Shaping the Future

Workforce

Long Term Conditions Care Area Workforce Report
1. Introduction

Long term conditions are health problems that require ongoing management, from the point of diagnosis, over the course of a lifetime. They include a wide range of health conditions including non-communicable diseases (e.g. cancer, respiratory, metabolic, neurological and cardiovascular disease), communicable diseases (e.g. HIV/AIDS), certain mental disorders (e.g. schizophrenia, depression), and ongoing impairments in structure (e.g. blindness, joint disorders).

A long term conditions patient pathway would typically span primary care, specialist secondary care, community care and social care which individuals would access according to need, intensity, severity and unpredictability of their symptoms.

The health needs of patients with long term conditions are met by a range of different staff groups including nurses, case managers, physiotherapists, occupational therapists, speech and language therapists, specialist clinicians, GPs, clinical psychologists, clinical pharmacists, dieticians, counsellors, respite care staff, rehabilitation staff, paid carers, informal carers and volunteers, social services and business/service managers.

2. Demand drivers

There are a number of drivers that will impact on long term conditions workforce demand over the next five years, including demographic changes, social and technological change and increasing expectations from patients, the Long Term Conditions Clinical Improvement Programme, policy and employment law, and others.

2.1 Demography

Evidence suggests that the likelihood of suffering with one or more long term conditions increases with age.

In the South Central region the number of people aged over 65 is expected to rise by 25% between 2010 and 2020, from 653,000 to 822,000. As indicated in Figure 1, this is a disproportionately large increase compared to that of other age groups in South Central’s population.

These extra years are not necessarily lived in good health or free from illness or disability. In 2004 in the UK, the disability-free life expectancy (DFLE) at birth was 62.3 for males and 64 for females\(^1\). The healthy life expectancy (HLE) – defined by the Office for National Statistics (ONS) as years spent in ‘good’ or ‘fairly good’ health (separate from having a disability) – is 68 for males in the UK and 70 for females. This means that, with life expectancies at 77.2 and 81.5 for males and females respectively, the average person can expect to live with a disability or illness, such as a long term condition, for between 9 and 16 years.

In South Central, the ageing population is likely to impact on chronic illness prevalence in the following ways:

- The number of people with a long term life limiting illness is forecast to reach nearly 350,000, compared with 275,000 in 2010 (see Figure 2).

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2 Revised 2006-based Sub national population projections, ONS
- Dementia prevalence is likely to increase by 30% from 47,000 in 2010 to 61,000 in 2020 (Figure 3).

![Figure 3: Forecast increase in dementia prevalence from 2010 to 2020.](image)

- The number of people suffering from a long standing health condition caused by ischaemic heart disease, stroke and bronchitis/emphysema is likely to increase, as shown in Figure 4.

![Figure 4: Forecast increase in prevalence of long standing health conditions caused by ischaemic heart disease, stroke, bronchitis/emphysema, from 2010 to 2020.](image)

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3 Revised 2006-based Sub national population projections, ONS
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2.2 Lifestyle changes
There is evidence that certain risk behaviours such as poor nutrition and lack of exercise, smoking, alcohol consumption above recommended limits and drug misuse are directly linked with the incidence of various chronic diseases including conditions such as diabetes, cardiovascular disease, pulmonary disease, liver disease, and mental disorders such as depression. It is not uncommon for a person to have more than one chronic condition, for example a combination of diabetes, hypertension and heart disease.

2.3 Social and technological change
Patients have ever-increasing expectations about the level of care that they receive. As well as delivering high standards of quality, patient-centred care, there is a need for organisations to help change public perception of the NHS and promote self management so that people are enabled to take personal responsibility for their health and well-being. This will necessarily involve supplying people with the right level and style of information. This change in emphasis is being enhanced through technological change enabling mobile working and remote monitoring of conditions via tele-health care.

2.4 South Central Long Term Conditions Clinical Improvement Programme
The South Central Clinical Improvement Programmes are currently in development. The long term conditions programme aims to make it easier for people to stay well, in control and able to have a good experience even when life becomes complicated. The theme of promoting self management forms a cornerstone of the clinical engagement process.

The Long Term Conditions programme will support people to develop confidence and competence in managing the challenges of living with their condition(s) in order to have a better quality of life, better clinical outcomes and make more appropriate use of resources. Workforce planning therefore needs to be aligned to these priorities.

The programme will include specific system wide pathway development and implementation in:

1. Chronic Obstructive Pulmonary Disease (incorporating the National Strategy and Home Oxygen Therapy re-procurement)
2. Heart failure (linked with Advancing Quality)
3. Diabetes (linked with Department of Health programme and ThinkGlucose)
4. Self management across all long term conditions pathways

Generic clinical components of each pathway will include:

a) Effective and timely diagnosis – this will increase the demand for primary care and diagnostic staff.

b) Appropriate information including support for carers available from front line staff with shared care protocols for referral for assessment.

c) Appropriate care co-ordination – this is also likely to require access to community and specialist clinical expertise.

d) Response to exacerbations / complexity – this will require access to specialist input when required, and will require case managers to ensure contingency plans are in place to manage need when an individual’s disease becomes unstable and to reduce the number of avoidable inpatient admissions.

e) End of life care and support where this is required – this may result in increased demand for elements of the palliative care workforce, nurses and healthcare assistants.
The programme will include targeted initiatives relating to:

- Specialised Commissioning – neurological conditions
- Managing Type 1 Diabetes in an Acute Hospital (ref ThinkGlucose)
- Telemedicine support for Long Term Conditions
- Re-procurement of Home Oxygen Therapy by 2011

Integrated within these core areas will be the necessary system reform to create the levers and incentives necessary to achieve large scale change along with workforce development and skills acquisition to support an integrated workforce plan.

2.5 Shift of care into the community

The 2006 White Paper – Our Health, Our Care, Our Say sets out an aim to shift many services into the community, including making more specialists available in traditional primary care settings. As well as traditional GP practices, these will include community hospitals, polyclinics, walk-in centres and patients’ own homes. This ties in with the drive towards personal care. Personal health budgets are being piloted nationally to assess the benefits of this approach. Successful roll out will ultimately require staff to be equipped with new skills to enable people to take control of their circumstances.

The Department of Health (DH) has also initiated the Quality Innovation Productivity Prevention (QIPP) agenda, and it is hoped that the shift to primary care will improve healthcare in each of these areas. The need for anticipatory care is particularly strong in long term conditions.

A shift to community settings will require staff who have been traditionally familiar with working in secondary care settings, as well as within specialties to transfer their skills to a new environment to support and service the evidence based care pathway.

2.6 European Working Time Directive and Employment Law

The second phase of the European Working Time Directive (EWTD) came into force in August 2009, stipulating a maximum 48 hour working week. This presents a significant challenge for the NHS. Although the Government has secured a limited derogation from the EWTD for an extra four hours per week, i.e. 52 hours, to be applied to doctors in training delivering 24-hour immediate care in hospitals, post 1 August 2009, this is a short-term solution. A number of trusts have applied in respect of particular specialties, such as anaesthetics, paediatrics and obstetrics and gynaecology. As a consequence services must be reconfigured to provide a sustainable solution to meeting EWTD requirements for the medium and longer term.

Other contemporary employment law also has an effect on productivity and cost of the workforce such as maternity and paternity leave entitlements.

2.7 Implications

Rising prevalence of long term conditions and the changes to the way services are delivered will have a significant impact on the demand for primary and community care services as these people are disproportionately higher users of health services – they take up 55% of GP appointments, 68% of outpatient and A&E attendances and 77% of inpatient bed days, and

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account for around 70% of overall healthcare spend. Current trends suggest significant growth in the number of very high intensity high cost users – these are often people with multiple co-morbidities. The additional associated cost pressure of caring for people with multiple co-morbidities could reach an estimated £4bn by 2016 nationally.

Our workforce challenge is therefore to prepare the existing qualified and non-qualified workforce for a future in which they will need to behave and work in different ways whilst also preparing the future workforce for the new environment. Increased numbers of people with LTC is likely, in the short term at least, to lead to an increase in emergency admissions. The demand for increased productivity in the acute care workforce will therefore rise.

A rise in demand is anticipated for the following existing staff groups and roles:

- Nurses, diagnostic staff and public health staff, in connection with the early screening and identification of patients with long term conditions in the community, as well as disease management and patient education
- Practitioners with high level skills in case management and assessment
- Specialist nurses and trained clinicians to undertake patient assessment and be responsible for making the decision as to a patient’s care ‘level’
- Community matrons, to be responsible for patient case management
- In addition, there is likely to be a continued demand for trained health and social care practitioners at band three and four in order to take on some of the more routine tasks that were currently carried out by registered staff in health and social care settings.

3. Workforce supply

It is difficult to quantify the contribution made specifically to the long term conditions care area by the wider long term conditions workforce. However, it is known that, within South Central, there is a falling supply of various staff groups known to be key for delivery of long term conditions care. These include

- Nurses (specifically in Test Valley. Contrary to this, nurse supply is increasing in Hampshire and the Isle of Wight)
- General Practitioners (National)
- Pharmacists

3.1 Nurses caring for Adults

The supply and demand modelling shows that if commissions are continued at the same level over the next 5 years there will be an overall gradual decrease in supply of general adult nurses in South Central. This is mainly due to retirement levels. The supply is currently made up of a minimum of 30% graduate nurses and 70% diploma nurses. However, Universities are working hard to increase the percentage of graduate nurses, and for 10/11 there will be a target for achievement of 50% graduate nurses on completion. The introduction of degree level registration for nurses may mean it is harder to recruit students, with some who have previously opted for the diploma course either not meeting the academic standard required or being adversely affected by changes to the bursary arrangements (bursary arrangements nationally are not yet decided).

Whilst the overall trend across NHS South Central indicates a gradual decrease in supply, there are also indications of a more pronounced imbalance between the supply and demand in the Thames Valley (Northern) part of NHS SC and the Hampshire and Isle of Wight (Southern) part.
of NHS SC, (assuming the location of Higher Education Institutions is a predictor for employment location), as shown in Figures 5a and b:

![Figure 5a: Forecast supply of general adult nurses in SC South.](image)

![Figure 5b: Forecast supply of general adult nurses in SC North.](image)

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8 NHS South Central Commissioning And Supply Tool 2009/10
However employers may review the skill mix of nursing teams and it is not yet clear what the impact of developing associate/assistant practitioners will be on demand for graduate nurses.

Nurses are also employed in non NHS settings and Figures 5a and b above show the projected supply relating to NHS employers. The additional workforce employed in the independent sector and nursing care homes, and the demand trends of these employers needs to be considered.

Discussions are taking place with Directors of Nursing to understand the local variations and plan education commissions accordingly. The intention is to move to an increase of 50% graduating with a degree in 2013.

When planning adult nursing supply to deliver a long term conditions pathway the following issues should to be considered:

- Is there sufficient placement capacity in the North to increase education commissions?
- Will the balance between the different levels of the workforce change significantly?
- What would be the impact on demand for graduate nursing, and Assistant/Associate Practitioners and therefore how might education commissioning numbers be affected?

### 3.2 Pharmacists

The number of commissions of pre registration pharmacy in South Central was increased from 32 to 41 (2009 intake). The 3 month vacancy rate for registered pharmacists has deteriorated significantly in the past year from 1.3% to 8%. This is now higher than the UK average 5.3%. Both these factors contribute to the forecast declining workforce supply.

In addition, in 2008/9, 19% registrants chose employment in other SHAs, and 12% in other non NHS health employment. 56% of registrants take up employment in NHS South Central.

The forecast growth for pharmacy shown in Figure 6 is taken from employers returns to the SHAs and reflects anticipated financial constraints.

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9 NHS South Central Commissioning And Supply Tool 2009/10
When planning pharmacist supply to deliver a long term conditions pathway the following issues should to be considered:

- Can employers do more to retain new registrants and other pharmacists in NHS SC?
- What is the impact of skill mix on future demand?
- Is there sufficient placement capacity to support increased commissions.
- Should a percentage of the LBR budget be ring fenced to provide access to the post graduate diploma to retain more staff

Table 1, below, highlights risks of potential retirement bulges within South Central for some of the staff groups (including adult nurses and pharmacists) that are key to long term conditions. Staff aged over 65 years could retire imminently, which may leave a gap in the workforce. Staff aged over 60 may retire at any point over the next five years. This must be accounted for in the workforce strategy. The table shows that the support worker staff group in South Central is most at risk of facing a retirement bulge in the next five years, followed by health care assistants.

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10 NHS South Central Commissioning And Supply Tool 2009/10
### Table 1: Potential retirement peaks for staff involved in long term conditions care

<table>
<thead>
<tr>
<th>Role</th>
<th>Total FTE</th>
<th>Portion of workforce aged 65+</th>
<th>Portion of workforce aged 60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Assistant (all clinical areas) – largely operating at bands 2 and 3</td>
<td>3469.97</td>
<td>2% (58.21 FTE)</td>
<td>7% (258.81 FTE)</td>
</tr>
<tr>
<td>Support worker – bands 1, 2 and 3</td>
<td>4190.52</td>
<td>3% (145.29 FTE)</td>
<td>13% (548.12 FTE)</td>
</tr>
<tr>
<td>District nurse – bands 6 and 7, primarily</td>
<td>451.31</td>
<td>0% (1.4 FTE)</td>
<td>4% (19.69 FTE)</td>
</tr>
<tr>
<td>Nurse consultant – bands 8a, b, c</td>
<td>45.34</td>
<td>0% (0 FTE)</td>
<td>6% (2.6 FTE)</td>
</tr>
<tr>
<td>Occupational therapist – primarily band 6, also bands 5 and 7</td>
<td>832.96</td>
<td>0% (0 FTE)</td>
<td>2% (13.55)</td>
</tr>
<tr>
<td>Pharmacist – bands 6, 7, 8a (largest group), 8b</td>
<td>399.54</td>
<td>0% (1.24 FTE)</td>
<td>1% (5.01 FTE)</td>
</tr>
</tbody>
</table>

3.3 Health care assistants

Healthcare assistants in South Central largely operate at bands 2 and 3. Figure 7 shows an age profile of this workforce, as of August 2009. Almost 7% of the healthcare assistant workforce in South Central, corresponding to nearly 260 FTE, is aged 60 or over and could therefore retire in the next 5-10 years.

![Age profile of HCAs in NHS SC (August 2009)](image)

Figure 7: Age profile of healthcare assistants in South Central, as of August 2009

3.4 Support workers

Support workers in South Central largely operate at bands 1, 2 and 3. Figure 8 shows an age profile of this workforce, as of August 2009. Almost 13% of the support worker workforce in South Central, corresponding to nearly 550 FTE, is aged 60 or over and could therefore retire in the next 5-10 years. Furthermore with age demographics an competition within the labour market attracting this group of the workforce is likely to become more challenging.

11 Electronic Staff Record Data Warehouse Data (reflecting the position as at end of August 2009)
3.5 Local Government and Social care provision
Financial restraint is already affecting local government which has more recently contracted out care services provision. A large portion of care is expected to be provided by social care. However, the contribution of care currently made by this sector is almost impossible to quantify. Even though there is an emerging trend of returning to in house provision for complex care, local authorities may be forced to reduce staff numbers. Reliance on telehealth and telecare as a substitute for face to face contact is more developed in some areas. This is very relevant for long term conditions services as social care is an integral part of best practice care pathways and will require new skills to make best use of such opportunities. Further work to establish a better picture of this is required in order to plan for the entire long term conditions pathway. This applies to the voluntary sector also.

3.6 Foundation degree programmes
Although graduates from foundation degree programmes will help to increase supply of some staff groups defining role specifications that become established alongside a professionally qualified and competent workforce capacity requires further attention.

4. Workforce priorities

4.1 Flexible workforce
The following list highlights priority areas in which the workforce must be developed in South Central to achieve improved outcomes:
- Diagnostics
- Care coordination and complex case management
- There must be the flexibility to invest and disinvest, and make tough decisions on education commissioning.
- Increase use of expert patient and self management programmes

4.2 Partnership working
- Including working across pathways, between health and social care, and also between healthcare professionals and the patient. Information transfer between different parts of

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12 Electronic Staff Record Data Warehouse Data (reflecting the position as at end of August 2009)
the workforce is key, and partnership working additionally aids the dissemination of best practice.

- Improved use of the third sector.

4.3 Productivity
- A single point of access and avoidance of duplication.
- Personal budgets – people should be empowered to hold and use personal budgets, with sufficient levels of quality control in place. Appropriate quality assurance around carers is also key.
- Contingency plans that avoid emergency admissions for Chronic Obstructive Pulmonary Disease, heart failure and diabetes in particular.

4.4 Leadership
- Plans must be sustainable.
- Aligned attitudes and behaviours of all care staff and patient receiving services (including managed expectations).

4.5 Architecture of specialism
Create an architecture of specialism that establishes an interface with primary care, as shown in Figure 9 below.

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>4.5 Architecture of specialism</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>4.5 Architecture of specialism</td>
</tr>
<tr>
<td>Strategic Theme</td>
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<tr>
<td>-----------------</td>
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</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>4.2 Partnership working</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 health sector employers.</td>
<td>4.3 Productivity</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>4.1 Flexible workforce</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>4.4 Leadership</td>
</tr>
</tbody>
</table>

6. Next Steps

Next steps for long term conditions include creating an architecture of specialism that establishes an interface with primary care, as shown in Figure 9 below.
Figure 9: Architecture of specialism for long term conditions

Steps to achieve this framework could include:

- Creating a flexible, moveable workforce that is less institutionally based.
- Changing the role of consultants to work in conjunction with GPs, and equally, raising the capability of GPs to work differently.
- Building new and existing skills of current workforce as well as undergraduates.
- Developing skills within the workforce to support the use of technology, and also to work in difficult settings.
- Training nurses and others to supervise networks rather than small teams, engage with tele-health care, and motivate patients to self-manage
- Safeguarding and caring for care workers.
- Focusing on retention
- Focusing on market management and quality of contracts.