Shaping the Future

Workforce

Interim Planned Care Area Workforce Report
This interim strategy outlines the current Planned Care area workforce context. The workforce strategy is subject to development as the Planned Care Area programme is finalised.

1. Introduction

Planned care can essentially be defined as the assessment, diagnosis and treatment of problems requiring clinical intervention not considered to need urgent or emergency care. Planned care can be provided by a huge number of people in a variety of settings including, GP practices, community hospitals, district general hospitals and specialist tertiary services. With increasing demographic changes occurring within South Central such as an increasing ageing population and increasing levels of obesity, ensuring a high quality planned care workforce is in place can be considered key.

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

The planned care programme is subject to further development. As such the purpose of this report is to provide a contextual view of the planned care area workforce within NHS South Central.

The main aims of this plan are as follows:

- To identify the current workforce demand drivers
- To identify any future forces for change
- To assess the current workforce supply
- To identify any key opportunities or areas of concern within the workforce supply
- To establish the key workforce priorities
- To produce preliminary actions regarding how to develop the workforce

2. Workforce demand

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

2.1 Increasing old age 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. Specifically within the South East (GOR), by the late 2020s:

- Over 40% of the population is predicted to be over the age of 50
- The number of people over the traditional retirement age of 65 is predicted to increase by nearly 50%
- 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. Consequently it is likely that health services will see a rise for demand for their services from this

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segment of the population, which is likely to have a particular effect on the planned care workforce.

2.2 Obesity levels in South Central
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. This increasing problem will have significant implications for health service providers, particularly within planned care, as obesity is directly linked to serious health problems and a lower life expectancy.

2.3 Prevalence of long term conditions
The prevalence of long term conditions is also likely to place additional demand on the need for planned 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. (Source: Workforce summit briefing paper, September 2009).

2.4 Our Health Our Care Our Say
Our Health Our Care Our Say created a shift towards providing more planned care in settings that are easy for patients to access and as close to home as possible. In particular the following specialities have been selected to develop models of care which provide increased levels of care ‘closer to home’:

- Ear nose and throat
- Trauma and orthopaedic services
- Dermatology
- Urology
- Gynaecology
- General surgery

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 optimum 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. Similarly consideration needs to be given to the development of the workforce in terms of training below AfC band 5 to take on some of the tasks currently carried out by qualified practitioners, and to develop staff that can work across organisations. Further skills development may also include the adoption of new roles such as physician’s assistants, though this needs to be considered in line with the current economic climate.

An additional consequence of ‘Our Health Our Care Our Say’ (2006) 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.

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2.5 Our Health Our Care Our Say: One Year On

On March 27th 2007 Opinion Leader, on behalf of the Department of Health, brought together a random selection of 84 people, who were part of the original group of people (a group of 1250) who took part in the initial deliberative events around Our Health Our Care Our Say. These individuals were engaged in a half day workshop in order to review progress in terms of the implementation of the white paper.

The group participants identified the following areas where there is potential for improvement:

- There was a degree of scepticism regarding ensuring that everyone will be able to access the new schemes being introduced under ‘Our Health Our Care Our Say’ (2006)
- Existing pilot schemes were well received, however there were various concerns raised such as how they will be financed in the future, whether access will be equal in terms of joining such schemes, and a fear that pilot schemes will be seen as a short term fix rather than long term solution.
- It was identified that there was a need for a much wider joining up of health care, social care and education in order to really prevent ill health
- There was a more general concern that action on the White paper has been slow.

The main priorities for the future remained similar to those originally described:

- Joint planning of health, social care and other services to ensure a smoother service
- Better access to GPs through longer opening hours and weekend opening
- More support for carers
- An increased focus on prevention, specifically NHS Life-check not being provided exclusively for young people
- High level of support for service change in the form of the development of specialist centres and the movement of services into the community.

Naturally findings from this project will reinforce the workforce demand generated by Our Health Our Care Our Say.

2.6 Working for a healthier tomorrow

In 2008 Dame Carol Black reviewed the health of Britain’s working age population in ‘working for a healthier tomorrow’ and outlined 3 key aims: the prevention of illness and promotion of health and well being, early intervention for those that develop a health condition, and an improvement in the health of those out of work. When you consider that the annual economic costs of sickness absence and individuals being out of work associated with working age ill-health are estimated to be over £100 billion by Black (2008), this is a crucial area for improvement.

Within Working for a Healthier Tomorrow (2008), various areas are highlighted which may lead to additional demand being placed on the planned care workforce, at least in the short term. A few of the more prominent issues include:

- A new ‘fit for work’ service is proposed which would use a case managed, multidisciplinary approach to provide treatment, advice, and guidance for
people in the early stages of sickness absence, with the intention of intervening whilst individuals are in the early stages of sickness absence and prevent short term sickness absence turning into long term sickness absence. ‘Fit for work’ case managers would refer people to a wide range of services dependent on their needs, including various NHS services. It is further argued that such a service should be available to all those in need, including individuals on incapacity benefits and other out of work benefits. Such a service would be likely to increase demand on the planned care workforce, in particular any staff involved in occupational health. Such a service needs careful consideration in light of the current economic climate.

- The report also argues that in order to support the health of the working age population, occupational health needs to be brought into mainstream healthcare and its practitioners must address a wider remit and establish working relationships with a wider range of groups including public health, general practice and vocational rehabilitation. Naturally this will increase demand on staff involved in the delivery of occupational health services.
- A shift in attitude, combined with clear professional leadership is also advocated, emphasising the importance of prevention and early intervention, with health practitioners altering their advice to encourage individuals to return to work wherever possible, and members of the health service leading by example. In order to achieve these aims, relevant training would need to be introduced.
- Black (2008) also found that GP’s often feel ill informed to be able to provide patients with advice on returning to work, therefore South Central should consider offering development opportunities to GPs to provide them with the appropriate knowledge to fulfil this need.

2.7 18 weeks wait targets
The 2009/2010 operating framework (DH 2009) sets a minimum operational standard that 90% of admitted patients and 95% of non admitted patients should wait no longer than 18 weeks between being referred by a GP and the start of their treatment, with the exception of when patients choose to wait or it is clinically inappropriate to proceed. The following graphs show South Central’s current performance against these targets:
Since October 2008, South Central as a whole has successfully met both the waiting times targets for admitted and non admitted patients. However data gathered by South Central Strategic Health Authority has highlighted that Trauma and Orthopaedics, Oral surgery, Ear Nose and Throat (ENT), and Neurosurgery have had difficulty consistently maintaining their 18 week targets (though it should be noted that aspects such as high volumes of patients and complexity of cases may have contributed to this).

As such South Central should review if this data is highlighting any areas of opportunity and if appropriate, review their service configuration and current pathways and seek to optimise them through techniques such as service redesign, skill mix reconfiguration and innovative ways of increasing productivity. New roles have aided some organisations in meeting 18 week targets such as the use of preoperative specialist practitioners and anaesthetic practitioners in orthopaedic surgery, and the use of physician’s assistants in increasing productivity.

According to the NHS workforce review team, in order to meet 18 week wait targets some organisations have had to implement a number of waiting list initiatives in order to clear backlogs, which often require additional expenditure through the use of agency staff and overtime. The challenge going forwards will be to sustain current 18 week wait targets in the face of limited resources.

2.8 Cancer
The incidence of cancer is currently increasing as people live longer, and an increasing number of people are alive having survived cancer. Furthermore our understanding of cancer is continually improving, providing new opportunities for prevention, early diagnosis and better treatment. A number of strategies and report should be considered when planning to meet the needs of cancer patients, such as the Cancer Reform Strategy (2007), the NHS services improvement programme, the National Radiotherapy Advisory Group report (2007), the National Chemotherapy

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5 Source: Performance and Compliance team, South Central SHA
6 Source: Performance and Compliance team, South Central SHA
Advisory Group draft report (2008), the NICE Improving Outcomes Guidance, and peer review measures. All of these should be reviewed with careful consideration to the planned care workforce. Where appropriate more detail has been given in the following section.

2.8.1 Cancer Reform Strategy (2007)
One of the more significant strategies relating to cancer is the Cancer Reform Strategy (2007), which builds on the progress made by the Cancer plan (2000) and sets out a clear direction for cancer services for the next 5 years (by 2012). In order to enable this, the strategy sets out a programme of action across six areas aimed at improving cancer service outcomes, and four aimed at ensuring a high quality level of delivery:

Actions to improve cancer outcomes:

- **Preventing cancer:** The strategy recognises that over half of all cancers could be prevented by changes to lifestyle, and as such advocates taking cross government action to encourage people to adopt healthy lifestyles.
- **Diagnosing cancer earlier:** The strategy highlights that late diagnosis is a major factor contributing to poor cancer survival rates, and the earlier cancer is diagnosed, the greater the chances of survival.
- **Ensuring better treatment:** The Cancer Reform Strategy (2007) aims to build on previous successes and ensure patients have fast access to high quality treatment including surgery, radiotherapy and drug treatment.
- **Living with and beyond cancer:** The strategy argues that whilst patient’s experience of care has improved in recent years, there is still room for improvement.
- **Reducing cancer inequalities:** The strategy places a high priority on reducing inequalities in cancer incidence and access to services and outcomes
- **Delivering care in appropriate settings:** The strategy sets out a range of ways in which service models for cancer could be improved, based on two key principles: firstly, that care should be delivered locally, for patient convenience wherever possible, and secondly that services should be centralised where necessary in order to improve outcomes.

Drivers for delivery:

- **Using information to improve quality and choice:** In order to effectively deliver the Cancer Reform Strategy (2007) collecting and using improved information on different aspects of cancer services and outcomes is key.
- **Stronger commissioning:** Commissioning will be particularly important in driving service quality and ensuring value for money.
- **Funding world class cancer care:** The strategy points out that the government is committed to funding world class cancer services but also expects the NHS to deliver value for money.
- **Building the future:** The strategy recommends continual reassessment of the progress made in tackling cancer in order to reflect new developments and opportunities.

The Cancer Reform Strategy (2007), has the potential to highlight opportunities for new ways of working, but at the same time will place additional demand on the workforce through other recommended actions. For example such actions include:

- Extending breast screening to nine screening rounds between 47 and 73 years, with a guarantee that women will have their first screening before the age of 50. The demand this could create should be eased through the use of
new technology, but still has the potential to place additional pressure on the workforce.

- By 2010 the NHS Bowel Cancer Screening programme should be extended to men and women aged 70 to 75 and in 2010 consideration will be given to roll out to people in their 50s. Again although the use of new technology should ease the impact, this is likely to place additional demand on the workforce.

- The strategy recommends extending the range of patients who benefit from the current 31 day standard, to cover all cancer treatments and with a greater number of people entering the 62 day pathway such as patients referred urgently by their GP and all patients with suspected cancer detected through national screening programmes. Naturally this will increase pressure on the pathway workforce.

As a consequence, South Central should undertake a complete review of the Cancer Reform Strategy (2007), in conjunction with developments identified by the Cancer services improvement programme, in order to identify any potential opportunities for workforce related service improvement methodologies, and assess the actions of the strategy and apply them where appropriate.

2.8.2 National Radiotherapy Advisory Group Report (February 2007)
The National Radiotherapy Advisory Group Report (NRAG) highlights that there is currently a gap of 63% between current activity and optimal treatment levels, if radiotherapy were to be given to all that might benefit. Furthermore it is likely this gap will increase when set against demand drivers such as the ageing population. Ultimately the report highlights that there is currently an insufficient amount of equipment and workforce in place to meet current or future radiotherapy need. Immediate action is needed in order to make up for the current workforce shortfall and plan for expansions in capacity. It is recommended that South Central reviews their progress against the various recommendations of the NRAG report, such as:

- Making the best use of current resources
- Supporting radiotherapy centres in developing local workforce proposals to deliver effective skills mix and service improvements and also to deliver capacity improvements.
- Ensuring the 4 tier skills model\(^7\) is fully implemented in all radiography departments, and that SHA commissioners and service employers are funding new roles in the model at advanced and consultant level.
- The development of a long term workforce strategy and supporting short term actions to maximise the current investment made in the current and trainee workforce.
- The development of NHS radiotherapy services to deliver 54,000 fractions\(^8\) per million population throughout the country by 2016 – a 91% increase on current activity. Due to the constraints of capacity NRAG recommends a stepped approach towards achieving this.

2.8.3 Chemotherapy Services in England: Ensuring quality and safety (draft paper) (November 2008)
The report aims to bring about a step change in the quality and safety of chemotherapy services for all adult patients with either solid cancers or haematological malignancies. The focus on the report is entirely on safety and quality

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\(^7\) A career progression framework issued for radiographers in 1999
\(^8\) Described as attendances for radiotherapy treatment
and it sets out a framework for planning and monitoring of services based on a care pathway model, recommending actions that need to be taken by commissioners and providers in order to ensure high quality care. As such this report should be carefully reviewed and where appropriate, recommendations should be applied to the South Central workforce. The following aims to provide an example of the type of relevant recommendations the report contains, but is by no means a comprehensive list:

- Effective leadership is needed at network and trust levels, for both elective chemotherapy services and/or acute oncology
- New roles within the oncology workforce should be encouraged in order to improve safety and quality and meet rising demand
- Training programmes should be developed.
- Decisions regarding the initiation of a programme of chemotherapy should be made at consultant level, unless there are exceptional circumstances. In order to ensure this, careful consideration would be needed by South Central to ensure appropriate capacity of senior staff.
- In order to assess and manage any complications relating from chemotherapy, as a minimum 24 hour access to telephone advice should be provided from an oncologist. Treat and transfer arrangements should be in place where organisations do not have suitable appropriate expertise for inpatient management, and if a patient receiving chemotherapy treatment presents to A&E or is admitted to hospital, the acute oncology team should be informed within 24 hours. Again careful consideration is needed around ensuring there is a suitably qualified and resourced workforce in place to meet such demands.

2.9 Dental access

The Department of Health is currently working with PCTs to ensure that by March 2011, anyone who is seeking NHS dentistry can gain access within a reasonable amount of time. This work can be broken down into 4 specific work streams:

- The development of a new robust and reflective indicator of the existing level of access to NHS dentistry.
- Supporting additional procurement of dental services, to enable the NHS to increase the capacity of good quality services to meet local demand
- Supporting gains through contract management, to ensure high quality services being delivered as outlined in dental contracts.
- Supporting local, regional and potentially national communications activities and stakeholder engagement and to raise patient awareness of the availability of good quality local NHS dental services and their entitlement to access them.

In terms of direct implications for the planned care workforce, the additional procurement of dental services is likely to increase the demand for dentists. This may also lead to the further development of the ‘Dentists with Special Interests or (DwSIs) role, which is defined as a dentist working in the primary care setting who provides services which are in addition and often complementary to their usual role. For instance special interests may include orthodontics, minor oral surgery, management skills, and so on. This role also ties in which the shift towards providing an increasing number of services in primary care settings.

3 Workforce supply

It is difficult to quantify and accurately profile the planned care workforce. However key staff groups can be identified. With this in mind, this section of the report aims to
provide a level of detail around the current level of supply of the planned care workforce, by examining key staff groups.

3.1 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.

3.1.1 Staff group
Based on this approach, there are approximately 19300fte 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.

3.1.2 Skills mix
Figure 3 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.
Figure 3 NHS South Central acute, elderly, general and community services nursing workforce

3.1.3 PCT/Acute split
It is also interesting to note the split between PCTs and the acute sector. Figure 4 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.

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9 Source: ESR Data Warehouse October 2009
3.1.4 Age

Figure 5 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.

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10 Source: ESR Data Warehouse October 2009
11 Source: ESR Data Warehouse October 2009
3.1.5 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.

3.1.6 Ethnicity
The majority of the workforce are 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%.

3.1.7 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.

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

3.2 Administration and Estates Staff
Table 1, 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 1, the majority of management staff work within central functions.

<table>
<thead>
<tr>
<th></th>
<th>Central Functions</th>
<th>Hotel, property and estates</th>
<th>Scientific, therapeutic and technical support</th>
<th>Clinical Support</th>
<th>Ambulance service support</th>
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<td>Senior Manager</td>
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<td>25.00</td>
<td>11.00</td>
<td>153.32</td>
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<td>Manager</td>
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<td>3.00</td>
<td>0.00</td>
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<tr>
<td>Total</td>
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<td>1189.48</td>
<td>800.42</td>
<td>6454.11</td>
<td>373.74</td>
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</table>

Table 1 Administration and Estates Staff

In order to further assess the planned care workforce, the supply of specific specialist professions have been assessed:

3.3 Occupational therapists
Within South Central if current commissioning levels are maintained then the supply of occupational therapists will gradually decline over the next 5 years. One issue that needs careful consideration is the improvement of student attrition levels which currently stand at 15%. Improvement of this rate would ensure best value for money is achieved.

12 Source: ESR Data Warehouse October 2009
A particular issue with occupational therapy is that it is difficult to gauge realistic demand. In particular it is difficult to quantify the demand emerging from social care employers and the impact of the current economic climate.

The current view moving forwards is that student commissions should be maintained this year, and possibly increased in 2010/11 after joint working with Social care. However clinical placement capacity is currently limited, and needs further development, possibly within social care settings. In addition to this, to further develop the occupational therapy workforce, skills mix needs careful consideration. For instance, it needs to be considered whether the role of assistants/associate practitioners should be further developed, or if there is sufficient availability of senior OTs in place to provide suitable student support.

### 3.4 Physiotherapists

Current supply modelling of physiotherapy in South Central shows a forecast slight decrease over the next 5 years. This may cause a slight gap between demand and supply, although appropriate workforce levels may be maintained through the use of new roles such as associate practitioners.

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13 Source: NHS SC CAST Tool 2009/10
3.5 Diagnostic Radiographers
Within South Central, it is predicted that at current education commissioning levels, the supply of diagnostic radiotherapy will gradually increase. However it should be noted that the demand shown within the graph below does not take into consideration any overall workforce growth that may result from changes to service models, independent sector employers demand, or specialism shortages.

The vacancy rate for diagnostic radiography currently stands at 4%. As a result increased demand is not yet showing in workforce expansion. At certain times of the year, there have been limited clinical placements available; however work has taken place to distribute capacity across South Central.

![Graph showing forecast demand for and supply of Diagnostic Radiography](image)

**Figure 7 Forecast demand for and supply of Diagnostic Radiography**

In October 2008, South Central scoped the demand for sonographers with provider trusts and found that demand is forecast to grow from 102.02ftes in 2009-10 to 130.14ftes in 2011-12. At the time of the survey 8.3% of funded establishment posts were vacant.

Another point of interest is that there was no intake on the Assistant Practitioner foundation degree in 2008/09 due to lack of demand for the service. Direct entry students can be recruited but this will put additional pressure on the capacity for clinical placements. Consequently, when developing the diagnostic radiotherapy workforce in order to meet the needs of planned care the following issues need consideration:

- What are the drivers for increasing demand for Diagnostic Radiography, how do we quantify potential growth and are we potentially training too many?
- What are the supply issues for ultra-sonographers and how can these be addressed? For instance would a direct entry route be appropriate and/or sustainable?

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14 Source: NHS SC CAST Tool 2009/10
15 Source: NHS SC CAST Tool 2009/10
• How is the training for Assistant Practitioners sustained, what is a viable cohort size and how should training be delivered?

3.6 Therapeutic Radiographers
When considering the supply of therapeutic radiographers it is important to understand and set it within the national context. As a consequence of the Cancer Reform Strategy (2007) recommendation that all patients should wait no longer than 31 days for second and subsequent radiotherapy treatment (a target to be reached by December 2010) significant growth is required. This is set in the background of a difficulty filling existing training places, and high in course attrition rates, of up to 50% nationally.

Within South Central current workforce modelling shows a significant supply shortage, with predicted decreases in supply over time. Consequently increased capacity requirements will not be met. The supply demand gap can be attributed to a variety of factors, however some of the key influences can be considered as high attrition rates from courses, and the increase in demand due to cancer waiting time targets.

![Figure 9 Forecast demand for and supply of Therapeutic Radiographers](image)

It should also be noted that there are currently high vacancy levels in both registered (4.9%) and non-registered staff groups (20.5%).

However a survey of trusts carried out in June 2009 showed forecast growth in therapeutic radiographers of 25.8% by June 2011-21 to approximately 168.39ftes, with maintenance of funded establishment numbers of Assistant Practitioners and Helpers/Assistants.

In order to improve the situation, it is recommended that South Central identifies ways to improve on attrition, retain staff, and maximise efficiency and skills mix.

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16 Source: NHS SC CAST Tool 2009/10
usage. However there is not an easy answer to addressing this supply gap, and it needs to be understood that an increase in education commissions will need to be matched by a similar increase in clinical placement capacity.

In addition to the points above, when considering the supply of the therapeutic radiotherapy workforce to meet the needs of planned care, South Central needs to consider the following:

- Review how training courses are currently being recruited to
- Consider the conversion of some undergraduate posts to post graduate training posts
- Make use of the virtual learning environments available to them
- Review the current system of clinical placement provision in an attempt to identify any opportunities for increasing the availability of places.

3.7 Operating Department Practitioners

Within South Central, current modelling predicts a small increase in supply of operating department practitioners over the next 5 years, though it should be noted that demand is difficult to forecast, and it may affected by the economic climate. There is a relatively low level of vacancies reported.

![Operating Department Practitioners](image)

**Figure 10 Forecast demand for and supply of Operating Department Practitioners**

One issue that does bear consideration is the current commissioning model. At present spot commissioning occurs in the Thames Valley area, whilst South Central has a contract in place in the South. It may be worth exploring the benefits of a more consistent model across the patch.

3.8 Musculoskeletal (MSK) pathway

It is more than likely that the planned care programme will aim to plan by care pathways. The MSK pathway would be one such example which is likely to see planning in this manner. As such, as part of this project we thought it would be beneficial to analyse a care pathway workforce as an initial example.

In order to achieve this we produced an aggregate profile of the main staff groups that are considered to be involved in MSK (physiotherapy, occupational therapy,

17 Source: NHS SC CAST Tool 2009/10
multi-therapies, trauma and orthopaedic, and sports and exercise medicine). We then looked at the workforce split and makeup for this workforce by acute organisations and PCTs, in order to identify any key trends. There were approximately 2702fte of staff across all PCT and acute organisations based on this approach.

Between 2-3% of the data returned was potentially miscoded, as such data should be taken to give a strong indication of key trends but not absolute figures. An action to come out of this is that South Central should contact those organisations mis-recording staff. A further point of note is that the following occupation descriptions were excluded from this profile, as they were considered not to wholly contribute to facilitation of the pathway: Instructor/teacher (S6), Tutor (S7), Student/trainee (S8).

As figure 11 shows overall the workforce is split fairly evenly between the two, with approximately 50.4% being based in PCTs and 49.6% being based in acute organisations. However within specific job roles large amounts of variation can be seen. For instance, approximately 95.4% of all medical staff were situated in acute organisations and all consultant therapists/scientists (though only 3.4fte were reported). However the majority of other staff tend to be based in PCTs. For instance approximately, 78.4% of assistant practitioners, 77.2% of technicians, 57.1% of managers, and 56.5% of therapists are based in PCTs.

<table>
<thead>
<tr>
<th>South Central workforce (fte) that would support MSK pathway by PCT and Acute organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2009</td>
</tr>
<tr>
<td>Medical and Dental</td>
</tr>
<tr>
<td>Consultant Therapist/Scientist</td>
</tr>
<tr>
<td>Manager</td>
</tr>
<tr>
<td>Therapist</td>
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<tr>
<td>Technician</td>
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<tr>
<td>Assistant Practitioner</td>
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<tr>
<td>Support Worker</td>
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<td>PCT</td>
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<td>35.0</td>
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<tr>
<td>8.5</td>
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<td>8.1</td>
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<tr>
<td>128.9</td>
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Figure 11 Musculoskeletal workforce, split between acute and community providers

Figures 12 and 13 examine the specialism mix with the acute organisations and community providers in South Central. Whilst there are many similar traits that exist between the two sectors there are also several differences worth commenting on. As commented on above, the acute sector employs a considerably larger amount of trauma and orthopaedic, and sports and exercise medicine medical staff. In addition to that, the PCT workforce can be argued to be slightly more diverse, in that they

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18 Source: ESR Data Warehouse, October 2009
employ almost all the multi-therapist staff, with the majority being at assistant practitioner or support worker level, and employ approximately 16% more physiotherapists, and 52% more occupational therapists.

Figure 12 MSK workforce in acute trusts

Figure 13 MSK workforce in community providers

3.9 Independent projects
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

19 Source: ESR Data Warehouse October 2009
20 Source: ESR Data Warehouse October 2009
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 Patient Choice
Patient choice is a major priority. Irrespective of entry point, patients will be provided with information and guidance on the full range of planned care options, details around the choice of interventions and expected clinical outcomes and be able to understand their symptoms and diagnosis to encourage self management. Suitable training opportunities for all staff should be developed to enable this.

4.2 Prevention and early intervention
A focus on prevention and early intervention will be key, and as such staff need to be trained appropriately.

Staying healthy needs to be actively promoted. The NHS should lead by example in terms of what we expect from staff and what the NHS can do for staff.

4.3 Promotion of self care
The promotion of self care is a major priority. As such staff need to be trained in concepts such as case management and patient motivation. Furthermore it would be beneficial for the member of staff managing a self care patient to cover more aspects of the process, such as the same individual who manages a patient being able to perform the diagnosis.

Regular management and monitoring of older patients could be established to prevent unplanned hospital admission and promote self care. There will likely be a need for new skills and competencies within the future nursing and AHP workforce, and for practitioners with higher levels of case management skills.

4.4 Collaborative working and development opportunities
There is a need to consider public awareness of care pathway entry points as ensuring patients enter the right pathway will lead to a more effective service. However in the first instance patients may also go to 3rd parties for advice such as gym trainers or social workers. It may be worth developing both collaborative working and development opportunities with such groups.

Integrated working between primary and secondary care should also be established coupled with joint working between health and social care. In particular it is important to establish a more formal framework for how occupational therapists will work in the community. In line with this, employment contracts should be reviewed to allow employees to work across organisations, which should enable pathway working.

Collaborative working should be established with clinical teams, managers and patients across South Central in order to redevelop planned care pathways.

Speciality boundaries between groups such as medics, Allied Health Professionals (AHPs) and nurses need to be removed to allow for greater collaborative working. It is possible that training and registration might be a way of facilitating this.
It may be beneficial for community and hospital discharge teams to work together, as there is currently a significant amount of duplication, which in turn slows the process of discharge (SC planned pathway report, 2007).

4.6 Mental and physical health
It needs to be ensured that the strong inter-relationship between mental and physical health is understood by all staff, and as such mental health care needs to be included in all physical health pathways.

Working for a healthier tomorrow (Black, 2008) – states that service commissioners should provide rapid access intervention teams to address patients physical and mental health problems. This is likely to increase demand for various AHP groups, including physiotherapists, and occupational therapists.

4.7 Appropriate pathways
The primary care workforce needs to be fully trained to ensure that they are able to identify conditions and transfer patients to the most appropriate pathway.

Patients should be triaged against an agreed protocol; regardless of where surgery is taking place in order to reduce variation and improve quality and productivity. Appropriate training opportunities need to be developed in order to enable this.

Defining tertiary pathways is vital for rare conditions. Patients receive improved services from clinicians who frequently deal with rare conditions (SC planned pathway report, 2007). Although multidisciplinary teams are recommended by NICE, it is difficult to define precisely what these services will deliver. Clarification is needed around what services necessitate tertiary referral.

4.8 Care closer to home
Care in the community will impact the AHP workforce. Training and ongoing development will be required to prepare practitioners for a different working environment.

4.9 Leadership
In order to create high quality leadership that will drive the workforce forwards all consultants should be offered a level of management training. Furthermore it is often the case that pure managers have no clinical experience, leading to gaps in their understanding of the system. As such pure managers should be given the opportunity to experience the clinical environment.

Leaders need to be aware of any advances in technology that may improve planned care and ensure that developments are reflected in training for registered and non-registered staff.

4.10 Information Analysis
Anecdotal evidence suggests it has often been difficult to recruit information analysts. These roles are crucial to monitoring and ensuring a consistent level of quality. As such analysts should be actively recruited and offered formal training opportunities.

5. Alignment with Workforce Strategy
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>
</table>
| 1. Share the journey: engage patients, carers and staff | 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. | 4.2 Prevention and early intervention  
4.3 Promotion of self care |
| 2. Plan and Prepare: Manage the Change              | 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. | 4.9 Leadership                                      |
| 3. Integrate and align: design a joint future       | 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. | 4.4 Collaborative working and development opportunities  
4.6 Mental and physical health |
| 4. Tighten up business: drive up quality and value   | 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. | 4.2 Prevention and early intervention |
| 5. Step up flexibility: develop the workforce       | 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. | 4.1 Patient Choice  
4.4 Collaborative working and development opportunities  
4.8 Care closer to home  
4.7 Appropriate pathways |
| 6. Be accountable: focus leadership                 | 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. | 4.9 Leadership  
4.10 Information Analysis |

**6. Next Steps**

- There needs to be a focus on preparing the current AHP and nursing workforce to take on extended and specialist roles in community settings
• We need to be aware of research areas that may affect planned care such as advances in technology.