Shaping the Future

Workforce

A strategy to develop the workforce in NHS South Central

2010 - 2015

Draft 9: SC SHA Board March 2010
# Shaping the Future

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Supporting Documents

1. NHS South Central Workforce Information Report
2. NHS South Central Education Commissioning Strategy
3. Clinical Care Area Workforce Reports and Priorities
4. End to End Workforce Planning System

Reserved for map

Fig 1: Map of NHS South Central, Primary Care Trusts (PCTs) and Local Authorities
Foreword:

Shaping the Future – the workforce strategy

This strategy is about people. The doctors, nurses, porters, estates staff, managers and support staff, allied health professionals and scientists, pharmacists and dental teams who work every day to make a difference for patients, clients, their families and friends.

This Workforce Strategy is a major work stream essential for the delivery of the overall South Central Shaping the Future programme and the six SHA priorities¹ that will drive the quality and productivity improvements. Shaping the Future is an integrated programme, led by the local NHS to deliver quality, harness innovation, improve productivity and build in prevention.

Shaping the Future — the workforce strategy, has been developed against the backdrop of a tight financial climate not just for health and social care, but for the UK economy in general. While there are undeniably tough times ahead as the NHS feels the impact of the global economic challenge, this strategy looks to take us through the next five years on our road to recovery.

A great deal of work has been done to ensure that the Shaping the Future programme and this workforce strategy are built on reliable demographic information, evidence of best practice, and our understanding of long term trends.

This strategy then must deal with the reality that we understand, and plan for what is yet to be realised. Our first step is to take action now and to focus on driving up, increasing patient safety, and chasing waste and variation out of the system. We must also keep in mind our longer term ambitions and make education and training investments that build the workforce that we need for five years and beyond.

We know that people who work in health care want to provide consistently excellent care, be productive and deliver good value for the public. We want to create new opportunities for our staff to have rich careers and opportunities for personal and professional development as we transform services.

This strategy aims to set out a sustainable, robust framework that will still be relevant in five years time. We have kept it simple and straightforward – I think we have done a great job – I hope you do too.

Andrea Young
Chief Executive
NHS South Central

¹ Six SHA Priorities are set out in Appendix 1 and Fig 3. Page 13.
Introduction

A Workforce strategy for Recovery

*Shaping the Future – the workforce strategy*, sets out a strategic framework for the NHS workforce in South Central for the next five years.

The strategy is designed to address six big **strategic challenges**. Challenges that will help the NHS deliver high quality, safe, patient care within a tight economic climate. Our six challenges were identified by leaders from the local NHS, education, the voluntary sector and social care.

Our ten **commitments** set out our response to the strategic challenges, and how these will be achieved is described more fully in the **pledges** that have been decided by a wide group of stakeholders from providers and commissioners across the NHS, social care and education sectors.

This strategy has therefore been developed and designed by the people who have a deep understanding of the needs of patients and the public in South Central, and the context in which we work.

By accepting that we are working in a challenging financial environment we will not compromise on quality or patient safety, and we will continue to strive to meet the expectations of patients and the public.

We recognise that delivering quality, getting it right first time, is best for patients and the most economic option of all. Only by involving patients, the public, our staff and stakeholders in implementing this strategy will this be possible.

Workforce planning and development is complex. It involves a web of stakeholders all of whom must understand their role and responsibility in the delivery of this strategy. Silo working that ignores the needs of the wider health and social care system is not an option.

The role of the Strategic Health Authority is to lead, support and innovate in workforce planning and development across the health system, but it is also our role to hold organisations to account for delivering the pledges that we have made together in this strategy.

This strategy then provides the framework for the development of the workforce in NHS South Central. We aspire to exceed national standards by working collaboratively across the region to deliver the best care we possibly can for patients. The strategy provides the clarity and direction for its delivery. I look forward to working with you to make it happen.

Katherine Fenton
Director of Clinical Standards and Workforce
NHS South Central
Executive Summary

What Will The Workforce Of The Future Look Like?

Today and tomorrow, improved quality in patient care needs to be delivered against the backdrop of considerable financial challenge and the drive for increased productivity. As society changes, and the population ages, there will be an increased demand for health services and public and patient expectations will increase. Yet we will need to deliver health care services without the levels of investment that we have seen over the past ten years.

To meet these challenges the workforce in NHS South Central needs to be more focussed on prevention and more productive, whilst maintaining a people centred approach.

We in NHS South Central, like the rest of the health service, plan to change health care services in the following ways, by:

- Providing more care closer to home
- Reducing the number of acute beds
- Standardising patient care pathways
- Investing in prevention and staying healthy
- Managing long term conditions in the community
- Providing high quality end of life care at home
- Reducing hospital admissions and attendances
- Ensuring maternity, newborn and child health services are configured for maximum productivity
- Managing learning disability and continuing care budgets with local partners
- Collaborating on commissioning of patient services.

Delivering health care closer to home will require the development of community based teams with individual staff members having greater autonomy and less direct supervision. This means staff will have to work in more flexible ways across organisational and professional boundaries.

Achieving this will require a collaborative approach between the SHA, commissioners, service, and education providers to plan and then develop the workforce to deliver the necessary changes.

The combined financial and demographic challenges mean we will have relatively less staff providing care, for more people with more complex needs in changing health care settings. There will be fewer staff employed dealing with people who are acutely ill and more staff will be community based working to help people manage their own conditions, as far as possible, whilst focussing on preventing longer term conditions arising.

For the past three years our staff costs have increased whilst there has been no overall change to the relative skill mix across the health care professions, this is unsustainable. Working with relatively less staff to deliver the new services will need a reassessment of the numbers and skills of our staff to ensure that our services remain affordable yet continue to deliver high quality and safe patient care. New

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2 The Case For Change p 9
3 Strategic Challenge 4 p.30
ways of working will mean increasing the number of highly competent support staff and increasing the efficient use of our expert clinical staff in selected areas of practice.4

Clinical and other leaders need to be relentless in their drive for improvement. Leaders will need to demonstrate their commitment to change by leading by example, being accountable and being open to change.5

Management and back office staff, as they are currently configured will be unaffordable in the future. As patient care is our priority we must consider making efficiency savings in this area in order to secure as much funding as possible is directed towards front line services.6

If our staff are to provide outstanding care and adapt to these new ways of working7 they deserve the best education possible. It is vital that staff have the right knowledge, skills and attitudes appropriate for each and every role across our services, and that these are transferrable across all health and social care sectors as care pathways develop.8

Educational pathways need to support the principle of life long learning, have flexible entry and exit routes and, as education commissioners, South Central SHA needs to commission high quality educational programmes that meet service demands.9

We need to ensure that the staff we attract tomorrow will reflect our population in terms of their socio economic background and cultural diversity, to be able to meet the health needs of the people of NHS South Central.10

Organisations can play their part in ensuring maximum efficiency and productivity from their staff by delivering excellent human resource management and best practice, and by setting realistic plans where workforce is aligned with service planning and finance and monitored across the region.

What Are We Doing About It?

This strategy is intended to provide a framework for the South Central SHA, service commissioners, service and education providers to move from producing annual short term plans towards planning and developing the workforce over a longer term of 3 – 10 years. 11

Through extensive consultation and development, the strategy provides a direct ‘line of sight’ between the SHA Strategic Priorities and local staff. It sets out the case for change, identifies six major challenges and describes what collectively we will do to address them. How we address the challenges is detailed in ten key commitments, and the actions required by each of the partners, (SHA, commissioners, providers and staff) is highlighted through a series of pledges.

4 Strategic challenge 4 p.28
5 Strategic challenge 6 p.37
6 Strategic challenge 4 p.33
7 Strategic challenge 5 p.35
8 Strategic challenge 3 p.26
9 Strategic challenge 5 p 35
10 Strategic challenge 1 p17
11 Strategic challenge 2 p20
Line of sight between SHA priorities and staff

SHA Strategic Priorities  (Why)

Strategic Challenges (What - regional)

Commitments (How)

Pledges (Who, what & when - specific)

SHA, Commissioner, Provider, Staff

What will success look like?

Progress in achieving our commitments will be measured by us being held to account on delivering the pledges on time. The pledges clearly set out what will be achieved and by whom. In addition there will be a range of annually produced planning documents including a workforce implementation plan and specific care pathway plans all with key performance indicators (KPIs) that will detail specific outputs and achievements. This then allows for flexibility for annual plans to be developed and measured whilst the strategy provides the overview and direction of travel.

Success will be measured by the workforce delivering patient care in different settings, staff working in extended roles and new ways to deliver patient pathways that commissioners have specified and reducing unit labour costs.

By 2015 we will have improved quality and patient safety across the region. Services will be provided closer to peoples' homes and will be more community based. Thus helping people to play a greater part in maintaining their own health and wellbeing by providing treatment or care earlier, with the aim of preventing unnecessary hospital admissions.

We will have invested in education and training to ensure the entire workforce is able to adapt to new ways of working. We will have met the financial challenges (of a 14% reduction in MPET funding by 2014) by commissioning new educational programmes based upon the needs the service, driving down duplication and waste whilst increasing funding for key roles.

Education and training will be delivered using the latest technology (e.g. e-learning via handheld devices) saving staff time, and there will be regional agreement over essential training, saving considerable time, money and effort by avoiding duplication and unnecessary training.

We will get the most from our staff by looking after them, with each organisation in NHS SC committing to the Skills Pledge and the NHS Constitution, and this will contribute to reducing sickness and turnover to meet or exceed national standards.

Finally we will have developed the skills and capacity across the region, and have in place the infrastructure, to be able to effectively plan workforce for the longer term and inform education commissioning, where health and social care stakeholders will be working collaboratively to ensure the best services are provided to the population of South Central.
The Case for Change

There are three areas where the assumptions we make about the future are critical: finance, service demand and healthcare policy priorities.

These assumptions underpin Shaping the Future - the Workforce Strategy, and inform the strategic planning decisions for the structure, competence and capacity of the future healthcare workforce in NHS South Central. 12

Finance

Financial growth in the public sector will not continue at the levels experienced in healthcare over the last ten years when growth has averaged at 7%. The Kings Fund report “How Cold Will it Be? The prospects for NHS funding”13 sets out three possible scenarios; Tepid, Cold and Arctic.

The premise is that 2010/11 funding levels will stay at 3.5% annual PCT real terms growth. However, from 2011/12 to 2013/14 the best case scenario will be 2% real terms growth, with the forecast worst case scenario being a real terms reduction of 2%.

What this means in money terms in NHS South Central is a potential financial funding gap of between £0.7bn and £1.3bn over three years from 2010/11, or savings of around 16% in every organisation.

It is estimated that 60-70% of the current health spend is on the workforce so it is likely that this predicted shortfall will impact on the workforce through workforce reductions (predominantly in non frontline staff), workforce related productivity improvements and changes to the workforce profile and skill mix.

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The NHS will need to deliver productivity gains of between 3.4% and 7.4% to meet the funding gap, but historically productivity gains have been under 1% per year, so a step change in productivity will be required. Local Authorities are also forecasting potential 10% reductions in the workforce.

**NHS South Central Healthcare Demand**

- 20% increase in over 65 year olds
- 10% increase in under 16 year olds
- Patient expectations of access and choice
- Increased prevalence of some diseases and conditions
- Reducing health inequalities

We know that demand for patient services will continue to grow driven by patient expectations about choice and access, and the increased prevalence of some diseases or conditions. In addition there are forecast demographic changes in the population with growth in both the numbers of older people and children. These groups both use high levels of health care.

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4 Appleby J. Nov 2009 NHS Employers Conference
The forecasts in NHS South Central show growth of the whole population over the next 10 years of 7.5% or 309,000. With the number of over 65 year olds increasing by 169,000 or 20%, and the number of children under 16 increasing by 74,000 or 10%.

The population is also increasing in diversity, and there are significant health inequalities across the region. The Audit Commissions “Place Survey”\textsuperscript{15} 2009 shows that in NHS South Central although people have an above average opinion of the place in which they live they have a lower than average sense of belonging – This is likely to impact on the levels of carer and voluntary support for the increasing elderly population as residents level of commitment to their community may be less.

There are housing shortages across the South East Region resulting in some areas of poor housing. Where housing is of a low standard this has a significant impact on people’s health and need for services.

In relation to the labour market in NHS South Central, the adult working age population in NHS SC is projected to grow by 2.4% over the next ten years from 2,730,300 to 2,796,000. However, as detailed earlier, this is a much lower level of growth than that expected in the number of older people and the number of children.

This will mean that over time there are less people of working age to provide services and at the same time demand for those services will increase. Unemployment in the South East is increasing but at 6% is lower than the national average of 8%.\textsuperscript{16}

\textbf{National Policy}

During a decade of reform and investment, the focus in health has been on increasing capacity and establishing a market-driven system. Even prior to financial forecasts, such as those of The Kings Fund report (How Cold Will it be? July 2009\textsuperscript{17}),

\begin{itemize}
  \item Control costs, improve value for money
  \item Patient safety and quality
  \item Prevention
  \item Reducing health inequalities
  \item Innovation and new technologies
  \item Joint Planning with local authorities
  \item Improving performance
\end{itemize}

\textsuperscript{15} http://www.audit-commission.gov.uk/localgov/audit/nis/Pages/placesurvey.aspx
\textsuperscript{16} Office for National Statistics July 2009
\textsuperscript{17} Kings Fund for Fiscal Studies. July 2009. “How Cold Will it Be: Prospects for NHS Funding
concerns were being raised about whether the benefits of the healthcare reforms were being realised. In particular the benefits of the NHS pay reforms (Agenda for Change, Consultant Contract and GP Pay) and the overall productivity of the health service have been questioned. Productivity historically in the NHS over the last few years is estimated at -0.4%.\textsuperscript{18}

As we enter the next decade there is a clear need to control and reduce costs and to improve productivity. Equally there is continued focus on quality improvement, reducing health inequalities, prevention before treatment, improving patient safety, using new technology and managing and improving performance.

Quality spans patient safety, patient experience and effectiveness of care and the staff that deliver patient services must ensure quality is the organising principle of the NHS.\textsuperscript{19} The National Quality Board has published its first annual report which includes the NICE quality standards definition.

\begin{table}
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\hline
\textbf{NICE quality standards definition} \\
A set of specific, concise statements that: \\
\begin{itemize}
\item act as markers of high quality, cost-effective patient care across a pathway or clinical area; \\
\item are derived from the best available evidence; \\
\item are produced collaboratively with the NHS and social care, along with their partners and service users. \\
\end{itemize} \\
\hline
\end{tabular}
\end{table}

Sustainability is also a key theme for public services across the South East region and local populations need to have access to skills development that enables them to work in their local communities, rather than having to travel to work.

“Putting People First”\textsuperscript{20} the national concordat for adult social care has a number of themes that align to health policy. These include ensuring that specialist skills are targeted at customer needs, personalised care and personal budgets, supported living for older people, and prevention and early intervention across the system.

“Working to Put People First”\textsuperscript{21} looks at the workforce implications of personalisation and “Facing up to the Task” assesses the development of social work in both adult and children’s services – integration with education, health and housing and also the impact of new technology. The recent Audit Commission report “Tomorrow’s People” also outlines the drivers for change and the need for Local Authorities to strategically plan their workforces.

The combined financial and demographic challenges mean we will have less staff providing care, for more people with more complex needs in changing health care settings. There will be fewer staff employed dealing with people who are acutely ill and more staff will be community based working to help people manage their own conditions, as far as possible, whilst focussing on preventing longer term conditions arising.

\textsuperscript{18}Appleby J. Nov 2009  NHS Employers Conference \\
\textsuperscript{19} 2009/10 National Quality Board annual report \\
\textsuperscript{20} DH Dec 2007  Putting People First – A Shared Vision and Commitment to Transformation of Adult Social Sevices \\
\textsuperscript{21} DH June 2008 Putting People First – Working to Make it Happen
The drive for shorter stays in hospital, and more care provided in the community, along with the benefits of joint planning at health economy level with local authorities will be critical. The evident alignment of Local Government strategic drivers and those of the NHS provides a platform for increased and effective joint working across the sectors\textsuperscript{22}.

\textsuperscript{22} Audit Commission, June 2008 Tomorrow’s people: building a local government workforce for the future
Strategic Context

Shaping the Future – the Workforce Strategy is rooted in “Towards a Healthier Future – a ten year vision for healthcare across South Central”23 that was set in the context of “A High Quality Workforce – Next Stage Review” DH June 2008.

NHS South Central Shaping the Future programme is an integrated programme, led by the local NHS, that will deliver the six SHA priorities24 that drive the quality and productivity improvements across the system.

The workforce strategy is built on three founding principles that underpin the workforce changes over the next five years. These are key to transforming patient services and delivering the South Central SHA six priorities.

The principles are:
- High quality affordable care
- System wide change
- Health and well being of staff

This reflects the SHAs' emerging six strategic priorities25 and the pledges made in this strategy link directly to delivering these – summarised in the ten overarching commitments.

The South Central Six Priorities are shown in the diagram below which links each priority to the ten overarching commitments made in this strategy (page 39/40).

South Central SHA Priorities

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23 http://www.southcentral.nhs.uk/page.php?id=249
24 Six SHA Priorities are set out in Appendix 1 and Fig 3. Page 13.
25 SC SHA Six Priorities Figure 2, Appendix 1.
Figure 3: South Central SHA Six Priorities

The six strategic challenges that follow, have been developed with a wide range of stakeholders across South Central and are cross cutting strategic themes, that are relevant to all the clinical care pathways.

Clinical care pathway interim workforce reports are available on the NESC website\textsuperscript{26}, and the care pathway priorities are summarised, as they currently stand, in Appendix 2.

An implementation plan for this strategy will be published in April 2010 that sets out the specific workforce changes that need to be made to support delivery of the pathway transformation plans in year one of this strategy.

\textsuperscript{26} \url{www.nesc.nhs.uk/about_nesc/workforce_strategy.aspx}
Strategic Challenge 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 healthcare within a sustainable framework.

Commitment

We will work with and engage the public\(^27\) (patients, service users, clients, carers and the general public) more fully, in workforce development and education of our staff by ensuring that public opinion and patient views are represented and used to drive and develop excellent education and training.

Key Issues

The implementation plans for this recovery strategy will involve new or extended roles, different ways of working, and reflect the hard decisions that have to be made about services in order to work within funding constraints.

The NHS Constitution\(^28\) sets out what staff, patients and the public can expect from the NHS. For staff it says:

- To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities
- To provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed
- To provide support and opportunities for staff to maintain their health, well-being and safety
- To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

The Constitution also sets out the responsibilities of staff, staff should aim:

- To maintain the highest standards of care and service, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole;
- To take up training and development opportunities provided over and above those legally required of your post;
- To play your part in sustainably improving services by working in partnership with patients, the public and communities;
- To be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation. You should contribute to a climate where the truth can be heard and the reporting of, and learning from, errors is encouraged; and
- To view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care.

\(^27\) Public is patients, users of services, carers, clients, general public.
\(^28\) DH Jan 2009 The NHS Constitution for England
Engaging the workforce, staff representative groups, patients, carers and the public at the earliest possible opportunity will enable roles and services to be better designed around the actual, rather than perceived needs of patients. We should build on the work of local authority forums and foundation trust approaches to engagement.

Managing people effectively brings significant cost benefits, and if done well will also result in a workforce that is engaged, proactive in attitude and not frustrated by the inefficiencies of the system(s) within which they work.

The case for improving the health and well-being of staff is set out in the recent Boorman report.\textsuperscript{29} The report emphasises the benefits to staff of taking responsibility for their own health and well-being and becoming exemplars for patient. It links improved outcomes for patients to investment in staff health and well-being.

As taxpayers, the public also has a right to understand how decisions about the workforce are being made, and can help share the responsibility for making those decisions. Respecting the public as active partners in making decisions about their own health choices forms a critical part of this engagement process.

Ensuring that every health and social care worker will be able to talk positively about the changes that they are involved in is a challenge. However, with time and effort spent in explaining change we will create ambassadors who will be able to connect the changes and see the benefits.

Patients themselves, carers and volunteers are also part of the “workforce”. They can, and do, contribute significantly to day to day care. Carers and volunteers make a very direct contribution and will be supported and provided with access to the necessary knowledge and skills.

Patients and the public also have an increasing role in managing their own health – whether by having a healthy lifestyle or playing an active part in the management of their own condition. This is not only respectful to patients as people; it also helps us to manage the increasing demand for services.

From a social care perspective “Putting People First”\textsuperscript{31} is the national concordat for adult social care and is about the development of truly personalised care packages and personal budgets. “Working to Put People First”\textsuperscript{32} assesses the workforce implications of personalisation and “Facing up to the Task” looks at the development of social work in adult and children’s services, integration (see Theme 5) with education, health and housing and also the impact of new technology.

It is also important that the ethnicity and diversity of the health care workforce reflects that of the population that it serves, and also that staff understand and actively promote equality and diversity in patient services.

\textsuperscript{29} Boorman S. Nov 2009. The NHS Health and Well Being Review Final Report
\textsuperscript{30} Planned Care Workforce Report, Long Term Conditions Workforce Report, Staying Healthy Workforce report
\textsuperscript{31} DH Dec 2007 Putting People First – A Shared Vision and Commitment to Transformation of Adult Social Services
\textsuperscript{32} DH June 2008 Putting People First – Working to Make it Happen
The ethnic breakdown of the current workforce employed in NHS South Central is shown in Figure 4.

**Figure 4: Ethnicity of NHS South Central NHS Trusts Workforce (FTE) September 2009**
Overall the population in the South East region (of which NHS South Central is part) is 89% white and 11% non-white, so the current NHS workforce is broadly reflective, however there is variation at different levels of the workforce and in different local populations within the region, and each organisation will need to ensure it has plans in place to ensure it is addressing this issue.

The ethnicity of the workforce by head count and pay band is shown in Figure 5. The data is shown divided into black and minority ethnic groups, non black and minority ethnic groups and those where ethnicity is not stated. Through the NHS South Central Human Resources Best Practice forum organisations will be encouraged to regularly monitor the ethnicity and diversity of their workforce.

**Figure 5: NHS South Central Ethnicity within Pay Bands (Headcount) – End September 2009**

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33 ESR Data Warehouse
## Making it Happen - Share the Journey: Engage Patients, Carers and Staff

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<tr>
<th>Pledge</th>
<th>Action</th>
<th>Timeframe</th>
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<tr>
<td><strong>South Central SHA will</strong></td>
<td>Support Investment in the development of patients, carers and volunteers as co-agents of care planning and delivery.</td>
<td>By 2011/12</td>
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<tr>
<td></td>
<td>Actively promote the involvement of patients and public in workforce development.</td>
<td>By 2012/13</td>
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<td></td>
<td>Continue to engage with trade unions and professional bodies to facilitate service change through the Social Partnership Forum.</td>
<td>By 2010/11</td>
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<td><strong>Commissioners will</strong></td>
<td>Commission services from NHS providers that are demonstrably committed to improving staff health and well being, building this into future contracts. (&quot;NHS Health and Well Being Review&quot; Boorman 2009 p.34).</td>
<td>By 2011/12</td>
</tr>
<tr>
<td></td>
<td>To participate and invest in local education, training and employment initiatives to improve the health and well-being of the local population.</td>
<td>By 2011/12</td>
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<td></td>
<td>Assure that providers have single equality schemes in place.</td>
<td>By 2010/11</td>
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<tr>
<td><strong>Service providers will</strong></td>
<td>Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families. (NHS Constitution).</td>
<td>By 2010/11</td>
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<tr>
<td></td>
<td>Include staff health and well being in local governance frameworks ensuring Board accountability. (NHS Health and Well Being Review” Boorman 2009 p22).</td>
<td>By 2011/12</td>
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<td></td>
<td>Promote and ensure ethnicity, diversity and equality of the workforce.</td>
<td>By 2010/11</td>
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<td></td>
<td>Develop skills of patients, carers and volunteers and engage the public in new roles and workforce development.</td>
<td>By 2011/12</td>
</tr>
<tr>
<td><strong>All Staff will</strong></td>
<td>Maintain the highest standards of care and service, taking responsibility not only for the care provided, but also for their wider contribution to the aims of their team and the NHS as a whole; Be open with patients, their families, carers or representatives, including if anything goes wrong;</td>
<td>2011 – 2015</td>
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34 ESR Data Warehouse  
36DH Jan 2009 NHS Constitution for England
welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation. Staff should contribute to a climate where the truth can be heard and the reporting of, and learning from, errors is encouraged;

View the services they provide from the standpoint of a patient. Staff will also involve patients, their families and carers working with them, their communities and other organisations, and making it clear who is responsible for their care. (NHS Constitution, Staff responsibilities)
Strategic Challenge 2: Plan and Prepare: Manage the Change

We must actively plan the workforce and prepare intelligently to respond to the challenge and scale of both the forecast increase in demand for healthcare services, and the reduction in spending on public services.

Commitment

We will work in partnership with the broader health and social care community to deliver this strategy by developing and agreeing a clear infrastructure that connects the different planning cycles and clearly sets out roles and responsibilities. We will also work to align individual staff development to organisational business plans, commissioning strategies, and regional strategic plans.

Key Issues

Shaping the Future37 aims to achieve large scale, sustainable, changes in the way patient care is delivered in NHS South Central. This scale of change, requires that the workforce, who deliver care, is strategically restructured, including planning for the decommissioning of some services. This means that management plans must achieve optimal skill mix, with the best patient outcomes, for the lowest cost (Challenge 5). It also means the effective management of vacancies and turnover (Challenge 4) as part of an agreed longer term plan to re-profile the workforce through a system wide approach (Challenge 3).

Our challenge is to ensure that actions we take today do not result in more intractable problems for tomorrow. We have learnt from experience that saving money in the short term on training and developing staff, or freezing recruitment, results in skills shortages, additional costs to rectify these in the future, and/or cost shifting to other parts of the system. Therefore short-term only planning, will not result in sustainable solutions.

To be effective workforce planning and development should be an integrated process with service and financial planning. The different elements of the integrated planning framework are shown below in Figure 6.38

Figure 6: Integrated Planning Framework

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37 NHS SC Shaping the Future – Quality and Productivity Challenge Framework
38 DH Dec 2009 Draft National Framework for planning and developing the workforce
Workforce planning and development encompasses five different systems that are linked together, these are:

- Service commissioning
- Workforce planning
- Education commissioning
- Education funding
- Governance and assurance

Workforce changes need to be managed skilfully, and a shift made from high risk short-term planning, to planning for resilience and sustainability of patient care. We need to protect resources for the strategic change priorities outlined in this strategy that make the most difference for patients.

This means that workforce plans should be phased and implemented at a pace that brings measured improvements to patient services and sustains quality care. Workforce plans should be completely aligned to service and financial plans at all levels of the healthcare system and based on common long-term objectives for services across health and social care.  

Figures 7 and 8 (below) are draft diagrams from DH guidance on the workforce planning framework to be published March 2010. They show how the workforce structures come together across different parts of the system, and set out key roles and responsibilities across the system. They also describe new national structures such as the Centre for Workforce Intelligence, the Professional Advisory Boards, and the Health Innovation and Education Clusters.

![Figure 7: National Workforce Planning and Development Inter-relationships](image)

39 Audit Commission 2009 Use of Resources Assessment, Key Performance Indicators. [http://www.audit-commission.gov.uk/health/audit/uor/Pages/Default_copy.aspx](http://www.audit-commission.gov.uk/health/audit/uor/Pages/Default_copy.aspx)

40 DH. Dec 2009. Draft National Framework Planning and Developing the Workforce
In NHS SC we will ensure that we work in partnership with the Centre for Workforce Intelligence, to focus on regional solutions to local issues, and maximise the benefit of this additional resource in workforce planning.

We will work to develop the two Health Innovation and Education Centre (HIEC) approved in NHS South Central, ensuring collaboration between HIECs and other partners over future years.

We will set out clearly who needs to do what and when in relation to workforce development planning and support organisations to develop the skills and capacity they may need.

![Figure 8: Key Roles and Responsibilities across the Health System](image)

In NHS South Central we will establish a Strategic Workforce Alliance (SWA) to provide leadership and advice on workforce development priorities. Figure 9, below sets out how this will work. The SWA will link to the DH planning system and in particular the Centre for Workforce Intelligence.
Education Commissioning plans will be established for a three year period, informed by the needs of employers, service commissioners, and current students. Demand and supply will be modelled based on future scenarios and data about the current workforce.

Education will be commissioned in response to workforce and financial plans, for example; some pre-registration student numbers may be reduced and the number of assistant/associate practitioners increased to support employer’s workforce re-profiling plans.

Training posts for post graduate medical specialities will also be reviewed. For example with an increase in non intervention techniques and a predicted national over supply of surgeons in training, the numbers of surgical specialty doctors may be reduced and re-investment made in new roles such as advanced nursing practice or converted to General Practitioners training posts.
## Making it Happen - Plan and Prepare – Manage the Change

<table>
<thead>
<tr>
<th>Pledge</th>
<th>Action</th>
<th>Time – frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Central SHA will</td>
<td>Work with commissioners and providers to implement an accountability framework for workforce development planning, setting out who should do what and by when.</td>
<td>By 2010/11</td>
</tr>
<tr>
<td></td>
<td>Use MPET(^{41}) flexibly and effectively to address agreed strategic education and training needs. Align education commissioning plans to service strategies and plans.</td>
<td>By 2011/12</td>
</tr>
<tr>
<td></td>
<td>Assure local health economy workforce development plans are aligned with finance, activity, leadership and informatics plans; and that NHS priorities will be delivered.</td>
<td>By 2010/11</td>
</tr>
<tr>
<td></td>
<td>Manage, with commissioners and trusts, disinvestment in medical training posts where there is projected over supply.(^{42})</td>
<td>By 2011/12</td>
</tr>
<tr>
<td>Commissioners will</td>
<td>Conduct an annual health economy workforce risk assessment. (DH Operating Framework 2009/10 guidance and, World Class Commissioning (WCC) Handbook Competency 10 level 2(^{43})).</td>
<td>By 2010/11</td>
</tr>
<tr>
<td></td>
<td>Work with providers to develop a system-wide (five-year) workforce development strategy and vision for the local health economy; identifying the key strategic health and social care workforce implications of commissioning (and decommissioning) strategies.(^{44})</td>
<td>By 2012/13</td>
</tr>
<tr>
<td></td>
<td>Assure the delivery of provider plans across the local health economy.(^{45}) Work with providers to seek assurance of the achievement of key government workforce policies and targets.(^{46})</td>
<td>By 2010/11</td>
</tr>
<tr>
<td>Service providers will</td>
<td>Integrate workforce plans into annual production/business plans (if not already, DH Operating Framework Guidance 2009/10).</td>
<td>By 2010/11</td>
</tr>
<tr>
<td></td>
<td>Develop and implement a plan to strategically restructure the workforce profile so patient services are sustainable and affordable.</td>
<td>2010-2015</td>
</tr>
<tr>
<td></td>
<td>Manage with the SHA/Deaneries planned disinvestment in medical training posts where there is projected over supply.</td>
<td>By 2012/13</td>
</tr>
<tr>
<td></td>
<td>Share workforce plans with commissioners as part of the annual iterative planning cycle.</td>
<td>By 2010/11</td>
</tr>
</tbody>
</table>

\(^{41}\) Multi Professional Training Levy – annual training and education funding to SHAs by DH

\(^{42}\) National Workforce Review Team, 2009/10 Assessment of Workforce Priorities

\(^{43}\) Perform risk analysis of, and manage, data on quality, access, patient feedback, operational workforce and workforce planning issues. WCC Handbook Competency 10 level 2,

\(^{44}\) Darzi A (2008). High Quality Care for All: NHS next stage review final report.

\(^{45}\) DH 2009/10 Operating Framework

Strategic Challenge 3: Integrate and Align: Design a Joint Future

We need to integrate and align our actions and take a system-wide perspective to the future workforce requirements in order to deliver the emerging service models and capitalise on workforce planning.

Commitment
We will work collaboratively on workforce planning and development at provider organisation level, between local PCT and local authority, and at regional level.

Key Issues
To respond to the scale of the financial and demographic challenge our workforce planning and workforce development need to expand flexibly beyond organisational boundaries.

We need to work together to develop joint strategies and joint spending plans to deliver better value. “Means to an End” sets out the rationale for joint financing of health and social care aiming to reduce duplication, eliminate gaps in services, achieve economies of scale and provision of more responsive services.

We need to plan the workforce that delivers care across local populations which means integrating workforce planning between PCTs and local authorities and other partners.

There are opportunities for consolidation of roles across health and social care that make more sense to patients and service users. There are also common local labour market concerns, where a joint approach would mean innovative solutions and working flexibly across traditional health and social care boundaries, instead of unconstructive competition.

Across health and social care we can align workforce development to changes that are already happening. These include:

- Transforming Community Services,
- PCT Collaborative Operating Model NHS South Central
- Development of category management for specific health conditions across PCTs in NHS South Central.
- “Total Place” - the local authority pilot work that looks holistically at the public funding across agencies in a local area and how effectively that is being used.

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47 Audit Commission Oct 2009 “Means to an End Joint Financing across health and social care”
48 Audit Commission Dec 2009 “One Place” Comprehensive Area Assessment
49 Total Place - http://www.localleadership.gov.uk/totalplace/
For example the mental health clinical care area workforce report\textsuperscript{50} highlights flexible working to bridge service transition points for service users. The long term conditions clinical care area workforce report\textsuperscript{51} focuses on developing skills for integrated health and social care roles.

To achieve this provider organisations, including GP practices, the third sector and independent sector, need to work collaboratively to ensure staff have the skills and competencies to deliver care across sectors and along the patients’ pathway. It is also critical that we ensure that changes made in one part of the system do not just shift costs from one area to another, resulting in no net benefit overall to public services.

It is critical that our staff have the right knowledge, skills and attitudes appropriate for each and every role across our services and these are transferrable across all health and social care sectors as care pathways develop.

South Central SHA will work in partnership with the Government Office of the South East (GOSE), the Learning and Skills Council, Skills for Health, Skills for Care, South East England Development Agency (SEEDA) and other regional bodies to create innovative and responsive joined up plans. In particular this strategy is aligned with the South East Skills for Health sector skills strategy and action plan.\textsuperscript{52}

Education commissioning decisions will be underpinned by partnership working with a variety of agencies; in particular education commissioning decisions to support the un-registered workforce.

\textbf{Reserved}

\textit{Example of Best Practice from a Clinical Care Pathway Group
(see Appendix 3 for case studies)}

\textsuperscript{50} Mental health clinical care area report – to be published as a supporting document to this strategy. \url{www.nesc.nhs.uk/about_nesc/workforce_strategy.aspx}

\textsuperscript{51} Long term conditions clinical care area report – to be published as a supporting document to this strategy. \url{www.nesc.nhs.uk/about_nesc/workforce_strategy.aspx}

\textsuperscript{52} Skills for Health South East, Health Sector Skills Strategy consultation Nov 2009
### Making it Happen – Integrate and Align: Design a Joint Future

<table>
<thead>
<tr>
<th>Pledge</th>
<th>Action</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>South Central SHA will</td>
<td>Set up a regional strategic workforce alliance to assure and challenge SHA workforce investment plans and make recommendations to SHA Board.</td>
<td>By 2010/11</td>
</tr>
<tr>
<td></td>
<td>Work with higher education providers and regional partners (such as Skills for Health, the Learning and Skills Council, Jobcentre Plus) on the implementation and achievement of key government workforce policies and targets and on joint workforce and education strategies.</td>
<td>2011 – 2015</td>
</tr>
<tr>
<td></td>
<td>Produce a joint implementation plan with Skills for Health sector skills strategy that reflects local health and social care priorities.</td>
<td>By 2011/12</td>
</tr>
<tr>
<td></td>
<td>Lead local health economy workforce planning for two years whilst allowing PCTs the opportunity to develop their own workforce planning capability with a view to taking this on by 2012.</td>
<td>2010/11</td>
</tr>
<tr>
<td>Commissioners will</td>
<td>Develop joint strategic workforce plans with local authorities and social care based on strategic needs assessment. (Comprehensive Area Assessment Audit Commission).</td>
<td>By 2012/13</td>
</tr>
<tr>
<td></td>
<td>To work collaboratively with other PCTs and local providers to develop shared improvement goals and cross-boundary working and to introduce key workforce metrics to drive quality improvement.</td>
<td>By 2011/12</td>
</tr>
<tr>
<td>Service providers will</td>
<td>Develop joint roles/teams that integrate health and social care where appropriate.</td>
<td>2010 onwards</td>
</tr>
<tr>
<td></td>
<td>Tackle the barriers that prevent integrated working between health, social care, third sector, community and primary care i.e. local policies and contracts</td>
<td>2011/12</td>
</tr>
<tr>
<td></td>
<td>Agree a system with other local employers to enable redeployment of people and joint recruitment initiatives to enable service change and respond to local labour market conditions.</td>
<td>2011 – 2013</td>
</tr>
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53 Skills for Health South East, Health Sector Skills Strategy consultation Nov 2009
Strategic Challenge 4: Tighten up Business: Drive up Quality and Value

We need to implement excellent human resource management across all health sector employers in order to ensure value for money, drive up quality and improve patient safety.

Commitment

We will develop the right people and skills, build a healthy and productive workforce and implement excellent management of our people across all health sector employers.

Key Issues

60 – 70% of health care spending in NHS South Central is spent on workforce costs, and around £300m is invested annually in the education of the current and future workforce. Shaping the Future and the NHS South Central QIPP Framework\textsuperscript{55} aim to drive out waste in processes and systems, and reduce variation across NHS South Central. Workforce efficiency and productivity is a key element in delivering this.

Excellent management of the workforce is essential in driving high quality employment practices and ensuring a positive focus on productivity, with an emphasis on staff engagement, health and well being of staff and developing capable teams and effective working practices.

Measuring productivity of individuals, teams and services is not straightforward. Value for money is the ratio of valued health system outputs to the associated expenditure\textsuperscript{56} and the work done (including that of non front-line support staff). Crucially, in healthcare this needs to be understood in relation to the patient outcomes that result, and the overall cost of the service.

The aim is to achieve more and improved patient care, at lower costs\textsuperscript{57}. Redesigning patient care processes is critical to achieving this. It is essential that process and system improvements are aligned with new ways of working for staff and implementation of more cost effective solutions such as role extension and role substitution. (see Challenge 5).

For the past three years our staff costs have increased whilst there has been no overall change to the relative skill mix across the health care professions, this is unsustainable. Working with relatively less staff to deliver improved services will need a reassessment of the numbers and skills of our staff to ensure that our services remain affordable yet continue to deliver high quality and safe patient care. New ways of working will mean increasing the number of highly competent support staff and ensuring the efficient use of expert clinical staff in selected areas of practice.

Workforce productivity is currently measured through the following input metrics (data): sickness absence, agency usage, turnover levels, vacancy data, recruitment data, equality indices, retention rates, team skill mix and average labour costs. Significant variation exists in these measures of performance across NHS South Central providers.

\textsuperscript{55} NHS SC QIPP Framework to be issued Feb 2010
\textsuperscript{56} Smith P.C. Sept 2009 “Measuring Value for Money in healthcare” University of York
\textsuperscript{57} NHS SC QIPP Framework to be issued Feb 2010
These metrics can be benchmarked nationally against similar provider organisations to identify opportunities for improvement and against other employers, to support organisations in becoming the best. (Supporting Document 1).

NHS providers will need to ensure they have in place data quality standards for the electronic staff record (ESR) from which many of these metrics are derived.

**Sickness and Absence Rates**

The NHS Constitution says that employers should provide support and opportunities for staff to maintain their health, well-being and safety.

The case for improving the health and well-being of staff is set out in the Boorman report\(^{58}\). The report emphasises the benefits to staff of taking responsibility for their own health and well being and becoming exemplars for patients, as well as the benefits for employers and organisations who can improve efficiency and decrease waste. Line managers have a critical role to play in implementing these recommendations.

The Boorman\(^{59}\) report says that 10.3 million working days, or equivalent to 45,000 full time equivalent (ftes) are lost due to absence every year in the NHS. The cost of this is £1.76bn. If the worst organisations can improve to the level of the best 3.4 million days could be gained and a saving of £555m made.

Sickness absence rates in NHS South Central have fallen over the past two years and organisations are actively managing sickness absence. The benchmark for sickness absence in NHS South Central is 4%. The sickness absence rates from April to September 2009 show that absence rates in NHS employers range from 3.06% to 4.7% (Figure 10).

![Figure 10: Range of sickness absence rates in NHS Trusts, April – September 2009](image)

In NHS South Central a reduction of 1% in sickness absence in theory could equate to as much as £27.5m saving.

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Agency Spending

Agency usage in non-foundation acute trusts in NHS South Central ranges from 2% to 4.5% (Fig 12). At November 2009, in non-foundation trusts, the combined agency cost rate was 3.8% or (as a percentage of total pay bill) £50.1m (Fig 11).

Figure 11: Agency Cost Rate 2009 NHS South Central Non Foundation Trusts, November 2009

Figure 12: Range of Agency Spend Acute Trusts NHS South Central November 2009

Average Labour Costs

The average labour costs (total earnings plus 25% on costs) have risen significantly across NHS South Central over the past three years. Average labour costs vary across NHS employers. Organisations should undertake a value for money and comparative analysis, in relation to patient outcomes, and category management to challenge comparative value for money of different services.

Figure 13 shows the approximate increase in average pay costs of staff employed in NHS Trusts in NHS South Central from September 2007 to June 2009. The approximate average pay cost (total earnings plus 25% on costs) has risen from £37,625 (Sept 2007) to £41,750 (June 2009).

However, we know that productivity has not risen during this period and the benefits of introducing new pay reforms, agenda for change, the new Consultant contract and the GP contract, need to be realised.
Nationally between 2000 and 2006 there has been an estimated drop in productivity of 2.5% (or 2% if quality improvements are taken into account). However the recent Audit Commission briefing “More for Less” says that Trusts seem to be taking the first steps to increasing productivity - unit costs for inpatient care fell in 2007/08 and have held steady in 2008/09.

![Figure 13: NHS SC Average Staff Costs 2007 – 2009](image)

**Turnover**

Staff turnover incurs costs related to recruitment, training and reduced productivity. It is estimated nationally that each 1% reduction in turnover saves 1% on pay bill in cash and efficiency costs. The turnover range in NHS South Central is 6.6% to 18.9%. A 1% reduction in turnover in NHS South Central in theory could therefore equate to a potential £28m efficiency saving.

The benchmark for NHS South Central is 15% which is based on the Chartered Institute for Personnel Development who quote national annual turnover as 15.7% across all sectors or 11.4% (all leavers) in the health sector.

![Figure 14: NHS Non Foundation Trusts Turnover range November 2009](image)

Managing our human resources effectively does bring significant cost benefits, and if done well, (Strategic Challenge 1) will also result in a workforce who are engaged, proactive and not frustrated by the inefficiencies of the system(s) within which they work.

**Skill Mix**

There is scope within all organisations for re-profiling the workforce so that overall labour costs are reduced. For instance a reduction of 5% (or 728ftes) Band 5 workforce reduces costs by approximately £21m across NHS South Central. An increase of the same number of staff at Band 4 costs approximately £17m. Similarly

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60 Smith P.C. Sept 2009 Measuring Value for Money in healthcare University of York
61 Audit Commission Nov 2009 “More for Less”
62 DH Productivity metrics 2006/7
63 CIPD http://www.cipd.co.uk/default.cipd
a reduction of 5% (232 ftes) Band 8 workforce saves approximately £17m whilst an increase of 232 ftes at Band 6 costs approximately £8.5m.

Skill mix change is also part of Strategic Challenge 5 which focuses on developing a more flexible workforce and the need for provider organisations to re-profile their workforces at local service level to address the financial and productivity challenges.

Implementing skill-mix initiatives will, in some cases, require a profound system reconfiguration and may not be realised in the short-term. However, the benefits of their implementation will lead to greater efficiencies while delivering improvements in quality and patient safety well into the future. Fundamental changes in service delivery will need to be based on sound analysis and comparison of various workforce skill mix profiles and the levels of activity they deliver. The local applicability of the more productive configurations can then be assessed.

In relation to value for money a further benchmark between organisations is their relative spend on management costs, management consultancy, administrative support and front line clinical services.

Management and back office staff, as they are currently configured, will be unaffordable in the future. As patient care is our priority we must consider making efficiency savings in this area in order to secure as much funding as possible is directed towards front line services.

The proportion of staff in administrative, management, and estate management roles varies across organisations in NHS South Central from 10% to 33% of total staff\(^{64}\). In the majority of trusts the current ratio is around one non clinical to every four to five clinical staff. Further analysis on the relative costs of the different staff profiles will be carried out as part of the SHA productivity benchmarking and Shaping the Future.\(^{65}\)

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\(^{64}\) Regional Data Warehouse September 2009

\(^{65}\) NHS SC Shaping the Future – the Quality and Productivity Challenge Framework
## Making it Happen: Tighten up Business, Drive up Quality and Value

<table>
<thead>
<tr>
<th>Pledge</th>
<th>Action</th>
<th>Time-frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>South Central SHA will</strong></td>
<td>Ensure implementation of the recommendations of the “NHS Health and Well Being Review” Boorman 2009.</td>
<td>By 2012/13</td>
</tr>
<tr>
<td></td>
<td>Develop top 5 workforce productivity metrics as part of the NHS SC QIPP framework.</td>
<td>2010/11</td>
</tr>
<tr>
<td></td>
<td>Provide benchmarking and best practice data, including the assessment of skill mix initiatives, measure and challenge variation in workforce productivity.</td>
<td>2010 - 15</td>
</tr>
<tr>
<td></td>
<td>Set and performance-manage contracts in collaboration with higher education institutions and providers for basic and post-basic education, to include value for money quality assurance and fitness for purpose.</td>
<td>By 2010/11</td>
</tr>
<tr>
<td><strong>Commissioners will</strong></td>
<td>Challenge variation in provider performance, including differences in workforce costs. (Ensuring efficiency and effectiveness of spend World Class Commissioning Handbook 66: Competency 11.)</td>
<td>By 2011/12</td>
</tr>
<tr>
<td></td>
<td>Manage relationships and contracts with providers to ensure delivery of high quality services and value for money. Work closely with providers to sustain and improve provision, and engage in constructive performance discussions to ensure continuous improvement. Data should support key performance indicators across all domains (e.g. quality, access, workforce) 67</td>
<td>By 2011/12</td>
</tr>
<tr>
<td></td>
<td>Commission services from providers that are demonstrably committed to improving staff health and well being, building this into future contracts. (“NHS Health and Well Being Review” Boorman 2009 p.34).</td>
<td>By 2011/12</td>
</tr>
<tr>
<td><strong>Service providers will</strong></td>
<td>Provide support and opportunities for staff to maintain their health, well-being and safety (NHS Constitution).</td>
<td>2010-2012</td>
</tr>
<tr>
<td></td>
<td>Provide staff health and well being services centred on prevention and aligned with public health policy. (“NHS Health and Well Being Review” Boorman 2009.)</td>
<td>By 2012/13</td>
</tr>
<tr>
<td></td>
<td>Ensure that staff are empowered to utilise their skills and knowledge to maximise the quality and productivity of the services they provide.</td>
<td>2010-15</td>
</tr>
<tr>
<td></td>
<td>Address variation in workforce productivity metrics – targeting and managing sickness absence, agency spending, turnover levels, and labour costs.</td>
<td>2010-15</td>
</tr>
<tr>
<td><strong>Staff will</strong></td>
<td>Play their part in sustainably improving services by working in partnership with patients, the public and communities; (NHS Constitution Responsibility)</td>
<td>2010-15</td>
</tr>
<tr>
<td></td>
<td>Take up training and development opportunities provided over and above those legally required of their post; (NHS Constitution responsibility).</td>
<td>2010-15</td>
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66DH Sept 2009 World Class Commissioning Assurance Handbook Yr 2  
67 DH Sept 2009 World Class Commissioning Competency 10 level 3
Strategic Challenge 5: Step up Flexibility, Develop the Workforce

To develop a more flexible workforce\(^{68}\) that can assimilate new skills rapidly and work in innovative ways to deliver the clinical care pathway\(^{69}\) improvement programmes across NHS SC and support the transition to community services and care closer to home.

**Commitment**

We will develop the knowledge and skills in the workforce needed by commissioners and provider organisations, supported by excellent clinical placements and training, and working across traditional boundaries.

**Key Issues**

To deliver the priorities identified in the NHS SC clinical care group improvement programmes the existing workforce (including support staff) will need to engage in focused skills development. Our staff deserve the best education possible if they are to provide outstanding care and adapt to these new ways of working.

This will include ensuring that non-specialist staff possess skills in promoting staying healthy\(^{70}\), end of life care skills\(^{71}\), the promotion of positive mental health, learning disability skills, and motivational skills.

Newly qualified practitioners should enter the workforce with the above skills and knowledge, and education providers will incorporate an agreed range of “generic” skills into curricula. In addition, newly qualified practitioners whether working in the acute or primary care setting need highly defined acuity skills with the ability to recognise the deteriorating patient. These skills and competencies will be embedded within all pre-registration programmes which will follow the patient journey, including in the primary and community care setting.

Redesign of clinical care pathways will result in extended and new roles that are better for patients and make best use of staff skills and time. This means we need to invest in improving the quality of our staff, engendering a more flexible approach to roles, more multi skilled staff who can focus on patient need and highly competent support staff who contribute to efficient running of services and “free up time to care”. An education programme to support the generic associate/assistant practitioner role will commence in 2010/11 and this work will be developed further with employers.

In addition, the expansion of maternity support workers and skill mix in neonatal services are highlighted in the Maternity and Newborn Clinical Care Area workforce report\(^{72}\). The Children, Young People and Families Workforce Report\(^{73}\) highlights

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\(^{68}\) Workforce means all health sector work force irrespective of role, grade or profession.

\(^{69}\) NHS SC 2008 Towards a Healthier Future, Next Stage Review

\(^{70}\) Staying Healthy Clinical Care Area Workforce Report NHS SC all at : [www.nesc.nhs.uk/about_nesc/workforce_strategy.aspx](http://www.nesc.nhs.uk/about_nesc/workforce_strategy.aspx)

\(^{71}\) End of Life Care Area Workforce Report NHS SC

\(^{72}\) Maternity and New Born Clinical Care Area Workforce Report NHS SC

\(^{73}\) Children, Young People and Families Clinical Care Area Report NHS SC
opportunities for skill mix review in Children’s’ Services such as health visiting, school nursing and speech and language therapy.

All organisations should look at skills and skill mix and plan to re-profile their workforces to maximise the use of health care support workers, apprentices and assistant/associate practitioners (Strategic Challenge 4). We should be prepared to tackle issues with inter professional team working, and encourage professionals to cross traditional practice boundaries where this improves patient care and responsiveness.

Different skills are needed to work in different settings; increasingly primary care and community staff74 will need to provide supervisory support for wider networks of staff, not just line management for a local team.

Current contracts and arrangements mean that it is not currently easy for staff to move between care settings or across organisational boundaries. Highly specialist clinical staff75 may need to work across organisations and rotas to provide the specialist element of care and new employment models need to support this.

Other enablers are, conversion courses for staff moving from an acute setting to a community one such as the “Community Up skilling Programme”76 commissioned from Oxford Brookes and Bournemouth Universities and education that supports working in virtual teams and networks.

Health innovation and education clusters (HIECS) are formal partnerships between NHS organisations, the higher Education sector, industry and other public and private sector organisations. They promote innovation in healthcare and can co-ordinate and provide professional education and training. The two HIECs in NHS South Central will be developed in collaboration with partners over the next five years.

Systematic promotion of innovation will be a key performance indicator of every education contract and innovation apparent through every stage of the education commissioning process.

There are opportunities for staff to have rewarding and varied careers in health care and national initiatives such as Modernising Nursing Careers77, AHPs and Scientists are tackling both the development of highly skilled registered staff as well as the competences of staff that provide the foundations of care at bands 2-4.

The NHS Constitution78 says that all staff should be provided with personal development, access to appropriate training for their jobs and line management support to succeed.

Educational pathways need to support the principle of life long learning, have flexible entry and exit routes and, as education commissioners, South Central SHA needs to be able to commission high quality educational programmes that meet service demands.

Skills development will also be linked to the use of new technology in patient care and use of IT to support systems and processes, as well as the use of simulation and technology in training staff.

74 Long Term Conditions Clinical Care Area Workforce Report NHS SC
75 Acute Care Area Workforce Report NHS SC
76 [www.nesc.nhs.uk/about_nesc/workforce_strategy.aspx](http://www.nesc.nhs.uk/about_nesc/workforce_strategy.aspx)
77 NHS SC 2009 Making Quality Personal - Nursing Strategy
78 DH Jan 2009 NHS Constitution for England
Finally, carers of patients, who may not be thought of as part of the workforce, but do provide significant amounts of care for individual patients, need to have the skills and knowledge to do this effectively and safely. (This is referred to previously in Strategic Challenge 1).

**Making it Happen - Step up Flexibility; Develop the Workforce**

<table>
<thead>
<tr>
<th>Pledge</th>
<th>Action</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td><strong>South Central SHA will</strong></td>
<td>Work with higher education providers(^{79}) and employers to commission the right education and training packages.</td>
<td>2010 - 15</td>
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<tr>
<td></td>
<td>Influence and engage with professional bodies and regulators to reduce barriers to new ways of working.</td>
<td>By 2011/12</td>
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<td><strong>Commissioners will</strong></td>
<td>Ensure service specifications and contracts enable team working across organisational boundaries.</td>
<td>2012 - 13</td>
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<td></td>
<td>Identify the impact of pathway redesign on workforce skills and competencies with providers and education commissioners. Apply improvement techniques in service or pathway redesign and, understand the implications on provider quality, productivity and workforce. (WCC Handbook Competency 8, level 2).(^{80})</td>
<td>2012 - 13</td>
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<td></td>
<td>Ensure the provision of education training placements is an integral part of standard contracted provider services.</td>
<td>By 2010/11</td>
</tr>
<tr>
<td><strong>Providers Will</strong></td>
<td>Re-profile the local workforce to ensure the most effective use of skill mix. Maximise the roles and opportunities for staff at Bands 1 – 4.</td>
<td>2010-15</td>
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<tr>
<td></td>
<td>Ensure that all staff have access to personal development, and appropriate training for their jobs and line management support to succeed. (NHS Constitution).(^{81})</td>
<td>By 2010/11</td>
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<td></td>
<td>Retrain staff to support changes to service delivery and respond to service demand.</td>
<td>2012-15</td>
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<td></td>
<td>Contribute to the curriculum design of education and training programmes.</td>
<td>2010-15</td>
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<td></td>
<td>Maintain their obligation to provide high quality education and training placements as set out in Learning Development Agreements.</td>
<td>2010-15</td>
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<td></td>
<td>Work to develop new partnership models with education providers e.g. Health Innovation Education Clusters (HIEC).</td>
<td>2010-15</td>
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<td></td>
<td>Develop employment models that facilitate cross organisational working.</td>
<td>2012-15</td>
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</table>

\(^{79}\) Higher Education Institutions, Further Education and other education providers

\(^{80}\) DH Sept 2009 World Class Commissioning Assurance Handbook Yr 2

\(^{81}\) DH Jan 2009 NHS Constitution for England
Strategic Challenge 6 – Be Accountable: Focus Leadership

We need a culture of accountability at all levels, and leadership that is focussed on delivering the best healthcare system in the world, in order to deliver service change.

Commitment
We will ensure improved health and well being of the workforce, resulting in measureable quality and productivity improvements by developing a culture of accountability at all levels. We will also ensure excellent management and leadership in workforce development and workforce planning to support system-wide change.

Key Issues
All staff, but particularly leaders, are accountable for the effective use of resources and for encouraging collaboration across the health and social care sectors, with the aim of improving patient care.

Clinical and other leaders, at all levels, need to be relentless in their drive for improvement. We will demonstrate our commitment to change by leading by example. For instance in supporting national pay restraint across the public sector, embracing innovative ways of working, and promoting the development of staff skills and competencies which are not constrained by professional demarcations.

Line managers need to be enabled to structure teams around patient care pathways and to produce real time outcome data. Line managers make a huge difference to effective team working and to staffs’ motivation to do well and sense of belonging.

The NHS Constitution 82 says that all staff should be provided with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities. Increasingly staff satisfaction is being used as a lead indicator for patient satisfaction and there is evidence that effective team working directly impacts outcomes for patients. 83

Reserved to highlight specific achievable

Leaders should model the behaviours and culture that patients expect, Clinical staff in particular are key in leading and sustaining change in healthcare systems that can improve both quality and productivity.

Managers and leaders also need different skills and competencies, such as commissioning/decommissioning skills, change management, procurement and tendering skills, business planning, productivity measurement and market management. 84 The ability to understand the impact of service changes, manage financial constraints and mitigate the associated workforce risks is critical.

82 DH Jan 2009 NHS Constitution for England
83 Ref Prof M West Aston University
Leadership is a strategic theme through all education commissioned programmes. A focus for 10/11 is service improvement and education providers will work closely with employers to find opportunities for students to learn from working on service improvement projects.

The SHA, commissioners and providers (including their Boards) should require regular reports and data to provide evidence of workforce performance and productivity that enable members to assure service quality and patient safety and develop their understanding of workforce development as an enabler of service change.

Reserved

Example of Best Practice from a Clinical Care Pathway Group
(see Appendix 3 for case studies)
## Making it Happen - Be Accountable: Focus Leadership

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<tr>
<th>Pledge</th>
<th>Action</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>South Central SHA will</td>
<td>Regularly report workforce issues and risks at SHA Board level.</td>
<td>By 2010/11</td>
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<tr>
<td></td>
<td>Invest in the development of leaders at all levels.</td>
<td>2010-15</td>
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<td></td>
<td>Develop and equip leaders and managers to recognise the link between staff health and well being and organisational performance. (NHS Health and Well Being Review” Boorman 2009 p9).</td>
<td>By 2011/12</td>
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<tr>
<td>Commissioners will</td>
<td>Regularly consider local health economy workforce risks at PCT Board.</td>
<td>By 2010/11</td>
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<td></td>
<td>Develop excellent management and leadership in workforce development and workforce planning to support system-wide change.</td>
<td>By 2010/11</td>
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<td></td>
<td>Understand and plan for the workforce implications when decommissioning, or commissioning services.</td>
<td>2010-15</td>
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<tr>
<td>Service providers will</td>
<td>Regularly consider and act on workforce issues and risks at trust Board level.</td>
<td>By 2010/11</td>
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<tr>
<td></td>
<td>Develop excellent management and leadership in workforce development and workforce planning to support system-wide change.</td>
<td>By 2010/11</td>
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<td></td>
<td>Invest in and empower leaders and line managers.</td>
<td>2010-15</td>
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<tr>
<td></td>
<td>Ensure that all staff have clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities. (NHS Constitution).</td>
<td>2011 – 13</td>
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<tr>
<td></td>
<td>Facilitate and enable teams to be structured around patient pathways. (A High Quality Workforce)(^{85})</td>
<td>2012 – 13</td>
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<td></td>
<td>Develop new ways of working across traditional boundaries.</td>
<td>2012-2014</td>
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<tr>
<td></td>
<td>Develop and equip leaders and managers to recognise the link between staff health and well being and organisational performance. (NHS Health and Well Being Review” Boorman 2009 p9).</td>
<td>By 2011/12</td>
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\(^{85}\) DH June 2008 A High Quality Workforce – next stage review
Our Commitments - In the next five years we will;

1. **Ensure best value for money for patients and taxpayers from the workforce.** (Strategic Challenge 4, and 5)
   
   by developing the right people and skills, and by implementing excellent management of our people, across all health sector employers.

2. **Actively plan the workforce and prepare intelligently to respond to the challenge and scale of both the forecast increase in demand for healthcare services, and the reduction in spending on public services.** (Strategic Challenge 2 and 3)
   
   By working in partnership with the broader health and social care community to deliver this strategy. Developing a clear infrastructure that connects the different planning cycles and clearly sets out roles and responsibilities. We will also work to align individual staff development to organisational business plans, commissioning strategies, and regional strategic plans.

3. **Develop a more flexible workforce** that can assimilate new skills rapidly and work in innovative ways to deliver the clinical care pathway improvement programmes and support the transition to community and home services. (Strategic Challenge 5 and 1)
   
   by developing the knowledge and skills demanded by commissioners and provider organisations, supported by excellent clinical placements, training, and working across traditional boundaries.

4. **Integrate and align our actions and take a system-wide perspective to future workforce requirements in order to deliver the emerging service models and capitalise on workforce planning.** (Strategic Challenge 3 and 2)
   
   by working collaboratively on workforce planning and development at provider organisation level, between local PCT and local authority, and at regional level.

5. **Support new ways of working and planning to ensure the workforce are fit for purpose and meet employers and public demands/expectations.** (Strategic Challenge 5 and 6).
   
   by implementing modernising health careers (medical, nursing, health care scientists and allied health

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86 Staff means all health sector workforce irrespective of role, grade or profession.
87 SC SHA 2008 Towards a Healthier Future, NHS SC Next Stage Review
professionals) and by ensuring excellent management and leadership in workforce development and workforce planning to support system-wide change.

6. **Ensure organisations fulfil their commitments in the skills pledge**\(^{88}\) (Strategic Challenge 1 and 5)  

   by each organisation in NHS SC signing the skills pledge and supporting staff to achieve a level 2 qualification (i.e. NVQ or similar).

7. **Work with and engage the public**\(^{89}\) (patients, service users, clients, carers and the general public) more fully, in workforce development and education of our staff (Strategic Challenge 1)  

   by ensuring that public opinion and patient views are represented and used to drive and develop excellent education and training.

8. **Ensure high quality education meets the needs of our staff irrespective of grade, role or seniority.** (Strategic Challenge 1 and 5)  

   by ensuring we implement world class education commissioning and meet the commitments of the NHS Constitution\(^{90}\).

9. **Meet the pledges in the NHS Constitution**\(^{91}\) to staff, and ensure our staff meet their responsibilities to patients, public and colleagues. (Strategic Challenge 1 and 4)  

   by the SHA, commissioners and providers working collaboratively to support the educational needs of our staff.

10. **Ensure improved health and well being of the workforce, resulting in measurable quality and productivity improvements.** (Strategic Challenge 4 and 6)  

    by developing a culture of accountability at all levels, excellent management and leadership that is focussed on delivering the best health care system in the world.

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\(^{88}\) HM Government, 2007 Skills Pledge - A Letter to Employers  
\(^{89}\) Public is patients, users of services, carers, clients, general public.  
\(^{90}\) DH Jan 2009 The NHS Constitution for England
<table>
<thead>
<tr>
<th>Benefits of Getting it Right</th>
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<tr>
<td><strong>Quality</strong></td>
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<tr>
<td>Improved patient care delivered efficiently and seamlessly</td>
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<td>Improved patient satisfaction and safety</td>
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<td>Appropriately trained staff with the skills and knowledge to deliver high quality care.</td>
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<tr>
<td>Engaged staff delivering better quality care.</td>
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<tr>
<td>Roles and services are designed around the actual needs of patients.</td>
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<td>Improved morale and happier, more motivated staff.</td>
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<td><strong>Innovation</strong></td>
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<tr>
<td>Harnessing of the workforce to make required service changes</td>
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<tr>
<td>Workforce solutions that support delivery of Shaping the Future and transformational change</td>
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<tr>
<td>Spread of best practice in people management, skill mix and new ways of working.</td>
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<tr>
<td>New roles and ways of working to deliver care for patient pathways and to support service improvement</td>
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<tr>
<td><strong>Productivity</strong></td>
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<tr>
<td>Better for patients and tax payers as the same or improved patient outcomes are delivered for less cost.</td>
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<tr>
<td>Better value for money from commissioned education.</td>
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<tr>
<td>A balance between short term imperatives and long term workforce planning solutions that are sustainable.</td>
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<tr>
<td>Engaged staff deliver better quality of care</td>
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<tr>
<td>Productive and effective team working</td>
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<tr>
<td><strong>Prevention</strong></td>
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<tr>
<td>The Public as partners in their own care and lifestyle choices</td>
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<tr>
<td>A system wide approach to workforce development planning across health and social care.</td>
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<tr>
<td>Workforce skills and availability match demand</td>
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<tr>
<td>Wider workforce trained to promote staying healthy</td>
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Appendix 1: Six South Central SHA Priorities

More detail to be added prior to publication
Appendix 2: Clinical Care Areas Workforce Priorities

In NHS South Central, following the publication of “Towards a Healthier Future”, Clinical Directors for each of the eight clinical care areas\(^{92}\), have been appointed to drive clinical improvement programmes that focus on key areas of service transformation.

There are also two enabling programmes – Strategy and Reform, and Information Management and Technology.

Fig 1: NHS Next Stage Review “Our NHS Our Future” 8 Clinical Pathway Groups

The interim Care Area workforce reports are available on the SHA website [nesc.nhs.uk/about_nesc/workforce_strategy.aspx](nesc.nhs.uk/about_nesc/workforce_strategy.aspx) they give an overview of the current workforce issues and workforce development priorities in each care area.

They cover both the workforce changes needed to ensure successful delivery of the clinical improvement programmes, and also the wider workforce issues in that care area.

The opportunities for quality and productivity service changes for each clinical pathway are summarised below, and when these are confirmed and further defined, the implementation plan for the strategy will include the actions that need to be taken to deliver the workforce changes that will support these priorities.

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\(^{92}\) NHS Next Stage Review, Our NHS Our Future
Opportunities for quality and productivity in the clinical pathways

**PLANNED CARE**

- Decommissioning of cosmetic and limited benefit procedures
- Enabling patients to make informed choices which help reduce unnecessary elective procedures – decision aids in SW England reduce hysterectomy rates by 20%
- Redesigning pathways for individual specialities such as musculoskeletal services
- Re-tender services which do not require full acute infrastructure – Liverpool reduced dermatology referrals by 90% by offering multidisciplinary clinics.
- Actively review all GP referrals

**LONG TERM CONDITIONS**

- Commission best-practice map of medicine/pathway interventions – redesigning community-based chronic obstructive pulmonary disease care in Manchester resulted in admission avoidance of at least 20% of non-elective inpatients
- Actively monitor patient lists electronically at regional, PCT and practice-level to aid case management
- Performance manage and incentivise groups of providers.

**END OF LIFE**

- Identify people nearing EOL and plan ahead
- Provide single point of access/key professional to co-ordinate care; accelerated discharge; palliative home care plan and home care nurses to enable more patients to die at home
- Enhance community care by tendering EOL services – Marie Curie Cancer Care won competitive tender for Lincs PCT
- Increase public awareness of out-of-hospital EOL care.
MENTAL HEALTH

- Optimise contracts and care packages – this has saved Northants PCT £11 - £22 million
- Improve dementia care in general hospitals
- Reduce out-of-area mental health placements
- Implement mental health liaison services to pre-emptively identify people with mental illness or drug/alcohol problems
- Establish a primary care mental health service to reduce inappropriate admissions.

MATERNITY AND NEWBORN

- Reduce the number of pregnant women being admitted to hospital by increasing community care
- Reduce the need for GP consultations through direct referral of women to midwives
- Reduce the number of Caesarean sections
- Reduce unnecessary neo-natal admissions
- Reconfigure services to enable safe and affordable future care

STAYING HEALTHY

- Implement NHS Health Checks across the whole SHA
- Reduce smoking
- Deliver high impact changes in alcohol advice and guidance
- Implement a fall prevention programme – Ipswich Hospital reduced fall rates by 68% in three months
- Increase breast feeding rates through campaign aimed at helping staff understand the rationale.
CHILDREN AND YOUNG PEOPLE

- Improve access to urgent care outside of hospital – Bury and Rochdale reduced numbers of children visiting doctors and hospital admissions through home visits
- Set clear standards for referrals and admissions
- Improve non-urgent out-of-hospital care – Asthma UK says more than 75% of hospital admissions due to asthma exacerbations are avoidable
- Consolidate services for children outside of hospital.

ACUTE CARE

- 12x7 primary care access to reduce A&E attendances – Hammersmith GPs see and treat 60% of attending patients
- Redesign ambulance delivery protocols so A&E is not default destination – London AS will deliver 200k fewer patients to A&E by 2013
- GP and nurse-led urgent care e.g. screening patients before arrival at A&E
- Nurse-led programmes to educate staff caring for long-term residents in nursing/residential homes.
Appendix 3:
Case Studies Linked to Strategic Challenges and Clinical Pathways

The following case studies will be incorporated into the main body of the strategy in the spaces indicated once it formatted for printing and are given here for information and to provide examples of best practice.

Case Study: Patients Train to be Mentors

Strategic Challenge 1: Share the journey: Engage Patients, Carers and Staff
Clinical Pathway: Long Term Conditions

Patients with long-term conditions are receiving training to act as mentors to students on a new two-year degree course.

The Health and Social Care Foundation Degree: Long-term Conditions Pathway enables patients with conditions such as diabetes and coronary heart disease to mentor to the students. The aim is that the mentors will increase the students’ understanding of what it is like to live with ongoing health issues.

“I might ask my service user mentor what they think about something or the way things are going. They talk to me personally about their condition and what that means for them,” said one student.

The initiative is supported by the Expert Patients Programme Community Interest Company, which recruits, trains and supports the service user mentors. Volunteers attend a six-week expert patient programme course and a two-day mentor skills preparation training course. The foundation degree is primarily targeted at healthcare assistants and other Band 3 NHS staff. The patient mentors complement other support for the students such as their academic mentors and practice supervisors.

Emma Wilton, Widening Participation Manager, said: “By adopting such an innovative method to educate and train our workforce we will grow of staff in Bands 1 to 4 who have an insightful, accurate understanding of the needs of our patients.”

Service User Mentors are supporting students studying at University of Southampton and Thames Valley University.
Case Study: Health Trainers
Strategic Challenge 2: Plan and Prepare – Manage the Change
Clinical Pathway: Staying Healthy

Members of the public are being trained as health trainers in an innovative scheme to help people live healthier lives. Health trainers work with individuals to help them meet their personal health goals whether that is to stop smoking, take up exercise or change their diet.

Health trainers must come from the local communities they serve and work where people can easily find them: at the local pharmacy, in community groups, or in GP surgeries for example. One Health Trainer scheme between Portsmouth PCT and the Hampshire Probation Service has received national recognition. Ex-offenders are trained as health trainers to give advice, information and support to other ex-offenders.

“Our health trainers are familiar with their clients’ problems: trouble with the law, probation, addiction, chaotic lifestyles,” said Brian Leigh at Hampshire Probation Service. “We have tailored the training following a survey of attendees at Portsmouth probation service and the major needs outlined were around drugs, alcohol, mental health and smoking.”

The scheme started as a pilot in 2007 and now receives over 100 referrals every month and involves 13 qualified health trainers. Careful selection of the health trainers has been key to the success and evidenced by the low drop-out rate, particularly for a group recruited from a socially challenging background. The benefits are extensive both for the health trainers, their clients and the NHS.

Case Study: Oxfordshire Workforce Development Collaborative
Strategic Challenge 3: Integrate and Align: Design a Joint Future
Clinical Pathway: Long Term Conditions

NHS, social care, education provider and third sector organisations in Oxfordshire have joined forces to form the Oxfordshire Workforce Development Programme in order to tackle workforce change where it is more resource effective join forces, or in order to deliver system-wide change. The programme was launched a year ago and has already made progress with projects in dementia and diabetes. Both conditions are set to rise in Oxfordshire and nationally with the influence of the sharp increase in numbers of older people.

The dementia project has involved NHS, social care and the third sector collaborating on a new pathway for a person with dementia and developing the competencies required for various roles along the pathway. The diabetes project has involved commissioners to define a new primary care focused pathway. The project identified the competences required in GP practices to deliver the newly commissioned service and undertook a gap analysis to identify development needs.

Projects for 2010/11 include an assessment of workforce supply and demand across health and social care as service provision changes and a review of management training to underpin improvements in quality and efficiency of health services in Oxfordshire.
Case Study: Employee Assistance and Redeployment Scheme
Strategic Challenge 4: Tighten Up Business: Drive up Quality and Value
Clinical Pathway: Acute/Planned Care

NHS organisations across Buckinghamshire have joined together to enable staff displaced by restructuring and service change in one organisation to smoothly fill vacancies in other parts of the local NHS. This proactive approach to working together has extended the opportunities available to displaced staff, while combining resources means that the NHS in Buckinghamshire has been able to set up a dedicated Employee Assistance and Redeployment Bureau (EARB).

The EARB covers clinical and non-clinical staff and is hosted by Buckinghamshire Hospitals. Staff, managers and recruiting organisations are provided with a structured and comprehensive redeployment service and practical support including a dedicated telephone line, help with job matching and a range of workshops.

Launched in November 2009, in its first three months 82 people have registered with the scheme of which 55 have already been successfully redeployed and only four people not successful in redeployment, and as such were offered redundancy.

“It is vital that the loss of staff is minimised and that valuable skills, knowledge and experience are retained within the NHS and thus ensure that redundancy is a last resort option, particularly within the economic and financial context in which we work,” said Sandra Hatton, Director of HR and Organisational Development at Buckinghamshire Hospitals NHS Trust.

“Organisational restructuring can be extremely stressful for the individual members of staff affected and the benefit and success of this scheme is its local focus and personal service.” The EARB is also exploring links with other local organisations so that staff are supported to find suitable roles in other parts of the public sector.

Case Study: Maternity Support Worker Competency Framework
Strategic Challenge 4: Tighten Up Business: Drive up Quality and Value
Clinical Pathway: Maternity and Newborn

Driven by national strategy and local need, a new standard competency framework has been developed for Maternity Support Workers (MSW) across NHS South Central. The MSW can complement a maternity team by supporting midwives in carrying out the care of women and their family. The new competency framework properly supports the MSWs learning, values the role and ultimately helps safeguard women and families.

The framework was developed by midwives from all trusts across NHS South Central working with Skills Academy for Health. The partnership working is a clear strength as the framework has region-wide recognition and acceptance.

The framework focuses on support workers at Bands 2 and 3. This is where the weight of MSWs are employed and the task group felt it was necessary to provide a solid competence base for workers at this level before considering a Band 4 role.

The framework is a significant step forward for the maternity workforce. It provides managers with a ‘Library of Competences’ that MSWs can achieve within NHS South Central and enables easier transfer of staff between roles and organisations.

The Royal College of Midwives has recently allowed MSWs to join as members, giving further recognition and value to the role.
Case Study: The Complex Case Manager/Community Matron
Strategic Challenge 5: Step-up Flexibility: Develop the Workforce

Clinical Pathway: Long Term Conditions

For many people, living with a Long Term Condition(s) is a balancing act to ensure that they remain well and living at home. Case management is a successful approach of giving people the support and care and interventions when appropriate to enable them to be managed within a GP primary care setting.

However, some people with a high risk of becoming unstable need additional pro-active support and this is being undertaken successfully by a community matron complex case management in a number of integrated health and social care teams particularly in Southampton and Oxfordshire.

The Community Matron, is responsible for co-ordinating all aspects of care for people who are most likely to remain unstable for long periods of time, are often difficult to stabilise and run the risk of repeated acute admissions and/or emergency department attendances with poor resolution of their complex problems.

Complex Case Management at this level involves liaising with primary care trusts, acute trusts, social care, therapists, community services including equipment services and general practice team members to enable effective and timely care, provided in the most appropriate setting.

The benefits for patients, their families and the agencies involved are the continuity of care with a senior and experienced nurse as the lead professional to co-ordinate and oversee an agreed care package to keep people stable for longer.

Case Study: Palliative Care Support Worker

Strategic Challenge 5: Step-Up Flexibility: Develop the Workforce
Clinical Pathway: End of Life

A new role in the Palliative Care Service team at Southampton Community Healthcare is giving more people the opportunity to die at home. Already evidence collected by the team has shown that people are not only taking up this opportunity, but that they and their carers are satisfied with the level of care that they receive. For health providers this has meant quicker NHS discharges and fewer nursing home places for people at the end of their life.

The palliative care support worker (PCSW) role was developed in response to national and regional guidelines. “The previous service configuration sometimes made it difficult to offer the choice of supporting people to die at home,” explained Helen Willis, District Nursing Sister at Southampton Community Healthcare.

Part of the challenge in developing the role was working with partners to develop the practical details to ensure continuity of care. The Service has had to work hard to set up and maintain the matrix structure that links the PCSW to the District Nursing Service, who undertake assessment and case management role, the joint Health & Social Care Rapid Response Service and Marie Curie Service who provide out of hours support. Staff find that working in this service offers significant job satisfaction while the long term benefits include less post bereavement issues for family and friends due to the intensive level of support they receive.
Case study: Practice Leader Programme

Strategic Challenge 6: Be accountable: Focus Leadership

Clinical Pathway: Planned Care

A new programme for GPs linking leadership skills development with service improvement is having an impact in Milton Keynes and Portsmouth, both areas of social deprivation and underperformance in national quality indicators.

The Practice leader Programme focussed on practice level service development as a means of improving patient care, changing thinking and developing leadership skills. In Milton Keynes 13 general practices and seven newly qualified GPs took part in the pilot. Participants took part in a fortnightly Action Learning Sets and monthly coaching where they focused on personal and practice development. GPs spent a day a fortnight implementing their practice-based service improvement projects.

In Milton Keynes 19 different redesign initiatives were developed impacting on more than 140,000 patients. All GPs showed significant improvements within the medical leadership competency framework. Nine GPs were awarded Postgraduate Certificate in General Practice. Five out of seven of the newly qualified GPs have stayed in Milton Keynes and are partners in the city.

“Culture change and ownership underpin the initiatives making the changes sustainable. GPs changed the way they think about themselves, their practice, their patients, problem solving and professional behaviour,” said Dr Marion Lynch, Associate Dean, Oxford Deanery. The shifts in perspective and transformative approaches to leadership are now being used to deliver new ways of addressing Darzi pathways.

The programme has been conceived as a pilot for the fifth year of the proposed five year GP speciality training.

Case Study: Simulation training drives improvements for sepsis patients

The Case for Change

Severe sepsis kills 1400 people worldwide a day. It costs £ 21 billion to treat, has a 50% mortality rate and is increasing in frequency. At Winchester and Eastleigh Healthcare Trusts (WEHCT), following a Sepsis audit, and in line with much national data, the time for patients with severe sepsis to receive antimicrobials was in some cases over seven hours.

Inspired by a visit to the National Air Traffic Service training centre in Swanwick to view their simulators and training programmes, the WEHCT team devised a memorable and easy to implement programme to promote early recognition and delivery of a sepsis care to junior doctors and multidisciplinary teams.

Using simulator training of real patient scenarios the programme combined theoretical, practical and discussion-based education and at only two hours was designed for minimum service reduction.
The simulator also enabled the team to use techniques from the airline industry to improve communication skills, and video-recorded performance to give detailed, constructive feedback on handover, team working and leadership.

Over 130 nurses and doctors and numerous students have now been trained and feedback has been universally positive. Participants felt they had retained more information from this style of education compared to traditional models. They also felt better prepared for the future and occasions when they had responsibility for managing septic patients.

Since this training model was introduced patients are receiving antimicrobials 75% quicker and the mortality rate from severe sepsis has dropped from 50% to 24%. The length of stay for these patients has reduced by 14% and with two patients admitted with severe sepsis every day at WECHT, this equates to a 1241 bed days saved per annum (£320,000).

“We are passionate about this type of learning experience to really drive forward improvement in patient safety and quality of care. There are many more similar symposiums for a variety of other conditions that could have the same template applied,” said Matt Inada-kim, Acute Care Consultant.

“In response to those who doubt the potential that Simulation training offers, Simulation never will be a complete replacement for experiential learning, but it can still help improve the outcomes for real patients,” said Matt.

The programme has received national recognition and was highly commended in the Patient Safety Awards, Education and Training category.
Appendix 4:  
Linked Strategies and Implementation Plans

Patient Care Area Reports

In addition to the 8 care pathway workforce reports there are further workforce plans and aligned strategies that cover specific professional groups or sections of the workforce. These are listed below with links to the full documents which can also be accessed via the South Central SHA website nesc.nhs.uk/about_nesc/workforce_strategy.aspx

<table>
<thead>
<tr>
<th>Current Status</th>
<th>Patient Care Area Reports</th>
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<tbody>
<tr>
<td>Task force reports available</td>
<td>Primary Care</td>
</tr>
<tr>
<td>Workforce report - end March 2010</td>
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<tr>
<td>NESC Website</td>
<td>Valued People Project (learning disability)</td>
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<tr>
<th>Profession Specific</th>
<th>Educaton Commissioning Strategy</th>
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<tbody>
<tr>
<td>Nursing Strategy – Making Quality Personal Published 2009</td>
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<tr>
<td>Dental Strategy</td>
<td>in production</td>
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<tr>
<td>Medical workforce plans by speciality</td>
<td>in production</td>
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<tr>
<td>Modernising Health care science workforce plan Planned</td>
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<tr>
<td>Allied Health Professionals</td>
<td>Proposed</td>
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<tr>
<td>Pharmacy</td>
<td>in production</td>
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<tr>
<td>Education Commissioning Strategy</td>
<td>in production</td>
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<tr>
<th>Others</th>
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<tbody>
<tr>
<td>Annual workforce operating plans Sign off March 2010</td>
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<tr>
<td>Health Economy Workforce Risk Assessments Sign off March 2010</td>
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<tr>
<td>End to End Workforce Planning system in production</td>
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<td>Apprenticeship Strategy Published May 2009</td>
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<td>Widening participation strategy Published March 2008</td>
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<tr>
<td>Leadership Development Strategy Published March 2009</td>
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<tr>
<td>Single Equality Scheme for 2009 – 2012 Published September 2009</td>
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Appendix 5: Acknowledgements

Workforce Strategy Reference Group

Many thanks to the following critical friends for their input and guidance throughout the development of this strategy.

Heather Aldridge, Specialist Palliative Care Strategy Advisor, Sue Ryder Care
Dr Jeannette Bartholomew, Head of School of Health Sciences and Social Work, University of Portsmouth
Stuart Carney, Deputy National Director of the UK Foundation Programme Office, and Registrar of the Academy of Medical Educators. Oxford University
Nadia Chambers, Clinical Director Long Term Conditions, South Central Strategic Health Authority
Professor Jessica Corner, Head of School of Health Sciences, University of Southampton.
Dr Robert Crouch OBE, Nurse Consultant, Southampton University Hospitals NHS Trust
Suzanne Cunningham, Clinical Director for Maternity and Newborn, South Central Strategic Health Authority
Judy Curson, Director of the NHS Workforce Review Team
Bob Deans, Chief Executive, Southampton City PCT
Sue Donaldson, Director of Human Resources, Oxford Radcliffe Hospitals NHS Trust
Dr Sue Duke, Consultant Practitioner in Cancer and Palliative Care Education, Southampton University
Dr Ann Ewens, Director of Continuing Professional Development, Oxford Brookes
Katherine Fenton, Director of Clinical Standards and Workforce, South Central Strategic Health Authority
Jonathan Fielden, Chief Medical Officer, Royal Berkshire NHS Trust
Nikki Griffiths, Strategic Learning and Development Manager, Hampshire County Council
Mark Hackett, Chief Executive, Southampton University Hospitals NHS Trust
Elizabeth Hale, Comprehensive Area Assessment Lead – Berkshire, Audit Commission
Tony Halton, Director of Nursing, Milton Keynes Hospital NHS Foundation Trust
Jonathan Horbury, Director of Development, Oxfordshire, Buckinghamshire, Mental Health NHS Trust
Allan Jolly, Associate Director Workforce and Education, South Central Strategic Health Authority
Peter Lees, Medical Director and Director of Leadership, South Central Strategic Health Authority
Ben Lloyd, Director of Finance, Investment and Performance, South Central Strategic Health Authority
John Newton, Regional Director of Public Health, South Central Strategic Health Authority
Dr Vicky Osgood, Postgraduate Dean - Wessex Deanery, NHS Education South Central
Anne Owen, Director of Clinical and Provider Services, Berkshire West PCT
Dr Stephen Richards, GP and Chair of the Clinical Executive, Oxfordshire PCT
Judy Saunders, Director of Human Resources and Organisational Development, Winchester and Eastleigh Healthcare NHS Trust
David Sines, Pro Vice Chancellor, Buckinghamshire New University
Fizz Thompson, Director of Clinical Services, South Central Ambulance Service NHS Trust
Dr Ros Tolcher, Medical Director and Joint Managing Director, Southampton Community Healthcare
Consultation Events

Shaping the Future - the workforce strategy was developed after wide stakeholder consultation and communication including the following consultation meetings or events.

Workforce Summit (workforce reference group)
Strategic Education Partnership Meetings
Directors of Nursing Forum
Directors of HR Forum
Mental Health Workforce Workshop
Maternity and Newborn Workforce Workshop
Health and Social Care Workforce Workshop
PCT Chief Executives
Directors of Finance
Health Care Scientists Forum
Allied Health Professionals Forum
Pharmacy network
Clinical Pathway Directors
HR Best Practice Forum
Mental Health Commissioners group
Social Partnership Forum
Directors of Finance
Board of Commissioners

The final consultation event was a Workforce Conference at which the final section for each of the strategic themes: Making it Happen was completed.

More information on the consultation and stakeholder engagement process that informed the development of this strategy is online at:

://www.nesc.nhs.uk/about_nesc/workforce_strategy.aspx

Comments:

If you would like to comment on this strategy

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monger@southcentral.nhs.uk

Workforce and Education is available on the NHS Education South Central Website

://www.nesc.nhs.uk/about_nesc/workforce_strategy.aspx

Corporate South Central Strategic Health Authority website : southcentral.nhs.uk

This strategy has been through a process of equality and diversity impact assessment.