Shaping the Future

Workforce

Interim Acute Care Area Workforce Report
1 Introduction

There is currently a lack of a universally agreed definition for acute care, however it is generally agreed that it involves both urgent and emergency care. The South Central Acute Care Pathway Report\(^1\) defines urgent and emergency care as follows:

“Urgent care provides the assessment and management of common problems where the patient thinks there is a moderate degree of urgency. Much of this care is delivered by General Practitioners and their teams, although GP out of hours services, Urgent care and Emergency Departments deal with an increasing number of patients with urgent care needs.”

“Emergency care is the assessment and management of illness and injury where the patient or the clinician thinks there is a need for immediate assessment and care for their problem. This care is provided mainly by out of hours services, Emergency Departments and hospitals”.

Acute care is provided by a range of service providers such as, pharmacy, advisor services such as NHS direct, first contact care such as GP ‘In Hours’ and ‘Out of Hours’, walk in centres, minor injury units, emergency departments (EDs), ambulance service, Acute medicine, Acute surgery, crisis intervention and primary care centres. The care area is vast and is delivered by a diverse workforce spanning primary, secondary and community care.

Within NHS South Central this workforce provides care across Berkshire, Buckinghamshire, Oxfordshire, Hampshire and the Isle of Wight, to a population of roughly 4 million people across 10,000 sq km.

The programme development of acute care is still in its early stages within South Central Strategic Health Authority. As such the main aim of this paper is to provide a contextual overview of the current acute care workforce within South Central, in the hopes that it will help to inform the acute care strategy.

The main aims of this plan are as follows:

- To identify any future forces for change
- To identify the current workforce demand drivers
- To assess the current workforce supply
- To establish the key workforce priorities in terms of developing the workforce
- To produce any initial actions that may be appropriate

2 Workforce demand

The following section outlines the key factors that can be seen as currently impacting on the acute care workforce demand, which need to be taken into consideration when evaluating how the workforce should be shaped moving forwards:

2.1 Ageing population
The Office of National Statistics (ONS) forecasts that the fastest growing age group in England are the over-75s, who are known to be some of the heaviest users of the health service.

Within the South East Coast (Government Office Region), by the late 2020s it is estimated that over 40 per cent of the population will be over the age of 50, that the number of people over the traditional retirement age of 65 will increase by nearly 50%, and that those aged over 85 will more than double in number. Furthermore within South Central the number of people aged over 65 is expected to rise by 25.9% between 2010 and 2020, from 653,100 to 822,100. It is likely that the increasing ageing population will lead to increased demand for various health services, including the increased use of acute care.

2.2 The prevalence of long term conditions
The prevalence of long term conditions is also likely to place additional demand on the need for acute care services. For instance when examined with the ageing population of South Central (one of the heaviest users of the health service) the number of people with long term limiting illnesses in people aged 65 and over is forecast to rise by 26.7% from approximately 275,961 in 2010 to 349,511 in 2020.

2.3 Increasing levels of obesity
Within the UK obesity is a growing problem, with one in three adults predicted to be overweight by 2012. Within South Central, the 2008 health profiles produced by the Association of Public Health Observatories show that 22.2% of adults living in the South Central region are currently obese. The increase in obesity levels in the region and associated health conditions is likely to lead to increased demand for many aspects of the health service, including acute care.

2.4 Alcohol
Alcohol consumption exerts particular demands on the acute care workforce. Nationally, overall alcohol consumption is much lower than it was 10 years ago, with the average units consumed by men falling between 1998 and 2005 from 17.2% to 15.8% per week. However due to a change in drinking habits, i.e. binge drinking, the demand on acute services has increased, with approximately 863,300 admissions relating to alcohol consumption in England occurring in 2007/2008. Furthermore a South Central press release includes information which states that on a typical Friday and Saturday night, up to three quarters of all Accident and Emergency (A&E) attendances are a result of alcohol.

As a consequence it needs to be ensured that the acute care workforce are able to identify and effectively manage patients with a range of alcohol induced problems, such as alcoholics, binge drinkers and those with long term alcohol related illnesses. This should be achieved through effective training and ensuring the workforce is suitably resourced. There also needs to be a level of collaboration between Emergency Department and other healthcare services. An additional point to note is that early identification and intervention from the appropriate service may prevent the

---


3 Workforce summit briefing paper, September 2009.


5 Health Episode Statistics (HES) data (2009)

need for later treatment in an ED, which would subsequently reduce the demand on acute services.

2.5 The increasing complexity of case mix
Within the European Union, approximately 2/3rds of individuals who have reached pensionable age have at least two chronic health conditions, and this overall EU trend is likely to be replicated in England7. This places unique pressures on acute care due largely to the time critical nature of the care required in understanding a patient’s health conditions and how this affects the treatment they require. Clearly in this situation the ability to act quickly and decisively is critical, and as such South Central needs to ensure that services are appropriately resourced with senior decision makers, who would be able to make decisions quickly.

2.6 Four hour target
In 2000 the NHS plan stated that by 2004, no patient should wait more than 4 hours in Accident and Emergency from arrival to admission, transfer or discharge, and in January 2005 a target of 98% of patients being seen within 4 hours was set. This can be seen as beneficial to the patient and to the NHS in the long term as ensuring the majority of patients are seen within this timeframe ensures any severe injury or illnesses are picked up on early and are less likely to develop into more serious conditions, which may require further NHS resources in order to treat the patient at a later stage.

As we can see from figure 1, since September 2008 the majority of patients have been seen within 4 hours, with the exception of December 2008, January 2009 and October 2009. Furthermore when this target was missed, it has only been marginally missed. For instance the lowest percentage of patients seen within 4 hours was 96.9% in December 2008 and most recently in October this year only 97.4% of patients were seen within this timeframe.

![South Central monthly A&E performance](image)

**Figure 1 Accident and Emergency 4-hour wait performance**

---

7 European Foundation for the Improvement of Living and Working Conditions, 2006

8 Source: Performance and Compliance team, South Central SHA
However it may be worth South Central investigating why the 4 hour target was missed during each occurrence and consider any necessary means of increasing productivity.

2.7 Ambulance response times
Treating patients in a timely manner reduces the initial time period where the patient’s illness or injury could worsen, resulting in the need for additional resources to treat the patient at a later stage. Ambulance services are expected to reach 75% of Category A (life threatening) calls within 8 minutes and 95% of category B (urgent but not life-threatening) calls within 19 minutes.

From the graph below we can see that on the whole, between September 2008 and October 2009 South Central ambulance services have largely met the category A target with the exception of a few months such as November and December. However in recent months this has started to decline slightly. South Central should review whether there is any opportunity for improvement here, or if it is simply due to factors such as volume of calls. In terms of the category B target to reach 95% of all urgent but not life threatening calls within 19 minutes, we can see from figure 2 that South Central’s ambulances services tend to struggle slightly to exceed this benchmark, with the average percentage of category B calls reached within a timely manner for the time period analysed being 94%. South Central should consider whether this is highlighted any potential improvement opportunities.

![South Central monthly ambulance performance graph](image)

Figure 2 Ambulance Response time performance

2.8 Our health Our Care Our Say
*Our Health Our Care Our Say* set a 10 year vision to provide good quality social care and health services in the communities where people live. The aim of the vision was essentially to provide a new direction for community care services, become more responsive to patient needs, and prevent ill health by the promotion of healthy lifestyles.

---

9 Source: Performance and Compliance team, South Central SHA
The workforce consequences of this shift are not fully understood, but it is likely that this shift in service provision will place additional demand on primary care. Therefore it will be paramount to ensure the primary care workforce is suitably resourced and configured to provide the best level of care possible. Training and CPD will be required to prepare practitioners for a different working environment, and the use of multi-professional teams needs to be considered to enable the transfer of some tasks currently carried out by medically qualified consultants, to qualified nurses and other appropriate practitioners. Further skills development may also include developing staff to work across organisations, the adoption of new roles such as physicians assistants, though this needs to be considered in line with the current economic climate.

An additional consequence of Our Health Our Care Our Say of note is that some aspects of providing more care in the community may be beneficial in terms of the development of existing staff. For example it is likely that many staff will be given greater opportunities to take on new roles and responsibilities, to work in a variety of settings, to consider innovative approaches to care, and to work in multidisciplinary teams.

2.9 Delivering care closer to home: meeting the challenge

Following the drive of the 2006 white paper Our health, our care, our say, Delivering Care Closer to Home was produced to share emerging practice; look at what national enablers can support shifting care; and highlight new products already developed to shift care by the Department of Health. The report highlights, what can be considered the key elements in the shift in care closer to home:

- Addressing inequalities
- Involving people as partners in designing services and delivering their care
- Providing integrated care
- Building commissioning capacity and capability
- The development of clinical and managerial leadership
- Developing estates and premises that are fit for the future
- Utilising workforce planning
- Greater use of technology

At present 27% of our health budget is spent on primary care, compared with an OECD average of 33%. Furthermore it is widely accepted that, there are 11 leading causes of hospital bed use in the UK, 8 of which could be treated more effectively in a community setting.

In relation to acute care, the report states that whilst acute services will be an absolutely vital part of the pathway, it will be increasingly feasible and for many patients preferable, to position more of the care pathway outside of the hospital setting. This is likely to need a shift in culture amongst the workforce, and ties in with many of the workforce development comments above. Specifically shifting care is likely to require effective clinical and managerial leadership to ensure a successful transition, to work with local communities to co-design change, and to grasp strategic opportunities. As such South Central needs to ensure that appropriate development opportunities are available. It is also likely that increasing levels of care in the community will place additional pressure on community urgent care services and ambulance services, due to their abilities to act as hub and connector.

The report also highlights a number of initiatives which are likely to have a knock-on effect for the acute care workforce. For instance a number of initiatives are being trialled to enable better self-management by patients of their own conditions. These include information prescriptions, individual social care budgets, and self-referral to physiotherapy. Improved self-management of patients’ own conditions, coupled with the development and increased use of pharmacists with a special interest (PhwSIs) who can provide services in locations convenient for the patient, has the potential to reduce demand for both urgent and emergency care. More schemes are also being trialled to enable patients to die in a place of their choice. Typically patients would prefer to die at home, but end up dying in hospital. By enabling more patients to die at home this should reduce the pressure on hospital beds, and consequently secondary care staff. However on the flip side the demand for primary care staff will most likely increase.

2.10 National Stroke Strategy

Every year approximately 110,000 people in England have a stroke and stroke is considered the third largest cause of death in England, with 11% of deaths being seen as a result of stroke. Furthermore the National Stroke Strategy\textsuperscript{12} reports that stroke costs the NHS and the economy £7 billion a year, £2.8 billion in direct costs to the NHS, £2.4 billion in informal care costs and £1.8 billion in income lost to productivity and disability.

The National Stroke Strategy was developed by six expert project groups, comprising of a wide range of relevant professionals, carers and voluntary associations. It was then further informed and refined via a formal consultation process. The strategy sets out a framework of quality markers for raising the quality of stroke prevention, treatment, care and support for over the next decade. Examples of these quality markers relevant to acute care include:

- That transient ischemic attacks (TIAs), or minor strokes, need to be regarded as an emergency and not an elective condition, because the time necessary for effective prevention of a more serious subsequent stroke is extremely short. High risk TIA patients need to be assessed by experts and, wherever possible, scanned using magnetic resonance imaging (MRI) within 24 hours of experiencing symptoms, and lower risk groups need to be seen within seven days and given follow up care. In order to achieve this South Central needs to give consideration to workforce capacity.

- People with suspected stroke should be immediately transferred to a hospital providing hyper acute services throughout the day and night. This includes expert clinical assessment, rapid imaging and the ability to deliver intravenous thrombolysis. They should receive an early multidisciplinary assessment, including swallow screening, and have prompt access to a high quality stroke unit. In order to achieve this South Central needs to give consideration to ensuring a suitably resourced and skilled workforce.

- Stroke networks should be established, in order to bring together key stakeholders and providers to review, organise and improve delivery of services across the care pathway. These will typically cover a population of roughly half a million to 2 million, and draw on existing service improvement expertise within cardiac networks.

• The transfer of care from hospital to community sector needs to be improved, and organisational working needs to fostered, in particular with the voluntary sector.
• A range of services need to be locally available to support the individual long term needs of people who have had a stroke and their carers.

The national stroke strategy states that current staffing numbers and skills mix profiles are insufficient to deliver the required input in stroke care pathways. Consequently a workforce review is needed, in conjunction with a workforce plan that defines the care pathway, and ensures that appropriate training is put in place to enable staff to service the pathway. Furthermore inter-professional and inter-agency teams should be considered which include staff who are competent in their roles, have stroke expertise, understand the roles of others, and are able to support the activities of other staff when required. This will help facilitate a high quality level of care.

The national stroke strategy provides a list of actions for achieving this, including points around ensuring effective leadership is in place, consideration of the development of new and more flexible roles, initiating competence based training for the extension of roles, the development of generic skills, and consideration of competences for non-specialist staff. Specifically recommended SHA actions include working collaboratively with primary care trusts, deaneries, higher education institutions, and provider organisations to drive workforce innovation and encourage the development of deaneries with a multi-professional focus. It would be advisable for South Central to review the stroke strategy and where appropriate review the application of the strategy’s recommendations.

3 Workforce supply

Where there are relevant cross overs, aspects of this supply section have been repeated in the planned care contextual paper.

3.1 Accident and Emergency medical workforce
The medical workforce has not been looked at in any real detail within this contextual paper, as medical information will be covered in the South Central Strategic Health Authority medical strategy. However a brief analysis of accident and emergency medical workforce shows that there are approximately 296 Full Time Equivalent (FTE) A&E medical staff employed within South Central, as at October 2009.

Table 1 provides the details of the numbers and percentage of staff employed by job role. This shows the largest numbers of staff are employed as Specialty Registrars, accounting for approximately 25.5%, consultants, accounting for approximately 18.4%, Specialist Registrars accounting for approximately 14.7% and Foundation House Officers, accounting for approximately 15.2%.
<table>
<thead>
<tr>
<th>Medical and Dental</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Specialist</td>
<td>9.7</td>
<td>3.3%</td>
</tr>
<tr>
<td>Clinical Assistant</td>
<td>1.5</td>
<td>0.5%</td>
</tr>
<tr>
<td>Consultant</td>
<td>54.5</td>
<td>18.4%</td>
</tr>
<tr>
<td>Foundation House Officer 1</td>
<td>1.0</td>
<td>0.3%</td>
</tr>
<tr>
<td>Foundation House Officer 2</td>
<td>44.0</td>
<td>14.9%</td>
</tr>
<tr>
<td>Hospital Practitioner</td>
<td>0.4</td>
<td>0.1%</td>
</tr>
<tr>
<td>Senior House Officer</td>
<td>34.0</td>
<td>11.5%</td>
</tr>
<tr>
<td>Specialist Registrar</td>
<td>43.7</td>
<td>14.7%</td>
</tr>
<tr>
<td>Specialty Doctor</td>
<td>22.4</td>
<td>7.5%</td>
</tr>
<tr>
<td>Specialty Registrar</td>
<td>75.6</td>
<td>25.5%</td>
</tr>
<tr>
<td>Staff Grade</td>
<td>6.5</td>
<td>2.2%</td>
</tr>
<tr>
<td>Trust Grade Doctor - SHO level</td>
<td>2.8</td>
<td>0.9%</td>
</tr>
<tr>
<td>Trust Grade Doctor - Specialist Registrar Level</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>296.1</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Table 1 Accident and Emergency medical workforce

The analysis of this workforce also revealed that approximately 95.2% of A&E medical staff work in the Acute sector, with the remaining 4.8% working in PCTs.

### 3.2 Ambulance workforce

In order to profile the South Central ambulance workforce, including all relevant support staff, information was pulled from the ESR data warehouse for any individuals who had ambulance services as their area of work, or who had an occupation code directly related to the ambulance workforce. The following profile provides a robust view of the key trends within the workforce.

#### 3.2.1 Ambulance workforce - Staff group

Based on this approach, the ambulance workforce across South Central as at October 2009 is approximately 2270 FTE. Of that number, approximately 48% of the workforce are employed within additional clinical services, 28% are employed as Allied Health Professionals and 17% are employed as administrative and clerical staff, as figure 3 shows.

More in depth analysis of each of these staff groups reveals the following:

- Within the additional clinical services staff group approximately 32.8% are employed as healthcare assistants, 27.3% are employed as technicians and 25.2% are employed as health care support workers.
- Within the Allied Health Professional (AHP) staff group approximately 68.1% are employed as paramedics, 23.4% are employed as paramedic managers, 6.7% are employed as paramedic specialist practitioners and 1.8% are employed as paramedic consultants.
- Within the administrative and clerical staff group approximately 47.5% of staff are employed as control assistants, 20.5% are employed as officers, and 10.5% are employed as clerical workers.

---

13 Source: ESR October 2009. Please note: Trust Grade Doctor – Specialist Registrar level headcount of 1 reported, with an FTE of 0.
3.2.2 Ambulance workforce - Skill mix

Figure 4 shows that approximately 30.9% of the workforce are employed at band 3, 25.9% are employed at band 5 and 19.4% are employed at band 4.

As approximately 76.2% of the workforce are employed at bands 3, 4 and 5, it was felt that further analysis would be useful into what job roles people were being employed at, within those AfC bands:

- The largest numbers of staff employed at band 3 within this workforce were employed as healthcare support workers, healthcare assistants and control

---

14 Source: ESR Data Warehouse October 2009.
15 Source: ESR Data Warehouse October 2009.
assistants, accounting for approximately 26.4%, 48.1% and 16.8% of all staff employed at band 3.

- Within band 4 the largest numbers of staff were employed as technicians within the additional clinical services staff group, accounting for approximately 65.8%, control assistants accounting for 7%, healthcare cadets, accounting for approximately 6.2% and officers within the administrative and clerical staff group, accounting for approximately 6.1% of staff employed at band 4.
- Within band 5 the largest numbers of staff within this workforce were employed as either paramedics, accounting for approximately, 69.4% of staff employed at this level, healthcare cadets, accounting for approximately 10.9%, and administrative officers, accounting for approximately 5.8%, of all staff employed at band 5 within this workforce.

Another point worth noting is that there are not many staff above band 6, as shown in figure 4. This may be an indication that there is a lack of leadership within the ambulance workforce at present. South Central should investigate whether this is the case, if so what the implications are.

3.2.3 Ambulance workforce - Age
Figure 5 shows the age profile of the ambulance workforce, based on this analysis, as at October 2009. From this we can see that, assuming a retirement age of 60, 7.3% of the overall workforce has reached retirement age, and a further 6.9% will reach retirement age within the next 5 years.

![Age Profile of South Central Ambulance workforce - October 2009](image)

**Figure 5 NHS South Central Ambulance workforce – age profile**

3.2.4 Ambulance workforce - Gender
Overall, the gender of this workforce is fairly evenly distributed, with approximately 54.3% of the workforce being male, and 45.7% being female. However it is worth highlighted that within the administrative and clerical staff group, approximately 66.4% are female, and within the nursing registered staff group approximately 81% are female. South Central needs to give careful consideration to the implications this could have on workforce supply due to issues such as maternity leave and the trend towards part time working.

---

16 Source: ESR Data Warehouse October 2009.
3.2.5 Ambulance workforce - Ethnicity
In terms of ethnicity, approximately 81.9% of the workforce are white. 15.5% of the workforce did not specify their ethnicity, however small numbers were also reported in various other ethnic groups.

3.2.6 Ambulance workforce - Sickness absence
This analysis has been carried out in order to gain an understanding of the ambulance workforce, including all underpinning and supporting staff. As such it is difficult to produce sickness absence data from the ESR data warehouse that would accurately correspond to this. However a clear indication of sickness absence can be gained from reviewing the South Central ambulance service (SCAS) trust’s monthly workforce performance report.

As you can see from figure 6 in October 2009 South Central ambulance service reported a sickness absence rate of 4.10%, slightly over South Centrals benchmark of 4%, but 1.5% under their planned sickness absence rate. Furthermore SCAS’s sickness absence rate has been in decline since August 2009.

![Sickness Absence Rate (%) Recorded one month in arrears](image)

Figure 6 South Central Ambulance Service Sickness Absence

3.2.7 Ambulance workforce - Turnover
To reiterate, this analysis has been carried out in order to gain an understanding of the ambulance workforce, including all underpinning and supporting staff. As such it is difficult to produce turnover data from the ESR data warehouse that would accurately correspond to this. However a clear indication of turnover figures can be gained from reviewing the South Central ambulance service (SCAS) trust’s monthly workforce performance report.

As you can see from figure 7 South Central’s ambulance service’s turnover rate has consistently been below the SHA benchmark of 15%, and their planned rate which stood at 9.4% in November 2009. In November 2009 South Central’s ambulance service trust achieved a turnover rate of 5.6%.

---

17 Source: SCAS workforce performance report, South Central workforce team
3.3 Nursing workforce supply
In order to gain some insight into the nursing workforce that would support planned and acute care, we produced an aggregate profile of the South Central nursing workforce based in acute general and elderly care and community services, whilst removing any staff directly identifiable as being in other care areas. Appropriate health care assistants and support workers were also included.

There was evidence in the data of organisations miscoding staff. The level of error is not statistically significant, however as a consequence the following data should not be viewed as absolute figures, but as providing a valid and robust indication of clear trends.

3.3.1 Nursing workforce - Staff group
Based on this approach, there are approximately 19300 FTE of staff in the nursing workforce that would serve planned and acute care, of which approximately 74% are in the nursing registered staff group and 24% are in the additional clinical services staff group. More in depth analysis of these staff groups reveal that the majority of nursing registered staff are employed as staff nurses, which accounts for approximately 58% of the nursing registered staff group. Within additional clinical services the majority of staff are employed as either healthcare assistants or healthcare support workers.

3.3.2 Nursing workforce - Skills mix
Figure 8 below shows that a significant number of staff are employed band 5, which accounts for approximately 41% of the workforce, and band 2 which accounts for 18%. More in depth analysis reveals that a large number of those working at band 5 are employed in roles such as staff nursing and community nursing, with nursing registered staff accounting for virtually all of those employed at band 5. Within band 2, the majority of staff are employed as either healthcare support workers or healthcare assistants, accounting for approximately 96% of the band 2 staff combined.

18 Source: SCAS workforce performance report, South Central workforce team
3.3.3 Nursing workforce - PCT/Acute split

It is also interesting to note the split between PCTs and the acute sector. Figure 8 below shows that the majority of the workforce that exists across these two sectors reside in the acute sector, which account for approximately 72% of the total number.

---

Source: ESR Data Warehouse October 2009
3.3.4 Nursing workforce - Age

Figure 10 shows that, assuming a retirement age of 60, approximately 4.4% of this workforce have already reached retirement age, and a further 10% will reach retirement age over the next 5 years.

---

20 Source: ESR Data Warehouse October 2009
21 Source: ESR Data Warehouse October 2009
3.3.5 Nursing workforce - Gender
This is a very female dominated workforce, with approximately 91% of the overall workforce being female. Specific staff groups that have a particularly high female presence include nursing registered staff, at approximately 92%, administrative and clerical with 92%, and additional clinical services where approximately 89% of their workforce is female. South Central need to consider the implications this may have on the workforce in terms of the potential for maternity leave and the increasing trend towards part time working.

3.3.6 Nursing workforce - Ethnicity
The majority of the workforce is white, accounting for approximately 73.6% of the workforce. Other substantial ethnic groups included Black African accounting for 3.7% of all staff, and Indian accounting for approximately 3.8%.

3.3.7 Nursing workforce - Sickness absence
From November 2008 to October 2009 this workforce had a sickness absence rate of approximately 4.6%, slightly over South Centrals 4% benchmark.

3.3.8 Nursing workforce - Turnover
From November 2008 to October 2009 this workforce had an average turnover rate of 11.5%, under South Centrals benchmark of 15%.

3.4 General Practitioners
Data from the information centre for September 2008 shows that within South Central strategic health authority there are 2561fte General Medical Practitioners, 880fte practice nurses. Furthermore 395fte of additional staff are involved in direct patient care in some respect, 3,177fte staff are involved in administrative and clerical work and 147fte staff are involved in ‘other’ activities.

<table>
<thead>
<tr>
<th>Staff Role</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical Practitioners</td>
<td>2,561</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>880</td>
</tr>
<tr>
<td>Direct Patient Care</td>
<td>395</td>
</tr>
<tr>
<td>Admin and Clerical</td>
<td>3,177</td>
</tr>
<tr>
<td>Other</td>
<td>147</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,160</strong></td>
</tr>
</tbody>
</table>

Table 2 General Practice Staff by Role

---

22 Source: Information Centre, data as at 30 September 2008. 2008 FTE figures have been collected based on the number of sessions or hours each GP works
It should be noted that general medical practitioners figure includes GP providers, GP registrars, GP retainers and ‘other GPS. This can be broken down as follows:

<table>
<thead>
<tr>
<th></th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Providers</td>
<td>1,943.7</td>
</tr>
<tr>
<td>Other GPs</td>
<td>316.2</td>
</tr>
<tr>
<td>GP Registrars</td>
<td>266.1</td>
</tr>
<tr>
<td>GP Retainers</td>
<td>34.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,560.8</strong></td>
</tr>
</tbody>
</table>

Table 3 General Medical Practitioners by type

3.5 Administration and Estates Staff

Table 4 shows the total (fte) of administrative and estates staff within South Central, by work area and occupation description, as at October 2009. This gives an indication of the levels of staffing within each area of work, for instance the table below shows that the largest number of admin and estates staff work in central functions, accounting for approximately 45% of the workforce, closely followed by clinical support which accounts for an additional 40%. It is also of interest to note the level of management and within which areas they work. For instance overall; senior managers account for approximately 6% of the administrative and estates workforce, and managers account for approximately 13%. As can be as seen from table 4, the majority of management staff work within central functions.

![Table 4 Administration and Estates Staff by Role and Area of Work](source)

3.5.1 Administration and Estates staff in the acute care organisations

The following table shows the administrative and estates workforce that was reported as being in the acute sector, as at October 2009. As can be seen from table 5 the majority of staff within the acute sector work within clinical support, accounting for approximately 46%, and central functions accounting for 40%. Furthermore the majority of the workforce were classified as clerical and administrative, accounting for approximately 79%.

![Table 5 Administration and Estates Staff in Acute Care Organisations by Role and Area of Work](source)

---

23 Source: Information Centre, data as at 30 September 2008
24 Source: ESR Data Warehouse, October 2009
25 Source: ESR Data Warehouse, October 2009
3.5.2 Administration and Estates Staff - Christmas tree

Figure 10 shows the administration and estates workforce within South Central's acute sector as at October 2009. As we can see from figure 10 the larger numbers of staff are employed at bands 2, accounting for approximately 23.7% of the workforce, band 4, accounting for approximately 22.5% of the workforce and band 3, accounting for approximately 19.26% of the workforce.

The fact that not many staff are employed band 7 and above, may indicate that there is currently a lack of leadership within this workforce. This is something South Central should investigate.

![Bar chart showing the distribution of staff across different bands as of October 2009.]

Figure 11 NHS South Central administration and estates workforce – skill mix

3.5.3 Administration and Estates Staff - Job role analysis

More in depth analysis of the administration and estates workforce within the acute sector as at October 2009 revealed that the largest numbers of staff were employed in the following roles:

- Clerical workers accounting for approximately 39.4%
- Administrative and clerical officers accounting for approximately 12.4%
- Managers (within the administrative and clerical staff group), accounting for approximately 12.2%
- Medical secretaries accounting for approximately 10.0%
- Senior managers accounting for approximately 5.3%
- Secretaries accounting for approximately 5.2%

3.6 Independent projects

---

26 Source: ESR Data Warehouse October 2009
Certain staff groups have intentionally not been given much focus, due to other independent projects being produced which cover these groups in a considerable level of detail. These projects include:

- South Central SHA’s pharmacy project
- South Central SHA’s Medical strategy
- Modernising Scientific Careers work

4. Workforce Priorities

The following section aims to identify key workforce priorities in terms of further developing the workforce to meet further demand:

4.1 Staff Engagement

Within South Central’s acute care workforce we need to ensure we are fostering an attitude of ambition around delivering the best possible service, in order to drive the workforce forward.

It needs to be ensured that all incentives are aligned across the workforce, and that incentives in the system drive the right approach. This should have the effect of creating a stronger team approach.

Staying healthy has the ability to improve health of the public and as such reduce the demand on EDs. NHS staff should lead by example. Therefore consideration should be given around what we expect from employees and what employees can expect from the NHS.

4.2 Care closer to home

In order to improve patient quality there is a real need to put patients first and consider new ways of taking care to the patient, in line with the increasing drive for more care in the community.

4.3 Leadership

There is a need for strong clinical leadership within acute care, and as such, people who possess the appropriate characteristics need to be identified and developed in order to help drive the workforce forward.

The increasing diversity of patient injury and illness, and increasing number of people with co-morbidities is driving the need for a multi-skilled and experienced workforce, and creates additional pressure as there is a need to understand complex conditions in a time pressured environment. Consequently it needs to be ensured that senior decision makers are available.

There is a need to provide specialist care in centralised specialist skills hubs, which would allow the workforce in this area to build up a level of specialist expertise.

We need to establish a workforce view across the whole region in order to determine what workforce will be required in the future in terms of both training and capacity.

4.4 Integration and collaboration

There should be a focus on integrated care, which would encourage staff to work more as a multi-organisational team and help to remove the barriers between primary and secondary care.
There should be a focus on collaborative working between all teams and consideration given to increased flexibility and multi-skilled staff. Consequently more rotational placements could be considered and clinicians need to be prepared to work more in the community, and possibly across multiple trusts.

Links should be established between acute care, planned care and long term conditions, in order to establish collaborative working methods. For instance, if patients with long term conditions receive an accurate diagnosis and are placed on the appropriate pathway, the potential need for acute services is reduced.

There needs to be a focus on reducing duplication of services.

Acute services need to be able to identify and effectively manage patients with various alcohol induced problems. There is also a need for collaboration between EDs and other health care services as earlier intervention from appropriate healthcare services may prevent the need for treatment in EDs.

4.5 Flexible workforce
South Central should use the current economic climate as an opportunity and use the current levels of unemployment to come out of the recession with a better quality workforce. The current climate provides a real opportunity to retain and attract the best people.

The filtering of patients to appropriate services is crucial to ensure all patients receive the most appropriate care. In order to aid this, accurate reporting tools should be established and consultation staff should be appropriately trained to ensure that patients are placed on the appropriate pathway.

The establishment of centralised services will benefit staff in training, giving them the opportunity to experience a wider case mix, and a higher volume of cases.

Within acute care networking and multisite working needs to become the norm for all specialist consultants, in order to create a more efficient, high quality service. It is likely that large-scale cultural change will be needed in order to achieve this.

In order to improve the quality of the service that is delivered, we need to make use of greater continued professional development, and where possible embed it in current working. For instance GPs should get constructive feedback on all referrals to specialists.

There is a need to drive quality amongst all general practitioners. As such South Central should redefine what is expected from GPs and make use of the GP contract as a method of beginning to achieve those expectations

There should be a shift in focus to early intervention and preventative care. As such GPs need to take an active interest, which may be encouraged through recognition of exemplary work and reviewing the GP contract.

New roles need to be developed such as emergency care practitioners (ECPs), emergency care assistants (ECAs), emergency nurse practitioners (ENPs), assistant practitioners (APs) and general practitioners with special interests (GPWSIs).
4.6 Making use of technology
Consideration should be given to better use of systems for sharing access to appropriate clinical information, remotely interpreting images and teleconference consultations between clinicians to ensure patients are not unnecessarily admitted and seriously ill patients (e.g. stroke and head injury patients) get timely access to appropriate diagnostics. Appropriate training should be made available to staff to maximise the return on investment in such systems.

South Central needs to ensure that it is aware of any technical advances or high tech specialist procedures, which may improve the quality of care. One such example is PPCI (Primary Percutaneous Coronary Intervention), often referred to as primary angioplasty. PPCI is a treatment for heart attack patients, where a small balloon is inserted on the end of a long thin tube via an artery, which is then able to unblock an artery that is carrying blood to the heart. PPCI has the potential to save even more lives than thrombolysis, and is also an option for many patients who cannot receive thrombolysis. Ultimately PPCI could lead to fewer heart attacks and strokes.

5. Workforce Strategy Alignment

The table below identifies the links between the themes and vision set out in the NHS South Central Shaping the Future Workforce Strategy 2010 to 2015 and the Staying Healthy workforce priorities.

<table>
<thead>
<tr>
<th>Strategic Theme</th>
<th>Vision</th>
<th>Alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Share the journey: engage patients, carers and staff</td>
<td>Patients, carers, staff and the general public all need to be engaged and play their part in ensuring the NHS continues to provide excellent health care within a sustainable framework.</td>
<td>4.1 Staff Engagement 4.2 Care closer to home</td>
</tr>
<tr>
<td>2. Plan and Prepare: Manage the Change</td>
<td>To respond to the challenge and scale of both the forecast increase in demand for health care services, and the reduction in spending on public services we must actively plan the workforce and prepare intelligently to manage the change.</td>
<td>4.3 Leadership</td>
</tr>
<tr>
<td>3. Integrate and align: design a joint future</td>
<td>To maximise the effectiveness of our workforce planning we need to integrate and align our actions, taking a system wide perspective on the future workforce requirements to deliver the emerging service models.</td>
<td>4.4 Integration and Collaboration</td>
</tr>
<tr>
<td>4. Tighten up business: drive up quality and value</td>
<td>To drive up quality and value, and reduce waste and variation in the way we deploy the workforce in NHS South Central, we need to implement excellent human resource management across all</td>
<td></td>
</tr>
<tr>
<td>5. Step up flexibility: develop the workforce</td>
<td>To develop a more flexible workforce that can assimilate new skills rapidly and work in new and innovative ways, by targeting skills development and developing new employment models.</td>
<td>4.2 Care Closer to home 4.5 Flexible workforce 4.6 Making use of technology</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>6. Be accountable: focus leadership</td>
<td>To enable the service changes that need to be delivered we need a culture of accountability at all levels, and leadership that is focussed on delivering the best health care system in the world.</td>
<td>4.3 Leadership</td>
</tr>
</tbody>
</table>

### 6. Next steps

- We need to identify current members of the workforce who have the potential for clinical leadership and nurture and develop those individuals who help drive the workforce forwards.

- Produce a comprehensive analysis of staff levels in acute care against clinical need.