HEE Workforce Planning and Strategic Framework (Framework 15)

2015/16 Call for Evidence

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

Section 1: Current and future workforce demand and supply

Section 2: Drivers of service demand change

Section 3: Patients and population

Section 4: Models of care

Section 5: Future workforce characteristics

Section 6: Any other evidence

Submissions should be completed and returned to HEE, using this form, by 30th June 2015 (see below for more information).

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

Making your submission

- We ask that, to maximise input, your submission is completed and returned to HEE by **30th June 2015**
- To submit your evidence please, complete this form. You can provide extracts of reports into the free text boxes below, or submit whole reports. Where an extract is provided, please reference the source.
- In submitting evidence you are invited to take into account the following:

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

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

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

- Please note, it is not *compulsory* to complete all sections for you to submit a response, but **in order to maximise the value of your submission in informing HEE's 2015/16 education commissions, section 1 should completed and returned by the 30th June 2015.** Later submissions are not wasted as we draw on Caff for Evidence returns throughout the year for a variety of purposes.

Your contact details

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

Name	Miss Afsana Choudhury
Job title/role in organisation	Workforce Planning Co-ordinator
Organisation (in full please)	The Royal College of Anaesthetists (RCoA) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI)
Contact email	achoudhury@rcoa.ac.uk
Contact number	02070921652
Submission version)if you resubmit at any point)	
Date	30 June 2015

Data Protection and Freedom of Information

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

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

Section 1 – Current and future workforce demand and supply

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

i) the high level indicators; supply, demand, and any forecast under / over supply

or if available

ii) the more granular components of these three components e.g. retirement rates, output from education relative to attrition

1.1 Summary forecasts

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

HEADLINE POINTS:

- The CfWI In-Depth Review on Anaesthetics and ICM published in February 2015, identified that baseline demand which is based on population growth and demographic changes alone is projected to increase by 25 per cent.
- We strongly recommend that ST3 numbers are maintained at the current level; indeed there is strong evidence from the comprehensive CfWI in-depth review to support a case for moderate increase in the medium to longer term.
- Unfilled ST3 posts over each of the last 3 years continue to be strong evidence that we need to increase core supply supporting a case for increasing core posts, either through growth of core Anaesthesia and/or ACCS Anaesthesia.
- We agree with the Faculty of Intensive Care Medicine (FICM) that there is strength of evidence to support a further increase in ICM workforce, but it must not be done at the detriment of the anaesthetic workforce.
- There is irrefutable evidence of the effect of future demography on demand for Anaesthesia care; demand that cannot be mitigated by a general policy direction to shift secondary (hospital) care to primary and community care.
- The majority of medical contribution to pain management services comes from anaesthetists and this must be taken account of in our workforce planning. There is significant evidence that this demand is growing and significant evidence of variation and inadequate provision which requires to be addressed. http://www.nationalpainaudit.org/
- The College and the NHS support consultant delivered services and recognise the contribution that trainees make. However where the amount of time those consultants spend in service is increased in association with a reduction in training numbers, the ability to provide supervised quality training is compromised. This became apparent following cuts to NTNs in Leeds in 2013 where the reduction in trainee numbers adversely affected the frequency of trainee/consultant interactions, in both service and training with significant cost implications to the Trust. Such issues appear prevalent in other specialties, most notably Emergency Medicine where a crisis point has been reached and remedial action required. It is essential to avoid a similar situation occurring in anaesthetics.
- The GMC 2015 National Trainee Survey results record, high outlier satisfaction for anaesthetics with 'overall satisfaction' rated the highest in hospital specialties 86.07/100. The specialty proves popular with trainees undertaking the anaesthetic programme.

GMC National Trainee survey 2015/indicator reports/postspecialty/overall satisfaction chart

Based on the above headlines we would expect that any changes to anaesthesia numbers will be based on robust anaesthesia workforce planning data rather than intrinsic factors.

1.1 Summary Forecasts

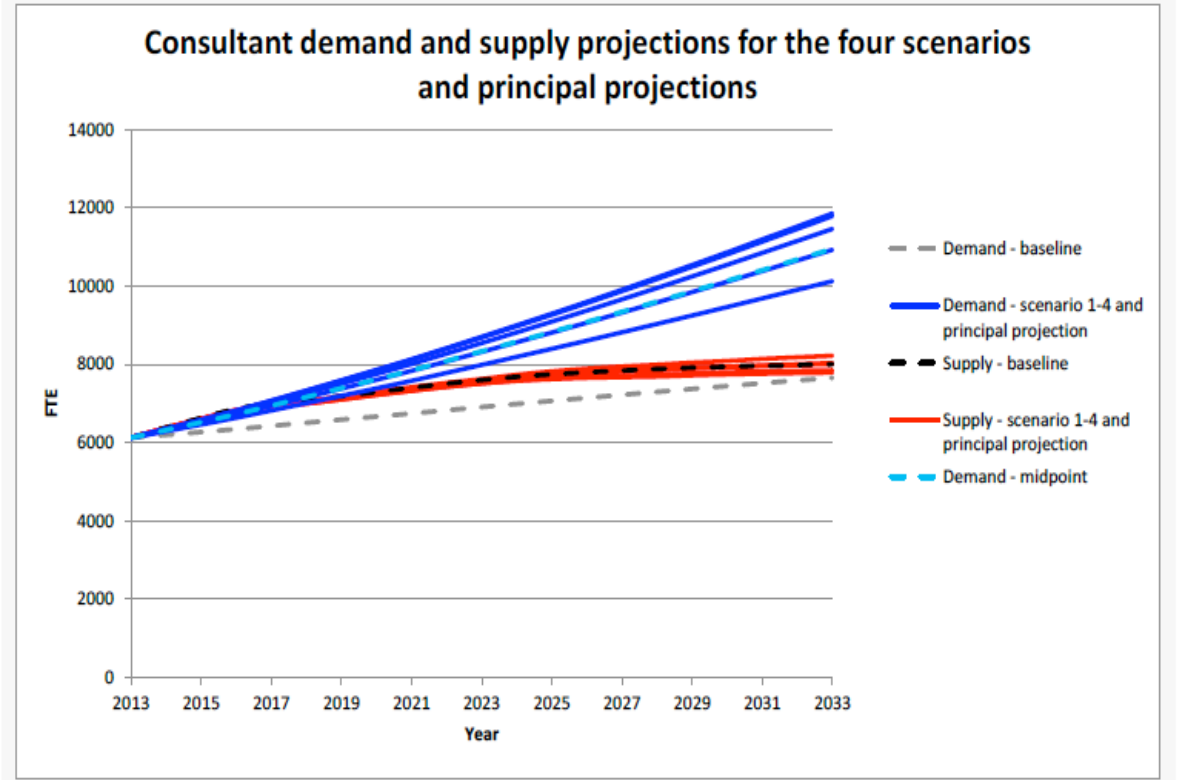
Centre for Workforce Intelligence (CfWI) In-Depth Review of Anaesthetics and ICM

The CfWI In-Depth Review on Anaesthetics and ICM published in February 2015 identified that by 2033 there would be a 25% baseline increase in demand, if we deliver only the services we provided in 2013, from approximately 6,100 to approximately 7,600 full time equivalents (FTE). However the CfWI review suggests that to meet 'expected' or 'most likely' future demand will need an increase in workforce of 4.7 per cent annually. This would see the number of anaesthetist and intensivist CCT holders needed rising to 11,800 FTE in 2033. If we continue with current numbers of training places, 'supply' is projected to increase by 31 per cent, from approximately 6,100 to approximately 8,000 FTE in Anaesthesia and ITU from 2013 to 2033. This would leave the NHS short of approximately 3,800 anaesthetist and intensivist CCT holders by 2033, in effect every NHS Trust being short of 10 to 20 consultants.

The Graph below is taken from the CfWI report. The black dotted line represents the current supply of training numbers and the workforce behaviour with no changes to key modelling assumptions. The 4 blue lines here represent the expected or most likely future demand according to the expert Delphi panel on the 4 scenarios that was presented before them. The future demand scenarios are higher than the supply line. This theme runs throughout the report.

In essence the report identifies the demand in services, provided by Anaesthetists and Intensivists exceeds the supply of CCT doctors out to 2033.

Demand scenarios outstrip supply scenarios for the combined A&ICM workforce.



Graph from CfWI In-Depth Review on Anaesthetics and ICM

Report can be found at http://www.cfwi.org.uk/publications/in-depth-review-of-the-anaesthetics-and-intensive-care-medicine-workforce/

CLWRota

CLWRota is a web based tool management system which helps NHS departments plan and report on anaesthetic activity. CLWRota manages around 7, 500 NHS anaesthetists (including trainees) around the UK, with 85 Trust using the rota.

The graph below is taken from CLW benchmark reports, published on their website. It shows the average mean taken from cross-departmental benchmarks done at six monthly intervals. The three measures are: extra sessions as a percentage of total department activity, solo sessions as a percentage of total department activity and study & professional leave as a percentage of consultant activity. The data clearly shows the dependence on extra sessions has been growing over the last three years, whereas the number of lists allocated to trainees working lists on their own has declined. After an initial decline in September 2012 study and professional leave rates

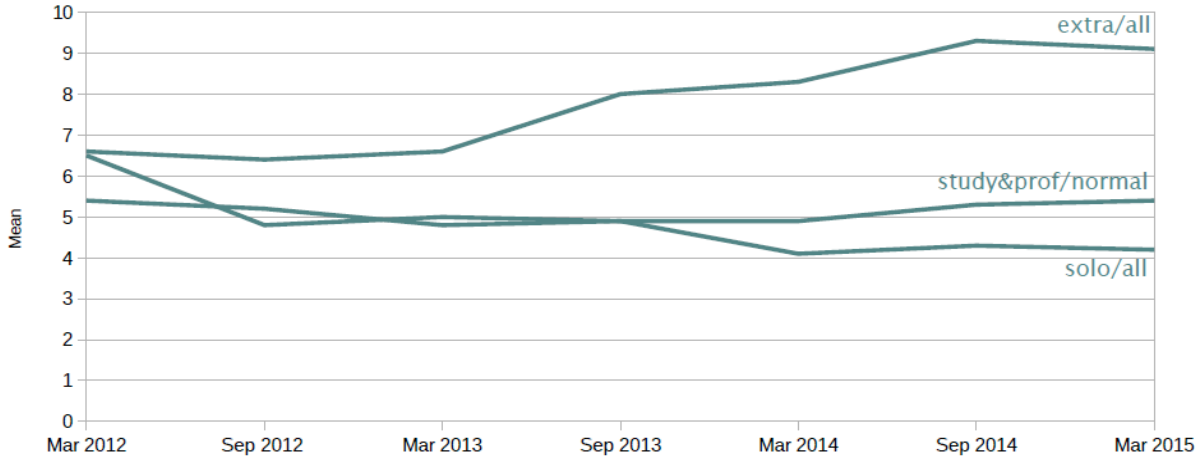
are reasonably static.

It can be seen from the graph that, in order to cover list work, departments rely much more heavily now than they did 3 years ago, on doctors doing additional sessions above and beyond their job plan, for which they are paid extra. Such work is done on a goodwill basis; the more people feel burnt out, pressurised and undervalued, the less effective this is as a way of meeting patient need. There has been an increase in demand for 3 session days and weekend work, much of which is being done as extra sessions. Therefore the rise in activity from 3 session days and in extra payed list work is being achieved without much increase in the number of anaesthestists.

CLW supports management of rotas in more than a third of UK anaesthesia departments. The key point about the CLW data is that it reveals a significant increment of extra work beyond full time contract. This is a strong consolidated measure of unmet need.

Please note that the CfWI in depth review (page above) also talks of unmet need and quotes ICM 25% and Anaesthetics 15% of need is unmet today.
http://www.cfwi.org.uk/publications/in-depth-review-of-the-anaesthetics-and-intensive-care-medicine-workforce/

It must be noted that this is indicative information, however still very powerful in what the data tells us.



Graph from http://clwrota.com/benchmarks/sept2014/

Doctors from the 'baby boomer' generation are willing to do extra work. Generation X and generation Y both have a different attitude to work-life balance, and may not be willing to agree to work on a sustained basis over and above contractual obligations. It would me much safer to train sufficient anaesthetists to cover services without relying on extra sessions or locum work.

1.2 Detailed / Component forecasts

Forecast Workforce Demand

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

1.2 Detailed/Component forecasts

Detailed component forecasts are described in CfWI in-depth review (above).
This strongly supports the need to maintain CCT output. This requires maintaining ST3 numbers and increasing core supply to ensure ST3 posts are filled.

Perioperative Medicine (PoM)

It is clear that there are significant gains for patient safety and outcomes associated with improvements in perioperative care for patients. Anaesthetists are ideally placed to lead these services and the Royal College of Anaesthetists has introduced a Perioperative Medicine Programme to promote the value of this work. The drivers behind it are;

- An increasing elderly population undergoing more and more complex surgical procedures
- Increasingly complex medical co-morbidity at the time of surgery
- Strong evidence that pre and post-operative interventions can improve outcomes and reduce complications
- An underlying requirement to use resources such as High Dependency and Critical Care facilities as efficiently as possible

In addition to the drivers behind improving patient care there are also reductions in junior surgical posts, in particular Foundation posts, which will require changes in the way that care is planned and delivered in the perioperative period.

Careful consideration of the medical effects associated with anaesthesia and surgery is essential to maximise the efficiency of services and avoid complications. The knowledge and skills required to undertake this role are considerable and it represents a natural extension to the role that consultant anaesthetists play in the care of patients. However, there are significant manpower requirements to ensure that patients may be assessed pre-operatively and stratified and followed up according to medical need. Currently there are around 250,000 patients per year that are identified as bring at particularly high risk and providing consultant-led perioperative care for this group will require an increase in consultant numbers.

Many hospitals have already established pre-operative assessment clinics but the scope and scale of these services are set to increase significantly over the coming

years. Given the complexity of this care it will need to be consultant-delivered. This will require additional numbers in the consultant workforce in all units to ensure that services are provided for the benefit of patients across the entire country. Changes to the training programme will support the development of this workforce. www.rcoa.ac.uk/perioperativemedicine

Dr Chris Carey, Head of School & Perioperative Medicine Task & Finish Group, Member

Workforce Productivity

There has been a huge drive over the last few years to have consultant cover for all activities so the number of solo list being done by trainees has reduced (see CLW graph page 6). This has increased the amount of consultant delivered activities without actually increasing the overall output i.e more new work delivered by consultants.

In departments where numbers of trainee anaesthetists have been cut, consultants have taken on out of hours and overnight work. This continues to adversely affect the frequency of trainee/consultant interactions, in both service and training as well as having significant cost implications for the Trust.

Seven Day Consultant Care

There is an expectation that the NHS will move to seven day working with Seven Day Consultant Present Care http://www.aomrc.org.uk/projects/seven.html; http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf. The quality of care delivered to patients admitted at weekends and on Bank Holidays needs to match that delivered during the week. **This will require an increase in the anaesthesia workforce.**

1.3 Forecast Supply from HEE commissioned education

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

1.3 Forecast Supply from HEE commissioned education

Under Recruitment

There continues to be growing concern over the inconsistent ST3 fill rates as the College had highlighted to HEE last year for 2013 and 2014. Results received recently for the ST3 August intake 2015 show 93.81%. Fill rates are still not 100% across the country, with some areas suffering poor fill. The College is increasingly aware that this is having an impact at departmental level with an increase to consultant workloads and gaps in rotas.

The College view is that, to correct the inconsistent ST3 underfill we strongly recommend a modest increase in core supply.

	ST3 2013					ST3 2014					ST3 2015		
UoA	Appointable Candidates	Posts	Accepted	Fill Rate		Appointa	Posts	Accepted	Fill Rate		Posts	Accepted	Fill Rate
HE East Midlands	14	9	9	100%		17	18	13	72.2%		25	25	100%
East Midlands South	6	12	12	100%		*above also includes EM south now HE East Midlands*					*above also includes EM south now HE East Midlands*		
East of England	8	11	11	100%		15	9	9	100%		8	8	100%
Kent, Surrey & Sussex	20	21	21	100%		27	23	23	100%		24	24	100%
London	110	103	103	100%		83	102	78	77.5%		85	85	100%
Mersey	13	12	12	100%		16	14	14	100%		20	20	100%
North Western	22	20	20	100%		25	24	24	100%		24	20	83.33%
Northern	13	20	10	50.00%		11	15	10	66.7%		27	15	55.56%
Oxford	12	12	12	100%		17	12	12	100%		12	12	100%
Severn	19	11	11	100%		*This is now included in HE South West (Severn) and (P*					*This is now included in HE South West (Severn) and (Peninsula)*		
South West Peninsula	9	11	11	100%		32	26	26	100%		24	24	100%
Wessex	11	10	10	100%		16	9	9	100%		11	11	100%
West Midlands	33	30	30	100%		19	23	16	69.6%		27	27	100%
Yorkshire and the Humber	20	28	20	71.43%		34	30	27	90.0%		25	25	100%
Scotland	40	50	30	60.00%		38	43	32	74.4%		43	36	83.72%
Wales	17	20	19	95.00%		24	18	18	100%		18	18	100%
Northern Ireland	9	10	9	90.00%		10	10	10	100%		15	14	93.33%
Totals	376	390	350	89.51%		384	375	321	85.6%		385	332	93.81%

ST3 Recruitment fill rates provided by Anaesthesia National Recruitment Office (ANRO)

1.4 Forecast Supply – Other Supply and Turnover

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

1.4 Forecast Supply – Other Supply and Turnover

From other education supply

There is no other Education supply for trained anaesthetists other than through the UK Anaesthesia Training Programme. We recognise that trained anaesthetists can be recruited from elsewhere in the world but we suggest that the advantage is in being self-sufficient within the UK.

To/from the devolved administrations

Maintaining the UK consistency in standards of training enable continuing cross border within the UK. We support maintaining this consistency.

To/from private and LA health and social care employers

Impact of the Independent Sector in anaesthetic workforce planning

The Independent (Private) Sector (IS) provides significant services to the NHS. The number of elective NHS admissions to private hospitals has grown from 19,620 in 2004/2005 to 394,260 in 2012/13, 5.1% of all NHS elective surgical admissions. Growth from 2011/12 was 13.3%. In 2012, NHS work represented 27.5% of all IS income and this was expected to grow to 28.8% in 2013.

The NHS "Choose and Book" policy is the main current driver of NHS work in private hospitals. As this is still poorly developed and understood by patients, there is significant potential for growth in demand. However, this will be constrained by current IS capacity, reducing NHS tariff and an improving privately funded market, as the economy improves. It is likely that new private capacity will become available to service increasing NHS demand and that growth in NHS demand will be satisfied.

Current growth is estimated at 13.3%. If this drops to only 50% of this for the next 5 years and then remains static, NHS admissions to the IS will grow to 544,000 per

annum by 2020, or 7% of all NHS elective activity, if this remains constant.

The substantial majority of these admissions require surgery and anaesthesia, or approx. 544,000 hours of anaesthetic consultant involvement, as a minimum estimate, or 136,000 private hospital 4 hour theatre sessions. If a consultant can supply 10 sessions each week working full time in the IS over 42 weeks a year, this will require 323 consultant anaesthetists to deliver the work. This is likely to be a considerable under-estimate. However, at a minimum, approximately 5% of the currently available consultant workforce of 6000 will be required full time in the private sector.

Currently, IS anaesthetic work is funded on a fee per case voluntary basis, over and above any NHS contractual duties. It could therefore be argued that this will have limited effects on anaesthetic workforce planning and could actually reduce the number of anaesthetists required in the NHS. However, there is increasing evidence that generation X and Y consultant anaesthetists are reluctant to engage in IS working, particularly for poorly remunerated NHS work, so that unless the economics change significantly, the IS will have to engage full time consultants, and/or, the NHS will have to provide funded time to service IS activity.

The impact of NHS contract changes is also likely to affect IS supply of anaesthetists. As the ratio of DCC to SPA funded time increases, less time will be available to service the IS. However, if consultant NHS income reduces, there may be greater interest in increasing income by working in the IS as well as the NHS, even for those in generations X and Y.

Therefore, it is recommended that workforce planning should incorporate an increase in trained anaesthetists to account for the impact of the IS on servicing NHS elective activity.

References : Private Acute Medical Care UK Market Report 2013. 2nd edition. LaingBuisson Ltd. 2014. ISBN 978 1 85440 179 3

To/from the international labour market

Locums appointed from the rest of the European Union and elsewhere are assumed to have the same level of training as UK CCT holders, but in reality take time to acclimatise to the NHS organizational culture.

To/from other sectors / career breaks and 'return to practice'

SAS Doctors

The speciality of anaesthesia has the largest number of SAS doctors and they are a significant proportion of anaesthetic workforce which is more than 25 percent http://www.rcoa.ac.uk/system/files/CSQ-2010-CensusResults.pdf. This is larger than in any other speciality.

SAS doctors are career grade doctors and contribute significantly to the anaesthetic services in the NHS. They anesthetise for elective operating lists independently depending on their experience and cover out of hours duties as first and second on calls regularly in their job plans. They cover maternity units and intensive care units during the day and out of hours regularly.

Several doctors are appointed to this grade to fill gaps in the anaesthetics service and shortage of staff at junior level and consultant level either on temporary or permanent basis. The number of locum doctors appointed is increasing all the time. Workforce planning must include SAS doctors.

To/from other professions (e.g. to HV or to management)

We recognise the need to factor in anaesthetic significant contribution to medical management as part of overall workforce demand.

Increased / decreased participation rates (more or less part time working)

Less Than Full Time (LTFT)

There are continuing concerns around variation in provision of flexible training. Inconsistent approach between LETBs with some only offering 50% slot shares while others provide the RCoA recommended minimum of 60%. The lower the percentage offered, the longer the time to complete the training in anaesthetics, mastering new skills and techniques and consolidating this experience when only working 50% is challenging, may take longer and can affect confidence levels. There has to be recognition of the additional cost to supporting LTFT – some Deaneries / LETB have a fund to "top up" 50% to 60%

- Combining trainees into slot shares leaves an empty FT training placement which cannot be backfilled due to the rigidity around national training numbers and LATS.

  The College recommends that less than full time training is managed on a whole time equivalent basis rather than head count (NTNs)

- GMC trainee survey 2014 figures show demand for LTFT training in anaesthetics continuing to increase - currently 12.8% which reflects a year on year rise. Notable in the 2014 GMC trainee data was the fact that 20% of anaesthetic LTFT trainees were male. This contrasts with less than 5% 7 years ago
- Published data "Influence of less than full time or full time on totality of training and subsequent consultant appointment in anaesthesia" Randive S, Johnston CL, Fowler AM, Evans CS Anaesthesia. 2015 Jun;70(6):686-90

  This project supported by the RCoA, reviewed outcome data from 1,200 anaesthetic trainees completing their training between 2009 and 2011. The College trainee database provided accurate information on each individual's training programme and this was matched with data collected by College from their representative on Advisory Appointment Committees. This showed average length of (full time) training to be longer than that predicted - 8yrs 5 months to complete the GMC approved 7 year competency based training programme. The figure for those who train LTFT in anaesthetics was relevant to workforce planning as it showed those who request LTFT only train on a part-time basis for limited periods of time and not the totality of the training programme. This may be unique to anaesthetics as this data has not been published from any other speciality to date. The take up of part-time consultant's posts was small regardless of whether training had been FT or LTFT.
- Demand for part-time consultant working may increase influenced by:
  - The expectation of having to work beyond 60 years of age
  - The impact of 2014 legislation on requesting flexible work
- The RCoA has led the way with active involvement in return to work initiatives to ensure trainees after maternity leave, a career break or sick leave are more likely to return to training successfully. The College in 2014 hosted their first Giving Anaesthetics Safely Again (GASAgain) simulation day and this educational day is now offered via the College in two other UK sites. The delivery of a structured return to work at all levels has been led by patient safety demands but ensures a seamless and supported return to the workplace for those in training.

Information provided by Drs Carolyn Evans (West Yorkshire, former Bernard Johnson Advisor, LTFT) and Dr Susan Underwood (Bristol, Bernard Johnson Advisor, LTFT)

Retirement

Recent changes in pension arrangements have seen an exodus of consultants in their late 50s and early 60s. Some have taken up opportunities to 'retire & return' but others have left the service.

The current normal pension age is now 65 years. Many consultants are retiring earlier than this. The reasons are multifactorial, but factors such as increasing evening and night work and the pressure to deliver more direct clinical care, often single handed, as a percentage of overall workload have been cited *(Redfern N Gallagher P The Ageing Anaesthetist Anaesthesia. 2014;69(1):1-5.* It is well-known that older people take longer to recover after overnight work *(Fatigue and the Anaesthetist 2014 AAGBI).*

Current pressures for increased utilization of NHS resources through evening and night time work are unattractive to many doctors and particularly those in front-line service specialties such as anaesthetics, and have the potential to be unsafe for older anaesthetists and their patients. A Canadian study found that anaesthetists aged 65 and older had 1.5 times the number of successful claims against them compared with anaesthetists < 51 years, leading to more severe injuries, despite the older anaesthetists' being involved in fewer complex cases. *[Tessler MJ, Shrier I, Steele RJ. Association between anaesthesiologist age and litigation Anesthesiology 2012; 116: 574-9]*

Section 2 - Drivers of service demand change

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
We believe that our population is **getting older**, and that for our workforce, preferences for a change in patterns in working is increasing.	Please note that the methodology CfWI used for the in-depth review of Anaesthetics and ICM included workforce modelling, Horizon Scanning, Scenario Generation and the Delphi Process. This required contribution from our committed members of the anaesthetic community and College Representatives (Council Members, Regional Advisors, Head of Schools) The CfWI in-depth review work covers these **sections 2,3,4,5** and have all been examined in detail in the published report, February 2015. **The College strongly recommends that ST3 numbers are maintained at the current level and that there should be an increase in core supply.**	How do you think this will have an impact as a driver of **service demand**?
The influence of technology is growing in healthcare and beyond, with staff and patients using it to **increase personalisation and control** in their life. What will be its possible impact in healthcare in the years ahead? The influence of **genomics and research** will also play a vital part.		How will technology and innovation impact on **service demand** in the near future, and what education/training will the current workforce need to meet that demand?

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
Wider factors are creating global pressures to **constrain the cost** of publicly funded healthcare, with the wider concept of wellness increasingly taking root which people will expect health service to respond to.		Economics will play a part in influencing **service demand** and NHS funding will shape service demand in the near future (QIPP, funding, economics).
Patients are going to want **high quality services anytime, any place, anywhere**, with a more equal (and challenging) relationship with staff, but one still based on care and a better work life balance.		What is the shorter term impact of changing patterns of expectations on **service demand**?

Section 3 – Patients and population

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
With people living longer with more people living with **multiple and complex conditions** (and with our workforce being currently predominantly trained to treat distinct and different disease in isolation after a health crisis has occurred). How can we educate/train the workforce to support the prevention of ill health and, where ill health occurs, support staff to work across organisational boundaries to support high quality care for people with a range of health needs (across physical, mental health and social care)?	Please note that the methodology CfWI used for the in-depth review of Anaesthetics and ICM included workforce modelling, Horizon Scanning, Scenario Generation and the Delphi Process. This required contribution from our committed members of the anaesthetic community and College Representatives (Council Members, Regional Advisors, Head of Schools) The CfWI in-depth review work covers these **sections 2,3,4,5** and have all been examined in detail in the published report, February 2015. **The College strongly recommends that ST3 Numbers are maintained at the current level and that there should be an increase in core supply.**	What are the possible/likely impacts on **service demand – activity and epidemiology**?
Our patients and population are likely to be at different stages of being **informed, active and engaged** in their own healthcare (including using for example, data and online records), with our challenge being to support the development of a workforce which can support high quality care for all patients.		How will needs **identified by patients and the public** affect service demand in the shorter term?

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

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
Five year forward view draws attention to the NHS being committed to making **substantial progress** in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds.		How can we use our levers in the **short term** to support this commitment?

Section 4 – Models of care

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
Five Year forward View outlines a number of possible future service models including • multispecialty community providers (MCPs), which may include a number of variants • integrated primary and acute care systems (PACS) • additional approaches to creating viable smaller hospitals • models of enhanced health in care homes The **expertise to support** the piloting and introduction of these models need to be considered. Existing NHS services and areas of the healthcare workforce may work with others in new and different ways (e.g. community pharmacy).	Please note that the methodology CfWI used for the in-depth review of Anaesthetics and ICM included workforce modelling, Horizon Scanning, Scenario Generation and the Delphi Process. This required contribution from our committed members of the anaesthetic community and College Representatives (Council Members, Regional Advisors, Head of Schools) The CfWI in-depth review work covers these **sections 2,3,4,5** and have all been examined in detail in the published report, February 2015. **The College strongly recommends that ST3 Numbers are maintained at the current level and that there should be an increase in core supply.**	How could **future service models** develop in the short term in line with these developments and the learning from the Vanguard sites, and what education/training will the current workforce need to make these models work?
Services are likely to become **increasingly integrated** in the future, enhanced through policies such as the Devolution of Local health and social care budgets, the integrated care pilots and integrated personal commissioning. Partnerships will become increasingly important, including with partners beyond NHS and social care.		How could **future service models** develop in the short term in line with these drivers, and what education/training will the current workforce need to make these models work?

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term**, specifically:
We may increasingly see **centres of specialisation** in some specialties in some areas.		How could **future service models** develop in the short term in line with these drivers?
We will see the ongoing development of services in the area of **urgent and emergency care**		How could **future service models** develop in the short term in line with these drivers?
Five Year Forward View highlights new developments such as the **evidence based diabetes prevention service** and **encouraging new capacity in under doctored areas.**		How could such approaches affect **service models** in the near future?

Section 5 – Future workforce characteristics

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
Below are the 5 future workforce characteristics set out in Framework 15	In your evidence please highlight any or all of the following: - Are these workforce characteristics still valid? - Any evidence you are aware of work which is underway and which contributes to the achievement of the workforce characteristics - Any gaps you are aware of Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term** education and training needs required for the current workforce to meet these characteristics:
The workforce will include the informal support that helps people prevent ill health and manage their own care as appropriate.	Please note that the methodology CfWI used for the in-depth review of Anaesthetics and ICM included workforce modelling, Horizon Scanning, Scenario Generation and the Delphi Process. This required contribution from our committed members of the anaesthetic community and College Representatives (Council Members, Regional Advisors, Head of Schools) The CfWI in-depth review work covers these **sections 2,3,4,5** and have all been examined in detail in the published report, February 2015. **The College strongly recommends that ST3 Numbers are maintained at the current level and that there should be an increase in core supply.**	
Have the skills, values and behaviours required to provide co-productive and traditional models of care as appropriate.		
Have adaptable skills responsive to evidence and innovation to enable 'whole person' care, with specialisation driven by patient rather than professional needs.		

Timescale/time horizon		
Framework 15 message:	**Longer term – to 15 years**	**Shorter term to 5 years**
Below are the 5 future workforce characteristics set out in Framework 15	In your evidence please highlight any or all of the following: - Are these workforce characteristics still valid? - Any evidence you are aware of work which is underway and which contributes to the achievement of the workforce characteristics - Any gaps you are aware of Please detail your evidence about the **longer term**	Please detail your evidence about the **shorter term** education and training needs required for the current workforce to meet these characteristics:
Have the skills, values, behaviours and support to provide safe, high quality care wherever and whenever the patient is, at all times and in all settings.		
Deliver the NHS Constitution: be able to bring the highest levels of knowledge and skill at times of basic human need when care and compassion are what matters most.		

Section 6 – Any other evidence not included elsewhere