

Avon, Gloucestershire and Wiltshire



Strategic Health Authority

Workforce Development Confederation

Unscheduled Care: Key Issues for Workforce Planning

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CONTENTS

CONTENTS	1
EXECUTIVE SUMMARY	3
1. INTRODUCTION	9
National context	10
NHS plan and four-hour target	10
Reforming Emergency Care	10
The Carson Report.....	10
Ambulance Improvement Checklist	11
Emergency Services Collaborative.....	11
2. SERVICES	12
NHS Direct.....	12
Minor injuries units and walk-in centres.....	13
Out Of Hours provision.....	13
Ambulance service.....	13
European Working Time Directive	14
Planning unscheduled care	14
Demand for unscheduled care	14
Development of a 24/7 service.....	15
Planning unscheduled care	15
Community services to reduce the need for emergency care	17
Patients with mental ill health	18
Patients with coronary heart disease.....	18
COPD	18
Diverting from ambulance and A&E	19
Interventions at Accident and Emergency	20
See and treat	20
Access to tests.....	21
Access to specialists.....	21
Bed availability	21
Assessment and observation	21
Specific care groups	21
The future for emergency care	23
Emergency Care networks	23
3. WORKFORCE	25
Developing staff roles and new roles.....	25
Training and funding	25
New trends.....	26
New roles.....	27
Support workers and assistant roles	27
Practitioner roles	28
4. LOCAL SERVICES.....	30
5. LABOUR MARKET TRENDS.....	36
General Employment Trends	36
International trends	36
England	36
Bristol, Avon and Wiltshire	37
NHS Employment trends.....	37
NHS in England	37

NHS in Avon, Gloucestershire and Wiltshire	38
Appendix 1	41
AVON, GLOUCESTERSHIRE AND WILTSHIRE LABOUR MARKETS.....	41
Bristol.....	41
Swindon	43
Gloucester	44
Appendix 2.....	45
LOCAL SERVICES IN DETAIL.....	45
Accident & Emergency.....	45
North Bristol trust.....	46
United Bristol	47
Swindon and Marlborough	48
Gloucester and Cheltenham.....	49
Wiltshire	49
Bath	49
REFERENCES.....	51
Document history	52

EXECUTIVE SUMMARY

This report has been commissioned to support the Local Delivery Plan with innovative service and workforce approaches for unscheduled care. The purpose is to highlight issues for a workshop on this topic. A few of the issues have been repeated under other headings, where they are equally applicable.

Planning

1. How can whole system planning be strengthened in this complex area? How can Emergency Care networks be made more robust and sustainable given variable picture reported across AGW?
2. What action needs to be taken to make emergency care more patient centred care, i.e. care will be:
 - personalised and needs based
 - subject to no unnecessary delays
 - simple to access
 - convenient for patients,
 - available as early as possible (emergency prevention)
 - integrated whole systems care i.e. patients can move from one part of the system to another without barriers, delays or having to start again. (Alberti)
3. Given the very different organisations involved in unscheduled care with their own cultures and ways of working, there would be great value in designing a range of pathways between organisations as well as within, for different patient groups, taking into account social circumstances. Service and role design needs to follow on from this.

Out-of-hours service

4. What will be the impact on current GP vacancy levels (average across AGW 11 per cent, 18 per cent Swindon and 16 per cent in north Somerset), and the impact of retirement (20 to 30 per cent of GPs are over 50). Would it be helpful to have the age profile broken down year by year for the over 50s?
5. Given national requirements for out-of-hours services, what is an appropriate ratio of GPs to other staff e.g. nurses, emergency care practitioners (ECPs), paramedics given their different skills in diagnosis and treatment, i.e. what is the appropriate skill mix?
6. What training and to what levels will be needed to train sufficient nurses, ECPs and others?
7. If staff are to undertake training to specialist and advanced levels, how can this be made more attractive given the impact of Agenda for Change and budget constraints? (Locally low uptake of free training places, reportedly because level

- 7 training would attract level 6 pay). How can this be reconciled with the growing demand for such nursing and AHP staff, given the likely shortage of GPs, given future retirements?
8. What needs to happen to integrate district nursing twilight services more closely into out-of-hours services (OOHS) in primary care? This group has a large caseload of vulnerable patients and are often an isolated, overburdened, with less access to training and support? What are the establishment, support and training implications?
 9. What are the trade offs between a centralised, easily accessible, well sign posted call centre and triage, against a more localised service providing continuity for patients and staff? In the former, a wider range of services are available, but the staff responsible for allocating patients have less ownership of the outcomes. This contrasts with the latter and where staff have a keener sense of ownership, as they are closer to the patient and the consequences of not dealing with cases effectively.
 10. What is the extent of the reported problem of the development of walk-in-centres (WiCs), MIUs encouraging OOHS to withdraw from treating patients seen by these centres? Is this a better use of resources or is it a problem?
 11. Is it likely that patient flows will equalise across out-of-hours providers, therefore cross billing for home visits and other services would be unnecessary? Is sufficient yet known about patient flows?
 12. Is there a greater role for paramedics based in primary care and working with out-of-hours services?
 13. Many paramedics leave the ambulance service in middle age because of lifting difficulties, to take up clerical or driving jobs. What is the scope for this trained and experienced group to be redeployed elsewhere where they could use their skills?
 14. What steps are being taken by NHS Direct to advertise their service to groups who typically have been found to contact them less, i.e. the over 65's, people with disabilities, less advantaged social groups, younger people?

Ambulance service

15. What scope is there to increase the testing capacity for ambulance staff across AGW, relaying the results to A&E, to speed the patient pathway?
16. What is the scope to expand the services run by paramedics, ECPs, nurses, pharmacists and others to treat people at home or elsewhere (with free transport provided if necessary) locally, and avoid the need for an ambulance journey? (In Essex 60 to 70 per cent of people making 999 calls are being treated in their own home.)
17. Where are ECPs best deployed – in ambulance call centres to redirect the call and obviate the need for an ambulance call out, or in the ambulance to undertake

- testing or treatment e.g. thrombolysis, or both? (West Midlands and Shropshire ambulance service found 50 per cent of category A calls made from a domestic address could be managed by a service other than ambulance for instance home care GP appointment etc – of the remaining half 50 per cent did not require a 999 ambulance and could be directed to the non 999 patient transport service for same day transfer to hospital.)
18. What is the scope for redeploying trained paramedic staff to other rolls in the NHS e.g. primary care, A&E, where their skills could be better utilised when they leave? (see 12 above)
 19. What scope is there to make more widespread use of primary angioplasty as opposed to thrombolysis? (Primary angioplasty is only slightly more expensive than thrombolysis but provides better health outcomes and reduces hospital length of stays. This impacts considerably on the ambulance service organisation to meet tight deadlines.)

Primary, community and social care infrastructure

20. What is the scope to strengthen this infrastructure, (home care, district nursing, primary care access, day care, schemes for specific high using groups or those with complex needs), to reduce unnecessary demand on unscheduled care services and hospital beds?
21. What is the scope particularly for developing targeted emergency prevention services for the elderly? (48 per cent of the elderly attending A&E require admission as against 20 per cent of other patients.)
22. Can GPs refer direct to intermediate care?
23. How can the district nursing twilight service be more effectively integrated and developed as part of the OOHS? What are training, support and establishment requirements to achieve this? (see 7 above)
24. What is the scope of increasing the attractiveness of night working and Saturday morning working for a range of staff for example district nurses who run the twilight service, working with known patients, many of whom will be elderly and vulnerable – will recruitment and retention designed to emphasise the positives of flexible hours of work, paid holiday and sick leave, index linked pensions, other feasible benefits, recruiting from a different pool e.g. women returning to work, part-time hours for women nearing or at retirement etc?

A&E departments

25. Two of AGWs A&E departments (Swindon and Bath), feature as case studies of good practice in Transforming Emergency Care. Most departments have implemented or anticipated many of the Collaborative's initiatives. What scope remains to build on the good practice and spread the best across the area, particularly to avoid waits in the four key areas - assessment, a specialist, a bed, access to tests? (primary care suites in A&E, near patient testing, pit stop for majors, psychiatric liaison in A&E etc)

26. How might the benefits accrue from developing further specific care group services for heavy users of A&E who present with complex problems – for instance children, those with mental health problems, the elderly and also in inner city areas substance abusers? (e.g. post falls follow up clinics for elderly) What would be staffing implications?
27. What is the scope and benefits for increasing the number of consultants available to A&E? (Particularly perhaps at Bath.)
28. What is a desirable skill mix in A&E and is it achieved across patch, i.e. ratio between junior medical staff and consultants, and a range of specialist nurses including emergency nurse practitioners, acute nurse practitioners and potentially majors nurse practitioners, and support/assistant posts? (What are the different outcomes for patients given a need for, speedy accurate and cost effective diagnosis and treatment?) There are mixed views – one unit thought it might be heavy with senior staff and another, the opposite. How are these decisions made?
29. What training needs to be in place for assistant, specialist and advanced levels and how will staff be encouraged to take training options?
30. Given that some of the A&E units appear to be meeting their four hour target on a sustainable basis, and have made considerable progress in implementing the Collaboratives work methods, what will be the impact of the reconfiguration of A&E services, particularly in the Bath and Bristol area? Will this produce benefits when the system as a whole is considered?
31. Are there conflicts between meeting the A&E four-hour wait target and waiting list targets for elective procedures? If this tension exists, how could services be rethought?
32. Are there plans to introduce primary angioplasty for CHD patients? This would impact on ambulance and catheter laboratory staff but reduce hospital length of stay.
33. What are the knock-on effects of investing in A&E services as against acute medicine or vice versa?
34. What additional steps are needed to manage the impact of EWTD and Hospital at Night expectations – what skill mix would work and how could it be put in place?
35. The performance of any one department is difficult to measure in isolation as volume and type of demand depends on the availability of other services. For each of the major A&E sites, what criteria will be used to inform decisions about reconfiguration/rationalisation of services, and/or investing in capacity for alternatives to A&E? Each proposal has workforce implications, and the availability of certain staff groups may be important in making local decisions.

Recruitment, retention training

36. What is the impact of training nurses for more specialist roles (ECP, ENP etc) on the overall pool of nurses? Is it possible to increase the overall recruitment of nursing staff to take account of the increasingly diverse roles in training? How can more traditional ward nurse and district nurses have training and development opportunities to take on expanded roles, when it can be difficult to release them for such opportunities?
37. What is the balance between training professionals to undertake a little of each others' jobs, with a view to offering patients a speedy and continuous service, and referring patients to other specialists, yet knowing when to refer on? (In community multidisciplinary teams for instance, when do nurses refer to OTs even though there may be a year wait, or can they do more themselves. In intermediate care, when do referrals have to be made to geriatricians, or can GPs do more? Across many services, staff need mental health training as most patients will not be engaged with formal psychiatric services? What additional training is required for groups?
38. What additional initiatives are needed to recruitment more GPs from the training scheme?
39. To what extent could or should the current and projected short-fall in GPs be compensated for by specialist nurses or others? If nurses and other groups will increasingly take up these tasks, is there sufficient training available, take up guaranteed, and backfill organised to meet the needs over the next decade and beyond? If not, what needs to happen for a rolling programme to be established and actively pursued?
40. How can the benefits of NHS employment (pensions, paid leave etc) and AGW locality be used to promote recruitment to assistant level roles where competition from other employers is most severe? What other measures would be needed – new recruitment pools, training opportunities, rotations, career structure etc?
41. If the primary care and social care infrastructure is built up, perhaps with particular reference to older people services, what would the impact in terms of requirements for nursing, AHP and assistant and other workers be? What additional recruitment, retention, career structures and training initiatives would need to be in place?
42. Is the ambulance budget adequate to train incoming technicians to paramedic level to meet the growing demands for paramedic staff, both within the ambulance service and primary care? How do the PCTs intend to meet the increased need for this staff group?
43. Given the reported difficulty of the ambulance trusts in recruiting more senior staff (post paramedic), what training, recruitment, retention or career structure initiatives would need to be in place to train up for post paramedic roles? Is the current number of places available for ECP training sufficient?

44. What about the introduction of ambulance care assistants for non-urgent response vehicles?
45. Managing patients with mental health problems appears to present difficulties in many out-of-hours settings. In addition to the appointment of dedicated posts for instance in primary care OOHS and A&E, some basic training for other staff appears to be needed.

1. INTRODUCTION

The Avon, Gloucester and Wiltshire Workforce Development Confederation commissioned Shared Solutions Consulting to produce a report to assist the LDP workforce group on Unscheduled Care. The objective is to identify the future workforce challenges, such as a much more competitive labour market that will have a profound impact on the NHS's capacity to recruit and retain staff. In addition, issues that pertain to key staff groups for this care group will be identified, such as the large number of pending GP retirements. This report explores service models in considerable depth, as workforce requirements cannot be properly understood and planned in isolation. A wider perspective is essential, as the role of patients and carers can have a large impact on the demand for services and staff. The more proactive patients and carers are, the fewer demands they make on the NHS in the medium to long-term. In addition, such patients require a different relationship to health and social care staff. This in turn has an implication for staff roles and training.

This report will cover the main components of unscheduled care provision i.e. referral and treatment services provided by out-of-hours primary care, NHS Direct, the ambulance service, and accident and emergency units. It will also touch on the interface with other services that impact on provision i.e. social care and in-patient provision. The demand for any one of these four main components is affected by other key providers and social care and in-patient services. Thus, capacity and good practice one area will impact positively on another area and vice versa. Thus examining capacity, costs and practices across the system as a whole, is as important as examining these in any one component.

The report outlines the main guidance and documents that inform the national framework, examples of developing practice, outlines aspects of local services and identifies some features of particular relevance to service development and workforce issues.

There is a summary of issues at the beginning of the report.

Along the patient pathway, interventions can occur at a number of points to prevent accidents or emergencies occurring. This may be described as emergency prevention and depends on proactive coordinated services being available for at risk populations. These services will include primary care, and access within 24 to 48 hours may be significant, availability of community nursing and pharmacy services as well as mental health and drug and alcohol services. Secondly, once the problem has occurred, and a patient makes a call, there is a need for good triage to be available preferably on a one - stop call basis, where decisions can be made as to whether the patient requires advice, can be redirected to another service and managed at home with perhaps input from an emergency care practitioner ECP, pharmacist, paramedic or other, or whether the patient needs to be an ambulance service and to be taken to A&E. Thirdly, once at A&E there is a need to meet the four-hour target and ensure speedy access to assessment and treatment. The fourth area is for timely and well managed discharges where the hand - over to primary care and social care services and the adequacy of their services may well determine the likelihood of future A&E calls and readmissions.

Focusing on preventing patients requiring emergency ambulance and attendance at A&E, is based on the assumption that patient well-being and outcomes will be improved

where early and timely interventions are available, and also that preventing such interventions may obviate the need for more costly and intensive services later on.

National context

There are a number of plans, reports and guidance focussed on unscheduled care provision. These include:

- The NHS Plan and the four-hour target
- The 10-year strategy Reforming Emergency Care, 2001
- Reviewing GP Out-of-Hours Services - Carson Report, 2001
- New National Quality Requirements for Out-of-Hours Services, 2004
- The Emergency Services Collaborative, Modernisation Agency, 2002
- The Ambulance Improvement Checklist, 2002
- Transforming Emergency Care in England 2004.

NHS plan and four-hour target

The target set for A&E was that by the end of 2004, all patients should be admitted, discharged or transferred within four hours of arrival.

Reforming Emergency Care

This 10 year strategy was based on six principles, chiefly, that services should be designed from the patient's point of view, the patient should be seen by the professional best able to deliver the service, without delays, caused by the absence of diagnostic or specialist advice.

The Carson Report

The key recommendations of the report were as follows:

- a prompt response for any patient requiring night or weekend services, with the option of, a doctor's home visit, if required, the patient to visit an out-of-hours centre, the patient to attend A&E, or telephone advice from a nurse
- consistent professional handling of calls for out-of-hours services.
- telephone access through which patients can be referred to other services without making a second call.
- integrated planning of out-of-hours services across primary care trusts.
- further integration between GP out-of-hours services, NHS Direct and A&E departments.

National Quality Requirements for Out-of-Hours Care

These come into force from January 2005. They state that PCTs will need to ensure that the services they provide or commission comply with the requirements. Some GP practices may choose to retain responsibility for the provision of out-of-hours services, but it is anticipated that compliance with the requirements could place disproportionate demands on some practices.

It is suggested that fluctuations in demand for out-of-hours services are predictable, enabling providers to plan the staffing of their service to ensure that a range of clinicians best equipped to meet the demands will be available.

The out-of-hours medical services used to be provided by individual general practices and then there was a trend for practices to form cooperatives covering specific geographical areas. More recently some of these cooperatives have joined with other unscheduled care providers to provide integrated out-of-hours services to local populations. One example is the Nottingham GP cooperative working with the local NHS walk in centre (WiC) to develop nurse's skills. Nurses now operate in an integrated clinical team in the out-of-hours primary care centre both supporting out-of-hours GPs and reducing the need for them. (8)

Ambulance Improvement Checklist

The checklist includes a list of actions the ambulance services can take to improve access to emergency care and achieve targets. These include:

- response times for A, B and C category calls.
- percentage of patients to receive thrombolysis within 60 minutes of calling help (70 per cent).
- key steps to achieving these targets include measures to speed up activation times, and secondly the ability to offer non-emergency calls an appropriate timely source of advice and care.
- a more skilled workforce delivering more healthcare intervention to patients.
- ambulance trusts becoming major players in the integration of unscheduled care and emergency care networks.

Emergency Services Collaborative

The Collaborative has targeted front line clinical teams, working with every acute trust with a 24-hour consultant-led A&E department, involving all staff.

Developments in ambulance services and out-of-hours services have focused largely on providing timely and appropriate care, avoiding the need for unnecessary ambulance call out and attendance at A&E, and the work of the Collaborative has had a greater emphasis on, once at A&E, avoiding unnecessary delays and admissions. The four most common causes identified for delays and difficulties in meeting the four-hour target are, waits for assessment, a specialist, a bed and/or diagnostic tests.

A number of new systems and procedures are now in place in many A&E departments, geared to addressing those problems.

2. SERVICES

There are a number of new services or new roles for existing services that have changed the national picture of services available and also changes to working hours and arrangements for hospital cover at night.

NHS Direct

NHS Direct provides a 24-hours a day, 7 days a week telephone nurse triage service. In 2002 it employed approximately 0.4 per cent of all full time equivalent qualified nurses in the NHS, 20 per cent of its nursing workforce coming from outside the NHS. Evidence indicates that NHS Direct can reduce demands on health services provided outside normal working hours. (National Audit Commission 2002, NHS Direct in England).

NHS Direct is the first response for calls to many out-of-hours GP cooperatives, with up to 50 per cent of patients accessing NHSD through this route not needing referrals to other services.

The NAO identified three challenges for NHSD – capacity, safety and the need to integrate with other front line healthcare services.

NHSD was experiencing problems in meeting the target to answer 90 per cent of telephone calls within 30 seconds and triaging 90 per cent of symptomatic calls within 20 minutes. They were also having problems meeting the target to have a call abandonment rate of less than 5 per cent. However, sites were meeting the target to action or assess 90 per cent of health information calls within three hours, and the target to have under 0.1 per cent of calls getting through to an engaged tone. (3)

NHS Direct is less used by some groups – younger people, people over 65, ethnic minority groups, less advantaged social groups and people with disabilities. These groups certainly have an equal or probably greater need for its service. A range of initiatives have been introduced by some sites to tackle this lack of awareness and under use.

South Yorkshire and South Humber NHS Direct have taken a proactive approach to reach young people and raise awareness with staff in a number of venues in youth clubs, schools and county shows to promote the services. Nationally there is a variation in how well host trusts and NHS Direct sites are integrated. (3)

The host trust for West Yorkshire NHSD is developing its new call centre as a single point of contact for emergency, patient transport, NHS Direct and out-of-hours services. (3)

It is planned that by 2006 the NHS Direct number becomes a single point of access for out-of-hours.

Regarding clinical information, NHS Direct responds to callers with a series of questions eliciting a yes/no answer. Staff use structured evidence based question frameworks to aid decision making and ensure they give accurate and appropriate advice. CHI found variable adherence to these protocols.

NHS Direct is the first response for calls to many out-of-hours GP cooperatives, with up to 50 per cent of patients accessing NHSD through this route not needing referrals to other services.

The emergency nurse advisor role based in the West Midlands and Shropshire ambulance service is an extension of the nursing role within NHS Direct. It provides a telephone response for individuals who call 999 and are prioritised as not immediately life threatening and needing only a basic life support response. ENA uses the same clinical assessment system used by all NHS Direct sites, and has saved a significant number of paramedic ambulance journeys daily by redirecting patients to a more appropriate service such as home care, GP appointment or non 999 patient transport service. (12)

NHS Direct is reported as committed to providing a good quality service and morale is generally high. However some sites experience recruitment and retention problems and some have addressed this by offering flexible working and over 60 per cent of staff work part time.

Minor injuries units and walk-in centres

The demand for emergency care services has risen in the last decade, with attendances increasing every year. However around half of patients visiting A&E have relatively minor injuries or illnesses, although this percentage varies depending on adequacy or accessibility of other parts of the health economy. In some parts of inner London the figure is estimated at about 48 to 50 per cent, because of poverty and disadvantaged populations, with problems accessing primary care. This figure is probably an overestimate for many other areas. However whatever the percentage, there have been a number of developments to ensure that these patients obtain speedy and appropriate care, without jeopardising the care of those who are more seriously ill.

In the last two years minor injury units (MIUs) and NH walk-in centres (WiCs) have been established, either attached to A&E departments or separately for instance in city centres. Those tend to be run by nurses. In the past MIUs focussed on injuries but now also deal with minor illnesses. WiCs were set up to provide convenient access for people with less serious and primary care complaints, typically offer access from 7am to 10pm 365 days a year.

Out Of Hours provision

Increasingly the design of out-of-hours is following developments in primary generally with nurse practitioner seeing same day appointments for triage and treatment and referring to the GP for more complicated presentations. They also are more likely to be involved in running a range of chronic disease management clinics. GPs are increasingly likely to focus on patients with problematic diagnoses and supporting chronic disease management where new, unexpected symptoms arise.

Ambulance service

The ambulance service now delivers more care to people faster than before, by improved response times, a more skilled workforce delivering healthcare intervention to

patients. In addition, it refers patients to alternative pathways for example emergency care practitioners, minor injuries units, the mental health crisis resolution team. Ambulance trusts increasing integration with the NHS has resulted in them being in some areas, major players in Emergency Care Networks, and a number of ambulance trusts now lead the provision of out-of-hours services.

Ambulance trusts have embraced new ways of working with expanded roles for paramedics and emergency care practitioners who are working with the ambulance service, and in the community in GP surgeries.

The Improvement Partnership for Ambulance Services was launched in 2003 was aimed at developing performance and also breaking down traditional boundaries between the ambulance trust and wider NHS so that the ambulance service can play a full contribution in emergency services.

European Working Time Directive

There are a number of initiatives designed to place hospitals in a better position to meet the WTD, which is also relevant to out-of-hours provision.

Case study

At North West London Hospitals Trust, medical and surgical patients will be assessed in the same unit by an emergency team comprising doctors from accident and emergency, medicine and surgery.

In north Devon the DGH are developing a project with three aims:

- *enabling the medical assessment unit to move to 24 hour opening 7 days a week*
- *the unit to be led by a nurse educator/practitioner who will be responsible for the development of nursing roles encompassing certain roles traditionally undertaken by doctors*
- *closer working between doctors covering A&E and the medical assessment, unit to enhance the flow of emergency medical admissions. (18)*

Planning unscheduled care

Demand for unscheduled care

Over the last 10 years the number of emergency incidents resulting in ambulance journeys has increased by over 60 per cent, the number of people attending hospital A&E departments each year has increased by over 16 per cent and the number of emergency admissions to hospital has increased by 20 per cent. This data highlights the need to manage the current emergency care workload differently. It appears that 20 per cent of patients attending A&E departments can manage their own care, 20 per cent need primary care services, 30 per cent have minor or moderate illness and the remaining 30 per cent require urgent care that can only be provided in a hospital setting. Therefore, many patients can receive the care they need in a non traditional way and many others will get the highest quality of care if referred from their point of access to a more appropriate service such as self care, social services, community mental health services or intermediate care. On a positive note, some of the most innovative roles for emergency care have been developed at times when recruitment has proved difficult, providing opportunities for staff to broaden their experience and develop their expertise. (12)

Development of a 24/7 service

The need for emergency care can occur at any time, although clearly there are patterns in demand. Many diagnostic services are crucial for the rapid assessment and diagnosis of patients who have urgent but not life threatening conditions and these services need to be available at evenings and weekends. Other services such as pharmacy, therapy, patient transport services and social services must also be available on a 24/7 basis, otherwise delays in discharge often occur because of the lack of these services around the clock, reduces the number of beds available, increases the waiting times in A&E and can affect the health of those no longer needing to be in hospital.

Planning unscheduled care

Planning unscheduled care is possibly more complex than planning in some areas. The planning of the unscheduled care pathways requires not just patient pathway design within the main providers, but organisations coming together to design a patient route between, and across their organisation.

In addition, to ambulance trusts, acute care trusts and A&E departments, primary care and the new arrangements for out-of-hours services, and NHS Direct there are also the services provided by Primary Care Trusts, particularly the district nursing service, the range of home care provision, the responsibility of social services, as well as what ever informal supports people have in their own homes or particularly for the elderly population, in residential or nursing homes. If unscheduled care was being designed on a blank sheet of paper, no one would design it with the numbers of organisations currently involved, nor design each one as it currently is. So unscheduled care brings together organisations that are very different, that have developed in a fairly ad hoc way, and in different geographical locations, the configuration of services varies. Much is made of patients attending A&E unnecessarily, or calling the out-of-hours services for something minor. However, given the rate of change within the NHS and social care, and the likelihood that if a patient moves from one area to another they cannot presume the same arrangements will obtain, and the fact that when ill or injured, no matter how minimally, most people are anxious, services should expect this.

This has implications for the way pathways or routes from care need to be designed, and then communicated effectively to patients, their carers and staff. At an anecdotal level there are enough stories about staff in the different organisations not being very confident dealing for instance with patients who present with mental health problems, and being very unclear where they might be able to refer them, so it is unsurprising if patients themselves cannot navigate through services.

The pathways need to be designed from the patient starting point (home or residential or nursing home or street/public place), or a visit to a WiC or an A&E department, or a phone call to, the GP, out-of-hours, NHS Direct, A&E. There will be different pathways for different categories of emergency and severity, and some particular pathways for particular diseases e.g. heart attack or stroke. However to complicate matters these pathways need to take account of the particular social and environmental factors of the caller. A frail elderly patient, who lives alone, is not in contact with neighbours, close family or friends, and cannot drive, is much more likely even if not a medical emergency, to require a home visit, paid transportation to a local centre, and/or a visit from a pharmacist to supply medication. So the services either need to come to the patient

through a home visiting pharmacist, nurse, GP, paramedic or other, or the patient needs to be transported by a skilled and sympathetic practitioner to a service for example a minor injury unit, walk in centre or primary care centre. It is at this stage of the pathway, that the links between primary care, out-of-hours services, the district nursing service, patient transport, and the ambulance service are particularly important.

Another pathway is for the patient for whom a visit to A&E and more intense assessment and intervention is required. However given that some people will always end up in A&E because they were taken ill in a public place because they either do not have the knowledge or the faith in local services, it maybe important that most A&E departments have a primary care unit or equivalent of a WiC or MIU, so that patients can be dealt with appropriately, without diverting A&E time from the more seriously ill or injured.

Although in a number of areas, considerable progress has been made in attempting to join up services planned collaboratively, there is no doubt that this remains a challenge for the diversity of providers. It is unclear as yet the extent to which the Emergency Care Networks will be able to facilitate the planning and integration required. These challenges at service level, clearly impact on staffing issues in both designing the right establishment of skill and seniority mix and recruitment and retention for existing roles, but also the training and reward elements that will be needed to encourage staff to develop their skills and knowledge for an expanded or redesigned role.

Emergency Prevention

There is growing acknowledgement that the focus of managing acute episodes of care and avoidable emergencies is not appropriate in terms of good care for patients, or sustainable in terms of managing an increasing number of people who will suffer from one or more long term conditions, which will rise with an ageing population. Patients with long term conditions or complications use over 60 per cent of hospital bed days, often as result of an emergency admission. In the NHS pilots of the American Evercare system, 3 per cent of the at risk over 65s accounted for 35 per cent of the unplanned admissions for that group. There is now experience in the UK primary care, confirmed by experience from American models, a systematic approach to managing patients with long term conditions underpinned by good prevention can be effective. (15)

It is estimated that at level one, 78 per cent of patients with the right support and only small improvements, can manage their own conditions and make less use of hospital care. At level two specific disease management provided mainly by primary care to recall, reviews and reassessment, with multidisciplinary teams providing high quality personalised care, can help avoid complications, slow down progression of their disease and promote good health and patients were then less likely to make demands on health and social care. For level three patients, with highly complex conditions, or often the elderly with three or more conditions, where a highly personalised service is available, reduced incidence of hospital admission have been achieved and reduced length of stay where admission has been required. Being systematic for level three patients has a high impact on resource use. Being systematic at levels one and two have a high impact on quality of care, quality of life and prevention of more complex problems in the future.

However there is relatively limited evidence of the effectiveness of preventive approaches in health and social care and much of this has been devoted to the under 65 population. With older people making heavier demands on emergency services, it is therefore important to look at where there is more solid evidence for preventive interventions reducing the need for health and social care services. Evidence is stronger

for influenza vaccinations, stroke rehabilitation, falls prevention (focussing on personal and environmental factors), and education in the self-management of chronic conditions such as arthritis. (6)

A number of services have focussed on case finding or service coordination. However the outcomes depend on the availability of appropriate local services and flexible support options. Continuity of care depends on the availability of day and community services.

Many schemes developed by PCTs are focussed on reducing unnecessary attendance at A&E, hospital admissions, and supporting particular patient groups with chronic disease (CHD, COPD) or known vulnerability as in the elderly population or mentally ill.

It is in this area of usually chronic disease management that nursing and AHP staff have a major role, working with well designed and updated protocols.

For greater detail, see *Long-term Care: Planning Issues*, Avon, Gloucestershire and Wiltshire WDC.

Community services to reduce the need for emergency care

Case studies

Older people

In Hertfordshire, health and social care coordinators have been appointed to prevent inappropriate admissions at crisis points and to coordinate health and social care services. These coordinators are based in PCTs and take direct referrals aiming to provide a flexible response, for up to two weeks only, to deal with crisis situations. They have access to a budget and refer people directly to different health and social services. Most of the coordinators are social workers or occupational therapists.

For patients aged over 75, on complicated medication regimes, where hospital admission has been due to medication problems, patient hospital discharge information is faxed to community pharmacists. The community pharmacist visits the patient at home for a medication review, liaises with the GP, produces a care plan and continues to monitor the patient.

To support the out-of-hours services, in Harrow and Hillingdon PCTs, 20 community pharmacists are on a rota to ensure that medicines from a pre-determined list and oxygen are available within one hour of a request from a GP with the out-of-hours cooperative (11).

North Sheffield PCT has an older people specialist team working with GPs, nurses and therapists offering support and development to nursing and residential homes. Care homes are invited to participate in a structured approach, aiming to reduce avoidable hospital admission by providing care in the home. (11)

In Epping, there is a geriatrician convened multidisciplinary conference, involving social workers, occupational therapists, physiotherapists, discharge coordinators, ward managers, intermediate care lead, modern matron and staff grade nurses who review health and social care needs and discharge arrangements for older people, to ensure timely and well managed discharged. (11)

Welwyn and Hatfield PCT have developed a multidisciplinary falls clinic for falls risk assessment, accepting referrals from primary care, A&E, ambulance and social services. Physically or mentally frail patients are assessed at home by a nurse specialist. About half are referred to other services including physiotherapy, occupational therapy, exercise classes or their GP or they are given pendant alarms. Patients receive at least one follow up visit for advice and to encourage exercise uptake. (11)

Case study of mix of community based services

In Dartford the PCT developed a range of community-based services to support timely discharge, or offer alternatives to acute hospital admissions. 187 acute admissions were prevented in seven months, average acute hospital stays for orthopaedics reduced by 25 per cent, and stroke in-patient length of stay reduced. The services introduced included:

- *the development of the closer to home strategy (one point of access).*
- *published a point of contact sheet for all GP desks, highlighting the options and promoting the telephone number.*
- *intermediate care team to take referrals from GPs of patients that would have been admitted, and also do a daily ward round of the medical assessment unit and A&E.*
- *appointment of nurse consultant in intermediate care.*
- *community stroke team.*
- *orthopaedic bridging team, to increase the number of hip and knee replacements performed, improved patient experience and reduced length of stay.*

Patients with mental ill health

Patients with mental health problems form a small but important minority of those attending A&E, but the complexity of their needs can prove disruptive to A&E departments and undermine their capacity to meet the four-hour target. The DoH has produced a new check list for staff to help improve access to care for mental health patients who often wait longer than the four hours. The DoH has also included access for patients with mental ill health as one of the measures in the current incentive scheme for trusts. Mental health trusts are currently working to qualify for incentive funding and achieve this by stating progress in developing 24-hour crises services. Mental health trusts, acute trusts and PCTs need to work together to provide access to mental health expertise in A&E departments and also to develop alternative services. Some departments have appointed mental health liaison workers in A&E.

Patients with coronary heart disease

Services to these patients have improved significantly in the last four years with the redesign of services and ambulance hospital and primary care teams working together. In many parts of the country paramedics administer thrombolytics resulting in faster access to treatment for patients, reducing door to needle time, and in many hospitals heart attack patients are now fast tracked having received thrombolysis on their journey to hospital or immediately on arrival at A&E. However, primary angioplasty is replacing thrombolysis for some patients, as it results in a better outcome and short length of stay.

COPD

Pressure on hospital services can be reduced:

In a randomised control trial of structured group education including an exercise component for people with COPD, hospital costs were reduced to £239 per patient compared to controls.

Thirty per cent fewer people with COPD were admitted to A&E in Lambeth and Southwark. In Castlefield the service for older people there was a 15 per cent reduction in unplanned admission. (15)

Brighton and Hove City PCT is exploring whether pharmacists could initially be involved in identifying undiagnosed COPD patients and later managing them, perhaps using supplementary prescribing. It is also developing a minor ailments service run by community pharmacies to relieve pressure on GPs while increasing choice and access for patients.

DVT

A primary care nurse led service treats patients with suspected DVT in the walk in centre at Arrowe Park Hospital, Wirral. The PCT developed the service in partnership with, doctors, nurses and pharmacists to reduce waiting times and avoidable hospital admissions.

Diverting from ambulance and A&E

Many initiatives have been instituted aimed at providing alternatives for the need for an emergency ambulance to visit a patient and secondly avoiding the need for inappropriate ambulance transportation to A&E. Paramedic and Emergency Care Practitioners (ECP) ambulance staff can undertake testing and treatment of patients on route for A&E or provide care in the patient's home.

Improved communication between the ambulance service and A&E speeds the pathway for patient to the appropriate service and intervention.

Data from the University of Southampton shows that up to 80 per cent of people presenting with an urgent need to primary care, can be safely managed by staff other than doctors. This is where the role of community paramedics and nurses can be valuable and appropriate. (13)

However it is important to acknowledge the different skills and strengths of doctors and nurses, and the different emphasis in their respective trainings. Currently with training as it has been, there is a greater emphasis throughout medical training on diagnosis particularly of rarer conditions and unusual presentations, and problems solving. Nurses' training to date appears to equip them to work better than doctors with patients requiring chronic disease management.

An example of an ambulance project, is that run by the Essex service where paramedics receive 21 weeks extra training and work as emergency care practitioners. They have been able to treat 60 to 70 per cent of people making 999 calls in their own home for instance catheterisation. For those people transported to hospital, half are referred direct to specialists, with the remaining 15 to 20 per cent requiring treatment in A&E. In many parts of the country, paramedics now administer thrombolytics, resulting in faster access to treatment for patients. (2)

The importance of knowledgeable and skilled response, from the organisations taking calls whether this be NHS Direct, out-of-hours services or the ambulance service, has been demonstrated by placing emergency nurse advisors in the ambulance control room project in the West Midlands and Shropshire ambulance service. This ENA project arose from the evolving role of nurse triage in NHS Direct, using software called Advanced Medical Priority Dispatch System. It was found that 50 per cent of all category A calls made from a domestic address could be managed by a service other than ambulance for instance home care, GP appointment etc. Of the remaining half 50 per cent did not require a 999 ambulance and could be directed to the non 999 patient transport service for same day transfer to hospital. The ENA triages forty to fifty calls per day and saved approximately 25 paramedic ambulance journeys per day. (Case Studies, ESC)

In some services, paramedics who have trained to become emergency care practitioners to work in the community, for instance based in GP surgeries. There is also the potential for ambulance staff to play an increasing role in the care of patients with long-term conditions and the prevention of the need for emergency care. (Alberti, 2004)

The Greater Manchester Unscheduled Care Network is planning to expand the recruitment of emergency care practitioners from paramedics and A&E and community nurses to include AHPs and will develop assistant and advanced ECP roles. For part of their training ECPs are based in A&E departments and in hours and out-of-hours primary care settings. Their role is defined to achieve the following:

- *A single practitioner will in certain patient pathways manage the patient throughout their journey either in the patient's home or temporarily in an urgent care centre.*
- *The ECP will help avoid unnecessary visits to A&E by ensuring patients receive the most appropriate care from health and social care services. (8)*

Ambulance services are developing alternative responses to responding to non urgent 999 category C calls. For instance Warwickshire ambulance service has a system of Alternative Response Vehicles and staff that attend low category calls, that might include older people or mental health patients who would otherwise have been dealt with by the emergency ambulance. This has decreased the workload for the paramedic ambulance crew freeing them up to deal with high category emergency calls. (12)

Interventions at Accident and Emergency

See and treat

About half of patients attending A&E have relatively minor illnesses or injuries and used to wait a long time to be seen and treated. The introduction of See and Treat, assessing and treating patients with minor injuries as soon as they arrive, is considered responsible for the largest overall reduction in waiting times for these patients. This reduces the tendency for queues to build up, and allows other teams of clinicians to deal with more serious cases. See and Treat models use a variety of clinicians including Emergency Nurse Practitioners (ENP) but are frequently nurse led. It has been claimed that 98 per cent of patients with minor injuries or illness are now seen and treated within four hours, the majority within two hours. (8)

To improve patient flow in some departments the role of receptionist has been expanded to ask patients basic questions to facilitate referral where appropriate to minors or majors area (16, 17)

Turning to patients requiring major assessment and observation or medical or surgical admissions, a number of other developments have proved successful.

Access to tests

Delays in accessing diagnostic investigations and results have been tackled in a number of ways, for instance point of care testing, use of protocols to enable allied health professionals to refer patients for diagnostic procedures, introducing dedicated link staff from pathology and pharmacy and reducing batching for pathology and x-rays.

Access to specialists

For patients with major conditions, delays can be avoided by insuring that there are sufficient senior clinical staff to meet anticipated demand to avoid the delays resulting from assessment by too junior staff.

A number of trusts have now adopted a version of physician of the week where a dedicated physician works with A&E and also with the assessment unit or short stay ward. This has reduced the length of stay and readmission rates for medical patients in Chester.

Some departments are attempting to eliminate triage even for majors, as in south Derbyshire where patients presenting within the major stream are seen, assessed and provided with initial treatment immediately on arrival, by the "pit stop" team, which includes a senior clinician, senior nurse, healthcare assistant and receptionist. Some patients can be discharged immediately from the "pit stop" area. (16, 17)

Bed availability

Tackling delays in bed availability has been helped by provision of discharge lounges, enabling patients ready for discharge to leave their ward in the morning and wait in the lounge freeing up the bed for new admission. Also patients being admitted for elective surgery can be admitted for same day surgery admissions (rather than day before), saving a night in hospital for both the patient and the NHS.

Assessment and observation

The establishment of a range of observation and short stay units ensures that patients requiring quick diagnosis and treatment have access to a dedicated short stay unit. An example is a 48-hour, ten bed observation unit for self harm patients, and in North Staffs, a 28 bed or short stay ward (48 hours) providing rapid access to investigations, reporting results and starting treatment, decreasing length of stay by four to one days. (16, 17)

Specific care groups

Other approaches include those targeted at specific patient groups who are high attenders at A&E, for instance older people or those who present particularly complex problems, such as those with mental health problems. A wide range of interventions have been initiated by trusts including:

Elderly

Establishment of an assessment team for older people including occupational therapists to provide assessment, rehabilitation, seven-day week service, and reduced the number of re-admissions (16, 17)

A falls assessment clinic was piloted to provide a mechanism for patients who attended A&E following a fall to ensure they received appropriate ongoing intervention either at home or in a community falls group. The clinic incorporated assessments undertaken by a multidisciplinary team (nursing, medicine, occupational therapy and physiotherapy), who agreed the intervention. Patients who had fallen but not been admitted to hospital would previously have had no intervention and may have fallen again. The falls group provides an ongoing assessment and education programme for patients over a 12 week period in order to prevent further falls. (14)

DVT

Patients with suspected DVT are managed on an outpatient basis at a nurse-practitioner DVT clinic avoiding unnecessary admissions (16, 17)

COPD

For COPD patients the establishment of a nurse led acute assessment service was developed in which specialist nurses provide assessment and investigation and prescribed a treatment package. This has resulted in a reduction in bed days (Wigan). (16, 17)

Mental health problems

Newcastle and North Tyneside Trust plans to appoint a mental health/acute care nurse practitioner who would rapidly assess people presenting with primarily mental health problems, and support, advise, treat, refer and/or discharge appropriately. At Wansbeck Hospital, Northumberland they hope to appoint a mental health A&E liaison nurse and to handle transient mental health problems which are secondary to acute trauma more effectively, provide mental health assessments to people who present to A&E and liaise with community staff to ensure continuity of planned care of individuals who had presented at A&E. By providing support and training, the new role aims to improve the mental health interventions of staff within the department that have not received mental health training.

CHD

For patients with CHD, thrombolysis has been a treatment of choice until the introduction of primary angioplasty and until the latter is more available thrombolysis will remain important. Primary angioplasty is only slightly more expensive than thrombolysis. The cost of the additional staff required to pay provide the spare capacity needed for rapid emergency access, only slightly outweighs the savings from a reduction in length of stay from seven to five days, and savings in thrombolysing drugs.

Communications between the ambulance service and catheter laboratories is pivotal and includes the electronic transmission of ECG results. Importantly, ambulance personnel ideally will make the diagnosis themselves with ECG interpretation and possibly finger prick blood tests etc. More ambulance time will be needed, as drivers would need to travel further to hospitals with catheter laboratories. This contrasts with the existing practice where patients are taken to the nearest hospital in the first instance, and then

transferred to a specialist centre. Performance measure would be door to balloon time, instead of the current door to needle time.

The Hammersmith Hospital now offers myocardial infarct patients better health outcomes by giving them primary angioplasty, as soon as they arrive in the catheter laboratory, open 24 hours a day. The length of stay has been reduced from 9¾ to 3 days. This was achieved with no additional funding. However the significant savings accrue to the purchasing PCTs, rather than the trusts. (19)

For patients requiring emergency access for surgery, the provision in Airedale of the direct access abscess service for GP referral reduced the length of time from admission to hospital to surgery to two hours from 30 hours reducing the overall length of stay to six hours from 2.4 days. This avoided the previous system of admission to surgical beds or referral to A&E with these patients often receiving low priority on the theatre list. (16,17)

The future for emergency care

The future systems are increasingly based on principles of patient centred care, i.e. care will be:

- personalised and needs based
- subject to no unnecessary delays
- simple to access
- convenient for patients,
- available as early as possible (emergency prevention)
- integrated whole systems care i.e. patients can move from one part of the system to another without barriers, delays or having to start again. (Alberti)

Emergency Care networks

It is envisaged that the new Emergency Care Networks (ECNs) will be central to ensuring that emergency care conforms to these six principles. They are intended to develop cross - boundary working, to integrate primary care trusts, acute trusts, social services, local authorities, ambulance trusts, pharmacies, mental health trusts, patients, the public, the voluntary sector, strategic health authorities, NHS Direct, out-of-hours providers and all those who provide emergency care. In the longer term PCTs may commission ECNs to deliver the full range of emergency care services. (8)

Development of these networks would particularly need to focus on the improved provision of care for older people who currently make up more than half of the medical admissions to acute hospitals who need simultaneous care from a number of providers.

Future improvements to emergency services will take advantage of the national programme for IT to help simplify patients' access through the system.

It is envisaged that MIUs and WiCs, where needed will be open 24 hours a day 7 days a week. Where possible they may be in the same place as out-of-hours GP services.

The co-location of primary care centres, local surgery or NHS walk-in centres will help provide an integrated user-friendly service for both office hours and out-of-hours care.

Emergency prevention will be seen to be a key focus for the ECNs. Emergency prevention needs to be targeted at those managing long-term conditions such as chronic respiratory disease, and older patients and those with mental health problems. Pre-emptive regular care has been shown to reduce drastically the number of admissions and to improve greatly patients' quality of life. Pre-emptive care also fits the new emphasis on long-term condition management. (*Choice, Responsiveness and Equity in the NHS, 2003 in 8*)

3. WORKFORCE

The rapid changes in the provision of unscheduled care have given rise to changes in jobs, the establishment of new roles, with the attendant impact on recruitment retention and training requirements.

Developing staff roles and new roles

Developing roles and staff in unscheduled care may be more of a challenge even than in other specialities. This is because several historically separate services with different organisational and structural designs, cultures, and employment practices are having to come together to provide a more integrated service for patients, therefore the challenge of designing a coherent workforce strategy in a “whole system” manner is more difficult. The big players are the acute trusts, the ambulance trusts, the primary care out-of-hours services and NHS Direct. However, other equally important staff groups are employed by social services and primary care trusts for instance, the district nursing service.

Inevitably, there has been a tendency for some roles to receive more attention, perhaps particularly newer roles like the emergency care practitioner. Other roles required attention because of changes to contracts or legislation, for example concerns about hospital cover at night, the Working Time Directive, and the change to GP contracts and the impact on out-of-hours services. Understandably, keeping the “show on the road” has been the main preoccupation, resulting in less emphasis on strategic plans to meet workforce needs over the next 10 years, taking account of training, recruitment, and retirement cycles. Attention to some groups who have potential to be part of unscheduled care has become in some areas rather marginalized, for instance district nurses. The more visible bottlenecks have been ironed out without always seeing the next bottleneck ahead.

A major challenge is ensuring that staff at all the levels required for a service are available. Looking at the nine levels, there is probably more concentration of effort at some and needs to be greater attention paid to developing levels one to four and a possible gap between levels five or six to eight.

There is likely to be rethinking of the role of GPs in primary care and also of nurses and AHPs. GPs, because of shortages and recognition of core skills may focus more on problematic diagnoses requiring longer consultations and supporting chronic disease management when conditions are volatile. Nurses will move increasingly into minor illness and injury and running chronic disease management clinics. With the required additional training to more advanced levels and a greater training focus on diagnosis, these boundaries may change.

Training and funding

There are also challenges about funding training so staff can expand and develop their role, and ensuring there is some consistency between the level of the training and remuneration. It may be important to take at least a 10-year plus time horizon to look at the funding trade offs and plan for the future workforce. In the AGW area, although many of its recruitment and retention problems are not as severe as in other parts of the country, the position regarding GPs and their current availability in some areas, and the impact of retirement over the next decade will be significant. Unless staff groups can be

trained in a rolling programme and move from level five to advanced and consultant practitioner levels, there will be a serious gap in staff working in unscheduled care able to operate at the level required.

Although GP students in training figures in AGW look as though they may match retirement figures, there is no guarantee that students will enter general practice, and 60% of students are now women who are less likely to work full time and be engaged in out of hours work.

There are a number of advanced courses on offer, with free places at NHSU course, and others at a number of universities near AGW e.g. UWE, Oxford Brookes, Cardiff and Bristol. Locally it was reported that of the 15 places available to AGW for advanced practitioner training, only five have been taken up. It was suggested that this was because although the training was designed for Level 7 posts, they attracted locally Level 6 pay.

New trends

The developments that are occurring nationally, mainly fall into the following areas:

- Nurse led teams for chronic disease, running minor injury and walk in units and managing assessment units.
- Community pharmacists working alongside other primary care professionals, using skills to deliver urgent care to patients and often having to expand service flexibility.
- Ambulance staff delivering healthcare interventions at the scene of accident, and improving the speed of interventions to coronary heart disease patients through the use of 12 lead ECG machines and the administration of thrombolytic drugs.

Generally, the impact of the changes has been the expansion of nursing, AHP and paramedic and support worker/healthcare assistant/technician roles. These are seen as essential developments, partly so that these staff groups can achieve better professional development and job satisfaction, which may impact on recruitment and retention, but more pragmatically because they are cheaper to employ.

To assist nurses developing lead roles, barriers have had to be removed for instance the extension of the range of medicines included in the nurse prescribers extended formulary.

One of the major new roles has been that of emergency care practitioner, currently recruited from paramedics and nurses, who are used to support general practice, support the out-of-hours services, support ambulance services and A&E departments, and see, treat and refer patients with the minimal need to refer to other professionals.

A number of roles have been redesigned, and new roles developed, and although there are common themes, particularly for ECPs, the roles tend to mean different things in different geographical locations, and also the settings in which they are employed. From many of the examples quoted later in this section, it does appear that these redesigned and new roles, are contributing to some core targets, for instance reducing the demand on A&E, reducing lengths of stay and assisting in maintaining patients in the community.

New roles

Support workers and assistant roles

Alternative response vehicle care assistant

The ARV attend low category (C) emergency calls in order to provide a more effective response than the traditional paramedic ambulance. It also attends certain high category life threatening calls where it was the closest ambulance to the incident. The ARV are crewed by ambulance care assistants who receive additional training in patient assessment, first response and moving and handling. The vehicle also has additional specialist mobile lifting equipment, moving and handling aids and a defibrillator/response kit.

The role was developed to reduce the workload of paramedic ambulance crews and free them for higher category emergency calls and deliver appropriate patient care within the timescale, and stream patients based on clinical need.

Community paramedic

This role was tested in both rural and urban environments. (At Shipston-on-Stour and Nuneaton) The role was devised to improve patient access to emergency and unscheduled care. The community paramedic was based in a GP surgery, minor injury unit or walk in centre. The paramedic responded to emergency calls in the local area and carried out home visits on behalf of the GP, to assess patients who had requested a home visit, patients who had recently been discharged, patients who had been assessed as at risk, and urgent referrals from other sources such as social services or NHS Direct. The community paramedic treated patients as appropriate, or referred them to the GP, A&E, minor injury unit, community hospital, intermediate care or social services.

During the pilot the paramedic achieved better response times to emergency calls and many home visits in much shorter response time than would have been the case for a GP.

The issue over liability as the paramedic was working for the ambulance service and GP, was resolved with the paramedic working within the scope of paramedic practice, and the ambulance service who provided the training, covering liability.

Support worker role

Intermediate care teams report reduced variation in delayed discharges as a result of implementing support worker roles. These roles enable older people to be discharged back into the community. Pilot sites are reporting that delayed discharges have been reduced from 11 to 7 per cent. These posts are at assistant practitioner level.

In Derbyshire a number of PCTs, acute trusts and social service departments, user and carers groups produced a pilot particularly designed to support the social care workforce taking on some responsibilities previously undertaken by health staff, to reduce hand-offs and help older people who have suffered a crisis to get back home and receive appropriate support. Home helps have been trained by therapists to assist the older person in areas of rehabilitation in daily life tasks and also in the administration of medication. This has been equated by Derby University to three credits at NVQ Level 3.

Healthcare practitioner/healthcare practitioner assistant

These two posts were piloted on a dedicated 14 bed assessment unit which receive direct admissions by GP referral or from A&E. Specific patient selection criteria are in place and the appropriate staff trained to ensure that suitable patients are included in the project.

Practitioner roles

Emergency care practitioner role

This has led to a reduction in people taken to A&E from 70 per cent to an average of 57 per cent over the first six months of the trial. 38 per cent of responses were treated at the scene or referred (non-conveyed) compared to 30 per cent previously, plus 2 per cent were referred and transported directly to more appropriate care pathways. These ECP posts were designated advanced practitioner level. (Ten High Impact Changes)

Emergency nurse practitioner A&E

Patients can be seen as soon as they arrive by a senior doctor or ENP, both are able to assess the patient, carry out necessary treatment and discharge. At Kettering General Hospital, 75 per cent of patients were discharged within one hour and 57 per cent of patients were seen within 30 minutes.

ENPs have been employed in high-risk care suites in A&E. In Lewisham University Hospital ENPs see, treat and discharge patients autonomously. They deal with minor injury and illness within parameters of practice and prescribe using patient group directions. They see any patient who presents to A&E and could have been seen by a GP. They can refer to other specialists autonomously.

Nurse specialist for older people in primary care

This post has been piloted in North East Derbyshire. Posts will include carrying out medication reviews in line with agreed protocols, developing outreach sessions for older people who are unable to attend surgery and developing joint planning of care. The objectives are to reduce admission/re-admission rates and calls to the GP services.

Major practitioner

The major practitioner works alongside SHOs assessing patients and initiating diagnostics and treatment. During the patients episode of care the practitioner provided a clinical assessment, active management, clinical care and made appropriate referrals to senior staff or specialist teams. The work was carried out under the supervision of the senior doctor on A&E. Training for this is currently being developed. Regarding outcomes, following the introduction of major practitioners more patients waited less than four hours.

Chronic disease practitioner (respiratory)

These roles were developed to respond to the growing incidence of respiratory illness and with one of the aims being to reduce attendance at A&E.

The post holder is responsible for managing a caseload of chronic respiratory disease patients, identifying discharge dates and monitoring patients through home visits, telephone consultations and an out-patient clinic. The new role enables patients with chronic respiratory disease to self manage and reduce the need for acute hospital

admission. It achieved a reduction of over 50 per cent in the attendance for these patients at A&E.

Mental health practitioner base with an out-of-hours GP cooperative

This post is yet to be piloted. The rationale proposed by the Cumbrian GP cooperative, with a vast majority of mental health calls received by out-of-hours were dealt with without reference to the existing care plans of patient records and the patient rarely received a multidisciplinary response. It is considered that a focus on the out-of-hours period would pay dividends as for example 21 per cent of emergency psychiatric admissions, half the trust, occurred during the out-of-hours period. (14)

Occupational therapists in A&E

This post reduces unnecessary hospital admissions and ensures hospital discharge is safe. Referrals can come from any A&E staff. An OT will provide a rapid assessment and discharge planning from A&E and improve assessment if admission is required. This minimises the likelihood of re-admission to A&E and facilitates continued maintenance in the community. (South Warwickshire Hospital Trust)

Community pharmacists

Increasingly community pharmacists will be members of the out-of-hours and primary care team, as at least a half of out-of-hours interventions depend on pharmacy availability.

Medical care practitioner

These posts are being piloted in sites in London, and there is an evaluation of the American trained physician assistant role in Birmingham and Black Country. NHSU is providing training. It is thought these posts will be particularly useful in primary care and acute care medicine and assist with some other priorities such as reducing waiting times, meeting A&E targets, changes to GP contracts, and the ability to deliver care in hospitals at night.

It appears there may still be a gap between the level to which many emergency care practitioners, nurse practitioners, majors practitioners are trained and a more senior level. There is a need to develop staff at senior practitioner, advanced practitioner and consultant practitioner level.

4. LOCAL SERVICES

Avon, Gloucester and Wiltshire (AGW) Strategic Health Authority (SHA) area provide services in 18 hospitals, managed by eight trusts, and primary care and community services, commissioned and managed by 12 primary care trusts, three ambulance trusts, a growing number of walk-in centres and minor injuries units, and NHS Direct for health advice 24 hours a day. It also has two treatment centres, one already operational in Weston and one soon to be opened in Swindon.

Service provision across the area is complex with little coterminosity between providers. Parts of the health economy are struggling financially, for instance Bristol. Service provision needs to be tailored to rural and scattered populations in parts of the area and much denser inner city needs, for instance, in Bristol. There are different models for out-of-hours primary care provision, NHS Direct operates differently across the patch and the three ambulance services for Avon, Gloucester and Wiltshire also have different approaches. ECNs are reported to be at different stages of development across AGW and some to have reportedly started but faltered.

For mental health patients presenting out-of-hours, there appear to be a number of problems about how well sign posted services are for patients and staff, where patients can be referred to, and staff training to manage this group who often present with complex problems. In rural areas it appears out-of-hours staff rely on in-patient departments and in urban areas are more likely to contact mental health crisis teams but not all services are equally geared up for this patient group. The model at Bath for example where there is a psychiatric liaison facility appears to work but perhaps has capacity problems. This is an area that needs to be addressed by both acute trusts, mental health trusts and PCTs.

Looking at staffing vacancies of over three months duration, as a whole the AGW area is average or in a better position than the rest of England for staff groups relating to unscheduled care. The exception is the ambulance service, although the figure at just over 1% was not considered a problem by the trusts.

However, despite the generally favourable national comparisons, there will be local problems. For example, for GPs, there is an 18% over 3-month vacancy rate in Swindon and 16% in N Somerset and an average of 11% across AGW. The percentage of GPs aged over 50, is 20% to 30% across AGW, and therefore primary care will be affected by high retirement rates over the coming decade.

Information is included in the following section on A&E, primary care out of hours, NHS Direct and the ambulance service. This is not intended to be comprehensive but included to give an indication of issues and challenges identified locally regarding service developments and workforce implications. More details of some services are in Appendix 2.

The Bristol labour market for healthcare assistant level staff and nurse aspirant staff is tight. Not only is there competition from outside the NHS but other trusts within the Bristol, Bath, Western and Cardiff area. Regarding recruitment and retention for more senior staff is easy, and there is currently a worry that the unit may be top heavy with senior staff which is a change from 18 months ago.

Staffing – the main issues are to do with morale which in the current target driven environment can be problematic. They are encouraging career breaks.

For nurse training they use Oxford Brookes University and the University of the West of England for ENP training for the autonomous practitioner training.

There has been a lack of AHPs in intermediate care, which were attributed partly to the general shortage and also to the lack of career structure in intermediate care. This has now to some extent been rectified with a head of therapy appointed and posts are becoming more attractive.

Nursing retention is particularly difficult for the out-of-hours service run by district nurses where there is competition from non health - employers, and the independent nursing sector who pay more. Solutions for this are seen to be to offer rotations, stress the new developments, training opportunities and also the perks of the job, for instance pensions, family friendly flexible hours, maternity pay and so on.

How can district nurses be integrated into primary care in - hours and out- of hours services, to make best use of, and develop their skills. Currently they are employed by different organisations (PCTs), frequently feel too overworked and isolated to participate in training and interprofessional activities. (This is a national problem not unique to AGW)

There are opportunities for staff to be appointed to joint health and social care assistant posts and provision between health and social care, with these staff offering home care and personal care. A new training is being developed. These staff are currently direct employees of social care but there is uncertainty as to whether this will continue or whether the service will be contracted out.

There is concern about the lack of mental health skills of staff working with elderly people, few of whom will actually be seen by the adult psychiatric services. Many older people present as confused and there are problems accepting the difficulty and being creative about dealing with it. A CPN is to be involved in training up staff in intermediate care centres, care and care homes and social care. Improved skills in this area appears to help avoid inappropriate A&E attendance or admission.

What scope is there to extending this type of services across AGW and what would be the workforce implications?

Staffing recruitment and retention are not a problem as the unit is seen to be well led with good opportunities for education, good teaching provision and an innovative department interested in research.

The training for ENPs is at UWE and is a part time course covering three modules on decision making, clinic examination skills and advance nurse practice. Two staff per year attend.

Are the training places available for ENPs sufficient to meet the future need for these staff? Are there sufficient courses and uptake at advanced levels?

Within A&E healthcare support workers or health emergency assistants are integrated into teams trained to NVQ Level 2 and on A and B grades. Recruitment to these groups is unproblematic.

The main staffing problem is the number of consultant posts available to A&E, secondly the availability of staff at night, and thirdly the change in medical training.

In Bath A&E there are three (compared with seven at Frenchay, seven at Salisbury, five at Swindon, five at Bristol Royal Infirmary and seven in north Bristol split between Southmead and Frenchay). This level apparently makes it difficult to field the desired consultant level input of 10 hours per day. There has been investment in acute medicine but this has not relieved pressure on A&E.

With the European Working Time Directive and the Hospital at Night Initiative, there can be difficulties if SHOs for surgery, gynaecology and ENT are operating at night and are then not available to A&E for assessment purposes.

Now junior doctors will only stay in departments for four months not six months therefore there will be three training cohorts passing through departments every year with an increased supervisory and training load on senior staff.

Recruitment is easy as the Bath trust is a new department with a national good name and a reputation for finding new ways of working. However new ways of working harder and smarter do produce some strain for staff because of the speed of change in work practices.

In Cheltenham and Gloucester hospitals, they have not adopted the ENP role but are looking at developing and updating the nursing role as a whole. They are concerned developing too many nurse specialisms for instance minors, majors and others, and want to focus on developing and enhancing skills for all groups where staff can undertake appropriate see and treat responses. They have no problems with recruitment and retention.

Out of Hours Services (OOHS)

There are at least five separate out-of-hours primary care models operating across SHA. It is regarded as unlikely that any one model would be appropriate across the AGW area given the different pattern of provision that has arisen, population density and variable recruitment and retention problems particularly for GPs, a key staff group. Many PCTs are also unclear as to the impact of the new GP contracts and aware that some of the provision currently available now may not be available in 2005.

NHSD has provided call handling and triage since October 2004 in N Somerset and W Wiltshire, and it is planned to roll this across the rest of AGW by 2006 when NHSD has the technical capacity to manage this.

There are issues to consider and trade offs to be made in designing OOHS including:

- centralised, easy, well sign posted access to out-of-hours provision
- cover for the entire period with the appropriate skill mix to meet anticipated demand.
- continuity for patients.

- an affordable and sustainable service that makes best use of a range of professional skills
- deciding on the balance between GPs, specialist nurses, pharmacists, paramedics, and others, and the seniority mix and attendant training needs
- a service that takes account of availability of GPs, specialist nurses, ECPs and AHPs
- a service that secures good patient outcomes and is cost effective for the size of area covered and the population density.
- tension between local continuous care service and central call handling. (Traditional local services, GP led have the benefits of local information, known patients and also the awareness that if problems are not resolved in the night they will represent in the morning. However with a call centre and a centralised service, it is less likely that unresolved problems will land in their surgery the following day.)
- continuity for staff so that patients treated out-of-hours return to the same service in the morning, with the incentive to resolve things during the night (as opposed to little action by OOHs and offloading to another service in office hours .
- reimbursing costs as patient flows are as yet unclear and so it is also unclear whether billing each other home visits and other services makes sense or whether costs will average out.

Generally effort has gone into managing the transition with GP contracts. There are some concerns that many of the services in their current form may not be sustainable in the long term either due to cost or availability of GPs. New provision is likely to require a multi-agency and multi-disciplinary team approach which straddles traditional boundaries using a range of skills, medical, nursing, AHPs including pharmacy, healthcare and social support workers, paramedics, emergency care practitioners, drivers and others.

One A&E department reported an increase in night referrals thought to be in part associated with patients not knowing where to go for out of hours services another department reported that some primary care services appeared to be referring patients with minor problems to WICs or MIUs.

NHS Direct

The development of NHS Direct has resulted in a drop of phone calls to A&E for advice as these now are managed by NHSD. It is thought that NHSD do sometimes suggest A&E referral even if necessary on a 'better to be safe than sorry' basis. Currently NHSD apparently does not have the capacity to offer PCT integrated harmonised call and triage system except in N Somerset and W Wiltshire. However it is planned that they will be able to offer a one call service after 2006.

Ambulance services

Avon and Wiltshire trusts appear to operate in a more similar manner than the Gloucestershire service.

Avon ambulance service has launched a project to implement, Treat and Refer. The project enables ambulance staff to provide a broader range of care for patients with options for treatment at home as well as admission to A&E and other alternatives.

The treat and refer scheme received £60,000 from the WDC and has trained paramedics with enhanced assessment skills to provide treatment at home or refer on to primary

care. There is a single point of entry for patients. The trust would like to train five trained paramedics and would like to be in a position to train all their paramedics. There is a scheme protocol for the range of patients and conditions that can be accepted by treat and refer. Staff were trained for a period of weeks in a mix of theory based sessions and practice at Royal United Bath's A&E department. They are starting a new scheme to train at UWE existing health staff as ECPs, to work on the OOHS handling category B and C calls, linked to NHS.

Recruitment for ambulance staff to train to be paramedics is easy and they have a good response to adverts. However they cannot recruit more senior staff. Therefore they are dependent on training incoming technicians to paramedical level but no WDC guaranteed income for this. This increasingly needs to be built in to PCT budgets. However there are four PCTs in Wiltshire and will need coordinated commissioning.

Retention is not a big problem until paramedic staff are older, when the lifting and handling requirements can be problematic. This results in skilled staff leaving the service to take on patient transport where they only have to undertake planned lifting, or office roles. This represents a waste of skilled, trained staff.

What is the scope to redeploy these staff to paramedic posts in primary care or A&E or other services developed as alternatives to A&E attendance?

It was reported that Gloucester ambulance service had integrated call handling with the out-of-hours provider, and good links with A&E. However concerns have been expressed about out-of-hours services using their provision and over referring to A&E and the sustainability of this approach cost wise.

At Bath and North East Somerset PCTs (BANES), call handling and nurse triage is provided by South Wilts OOHS. They are considering introducing a community pharmacist to the OOHS team and co-locating the OOHS to a WiC near an in-supermarket pharmacy. There are two primary care centres, one at Poulton Hospital where there is a MIU and nurses provide a service from 6pm till 10pm. After 10pm a ward nurse covers through the night. The other is a WiC at Royal United A&E in Bath, with nurses providing a Saturday and Sunday and evening service. The WiC is staffed by ENPs trained at the U W E course.

NHS Direct has insufficient capacity currently to provide call handling for BANES.

There is a twilight nursing service provided by district nurses who work days but also provide a night service for known patients. This emerged from the palliative care service.

There are few problems recruiting nursing staff in this area but a problem in attracting nursing staff to work nights and weekends. There is also difficulty at Poulton Hospital in attracting ward nurses to do the night cover for the WiC. It is also not easy to attract district nurses to the twilight nursing service where the pay is poor and the hours unsocial. However for the WiC recruitment is easy. Agency staff are ill-equipped for these more specialist nursing roles.

The GPs have bid to be service providers. Currently all the GPs are on rotas for the OOHS and currently there are no salaried GPs. They consider they are probably too

overstaffed with GPs for OOHS, with three and two on call. They plan always to have GP cover but probably fewer GPs and more nurses, ENPs, ECPs and the involvement of community pharmacists. There is a concern that the current scheme is slightly unsustainable and overspent.

They are planning to train medical care practitioners for the OOHS, which would provide a level of medical cover but would be cheaper than the GP service. There has been a request for nominees within the SHA area for the Physician Assistant MSc course. This could be a considerable saving in salary costs.

What will be the take up for MCP training and the impact on the need for GPs and practitioner and more advanced level ENPs and ECPs?

In the South Gloucester and North Bristol area a fairly traditional out-of-hours service has been negotiated with the GP co-operative. There is a GP service from 6pm to 8am. There are plans to introduce nurse triage when NHS Direct has the technical capacity to operate this which may then result in the ability to run the system on two doctors instead of the current three. They have also negotiated to purchase materials from the PCT which can be done much more cheaply than by the GP co-operative. It is thought this is a sustainable model and because they have negotiated a contract with the existing co-operative they are anticipating few problems with the recruitment.

Across Gloucester ambulance trust area, there is a different system with the out-of-hours service co-located in the ambulance call centre. The ambulance service can provide a mobile GP cover for home visits so that primary care unit working alongside A&E divert A&E attenders who do not need A&E mainstream.

5. LABOUR MARKET TRENDS

Introduction

This overview identifies the long-term trends from local, national and international labour markets. While the perspective in some cases is up to ten years ahead, the action to address them needs to be taken very soon to counteract the powerful trends that are taking place.

It makes the case that it will be harder for all employers to recruit and retain staff, as the labour force will decline while the demand for labour will increase. The NHS therefore, has to improve its attractiveness to current and potential employees, merely to stand still.

General Employment Trends

International trends

- Most populations in developed countries are aging
- International competition for skilled labour will increase
 - America alone needs more than one million new and replacement nurses be needed by 2012ⁱ.
 - More UK based nurses are leaving for the USA. In 2002-03, more than 2,200 verification checks on UK-based nurses were requested by American employers, up from just over 1,000 the previous yearⁱⁱ.
 - Nurses and other healthcare staff in the Philippines will be attracted to America, where they have historic links in preference to Britain.

England

Supply

- The UK population is ageing – so is the workforce.
 - Older workers may want to work fewer hours and value flexibility in employment
- The national labour market will shrink by 700,000 by 2010.
 - Competition for labour will increase, especially for those with skills that are valuable outside healthcare. Therefore, NHS wastage and vacancies could increase as a result.
- The number of school leavers will decline and yet a higher percentage will go on to university – the Government target is 50 per cent.

Demand

- The demand for labour will grow by an additional 2m jobs by 2010.
 - Competition for labour and NHS vacancies and wastage could increase further
 - The growing demand from service sector employers will increase the competition for women in employees, which will affect the NHS disproportionately, as it has a predominately female workforce.
- The public sector proportion of the UK workforce is declining.

Bristol, Avon and Wiltshire

Bristol

- There is plenty of competition for labour between employers in banking, insurance and finance and IT related employment. This is evidenced by a very rapid decline in unemployment and the large number of clerical vacancies.
- Unemployment affects young people from deprived areas who have performed poorly at school and who lack employment related skills.
- Bristol school leavers have poorer results than the national average.

Swindon

- Pay rates are high and average household income is above the national average.
- The low skill base of the population is a threat to the town's continued prosperity.
- Unemployment is concentrated amongst the over 45s whose former employers have recently shed staff.

Gloucester

- Unemployment rates are in line with national average, but are above those of the county.

Competition

- Expansion in demand for employment locally: the docks are likely to require male, skilled manual labour. However, the airport expansion will recruit a large number of women – i.e. serious competition with the NHS

NHS Employment trends

NHS in England

Past trends

- The NHS workforce is growing at a rate of 3.1% a year.
- Medical staff growth is 3% a year and Therapists growth is 4% a year.
- UK stands out among other western nations as the country that is most heavily reliant on recruiting nurses from the developing world, with nearly 10,000 people from developing nations registering to work as nurses in the UK between 2000/1 - 2002/3ⁱⁱⁱ.

Future Demand

- Ageing population; by 2011 16.5% of the UK will be over 65.
- Increase in long-term conditions.
- Changing patterns of service delivery.
- Increased demand for staff.
- By 2010 the NHS will need to increase its workforce by 200,000 jobs
- Recruitment of 150,000 HCAs.

Supply

- Over 80% of existing professional and assistant staff need to be replaced by 2010.
- Number of nurses retiring will double between 2005 and 2015, with 27 per cent being aged over 50.
- Shortages of professional staff – 25,000 doctors by 2020.

- The feminisation of medicine (60 per cent of medical school intakes are female) will require more doctors to work a given number of hours, as women have shorter working lifetimes due to career breaks.

NHS in Avon, Gloucestershire and Wiltshire

Overview

- The AGW area has had far fewer recruitment problems for professional staff than the rest of the country. However, administrative and clerical staffing has been problematic, with the competition from the financial sector. This means that there has much less pressure to introduce new roles and to change skill mix.

Reference costs

- The historic overspends in Bristol suggest that reference costs are likely to be above average in many cases. This will produce major pressures to increase productivity through improved working processes. In addition, there are likely to be also be skill mix reviews to see whether other types of staff could undertake the work at lower cost.

Promoting NHS careers

- How can we sell careers not jobs? Starting pay is very poor in the NHS, yet little is made of the extensive training and opportunities for promotion.

Targeting graduates

- There are a large number of graduates who find it difficult to get jobs. Why not aggressively target sports scientists, biologists, psychologists?

Impact of IT

- More IT will reduce the demand for clinical records staff, but increase the demand for staff IT staff and information analysts. The data goldmine will enable the NHS to evaluate the impact of different drug regimes and care strategies much more effectively.

Demand and supply

- Plurality of providers – the greater use of the independent sector. This could drain more staff away from NHS and on the other hand, possibly encourage more efficient practices in the NHS.

Danger of pay spirals

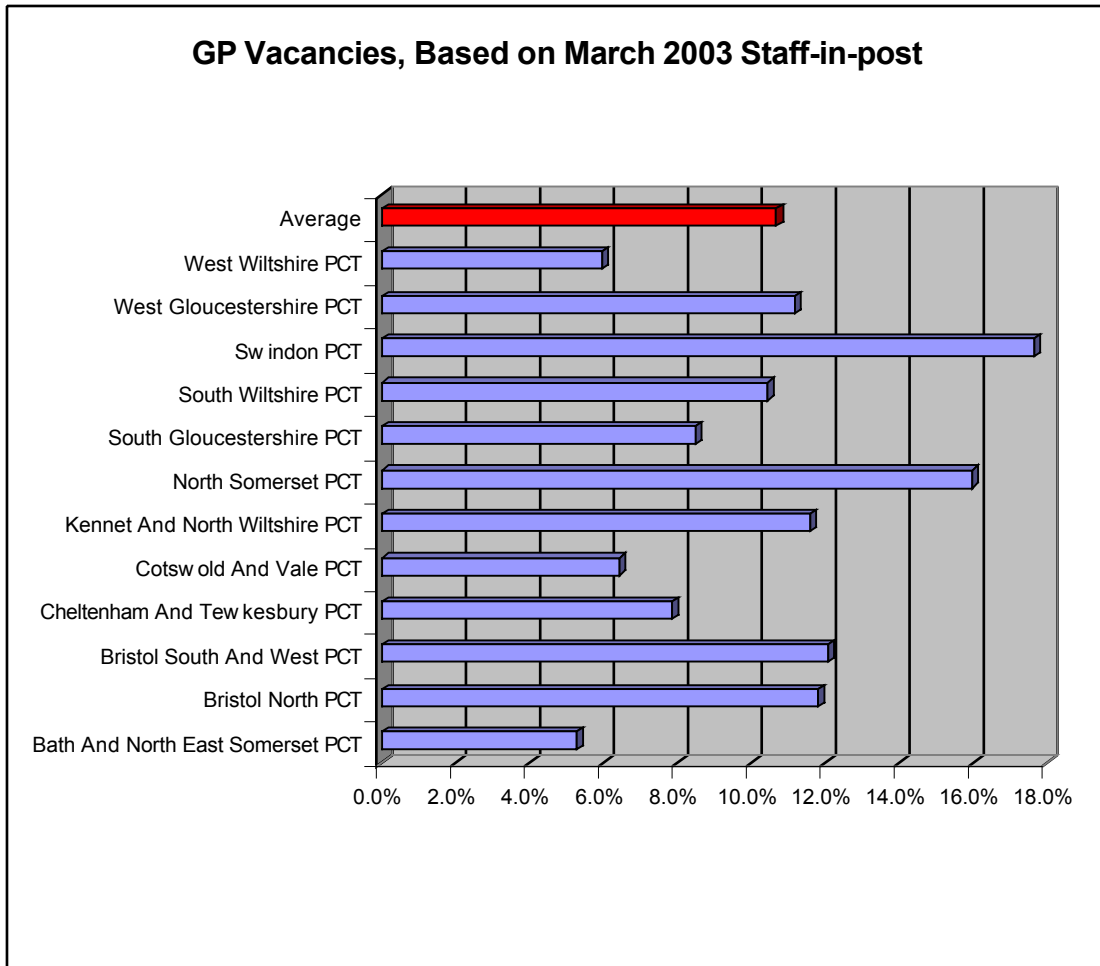
- There is a danger that health and social care organisations faced with growing staff shortages will compete against each other very intensively, resulting in upward pay pressures, unless a coordinated approach is made to the problem by employers.

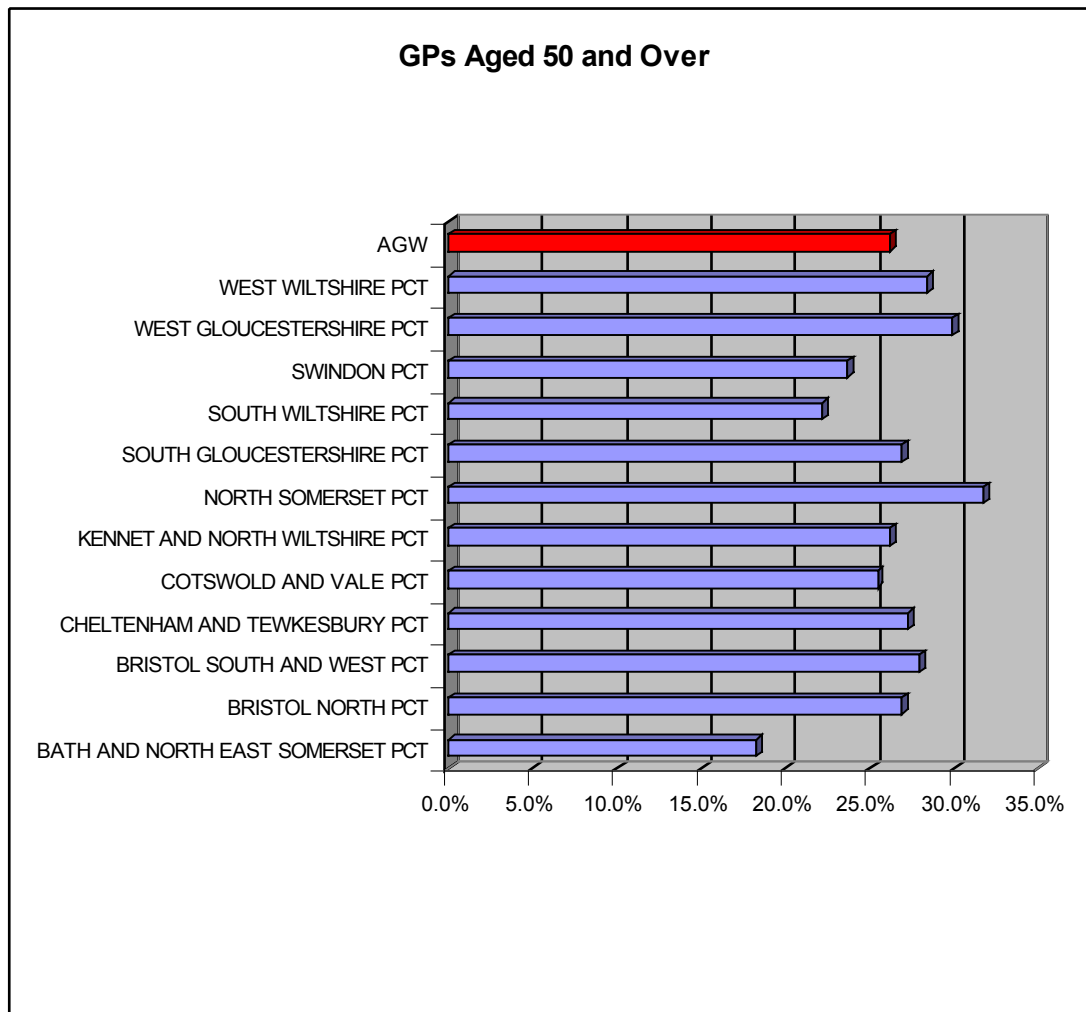
GPs

- There is a 11 per cent vacancy rate across AGW, with serious shortages in Swindon (18 per cent) and North Somerset (16 per cent).
- There will be a major problem trying to replace aging GPs as 26 per cent are aged 50 and above. This problem is particularly marked in North Somerset, where over a third are in that age group. This is on top of the very high current vacancy rate referred to in the previous paragraph.

Diagnostic radiographers

- They are in great demand and from an intake of 20, three obtained work within AGW and a further five obtained work in neighbouring Health Authorities. The destination of five was unknown. One interestingly joined Barclays Bank.





Staff groups related to Unscheduled care – Vacancies 3 Months or More

	Significantly above ave.	Somewhat above average	Average	Somewhat below ave.	Significantly below ave.
Accident and emergency consultants				✓	
GPs			✓		
Adult Nurses				✓	
Ambulance staff *	✓				

* The actual figure for long-term vacancies was just over 1 per cent and this was not considered to be a problem by the ambulance trust.

AVON, GLOUCESTERSHIRE AND WILTSHIRE LABOUR MARKETS

Bristol

Main employers by sector

Key business sectors in the sub-region include aerospace and defence, printing and packaging, financial services, electronics and electrical engineering, and creative industries.

The aerospace industry in the South West directly employs over 40,000 people - and the Bristol area is at the heart of this. As well as the major names like Airbus and Rolls Royce, there are hundreds of smaller enterprises that have a vital role to play. This is reflected in much high index figures for knowledge based industries Bristol (120) and South West (124) compared with the UK (100).^{iv}

Banking, finance and insurance sector, employing 28 per cent of the Bristol workforce is very large compared with England as a whole.

The Printing, Packaging and Graphic Communications sector is the United Kingdom's sixth largest industry, with a turnover of £13 billion.

Over the past 20 years, it has been transformed from a traditional craft-based industry to a leader in ICT and digital technology.

Bristol Employment by Sector

Sector	Employees	%
Manufacturing Industries	23,900	9.8%
Utilities / Agriculture	1,200	0.5%
Construction	12,100	5%
Distribution / Hotels & Restaurants	49,400	20.3%
Transport & Communications	12,500	5.2%
Finance, Insurance and Business Services	68,800	28.2%
Public Administration, Education and Health	64,000	26.3%
Other Services	11,700	4.8%
Total	243,900	100.0%

Source: ONS Annual Business Inquiry 2002

Population and employment trends

The population of Bristol is projected to grow at a lesser rate (2.9 per cent) than England (3.8 per cent). However, the South West is likely to grow at a faster rate (5.8 per cent). Bristol has relatively more affluent blue collar workers and hard pressed families and single parent families receiving income support and high numbers of young children. Bristol has a higher rate of deprivation (29) than England (22)^v. A quarter of the Bristol population live in the most deprived 10% of wards in England.^{vi} This is where most of the young unemployed are concentrated who are thought to have low skill levels, as they seek unskilled jobs. They represent a larger problem for Bristol than unemployed people over 45. The South West in comparison has more affluent people in their 50s and senior citizens. This is reflected in a lower deprivation score (19) than England.

Employment in Bristol grew by 5 per cent 10,700 jobs between 1993 and 1998, particularly for the more skilled jobs and it is expected that this growth will continue in the short-term. In tandem with this, unemployment fell from 8.2 per cent to 3.4 per cent, which is lower than the UK average rate between 1996 and 2000. Unemployment in the South West is even lower 2.7 per cent.

Vacancies in Bristol were heavily concentrated in the distribution, hotels and restaurant sector and in banking, finance and insurance. The latter is reflected in difficult to recruit occupations, where clerical posts were the worst affected. ICT recruitment difficulties are also a growing problem. Bristol employers suffer to a greater extent from the recruitment difficulties than most others in the South West.

A survey of employers noted that a greater use was made of 'family friendly' policies in Bristol, which was attributed to the tight labour market^{vii}. The Bristol labour market is largely self-contained, with three quarters of employed residents working within the area.

Education

Secondary school performance in Bristol is below the national average. A higher percentage of school children are disadvantaged in that they have special educational needs and suffer from exclusion. Furthermore, more children are looked after. Nevertheless, a growing percentage progress to higher and further education with a diminishing number seeking jobs (16 per cent) in 1999^{viii}.

Skill Attainment Levels

Bristol and Area - Age	Bristol	England
with NVQ 4+	31.8%	23.5%
with NVQ 3+	15.8%	13.9%
with NVQ 2+	13.2%	14.9%
with NVQ 1+	16.1%	15.5%
with other qualifications	6.3%	9.1%
with no qualifications	11.8%	16%

Source: Nomis, ONS, Local Area Labour Force Survey 2001

Swindon

(Source www.swindon.gov.uk/business/economics.htm)

Economic overview

Despite a recent slowdown, the Swindon economy continues to be strong and competitive. The average earnings of local workers are high, and the average household income is well above the national level. Swindon is especially strong in the high and medium high tech sector, with twice as large a proportion of employees working in this sector as the UK as a whole. In Swindon, the overall new business activity is comparatively low and the number of companies de-registered has had a significant increase.

Service sector

In the past few years, the service sector has accounted for most of the employment growth in Swindon. Newly-available data, however, reveals that the productivity of the local service sector is falling below the national average. With the level of wages in Swindon comparatively high, the low productivity of the service sector is undermining its competitiveness. This needs to be addressed through raising the productivity of the existing service sector and attracting more high value added service industries into the town.

Qualifications of workforce

One of the biggest challenges for Swindon is to continually improve the qualifications of its workforce. As a major economic centre, Swindon is still far behind many of its competitors in the qualification attainment of its workforce. This needs to be urgently addressed by all education and training providers if Swindon is to stay a high-tech centre, improve its productivity, retain existing investment and attract high quality jobs into the town.

Local downward employment trends

The indicators have revealed that the general slowdown of the economy has begun to affect the workforce in Swindon. There has been a persistent monthly increase in long-term unemployment over the past year while nationally the level has come down. This indicates a skill mismatch problem in the local labour market, which will become increasingly an issue as the local industrial mix starts to change. Therefore support for redundant workers and an accurate assessment of future skill requirements for Swindon is essential.

There has also been a sharp increase in inactivity among the local workforce over the past year against the background of a series of local redundancies. This reflects an increase in under-employment among some groups of local people, especially the lower skilled workers and older people. The extent and the nature of the problem needs to be assessed so that effective policies can be put in place to support these people back to work so that they can continue to contribute to the local economy.

Gloucester

(Source: <http://www.gloucester.gov.uk/libraries/templates/page.asp?URN=71>)

The city's population is 109,888 and 7.5 per cent of the residents are from black and ethnic minority communities. The age structure of the population is similar to that of England and Wales with 32.08% of the population of Gloucester being under 25 and 14.96% being over 65. The population is expected to follow the national trends and for there to be an increase in elderly people and single person households in the future, increasing demand on housing and health services.

Good communications by road, river, canal and railways historically made the city attractive for manufacturing. Local employment is now mostly in health, education, public services, wholesale, distribution and manufacturing. Unemployment in Gloucester stands at 3.4%, which is high compared to the county average of 1.8% but is equal to unemployment in England and Wales overall.

LOCAL SERVICES IN DETAIL

Accident & Emergency

There are A&E departments across AGW, with two trusts in Bristol and one in nearby Bath serving the area of highest population density. Two of the A&E departments, Bath and Swindon, are quoted as case studies in Transforming Emergency Care. Most departments seem to have gone a considerable way in anticipating or implementing the Collaborative's initiatives and achieving the 4-hour target. However some acknowledged doubts as to how sustainable some of the high figures (98%) were.

All operated in different environments with regard to the level of primary care provision, social care infrastructure, alternatives to attending A&E or hospital admission. These services impact on the demand for A&E.

West Wiltshire PCT has introduced rapid response teams in order to avoid patients being admitted to hospital. The teams provide nursing and social care in people's home. An intermediate care team which also provides home support has enabled some patients to leave hospital earlier.

South Wiltshire PCT has introduced a hospital alternatives team designed to prevent unnecessary hospital admission and boost support for services at home. The team is staffed by a medical consultant, nurses, mental health workers, therapists and social workers and helps assess patients, provide advice and support, and give GPs appropriate alternatives to hospital admission for patients.

Staff report that the establishment of WiCs and MIUs has not had the effect anticipated in reducing demand for A&E. They perhaps provided a better service or have uncovered new need. This appears to be different from the infrastructure that staff report has the effect of reducing demand for A&E e.g. proactive primary care and community hospitals.

There are difficulties reported between trusts collaborating and reciprocating to take A&E patients when one department is busy.

Regarding national targets, there is perceived to be some conflict within trusts between waiting list targets for elective procedures and the emergency four-hour targets.

Currently most departments considered they were doing reasonably well but there is a rather uncertain future caused by firstly the impact of GP contracts, which apparently is resulting in some surgeries not treating minor injuries and referring them to A&E. Secondly there are concerns that the planned reconfiguration of Frenchay and Southmead services, with Southmead being downgraded to a minor injuries unit and closing at night and emergencies being concentrated in Frenchay, may lead to an increased demand for other services and undermine the progress made. Thirdly there are concerns about the impact of a severe winter adversely affecting targets.

With services in some places meeting wait targets and call response targets, there is some concern about how this could be sustained if there was particularly severe weather

or for instance an influenza epidemic, particularly as this would affect older people who would need the medical care.

Most sites had little problem with staff recruitment except for cadet and support workers staff for whom there is stiff competition for workers from the commercial sector and independent health providers who pay more.

Regarding skill and seniority mix, there were mixed views about whether the balance was right for the needs of A&E with one department reportedly light at senior levels and another concerned they may be a bit top heavy.

North Bristol trust

Infrastructure

In this trust, Frenchay Hospital has a wider community infrastructure, with a hospital at home scheme, as compared with Southmead Hospital with a more rural catchment area and a less developed infrastructure resulting in a higher percentage of A&E attenders. There are plans to develop Frenchay's capacity for acute admissions, and changing Southmead's A&E function to a MIU.

If the result of better developed infrastructure in primary and social care, is higher A&E 'unnecessary' attenders, what are the financial and patient care benefits of building up these structures?

The A&E department has no walk in centre or minor injuries unit and there are no plans for this although they may plan for a satellite in the city centre.

The ambulance service link is with Avon which provides thrombolysis. There is a shared contract between NHS Direct and A&E with a G grade nurse alternating between the two.

A&E provision

The two primary sites share and rotate staff in elective and emergency, the latter being more attractive to staff. The elective site is a nurse led service with fewer doctors and the emergency site has a higher doctor: nurse ratio.

They run a See and Treat service and in terms of meeting the four hour target are in the mid 90s. However there are concerns about sustainability.

Healthcare assistants are employed in reception tasks and as emergency room assistants and trained to NVQ Level 2.

Near patient testing is available in all clinical areas.

There is a clinical decision unit that has an observation ward but as the hospital is very busy this gets blocked. There are two discharge lounges that facilitate prompt discharge and free up beds for admission.

As far as possible known patients who come to the elective A&E site go back to the original ward.

For specific groups there is a psychiatric liaison scheme for patients presenting with mental health problems, senior physiotherapist for patients with muscular-skeletal problems, and a registered sick children's nurse available in A&E.

United Bristol

Alternatives to A&E

In United Bristol area there are a number of alternatives to attending A&E. These include:

- offering GP referrals an urgent outpatient appointment
- referral to social services residential home or a nursing home
- an Acute Response Team, based in the hospital which offers domiciliary care.
- in the Bristol south and west PCT area there is provision for direct referrals from the ambulance service to intermediate care.
- a new community hospital in south Bristol with 50 to 60 beds which is a second stage care rehabilitation unit that takes direct GP referrals. There is also an issue here about whether every older person needs to be assessed by a geriatrician and what a GP can do. Staff for this hospital are likely to come from the closure of Bristol General, but it is hoped will undertake rather different roles. The hospital is a nurse and therapy led unit.

These services better meet the need people may be too ill to be at home but not sufficiently ill for hospital.

Older people who do end up in A&E are to be referred to the multi disciplinary case management team for follow up. The staffing of the case management team includes a CPN, social workers, physiotherapists, OTs and an older people's nurse specialist. There are multi agency and multi disciplinary issues about whether the nurses can be trained to do assessment rather than having to refer patients to an OT, where there is a year's waiting list. There is concern that professional skills may be under-valued.

How skilled-up each profession can become to be able to see patients on their own but know when they need to refer to another professional. How to skill up?

A&E

In the department, the Emergency Services Collaborative has helped crystallise developments that were already in the pipeline. There is a MIU that is part of A&E that has hit its 98 per cent target. The MIU is staffed by emergency nurse practitioners at H and G grade.

There are WiCs in Bristol city centre and south Bristol. It was thought these would decrease attenders at United Bristol A&E, but attendances have increased and are now running at 40,000 annually.

There are fewer unnecessary attenders than the national average but a high proportion of substance abusers and consideration about developing alternative services for these potential patients such as ambulatory care.

Is there a case for developing alternative services to A&E in Bristol for substance abusers?

There is a See and Treat service run by doctors and ENPs who are available for 12 hours from 10am to 10pm. There is also an extended role for physiotherapy practitioners available from 9 to 5 to deal with muscular skeletal injuries. There is a high rate of young attenders involved in out-of-hours drinking and assault incidents.

Currently there is no near patient testing, x-rays or pathology, but there is an arrangement for orange forms for A&E patients for pathology which ensures a faster tracking. More senior doctors tend to be more discerning and request fewer tests which eases the pressures on pathology. Although there are not near patient testing schemes, ENPs can request most x-rays and D and E grade nurses can provide triage for minor x-rays.

For majors there is a triage service provided by an SHO and Senior Registrar. There are plans to consider a majors see and treat unit as in Derby and plans to consider training majors nurse practitioners however there are apparently issues for training support for management of risk and indemnity.

There is a surgical assessment unit with GP direct referral and a medical assessment unit providing GP referral.

For specific patient groups at United Bristol, there is a special paediatric unit, respiratory scheme operating from 9 to 5, discharge lounges and a clinical support unit. There is an observation unit of eight beds for overdose and psychiatric patients, chest pain observation trolley scheme for low risk patients.

Forging closer links between the ambulance services and A&E, has reportedly encountered some problems because of insufficient radio time for ambulance and A&E staff to communicate. There is some reluctance to use mobile phones with the quality of communication available and the reluctance to abandon face to face communication between staff. However paramedics do undertake pre hospital thrombolysis.

There is apparently an issue about attitudes to change and publicising the training that staff are now receiving. Paramedics apparently used to take blood samples but these used to be thrown away by A&E departments, and there is a need to update staff about the tasks that people are able to undertake.

With regard to direct admission, Bath hospital has been reluctant to develop this with the ambulance service because their view is that the hospital would need to be operating at a 80 to 85 per cent capacity whereas actually they are operating at a 95 per cent capacity.

Swindon and Marlborough

This department has met the 4 hour target for about 98% of cases, a rise from 65% of cases a year previously. This improvement was attributed to leadership at executive level, and from key front line staff, commitment from the wider health and social care economy with a support team working on discharges and ENPs rotas to match demand, and using the Collaborative methodology making small scale changes assessing results before full implementation.. (Alberti)

Gloucester and Cheltenham

Hospitals in this area work with only the Gloucester ambulance service and this tends to simplify relationships. Cheltenham has a primary care suite co-located with A&E and it is planned for this to be the case in Gloucester. They have six community hospitals in the area that provide a range of services during the day with reduced scope at night, but this infrastructure and a good primary care service reduces some of the pressure on the hospital.

Wiltshire

Wiltshire Ambulance trust will be employing ECPs who will be trained at the UWE. There are six places per annum and these posts will be backfilled. The service are discussing with commissioners the best use of ECPs, for nurse triage in the call centre to avoid an ambulance call out, or out with the ambulance which may obviate the need for A&E attendance. The Ambulance trust would like to be able to offer both. However, currently each PCT has a different out-of-hours system. Therefore it would not be possible at the moment to operate one nurse triage system for all calls run by the ambulance trust or PCT, where calls could be allocated to a GP, MIU, ECP visit or other.

The trust employs two community paramedics to work in GP surgeries who can respond to emergency category A calls, able to home visit and give immediate life saving care whilst patients await an ambulance. They also work under supervision supporting the practice's work.

All the ambulances are equipped to carry out thrombolysis and communicate the results to A&E departments.

Bath

Context and infrastructure

There is a WiC in the city centre and a MIU at Poulton Hospital staffed by ENPs. However these two centres have not reduced demand on A&E as anticipated.

The percentage of attenders at this A&E department is only about 12 per cent unnecessary compared with the 40 per cent figure. Apart from queries about the validity of this figure outside London and other heavily use inner city areas, in this area there is a very good primary care infrastructure where GPs hold on to patients and offer care so there is less demands on A&E. Also although this A&E department covers a half a million catchment area there are community hospitals that filter out demand therefore accept in its immediate environment, Bath Hospital is used as a second tier referral.

The performance of any one department is difficult to measure in isolation as volume and type of demand depends on the availability of other services. For each of the major A&E sites, what criteria will be used to inform decisions about reconfiguration/rationalisation of services, and/or investing in capacity for alternatives to A&E? Each proposal has workforce implications, and the availability of certain staff groups may be important in making local decisions.

Prediction of peak demand for A&E is now proving less reliable with a junior and senior doctor now working flat out in the early morning. There are a number of reasons for this, thought locally to be associated with changes in primary care out-of-hours arrangements, patients assuming GPs now do not provide an out-of-hours provision, and

the development of a 24/7 society. The PCTs are planning to release information about the new arrangements for out-of-hours care which is hoped might relieve the situation.

A&E

The A&E department has both changed the way people work and invested in more staff. The pressure on A&E is reported to be intense. However they have met the four hour target sustained at 98%. This was achieved by a whole systems approach including pharmacy, diagnostics, portering, transport, nursing medicine, AHPs, practitioners and managers.

The decision to refer to minors or majors is largely taken by the ambulance service or patient. However they have introduced patient priority, a five-category scheme for receptionist triage, including burns, eye injuries, deformed limb, uncontrollable bleeding. Initially receptionists were resistant because of the increased responsibility, but have apparently been persuaded because of the efficiency in directing patients to the most appropriate work stream.

Minors

In addition to ENPs, a well developed group in A&E for minors in See and Treat, there are acute nurse practitioners (ANPs) work in majors in pathways designed for stroke and other conditions. The business case for training ANPs is being explored and training is likely to include a combination of on site training and release to UWE.

The See and Treat versus the triage model, is regarded as clearly efficient from the patient point of view but when the department is experiencing heavy demand, some patients can still wait for a considerable period.

Majors

Other changes included improving links with in-patient specialities. A junior doctor from orthopaedics links to A&E to try and avoid unnecessary admissions, and there are close links with general medicine with the appointment of acute consultant physicians and junior doctors to work with A&E. There is a medical assessment unit for short stay admissions, an observation ward attached to A&E and an ambulatory care unit, which avoids unnecessary admissions. There are still problems with general surgery and relationships with A&E as surgeons who may be on take may be operating. This has led to the appointment of two surgical nurse practitioners who can do bloods and x-ray referrals, which shortens timescales.

The department has adopted many of the Collaborative's initiatives, for instance nurse requesting blood and x-rays, near patient testing, avoiding batching.

Specific groups

For specific groups there are a number of pathways for instance a chest pain pathway. For children there is direct access through out-patients to a children's unit. For the mentally ill there is a good service with liaison adult psychiatry. For the over 65s there is a problem about the lack of social and professional infrastructure in the county between families, voluntary and statutory organisations who all are keen on hospital admission which creates problems for presenting admission and arranging discharges. This problem is not helped by the lack of coterminosity between three PCTs and social services.

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ⁱ U.S. Bureau of Labor Statistics published in the February 2004 Monthly Labor Review,

ⁱⁱ RCN Report, quoted in Observer, 31 October 2004

ⁱⁱⁱ RCN warns of fragile future of the nursing profession, Press Release, 1 November 2004

^{iv} WESTEC Community Profile - Bristol

^v Department of the Environment, Transport and the Regions, Indices of Deprivation 2000, quoted in *ibid*

^{vi} *Ibid*, p.24

^{vii} *Ibid*, p.38

^{viii} *Ibid*, p.103