South East Clinical Senate

South East

Clinical

senate

Teaching, Training and Research: Workforce Considerations for Major Service Change

January 2024

Email: england.clinicalsenatesec@nhs.net
Web: www.secsenate.nhs.uk

Foreword

I am delighted to recommend this South East Clinical Senate report describing Teaching, Training and Research: Workforce Considerations for Major Service Change. The report is an adjunct to, and complements, our update of The Clinical Co-Dependencies of Acute Hospital Services report. Service delivery can never be considered in isolation. Education, training, and research are integral to delivery of quality services and by extension to service change and reconfiguration.

This report comes at a time when the NHS has undergone profound changes in response to the COVID-19 pandemic and is both recovering and restructuring whilst also responding to significant workforce challenges. We are heavily indebted to those who have contributed to the report's preparation and review. They have reminded us of the importance of workplace-based learning to diminish the gap between theory and practice, the crucial importance of linking training, education and research to service delivery, and the significant gaps that exist in time, resource, and facilities to support these essential activities. I strongly believe that implementation of recommendations within the report will help address these gaps for the future.

I hope that this report, together with the suite of published reports from the South East Clinical Senate including: Embedding Healthcare Sustainability in Major Service Change; Health Inequalities Within the Southeast Region Through a Service Change Lens; and The Clinical Co-Dependencies of Acute Hospital Services will form a valuable resource for systems designing service change and senate review panel members reviewing cases for change.

Dr Paul Stevens,

Chair South East Clinical Senate

Table of Contents

Introduction

This document includes the key issues and considerations of service reconfiguration for allied health professions, healthcare science, medicine, nursing and midwifery and pharmacy. Since the publication of our 2014 report, 'The Clinical Co-Dependencies of Acute Hospital Services',[1] in which the teaching, training and research considerations for medicine were considered, the NHS has continued to experience significant workforce challenges, not just in medicine but across all healthcare professions. Added to these challenges has been the impact of the COVID-19 pandemic and while the pandemic resulted in innovations in some practice areas, in others their fragility was exposed with some service provision shown to be severely lacking. As we continue our post pandemic recovery the challenges impacting care delivery continue to be a significant part of the service change process, presenting a wicked problem for many integrated care boards (ICBs) and providers undertaking service reconfigurations.

New guidance such as the NHS 2023/24 priorities and operational planning guidance[2] has a focus on post pandemic recovery, progressing the aspirations of the Long Term Plan (LTP)[3] and transforming the health and care system for the future. This guidance identifies workforce recruitment, retention, and training needs through delivery of the NHS people promise[4] and the recently published NHS Long Term Workforce Plan (LTWP).[5]

The LTWP[5] describes the extent of a predicted workforce shortfall in the face of demographic change. The plan aims to build on existing ambitions to expand the workforce, such as increasing medical school places and the number of nurses working in the NHS, improving monitoring of staff morale, ensuring the right skill mix to deliver patient care and supporting return to practice, ensuring a workforce fit to meet the needs of the future.

Workforce planning and the impact of service reconfiguration for current and future workforce generations needs to be a high priority for system leaders, with recognition that workforce training is an additional time pressure, and the health service continues to recover from a training deficit as a legacy of COVID-19 pandemic pressures. The workforce plan sets out a strategic direction for the long term, and includes action to be taken locally, regionally, and nationally in the short to medium term to address current workforce challenges. Those actions fall into three priority areas:

Train: significantly increasing education and training, together with increasing apprenticeships and alternative routes into health care professional roles, to meet the changing needs of patients and support the ongoing transformation of care.

Retain: ensuring the NHS keeps more of their staff by better supporting people throughout their careers and working to improve the culture and leadership across NHS organisations.

Reform: improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services

[1] The-Clinical-Co-dependencies-of-Acute-Hospital-Services.pdf (secsenate.nhs.uk)
[2] 2023/24 priorities and operational planning guidance
[3] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[4] NHS England » Our NHS People Promise
[5] NHS Long Term Workforce Plan (england.nhs.uk)

where they are needed most, and ensuring staff have the right skills to take advantage of new technology that helps provide the care patients need more effectively and efficiently.

In 2022 the Health and Care Act[6] saw Integrated Care Systems (ICSs) placed on a statutory footing, with the setting up of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) through which ICSs work to meet four key aims:[7]

- Improve outcomes in population health and healthcare.
- Tackle inequalities in outcomes, experience, and access.
- Enhance productivity and value for money.
- Help the NHS support broader social and economic development.

Meeting these aims involves collaboration of services across smaller geographies termed 'places' and 'neighbourhoods'. Critical to success is a skilled and supported workforce.

Additionally, GP practices are working together with community, mental health, social care, pharmacy, hospital, and voluntary services in their local areas in groups of practices known as primary care networks (PCNs).

Care collaboratives are also being developed aiming to 'address common challenges, provide more integrated care pathways, and deliver more sustainable services'.[8] Potential benefits of provider collaboratives include reducing unwarranted variation in outcomes and access, maximising economies of scale, and improving recruitment and retention of staff.

Working in this way enables collaboration at scale, which may offer unique transformation opportunities to tackle current and future workforce challenges, by offering a wider scale of development opportunities, to improve staff recruitment and retention. This should include shared training opportunities, leadership development programmes, joint appointments, flexible working options and additional support for staff health and wellbeing.

To facilitate this, due importance and consideration should be given to healthcare professionals teaching, training, and research agendas whenever service change is considered. There are opportunities from greater integration of, and coordination between, providers for all these three areas, which will maximise the skills, recruitment and retention of the workforce, and research activity (and income). But there are also significant risks if pathways become fragmented through poorly planned reconfigurations or expansion in alternative providers.

Delivery of frontline health services relies heavily on human interventions and is therefore very dependent on having sufficient skilled staff. Many of these interventions are conducted face-to-face, so options to work from home that are available to professionals in other industries are more limited. It is vital when services are reconfigured, that staff happiness, wellbeing and job-satisfaction are monitored and supported, to aid retention of this valuable resource.

[6] Health and Care Act 2022
[7] Integrated Care Systems: design framework
[8] Providers Deliver: Collaborating for better care (nhsproviders.org) and collabs-benefits-report-1e.pdf (nhsproviders.org)

In the southeast, the latest Office for National Statistics (ONS) (January 2023)[9] data estimates the size of the population at 9,278,100, of which the Female to Male gender split is 51.08% / 48.92%, respectively. The latest ONS Labour Force Survey[10] also suggests that in the southeast the employment rate of working age people aged 16 to 64 years is at 77.8%, and the average unemployment rate at 3.5%. The percentage of economically inactive people aged 16 to 64 years is at 19.3%, with the UK average 21.5%.

In comparison with other regions, the southeast has known factors which can be a challenge in the recruitment of healthcare professionals. Some of these factors include higher than average cost of living considerations, relatively poor transport links and the coastal geography.

The Kings Fund[11] noted that despite slightly higher than average recruitment compared to other regions, 'success in recruitment has not always translated into a reduction in workforce shortages. For example, the southeast grew its full-time equivalent workforce by 17 per cent, yet its vacancy rate grew by more than 12 per cent.'

This report considers health professional groups separately to allow systems undergoing reconfiguration to appreciate the important issues for each group equally. It aims to highlight areas for particular consideration when a service is undergoing reconfiguration and although similar there are particular pinch points for each profession which are explored in the narrative that follows. Healthcare professionals working to meet the ambition of a more joined up and personalised health service outlined in the LTP frequently provide care not only in the acute setting but in teams at place and within neighbourhoods. There are considerations and challenges for the professional groups working across these settings throughout their careers. This together with the move for more multi-professional working and learning described in the NHS LTWP and which is already being realised in Trusts across the country will require systems' transformation plans to consider professional groups in a much more joined up way in the future.

Undergraduate training, apprenticeships, postgraduate training, research and continuous professional development must be considered for all members of the multi-professional health and care workforce. It will be essential that Higher Education Institutes and ICB leads for each professional group are involved in service reconfiguration planning.

[9] Office for National Statistics data
[10] Labour market in the regions of the UK - Office for National Statistics
[11] Is the NHS on track to recruit 50,000 more nurses? | The King's Fund (kingsfund.org.uk)

ALLIED HEALTH PROFESSIONS

Background

The Allied Health Professions (AHPs) comprise of 15 distinct occupations including: art therapists, dietitians, drama therapists, music therapists, occupational therapists, operating department practitioners, orthoptists, osteopaths, paramedics, physiotherapists, podiatrists, prosthetists and orthotists, diagnostic and therapeutic radiographers, and speech and language therapists.

The NHS LTP[3] acknowledges that AHPs can significantly support the demand profile the NHS faces and AHPs have a unique contribution to make. In collaboration with the wider healthcare system, they address service delivery challenges and priorities. This includes continued support of the health and social care systems' COVID-19 recovery, enabling care closer to home, as well as expanding capacity within primary and community care with new ways of working for earlier intervention and prevention in the patient pathway.

'An effective supply of new AHPs and retaining existing staff across professions and geography are imperative for robust deployment and development to ensure the system has the right workforce, with the right skills, in the right place to deliver high-quality care' [12]

There are a number of key priorities to consider for current services and for those undergoing reconfiguration for an effective AHP workforce supply, and teaching, training and development of the professions to optimise their position to contribute to a 21st-century workforce.

Undergraduate and postgraduate training issues

Stimulate demand: Making AHPs the career of choice

Focused support for local systems to grow their workforce to include registered and non-registered AHP workforce is necessary. This includes the production of resources to drive careers work and broaden routes into the professions and services locally. It is important for commissioners and providers to work in partnership to promote diversity and widening participation activity thus enabling a workforce that better represents the community they serve.

Increase capacity: Enabling the AHP workforce to deliver and grow

Critical to growing the AHP workforce is maximising new and returning workforce supply through planned and sustained careers and return to practice. Systems undergoing service transformation need to consider how roles and ways of working may be modernised in line with NHS People Plan[13] requirements to ensure a supply of 21st-century graduates and careers. Delivering new roles and ways of working to optimise the scope of practice, promote clinical leadership along with effective skill mix and high functioning integrated multidisciplinary teams across health and social care, enabling person-centred care closer to home will be key.

[12] The Allied Health Professions (AHP)for England: 2022 to 2027 AHPs Deliver
[13] We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf (england.nhs.uk)

As with all healthcare professions reconfiguration for AHP learners in the system has the potential to have a destabilising effect and continued provision and creation of quality learning environments which incorporate significant practice-based learning is crucial. This will need to reflect the NHS LTWP clinical placement expansion and the AHP Educator career framework[14] a developmental career wide resource for all those engaged in the education and development of AHPs and the wider health & care multi-professional team. Involvement of chief AHP's and Higher Education Institutes (HEIs) will be required.

Bridge the gap between education and employment

The entry routes into AHP roles include pre and postgraduate courses. Exploration of potential alternatives to traditional routes, such as apprenticeship entry need to be supported and explored. Pre-registration Masters programmes are an entry route for second careers and attractive to a workforce that may already be settled as part of the local community making them vulnerable when service reconfiguring requires a change in location.

During service reconfiguration retention of newly qualified staff is a key concern. Preceptorship programmes are key to assisting newly qualified AHPs to transition from being a student to part of the qualified workforce.

The Allied Health Professions Support Workforce plays an important role in delivering safe and effective care for service users across health and care. Support workforce staff are more likely to live locally with reduced options for relocation should services be reconfigured. Optimising the role of the support workforce within each profession through the development of a career framework and educational review is key.

Continuous Professional Development (CPD) and Research

The impact of the reconfiguration of services on Continuous Professional Development (CPD) and research activity should not be underestimated. Consideration of how AHP roles work effectively across the four pillars of practice; clinical, leadership, education and research is essential. AHPs need to be supported to develop throughout their career, via enhanced, advanced and consultant practice. Optimising the scope of practice, along with effective skill mix and high functioning integrated multidisciplinary teams across health and social care is essential for a skilled AHP workforce, recruitment and retention and enabling person-centred care closer to home, thus facilitating more integrated and joined up care.

The AHP Research and Innovation Strategy for England[15] encourages national strategic research agendas and priorities to be inclusive of Allied Health research and innovation. This will enhance opportunities for all AHPs at all career stages to be involved in research and enable delivery of excellence in evidence-based allied health practice.

[14] Allied-Health-Professions-Educator-Framework.pdf (councilofdeans.org.uk)
[15] HEE Allied Health Professions Research and Innovation Strategy

HEALTHCARE SCIENCE

Healthcare Science (HCS) spans more than 50 disciplines, which fall into 4 broad categories: Life Sciences, Medical Physics and Clinical Engineering, Physiological Sciences and Bioinformatics. There are more than 56,000 HCS staff working in the NHS and public health sector in the UK and their work underpins 80% of all diagnoses. Services provided by HCS staff enable more than a billion diagnostic and scientific investigations per annum and provide critical support in the delivery of highly specialised therapies, such as radiotherapy and CAR-T therapy.[16]

There are considerable challenges with teaching, training and retention of the skilled scientific workforce providing HCS and any service reconfiguration needs to be careful not to destabilise existing and establishing networks that have been formed to improve skill sets and recruitment and retention.

Background

There are endemic shortages in workforce across all HCS disciplines. Demand for the services provided by HCS professionals is projected to increase substantially. For example, the Richards review outlined the need for an additional 220 Physicists by 2025 to support diagnostic imaging. In Pathology, the recommendation is to expand the workforce. Histopathologists and other Healthcare Scientists, including Advanced Practitioners are specifically highlighted, with a recommendation that review of the skill mix should form an integral part of the workforce expansion programme.[17] The cardiology workforce also needs to expand to meet the needs of the aging population.

Major factors impacting teaching, development, training, and research are:

- a shortage of skilled trainers and educators with the time to teach, mentor and supervise trainees and apprentices working through accredited programmes.
- funding and resources.
- lack of salary support for apprenticeships, requiring business cases to support new apprentice roles.
- lack of training providers / education institutions for HCS across the southeast.

Although there is no formal HCS Workforce Board with accountability in the southeast, there are a number of formal and informal networks at various stages of maturity, which support teaching, training, development and research. It is recommended that services considering reconfiguration engage with these to ensure the already recognised benefits are sustained and to explore opportunities for enhancing and developing existing ways of teaching, training, and supporting the healthcare science workforce.

[16] Science in healthcare: Delivering the NHS Long Term Plan. The Chief Scientific Officer's strategy. March 2020
[17] Diagnostics: Recovery and Renewal. Report of the Independent Review of Diagnostic Services for NHS England. Professor Sir Mike Richards CBE, October 2020

Programmes and networks

Imaging networks

NHS England and NHS Improvement created a national strategy for the creation of 18 imaging networks across England by 2023.[18] According to the strategy, benefits of the imaging networks include:

- Staffing consistency and flexibility supporting enhanced personal development.
- Sharing and levelling of resources for both staff and equipment.
- Maintaining high quality learning and training environments.

Service reconfiguration will be required with the rapid development of the Community Diagnostic Centre (CDC) programme and an overall increase in demand for imaging across multiple patient pathways, including cancer and dementia. Workforce consideration will be key to their successful implementation and sustainability.

Pathology networks

In September 2017, NHS Improvement wrote to NHS Trusts proposing that 29 Pathology Networks were established across England.[19] In addition to projected savings of £200M per annum by 2020/21, the Networks must take a multi-provider approach to shared systems, such as Laboratory Information Management Systems (LIMS) and Managed Equipment Services (MES). Other domains include leadership, governance, quality, operational and workforce.

Networks are expected to obtain 'maturing' status by March 2025.[20] Having an effectively single service across a system-wide network brings significant opportunities for improvements in workforce teaching, training, and development. In part, this comes from the fact that all laboratories in the network will use the same equipment, information systems and standard operating procedures, allowing greater flexibility for staff to move between laboratories. Further benefits come from the efficiencies created by pooling teaching, training, and development resources over a larger workforce in the same network. This allows for targeted improvements to be made equitably across the whole network, for example:

- Centrally funded MSc programme for staff, competitive entry across the network.
- Programme of supervision and mentoring for senior scientists working towards FRCPath to obtain Consultant status.
- Programme supporting Health & Care Professions Council (HCPC) registered Biomedical Scientists to obtain specialist certificates.
- Expedited programme for graduates and trainees to achieve HCPC registration.

[18] Transforming imaging services in England: a national strategy for imaging networks. Published November 2019 by NHS England and NHS Improvement
[19] NHS Improvement pathology networking in England: the state of the nation. Published September 2019 by NHS Improvement
[20] Dozens of trusts still not sharing single pathology service | News | Health Service Journal (hsj.co.uk)

HCS Network – South England

An online HCS collaboration Network has been developed on the FutureNHS Platform, designed to enhance teaching, development, training, and research in HCS.[21] This has evolved from a Network originally designed in Kent and Medway.

The Network brings the 4 HCS groups together online under a single umbrella: Pathology (Laboratory) Sciences, Medical Physics and Clinical Engineering, Physiological Sciences and Bioinformatics. It is designed to be accessible and convenient to engage with, inclusive and open to anybody with an interest in HCS. The Network therefore facilitates a bottom-up approach to advancing HCS. Facilities on the online network include:

- Resources for employers planning new teaching, development, training, and research programmes.
- Leadership and career development.
- Links between healthcare, education, and government providers across the Integrated Care Systems.
- Finding a mentor or viva-exam practice.
- Continuing Professional Development resources, webinar and seminar programmes.
- Information about healthcare careers, training programmes and resources for teaching staff and students at schools, colleges, and universities.
- Apprenticeship and placement information.
- Research Hub and research funding opportunities.

Whilst the Network is designed to be a one-stop-shop to view, link and download a plethora of HCS resources in one place, its utility is further enhanced by its targeted communications functions and collaborative discussion forums.

Undergraduate and postgraduate training issues

Pathology

Exemplar programmes have been established in Sussex, and Kent and Medway. In Sussex, several of the Trusts' Pathology departments have biomedical science degree sandwich placement students for a year. In 2022, the system HCS Lead secured funding from Health Education England (HEE) for 8 additional placement students to be recruited across Sussex. They were paid £10,000 each for the year. Within that year the students work in the laboratories doing workplace training. They simultaneously complete the Institute of Biomedical Science (IBMS) registration portfolio and gain their HCPC registration. At the end of their degree, they can apply for band 5 Biomedical Scientist jobs and have one year's laboratory experience which means they immediately undertake work requiring registration.

The biomedical science sandwich placements have, in recent years, produced at least a 75% retention rate in Sussex. In the last cohort of eight students, seven remained in the profession and

[21] https://future.nhs.uk/KentMedwayHealthScience or email kmicb.hcs@nhs.net to join

six of those within Sussex. It is an excellent tool for retention of appropriately trained staff by capitalising on the 'grow your own' ethos. The placement students contribute to a stable workforce pipeline.

Medical Physics and Clinical Engineering

NHS England (South East Region) has appointed a Medical Physics and Clinical Engineering Practice Educator for southeast England, who is creating a regional training network. One objective is to review what the barriers are to providing training of more Clinical Scientists in Medical Physics to meet the projected demand. Regional models of training developed in London are being implemented, which deliver efficiencies via simple economies of scale. An exemplar training day is provided by a Head of Service who teaches radiation emergency response to 20 trainees from across London in a single day. Other examples include pooling expertise from departments across the southeast to deliver training in specialist areas not provided by all departments; this can also give opportunities for smaller departments to be better involved with staff training and education. A system-wide Medical Physics and Clinical Engineering (MPACE) Network is being developed in Kent and Medway in late 2023. The network will provide opportunities for MPACE services in different NHS Trusts across the system to collaborate on improving service resilience, education, training, and workforce development. The services can work together on development opportunities that would benefit from a system-wide approach.

Physiological Sciences

The Physiological Science workforce is diversified over a broad range of specialisms. There are regional and national Physiological Science networks and southeast communities of practice which are specialism specific. There have been targeted offerings for workforce teaching, training, and development, for example the 2022 HEE funding targeted at Sleep Physiology and Cardio-respiratory Physiology apprenticeships.[22]

An exemplar Physiological Science programme is a new Level 7 qualification in Exercise Physiology currently being developed to meet specialist training requirements for staff working in three patient pathways: rehabilitation for cancer surgery, Cardiopulmonary Exercise Testing (CPET) and heart valve services. Development of this new qualification came from links made between discussions with several different groups by the system HCS lead. A further example is the NHSE-funded shared training programme for echocardiography. These examples further accentuate the importance of the system strategic roles and their ability to work across a region.

Bioinformatics

There are 90 Scientist Training Programme (STP) training posts being offered in Bioinformatics, Genomics or Scientific Computing in England in 2023.[23] Many of these are being offered in city locations but there is no major presence in the southeast. These specialisms are, however,

[22] HCS Apprenticeships: Training Grants & Demand Scoping 2022/23. Guidance for employers: South East. Published 2022 by Health Education England
[23] Scientist Training Programme (STP) 2023 posts, Health Education England: Scientist Training Programme (STP) 2023 posts — Scientist Training Programme (hee.nhs.uk)

projected to become more prevalent in the near future, as the techniques move into mainstream medicine.

The NHS England 2022 genomics report[24] details a 5-year strategy for increasing genomic techniques into patient treatment pathways. Two of the priorities listed in the report are:

- Building greater clinical and professional leadership and developing the capacity and capability of the workforce; and
- Developing national and international collaborations and partnerships.

The links between genomics, bioinformatics, artificial intelligence, and traditional medicine create novel opportunities for healthcare scientists across the professions to engage. There will be strong links with pathology sciences in the provision of genomic diagnostic services; scientific computing expertise may come from medical physics and clinical engineering, or data science services and physiological sciences will use genomic approaches in personalised diagnostic and treatment pathways. Having Healthcare Scientists at the forefront of these medical innovations will attract high-achieving individuals from academic programmes and other areas into the workforce.

Research

Recruitment and retention are enhanced by enabling staff to undertake research alongside routine work, with potential links to academic institutions and funding. An additional benefit is that research projects may be structured to answer specific questions that will make improvements to the scientific work of the department. The benefits to HCS staff from integrating into multi-disciplinary clinical trials teams should not be underestimated.

Clinical-scientific research is part of all scientific degree programmes and training schemes. Projects range from those required by Bachelor degree programmes, carried out at university, through to doctoral and post-doctoral research, for example the academic PhD, or the DClinSci qualification in the Higher Specialist Scientist Training programme,[25] carried out in the workplace. This creates opportunities for research and innovation to be maintained in busy departments alongside routine clinical work.

There are system-wide and regional organisations set up to specifically support research and development in healthcare, such as Research and Innovation Collaboratives and Clinical Research Networks. Scientific staff may be formally involved in Clinical Trials, for example in provision of parts of the diagnostic or treatment pathway.

[24] Accelerating genomic medicine in the NHS: A strategy for embedding genomics in the NHS over the next 5 years. Published 2022 by NHS England

[25] The academic part of the HSST: Guidance about the academic part of the programme for HSST trainees: The academic part of the HSST — Higher Specialist Scientist Training programme (hee.nhs.uk)

MEDICINE

Background

The NHS LTWP[5] ambition is to expand medical school places by a third, to 10,000 by 2028/29 and double the number of medical school training places taking the total number of places up to 15,000 a year by 2031/32, with more medical school places in areas with the greatest shortages, to level up training and help address geographical inequity. Medical degree apprenticeships and increased numbers of physician associates will also be introduced. To support this existing medical schools will increase the number of places and the first new medical schools will be available from September 2025, together with moving to shorten the 5 - 6 year degree programmes to 4 years. There are now 37 undergraduate medical schools in the UK. Four new schools have opened recently, one of which is in Canterbury. The Brighton and Sussex Medical School (BSMS) is still one of the UK's newer schools, founded in the last 20 years, and Surrey is actively planning to start a new private medical school soon.

There remains an evolving relationship between city-focused former deaneries and their peripheral neighbours as part of the current re-organisation of postgraduate educational structures across the country, particularly in relationship to postgraduate specialist medical training. More locally or regionally focused training programmes are evolving but the success of any such programme remains highly predicated upon its ability to deliver the full range of clinical training opportunities within the relevant patch.

The NHS LTWP provides the opportunity to support the medical profession to adapt to meet future patient needs. There is a recognition that medical training requires a better balance of generalist and specialist skills that equips people to provide joined-up care for patients with multiple morbidities.

An underappreciated additional pressure arises from locally employed doctors and UK graduates choosing SAS/Specialist training as a career route and the supervision, training, and education of these groups. Furthermore, the increasing recruitment of international medical graduates engenders additional time for induction, education, and training specific to these groups as they acclimatise to the NHS.

Undergraduate considerations

It is essential that medical schools be included as stakeholders in any discussions regarding service delivery. The success of UK undergraduate medical education reflects the commitment and enthusiasm of clinical teachers not only in the schools themselves, but also in many partner Trusts and primary care. Significant extra NHS funding supports undergraduate teaching. The curriculum needs to stay fit for purpose to produce doctors with the appropriate skills and competencies to practise in the modern NHS. However, care is increasingly delivered in different ways and in different settings, particularly as Integrated Care Systems evolve. It will be incumbent upon our schools and their partner organisations to ensure that undergraduates who train in the regions are exposed to these new ways of working, and that medical students are not 'forgotten' in the planning of new integrated care frameworks, as it is in these very 'systems' that our graduates

will be working in the future. Care will be increasingly provided by a multi-professional team, something that also needs to be embraced in current undergraduate curriculum development.

Having two, and potentially a third, medical school in Kent, Surrey, Sussex, with a further three medical schools across Thames Valley and Wessex and potentially a fourth, as well as being adjacent to South London, which has highly-regarded medical schools with large numbers of students, means that there will be inevitable 'competition' for clinical placements – in both acute and community settings. Any service reconfiguration at a local or regional level should include an impact assessment on teaching and learning for both undergraduate and postgraduate trainees, and a commitment from healthcare commissioners and providers to continue to deliver high-quality teaching and learning opportunities. Careful prospective planning will be the key, taking care to engage with all the relevant educational stakeholders, including, if feasible, undergraduate, and postgraduate education representatives.

There remain many challenges to the quality and coherence of undergraduate medical education. Much of the popularity and success of BSMS as one of the southeast region's medical schools, relates to its teaching in the clinical domain of the gamut of specialist services, either delivered at the base hospital in Brighton or collaboratively through its partner hospitals within the region. This is increasingly the case with the recent large increase in student numbers. Adequate resourcing, both physical and human is going to be critical to facilitate regional hospitals to accommodate specialty placements. Fragmentation of services and providers in some areas, for example HIV and sexual health medicine, dermatology, and rheumatology, risks jeopardising the delivery of high-quality teaching in these specialties. It is important for systems to be mindful that changes in training programmes need to be able to satisfy the requirements of General Medical Council (GMC) recognition.

Major changes to where core services such as acute medicine or acute surgical services are delivered will have consequences for student experience and quality of teaching and therefore need engagement with medical schools as key stakeholders and funding partners. The position of education, undergraduate and postgraduate, (as well as research – see below) needs to be viewed in three specific contexts: Appointments, Job-planning, and Appraisal.

Postgraduate considerations

In many specialities there has been an intention to 'repatriate' specialty medical training rotations into the regions from the major urban centres. However there has long been a recognition that in the absence of, for example, bone marrow transplantation (in a haematology training scheme) or renal transplantation (in a nephrology training scheme), a regional scheme would be unable to provide the full range of clinical exposure in specific aspects of these specialities without commissioning the requisite curriculum coverage from, for example, transplant centres in London, with the majority of training provided in region. Workforce planning at regional and local level needs to take into account the additional requirements of education, training and research activities as repatriation of postgraduate training posts continues. Coordination and planning with Directors of Medical Education (DMEs) is required in order to ensure the workforce being recruited and their training aligns with the population needs of that geography. The same considerations apply to the non-medical clinical training schemes. Hospital networks therefore need to take

account of the training implications and requirements of specific specialty schemes when looking at reconfigurations, for example, in cancer medicine or specialist surgery.

For a number of specialties, particularly those with a primarily outpatient workload, there remain risks to training schemes. In musculoskeletal services, for example, regional programmes currently attract good quality trainees, but any rotation not based specifically around a specialist centre with the vast majority of the services delivered in the community, requires a different approach if training is to remain sustainable. It is therefore vital that postgraduate training implications are factored in from the beginning of any change process. A 2021 GMC report suggests that around 80% of postgraduate trainees go onto work within 50 miles of the postcode in which they trained (48% are within 10 miles).[26] There is also no doubt that in addition to 'core' service-based clinical training, the provision of additional academically focused training opportunities is a major attraction to trainees. Education, Research or Leadership initiatives are innovations that attract and retain trainees and both NHS and University-based investment in clinical research-focused posts (not only medical but on a multi-professional basis) will be required to attract and retain the best staff in many regions in the UK outside major centres, particularly when there are no links to an established medical school. Provision of pathways and facilitation of these opportunities will require consideration when reconfiguring services to ensure services retain a highly qualified and motivated medical workforce.

Research

There remains much variation in the amount and quality of clinical research across different UK regions, reflecting among other things availability of, and access to, adequate resource (physical and financial). In some areas there may be no medical school, or a relatively small and 'young' one, with no fully active Clinical Research Facility (CRF), Clinical Trials Unit (CTU) or Applied Research Collaboration (ARC). In other areas there may be a higher education institution (HEI) which, whilst academically strong in other areas, does not have a strong tradition of research in either mainstream biomedical or clinical research. The greatest strength in clinical research is nearly always in areas where there is clear academic leadership and often in domains where care is delivered on a 'networked' model, e.g., in cancer medicine. When effective synergies can be developed between university and clinical partners, the benefits are clear and immediate and require thoughtful consideration during planned reconfigurations.

Both fragmentation and paradoxically, centralisation, of clinical services are major risks to quality clinical research and equality of patient access to it. There continues to be inequity of access for patients to studies, depending on whether their care is delivered by a specialist centre, often in a city, or more peripherally. This continues to apply in many different clinical domains – a patient with even a relatively common, but 'complex' condition, such as Lupus, Multiple Sclerosis, or inflammatory bowel disease, will have a hugely reduced chance of participating in a trial if they live, and are cared for, away from a designated specialist centre.

There are several challenges which need to be taken into consideration from the research perspective when considering new ways of providing a service. These include:

[26] https://data.gmc-uk.org/gmcdata/home/#/reports/Doctor%20moves/Distance%20dashboard/report

- Governance and sponsorship: will all providers have systems in place, understand need and be research knowledgeable? Challenges will also need to be faced at ICS level. How will we move towards ICBs taking sponsorship responsibility and having knowledge and infrastructure to support research governance?
- In many domains the increase in complexity of patient service delivery, often multi-professional in nature, will require complex project management to organise and bring teams together to deliver studies.
- Issues around Excess Treatment Costs: where will responsibility lie?
- Follow up of clinical trial patients (even when a study is delivered in a 'central' facility): potentially an added and costly burden, with real issues about information transfer and clinical responsibility.
- Studies that include a review of a patient pathway, particularly across fragmented services are likely to be more complex and potentially present challenges for longer term studies. This could impact on the take up of long duration studies as it may not be clear where and how services will be provided in the future. Many studies in for example cancer, diabetes, cardiovascular, kidney medicine and rheumatology are long term (1 – 5 years), due to the natural history of the conditions involved.
- Alternative / private provider and contractual arrangements: participation in research may well not be on the service provision specification of a new provider, and its omission from service provision contracts (as with teaching and training) may be a factor enabling a potential provider to offer a more financially competitive product. This could be addressed by making becoming 'research ready' a requirement of any new contract. Otherwise, patients may be ineligible to participate in studies.
- Small providers may only be contracted to provide the 'simpler' clinical services, with no critical mass to support research. Such a provider may only be involved in research around these restricted services, and it would not be cost-effective for them to put in place the appropriate governance arrangements.
- Industrial collaborations: pharmaceutical companies often need to deliver a study across different sites depending on the clinical domain and stage of study. There are challenges where trials need to cross several different providers or a mix of NHS, academic and other collaborators.

NURSING and MIDWIFERY

During service reconfiguration the following key professional areas require specific consideration:

- The extant nursing and midwifery employment landscape.
- Pre-qualifying (direct and apprenticeship route) students.
- Postgraduate / post registration nursing and midwifery.
- Newly qualified nurses and midwives for the first two years post qualification.
- Advanced Nurse / Midwife Practitioners.
- Internationally recruited nurses and midwives.
- Nurses and midwives engaged in research and Continuous Professional Development (CPD) activities.
- The commitments detailed in the Multi-professional Education and Training Investment Plan (METIP).

These areas will be considered below.

Background

Nursing has been on the UK Government's 'shortage occupation list' for the past 6 years, and the situation is likely to worsen.[27] The most recent data demonstrate that in the first months of 2022/23 the NHS saw a sudden rise in vacant nursing posts.[28] There is now a record high of 46,000 vacant nursing posts[28] despite various government initiatives to invest in creating more nurse training places, re-introduce a student nurse maintenance grant and incentivise international recruitment.

The growing vacancy rates are in part driven by a pervasive increase in demand for nurses across the NHS. However, a King's Fund analysis[29] suggests that the issue is being exacerbated by an increase in the number of nurses choosing to leave the NHS, with more than 34,000 nurses leaving their role, an increase of 25 per cent on the previous year. The current rate of increase is not due to people retiring. It is younger nurses who are leaving their roles in the NHS in the greatest numbers. Two-thirds, or nearly 23,000, of those who left over the past year were under 45 years of age, an increase of 26 per cent on the previous year. The Nursing Midwifery Council (NMC) 2022 survey[30] cite the following top reasons for nurses leaving the register (other than for retirement): change in personal circumstances; too much pressure including stress and poor mental health, and workplace culture.

The M5 Operational Workforce report (August 2023) for all six Integrated Care Systems in the southeast suggests that the total percentage of vacancies in nursing and midwifery is high across the region at 11.6% compared to 12% of the same month last year. All mental health trusts are reporting high rates of vacancies for the registered nursing and midwifery staff group. This means as a region we likely have a shortage of workforce supply when it comes to mental health

[27] The King's Fund (2019) Closing the gap. Key areas for action on the health and care workforce https://www.kingsfund.org.uk/publications/closing-gap-health-care-workforce
[28] The NHS nursing workforce – have the floodgates opened? | The King's Fund (kingsfund.org.uk)
[29] https://www.kingsfund.org.uk/blog/2022/10/nhs-nursing-workforce
[30] NMC Leavers Survey (2022) Leavers' survey 2022 (nmc.org.uk)

nurses. NHS Digital data[31] indicate that for the southeast region the proportion of nurses leaving in the year to June 2022 varied from 9.4% to 16.9%.

The focus needs to be in retaining nurses within the profession from the preceptorship period through to retirement. With the lens of service regional reconfiguration, the potential deleterious impact on retention of staff needs to be carefully considered, with mitigations built in to meet the nursing target ambitions detailed in the LTWP.[5] There are risks that any reconfiguration may 'push' nurses out of the southeast region, either for training or employment reasons.

The training offered is already 'patchy' in the region for some disciplines. For example, the southeast is poorly served by its Universities for Learning Disability pre-qualifying Nursing. There are large geographical areas, particularly East and West Sussex where the travel distance to universities is significant and likely to either preclude enrolment or encourage relocation out of the region.

Pre-qualifying considerations (direct and apprenticeship routes)

There are currently 23 different Universities, who have student pre-qualifying nursing and Trainee Nursing Associate placements in the southeast for 7,460 apprenticeship and direct entry (UCAS) students.[32]

The combination of the number of learners, the varying study modalities, and the shortage of placement opportunities, creates a particularly complex landscape when considering any service change. It is essential that those Universities which are likely to be impacted by service change are consulted at an early stage to consider the impact on placements.

Aside from the pipeline consideration, reconfiguration of services may have an unanticipated impact directly on the students. Attrition from nursing education in the UK is high. A report based on a freedom-of-information request by the Nursing Standard demonstrated 1 in 4 student nurses left their degree programme prior to completion in 2018/2019.[33] Health Education England's RePAIR (Reducing Pre-registration Attrition and Improving Retention)[34] project, reiterate that attrition is a multi-causal problem, influenced by a wide variety of factors including personal reasons, lack of integration, lack of preparation and financial difficulties. Any service reconfiguration, which negatively impacts students' placement experience, needs to be carefully considered to avoid worsening the standing 25% attrition.

[31] Peak leaving? A spotlight on nurse leaver rates in the UK | Nuffield Trust
[32] South East Student Data Dashboard for clinical programmes, June 2023: 2.2 Education Map – accessed 17.11.2023
[33] Jones-Berry, S. (2020). *Student attrition: why do nursing students leave their course before completion?* https://rcni.com/nursing-standard/newsroom/news/student-attrition-why-do-nursing-students-leave-their-course-completion-169446
[34] Lovegrove MJ. (2018) Reducing pre-registration attrition and improving retention (RePAIR). England: Health Education England Digital Team - RePAIR Report 2018_FINAL.pdf - All Documents (sharepoint.com)

Postgraduate/ post registration nursing considerations

Nursing has a complex workforce in terms of the multiple roles and career expectations and trajectories; nursing careers are not formalised in the same way as medical careers. It is therefore perhaps unsurprising that there are a multitude of post-registration nursing considerations, which must occur during periods of service reconfiguration. Service reconfiguration is likely to have an impact on all nurses. We have chosen to consider the impact on specific groups as exemplars: those within the first two years of qualifying, Advanced Nurse Practitioners, and international recruits.

The first two years post qualifying as a nurse

Preceptorship is a structured support mechanism for newly qualified practitioners. This support helps newly qualified nurses to translate and embed their knowledge into practice, grow in confidence and have the best possible start to their new careers.[35] All newly registered nurses, nursing associates, and midwives should receive preceptorship in their first-year post-registration.[36]

There is strong consensus that the first-year post qualification is a particularly challenging period for nurses.[37,38,39] Although reliable statistics on leavers during this time are difficult to find, estimates are relatively consistent.[40] A review undertaken by Health Education England in 2014 found that newly qualified nurses are particularly likely to leave the profession. Burnout and stress were reported as particularly high in young newly qualified nurses, when turnover rates are high within the first year of qualification and remain high, or even rise during the second year of employment before reducing.[41] Newly qualified nurses are unlikely to be sufficiently empowered to cope with work-related stressors and to orchestrate satisfactory working conditions for themselves.[42] This means it is particularly important to consider the impact of any service reconfiguration on nurses that have qualified within the last two years: this is a time when newly qualified nurses may be particularly vulnerable to service change, and they may even decide to leave the profession altogether.

[35] NHSE (2022) *National Preceptorship Framework for Nursing* https://www.england.nhs.uk/wp-content/uploads/2022/10/B1918_i_National-preceptorship-framework-for-nursing-10-October-2022.pdf
[36] Nursing and Midwifery Council 2020 Principles of Preceptorship https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-principles-for-preceptorship-a5.pdf
[37] Bick, C. (2000). *Please help! I'm newly qualified*. Nursing Standard, 5(14), p44-47
[38] Bradley, S. (1998). *Prepared for practice? Exploring the experiences of newly qualified Project 2000 child branch staff nurses*. NT Research, 4, p292-301.
[39] Collard, S. S., Scammell, J., & Tee, S. (2020). Closing the gap on nurse retention: A scoping review of implications for undergraduate education. Nurse Education Today, 84 (PDF) Closing the gap on nurse retention: A scoping review of implications for undergraduate education (researchgate.net)
[40] O'Driscoll, M., Allan, H., Traynor, M., (2022) Preceptorship: what works?': an integrative literature review, Middlesex University Preceptorship-review-corrected-refs.pdf (workforceskills.nhs.uk)
[41] Health Education England. (2014). Growing Nursing Numbers: Literature Review on Nurses Leaving the NHS. Nurses leaving practice - Literature Review.pdf (hee.nhs.uk)
[42] Heinen, M. M., Achterberg, T.V., Schwendimann, R., Zander, B., Matthews, A., Kózka, M., Ensio, A., Sjetne, I.S., , Casbas, S.M., Ball, J., Schoonhoven, L. (2013) *Nurses' intention to leave their profession: A cross sectional observational study in 10 European countries.* International Journal of Nursing Studies. 50(2), p174-84

Advanced Nurse Practitioners

Nurses work as Advanced Nurse Practitioners (ANPs) across primary, secondary and community settings and may be particularly vulnerable to service reconfiguration, depending on their speciality and the service reconfiguration. ANPs often work in speciality areas, for example, level 3 neonatal intensive care units. If a unit's designation alters, the ANPs role would necessarily change and perhaps even become redundant. ANP roles may not be readily transportable across services, which may lead ANPs relocating when services are reconfigured. Similarly, if new services are established, which require ANPs, their recruitment or the 2 - 3 year training period of existing staff to be ANPs will require consideration.

Internationally recruited nurses

During periods of service reconfiguration, nurses recruited from abroad must be carefully considered. Despite the plethora of nursing education programmes offered in all four UK nations, there has not been enough new UK-educated nurses to fill recruitment requirements. Therefore, the NHS is reliant upon recruiting nurses trained in different countries. These nurses currently make up half of new registrants with the NMC.[43] It is essential that internationally recruited nurses are carefully recruited, integrated, supported, and retained to ensure that international recruitment provides a valid solution to the problem of under staffing.[27] Reconfiguration may unsettle internationally recruited nurses, potentially leading to an unsuccessful relocation.

Research and Continuous Professional Development (CPD) considerations

During any reconfiguration of services, a scoping exercise needs to be undertaken to consider the impact on research and CPD activity.

Nurses engage with research through various mechanisms; some activity may be more vulnerable to service reconfiguration than others. For example, some nurses undertake PhD / Doctoral / Post-Doctoral / Masters studies, which may be funded (or part funded) by their employer. The research may be directly linked to specialities. Some nurses are involved in research by undertaking various research positions, which are often linked with specific specialities. For example, a research nurse specialist may coordinate complex cancer related research trials within a Trust. When reconfiguring services, the impact on such roles needs to be considered as well as the funding mechanism, relationships with the education institution and research focus to consider the impact and required mitigations.

In relation to continuing professional development, the Kings Fund,[27] referencing the Organisation for Economic Cooperation and Development, 2016 outlines compelling evidence that the skills of the current health care workforce may be poorly aligned to patient need. This needs to be seriously considered in any reconfiguration where staffing and the development offered will have been based on service provision and patient needs. This report outlines how under-skilling creates quality and safety issues, while over-skilling is inefficient and lowers morale. While any service

[43] https://www.nmc.org.uk/about-us/reports-and-accounts/registration-statistics/

redesign can present challenges, it may also present new opportunities for ongoing development and widening of career pathways. Recognising the positive impact on retention that development and pathways can offer NHS Employers describe opportunities for improving retention such as internal transfers and rotational posts across departments, sites, or organisations.[44]

NHS England is working closely with ICSs and partners to review existing people management systems. The NHS Digital Staff Passport enables staff to move easily between NHS organisations, reducing unnecessary duplication of employment checks and mandatory training. Subject to successful completion of a pilot phase that is currently underway, ICSs will be encouraged to adopt the NHS Digital Staff Passport at pace. Full roll out of the Digital Staff Passport is expected to be available by August 2025.

Multi-professional Education and Training Investment Plan (METIP)

The METIP sets out the planned education and training activity, across all professions which NHSE plan to fund in the following financial year. NHSE funding supports clinical placement capacity through education and training tariffs, commissioned education and training programmes and salary support for education programmes undertaken whilst learners are employed in the NHS.

Any reconfiguration of service provision should take into consideration the training and development requirements of both the current and future workforce, with consideration of potential vulnerability of future supply, the market for providing training, the training model used, and the arrangement and complexity of the training pathways. This includes any learners who are on a programme of education / training as part of a NHSE training provision contract, as the contract will remain in full force and effect in relation to such learners until their programmes of education / training is completed, or, if this is not feasible, the provider will, with the agreement of NHSE in writing, organise alternative provision of a comparable standard and quality. The employers and provider must cooperate fully with NHSE or any replacement employer or supplier during any re-procurement and handover period prior to and following the expiry or earlier termination of the contract. This cooperation must extend to providing access to all information relevant to the operation of the training contract, as reasonably required by NHSE to achieve a fair and transparent re-procurement and / or an effective transition without disruption to routine operational requirements.

[44] NHS Employers (2022a). Improving staff retention handbook. Improving staff retention | NHS Employers NHS Employers (2022b)- Improving the retention of registered nurses and midwives: A toolkit for line managers and employers Improving the retention of registered nurses and midwives | NHS Employers

MIDWIFERY

Pre-qualifying considerations (direct and apprenticeship routes, shortened course for registered nurses)

Applications to study midwifery come through similar routes as nursing; the traditional UCAS direct entry route and the apprentice route. Those who have previously been educated as an adult nurse are eligible to study via a shortened route, requiring reduced time in university and in the placement setting. This usually takes 21 - 24 months, as opposed to the three-year (or more) direct entry programme for those who are not already adult nurses. This shortened route can be offered as an apprenticeship or a direct entry. In all cases, study can be offered at Bachelor of Science or Master of Science level – and often Universities offer a selection of all potential routes to qualification to widen the interest base to midwifery education at their institution.

There are currently 20 different Universities offering one or more routes into midwifery education in the southeast region. Although student midwives have the opportunity to experience a range of placement experiences across community and hospital settings, the limiting factor for student numbers on midwifery programmes is usually placement capacity. This was recognised as a significant issue by HEE and the NHS, due to a significant, and increasing, maternity workforce shortfall. In 2018 HEE committed to expand midwifery placement capacity, and hence student numbers, by 25% over 4 years.[45]

This increase in student placement capacity, and student numbers overall must surely be seen as beneficial in a profession currently working at a substantial shortfall. However, direct entry students are required to work a minimum of 2,300 hours in clinical practice (shortened route students 1,800 hours) comprising 50% of their overall learning and encompassing the full range of clinical settings for effective midwifery provision.[46]

The recent changes on Midwifery Continuity of Carer (MCoC) ambitions following the Ockenden report,[47] together with the Royal College of Midwifery (RCM) supporting MCoC on the clinical evidence yet expressing concerns that staffing levels are currently inadequate for it to be successfully implemented,[48] creates uncertainty amongst university and placement partners alike. Any changes should be carefully considered in light of the NMC requirement for midwifery students to experience MCoC making access to relevant learning experiences across the childbearing continuum a priority.

Thus, ensuring a high quality of placement provision, which is beneficial to student learning, and not just delivering practice hours requirements for qualification, is highly complex. It necessarily requires a substantial time investment from university staff and placement facilitators within placement Trusts and is often a fine balancing act. The slightest change to service provision, therefore, is likely to have a substantial impact on planning and delivery of meaningful learning experiences for learners and this should be carefully considered, seeking input from the Lead

[45] Midwifery training places expansion | Health Education England (hee.nhs.uk)
[46] Standards for preregistration midwifery education (nmc.org.uk)
[47] OCKENDEN REPORT - FINAL (ockendenmaternityreview.org.uk)
[48] rcm-pay-review-body-evidence-2022.pdf

Midwife for Education in relevant Universities, from the outset of any service reconfiguration. In particular, the variety of study modalities and the impact of reconfiguration on these, should be fully considered.

The RePAIR (Reducing Pre-registration Attrition and Improving Retention)[34] project reported an average attrition rate for midwifery students of 13.6% between the academic years of 2009/2010 and 2014/2015. This is a substantial and costly level of attrition. Any service configuration which negatively impacts student learning experience is likely to further increase this figure.

Postgraduate / post registration midwifery considerations

The consideration for this area is similar to nursing, the wide range of employment opportunities within the midwifery profession once qualified negates the ability to consider the influence of service reconfiguration on all such midwives. However, the areas of vulnerability to service change are similar and the midwifery specific considerations are outlined below.

The first two years post qualifying

It is undeniable that the immediate post-qualification period for midwives is at-risk from service reconfiguration. In 2022 there was a reported shortfall of just over 2000 midwives.[28] Retention is key with attrition rates at their highest in the first two years post qualifying.

Although birth rates in England continue to fall, women are requiring more complex care.[49] In order to progress as a midwife there are a number of competencies that need to be achieved. Midwives like nurses should receive preceptorship to consolidate knowledge and skills; the main aim and impact of preceptorship is to positively influence retention rates for newly qualified midwives.[50] Appropriate clinical experience during this period in a midwife's career needs to be prioritised and service change proposals need to be cognisant of the impact on the experience and subsequent retention of their newly qualified midwifery workforce.

Advanced Clinical Practice (ACP) and Consultant Midwives

In 2017 HEE produced the multi professional framework for advanced clinical practice, advanced clinical practice is underpinned by master level award or equivalent.[51] Consultant midwives represent clinical excellence, leadership, and academic capability.[52] As with nursing, consultant and advanced clinical practice midwives work in specialist areas and the same service change challenges can be applied.

[49] Smith, J (2021) Nurturing maternity staff. London: Pinter and Martin
[50] NHS England » National preceptorship framework for midwifery
[51] Advanced Clinical Practice in Midwifery (hee.nhs.uk)
[52] Website Document templates (rcm.org.uk)

International midwifery recruitment

One focus of international recruitment has been to increase nurses and midwives working in the NHS[53] and this is an increasingly important recruitment strategy for Trusts. The challenges and considerations for service reconfigurations are similar to nursing and are therefore not repeated here.

Research and Continuous Professional Development (CPD) considerations

There is a national imperative for high quality and safe maternity care, and it is increasingly common to see secondments for research midwife roles and research development is important to the profession. However, midwives continue to have less opportunities for research fellowships than their medical colleagues. Services need to consider staff movement across the local maternity and neonatal system (LMNS) and expose all professions to research opportunities. As for nursing the impact of service reconfiguration on research and CPD in midwifery needs to be given a high priority.

PHARMACY

During service reconfiguration the following key professional areas require consideration specifically in relation to Pharmacy workforce, training, and education:

- **Reforms to the** initial education and training of pharmacists,[54] which will result in pharmacists entering the workforce as independent prescribers from the point of registration, from July 2026 onwards.
- **Development of the registered pharmacist workforce**, specifically the NHS's ambition to train an additional 3000 Pharmacist Independent prescribers[55] in all sectors by 2026 initially and continuing thereafter.
- **Utilisation of advanced level and consultant Pharmacists** to deliver service priorities at an organisational, system and regional level in the southeast.
- **Growth in the number of pharmacy technicians in the health service,** driven by significant policy reforms including the expansion of Pharmacy Technicians training places via the apprenticeship route.
- Post-registration development **for Pharmacy Technicians[56]** which will enable Pharmacy Technicians to deliver more clinical services in the future.
- **Pharmacy workforce in aseptic and technical services.**
- **The role of Pharmacy Support staff** in future service models.

[53] NHS England » International nursing and midwifery associations
[54] Standards for the initial education and training of pharmacists – Interim learning outcomes (pharmacyregulation.org)
[55] Independent Prescribing | Health Education England (hee.nhs.uk
[56] Criteria for registration as a pharmacy technician in Great Britain (pharmacyregulation.org)

Background

The NHS LTWP[5] outlines an ambitious plan to train, retain and reform the NHS workforce both now, and into the future. Aligned to this, Pharmacy workforce, training and education is going through a period of significant reform, encompassing changes to the initial education and training of pharmacists, supporting the development of more pharmacist independent prescribers, and growing the number of pharmacy technicians training and working across all sectors of Pharmacy.

Pharmacy professionals work across all sectors of care, including in the NHS managed sector, primary care including in general practices and primary care networks, community pharmacies and other settings such as mental health services, health and justice services, integrated care system (ICS) teams and the pharmaceutical industry amongst others.

Reforms to the Initial Education and Training of Pharmacists

The Initial Education and Training of Pharmacists (IETP) is a 5-year period consisting of the 4-year undergraduate MPharm degree, followed by a 1-year foundation training year. Professional registration with the General Pharmaceutical Council (GPhC) then takes place at the end of year 5.

In 2021, the GPhC published a new set of standards for the IETP, including a new set of clinically enhanced learning outcomes (incorporating independent prescribing) and describing a new set of responsibilities for the statutory education bodies (SEBs), including NHS England.

MPharm (Years 1 to 4) considerations:

A key aspect of this reform relates to The Department for Health and Social Care's addition of undergraduate pharmacy students to the list of professions eligible for education and training tariff from September 2022. This means that schools of pharmacy are now able to plan clinical placements within the MPharm degree that are supported by clinical tariff payment.

There are four schools of Pharmacy in the southeast of England.

Schools of Pharmacy place MPharm undergraduates in the following settings:

- NHS managed sector (for example, secondary care, mental health trusts, etc).
- General practice or primary care networks.
- Community pharmacies.
- Other healthcare providers delivering NHS contracted service.

Provision of clinical placements for MPharm undergraduates are key to ensuring we have a pharmacist workforce, with the knowledge, skills, and behaviours to deliver high-quality care to patients in the future. They also serve as a key component of the workforce pipeline, as we strive to train and retain learners and graduates.

- A key consideration of any service reconfiguration should be whether the future service design will be able to support MPharm learners on clinical placements during their undergraduate programme.

Foundation Training Year (Year 5) considerations:

The fifth year of the initial education and training of pharmacists is the foundation training year. It consolidates their initial learning and education, offers on-the-job, practical training in a clinical setting or settings, enabling trainee pharmacists to build upon their pharmacy knowledge, understanding, skills and behaviours, and previous experience, and apply them to enhance their knowledge and skills in preparation for registration. Pharmacist foundation training is designed to give trainee pharmacists the support, direction, information, and resources they need to bridge the transition from studying to registering as pharmacists. Trainee pharmacists will require access to a prescribing learning environment as part of their foundation training year from 2026 onwards, to enable them to successfully complete their foundation training and register with the general pharmaceutical council. Key considerations around this for future service reconfigurations include.

- Educator capacity – support and development for the educational supervisors and designated prescribing practitioners (DPP's) who will be required to support these learners in practice moving forward.
- Estate and IT capacity – having the right estates environment and IT infrastructures in place to support learners.
- Job planning for existing staff will be central to ensuring that organisations are able to meet these training requirements moving forward.

Development of the registered pharmacist workforce including advanced and consultant level practice for Pharmacist

Upon registration with the General Pharmaceutical Council, Pharmacists work across a range of care settings. Pharmacists (and Pharmacy Technicians) are required to undertake yearly revalidation[57] and continuing professional development (CPD).

The Royal Pharmaceutical Society (RPS) overseas credentialling of Pharmacists at different stages in their post-registration development journeys; Post-registration Foundation Training, Core Advanced Practice and consultant Practice.

Service redesign leads should consider the Pharmacy roles required within any future services, and at what level of practice they require those roles to function at. Consultant Pharmacist posts particularly should be considered in the wider context of developing cross organisational, system level patient pathways.

Growing the Pharmacy Technician workforce

Pharmacy Technicians work across areas of the health service where medicines are handled, including areas where medicines are supplied or administered. Initial Education and Training (IET) supports Pharmacy Technicians to work in community pharmacy, general practice, hospitals, health and justice settings, mental health, and community health services.

[57] Revalidation for pharmacists and pharmacy technicians | General Pharmaceutical Council (pharmacyregulation.org)

As registered professionals, Pharmacy Technicians deliver a wide range of clinical and operational services across sectors, and service leads should consider how best to maximise their skills, capitalising on their registered status to deliver high-quality services to patients alongside the wider multi-disciplinary team.

Pharmacy workforce in Aseptic and Technical Services

Training and retaining a pharmacy workforce in aseptic, technical and cancer services is key to ensuring that patients on cancer and other pathways have timely access to specialist medicines and treatments. However, workforce shortages, and a limited pipeline of trainees has presented challenges to the ongoing delivery of these vital services.

NHS England has commissioned an infusions and special medicines programme board to review the pharmacy workforce in Aseptic and Technical Services in England.

This is an evolving area of working nationally. The regional NHS England Workforce, Training and Education Pharmacy Team is linked to this work, alongside cancer network teams and Pharmacy services leads within NHS organisation. It is recommended that organisations considering service redesign in this area contact the above for current information in this area.

Healthcare support staff

Healthcare support staff refers to staff within multi-disciplinary teams who are not registered professionals. They are critical to teams' ability to provide safe and high-quality patient care, playing a vital role enabling the NHS to meet complex health challenges.[58] It is estimated that approximately 60% of care (in hospitals, care homes and homes of individuals) is provided by non-registered care workers.[59]

Healthcare support staff may experience inconsistent access to training and further development opportunities. It is acknowledged to retain support staff and for them to feel valued this needs to improve. In addition, the NHS LTWP[5] makes reference to the need to grow this section of the workforce and widen the access for support workers to become registered professionals.

There are a number of frameworks to support the recruitment and retention of support workers described in the NHS LTWP. As for registered professionals, ICBs and providers undergoing reconfiguration of services will be required to play significant attention to their support workforce to realise their service change plans, which will demand close involvement of heads of service and educational leads.

[58] 2348-Shape-of-caring-review-FINAL.pdf (hee.nhs.uk)
[59] (PDF) The Nature and Consequences of Support Workers in a Hospital Setting (researchgate.net)

Summary and recommendations

- It is vital that undergraduate teaching, postgraduate training, and research remain high priority and explicit on the agendas of all stakeholder organisations (commissioners and providers) involved in planning changes in service delivery configurations. Expert representatives from these three areas should be involved in any service change proposal.
- The NHS Long term Workforce Plan states an ambition for 22% of training for clinical staff to be through apprenticeship routes by 2031/32. Although details of apprenticeship training for each profession is yet to be finalised such training will be a predominately more workplace-based pathway, it is therefore reasonable to assume learners on these schemes could be greatly affected by service reconfigurations and support for this part of the workforce will require specific attention by transformation programme teams. Funding for education, training and salary support for apprenticeships will be an important enabler.
- Support for the skilled workforce, required for supervision and training, will be an important part of any service change. The skilled workforce is already stretched and may be supported by greater use of automated training tools, such as virtual reality and artificial intelligence-based systems. These could replace some of the face-to-face engagement required prior to assessment and verification of training.
- Collaborative professional networks are a significant support mechanism for the workforce during service change. They may be used to rapidly disseminate information, as a training, education, and workforce development resource and as a platform for professionals across Integrated Care Systems to communicate and collaborate.
- Recognition that training is an additional time pressure is required and workforce planning needs to incorporate this to recover from training deficit as a legacy of pandemic pressures.
- The unregistered workforce provides a significant proportion of patient care and need to be given a high priority when redesigning services.
- The importance of staff wellbeing and workplace culture has been spotlighted by the COVID-19 pandemic. Both are critical for staff retention and kinder care for patients. Any service transformation requires robust leadership support for the current and future workforce.

Conclusion

There are significant workforce challenges right across health and social care, which will impact on the provision of hospital-based services, and how they are configured.

It is essential that the skills of the future health and care workforce are clearly articulated, and professional barriers are broken down wherever appropriate, to ensure flexibility and adaptability of the workforce is aligned with the needs and choices of patients, an ever-increasing number of whom have long term, chronic conditions, and mental health needs. Clarity is required as to where the future workforce needs to be expanded (in the community, in hospitals, or both) to appropriately address patient need and patient choice. The skills required and the range of professions that could provide these skills using innovative models should then be described. Workforce planning and training then needs to be rapidly aligned with these identified requirements and with the ambitions of the NHS Long Term Workforce Plan.

There are both opportunities and risks from service reconfiguration for health care professional teaching, training, and research. For undergraduate degree courses, the curriculum and experience that can be offered to students must remain comprehensive, accessible, and coordinated if across a network of provider organisations. For postgraduate training, the centralisation of specialist services will increasingly require collaboration across training scheme boundaries to ensure exposure and experience is gained. Postgraduate courses and continuous professional development should be offered to aid in recruiting and retaining a high-quality clinical workforce. Support during service reconfiguration for apprenticeship learners who will be on a more workplace-based pathway than traditional entry routes will require specific consideration during service reconfiguration to ensure retention and quality of training provided.

The delivery of high-quality clinical research is in the interests of patients, providers and the health economy and must be nurtured. This requires strong leadership from the region’s specialist centres and coordination with all key provider organisations,

Overall, it is vital that undergraduate and postgraduate teaching, postgraduate training, and research and development remain high and explicit on the agendas of all stakeholder organisations (ICSs, ICBs, commissioners and providers) involved in planning changes in service delivery, and expert representatives from these three areas should be involved in any service change proposal.

Contributors

The South East Clinical Senate would like to thank the following people for their significant contributions to this report:

NAME	JOB TITLE	PLACE OF WORK
Paul Stevens	South East Clinical Senate Chair Consultant Nephrologist	East Kent Hospitals NHS Foundation Trust
Sara Bolton	Chief Allied Health Professional	Medical Directorate, NHSE South East
Jane Carpenter	Programme Lead, Midwifery and Lead Midwife for Education	Oxford School of Nursing and Midwifery, Oxford Brookes University
Shane Costigan	Pharmacy Dean, Regional Head of Pharmacy	Workforce, Training and Education Directorate, NHSE South East
Kevin Davies	Kent Surrey Sussex LCRN Deputy Clinical Director; Emeritus Chair of Medicine, BSMS	University of Brighton
Karen Harrison-White	Programme Lead for Nursing, Honorary Professor (Brunel University London)	Workforce, Training and Education Directorate, NHSE South East
Wendy Keating	Assistant Director of Nursing- Professional and System Development	Nursing Directorate, NHS England - South East Region
Mark Knight	Chief Healthcare Scientist	NHS Kent and Medway ICB
Karol Kuczera	Workforce and Organisational Development Manager	Workforce, Training and Education Directorate, NHSE South East
Paul Sadler	Postgraduate Dean	Wessex and Thames Valley Regional Postgraduate Dean – NHSE South East
Emily Steward	Head of South East Clinical Senate	NHSE South East
Jo Szram	Postgraduate Dean	Kent Surrey Sussex Regional Postgraduate Dean – NHSE South East
Rebecca Tyrell	Regional Head of Allied health Professions	Workforce, Training and Education Directorate, NHSE South East