NHS
Health Education England

HEE Workforce Planning and Strategic Framework (Framework 15)

2015/16 Call for Evidence

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

Section 1: Current and future workforce demand and supply

Section 2: Drivers of service demand change

Section 3: Patients and population

Section 4: Models of care

Section 5: Future workforce characteristics

Section 6: Any other evidence

Submissions should be completed and returned to HEE, using this form, by 30th June 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:

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Job title/role in organisation	Chair of the Specialty Advisory Committee in Diagnostic Neuropathology
Organisation (in full please)	Royal College of Pathologists
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Contact number	07941 326440 / 020 7451 6726
Submission version (if you resubmit at any point)	1
Date	30/06/2015

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

On the basis of national workload and workforce surveys, the Royal College of Pathologists recommended that there should be one full-time equivalent neuropathologist per 1,000,000 population to achieve adequate neuropathology cover (2009 Code of Practice for Histopathologists and Histopathology services). Best evidence collated by the British Neuropathology Society (2011-2013) suggests that there are 54 consultants working in Neuropathology in England, at 21 centres. They work a total of 280 DCCs, equating to approximately 33 full-time equivalents, assuming a 10PA role with 1.5 SPAs. The current population estimate for England is 51 million. Since 2009, the increasing complexity of cases, to include for example layered reporting of molecular results in cancer work, risk stratification of paediatric tumours, means that this may no longer reflect current or future workload. The 2009 figures, translated to today's population equates to a shortfall of 29 consultants working at current DCC rates.

The current DCC rates of the English Neuropathology community is largely due to the high proportion of Neuropathologists who have joint academic / NHS appointments. This is a long-standing and on-going feature of the specialty and reflects our expertise and interest in clinical academic medicine. The niche delivered by Neuropathologists in terms of clinical research and education cannot be overlooked. Although these are hard to define in current DCC estimates, the contributions made to future treatment development should not be underestimated.

As a relatively small specialty, Neuropathology is susceptible to problems arising if and when pathologists move within the devolved nations of the UK.

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

The current British Neuropathology Service Specification (v18) was referenced in last year's HEE submission and remains unchanged. These documents may be seen at http://www.bns.org.uk/information/ (click on *link to File Archive,* open *General Publications)*
In addition, the British Neuropathological Society together with the Specialty Advisory Committee in Neuropathology at the Royal College of Pathologists has recently submitted an updated service specification to NHS England which describes the concept of Neuropathology networks to further underpin the service provided. This is likely to partly address the shortfall of consultant FTEs described above.

There are several relatively long-standing vacant Neuropathology posts within England. Aside from this, there are niche areas of neuropathology (particularly paediatric neuropathology) where consultant provision is limited to a very few individuals, and this imparts additional risk on a super-specialist service. Training in this area is exceedingly limited, when diagnostic capacity needs to increase to reflect evolving paediatric oncology practices, and molecular capacity that impacts directly on patient survival and quality of life. We appreciate the national strategic context of wishing to limit the pre-CCT training of committed super-specialists, but accessibility of our small trainee population to this pre-existing workload needs to increase to shape the workforce of the future.

1.3 Forecast Supply from HEE commissioned education

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

Accurate Neuropathology 2015 training numbers demonstrate 9 Diagnostic Neuropathology trainees within England, on the four-year programme, of whom 6 have been recruited through the new specialty national recruitment scheme in the last two years (one of the nine through the Spring 2015 round). Attrition rates are very low, but under recruitment has been a problem: as previously stated, we aim to recruit a steady state of 3 trainees a year, but have had a shortfall to fill over the last two years. Although we have recruited successfully to steady state requirements we have not filled the shortfall of approximately 3 trainees. Employment on completion of training has not been an issue in recent years: in fact the contrary, there are insufficient UK trainees to address the shortfall described in **section 1.1**

Figure 2 in **section 6** below illustrates how the peak of consultant workforce numbers relates to that cohort whose retirement is imminent. The current shortfall, under-recruitment and imminent reduction in consultant numbers combine at a time of increased workload to potentially create an insurmountable problem in terms of service delivery.

Under recruitment has been due in part to the number of applications from appointable candidates; however additional failures have come about through geographical availability of training programmes at each recruitment round, counterbalanced with ST3 level candidates placing geography above specialty in terms of placement priorities. This is a well-recognised phenomenon, not in any way restricted to pathology, perhaps best evidenced by the Royal College of Physicians 'Census of consultant physicians and higher specialty trainees in the UK' Full report 2013-14, Dr Harriet Gordon, Director, Medical Workforce Unit, commentary on census data page 3 and R21 Factors affecting job application on page 154.

National recruitment is run by London Postgraduate Medical and Dental Education. There are up to two recruitment rounds per year, within the specified recruitment windows. Given the numbers of trainees required, it is difficult for individual LETBs to balance the national requirement with their local need.

There was no additional funding laid aside when the Diagnostic Neuropathology gained specialty status (it was previously locally funded as a subspecialty training opportunity in Histopathology). Since Diagnostic Neuropathology recruitment occurs in the same window as Histopathology, this often means that LETBs are unsure whether they can fund a Diagnostic Neuropathology post for a particular recruitment round, as the post may be filled by Histopathology in the same time frame.

To begin to address this in 2016 there is a need for the 4-5 training posts in Neuropathology to be funded via a separate, protected, stream to Histopathology. This more accurately reflects both our (independent) specialty status and that trainees can enter the training programme from Histopathology, Neurology and Neurosurgery; the process is not one merely of transferring a histopathology number into a Diagnostic Neuropathology number in the middle of the Histopathology training programme. In this model, each appointable applicant, in order of the rank following interview, would be assigned funding and would choose their preferred approved training programme that was incompletely filled: the onus on the local approved training programme to secure funding for a particular round would be removed. The model would not operate to the detriment of Histopathology training numbers but would add clarity to the national picture of pathology recruitment.

This process has been discussed with the Chair of the Cellular Pathology Specialty Advisory Committee at the Royal College of Pathologists, Workforce Lead at the Royal College of Pathologists, Chair of COPMeD and our Lead Dean.

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

Within the devolved nations, there is currently no approved training programme in Wales. Planning for the Scottish training programme, sufficient to address acknowledged local consultant requirements is in progress. Issues such as retirement and growing workload have been addressed previously.

As demonstrated, Neuropathology has close relationships with academic neuroscience and medical education. The delivery of Diagnostic Neuropathology services to NHS England is critically dependent on the NHS DCC activities of clinical academic Neuropathology staff, and their associated SPA-related contributions. There is a need for increased academic training opportunities in Diagnostic Neuropathology, which will be pursued through other means.

International recruitment occurs at a relatively stable rate at both trainee and consultant level. Attempts to address the current consultant shortfall by through overseas recruitment have been challenging and have been met with variable long-term success.

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.	Average SPAs per Neuropathology consultant may already reflect unusual workforce preferences	Service demand will increase reflecting increased diagnostic work on CNS tumour cases, for example with layered reporting, and more aggressive treatment of older patients. More in depth analysis of neurodegenerative brain specimens occurs, but this is not always within NHS job plans.
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.	Neuropathology guidance already covers the process of "layered reporting" such that molecular information is incorporated by the Neuropathologist into the final summary report for each malignancy. This is further detailed in the recent NHSE service specification submission.	As described in the service specification and relating to increased presence of molecular neuropathology in future curricula. Telepathology can allow remote coverage for intra-operative diagnostics and MDTs.
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.	The network model of service provision, as described in the service specification revision, begins to address this, but this remains a serious concern for the future of service provision.	We already have a shortfall of consultants and predictable further shortfall relating to imminent retirement. We have illustrated the relatively low DCC rate of our current consultant workforce. Issues such as affordability are essential for the public as a whole, but small reductions in Neuropathology funding will have dramatic and likely insurmountable impact on Neuropathology service and training, as a consequence of our specific demographic.
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.	The mean SPA time of England Neuropathologists will not easily cover a longer working day / 7 day a week service without additional consideration to job planning and increased recruitment.	As described, there is currently insufficient staffing (DCC per population) to cover a 5-day/week service. This gap will be exacerbated by transition to a 7 day a week service. The Scottish experience of the development of National Key Performance Indicators has impacted on molecular diagnostic turnaround times.

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)?	Our research-active service is well placed to begin to define these issues, please see the shorter-term statement as an example.	For example: Risk stratification by neuropathologists in what was previously considered one form of common paediatric CNS tumour (medulloblastoma). This balances adjuvant therapy to increase survival in children with higher-risk medulloblastomas with the potential neurodisability caused by unnecessary adjuvant therapy in children with lower-risk medulloblastomas, through the multidisciplinary team, with detailed neuropathology input. Reducing the number of children who potentially have 80 years of neurodisability, without increasing mortality, is an important priority.
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.	Consultants need to ensure reports are phrased in such a way as to be suitable to be read by patients and healthcare providers. If the Government opens patient records to the patients, it is inevitable that there would be a huge uptake.	Consultants need to ensure reports are phrased in such a way as to be suitable to be read by patients, who increasingly request access to their reports, and healthcare providers. If the Government opens patient records to the patients, it is inevitable that there would be a huge uptake. The need to demonstrate equal access to the same standard of the neuropathology service, including intra-operative diagnostics and molecular tests.

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	We do not know at present	We do not know at present
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)*.	Unlikely to affect Neuropathology	Unlikely to affect Neuropathology
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	Unlikely to affect Neuropathology	Unlikely to affect Neuropathology

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.	Equality and diversity and non-discriminatory ladders of opportunity are integral to our workplaces and to RCPath.	Equality and diversity and non-discriminatory ladders of opportunity are integral to our workplaces and to RCPath. The current ratio of male: female consultants, illustrated in **Figure 3** is, however, noted.

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).	As for shorter term	Increases to Neurosurgical workload and workforce should be reflected in Neuropathologist numbers. As non-surgical therapeutic options (for example stereotactic radiosurgery) become increasingly available the diagnostic workload may end up shifting in relation to neurosurgical figures.
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.	We do not know at present	We do not know at present

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.	We do not know at present	We do not know at present
We will see the ongoing development of services in the area of **urgent and emergency care**	We do not know at present	We do not know at present
Five Year Forward View highlights new developments such as the **evidence based diabetes prevention service** and **encouraging new capacity in under doctored areas.**	We do not know at present	We do not know at present

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.	We do not know at present	We do not know at present
Have the skills, values and behaviours required to provide co-productive and traditional models of care as appropriate.	We do not know at present	We do not know at present
Have adaptable skills responsive to evidence and innovation to enable 'whole person' care, with specialisation driven by patient rather than professional needs.	We do not know at present	We do not know at present
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.	Unlikely to affect Neuropathology / We do not know at present	Unlikely to affect Neuropathology / We do not know at present
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.	The former, we would argue is already in place, within the constraints of current job planning mechanisms	The former, we would argue, is already in place, within the constraints of current job planning mechanisms.

Section 6 – Any other evidence not included elsewhere

Figure 1
Raw number of Consultants by region (i.e. not translated into FTE)

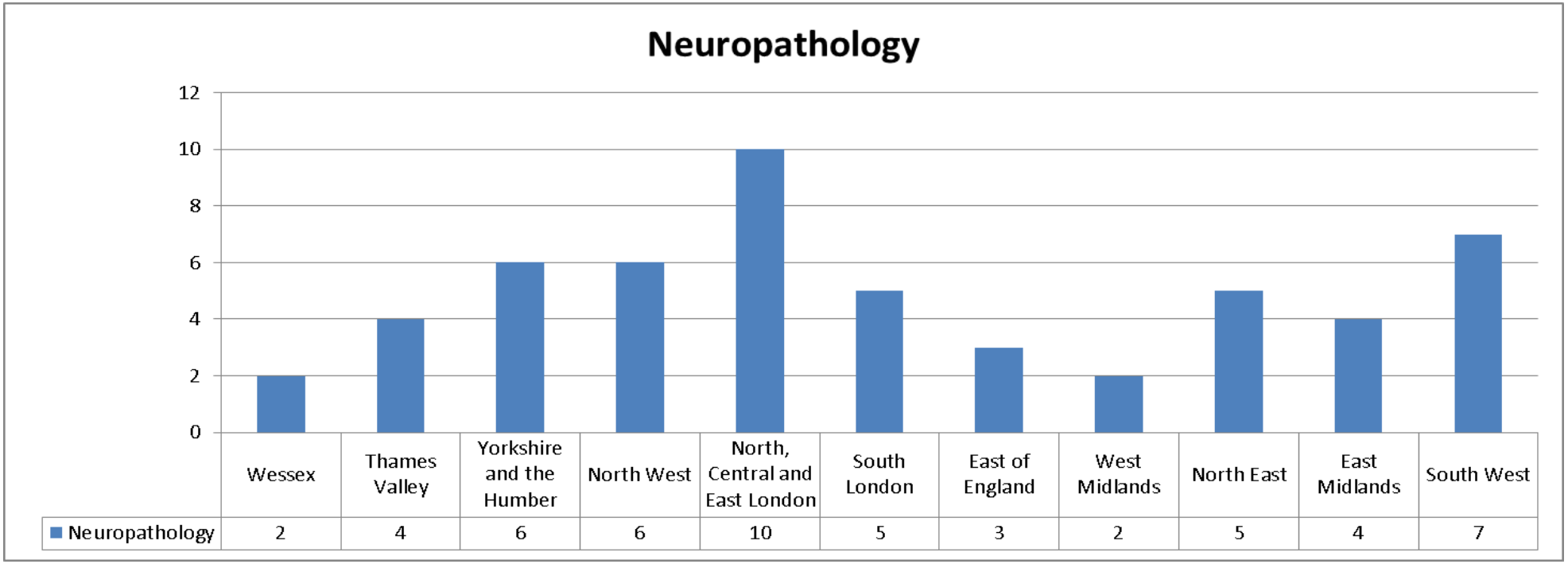


Figure 2 Consultant total by age

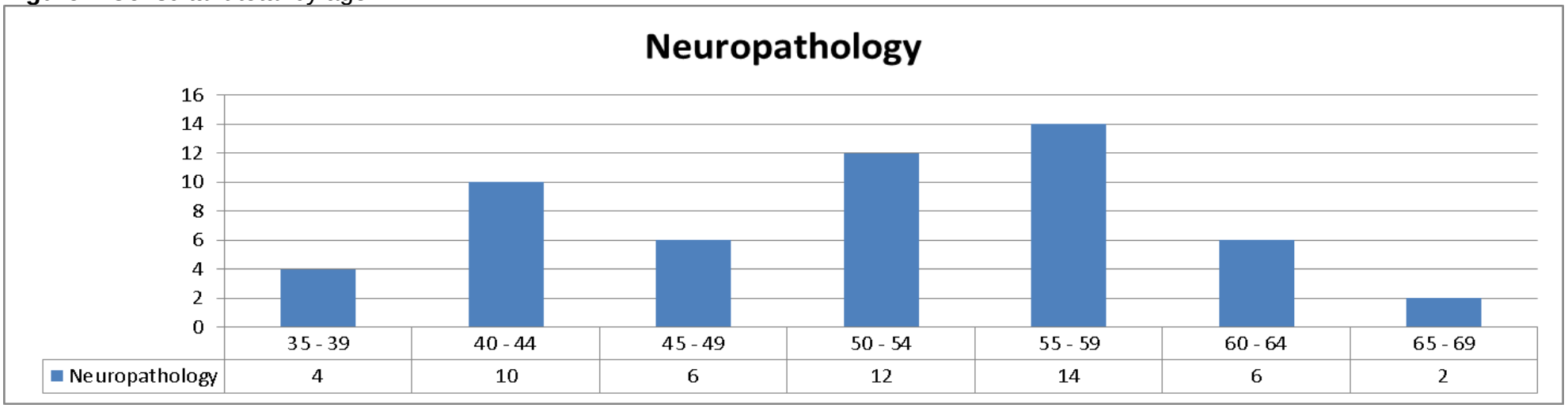


Figure 3 Consultant total by gender

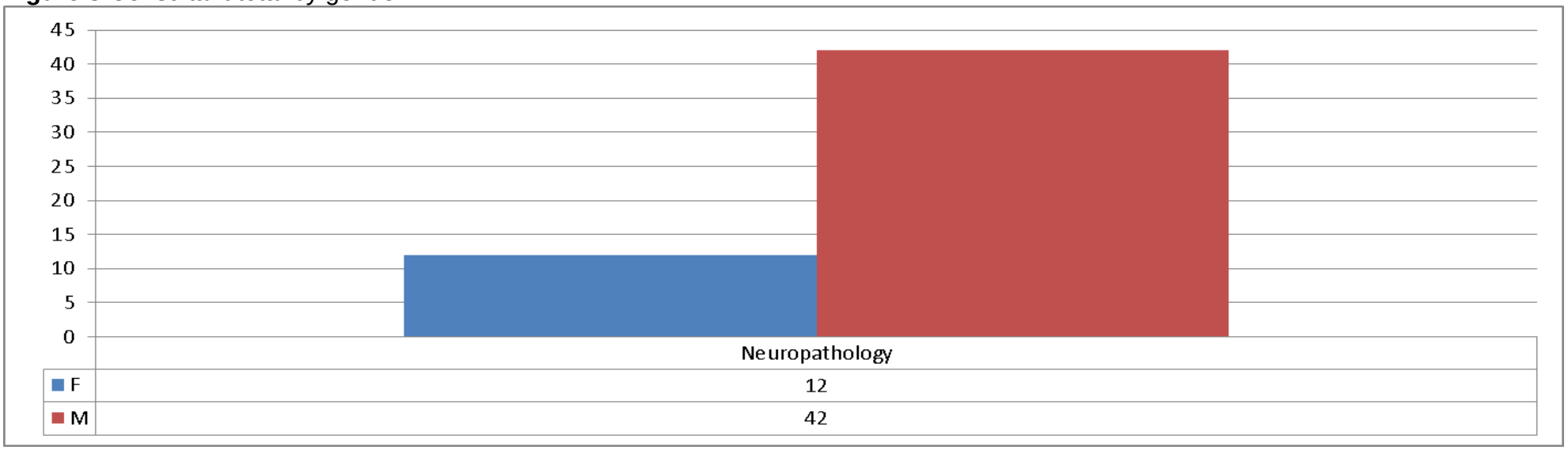
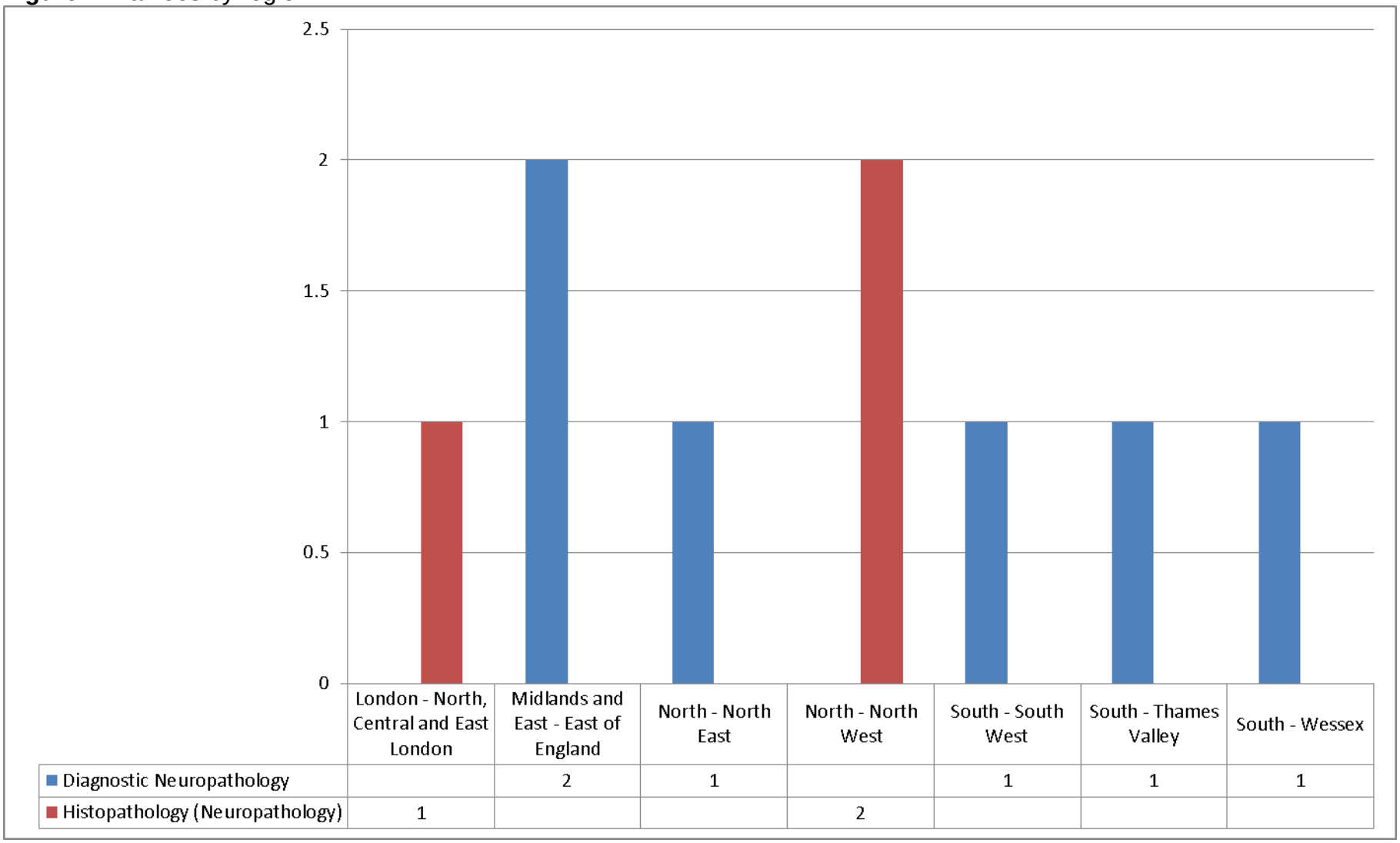


Figure 4 Trainees by region



	London - North, Central and East London	Midlands and East - East of England	North - North East	North - North West	South - South West	South - Thames Valley	South - Wessex
Diagnostic Neuropathology		2	1		1	1	1
Histopathology (Neuropathology)	1			2			