Assessment of Workforce Priorities 2009/10

Care areas:
- Children, including health visitors
- Maternity and newborn, including obstetrics and gynaecology
- Staying healthy

Cross-cutting:
- Diagnostics
- Dementia
- Mid-grade doctors
- Therapeutics

Specialties and professions:
- Nationally planned specialties
- Nursing
- Operating department practitioners
- Pharmacy

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WRT Assessment of Workforce Priorities
Summer 2009

Purpose of this document

The NHS Workforce Review Team (WRT) is a group of dedicated healthcare workforce planners who provide objective modelling, analysis and evidence-based recommendations to facilitate patient-centred and clinically driven strategic decision making across the healthcare workforce. WRT is commissioned by the Department of Health (DH) and the 10 Strategic Health Authorities (SHAs) to make an annual assessment of priority issues within workforce in health and social care, based on healthcare policy and workforce need.

This document serves as an executive summary to WRT’s work since July 2008 and is primarily for SHA Directors of Workforce, DH and PCTs; it will also be of interest to employers, educational providers and professional bodies. It aims to set out the key priorities and issues for the healthcare workforce in England.

WRT is carrying out a significant development programme for 2009/10. Workforce intelligence and information has been increasingly gathered through WRT’s networks on a pathway basis. WRT is working through the eight Darzi areas and eight separate patient pathways and will publish workforce reports on these groups over the course of 2009.

The pathway work focusing on the eight areas identified in the Next Stage Review will inform a comprehensive demand modelling exercise. WRT has been developing a demand modelling approach over the past two years that focuses on assessing demand across healthcare (not just NHS) based on changing demography, epidemiology, policy and workforce. The process of calibrating the assumptions in this model is informed by WRT’s engagement with the SHAs and professional bodies, including royal colleges, and regulatory bodies. To complement this quantitative demand modelling, WRT is carrying out a strategic scenario exercise that will provide a framework for considering longer term (15+ years) issues.

This work is proceeding alongside the existing WRT supply modelling for 155 specialties and professions. WRT uses data from the Information Centre for Health and Social Care (IC), DH, professional bodies, including royal colleges, and regulatory bodies in order to produce supply forecasts for the healthcare workforce. To further inform this modelling, WRT holds a series of stakeholder engagement meetings to gain information updates and to test current assumptions.

Since 2008 WRT has led a process with NHS Employers (NHSE) and Skills for Health (SFH) working closely with the Migration Advisory Committee (MAC) to establish a methodology, to underpin analysis of the healthcare professions for future annual updates to the National Shortage Occupation List (NSOL). The WRT submission, based on our annual evidence gathering, provides the MAC with bottom-up analysis and information for skilled occupations in the healthcare sector at a level of detail beyond the Standard Occupational Classification unit groups. The specialties/professions recommended to be on the NSOL meet the criteria set out by the MAC, in that they are skilled, in shortage and overseas recruitment is a sensible mechanism for alleviating the shortage [This document provides additional information on mechanisms outside international recruitment for alleviating particular shortages in these groups. The other groups included in this document either do not have a national shortage, or cannot use international recruitment as a mechanism for workforce growth but do have specific workforce issues that are discussed here in detail.

For more detailed information on individual specialties and professions there are workforce summary documents for each of the specialties and professions on the WRT website at http://www.wrt.nhs.uk/index.php/work/specs-profs. Workforce planners and commissioners are encouraged to refer to these documents when working on their plans.

During its information gathering since the 2008 AWP WRT has analysed workforce data, demand drivers and supply modelling for care areas and specialties and professions. This information has been used to identify areas where there is evidence of room for growth in the NHS workforce, or
where action should be taken to maintain the workforce in the medium to long term. The following areas have been identified:

Care areas
- Children’s inc. health visitors
- Maternity and newborn inc. obstetrics and gynaecology
- Staying healthy

Cross-cutting
- Diagnostics
- Dementia
- Mid-Grade doctors
- Therapeutics

Specialties/professions
- Nationally planned specialties
- Nursing
- Operating department practitioners
- Pharmacy

Next steps...

In order to take this work forward WRT will visit each SHA during May and June 2009 to meet with their workforce teams in order to:

- provide further explanation and advice on the issues raised herein
- seek views
- gain a better understanding of the regional picture
- discuss how the 2008 AWP influenced SHA workforce plans

This document will be available for consultation until Friday 17 July 2009; comments are welcomed to AWP.feedback@wrtnhs.org. A final version will be available from Monday 7 September 2009.

During the Summer, WRT will make a submission to the MAC to support a submission to Government in September recommending updates to the shortage occupation list for the UK. Information gathered during the first part of the consultation period for this document will be used in this submission.

Context

2009/10 sees the NHS facing a different growth trajectory to recent years. The Operating Framework for 2009/10 reiterated the expectation for the NHS to identify and deliver 3% cash-releasing efficiency savings for each of the two remaining years of the current spending review period, ending 2010/11. The Operating Framework also stated that, in the current economic climate, it is appropriate that the NHS, along with other public services, goes further and deeper in making efficiencies to contribute to returning the economy to balance in the timescales identified in the Pre-Budget Report (The Operating Framework for 2009/10 for the NHS in England, DH). SHAs and employers should work collaboratively to identify and agree areas which require continued investment. The implementation of Modernising Healthcare Careers – a programme of work across the healthcare workforce with the objective of modernising career and training structures across the NHS – aims to impact positively on workforce availability and productivity.

The NHS could benefit from the workforce opportunities afforded by the economic downturn; for example, anecdotal evidence suggests a trend is already underway, which sees the NHS enjoying an influx of people entering or returning to the workforce as a result of cut-backs in other sectors and a desire for greater perceived security offered by a career in the NHS.
The Office for National Statistics (ONS) forecasts that the population in England will exceed 60 million by 2031 (2006-based national population projections, ONS, 2007). The fastest growing group within this will be the over-75s, some of the heaviest users of health and social services. Their number is forecast to reach 6.8 million by 2031, which would equate to growth of 75% over 25 years (ONS, 2007). The reflection of this change in the demographics of the healthcare workforce may result in increasing uptake of options such as flexible retirement. The birth rate in England is also increasing. The most recent birth projections by the Government Actuaries Department (GAD, 2006) forecast the number of births in England will continue to increase steadily until 2020. Workforce planning must be considered in the context of these changes in addition to other health issues, such as increasing levels of obesity and the rise of associated chronic disease. These in turn are drivers of health service utilisation.

A key consideration in the drive to shift care into the community will be to bridge the gap between health and social care provision. Commissioners from these sectors are encouraged to work together to ensure that patients receive a good quality, consistent level of care, whether it is funded and delivered by the NHS or local government. A particularly important focus will be the continual monitoring and provision of therapy and support to patients following discharge from hospital. A coordinated effort will be required from all sectors in order to create the workforce required to deliver this care.

Better health for people with learning disabilities is a key priority and Valuing People Now (DH, 19 January 2009) sets out the Government’s three year strategy. It responds to the concerns set out in the Joint Committee on Human Rights report A Life Like Any Other? that adults with learning disabilities are particularly vulnerable to breaches of their human rights. Key issues for the NHS are to achieve full inclusion of people with learning disabilities into mainstream work. The workforce implications of this will include a drive towards personalisation of care, and a commitment to increase the knowledge base for the workforce. A challenge presented by another programme of work intended to benefit vulnerable groups, Improving Access to Psychological Therapies (IAPT), is the creation of a new workforce of psychological therapists. Employers will need to undertake a workforce capacity assessment in order to understand its impact on the local workforce and the programme’s success depends critically on good commissioning of training by SHAs and on the commissioning of National Institute for Clinical Excellence -compliant services by PCTs.

These issues highlight the need for a longer term view of the possible future of the NHS and wider healthcare provision. Over late Spring/Summer 2009, WRT will be carrying out a scenario planning exercise to try and determine the forces driving the NHS workforce as a system, identifying potential scenarios based on both pre-determined events and uncertainties. In order to address the issues raised by current horizon scanning work (eg developing technologies and therapies), WRT is looking forward to the possible situation 15+ years from now, when the health service and the nation’s demographics as a whole are likely to be very different. The aim of this work is to give a strategic context for WRT’s long term output and make our workforce forecasts more robust.

Maternity and newborn

Midwives

In February 2008, the Secretary of State for Health announced a package of measures to support SHAs’ plans to recruit an extra 4,000 midwives to the NHS by September 2012. Along with this initiative, employers and SHAs need to provide clarity about future models of care in maternity services and ensure that they have the workforce sufficient to implement the directives of this policy. The report Towards Better Births (Healthcare Commission, July 2008) reinforced the need for this expansion and provides a CD of data to enable local benchmarking. The workforce position in maternity services varies across the country. Retention of the maternity workforce and succession planning for leadership roles for senior midwives will be a key component to achieving this, as will the retention of midwives currently in training. SHAs should focus on reducing attrition rates from 3 year and 18 month midwifery courses.

Future maternity services must be planned to address current challenges, including improving outcomes for vulnerable and disadvantaged families and the increased complexity of case mix, eg the increased incidence of diabetes and obesity.
Suggested mitigation strategies: Midwifery

- SHAs will need to work with PCTs and providers to achieve – and keep under regular review – the planned expansion through increased training, alongside improved recruitment, retention and return to practice.
- SHAs need to review their investment in the 18 month training programme against their expansion plans.
- Employers and SHAs to provide clarity about future models of care in maternity services, with particular focus on retention of the workforce and succession planning for leadership roles.

Maternity support workers

The utilisation of Maternity Support Workers (MSWs) can help free up some midwifery time through carrying out routine tasks such as taking blood samples, making observations such as temperature, pulse, blood pressure and breathing, carrying out administrative duties, preparing equipment and cleaning up after sessions.

Health visitors

Health visitors have an essential role in the care of newborns. Investigation into the required growth of the NHS health visiting workforce, together with further definition of roles and responsibilities, particularly to ensure children are safeguarded, is due to be undertaken this year as part of the Government’s Action on Health Visiting programme.

Obstetrics and gynaecology

The Royal College of Obstetrics and Gynaecology (RCOG) 2007 report Safer Childbirth sets out a number of ‘gold standards’, including consultant expansion to ensure 168 hour consultant presence in the largest maternity units. To meet this level of cover, the report states that the service will need a total workforce of 2,700 FTE consultants by 2010. The report further discusses whether this requirement could be reduced to 2,000 – 2,200 FTE when flexible working and the anticipated reconfiguration of many services is taken into account.

The September 2008 NHS Information Centre (IC) census recorded 1,570 headcount and 1,492 full-time equivalent (FTE) consultants in obstetrics and gynaecology – an FTE to headcount ratio of 0.95. Age profile data illustrates that over half the consultants in this specialty are aged 40-49 years; there is therefore no imminent retirement concern.

The current consultant workforce in obstetrics and gynaecology is approximately 33% female and 67% male, and to date the proportion working part time has remained relatively static. It is not clear how participation rates may change in the future, but generational differences in attitude to work, an increase in the number of female obstetricians and a workforce trained under Working Time Directive would suggest that part time working is likely to become more common.

Birth projections by the Government Actuaries Department (GAD) in 2006 predict the birth rate in England will continue to rise, which is likely to increase the demand for obstetric services.

The Department of Health has made a total of £310 million available to the NHS in recurrent PCT allocations to support the sustainable implementation of the Working Time Directive. £50 million of this £310 million was allocated to support sustainable trained doctor solutions particularly in paediatrics and obstetrics. Trusts should focus on ensuring that the work in achieving compliance is maintained in sustainable service design.

Suggested mitigation strategies: Obstetrics and gynaecology

- Expansion in the number of trained doctors is needed in order to meet standards set out in Safer Childbirth. Employers will also need to reconfigure services to sustain round-the-clock consultant cover.
- SHAs and employers should review their plans in light of the potential decrease in participation rates.

Neonatal services

Neonatal services have been identified as a key area in maternity and newborn care. The neonatal taskforce is an NHS led group established by DH. The taskforce comprises four working groups: data
for commissioning; transfer (transport), surgery and workforce. The aim of the group is to support the NHS to identify and deliver improvements to neonatal services.

**Children’s**

The Operating Framework for 2009/10 has reiterated the key priority of improving children’s health and reducing health inequalities.

There will be an overall increase in demand for the paediatric workforce (including community, acute and specialist consultants, paediatric dentists, staff grade doctors and advanced nurse practitioners), particularly to support children with complex and long term conditions and the management of neonatal emergency health care. An expansion in the number of advanced nursing practitioners and neonatal nurses could support paediatricians in meeting current demand for these services.

Demand for community paediatricians is increasing as delivery of child health care is further shifted towards community settings, to improve access for children and families, in line with the recommendations set out by *Our Health, Our Care, Our Say* (DH, 2006) and the Child Health Strategy (*Healthy lives, brighter futures – The Strategy for Children’s and Young People’s Health*, DH, 2009). Nurse practitioners have been identified as a key staff group. In the future, it is expected that nurse to doctor ratios will increase and the role of nurses will expand with more specialist nurses. According to analysis of the 2008 IC Census data, retirement levels of the current nursing workforce in primary care in the next 5 to 10 years are: 20% of health visitors, 15% of school nurses and 17% of district nurses. Employers need to focus on retaining their current workforce and developing staff. Specifically, nurses must be given the opportunity to acquire appropriate clinical and leadership skills to deliver new ways of working. There is also a need for employers to consider succession planning for senior clinical and leadership roles, as well as working in association with higher education institutions (HEIs) and other education providers towards the future nurse educator roles.

The Laming Report (The Lord Laming, March 2009) emphasised the safeguarding and child protection roles within the children’s workforce with an emphasis on interagency working. The need for improved understanding of the children’s workforce was also highlighted, particularly paediatricians, midwives, health visitors, GPs and school nurses.

**Paediatrics**

The RCPCH workforce census 2007 estimated that 6,000 (4,200 FTE) consultants, split evenly between community, acute and specialist medicine roles are required to deliver the service. This is equivalent to 5,028 (3,520 FTE) paediatricians in England, based on 2006 relative population data for the UK and England from ONS. If the number of doctors in training remains constant, WRT’s modelling forecasts that it will be 20 years before this level of workforce expansion could be achieved. However it is currently unclear whether this level of expansion reflects actual demand from the service.

The Department of Health has made a total of £310 million available to the NHS in recurrent PCT allocations to support the sustainable implementation of the Working Time Directive. £50 million of this £310 million was allocated to support sustainable trained doctor solutions particularly in paediatrics and obstetrics. Trusts should focus on ensuring that the work in achieving compliance is maintained in sustainable service design.

**Suggested mitigation strategies: Paediatrics**

- New certificate of completion of training (CCT) holders should be encouraged to take up posts in community paediatrics.
- Suitable skill mix involving general practitioners, allied health professionals and community nursing practitioners within the multidisciplinary team needs to be considered. To meet demand, strategies for community paediatricians may need to consider the different roles within the multidisciplinary team, as configuration of paediatric services in the community is developed.
- SHAs and employers should consider the potential decrease in participation rates in their workforce planning.
Speech and language therapists

The report of the Bercow review was published in Summer 2008 (Bercow, 8 July 2008). It was established to investigate the services for children and young people with speech, language and communication needs. DH is currently working to quantify the workforce implications of the recommendations. This could result in increased demand for speech and language therapists from social and education services.

Suggested mitigation strategies: Speech and language therapists

- SHAs should be prepared to respond to the outcomes of the Bercow review including adjusting commissions and maximising the use of assistant practitioners.

Health visitors

The Child Health Strategy places health visitors at the centre of the community health care team to promote children’s and young people’s health (Healthy lives, brighter futures – The Strategy for Children’s and Young People’s Health, DH, 2009). It is expected that the health visitor workforce will work in a variety of settings including children’s care centres, schools and GP surgeries, in addition to being required to deliver intensive schedules of home visits. It is likely that growth in the current health visitor workforce will be necessary to ensure each Sure Start Children’s community care centre has access to one named health visitor (the Government has pledged provision for 3,500 centres nationally by 2010, see http://www.direct.gov.uk/en/Parents/Preschooldevelopmentandlearning/NurseriesPlaygroupsReceptio nClasses/DG_173054).

Currently, there are 11,190 (headcount, 8,764 FTE) health visitors in England (IC Census, 2008). The age profile of the current NHS workforce indicates that the number of staff aged over 55 years is 20% (IC Census, 2008).

Investigation into the required growth of the NHS health visiting workforce, together with further definition of roles and responsibilities, particularly to ensure children are safeguarded, is set to be undertaken this year as part of the Government’s Action on Health Visiting programme. Increased emphasis on safeguarding may be at the expense of prevention and health promotion.

Suggested mitigation strategies: Health visitors

- Collaborative working, especially with school nurses.
- Enhanced education and training for health visitors relating to paediatric medicine and communication development.

Nursing

Currently, overall supply of the nursing workforce largely meets demand on a national basis (with regional variations). Information Centre (IC) 2008 census data recorded nearly 8,000 additional nurses in September 2008 than in September 2007. However, a sharp reduction in total nursing commissions (degree and diploma) in England between 2005/06 and 2007/08 will result in fewer trainees coming through the system from 2009 onwards and lower numbers of newly qualified nurses than in previous years. SHA commissioning intentions for 2009/10 show that a number of SHAs have decided to increase the number of nursing places at HEIs, a positive response to recommendations made in WRT's AWP 2008. SHAs should plan in the context of actual commissions historically being lower than planned commissions. SHAs need to focus on retaining their current workforce through initiatives such as flexible retirement. International recruitment could also be used to increase nursing supply.

Some areas of nursing remain difficult to recruit to; for example, intelligence indicates that nursing homes in particular have significant international recruitment to fill vacancies; and nursing roles in theatres and critical care units are often difficult to recruit to. Recruitment initiatives may be required to fill the immediate vacancies for senior posts and specialties that have been hard to recruit to historically (eg theatre nursing). As a result of recruitment issues, both theatre nurse and critical care nurse (nurses working in critical units with a Level 2 or Level 3 classification) appear on the MAC recommended shortage occupation list for Government approval.
There are a number of forthcoming developments that will impact on the future workforce. Modernising Nursing Careers (MNC) could potentially change career pathways for nurses. Also the Nursing and Midwifery Council announced in Summer 2008 that the minimum award for UK pre-registration programmes leading to registration as a nurse will be a degree (http://www.nmc-uk.org/aArticle.aspx?ArticleID=3396). The NMC is now reviewing pre-registration nursing standards (http://www.nmc-uk.org/aArticle.aspx?ArticleID=3566) including the development of competencies, that is, the knowledge, skills and attitudes that nurses need to provide safe and effective care to all patient and client groups. WRT will be reviewing the potential impact of this in the coming months.

The Commission on the Future of Nursing and Midwifery has been established to advise the Government on the future role of nurses and midwives. This work will build on that identified in Lord Darzi’s report ‘High Quality Care for All’ (June 2008) and consider how nurses can further improve safety, champion high quality patient care and acquire more freedom to manage, commission and run their own services. The Commission is due to report to the Prime Minister by March 2010.

**Suggested mitigation strategies: Nursing**
- SHAs to consider increasing current commissioning levels in light of the latest WRT forecasts.
- Employers to focus on retaining and developing the current workforce.
- Employers to ensure that nurses have the appropriate clinical and leadership skills to deliver new ways of working.
- PCTs and employers to increase availability of community placements, including in nursing homes.
- Recruitment and training initiatives to fill immediate vacancies in areas that are historically difficult to recruit to, such as theatre and critical care nursing.
- Employers and HEIs to collaborate on developing the future of nurse educator roles.
- Recruitment initiatives to encourage nurses to work in a primary care setting.
- There is little data on the higher specialist nurse workforce. SHAs should emphasise the importance of fully completing the existing data fields within ESR to improve data quality on this workforce and assist effective workforce planning.

**Mid-grade doctors**

The Modernising Medical Careers programme aims to develop the career pathway for doctors, reducing the reliance for service delivery on mid-grade rota and providing an emphasis on the sustainability of medical services.

Geographical variations in the distribution of the medical workforce exist. Even specialties that are broadly in balance may require adjustment in the distribution of training posts to address inequalities as the natural mobility of the medical workforce cannot be relied upon.

Changes in service delivery and advances in technology mean that the demand for trained doctors in particular specialties is changing. Future graduate expectations need to be carefully managed, as it is likely that the availability of training places in certain specialties will be different from those available previously.

**Suggested mitigation strategies: Mid-grade doctors**
- SHAs and deaneries should be aware that local decisions can affect the wider workforce picture beyond any specific locality and that they should therefore be made in light of the national situation.
- There is a growing need to address the inequality of distribution through the future allocation of junior doctor posts. Any such changes must be made whilst taking the national supply situation in to account.
- Doctors should have improved access to support for career planning to inform their choice of specialty.
Staying healthy

As a major focus of the Next Stage Review (NSR) and two White Papers, Choosing Health (2004) and Our Health, Our Care, Our Say (2006), public health has been a key priority for the Government over the past decade. Dame Carol Black’s report, Working for a Healthier Tomorrow (2008) outlined the economic and social benefits of sustaining the health and well-being of the working age population. Although its workforce recommendations mainly concern occupational health, the report indicates public health specialties are to play a key role in a coordinated approach to health in the working age population. Public health specialists also have a role to play in the effective commissioning of services.

The workforce delivering public health interventions should reflect the needs of the local population and service models should consider the range of different professional groups who can facilitate the delivery of the public health service beyond public health consultants. The demand for health visitors is likely to increase as The Child Health Strategy places health visitors at the centre of the community health care team to promote children’s and young people’s health (Healthy lives, brighter futures – The Strategy for Children’s and Young People’s Health, DH, 2009). Investigation into the required growth of the NHS health visiting workforce, together with further definition of roles and responsibilities is set to be undertaken this year as part of the Government’s Action on Health Visiting programme.

The number of public health consultants has remained static since 1997, with small variations from a headcount of around 800. If current training levels are sustained, WRT supply modelling forecasts the number of public health specialists will probably decline over the next fifteen years.

Senior staffing levels in public health do not show correlation to weighted capitation, which is a proxy for population need. London and the South East have relatively more staff than their weighted capitation would indicate; the North East, North West, Yorkshire and the Humber, East Midlands and West Midlands have less – despite having some areas of deprivation, with populations in the poorest health. This can be alleviated by deaneries and SHAs increasing specialist training posts, particularly non-medical ‘top up training’, which will provide a more rapid boost to specialist staffing numbers. Any such increases could be specifically targeted at regions with relatively low current levels of senior public health staff.

WRT supply modelling indicates that the specialist dental public health workforce is decreasing, and forecasts that it will continue to decrease. Expansion of the specialist workforce could be achieved through the establishment of top-up training and creation of more training places. The wider dental public health workforce also requires assessment, particularly in the areas of oral health improvement and clinical quality.

Best practice will need to be shared in many areas that are currently not professionally regulated, eg smoking cessation services. Data on the wider workforce is currently sparse, making accurate, regional workforce planning difficult. Development of the way information is recorded in ESR could potentially fill this data gap for the NHS public health workforce.

Suggested mitigation strategies: Staying healthy

- SHAs should consider undertaking assessments in order to understand the public health needs of their population and consider the range of different professional groups who can facilitate delivery of the public health service.
- In the short term, the specialist workforce can be increased by an expansion in ‘top up’ training schemes and a focus on the development of the multi-professional public health workforce.
- Longer term supply can be generated by the creation of more training posts for public health specialists and increased emphasis by deaneries on encouraging trainees into public health.
- Deaneries and employers could provide increased opportunities for dual accreditation.
- Data gathering efforts on the wider public health workforce should continue to produce a clearer picture of demand for public health consultants and enable more effective planning.
- SHAs, PCTs and deaneries to develop plans to expand the specialist and practitioner-level dental public health workforce.
- SHAs and PCTs to review their approaches to retention of the scarce public health workforce.
- SHAs should work with HEIs to develop public health competencies as a feature of pre-registration training to extend the workforce able to deliver public health.
Operating Department Practitioners (ODPs)

ODPs appear on the MAC recommended shortage occupation list for Government approval.

WRT’s work indicates that the number of practising ODPs nationally is broadly equal to service demand. However, many NHS organisations report difficulties filling substantive vacancies. Intelligence indicates this is because many ODPs leave the NHS mid-career and continue to work through agencies. There are a number of anecdotal reasons for this trend which include:

- agencies provide higher rates of pay than the NHS
- agencies give improved terms and conditions, so ODPs can avoid out of hours working
- agencies give greater flexibility for ODPs with families or carer commitments
- a perceived lack of opportunities for career progression for ODPs within the NHS

Currently the ODP training programme is a diploma course, which is a precursor to primary registration. However there is a move to become an all graduate entry profession with a new three year BSc ODP degree starting in 2012, which will become the criteria for registration. There may be opportunities to complete modules towards an early BSc in 2010-12, meaning individuals could graduate earlier than 2015. Reports outlining these proposals are being prepared for December 2009.

In addition there is a considerable skill overlap between the ODP workforce and qualified nurses who choose to work in theatre, particularly as anaesthetic nurses. As a result some organisations do not employ ODPs in their theatre teams.

Suggested mitigation strategies: Operating Department Practitioners
- Employers should develop more defined career pathways and opportunities for career progression
- Employers should ensure NHS terms and conditions, and benefits, eg pensions, Improving Working Lives, are promoted to make NHS posts more attractive.

Diagnostics

The following healthcare scientists appear on the MAC recommended shortage occupation list for Government approval: cardiac physiologist, clinical neurophysiologist, clinical vascular scientist, HPC registered ophthalmic and vision scientist, respiratory physiologist and sleep physiologist.


Access to diagnostic services is vital in maintaining the success of meeting 18-week patient pathways. Evidence gathered by WRT indicates that in some areas diagnostic targets are being achieved with the use of agency staff and significant overtime working. It is likely that, without initiatives to redesign services and increase in parts of the workforce, considerable expenditure on agency staff and other short term solutions will continue to be required.

To achieve the shift of provision of care to community settings, it is essential that appropriate diagnostics are also moved into the community. The focus on preventing hospital admissions for patients with long term conditions by improving management and access to specialist care in the community will need significant support from diagnostic services. A number of new screening programmes and changes to existing programmes are impacting on the diagnostic workforce.

There is uncertainty in the future training route and career structure of these specialist groups. Current training routes and funding streams are complex; the Modernising Scientific Careers programme aims to provide solutions to these issues.
Suggested mitigation strategies: Diagnostics

- SHAs and employers to continue their focus on training and recruitment of new scientists to increase the size of the permanent workforce.
- Establishment of structured training and career progression for healthcare scientists (Modernising Scientific Careers) supported by appropriate increases in investment.
- Service redesign to account for both the contribution of healthcare scientists and the opportunities offered by development of this workforce.

Dementia

Dementia costs the UK economy £17 billion a year, and in the next 30 years the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year (DH 2009). The National Dementia Strategy (DH 2009) is a five year plan to ensure that significant improvements are made to dementia services across three key areas:

- improved awareness
- earlier diagnosis and intervention
- higher quality of care

The need for improved training is a priority that cuts across all the themes in the Strategy. All health and social care staff involved in the care of people who may have dementia should have the necessary skills to provide the best quality of care in the roles and settings where they work. This is to be achieved by effective basic training and continuous professional and vocational development in dementia.

There could be a case for the development of new specialist services to facilitate earlier diagnosis and intervention although the impact of changing the service model in this direction would require careful exploration. These services would provide a simple single focus for referrals from primary care, complementing rather than replacing the work currently undertaken by old age psychiatry, geriatrics, neurology or primary care. Such a service might be delivered by any of a number of types of specialist with diagnostic skills in dementia.

Suggested mitigation strategies: Dementia

- SHAs and employers to focus on providing appropriate training and development opportunities to fill locally identified gaps in the workforce caring for dementia patients.
- In the medium and longer-term, curricula for undergraduate professional qualifications and continuing professional development (CPD) for doctors, nurses, therapists, other relevant health service staff and social care staff should contain modules on dementia care.

Pharmacy workforce including: Pharmacists, Pharmacy Technicians and Pharmacy Assistants

Pharmacists working in hospitals appear on the MAC recommended shortage occupation list for Government approval.

WRT analysis suggests evidence of room for growth of pharmacists in the NHS managed sector in England. High vacancy rates coupled with a number of recent demand drivers including the pharmacy White Paper, the NHS Next Stage Review and professional regulatory changes will increase demand for the pharmacy workforce. Although the number of available pharmacists is likely to increase, continuing the trend of recent years, there are some key supply issues in the context of a more pluralistic provision of services and an ageing population increasingly reliant on medicines to maintain health.

Pharmacist vacancy rates in the NHS managed sector remain high, making an expansion of services difficult to achieve. The NHS Pharmacy Education and Development Committee (NHSPEDC) survey in May 2008 highlighted that vacancy rates in England of established qualified pharmacy posts in the NHS managed sector at Band 6 (23%) and Band 7 (18%) were the highest. The average vacancy
rate for all pharmacists in the NHS managed sector in England was 14%. Equivalent data for NHS hospital pharmacy technicians was 9% and for NHS hospital pharmacy assistants 8%. This indicates a room for growth across the NHS pharmacy workforce. This situation may also apply to pharmacy staff in other sectors including: community pharmacy, academia and the pharmaceutical industry though vacancy data is not currently available. Other supply issues include the increased proportion of female pharmacists in the workforce and a tendency towards part time and/or portfolio working.

A survey conducted by WRT in February 2009 examining pharmacy workforce recruitment and retention issues in the NHS managed sector, indicated that the high levels of vacancies are impacting on service provision; this includes prioritisation of core services and reduced availability for non-core work such as service and national initiative development.

In the future, as part of the Medical Education England (MEE) Board, the MEE Pharmacy Board will make recommendations on training for pharmacists.

**Suggested mitigation strategies: Pharmacy workforce**

- In order to support growth of the pharmacist workforce and address vacancy rates, an expansion of the number of pre-registration trainee pharmacist placements in the NHS managed sector is required. Importantly, this should be in combination with other recruitment and retention initiatives to attract an increasing number of the pharmacy graduates into the NHS managed sector and the provision of an improved training infrastructure.
- Closer working of organisations providing NHS services across primary and secondary care is needed. This could include placement rotations for pre-registration trainee pharmacists between hospitals, PCTs, mental health trusts and community pharmacies (or indeed joint posts). Such initiatives will increase the exposure of trainees to different environments, allow sharing of responsibility for training and better prepare them for roles delivering clinical services in the community (an action required by the pharmacy White Paper).
- Changes in education and training of pharmacy support staff will be needed if they are to take on more duties that were traditionally the remit of pharmacists, qualifications in Medicines Management and Public Health etc will need developing.

**Therapeutics**

HPC registered diagnostic radiographer, HPC registered therapeutic radiographer and sonographer appear on the MAC recommended shortage occupation list for Government approval.

The *Cancer Reform Strategy* (Department of Health, December 2007) pledged to expand the capacity and effectiveness of radiotherapy services. This is expected to result in a significant demand for therapeutic radiographers and the radiotherapy physics and engineering workforce, in particular the workforce with skills in radiotherapy treatment planning (dosimetry). The dosimetry workforce comes from practitioners whose background is either in therapeutic radiography or healthcare science physics.

One of the key constraints in increasing the therapeutic radiography workforce is the difficulty in filling existing training places (in 2007 only about 75% of training places were filled, available data from 2008 suggests a similar ratio). Some courses also have very high attrition rates (approximately 50%). DH has invested £5,000,000 in facilities for virtual learning for radiotherapy students. The goal of the scheme is to reduce attrition in training. SHAs should also consider converting some undergraduate courses to graduate training schemes which are expected to have lower attrition rates.

There is also continued significant evidence of room for growth in both clinical scientists and clinical technologists in radiotherapy physics. Nuclear medicine scientists and radiotherapy physicists and staff working in diagnostic radiology appear on the MAC recommended shortage occupation list for Government approval. In the medium term, the establishment of structured training and career progression for healthcare scientists as part of the Modernising Scientific Careers programme will help this workforce to reach supply-demand balance. However, in the interim, SHAs and employers will need to ensure continued focus on training new scientists. In particular, they should consider opportunities for expansion such as those offered by Bristol Oncology Centre, where an initiative to
train practitioners directly in radiotherapy planning whilst studying for a clinical technology degree has been developed.

**Suggested mitigation strategies: Therapeutics**

- SHAs and HEIs to review strategies for recruiting more students to radiotherapy courses and to reduce in-course attrition.
- HEIs to use the full potential of virtual training environments for radiotherapy students, in the light of the DH investment.
- SHAs/HEIs to convert some undergraduate training courses to graduate training schemes for therapeutic radiographers.
- SHAs/employers to focus on increasing the output of new scientists and technologists in radiotherapy physics.

**Nationally planned specialties and professions**

The NSR final report, *A High Quality Workforce*, stated that ‘the Department of Health (and the Department for Innovation, Universities and Skills) will commission medical and dental undergraduates and low volume specialty professions nationally’ (Department of Health, June 2008).

WRT has identified the specialties and professions requiring national planning (see appendix 1) and is continuing to monitor their workforce issues to provide a solid foundation for the new strategic activities.
Appendix 1: Nationally planned specialties and professions

The following list is based on work carried out by WRT up to November 2007 on the specialties and professions that require a nationally planned approach in line with that suggested in *A High Quality Workforce* (Department of Health, June 2008).

**Medical specialties**
WRT, in conjunction with the Deans’ Workforce Group and the Conference of Postgraduate Medical Deans (COPMeD), has compiled a list of medical specialties and sub-specialties which it believes should be considered for either a national planning and funding mechanism or for special attention by inter-SHA planning processes. These are:

- Medical ophthalmology
- Allergy
- Audiological medicine
- Intensive care medicine
- Nuclear medicine
- Clinical pharmacology and therapeutics
- Paediatric cardiology
- Clinical neurophysiology
- Immunology
- Cleft lip and palate
- Hand surgery
- Head and neck surgery
- Sexual and reproductive health
- Stroke medicine

**Dental specialties**
Consultation with the Committee of Postgraduate Dental Deans and Directors (COPDEND) identified that, due to their small workforce numbers, all dental specialties (except orthodontics) could benefit from national planning.

In the future, as part of the MEE Board, the Modernising Dental Careers (MDC) Programme Board will make recommendations on dental training.

**Dental care professions**
Within the dental care professions the following have been identified: orthodontic therapists, dental therapists, dental technicians and clinical dental technicians.

**AHPs**
Two groups have been identified: orthoptists (commissioned by two SHAs in northern England, from which the UK and Ireland draw trainees) and prosthetists and orthotists (training in one centre in NHS North West and one in Scotland).

In addition, there are professions which have a number of small courses; some of these could cease if commissioned numbers were reduced by five or more. In these cases, eg chiropody and podiatry, a national view on how to sustain a sufficient number of courses might be appropriate.

**Healthcare scientists**
Dependent on the final outcome of the Modernising Scientific Careers programme, it is proposed that the following areas of healthcare science should be put forward for inclusion:

- Life sciences: analytical toxicology and higher specialist training for microbiology as a high priority. The following should also be considered: histocompatibility and immunogenetics, embryology, and paediatric metabolic biochemistry.
- Physiological sciences: neurophysiology and GI physiology as a high priority. The following should also be considered: clinical vascular scientists, ophthalmic and vision science
(including clinical scientists performing electrophysiology eye tests), respiratory physiologists and sleep physiologists (including clinical scientists).

- Engineering and the physical sciences: clinical scientists and clinical technologists focusing on nuclear medicine and radiotherapy physics as a high priority. Also to be considered should be rehabilitation engineers – both clinical scientists and clinical technologists – maxillofacial prosthetists and those in radiation protection and monitoring.

In addition to the above healthcare science groups, consideration should be given to sonography/ultrasonography, radiopharmacy, dosimetrists and electron microscopy.