

**HEE Strategic Development Framework 2013 - Call for Evidence Template**

To submit your evidence please complete this form. Please make your submissions relevant to the categories provided in the boxes. We have themed our requests for evidence around the three critical steps we need to take to try and find the answer to our key question:

*What would we need to include in a strategic framework that future proofs the workforce for the 21st century?*

You can include extracts of reports into the free text boxes below, or submit a whole report with this form by clicking on the email at the bottom of this form. Please mark clearly in the email which of the below categories the report/evidence relates to, including any relevant page numbers. Where an extract is provided, please reference the source.

Please use the text box on page 5 to submit any information/evidence that does not fit the below categories. You can also leave any comments/observations in the free text box.

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

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Job title: Secretary

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**Form submission:**

We are not expecting you to commission new work to answer these questions, but we would welcome sight of any intelligence and evidence you already have on these issues. It would be most helpful if you could share any existing documents by **5th August 2013**, as this will enable us to incorporate them into our first draft, but we will of course continue to review any submissions after that date.

Once completed please submit the form via email to HEE.StrategicIntentFeedback@nhs.net making sure all supporting documents are also attached to the email. Please make the subject of the email: ***HEE Strategic Development Framework - Call for Evidence - [Insert your organisation’s name]***

**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. If you want the information in your response to be kept within HEE’s executive processes, you should make this clear in your submission, although we cannot guarantee to be able to do this.

**Step 1 – A set of shared assumptions about the future**

We need to start with a shared set of assumptions on how future services will be delivered. There are a number of examples of this that cover differing time spans from 5 to 25 years into the future. Below is an example from the Kings Fund that describes 10 key characteristics of future services:

**Illustrative example of 10 key characteristics of the way future services may be delivered:**

1. ***Care is holistic and centred on the person***
2. ***Care is customised according to patient needs and values***
3. ***The patient is the source of control***
4. ***Knowledge is shared and information flows freely***
5. ***Decision-making is evidence-based***
6. ***Safety is a system property***
7. ***Transparency is necessary***
8. ***Needs are anticipated***
9. ***Waste is continuously decreased***
10. ***Co-operation among clinicians is a priority***

**Do you agree with the above assumptions of future services? Do they define what success would look like to our patients, carers and communities/populations? Given lead-in times for changing services and education, how far ahead should we look: 10, 15 or more years?**

Agree with the addition of

* services are available 7 days a week that are able to provide adequate support for emergency/urgent care available 24/7 and
* services are sustainable through the recruitment and training of the next generation of health care professionals

and with the acknowledgement that there will have to be exceptions to the principles: decision making can only be evidence based where such a base exists, and the need to create an evidence base in well conducted research may mean the decision is based, with explicit patient approval, on that necessity. Secondly, the patient may not always be able to be the source of control if suffering from conditions that obscure such an ability. The need to treat the patient according to their needs remains, of course, paramount.

Looking ahead more than 10 years given changes in societal expectations, the advance of technology and shifts in the political environment may be impractical.

**Step 2 – The implications of these assumptions for our workforce**

Using the assumptions described in Step 1 about future services the next step is to determine what this means for the workforce.

**What are the key workforce, education and training challenges to meet these changes to services?**

It would be helpful to include in your response reference to the following implications: the type of skills we will need our workforce to have e.g. generalist, specialist, multidisciplinary teams; what setting they will need to work in e.g. primary and community; in what number and with what types of behaviours and values.

This response reflects the physician perspective.

The rising interest in general skills and competences reflects the need in medicine to manage the breadth of presentation and increasing numbers of acutely ill patients, in part driven by demography and in part by the spectrum of chronic ill health. Patients have a right to expect “expertise” and community-based, broad spectrum generalists will not always be in the best position to determine or deliver diagnosis and/or treatment. Local specialists covering common conditions, in particular those with particular skills in geriatric medicine will be required to support community-based family doctors and their teams.

Whilst admission to hospital should be avoided where possible, equitable access to specialist expertise must be available and this may be challenging in more remote and sparsely populated areas of England. Super specialist expertise should be regionally based and therefore at a distance for many patients and their families, and transport/accommodation arrangements will need some thought.

Community provision to support early discharge from an inpatient facility or to prevent admission will be of benefit, but current arrangements need a radical overhaul to generate competent community-based teams with options for delivery of care and with the confidence to avoid referral to an acute hospital. These alternatives must be established as effective and safe to avoid inadvertent age discrimination and certainly before any changes in capacity in acute hospitals are implemented. Valuing general skills and competences is essential to firmly establish the status of the generalist role, and there should be investment in teams to remove the current unpopularity of hospital medicine with trainees.

Providing a more flexible approach to career development will deliver pluripotential trainees with the ability to choose their preferred career according to the (changing) needs of the service and their own lifestyle choices.

**Step 3 – Identifying where we are now and what steps we need to take to close any gaps**

Once we are clearer on what we need for the future we need to know how near or far our current workforce is in terms of skills, numbers behaviours and values from the findings in step 2. This will help us to identify the challenges we face to make to our education and training system – investment and curriculum, careers advice, recruitment and selection processes, workforce planning etc. to bring about the transformation to future proof our workforce.

**How can we meet these challenges? Please supply any areas of best practice of transformation in education, training and workforce planning that will help us determine what we need to do to future proof our workforce to deliver 21st century services.**

Increasing lengths of time that the trainee spends with a specific team is essential to improve the training experience for both trainee and trainer. Short attachments and erratic, continuously changing shift patterns damage team building and impede early problem identification of trainees. It is also detrimental to the delivery of fair, safe and considered assessment.

Training the trainers to required minimum demonstrable competences in training and mentorship will improve standards and address professionalism. Valuing those who train by engineering adequate time for their training role in their job plan and improving their status will attract the best into medical training. Recognising that not all doctors may or should be trainers will be important.

Workforce planning has to take account of open-ended retirement ages and demographic changes that result in higher numbers of trainees and trained doctors seeking to work less than 10 sessions and taking career breaks. Tapering careers towards the end of working lives should retain valued staff for longer and make best use of their skills and experience.

Best practice in rota design should be shared to match patient flow with staff availability and skill mix, with due account for sustaining team structures, training time and predictable absence.

Revalidation should reflect quality improvement and career development needs in addition to safe practice.

National overview of local workforce planning and training arrangements will be critical, particularly in term of lifelong learning and “credentialing” as service needs change.

Team working across discipline and sector boundaries will increase in order to deliver more effective and efficient care; for example specialist geriatricians working with their generalist community-based colleagues and their hospital-based colleagues, and all supported by a multidisciplinary team of specialist nurse and allied health professionals.

**General / Other evidence not included elsewhere**

Insert evidence here….