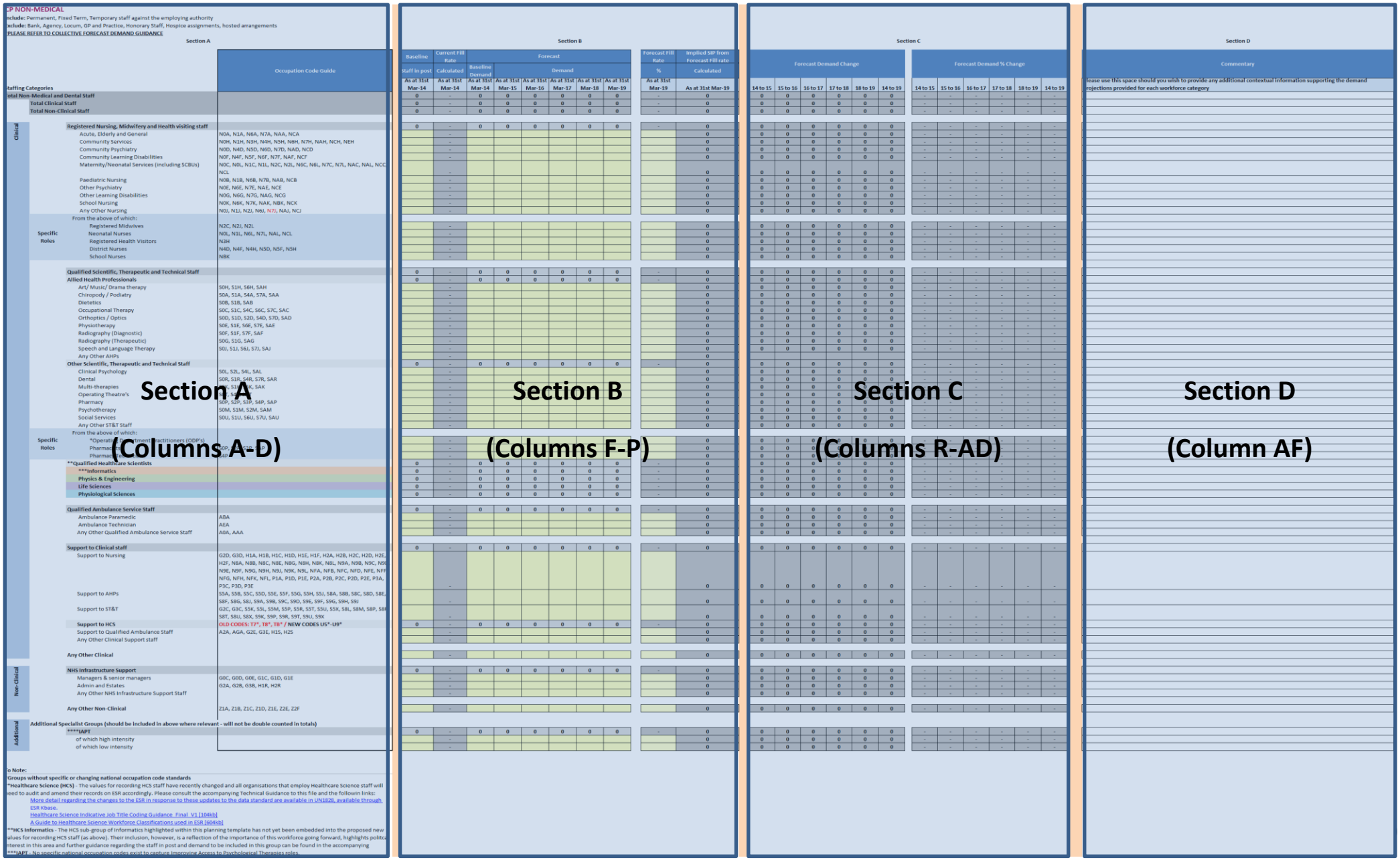
- **Column D-Org Type = Other, please specify** – where "Other" is selected against the organisation type in column C, please specify what organisation type it is in the free text box in column D on the same row

- **Column E-ESR or Non-ESR:** Select yes or no from drop down list to identify whether the organisation listed on the same row in column B is on the Electronic Staff Record (ESR) or not

***Please continue to add as many rows to the bottom of the table as you need to ensure all organisations contributing to your aggregate LETB plan are covered**

8.4 CP (Core Provider) Non-Medical Tab

Diagram 5: Workforce Demand Template: Tab 3. CP Non-medical



8.4.1 Summary of Core Changes to the Non-Medical template this year

Further to consensus of the National Workforce Planners network, the following changes are apparent from last year's non-medical demand template:

- **Community Nursing** – given the political interest and growing workforce demand as more services shift into a community setting, the community nursing sub-categories of this group have been extended this year from a high level "Community Services" grouping into the following;
  - Community Services
  - Community Psychiatry
  - Community Learning Disabilities

A separate line for "of which District Nurses" has also been embedded to capture the demand needs of this particular role.

These categories more closely align to HSCIC groupings and have specific occupation codes attached to them which can be found in the CP Non-medical tab next to the groups and/or in the separate occupation code tool tab.

- **Education Staff** - that were previously included as a separate line under the Registered Nursing, Midwifery and Health Visiting Staff are now embedded within the "Other Nursing" line as this was deemed to be a relatively small category of staff to which there isn't a specific identifiable education training route.

- **Maternity Services** - a separate line for "Neonatal Nurses" has been embedded to capture the demand needs of this particular role - it was deemed there is a lot of interest in this category and there are specific workforce occupation codes that can be attributed to this group.

- **IAPT** - sub-categories have been extended to cover; "of which High Intensity" and "of which Low Intensity" given the political interest and link to specific mandate measurable under our responsibility as HENW and HEE to deliver upon. The following section (**8.4.2**) provides an IAPT supplement to aid defining of this workforce against which there aren't currently any specific attributable occupation codes. It was deemed IAPT should no longer be included under the Scientific, Therapeutic & Technical category (as with last year's template) as they cut across a range of other areas. As such these lines have been separated out towards the bottom of the non-medical template. It is the view that roles working within an IAPT service will/may be included within staffing categories listed between rows 9-82 of the CP Non-medical tab – therefore figures entered in the dedicated IAPT section, rows 85-87 will not be separately added to the Non-medical totals so as not to double count

- **Qualified Healthcare Scientists –** sub-categories have been amended to align to the transitioning occupation code structure for this group; "Informatics", "Physics and Engineering", "Life Sciences" and "Physiological Sciences" – rows 56 – 60 in the CP Non-Medical tab will directly pull data inputted into a new CP HCS tab. Section **8.5.1** of this document provides further information to aid completion of the separate CP HCS tab

8.4.2 Planning the Psychological Therapies and IAPT Workforce

Informed by; Psychological Therapies Workforce Group and Sue Ambler (Head of Education & Training, HEE)

HENW and HEE are required to report progress against the DH national target of 6000 more IAPT practitioners. This includes monitoring and reporting numbers trained against numbers working within and beyond NHS funded care. HE NW and HEE will need to identify and consider regional commissioning of high intensity practitioners in order to meet the national target. The dataset proposed should be designed to inform education training and commissioning as well workforce planning.

The IAPT census have been carried out previously in 2011 and 2012 however was not carried out in 2013. Comparison between the census' carried out previously has proven difficult due to validation issues

and questionable response rates (known providers not contributing). HEE and NHS England are currently coordinating the dissemination of the 2014 IAPT Workforce Census. Previous challenges from an analytical perspective include duplicate counting and this current census aims to eliminate this issue by identifying categories where this could occur and providing clear, specific guidance to clarify which figures are being requested. Going forward there is ministerial interest and the aim to be able to extract reliable data directly from ESR rather than carrying out a separate census.
Data definitions must now be considered across the Census, ESR HSCIC work, WMDS, forecast demand template 14/15, and all other relevant information sources to ensure definitions are suitably aligned as this work needs to demonstrate scope for continuity. Workforce Planning in particular relies on this continuity to build a picture over time, offer trend analysis as the resulting figures are used to initiate conversation with providers on whether they consider retention and support expansion of a high and low intensity IAPT workforce.
Whilst there must be adequate focus on collecting workforce figures for delivering the IAPT programme, considerable attention must also be given to the remaining Psychological therapies workforce. This focus is taken by the Psychologists and Psychological Therapists Workforce meeting which is chaired by the HSCIC. The current national Occupation Code Manual states that IAPT workers should be coded as S1M regardless of whether they are high intensity practitioners or not. It was agreed in the meeting a meeting of this group that PWP's should be more accurately coded as S5M in the interim until revised structures are implemented.

This group provides a collaborative space from across a number of organisations who have an interest in Psychological services or the IAPT programme in general to be able to bring together a body of expertise upon which to review and discuss data standards and definitions for these services in both the short term collections and longer term pieces of work.
So far, the group:

- Has agreed the Scope of Task for the sub-group (as previously approved by WIRG) and the outline timeline for the work, and is due to share this progress with a range of stakeholders / potential contributors for information.
- Is due to generate from discussion at these meetings, a first draft of the proposed changes – for further review.
- Is due to develop outline suggestions to be shared round the group prior to their discussion at WIRG at its meeting on the 13th of March.
- Has agreed that the out-put of this group will include updates to the data standards, the development of guidance materials and also the promotion of the changes and importance of this element of the workforce.

8.4.2.1 IAPT Supporting Links/Documents:

- **NHS Improving Access to Psychological Therapies (IAPT) dedicated website and workforce pages:** http://www.iapt.nhs.uk/workforce/
- **DH (2012) IAPT three-year report, The first million patients**
  - http://www.iapt.nhs.uk/silo/files/iapt-3-year-report.pdf
- **IAPT Programme, DH (2012) Improving Access to Psychological Therapies, Guidance for Commissioning IAPT Training 2012/13, Revised July 2012**
  - http://www.iapt.nhs.uk/silo/files/guidance-for-commissioning-iapt-training-201213.pdf
- **HSCIC (2012) Improving Access to Psychological Therapies Dataset**
  - http://www.hscic.gov.uk/iapt
- **NHS Careers, Psychological Wellbeing Practitioner**
  - http://www.nhscareers.nhs.uk/explore-by-career/psychological-therapies/careers-in-psychological-therapies/psychological-wellbeing-practitioner/
- **NHS Careers, High Intensity Therapist**
  - http://www.nhscareers.nhs.uk/explore-by-career/psychological-therapies/careers-in-psychological-therapies/high-intensity-therapist/

8.4.3 Section A: (Columns A-D)

Diagram 6: Workforce Demand Template: Tab 3. CP Non-medical - Section A

Section A

Staffing Categories			Occupation Code Guide
Total Non-Medical and Dental Staff			
	Total Clinical Staff		
	Total Non-Clinical Staff		
Clinical		**Registered Nursing, Midwifery and Health visiting staff**	
		Acute, Elderly and General	N0A, N1A, N6A, N7A, NAA, NCA
		Community Services	N0H, N1H, N3H, N4H, N5H, N6H, N7H, NAH, NCH, NEH
		Community Psychiatry	N0D, N4D, N5D, N6D, N7D, NAD, NCD
		Community Learning Disabilities	N0F, N4F, N5F, N6F, N7F, NAF, NCF
		Maternity/Neonatal Services (including SCBUs)	N0C, N0L, N1C, N1L, N2C, N2L, N6C, N6L, N7C, N7L, NAC, NAL, NCC, NCL
		Paediatric Nursing	N0B, N1B, N6B, N7B, NAB, NCB
		Other Psychiatry	N0E, N6E, N7E, NAE, NCE
		Other Learning Disabilities	N0G, N6G, N7G, NAG, NCG
		School Nursing	N0K, N6K, N7K, NAK, NBK, NCK
		Any Other Nursing	N0J, N1J, N2J, N6J, N7J, NAJ, NCJ
	Specific Roles	From the above of which:	
		Registered Midwives	N2C, N2J, N2L
		Neonatal Nurses	N0L, N1L, N6L, N7L, NAL, NCL
		Registered Health Visitors	N3H
		District Nurses	N4D, N4F, N4H, N5D, N5F, N5H
		School Nurses	NBK
		Qualified Scientific, Therapeutic and Technical Staff	
		Allied Health Professionals	
		Art/ Music/ Drama therapy	S0H, S1H, S6H, SAH
		Chiropody / Podiatry	S0A, S1A, S4A, S7A, SAA
		Dietetics	S0B, S1B, SAB
		Occupational Therapy	S0C, S1C, S4C, S6C, S7C, SAC
		Orthoptics / Optics	S0D, S1D, S2D, S4D, S7D, SAD
		Physiotherapy	S0E, S1E, S6E, S7E, SAE
		Radiography (Diagnostic)	S0F, S1F, S7F, SAF
		Radiography (Therapeutic)	S0G, S1G, SAG
		Speech and Language Therapy	S0J, S1J, S6J, S7J, SAJ
		Any Other AHPs	
		Other Scientific, Therapeutic and Technical Staff	
		Clinical Psychology	S0L, S2L, S4L, SAL
		Dental	S0R, S1R, S4R, S7R, SAR
		Multi-therapies	S0K, S1K, S6K, SAK
		Operating Theatre's	S0T, S4T, SAT
		Pharmacy	S0P, S2P, S3P, S4P, SAP
		Psychotherapy	S0M, S1M, S2M, SAM
		Social Services	S0U, S1U, S6U, S7U, SAU
		Any Other ST&T Staff	
	Specific Roles	From the above of which:	
		*Operating Department Practitioners (ODP's)	
		Pharmacists	S0P, S2P, S3P, SAP
		Pharmacy Technicians	S4P
		****Qualified Healthcare Scientists**	
		*****Informatics**	
		Physics & Engineering	
		Life Sciences	
		Physiological Sciences	
		Qualified Ambulance Service Staff	
		Ambulance Paramedic	ABA
		Ambulance Technician	AEA
		Any Other Qualified Ambulance Service Staff	A0A, AAA
		Support to Clinical staff	
		Support to Nursing	G2D, G3D, H1A, H1B, H1C, H1D, H1E, H1F, H2A, H2B, H2C, H2D, H2E, H2F, N8A, N8B, N8C, N8E, N8G, N8H, N8K, N8L, N9A, N9B, N9C, N9D, N9E, N9F, N9G, N9H, N9J, N9K, N9L, NFA, NFB, NFC, NFD, NFE, NFF, NFG, NFH, NFK, NFL, P1A, P1D, P1E, P2A, P2B, P2C, P2D, P2E, P3A, P3C, P3D, P3E
		Support to AHPs	S5A, S5B, S5C, S5D, S5E, S5F, S5G, S5H, S5J, S8A, S8B, S8C, S8D, S8E, S8F, S8G, S8J, S9A, S9B, S9C, S9D, S9E, S9F, S9G, S9H, S9J
		Support to ST&T	G2C, G3C, S5K, S5L, S5M, S5P, S5R, S5T, S5U, S5X, S8L, S8M, S8P, S8R, S8T, S8U, S8X, S9K, S9P, S9R, S9T, S9U, S9X
		Support to HCS	**OLD CODES: T7*, T8*, TB* / NEW CODES U5*-U9***
		Support to Qualified Ambulance Staff	A2A, AGA, G2E, G3E, H1S, H2S
		Any Other Clinical Support staff	
		Any Other Clinical	
Non-Clinical		**NHS Infrastructure Support**	
		Managers & senior managers	G0C, G0D, G0E, G1C, G1D, G1E
		Admin and Estates	G2A, G2B, G3B, H1R, H2R
		Any Other NHS Infrastructure Support Staff	
		Any Other Non-Clinical	Z1A, Z1B, Z1C, Z1D, Z1E, Z2E, Z2F
Additional	**Additional Specialist Groups (should be included in above where relevant - will not be double counted in totals)**		
		******IAPT**	
		of which high intensity	
		of which low intensity	

To Note:

***Groups without specific or changing national occupation code standards**

****Healthcare Science (HCS)** - The values for recording HCS staff have recently changed and all organisations that employ Healthcare Science staff will need to audit and amend their records on ESR accordingly. Please consult the accompanying Technical Guidance to this file and the followin links:

More detail regarding the changes to the ESR in response to these updates to the data standard are available in UN1828, available through ESR Kbase.

Healthcare Science Indicative Job Title Coding Guidance_Final_V1 [104kb]

A Guide to Healthcare Science Workforce Classifications used in ESR [604kb]

*****HCS Informatics** - The HCS sub-group of Informatics highlighted within this planning template has not yet been embedded into the proposed new values for recording HCS staff (as above). Their inclusion, however, is a reflection of the importance of this workforce going forward, highlights politcal interest in this area and further guidance regarding the staff in post and demand to be included in this group can be found in the accompanying

******IAPT** - No specific national occupation codes exist to capture Improving Access to Psychological Therapies roles.

Column A: Provides an indication of whether the staffing categories listed in Column C are classified as; Clinical / Non-clinical staff or Additional (specialist groups)

Column B: Highlights those rows which relate to specific clinical roles which due to either their specialist commissioning route or high political interest require their own forecast demand projection as well as being included in the composition of their relative aggregate staffing category; i.e.

- **Relative staffing category:** Maternity/Neonatal Services (including SCBU's)
- **Specific Role:** Registered Midwives

Column C: Highlights aggregate row staffing categories and provides the names of their corresponding sub-areas and specific roles

Column D: Provides a guide to the national standard occupation codes that should contribute to the composition of a specific staffing category. These codes should be used as a guide for Providers when completing the Baseline Staff in Post position (Column F) as at Mar-14. Future forecast demand for Mar-14 through to Mar-19 (Columns H through to M) should then reflect the projected in year demand positions against those staffing categories

To note:

i. Rows highlighted in grey represent an automatically calculated/aggregate row or an "any other"

ii. Rows where no occupation codes are provided against the staffing category represent either an automatically calculated/aggregate row or an "any other" row to capture any other staff (down to local interpretation or due to inadequate coding/data quality issues) that cannot be placed within one of the other named rows

iii. ***** Star symbols mark those staffing categories without specific or changing national occupation code standards i.e. Healthcare Scientists and IAPT (Improving Access to Psychological Therapies) – where this is the case further notes are provided towards the bottom of the CP Non-medical template

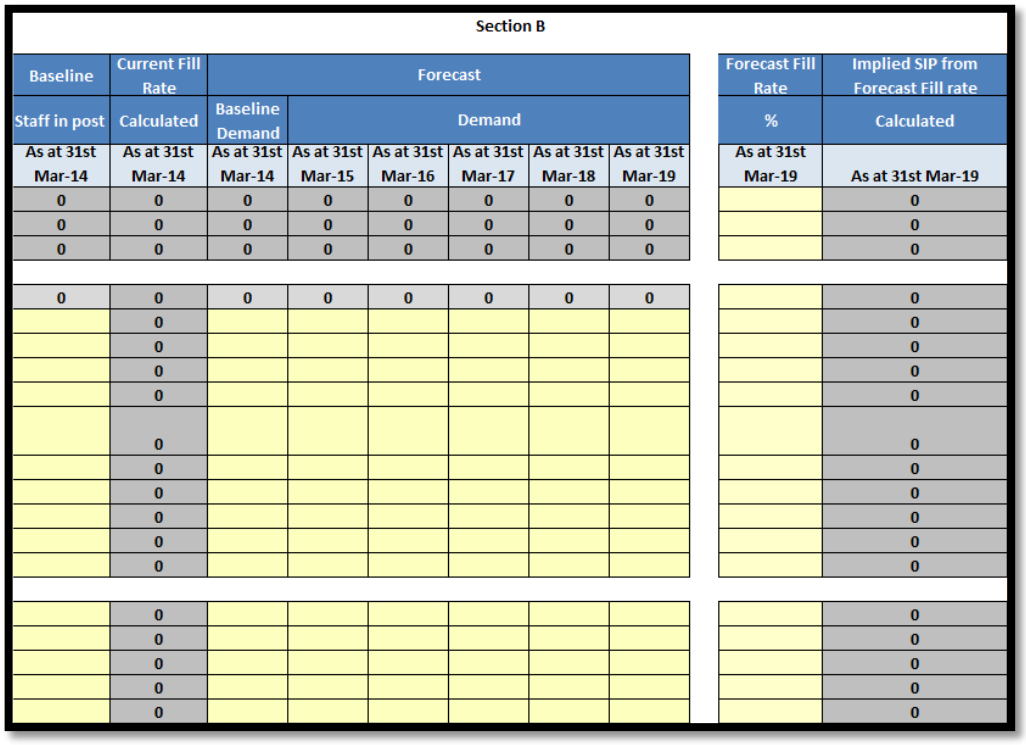
iv. Staffing categories have been aligned as closely as possible to the HSCIC standard published categories

v. A fuller occupation code list is available in tab 7 of the Collective Forecast Demand Template. This provides a map as to which occupation codes relate to which staffing category and/or specific role within the CP Non-medical template, Tab 3. Against these are mapped the high level HSCIC standard published categories

vi. Where an occupation code is coloured red i.e. **N7J -** this highlights either a redundant or old occupation code that is no longer available in the Electronic Staff Record (ESR) against which to record a new staff position. However some roles may still be recorded as such in ESR where they were added onto the code when it was still "open" – this presents a data quality issue where staff recorded against these codes should have been moved, at source, to an updated, new or alternative code

8.4.3 Section B: (Columns F-P)

Diagram 7: Workforce Demand Template: Tab 3. CP Non-medical - Section B



Section B

Baseline	Current Fill Rate	Forecast						Forecast Fill Rate	Implied SIP from Forecast Fill rate
Staff in post	Calculated	Baseline Demand	Demand					%	Calculated
As at 31st Mar-14	As at 31st Mar-14	As at 31st Mar-14	As at 31st Mar-15	As at 31st Mar-16	As at 31st Mar-17	As at 31st Mar-18	As at 31st Mar-19	As at 31st Mar-19	As at 31st Mar-19
0	0	0	0	0	0	0	0		0
0	0	0	0	0	0	0	0		0
0	0	0	0	0	0	0	0		0
0	0	0	0	0	0	0	0		0
	0								0
	0								0
	0								0
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	0								0
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	0								0
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	0								0
	0								0
	0								0
	0								0

Against each of the staffing categories outlined in Section A of the CP Non-medical template, Tab 3, the following figures are required in Section B (Columns F through to P):

Column F: Baseline Staff in Post - Full time equivalent (FTE) staff in post, directly employed by the Provider organisation as at Mar-14 (exclusive of; agency, bank, locum, vacant posts or hosted staff)

Column G: Current Fill Rate – **AUTOMATICALLY CALCULATED NO INPUT NEEDED** – this is calculated as the Baseline Staff in Post (Column F) as a proportion of Baseline Demand as at Mar-14 (Column H).

Column H: Baseline Demand - The required workforce establishment as at Mar-14 (reflective of the replacement for leavers plus predicted change in capacity required plus vacant posts)

Columns I-M: Forecast Demand – The in-year forecast required workforce establishment as at Mar-15 through to Mar-19 (reflective of the replacement for leavers plus predicted change in capacity required plus vacant posts)

Column O: Forecast Fill Rate % - This column should represent the percentage (%) of Forecast Demand as at Mar-19 that will be filled by Staff in Post FTE at this point in time. i.e.

- Forecast Demand as at Mar-14 for Chiropodists/Podiatrists = 300 inputted
- Forecast Fill Rate % = 90% inputted

The above would suggest that 90% or 270 Chiropodist/Podiatrist are in post with the remainder expected to be a composition of; vacant posts across substantive and agency, bank and locum staff.

Column P: Implied SIP from Forecast Fill Rate - AUTOMATICALLY CALCULATED NO INPUT NEEDED – this is calculated (for each row) as; Forecast demand figure inputted as at Mar-15 minus (Forecast demand figure inputted as at Mar-15 multiplied by the percentage (%) Forecast Fill Rate % figure inputted) i.e.

- Forecast Demand as at Mar-14 for Chiropodists/Podiatrists = 300 inputted
- Forecast Fill Rate % = 10% inputted
- **Implied SIP from Forecast Fill Rate = 300 – (300 X 10%) = 270 Staff in Post FTE**

To note:

i. Cells/Rows highlighted in grey represent an automatically calculated/aggregate cell/row or a cell/row which automatically pulls a data extract from an alternative worksheet in the Workforce Forecast Demand Template i.e. Healthcare Science totals are pulled through from the CP HCS template, Tab 4.

ii. Cells/Rows highlighted in yellow represent a required input in terms of; FTE (Column F), Demand (Columns I-M) or percentage (%) (Column O)

8.4.4 Section C: (Columns R-AD)

Diagram 8: Workforce Demand Template: Tab 3. CP Non-medical - Section C

Section C											
Forecast Demand Change						Forecast Demand % Change					
14 to 15	15 to 16	16 to 17	17 to 18	18 to 19	14 to 19	14 to 15	15 to 16	16 to 17	17 to 18	18 to 19	14 to 19
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-
0	0	0	0	0	0	-	-	-	-	-	-

Against each of the staffing categories outlined in Section A and figures inputted into Section B of the CP Non-medical template, Tab 3, the following figures are automatically calculated in Section C (Columns R through to AD):

Columns R-W: Forecast Change - <u>AUTOMATICALLY CALCULATED NO INPUT NEEDED</u> – Columns R-V automatically calculate the year on year change in demand numbers entered in Section B. Column W automatically calculates the change in demand numbers entered in Section B from as at Mar-14 to as at Mar-19

Columns Y-AD: Forecast % Change - <u>AUTOMATICALLY CALCULATED NO INPUT NEEDED</u> – Columns Y-AC automatically calculate the year on year percentage change in demand numbers entered in Section B. Column AD automatically calculates the change in demand numbers entered in Section B from as at Mar-14 to as at Mar-19

To note:

i. The forecast demand change and percentage change highlighted across these rows and columns, upon entering demand figures in Section B, can be used as a sense check to validate any erroneous figures that may present themselves to the user

8.4.5 Section D: (Column AF)

Diagram 9: Workforce Demand Template: Tab 3. CP Non-medical - Section D

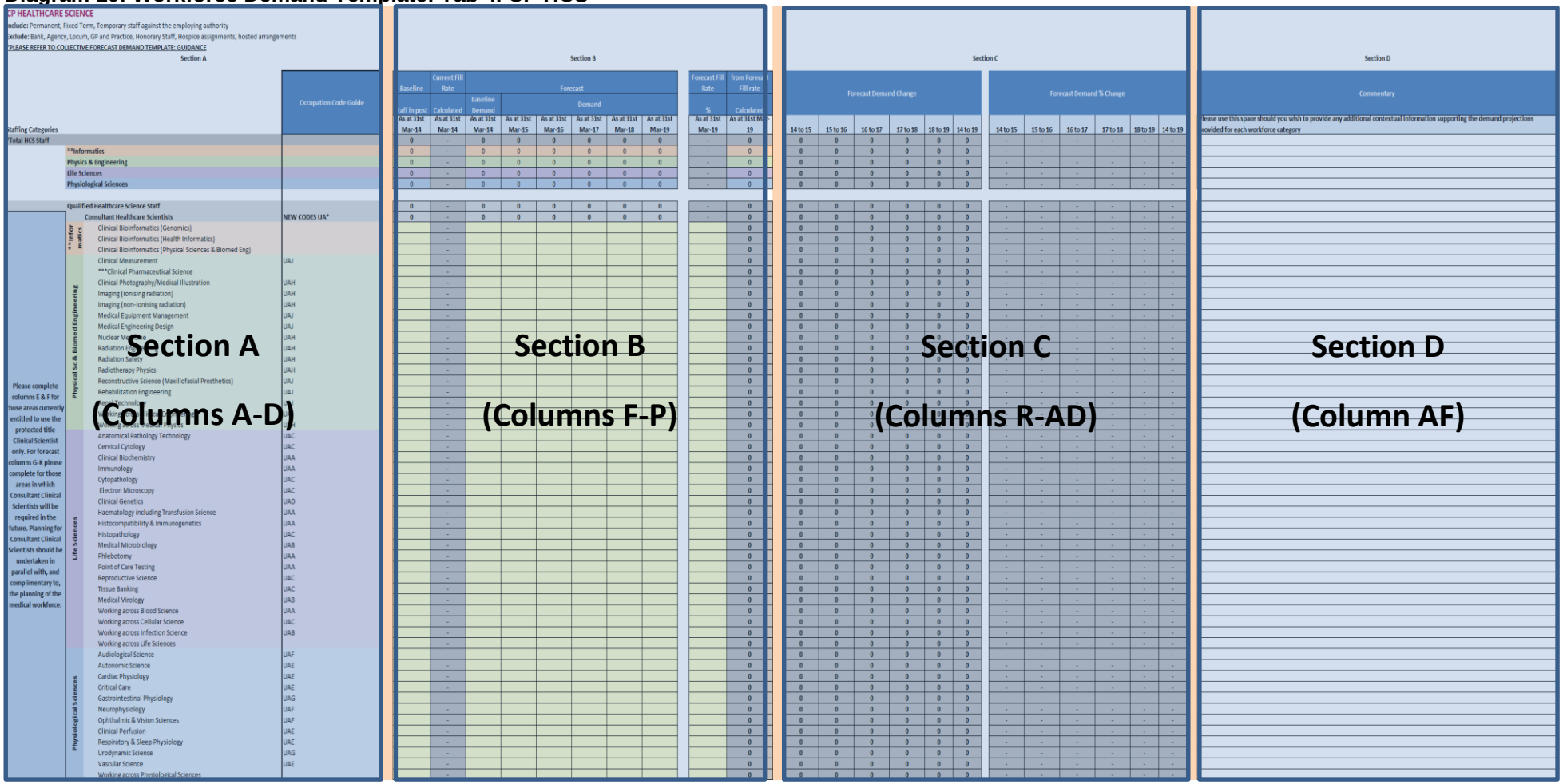
Section D
Commentary
Please use this space should you wish to provide any additional contextual information supporting the demand projections provided for each workforce category

Column AF: Commentary – This space should be utilised by the LETB user should they wish to provide any additional contextual/qualitative information supporting the demand projections presented in Section B i.e.

- A significant workforce reduction in the pharmacy staffing category in years 4 and 5 of the plan (i.e. as at Mar-18 and as at Mar-19) may be explained due to a particular large acute moving this service into a community setting

8.5 CP (Core Provider) Healthcare Science Tab

Diagram 10: Workforce Demand Template: Tab 4. CP HCS



8.5.1 Planning the Healthcare Science (HCS) Workforce

Informed by: HSCIC, Dr Richard Billings (Professional Adviser Healthcare Science, HEE) and Modernising Scientific Careers (MSC) Team, HEE

Planning for HCS is being undertaken as part of the mainstream HENW and HEE process. The following offers some rationale, highlights specific considerations and provides a list of Scientific Network Leads who can provide support in identifying local Senior HCS Service Leads, with whom workforce planners should be in conversation.

8.5.1.1 Background

The HCS workforce number is 48,000 headcount, of which around 32,000 are qualified at undergraduate, masters, or doctoral level. The remaining approximately 16,000 support staff attains a variety of different vocational qualifications up to and including Foundation Degree level. This 48,000 or so strong workforce occupies posts in around 50 different scientific specialisms. The majority of these posts are discipline-specific, however, some of the support roles do span specialisms within a theme, and some span across themes – and these cross-discipline roles are likely to become more prevalent in the future.

The entire HCS workforce makes up only about 5% of the total NHS staff, but they influence over 80% of all diagnostic decisions. Given that in some HCS specialisms the national workforce may only number a few hundred, it can be seen that quite minor variations in workforce capacity may jeopardise patient pathways reliant on those specialist services.

Not all of the specialist services within HCS are necessarily represented in any great number in every Trust - so whilst it is important to retain local decision-making in the planning and shaping of services, 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 is adopted for HCS, which is coordinated by HE West Midlands (HEWM) on behalf of the other LETBs.

The education and training in healthcare science (rather like medicine) is specific to each specialism – at least for Career Framework (CF) level 5 and above. There is no ‘generic’ healthcare science qualification.

There is also no assumption in HCS that all trainees (at whatever level) will gradually progress through to Consultant Healthcare Scientist level (although the MSC framework does make this a theoretical possibility). Each level (Assistant/Associate, Practitioner, Scientist, and Consultant Scientist) has a career aim and job role in its own right, with its own education and training requirement.

Planning the HCS workforce therefore needs to be undertaken not only on a specialism basis, but also on the basis of the career framework level of the role – and this is reflected in the proposed templates for scoping education commissions and also for the 5-year workforce forecast.

The scientific specialisms listed in the forecast demand template have been grouped according to the scientific divisions in which they sit, so as to try and indicate which service managers, planners may need to liaise with.

8.5.1.2 Workforce Planning Drivers

Recognising the contribution that healthcare science makes to improved quality and patient outcomes - including clinical effectiveness, patient experience and safety, the headline key strategic drivers for workforce planning in healthcare science - to promote conversations between planners, commissioners, and providers include:

- The provision of seven-day services and the skill mix needed to provide safe and effective care (scientific and diagnostic services are seen as key as outlined in Bruce Keogh’s forum report).

- The potential for science and new technology to transform outcomes.
- The move of some services from secondary to primary/community care – and diagnostics delivered nearer to the patient.
- The provision of support for patients (particularly with long-term conditions) to self-manage.
- New models of urgent and emergency care.
- The transparency agenda - and the contribution HCS can make in the interpretation of data for patients.

To take account of these drivers, some are non-exhaustively exampled by the following considerations:

1. **Changes to service delivery that will alter the workforce requirements in relation to:**
    - The place where service is delivered – this may be in a hospital-based or laboratory setting, but increasingly for some fields (and potentially more so in the future) services may be delivered in or near to a patient's home setting e.g. in point of care testing (POCT), tele-medicine etc…
    - The workforce numbers required to deliver services that are under pressure from the expanding needs of e.g. 24/7 access to diagnostics, and from the increase in diagnostic referrals due to an ageing population, from the increasing use of specific techniques – for example Cardiac Ultrasound and Rhythm Management, EEG Telemetry, Vascular Ultrasound, and the investigation and treatment of Fertility Disorders etc…
    - The workforce need of non-NHS providers of NHS services such as NHS Blood Transfusion service, and Audiology, Pathology, and Fertility services in the private sector etc…

2. **Impact of the different knowledge and skill requirements of new scientific developments and technical innovations** for example in Clinical Bioinformatics requiring Healthcare Scientists in the fast expanding fields of Genomics, 3D imaging, and the Virtual Physiological Human etc. Planning needs to also take account of these new and emerging areas of HCS, even though these are still to be reflected in the new ESR occupation codes. Additional guidance on workforce roles in these areas has been provided.

3. **The impact on workforce profiles of the introduction of new ways of working including:**
    - Increasing the number of HCS Associates and HCS Assistants – the introduction of Apprenticeship and Higher Apprenticeship schemes, the envisioned availability of voluntary registration, and the improvements in education and training, have facilitated the greater use of these support staff in the workforce skill-mix.
    - Creating new roles across HCS specialisms or across HCS themes to produce efficiencies in bringing diagnostics closer to a patient's home setting.

4. **The potential role of Consultant Clinical Scientists when planning for the consultant medical workforce** e.g. in Microbiology, Clinical Biochemistry, Immunology, Genetics, Reproductive Science, Histocompatibility & Immunogenetics, and Electrophysiology of Vision – in which roles traditionally occupied by medical consultants have been successfully filled by Clinical Scientists. The HSST programme has been designed to provide the workforce with high quality Clinical Scientists able to operate at consultant level. In addition, in Radiopharmacy and other areas of technical pharmacy (Aseptics, Quality Assurance and Manufacturing) it is becoming increasingly difficult to recruit to Pharmacist posts. Many centres are recruiting Clinical Scientists to fill these posts and the new STP in Clinical Pharmaceutical Science has been designed to provide an education and training framework to meet this workforce need.

5. **The impact of UK or EU policy directives and imperatives on workforce numbers in specific areas of service** - e.g. Medical Physics Expert (MPE) and Radiotherapy Services.
    - The role of the MPE is to ensure the safety of patients undergoing diagnosis or treatment using X-rays or Radioactive Material. They are currently required by law, based on an EU Directive (the European Basic Safety Standard) currently being revised at an EU level. The MPE project in MSC has established a framework for education and training and national

recognition of the MPE as part of the MSC Accredited Scientific Practice (ASP) framework. MPE will be adopted into law as and when the legislation to support the revised BSS is brought into UK law by 2018.

- Radiotherapy services will continue to expand to meet the growth in cancer services. Seven-day Radiotherapy services will become the norm, requiring an expansion of the Clinical Scientist and HCS Practitioner workforce in Medical Physics. Allied to this, with improved cancer survival rates, advances in reconstructive surgery, and the use of 3D imaging and 3D construction techniques, the maxillofacial prosthetics workforce is also under pressure to expand and the STP in Reconstructive Science is designed to address this specific workforce need.
- Medical Physics is one of the areas on the Migration Advisory Council (MAC) shortage occupation register. In order to facilitate a boost in workforce numbers, MSC has defined accelerated Graduate Diploma programmes in Radiotherapy Physics, Nuclear Medicine, and Radiation Physics.

6. **A review of technical cardiology services** is currently in train, and its recommendations for workforce transformation are due to report March 2014.

8.5.1.3 Informatics

The HCS sub-group of Informatics highlighted within the forecast demand template has not yet been embedded into the proposed new values for recording HCS staff (as above). Their inclusion, however, is a reflection of the importance of this workforce going forward, highlights political interest in this area and the guidance following provides further information regarding their role in different disciplines:

The Role of Bioinformatics in Clinical Laboratory Genetics and Genomics

Bioinformatics as a discipline has a broad range of functions and the application of bioinformatics in clinical practice and in particular to diagnostic testing is a relatively new and growing specialist area within Healthcare Science. The role of the Genetics Clinical Scientist with respect to bioinformatics includes the ability to be able to interpret and integrate evidence from bio-informatic tools and resources into the interpretation and reporting of genetic test results that impact directly on patients. They also need to know the relevance and limitations of data to these results, the influence of user interfaces on results and the limitation of methods used to validate data submissions. Scientists oversee and ensure the clinical validity and safety of applications and play an effective role in the development of bioinformatic strategies for the introduction of testing technologies to the clinical setting to influence and improve current and future practice. Increasingly they will need to understand the bioinformatic requirements of a new clinical service and advise on the strategy to be used for its safe and effective introduction.

Bioinformatics combines molecular biology, genomics, computational biology and information technology (IT) and is key to the effective adoption in the NHS of new technology such as next generation sequencing (NGS). This has been recognised in both the House of Lords Genomic Medicine report in 2009 and the HGSG report of 2012.

The essential roles of a Clinical Bioinformatician within a genetics / molecular pathology laboratory will include:

1. **Improved data handling**
   a. Automating the transfer of raw data from gene sequencing machines into local data storage and ultimately appropriately governed “cloud” based storage;
   b. Development and integration of IT workflows (including with LIMS) across whole laboratory, directorate, NHS systems, and central data repositories;
2. **Improved data processing and analysis**
   a. Automating effective accurate alignment of the “reads” from multiple patients samples against known reference genomes;
   b. Appraisal, validation and implementation of software for detecting and annotating sequence variants or potential mutations;

c. Mapping and documentation of sequence variants against known inherited and somatic mutations in publicly available databases; filtering massive datasets;
d. Developing seamless integration of highly filtered outputs from these software packages into the WMRGL patient database;
e. Creating algorithms and analysis workflows for whole exome sequences;

3. **Improved clinical interpretation**
   a. Adoption (and development) of novel algorithms to further maximise future use of NGS once the technology has fully matured e.g. ultimately for whole genome copy number and chromosomal rearrangement analysis for all developmental disorder and cancer referrals and integration with other biological information (towards "systems biology");
   b. Integration of data with other clinical data systems such as electronic health records, global variant databases and therapy protocols;
   c. Human and IT network links with university bioinformatics resources and the proposed Institute of Biomedical Informatics (HGSG report);
4. **Conforming with legislation**
   a. Understanding, implementing and monitoring future legislation needs for retention and storage of whole genome patient datasets;
5. **Research**
   a. Contributing to and leading research projects requiring bioinformatics input;
   b. Data mining of large datasets;
6. **Training**
   a. Training and support for clinical scientists and clinicians in the genetics service;
   b. Contributing to the training of the next generation of NHS staff.

The Role of Bioinformatics in Physical Sciences and Clinical Engineering

The role of clinical scientist in bioinformatics and Information Communication Technology (ICT) in Medical Physics and Clinical Engineering includes the development of novel image and signal processing applications, e.g. methods of non-linear image registration. They are involved in mathematical modelling of systems in medicine, e.g. virtual physiological human, radiation dose distributions, modelling specific disease systems. Scientists oversee the interconnection of critical patient safety computer systems, e.g. networks planning, imaging, controlling and verifying radiotherapy treatments. They are involved in synthesising large datasets to develop improved indicators of disease and response to treatment, e.g. ways of identifying deteriorating conditions in patients.

The Role of Bioinformatics in Health Informatics

Health Informatics Science focuses on:

1. **Safety** (avoidance of adverse incidents)
2. **Effectiveness** (evidence-base treatment and care)
3. **Patient-centred approach** (recognition of the responsibility of an individual and enabling efficient access to quality information)
4. **Efficiency** (reduction in delays in care and avoidance of waste (underuse/overuse) of resources (including money, people, equipment, supplies and energy)
5. **Equity** (reduces variation in care provision based on individuals' traits)

The role of the Bioinformatics - Health Informatics Scientists may or may not cover all the areas, depending of the organisational need. However, they will be proficient in:

- Interpretation, integration and reporting of a range of data (highly complex, both structured and unstructured), intelligence and evidence from large datasets (Big data) that an organisation /system produces;
- Explaining the significance of data in a way that can be easily understood by others (patients, clinicians and managers);
- Data mining, handling and processing;
- Advising peers and colleagues on best practice in:
  - data and information security
  - patient confidentiality

- record sharing
- information sharing with patients/clients
- records access by patients and carers

- Reviewing opportunities for the application of tele-health or tele-medicine in the host organisation.

In addition, they will contribute to (and lead): research projects requiring bioinformatics – health informatics input and training and support of clinical scientists and clinicians in health informatics.

8.5.1.4 National Occupation Code Changes

It is known amongst information and professional colleagues that this workforce was not truly reflective of the current reality – mainly because of inadequate coding availability in the National Workforce Dataset (NWD) and hence data quality issues arising from Electronic Staff Record (ESR) extracted data.

It was initially found that only 16 of the 40+ scientific specialisms were available to be coded satisfactorily in ESR and, as such, a national level project was undertaken, led by the HSCIC, to modify the NWD and hence the ESR to allow coding of the whole HCS workforce – the aim going forward is to work to include HCS informatics in future iterations.

The values for Healthcare Science (HCS) have recently changed and all organisations that employ Healthcare Science staff will need to audit and amend their records on ESR accordingly. These new HCS classifications were introduced into ESR in release 21 at the end of December 2013 and the old values will no longer be available for selection. The new classifications should be applied to existing Positions as soon as possible and with effect from 1st January 2014. The HSCIC will be monitoring the uptake of the new coding scheme from March 2014 until it is fully implemented.
More detail regarding the changes to the ESR in response to these updates to the data standard are available in UN1828, available through ESR Kbase.
Two **guidance documents** have been published to help with this process;
1) The **Healthcare Science Indicative Job Title Guidance** document. This contains a list of indicative Job Titles which reflect roles undertaken in Healthcare Science and the recommended Job Role, Area of Work and Occupation Code values.

Healthcare Science Indicative Job Title Coding Guidance_Final_V1 [104kb]

2) The **Guide to Healthcare Science Workforce Classifications used in ESR.** This contains guidance on the usage of Staff Group, Job Role, Area of Work and Occupation Code values for Healthcare Science staff as determined by the National Workforce Data Set (NWD) and made available in the Electronic Staff Record (ESR) and other systems.

A Guide to Healthcare Science Workforce Classifications used in ESR [604kb]

These guidance documents are intended to be 'living' documents which will be reviewed and updated as required. The HSCIC welcomes any comments, questions and suggestions for additions to these documents. Please get in touch with the HSCIC Workforce team via enquiries@hscic.gov.uk quoting 'Healthcare Science Guidance documents' in your subject line.

8.5.1.5 HCS Supporting Documents:

i. **National Minimum Dataset (NMD) guidance documents:**
http://www.hscic.gov.uk/article/2267/National-Workforce-Data-Set-NWD-guidance-documents
ii. **Electronic Staff Record (ESR) K-Base:**
https://www.electronicstaffrecord.nhs.uk/kbase/login/5303/afile_enter/
iii. **HSCIC, Workforce Census, 2012:**
http://www.hscic.gov.uk/searchcatalogue?topics=2%2fWorkforce%2fStaff+numbers%2fAll+NHS+staff&infotype=0%2fOfficial+statistics&sort=Relevance&size=10&page=2#top
iv. **Modernising Scientific Careers programme:**
http://www.cmgs.org/Modernising%20Scientific%20Careers/MSC%20OVERVIEW%20SHEET%20FINAL%2023%20NOV.pdf

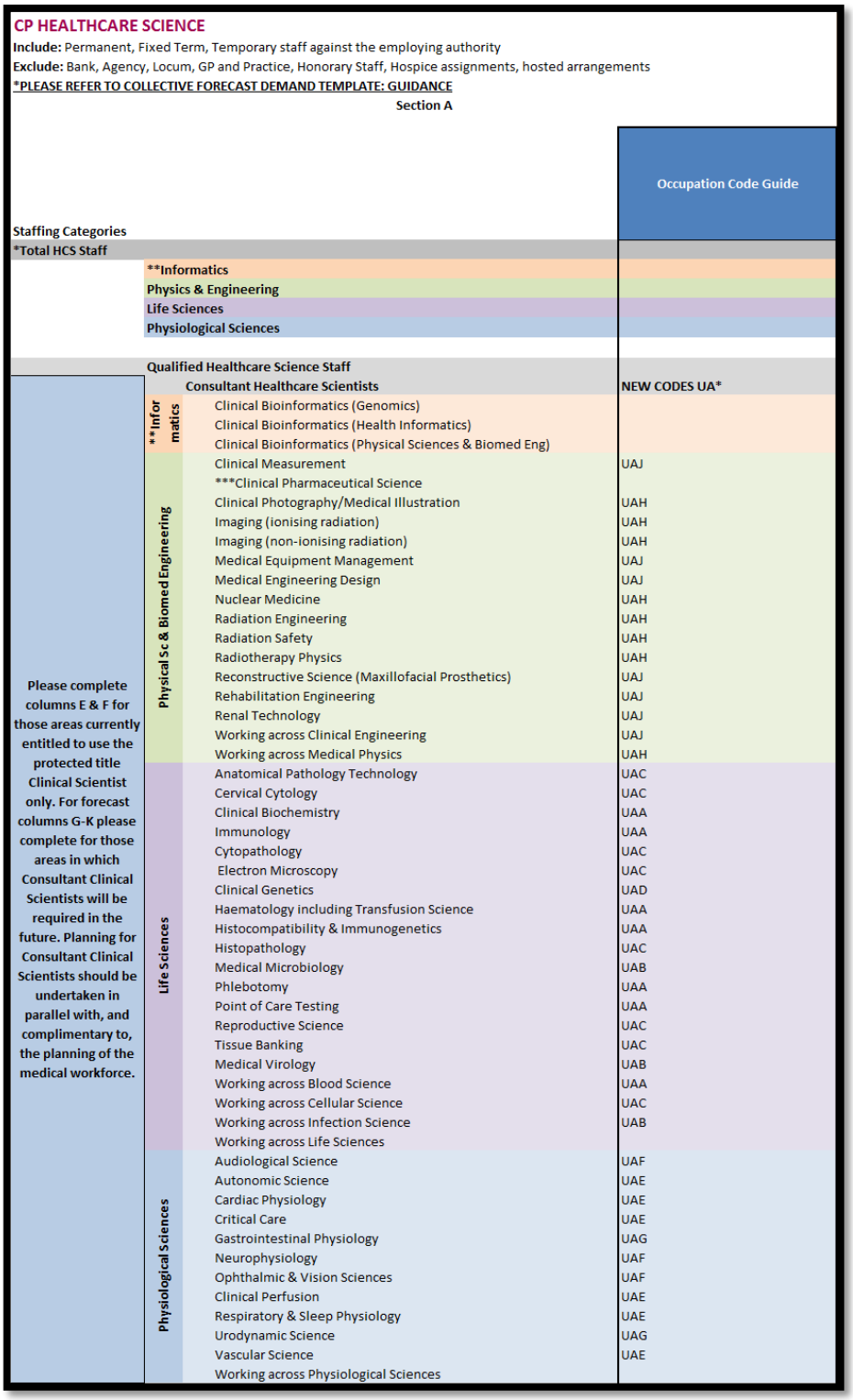
v. **The Delivery of 21st Century Services – The Implications for the Evolution of the Healthcare Science Workforce:** http://hee.nhs.uk/2014/02/07/the-delivery-of-21st-century-services-the-implications-for-the-evolution-of-the-healthcare-science-workforce/

vi. **Higher Specialist Scientific Training scheme:** http://hee.nhs.uk/2014/01/24/hee-publishes-modernising-scientific-careers-scaling-the-heights-report/

vii. **Workforce need in Radiotherapy Physics:** https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213151/Radiotherapy-Services-in-England-2012.pdf

8.5.2 Section A: (Columns A-D)

Diagram 11: Workforce Demand Template: Tab 4. CP HCS - Section A



CP HEALTHCARE SCIENCE

Include: Permanent, Fixed Term, Temporary staff against the employing authority

Exclude: Bank, Agency, Locum, GP and Practice, Honorary Staff, Hospice assignments, hosted arrangements

*PLEASE REFER TO COLLECTIVE FORECAST DEMAND TEMPLATE: GUIDANCE

Section A

Staffing Categories			Occupation Code Guide
*Total HCS Staff			
	**Informatics		
	Physics & Engineering		
	Life Sciences		
	Physiological Sciences		
	Qualified Healthcare Science Staff		
Please complete columns E & F for those areas currently entitled to use the protected title Clinical Scientist only. For forecast columns G-K please complete for those areas in which Consultant Clinical Scientists will be required in the future. Planning for Consultant Clinical Scientists should be undertaken in parallel with, and complimentary to, the planning of the medical workforce.	Consultant Healthcare Scientists		NEW CODES UA*
	**Informatics	Clinical Bioinformatics (Genomics)	
		Clinical Bioinformatics (Health Informatics)	
		Clinical Bioinformatics (Physical Sciences & Biomed Eng)	
	Physical Sc & Biomed Engineering	Clinical Measurement	UAJ
		***Clinical Pharmaceutical Science	
		Clinical Photography/Medical Illustration	UAH
		Imaging (ionising radiation)	UAH
		Imaging (non-ionising radiation)	UAH
		Medical Equipment Management	UAJ
		Medical Engineering Design	UAJ
		Nuclear Medicine	UAH
		Radiation Engineering	UAH
		Radiation Safety	UAH
		Radiotherapy Physics	UAH
		Reconstructive Science (Maxillofacial Prosthetics)	UAJ
		Rehabilitation Engineering	UAJ
		Renal Technology	UAJ
		Working across Clinical Engineering	UAJ
		Working across Medical Physics	UAH
	Life Sciences	Anatomical Pathology Technology	UAC
		Cervical Cytology	UAC
		Clinical Biochemistry	UAA
		Immunology	UAA
		Cytopathology	UAC
		Electron Microscopy	UAC
		Clinical Genetics	UAD
		Haematology including Transfusion Science	UAA
		Histocompatibility & Immunogenetics	UAA
		Histopathology	UAC
		Medical Microbiology	UAB
		Phlebotomy	UAA
		Point of Care Testing	UAA
		Reproductive Science	UAC
		Tissue Banking	UAC
		Medical Virology	UAB
		Working across Blood Science	UAA
		Working across Cellular Science	UAC
		Working across Infection Science	UAB
		Working across Life Sciences	
	Physiological Sciences	Audiological Science	UAF
		Autonomic Science	UAE
		Cardiac Physiology	UAE
		Critical Care	UAE
		Gastrointestinal Physiology	UAG
		Neurophysiology	UAF
		Ophthalmic & Vision Sciences	UAF
		Clinical Perfusion	UAE
		Respiratory & Sleep Physiology	UAE
		Urodynamic Science	UAG
		Vascular Science	UAE
		Working across Physiological Sciences	

Column A: Provides further explanatory text as to the process and means by which the figures to be inputted in Section B should be arrived

Column B: Highlights aggregate row staffing categories and provides the name of those rows which relate to specific HCS divisions i.e. Life Sciences

Column C: Highlights aggregate career framework staffing levels and provides the names of sub areas of work i.e. **Consultant Healthcare Scientist**

Life Sciences

Genetics

Column D: Provides a guide to the national standard occupation codes that should contribute to the composition of a specific staffing category. These codes should be used as a guide for Providers when completing the Baseline Staff in Post position (Column F) as at Mar-14. Future forecast demand for Mar-14 through to Mar-19 (Columns H through to M) should then reflect the projected in year demand positions against those staffing categories

To note:

i. The values for recording HCS staff have recently changed and all organisations that employ Healthcare Science staff will need to audit and amend their records on ESR accordingly.

ii. The HCS sub-group of Informatics highlighted within the forecast demand template has not yet been embedded into the proposed new values for recording HCS staff (as above). Their inclusion, however, is a reflection of the importance of this workforce going forward and highlights politcal interest in this area.

iii. Given the transitional arrangement as current scientist positions are recoded into the new U matrix coding structure (in the case of the Electronic Staff Record), conversations will need to be had in parallel with service managers and scientists at a Trust level to ensure the Baseline Staff in Post (Column F) as at Mar-14 and future forecast demand for Mar-14 through to Mar-19 (Columns H through to M) is most accurately as possible mapped into this new arrangement.

iv. The contact list of Scientific Network leads in each LETB should/can be utilised as a reference source, should anyone require further support.

v. The forecast demand template, HCS tab looks mainly at 4 scientific areas - Pathology (Life Science), Physiology (ECG etc), Physics (Medical Physics & Engineering), and Informatics. It would be advised to contact a senior manager/scientist from those areas who may be able to assist further in terms of data provision.

vi. Colour coding is used to highlight rows relating to a specific divisional area as below:

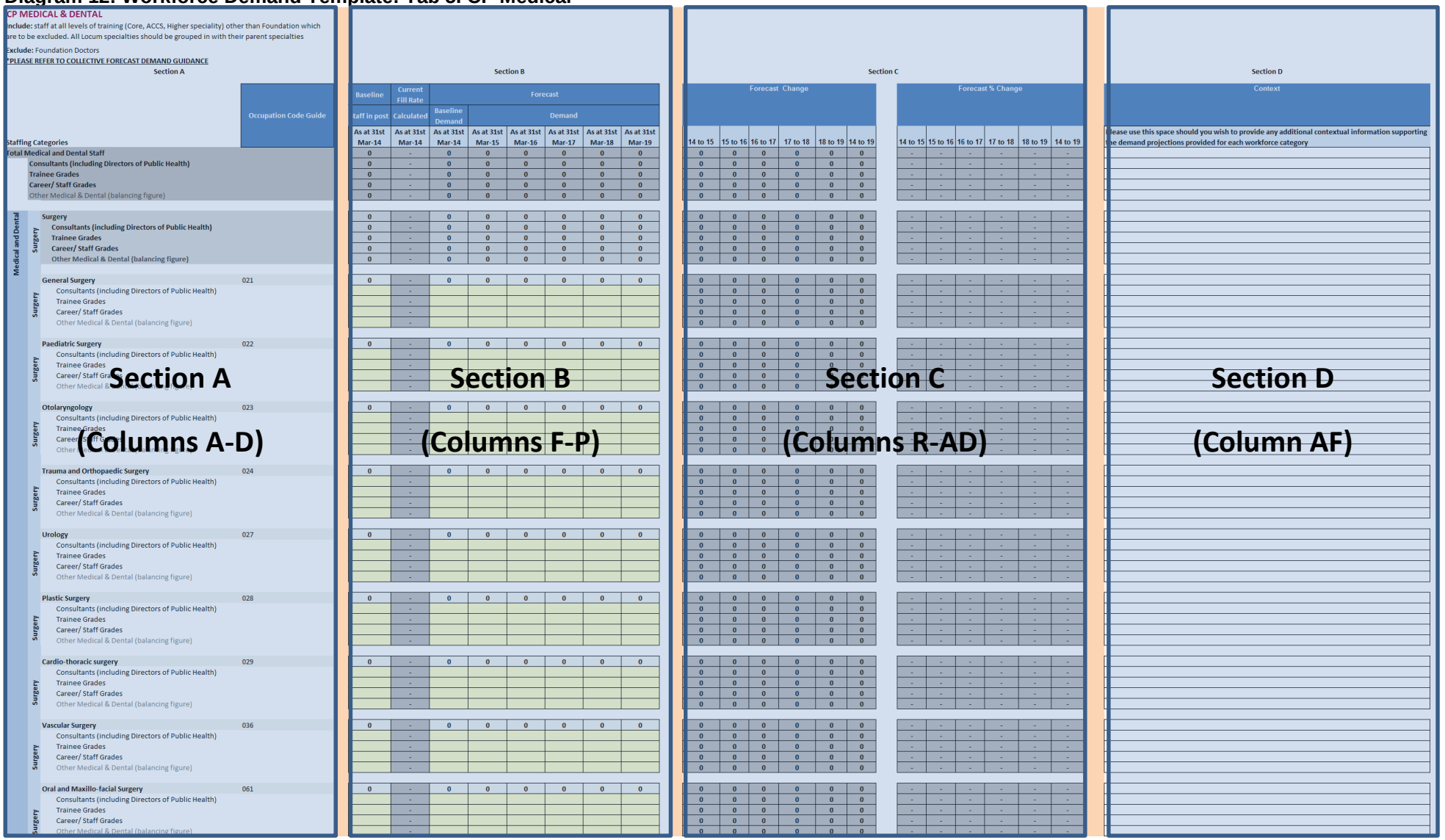
Informatics
Physics & Engineering
Life Sciences
Physiological Sciences

For Completion of Sections; B, C and D please refer to the same guidance provided earlier in this document for the Non-medical tab 4. Please use the hyperlinks below to go directly to these sections:

- **Section B**
- **Section C**
- **Section D**

8.6 CP (Core Provider) Medical Tab

Diagram 12: Workforce Demand Template: Tab 5. CP Medical



8.6.1 Planning the Medical Workforce

Informed by; Medical Workforce Advisory Group (MWAG), John Stock (Workforce Planning and Analysis Lead, HEE) and National Workforce Planners discussion

Determining the appropriate level of medical training posts to meet future demand for medical staff is a complex undertaking that can only be successful when it :

- Weighs the uncertainty that surrounds both supply and demand over the long time span it takes to train medical staff;
- Acknowledges that post graduate doctors in training makes a significant contribution to service and that while in training doctors make a service contribution to specialties other than the one in which they are training;
- Takes account of flows of medical staff to and from the rest of the UK, Europe and the wider world;
- Recognises that the medical workforce is not homogenous and all of the above need to be considered at the level of specialty;
- Takes account of non-NHS service provision for some key specialties.

However the implications for patients and the opportunity costs of over- or under-investment are profound. Training an over-supply in one area (be it in medical staffing, other groups or wider workforce development) risks under-investment in other areas. Hence HEE's investment decisions must seek to balance such risks by basing education commissioning decisions on analysis and evidence.

HEE and LETBs are developing data sources and processes to support planning at Regional and National level. Providers are key to that process of development. It is understood that:

- Individual providers are unlikely to be in a position to forecast accurately long term demand for medical staff;
- Providers may not have fully developed workforce plans which take into account the mix of doctors in training and other 'non-training grades' in all specialties.

Nevertheless it is important that LETBs and providers develop their dialogue about future demand for:

- Fully qualified specialty doctors (i.e. CCT holders whether working in consultant or other roles);

- Other doctors delivering service whether in training or in other roles.

This is important for the following reasons:

- Current supply forecasts indicate that in many specialties the number of CCT holders (i.e. doctors eligible to work at consultant level) will continue to grow for several years as the number of trainee doctors are already in training posts will inevitably fuel this supply. Asking providers to forecast demand equips HEE and LETBs to assess the extent to which perceived demand and forecast supply are aligned. Demand estimates from providers add to the overall store of information which can be used in conjunction with other intelligence to inform discussions, support decisions and suggest policy and intervention.
- Collecting providers'' views on the mix of doctors in training and doctors other than consultants not in training will stimulate and support local and national conversations about how the medical workforce of the future might be structured, and what changes might be made in the balance between consultants, trainees and other grades to support service delivery and develop consultant supply.

Hence Medical Workforce Demand Tab asks providers to input for each medical Specialty:

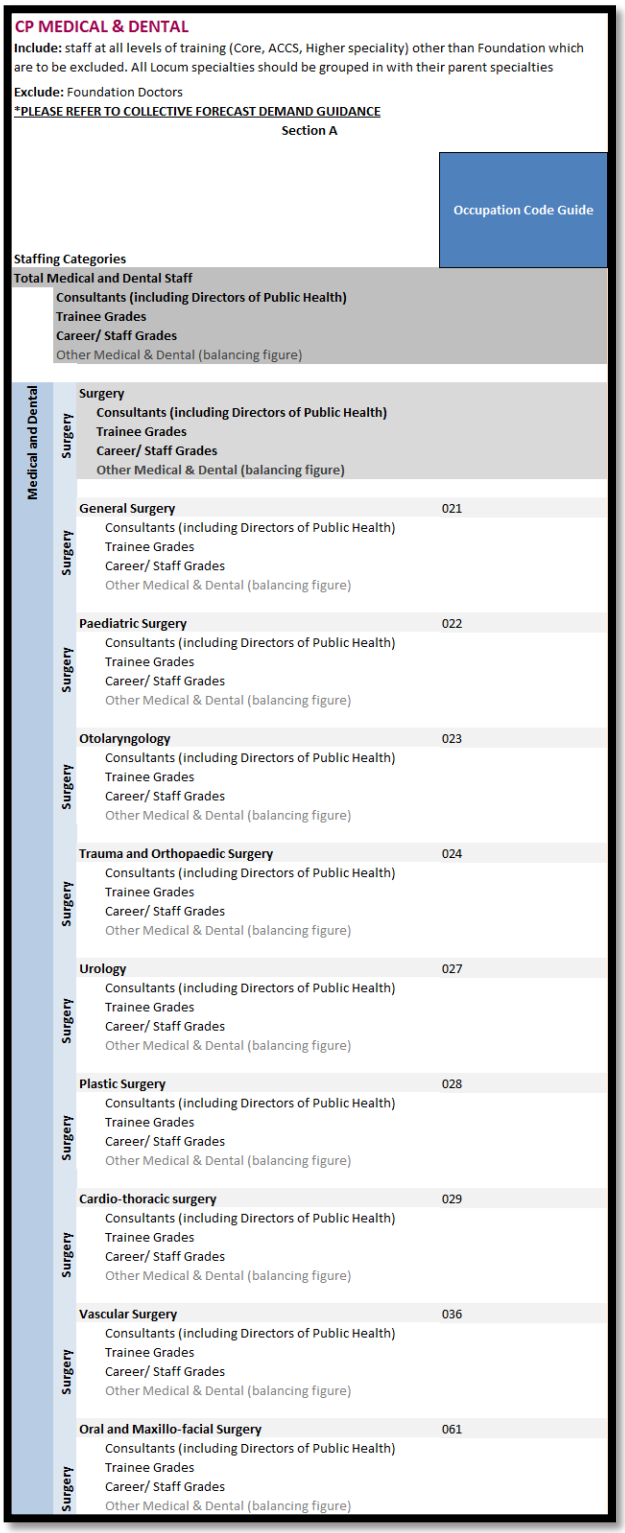
- The number (FTE) of **Consultants** (including Directors of Public Health) working in that specialty
- The number (FTE) of **Doctors in training** working in each specialty irrespective of the level of training (i.e. including Core, ACCS etc) but excluding Foundation trainees). Please note that they may not be training in the same specialty.
- The number (WTE) of **other doctors working in the specialty who are neither Consultants nor in training grades** (Career/ Staff Grades) such as: Staff grades and Associate Specialists, Specialty Doctors, Clinical Assistants and Hospital Practitioners, Senior Clinical Medical Officer, Trust Grade Doctor - Career Grade level, Dental Officer, Senior Dental Officer, Medical Director, General Medical/ Dental Practitioner, Senior Lectures etc.

- **Other Medical & Dental** (balancing figure)

The purpose of collecting the data in this way is to stimulate the conversations that must take place at LETB level as part of the process of developing coherent medical workforce plans.

8.6.2 Section A: (Columns A-D)

Diagram 13: Workforce Demand Template: Tab 3. CP Medical - Section A



CP MEDICAL & DENTAL

Include: staff at all levels of training (Core, ACCS, Higher speciality) other than Foundation which are to be excluded. All Locum specialties should be grouped in with their parent specialties

Exclude: Foundation Doctors

*PLEASE REFER TO COLLECTIVE FORECAST DEMAND GUIDANCE

Section A

		Staffing Categories	Occupation Code Guide
		Total Medical and Dental Staff	
		Consultants (including Directors of Public Health)	
		Trainee Grades	
		Career/ Staff Grades	
		Other Medical & Dental (balancing figure)	
Medical and Dental	Surgery	**Surgery**	
		Consultants (including Directors of Public Health)	
		Trainee Grades	
		Career/ Staff Grades	
		Other Medical & Dental (balancing figure)	
	Surgery	**General Surgery**	021
		Consultants (including Directors of Public Health)	
		Trainee Grades	
		Career/ Staff Grades	
		Other Medical & Dental (balancing figure)	
	Surgery	**Paediatric Surgery**	022
		Consultants (including Directors of Public Health)	
		Trainee Grades	
		Career/ Staff Grades	
		Other Medical & Dental (balancing figure)	
	Surgery	**Otolaryngology**	023
		Consultants (including Directors of Public Health)	
		Trainee Grades	
		Career/ Staff Grades	
		Other Medical & Dental (balancing figure)	
	Surgery	**Trauma and Orthopaedic Surgery**	024
		Consultants (including Directors of Public Health)	
		Trainee Grades	
		Career/ Staff Grades	
		Other Medical & Dental (balancing figure)	
	Surgery	**Urology**	027
		Consultants (including Directors of Public Health)	
		Trainee Grades	
		Career/ Staff Grades	
		Other Medical & Dental (balancing figure)	
	Surgery	**Plastic Surgery**	028
		Consultants (including Directors of Public Health)	
		Trainee Grades	
		Career/ Staff Grades	
		Other Medical & Dental (balancing figure)	
	Surgery	**Cardio-thoracic surgery**	029
		Consultants (including Directors of Public Health)	
		Trainee Grades	
		Career/ Staff Grades	
		Other Medical & Dental (balancing figure)	
	Surgery	**Vascular Surgery**	036
		Consultants (including Directors of Public Health)	
		Trainee Grades	
		Career/ Staff Grades	
		Other Medical & Dental (balancing figure)	
	Surgery	**Oral and Maxillo-facial Surgery**	061
		Consultants (including Directors of Public Health)	
		Trainee Grades	
		Career/ Staff Grades	
		Other Medical & Dental (balancing figure)	

Column A: Simply a run through header against all rows in the CP Medical, Tab 5 that states "Medical & Dental"

Column B: Provides a run through header which highlights the parent specialty against the corresponding sub-specialties and sub-medical grades i.e. Surgery

Column C: Highlights aggregate sub-specialty levels and provides the names of sub sub-medical grades i.e.

Surgery
Plastic Surgery
Trainee Grades

Column D: Provides a guide to the national standard occupation codes that should contribute to the composition of a specific staffing category. These codes should be used as a guide for Providers when completing the Baseline Staff in Post position (Column F) as at Mar-14. Future forecast demand for Mar-14 through to Mar-19 (Columns H through to M) should then reflect the projected in year demand positions against those staffing categories

To note:

i. Medical workforce is planned in a different way without intentional vacancies. HEE LETB planners specifically agreed that Forecast fill rate for Medical staff should not be included in the demand template, as Providers aim to fill all of their medical posts and do not **PLAN** to have consultants or Doctors in training vacancies. If the demand template included such a column, we would be getting back a series of 100% returns.

8.6.3 Section B: (Columns F-M)

Diagram 14: Workforce Demand Template: Tab 3. CP Medical - Section B

Section B

Baseline	Current Fill Rate	Forecast					
Staff in post	Calculated	Baseline Demand	Demand				
As at 31st Mar-14	As at 31st Mar-14	As at 31st Mar-14	As at 31st Mar-15	As at 31st Mar-16	As at 31st Mar-17	As at 31st Mar-18	As at 31st Mar-19
0	-	0	0	0	0	0	0
0	-	0	0	0	0	0	0
0	-	0	0	0	0	0	0
0	-	0	0	0	0	0	0
0	-	0	0	0	0	0	0
0	-	0	0	0	0	0	0
0	-	0	0	0	0	0	0
0	-	0	0	0	0	0	0
0	-	0	0	0	0	0	0
0	-	0	0	0	0	0	0
0	-	0	0	0	0	0	0
	-						
	-						
	-						
	-						
0	-	0	0	0	0	0	0
	-						
	-						
	-						
	-						
0	-	0	0	0	0	0	0

Against each of the staffing categories outlined in Section A of the CP Medical template, Tab 5, the following figures are required in Section B (Columns F through to M):

Column F: Baseline Staff in Post - Full time equivalent (FTE) staff in post, directly employed by the Provider organisation as at Mar-14 (Including: staff at all levels of training (Core, ACCS, Higher speciality) other than Foundation which are to be excluded. All Locum specialties should be grouped in with their parent specialties) / (Excluding: Foundation Doctors)

Column G: Current Fill Rate – **AUTOMATICALLY CALCULATED NO INPUT NEEDED** – this is calculated as the Baseline Staff in Post (Column F) as a proportion of Baseline Demand as at Mar-14 (Column H).

Column H: Baseline Demand - The required workforce establishment as at Mar-14 (reflective of the replacement for leavers plus predicted change in capacity required plus vacant posts)

Columns I-M: Forecast Demand – The in-year forecast required workforce establishment as at Mar-15 through to Mar-19 (reflective of the replacement for leavers plus predicted change in capacity required plus vacant posts)

For Completion of Sections; C and D please refer to the same guidance provided earlier in this document for the Non-medical tab 4. Please use the hyperlinks below to go directly to these sections:

- **Section C**
- **Section D**

8.7 Occupation Code Tool Tab

Informed by; National standards occupation code manual
Link: http://www.hscic.gov.uk/article/2268/NHS-Occupation-Codes

Provides a complete list of the standard national occupation codes against the standard descriptions.

Diagram 16: Workforce Demand Template: OCC CODE_TOOL Tab

OCC CODE TOOL
*PLEASE REFER TO COLLECTIVE FORECAST DEMAND GUIDANCE

National Standard Occupation Codes		Planning Groups					HSCIC Grouping		
Occ	Occ Code Description	High Level Group: Mec	Sub Group 1: Med, D	Sub Group 2:	Sub Group 3:	Sub Group 4:	High Level Group:	Sub Group 1:	Sub Group 2:
001	General (Internal) Medicine	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	General Internal / Acute	HCHS Doctors (non-locums)	Hospital Doctor- General (internal) medicine	General Medicine Specialties
002	Paediatrics	Medical & Dental	Medical & Dental	Medical & Dental	Run-through Specialties	Paediatrics	HCHS Doctors (non-locums)	Hospital Doctor- Paediatrics	Paediatric Specialties
003	Infectious Diseases	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Infectious Diseases	HCHS Doctors (non-locums)	Hospital Doctor- Infectious diseases	General Medicine Specialties
004	Respiratory Medicine	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Respiratory Medicine	HCHS Doctors (non-locums)	Hospital Doctor- Respiratory medicine	General Medicine Specialties
005	Dermatology	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Dermatology	HCHS Doctors (non-locums)	Hospital Doctor- Dermatology	General Medicine Specialties
006	Neurology	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Neurology	HCHS Doctors (non-locums)	Hospital Doctor- Neurology	General Medicine Specialties
007	Cardiology	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Cardiology	HCHS Doctors (non-locums)	Hospital Doctor- Cardiology	General Medicine Specialties
008	Rheumatology	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Rheumatology	HCHS Doctors (non-locums)	Hospital Doctor- Rheumatology	General Medicine Specialties
009	Genito-Urinary Medicine	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Genito-Urinary Medicine	HCHS Doctors (non-locums)	Hospital Doctor- Genito-urinary medicine	General Medicine Specialties
010	Clinical Pharmacology and Therapeutics	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Clinical Pharmacology	HCHS Doctors (non-locums)	Hospital Doctor- Clinical pharmacology and therapeutics	General Medicine Specialties
011	Geriatric Medicine	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Geriatric Medicine	HCHS Doctors (non-locums)	Hospital Doctor- Geriatric medicine	General Medicine Specialties
012	Medical Oncology	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Medical Oncology	HCHS Doctors (non-locums)	Hospital Doctor- Medical oncology	General Medicine Specialties
013	Clinical Physiology	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Clinical Physiology/Neurophysiology	HCHS Doctors (non-locums)	Hospital Doctor- Clinical physiology	General Medicine Specialties
014	Clinical Neurophysiology	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Clinical Physiology/Neurophysiology	HCHS Doctors (non-locums)	Hospital Doctor- Clinical neurophysiology	General Medicine Specialties
015	Renal Medicine	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Renal Medicine	HCHS Doctors (non-locums)	Hospital Doctor- Renal medicine	General Medicine Specialties
016	Nuclear Medicine	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Nuclear Medicine	HCHS Doctors (non-locums)	Hospital Doctor- Nuclear medicine	Radiology Specialties
017	Endocrinology and Diabetes Mellitus	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Endocrinology and Diabetes	HCHS Doctors (non-locums)	Hospital Doctor- Endocrinology and diabetes mellitus	General Medicine Specialties
018	Gastro-enterology	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Gastroenterology	HCHS Doctors (non-locums)	Hospital Doctor- Gastroenterology	General Medicine Specialties
019	Audiological Medicine	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Audiology	HCHS Doctors (non-locums)	Hospital Doctor- Audiological medicine	General Medicine Specialties
020	Clinical Genetics	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Clinical Genetics/Cyto/Molecular	HCHS Doctors (non-locums)	Hospital Doctor- Clinical genetics	General Medicine Specialties
021	General Surgery	Medical & Dental	Medical & Dental	Medical & Dental	Surgery	General Surgery	HCHS Doctors (non-locums)	Hospital Doctor- General surgery	Surgical Specialties
022	Paediatric Surgery	Medical & Dental	Medical & Dental	Medical & Dental	Surgery	Paediatric Surgery	HCHS Doctors (non-locums)	Hospital Doctor- Paediatric surgery	Surgical Specialties
023	Otolaryngology	Medical & Dental	Medical & Dental	Medical & Dental	Surgery	Otolaryngology	HCHS Doctors (non-locums)	Hospital Doctor- Otolaryngology	Surgical Specialties
024	Trauma and Orthopaedic Surgery	Medical & Dental	Medical & Dental	Medical & Dental	Surgery	Trauma and Orthopaedic Surgery	HCHS Doctors (non-locums)	Hospital Doctor- Trauma and orthopaedic surgery	Surgical Specialties
025	Ophthalmology	Medical & Dental	Medical & Dental	Medical & Dental	Run-through Specialties	Ophthalmology	HCHS Doctors (non-locums)	Hospital Doctor- Ophthalmology	Surgical Specialties
026	Clinical Oncology	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Clinical Oncology	HCHS Doctors (non-locums)	Hospital Doctor- Clinical oncology	Clinical Oncology Specialties
027	Urology	Medical & Dental	Medical & Dental	Medical & Dental	Surgery	Urology	HCHS Doctors (non-locums)	Hospital Doctor- Urology	Surgical Specialties
028	Plastic Surgery	Medical & Dental	Medical & Dental	Medical & Dental	Surgery	Plastic Surgery	HCHS Doctors (non-locums)	Hospital Doctor- Plastic surgery	Surgical Specialties
029	Cardio-thoracic Surgery	Medical & Dental	Medical & Dental	Medical & Dental	Surgery	Cardiothoracic Surgery	HCHS Doctors (non-locums)	Hospital Doctor- Cardio-thoracic surgery	Surgical Specialties
030	Accident and Emergency Medicine	Medical & Dental	Medical & Dental	Medical & Dental	Accident & Emergency		HCHS Doctors (non-locums)	Hospital Doctor- Accident & emergency medicine	A&E Specialties
031	Neurosurgery	Medical & Dental	Medical & Dental	Medical & Dental	Run-through Specialties	Neurosurgery	HCHS Doctors (non-locums)	Hospital Doctor- Neurosurgery	Surgical Specialties
032	Tropical Medicine	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Tropical Medicine	HCHS Doctors (non-locums)	Hospital Doctor- Tropical medicine	General Medicine Specialties
033	Allergy	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	Allergy	HCHS Doctors (non-locums)	Hospital Doctor- Allergy	General Medicine Specialties
034	Intensive Care Medicine	Medical & Dental	Medical & Dental	Medical & Dental	Intensive Care Medicine		HCHS Doctors (non-locums)	Hospital Doctor- Intensive care medicine	Anaesthetics Specialties
035	Acute Internal Medicine	Medical & Dental	Medical & Dental	Medical & Dental	Uncoupled Specialties	General Internal / Acute	HCHS Doctors (non-locums)	Hospital Doctor- Acute Internal Medicine	General Medicine Specialties
036	Vascular Surgery	Medical & Dental	Medical & Dental	Medical & Dental	Surgery	Vascular Surgery	HCHS Doctors (non-locums)	Hospital Doctor- Vascular surgery	Surgical Specialties
040	Obstetrics and Gynaecology	Medical & Dental	Medical & Dental	Medical & Dental	Run-through Specialties	Obstetrics and Gynaecology	HCHS Doctors (non-locums)	Hospital Doctor- Obstetrics and Gynaecology	Obstetrics & Gynaecology Specialties
041	Hospital Doctor- Community Sexual and Repro	Medical & Dental	Medical & Dental	Medical & Dental	Run-through Specialties	Hospital Doctor- Community Sexual and Reproducti	HCHS Doctors (non-locums)	Hospital Doctor- Community Sexual and Reproductive Health	Obstetrics & Gynaecology Specialties
045	Dental and Maxillofacial Radiology	Medical & Dental	Medical & Dental	Medical & Dental	Dentistry	Dental and Maxillofacial Radiology	HCHS Doctors (non-locums)	Hospital Doctor- Dental and Maxillofacial Radiology	Dental Specialties
046	Oral and Maxillofacial Pathology	Medical & Dental	Medical & Dental	Medical & Dental	Dentistry	Oral and Maxillofacial Pathology	HCHS Doctors (non-locums)	Hospital Doctor- Oral and Maxillofacial Pathology	Dental Specialties
047	Oral Microbiology	Medical & Dental	Medical & Dental	Medical & Dental	Dentistry	Oral Microbiology	HCHS Doctors (non-locums)	Hospital Doctor- Oral Microbiology	Dental Specialties
048	Oral Medicine	Medical & Dental	Medical & Dental	Medical & Dental	Dentistry	Oral Medicine	HCHS Doctors (non-locums)	Hospital Doctor- Oral Medicine	Dental Specialties
049	Paediatric Neurology	Medical & Dental	Medical & Dental	Medical & Dental	Run-through Specialties	Paediatrics	HCHS Doctors (non-locums)	Hospital Doctor- Paediatric neurology	Paediatric Specialties
051	Psychiatry of Learning Disability	Medical & Dental	Medical & Dental	Medical & Dental	Psychiatry	Psychiatry of Learning Disability	HCHS Doctors (non-locums)	Hospital Doctor- Psychiatry of learning disability	Psychiatry Specialties
052	General Psychiatry	Medical & Dental	Medical & Dental	Medical & Dental	Psychiatry	General Adult Psychiatry	HCHS Doctors (non-locums)	Hospital Doctor- General psychiatry	Psychiatry Specialties
053	Child and Adolescent Psychiatry	Medical & Dental	Medical & Dental	Medical & Dental	Psychiatry	Child & Adolescent Psychiatry	HCHS Doctors (non-locums)	Hospital Doctor- Child and adolescent psychiatry	Psychiatry Specialties
054	Forensic Psychiatry	Medical & Dental	Medical & Dental	Medical & Dental	Psychiatry	Forensic Psychiatry	HCHS Doctors (non-locums)	Hospital Doctor- Forensic psychiatry	Psychiatry Specialties
055	Psychotherapy	Medical & Dental	Medical & Dental	Medical & Dental	Psychiatry	Psychotherapy	HCHS Doctors (non-locums)	Hospital Doctor- Psychotherapy	Psychiatry Specialties
056	Old Age Psychiatry	Medical & Dental	Medical & Dental	Medical & Dental	Psychiatry	Old Age Psychiatry	HCHS Doctors (non-locums)	Hospital Doctor- Old age psychiatry	Psychiatry Specialties
061	Oral and Maxillo-Facial Surgery	Medical & Dental	Medical & Dental	Medical & Dental	Surgery	Oral and Maxillofacial Surgery	HCHS Doctors (non-locums)	Hospital Doctor- Oral and maxillo-facial surgery	Dental Specialties
062	Orthodontics	Medical & Dental	Medical & Dental	Medical & Dental	Dentistry	Orthodontics	HCHS Doctors (non-locums)	Hospital Doctor- Orthodontics	Dental Specialties
063	Restorative Dentistry	Medical & Dental	Medical & Dental	Medical & Dental	Dentistry	Restorative Dentistry	HCHS Doctors (non-locums)	Hospital Doctor- Restorative Dentistry	Dental Specialties
064	Paediatric Dentistry	Medical & Dental	Medical & Dental	Medical & Dental	Dentistry	Paediatric Dentistry	HCHS Doctors (non-locums)	Hospital Doctor- Paediatric Dentistry	Dental Specialties
066	Oral Surgery	Medical & Dental	Medical & Dental	Medical & Dental	Dentistry	Oral Surgery	HCHS Doctors (non-locums)	Hospital Doctor- Oral Surgery	Dental Specialties
067	Endodontics	Medical & Dental	Medical & Dental	Medical & Dental	Dentistry	Endodontics	HCHS Doctors (non-locums)	Hospital Doctor- Endodontics	Dental Specialties
068	Periodontics	Medical & Dental	Medical & Dental	Medical & Dental	Dentistry	Periodontics	HCHS Doctors (non-locums)	Hospital Doctor- Periodontics	Dental Specialties
069	Prosthodontics	Medical & Dental	Medical & Dental	Medical & Dental	Dentistry	Prosthodontics	HCHS Doctors (non-locums)	Hospital Doctor- Prosthodontics	Dental Specialties
070	Special Care Dentistry	Medical & Dental	Medical & Dental	Medical & Dental	Dentistry	Special Care Dentistry	HCHS Doctors (non-locums)	Hospital Doctor- Special Care Dentistry	Dental Specialties
071	General Pathology	Medical & Dental	Medical & Dental	Medical & Dental	Run-through Specialties	General Pathology	HCHS Doctors (non-locums)	Hospital Doctor- General pathology	Pathology Specialties
072	Chemical Pathology	Medical & Dental	Medical & Dental	Medical & Dental	Run-through Specialties	Chemical Pathology	HCHS Doctors (non-locums)	Hospital Doctor- Chemical pathology	Pathology Specialties

The NHS Occupation codes are an agreed set of codes used nationally to categorise the NHS workforce. They cover all staff in Hospital and Community Health Services (HCHS), both medical, non-medical and administrative with the aim of identifying the numbers and profile of staff within the NHS in a consistent way. These codes are maintained and routinely reviewed by The NHS Health and Social Care Information Centre to ensure that they remain fit for purpose.

Columns A-B: Provide the occupation code number and respective standard description

Columns D-H: Provides a cross- mapping of the standard NHS occupation codes against the higher level and sub-level staff categories they apply to as they appear within the forecast demand template

Columns J-L: Provides a cross- mapping of the standard NHS occupation codes against the higher level and sub-level staff categories they apply to as they appear in HSCIC publication

To note:

i. The following definitions are true of available fields in the Electronic Staff Record:

Job Title – free text – not to be confused with 'Job Role'

Occupation Code – this is based on Professional background and is linked to both the area they work in and the role of the job. Official statistics are based on Occupation Code with addition detail coming from 'Job Role' and 'Area of Work'. Date on 'Job Role' and 'Area of Work' are not currently published as Official Statistics.

Area of Work – has three levels, primary, secondary or tertiary but tertiary is the only level seen by ESR administrators. It is essential that the tertiary field is unique. The primary and secondary fields are used for grouping in the ESR data warehouse and for analysis.

Job Role – There are over 100 job roles which are grouped into 9 separate 'Staff Groups'. Job Role is not unique as it is constrained by Staff Group.

Any combination of Occupation Code, Area of Work and Job Role is possible to allow the capture of information for any multidisciplinary team. Some combinations will be more likely than others and some are likely to be due to data quality issues. The only systematic link is the constraining of Job Roles within the Staff Groups. Additional information is available by looking at fields such as Professional Registration and Pay Scale / Band.

8.8 CP (Core Provider) – Non-Medical Supply Tab

Diagram 17: Workforce Supply Template Tab 3.1

CP NON-MEDICAL Supply
Include: Permanent, Fixed Term, Temporary staff against the employing authority
Exclude: Bank, Agency, Locum, GP and Practice, Honorary Staff, Hospice assignments, hosted arrangements
***PLEASE REFER TO WORKFORCE FORECAST DEMAND TEMPLATE: GUIDANCE**

Section A			Section B						Section C										Section D
		Occupation Code Guide	How many Band 5's recruited	Forecast Recruitment of Band 5s					Recruitment Change						Recruitment % Change					Commentary
Staffing Categories			1st April 2013 to 31st March 2014	1st April 2014 to 31st March 2015	1st April 2015 to 31st March 2016	1st April 2016 to 31st March 2017	1st April 2017 to 31st March 2018	1st April 2018 to 31st March 2019	14 to 15	15 to 16	16 to 17	17 to 18	18 to 19	14 to 19	14 to 15	15 to 16	16 to 17	17 to 18	18 to 19	Please use this space should you wish to provide any additional contextual information supporting the recruitment projections provided for each workforce category
Total Non-Medical and Dental Staff			0	0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	
Total Clinical Staff			0	0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	
Total Non-Clinical Staff			0	0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	
Clinical	**Registered Nursing, Midwifery and Health visiting staff**		0	0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	
	Acute, Elderly and General	N0A, N1A, N5A, N7A, NAA, NCA							0	0	0	0	0	0	-	-	-	-	-	
	Community Services	N0H, N1H, N3H, N4H, N5H, N6H, N7H, NAH, NCH, NEH							0	0	0	0	0	0	-	-	-	-	-	
	Community Psychiatry	N0D, N4D, N5D, N6D, N7D, NAD, NCD							0	0	0	0	0	0	-	-	-	-	-	
	Community Learning Disabilities	N0F, N4F, N5F, N6F, N7F, NAF, NCF							0	0	0	0	0	0	-	-	-	-	-	
	Maternity/Neonatal Services (including SCBUs)	N0C, N0L, N1C, N1L, N2C, N2L, N6C, N6L, N7C, N7L, NAC, NAL, NCC, NCL							0	0	0	0	0	0	-	-	-	-	-	
	Paediatric Nursing	N0B, N1B, N6B, N7B, NAB, NCB							0	0	0	0	0	0	-	-	-	-	-	
	Other Psychiatry	N0E, N6E, N7E, NAE, NCE							0	0	0	0	0	0	-	-	-	-	-	
	Other Learning Disabilities	N0G, N6G, N7G, NAG, NCG							0	0	0	0	0	0	-	-	-	-	-	
	School Nursing	N0K, N6K, N7K, NAK, NBK, NCK							0	0	0	0	0	0	-	-	-	-	-	
	Any Other Nursing	N0J, N1J, N2J, N6J, N7J, NAJ, NCJ							0	0	0	0	0	0	-	-	-	-	-	
	From the above of which:																			
	Specific Roles: Registered Midwives	N2C, N2J, N2L							0	0	0	0	0	-	-	-	-	-	-	
	Specific Roles: Neonatal Nurses	N0L, N1L, N6L, N7L, NAL, NCL							0	0	0	0	0	-	-	-	-	-	-	
	Specific Roles: Registered Health Visitors	N3H							0	0	0	0	0	-	-	-	-	-	-	
	Specific Roles: District Nurses	N4D, N4F, N4H, N5D, N5F, N5H							0	0	0	0	0	-	-	-	-	-	-	
	Specific Roles: School Nurses	NBK							0	0	0	0	0	-	-	-	-	-	-	
	Qualified Scientific, Therapeutic and Technical Staff		0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	-	
	Allied Health Professionals		0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	-	
	Art/ Music/ Drama therapy	S0H, S1H, S6H, SAH							0	0	0	0	0	-	-	-	-	-	-	
	Chiropody / Podiatry	S0A, S1A, S4A, S7A, SAA							0	0	0	0	0	-	-	-	-	-	-	
	Dietetics	S0B, S1B, SAB							0	0	0	0	0	-	-	-	-	-	-	
	Occupational Therapy	S0C, S1C, S4C, S6C, S7C, SAC							0	0	0	0	0	-	-	-	-	-	-	
	Orthoptics / Optics	S0D, S1D, S2D, S4D, S7D, SAD							0	0	0	0	0	-	-	-	-	-	-	
	Physiotherapy	S0E, S1E, S6E, S7E, SAE							0	0	0	0	0	-	-	-	-	-	-	
	Radiography (Diagnostic)	S0F, S1F, S7F, SAF							0	0	0	0	0	-	-	-	-	-	-	
	Radiography (Therapeutic)	S0G, S1G, SAG							0	0	0	0	0	-	-	-	-	-	-	
	Speech and Language Therapy	S0J, S1J, S6J, S7J, SAJ							0	0	0	0	0	-	-	-	-	-	-	
	Any Other AHPs								0	0	0	0	0	-	-	-	-	-	-	
	Other Scientific, Therapeutic and Technical Staff		0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	-	
	Clinical Psychology	S0L, S2L, S4L, SAL							0	0	0	0	0	-	-	-	-	-	-	
	Dental	S0R, S1R, S4R, S7R, SAR							0	0	0	0	0	-	-	-	-	-	-	
	Multi-therapies	S0K, S1K, S6K, SAK							0	0	0	0	0	-	-	-	-	-	-	
	Operating Theatre's	S0T, S4T, SAT							0	0	0	0	0	-	-	-	-	-	-	
	Pharmacy	S0P, S2P, S3P, S4P, SAP							0	0	0	0	0	-	-	-	-	-	-	
	Psychotherapy	S0M, S1M, S2M, SAM							0	0	0	0	0	-	-	-	-	-	-	
	Social Services	S0U, S1U, S6U, S7U, SAU							0	0	0	0	0	-	-	-	-	-	-	
	Any Other ST&T Staff	S0X, S1X, S2X, S3X, S4X, S6X, S7X, SAX							0	0	0	0	0	-	-	-	-	-	-	
	From the above of which:																			
	Specific Roles: *Operating Department Practitioners (ODP's)								0	0	0	0	0	-	-	-	-	-	-	
	Specific Roles: Pharmacists	S0P, S2P, S3P, SAP							0	0	0	0	0	-	-	-	-	-	-	
	Specific Roles: Pharmacy Technicians	S4P							0	0	0	0	0	-	-	-	-	-	-	
	Qualified Healthcare Scientists								0	0	0	0	0	-	-	-	-	-	-	
	***Informatics								0	0	0	0	0	-	-	-	-	-	-	
	Physics & Engineering								0	0	0	0	0	-	-	-	-	-	-	
	Life Sciences								0	0	0	0	0	-	-	-	-	-	-	
	Physiological Sciences								0	0	0	0	0	-	-	-	-	-	-	
	Qualified Ambulance Service Staff		0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	-	
	Ambulance Paramedic	ABA							0	0	0	0	0	-	-	-	-	-	-	
	Ambulance Technician	AEA							0	0	0	0	0	-	-	-	-	-	-	
	Any Other Qualified Ambulance Service Staff	A0A, AAA							0	0	0	0	0	-	-	-	-	-	-	
Additional	**Additional Specialist Groups (should be included in above where relevant - will not be double counted in totals)**																			
	****IAPT		0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	-	
	of which high intensity								0	0	0	0	0	-	-	-	-	-	-	
	of which low intensity								0	0	0	0	0	-	-	-	-	-	-	

To Note:

***Groups without specific or changing national occupation code standards**

****Healthcare Science (HCS)** - The values for recording HCS staff have recently changed and all organisations that employ Healthcare Science staff will need to audit and amend their records on ESR accordingly. Please consult the accompanying Technical Guidance to this file and the followin links:

More detail regarding the changes to the ESR in response to these updates to the data standard are available in UN1828, available through ESR Kbase.

Healthcare Science Indicative Job Title Coding Guidance_Final_V1 [104kb]

A Guide to Healthcare Science Workforce Classifications used in ESR [604kb]

*****HCS Informatics -** The HCS sub-group of Informatics highlighted within this planning template has not yet been embedded into the proposed new values for recording HCS staff (as above). Their inclusion, however, is a reflection of the importance of this workforce going forward, highlights political interest in this area and

******IAPT** - No specific national occupation codes exist to capture Improving Access to Psychological Therapies roles.

8.8.1 Summary of Core Changes to the Non-Medical Supply Template this year

Further to consensus of the National Workforce Planners network, the following changes are apparent from last year's non-medical supply template

- **Community Nursing** – given the political interest and growing workforce supply as more services shift into a community setting, the community nursing sub-categories of this group have been extended this year from a high level "Community Services" grouping into the following;
    - Community Services
    - Community Psychiatry
    - Community Learning Disabilities

A separate line for "of which District Nurses" has also been embedded to capture the supply needs of this particular role.

These categories more closely align to HSCIC groupings and have specific occupation codes attached to them which can be found in the CP Non-medical supply tab next to the groups and/or in the separate occupation code tool tab.

- **Education Staff** - that were previously included as a separate line under the Registered Nursing, Midwifery and Health Visiting Staff are now embedded within the "Other Nursing" line as this was deemed to be a relatively small category of staff to which there isn't a specific identifiable education training route.

- **Maternity Services** - a separate line for "Neonatal Nurses" has been embedded to capture the supply needs of this particular role - it was deemed there is a lot of interest in this category and there are specific workforce occupation codes that can be attributed to this group.

- **IAPT** - sub-categories have been extended to cover; "of which High Intensity" and "of which Low Intensity" given the political interest and link to specific mandate measurable under our responsibility as HENW and HEE to deliver upon. The following section (**8.4.2**) provides an IAPT supplement to aid defining of this workforce against which there aren't currently any specific attributable occupation codes. It was deemed IAPT should no longer be included under the Scientific, Therapeutic & Technical category (as with last year's template) as they cut across a range of other areas. As such these lines have been separated out towards the bottom of the non-medical template. It is the view that roles working within an IAPT service will/may be included within staffing categories listed between rows 9-82 of the CP Non-medical tab – therefore figures entered in the dedicated IAPT section, rows 85-87 will not be separately added to the Non-medical totals so as not to double count

- **Qualified Healthcare Scientists –** sub-categories have been amended to align to the transitioning occupation code structure for this group; "Informatics", "Physics and Engineering", "Life Sciences" and "Physiological Sciences" – rows 56 – 60 in the CP Non-Medical tab will directly pull data inputted into a new CP HCS tab. Section **8.5.1** of this document provides further information to aid completion of the separate CP HCS tab

8.8.2 Section A: (Columns A-D)

Diagram 18: Workforce Supply Template: Tab 3.1 Non-Medical Supply – Section A

CP NON-MEDICAL Supply

Include: Permanent, Fixed Term, Temporary staff against the employing authority

Exclude: Bank, Agency, Locum, GP and Practice, Honorary Staff, Hospice assignments, hosted arrangements

***PLEASE REFER TO WORKFORCE FORECAST DEMAND TEMPLATE: GUIDANCE**

Section A

			Occupation Code Guide
Staffing Categories			
Total Non-Medical and Dental Staff			
	Total Clinical Staff		
	Total Non-Clinical Staff		
Clinical			
		Registered Nursing, Midwifery and Health visiting staff	
		Acute, Elderly and General	N0A, N1A, N6A, N7A, NAA, NCA
		Community Services	N0H, N1H, N3H, N4H, N5H, N6H, N7H, NAH, NCH, NEH
		Community Psychiatry	N0D, N4D, N5D, N6D, N7D, NAD, NCD
		Community Learning Disabilities	N0F, N4F, N5F, N6F, N7F, NAF, NCF
		Maternity/Neonatal Services (including SCBUs)	N0C, N0L, N1C, N1L, N2C, N2L, N6C, N6L, N7C, N7L, NAC, NAL, NCC, NCL
		Paediatric Nursing	N0B, N1B, N6B, N7B, NAB, NCB
		Other Psychiatry	N0E, N6E, N7E, NAE, NCE
		Other Learning Disabilities	N0G, N6G, N7G, NAG, NCG
		School Nursing	N0K, N6K, N7K, NAK, NBK, NCK
		Any Other Nursing	N0J, N1J, N2J, N6J, N7J, NAJ, NCJ
	Specific Roles	From the above of which:	
		Registered Midwives	N2C, N2J, N2L
		Neonatal Nurses	N0L, N1L, N6L, N7L, NAL, NCL
		Registered Health Visitors	N3H
		District Nurses	N4D, N4F, N4H, N5D, N5F, N5H
		School Nurses	NBK
		Qualified Scientific, Therapeutic and Technical Staff	
		Allied Health Professionals	
		Art/ Music/ Drama therapy	S0H, S1H, S6H, SAH
		Chiropody / Podiatry	S0A, S1A, S4A, S7A, SAA
		Dietetics	S0B, S1B, SAB
		Occupational Therapy	S0C, S1C, S4C, S6C, S7C, SAC
		Orthoptics / Optics	S0D, S1D, S2D, S4D, S7D, SAD
		Physiotherapy	S0E, S1E, S6E, S7E, SAE
		Radiography (Diagnostic)	S0F, S1F, S7F, SAF
		Radiography (Therapeutic)	S0G, S1G, SAG
		Speech and Language Therapy	S0J, S1J, S6J, S7J, SAJ
		Any Other AHPs	
		Other Scientific, Therapeutic and Technical Staff	
		Clinical Psychology	S0L, S2L, S4L, SAL
		Dental	S0R, S1R, S4R, S7R, SAR
		Multi-therapies	S0K, S1K, S6K, SAK
		Operating Theatre's	S0T, S4T, SAT
		Pharmacy	S0P, S2P, S3P, S4P, SAP
		Psychotherapy	S0M, S1M, S2M, SAM
		Social Services	S0U, S1U, S6U, S7U, SAU
		Any Other ST&T Staff	S0X, S1X, S2X, S3X, S4X, S6X, S7X, SAX
	Specific Roles	From the above of which:	
		*Operating Department Practitioners (ODP's)	
		Pharmacists	S0P, S2P, S3P, SAP
		Pharmacy Technicians	S4P
		****Qualified Healthcare Scientists**	
		*****Informatics**	
		Physics & Engineering	
		Life Sciences	
		Physiological Sciences	
		Qualified Ambulance Service Staff	
		Ambulance Paramedic	ABA
		Ambulance Technician	AEA
		Any Other Qualified Ambulance Service Staff	A0A, AAA
Additional	**Additional Specialist Groups (should be included in above where relevant - will not be double counted in totals)**		
		******IAPT**	
		of which high intensity	
		of which low intensity	

Column A: Provides an indication of whether the staffing categories listed in Column C are classified as; Clinical / Non-clinical staff or Additional (specialist groups)

Column B: Highlights those rows which relate to specific clinical roles which due to either their specialist commissioning route or high political interest require their own forecast supply projection as well as being included in the composition of their relative aggregate staffing category; i.e.

- **Relative staffing category:** Maternity/Neonatal Services (including SCBU's)
- **Specific Role:** Registered Midwives

Column C: Highlights aggregate row staffing categories and provides the names of their corresponding sub-areas and specific roles

Column D: Provides a guide to the national standard occupation codes that should contribute to the composition of a specific staffing category. These codes should be used as a guide for Providers when completing the Baseline Staff in Post position (Column F) as at Mar-14. Future forecast supply for Mar-14 through to Mar-19 (Columns H through to M) should then reflect the projected in year supply positions against those staffing categories

To note:

i. Rows highlighted in grey represent an automatically calculated/aggregate row or an "any other"

ii. Rows where no occupation codes are provided against the staffing category represent either an automatically calculated/aggregate row or an "any other" row to capture any other staff (down to local interpretation or due to inadequate coding/data quality issues) that cannot be placed within one of the other named rows

iii. ***** Star symbols mark those staffing categories without specific or changing national occupation code standards i.e. Healthcare Scientists and IAPT (Improving Access to Psychological Therapies) – where this is the case further notes are provided towards the bottom of the CP Non-medical supply template

iv. Staffing categories have been aligned as closely as possible to the HSCIC standard published categories

v. A fuller occupation code list is available in tab 7 of the Collective Forecast Demand Template. This provides a map as to which occupation codes relate to which staffing category and/or specific role within the CP Non-medical supply template, Tab 3. Against these are mapped the high level HSCIC standard published categories

vi. Where an occupation code is coloured red i.e. **N7J -** this highlights either a redundant or old occupation code that is no longer available in the Electronic Staff Record (ESR) against which to record a new staff position. However some roles may still be recorded as such in ESR where they were added onto the code when it was still "open" – this presents a data quality issue where staff recorded against these codes should have been moved, at source, to an updated, new or alternative code

8.8.3 Section B: (Columns F-Y)
Diagram 19: Workforce Supply Template: Tab 3.1 CP Non-Medical Supply – Section B

Section B						Section C										
How many Band 5's recruited	Forecast Recruitment of Band 5s					Recruitment Change						Recruitment % Change				
1st April 2013 to 31st March 2014	1st April 2014 to 31st March 2015	1st April 2015 to 31st March 2016	1st April 2016 to 31st March 2017	1st April 2017 to 31st March 2018	1st April 2018 to 31st March 2019	14 to 15	15 to 16	16 to 17	17 to 18	18 to 19	14 to 19	14 to 15	15 to 16	16 to 17	17 to 18	18 to 19
0	0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-
0	0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-
0	0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-
0	0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-
						0	0	0	0	0	0	-	-	-	-	-
						0	0	0	0	0	0	-	-	-	-	-
						0	0	0	0	0	0	-	-	-	-	-
						0	0	0	0	0	0	-	-	-	-	-
						0	0	0	0	0	0	-	-	-	-	-
						0	0	0	0	0	0	-	-	-	-	-
						0	0	0	0	0	0	-	-	-	-	-
						0	0	0	0	0	0	-	-	-	-	-
						0	0	0	0	0	0	-	-	-	-	-
						0	0	0	0	0	0	-	-	-	-	-
						0	0	0	0	0	-	-	-	-	-	-
						0	0	0	0	0	-	-	-	-	-	-
						0	0	0	0	0	-	-	-	-	-	-
						0	0	0	0	0	-	-	-	-	-	-
						0	0	0	0	0	-	-	-	-	-	-

Against each of the staffing categories outlined in Section A of the CP Non-medical supply template, Tab 3.1 the following figures are required in Section B (Columns F through to Y):

> **Column F: Baseline Supply 1st April 2013 to 31st March 2014** - Full time equivalent (FTE) staff in post, directly recruited at Band 5 by the Provider organisation as at Mar-14 (exclusive of; agency, bank, locum, vacant posts or hosted staff)
>
> **Columns G-K: Forecast Supply** – The in-year forecast supply recruitment at Band 5 as at Mar-15 through to Mar-19.

Against each of the staffing categories outlined in Section A and figures inputted into Section B of the CP Non-medical supply template, Tab 3.1, the following figures are automatically calculated in Section C (Columns N through to Y):

> **Columns N-S: Forecast Change - <u>AUTOMATICALLY CALCULATED NO INPUT NEEDED</u>** – Columns R-V automatically calculate the year on year change in supply numbers entered in Section B.
>
> **Columns U-Y: Forecast % Change - <u>AUTOMATICALLY CALCULATED NO INPUT NEEDED</u>** – Columns Y-AC automatically calculate the year on year percentage change in supply numbers entered in Section B.

To note:

> The forecast supply change and percentage change highlighted across these rows and columns, upon entering demand figures in Section B, can be used as a sense check to validate any erroneous figures that may present themselves to the user

8.8.3 Section D (Column AA)
Diagram 20: Workforce Supply Template: Tab 3.1 CP Non-Medical Supply – Section D

Section D

Commentary
Please use this space should you wish to provide any additional contextual information supporting the recruitment projections provided for each workforce category

Column AA: Commentary – This space should be utilised by the LETB user should they wish to provide any additional contextual/qualitative information supporting the supply projections presented in Section B i.e.

- A significant workforce reduction in the pharmacy staffing category in years 4 and 5 of the plan (i.e. as at Mar-18 and as at Mar-19) may be explained due to a particular large acute moving this service into a community setting

8.9 CP (Core Provider) Workforce Transformation Tab

Diagram 21: Workforce Transformation Template: Tab 5.1 CP Workforce Transformation

***PLEASE REFER TO WORKFORCE FORECAST DEMAND TEMPLATE: GUIDANCE**

*PLEASE REFER TO WORKFORCE FORECAST DEMAND TEMPLATE: GUIDANCE

	Baseline	Forecast						Difference Baseline & Estab Mar-14		Forecast Change Mar-14 to Mar-19		Annual % Change				
	Staff in post	"Establishment"														
Trainee Practitioners Demand (FTE)	As at 31st Mar-14	As at 31st Mar-14	As at 31st Mar-15	As at 31st Mar-16	As at 31st Mar-17	As at 31st Mar-18	As at 31st Mar-19	Change	% Change	Change	% Change	14 to 15	15 to 16	16 to 17	17 to 18	18 to 19
Trainee Assistant Practitioners Health and Social Care								0	-	0	-	-	-	-	-	-
Trainee Assistant Practitioners Radiotherapy								0	-	0	-	-	-	-	-	-
Trainee Assistant Practitioners Radiology								0	-	0	-	-	-	-	-	-
Trainee Assistant Practitioners Forensic (Learning Disability)								0	-	0	-	-	-	-	-	-
Trainee Associate Practitioners Life Sciences								0	-	0	-	-	-	-	-	-
Trainee Associate Practitioners Physiological Sciences								0	-	0	-	-	-	-	-	-
Trainee Associate Practitioners Medical Physics and Clinical Engineering								0	-	0	-	-	-	-	-	-
Trainee Surgical Care Practitioners								0	-	0	-	-	-	-	-	-
Trainee Advanced Practitioners								0	-	0	-	-	-	-	-	-
Trainee Physician Assistants: Anaesthesia								0	-	0	-	-	-	-	-	-
Trainee Physician Assistants: Acute Medicine								0	-	0	-	-	-	-	-	-
Trainee Physician Assistants: General Practice								0	-	0	-	-	-	-	-	-
Totals	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0	-	0	-	-	-	-	-	-

	Baseline	Forecast						Difference Baseline & Estab Mar-14		Forecast Change Mar-14 to Mar-19		Annual % Change				
	Staff in post	"Establishment"														
Qualified Practitioners in Post (FTE)	As at 31st Mar-14	As at 31st Mar-14	As at 31st Mar-15	As at 31st Mar-16	As at 31st Mar-17	As at 31st Mar-18	As at 31st Mar-19	Change	% Change	Change	% Change	14 to 15	15 to 16	16 to 17	17 to 18	18 to 19
Assistant Practitioners Health and Social Care								0	-	0	-	-	-	-	-	-
Assistant Practitioners Radiotherapy								0	-	0	-	-	-	-	-	-
Assistant Practitioners Radiology								0	-	0	-	-	-	-	-	-
Assistant Practitioners Forensic (Learning Disability)								0	-	0	-	-	-	-	-	-
Associate Practitioners Life Sciences								0	-	0	-	-	-	-	-	-
Associate Practitioners Physiological Sciences								0	-	0	-	-	-	-	-	-
Trainee Associate Practitioners Medical Physics and Clinical Engineering								0	-	0	-	-	-	-	-	-
Surgical Care Practitioners								0	-	0	-	-	-	-	-	-
Advanced Practitioners								0	-	0	-	-	-	-	-	-
Physician Assistants: Anaesthesia								0	-	0	-	-	-	-	-	-
Physician Assistants: Acute Medicine								0	-	0	-	-	-	-	-	-
Physician Assistants: General Practice								0	-	0	-	-	-	-	-	-
Consultant Practitioners								0	-	0	-	-	-	-	-	-
Totals	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0	-	0	-	-	-	-	-	-

Following on from previous years submissions, again the collection includes demand for trainee practitioner workforce and qualified practitioner workforce as part of the workforce transformation process. If there are additional new roles required, please add them to the worksheet and reference in the workforce planning narrative document.

For this workforce there are a small selection of occupation codes that are used and a range of job roles linking to assistant, advanced and associate practitioners.

Trainee Practitioner Section

Against each of the trainee categories outlined in Section B of the CP Workforce Transformation template, tab 5.1, the following figures are required in baseline and forecast section, (Column C and Columns D to I):

Column C: Baseline Staff in Post – Full time equivalent (FTE) staff in post, directly employed by the Provider organisation as at March 2014 for trainee practitioners (exclusive of; agency, bank, locum, vacant posts or hosted staff).

Columns D-I: Forecast Demand – The in-year forecast workforce demand of the number of trainee practitioners you want to access training programmes as at March 2015 to March 2019. Please ensure that the numbers are consistent with the business case proposal for trainee practitioners.

Qualified Practitioner Section

Against each of the trainee categories outlined in Section B of the CP Workforce Transformation template, tab 5.1, the following figures are required in baseline and forecast section, (Column C and Columns D to I):

Column C: Baseline Staff in Post – Full time equivalent (FTE) staff in post, directly employed by the Provider organisation as at March 2014 for qualified practitioners (exclusive of; agency, bank, locum, vacant posts or hosted staff).

Columns D-I: Forecast Demand – The in-year forecast required workforce establishment as at March 2015 through to March 2019 (reflective of the replacement of leavers plus predicted change in capacity required plus vacant posts).

9. Support

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