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Milton Keynes and South Midlands Expansion: Workforce Briefing

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EXECUTIVE SUMMARY

The challenge to meet the demand for a substantial increase is very challenging and will be achieved by:

Improving education and training

Increases in education commissions and innovative, shorter courses that produce staff more quickly.

- Increasing education commissions of doctors, nurses, allied health professions and health scientists
- Modernise medical career by shortening training, enabling a faster response to changes in demand

Improving recruitment and retention

- Overseas recruitment of GPs, consultants, nurses and allied health professionals

Labour substitution

- Substitute hard to recruit staff by those who will be easier to recruit, e.g. introducing physicians' assistants to work in primary care and accident and emergency, which will replace doctors.

Increasing the integration of health and social care services

We will skill up social care staff to do some tasks that currently require a visit from a district nurse, e.g. putting drops into clients' eyes. There are many more developments that we have not been able to touch on, due to the short time required to produce this briefing.

Providing more efficient services with new models of care

Provide more efficient and effective services in primary and community care that support patients with chronic diseases and mental illness, so that they make much less use of hospitals and GP time. In addition, day case surgery in treatment centres will reduce the demand for hospital beds.

Some of the following reflect Government policy that is being implemented across the country, e.g. mental health new roles and services, while other changes represent options that will be explored with clinicians. Major change is best implemented with the involvement and commitment of staff, particularly clinicians, rather than being externally imposed.

- The additional investment in health care will be offer a greenfield site opportunity to provide much more efficient, patient centred care with a strong, primary care focus. This is a unique opportunity.
- Help patients with chronic diseases to become more self-reliant through the expert patient programme.
- Improve mental health services in primary care and release a significant amount of GP time.
- Reduce the demand on accident and emergency and hospital beds by proactively supporting frail and elderly patients through highly trained district nurses. This uses the Evercare model of care, imported from the USA.

- Reduce the demand on accident and emergency by opening more minor injury centres staffed by emergency nurse practitioners and paramedical staff.
- Reduce the demand on hospitals by opening 80 treatment centres in England that specialise in high volume, day case procedures with long waiting lists, e.g. ophthalmology.
- Increase the efficiency of hospitals by treating more patients in the same number of beds. For instance, the length of stay in American for patients with hip replacements is only four days, compared to 12 in England.
- Increase the efficiency of laboratories through modernisation – new equipment and improved working processes.

Use housing as a recruitment aid

The additional housing is a great opportunity to attract NHS and Social Care staff to the area.

- The huge housing expansion will be a great opportunity for the NHS to use it as a recruitment incentive. This would involve developing a special NHS housing scheme.
- Some of the new population will work for the health and social care sector anyway and could be recruited into local employment.

1. BACKGROUND

The following tables reflect the additional health and social care staff required for the population growth and age profile, produced by Matrix.[1] The increases for GPs are unachievable on a like-for-like basis. However, if Physicians Assistants were introduced and primary care mental health services and chronic disease management programmes were expanded, the service could be provided through other means.

However, these figures do not take into account new models of care, such as chronic disease management or the extensive use of new roles such as physicians' assistants who could substantially reduce the demand for additional GPs. Innovative approaches that are being implemented, or represent future options, are presented in this report. However, the impact on workforce numbers by staff group of these service and workforce scenarios will be commissioned shortly as a major piece of work.

Table 1 – Demand for NHS Staff
(Source: Matrix Report, page 36)

Staff group	2002	2021			2031		
	WTE	WTE	Additional to 2002 baseline	Increase	WTE	Additional to 2002 baseline	Increase
All doctors	3,026	4,196	1,171	39%	4,894	1,868	62%
GPs	903	1,259	356	39%	1,468	565	63%
Medical and dental staff	1,378	1,906	527	38%	2,222	844	61%
Consultants	792	1,084	292	37%	1,265	473	60%
Nurses, midwives and health visitors	8,840	11,923	3,083	35%	13,905	5,065	57%
GP practice nurses	380	462	82	22%	539	159	42%
Scientific, therapeutic and technical staff	1,727	3,210	1,483	86%	3,743	2,017	117%
Qualified ambulance staff	475	578	103	22%	674	199	42%
Total	**17,521**	**24,619**	**7,097**	**41%**	**28,709**	**11,188**	**64%**

Table 2 – Demand for Social Care Staff
(Source Matrix Report p.37)

Staff group	2002	2021			2031		
	WTE	WTE	Additional to 2002 baseline	Increase	WTE	Additional to 2002 baseline	Increase
Area office/field work staff	3,422	4,161	739	22%	4,852	1,430	42%
Residential care staff	1,616	1,965	349	22%	2,291	676	42%
Day care staff	919	1,117	199	22%	1,303	384	42%
Total	**5,957**	**7,243**	**1,287**	**22%**	**8,447**	**2,490**	**42%**

[1] *Milton Keynes and South Midlands: Support to the submission for the examination in public final report* (draft), Matrix, 22 March 3004

2. QUESTIONS AND ANSWERS

1. *Given that some areas provide a substandard GP service now (Milton Keynes has 48.9 GPs per 100,000 population compared with the national average of 53.2; seven practices have closed their lists[2]), how can this service cope with a massive population expansion?*

   This will be addressed by increasing the number of doctors in training, overseas recruitment, the introduction of Physicians' Assistants, making better used of specially trained nurses in chronic disease management and additional staff with mental health training.

   The details are as follows:

   a) Increasing the number of doctors in training by 60 per cent between 1997 and 2003 (See: Training More Doctors, page Doctors 8).

   b) Overseas recruitment – Italian GPs have been recruited (LNR).

   c) Exploring the introduction of Physicians' Assistants who will undertake much work that does not require the GP's expertise. They have been used with great success for decades in the USA and very recently in the West Midlands (See: New staff roles: Physicians Assistants, page 10).

   d) Making more use of better trained nurses who are managing a growing range of patients with chronic conditions, such as asthma and diabetes (See Chronic Disease Management, page 12).

   e) Exploring use more health care assistants to support nurses by clustering GPs to work together in larger centres. One model that will be evaluated is to set up centres covering 20,000 patients (See: page 14).

   f) Addressing the unmet needs of people with mental health problems that account for one in four of consultations through the introduction of new staff roles working in primary care such as graduate mental health workers (See: page 16)

2. *Won't such a large expansion require a very substantial increase in the number of hospital beds, resulting in much more use of land and traffic congestion and parking problems?*

   We will reduce the length of stay and treat more patients in a given number of beds. This will be achieved through increases in day case work in new treatment centres, by patients being taught how to look after their own conditions more effective and through chronic disease management.

   The details are as follows:

   a) Treatment Centres: (See: page 15)

   b) Self and shared care: (See page:12)

[2] Milton Keynes PCT Trust Board, 27 June 2002, accessed from the Internet on 10 March 2004

c) Proactively managing patients with chronic diseases, so that their conditions do not deteriorate so often and thus being able to support them in the community (See page:12)

d) Providing more mental health services outside hospitals, such as in primary care (See page:16).

3. *What about the problem with dentists, as many have closed their lists to NHS patients?*

   This is a difficult national problem that will be lessened by the opening of a new dental school in Leicester, with outreach to the rest of the WDC.

   - A new dental school is being opened in Leicester with outreach to the rest of the WDC (LNR).
   - However, it is acknowledged that the shortage of dentists is a national problem, so that progress is likely to be slow.

4. *What is going to happen about the long waiting times for diagnostic services, caused by a shortage of consultant radiologists and radiographers (which impacts adversely on cancer and coronary heart disease)?*

   - An expansion in the numbers of advanced practitioner radiographers will meet the shortage of radiologists and the introduction of assistant practitioner radiographers will meet the shortage of radiographers.

5. *What about the shortage of midwives, given the new population is likely to have a higher than average birth rate?*

   One of our WDCs is the national lead to improve recruitment and retention, we have increased commissions and employed more support staff to take on some of the more straight forward tasks from midwives.

   - This is a top priority for management attention and Bedfordshire and Hertfordshire are the national lead for midwifery recruitment and retention (BH).
   - Education commissions have been increased (LNR).
   - Health care assistant roles have been developed to provide more support to midwives. (All)

6. *What about the long waits in accident emergency departments, won't they be very much worse, given the large increase in population*?

We will provide many more services for patients who turn up in accident and emergency departments because there is no where else to go. These services include teaching patients how to look after their own conditions and highly trained nurses to support patients with chronic diseases. We will also open more, strategically located walk-in centres.

   - Many patients in accident and emergency department are there because they have chronic conditions that have not been effectively managed. This will be addressed by:

  - teaching patients and carers how to manage their conditions more effectively (see page: 12)
  - highly trained nurses proactively supporting patients in the community (Evercare – see page 13)

- Other patients are there due to the lack of other emergency services. This will be addressed by creating more strategically located, nurse led walk-in centres.

3. EDUCATION AND TRAINING

Local initiatives

Working with schools
Schools are regularly visited to promote the wide range of NHS careers (All).

Accessing deprived young people
Access courses have been developed to support deprived young people, such as youth offenders in order to open up NHS careers for them (LNR).

Improved retention of students

- Improving retention of students by targeting recruitment more effectively to those who are really committed to an NHS career (LNR).
- In addition, commissioning of occupational therapists and physiotherapists will done on a local basis to encourage the recruitment of students from the local labour market who are more likely to seek local employment on qualification (LNR). Similar scheme operated by the other WDCs.
- More support workers are being recruited into professional courses, increasing the percentage of qualifying students who will continue to work locally (All). They represent 20 per of the intake of nursing and allied health profession courses (LNR).

Increasing education commissions
Nursing commissions continue to rise at a slow but sustainable rate at University College Northampton (LNR). There are similar trends in the other WDCs.

Modernising medical careers
This will shorten the length of training so that it is easier and quicker to respond to changes in demand between the medical specialties. However, this will create demand for replacement staff for junior doctors, as the latter will contribute less to patient care.

Training More Doctors: National Initiative

Background
The NHS has the fewest doctors in Europe with 179, per 100,000 population. It is government policy to increase their numbers. However, given that there are now many more women entering the profession who may take career breaks for family reasons, a part of the increase in training numbers will be required to meet the shorter lifetime careers of the next generation of doctors.

Action

- Medical school intakes have increased by 60 per cent (2,281) from 3,749 to 6,030 in England since 1997.
- Four new medical campuses have been opened since 2000.
- Medical education has a stronger applied focus due to innovations in medical training and curriculum.

Source
More doctors in training than ever before, Press Release 2004/0094, Department of Health, 8 March 2004

4. IMPROVING RECRUITMENT AND RETENTION

Overseas recruitment

- GPs have been recruited from Italy (LNR).
- Nurses have been recruited from the Philippines and India (All WDCs).
- Psychiatrists successfully recruited (B&H).
- Radiographers, Physiotherapists and Occupational Therapists recruited from the Philippines (B&H).

E-Recruitment

More use is being made of E-recruitment, which both speeds up the process and attracts applicants from anywhere in the world (All and especially TV).

Housing Assistance

A database matching properties to applicants is being used to help staff find accommodation in Hertfordshire that has a severe shortage of affordable housing. In addition, the housing expert John Yates is advising on other measures (B&H).

Retaining new recruits

Preceptorships are being used to give newly qualified nurses more support during their first year of employment, to help them over the difficult transition from being a student to being an active member of a team (All).

5. LABOUR SUBSTITUTION

Developing support work roles to release professional staff

Assistant practitioner roles are being introduced to address the shortage of graduate radiographers (All WDCs).

Using professional staff to compensate for the shortage of consultants

- Consultant radiologists who are in very short supply are handing over some of their tasks to Radiographers who have been trained as advanced practitioners (All WDCs).
- Consultant histopathologists have trained biomedical scientists to undertake certain tests, which were previously their own exclusive, preserve (All WDCs).
- Multi-professional, advanced practitioner courses have been developed covering strokes, muscular skeletal care that will provide more integrated care to patients, saving staff time, as they are multi-skilled.
- A growing number of nurses and allied health professionals are being trained in prescribing, which will reduce will free up doctors.

Using *GPs* with a Special Interest (GPwSI) to compensate for the shortage of consultants

- Consultant time is saved as a few of their sessions are being undertaken by (GPwSI). However, the shortage of GPs means that the scope for these developments is limited (All).

New staff roles: accident and emergency and emergency care

- Accident and emergency technicians introduced (East and North Herts).
- Emergency care practitioner (Bedfordshire and Hertfordshire Ambulance Paramedic Service)

New roles in surgery

- Perioperative surgical assistants (B&H).

Community Diabetes Staff

- Nurse consultant in Community Diabetes develops and provides more effective community based services so that patients require fewer hospital visits (Hertsmere PCT and South East Hertfordshire PCT).
- Diabetes care technician has been introduced to support professional staff (Hertsmere PCT and South East Hertfordshire PCT).

New staff roles: Physicians Assistants

Objectives

- To compensate for some of the shortages of GPs and doctors Physicians Assistants work in accident and emergency and primary at a level of practitioner below that of doctor and they work under the supervision of doctors.
- Another attraction of Physicians' Assistants is that they could be easier recruit, once courses have been set up, than nurse practitioners.

- Physicians' Assistants can play a major role in managing patients with chronic diseases.

Background
The role was created in the USA to employ the skills of medically trained soldiers returning from the Vietnam War. Today, they are usually sciences graduates who are trained intensively in general medicine and first contact or acute medicine. They must undertake a rigorous recertification programme every six years. Physicians' assistants are the fastest growing group off medical professionals in the USA. Half of them work in primary care and a quarter are in accident and emergency.

Action
Rowley Regis and Tipton PCT has successfully employed two Physicians' Assistants, recruited from the USA to work in two general practices. They have their own patient lists. They perform physical examinations, diagnose illness, treat mental health problems, monitor low risk pregnancies, order and interpret tests. Physicians' Assistants see up to 22 patients a day, with 15 minute appointments.

They work under the supervision of GPs and are paid £40-45,000, compared to GPs who are paid £60-80,000.

The trust is now recruiting a further 12 and extending the scheme to emergency care, six of whom will divide their time between accident and emergency and primary care. The PCT is developing a training programme with Birmingham University and exploring how to register qualifying students with professional registration councils.

Physicians Assistants, probably working at a slightly lower level than the above are being introduced (East and North Herts).

Source
Assistants required, Health Service Journal, 11 March 2004, p 26

6. NEW MODELS OF CARE

Self-care and shared care: The Expert Patient Programme

Objective
Reduce the demand for health care services by informing and empowering patients and carers to undertake more care themselves.

Background
Kaiser in the USA teaches orthopaedic patients how to dress themselves, the exercises they need to undertake and how to administer medication such as anticoagulation in the home.

The expert patient programme in England is based on *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century*, published in September 2001. Research shows that people with chronic conditions are best placed to manage their own condition.

Action
The programme trains patients with long-term chronic conditions to manage their condition more effectively on a day-to-day basis. The course involves six, 2½ hour sessions, held once a week. People who have the condition themselves lead the programme.

Chronic Disease Management

Objectives
This is to cut the number of visits to GPs, accident and emergency departments and the usage of hospital beds.

Outcomes
The number of hospital admissions for people with chronic diseases has been reduced by 50 per cent, by Evercare in the USA.

Kaiser Permanente in the USA uses a quarter of the number of the beds days for leading causes of admissions like asthma, stroke for the over 65 population[3]. This has been achieved by chronic disease management, facilitated by closer integration between specialists and generalists.

The results of a pilot of active management of conditions for older people showed a 15 per cent reduction in admissions and a 31 per cent reduction of length of stay in Castlefields Health Centre, UK.

Background

- There are 17.5 million people with chronic diseases such as diabetes and asthma in the UK. They take up 80 per cent of GP consultations.
- Around 3 per cent of the at-risk elderly population were responsible for 35 per cent of the unplanned hospital admissions. Many of these people were not in

[3] *Managing new realities – integrating the care landscape*, Speech by John Reid, 11 March 2004

contact with any community health service. Many of their conditions were entirely preventable, had they been treated at an early stage.[4]

- The World Health Organisation estimates that the incidence of chronic diseases in the over 65s would have doubled by 2030.

Framework
This consists of three elements:

- The first is self-care support, so that patients are better placed to take control of their conditions
- Then disease management, in which multi-disciplinary teams provide high evidence-based care to patients, often through the use of specialist nurses
- Case management, in which patients with complex needs are identified and supported by skilled practitioners working in an integrated care system.

This is underpinned by 'fully engaged community action to prevent illness and promote healthy living.

Action
The government is launching case management demonstration sites in each of the 28 Strategic Health Authorities. These schemes will:

- maintain health and promote well-being
- detect early changes in condition and prevent unnecessary admissions
- when admissions do occur, facilitate safe, early discharge

GPs are rewarded for providing better chronic disease management services under the new GMS contract.

The introduction of integrated computer based patient records will provide a far firmer foundation to manage patients with chronic diseases.

In order to support the move to supporting patients in the community, new posts have been created there rather than in hospitals, such as community specialist diabetes nurses who deliver clinics and provide additional support through consultation and education.

Source
Managing new realities – integrating the care landscape, Speech by John Reid, 11 March 2004

Evercare

Objective
To keep elderly people healthy and, when they do become ill, to avoid unnecessary hospital admissions by offering a greater range of services in the community and treating people in the lease intensive setting. This entails the proactive management of high-risk patients.

Action
9 PCTs are adopting and implementing this model of care, including Luton PCT.

Source
The much of above information was obtained from, *A better life for people with chronic disease*, Department of Health Press Release, Reference number 2004/0099, 11 March 2004. The exception to this is shown in the footnote.

Expanding primary care

The following table explores the option to cluster GPs together in larger units in order to expand substantially the services that they can offer, including the provision of diagnostic tests. This would enable a greater use to be made of a wide range of staff that will require fewer GPs than the traditional model.

Table 3 - Large primary care centres compared with current ones

Characteristics	Current Primary Care	Future possible model
Size	Small (2 – 3,000 patients)	Large (20,000 patients)
Accommodation	Cramped, domestic accommodation	Purpose built premises
Level of technology	Low	High
Clinical workforce	Mainly GPs	Mix of GPs, physicians assistants, nurses and health care assistants
Referrals to acute	Many, due to lack of diagnostic resources and staff	Fewer, more diagnostic equipment, physiotherapists etc on site on a sessional basis
Care of patients	Mainly reactive: wait till ill patients turn up	Proactive: keeping patients well.
Information Communications Tech	Limited to practice based systems and reliant on letters from hospital	Full patient information that can be clinically audited though the integrated patient record
Mental health services	Very restricted: referred to community health teams	Primary care mental health workers
Social issues	Take up too much of GP time	Carried out

Reducing Hospital lengths of stay

Objectives
To improve efficiency by treating more patients without additional beds, which also results in higher staff productivity.

Background
There are considerable differences between hospitals both within England and between England and the USA regarding length of stay.

Outcomes
The average length of stay for patients recovering from hip replacement surgery has been reduced to four days by Kaiser Permanente in the USA, compared to 12 days

in the NHS[5]. However, Epson has been able to reduce length of stay down to five days.

Action
Nurse Led Discharge Co-ordinator has been introduced to reduce length of stay by reducing delays related to discharge (Luton & Dunstable Hospital)

Treatment Centres

Objective
To reduce waiting times by undertaking operations and diagnostic tests uninterrupted by emergency work that leads to cancellations.

Background
Treatment centres are dedicated units that provide pre-booked day and short stay surgery and diagnostic procedures in procedures with long waiting lists, such as ophthalmology and orthopaedics.

Action
There will be 80 Treatment Centres undertaking 250,000 operations a year by 2005.

In terms of staffing, in order not to deplete the NHS of staff, some of the treatment centres will be staffed by employees of overseas contactors.

Intermediate care

Objective
To support older people's capacity to live in their own homes through carefully targeted interventions and rehabilitation.

To reduce the demand on hospital beds by providing rehabilitation for older people in settings designed for that purpose

The National Service Framework[6] states that Intermediate Care Services should focus on three key points on the pathway of care (paragraph 3.13):

- responding to or averting a crisis
- active rehabilitation following an acute hospital stay
- where long term care is being considered

Intermediate Care Services should (paragraph 3.12):

- be targeted at people who would otherwise face unnecessary prolonged hospital stays or avoidable admission to acute inpatient care, long term residential care or continuing NHS inpatient care
- be provided on the basis of a comprehensive assessment resulting in a structured individual care plan that involves active treatment and rehabilitation
- be designed to maximise independence and to enable patients/users to remain or resume living at home

[5] Speech by John Reid, Secretary of State for Health, *Learning from the market*, not copying it, 4 November 2003
[6] *National Service Framework for Older People*, Department of Health, 2001

- involve short term intervention typically lasting no longer than 6 weeks and frequently as little as 1 - 2 weeks or less

- involve cross professional working in the framework of a single assessment process, a single professional record and shared protocols.

Intermediate Care Services will be provided by a core team of professionals including General Practitioners and hospital doctors, nurses, physiotherapists, occupational therapists, speech and language therapists and social workers, with support from care assistants and administrative staff.

Action
Intermediate care has been introduced across all StHAs.

Improving Mental Health Services

Background
The lack of mental health services in primary care has resulted in GPs spending a quarter of their time dealing with patients whose symptoms are caused by mental health problems. However, as these patients are unlikely to be a serious risk to themselves or others, they are not usually offered a mental health service. When they are referred to community mental health teams, they are often classified as "worried well", in comparison to people suffering from depression or schizophrenia.

Action
The following are being implemented as part of a national strategy:

- 1000 new graduate primary care mental health workers to provide brief therapies of proven effectiveness in general practice – draws on 10,000 BSc Psychology graduates each year;
- 50 early intervention teams to reduce the period of untreated psychosis in young people;
- 335 crisis resolution teams;
- 50 more assertive outreach teams;
- 500 more community mental health staff to work in primary care, A&E and with NHS direct;

New role: primary care mental health workers

They will provide brief evidence-based techniques such as anxiety management, problem solving and other brief structured treatments can be applied in routine primary care and there is evidence that staff can be trained to deliver these safely. For example, interpersonal counselling seems at least equivalent to medication in the short term for people with common emotional problems such as anxiety, depression, acute stress reaction and adjustment disorder. Brief treatments have also been shown to be effective in the management of health risk behaviours such as smoking, alcohol problems, unexplained physical symptoms and areas related to mental health such as sleep problems or regulation of long-term benzodiazepine or hypnotic drug use.

New role: Support, Time and Recovery worker

The STR worker role has been designed for non-professionally affiliated staff working in hospitals and the community, to support people with a wide variety of mental health problems. Although they work as part of a team and are supervised, STR

workers spend most of their time working with service users. They provide companionship and practical support to aid recovery, helping service users reintegrate into the community and achieve an independent lifestyle.

New role: Gateway worker

500 additional community mental health staff (known as Gateway workers) will be employed to work with GPs and primary care teams, with NHS direct and in A&E departments to respond to people who need immediate help. These staff will be able to call on crisis resolution teams if necessary. It is intended that these new workers should be in place by 2004.

Modernising Social Care

The following points provide some indication of how social care is changing. However, they are far from complete.

Children's services

Social Service departments are engaged in a wide range of service improvements, such as:

- Improving the health and education outcomes of looked after children as part of *Quality Protects.* The aim is to increase by 10 per cent the numbers of young people gaining three or more GCSE. This includes career plans, homework and Saturday clubs.

A large investment in training is recommended in *Integrated and Qualified*[7], this includes, that:

- 80 per cent of all care staff in homes have complete their level 3 NVQ in Caring for Children and Young People by January 2005
- a new qualification is introduced for all supervisory staff who are not the registered managers

Children's Trusts will have major workforce implications. However, much depends on the range of staff groups that they will employ and the number and importance of staff groups employed by other organisations.

Learning disabilities

Services have been changed from an institutional to a client focus. This is reflected in the plans for clients to move into employment and to be sustained there along with creating more jobs and work placements. Day opportunities have been expanded in main stream settings. This will have a significant impact on the workforce.

Mental health

One option that will be explored is developing an adult placement service, an adult version of fostering. In-house staff would provide carers with mental health training. The scheme approach is highly regarded by the King's Fund and a Best Value Reviews.

[7] *Integrated and Qualified*, Topss England, October 2003