Health Education England

A new approach to workforce, education and training

Wendy Reid
Medical Director
Sep 2013
“HEE will provide leadership for the new education and training system. It will ensure that the shape and skills of the future health and public health workforce evolves to sustain high quality outcomes for patients in the face of demographic and technological change.”

“HEE will ensure that the workforce has the right skills, behaviours and training and is available in the right numbers, to support the delivery of excellent healthcare and drive improvement. HEE will support healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through development of the Local Education and Training Boards (LETBs) which are statutory committees of HEE.”
Clarity of Purpose

• **Quality of care** is our organising principle

• We have a whole workforce responsibility for England
  • Band 1-4
  • Doctors, nurses, scientists, AHPs +
  • CPD
  • Undergraduate and postgraduate education including academic
  • Careers Service
• We will operate through our 13 LETB’s, central offices London, Leeds and Birmingham
Number of staff 000's

- Managers and senior managers: 38
- Hospital and community medical and dental staff: 106
- GPs: 40
- Professionally qualified clinical staff: 686
- Qualified nursing, midwifery & health visiting staff: 370
- Support to clinical staff: 347
- Other qualified scientific, therapeutic and technical staff: 171
- Hospital and community central functions and estates: 182
- Infrastructure support: 321
- GP practice staff: 101
How we talk about HEE

HEE and our LETBs are the NHS engine that will deliver a better health and healthcare workforce for England.

We are responsible for the education; training; and personal development of every member of staff, starting with recruiting for values from our schools and into our Universities.

We are employer led, working to provide the right workforce, with the right skills and values, in the right place at the right time, to better meet the needs and wants of patients.

*Our mission is to improve health outcomes for the people of England by developing people for health and healthcare.*

www.hee.nhs.uk
The Journey so far…

- Appointed 95+% of our people
- Set up Board and Governing Bodies
- Established bases around country
- Delivered Authorisation
- Introduced ourselves to new world
- Produced business and investment plans
- Responded to Francis Inquiry
- Received our Mandate May 2013
LETBs

- Total of 13 LETBs (15 Postgraduate Deans)
- Committees of HEE
- Not Statutory Bodies
- Provider led
- Stakeholder representation
- Core leadership of:
  - Managing Director
  - Independent Chair
  - Director of Education and Quality
  - Head of Finance
- Dispersed HEE leadership
- Deanery functions part of LETBs
Our new policy landscape

- Local priorities
- Government priorities
- National priorities
HEE Budget:

£4.89 billion

£60,000 to train a nurse or AHP
£560,000 to train a new medical consultant
£490,000 to train a new GP

91000 non-medical pre-registration students
44600 postgraduate medical and dental students
23000 undergraduate medical and dental students

£9,500 per minute
Our Strategic Intent Document - feedback

- Majority of respondents agree with HEE’s purpose, values and ways of working.
- HEE’s strategic priorities are widely supported.
- Question as to whether the proposed priorities are too medically focused
- More consideration could be given as to how HEE may work with non-NHS providers.
- The Strategic Intent Document can still be found at www.hee.nhs.uk
Advisory Structures

• HEE reviewing the way it seeks advice and expertise to inform its decisions, including new advisory structures (uni and multi-professional)

• Loud patient/public voice

• Stronger connections between local workforce and national policy & advice
HEE’s Mandate

- Pre-degree experience
- Focus on culture change/ Francis
- Minimum Training Standards
- Strategy for Bands 1-4
- NHS Careers Service
- Situational Judgement Testing
- Dementia training
- Leadership of CPD
- Identifying training needs
- 50% medical students to GP
- Emergency medicine
- Improving GP training

www.hee.nhs.uk
The context 2013 and beyond: Change that is:

• Political
• Economic
• Technological
• Societal

...and Professional
‘Politics’

- UK – 4 devolved health systems
- Health and Social Care Bill 2012
- Separation of NHS and Public Health in England
- New system of commissioning service and education in England
- 4 country regulation of quality
- Move towards integration of health and social care possible
- International politics – workforce, UK PLC, global competition
‘Economy’

- Health budget ‘ring-fenced’ but no increase
- Reduction in ‘health’ with recession
- Research funding restrictions
- More people retiring later
- Pensions
- Re-negotiation of doctors contract
- Multiple providers of health care
The NHS is facing a significant financial challenge, with an estimated funding gap of between £15-20 billion that needs to be resolved by 2014. The impact of this will be felt across all specialties; new ways of working and service redesign will be essential if the efficiency aims of the Quality, Innovation, Productivity and Prevention (QIPP) agenda are to be realised, while improving the quality of care delivered.
‘Technology’

• Empowers patients
• Globalises health
• Raises costs initially
• Increases efficiency

But...we do not know what’s coming:
‘Societal’

- Patient power – new relationship between the public & doctors and between patients & the NHS
- Public expectations of ‘quality’
- Demographics of medical workforce
Context....

Winterbourne
Worcester Acute
Morecambe Bay
What Francis said…

“What Francis said…

“Staff treated patients and those close to them with what appeared to be callous indifference.”

“The culture at the Trust was not conducive to providing good care for patients.”

“The system of regulation and oversight of medical training and education in place between 2005 and 2009 failed to detect any concerns about the Trust other than matters regarded as of no exceptional significance.”
Francis Word Cloud

Top 5 phrases…

Culture
Standards
Caring
Patient First
Compassionate Nursing

The Next Nine…

Good faith
Quality of care
Values
Training
Education
Responsibility
Candour
Intervention
Principles

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Ambition and Challenges

Workforce of the 1980s moving to...
- 7 day service
- Globalisation
- Primary/community vs hospital
- Curative vs palliative/LTCs
- ‘Feminisation’ of workforces
- New roles (nurse/pharmacists etc)

New technology...
- Education – e-learning, technology
- Translating academic output into care
- Healthcare delivery

Challenges...
- Tariff
- Levy
- Distribution
- Obamacare
Teams save lives

Mean mortality index

% staff working in teams

Source:
Health Care Team Effectiveness Project, Aston University, Birmingham, England

www.hee.nhs.uk
Missed opportunities for diabetes prevention: post-pregnancy follow-up of women with gestational diabetes mellitus in England

Authors: Pierce, Mary; Modder, Jo; Mortagy, Iman; Springett, Anna; Hughes, Heather; Baldeweg, Stephanie

Source: British Journal of General Practice, Volume 61, Number 591, October 2011, pp. e611-e619(9)

Publisher: Royal College of General Practitioners

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Response rates
60% (915/1532) GPs, 93% (342/368) specialists; 80% of GPs and 98% of specialists reported women with GDM had short-term follow-up.

Twenty per cent of GPs had difficulty in discovering women had been diagnosed with GDM in secondary care. Seventy-three per cent of specialists recommended long-term follow-up; only 39% of GPs recalled women with GDM for this. A minority of GPs and specialists had joint follow-up protocols

Conclusion
Follow-up of GDM in England diverged from national guidance. Despite consensus that short-term follow-up occurred, primary and secondary care doctors disagreed about the tests and responsibility for follow-up. There was lack of long-term follow-up. Agreement about the NICE guideline, its promotion and effective implementation by primary and secondary care, and the systematic recall of women with GDM for long-term follow-up is required.
Trainee & Consultant Expansion

Consultant and trainee numbers in England, 1999–2009

- Trainees and equivalent
- Consultants

The effect of service pressures on training Drs:

- Gaps in rotas
- Reduced training opportunities
- Risk of reduced popularity of shift specialties
- Service re-design sometimes means more trust doctors not consultants? New roles
A competency based team

Gain new competencies

Refined and functional team

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What should the clinical team look like?
New ways of working

- Team work – limited concept of integrated teams within NHS
- Teams – hierarchical, mostly based in single sector and single service
- New roles develop with no national agreement, regulatory process or workforce planning
Beyond simulation – training in the workplace and apprenticeship:

• How will we produce ‘the expert’?
• How will clinical teams develop professionally?
• Will multi professional training happen?
• How will new professions develop?
Use of simulation accelerates the acquisition of skills in all professions:
Deaths reduced at speciality ward level

Surgical Wards – Cardiac Arrest Data

Hospital at Night team Introduced

Total 04 = 33   Total 05 = 12   Reduction of 56%

Colorectal, Urology, Vascular, Obgyn, ENT
Workforce Planning

- First integrated workforce plan for NHS
- 5 year horizon
- aggregated from LETB evidence
- checks and balances with professions and service
- will drive investment
- response to innovation requires planning horizons beyond annual recruitment
Balancing workforce supply and demand

**Economic Context**
- Right Skills
- Right Numbers
- Right Values and behaviours
- Right Place

**Political Context**
- Demographics
- Disease Prevalence
- Innovation
- Patient Expectations

**Today and Tomorrow**

**Quality**
Next best guess in workforce planning: Retirement?

- Doctors work to 70, will everyone else?
- Will there be gender differences?
- Career development?
- Are there safety issues?
- New roles?
- Block opportunities for younger people?
The future needs ambition and innovation:

• Workforce of the 20th century needs to embrace......
  - 24/7 service
  - Globalisation
  - Primary/community vs hospital
  - Curative vs palliative/LTCs

• New technology
  - Genomics – *personalised care*
  - Education – *simulation*
  - Healthcare delivery – *telemedicine, robotics*

• Innovation
  - academic/research into practice
  - New roles (e.g. PA/nurse practitioner/pharmacist)
Ambition for the future

In order to develop the workforce of the future, we need to predict future changes in health and healthcare based on what we understand now…

<table>
<thead>
<tr>
<th>Current approach</th>
<th>New rules for 21\textsuperscript{st} century healthcare*</th>
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<tbody>
<tr>
<td>Care is based primarily on visits</td>
<td>Care is based on continuous healing relationships</td>
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<tr>
<td>Preference is given to professional roles over the system</td>
<td>Co-operation among clinicians is a priority</td>
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* Based on work by the King’s Fund

… and plan workforce training and education to ensure demand and supply are in balance…
Outcomes

Success?

“HeE exists for one reason alone - to improve the quality of healthcare delivered to patients”

Success criteria

• Improvements in safety
• Improvements in experience
• Improvements in clinical outcomes
• Spreading innovation
For further enquiries

Visit: www.hee.nhs.uk
Email: hee.enquiries@nhs.net
Twitter: @NHS_HealthEdEng