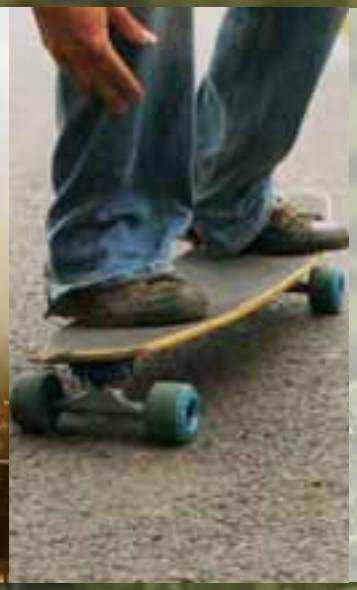

INVESTING FOR HEALTH

A Strategic Framework for the West Midlands

Appendix 12 Investing for the Workforce 2007 – 2012

Go to **www.ifh.westmidlands.nhs.uk** to see the latest news and developments on *Investing for Health*

NHS West Midlands

FOREWORD

Investing for Health sets out the strategic framework for the National Health Service (NHS) in the West Midlands for the next 5 years. It identifies action to tackle 7 big challenges. The improvements envisaged demand a skilled and knowledgeable workforce equipped to provide high quality services when and where they are needed. This document sets out our plans to secure and sustain that workforce to 2012 and beyond.

Investing for the Workforce provides a comprehensive account of our plans to build on the progress already made and to further develop workforce capacity and capability across the West Midlands. Around 70% of the NHS budget is spent employing and developing staff, so it is essential that we have efficient and effective systems in place to secure, develop and deploy the healthcare workforce. These systems are overseen by the Workforce Deanery, which aims to provide strategic leadership and to foster the partnerships that will be necessary to deliver the commitments detailed in this document.

The aspirations to provide safer and more responsive health services, to offer greater choice, to improve quality and to deliver person-centred care, depends on having a competent and flexible workforce. In addition to the high levels of skill already achieved by many sections of the workforce, in future healthcare staff will need to develop new competences and adopt new ways of working. In short, our challenge is not only to sustain, but also to transform the healthcare workforce. This document sets out how we propose to go about it.

We start from a firm foundation, a multi-professional Workforce Deanery that brings together all aspects of workforce developments, enabling us to address challenges associated with recruitment, retention, workforce modelling and planning, team working and productivity, education commissioning and

quality assurance and role and career development. *Investing for the Workforce* describes how we will lead and support workforce transformation, working through strategic partnerships with the NHS and other organisations in the West Midlands and beyond.

We face a challenging agenda. An unprecedented 20% growth in the workforce between 2000 and 2006 arose from investment associated with *The NHS Plan*, a rate of expansion that is unlikely to be repeated in the foreseeable future. Our task now is to realise the benefits of this larger, well-trained workforce by developing and deploying staff to maximise their contribution and productivity. In doing so, we need to be sensitive to the particular needs and circumstances of local health economies, but we must also take account of the national policies that will impact on workforce development. These include programmes to modernise healthcare careers; the Working Time Directive; the drive to promote healthy lifestyles, prevent illness and reduce health inequalities; and the need to ensure that advances in science and technology are properly reflected in health professional education.

In the West Midlands we have benefited from a hard-working and motivated healthcare workforce. To sustain and nurture this dedication we need to ensure that pockets of innovation are publicised and spread, so that best practice becomes universal practice. We need to support competency-based education and training to promote greater flexibility, shared learning and role innovation. We need to be in a position to offer satisfying careers to all healthcare staff by providing appropriate training and development, by supporting movement up the skills escalator and by spotting talent and developing future leaders. Together we must work to ensure that every member of staff is able to maximise their contribution to health and healthcare. This document describes how we plan to lead that process.

Our concern in preparing this document was to publicise and account for our plans and commitments. We have undertaken an equalities impact assessment to ensure that those commitments do not adversely affect any minority group. In essence, *Investing for the Workforce* identifies the main drivers and challenges to be tackled in order to sustain and transform the healthcare workforce in the West Midlands. It establishes the direction of travel and details initial programmes of work, but our plans are not set in stone. We recognise the need to keep the strategy under review and to refine it as new policies and challenges emerge, not least Lord Darzi's final report of the work he is leading under the banner of Our NHS, Our Future.

Finally, I should like to emphasise that we would very much welcome comments and contributions from patient groups, professionals and partner organisations so that we can ensure that *Investing for the Workforce* remains the dynamic and responsive workforce strategy we set out to design.

Peter Blythin

DIRECTOR OF NURSING AND WORKFORCE
NHS WEST MIDLANDS

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INTRODUCTION

NHS West Midlands is one of ten Strategic Health Authorities (SHAs) in the English NHS. It is responsible for providing strategic oversight and leadership of the healthcare system across the region. The strategy for the next 5 years is set out in *Investing for Health* (www.ifh.westmidlands.nhs.uk).[1] The availability of a high quality workforce is key to delivering this strategy. NHS West Midlands has established a multi-professional Workforce Deanery (WD) to lead this work. The WD needs to secure and develop a healthcare workforce in sufficient numbers and with the appropriate skills to provide the range and quality of services envisaged. This demands workforce planning and development, education commissioning and delivery of postgraduate medical and dental education at a strategic level, on behalf of all healthcare providers in the region. This document sets out the strategic intentions for the development of the workforce to meet the needs of the NHS in the 21st century.

Workforce development is an important and significant responsibility for NHS West Midlands. Around 70% of the NHS budget is spent on employing and developing staff. In the West Midlands, the NHS employs around 125,000 people and makes a substantial contribution to developing the skills and qualifications of local people. In 2007/08 the WD will invest £426 million to educate over 13,500 non-medical staff, such as nurses and allied health professionals (AHPs), and nearly 4,000 medical trainees, as well as upskilling and retraining the existing workforce. It is essential that the WD invest wisely to secure the workforce needed

for the future and that there is proper stewardship of this substantial budget.

This document, *Investing for the Workforce*, identifies the main workforce challenges we face and sets out the WDs plans to tackle them. The workforce strategy has been developed to support *Investing for Health*[1] but also to seize opportunities for innovation that have arisen from the creation of a new, unified WD. In particular, the WD will:

- provide authoritative and intelligent analysis of the workforce
- understand, plan and influence workforce demand/supply and support collaboration and coherent integrated planning across the health economy
- promote multidisciplinary collaboration in education planning and provision
- capitalise on the education commissioning expertise to realise cost and quality benefits
- streamline education quality monitoring, to eliminate duplication and to reduce the burden on NHS and education providers
- use the increased capacity and concentration of expertise within the WD to drive workforce innovation
- recruit junior doctors and deliver postgraduate medical and dental education and training
- commission and support an appropriate workforce skill mix, which enables high quality, productive service delivery
- strengthen and enhance partnerships with public, independent and voluntary sector organisations, to ensure that workforce development and education commissioning are consistent with the needs of healthcare providers.

This workforce strategy focuses on service improvement and has been developed to respond to the 7 key challenges identified in *Investing for Health*.[1]

7 KEY CHALLENGES

Challenge 1 - Despite improvements in overall health status, inequalities in health have widened.

The WD will develop the workforce to target the geographical and health inequalities across the West Midlands, working with healthcare providers to support the development of new roles in health promotion and protection and to ensure that the workforce represents the community it serves.

Challenge 2 - We are not investing enough in prevention.

The WD will increase the availability of public health skills across the 4 tiers of the public health workforce. There will also be continuing development of the primary and secondary care workforce in prevention skills, improving access to healthcare services and supporting self-care.

Challenge 3 - There remains an unjustifiable variability in the quality and safety of services and individual care, and a significant number of complaints are about standards of fundamental care.

The WD will ensure that all education programmes commissioned are fit for purpose and of high quality, to ensure safe patient care (including patient safety and infection control and prevention). Delivering high standards in the delivery of healthcare will be a key priority in the commissioning of clinical leadership programmes and the development of clinical systems improvement.

Challenge 4 - The rate of cost pressures arising from doing more of the same with an ageing population, a rising tide of long-term conditions and an accelerating pace of technological development in providing responses to illness outstrip any conceivable rate of increased funding.

Productivity and a more targeted skill mix are the core business of the WD. This will underpin changes to education commissioning numbers and the implementation of new ways of working, which will enable greater flexibility of the workforce in all health settings.

Challenge 5 - The public, our customers, have little confidence that their local NHS will get better.

The WD will engage with patients and the public in the development, commissioning and delivery of education programmes. This will be undertaken through the stakeholder engagement process and alignment with the general public engagement process of NHS West Midlands.

Challenge 6 - We continue to spend substantial amounts of resources on clinical activities where the evidence suggests there is little or no return on the investment in terms of improved health or where the evidence shows that there are other, better and more cost-effective alternatives.

The WD will work with Higher Education Institutions (HEIs) and healthcare providers to ensure that education programmes and training are fit for purpose, using a robust quality assurance framework. Workforce planning will be better integrated with service and financial planning.

Challenge 7 - Patients expect services to be joined up and to have co-ordination across teams caring for them, and yet the fact is that, at present, patients and the public often struggle to understand how services work.

The WD will strengthen approaches to multidisciplinary education and learning and working, including leadership development, team working and advanced practice roles, to ensure that NHS staff are enabled to work more collaboratively and are customer-focused.

To facilitate delivery of this strategy, the WD has established robust consultation via a Regional Stakeholder Board, 5 Locality Workforce Boards, a Regional Social Partnership Forum and a Health and Education Strategic Partnership (HESP).

This workforce strategy reflects the priorities set out in *Investing for Health*[1] in relation to the overview of the West Midlands and focuses on the workforce who work with and for the NHS, whatever the healthcare setting. The workforce priorities to address the 7 challenges follow the 5 strategic themes of NHS West Midlands, which are:

- Full Engagement
- Improving Quality and Safety
- Care Closer to Home
- Sustainable Services and Sustainable Local Health Systems
- Organisations Fit for Purpose

In the remainder of this document, the workforce priorities have been mapped into this framework. In addition, the workforce themes relating to delivery of the 10 West Midlands wide collaborative projects can be found in Appendix A.

The WD vision

The WD vision is to match multidisciplinary workforce development with strategic and operational service priorities, to deliver planned improvements for high quality, patient-centred services. To achieve this ambitious vision, the WD will work in partnership with Primary Care Trusts (PCTs), providers of healthcare, HEIs, patients and the public to:

- implement a co-ordinated response to the Health Select Committee Report on workforce planning[2] across Local Health Economies (LHEs)
- facilitate a co-ordinated approach to widening participation in NHS careers
- extend economies of scale for the West Midlands in the delivery and development of education, training and research development
- assess, evaluate and, where appropriate, modify education and training programmes, to ensure that the people trained are fit for purpose
- implement the delivery of Modernising Healthcare Careers[3]
- work with HEIs to design and develop new and innovative approaches to learning
- develop, set and monitor clear standards in commissioning specifications
- provide leadership and direction in the workforce development and application of new roles and effective skill mix
- ensure that patient safety and productivity are integral in the commissioning and delivery of all education programmes
- equip the workforce to have the ability to respond to, and work with, the most innovative technologies
- implement quality assurance frameworks for the delivery and application of education and training for which the WD has lead responsibility
- ensure that equality and diversity are central to the delivery of healthcare.

1. CHAPTER ONE Current Workforce across the West Midlands

1.1 Introduction

NHS West Midlands has a specific remit to commission workforce education and training and also to provide postgraduate medical education, to ensure the availability of an appropriate healthcare workforce for all healthcare providers. The WD is the vehicle for delivering this remit. To plan the workforce and commission education and training effectively, it is important to understand the current workforce, workforce trends and future supply.

The overall healthcare workforce is made up of people who work with, and for, the NHS. These include: those directly employed by the NHS (referred to as 'the NHS-employed workforce'); independent contractors, such as those in general practice, pharmacy, dentistry and optometry; independent sector employees; and voluntary sector organisations providing services such as hospices. Carers who look after friends and relatives are also a vital but often unrecognised element. The most detailed information is available about those directly employed by the NHS.

Further information relating to the demographics of the West Midlands can be found on the *Investing for Health*[1] website (www.ifh.westmidlands.nhs.uk) in the 'Overview of the West Midlands' section.

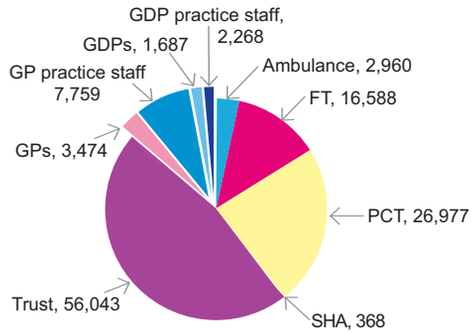
1.2 Workforce information

The NHS in the West Midlands directly employed 124,491 people in 2006 (102,936 Full-Time Equivalents (FTEs)). This represents about 5% of the total numbers in employment in the region.[4] The NHS employed workforce has grown by 13% since 2001. In addition, there are 21,025 (15,188 FTEs) general practitioners (GPs) and general dental practitioners (GDPs), together with their practice staff. This makes a total of 118,124 FTEs. There are also a significant number of people working for other independent contractors. For example, two-thirds of pharmacists and a third of physiotherapists work outside the NHS; however, there is limited availability of this data.

The overall healthcare workforce also includes people working in the private and voluntary sectors and in social care. However, there is no centrally collected data on the numbers employed by other organisations or self-employed.

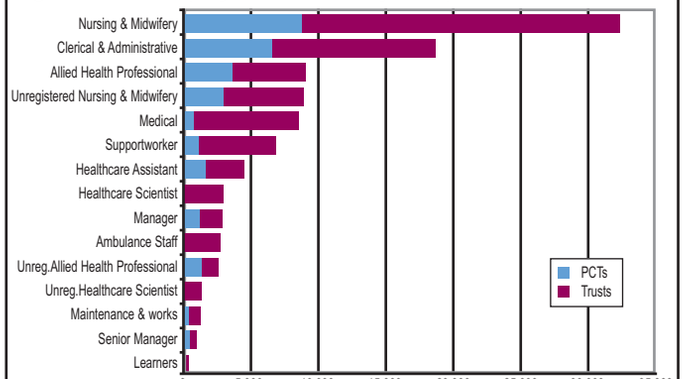
The WD will aim to improve data collection where data is currently unavailable.

Figure 1: NHS workforce in the West Midlands September 2006 (FTEs)



Sources: NHS staff census 2006,[4] NHS estimate of GDPs, NHS West Midlands survey of staff

Figure 2: NHS employed workforce by occupation and sector 2006



Source: NHS staff census 2006[4]

1.2.1 Primary care

A quarter of GPs work part-time. GPs in the West Midlands area are more likely to be over 55 years old (25% of GPs) than in England as a whole (21%). They are also less likely to practice single-handedly, with 20% of practices having only one GP compared with 27% nationally. There were 1,078 community pharmacies in the West Midlands in 2005/06, but there is no centrally collected data about their workforce.

Just over a quarter of NHS employed staff work in PCTs. The proportion of staff employed by PCTs has risen slightly since 2002, from 23% of the workforce to 26%.

The largest group of staff working in PCTs are nurses, accounting for a third of the total (13% of nurses in PCTs are district nurses and community matrons). AHPs account for 12% of PCT staff, and healthcare assistants (HCAs) for 5%. Increasingly, nurses and AHPs in primary care are delivering advanced services that have previously been delivered in secondary care settings.

There are 932 FTE health visitors in the West Midlands. NHS staff census figures indicate a reduction of 16% in the West Midlands since 2004. This is a faster rate of reduction than for England as a whole (9%), although known anomalies in coding of the occupation of health visitors in some areas means that the rate of reduction is smaller than this, and likely to be more in line with the rate for England. These anomalies have since been rectified. Health visitors have an older age profile than many other groups, with 37% aged over 50 years, compared with nurses in general, of which only 18% are aged over 50 years.

1.2.1.1 Healthcare in secure environments

PCTs are responsible for the provision in prisons and young offenders institutions of health services which are of the same type and quality as those that the general public receive in the community. Numbers and type of healthcare staff are included within PCT staffing numbers.

1.2.2 Secondary care

More than half of NHS-employed staff are employed in acute trusts (57%). There are 7 Foundation Trusts (FTs) in the NHS West Midlands region as at September 2007, accounting for a further 16% of staff, totalling 73% of all NHS staff. A third of the staff in acute trusts (including FTs) are nurses, 10% are doctors and 8% are AHPs.

1.2.3 Social care workforce

The Skills for Care report *The State of the Social Care Workforce 2004*[5] estimated that across England 922,000 people were in paid employment in core areas of social care, defined as including social work, residential, day and domiciliary care staff in all sectors, agency staff and a limited number of NHS staff. It is estimated that unpaid carers account for 5 million people, although data specific to the West Midlands is not available.

TABLE 1

Service	Headcount (and % of total)
Older people	559,000 (61%)
Adults with disabilities	177,000 (19%)
Childrens services	123,000 (13%)
Mental health	63,000 (7%)
Total	**922,000**

Source: The State of the Social Care Workforce, 2004

The WD will work with PCT commissioners and the wider health and social care economy to ensure availability of relevant workforce information for the social care workforce across the West Midlands.

1.2.4 Plurality of provision

There is increasing plurality of provision of secondary care services. Within the West Midlands (as at February 2008), there were 37 NHS trusts, 7 FTs and 17 independent sector providers of elective surgery and two main independent sector providers for diagnostics. Patient choice will increasingly determine the extent of provision at different providers. The WD will need to develop ways of assessing future demand across these providers. However, plurality of provision where providers can emerge relatively quickly, makes identification of longer-term workforce needs more difficult.

1.3 Workforce trends

The NHS staff census shows that the numbers employed by the NHS in the West Midlands have grown by 13% since 2001, from 110,241 in 2001 to 124,491 in 2006 - headcount (88,537 to 102,936 FTEs) in line with *The NHS Plan*.[6] This compares with an increase in the population of the West Midlands of 1.6% between 2001 and 2005 (the latest year for which data is available). All occupation groups have increased, including qualified ambulance staff (28%). Medical staff grew by 47% overall, with the number of consultants growing by 31% and the number of GPs by 20%.

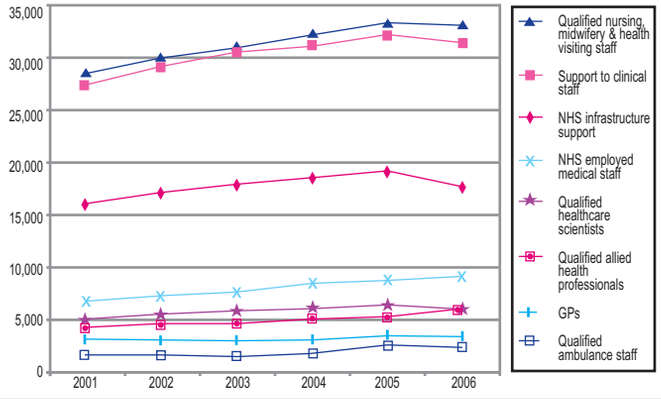
Numbers of staff declined for the first time between September 2005 and September 2006. This was mainly due to the need to achieve a balanced financial position and the attainment of the workforce growth targets set out in *The NHS Plan*.[6] The main changes were:

- an overall reduction in staff (-3.1%), with the West Midlands having a larger percentage reduction than for England as a whole (-1.4%)
- the overall reduction comprised a decrease in non-medical staff of 3,555 (FTEs) (-3.6%) and an increase in medical staff of 253 (FTEs) (+3.0%), as medical school output continued to grow in line with the targets set out in *The NHS Plan*:[6] in 2000. This was a similar pattern to England as a whole, although the West Midlands had a larger reduction in non-medical staff (-4.4% compared with -3.4%) and a smaller increase in medical staff (+3.0% compared with +4.1%).

The staff reduction was achieved through managing staff turnover and natural wastage and a reduction in part-time working, as headcount reduction was generally more than in FTEs. During 2006/07, there were 661 redundancies among the overall reduction of 3,302 FTEs.

The NHS workforce is now currently in a period of consolidation after a period of substantial growth, and it seems unlikely that future resource allocations will allow significant workforce growth in the foreseeable future. The emphasis, therefore, will need to be on improvements in productivity and (aligned with national policy) increasing the provision of services in primary and community care. These changes will need to be reflected in emerging education and training commissioning plans.

Figure 3: NHS workforce 2001-2006 by occupation group - West Midlands



Source: NHS staff census 2006[4]

1.4 Demographics of the healthcare workforce

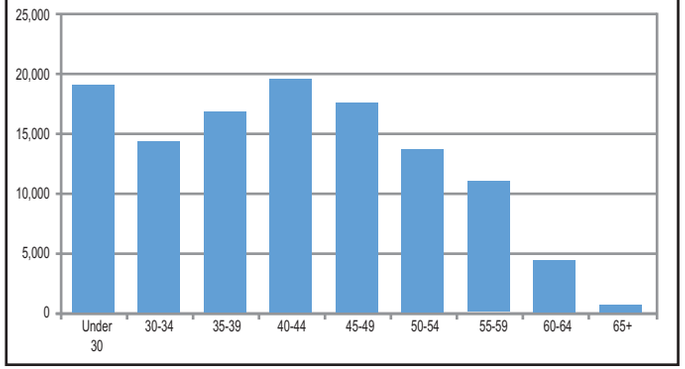
The age, gender and ethnicity composition of the workforce are important in assessing whether the workforce reflects the population from which it is drawn and future staff requirements.

This disguises some significant differences in the age composition of different groups and areas. Qualified AHPs have the youngest age profile, with 26% aged under 30 years and 18% over 50 years. The group with the oldest profile is maintenance and works, with 5% under 30 and 57% over 50 years. Nurses are particularly concentrated in the 30 - 50 years age group, with 18% of nurses aged over 50 years.

There will be implications for future staff requirements as the workforce ages. Current projections show that there will be increases in the numbers reaching retirement age over the next 5 years, although changes to retirement age, NHS pensions and age discrimination legislation make it difficult to forecast the impact on staff numbers.

A higher proportion of women than men work part-time, with the FTE to headcount ratio of 0.82

Figure 4: NHS workforce by age group 2006 (medical and non-medical)



Source: NHS staff census 2006[4]

compared with 0.95 for men. The highest proportions of women are HCAs (89%), clerical assistants (88%) and nurses and midwives (83%). The highest proportion of men work in maintenance and works (97%) and as ambulance staff (73%).

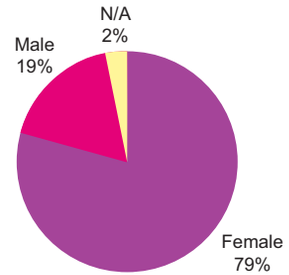
There are significant differences in the ethnicity of the population and of the workforce across the West Midlands. Birmingham and the Black Country has the highest proportion of NHS staff from black and minority ethnic (BME) groups, with 22% of the population and 29% of the NHS workforce from BME groups. The south of the West Midlands has the next highest BME proportions (7% of its population and 13% of the workforce), followed by Shropshire and Staffordshire, with 4% of the population and 8% of the workforce. The WD would expect to see variation in the ethnicity of the workforce across the West Midlands, to reflect the

population variation across the LHEs. The WD encourages the integration of refugee health practitioners as one route to diversifying the workforce to match the population groups of the local community.

Across the NHS employed workforce in the West Midlands as a whole, 12.9% are from minority ethnic groups. The workforce does not mirror the population, and a number of minority ethnic groups are under-represented. There is also variable representation of BME groups across the medical and non-medical professions for example, ambulance staff, maintenance and works staff and senior managers when compared with the population in the West Midlands.

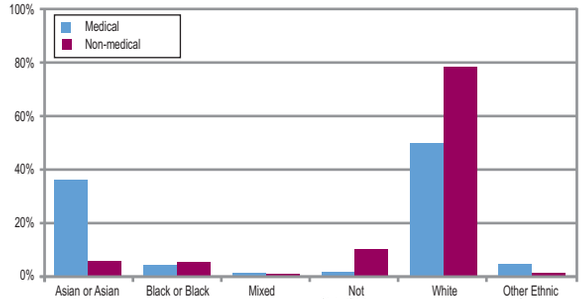
Overall, 78% of the NHS employed, non-medical workforce is white, and 22% are from various minority ethnic groups. The West Midlands NHS employed medical and dental workforce is more diverse than the non-medical workforce, with 49% of staff from minority ethnic groups. No central source of information about the ethnic group of GPs and dentists or their staff is available.

Figure 5: NHS employed workforce by gender West Midlands 2006



Source: NHS staff census 2006[4]

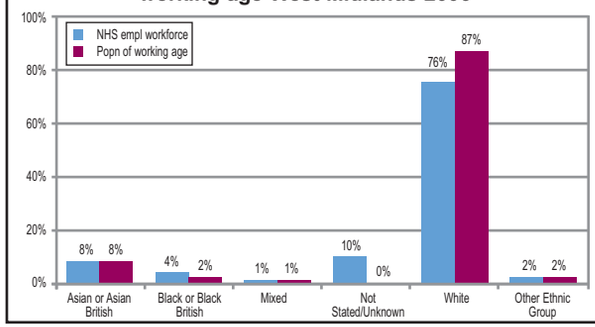
Figure 7: NHS employed workforce by ethnic group West Midlands 2006



Source: NHS staff census 2006[4]

Skills for Health and the Learning and Skills Council (LSC) have developed a West Midlands wide profile on the health and social care workforce.[7,8]

Figure 6: NHS employed workforce and population of working age West Midlands 2006

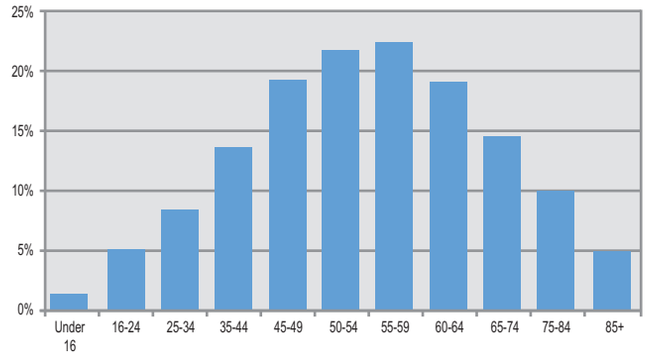


Sources: NHS staff census 2006[4]; Annual Population Survey 2005-06, Office for National Statistics

1.4.1 Unpaid workforce

In addition to the formal healthcare provided by the NHS, there is also a great deal of unpaid care provided by friends and relatives. The 2001 Census provides an indication of the scale of unpaid care in the West Midlands: just over 10% of the population said that they were providing unpaid care for another person with long-term physical or mental ill-health or disability or problems related to old age. This rose to over 20% of people in the 50 - 54 and 55 - 59 age groups. No further data is available about changes to carers' numbers either nationally or regionally.

Figure 8: Percentage of people in each age group who are unpaid carers West Midlands 2001



Source: Population census 2001[9]

1.5 Demand

Future workforce demand is the most difficult element to estimate. There has been a rapid pace of change in the NHS over recent years and this is likely to continue. Factors likely to affect the demand for the workforce in the future include:

- changes in population demographics
- increasing levels of care outside hospitals
- contestability and choice
- changes in skill mix and new ways of working
- new treatments and changes in technology
- changes in public expectation.

The impact of many of these over the commissioning period is not easily quantifiable. Therefore it is important that better systems to ensure the future and current workforce will be planned and developed to meet demand.

Further detail can be found in **Chapter 7**.

1.6 Supply

The WD is able to take an overview of the future workforce supply across the region, for both NHS and other employers. The WD aims to match the supply of healthcare staff in the West Midlands with the demand for trained staff in the area, without the need in net terms to rely on attracting staff from other areas or to export staff to other areas. The WD reviews supply and demand for each occupation and takes into account the workforce requirements expressed by trusts and PCTs, together with other financial and service requirements.

The largest occupation group of NHS employed staff is adult and general nurses. There were 40,130 (headcount) in total employed by the NHS in the West Midlands in September 2006, with 19% aged over 50 years. This means that numbers of retirements are expected to increase by more than half over the period to 2012. Based on current trends, the overall numbers entering the profession will be slightly lower than the numbers expected to leave. There are indications that the demand for adult and general nurses may fall over the period, due to changes in provision, particularly in the acute sector. The age profile of this group suggests that losses through retirements will continue to rise beyond 2012.

The next largest group is registered mental health nurses. There were 4,449 in total employed by the NHS in the West Midlands in 2006. Previous increases in the number of places commissioned were designed to address shortages of this group. Continuation of the current level of commissions is therefore likely to lead to a significant increase in the supply of mental health nurses. The demand for mental health nurses now appears to be being met (although there may be local differences across the region) and further increases may lead to over-supply.

The current numbers of places commissioned for learning disabilities and sick children's nurses appear to be greater than the numbers required to replace current numbers. There is a degree of uncertainty around the future provision of facilities for people with learning disabilities, as increasing amounts of care are provided in the community. It is crucial we develop partnerships with providers of these services to ensure consistent supply of such nurses.

The supply of qualified midwives will increase, given the current level of education commissions. The demand for midwives is also expected to rise over the period, through the implementation of the standards set out in *Maternity Matters*.[10]

There is a mixed picture for AHPs, with the current supply of physiotherapists, podiatrists and speech and language therapists likely to exceed replacement levels. The supply of occupational

therapists and clinical psychologists is likely to be below replacement levels and the supply of operating department practitioners, diagnostic and therapeutic radiographers is likely to broadly maintain existing staffing numbers. Achieving balance in future supply will be vital.

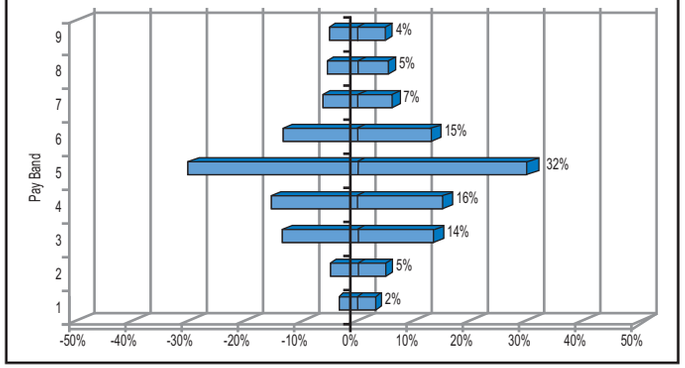
The WD has modelled the number of people by occupation (and within nursing, by nursing branch) that are likely to be available to the NHS over the next 4 years, as changes to current commissioning numbers in 2008/09 will not be seen in the supply of new graduates until at least 2011.

The WD will work with healthcare providers to develop workforce planning processes and to obtain agreed workforce plans for the period up to 2012. This will inform the pre-registration education commissioning process and the commissioning plan (see Appendix C), and identify priorities for development of the current workforce. Analysis of such variables as numbers of retirements, leavers and new graduates provides an indication of the future implications of continuing the current levels of education commissions. Forecast supply figures provide only part of the picture, and need to be set alongside estimates of future demand. In many instances, replacement of current numbers will not be appropriate to meet the changing needs of patients, changes in service provision and improvements in treatment methods. Education commissioning is currently based on occupations; workforce planning will increasingly be based on assessing the competences required and having multi-skilled staff that are able to meet needs in a flexible way. There is a need to ensure that the education programmes we commission change accordingly.

1.7 Skill mix of the workforce

As well as looking at occupation groups, it is also possible to look at the NHS-employed workforce in terms of the banding of posts under Agenda for Change. Data on the banding of individuals is not currently collected, but an approximation of the different skill levels

Figure 9: NHS employed workforce by pay band, West Midlands 2006



Source: NHS staff census 2006[4]

can be obtained by allocation of bands to occupation codes. This can then be represented in a diagram referred to as a 'Christmas tree', which provides a visual representation of the NHS career framework. The introduction of the Electronic Staff Record (ESR) will provide this data.

Christmas trees have been drawn up for the NHS employed workforce and for clinical (medical, AHP and nursing) staff. These show that the largest proportions of NHS employed staff are at pay band 5. The distribution of staff across skill levels in the NHS shows that there is scope for the introduction of more staff in some of the lower bands to take on work in support of more highly skilled and professionally registered staff and this may be useful when looking at improving productivity and skill mix changes.

1.8 Medical workforce

Medical school places are defined and agreed nationally. When Modernising Medical Careers (MMC)[11] is fully implemented, it is expected that half of medical school leavers will enter GP specialty training programmes. Approximately 50% of the output from medical schools will need to become GPs, with the others entering hospital specialties. This will require a significant expansion in the GP training programme. In addition, the nature of GP training is changing. Previously, doctors would spend 2 years in appropriate hospital specialties (such as paediatrics, A&E, medicine and obstetrics) and then 1 year based in general practice. Following the introduction of the new GP specialty training curriculum in August 2007, programmes will have a higher proportion of their time based in general practice: 20 months in general practice and only 16 months in hospital specialties. This will have a significant impact in terms of numbers of posts in acute trusts required from GP training. Therefore, there will be a progressive shift of funding of training posts from secondary care to primary care. This will need careful analysis of the overall workforce medical and non-medical with development of skills in the non-medical workforce to replace service provision from training posts.

Some hospital and community medical specialties need to grow, in particular palliative care, genito-urinary medicine and haematology (as historically there have been only small numbers of training places in these specialties in the West Midlands). Funding has been secured for training places in these specialties, allowing expansion, which will need continued support. Emergency medicine and acute medicine are also likely to need to expand, as further emphasis is put on a consultant-led service in the emergency admissions areas. As the level of experience of trainees falls with the introduction of run-through training,

particularly in emergency departments, obstetric departments and paediatric departments, there will also be a need for expansion of skills in non-medical staff and probable expansion in consultant numbers. The Working Time Directive (WTD)[12] limits of 48-hour working weeks, impacting in August 2009, will also require strengthening of hospital at night teams, to make best use of all groups of staff in delivering care 24/7.

Some specialties, such as surgery and anaesthesia, have a significant mismatch between the number of posts at junior training level and number of consultants required. A large number of the current junior-level training posts will no longer be required. This will pose a problem for trusts, because service is currently provided by posts that will no longer be needed for training purposes. This will require action by trusts, so that service provision can continue in a different working model. Where this involves training for new or extended non-medical roles, the training time needs to be built into service plans. While the number of training posts in anaesthesia and surgery will be reduced, the total number of training posts required to deliver MMC across the region will remain fairly constant. Funding from those posts will, therefore, be required to fund placements in primary care and increase the hospital specialties mentioned above.

1.9 A workforce for the 21st century

To ensure that there is a workforce that meets the needs of the 21st century, significant improvements are needed to strengthen workforce information and subsequent workforce planning. The collation of workforce information and planning will increasingly require involvement from PCT commissioners, to look at the services that are delivered across a locality and the workforce required.

The development of robust service plans for healthcare must include a comprehensive assessment of the workforce. The aim of the Workforce Transformation Project (Project 9) in *Investing for Health*[1] is to develop and implement a new practical methodology to plan and deliver the large-scale workforce and skills changes necessary for whole health system transformation from acute hospital care towards care closer to home. The project will work with the *Towards 2010* project[13] in Sandwell and West Birmingham and the *Fit for the Future* project in North Staffordshire. This approach will then be replicated across the West Midlands, as each health economy develops a clear vision for services in 2012, as outlined in *Investing for Health*.[1]

1.10 Conclusion

The NHS is a major employer in the West Midlands, accounting for around 5% of the workforce. There has been a significant level of growth in the healthcare workforce since 2001, which is now slowing down. It will be important for the future to ensure that healthcare is an attractive career option for young people and BME groups, especially in Birmingham and the Black Country areas.

Supply modelling has indicated that there will need to be adjustments to education commissioning programmes in future years, to ensure that the available workforce is in alignment with demand from employers.

We need continuous improvement in workforce planning through the development of workforce planning in trusts and PCTs, the development of integrated plans for each LHE and exemplar workforce transformation projects. The proposals for this are set out in Chapter 7.

Summary

- The NHS in the West Midlands directly employed 124,491 people in 2006, 57% of which are employed in acute trusts.
- The number of people employed by the NHS in the West Midlands has risen by 13% since 2001 in line with *The NHS Plan*.[6]
- The age, gender and ethnicity composition of the workforce are important in assessing whether the workforce reflects the population from which it is drawn and future staff requirements.
- In addition to staff directly employed by the NHS and social care, there are a large number of carers providing unpaid healthcare.
- Matching the future demand and supply of healthcare staff is key to ensuring that in net terms the West Midlands does not need to rely on attracting or exporting staff from other geographical areas.
- To ensure that there is a workforce that meets the needs of the 21st century, significant improvements are needed to strengthen workforce information and subsequent workforce planning.

2. CHAPTER TWO Key Workforce Drivers

2.1 Introduction

The NHS Plan[6] sets out a clear agenda for action to improve the use of human resources which is amplified in the current programme of health reform within the NHS in England Operating Framework 2007/08. The reforms focus on improving the working lives and careers of NHS employees and the capability of employers to maximise the contribution of the workforce.

The development of a flexible, adaptable workforce, capable of moving between organisations and sustaining continuous service improvement, is critical to the development of effective and efficient healthcare. Each healthcare organisation must be able to recruit the right people, deploy them effectively, continuously develop them and then motivate them to perform to deliver effective and productive services.

Employing and retaining people of the calibre and value needed to deliver the best possible care and best value doesn't happen without effort. The NHS is evolving at a great pace and it needs to keep people who are doing a good job by being a good employer that provides good leaders, opportunities to develop, opportunities to be heard, opportunities to recognise individual and personal contributions and opportunities to work differently. Local NHS organisations, while they still have much to do, equally have much to be proud of, which combined with the modern pay and conditions of service makes them attractive employers.

This chapter discusses national drivers, operational principles and workforce delivery priorities that will impact on the development of the workforce.

2.2 *National drivers*

2.2.1 Modernising Healthcare Careers

Modernising Healthcare Careers (MHC)[3] is the overall strategy for reforming career development and is intended to maximise the mutual benefits for patients, staff and employers of the development of a competence-based workforce, pay modernisation, regulation and staff development.

The aims of MHC are to support and develop:

- competences to cover the functions and contributions of the different staff groups
- a career framework populated with transferable roles
- modernised frameworks for education and training
- practical career pathways describing career routes that will facilitate skills escalation, transfer and progression.

There are a number of strands to MHC:

- Modernising Medical Careers (MMC)
- Modernising Dental Careers (MDC)
- Modernising Nursing Careers (MNC)
- Modernising Healthcare Science Careers (MHCSC)
- Modernising Allied Health Professional Careers (MAHPC)

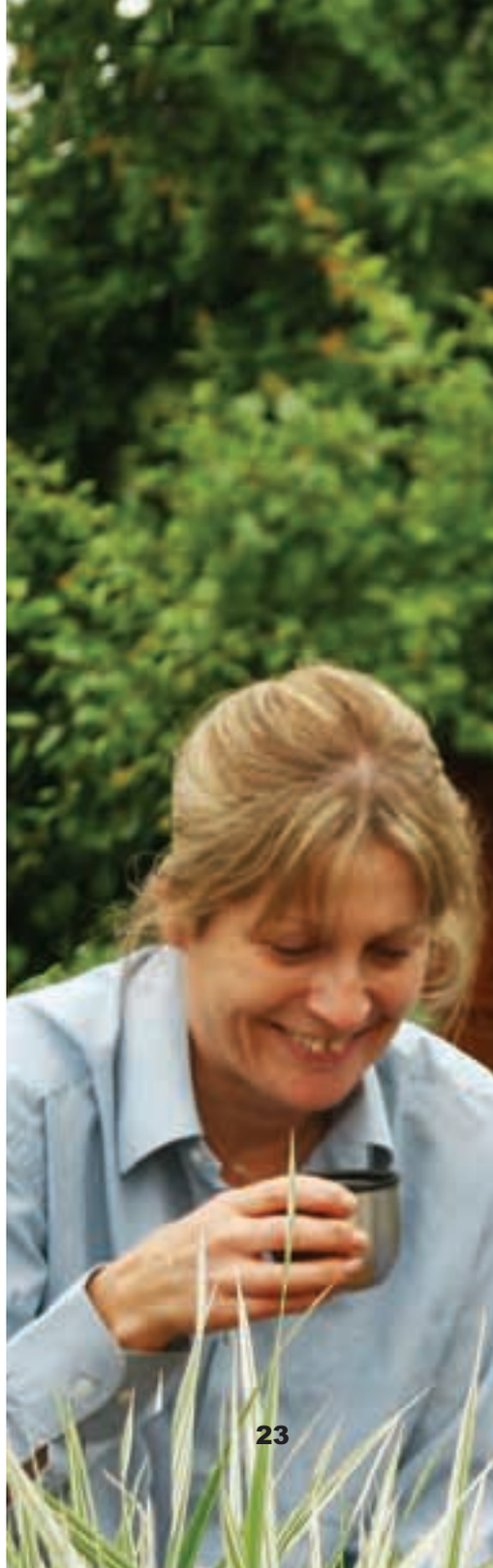
2.2.1.1 Modernising Medical Careers

Modernising Medical Careers (MMC)[11] is a major reform of postgraduate medical education, aiming to improve patient care by delivering a modernised, competency-based training and focused career structure for doctors in more than 60 specialties. The transition period will run from 2007 to 2012 (www.mmc.nhs.uk).

MMC has been identified by the Department of Health (DH) as one of the key workforce drivers and a key enabler for delivering other flagship programmes, including Productive Time,[14] Hospital at Night[15] and full WTD compliance. A diagram of the implementation of MMC can be found in Appendix D.

2.2.1.2 Modernising Dental Careers

The new Modernising Dental Careers (MDC)[16] programme will be structured as a 'run-through' 2 year programme, integrating education and training, and emphasising and addressing new key priority topics. A curriculum for the 2 year programme of MDC has been agreed, with the overall aim of improving the continuing education and training of new dental graduates that focuses on improving patient experience. The first year will be in NHS primary dental care (using the current 60 vocational training places in the West Midlands). A second year will offer a mixture of secondary



care and experience in NHS specialist practice and salaried dental service.

The programme is aimed at improving patient satisfaction with NHS dentistry, skill mix, evidence-based dentistry, health promotion and disease prevention.

2.2.1.3 Modernising Nursing Careers

Modernising Nursing Careers (MNC)[17] sets the direction for nursing careers and identifies a series of priorities and actions intended to prepare nurses to lead and co-ordinate care in new environments determined by the changing healthcare needs of patients and clients. This programme demands that nurses expand both their competence and confidence to lead and manage a range of health and health-related settings. The 4 priorities are:

- modernising the image of nursing and nursing careers
- developing a competent and flexible nursing workforce
- updating career pathways and career choices
- preparing to lead in a changed healthcare system.

A framework for the future of postgraduate nursing careers will go out to national consultation in autumn 2007. The framework covers nurses from all branches and locations and proposes that nurses follow the progression of patients as they move between health and illness, dependence and independence, and institutional and community-based care. Nurses will move from novice to expert along one of the patient pathways, as they gain skills and experience. Nurses with advanced professional skills will manage patients with the most complex needs or will lead multi-skilled teams.

A review into the future role of the health visitor, *Facing the Future* (2007),[18] identified the need to reform the existing health visiting service into a fully integrated preventive service for children and families within a public health context. Two primary roles have been identified, for which the skills and knowledge of the health visitor are an essential requirement:

- leading and delivering a renewed child health promotion programme for all young children and families
- intensive early intervention and prevention for families who need help most.

The review will impact on how PCTs commission services; this will focus on commissioning a service and not the professional role. This will also have an impact on how the WD commissions training programmes for future health visiting professionals.

2.2.1.4 Modernising Healthcare Scientist Careers

The aim of Modernising Healthcare Science Careers[19] is to deliver:

- modernised, competence-based role descriptors in accordance with the Healthcare Science Career Framework
- modernised supporting education and training pathways and programmes linked to an award and qualification framework aimed at providing greater flexibility and informed by the Healthcare Science Career Framework level descriptors
- modernised pre-registration education packages, based on fitness for purpose and competence requirements.

2.2.1.5 Modernising Allied Health Professionals Careers

Skills for Health, in partnership with the DH is developing a competency - based career framework for AHPs and related staff.[20]

The project has 3 main aspects:

- develop competences and ensure they are relevant to the work of AHPs and their staff
- link AHP roles into the career framework
- develop a framework of awards and qualifications for the work of AHPs and their staff that will allow more flexible career development.

The WDs approach to implementation of MHC is set out in Chapters 4 and 8.

2.2.2 Pharmacy education 'Fit For The Future'

To support the expanding role of the pharmacist, the Royal Pharmaceutical Society of Great Britain (RPSGB) is undertaking a review of education policy, including quality management of pharmacy staff regulation, mandatory continuing professional development (CPD) and revalidation as a result of the Pharmacists and Pharmacy Technicians Order 2007 (Section 60 Order),[21] which replaces the Pharmacy Act 1954.

This new legislation will support the review of skill mix and role redesign to maximise efficiencies and productivity within the pharmacy workforce (e.g. pharmacy technician registration with the RPSGB is now mandatory). If there are insufficient registered pharmacy technicians, this will limit services and potentially stifle role and service redesign and productivity.

Within *The NHS Plan*,[6] the Government's programme for pharmacy represents an unprecedented agenda for change and modernisation to achieve better use of medicines and improved

care for patients. Ensuring the supply of pharmacists and pharmacy technicians and extending the roles of pharmacists and their staff are key to these aims.

The WDs approach to the implementation of pharmacy education development is set out in Chapters 4 and 5.

2.2.3 Working Time Directive

The WTD is health and safety legislation that was introduced in 1998. For doctors in training, a phased implementation began in August 2004. Currently doctors in training can work up to 58 hours per week on average, but in August 2009 this limit will be significantly reduced to 48 hours, in line with the rest of the UKs working population. This will have significant implications for junior doctors working practices in ensuring educationally viable duty rotas, and will have a wider implication for provision of clinical services, particularly out of hours. Compliance with the WTD will be a key driver in the need to work differently and to consider skill mix changes and will have a broad implication for new ways of working for non-medical staff.

The WDs approach to implementation of the WTD 2009 is set out in Chapter 8.

2.2.4 Workforce planning skills

The House of Commons Health Select Committee Report on Workforce Planning[2] expressed concern about the quality, type and capacity of workforce planning within the NHS. The report highlighted a series of recommendations for improvement, to help ensure a workforce that is fit for purpose. These included:

- strengthening workforce planning capacity and capability
- aligning workforce, service and financial planning.

The WDs approach to implementation of workforce planning is set out in Chapter 7.

2.3 Operational principles

2.3.1 Leadership development

Developing capable leaders is a key requirement for the future of healthcare. The key priorities for leadership are:

- having in place a succession system for Chief Executive Officer (CEO) posts
- senior leaders capable of implementing the health reform agenda, with increasing emphasis on patient, public and staff engagement
- the development of clinical leaders

- meeting the leadership and race equality action plan targets.

The NHS Institute for Innovation and Improvement[22] has highlighted developing a management and leadership strategy as a priority for SHAs, to ensure development of current managers and leaders and also successors. The evolving national strategy of competency milestones for the careers of doctors requires the development of a detailed approach in the longer term for all other clinical professional groups. In addition, the national management development initiative is aimed at supporting the development of senior managers whose next career move is deemed to be into a Board-level director position.

The WDs approach to implementation of leadership development is set out in Chapter 7.

2.3.2 Productivity

Demands on the healthcare system will grow as a result of an increasingly ageing population, associated co-morbidity and other demographic changes that are highlighted in *Investing for Health*[1] (www.ifh.westmidlands.nhs.uk), in the Overview of the West Midlands section.

Providing quality healthcare, while containing costs and maximising value, is an ongoing leadership challenge for the NHS. Continuing to deliver healthcare in the same way is unsustainable. Healthcare must be delivered in a different way and workforce productivity increased.

The NHS Institute for Innovation and Improvement has developed a series of programmes focused on improving productivity, such as the Productive Ward programme,[23] recognising that productivity gains are directly linked to workforce development. Productivity is improved by using a skill mix whereby staff focus on the work that they (and only they) have the skills, competences and knowledge to undertake. For example, advanced practitioners improve medical productivity by enabling a consultant-led, rather than a consultant - provided, service. By using this process, where it is safe, training can be used to move tasks and skills down the skills escalator so that highly skilled staff may concentrate on more complex care.

Lean thinking principles are also increasingly being used in business, as waste of resources (time, money, supplies, skills, training, education or goodwill) result in a decreased value for money. Technological advances may also provide an opportunity for increased productivity.

The WDs approach to implementation of productivity initiatives is set out in Chapter 7.

2.3.3 New ways of working

Providing modern high quality health services, which meet access targets and are located nearer to the patients home, will require services to be redesigned and staff to work differently. Changes include: extending and enhancing the skills of some existing staff; giving staff the skills and knowledge to work in different settings; developing new roles; and changing the skill mix within teams to improve the efficiency of service provision.

By having an appropriately constituted workforce with effective skill mix across the health community at all levels of the skills escalator, health and social care organisations can meet the changing health needs of their population and maintain financial balance.

A fundamental change to provide better integration between those working in the NHS and those working in social care is required to ensure seamless care for patients. A better integrated workforce designed around the needs of people who use services and supported by common education frameworks, information systems, career frameworks and rewards can deliver more effective personalised care. The key to closer integration will be joint service and workforce planning. The NHS and local authorities will integrate workforce planning into corporate and service planning. DH is developing plans to achieve this in line with proposals to align service and budgetary planning across health and social care, in consultation with stakeholders. Workforce issues will also be fully integrated in service improvement planning by the Care Services Improvement Partnership (CSIP) and the NHS Integrated Service Improvement Programme (ISIP).

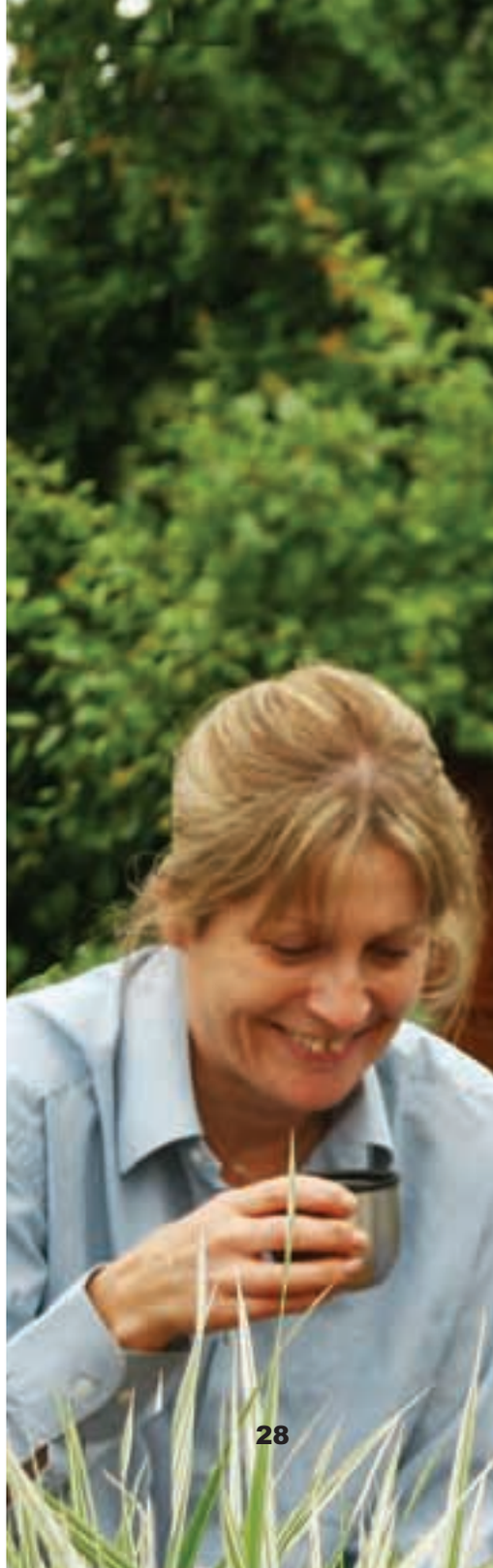
The WDs approach to implementation of new ways of working is set out in Chapter 6 and in *Investing for Health*[1] Project 9.

2.3.4 Assistant practitioners

The development of staff at bands 3 and 4 of the career framework[24] focuses largely on assistant practitioner roles. Their remit involves delivering care that has previously been in the remit of registered professionals by protocol under the direction and supervision of a registered practitioner. This skill transfer aids productivity, by enabling a professionally led rather than a professionally provided service.

Staff with the commitment and ability will develop and move up the career framework and have the opportunity to access education and training programmes that lead to professional registration.

The WDs approach to implementation of assistant practitioners is set out in Chapter 4.



2.4 Workforce delivery priorities

2.4.1 Strategic human resources

Strategic human resource management is a complex process to deliver the future direction of an organisation. It covers longer-term workforce issues and macro-concerns around structure, quality, culture, values, commitment and matching resources to future need.

New employment opportunities and scope will be facilitated by realising the benefits of Agenda for Change the Knowledge and Skills Framework (KSF)[25] and the General Medical Contract and General Dental Contract. The newly introduced pay system ensures fair and better pay, a clear system for career progression, and better recruitment and retention. For the first time, staff are paid on the basis of the jobs they are doing, the skills and knowledge they apply to jobs and team working.

The KSF[25] is linked to annual development reviews and personal development plans. It supports better personal development and career progression and allows staff to progress by taking on new responsibilities. This will allow jobs to be designed around patient and staff needs, improving overall productivity by having greater innovation in the deployment of staff and job satisfaction. The KSF is a developing framework that will enable people and jobs to cross organisational and professional qualification boundaries.

The KSF is about investing in organisations intellectual capital. It promotes employee development, enables improvements in workforce decision-making processes and informs education commissioning. The KSF offers the potential to improve:

- partnership working
- recruitment and retention
- sickness levels
- workforce planning.

Similarly, appraisal has been introduced in England by DH and the General Medical Council (GMC) for doctors working in the NHS. The aim is to give doctors regular feedback on past performance and continuing progress and to identify education and development needs as part of a doctors career development.

The ESR[26] will enable the evaluation and reporting of workforce data and for the first time will be used by all 600-plus NHS organisations throughout England and Wales. It is one of the worlds largest IT implementations and by spring 2008 will replace the 29 payroll and over 38 human resource systems used in the NHS. The ESR programme is an important building block in

achieving the modernisation of services and will enable increased flexibility of the workforce by:

- designing jobs around the needs of patients, rather than around grading definitions
- defining the core skills and knowledge that staff need to develop in each job
- defining competences and outcome indicators, so benefits can be measured
- improving recruitment and retention of staff.

The NHS Plan[6] makes a commitment to invest in the NHS workforce. It recognises that a modern NHS must improve the working environment. Improving the working lives of the workforce contributes directly to better patient care through improved recruitment and retention and by ensuring a highly motivated workforce that is able to deliver high quality patient care. The way organisations value their workforce is part of the core performance measures and is thus linked to the financial resources they receive.

Although 2006 saw the end of the Improving Working Lives (IWL) accreditation process,[27] this is not the end of the IWL principles being applied in the NHS. The basis of IWL is still very much seen as the cornerstone of the NHS work on becoming a good, healthy employer. As such, its standards are used by regulatory bodies to assess organisations. Organisations have mainstreamed IWL processes to them help deliver core and development standards for the future. The Health, Work and Well-being Strategy[28] and the Positively Diverse Programme[29] will continue to drive forward the IWL agenda.

The WDs approach to implementation of strategic human resources is set out in Chapter 7.

2.4.2 Equality and diversity

Equality and diversity are central to the NHS and its way of working and how it expects its partners to work. Staff working across a health economy need to reflect the diverse communities they serve, to ensure equitable access to services. Services should, where possible, be sensitive to individual patient needs, so that the workforce is able to respond fully to the needs of all patients.

The WDs approach to implementation of equality and diversity is set out in Chapter 4.

2.4.3 Widening participation

Skill mix changes need to cover the whole of the career framework[24] to enable the appropriate transfer of skills and development of protocol. The development of bands 1 - 4 has traditionally been less evident than in other levels in the career framework. The need to widen participation in learning and to develop the supply of sufficient and well-trained staff for the future is now recognised and documented in the Leitch Review of Skills in the Global Economy, 2006.[30]

The WDs approach to implementation of widening participation is set out in Chapter 4.

2.4.4 Knowledge management

Knowledge management provides the NHS with a learning framework, an organisational memory and information to support clinical practice and research and development.

The strategic goals for knowledge management are:

- all NHS clinical staff using the National Library for Health[31] and incorporating this knowledge into learning and practice
- agreement across HEIs to promote the development of information literacy skills which are transferable in the workplace
- library services providing modular learning, using knowledge management and e-learning methods to support the KSF of clinical and non-clinical staff
- library services not only supporting education, but also demonstrating outcomes which specifically improve clinical engagement with an evidence base.

Knowledge management requires a framework for the development of personal skills and application of smart technologies. In the UK, the National Library for Health[31] is one of the most important technologies. This aims to bring together in a single place all the evaluated knowledge in clinical care and includes a depository of e-learning. Over time, the National Library of Health will be a unique tool in the campaign to reduce ineffective and inefficient practice.

The technologies of knowledge management are advancing rapidly and these technologies will facilitate the growth of e-learning. These include Google, social networking and internet blogs which students use as part of the blended methods of learning developed in HEIs.

In 2005 the National Workforce Group published a framework, *Supporting Best Practice in e-learning across the NHS*.[32] This framework included the development of a road map in 2006: *Modernising healthcare training: e-learning in healthcare services*.[33] Subsequently the UK Alliance for e-learning in Health was established, to support and champion e-learning.

The WDs approach to the implementation of knowledge management is set out in Chapter 8.

2.4.5 Involving patients and people in learning

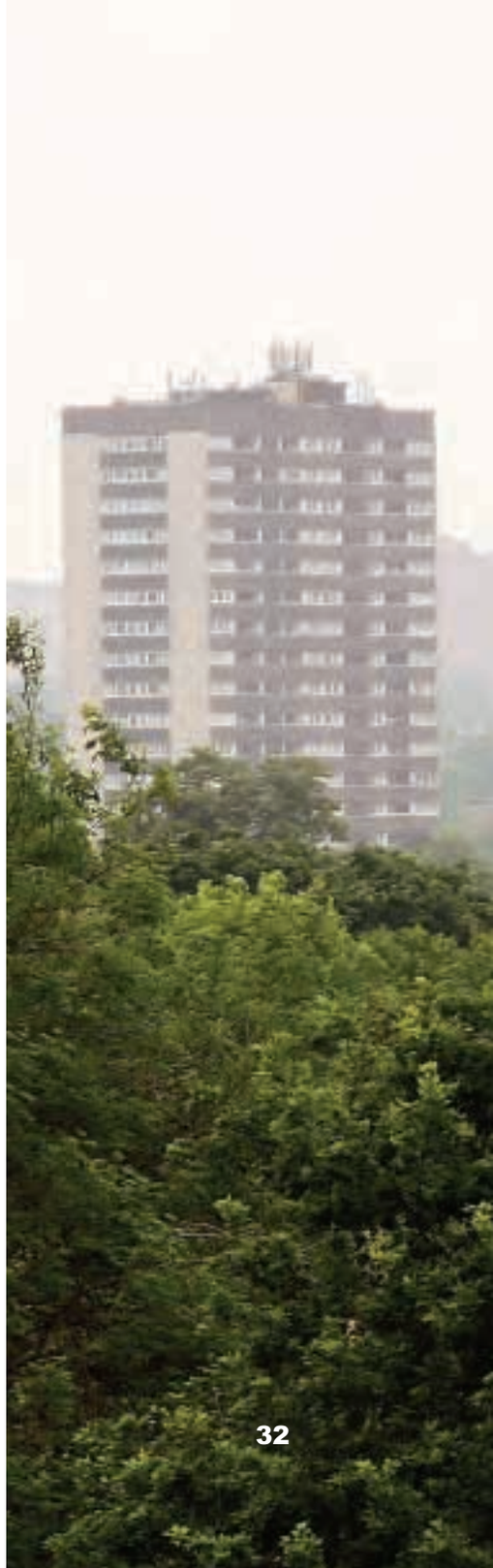
It is essential for all healthcare organisations and practitioners to plan and deliver healthcare that matches patients needs and preferences within the limits of resources. To achieve this, patients, carers and members of the public need to be involved in the planning and commissioning of education and training and workforce development. It is proven that the healthcare workforce can benefit from patient-centred learning through the practical and advisory contributions that lay people can make to education and teaching programmes. Consequently, this will enable educational providers to plan and deliver programmes that are fit for purpose.

The WDs approach to involving patients and the public in learning is set out in Chapter 8.

Summary - Key Workforce Drivers

The key workforce drivers are to:

- oversee the development of a flexible, adaptable workforce that is capable of sustaining continuous service improvement in order to deliver effective and efficient healthcare
- modernise healthcare careers to maximise the benefits for patients, staff and employers of a competence-based workforce
- provide quality healthcare, while maximising value and productivity
- extend and enhance the skills of existing staff and teams at all levels on the career framework and develop new roles enabling healthcare to be provided in different settings
- realise the benefits of Agenda for Change, the KSF and the consultant contracts
- develop capable leaders, both clinical and non-clinical, at all levels within the NHS as a key priority for the future of healthcare.



3. CHAPTER THREE Investing for the Workforce: Full Engagement

3.1 Introduction

A key priority for the WD is increasing investment in education and training to enable a shift towards preventative and 'wellness' services. Using a clear widening participation strategy, the WD will further develop the workforce in order to tackle inequalities head on, thus ensuring that healthcare services meet the needs of all patients through:

- the public health workforce including new roles
- patient empowerment and self-care programmes
- patient and public involvement
- lifestyle management services.

The WD will ensure that patients and the public are informed and involved in the design of education and training programmes which are accessible to the local population. The WD will ensure that the workforce reflects the community it serves: the NHS is a significant employer and has a responsibility to contribute to the regeneration of communities in ensuring that the social profile of the healthcare workforce closely reflects the social composition of the community it serves. The promotion of equity and diversity is a key principle upon which the workforce will be developed. The WD will promote equality of opportunity for all and develop a culture in which all forms of discrimination are considered unacceptable. It will act as a model employer, lead in good employment practice and raise employee awareness and understanding of equality and diversity issues across the West Midlands.

The infrastructure of public health has changed over recent years. A previously centralised and medicalised service has been dispersed to operate across a network of organisations. This time of change offers new opportunities for maximising the public health skills and experience of a very wide and multidisciplinary workforce within the broader models of public health.

Public health professionals work in a myriad of public sector and other organisations. The role of public health is changing fast. With the opening of the UK Register for Voluntary Registration of Specialists[34] at the equivalent of consultant level, there are now career routes for public health professionals from a variety of backgrounds. There are various training and competence development opportunities.

3.2 Reducing health inequalities

3.2.1 Fully engaged scenario

NHS West Midlands is committed to workforce development to bring about the fully engaged scenario outlined in the Wanless reports for HM Treasury.[35]

The Faculty of Public Health[36] has produced recommendations for staffing levels per 100,000 population. A challenge for the WD will be to work with trusts to ensure that reorganisations maintain expertise within departments, and that structures in new PCTs are aiming above target service levels. Following C*ommissioning a Patient-Led NHS*[37] implementation and the Health Protection Agency review,[38] the WD will audit posts and structures against the national planning levels and pre-reorganisation levels.

The 2001 *Report of the Chief Medical Officer's Project to Strengthen the Public Health Function*[39] talks about three broad categories of the public health function and more recently a fourth addition being health trainers.

Level 1 - The specialist workforce, i.e. those on the UK voluntary register for public health specialists,[34] consultants in public health and directors of public health.

Academic senior staffing is well established in Birmingham and the Black Country and developing well at Warwick University. The priority is to develop a viable public health academic establishment in Keele/Staffordshire Universities. Academic dental public health needs development at the School of Dentistry, University of Birmingham, to ensure that it has the capacity and capability to provide an academic and research lead for the delivery of *Investing for Health*[1] in the field of oral health and dental services for the improvement of NHS dentistry.

Level 2 - Public health practitioners, i.e. staff whose main role is public health (e.g. health improvement specialists, information specialists).

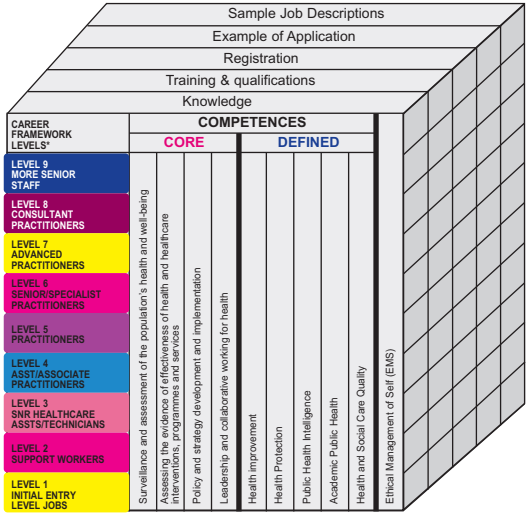
The WD will scope out the current public health practitioner workforce as part of the overall development of the West Midlands public health workforce strategy, to understand the roles and education and training of this workforce group.

Level 3 - The wider workforce, i.e. primary care staff or staff whose main role is not typically public health but who have a role to play in reaching the fully engaged scenario. The wider public health workforce can make a huge contribution to the public health agenda, e.g. front-line workforce contributing to smoking cessation, childhood obesity/weight management.

Skills for Health, in partnership with National Workforce Projects, are leading on a flexible career framework which will bring together public health competences[40], underpinning knowledge, training qualification routes, registration requirements and a database of job descriptions across the 9 career levels in the career framework. The framework will identify skills gaps and structural weaknesses in the deployment of staff and develop capacity of the workforce.

The WD will launch the PHRUBIK framework[40] to map the competences of the wider workforce in organisations across the West Midlands. The WD will analyse coverage of the dimensions of the framework in courses available. In partnership with Skills for Health, and the WD, PCTs will be encouraged to benchmark current competency and roles against the national career framework for the practitioner and wider public health workforce (levels 1-7), including children's services, sexual health services and maternity services.

Figure 10: Multi-disciplinary/multi-agency Public Health Career Framwork The PHRUBIK Cube



Level 4 - Health trainers, new entrants to the NHS, likely to have no or low level of qualification, who will require recruitment and training to Level 1 entry.

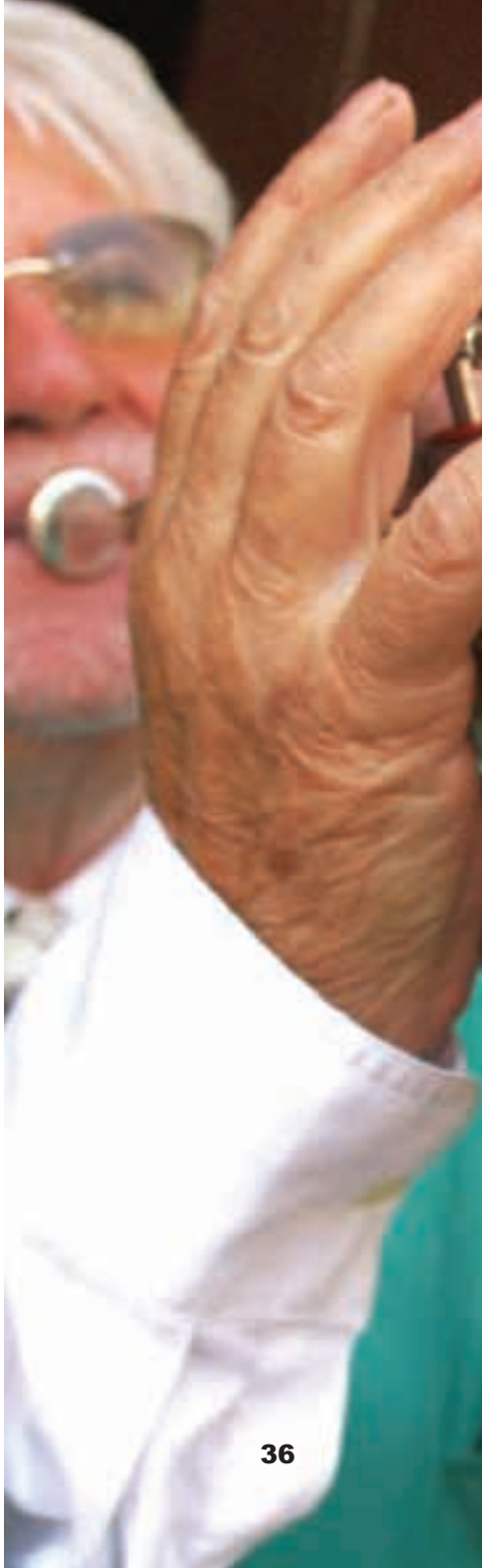
Health trainer services provide a one-to-one service of personalised, tailored information and practical support to motivate individuals who want help to adopt healthier lifestyles (for example, the at risk population). Health trainers are recruited from deprived communities, their prior life experience and understanding of what it means to live in, or be part of, that community are key aspects of their ability to deliver the role. Health trainers can recommend sources of specialist support where appropriate (stop smoking services, weight management, etc).

They will identify with the individuals the barriers to change and help them to overcome these. Focusing on deprived communities, health trainers can be seen as a powerful means of contributing to meeting the reduction of health inequalities targets set by government and in Local Delivery Plans (LDPs) and Local Area Agreements.

NHS West Midlands will develop a centre of excellence for training health trainers and their managers, and commission courses appropriately to ensure fitness to practise. Building on the previous commitment and the collective work since early-adopter status from 2005, it is expected that there will be 380 health trainers in post by December 2008.

A comprehensive mapping exercise will be undertaken across all PCTs within the West Midlands around all public health education and learning delivered to the primary care workforce and modes of delivery. This will inform the WD's future commissioning of learning packages.

A change in focus to concentrate on upstream interventions (such as smoking cessation, support for mental well-being, diet and exercise), to enable patients to recognise their own lifestyle risk



factors and take steps to tackle these, will impact on the workforce. The health trainer workforce will be expanded to target specific groups with high levels of lifestyle risk and the WD will consider further development of patient and public-led interventions to support patients before they develop long-term conditions.

3.2.2 West Midlands Teaching Public Health Network (WMTPN)

The WMTPHN[41] was formed in early 2007 from the allocation of national development monies and will continue to be funded until 2009 to work with all tiers of the public health workforce. The WMTPHN works in close partnership with the WD to ensure the vision of increasing the standard, range and availability of public health training in the West Midlands, in order to improve the health of the region's population.

An initial step has been to pilot distance learning programmes as a medium for developing skills at Tier 3 the wider workforce. The WMTPHN has commissioned the Open University to run a pilot programme, Promoting Public Health Skills: Perspectives and Practice,[42] for 30 students from NHS and non-NHS organisations. This will be evaluated and rolled out, subject to satisfactory evaluation.

3.3 Patient and public involvement

The WD will incorporate public and patient involvement in workforce development in all healthcare settings and encourage involvement in any planning or design of service change or improvement in trusts, PCTs, independent contractor practices, private providers and workforce development in general. The WD will continue to utilise market research commissioned by NHS West Midlands to ensure that the views and the attitudes of patients and the public are being addressed within healthcare services.

3.3.1 Information for patients

Equip[43] is a unique resource developed in the West Midlands as part of the Library Unit of the WD. *Investing for Health*[1] identifies the resource as a foundation stone for full public engagement. The strategy also proposes a development programme to ensure that this resource is redesigned to become a primary resource for all healthcare professionals as well as a one-stop shop for the public. In addition to acting as the host for Equip, the WD will take this opportunity for access to a substantial network of patient and public expertise. Our challenge will be to redefine inter-professional learning to include patients and the public. This resource will be critical to the WDs success.

3.3.2 Supporting patients' self-care

The emphasis is on what can be done in primary care to increase the frequency and extent to which people self-care; and the potential benefits of providing people with an integrated and enhanced support system for self-care in relation to maintaining good health and lifestyle as well as in the care of their minor ailments, acute illnesses and long-term conditions. The focus will be on helping acute trusts and PCTs by training and educating the workforce. The knowledge, skills and competences needed vary according to role and complexity of the patient and clients need.

Investing for Health[1] shows the relationship of self-care to low-risk, high-risk and complex cases Level 1 is supported self-care. Level 2 is disease management for people with complex needs in the care of single or multiple conditions. Level 3 involves case management of the most vulnerable people who have highly complex multiple long-term conditions.

The WD will help NHS organisations and the wider healthcare workforce where they work to deliver healthcare to:

Figure 11: The self-care continuum (adapted from Working in Partnership Programme[44])

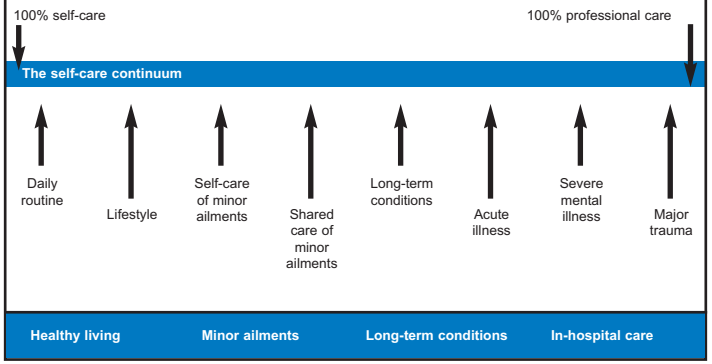


Figure 11 shows that self-care is a continuum, which WD will underpin with training and educational programmes.

- provide support and resources for community-based, self-care skills training programmes and initiatives that specifically target hard-to-reach groups and address health inequalities
- build on the role of community nurse practitioners to support patients self-care
- provide psychological therapies along the continuum of care.

The WD will support those involved in community development to:

- share training programmes for peer health workers

- develop accreditation processes to speed up spread and enable transfer of skills to lay people
- encourage community pharmacists to provide self-care support, resources and advice in an integrated multidisciplinary approach to ensure consistency of messages.

The WD will require education providers to:

- review health professional training with the intention of incorporating the knowledge, ability and skills to provide self-care support at all stages in the curriculum
- review content of curriculum relating to health and self-care with a view to identifying opportunities to introduce self-care skills development.

This should help to:

- develop the role of the workforce to signpost self-care support resources, supplying the support tools to enable this role to happen
- develop the role of clinicians in fostering good practitioner - patient relationships, strengthening patient participation in decision-making and operating in line with the evidence base of clinical effectiveness of self-care.

3.3.3 Expert Patient Programme

The Expert Patient Programme (EPP)[45] supports the delivery of national policy commitments made in *Choosing Health*[46] and *Our Health, Our Care, Our Say*.[47]

The programme also addresses the concerns expressed by the Wanless report[35] about future financial pressures on the NHS and the importance of supporting self-care management.

The basis of the EPP is the self-management course developed at the Stanford Patient Education Centre in California[48] and delivered in England through lay tutors trained in the course manual and supported by competent volunteer managers. The main mechanisms to be put in place include identifying such patients by:

- scrutinising general practice long-term conditions (LTCs) registers and sending patients information
- identifying patients at the surgery or clinic and giving specific encouragement
- offering the course as part of another patient education programme where disease-specific or professionally-led modules can be introduced before or after the generic course.

3.3.4 Widening participation

Widening participation is a priority for the WD and will cover:

- ensuring the healthcare workforce is representative of the local community
- encouraging new and different groups into the healthcare workforce

- work with schools and further education institutions
- supporting local regeneration projects.

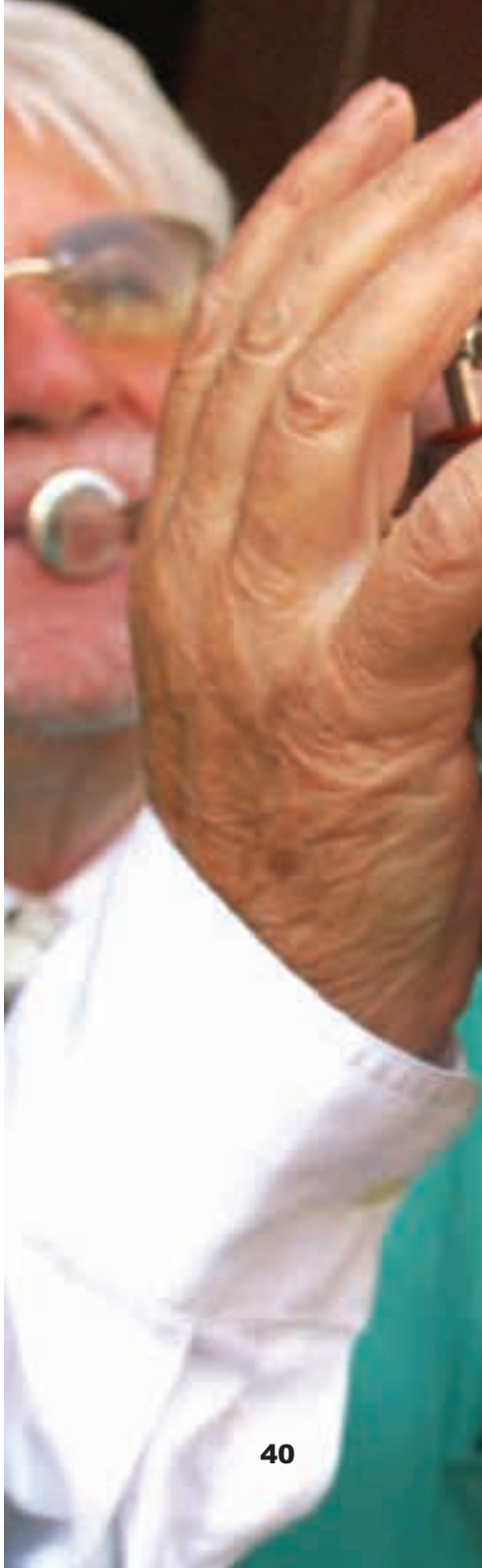
To facilitate increasing access to healthcare careers, the WD will:

- support local best practice projects to share learning strategies across the region, on an adopt or adapt basis, particularly to support SHA priorities in relation to the shift to primary care
- develop common and generic roles, which easily adapt to changing structures and shifts in the workforce in the medium term
- make explicit links to the 14 to 19 years agenda[49]
- evaluate the impact of assistant practitioners as part of the embedded 4 tier model of radiography practice.

The WD will produce a strategy for the 14 to 19 years agenda[49] which:

- delivers tailored education targeting the 14 to 19 year age range to build the competences needed to fill the healthcare roles of the future. The use of the Skills for Health competences and competence frameworks will be a critical success factor in this process. A need therefore exists for much more focused attention on integrating vocational skills into the school curriculum by both education providers and employers
- provides accredited, health-related courses that offer vocational pathways into the NHS and introduce pupils to the realities of working in healthcare
- develops a vocational centre for healthcare education that offers pupils an interactive experience of healthcare by involving them in realistic scenarios. This will increase the capacity and capability of employers to increase pupil access to healthcare professionals and healthcare environments
- establishes a strong relationship between local healthcare employers and their local college to launch a faculty of healthcare careers, which will provide an integrated approach to accessing and developing NHS careers. The partnership will encourage young people and adults to take up healthcare-related jobs, by providing structured training programmes with work-based learning and formal qualifications.

The WD will develop work in partnership with Skills for Health, employers and regional Learning and Skills Council (LSC)[50], which will contribute to the education of the wider workforce. This will involve working in partnership with the Lifelong Learning Networks (LLNs) which have established a further and higher education system with employers across the West Midlands to focus on progression into and through vocational education. The LLNs will aim to: create new learning opportunities; forge agreement across institutions on how qualifications are valued; and produce publicity



to help people understand how they can progress through the system. Networks will clarify existing progression opportunities and engage in collaborative curriculum development with employers in order to meet the needs of the vocational learning.

Summary - Full Engagement

To support full engagement, the WD will:

- increase investment in preventative and wellness services education and training, to enable a shift towards upstream intervention
- develop the workforce to tackle inequalities and to ensure that healthcare services meet the needs of all patients
- support PCTs to ensure the effective delivery of the 4 tiers of public health workforce detailed in the 2001 *Report of the Chief Medical Officer Project to Strengthen the Public Health Function*
- host and redesign Equip to become a primary resource for all healthcare professionals that redefines inter-professional learning to include patients and the public
- increase the frequency and extent to which people self-care in relation to minor ailments, acute illnesses and LTCs, by providing the knowledge, skills and competences required
- support local best practice projects and develop roles to widen participation to increase local community representation and support local regeneration projects
- produce a strategy for 14 to 19 year olds to fill the healthcare roles of the future and assist NHS employers to increase access to healthcare careers.

4. CHAPTER FOUR Investing for the Workforce: Improving Quality and Safety

4.1 Introduction

It is undeniable that health services across the West Midlands are of variable quality and safety standards. This is also true nationally and internationally. It is the duty of the NHS to minimise that variability, while raising the overall standard of services for patients.

The WD has clinical quality, safety and patient experience at the centre of its education commissioning and quality assurance framework. The WD quality assurance framework is integral in the drive for the continuous and sustained development of highly trained staff who are fit for purpose. This will be achieved by:

- supporting a strong professional regulation framework
- ensuring robust medicines management
- supporting the workforce to reduce healthcare-associated infections (HCAIs)
- enhancing the focus on safety and quality as part of core training
- implementing MMC[11]
- realising the benefits of MHC[3]
- ensuring high quality education curricula
- engaging in research and development.

Multi-professional learning and working are key to the evolution of team-based healthcare and efficient and safe services in all health settings.

4.2 Improving quality and safety of services

4.2.1 Professional regulation

Regulation as a function is to protect the public and ensure fitness for purpose and practice. Its overriding interest is the safety and quality of the care that patients receive from health professionals. The White Paper *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st century*[51] sets out a framework through which patients, the public, the professions and the Government can secure a new settlement that assures the safety of patients and their continuing confidence in the professions while treating dedicated health professionals fairly and independently.

The WD will:

- review changes in the development of professional regulation for doctors and other health professionals, and for new roles not currently regulated
- enable trusts and PCTs to understand the new and anticipated requirements
- set up new systems in developing education for new/extended roles and healthcare support workers.

The WD will encourage NHS employers and independent contractors to ensure that staff can access high quality CPD and apply their learning in modernised service delivery. CPD should be fit for purpose, and matched to professional and service requirements that feature in agreed personal development plans (PDPs) emerging from annual appraisals and performance reviews. The WD will require education providers to share information about the extent and quality of CPD they provide, to increase access and availability to CPD resources across the West Midlands with a shared understanding of level and target participants.

4.2.2 Regulation of healthcare professionals

The challenges for the WD are to ensure that:

- WD-commissioned healthcare programmes have currency and transferability and can demonstrate they meet the standards required at point of entry of qualification to ensure healthcare professionals are fit for purpose and practice
- the national governance model for new and emerging roles is implemented across the West Midlands
- recognised support is provided for those staff in training considered to be failing in practice, so that the WD not only protects the public and service but also supports the individual
- collaboration with key stakeholders is provided effectively in relation to the proposed regulation of support workers and trainees.

Key issues for the WD and stakeholders are to determine key responsibilities following national guidance to support:

- healthcare providers to meet new regulatory requirements pertaining to re-license and re-certification
- local trusts and PCTs to meet new regulatory requirements for Nursing and Midwifery Council (NMC) standards for mentorship and supporting students in clinical practice[52]
- support local trusts and PCTs to meet new regulatory requirements for achievement of AHPs portfolio recommendations
- PCTs and dental practices to meet the new regulatory requirements of the GDC[53] for the registration of all dental care professionals by July 2008, including consequential requirements for subsequent re-certification and re-validation
- local CPD/learning beyond registration (LBR) requirements at interface service level, to ensure that practitioners are equipped with appropriate skills and knowledge to perform competently and efficiently in their roles.

Working in collaboration with employers, HEIs, education providers and stakeholders, the WD will refine, review and develop curricula which meet professional body requirements and produce practitioners who are fit for purpose and practice. In addition, the WD will ensure that standards of education commissioned meet national requirements for new and emerging roles.

4.2.3 Prescribing and medicines management

4.2.3.1 Prescribing

A prescribed medicine is the most frequent clinical service provided for patients in the community or in hospital practice. Patients have a right to expect their prescribers to be competent and to expect local access to medicines. The annual NHS West Midlands spend on medicines is over £1 billion. Medicines and prescribing achieve great benefits for patients, but also represent a significant risk to the NHS and a health risk to patients.

The WD will invest in strategies to support safe prescribing by strengthening and supporting the improvement of prescribing education and training for:

- junior doctors
- emerging non-medical prescribers
- practising prescribers.

The WD will work with national and local partners to review how junior doctors learn to prescribe. The WD Heads of Foundation

Schools will facilitate this work, in partnership with undergraduate medical schools and stakeholders.

Traditionally, prescribing has been a medical role. Over recent years, the legal framework for prescribing has been transformed, to facilitate prescribing by appropriately trained and registered nurses, pharmacists and AHPs.

The expansion of Non-Medical Prescribing (NMP) will support trusts to redesign services, to realise the potential benefits of large sections of their workforce and give patients wider access to medicines. The WD recognises the need to sustain NMP basic training and support for this innovation, and will invest in training and development of new prescribers.

To support trusts to realise the benefits and manage and minimise the risks associated with multi-professional prescribing, the WD will:

- identify prescribing competences across both medical and non-medical prescribing
- work with national and local partners to investigate and support mechanisms to improve prescribing education and training for junior doctors and non-medical prescribers
- ensure appropriate accredited post-basic prescribing training programmes for NMP are available across the West Midlands
- in partnership with trusts, invest in the expansion of nurses, pharmacists and AHPs trained to prescribe
- support the expansion of prescribing for advanced and specialist roles for nurses and other healthcare professionals and new and developing roles and services
- with partners and stakeholders, support access to appropriate multi-professional CPD to develop and maintain competence of all prescribers, to support safe, cost-effective and appropriate prescribing
- include the development of NMP as a priority in all aspects of the WDs portfolio, e.g. leadership, innovation, education and training, new roles, extension of roles and role redesign and quality assurance of education and training programmes.

4.2.3.2 Medicines management

It is estimated that problems with medicine, such as poor compliance and adverse effects. account for 15% of emergency hospital admissions.[54] Modernisation of medicines management in secondary care will: have positive benefits on NHS capacity; increase patient safety; improve financial control; and have a positive impact on prescribing of medicines in primary care, as a large majority of prescriptions are initiated in hospitals.

The pharmacy workforce is fundamental in managing the planning, choice and use of medicines. Community pharmacy is one of the

few health services that are visited by healthy as well as ill people. Community pharmacists/staff are available to give advice on health issues, as well as to dispense and give advice on medicines. Community pharmacists offer flexible access in primary care.

The WD will support PCTs, through investment in education and training, to integrate community pharmacy services into primary care services and to further implement the community pharmacy contractual framework.

4.2.4 Patient safety

Patient safety means:

- avoiding accidental harm, e.g. HCAI, ensuring that the necessary arrangements are in place when things do not go as planned (prompt diagnosis and appropriate treatment)
- ensuring that robust risk assessments are in place to help make good decisions.

There is widespread excellence in the healthcare practice across the West Midlands that thousands of patients receive on a daily basis. Clinicians, managers and Boards across the NHS in the West Midlands are highly motivated to drive up quality and safety, but need help to do it. Patients and the public are increasingly aware of issues of quality and safety especially as a result of the national media coverage and focus on HCAIs and other high profile media cases.

Quality and safety can be achieved by workforce education on:

- consent and patient involvement
- identifying, preventing and managing adverse events and near misses
- use and recording of data
- working safely, such as teamwork and risk reduction strategies
- ethics and fitness to practise
- multi-professional CPD.

Workforce education and training highlight that patient safety, HCAIs, infection control/prevention and hospital cleanliness are everybody's business and that every healthcare professional should provide the right care every time preventing wrong procedure and wrong patient treatment.

NHS West Midlands is working to develop a set of quality metrics for monitoring the quality of care and patient experience within the NHS. The broad themes of this work include:

- patient safety - avoidable deaths, HCAIs, medication errors, falls and wrong procedures
- patient feedback - designed to ascertain involvement of

individual patients in their care, treatment with dignity and respect, acceptability of the environment (including food)

- patient experience - e.g. prevalence of pressure ulcers, number of patient moves during inpatient stay, re-admission rates
- efficiency measures for both providers and commissioners relating to Better Care, Better Value productivity indicators.[55]

4.2.4.1 Team handover

All healthcare professionals need to recognise their responsibilities to ensure team handover techniques and reduce avoidable errors, using appropriate clinical governance arrangements to protect patients.

The WD will:

- produce guidance for education providers to ensure the development of team handover as part of the core curricula for all healthcare professionals
- pilot a project in conjunction with the Risk Management Foundation to promote patient safety and good practice by disseminating lessons learnt to other professions, initially looking at obstetrics
- analyse data collated from trainee surveys and student evaluations to ensure compliance with Postgraduate Medical Education and Training Board (PMETB) standards.[56] Action plans will be developed in conjunction with stakeholders, as appropriate.

4.2.4.2 Improvement training

To embed a culture of continuous improvement in patient care, the WD will work towards all professional and educational programmes commissioned to include specific components designed to give all staff core improvement skills. The skills will provide the workforce with the confidence and skills to challenge individuals and organisations when practice is not acceptable.

Implementation of improvement training can be found in Chapter 8.

4.2.4.3 Healthcare associated infections

The term healthcare associated infections (HCAIs) encompasses any infection by any infectious agent acquired as a consequence of a persons treatment or which is acquired by a healthcare worker in the course of their duties.[57]

Approximately 9% of UK hospital patients contract HCAIs and these infections cost around £1 billion per year,[57] the equivalent to the annual running costs of eight NHS hospitals. The Chief Nursing Officers[57] top priority is to improve hospital cleanliness and tackle MRSA and other hospital infections, particularly *Clostridium difficile*.

HCAIs and patient safety can be improved. The WD will:

- enhance the undergraduate nursing/medical/AHP curriculum to include an improved focus on HCAIs
- develop the train-the-trainer safety and quality packages for implementation across the West Midlands
- develop the delivery and quality assurance (QA) of an infection control and hand contamination vocational qualification available to all staff in support services
- ensure training and education providers are kept fully briefed on current practice and DH policy
- have an education and training lead in each organisation, monitoring compliance and impact on patient quality and safety
- audit, monitor, report and evaluate through QA systems currently in place.

It is important that all HEIs delivering non-medical education and the WD foundation and postgraduate medical and dental schools ensure that healthcare workers are fit for practice in terms of understanding the principles of infection control. The WD will work with partners through appropriate groups to improve teaching and attainment of skills acquisition for the principles of infection control. This will be undertaken for pre- and post-registration curriculum for all medical, dental and non-medical staff where necessary, in order to improve HCAI rates and patient safety. The WD will work to improve the basic mandatory training within trusts to develop a competency-based learning package.

4.2.5 Staff safety: managing violence and aggression

Work-related violence is now considered by many as one of the most serious occupational hazards facing staff working in the healthcare sector. Clinical governance ensures that the WD has robust arrangements in place for the training of staff. Management of Actual and Potential Aggression (MAPA) is a training programme that forms a mandatory part of trust training in mental health services. The training includes de-escalation, physical restraint and breakaway techniques in line with National Institute for Health and Clinical Excellence (NICE) guidance on *Violence: The Short-Term Management of Disturbed/Violent Behaviour in In-patient Psychiatric Settings and Emergency Departments* (2005).[58] The WD will scope out the current provision of training provided across trusts and consider the development of a regional programme in line with MAPA.

Implementation of staff safety training can be found in Chapter 8.

4.3 Providing high quality education

4.3.1 Modernising Healthcare Careers

MHC[3] aims to ensure a consistent policy across all UK governments and assemblies and provide high quality healthcare that is safe, accessible and patient-centred. The implementation of each of the MHC programmes is at different stages, as outlined in Chapter 2.

The developments of advanced and assistant practice are key parts of the career framework that forms part of the main strategies to support the implementation of MNC,[17] MAHPC[20] and MHCSC.[19] These strategies aim to provide a consistent, high quality, transferable, competency-based education and training framework for staff going into these roles.

Implementation of MMC can be found in Chapter 10.

4.3.2 Advanced practice

The WD will encourage the development of practitioners with special interest (e.g. GPs, pharmacists, nurses, AHPs, etc) in safe, quality-assured ways. As part of sustaining improvements in healthcare services, it is vital to enable highly skilled clinical staff to remain in practice. Such elements as the developing career framework within the NHS, the blurring of professional boundaries of work, and the need to provide redesigned Clinical Pathways of care (underpinned by the Agenda for Change pay modernisation scheme) have clearly identified the roles of advanced and consultant practitioners.

The emerging advanced nurse model from the Nursing and Midwifery Council (2005)[59] can be found in Appendix E. Other professional roles are also taking on extended/specialist roles to ensure more fluid and effective patient pathways. Practitioners with a specialist interest (PwSIs) and advanced practice have increased in number, in primary care settings providing more care in the community.

The generic features that distinguish advanced practitioners are:

- use of knowledge in practice
- critical thinking and analytical skills
- clinical judgement and decision-making skills
- professional leadership and clinical enquiry
- coaching and mentoring skills
- research skills
- changing practice.

To date, there have been over 100 non-medical consultant appointments across the West Midlands, including nurses, physiotherapists, dietitians, radiographers and pharmacists. Over 50% have been developed through NHS West Midlands sponsored clinical masters scheme, and many of these appointments have led to the development of new services, improved access to services, and the delivery of expert care and professional clinical leadership. The WD will continue to commission the clinical masters scheme for aspiring consultants, with the aim of improving leadership, self-awareness, political acumen and business skills. On completion, the participant will apply for consultant posts, where they will spend 50% of their time providing expert clinical input, with the other 50% divided between education and practice development, consultancy, research and audit activity.

In order to prepare experienced practitioners for advanced practice, innovation and leading healthcare developments, the WD will continue to commission education for advanced practice roles. Future commissioning will include some elements of the clinical masters scheme being integrated into rotational programmes within the new postgraduate deanery schools, to provide opportunities for joint learning between doctors in training and advanced practitioners.

The WD will work in partnership with HEIs and across HEIs, to ensure that there is delivery of specific advanced practice-level clinical outcomes as well as the generic features of advanced practice.

4.3.3 Assistant practice

The development of assistant practice was prompted by a desire from within the NHS to widen participation in learning[60] to meet the future demands for sufficient and well-trained staff, improve productivity and enhance patient pathways.

An assistant practitioner works at Level 4 on the NHS Career Framework[24] and is defined as: someone probably studying for foundation degree or equivalent. Their remit will involve them in delivering protocol based care that had previously been in the remit of registered professionals, under the direction and supervision of a state registered practitioner (Skills for Health, 2005).

The WD will invest in the development of the non-professionally qualified workforce by reviewing and mapping existing education and learning provision across Levels 1 to 4 of the Career Framework to produce a workforce plan which facilitates the development and delivery of robust training programmes and their subsequent evaluation. Examples to be progressed include assistant theatre practitioners, maternity support workers, generic health and social care foundation degrees, and staff delivering low-intensity interventions in mental health.

4.3.4 Widening participation

NHS West Midlands is working in partnership with Skills for Health and the LSC to develop a joint investment framework to ensure that maximum benefits are realised from the resources available. The intention is that the joint investment framework will operate over a 3 year rolling timeframe.

This work will build on the principles of Train to Gain[61] and Skills for Life[62] and will work towards achieving the skills pledge which expects that employers will commit (voluntarily) to train all eligible employees to education Level 2 in the workplace.

In addition to developing the current workforce, the Health Service needs to actively work with the workforce of the future. Engagement with school pupils through the 14 to 19 years apprenticeship is essential to providing a continuity of development from school age through to the top of the career framework.

NHS West Midlands will support and contribute to the delivery of the 3 key challenges identified in the Public Sector Skills Challenge.[63]

4.3.5 Research and development

Best Research for Best Health[64] is the national strategy for promoting high quality research in the NHS. It proposes far-reaching changes to the way in which the NHS funds and manages research and development that will have implications for NHS trusts.

The WD will work with NHS organisations to identify and develop focused research strategies, and to underpin these with strong partnerships between the NHS and local universities. The WD will work to ensure that workforce issues are integrated into research activity to support effective workforce planning. In addition, the WD will maximise the opportunities arising from national and regional clinical academic initiatives across all professions, e.g. the Walport initiative[65] to ensure that research and development capacity is retained and enhanced.

Chapter 8 outlines how the WD will ensure that the education and training it commissions will ensure a safe, highly trained workforce that is fit for purpose.

Summary - Improving quality and safety

To support the improving quality and safety agenda, the WD will:

- ensure that clinical quality, safety and the patient experience are at the centre of education commissioning
- invest in strategies to support safe prescribing for junior doctors, non-medical and practising prescribers and expand NMP to give patients wider access to medicines
- ensure that healthcare workers have the required infection control skills to improve HCAI rates and patient safety
- develop specialist and advanced practice in safe, quality assured ways
- enable highly skilled clinical staff to remain in practice through the development and support of advanced and consultant practitioner roles
- develop the non-professionally qualified workforce by reviewing, enhancing and mapping learning provision across Levels 1 to 4 of the Career Framework to facilitate delivery of robust training programmes.

5. CHAPTER FIVE Investing for the Workforce: Care Closer to Home

5.1 Introduction

Approximately 90% of patient contacts within the NHS take place outside hospitals and there is an increasing need to increase access and provide more services closer to home. The WD will work in partnership with organisations to ensure the development of a highly trained and flexible workforce that is able to provide high quality integrated care, aiming to improve access to healthcare services:

- for patients needing to use mental health services
- for patients needing NHS dentistry
- to support patients with LTCs
- to support end-of-life (EoL) care.

5.2 Improving access to healthcare

Improving access to healthcare means patients can receive care advice and information at the point of need and at times and in locations convenient to them. There is an increasing range of healthcare providers in different settings. These changes have implications for the workforce delivering services, in particular for the:

- size of the workforce in primary care
- competences of the workforce within the community, who may be delivering care traditionally provided in a hospital setting.

Improving access to healthcare poses significant workforce challenges, to ensure that appropriately qualified staff can deliver services in the right place at the right time. The WD will provide expertise to organisations supporting workforce planning and development, addressing access to healthcare and ensuring services are accessible at the point of need. This will include supporting the shift of service from hospitals to the community.

5.2.1 Plurality of provision

Increasing the number of providers of health and social care will improve access to services and provide a realistic choice option, for example for patients as part of the Extended Choice Network for elective care.[66]

With the expansion of the third sector, such as the independent sector (IS) and the voluntary sector, in the provision of health and social care, the WD will work with alternative providers to address workforce issues in relation to:

- the impact of a consultant-delivered service in the IS, which may prevent junior doctors from obtaining appropriate practical experience. The resolution of this requires input from the PMETB, PCT commissioners, the Healthcare Commission, IS providers and the contract management boards
- realising the benefits from training capacity which forms part of contracts with IS treatment centres,[67] ensuring:
  - consistency of supervision for placements
  - capacity for placements that give experience in routine procedures
  - managing placements with the expansion of mobile facilities, as the physical environment may not increase placement capacity
- developing relationships between the third sector and relevant HEIs, to promote effective use of placement opportunities, where they exist
- working with regulators, DH Commercial Directorate and the

Independent Healthcare Forum[68] to strengthen understanding of:

- current training of the third sector workforce
- future workforce planning, which will need to include third sector providers to ensure that the levels of workforce supply are appropriate.

5.2.2 18 weeks and diagnostics

Work to reduce waiting times for patients will continue, with plans in place for a maximum waiting time of 18 weeks from GP referral to the start of treatment by December 2008.[69]

Three main challenges for the workforce are:

- workforce capacity, e.g. audiology services
- workforce capability, e.g. complex orthopaedic procedures
- sustainability, e.g. in light of MMC and WTD 2009 and the impact on the availability of junior doctors.

The WD will create an 18 week Workforce Support Unit, to enable tailored initiatives to be delivered in partnership with PCTs and providers to create a workforce that can achieve and sustain the target. The first step will be to undertake an analysis of the 18 week workforce. The WD will develop a diagnostic tool as a national pilot with the DH 18 week Workforce Development Team. The template will be used by all SHAs to raise awareness and understanding of the specific workforce challenges that SHAs face to deliver the 18 week target.

The 18 week Workforce Support Unit will:

- support PCT and Practice Based Commissioners to understand the workforce implications of changes to patient pathways to deliver the 18 week RTT[69] and Care Closer to Home [47]
- scope out and model the impact that MMC[11] and WTD 2009[12] has on the WD and workforce productivity on progress/long-term achievements of the 18 week targets
- develop tailored packages of support for organisations based on their individual 18 week workforce action plans, in partnership with the five locality workforce Boards
- define skill mix and education and training, and influence education commissioning requirements to increase capacity and sustainability within the workforce and to enable sustainable 18 week pathways.

5.2.3 Pharmacy workforce

The pharmacy workforce is a major resource for health improvement, and can offer wide access to a broad range of healthcare services for patients. Community pharmacies are becoming an important health service within local communities.

They are well placed to focus on promoting well-being, better lifestyles and better medicines management services and are often accessible when other health services in primary care are closed. Modernised medicines management services in mental health trusts and acute trusts can ensure medicines are used safely and effectively and can reduce delays in discharge from hospitals due to medicines-related issues.

The WD will support PCTs to achieve:

- further implementation of the community pharmacy contractual framework by investment in, and development of, harmonised accreditation training programmes for the pharmacy workforce across the West Midlands
- capacity of consultant pharmacists, pharmacists with special interests and pharmacist independent prescribers by investment in training programmes and multi-professional leadership.

The WD will provide the workforce expertise necessary for development of new and extended roles within the pharmacy workforce and support the modernisation of the pharmacy workforce in partnership with stakeholders. This will be undertaken with investment in pharmacy education and training to support modern and appropriate pre- and post-registration education and training programmes delivered in partnership with local education providers.

The WD will work in partnership with the RPSGB to undertake A Quality Management Feasibility Study for the Pharmacy Pre-registration Scheme.[21] This is the first study of its kind in England. The benefits of this study will be to:

- extend training into all sectors of service provision to support the direction of care provision from secondary to primary care, and further support pre-registration pharmacists to prepare for their expanding role in community pharmacy
- explore all aspects of pre-registration pharmacy training and its quality management
- develop multi-professional training with junior doctors, nurses and other health professionals, as appropriate.

5.2.4 Healthcare in secure environments

The WD will scope out current workforce development in secure environments, identify gaps in healthcare and commission appropriate education and training programmes accordingly. This will minimise and eliminate gaps between workforce development and practice which influence any differential in standards of healthcare provision for secure environments and for the general public in the community. The numbers of secure mental health beds and prison in-reach services within the West Midlands has

increased significantly in recent years. To meet the workforce development needs, the WD will enable wider access to appropriate training courses.

5.3 Mental health

The priorities for mental health services must be driven by current DH policy developments and, as outlined in *Breaking Down Barriers*,[70] need to ensure that services include:

- Care Closer to Home[47]
- earlier intervention
- 24/7 home treatment
- tailored care
- better access to modern drugs
- multidisciplinary teams (MDTs) across specialist mental health providers, primary care, employment, housing and social support
- talking therapies.

To support this change, the workforce will be required to be flexible to meet the changing demands of service provision. This can be achieved through new ways of working and skill mix change, which will require some changes to how training and education are delivered.

Mental Health: New Ways of Working for Everyone[71] provides guidance on how to develop and sustain a capable and flexible workforce for mental health. This guidance provides a framework not only for those of working age but also for older people and children and adolescents. The principles underpinning this approach are:

- matching knowledge and skills of practitioners to the needs of the individual (more complex needs met by more experienced and skilled workers)
- the development of competences rather than professions within the workforce
- dispersed leadership where work is not delegated by one single profession but by the most experienced and skilled
- sharing of knowledge, skills and competences across professional and practitioner boundaries
- team approaches.

New Ways of Working will be supported by the WD through a number of initiatives, including:

- a focused implementation programme for the delivery of a sustainable 5 year rolling programme to enable sharing of best practice across the West Midlands

- learning sets for senior operational and board-level staff
- training for trainers and supporting the implementation of the Creating Capable Teams Toolkit.[60]

By adopting the principles in *Mental Health: New Ways of Working for Everyone*[71] there will be changes in workforce configuration and roles and responsibilities that are undertaken. Some roles will be extended, for example introduction of responsible clinicians and approved mental health practitioners as set out in the Mental Health Act 2007,[72] which will enable healthcare professionals to undertake duties which traditionally were the remit of approved social workers and responsible medical officers. Additional training for registered health staff to take on these areas of practice will be required.

There will be a focus on the development of skills in talking therapies across the workforce in primary and secondary care, including evidence-based approaches such as cognitive behavioural therapy. A modular education and training programme will be developed to equip a range of new and existing roles to provide low-intensity interventions to people experiencing anxiety and depression. A review of current commissions will be undertaken to increase skills in talking therapies at pre-registration level.

The provision of a workforce to meet the demands of mental health services will not only be drawn from the traditional professional groups but will also look to increase participation from areas of the community that have not previously received training to equip them with specific skills and competences to fulfil roles within which they are working, for example community development worker in mental health.

5.3.1 West Midlands improving access to psychological therapies programme

The national Improving Access to Psychological Therapies Programme[73] is based on a stepped care approach as outlined in the NICE guidelines for anxiety and depression. The initial steps support the principles of guided self-help and early interventions, thus decreasing referrals into secondary care. As part of this programme, a pathfinder site has been developed in the West Midlands. In addition, PCTs will be encouraged and supported to take on this way of working. Future training for the workforce will be developed to respond to this initiative.

5.3.2 Child and adolescent mental health services (CAMHS)

The age of service provision for child and adolescent psychiatry has risen from 16 to 18 years, leading to increasing demand for services. A recent review of workforce issues identified a number of key themes for the CAMHS workforce, now incorporated in the *Report on the Implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services*[74] as a means of delivering good practice. The WD will support workforce development for this.

In partnership with CSIP, our work will involve:

- working with service providers to create new roles in CAMHS
- widening the recruitment pool and so complementing existing staff types, e.g. within primary care development of Tier 1 professionals, to increase access
- developing Tier 1 training and a foundation degree for all staff working with children who need CAMHS input
- focusing on skills escalation of MDTs, to support more robust competency-based workforce planning across the team.

5.4 NHS dentistry

Developing a dental workforce committed to the delivery of high quality care is key to improving access to NHS dental services. A service priority is to support NHS primary dental care, and specifically to improve access for patients to high quality NHS dentists for regular ongoing treatment.

The majority of dentists work in primary care in general dental practice (90%), with the remaining in specialist practice (hospital, university teaching and research). The general dental practitioner is increasingly becoming the team leader within a multi-professional team. The supply of dentists is increasing after a 15 year period of reduced levels, and by 2009 there will be a 25% increase in UK dental graduate output from dental schools. To ensure appropriate training, the WD has anticipated an increase in the number of Vocational Training Scheme practices across the West Midlands from 60 to 72.

To support primary care dentistry, the WD will look to enhance skill mix in the dental workforce to include more dental nurses and dental therapists. Dental therapists have been graduating since 2006, and there is an urgent need to ensure that they are recruited, retained and fully used in NHS dental practices. This will require close liaison with PCTs and NHS committed dentists to increase the number of dental therapists within teams to enhance skill mix. Dentists will be able to concentrate more on leadership and the provision of complex dental treatments where demand is

increasing owing to the ageing population. The pilot foundation programme will be evaluated, which will inform future delivery.

Workforce planning in dentistry is compromised by the lack of information about the workforce in dental practice, which comprises some 90% of all dentistry. The WD will work with PCTs to address this issue as a matter of urgency.

Dental Nurse (DN) supply is of concern, as there is no national planning system and numbers are determined by local needs. After July 2008, all DNs will need to be registered with the GDC[53] or to be on an approved training programme. If this is not managed, it will have a significant impact on the availability of dental services. There are insufficient training places to ensure an adequate supply of DNs to NHS practices in the West Midlands. This staff group has a poor retention rate. The WD Dental Strategy aims to increase numbers of DNs and retain experienced DNs by promoting CPD, enabling development within a skills escalator approach and ensuring that they remain fit for purpose with the changing needs of patients. Working in collaboration with the LSC, the WD aims to increase the range and number of DN training providers. A key aspect of the strategy is the development of DNs and the link with opportunities to develop skills and widening participation from the 14 to 19 year old workforce, in addition to attracting a new workforce to the NHS as part of economic regeneration schemes.

To meet the necessary increase in UK dental graduates, there is a need to increase the total of dental vocational trainers, a number of which started in August 2007 in the West Midlands and are highly committed to the NHS. Their personal and practice commitment to the provision of NHS services has an overall average of over 70% (previous national requirement 20% commitment to the NHS). The advantage of this is that new graduates are working in good-quality NHS practices, which provides practical experience and leads to dentists who are enthused and motivated to continue their careers in the NHS. This is the first time that the West Midlands has achieved such a high average NHS commitment in Vocational Training (VT) practices. Achieving and maintaining this success will keep the West Midlands at the forefront of dental VT developments.

In order to achieve the appropriate workforce during the next 5 years, the WD will:

- ensure the adequate provision of DN training places
- support the introduction of dental therapists into NHS practices
- further the development of NHS committed, long-term VT practices, particularly in view of the 25% increase in UK dental graduates in 2009
- support the introduction of a pilot MDC[16] programme to improve standards of care (additional information can be found in Chapter 2)

- ensure that multi-professional CPD is readily available and accessible for the whole of the modern dental team across the West Midlands
- ensure that the WD (working with PCTs) establishes a robust data information system about staffing in dental practices, to enable purposeful workforce planning in dentistry.

5.5 Long-term conditions and end-of-life care

The range of medical specialties is large (more than 60) and the non-medical workforce does not necessarily divide into the same discrete areas. Medical specialties that form natural clusters in terms of the workforce competences for workforce planning and development are:

- LTCs
- EOL care
- vascular diseases forming a network that links the stroke, cardiac, diabetes and renal workforce.

5.5.1 LTCs

The NHS and social care Long-term Conditions Model is national policy.[75] Evidence has shown that intensive, ongoing and personalised case management can improve the quality of life and outcomes for patients at greatest risk, dramatically reducing emergency admissions and enabling those who are admitted to return home more quickly. Up to 80% of all emergency inpatient care is for people with LTCs. In parts of the West Midlands, the rates are even higher. Ensuring more efficient and effective care of patients with LTCs could release significant resources, as well as improving health outcomes for people.

Significant workforce changes are required to provide more joined-up and effective services for patients with LTCs. As patients with increasingly complex packages of health and social care support are cared for in the community wherever possible, the clinical and social support they require will demand changes in the way in which the community workforce operates. Different care will be provided, based on the level of engagement in the patient care package as outlined in *Investing for Health*.[1]

The principles of case management are essentially to act as both provider and procurer of care and to take responsibility for ensuring that all health and social care needs are met. Although specifically associated as a model of care used by community matrons for patients with a high degree of risk and often multiple problems, case management can be fulfilled by other health professionals, such as physiotherapists and occupational therapists.

Across the West Midlands, there is a variation in the development of both community matrons and case managers. It is important that

the WD scopes out and evaluates in partnership with PCTs current education, training and CPD for these roles. The WD will then respond by developing education programmes that are fit for purpose for the future.

The skills and training of the staff providing care and case management need to match the requirements of local population. This demands detailed understanding of the needs of the at risk population and development of the appropriate education and training programmes. These should include support and training for the patient to enable them to manage their condition. The WD will scope out and pilot multidisciplinary training programmes that strengthen education on patient self-management and widen participation at assistant practitioner level. The WD will then commission the development of CPD courses for clinicians, with agreed standards and competences.

Many patients with LTCs require rehabilitation services, which should be tailored according to their needs (i.e. to enable people to retain independence for as long as possible). The WD will work with organisations to ensure appropriate rehabilitation training programmes that support the appropriate skill mix and levels of expertise within MDTs.

5.5.2 EOL and palliative care

The WD will develop and build on palliative care programmes and best practice in palliative care to include all EOL care patients. At present, palliative care tends to focus on cancer care. It needs to be broadened to include all degenerative conditions.

5.5.2.1 EOL care

EOL care embraces the principles of supportive and palliative care to all those with an LTC, whatever their age, and their carers. In reality this may mean the last year or two of life for those with many LTCs and longer for others, particularly, for example, those with dementia or young adults with certain neurological conditions. The vast majority of EOL care is provided by generalists in many roles. They may be supported in a variety of ways by specialist practitioners, some of whom are specialists in supportive and palliative care providing input to the most complex symptoms and situations during EOL care and after death for the family and carers.

A variety of patient choice data sources illustrate the desire of over 80% of people to die in their home or community setting. Yet currently across the West Midlands, over 56% of deaths take place in an acute setting, often in situations where preferred place of care has never been discussed, recorded or made known and/or no dialogue between clinician, patient and carer has taken place. These discussions are needed, so that informed choices for setting

and treatment options for EOL care can become a reality.

The WD will lead:

- the development of an overall education and training plan for EOL care, which becomes embedded to address the needs of staff in all pre-registration and post-registration curricula, and ongoing development programmes for all staff, in whatever setting
- work with partner organisations for the 14 to 19 age groups and other education programmes to include loss, dying and death as part of any life journey programmes
- the roll-out of the newly developed consultant with a special interest role in palliative medicine. The development of other specialist interest roles, such as in renal, cardiac and respiratory medicine, are in the pilot phase at present across NHS West Midlands and in the Pan-Birmingham Palliative Care Network
- the development of new roles to support rapid response to symptoms that arise despite advanced planning, such as the paramedic role that then prevents use of 999 services and unscheduled admission to care services in acute settings
- the development of links between those services that provide respite, supportive or terminal care, for example care homes, to provide education rotations in generalist and specialist EOL care.

The WD will develop a strategy which identifies:

- the future profile of the EOL care workforce in terms of meeting patient and carer needs, demographic influences and PCT commissioning intentions
- whether the range of programmes available is fit for purpose and ensures that appropriate education and training are provided and accredited across the West Midlands. The opportunity exists to build on existing programmes using a hub and spoke model
- career pathways needed for all staff who want to specialise in this area.

Some hospices across the West Midlands currently deliver EOL education programmes. An initial scoping of the education and training programmes provided by hospices and universities, as well as in-house sessions provided within acute trusts and PCTs will be completed. This work will be developed to consider whether the range of programmes offered meets the future needs of the EOL care workforce, as many are labelled as 'palliative care' with a strong focus on cancer care.

5.5.2.2 Children's palliative care

The lack of status for palliative care and lack of recognition of it as a specialism makes it difficult to develop expertise among the healthcare workforce.

The independent review of palliative care services for children and young people in England[76] highlights various workforce issues in relation to palliative care services to meet the needs of children and families. Following the independent review, the WD will implement the recommendations on how paediatric palliative care could be developed as a recognised sub-specialty, by ensuring that the principles of paediatric palliative care are taught to all trainee paediatricians and GPs. A career pathway will be developed for nurses specialising in palliative care for children and young people, and work will focus on the development of a workforce strategy for nurses and other staff, including play therapists and support workers. Current commissioning will be reviewed in the West Midlands and developed according to recommendations nationally.

Summary – Care Closer to Home

In order to deliver the Care Closer to Home agenda, the WD will:

- ensure the development of a competent and flexible workforce that is able to provide high quality, integrated care
- develop an 18 week Workforce Support Unit that can achieve and sustain the RTT
- facilitate workforce reconfiguration within mental health to meet the demands of service provision, by increasing participation from areas of the wider mental health workforce
- support access to primary care dentistry, by enhancing skill mix in the dental workforce to include more dental nurses and therapists
- increase the number of Vocational Training Scheme practices across the West Midlands to support a 25% increase in UK dental graduate output from dental schools by 2009
- enable the workforce changes required to provide more joined-up and effective services for patients with LTCs.

6. CHAPTER SIX Investing for the Workforce: Sustainable Services and Sustainable Local Health Systems

6.1 Introduction

To enable *Care Closer to Home*,[47] there is a need to manage the consequences of the shift in workforce from secondary to primary and community care. We need to ensure that services are local where possible and specialist where necessary. This will require increased flexibility and availability from the primary and community care workforce. In order to support service transformation, the WD will focus on:

- A&E, urgent care and out-of-hours services
- emergency surgery
- paediatric and obstetric services.

6.2 Secondary to primary and community care shift

The workforce in primary and community care is changing and expanding in response to the fact that secondary care-based services are now being provided closer to the patients home; the development of new services in general practice; and new independent healthcare providers. Practice Based Commissioning will be a catalyst for this shift.

A wide range of services are being transferred from hospital settings to the community, and new services are being developed by general practices, PCTs and other providers that care for people with both acute conditions and LTCs, as well as offering preventive services to improve access to healthcare services. There is also a drive in some areas for acute healthcare organisations to provide outreach services in primary care.

Local projects will be initiated to take an overview of the current GP and other professional workforce across the region, and to recommend where NHS West Midlands might want to be and how it might get there. Working with PCTs, the WD will understand the factors affecting the recruitment, training, development and retention of primary and community care nursing staff to understand local delivery models and inform the future commissioning of programmes that are fit for purpose. These projects should then enable meaningful workforce planning that includes appropriate GP training and the commissioning of appropriate training for other professions as well as greater integration of planning for the medical and non-medical workforce in primary care.

The West Midlands would need to recruit approximately 170 FTE GPs and 52 FTE practice staff to reach the national average of GPs per head of population.[1] However, such increases might not be required if the West Midlands embraces efficient new ways of working, such as an appropriate skills mix and effective case management of those with complex LTCs. Conversely, this scenario may be too cautious if an increased number of GPs embrace increased clinical responsibilities, such as PwSIs or more involvement with out-of-hours provision.

The provision of surgery within community hospitals and minor surgery within general practices will require staff to have the skills to manage the surgical patient, as well as more highly developed skills as staff are increasingly required to deliver specialist, complex and emergency surgery. This will be subject to the development of appropriate premises in primary and community care settings.

To effect the shift of services from secondary to primary care, the WD will work with PCTs and independent contractors to include general practice and other primary care providers to understand the productivity and efficiency of their workforce and to realise opportunities for building the skill mix, where appropriate. The work will start by looking at productivity in community hospitals.

The development of new and extended roles will help to build the capacity of the workforce to deliver Care Closer to Home while increasing efficiency. For example, the physician assistant role is relatively new to the UK. While not a doctor, the physician assistant works to the medical model, with the attitudes, skills and knowledge to deliver holistic care and treatment within the general medicine and/or general practice team under defined levels of supervision. The WD will support the introduction and evaluation of the UK-trained physician assistant as a means of enabling a different skill mix within areas of the medical workforce. This will allow highly trained doctors to use their knowledge and skills to best effect, increasing capacity. The emerging evidence from the introduction of physician assistants trained in the US and from pilot sites in this country is supportive of the role.[77]

The WD will develop a network of primary care leads to enable the sharing of practice issues and solutions and to showcase innovative workforce models across the West Midlands. A series of themed events will be held to encourage the sharing of good practice across the primary and community care workforce.

6.2.1 Structured transfer of staff

To deliver *Care Closer to Home*,[47] a West Midlands framework will be created for the structured transfer of secondary care staff into primary care. The framework will scope out services that are being transferred into primary care settings by PCT and the types of roles that are being transferred or developed in primary care in response. The WD will then feed these findings into the wider review of its education commissioning to ensure that the education and training programmes are fit for purpose for the community workforce. It is also a priority to ensure that staff transferred into primary care are able to maintain their competences and, if necessary, rotate across organisational boundaries in order to achieve this.

The effect of shifting care from hospitals to the community will need to be reflected in the training on new technology and also in developing a workforce that has the confidence to manage patient care in different settings (e.g. intravenous antibiotics in the community). As new ways of working become more established in

primary and community care and the skill mix alters, the workload and scope of practitioners may change. Staff with generic competences should be able to move more readily across health settings with transferable skills, according to local need.

To ensure that the future medical workforce can meet the future healthcare workforce needs, the changes listed in the table below need to occur.

The WD will work with local healthcare organisations and HEIs to develop programmes that support the primary care focus for the training of healthcare professionals. There is a need to ensure that pre- and post-registration courses will have an increased emphasis on the primary care setting to ensure fitness for purpose.

The WD will work with the existing primary and secondary care workforce to enable them to work confidently with GPs and other professionals as part of integrated community health and social care teams. The WD will prioritise the need to review the commissioning of specialist practice training and how each primary care nursing (including general practice nurses) professional group contributes to the delivery of that service. This intelligence

Medical specialty	Change required
General Practice	Increase the knowledge and skills to aid the transfer of services into the community through the new GP specialty training curricula
Surgery and anaesthesia	Decrease training posts to correct the historical imbalance of senior house officer-level and specialist registrar-level posts, this will have implications for service provision
Intensivists	Increase numbers following the introduction of the Critical Care Certificate of Completion of Training (CCT) to support the management of critically ill patients
Small specialties - (i.e. allergy, learning disabilities, stroke care, sports and exercise medicine)	Increase the number of consultants in these areas to reflect the increasing need for specialist skills
Palliative Care	Increase the number of training posts to meet current shortages
Emergency and Acute Medicine	Increase the number of training posts, as this is increasingly becoming a consultant-led service in light of service redesign

combined with the national MNC[17] work and work with professional and educational leads for health visiting and other specialist practice will inform a robust plan for the development of this workforce along a career pathway. This will be underpinned by robust competency-based training commissioned from local HEIs.

The WD will encourage pilot projects such as those involving social enterprise. These help to evolve new skill-mix models such as a one-stop shop approach to the delivery of combined or collaborative health, social and community care. Evaluation will be a key component of such projects, so that learning is transferable to other settings and can be widely disseminated in a practical way.

6.2.2 CPD framework across organisational boundaries

The WD will support the healthcare organisations in co-ordinating and improving access to identified CPD to meet the workforce's needs and to maintain skills. The WD will collate and disseminate information about the range, content and quality of the learning activities and resources currently available in the West Midlands region and beyond. This will include recommending principles for gauging the relevance and quality of CPD provision and engaging with healthcare providers and education providers to enable the sharing of CPD resources to promote multidisciplinary learning and equal access to learning opportunities.

6.3 Large-scale workforce change

6.3.1 Productivity and skill mix

The increasing demands for healthcare from an older population and the rising costs of current provision at a time when the past level of growth in NHS funding is likely to slow mean that there will have to be an increasing focus on efficiency and productivity rather than growth. Productivity underpins this workforce strategy and the WD will ensure that reviews of productivity and skill mix underpin any workforce planning and development. The WD will support the workforce analysis of the Productivity Improvement Programme.[1] A further piece of work will look at improving skill mix and productivity in line with the introduction of MDC.[16] The WD will use the outcomes of these projects to inform workforce planning.

The WD will establish a project with Skills for Health covering operating theatres, emergency care, the shift from secondary to primary care, LTCs and maternity provision. The project will map current roles across the career framework and will review skill mix and productivity. These projects will provide an overview of role development and the WD will review education and training. The WD will ensure that there is a standardised approach where appropriate for education and training, which ensures safety for

patients, but also transferability of the workforce across different healthcare settings.

With the NHS Institute for Innovation and Improvement, the WD will support the roll-out of the productive ward methodology[23] across acute and specialist healthcare providers. This work will not only improve productivity, but will also identify ways to improve skill mix, patient safety and patient experiences. The former will be used to inform workforce planning and development. Learning from local productivity and skill mix changes and from work with the NHS Institute and Skills for Health will be shared across the SHA and wider healthcare services.

Improving the effectiveness of the workforce is a key element of overall productivity improvement. The WD will encourage education providers to work closely with local NHS organisations on workforce planning and development, to encourage joint working on training, the application of new models of productivity and skill mix and their evaluation. The WD will build on work with partners in education and service development to promote new models of working, including lean thinking that is focused on making the most of opportunities to deliver cost-effective healthcare (e.g. Practice Based Commissioning and clinical systems improvement).

Support will be given to provider organisations to develop PwSI posts in their locality that match service need and increase consistency of standards. This will boost the quality and scope of PwSI services across the West Midlands, identifying good practice and encouraging new initiatives. Work will be undertaken with healthcare providers to enable them to accredit such practitioners in consistent and valid ways as required by national guidance.

6.3.2 Emergency, urgent and out-of-hours care (including ambulance staff)

Emergency and unscheduled care goes beyond the traditional A&E and GP out-of-hours services, including walk-in centres, patients' homes, and other settings. It includes all services that offer emergency and unplanned care outside regular working hours.

The increased emphasis on access to emergency and urgent care will require changes in the way staff work. There is a need to expand the skills of the primary and community care workforce to triage patients and where appropriate assess, treat and manage urgent conditions using a variety of access routes. Increasingly innovative ways of delivering care will be provided, for example using integrated A&E, walk-in and GP out-of-hours services, and screening for urgent and primary care through one telephone number.

We will need to adopt innovative approaches to the delivery of acute medical care and will have to re-examine the roles of

healthcare staff including nurses, therapists and ambulance staff. In A&E departments, emergency nurse practitioners are increasingly managing patients independently. Increasing the skills of the nursing workforce to undertake advanced practice (e.g. interpreting X-rays and other diagnostic tests) will improve access to services. Emergency care practitioners use the skills of paramedics and other professionals (such as nurses) to support the first contact needs of patients in unscheduled care. They can support general practices, out-of-hours services, ambulance services, emergency departments and see, treat or refer to other professionals patients with minimal need. Emergency Care Practitioners are a valuable addition to emergency care, and their work within MDTs can reduce the pressure on A&E and ambulance services.

The WD will:

- increase the number of emergency and acute medicine consultants
- where appropriate, commission emergency care practitioners
- in partnership with providers support the development of advanced practice within ambulance and A&E services.

The ambulance services review *Taking Healthcare to the Patient*[78] made a number of recommendations relating to the development of the ambulance workforce, to achieve the vision of a modernised workforce that is able to provide a greater range of mobile urgent care. A greater range of competences and underpinning knowledge will be needed while maintaining the vocational nature of ambulance services staff training. As outlined in *Investing for Health*,[1] for high-impact care pathways such as acute stroke there will be a need to enhance ambulance staff triage. The WD will respond to the recommendations of the report by working in partnership with HEIs and ambulance trusts to address any educational and training needs.

Urgent care teams (where relevant) should increasingly give advice, assessment, diagnosis, treatment and care in or close to patients' homes. This care will need to be provided by teams that are flexible, multidisciplinary and able to work across health and social care.

The WD will:

- scope out the current workforce to determine who is delivering emergency, urgent and unscheduled care
- assess the workforce implications of different models of care and support the educational development of emergency care teams
- assess the implications for the workforce of the proposed reconfiguration of emergency services this is closely aligned

with the work of the Clinical Pathways Group on Acute Care set up under the Darzi Review, Our NHS, Our Future.

6.3.3 Surgery and anaesthesia

The surgical and anaesthetic workforce is a complex mix of professional groups that provide services within pre-operative, intra-operative and post-operative care, intensive care and ophthalmology. A number of key workforce drivers are having an impact on this workforce: these include decreases in medical staff capacity within surgery and anaesthesia in light of MMC,[11] WTD 2009[12] and the 18 week RTT target.[69] These changes will require a wider skill mix to enable the current service provision to be maintained.

The WD will prioritise securing the supply of key groups and ensuring their skill and competence within specialist fields. Particular attention will be paid to the supply and balance of:

- surgeons and anaesthetists
- operating department practitioners and theatre nurses
- orthoptists.

Over the forthcoming years there will be a review of the education and training of a number of professional groups to ensure fitness for purpose, starting with:

- operating department practitioners
- orthoptists.

The WD will:

- work with trusts to review the current workforce skill mix within surgery and facilitate the development of specialist practitioners across professional boundaries
- commission education programmes to support the development of the workforce (e.g. perioperative specialist practitioners and advanced scrub practitioners)
- commission training for anaesthesia practitioners to increase capacity within anaesthesia teams
- identify the competences required within out-of-hours and hospital at night provision of surgical and anaesthetic services
- identify core competences for specialist training for staff groups within anaesthesia, theatres and critical care. Although these groups may be generalised, they represent a number of specialist areas (such as neurosurgery and cardiothoracic surgery) with very specific workforce demand and supply issues.

A key role in supporting service delivery will be to foster and promote innovation, which involves:

- developing a competence framework for specialist clinical qualifications across non-medical professions within surgery, anaesthesia, and critical care which use National Service Frameworks to ensure transferable roles and standards supported by interprofessional education
- developing a workforce strategy for eye care services across the West Midlands.

An assessment of the impact on the workforce of the proposed reconfigurations of maternity and emergency services[1] will be completed for:

- provision of emergency surgery
- obstetric anaesthesia including pain relief.

Education programmes will then be developed as appropriate. This will be aligned with the work of the Clinical Pathways Group on Acute Care set up under the Darzi Review, Our NHS, Our Future.

6.3.4 Obstetric services

Maternity services are currently going through a period of significant change. *Maternity Matters*,[10] builds on the maternity services commitment outlined in *Our Health, Our Care, Our Say*[47] and is an important step towards a modernised, woman-focused and family-centred maternity service.

Maternity Matters[10] highlights the Government's commitment to developing a high quality, safe and accessible maternity service through the introduction of national choice guarantees for women. By 2009, all women will have choice over the type of care they receive, together with improved access to services and continuity of midwifery care and support. *Maternity Matters* also emphasises the need for all women to be supported and encouraged to have as normal a pregnancy and birth as possible.

Offering choice over where and how to give birth will lead to more flexible, responsive and accessible maternity services. New and different types of care will be developed and designed to meet the needs of all women; but particularly those women and families who need additional support in our most deprived communities.

Work is required to identify the workforce implications for midwives, gynaecologists and obstetricians giving mothers the choice to have a home birth, for example. In response, the WD will increase the number and output of obstetricians and gynaecologists with the introduction of MMC[11] to increase the output of CCT holders. The WD will further develop new roles such as maternity support workers to ensure consistency of approach, transferability and sustainability of the role across the region through a competency framework. This will release capacity and will enable midwives to concentrate on midwifery duties to support *Maternity Matters* implementation.

Strong leadership skills are required from heads of midwifery and the WD is supporting a leadership programme to enable succession planning for future heads of midwifery. This will facilitate future innovation, service development and a change in culture across midwifery services to support *Maternity Matters*.[10]

The WD will lead on the modernisation of the maternity workforce and will produce a comprehensive implementation plan to support organisations to develop their local workforce plans.

6.3.5 Paediatrics

Currently there is an ambitious agenda to improve services for children, young people and families. Children's services are transforming through the Every Child Matters[79] agenda, which promotes a new approach to services for children and young people. Every Child Matters aims to address inequalities such as infant and perinatal mortality rates, childhood obesity and other public sector health targets.

Local hospital reconfigurations will have implications for local inpatient paediatrics, A&E, neonatal services, maternity services and the workforce; assessment of impact will be undertaken in line with *Principles/recommendations for Paediatric and Maternity Service Provision*.[1] These principles combined with the risk assessment work commissioned by the SHA from the consultancy Durrow will be key to planning the future pattern of services across the West Midlands.

Ensuring the correct workforce will enable the best possible outcomes for all children and young people and will reduce inequalities between the most disadvantaged groups and the rest of the population.

The challenges for the workforce in respect of children's services include:

- the appropriate skill mix. One key workforce development area to support the sustainability of services will be around increasing the number of advanced nurse practitioners in paediatrics and neonatal services and supporting the reconfiguration agenda
- the introduction of new multidisciplinary, cross-sector initiatives such as children's centres and taking midwifery and children's care into different settings, working in new partnerships in order to meet the range of needs in new ways. There are diverse approaches to the skill mix, models of care, under/over capacity, varied outcomes and levels of support for vulnerable and at-risk children and their families
- the WD will identify the competences required to recognise the

unwell child at all tiers: at home or at school, by GPs/primary care professionals, in receiving units, hospital at home and ambulance services. It is essential that GPs do not lose the skills to recognise and manage acute illness in children, as a reducing proportion of general practitioners have postgraduate experience of inpatient paediatrics. The WD will support joint medical/non-medical training in assessing the ill child and other areas of commonality (such as leadership)

- there are significant issues for paediatricians around the safeguarding agenda in terms of local capacity to provide a rapid response in the event of any sudden deaths (under the age of 18) that need police investigation. The WD will review what extra capacity is needed to highlight any gaps in skills.

A workforce review will be undertaken to:

- scope geographical variations in the way services are delivered (such as hospital at home) to enhance the delivery of workable solutions. This will inform future education commissions to ensure that courses are fit for purpose to include areas such as public health and examining the ill child
- create opportunities for increasing the numbers of specialist nurses, advanced nurse practitioners and consultant nurses in neonatal services and paediatrics. This will include the development of a neonatal workforce strategy to address local shortages and the ageing workforce profile of neonatal nurse practitioners.

Advanced nurse practitioners and others working in walk-in centres and similar services where children are likely to be seen should have the appropriate competences for triage, the recognition of serious illness and child protection issues. These people should also be aware of the problems around adolescence, particularly in relation to mental health issues. The WD will map competency levels and education programmes to recognise the unwell child. It will develop appropriate training packages to enhance skills within the workforce to support reconfigurations.

In areas some distance from inpatient paediatrics, the primary/community-based service has a critical role to play in supporting safe, home-based care for children. Mapping of the workforce will be undertaken to form part of the reconfiguration work and any competency gaps will be identified and addressed accordingly. The WD expects GPs to ensure that their competence and confidence in managing acutely ill children (and in obstetric care) is maintained. There is scope to make imaginative use of GPwSIs by commissioning a postgraduate award in paediatrics.

Summary - Sustainable Services and Sustainable Local Health Systems

To support sustainable services and sustainable local health systems, the WD will:

- manage the workforce consequences of shifting care from an acute setting to Care Closer to Home and commission education programmes to support the development of staff
- re-examine the roles of healthcare staff (including nurses, therapists and ambulance staff) to meet the agenda for access to emergency/urgent care
- utilise information from productivity programmes to influence workforce planning and development, working with education providers and NHS organisations on the training, application and evaluation of new models of care
- assess and manage the workforce implications of the proposed reconfigurations of A&E, emergency surgery, obstetrics and paediatric services
- lead on the modernisation of the maternity workforce to support a high quality, safe and accessible maternity service through the introduction of the national choice guarantees for women detailed in *Maternity Matters*.[10]

7. CHAPTER SEVEN Investing for the Workforce: Organisations Fit for Purpose

7.1 Introduction

Workforce planning for the health economy is challenging and complex. There has been a fundamental shift from it being viewed as a 'back office' activity to being acknowledged as a priority for the sustainability of the NHS. The future workforce will need to anticipate and prepare for the impact of demographic, technical and policy trends on future service requirements. The House of Commons Health Select Committee report on Workforce Planning[2] emphasises the importance of workforce planning in the NHS.

Investing for Health[1] identifies 'workforce transformation' as one of the 10 West Midlands wide projects needed to deliver the changes to meet the challenges of the next five years.

This chapter outlines how the WD intends to strengthen workforce planning within the NHS West Midlands to ensure that it delivers a workforce with the right skills at the right time to support delivery of *Investing for Health*.[1]

The WD will support and encourage the management of the workforce in organisations to develop capacity to:

- lead workforce development and planning across local health economies to support the wider objectives
- support the development of commissioning capability in workforce planning across local health economies
- develop leadership programmes
- work in partnership with the independent and voluntary sectors where appropriate and possible to ensure development of the wider workforce
- work with trusts to identify the workforce demand and training programmes for the nationally identified shortage professions
- ensure that the workforce needs of the National Programme for IT (NPfIT) are addressed
- enable robust workforce development strategies in all healthcare organisations.

7.2 Strengthening workforce planning

7.2.1 Workforce demand

Rising demands for healthcare from an older population, with increasing longevity, declining fertility rates and the disproportionate size of the 'baby boom' generation, means that there will have to be an increasing focus on productivity, flexibility and improvements in skill mix rather than workforce growth. More information can be found in *Demography is Destiny*.[80]

When analysing future demand for the workforce, the WD will give consideration to demographic and social trends, technology, key policy changes and the interdependencies of these factors. Anticipated levels of change will be influenced by:

- productivity metrics[55]
- patient conditions that can be treated
- quality of care
- workforce productivity
- changes in skill mix
- increases in activity
- focusing on prevention
- reductions in waiting times
- independent sector activity
- increased focus on primary care
- technological changes
- the target of 18 weeks from RTT.[69]

Investing for Health[1] sets out the need to provide *Care Closer to Home* and explains how this will be introduced systematically, through improving the care of people with LTCs; supporting people at the end of life; building the quality and accessibility of primary care; and improving the availability of NHS dentistry. It quantifies the potential size of the changes, based on an analysis of the way services are currently provided, as equivalent to approximately 11% of PCT expenditure on services covered by the national tariff.

Current indications are that there will continue to be a slight reduction in the NHS workforce this year in order to maintain financial balance. Improvements in productivity should be subject to the following principles:

- service quality is maintained or improved
- safety of patients is not compromised
- performance targets in areas such as waiting times are met.

The workforce of the future also needs to be financially viable. In recent years, NHS finance has grown on average by 7.7%. The Comprehensive Spending Review released in autumn 2007

indicates that for the 3 years from 2008/09, funding will grow at around 4% in real terms.

7.2.2 Workforce supply

The NHS is undergoing a period of rapid change. Changes to the way the NHS operates and in the way in which healthcare services are delivered which will impact on the workforce supply for the future, include:

- raising the school leaving age
- raising the retirement age
- age and race relations discrimination legislation
- changes to pension plans
- increased part-time working
- changing demography, e.g. ageing population
- changes in lifestyle
- availability of refugee health professionals
- competition from other employers.

The supply of the future workforce will need to take into account demographic changes such as retirement profiles, legal changes for example the WTD 2009,[12] domestic training supply and the international labour market.

The draft annual Workforce Risk Assessment, published by the NHS Workforce Review Team (WRT) in July 2007,[81] provides a national overview on occupations and identifies professions that are at risk of over or under supply. The WD will work with the WRT to identify and respond to the risks in relation to the West Midlands.

The main issues identified in the draft 2007 risk assessment are:

- reductions in GP registrar posts in some SHAs and the extension of the training period to 18 months, which may lead to reductions in future numbers of GPs
- graduate unemployment due to productivity gains and service changes may lead to increased attrition from university courses, impacting on future supply
- the impact of the WTD
- the target of 18 weeks referral to treatment need to ensure that the changes made are sustainable
- productivity gains
- consultant supply and demand.

However, these issues need to be overlaid with an understanding of local conditions, which vary between regions and localities.

7.2.2.1 International recruitment

The WD is committed to the integration, training and education of all non-UK medically qualified doctors and dentists. Overseas doctors form more than 30% of the medical workforce. There are currently no statistics for other international non-medical staff.

Working with the Refugee Council and a variety of organisations in the area of international recruitment, the WD will support particular refugee doctors, nurses and AHPs in their careers and their personal development so that they are able to make successful applications for suitable jobs in the NHS. The WD will commission practical generic support in the form of careers information, advice, guidance and counselling along with coaching and mentoring, as appropriate; professional and academic support in English language; and communication skills.

Doctors whose primary medical qualification is from outside the European Union will be required to apply for a work permit before they are permitted to take up paid employment. Overseas doctors seeking employment in the UK are supported by induction programmes, demand driven and work permit/training application support.

7.2.3 Forecasting future requirements

Anticipating future workforce requirements is a key role of NHS West Midlands. Assessment of future workforce needs to consider the increasing plurality of providers, contestability between them and a slow down in the rate of financial growth.

The sustainable development and organisational capability to deliver future health services will be taken forward in how the West Midlands embraces the national view of the NHS, Our NHS, Our Future, which will lead through to Lord Darzi's final report in June 2008. This will include local workforce plans that respond to local needs and local preferences in the context of evidence from the Darzi Review informing organisations about highest quality care. The WD will work with organisations to ensure that future workforce models fully reflect the proposals emerging from Our NHS, Our Future. The West Midlands response to Our NHS, Our Future is outlined in Chapter 1 of *Investing for Health*.[1]

The WD will work with organisations to ensure:

- integration of service, financial and workforce planning
- that their workforce plans are able to meet all foreseeable challenges in workforce and technological changes
- services based on clear and efficient competency-based patient pathways, which are based on needs of local people as defined by PCTs and Practice Based Commissioners.

PCTs have a major role in defining the workforce of the future. As commissioners, PCTs will be well placed to work with the WD to ensure co-ordination between finance, service and workforce planning at a local level. PCTs will need to assure themselves that there is an appropriate, affordable and competent workforce to

deliver the services they commission and that it is broadly representative of the population it serves. The WD will challenge existing assumptions by healthcare providers and ensure that workforce planning reflects policy development and national trends.

Using evidence and learning from the Productivity Improvement Programme and the Better Care, Better Value indicators, the WD will query workforce planning and skill mix assumptions.

The WD will continue to develop opportunities to engage with foundation trusts and voluntary and independent sector providers in relation to future workforce requirements; this will also apply to support services such as occupational health.

Working in partnership with the national WRT and NWP, the WD will strengthen the analytical approach to workforce planning and will collate intelligence on national trends and small occupational groups.

The estimated future workforce requirements will be linked to the financial resources expected to be available through the long-term service planning models submitted by each NHS provider organisation. Improvements in workforce planning will need to take account of the complexity of the finance cycles in April, the education cycles in September and projected activity changes through the 3 year LDP process in February/March. Work will be undertaken to strengthen the workforce information provided, align planning cycles and ensure a 5 year vision for the health economy to enable long-term strategic workforce planning. The WD will require organisations to have their annual workforce planning aligned to the LDP process.

The WD will influence the national agenda on medical workforce planning, which has historically been defined centrally to highlight the medical workforce required across the West Midlands. The WD will work with the WRT to influence medical workforce planning numbers across the medical specialties within the West Midlands. The medical workforce planning can then be more closely aligned to non-medical workforce planning and allow workforce planning to be integrated for all workforce groups, including all bands on Agenda for Change.

The improvements that the WD is making to the forecasting of future requirements are necessary to adapt to changing circumstances. These changes include the way healthcare is commissioned and delivered, the restructuring and re-configuration of services and organisations and the changing financial climate for the NHS, which require increasing partnership working with organisations. It is also important to link workforce

requirements to financial plans. By modelling the future supply of the workforce based on numbers currently on clinical education courses or employed by the NHS, and linking estimates of future demand to service and financial plans, the WD will improve the co-ordination of these different aspects and improve the accuracy of our forecasts.

Workforce and succession planning for their own needs is the responsibility of individual organisations. The WD needs to predict future requirements in order to commission the appropriate number of pre-registration education places for clinical groups, in addition to identifying training needs for support roles such as administrative staff. The process outlined above is designed to ensure that organisations are equipped to develop workforce plans to deliver services effectively and efficiently while meeting the strategic requirements of the WD.

The WD will use a central framework for workforce planning that can be locally implemented across the LHE. The framework used will be based on national and international best practice and will be used to model workforce changes which address the impact of new policies and service reconfiguration. The WD will review and evaluate demand models available for use locally.

7.2.3.1 Medical forecasting

The introduction of MMC[11] provides a more clearly defined pathway in training GPs and consultants and will clearly have significant implications for medical workforce planning and the way in which healthcare services are delivered. In the previous system there was a significant imbalance between the more junior grades in medical posts and the senior grades, meaning that significant numbers of doctors spent several years in predominantly service-related posts, with little chance of progressing in their chosen specialty. Although these doctors did ultimately progress, career guidance was often patchy. The streamlining of the career pathway allows workforce planning principles to be applied at a much earlier stage of the medical career, as the decisions about the final destination hospital specialist or GP are made at an earlier stage. Better matching of numbers of doctor numbers at junior and senior stages will ultimately be a more effective way of training, with less wastage, but will also reduce the pool of doctors in service grades who previously provided much of the routine care in hospital trusts. This will also provide the opportunity for further development of GPwSIs.

In partnership with providers of care, the WD will improve forecasting of medical workforce requirements. This will be

underpinned by appropriate distribution and redistribution of training posts, both geographically and between primary and secondary care. Earlier and more professional careers advice and opportunities to direct doctors in training to the appropriate career destination will be developed.

7.2.4 Improving data quality

Work will continue with DH and healthcare organisations to improve the quality and scope of workforce information. Increasing use will be made of the ESR data warehouse[26] as it is rolled out to all NHS organisations by April 2008. This will provide more detailed information for use by NHS organisations. While responsibility for the roll-out process rests with contractors, the WD continues to provide advice and support to organisations.

It is currently difficult to analyse workforce information by care group. This is increasingly important as it relates to national service frameworks, commissioned patient pathways and dissemination of information such as the primary dental care workforce.

The WD has a responsibility to ensure that the workforce information is accurate and detailed. The WD will work with organisations to improve data quality where necessary, and with DH to develop appropriate guidance and definitions. For example, there is no robust data set or data collection set for dental teams in primary care, either locally or nationally. There is a need to agree a data set and definitions and establish a system for collecting the data. Monitoring of changes in the skill mix will also be possible through analysis of annual workforce census and ESR and e-KSF data, once rolled out.

The WD will use qualitative methodology such as focus groups and telephone surveys to take an overview of key workforce groups in primary care and to discuss and recommend what needs to be done to improve understanding of the primary care workforce. This should enable meaningful workforce planning that includes appropriate commissioning of training and anticipatory support in the context of greater integration of planning for the medical and non-medical workforces in primary care.

The WD will work with independent and voluntary sector providers to develop information about their current workforce and future needs to ensure a LHE approach to workforce development. The WD will also develop our engagement with the Armed Forces, social care, social enterprise and independent contractors.

7.2.4.1 Local Delivery Plans

LDPs are the principal means of planning future healthcare delivery across LHEs. In 2007/08, PCTs will prepare 3 year plans

for the delivery of health services, which will then be reviewed annually. Although PCT commissioners are responsible for completing most of the plan, provider trusts also need to complete the section on future workforce.

It is important that financial and service plans are integrated with workforce plans. By strengthening workforce planning capacity, aligning the workforce planning cycle with the LDP cycle and raising awareness of the process, the WD will develop much stronger links between the different planning processes.

7.2.4.2 Financial Information Monitoring System (FIMS)

All PCTs and trusts submit annual plans and monthly returns to NHS West Midlands for FIMS, which is currently under review. This return now includes workforce information as well as financial data.

The WD aggregates the detailed workforce information and quality assures the workforce data before sending it to DH. FIMS returns provide useful monthly monitoring information on the current workforce, paybill, expenditure on bank and agency staff, sickness, and staff turnover. The WD uses this information to provide comparative data to organisations on performance each month, variance from planned figures and monitor trends across the region. The WD will continue to monitor human resources (HR) indicators through the monthly FIMS returns and increasingly through the ESR data warehouse. Action will be taken on an exception basis to help organisations to improve their performance where necessary.

NHS West Midlands uses this information alongside the finance and service data provided through FIMS to monitor organisations performance against plans each month in conjunction with the WD. The WD will strengthen the alignment of the analysis of workforce, service and financial information.

7.2.5 Strengthening workforce planning capacity and capability

Workforce planning is a key responsibility of healthcare organisations if they are to deliver services effectively and efficiently. There is a need to build workforce planning capacity and capability to ensure the development and implementation of robust and realistic workforce plans. In particular, the development of capacity planning, investment appraisal and approval processes in PCTs will need to be strengthened.

The WD will work with the newly established stakeholder structure through the 5 Workforce Locality Boards (set out in Chapter 9) to strengthen workforce planning, modelling and development, including refining the proposals for developing workforce planning

capability. The WD stakeholder structure will enable local action on workforce issues, shared delivery of education programmes and workforce planning. This will allow a seamless approach to integrated service planning to ensure delivery and best value.

The WD will implement a 3 tier approach to delivering training and support to organisations to achieve enhanced workforce planning capacity and capability:

7.2.5.1 NHS West Midlands

The WD will strengthen capacity and capability to forecast future supply and demand, assess the workforce impact of new policies, improve the quality and analysis of workforce information and ensure integration with service, financial planning and monitoring. The WD will work with other SHAs, the national WRT, NWP and external experts to develop internal capability.

7.2.5.2 PCTs - Commissioners

The WD will work with PCTs to analyse future workforce demand and to ensure that services and workforce planning become integrated to deliver the services required to meet the needs of their population. The WD will integrate workforce planning into education programmes that have been developed for commissioners on service and financial planning. Further development is planned for commissioners as highlighted later in the document.

7.2.5.3 Providers of healthcare

Chief executives: The WD will commission a bespoke masterclass for chief executives, commissioners and senior managers to widen their awareness and knowledge of workforce planning.

Directors and directorate managers: The WD, working with directorate managers responsible for care group areas, will support the development of workforce planning forums appropriate for each service area and commission an ongoing programme of workshops dealing with different aspects of workforce planning process.

The WD will engage with all healthcare providers across the West Midlands including independent contractors, social care and the voluntary and independent sectors, in order to strengthen workforce planning capacity and capability.

To embed changes in organisations and to provide continuing support, a learning network will be established which will enable people with workforce planning responsibilities to share experience, expertise and solutions. The network will support workforce planning champions to train others and to champion the

idea of workforce planning. The WD will commission an accredited workforce planning course based on the postgraduate certificate in workforce planning developed by NWP and Thames Valley University.[82]

In future years, a train the trainers programme will be commissioned to develop the capability of trusts and PCTs to develop workforce planning training as part of their own management and leadership development processes. This will support self-sustaining workforce planning. Working closely with other national and regional organisations and groups such as Advantage West Midlands, Regional Skills Council, the LSC, Skills for Health, Skills for Care and Jobcentre Plus, work will be undertaken to ensure the development of complementary strategies to enable the effective implementation and delivery of policies.

The WD will evaluate changes made to the workforce planning process; this will enable it to learn from experience and ensure that the work that has been done around the planning of medical numbers for MMC is built on, in order to better integrate medical and non-medical workforce planning.

7.2.6 Competency-based workforce planning

Competency-based workforce planning is based on assessing the skills and competences required to deliver a service, and then designing a workforce which meets this. This is in contrast to traditional approaches to workforce planning, which often rely on ratios of staff to patients and on rigid occupational divisions. The key advantage of a competency-based approach is that it increases the flexibility of the workforce, breaks down professional barriers and allows a more appropriate matching of the skills required to the needs of patients. Skills for Health has mapped a wide range of competences that can be used to assess the existing workforce against service needs, and NWP has developed an e-learning tool[83] to help organisations and individuals to apply this approach in practice. The WD, through the proposals set out above, will help to embed these skills in organisations and assist them to apply the skills in practice.

7.2.7 Large-scale transition projects

Investing for Health[1] identifies two initial projects which aim to change significantly the balance of services between hospital care and community care: *Towards 2010*[13] in Sandwell and West Birmingham, and *Fit for the Future* in North Staffordshire. These projects will need to develop robust methodologies to determine future workforce needs and identify education and training requirements. The WD will provide resources including both expertise and financial support to assist the development of

appropriate models and processes, as part of a major project being established by NHS West Midlands during 2007. The knowledge and experience gained from these projects will then be applied to other large-scale changes with workforce implications.

Both *Fit for the Future* and *Towards 2010* will be subject to an external review of progress against these plans. The workforce in the economy will form part of the annual external assessment that the SHA is undertaking at the request of these projects.

The Workforce Transformation project will also scope the workforce implications of the 8 Clinical Pathways within Our NHS, Our Future.

7.3 Leadership

To implement the current health reform agenda, it is essential that the NHS has capable senior leaders (both clinical and non-clinical) able to lead a diverse workforce with strong patient, public and staff engagement skills. The WD will support the development of very senior managers and clinical leaders in enhancing their portfolio of leadership skills to be in line with the requirements of a changing NHS and the new roles and responsibilities that will be required. By piloting and promoting a system for managing the talent and succession planning across the West Midlands, the WD will support the career management of senior managers and clinicians and will inform the SHA and chief executives of the capacity and areas of risk. The WD will seek to do this by:

- Developing a detailed approach in the longer term for all clinical professional groups. This will follow on from the evolving national strategy of competency milestones for the careers of doctors, including doctors in training, e.g. the Safeguarding Children report.
- Supporting the development both of very senior managers and clinical leaders in enhancing their portfolio of leadership skills in line with the requirements of a changing NHS. This will be achieved through the continuation of the West Midlands Leadership Initiative aimed at potential chief executives and through a middle manager programme aimed at potential directors.
- Delivering the continuing service improvement agenda, it is essential that doctors are positively involved as participants and leaders of this process. This agenda is recognised at the very highest level in the NHS and a national project, Encasing Medical Engagement, is a component of the long-term cultural change embodied in the concept. The project will see an integrated competency framework providing a blueprint for management/leadership development for undergraduate, postgraduate and post-registration doctors. The national

leadership programmes offered through the SHA are addressing the needs of some senior doctors, however a key omission in the pattern of provision are programmes for new consultants and new GPs. Opportunities for capturing newly qualified doctors also need to be recognised to support change and improvement. No systematic provision exists, and it will be a priority for development.

- Enabling executive nurses have a critical role to play in enabling their Boards and organisations, whether they are commissioners or service providers, to view the business of caring as much a part of their agenda as the financial bottom line.[84] Nurses will need to be champions of new ways of delivering healthcare. A new programme will underpin successful succession planning for the role of nurse director, who will address the necessary actions that will take patient care issues from the bedside to the boardroom and prepare aspirant nurse directors for corporate posts.
- Developing an intermediate tier of competent commissioning managers to support and succeed those currently in executive level positions. Future leadership development for commissioning managers to be aimed jointly at GP Practice Based Commissioners and PCT managers to foster co-operative working environments.
- Piloting and promoting a system for managing the leadership talent within the West Midlands, which will support the career management of senior managers and clinicians and also inform the SHA of the capacity and areas of risk. The developing use of a talent studio software system will be explored as the vehicle for this purpose.
- Focusing on diversity issues with particular emphasis on the development areas highlighted in the national Leadership and Race Equality Action Plan (LREAP)[85] and ensuring that the leadership of organisations represents the community. The WD will work with the NHS Institute for Innovation and Improvement to identify the needs and the most appropriate ways to meet them.
- Acknowledging that there is a wealth of consultancy-style talent within the West Midlands health economy, much of which is underused. To provide managers possessing such skills with the opportunity to put them into practice and, in turn, support the health economy with service improvements and assisting in the development of other health service colleagues, it is proposed to identify such talent and establish a talent bank of managers with specifically identified skills. A network has been established of senior managers from across the West Midlands health economy who have undertaken the Certificate of Coaching through the School of Coaching (accredited by Strathclyde University). It is proposed to support a further ten senior managers through this programme in the current financial year in order to boost the current resource. This will be

a valuable resource for supporting the succession planning of senior leaders within the West Midlands.

- Supporting the development of NHS Boards. The WD will work closely with colleagues from the King's Fund, the NHS Institute and the Appointments Commission to ensure that all NHS West Midlands trust Boards are fit for purpose to meet the challenges of the next 5 years.
- Supporting the development of aspirant AHPs and healthcare scientists to enable the creation of a leadership framework as part of the implementation of MHC.[3]
- Supporting the leadership development of HR and finance specialists to underpin successful succession planning for director posts.

7.4 Workforce delivery priorities

7.4.1 Managing workforce development

The WD education and training commissions will underpin the NHS Career Framework,[24] supporting staff to gain knowledge and skills that enable them to progress along a suitable career pathway.

For some newly qualified graduates, and doctors and dentists training under MMC[11] and MDC,[16] competition for posts will be greater than in previous years. To maximise opportunities for graduates and meet the needs of trained staff, the WD will deliver a co-ordinated strategy to ascertain the level of unplaced graduates and identify employment opportunities. The WD will develop a talent pool of all new qualifiers seeking first posts through the use of NHS Jobs[86] and through close collaboration with local employers, HEIs and social care and independent and third sector employers. Information on the numbers of new qualifiers and forecasts for demand will need to be accurate and integrated to ensure that high quality careers advice and information can be provided.

For doctors and dentists, there are specific issues related to the introduction of MMC/MDC and the implementation of the Medical Training Application Service (MTAS), the online recruitment system for doctors in 2007. The career pathways for doctors and dentists are multiple and complex. Support for junior doctors and dentists will be provided through a network of clinical tutors, educational supervisors, specialty training committees and Specialty Schools, and information tools will be available through online services. The WD will provide advice, guidance and counselling services through a local network of trained experts.

The WD will facilitate effective career advice and guidance for doctors in training, and throughout their careers will encourage retention through web-based resources, enhancing the career

guidance skills of medical clinical and educational supervisors and providing in-depth careers planning.

The WD will commission a series of taster workshops for doctors established in their consultant and GP careers to enhance their professional development and demonstrate opportunities to develop special interests and expertise. The development will include options for their career diversification into selection from leadership, medical education, research, coaching, writing for publication, special clinical interest, becoming a college/CPD tutor, career change and management.

7.4.2 Talent pool

Increased investment in pre-registration education and training commissioning has resulted in workforce supply exceeding demand. Competition for posts is high and students are finding it difficult to find their first post-qualification position. Projected numbers of retirements among healthcare professionals indicates that the NHS will need to employ greater numbers of healthcare professionals over the coming years.

Every effort is required to protect the valuable skills of newly qualified healthcare professionals and consideration of long-term education supply of a skilled health and social care workforce to avoid workforce shortages in the future.

NHS West Midlands has agreed to the seven recommendations of the Social Partnership Forum Action Plan,[87] and will develop talent pools of all new qualifiers seeking their first post, using NHS Jobs,[86] to identify and quantify and support employers and potential employees.

The WD will work with employers to determine numbers of new qualifiers appointed in 2006 and plans for employing new qualifiers in 2007 and beyond. This data will inform the development of appropriate mechanisms for bringing employers together across all sectors with the Regional Development Agency, to facilitate employment of newly qualified healthcare professionals.

NHS West Midlands is leading the partnership approach across sectors to audit e-staffing requirements, aid demand forecasting and ensure that commissioners endorse forecasts.

7.4.3 Local health economy development

7.4.3.1 Organisational development

In order to change the shape of healthcare organisations it is important to create an articulate and empowered workforce at all levels and enable true partnership working. Working with healthcare organisations, the WD will strengthen workforce

planning and use the HR tools available such as ESR[26] and e-KSF to develop a healthcare system for the 21st century. The WD will work with organisations to realise the benefits of these tools and develop management systems that are self-sufficient and accessible to staff. The WD will work to further develop and align ESR and e-KSF to enhance their effectiveness.

7.4.3.2 Support for commissioners

PCTs will need to play an increasing role in workforce planning. As commissioners, they will be well placed to work with the NHS West Midlands to ensure co-ordination between finance, activity and workforce. PCTs will need to assure themselves that providers have the appropriate number of staff with the right skill mix to deliver the services they commission, and will be involved in specifying new services to reflect changes in policy, demography and treatment methods. As commissioners of services, PCTs and other Practice Based Commissioners will be well placed to include workforce specifications in care pathways within contracts with providers. The WD will provide workforce specialist expertise to support commissioners of services as part of the wider programmes identified in *Investing for Health*[1] by scoping what is required, what needs to be done and developing support as appropriate.

7.4.3.3 Trust development

Over the next 5 years, the Government intends all provider trusts to become FTs in order to devolve decision-making from central government control to local organisations and communities, which are more responsive to the needs of the local population. FTs are regulated by Monitor, which authorises and regulates NHS FTs, making sure they are well managed and financially strong, delivering excellent healthcare for patients.

The concept of FTs raises some significant issues, as they have no requirement to participate in region-wide workforce planning. In July 2007 there were 5 FTs in the West Midlands, accounting for almost one in six of the NHS employed workforce. However, the WD remains responsible for ensuring that the future needs of qualified healthcare staff are met. It is vital that NHS West Midlands continues to develop good relations with FTs in the area and collaborates with them in assessing future workforce requirements. This will ensure that FTs have the workforce they require to provide healthcare.

The WD will need to be closely involved in the process of ensuring that PCTs are fit for purpose, particularly in the development of plans for the delivery of services in each health economy. The proposals for strengthening workforce planning set under the Workforce delivery priorities heading will help to develop cross-

organisational working and to improve the quality of workforce information included in LDPs.

7.4.3.4 Capital development projects

Education takes place in a variety of settings including classrooms and simulator centres, and it is important that these learning environments are of a high quality and provide contemporary education opportunities.

The WD will encourage the development of high quality education facilities through the application of commissioning contracts where appropriate. It will encourage cross-organisational use of these facilities and will develop criteria for supporting developments.

7.4.3.5 National Programme for Information Technology (NPfIT)

The NPfIT[88] is aimed at supporting improvements in the way the NHS supplies services to patients through the better use of IT. The technology is being designed with the intention that staff are fully supported by IT systems to assist them in providing the best quality of care for patients. It is obviously key that the clinical staff that will eventually be using these systems are fully engaged in designing how these systems will work. It is also essential that they are appropriately trained to use such systems.

It is estimated that approximately 800,000 NHS staff will become direct users of the new IT systems and services that are being introduced by NHS Connecting for Health: NHS Care Records Service; Choose and Book; Picture, Archiving and Communications System and the Electronic Prescribing Service.

Work is under way to ensure that the benefits of new IT systems are realised for patients and their carers, as well as for clinical and operational staff. In many cases the need to change and improve services is already well understood, and the improved IT will help organisations to make that change happen. The 3 key elements of improving the way in which services are delivered to patients will rely on people, processes and technology. All 3 elements need to work together, and the delivery of benefits through the NPfIT is dependent on engagement with the workforce.

Detailed work will be required to understand the benefits that can be gained from using IT at different points along the patient pathway to reduce waiting times (e.g. by making electronic radiology images available direct to the doctor treating the patient). This will also require an assessment of the skills required by those using the technology to ensure that the maximum benefit is gained. It will be the responsibility of NHS organisations, particularly PCTs, to ensure that they have the necessary organisational

development strategies to ensure that staff are equipped to work in a technology enabled environment.

As new technologies such as email, text messaging and remote monitoring from assistive technology equipment such as blood pressure monitors become the norm, the WD will need to ensure that our staff have the communication skills and technical ability required. The WD will encourage and accelerate the uptake, spread and creative use of technologies and software by ensuring that education and training programmes are fit for purpose and reflect the new technologies and clinical knowledge to support patients in the community.

The WD will work in partnership with the technology cluster healthcare providers to support the education and training of the workforce in line with the Education and Training Strategy of NHS Connecting for Health.[88] This will include the development of leadership training.

7.4.4 Performance monitoring

The WD will continue to monitor HR indicators such as sickness absence, use of agency staff and turnover through the monthly FIMS returns, Purchasing and Supply Agency reports and, increasingly, through the ESR data warehouse. Action will be taken on an exceptional basis to help organisations to improve their performance where appropriate.

7.4.4.1 KSF and Agenda For Change

NHS West Midlands wishes to be satisfied that trusts are operating within agreed frameworks. The KSF[25] is the development review process agreed across the NHS in the UK.

Organisations will need to prove that they have an ongoing cycle for the review, development and evaluation of all staff. This should clearly link organisational and individual development needs.

The KSF will allow jobs to be designed around patient and staff needs, improving overall productivity and job satisfaction for staff. Organisations need to prove how they are using, deploying and developing their workforce to achieve better patient care.

Key performance indicators, some of which are identified within the Service Level Agreement (SLA):

- ensure monitoring of KSF appraisals is undertaken
- staff survey results on staff undertaking training show progressive improvements among all staff groups.

The WD will support and encourage the analysis and co-ordination of learning needs resulting from appraisals and KSF reviews across organisations that support personal and professional

development and professional regulation/ revalidation. This will underpin the WD support for the region's workforce in CPD to meet their learning needs as required for their roles, and the revalidation/re-registration of their professional status. The WD will recommend best practice for trusts/PCTs and independent contractor practices in evolving a learning organisation culture and applying it to establish learning and training. This will support clinical governance and the preparation for revalidation of doctors and non-medical health professionals. The WD aims to establish a way of accrediting the learning culture in trusts, PCTs and the SHA: Level 1 would describe a trust or PCT with ad hoc learning activities and Level 3 would describe a trust that pools the learning needs of its workforce identified through appraisals and service development and planning that provides learning resources to match needs, and that creates learning opportunities across the health economy.

7.4.4.2 Staff survey

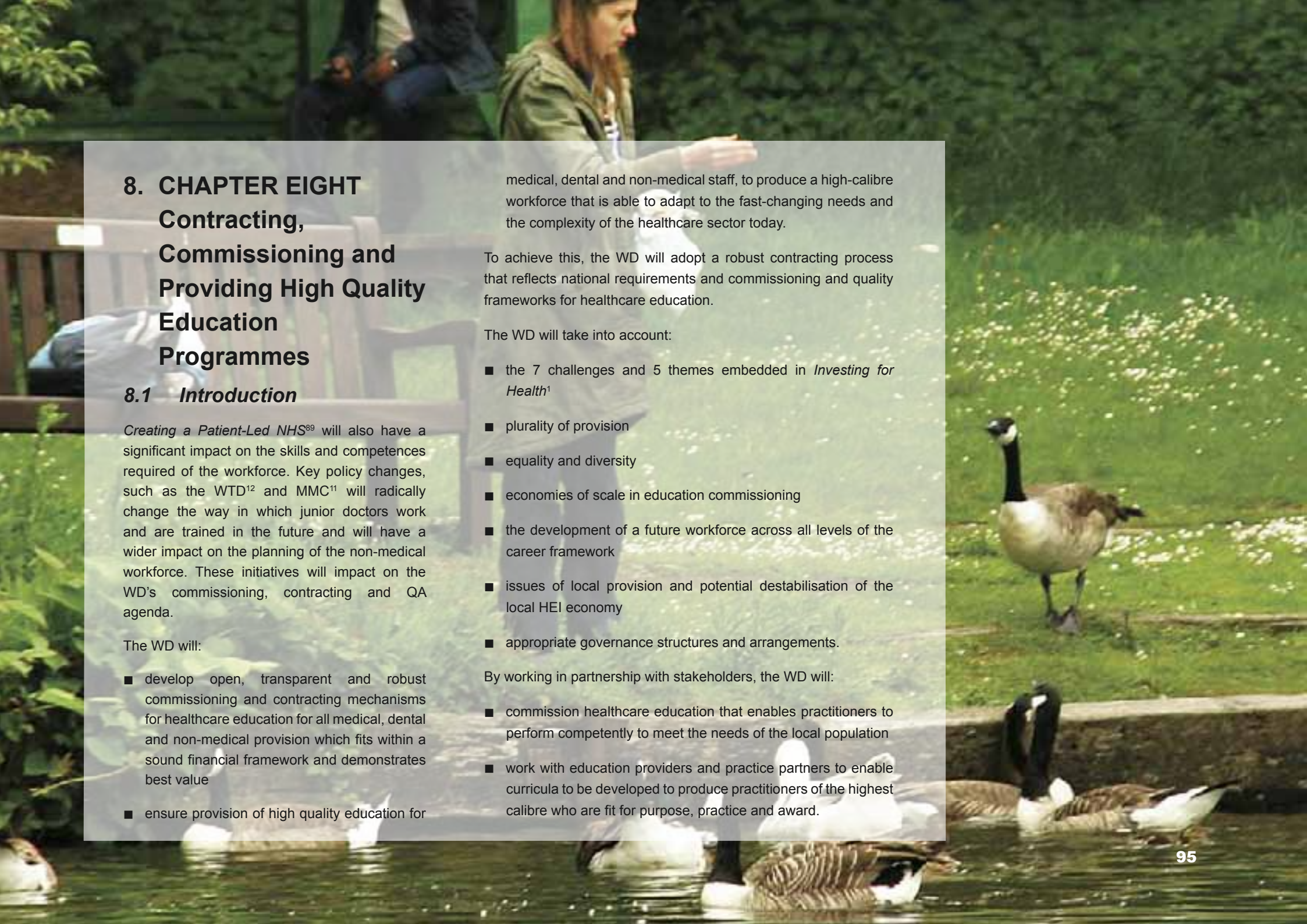
Staff surveys provide information on the attitudes and experiences of staff. This enables organisations to spot potential problems in the KSF process or in training and development provision. All trusts have their own data and the NHS West Midlands will be able to compare the experience of staff development across the region.

Organisations need to show how they are using the information from the staff surveys to meet DH core standards, meet the development needs of staff, and inform developments and provision to improve the performance of the organisation.

Summary - Organisations Fit for Purpose

In order to deliver the agenda for organisations becoming fit for purpose, the WD will:

- build workforce planning capacity and capability across local health economies
- work with healthcare services to develop integrated service, financial and workforce planning
- support the development of very senior managers and clinical leaders to be able to lead a diverse workforce with strong patient, public and staff engagement skills
- ensure that staff have the competences to utilise the technologies and derive benefits from the NPfIT to support patients in the community
- work with organisations to ensure that they have knowledge and expertise about the workforce to support it to become fit for purpose
- catalyse the analysis and co-ordination of learning needs across organisations to support personal and professional development.



8. CHAPTER EIGHT Contracting, Commissioning and Providing High Quality Education Programmes

8.1 Introduction

Creating a Patient-Led NHS[89] will also have a significant impact on the skills and competences required of the workforce. Key policy changes, such as the WTD[12] and MMC[11] will radically change the way in which junior doctors work and are trained in the future and will have a wider impact on the planning of the non-medical workforce. These initiatives will impact on the WD's commissioning, contracting and QA agenda.

The WD will:

- develop open, transparent and robust commissioning and contracting mechanisms for healthcare education for all medical, dental and non-medical provision which fits within a sound financial framework and demonstrates best value
- ensure provision of high quality education for medical, dental and non-medical staff, to produce a high-calibre workforce that is able to adapt to the fast-changing needs and the complexity of the healthcare sector today.

To achieve this, the WD will adopt a robust contracting process that reflects national requirements and commissioning and quality frameworks for healthcare education.

The WD will take into account:

- the 7 challenges and 5 themes embedded in *Investing for Health*[1]
- plurality of provision
- equality and diversity
- economies of scale in education commissioning
- the development of a future workforce across all levels of the career framework
- issues of local provision and potential destabilisation of the local HEI economy
- appropriate governance structures and arrangements.

By working in partnership with stakeholders, the WD will:

- commission healthcare education that enables practitioners to perform competently to meet the needs of the local population
- work with education providers and practice partners to enable curricula to be developed to produce practitioners of the highest calibre who are fit for purpose, practice and award.

8.2 *Financial framework: Multi-Professional Education and Training (MPET) levy*

The MPET levy[90] is a financial resource devolved from DH. The WD informs the allocation process by submitting workforce planning data, to demonstrate the workforce needs of the West Midlands.

Information from groups such as the Workforce Numbers Advisory Board, national workforce care groups, the NHS WRT, the Conference of Postgraduate Medical Deans and the Committee of General Practice Education Directors informs SHAs of the appropriate number of commissions that are required nationally, in order to have the right number of people in the right place, with the right skills, at the right time.

The key purpose of financial management of the MPET levy is to support the achievement of high quality healthcare services by developing a competent and diverse workforce within NHS West Midlands.

In 2007/08, the WD received £426 million from the national MPET levy. The levy consists of 3 elements:

- Non-Medical Education and Training (NMET)
- Medical and Dental Education Levy (MADEL)
- Service Increment for Teaching (SIFT).

The percentage overall budget for each element and spend by funding stream are outlined in Figure 12 and Table 2.

Figure 12: MPET budget by funding stream 2007/08

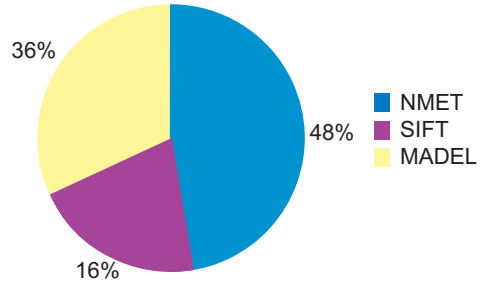


TABLE 2: MPET spend by funding stream (HEI/Trust)

Element	HEIs £m	Trusts/PCTs £m	Other £m	Total £m
NMET	75	130	0	205
MADEL	2	147	4	152
SIFT	0	64	5	69
Total	**77**	**341**	**9**	**426**

The planning cycle for each of the 3 funding elements, together with additional detail, can be found in Appendix F.

8.3 Commissioning and contracting

8.3.1 Commissioning framework

A modernised commissioning process ensures that education programmes build the competences required in the workforce, to deliver a service that is responsive to the needs of the population. The WD will continue to work with trusts and PCTs to review the process for determining workforce commissioning to match the needs of the local health economy and will focus on:

- the NHS moving from a position of growth to one of consolidation
- strengthened workforce planning that is locality based
- plurality of provision
- organisational and service reconfiguration
- improved productivity and patient safety
- increased patient and public engagement
- new ways of working and new roles
- the need to move to a more flexible and adaptable workforce
- robust educational programmes that reflect the diverse and complex nature of the career framework and Care Closer to Home
- the shift from secondary to primary and community care, e.g. in pre-registration nursing and mental health
- increasing the number of clinical placements in primary care
- the need for a multi-professional approach to education and training
- a combined health and social services model, e.g. in learning disabilities.

It is essential that education programmes produce a future workforce that is competent and fit to practise. Education programmes need to be built on workforce competences that are aligned to service and allow transferable standards and flexibility of skills across the workforce. The WD will work with education providers to ensure continual improvement and match with service needs and education programme delivery.

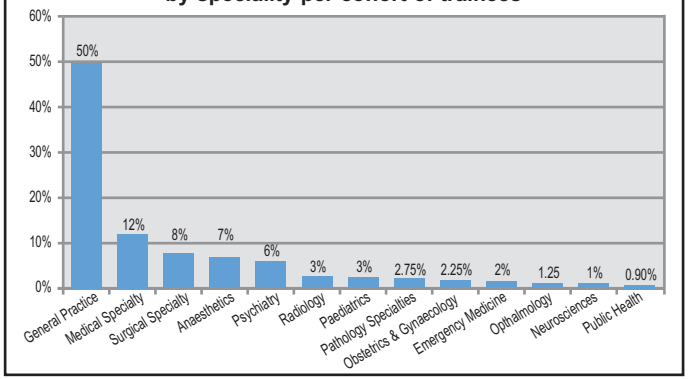
Public, patient and user involvement is an important aspect in the development of medical and non-medical curricula to ensure that graduates have an understanding of the needs of service users. The WD is developing QA monitoring mechanisms to capture the voice of service users, to enhance the provision of commissioned education programmes.

8.3.1.1 Medical and dental commissioning

Medical workforce planning is led nationally, with local modelling and input from the WD. Extensive work has been undertaken with the West Midlands to model the medical workforce to ensure that the WD is able to deliver the right number and type of doctors to meet local demand. The predicted output by specialty has been calculated from the end point of trainees, i.e. the current ratio of GPs to consultants by specialty in the national medical workforce. This gives an indication of required output from which to start modelling; however, for specialties that are not in a steady state (i.e. are in growth or decline), this will continue to be adjusted to reflect current trends. In order to improve the effectiveness of modelling and ensure a fit with service need, the medical numbers will need to be integrated with those for the non-medical workforce. The challenge will be to ensure that the right number of training posts within the right specialties is delivered, with the appropriate mix of qualified hospital specialists and GPs. This was discussed in Chapter 1.

Figure 13 shows the proportion of medical training programmes required by specialty, which can be applied to each cohort of trainees to ensure that the WD delivers the right number of appropriately qualified doctors for the region.

Figure 13: Required proportion of medical training programmes by speciality per cohort of trainees



Source: West Midlands Deanery MMC Workforce Modelling June 2007

8.3.1.2 Geographical equity across the region

It is fundamentally important that all NHS employers have the opportunity to train the medical specialists and GPs of the future, and the WD is committed to ensuring that training posts are made available across the region. Training programmes are being constructed to ensure that the number of posts in each region broadly reflects as:

- 25% in Shropshire and Staffordshire
- 25% in Coventry, Warwickshire, Herefordshire and Worcestershire
- 50% in Birmingham and the Black Country.

This will take approximately 5 years to deliver and the WD will work with employers across the West Midlands to drive this forward.

8.3.1.3 Delivery of medical and dental education

Medical specialty run-through training programmes will be managed by schools of postgraduate medical education (postgraduate schools) as part of a new structure, fusing the responsibilities of the Royal Colleges and the Deaneries.

There are 11 postgraduate schools in the West Midlands WD (Appendix G). Two are already well established (the School of Surgery and the School of Medicine). The postgraduate schools will:

- manage the training of doctors within their programmes, fusing the two previous grades of Senior House Officer and Specialist Registrar into one run-through grade'
- take the trainee from application after foundation training through to the delivery of a Certificate of Completion of Training (CCT) and eligibility for consultant or GP appointment
- promote, maintain and continuously improve the standards of postgraduate medical and dental education, training, assessment and accreditation to secure appropriate educational outcomes as defined by the PMETB,[56] the GMC[91] and the GDC[53]
- work in partnership with the WDs quality management team to ensure that this quality is maintained
- contribute to multi-professional planning and the wider WD development of careers support and guidance offered by trusts, medical schools and the WD
- promote best evidence medical education[92] and education research.

This will be achieved by the WD:

- approving postgraduate medical and dental education and training placements, programmes and courses
- accrediting postgraduate education, as well as training institutions and trainers
- quality managing the postgraduate medical and dental education and training system

- ensuring that workplace-based assessments, including record of in-training assessments undertaken as part of training, are reliable and fair
- promoting the career management strategy across undergraduate and postgraduate training continua and CPD
- supporting the development of academic medicine and dentistry
- supporting the needs of those wishing to train flexibly
- ensuring that trainees are equipped with the attitude and skills to continue learning throughout their careers.

8.3.1.4 Assessment of medical trainees

With the introduction of MMC,[11] the number of trainees being recruited and assessed by the WD has doubled. In 2007, the difficulties experienced locally due to the failure of the national online recruitment system, MTAS, have meant that it is even more critical to work with employers to plan and deliver future MMC recruitment. The WD will improve systems and processes to ensure fitness for purpose. This work will focus on:

- the further development of foundation schools and postgraduate schools of medicine, which were introduced in 2007 to manage and deliver medical education
- the development of information systems that service the needs of all stakeholders, both internal and external
- a review of the current structure within the recruitment teams
- a review of the role of medical staffing departments within trusts to support the regional recruitment of training grade doctors
- integrated medical and non-medical workforce planning.

8.3.1.5 Assessment of medical trainees

The development of a new competency-based curriculum for each training programme underpins the MMC career structure.[11] Appendix H shows the detailed breakdown of MMC programmes. The postgraduate schools will be responsible for introducing, embedding and delivering the curricula and monitoring the outcomes, including reviewing training posts and rotations to ensure that they are educationally appropriate. In addition, postgraduate schools will be responsible for ensuring more intensive and rigorous supervision of trainees, including through:

- formal assessment of competence

- review of in-training assessments
- appraisals throughout training.

8.3.1.6 Factors for trusts to consider

The WD will continue to work with employers to convert and develop training posts and support trainees. It is worth noting that as posts convert from specialty training posts to GP core stream and F2 posts, potentially the trainees will be less experienced. This may have a service impact for trusts so planning will be needed in order to identify skill mix changes, for example as a result of new roles.

Additionally, the requirement to reduce rotas to 48 hours in order to be WTD compliant[12] by 2009 will impact on trainees. Rotas will need to be redesigned with more use of hospital at night principles.

8.3.2 General practitioner specialty training

The WDs national allocation of places for doctors to train to become GPs is currently 328 per year. The School of Postgraduate General Practice Education delivers training to approximately 1,000 trainee GPs in the full 3 year specialty training programme at any one time. The national curriculum is set by the Royal College of General Practitioners and locally approximately 70 GP medical educators (16.6 FTEs) and 560 GP trainers deliver training to the quality standards set by the PMETB.[56] Of Foundation Year 2 doctors, 55% spend 4 months in general practice-based training.

By August 2008, the WD will extend the proportion of time individual trainee doctors spend training in general practice to at least 50% of their total training.

The WD also hosts approximately 150 GP retainers as part of the national scheme and flexible career scheme sessional GPs in the GP training practices across the West Midlands, in order to address retention issues.

8.3.3 Dental commissioning

The WD will continue to shape the dental workforce using a multidisciplinary model that ensures that dental education commissioning meets the needs of the West Midlands healthcare population and improves access to NHS dentistry.

The WD will:

- facilitate training through MDTs that have an evidence-based approach to clinical practice, and understand and are responsive to the needs of the population
- develop NHS committed vocational training practices and trainers

- develop a more equitable distribution of training practices around the West Midlands
- ensure that dentists who want to work in the NHS are recruited and trained through run-through and vocational training programmes, with assessment in line with GDC requirements
- ensure adequate CPD is available for the whole dental team, to meet the GDC mandatory requirements from 2008
- protect the current national fund for dental CPD for use by the whole dental team
- work in partnership with the LSC and education providers to ensure that there is an adequate provision of dental nurse training places in the West Midlands
- commission a foundation programme for new therapist graduates as a means of introducing them into NHS practices
- evaluate the outcome of the foundation programme
- support the introduction of the MDC programme for new dental graduates.

8.3.4 Non-medical education commissioning

The non-medical workforce, including support to clinical staff, forms approximately 68% of the workforce in England. In 2007/08, national and/or local intelligence has been used to inform decision making such as WRT recommendations. Non-medical education is influenced by local workforce plans, placement availability and national policy, e.g. the shift from diploma to degree. In future years, the WD will deliver a yearly commissioning plan informed by robust locality based workforce planning data aligned to the LDP.

Appendix I demonstrates the range of pre-registration programmes commissioned with each HEI and other providers, and the number of commissions placed for the 2007/08 academic year. Appendix J lists the total student population for each of the pre-registration programmes. Collectively these appendices show the complexity of the contracts held within the West Midlands.

The WD will work with healthcare providers to determine the likely future demand for the workforce and will reconcile this with the current and predicted supply. The WD will also work with HEIs to ensure that appropriate education courses are provided to meet these needs. For example, with the shift in services from secondary to community and primary care, the undergraduate training programmes for nurses and AHPs will need to increase the focus on the competences required to deliver care in primary and community settings.

8.3.5 Pharmacy education and training

In the West Midlands there are currently 3 schools of pharmacy: at Aston University, Keele University and Wolverhampton University. The growth in pharmacy school output will help to ensure capacity of undergraduates for pre-registration pharmacy training to meet service demand for the pharmacy workforce across the West Midlands.

The WD commissions pre- and post-registration specialist training for the pharmacy workforce currently pre-registration pharmacy trainees are trained across 22 NHS trusts.

The WD will:

- support the continued development of a competent and flexible pharmacy workforce to support the modernisation of NHS services and safe and cost-effective medicines management for patients
- work in partnership with stakeholders to support the delivery of pharmacy workforce capacity through its commissioning plan
- facilitate the co-ordination of recruitment, placements and training of pre-registration pharmacists.

8.3.6 Healthcare scientists' education and training

Healthcare scientists form approximately 4% of the NHS workforce in the West Midlands and represent some 50 disciplines. Delivering education and training for this part of the workforce accounts for 4.8% of the NMET levy. Scientists often enter the healthcare workforce in an indirect manner following completion of science-based graduate education programmes funded by the Higher Education Funding Council for England.[93]

The WD will:

- work in partnership with the DH Chief Scientific Officer to host a Modernising Healthcare Science Careers national pilot project on education and training
- develop a competency-based education commissioning model for healthcare scientists which promotes multi-professional learning and delivers curricula that are fit for purpose, practice and award
- work with education providers to ensure that curricula are developed to reflect the changing roles of this workforce in the context of:
  - multi-professional learning
  - delivering RTT targets for diagnostics
  - Care Closer to Home.

8.3.7 Flexible training

All NHS doctors in training programmes have the right to apply for the flexible training scheme. In addition, the Flexible Working (Eligibility, Complaints and Remedies) (Amendment) Regulations 2006[94] give anyone with carer responsibilities the right to apply to work flexibly. It is anticipated that the demand is likely to grow with the increase in numbers of female medical students and demand for flexible working patterns.

For non-medical trainees, support is provided through the creation of flexible training routes in conjunction with the appropriate HEIs. All non-medical healthcare trainees have access to flexible programme training routes. All routes can be provided on a part-time basis under negotiation.

8.4 Contracting framework

A national contract and benchmark includes prices for some NMET pre-registration education programmes[95] have been implemented, following guidance issued by DH. This ensures a common and consistent approach for all commissioned healthcare education programmes and enables HEIs to have open and transparent pricing systems, thus ensuring value and equity in delivery of programmes.

By 2008, the WD will:

- implement the national contract for NMET provision for those contracts not yet converted
- when nationally determined, apply benchmark prices to provision not currently benchmarked
- implement updated MADEL contracts
- review the medical information management system
- implement robust contractual frameworks with:
  - local trusts and PCTs for smaller, non-medical provision
  - foundation schools
  - 11 postgraduate medical schools
  - GP training schemes.

In collaboration with medical schools and SIFT committees, the WD will review medical and dental SIFT contracts and QA elements to strengthen educational provision and clinical placement support.

The WD will work in partnership with HEIs and other education providers via the HESP to ensure that they are responsive, have the ability to be flexible in terms of delivery and are willing to collaborate with partners. An element of entrepreneurialism is desired to ensure provision is of a high standard and that contracts

are revised within the framework agreements.

The WD has a duty to work in collaboration with partners from local trusts and PCTs to ensure that provision from HEIs is responsive and flexible enough to meet the needs of the NHS. It reserves the right to remove provision that is deemed to be unfit for purpose or that is not demonstrating value for money. The WD will encourage HEIs to work collaboratively, recognising the spirit of competition to enhance and improve services commissioned.

Through this process, the WD will continually improve education delivery and ensure that best value from contracts is maintained.

The WD will deliver on a number of key performance indicators in relation to contracting and commissioning, which are identified in the SLA with DH (see Appendix K).

8.5 Fitness for purpose, practice and award

To ensure that practitioners at all levels are fit for purpose, practice and award, there is a need to challenge and transform traditional curricula models currently in use. There is also a need to develop innovative curricula that encourage multi-professional learning, for all healthcare education commissioned programmes. It is imperative that curricula are continually revisited through validation panels and forums with stakeholders, to ensure that national and local demands for education and training of healthcare professionals are met.

With an increasing demand for specialisation of services by appropriate healthcare professionals, there will continue to be a shift in ratios of the skilled and qualified professionally registered workforce. This needs to be balanced against the requirement for more generalist roles, particularly with the shift of services into primary care. This shift will have implications for education providers.

It is essential to develop pre- and post-registration education that contains specific modules embedded throughout the course of all programmes related to:

- patient and public involvement
- the clinical governance agenda
- equality and diversity.

The WD, University of Birmingham and University of Central England, through the Centre of Innovation and Training in Elective Care, will be undertaking a collaborative project to develop a simulation exercise based on care pathways to ensure that graduates and diplomats are competent to practice.

The WD will work with the postgraduate schools to:

- introduce and embed competency-based curricula into training programmes
- deliver the curricula
- monitor outcomes, including reviewing training posts and rotations to ensure that they are educationally appropriate
- ensure the delivery of a more intensive and rigorous supervision of trainees, including:
  - formal assessment of competence
  - review of in-training assessments.

8.6 Practitioners, doctors and dentists in difficulty

The safety of patients, students/trainees and qualified medical staff at all levels must meet the requirements of clinical governance, the WD built-in processes which identify practitioners in difficulty. These mechanisms ensure that practitioners deemed unfit to practice or who are failing in practice are supported appropriately and sensitively following robust HR guidance.

The WD will:

- accept referrals from GP trainers, clinical tutors and training committee chairs about trainees who are experiencing difficulty
- accept referrals from relevant bodies, including PCTs and the GDC, regarding the retraining and reassessment of dentists in training
- work together with partners to develop tailored plans for retraining individuals.

Within non-medical training provision, the WD engages with practice staff and HEIs to ensure that guidance and support are available to those supporting and assessing students in line with professional body requirements and academic institution requirements. Through our quality groups, there are established fitness to practice panels where the WD can identify controls and measures to support individuals who are deemed to be struggling in practice environments, involving work with mentors and assessors.

8.7 Quality assurance

8.7.1 Ensuring delivery and best value

The WD has a responsibility through the PMETB[56] and Skills for Health[96] to quality monitor and assure all healthcare education that is commissioned. This involves:

- QA, monitoring and enhancement of non-medical education, medical and dental education
- QA of library services in local trusts and PCTs

- accreditation of facilities and accommodation for medical trainees
- implementation of the WTD legislation and ensuring compliance
- approval and re-approval of medical posts and PMETB standards.

The key challenge for the WD is to develop robust QA processes that are transparent, equitable, coherent and consistent.

The WD will implement a QA framework that adheres to the following principles:

- a robust set of processes to provide public and professional reassurance about the standards and quality of all healthcare education
- providers of education and postgraduate schools will be held to account to continually improve the quality of education provision and will consider imposing penalties for repeated non-compliance
- equal importance will be accorded to the clinical placement component of education programmes and the academic components of curricula
- compliance and synergy with national standards, such as PMETB, Skills for Health, Quality Assurance Agency, Healthcare Commission and NHS Litigation Authority standards
- requirements of the Royal Colleges, regulatory bodies and accrediting bodies.

8.7.2 Equality and diversity

Equality and diversity are integral parts of the processes employed for QA and monitoring. The QA Team uses the national standards for PMETB and Skills for Health. These standards reflect the issues in relation to equality and diversity their entirety. The standards require the WD to demonstrate a commitment to the safety of patients, carers, staff and students and a commitment to promoting diversity, inclusion and equality of opportunity for all.

8.7.3 Medical quality assurance

Currently, the PMETB has responsibility for overall monitoring, assurance and enhancement of all foundation programmes and medical education. The PMETB is currently reviewing its QA framework. Guidance is awaited regarding QA for dentistry. The new medical QA framework can be seen in Appendix L.

In the interim, the WD has streamlined processes and has mapped QA systems to follow the principles of self-evaluation and peer support using a 360-degree approach taking into account the trainee survey, PMETB standards, PMETB visits and Royal College recommendations and a local electronic survey approach.

This has been done for the foundation and postgraduate medical schools.

8.7.3.1 Challenges to date for medical and dental quality

After recent quality monitoring, the following have been identified as key themes for risk management and enhancement. In the short term the WD will address issues in relation to:

- reported consultant bullying
- health and safety of trainees in practice settings
- the development of consistent and coherent induction programmes for trainees
- the development of train the trainer days to ensure consistent inter-rate reliability of assessment in the clinical setting
- study leave
- perceptions in relation to the WTD
- out of programme experience, which will have an impact in terms of defining a process and backfill arrangement for posts.

The WD will develop consistent approaches to address education provision in order to:

- ensure that quality monitoring and assurance are seen as core functions and actively address the issues that relate to risk management
- continually seek enhancements
- disseminate best practice and drive forward innovation
- identify all stakeholders responsibilities
- make links to influence contracting and commissioning plans that reflect local demand and that are current and contemporary in terms of delivery.

8.7.3.2 Quality assurance for approval and re-approval of medical posts

All training leading to a CCT must be supervised and aligned to posts and programmes approved by the PMETB. All posts must be approved if the trainee is to complete their CCT.

Approval applies to fixed-term specialist training appointments (FTSTAs) so that doctors entering specialist training programmes above ST1 at FTSTA at a later stage can be assured that they will be eligible for the award of a CCT on successful completion. Doctors entering career grades after FTSTA will also have the statutory minimum requirements to ensure eligibility for specialist registration through equivalence routes.

The WD will also ensure that it delivers all foundation programmes to the approved curriculum requirements and will ensure that all training posts have:

- an agreed and adequate source of funding
- approved training sites/locations
- educational and training support in place.

8.7.4 Non-medical education quality

QA for non-medical education needs to meet the requirements of the MPET National Standard Contract. As with medical QA, national guidance for the longer term is awaited from Skills for Health, following their QA framework[96] review consultation in autumn 2007.

In the interim, the WD has engaged stakeholders and education providers in the process of ongoing quality monitoring and enhancement. The process of non-medical quality monitoring and enhancement is explained in Appendix M.

The WD also has responsibility to quality assure the provision for smaller professions. Although the commissions within this context are on a smaller scale, the WD has developed a framework that adapts the principles of ongoing quality monitoring and enhancement and monitors the provision accordingly, to ensure continual improvement.

The WD will deliver on a number of key performance indicators in relation to QA, which are identified in the SLA with DH (see Appendix N).

8.7.5 Knowledge management

8.7.5.1 Quality assurance of library and knowledge management services

West Midlands Library Services Development Unit works with the NHS Institute for Innovation and Improvement through the National Library for Health team to develop improved clinical engagement with the knowledge base, following on from the issues arising from the Bristol inquiry. The Unit works in national consortia, including a national forum working with the NHS Purchasing and Supply Agency to ensure that funding is invested wisely and to use national purchasing power to good effect.

The WD requires that all library services engage with their stakeholders. This will ensure that local library service planning is integrated with local needs, especially in the context of evidence-based practice, productivity and patient engagement.

Library services are key to local learning. This constitutes the highest reason for the use of library services, i.e. supporting staff who are improving their qualifications at the same time as maintaining their work. User feedback indicates that they could not have completed their studies without the support of the local library service. Libraries provide learning resources to be used both in the workplace and increasingly from home to enhance flexibility and availability of learning.

8.7.5.2 E-learning

As the national e-learning debate has now moved on to local action, the WD role will grow a culture which is open to change and seeks out and implements good practice. The WD recognises the strengths of e-learning:

- offering flexibility in the learning process
- providing an opportunity to collaborate and share good practice and learning objectives across organisations
- developing the skill of the workforce in the use of information technology
- reducing costs compared with classroom learning
- facilitating multi-professional learning.

The WD will provide leadership by example and, working with the NHS Core Learning Unit,[97] will:

- develop a network and learning from potential e-learning champions to include clinical tutors, training managers and specialist trainers
- promote the work-based learning resources of the NHS Core Learning Unit core curriculum induction requirements of all health-related staff
- harvest the skills of e-learning knowledge accumulated by our HEI partners and relate it to flexible learning in the clinical workplace.

Library services are ideally positioned to be local agents of change. New roles are becoming established for example skills trainers, clinical question response services, work-based learning. Library services are critical to the diffusion of knowledge about efficient and effective practice. The WD will signal the direction for modernisation in learning by enabling library services to be advocates of e-learning and the new tools of knowledge management, working with providers to develop common standards such as Equip.[43]

8.7.6 WTD and links to the quality assurance provision

QA will be pivotal for long-term success of the implementation of WTD 2009. The Deanery Action Team is well placed within the WD to provide technical rota design advice and support for redesigning current rotas and for introducing new ways of working. The QA Team will provide the evidence needed to establish confidence among all concerned that quality related activities are being performed effectively.

The Deanery Action Team will use a new software tool (Medical Resource Manager) to:

- benchmark all rotas for WTD 2009 compliance

- help the SHA to support trusts as they move towards the WTD 2009 targets.

By 2009 the Deanery Action Team will work with the QA Team and partners to establish robust and sustainable rotas that will meet service needs and ensure delivery of high quality education.

Summary - Contracting, Commissioning and Providing High Quality Education Programmes

To underpin robust contracting and commissioning, the WD will:

- develop open, transparent, robust commissioning and contracting mechanisms for healthcare education that fits within a sound financial framework and demonstrates best value
- ensure provision of high quality education to produce a high calibre and diverse workforce able to adapt to the fast changing needs and complexity of healthcare today
- operate a consistent approach for all commissioned healthcare education programmes, to ensure value and equity in delivery
- work with stakeholders to develop innovative curricula that encourage multi-professional learning that meets national and local demands for education and training
- ensure that students/trainees at all levels meet clinical governance requirements
- implement a detailed QA framework that complies with the national standards and regulatory and accrediting bodies.

9. CHAPTER NINE
Making it Happen

This workforce strategy underpins *Investing for Health*,[1] NHS West Midlands 5 year strategic framework. It sets out the workforce challenges and a vision for future investment and shaping of the workforce.

NHS West Midlands is responsible for leading the regional workforce strategy and fulfils this function through the WD. This strategy will only make a difference if actions are delivered. Workforce benefits can only be realised if all healthcare providers and commissioners ambitiously deliver the workforce changes that are needed in order to create a patient-centred, world-class workforce.

In leading this workforce transformation, the WD will have key principles in operation to make it happen, including:

- investments that demonstrate productivity gains and value for money
- multidisciplinary education
- equality and diversity
- continued improvement in the educational experience
- flexible and high quality curricula that continue to be fit for purpose
- promotion of the continued development of the workforce
- openness and transparency in its operations
- workforce planning and developments that are wholly integrated with service delivery.

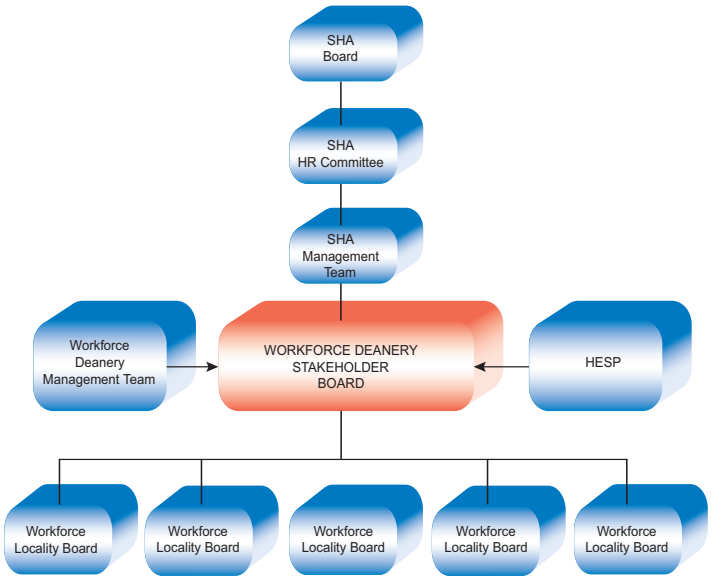
The WD has been structured (Appendix P) to enable workforce planning to be aligned to integrate care pathway planning and development, in addition to maximising opportunities for multidisciplinary workforce solutions and education delivery. It has a strong commissioning and contracting function, which will work in partnership with both universities and postgraduate medical schools to deliver the highest quality education possible. In addition, the WD will work on areas that may benefit from a region-wide partnership approach.

Fundamental to the achievement of this workforce strategy is engagement with key partners and stakeholders. The current challenges of workforce planning are exacerbated by ineffective systems, firstly for forecasting future workforce requirements and secondly for increasing the flexibility of the workforce in its ability to develop competences at a pace and quality required by service modernisation. A stakeholder structure that enables local action on these issues will enhance the capability and capacity of the workforce of the future. In addition, organisations coming together to plan and invest in workforce developments will enable shared delivery of education programmes and workforce planning that is scrutinised at a local level to ensure seamless planning with service developments, e.g. secondary to primary care shift.

The WD Stakeholder Board, the HESP and the relationships that we have with other critical organisations such as Skills for Health, the LSC and our colleagues in the health and social care sector will help us to target our workforce development resources and intelligence towards a patient-led NHS that uses available resources as effectively and as fairly as possible to promote health, reduce health inequalities and deliver the best and safest possible healthcare.

9.1 The governance structure

Figure 14: The governance structure



9.1.1 Stakeholder Board

The Stakeholder Board will be responsible for:

- developing strategic and operational workforce plans for submission to the SHA for formal approval
- monitoring of progress and performance on behalf of the SHA and stakeholders, supported by transparency
- allocating total funds
- reporting on proportionate spend in categories of activity
- reporting on commissions by geographical locality
- receiving and approving recommendations for local investment from the Workforce Locality Boards
- ensuring, where appropriate, that there is consistency, to avoid duplication and ensure best value
- receiving recommendations from the HESP for quality or investment initiatives
- supporting partnership working as a core principle in the development of the workforce.

9.1.2 Workforce Locality Boards

The Workforce Locality Boards will be chaired by a local CEO and will comprise representatives from all NHS organisations. This model will facilitate increased flexibility of the workforce across care pathways, encouraging providers of healthcare to innovate in enabling the workforce to move more easily across secondary and primary care settings.

They will cover the 5 health economies of:

- Shropshire, Staffordshire and Stoke
- Birmingham, Solihull and Sandwell
- the Black Country
- Coventry and Warwickshire
- Hereford and Worcestershire.

Responsibilities will include:

- planning the workforce across health economies, enabling workforce flow to follow patient flow through more integrated systems of workforce planning across the workforce in hospital settings and allowing the workforce to provide care closer to patients' homes
- problem-solving workforce issues at a local level, including examining relevant business cases that have an implication for the workforce across the locality
- contributing to the commissioning plans of the WD, ensuring

university-delivered education programmes are provided across the West Midlands

- providing a stronger employer voice on the fitness for purpose of university-delivered education programmes
- ensuring that WD investment plans are broadly representative of the needs of the service.

9.1.3 Regional Social Partnership Forum

The Regional Social Partnership Forum has been established to ensure that the principles underpinning the partnership agreement framework agreed by DH, NHS Employers and NHS trade unions operates effectively across the West Midlands. The forum will be used to discuss, debate and involve partners in the development and the implementation of the workforce policy implications.

9.1.4 Health and Education Strategic Partnership

The HESP has been established across the West Midlands. It has membership from HEIs, and is co-chaired between NHS West Midlands, Head of Workforce Development and a University Dean of Health, who will also be a member of the Stakeholder Board. Its remit is to:

- ensure that the strategic direction of the organisations providing health services, education and research are shared and aligned where possible
- understand the impact of partners' strategic plans across the health and education sectors, particularly where major change is envisaged
- ensure that the NHS and higher and further education sectors across the West Midlands are able to respond to future developments in both health and education
- work together collectively to maximise the resources available for health and education across the West Midlands
- make health and education providers across the West Midlands employers and trainers of choice and ensure that they are at the forefront of health and educational development, through including the development of new roles and educational and research programmes that reflect a radical vision for healthcare.

9.2 Monitoring/performance

The delivery of this strategy will have a significant impact on the workforce challenges underpinning *Investing for Health*[1] outlined in Chapter 1.

Chapters 3 to 7 outline the key priorities that will impact on the 7 big challenges.

Appendix A demonstrates how the workforce priorities are aligned to the *Investing for Health*[1] strategic priorities and how they impact

on the 7 big challenges. Future investment in workforce priorities will be aligned to this framework. In addition, Appendix A outlines the integral workforce themes involved in the *Investing for Health* 10 West Midlands wide projects.

The WD can only add value if commitments are delivered and monitored. An annual business plan will monitor activity and investments and will be shared with our partners.

The proposals for development laid out within this document will influence future investment plans and focus in relation to investment in specific development initiatives. The business plan will provide a framework to monitor progress through measurable performance indicators and targets and a mechanism to review performance against those targets at both corporate and local levels through the structure outlined above.

9.3 Communication

Robust and effective communication is essential, to:

- increase peoples' understanding of the WDs work priorities
- ensure that NHS organisations, stakeholders and partners are aware of the WDs vision and plans for the future
- listen, through the stakeholder structure, to the needs and views of the organisations the WD serves so that the right priorities can be established and responsive initiatives developed
- maintain an appropriate and positive WD profile and identity as part of NHS West Midlands
- ensure an effective, aware and motivated workforce
- contribute to the healthcare debate and discussions around workforce issues in a variety of forums at a local, regional and national level.

Summary - Making it Happen

- This workforce strategy provides a co-ordinated response to workforce issues surrounding the changing needs of the NHS across the West Midlands. Success in delivery will bring real benefits to patients and the public. As the pace of reform within the NHS increases, complex interdependencies within the key policy changes will affect patient care. Some of these changes will affect the demand for different types of healthcare staff, and there is a need to prepare the workforce of tomorrow.
- With the growing demands for healthcare from an increasingly older population and without a parallel rise in healthcare resources, there is a need to focus on increasing productivity and reviewing skill mix, rather than workforce expansion.
- The WD will ensure that the workforce contribution that underpins the delivery of *Investing for Health*,[1] is delivered, through effective workforce planning and development with a variety of partners across the West Midlands. This will reflect the education commissioning and delivery of postgraduate medical education and training.
- This strategy makes sense in the context of *Investing for Health*[1] It considers the population served by the NHS West Midlands, as well as the strengths and limitations of the current workforce, and explains the key workforce drivers. In order to address the 7 challenges discussed in *Investing for Health*,[1] the workforce strategy outlines how workforce development and commissioning will match the 5 strategic themes. The WDs goals on workforce planning are outlined and education commissioning programmes examined. Finally, this chapter demonstrates how the WD will achieve its vision.
- The strategy outlines the WDs approach to ensuring education and training that is fit for purpose, to enable a future productive workforce for the 21st century and, in partnership with its providers, to deliver planned improvements for high quality, patient-centred services.

GLOSSARY

A&E	Accident and Emergency
AfC	Agenda for Change
AHP	Allied Health Professional
BEME	Best Evidence Medical Education
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCT	Certificate of Completion of Training
CEO	Chief Executive Officer
CPD	Continuing Professional Development
CSIP	Care Services Improvement Partnership
DH	Department of Health
DN	Dental Nurse
EOL	End Of Life
EPP	Expert Patient Programme
ESR	Electronic Staff Record
FIMS	Financial Information Monitoring System
FT	Foundation Trust
FTE	Full-Time Equivalent
FTSTA	Fixed-Term Specialist Training Appointment
GDC	General Dental Council
GDP	General Dental Practitioner
GDS	General Dental Services
GMC	General Medical Contract
GMS	General Medical Services
GP	General Practitioner
HCA	Healthcare Assistant
HCAI	Healthcare Associated Infection
HEI	Higher Education Institution
HESP	Health and Education Strategic Partnership
HR	Human Resources
IS	Independent Sector
ISIP	Integrated Service Improvement Programme
IWL	Improving Working Lives
KSF	Knowledge and Skills Framework
LBR	Learning Beyond Registration
LDP	Local Delivery Plan
LHE	Local Health Economy
LSC	Learning and Skills Council
LTC	Long-Term Condition
MADEL	Medical and Dental Education Levy
MAPA	Management of Actual and Potential Aggression
MDC	Modernising Dental Careers
MDT	Multidisciplinary Team
MHC	Modernising Healthcare Careers
MMC	Modernising Medical Careers
MNC	Modernising Nursing Careers
MPET	Multi-Professional Education and Training
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NLH	National Library for Health
NMC	Nursing and Midwifery Council
NMET	Non-Medical Education and Training
NMP	Non-Medical Prescribing

NPfIT	National Programme for Information Technology
NVQ	National Vocational Qualification
PCT	Primary Care Trust
PDP	Personal Development Plan
PMETB	Postgraduate Medical Education and Training Board
PwSI	Practitioner with a Special Interest
QA	Quality Assurance
RPSGB	Royal Pharmaceutical Society of Great Britain
SHA	Strategic Health Authority
SIFT	Service Increment for Training
ST&T	Scientific, Technical and Therapeutic
VT	Vocational Training
WD	Workforce Deanery
WMTPHN	West Midlands Teaching Public Health Network
WRT	Workforce Review Team
WTD	Working Time Directive

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APPENDIX A

Alignment of workforce priorities to *Investing for Health* and how the strategic priorities contribute to tackling the 7 Big Challenges

		STRATEGIC PRIORITIES				
		Full Engagement	**Improving Quality and Safety**	**Care Closer to Home**	**Sustainability**	**Organisations Fit for Purpose**
SEVEN BIG CHALLENGES	**Inequalities widening**	Health trainers Public health workforce	Safety training Healthcare Acquired Infections	Self-care Expert Patient Programme Access	Access	Workforce/HR metrics monitoring Widening participation Leadership – BME
	Significant variability in the quality and safety of services	Access Public health workforce	Core commissions Modernising Healthcare Careers Medicines management	Productivity in Primary Care Trusts Flexible workforce in primary care Prescribing	Education research Mental health and social care development	Connecting for health Workforce plan and model
	Lack of upstream investment	Lifestyle/Equip Widening participation	Improvement skills Quality assurance Public health training integrated care commissions	Self-care EPP	Flexible workforce in primary care	Public health workforce development/network
	Buying things that don't work	Managing workforce development	Knowledge management Multi-professional CPD courses Learning networks Work with Higher Education Institutions regarding fitness for purpose	End of Life/Palliative care Hospice, rehabilitation	Workforce plan and model	Commissioner support Leadership
	Costs increasing faster than income	Public health	Competency based career framework Community nursing review	Urgent/Emergency/Unscheduled care Out-of-hours Care Long-term conditions	Reconfiguring services-Paediatrics/Obstetrics/Surgery/Accident and Emergency	Skills for Health project
	Lack of public confidence in services	Self-care Patient and public involvement	Patient and public involvement	Dental access	Reconfiguring services-Paediatrics/Obstetrics/Surgery/Accident and Emergency	Staff survey
	Complex systems difficult to navigate	Access workforce reflect systems of care, available/affordable/trained	18 Weeks Secondary to primary shift	Secondary to primary shift	Workforce planning	Care pathway workforce planning

How the workforce themes contribute to delivery of the 10 West Midlands wide project

5 Strategic Themes		10 West Midlands Wide Projects									
		Market development for lifestyle risk management services	Commissioner collaboration on upstream interventions	Towards consumer directed care	Real time patient experience feedback	Safest and highest quality services in the country	Systematic provision of information on quality of primary care services	Development of care pathways	A clear vision for each health economy	Workforce transformation	Productivity improvement project
FE	Patient and Public Involvement			X	X						
FE	Decreasing Health Inequalities	X	X						X		
IQS	Improving Quality and Safety of Services including Modernising Healthcare Careers					X			X	X	
IQS	Providing High quality Education					X		X		X	X
CCH	LTC & End of Life (including self-care Expert Patient Programme)	X		X				X			
CCH	Access (including 18 Weeks, Dentist, Cancer)			X				X	X		
S	Secondary to Primary Care Shift					X				X	
S	Large Scale Workforce Change					X			X	X	X
OffP	Leadership			X						X	X
OffP	Workforce Delivery Priorities									X	X
OffP	Commissioning and Quality Assurance	X		X		X				X	
OffP	Workforce Planning and Modelling	X					X	X	X	X	X

APPENDIX B

Secondary care workforce numbers (in Full Time Equivalents (FTE))

WOMEN'S SERVICES	FTE
Obstetrics and Gynaecology	471
Midwives	2,089
Other qualified nurses - maternity	483
Maternity support workers/ trained healthcare assistants - maternity	216
Other support to doctors and nursing staff	400

CHILDREN'S SERVICES	FTE
Paediatricians	609
Paediatric cardiology	60
Paediatric surgery	39
Sick children's nurses	1,585
Healthcare assistants - paediatrics	457

MENTAL HEALTH	FTE
Child and adolescent psychiatry	97
Forensic psychiatry	45
General Psychiatry	603
Learning disabilities	79
Old age psychiatry	71
Psychotherapy	15
Mental health nurses	3,879
Learning disability nurses	850

MENTAL HEALTH CONTINUED	FTE
Qualified Allied Health Professional (AHP)	25
Other qualified Scientific, Therapeutic and Technical (ST&T) staff	626
Support to ST&T staff	340
Other support to doctors and nursing staff	4,474
(includes mental health services provided by PCTs)	

SURGERY AND ANAESTHETICS	FTE
Anaesthetics (including intensive care)	1,050
Cardiothoracic surgery	84
General surgery	678
Neurosurgery	60
Ophthalmology	230
Oral & maxillofacial surgery	76
Oral surgery	11
Otolaryngology	185
Plastic surgery	74
Trauma and orthopaedic surgery	583
Intensivists	
Other qualified ST&T	635
Support to ST&T staff	220

DIAGNOSTIC SPECIALTIES	FTE
Chemical pathology	22
Clinical cytogenetics and molecular genetics	4
Clinical pharmacology and therapeutics	11
Clinical radiology	283
Histopathology	158
Medical microbiology and virology	55
Medical pathology	
Qualified AHP	1,205
Other qualified ST&T	245
Support to ST&T staff	1,167
Qualified healthcare scientists - life sciences/pathology	1,589
- Physiological Scientists	530
- Clinical Engineering and Physical Sciences	442
- Other	151

MEDICINE	FTE
Cardiology	209
Clinical genetics	12
Clinical neurophysiology	14
Clinical oncology	59
Dermatology	89
Endocrinology and diabetes mellitus	123
Gastroenterology	177

MEDICINE CONTINUED	FTE
Genito-urinary medicine	62
Geriatric medicine	241
Haematology	107
Immunology	5
Infectious diseases	23
Medical oncology	55
Medical ophthalmology	1
Neurology	76
Nuclear medicine	2
Occupational health	14
Palliative medicine	30
Public health medicine	87
Rehabilitation medicine	32
Renal medicine	98
Respiratory medicine	155
Rheumatology	108
Urology	111
Qualified AHP	1,133
Other qualified ST&T	49
Support to ST&T staff	491

EMERGENCY CARE	FTE
Accident and emergency consultants	441
Qualified ambulance service staff	1,761
Support to qualified ambulance staff	952

APPENDIX C

Commissioning Plan 2007/08

COURSES	Birmingham	Birmingham City University	Wolverhampton	Aston	Matthew Boulton College	Coventry	Worcester	Keele	Stafford	Other	TOTAL
	07/08	07/08	07/08	07/08	07/08	07/08	07/08	07/08	07/08	07/08	07/08
Nursing											
Dip HE Adult	27	483	413	-	-	193	177	100	164	-	1,557
BSc Adult	65	54	20	-	-	56	-	26	30	-	251
Dip HE Child	-	92	58	-	-	-	14	10	11	-	185
BSc Child	19	28	-	-	-	21	-	10	11	-	89
Dip HE Learning Disabilities	-	47	43	-	-	22	14	19	-	-	145
BSc Learning Disabilities	-	14	-	-	-	-	-	5	-	-	19
Dip HE Mental Health	-	142	69	-	-	44	48	33	57	-	393
BSc Mental Health	21	10	-	-	-	16	-	10	10	-	67
BSc Midwifery	-	50	42	-	-	21	40	20	15	-	188
BSc Midwifery Shortened	-	32	17	-	-	11	-	-	14	-	74
Nursing and midwifery total	132	952	662	-	-	384	293	233	312	-	2,968
Allied Health Professionals (AHPs) and Health Care Scientists											
BSc Podiatry	-	-	-	-	48	-	-	-	-	-	48
BSc Dietetics	-	-	-	-	-	45	-	-	-	-	45
BSc Occupational Therapy (full time)	-	-	-	-	-	127	-	-	-	-	127
BSc Occupational Therapy (part time) In-service	-	-	-	-	-	15	-	-	10	-	25
BSc Physiotherapy	86	-	-	-	-	81	-	81	-	-	248
MSc Physiotherapy (pre-registration)	22	-	-	-	-	-	-	-	-	-	22
BSc Speech and Language Therapy	-	87	-	-	-	-	-	-	-	-	87
BSc Therapeutic Radiography	-	28	-	-	-	-	-	-	-	-	28
BSc Diagnostic Radiography	-	102	-	-	-	-	-	-	-	9	111
Dip HE ODP	-	70	-	-	-	25	-	-	-	-	95
NVQ3 ODP	-	-	-	-	-	-	-	16	16	-	32
MSc Pharmacy	-	-	-	-	-	-	-	45	-	-	45
Physiological Measurement and Medical Technology	-	-	-	-	-	-	-	-	-	38	38
Dental Hygiene/Therapists BSc	25	-	-	-	-	-	-	-	-	-	25
Dental nurses (NVQ)	25	-	-	-	-	-	-	-	-	-	25
MSc Child Psychotherapy	-	-	-	-	-	-	-	-	-	5	5
PhD Clinical Psychology	21	-	-	-	-	16	-	-	10	-	47
BSc Audiology	-	-	-	31	-	-	-	-	-	-	31
MSc Audiology	-	-	-	-	-	-	-	-	-	1	1
BSc Biomedical Sciences	-	-	55	-	-	-	-	-	-	-	55
MSc Clinical Biochemistry	-	-	-	-	-	-	-	-	-	5	5
Clinical Cytogenetics	-	-	-	-	-	-	-	-	-	6	6
Clinical Molecular Genetics	-	-	-	-	-	-	-	-	-	6	6
Clinical Haematology	-	-	-	-	-	-	-	-	-	1	1
Clinical Immunology	-	-	-	-	-	-	-	-	-	1	1
Clinical Microbiology	-	-	-	-	-	-	-	-	-	1	1
Medical Physics	-	-	-	-	-	-	-	-	-	7	7
Rehabilitation Engineering	-	-	-	-	-	-	-	-	-	2	2
Paediatric Metabolic Biochemistry	-	-	-	-	-	-	-	-	-	1	1
AHPs and Health Care Scientists total	179	287	55	31	48	309	0	142	36	83	1170
GRAND TOTAL	**311**	**1,239**	**717**	**31**	**48**	**693**	**293**	**375**	**348**	**83**	**4,138**

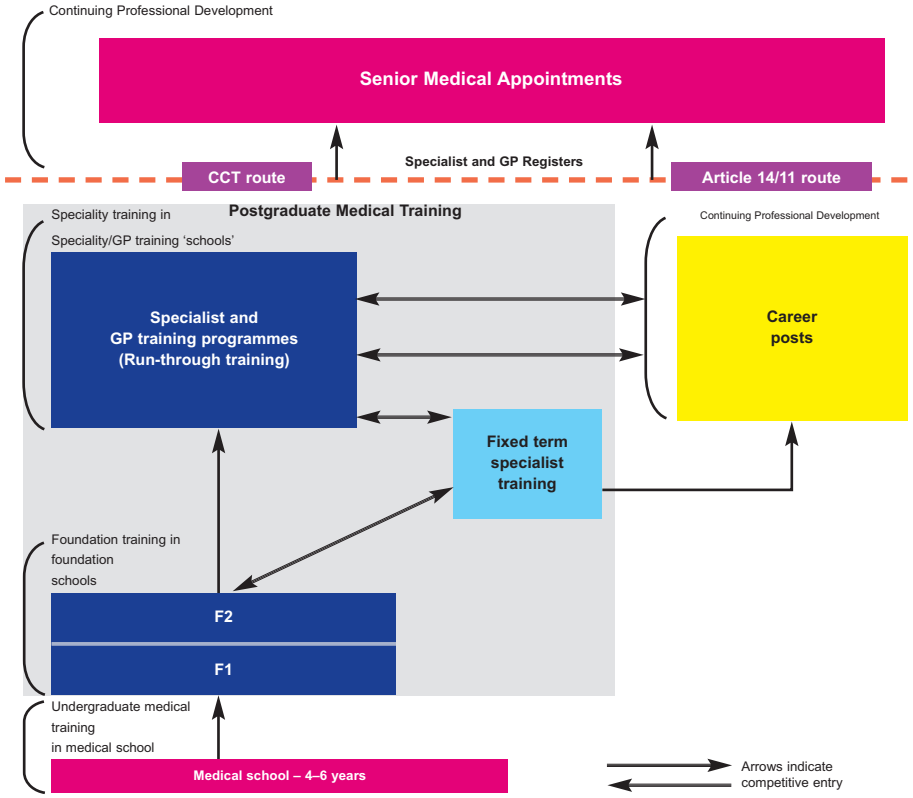
APPENDIX D

MMC Diagram

Modernising Medical Careers (MMC) framework diagram

'To develop a workforce of trained doctors working within clinical teams, who provide the majority of front-line medical management and care for patients'.

UK MMC Career Framework



The new model of medical education, introduced nationally in 2007, is supported by the development of national recognised, Postgraduate Medical Education and Training Board, competency based curricula. Full implementation of MMC will take up to five years and during that time there are a number of challenges which need to be effectively managed:

- integrating medical and non-medical workforce planning
- geographical equity across the West Midlands
- role of the Workforce Deanery
- assessment of trainees.

APPENDIX E

Advanced nursing model

The emerging advanced nursing model from the Nursing and Midwifery Council (2005) has proposed the following definition (which may include Masters level thinking when it is approved at the later end of 2007):

Advanced nurse practitioners are highly skilled nurses who can:

- lead in the provision of exemplar nursing practice
- carry out physical examinations
- use their expert knowledge and clinical judgement to decide whether to refer patients for investigations and make diagnoses
- decide on and carry out treatment, including the prescribing of medicines, or refer patients to an appropriate specialist
- use their extensive practice experience to plan and provide skilled and competent care to meet patients health and social care needs, involving other members of the healthcare team as appropriate
- ensure the provision of continuity of care including the follow-up visits
- assess and evaluate, with patients, the effectiveness of the treatment and care provided and make changes as needed
- work autonomously, although often as part of a health team that they will lead
- act as a leader of the team, make sure that each patient's treatment and care is based on best practice
- undertake research and development.

APPENDIX F

Multi - Professional Educations and Training (MPET) levy explained

The planning cycle for each of the three funding streams is as follows:

- **Non-Medical Education and Training Levy (NMET)** – a maximum 5 year planning cycle, with micro-modelling at a local level, based on demand profiles from available data.
- **Service Increment for Training (SIFT)** - a maximum 15 year planning cycle (inclusive of postgraduate training), with macro-modelling at a national level, based on policy drivers such as *The NHS Plan*, etc.
- **Medical and Dental Education Levy (MADEL)** - a maximum 10 year planning cycle, with macro-modelling at a national level with an approach based on floors (nationally funded) and ceilings (locally funded) posts.

Non-Medical Education and Training Funding (NMET)

NMET is specific funding to support education and training for all non-medical healthcare staff. This includes the provision of:

- education for all pre-registration education
- local support for trainees in clinical placements to attain skills development and consolidate learning
- education for all learning beyond registration for skills and competency development for qualified practitioners
- education for continuing professional development this is defined as attainment of education and training for all staff who support services provided by and for the NHS
- collaborative working with external agencies for example the learning and skills council for skills development for levels 1 to 4 to support the initiatives such as foundation degrees, NVQs and assistant practitioner programmes that are aligned to the career framework.

Service Increment for Teaching (SIFT)

SIFT funding supports the costs of providing clinical placements and facilities in trusts and general practices for teaching undergraduate doctors in years three to five of their education. SIFT funding is managed by a local committee which reports to NHS West Midlands.

The growth in the medical schools at Keele University and Warwick University and the large expansion at Birmingham Medical School now gives the region the opportunity to be self sufficient. The WD, working on behalf of local employers, will train and develop the medical workforce of the future to support the delivery of local priorities.

Dental SIFT (DSIFT) funding, which supports the costs of clinical teaching of dental undergraduates, has been devolved to the Strategic Health Authority with effect from 1st April 2007. The WD will work to ensure that dental undergraduate education programmes will train and develop the dental workforce of the future to support the delivery of local priorities for NHS dentistry and oral health improvement

The number of foundation doctors in the West Midlands will rise to 690 per year from the current level of 540. Table A below demonstrates the current undergraduate medical student population.

2007/8 SIFT undergraduate student population

TABLE A

West Midlands	Pre-Clinical Years		Clinical Years		
	Year 1	Year 2	Year 3	Year 4	Year 5
TOTAL	**491**	**704**	**682**	**657**	**619**

Medical and Dental Education Levy

The MADEL budget supports the postgraduate education of doctors, dentists and general practitioners. This budget provides trusts and Primary Care Trusts with subsidies for the costs towards doctors, dentists and GPs in training, as well as funding specific educational activities and initiatives.

Table B outlines the numbers of foundation doctors.

TABLE B

Training programme		Academic year	
	2005/06	2006/07	2007/08
Foundation year 1 (FY1)	480	517	597
Foundation year 2 (FY2)	393	531	540
Including:			
GP	7	85	85
Academic	1	8	9
Shortage	0	13	13
Public health	15	14	14

Notes:

The derivation of specialist FY2 posts is as follows:

FY2 GP posts	55%
FY2 academic posts	5%
FY2 shortage specialities	10%

Based on FY1 posts for the previous year.

This demonstrates the future educational commitments required to support postgraduate medical education.

APPENDIX G

Schools of Postgraduate Medical Education

The 11 postgraduate schools of medical education are:

- Anaesthesia, Critical Care and Emergency Medicine
- Dentistry
- General Practice
- Medicine
- Obstetrics and Gynaecology
- Paediatrics
- Pathology
- Psychiatry
- Public Health
- Radiology
- Surgery and Ophthalmology.

APPENDIX H

Breakdown of Modernising Medical Careers Programmes:

Core Streams: Brief Overview

1.0: Acute Care Common Stem (ACCS)

Two year core training for Emergency, Medicine, Acute Medicine and Anaesthetics. At present there is no run-through grade for Intensive Care Medicine therefore no numbers have been included. It is expected that a run-through grade will be introduced in 2008/09.

CORE PROGRAMME IN STEADY STATE – minimum of 18 per year

- competitive entry at Specialty Training (ST) 1
- allocation into run-through specialty at ST3.

2.0: Anaesthetics Run Through:

Two years core programme for anaesthetics

CORE PROGRAMME IN STEADY STATE – 40 per year

- competitive entry at ST1
- direct entry at ST2 for trainees who have completed ACCS.

3.0: Basic Surgical Training (BST)

Two year core training for general surgery, cardiothoracic surgery, trauma & orthopaedics, ear nose and throat (ENT), plastic surgery and paediatric surgery.

Exit after one year into urology and oral maxillofacial surgery.

CORE PROGRAMME IN STEADY STATE - 51 per year

- competitive entry at ST1
- themed and generic programmes at core level
- allocation into run-through specialty at ST3.

4.0: Core Medical Training

Two year core training programme to feed all medical specialties

CORE PROGRAMME IN STEADY STATE - 90 per year

- competitive entry at ST1
- allocation into run-through specialty at ST3.

5.0: Basic Neurosciences Training

Two year core programme split into 2 streams to feed neurology & neurophysiology (medical) and neurosurgery (surgical)

CORE PROGRAMME IN STEADY STATE - 12 per year

- competitive entry at ST1
- allocation into run-through specialty at ST3.

6.0: General Practice

Three year programme, ideally with 16 months in hospital specialties and 20 months in GP.

CORE PROGRAMME IN STEADY STATE - 345 per year

- competitive entry at ST1.

7.0: Paediatrics

Three year core programme for paediatrics

CORE PROGRAMME IN STEADY STATE - minimum 36 per year (minimum)

- competitive entry at ST1.

8.0: Obstetrics & Gynaecology

Two year core programme for obstetrics and gynaecology

CORE PROGRAMME IN STEADY STATE - 16 / year

- competitive entry at ST1.

9.0: Psychiatry Core Training

Three year core programme for all psychiatry specialties

CORE PROGRAMME IN STEADY STATE - minimum of 38 per year

- competitive entry at ST1
- allocation into run-through specialty at ST4.

10.0: Ophthalmology

Run-through programme for ophthalmology

CORE PROGRAMME IN STEADY STATE - 8 per year

- competitive entry at ST1.

11.0: Radiology

CORE PROGRAMME IN STEADY STATE - 18 per year

- competitive entry at ST1.

12.0: Public Health

CORE PROGRAMME IN STEADY STATE - 9 per year (medical & non-medical)

- competitive entry at ST1.

13.0: Pathology Groups

Run through programme from ST1 in each specialty.

- competitive entry at ST1
- histopathology - current output of 7 per year, but model suggests growth to an output of 12 per year
- microbiology - current output of 3 per year, but model suggests growth to an output of 5 per year
- chemical pathology - current output of 1 per year, but model suggests growth to an output of 2 per year.

APPENDIX I

Range of Pre-registration Education Commissions

NURSING AND MIDWIFERY
Dip HE Adult
BSc Adult
Dip HE Child
BSc Child
Dip HE Learning Disabilities
BSc Learning Disabilities
Dip HE Mental Health
BSc Mental Health
BSc Midwifery
BSc Midwifery Shortened

ALLIED HEALTH PROFESSIONALS AND HEALTHCARE SCIENTISTS
BSc Podiatry
BSc Dietetics
BSc Occupational Therapy (full time)
BSc Occupational Therapy (part time in-service)
BSc Physiotherapy
MSc Physiotherapy (pre-registration)
BSc Speech and Language Therapy
BSc Therapeutic Radiography
BSc Diagnostic Radiography
Dip HE Operating Department Practitioners
MSc Pharmacy
Physiological Measurement and Medical Technology
Dental Hygiene/Therapists BSc
Dental Nurses NVQ
MSc Child Psychotherapy
PhD Clinical Psychology
BSc Audiology
MSc Audiology
BSc Biomedical Sciences
MSc Clinical Biochemistry
Clinical Cytogenetics
Clinical Molecular Genetics
Clinical Haematology
Clinical Immunology
Clinical Microbiology
Medical Physics
Rehabilitation Engineering
Paediatric Metabolic Biochemistry

APPENDIX J

Student Population 2007/08

	Birmingham	Birmingham City University	Wolverhampton	Aston	Matthew Boulton College	Coventry	Worcester	Keele	Stafford	Other	TOTAL
Nursing and midwifery											
Dip HE Adult	74	1,269	1,148	-	-	505	394	285	394	-	4,069
BSc Adult	154	159	103	-	-	101	-	61	80	-	658
Dip HE Child	-	246	161	-	-	-	42	33	25	-	507
BSc Child	48	82	1	-	-	56	-	37	33	-	257
Dip HE Learning Disabilities	-	108	85	-	-	54	16	29	-	-	238
BSc Learning Disabilities	-	5	-	-	-	-	-	8	-	-	67
Dip HE Mental Health	20	373	233	-	-	151	95	82	145	-	1,099
BSc Mental Health	34	29	-	-	-	16	-	20	29	-	128
BSc Midwifery	-	135	101	-	-	63	92	69	37	-	497
BSc Midwifery Shortened	-	24	12	-	-	5	-	-	-	-	41
Nursing and midwifery total	330	2,418	1,844	0	0	951	639	624	743	0	7,549
Allied Health Professionals and Healthcare Scientists	-	-	-	-	-	-	-	-	-	-	
BSc Podiatry	-	-	-	-	98	-	-	-	-	-	98
BSc Dietetics	-	-	-	-	-	126	-	-	-	-	126
BSc Occupational Therapy (full time)	-	-	-	-	-	354	-	-	-	-	354
BSc Occupational Therapy (part time in-service)	-	-	-	-	-	37	-	-	-	-	37
BSc Physiotherapy	280	-	-	-	-	274	-	-	-	-	554
MSc Physiotherapy (pre-registration)	37	-	-	-	-	-	-	-	-	-	37
BSc Speech and Language Therapy	-	275	-	-	-	-	-	-	-	-	275
BSc Therapeutic Radiography	-	55	-	-	-	-	-	-	-	-	55
BSc Diagnostic Radiography	-	255	-	-	-	-	-	-	-	-	255
Dip HE Operating Department Practitioners	-	71	-	-	-	38	-	20	38	-	167
NVQ3 Operating Department Practitioners	-	-	-	-	-	-	-	-	-	-	0
MSc Pharmacy	-	-	-	-	-	-	-	45	-	-	45
Physiological Measurement & Medical Technology	-	-	-	-	-	-	-	-	-	34	34
Dental Hygiene/Therapists BSc	-	-	-	-	-	-	-	-	-	67	67
Dental Nurses (NVQ)	-	-	-	-	-	-	-	-	-	50	50
MSc Child Psychotherapy	-	-	-	-	-	-	-	-	-	15	15
PhD Clinical Psychology	71	-	-	-	-	45	-	-	28	-	144
BSc Audiology	-	-	-	103	-	-	-	-	-	-	103
MSc Audiology	-	-	-	-	-	-	-	-	-	2	2
BSc Biomedical Sciences	-	-	-	-	-	-	-	-	-	55	55
MSc Clinical Biochemistry	-	-	-	-	-	-	-	-	-	12	12
Clinical Cytogenetics	-	-	-	-	-	-	-	-	-	18	18
Clinical Molecular Genetics	-	-	-	-	-	-	-	-	-	14	14
Clinical Haematology	-	-	-	-	-	-	-	-	-	-	0
Clinical Immunology	-	-	-	-	-	-	-	-	-	2	2
Clinical Microbiology	-	-	-	-	-	-	-	-	-	2	2
Medical Physics	-	-	-	-	-	-	-	-	-	12	12
Rehabilitation Engineering	-	-	-	-	-	-	-	-	-	3	3
Anaesthetics Practitioners	2	-	-	-	-	-	-	-	-	-	2
Paediatric Metabolic Biochemistry										1	1
Allied Health Professionals and Healthcare Scientists	390	656	0	103	98	874	0	65	66	287	2,539
GRAND TOTAL	**720**	**3,074**	**1,844**	**103**	**98**	**1,825**	**639**	**689**	**809**	**287**	**10,088**

APPENDIX K

Contracting and Commissioning Key Performance Indicators

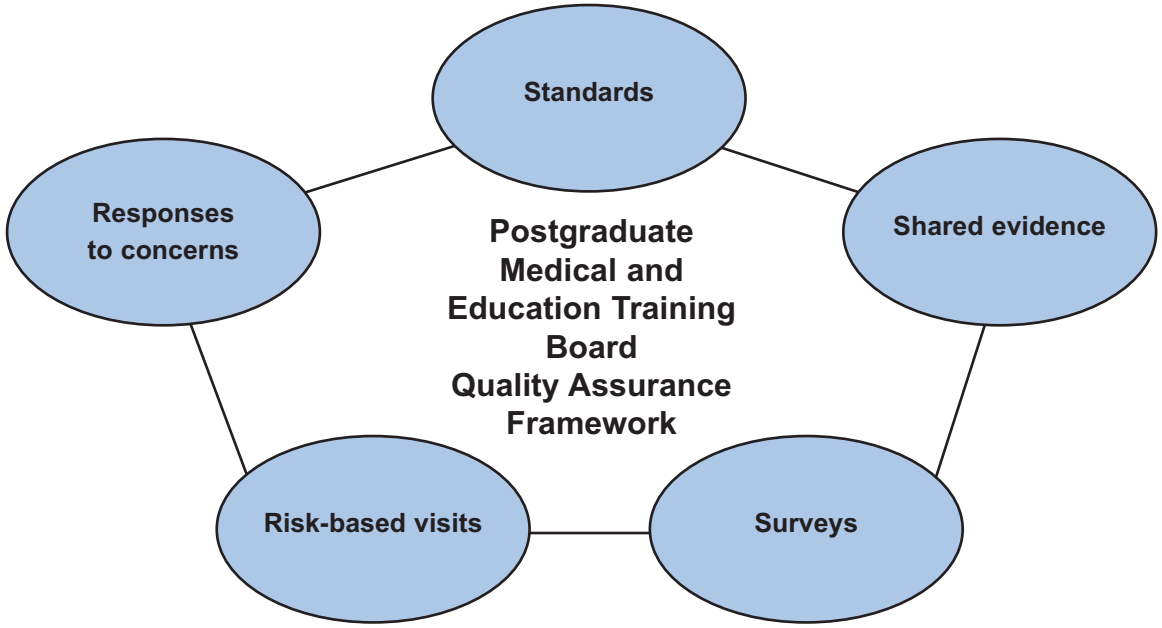
The Workforce Deanery (WD) will deliver on the key performance indicators some of which are identified in the Service Level Agreement with the Department of Health. The WD will:

- develop plans for the delivery of services to patients in long-term workforce need and local financial plans
- implement contracts based on the national benchmark price for the remaining 20% of provision
- produce guidance and timelines for non-medical contracts in place to demonstrate best value and guidance
- review and implement Medical and Dental Education Levy (MADEL) contracts with all providers, ensuring that appropriate evaluation mechanisms exist
- review and implement service level agreements for all providers of non-medical smaller professions
- produce plans to demonstrate that the numbers of foundation year 1 and 2 placements available match medical school output with nationally agreed headroom
- work with local partners to achieve appropriate numbers of trained non-medical prescribers as identified
- produce figures on the breakdown of training programmes by specialty to show a progression towards agreed increases in community based training reflecting national and local workforce planning predictions
- produce plans that determine how we intend to improve recruitment and retention in shortage specialties
- produce guidance and local criteria to ensure that all approved academic fellows are funded based on nationally agreed rates
- produce guidance and local criteria to ensure that all approved clinical lecturer costs are funded based on nationally agreed rates
- produce guidance for local trusts/PCTs to determine the Agenda for Change (AfC) pay scales for trainees embarking on non-medical healthcare programmes
- provide analysis of data collated to appropriate quality teams to ensure evidence based decision making to enhance provision and to determine NHS/exceptions
- scope and address the AfC implications in relation to public health trainees
- through appropriate revalidation panels and contracting processes work collaboratively with clinical partners and education providers to ensure that current curricula for all healthcare education programmes commissioned for non-medical and medical healthcare professionals will embed core skills as a minimum standard
- work collaboratively with colleagues to realise the commissioning intent for the joint planning and co investment planning framework with the Learning and Skills Council
- produce and implement contracts for all postgraduate and foundation schools
- produce and implement an audit framework for GP education
- develop appropriate systems/structures for faculty development
- continually engage in research and development activity to enhance provision.

APPENDIX L

Medical Quality Assurance Model

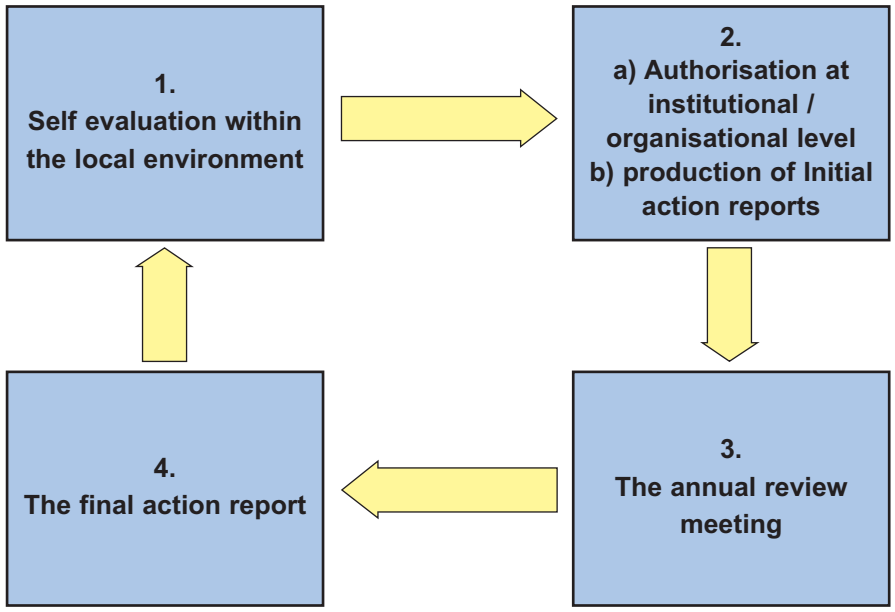
The new medical quality assurance framework will consist of the following elements:



APPENDIX M

Non-medical quality monitoring process

The process of quality monitoring and enhancement incorporates four elements:



The whole process is a 360° approach based upon exception reporting. Each of the Higher Education Institutions (HEIs) contracted with are either using this approach or are moving towards this approach.

To self evaluate all clinical placements, HEIs assess themselves against interim standards that have been developed by Skills for Health. During summer 2007, the Workforce Deanery (WD) will hold annual reviews with:

- University of Birmingham
- University of Central England
- University of Wolverhampton
- Aston University
- Matthew Boulton College.

During the winter period of 2007/08, the WD will hold annual reviews with:

- Coventry University
- University of Worcester
- Keele University
- Staffordshire University.

APPENDIX N

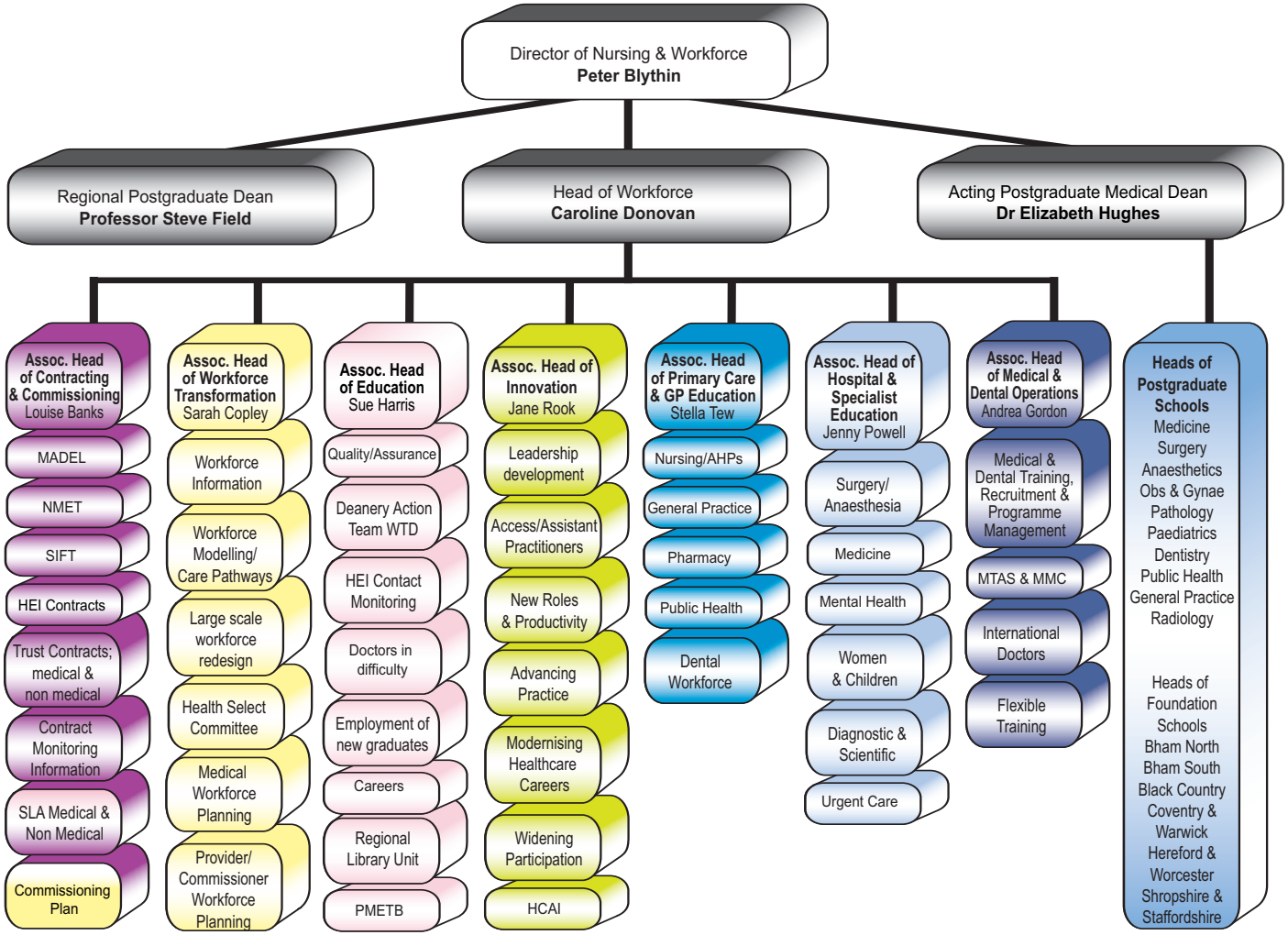
Quality Assurance Key Performance Indicators

The Workforce Deanery (WD) will deliver on the Key Performance Indicators, some of which are identified in the Service Level Agreement with the Department of Health. The WD will:

- implement new quality assurance frameworks as they arise nationally and interpret into a local context with our partners and key stakeholders
- ensure that robust arrangements are in place for medical and non-medical provision to monitor the quality of training against quality assurance agreements, Skills for Health (SfH), General Medical Council/General Dental Council standards and improve student satisfaction with clinical training and fitness for purpose of trainees completing training
- ensure that contracts and service level agreements reflect the support required by students on clinical placements
- ensure that sufficient medical and dental placements are available for local medical and dental students
- ensure that dental placements are funded based on the nationally agreed dental placement rate
- ensure that quality management arrangements are in place to meet Postgraduate Medical Education and Training Board (PMETB) standards for local quality control and all PMETB/SfH mandatory conditions can be met
- ensure that arrangements are in place (either directly or via higher education partners and others) to monitor the satisfaction of students and trainees and the satisfaction of employers with output from training
- continue collaboration with local trusts and PCTs to determine the risks associated with the implementation of Working Time Directive and to identify processes to reduce the financial risk to organisations
- facilitate and support the development of consistent, coherent and strategic approaches to clinical placement support
- continue collaboration with local trusts and PCTs to determine risks identified through library accreditation and facilities visits
- identify solutions to reduce any financial risks to organisations at the same time as increasing local support and satisfaction for students and trainees
- continue to develop joint strategies with Higher Education Institutions for the management and reduction of attrition for each pre registration profession
- develop a robust process for monitoring and analysis of the Record of In-Training Assessment process.

APPENDIX P

Workforce Deanery Structure



INVESTING FOR HEALTH

A Strategic Framework for the West Midlands

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