

Primary Care Trust Workforce Planning and Development

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The software accompanying this book can be downloaded free of charge from www.healthcareworkforce.org.uk. If you have problems accessing the software then please e-mail the author: k.hurst@leeds.ac.uk

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Preface

Primary and community care managers face the same workforce planning and development challenges as their hospital counterparts. They wrestle with both sides of the workforce planning and development (WP&D) equation: what size and mix of staff are needed to meet the locality's demands on one side, and once recruited how are staff retained and developed on the other. However, one large difference between community and hospital managers' efforts is that the former do not have the breadth and depth of approaches open to hospital managers (80 methods and related data at the last count). Consequently, information and algorithms to help primary care trust (PCT) managers plan and develop their teams are lacking. Any PCT manager faced with historically-based establishments, which at best are irrational and at worst fail to meet the locality's demands and generate inequitable workloads, would be forgiven for thinking he or she was the workforce planner Cinderella. However, a glass slipper is to hand.

What compound PCT managers' problems are the NHS modernization programmes, which call for new ways of doing things (such as Evercare and Advanced Access), against which they are regularly assessed. Moreover, accounting for almost three-quarters of PCT expenditure, staffing is not cheap and mistakes are not only costly to rectify but also subject to the 'oil tanker syndrome' where the effect of reversing the ship's propellers takes a protracted length of time before the vessel decelerates. Additionally, some healthcare professionals know they are a scarce resource and can choose when and where to work. Unbalanced workforce planning generates a vicious cycle; rising demand from primary and community care patients increases the workload for an already stretched workforce suffering long-term vacancies (up to 14%). Little wonder that employees move on. Less anecdotally but equally sobering, trust managers in one of the author's fieldwork sites were replacing one in six staff each year, which was thought to be workload stress-related – hardly conducive to good quality and continuous patient care.

It's only fair, therefore, that PCT managers are given the tools do their job: so now the good news. Agencies supporting and guiding managers, such as the Department of Health (DH), Office for National Statistics

(ONS) and the Healthcare Commission, have systematically collected and summarized a comprehensive list of WP&D variables and data (90 at the latest count). Moreover, once permission to copy these variables and data is obtained (a straightforward process), WP&D variables and data are easily called up by computer. Users will notice that information is almost always organized by co-terminus PCT and Local Authority, incredible foresight for which someone deserves an award. Consequently, all the tumblers fall into place, opening a door to a WP&D solution-rich vault. One task remained, however, that of pulling together the PCT-based data from several agencies into one location, organizing them, and writing guidance material that ‘walks’ managers through the information and options.

Accompanying this book (the guide), therefore, is software (see later for the URL), which is the vault. Readers are introduced to the PCT WP&D software’s nature and utility via a case study PCT. They should find it easy to replace the case study trust’s data with their own and draw similar or different WP&D conclusions and recommendations. The software’s structure means that managers can benchmark their locality’s demographic, socio-economic, morbidity, mortality, activity, performance and staffing data with PCTs in the same socio-economic band. They also can compare their trust’s state-of-play with 3-star PCTs while other, equally ingenious comparisons are possible.

Also included in this book is a detailed annotated bibliography dedicated to PCT WP&D. Publications are referenced in the usual way but additionally a précis is attached so that readers can judge the material’s merits before following-up key issues at the source. The annotated bibliography uses key words such as community patient dependency. Consequently, readers should be able to capitalise on these three reserves. It is intended to keep the software fresh so that managers can access state-of-the-art information thereby extending the book’s shelf life immeasurably.

Despite the composite PCT WP&D database’s value, the variables’ and data’s implications can take time and effort to unravel. For example, should trust managers use the Census population or GP list size as the denominator for estimating the number of staff? Workshops, therefore, are being organized to help PCT managers explore the software and book. A helpline is also open for readers and software users (helpline and workshops are free and queries should be directed to the author using the e-mail address below). What only remains, therefore, is to wish readers successful forays into the world of primary and community WP&D.

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CHAPTER ONE

Introduction, background and context

There can be little doubt about the importance of National Health Service (NHS) workforce planning – especially staff demand and supply – not least because health and social services employ one in ten people from the UK working population and staff costs account for two-thirds of NHS expenditure (Kendall and Lissauer 2003). Although these data relate to the whole NHS, this book focuses on the primary and community-care workforce planning and development.

Primary care and community care are defined in many ways. Their main distinguishing features are the setting in which care is given and the professionals who provide the service. Primary care is the first-contact, continuous and coordinated care of individuals. Community care, on the other hand, is linked to a much wider social network. Primary and community care, therefore, are not synonymous with general practice, but they do subsume it (Mackenzie and Ross 1997). Consequently, primary care and community care are distinguished in this book because the service context influences workforce planning and development.

Primary and community care are said to have six cardinal principles (Department of Health or DoH 1993a, 1993b, 2000a, 2001a, 2002b; Hodder 1995; Richards et al. 2000; Hyde 2001):

1. Safe, effective, efficient, devolved, open and accountable community services.
2. Accessible and appropriate services designed to meet community and individual needs, which include a range of treatment choices.
3. Access to named, skilled practitioners.
4. Services that do not discriminate between any individual or group.
5. Twenty-four-hour seamless care among primary, community and secondary settings.
6. Owing to the remote and isolated working, good employment practices that, for example, minimize workplace violence.

The intention behind these six principles is to help vulnerable people live independently in their homes or other community settings. They should

raise community patients' quality of life while at the same time reducing costly, institutional care (Anonymous 1994). Maintaining these cardinal principles through efficient and effective community and primary care workforce planning and development have become a primary care trust (PCT) priority in recent months (DoH 2001a; Bosma and Higgins 2002; Tobin 2002).

Workforce planning and development definitions

Initially, Department of Health policy documents indicated that primary and community care workforce planning and development were about predicting the future demand for different types of practitioners while seeking to match supply with the demand for staff. Later the Department of Health (DoH 2001a, p. 12, 2002b, para 1.2) presented a more sophisticated definition of workforce planning and development:

[workforce planning and development is a] dynamic process that aims to ensure PCTs have the right people with the right skills in the right place at the right time. This means the processes used to determine the workforce of today and the future needs to be a rigorous one, using knowledge held within an organisation supported by techniques that assess the future.

The premises on which the Department of Health's (2001a, p. 15) rationale for this definition are based are:

Increasing the number of staff training for an NHS career is vital if we are to increase the capacity of the NHS and its ability to deliver faster and better care for patients. It is not by itself enough to deliver the increases in staff numbers we need, particularly in the short term. We shall, therefore, intensify our drive to attract people to healthcare careers, to retain them when they have joined the NHS and to encourage those who have left to return to practice, and we shall step up our plans for international recruitment to meet demands in the short term before an increased number of staff come through training.

The relationship between the demand for staff and their supply is underlined in this quotation. An earlier Department of Health report (2000b) indicated a growing concern with NHS and higher education staff efforts to address workforce demand and supply. Workforce planning, the staff felt, should be embedded in the NHS culture which ought to lead to efficient and effective workforce planning and development. These are needed not only to reduce short-term staffing solutions but also to meet the demand for future health-care needs. Workforce planning and development can be represented as shown in Figure 1.1 (DoH 2000a).

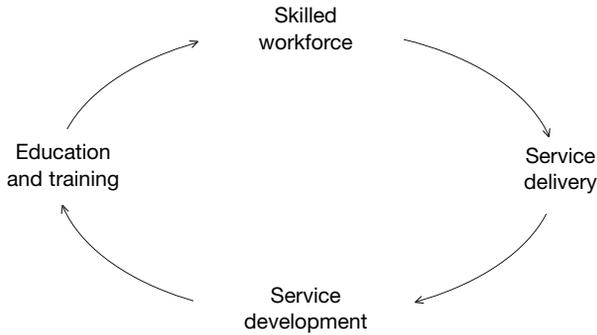


Figure 1.1 Workforce planning and development.

Driving and restraining forces

Without doubt primary and community care staff have an important NHS role. Despite their importance, historically, low levels of spending and understaffing (compared with Europe, for example) meant that too few workers struggled to provide care in challenging circumstances. Moreover, work pressures increased relentlessly and, coupled with a better informed and less deferential public, meant that practitioners faced even greater challenges (Kendall and Lissauer 2003). Researchers such as Lewis and deBene (1994) and Latimer and Ashburner (1997) believed that primary and community care success depended on services meeting the following challenges:

- Primary and community carers are capable of raising their contribution.
- Health services are based in the right care setting – caring rather than curing services are more appropriate in the community than in hospitals and community patients are capable of self-care. Similarly, health promotion is more suited to primary care.
- Increasing hospital throughput and transfer of services between health and social care mean that secondary care efficiency and effectiveness will suffer if primary and community care staff do not raise their game.
- The biomedical model alone cannot meet a modern primary and community care agenda.
- Learning about a population, especially inner cities, whose health needs are unmet.

One positive feature of recent health-care policy and practice developments is that, after years of chronic under-funding, resources are being moved from acute to primary and community care (Latimer and Ashburner 1997). Nevertheless, a number of driving and restraining forces govern PCT management and practice (DoH 2002b) (Table 1.1).

Table 1.1 Driving and restraining forces that govern primary care trust management and practice

Driving	Restraining
Increasing staff autonomy	Extended role limitations
Prevention and caring as important as curing	Recruitment and retention
Hospital efficiency and effectiveness	Competing for resources
Local population health-care needs	Inverse care law
Policy developments	Sparse workforce planning and development data and methods
Patient choice	
Continuous quality improvement	
New General Medical Service contract	Traditional professional groups

PCT managers have varying degrees of control over these drivers. Moreover, only 9% of managers in a recent survey felt that their workforce planning and development efforts were supported by their superiors and subordinates (Bosma and Higgins 2002). One reason for the lack of support and confidence is that PCT managers, unlike their hospital counterparts, do not have the variety of methods for estimating appropriate size and mix of health-care teams that are available to their hospital counterparts (Hurst 2003). Most of the primary and community care workforce planning literature is anecdotal and only a handful of systematic, empirically determined methods are available (Syson-Nibbs 1997; Richards et al. 2000; Tobin 2002). In addition, few national community and primary staffing models exist and, of the broader ones out there, none accommodates the implications of recent policy and practice developments such as the following:

- National Service Frameworks (NSFs)
- Modernization programmes, such as the Changing Workforce Programme, which address pay, learning, personal development and professional regulation
- Liberating the Talents
- National Primary Care Development Team initiatives
- New General Medical Service contract and Personal Medical Service pilots.

These more recent policy and practice initiatives are guaranteed to shape the future primary and community care workforce (Buchan and Edwards

2000; DoH 2002b, 2002c; NHS Workforce Taskforce et al. 2002) because of the following:

- Widening patient choice
- Strengthening patient voices
- Local strategies for tackling inequalities
- The availability of round-the-clock primary and community care
- Ageing population and increasing chronic illness
- Improving interfaces between primary and secondary care
- Increasing secondary care in the community
- Increasingly technological care and service innovations such as NHS Direct and walk-in centres
- One-service approach to health and social care
- Re-designing roles and tasks and broadening staff mix
- Extending practitioner roles
- Strengthened leadership at the coalface
- Focusing on prevention.

Clearly, future workforce planning and development endeavours in the primary and community care sectors have to address a range of management and clinical issues.

Workforce planning and development method issues

Different workforce planning and development needs and approaches make it difficult for managers to look across primary and secondary care settings in a uniform way. Moreover, people's need for care is not always neatly divided into primary and secondary care domains, and staff should not be categorized in this way either. Unfortunately, this may mean that fragmented and uniprofessional approaches to workforce planning and development remain despite recent attempts to improve integration. Dissonance is heightened when Department of Health policy makers (2000a, 2002c) believed that primary and community care workforce planning:

- failed to build research and development into planning, although, as we shall see later, the breadth and depth of workforce-related data are strong, there is a shortage of empirically determined techniques for modelling them
- has inconsistent focus on staff mix
- managers were not motivated to improve their strategies until recent health policy documents and guidance emerged and, consequently, a willingness to change followed.

Recent major policies such as *Liberating the Talents* (DoH 2002c) try to encapsulate workforce planning driving and restraining issues, and integrate planning and development, within three new categories of work:

1. First contact: acute assessment, diagnosis, treatment, care and referral.
2. Continuing care: NSF-oriented rehabilitation and chronic disease management.
3. Public health: promotion and protection that improve health and reduce inequalities.

Implementation of this framework may give PCT managers an even greater workforce planning and development challenge because specific data tend to be organized along traditional workforce lines, i.e. health visiting, district nursing, community therapists, etc. Currently, the literature reveals four broad primary and community care workforce planning and development categories:

1. Professional judgement or manager–practitioner consensus approaches
2. Population and health needs based
3. Caseload analysis
4. Acuity or workload methods that use patient classification and activity times.

The first method, professionally judging the level of staffing in the context of safety and quality of primary and community care, is identical to the inpatient counterpart of the same name (Waite 1986). A team of locally knowledgeable managers and practitioners decide a care team's size and mix. The method is quick and inexpensive but results are often labelled subjective because there are few empirical underpinnings. The second method, health needs analysis, uses:

- demographic and biographic variables such as population density and age (Coffey undated; Piggott 1988; DoH 2002a)
- socioeconomic data such as deprivation and housing (Piggott 1988; Ebeid 2000)
- morbidity and mortality data such as General Health Questionnaire (GHQ) scores (Durrand 1989).

These variables and data provide a good base from which to determine the size and mix of teams. Obviously, to make this approach workable, staffing ratios such as the number of district nurses per head of population are also required. The method's value lies in its staffing algorithms which reflect, for example, a locality's deprivation or geographical spread. In later chapters, relevant data for each PCT are provided for the reader.

The third or caseload analysis method, which includes data such as the number of contacts, is another important and useful approach to estimating the size and mix of care teams (Waite 1986; Luft 1990; Frame and O'Donnell 1996). However, merely attaching care times to activities and using the results are not enough (Coffey, undated). Drennan (1990a) explains how invaluable dependency and workload data can be. Later, however, she showed that similar-sized caseloads did not always generate the same amount of work, i.e. caseload size did not always equate to workload (Drennan 1990b). Moreover, Buchan (1999) explained how stress-related job dissatisfaction is influenced by workload, which implies that getting caseload right is imperative in these days of staff and skills shortage. In short, these data are also useful for improving recruitment and retention.

Several authors indicate the information needed for caseload analysis although information will vary depending on the professional group (Dobby and Barnes 1987a; Barret and Hudson 1997; Audit Commission 1999; Dewis 2001):

- service objectives and referral criteria
- new referral numbers
- number and type of assessments and reassessments
- essential and non-essential work
- community patient age distribution
- direct and indirect care
- clerical and administrative work
- travelling
- time spent on the practitioner's caseload.

Dewis (2001) recommended that model caseloads be built from these data before practice teams are benchmarked against them. Once these data are available, it just remains either to modify policies and procedures or to make staffing adjustments. Consequently, another important application of the caseload approach is to modify a practitioner's workload to establish equity as well as reviewing the number and mix of staff.

There is overlap between the caseload analysis approach and the fourth workforce-planning category – the dependency-acuity method. The latter, however, aggregates data from a number of localities (Audit Commission 1999). Goldstone et al. (2000) developed and tested the dependency-acuity method extensively in the community, which Goldstone and his colleagues had started 20 years earlier (Goldstone and Worrall 1980). They concluded that two systematically collected data-sets – patient characteristics and staff activity – help primary and community care managers.

The dependency–acuity protocol is clear and logical:

- Each patient is assigned to a dependency group that ranges from one (minimum) to four (maximum reliance on carers).
- To accommodate domestic variables, weighting is added to the dependency scores for community patients with below-average family support.

Dependency and the corresponding amount of nursing effort (in minutes) are entered into a simple algorithm given in Goldstone et al. (2000). The advantage of community dependency–acuity systems is that they offer a standardized approach that avoids duplicating effort in other PCTs. The validity and reliability of instruments can easily be tested (compared with, for example, health needs assessment measures). Consequently, the outcomes are operationally and strategically valuable data (Drennan 1990b; Goldstone et al. 2000).

Unlike hospitals, the community is never ‘full’, which makes workload measures even more important to ensure workload equity. Consequently, primary and community care dependency–acuity data have several valuable functions (Coffey, undated; Fitton 1984b; Luft 1990; Frame and O’Donnell 1996):

- Tracking and comparing dependency and workload over time and between areas
- Equalizing, rationalizing and prioritizing work
- Highlighting mismatches between ideal and actual staffing
- Indicating informal carers’ contribution to patient care
- Encouraging a common language between commissioners and practitioners
- Assisting decision-making about the size and mix of community teams
- Informing joint working with social services.

Dewis (2001) criticizes the primary and community workforce-planning armoury because:

- retrospective and aggregated data are less valuable
- dependency ratings can be subjective and inflated
- non-standard community patient dependency scoring systems are used
- data processing errors are not uncommon.

Given the lack of consensus and workforce planning and development’s controversial nature, a multifaceted approach ought to be used.