Avon, Gloucestershire and Wiltshire

Strategic Health Authority

Workforce Development Confederation

Long-term Conditions: Key Issues for Workforce Planning

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EXECUTIVE SUMMARY

This report has been commissioned to support the Local Delivery Plan with innovative service and workforce approaches for people with long-term conditions. The purpose is to highlight issues for a workshop on this topic.

The NHS attention has firmly swung towards the identification and active management of people with long term conditions. From nowhere, there is now a general recognition that people with chronic illnesses do and will create the largest demand on health and social care resources and that the existing systems are inadequate to deal with their current, let alone the future needs. A multiplicity of pilots is underway that have in common:

- the desire to become patient rather than disease centred;
- a re-assessment of the value of high quality general practice and primary care teams
- better and earlier diagnosis and supported self management;
- active communication and analysis to identify of the people at risk of hospital admission;
- a redesign of roles to encompass the diagnostic, assessment and treatment skills of GPs, community nurses and social workers together with the coordination and communication skills of key workers more familiar to mental health services;
- the improved use of IT and the interrogation of databases for call and recall and monitoring
- improved medicines management and rationalization of prescriptions
- a recognition that our care for people in their last years of life is inequitable – people with cancer receive better holistic care than those with non-malignant but fatal disease.

? The questions are, *will all people with long term conditions benefit from the new arrangements or just those with repeated hospital admissions? How feasible is it to mainstream all the lessons from the pilots? Do the resources exist to mainstream them across all the PCTs in Avon, Gloucestershire and Wiltshire?*

Key assumption

The most important underlying assumption made by those who have led the pilots is that you have all the resource you need in the system to manage long term conditions well, they just need to be used differently.

The four elements of this resource are:

- Patients and their families
- Existing NHS, voluntary sector and local authority staff: their knowledge, experience, ideas and energy
- The evidence-base of what is known to work and what does not. For example, there is good evidence to support efficacy of asthma action plans, yet many people with asthma do not have personal action plans and have uncontrolled asthma.
- Good practice examples that show things can be done more effectively and efficiently: e.g. Kaiser Permanente's work on tiered care; case management of frail older people by United Healthcare's Evercare scheme and Castlefields' case management; Pfizer Healthcare Solutions' and Serum's telephone interventions; Joanne Lynn and RAND's work on end of life care.

This paper highlights the issues for discussion, and then provides the background to these issues.

THE ISSUES FOR DEBATE

Belief and culture

- ? Is there a general belief amongst the leaders in the AGW health community that there are sufficient resources? If not, why not?
- ? What is your aim in improving the management of long term conditions – reducing hospital admissions and expenditure, or improving quality of life for all people with long term conditions, even if there is no financial gain, or both
- ? Where is the balance of your attention across Tier 1, 2 and 3 of the Kaiser triangle
- ? Are your services organised around diagnosis or patient need: typically, health services have been organised around diagnosis, but many people either do not have one, or have multiple diagnoses
- ? How are patients and their families being systematically involved in designing services, in supporting other people with long term conditions, monitoring services and monitoring their own condition
- ? Can each PCT identify at least one patient who is actively engaged in designing services
- ? Is there a desire to ensure services are sufficiently accessible and available for people with long term conditions; that is in the funded community services
- ? How is health information made available systematically to people to prevent the development of chronic illnesses – how are health promotion activities such as smoking cessation and public health activities coordinated
- ? How can health promotion be built into more roles: what scope does the new competency framework announced in Choosing Health provide
- ? Is general practice nurtured
- ? Are people treated as individuals who are due continuity of care throughout the potentially lengthy period of their life when they are disabled by their illness
- ? Are the patients with needs at "tier 2" of the Kaiser triangle going to benefit from improvements to their quality of life, or do they have to wait until they are sicker
- ? Is every professional who works with people with long term conditions able to support them in their last years of life and deal with the inevitable uncertainty
- ? Do the families of people with long term conditions get properly supported? Does anyone make contact with the bereaved carer after a death?
- ? Do you have a systematic way of finding, developing and supporting clinical champions
- ? Are you providing equity of opportunity of training and of posts for AHPs when developing new and extended roles, or is there a preference given to nurses
- ? Does the system acknowledge that managing confusional states and cognitive impairment will be part of the job and are professionals trained and supported to deal with this and the problems of decision-making when a person cannot make their own decisions
- ? Does everyone have permission to test improvements or is there a risk-averse culture
- ? Is there a no-blame environment and behaviours
- ? Are all the potential roles of doctors and particularly GPs acknowledged as well as the opportunities of changing roles for nurses: that is, does the right balance exist between generalist and specialist roles
- ? Are the non-specialist community posts such as district nursing, senior I

physiotherapists, perceived as interesting jobs with prospects of career progression

- Are you ready for extending prescribing beyond nurses and pharmacists
- Do your interests in role design, knowledge management, training and mentoring span agencies including voluntary, local authority (education, recreation, social services, environmental health) and private health sector partners (e.g. nursing and residential care homes)

Knowledge management

- How will you ensure that new evidence about the causes of chronic disease and effective primary and secondary prevention interventions is spread systematically to the workforce (and equally, evidence about ineffective interventions is acted upon, and those interventions stopped)
- Do the skills exist locally to introduce personally held records (electronic or print)
- Interrogating IT systems caused a slowdown in the Evercare implementation, do sufficient skills exist to interrogate clinical systems
- How are you supporting the development of communities of practice to enable fast and effective knowledge sharing
- Do the skills exist to develop and introduce shared diagnosis and management templates between general practice, community and home care and secondary care
- How are you supporting the sustainable exchange of knowledge between specialists (particularly consultants) and generalist nurses and therapists who are being trained to take on specialist roles in the community

Training and mentoring

- How are you spreading the Expert Patient programme systematically – are you learning from best local practice where there are active programmes
- How will the right health promotion messages be communicated systematically and consistently by so many different staff groups: how will you utilize the new frameworks in Choosing Health
- Have you commissioned the right courses for extended skills
- Does UWE deliver adequate practical work-based training when it is needed for AHPs to support role redesign
- Do you have sufficient experienced masters-qualified nurse practitioner mentors to mentor and supervise new advanced practitioners
- Do you have sufficient incentives to offer GP mentors of advanced practitioners to compensate for their time
- Do you have sufficient consultant and mentors with time (not taken up by training their own junior staff and seeing patients) to train, mentor and supervise new roles such as practitioners with a special interest
- In rural areas, where there may be less cover due to smaller teams, how are the competing needs of training and delivering a service to be managed
- Do you have appropriate courses to support the use by patients and professionals of technology for diagnosis, home monitoring and record-keeping
- Medicines management is a critical part of managing people with long term conditions, are there sufficient courses and support available e.g. extended and supplementary prescribing, identifying patients at risk of polypharmacy
- Are there sufficient people with the skills to analyse prescribing patterns

Recruitment and retention

- ? How will you address the current GP vacancies that will be made much worse through retirements?
- ? To what extent will district nursing retirements be covered by recruitment from the acute and what impact will this have on their services
- ? Have you identified sources of new recruits: those currently out of work who may need assistance to join the workforce
- ? Are there new opportunities for unqualified staff e.g. health trainers; generic rehabilitation assistants; staff to help patients with a care plan carry out the physical plan; diagnostic technicians e.g. for offering spirometry and phlebotomy
- ? Could you develop the role of therapy support worker to maximise the use of physiotherapists; for example these would be Physiotherapy Assistant grade, with some acute experience and additional training in exercise instruction
- ? Have you set aside sufficient funding for training and recruitment of these unqualified posts
- ? How might you take advantage of the Innovations Fund for workforce design announced in Choosing Health
- ? Are funded posts matched to numbers in training. For example, University of West England physiotherapy intake has doubled in the last few years from 60 to 120, but graduates are struggling to find appropriate jobs despite patients' need for physiotherapy.
- ? What images do you portray of community nursing and community therapy work – are they attractive
- ? How can you make some of the least attractive roles more attractive e.g. severe shortages of respiratory physiotherapists and physiotherapists working on acute medical wards
- ? Given the likely input required in the forthcoming long term conditions (neurological) white paper by AHPs; existing shortages in certain services; and the under-funding of existing services (e.g. lack of community pulmonary rehabilitation, one of the known effective interventions for COPD, and cardiac rehabilitation for people with heart failure), does someone have a WDC-wide realistic achievable workforce plan for AHPs
- ? Can you genuinely offer flexible working
- ? Can you cover 24/7
- ? Is there a skills escalator and career ladder for experience and skills for nurses and AHPs
- ? Are you ensuring that Community Matrons could be recruited from AHP professionals not just nursing (if prescribing legislation is changed)
- ? Have you succession plans in place where you have a single individual leading a service e.g. GPwSI
- ? SHAs will be responsible for ensuring robust, capable public health networks exist to lead the implementation of Choosing Health: how will you do this
- ? Do you have a way to pay family carers, where they are on low income but so that you do not compromise benefits
- ? Do you support family carers through organisations, online conversations and newsletters
- ? Have you considered strategic involvement of the pharmaceutical sector. For example, Keele University Medicines Management Department has been piloting

an outcomes guarantee scheme where a pharmaceutical company and prescribing stakeholders (such as the strategic health authority and primary care trust) agree on the outcomes that they would expect from a drug in a given indication, in this case a lipid lowering statin.[1] If the drug fails to fulfil expectations, the pharmaceutical company refunds the health service for the cost of the drug. This encourages the pharmaceutical company to use its human and evidence resource to promote responsible prescribing and ensures that healthcare resources are not wasted on ineffective treatments. NICE's shared risk policy for interferon beta in multiple sclerosis, and the subsequent commentary, has raised awareness of the potential for such schemes.

? Many pharmaceutical companies offer short-term placements of qualified staff to interrogate GP systems to case-find for chronic disease. Are you using this potential strategically?

? Can you complete this table for the WDC area to get a sense of how your traditional pool of employees will change over time

Year	80+ population (number)	Number of women aged 40-60 (who currently provide much of para-professional care in nursing homes and at home)
2000		
2030		

Safety and risk management

(as defined in the following diagram)

? Are standards in place to monitor and accredit new roles

? Are you following the good practice guidance regarding PwSIs[2,3]

? How are non-NHS roles regulated e.g. exercise tutors, sports therapists

? Have you identified any regulatory barriers to role redesign, if so, how are you taking this forward e.g. AHPs prescribing

? Do staff use validated tools for risk assessment

? Are lines of accountability clear

? What's the role of the Board in ensuring public safety with the development of new roles for both patients and staff

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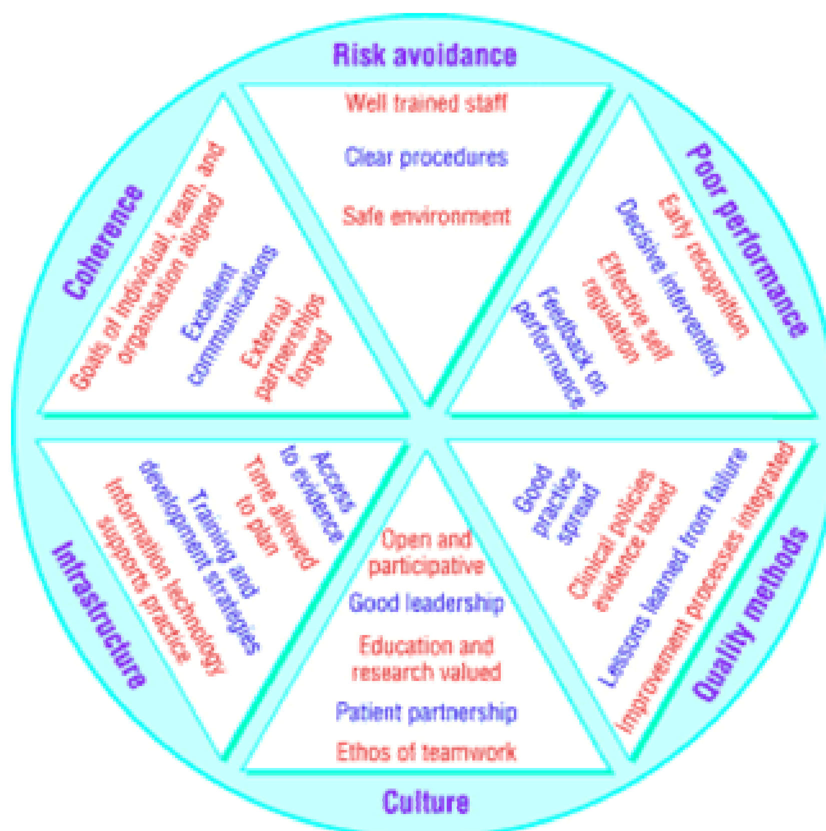
[1] Chapman S, Reeve E, Rajaratnam G, Neary R. Related Articles, Links
Setting up an outcomes guarantee for pharmaceuticals: new approach to risk sharing in primary care. BMJ. 2003 Mar 29;326(7391):707-9.

[2] Birch K. Developing Practitioner with Special Interest (PwSI) services: managing the risks. DoH Aug 2004 Gateway Ref 3198

[3] NatPaCT clinical governan ce and accreditation frameworks
http://www.natpact.nhs.uk/cms/352.php.



Model of risk management[4]

Clinical issues[5]

There is a general acknowledgement that one of the least developed services for people with long term conditions is end of life care for people with non-malignant conditions. As a test, in each PCT, plot the next 10 deaths of a target population (e.g. severe COPD). Ask what percentage

- Have a known living will?
- Have known resuscitation status
- Have an end of life care plan
- Died in their preferred place of death

Ask clinical teams ***"would you be surprised if this patient died in 6 months***?" From this, develop a target group of known patients who deserve to have discussions about end of life.

Do all members of the clinical team have the competencies to

- Recognise the importance of this analysis
- Initiate this conversation
- Guide the patient to make choices
- Guide the patient through the system e.g. to DNs

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[4] ***Adapted from:*** Clinical governance and the drive for quality improvement in the new NHS in England, Gabriel Scally and Liam J Donaldson, BMJ 317 (7150): 61-65, (4th July), cited on West Suffolk Hospitals NHS Trust website see http://www.wsufftrust.org.uk/Governance/default.htm

[5] http://www.medicaring.org/educate/navigate/sourcebook.html

Leadership and management

- ? Does your chosen model of preventing, diagnosing and managing long term conditions work locally, with buy-in from GPs and hospital consultants
- ? Can you in health knowledge and behaviour to reduce the future incidence of chronic disease
- ? Do your staff provide good role models in terms of healthy living: do you provide an environment and culture to enable this
- ? How is Agenda for provide pump-priming money if necessary
- ? Do you have patient buy-in
- ? Do you have social services buy-in
- ? Do you have strong project management to get it started
- ? Are the plans grounded in a solid assessment of local needs
- ? Does management have the skills to mainstream it
- ? Do you have the skills to install rigorous evaluation
- ? Who keeps an overview to ensure there is the right balance of investment in supported self management, care/case management and population management
- ? Who facilitates partnerships with the voluntary sector to achieve supported self-help for all
- ? Is there a programme to support the development of leadership skills to organize projects and achieve service modernization for results; are managers equipped with the skills to enable them to identify the critical path and rapidly remove rate limiting obstacles; do they possess communication skills to hasten organizational understanding of the changes in an organization
- ? Who is championing improvement in quality of life as the driver for change rather than reductions in hospital admissions
- ? Do you have strong public health leadership to drive health improvement and changes Change being driven through: do your staff feel it is offering new rewards

1. INTRODUCTION

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

2. SCOPE

Long term conditions last at least a year. They are normally due to a chronic disease that is not curable although its affects can often be mediated by a range of treatments. Most people with a chronic disease suffer symptoms such as breathlessness, pain, immobility, anxiety that need to be actively managed to prevent the person being disabled by the condition. Typically younger people have just one chronic disease. However older people tend to have more than one, and these can impair their ability to live independently, and may lead to their death, such as COPD and heart failure. This paper does not refer specifically to long term neurological conditions, as the NSF on this is awaited in late 2004. However, most of the principles hold true for neurological condition. The issue is that they all require recruitment, redeployment and training.

3. BURDEN OF DISEASE

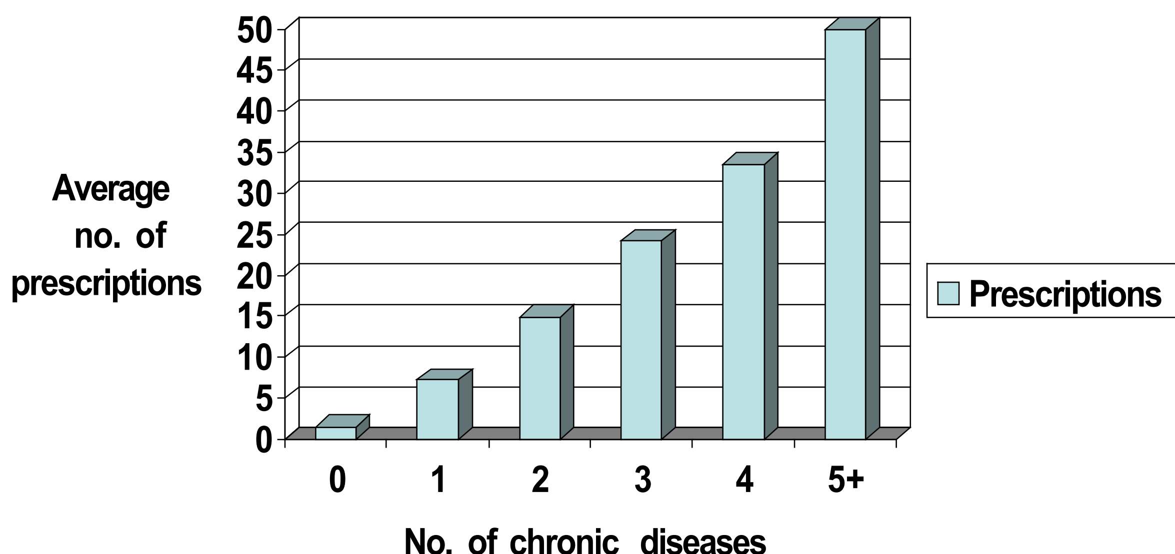
Patient experience

- The burden of the condition on both the individual and the care services depends on the moment, and on the nature of the disease: some diseases such as arthritis and asthma, hearing and vision problems can be disabling unless actively controlled under a care plan agreed between the sufferer and their professional carer, however, they are rarely fatal.
- Others, such as cancers and organ failures such COPD and heart failure are fatal and progressive, but people may live with the symptoms for many years before they reach the last years of their life. Whilst most older people will eventually have to deal with one of these, Joanne Lynn[6] estimates that between 20% and 40% of the over 65s will be disabled at any one time from the disease from which they will die. However, nearly all can expect to be chronically ill for an extended period at the end of their lives.
- American studies show most Americans spend approximately two years of their final years disabled enough to need someone to help with routine activities of daily living because of chronic illness.

[6] Lynn J, Adamson D M. Living Well at the End of Life. Adapting Health Care to Serious Chronic Illness in Old Age. RAND Health 2003.

NHS utilisation: the scope for improvement

- 80% of primary care consultations relate to chronic conditions.
- 40% of those in hospital are there as a direct result of one or more chronic conditions.
- DoH analysis of inpatient activity suggests that on average 5% of inpatients account for 42% of all inpatient days due to long and repeated admissions; 10% of patients account for 55% of inpatient days.
- Pharmacological management of chronic disease is a key intervention, with the potential for spiralling costs.
- The size of the potential market for pharmaceuticals encourages most of the major companies to invest in chronic disease and increase sales of prescription drugs. Typically the new generation drugs are significantly more expensive than the older drugs. For example, diabetes drugs have not changed significantly for 30 years and are extremely low cost, but new generation drugs are now available. Prescriptions for combination inhalers for asthma have increased about 1000% in many PCTs, and they are significantly more expensive than separate inhalers.
- The number of prescriptions increases with comorbidities[7]



- Many hospitals report an increase in referrals for diagnostic tests (E.g. for echocardiograms) as the result of the new QoF that incentivises practices to confirm diagnosis with objective tests that may not be available in practices. There are workload implications in this unless there is consideration of alternatives. For example, a, BNP test requires a lower skill level and can exclude those with normal readings who will then not require an echocardiogram.

? What is the appropriate practice-based/community based skill-mix if equipment could be made available such as spirometers, and ECG machines or BNP testing

[7] Chris Dowse, MA summit on long term conditions http://www.natpact.nhs.uk/news/index.php?article_request=1185

Older people most at risk

- By 2030 the DoH estimates that the prevalence of chronic conditions in the over 65 age group will have DOUBLED.

- Evercare pilots have discovered that the identified high-risk population (e.g. those with two or more unplanned hospitalisations in the past year) represent 3% of people over 65 years of age but are responsible for 35% of unplanned hospitalisations for all people over 65 years of age in participating PCTs. Many admissions were avoidable (urinary tract infection, dehydration)
- Many high-risk patients are not actively being managed by the system. Only 24% of Evercare patients were on active district nursing caseloads, and only one third were known to Social Services.
- Contrary to expectations, this high-risk population cared for by Evercare primarily lived in the community: 75% lived in their private homes, 6% were in residential care homes, and 10% were in nursing care homes.
- Older people are the main users of the NHS. While they make up about one fifth of the population, they occupy almost two thirds of general and acute beds. They are also three times more likely to be admitted to hospital than the population as a whole.[8]
- Nearly half of the Social Services budget in 1999/2000 was spent on people over age 65.[9]

Dying from chronic disease

- The most common causes of death are now CHD, cancer, stroke, chronic respiratory disease, injury, diabetes and dementia, with multi-factorial frailty in the last years of life for a large proportion of the population.
- People with cancer and some other conditions tend to have a relatively short period of decline leading to death; they represent about 1/5 of those who die
- People with organ system failure tend to have longer term limitations with intermittent exacerbations, from which, at some point they will die; they represent about 1/5 of those who die
- Frailty: some older people have no specific condition but their body's systems have little reserve, and there comes a tipping point for them when, due to a small upset, their frailty tips over to cascading health problems and eventual death. They represent about 2/5 of those who die and can often live for a decade with increasing symptoms and disability.
- As many as half of those aged 85 and over have a cognitive deficit before they die.
- In the UK most people die in hospital.
- Paid professionals provide the majority of care

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[8] UK National Audit Office

- [9] National Services Framework for Older People

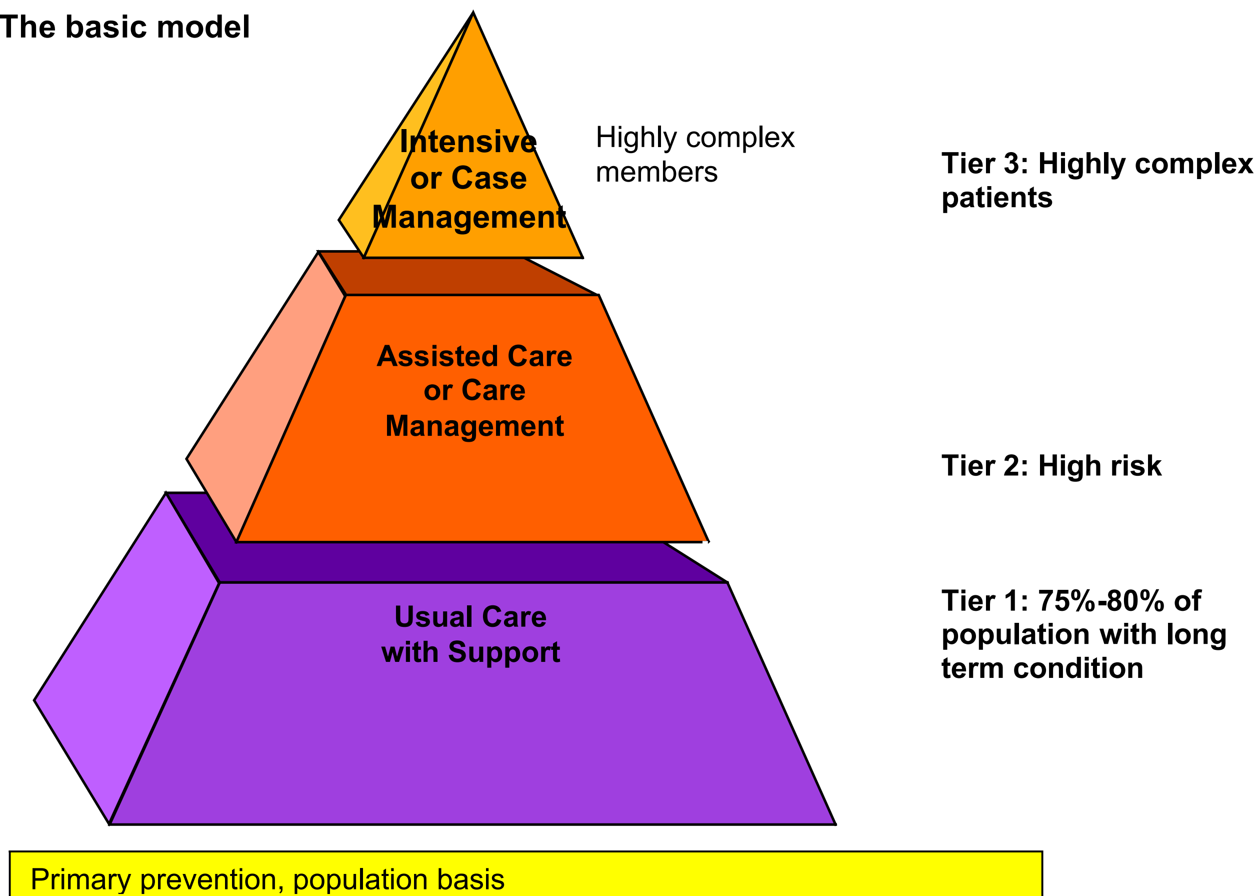
4. MODELS OF CARE

Kaiser tiered model

The current DoH model for provision of care is based on the Kaiser Permanente experience, and suggests tiered care, depending on the level of need of patients. These needs are likely to change over time.

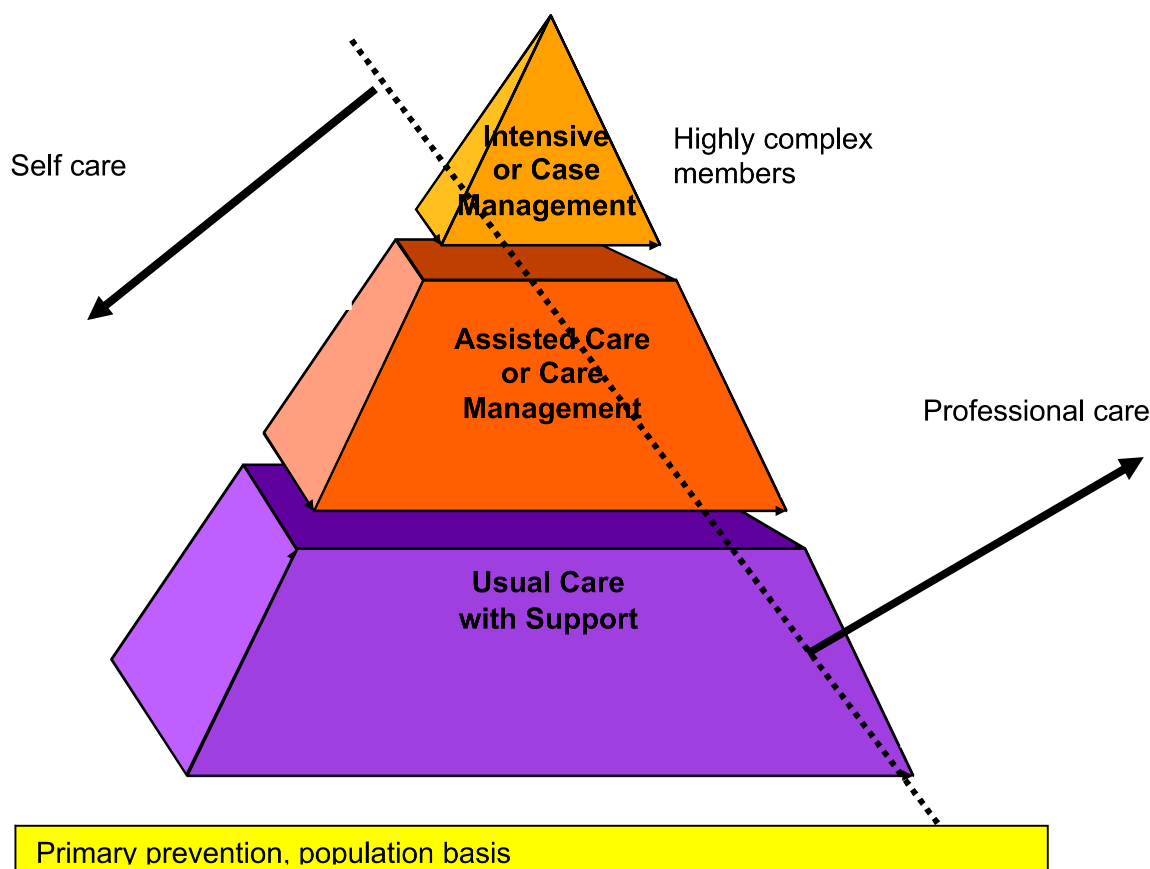
The basic model suggests that many patients and their families have the potential to look after themselves once they have received a correct diagnosis and treatment plan (Tier 1). It requires health service professionals to perceive themselves as being there to support patients to live as independent and safe a life as possible. So that, primary care is there for when patients feel unable to cope alone any more. More specialist services, either in primary care, or in secondary care, exist to support primary care and patients when they feel unable to cope together (Tier 2). In addition, some patients have such complex needs that they need support in coordinating their social and health care and in proactively managing their symptoms (Tier 3). The **assertive outreach model**, previously used only for mental health, has been favoured to target service users at risk of admission, but who, with social, medical and nursing support can be kept at home safely and appropriately.

The basic model



Revised model

A revised model shows that there is a role for patient and family involvement at each tier of care; at many times it is the most significant element. This seems to have more value as a model.



5. PRIMARY PREVENTION: WHOSE JOB IS IT?

The starting point therefore, should be to prevent the multiplication of long term conditions. There is however, no accepted single model of prevention in the NHS except for addressing one of the major risk factors of chronic disease – smoking. There is, until 2006 a national smoking cessation programme. However, even that has been driven by the CHD agenda, and pays less attention to respiratory disease. Yet 20% of smokers will develop COPD, which is set to create the 5th biggest burden of disease globally by 2010 (World Bank, GOLD[10]). No other risk factor has had a national programme or agreed approach although this may change with Choosing Health implementation. It is dependent on local public health and health promotion initiatives, sometimes in partnership with other local agencies such as the local authority.

[10] http://www.goldcopd.com/

Smoking cessation

- ? Does each PCT have a long term plan for smoking cessation once the ring-fenced monies end
- ? Is there an equal balance given to the prevention of respiratory disease as cardio-vascular disease in the smoking cessation messages
- ? Are there sufficient trained staff in smoking cessation in acute trusts, pharmacies and other areas of primary care and the community

Public health role of nurses

This is a much talked-about subject, particularly amongst health visitors.

- ? How is their public health role to be balanced with a care and case management role
- ? Who is ensuring proper integration between public health departments and community nursing
- ? Preston PCT has just advertised for a Nurse Consultant in Public Health with exactly that brief. How are you planning to organise it locally
- ? Do health visitors and other community staff have the right competences in motivational interviewing, providing education and advice and guiding people through local options for self-help

Knowing the evidence base

There is also a paucity of evidence about what causes some chronic conditions. For example, what causes (rather than triggers) asthma?

- ? How will you ensure that as new evidence emerges it is fed quickly into practice

Socio-economic status and ethnicity, genetic counselling

There is a recognition, from the evidence, that lower socio-economic status worsens a person's risk of developing some chronic illnesses and that other factors play a role in specific conditions. People of African descent living in the UK have a much greater risk of dying of stroke and people of South Asian origin living in the UK have a much greater risk of dying of coronary heart disease due in part to the higher prevalence of hypertension and diabetes respectively.[11]

- ? Are there sufficient staff with the cultural understanding to support people from ethnic groups who are particularly at risk
- ? Are staff sufficiently aware of genetic causes of chronic disease to counsel prospective parents

Campaigning skills

Many of the national voluntary organisations campaign to alert the public to the health risks of certain behaviours such as smoking, eating a high cholesterol diet, insufficient exercise. Choosing Health acknowledges that messages need to use social marketing techniques and new technology and be provided in a credible way (as commentators have noted, discrete from Government).

- ? However, who is giving out these same messages systematically and consistently locally?

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[11] http://www.dh.gov.uk/PolicyAndGuidance/ResearchAndDevelopment/ResearchAndDevelopmentAZ/CardiovascularDiseaseAndStroke/CardiovascularDiseaseAndStrokeArticle/fs/en?CONTENT_ID=4001804&chk=ohOd2q

- ? Who has the skills to run local campaigns?
- ? Are these the responsibility of communications staff without necessarily any health knowledge or health professionals without campaigning skills or time?

6. TIERS 1 AND 2

The crucial first step is accurate diagnosis. Evidence suggests that as many of 50% of those with Type 2 diabetes are not diagnosed, and there are similar estimates for COPD and heart failure. Of those who are diagnosed, many patients would wish for a more timely diagnosis and guidance to self-help. The policy drivers are in place to improve this: the NSFs for Older People, Diabetes, Cancer and the QoF in primary care.

- ? Is there sufficient training, supervision, quality control in place for high quality diagnosis
- ? Are GPs prepared to make an early diagnosis of a chronic disease. This requires sufficient knowledge about what they can do if they find a positive diagnosis. For example some 30 year olds who began smoking when they were 10, might now have breathing problems which are signs of early COPD. Are they diagnosed? Are they offered appropriate pharmacotherapy and exercise training.
- ? What are the most cost effective ways of providing a comprehensive service e.g. the Bristol hospital spirometry service uses an unsupervised unqualified assistant (who receives training and support from the hospital) to undertake the spirometry and the readings are interpreted and fed back to GPs via the consultant respiratory physiologist. In other PCTs, e.g. Wyre, a PCT–employed spirometry technician who, through a regular schedule of visits to each practice has built up a PCT-wide consistent register of people with COPD.
- ? Could short and effective training courses for spirometry be developed that are attractive to GPs who are not inclined to attend or send their practice nurses away for long courses. Could these be developed with the manufacturers? Could a local primary care specialist be trained to help with interpretation
- ? The NICE guidelines for diagnosis of heart failure suggest either BNP testing plus echocardiography and interpretation for those with abnormal results, or the provision of ECG testing and interpretation in practices. Currently many areas just use echocardiology that can be expensive option in terms of cardiology time and cost. What model would be most practical for you in terms of workforce requirements?
- ? Pathways exist or are in development for most long term conditions such as asthma, COPD, heart failure and diabetes and stroke services exist, in different forms in the WDC area, which provide rehabilitation for people to reduce long term disability. However, Choosing Health proposes a new obesity clinical pathway and better obesity services. How would these be staffed and organised

Self management

Patients may want to self manage, but they need support to do that. In the USA, there are some interesting roles as health coaches, to support people to live independently and seek help when appropriate.[12] Health coaches are certified healthcare professionals with an average of 15-20 years of experience who support

[12] http://www.healthwise.org/p_selfcare.aspx

people with long term conditions who enroll on their programme and either self-manage using the company's database, or coach them to improve their decision-making using a set of branded tools. Choosing Health introduces a similar concept of health trainer, who may be recruited from existing staff or the local community.

- ? Do you have the skills internally or the budget to commission computerized programmes to support self-help
- ? There are a number of anxiety and depression programmes available, and NHS Direct on-line – is your workforce aware of these and able to guide patients through them
- ? Are you sharing good local practice regarding the roll-out of the Expert Patient programme
- ? Are you ensuring that disease-specific information is also made available e.g. about COPD or heart failure in rehabilitation programmes or in collaboration with local support groups
- ? How are you supporting people to self-manage over the long-term

In the UK, Serum is piloting a telephone-coaching model to improve concordance with asthma management. It builds on telephone approaches used elsewhere for improving people's concordance with management programmes for mental health problems such as schizophrenia. Its one-year outcome data show:

- 69% improvement in patients self reported asthma status
- 40% reduction in reliever medication use
- 39% improvement in self reported preventer medication compliance
- Estimated 64% reduction in unplanned asthma admissions
- Reduction in emergency primary care visits and use of additional resources
- 86% of patients feel that they have a better understanding of their asthma
- Extensive patient feedback on improved motivation, quality of life and functional ability

A PCT might not be able to afford this additional service. However, existing health professionals could use telephone consultations. Evidence suggests they offer similar patient satisfaction and are more time-efficient particularly for recall programmes.[13]

- ? Are telephone consultations widely available in primary care? Do practitioners routinely offer these to patients with chronic diseases

Treatment

From a patient's perspective, once they have a diagnosis and symptoms, no matter how severe they are, they need:

- The best possible control of their symptoms, and proactive management in line with approved guidelines
- Structured care to defined standards including onward referral and a call and recall programme
- Education about controlling their own symptoms

[13] Pinnock H, Bawden R, Proctor S, Wolfe S, Scullion J, Price D, Sheikh A.
Accessibility, acceptability, and effectiveness in primary care of routine telephone review of asthma: pragmatic, randomised controlled trial.
BMJ. 2003 Mar 1;326(7387):477-9.

- Proactive medicines management and record keeping

The role of primary care: quality and outcomes framework

The implementation of the Quality and Outcomes Framework provides a new opportunity to achieve these objectives.

? How is primary care being supported to deliver on all 10 of the clinical quality indicators

? Is the local health system sharing information to be able to hold population-wide registers that can be readily accessed by all relevant health professionals and commissioners

? Is there scope to offer group consultations for newly diagnosed patients. where a multidisciplinary team explains the disease, interventions and what help, including self-help is available. Between them the attending patients might learn more as, collectively, they are likely to ask more questions

Community nursing and therapy posts

Many healthcare organisations have experimented with skill mix to improve the efficiency of delivering treatment and monitoring symptoms. Examples of generalisable findings include:

? Nurses and other non-physicians are increasingly managing chronic diseases and evidence suggests they may be better at it than doctors[14] [15] Is this belief shared locally

? Are the opportunities for trained healthcare assistants fully developed. In Peterborough, annual diabetes reviews are performed by trained healthcare assistants[16]

? Retinopathy screening can be performed by a trained technician and established retinopathy monitored by trained nurses or a GPwSI. This would reduce pressure on the ophthalmology departments. In South Warwickshire they predict it would create a 25% reduction in pressure on the ophthalmology department.

? Patients are often sufficiently reassured knowing a specialist is available to them if they need him/her that often, anecdotally, they make less demand on the service than if they are discharged from it, or are not given access. For those patients who need care management, for example, patients who currently attend a specialist nurse-run heart failure clinic, are there sufficient specialist staff available. What happens when the specialist nurse is absent, who can the patient speak to for reassurance or advice

Telephone intervention

The Pfizer Health Solutions model of telephone intervention is testing whether there are efficiencies and advantages in care management by telephone. It is working with 600 high risk patients in Haringey with CHD, CHF or diabetes. Four care managers will work with these patients, supported by software that will contain national and local guidelines.

? Would you be interested in testing out this model

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[14] Horrock S. Anderson E. Salisbury C. Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors BMJ 2002;324:819-23

[15] Renders, CM., et al. Interventions to improve the management of diabetes mellitus in primary care outpatient and community settings. Cochrane Review in The Cochrane Library, Issue 2, 2001. Oxford: Update Software. Cited in Matrix Report to Redbridge PCT

[16] Peterborough. HSJ 4 Sept 2003 28-29

Generalist and specialist posts: getting the right balance[17]

Whilst patients want support from someone with specialist knowledge, there remains an important role for generalist district nurses and community therapists, albeit with an improved career structure that allows for moves to posts with a special interest, or to advanced posts such as those that support Tier 3 patients.

- ? How easy is it to recruit to these generalist posts? Would a focus on supporting people with chronic illness help recruitment?
- ? Do existing staff have the right competences to support people at home or in the community? For example, could they offer advice on inhaler technique, on appropriate and safe exercise, on pain relief?
- ? Do they have cognitive behavioural skills to help people learn to cope with the anxiety and depression that frequently accompanies people with long term conditions.
- ? Many people with long term conditions such as heart disease, COPD, heart failure would benefit from a rehabilitation programme, is there scope to offer a shared clinic, recognising that many people will have more than disease, or shared symptoms such as breathlessness.
- ? The aim of rehabilitation programmes is disease or symptom mastery. Lambeth and Southwark health community have shown how people with COPD can be supported to step down to community exercise programmes run by exercise instructors with additional training. Equally, recently diagnosed patients can benefit from this more inclusive form of exercise rather than a formal pulmonary rehabilitation programme that is normally geared to people with moderate to severe disease. This model is used in Bath for back pain; and Bristol South and West run an Extend exercise group at a lunch club for older people using a technical instructor and physiotherapy assistant.
- ? The NICE guidelines on COPD lay out requirements for pulmonary rehabilitation. These are proving a challenge to local PCTs. Is sufficient resource being invested to establish a multi-disciplinary team? Does it have the right balance of qualified staff and new staff such as exercise instructors, people with skills in cognitive behavioural approaches, and teaching skills to be effective, safe and sustainable.
- ? People with arthritis form a large part of clinical caseloads for domiciliary and for musculoskeletal physiotherapists; are you sharing local good practice with physiotherapy-led clinics for steroid injections and for rapid advice?
- ? Given the numbers of people with arthritis, the most common long term condition, are funded staffing levels adequate
- ? The presence of the Royal National Hospital for Rheumatic Diseases means that many local people with arthritis receive an excellent specialist service; does it provide a sufficient role as clinical champion and help develop local community staff and patient expertise

Pharmacists and the New Pharmacy Contract

- ? How will you engage pharmacists in secondary prevention by supporting patients to monitor their condition, to manage repeat prescribing better and to offer pharmacological advice.

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[17] Personal communication with Fiona Cook, Claire Madsen and Jane Heighway

- Have you a goal for engaging pharmacists in supplementary prescribing schemes?
- Have you set aside sufficient budget for appropriate training and commissioning?

Practitioners with a special interest

The NHS Plan (DoH 2002) first described this role. It has subsequently been described in detail at http://www.gpwsi.org/subindex.shtml However, the role of PwSIs in the support of people with long term conditions is less developed than those in procedural based activity. The scope of these roles is vast. It would seem that PwSIs or PwSI teams could be employed to support Tiers 1, 2 and 3.

PwSIs at Tier 1

There is a potential role for a PwSI to develop Expert Patient and Expert Carer schemes; to develop programmes to help people manage symptoms such as breathlessness and immobility through exercise programmes, to develop a programme of public awareness, to develop patient education resources such as libraries in new health centres, personally-held records, and to coordinate the new roles of pharmacists. They would need strategic planning skills, communication skills and leadership ability.

PwSIs at Tier 2

At Tier 2, GPs or consultants might refer patients to a PwSI to work with them on their care plan if there were problems with concordance. GPwSIs might assess referrals to outpatients and develop intermediate care services for those patients who could be managed in the community rather than at outpatients if the right services existed. GPwSIs might develop an education programme for primary care implementation of the QoF and support the spread of diagnostic and management templates and referral protocols to improve decision-making, record-keeping and communication between primary and secondary care.

PwSIs at Tier 3

As shown below, the models of care at Tier 3 require a collaboration between a case manager or keyworker, the primary care team, and potentially also with specialists. The Evercare model, for example, uses Advanced Primary Practitioners as keyworkers. They are proactive generalists, not specialists. Therefore they will need specialist support when the patient's needs exceed their generalist knowledge. This might be a role for a GPwSI or PwSI. Alternatively, an advanced primary practitioner who develops a special interest might take this role over time, but this would need to be dependent on prior knowledge and skills. For example, an advanced primary practitioner recruited from an acute medical ward might have more appropriate experience than one recruited from district nursing.

7. TIER 3

This is the area of most attention at the moment in terms of role redesign, recruitment and training.

Evercare

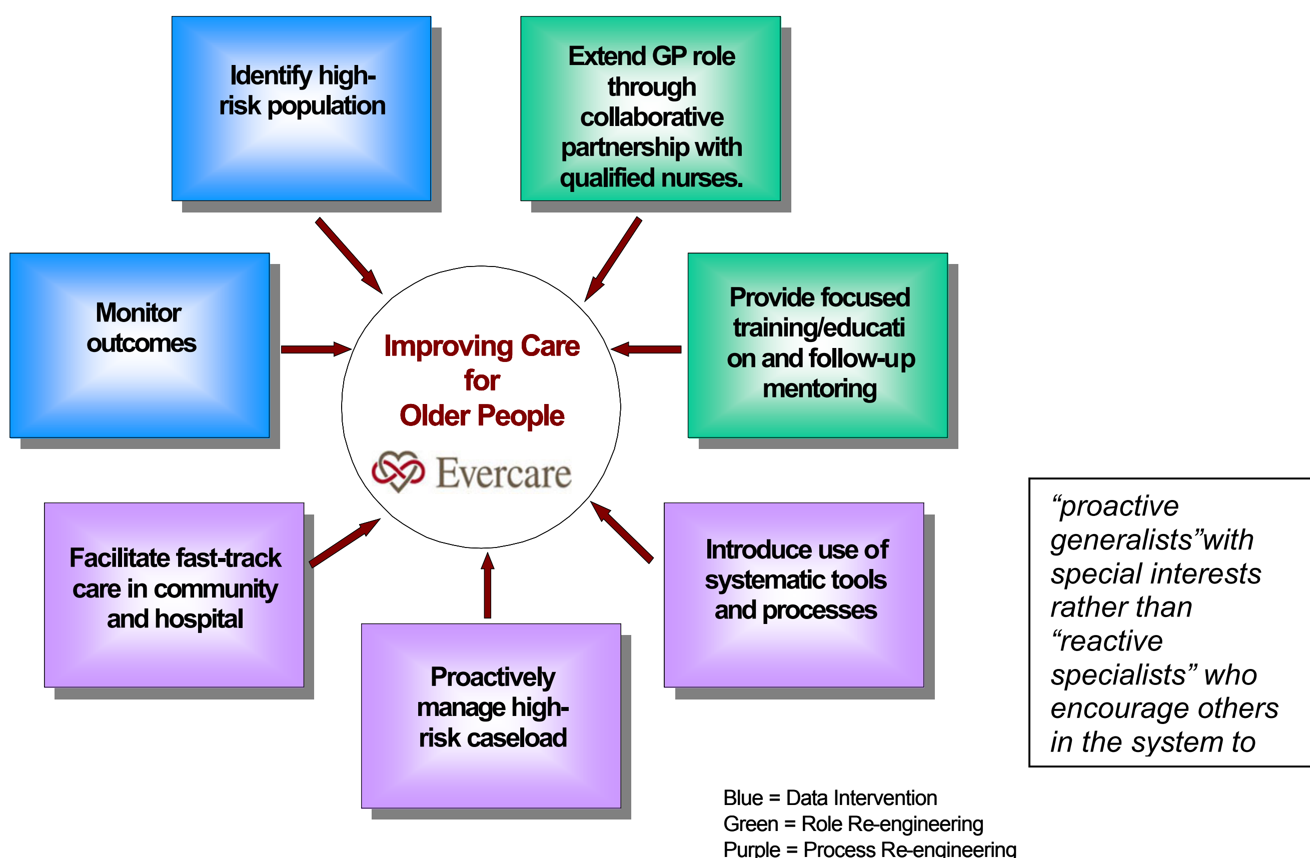
One model that is being rolled out in the UK is the United Healthcare Evercare model, piloted in 9 sites including Bristol and S Gloucestershire. This employs advanced primary practitioners (APPs), typically nurses with experience of working autonomously, as keyworkers who liaise with the patient and their practice team to manage their needs and to prevent hospital admission. It has similarities to the

CHMT assertive outreach model for managing patients with severe mental illness in the community, and calls for staff with many of the same attributes. The patients are identified from GP lists by sorting for patients over 65 (although some pilots now want to extend this to anyone with complex needs) who have had 2 or more hospital admissions in the last year (locally the criterion was set at 3 or more). This is often the first time practices have looked systematically at their patient's profile, since the patient may, following an admission, have received the majority of his/her care from inpatient and outpatient staff within the hospital who tend to work reactively. It is often a revelation to practices to discover how many admissions, consultations and nurse contacts one of their patients has had in the last 12 months.

At this stage, results have not been published, the publications relate to case-finding and data analysis which has given a powerful insight into why things need to change and improve.

There are five key principles that guide Evercare's interventions:

- Apply an individualized, whole-person approach to care of older persons with all interventions focused on promoting maximal function, independence, comfort, and quality of life.



- Use primary care as the central organising force for health care across the system.
- Provide care in the least invasive manner, in the least intensive setting which will be the most efficient use of NHS resources and enable the freeing up of resource for new purposes.

- Avoid adverse effects of medications and polypharmacy.
- Use data to strengthen decision-making.

Nursing competencies

The five advanced nursing core competencies that build on Liberating the Talents[18] are

- clinician
- care orchestrator
- communicator
- coach and
- champion

The most successful advanced primary practitioners have well-developed thinking skills, self-confidence and assertiveness which are not easy attributes to gain rapidly. The first recruits have had to sell the role, and develop an equal relationship with doctors, which a number have found very challenging, and demonstrates the need for strong mentoring and support and the right person selection.[19]

A more detailed list of their competences includes:

- History taking, physical examination and nursing assessment
- Advanced diagnostic skills including differential diagnosis
- Risk analysis
- Management of exacerbations (that those without an acute medical background have found particularly challenging)
- The right beliefs about patient choice
- Medication review and prescribing
- Health promotion and education (hard when dealing with the very elderly population)
- Coordination skills to facilitate hospital discharge
- Communication skills
- Assertiveness
- Skills to manage end of life

Most of those recruited have been district nurses with over 6 year's experience – the median of the pilot was 16-20 years.

- ? Where will the next generation of advanced nurses come from
- ? Luton tPCT is rolling out the programme 24/7 to aim to eliminate unnecessary admissions and estimates it will need a total of 30 WTEs (the total population is 185,000) who each have a caseload of at least 50, increasing to 75. North Bristol has a similar caseload of about 50. What is the optimum number? What would be the implications of 24/7 coverage in the WDC area
- ? These nurses are normally on H grade, moving to I grades once their training is completed. Do the PCTs have sufficient resource to pay for this
- ? Evercare has been commissioned to produce a leave-behind training package that will be used by UK nurse practitioner mentors, with The University of the West of England educational support. Are there sufficient masters-qualified mentors, and advanced generalist training modules commissioned to continue the scheme once Evercare has left.

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[18] Liberating the Talents. DoH 2002
[19] Personal communication, Gill Bedson Luton tPCT and Martin Howard, North Bristol PCT

? Analysis of reasons for admission of Evercare patients (three out of four who were not on DN caseloads) shows that the APPs will need specific clinical skills in the top ten diagnoses of:

1. Chest pain, unspecified,
2. Chronic obstruct pulmonary disease with acute exacerbation, unspecified
3. Chronic obstruct pulmonary disease with acute lower respiratory infection
4. Unstable angina
5. Urinary tract infection, site not specified
6. Syncope and collapse
7. Unspecified acute lower respiratory infection
8. Atrial fibrillation and flutter
9. Congestive heart failure
10. Angina pectoris, unspecified

? In addition, APPs have found that they need skills in managing people with confusional states and cognitive impairment What lessons can be learnt about required competencies from South Gloucestershire where one of the nurses has a nursing home caseload

? What will be the impact on the district nursing workforce if more are recruited to advanced nurse posts. Is there a reduction in their workload due to the work done by the APP colleagues?

? Will the possibilities of career progression encourage applicants to district nursing

? What accreditation model is in place for APPs? Will they be registered as nurse practitioners or APPs?

? Are the domains of practice that will guide accreditation in place, and are there sufficient learning modules in place?

GP role

In the Evercare model, the GP must collaborate with the nurse and provide mentoring, which is a demanding role.

? How will GPs be incentivised to mentor? Will they be paid?

Geriatrician role

This is also crucial in the Evercare model, but in the pilots progress was hampered by the lack of community-based geriatrician support.

? What is your commitment to community based geriatricians

ICT staff

The lack of people with sufficient analytical skills to interrogate the data has been identified as a challenge in the local pilots, particularly given the difficult task of using different GP clinical systems.

? How will this be overcome in the future

Castlefields Model

The Castlefields model spans Tiers 2 and 3 and relies more on the GP to diagnose the patient, and then uses a DN/Social worker team to coordinate appropriate care. District nurses acquired the additional20%-30% of competences required through a 3-4 day training programme supplied by Conrane Consultancy. It discovered a

caseload of 100 patients from a practice population of 12,000 It has published its results:

- 15% reduction in unplanned admissions
- 31% reduction in hospital LOS (6.2 to 4.3)
- Total hospital bed days fell by 41%
- GP practice visits fell by 30%,
- No increase in social care costs
- Better patient experience
- Improved integration + more appropriate referrals

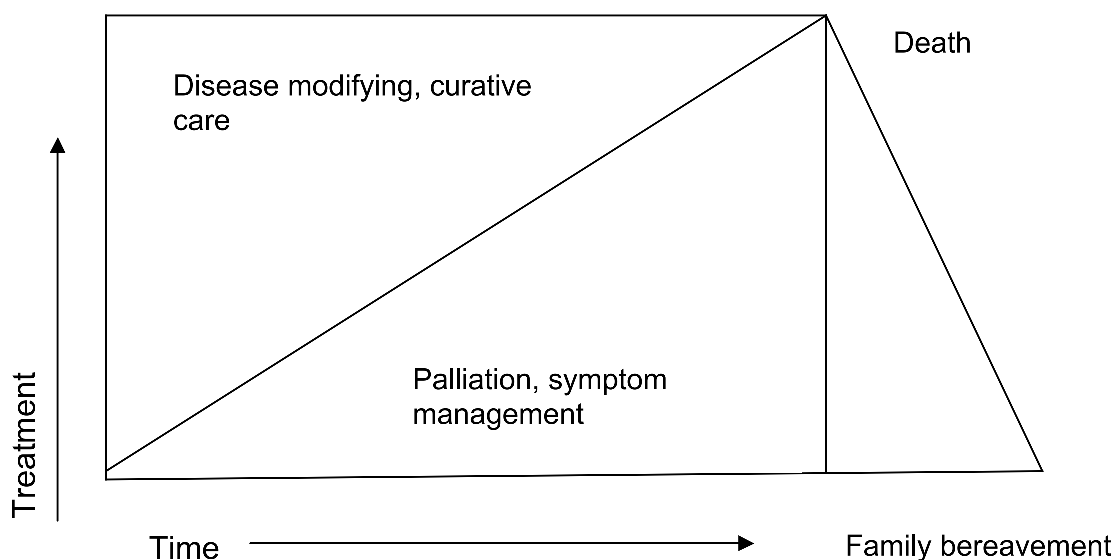
? Is this model more cost-effective

? Is it more sustainable, using existing roles differently

? Practice-based commissioning opens up the possibility of practices, or groups of practices, choosing different models. How will the overall impact on the workforce of potentially different models be managed.

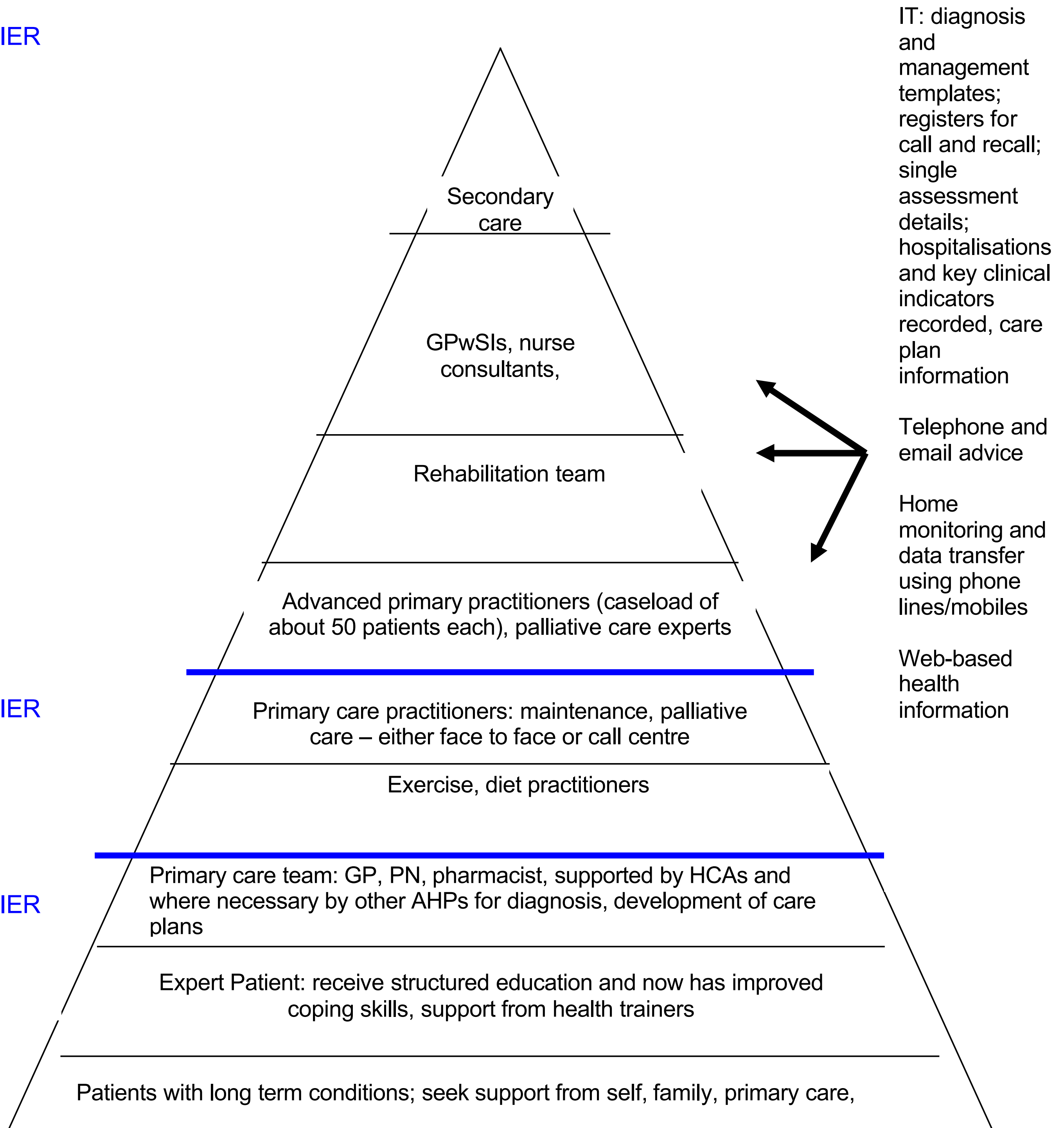
8. TERMINAL CARE

Terminal care is an important and underdeveloped area of care for people with long term conditions. The Kaiser model requires a transition from disease-based specialist services, to people-centred services, that support the patient and family to actively manage their symptoms and their life, drawing on specialists where necessary. In addition, Joanne Lynn argues that instead of a sharp transition from stability to dying, which is again how services have been organised in the past, most people have a vague prognosis, and are living on thin ice, sometimes for no more than a week, but sometimes for years. Therefore, a more useful way of organising services is:



? Are all your community staff able to actively manage symptoms of pain, anxiety, depression, breathlessness and sleeplessness and discuss end of life care?

9. CONCLUSION: THE NEW WORKFORCE FOR LONG TERM CONDITIONS



10. LABOUR MARKET TRENDS

Introduction

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

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

General Employment Trends

International trends

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

England

Supply

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

Demand

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

Bristol, Avon and Wiltshire

Bristol

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

Swindon

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

Gloucester

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

Competition

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

NHS Employment trends

NHS in England

Past trends

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

Future Demand.

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

Supply

- Over 80% of existing professional and assistant staff need to be replaced by 2010.

- Number of nurses retiring will double between 2005 and 2015, with 27 per cent being aged over 50.
- Shortages of professional staff – 25,000 doctors by 2020.
- The feminisation of medicine (60 per cent of medical school intakes are female) will require more doctors to work a given number of hours, as women have shorter working lifetimes due to career breaks.

NHS in Avon, Gloucestershire and Wiltshire

Overview

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

Reference costs

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

Promoting NHS careers

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

Targeting graduates

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

Impact of IT

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

Demand and supply

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

Danger of pay spirals

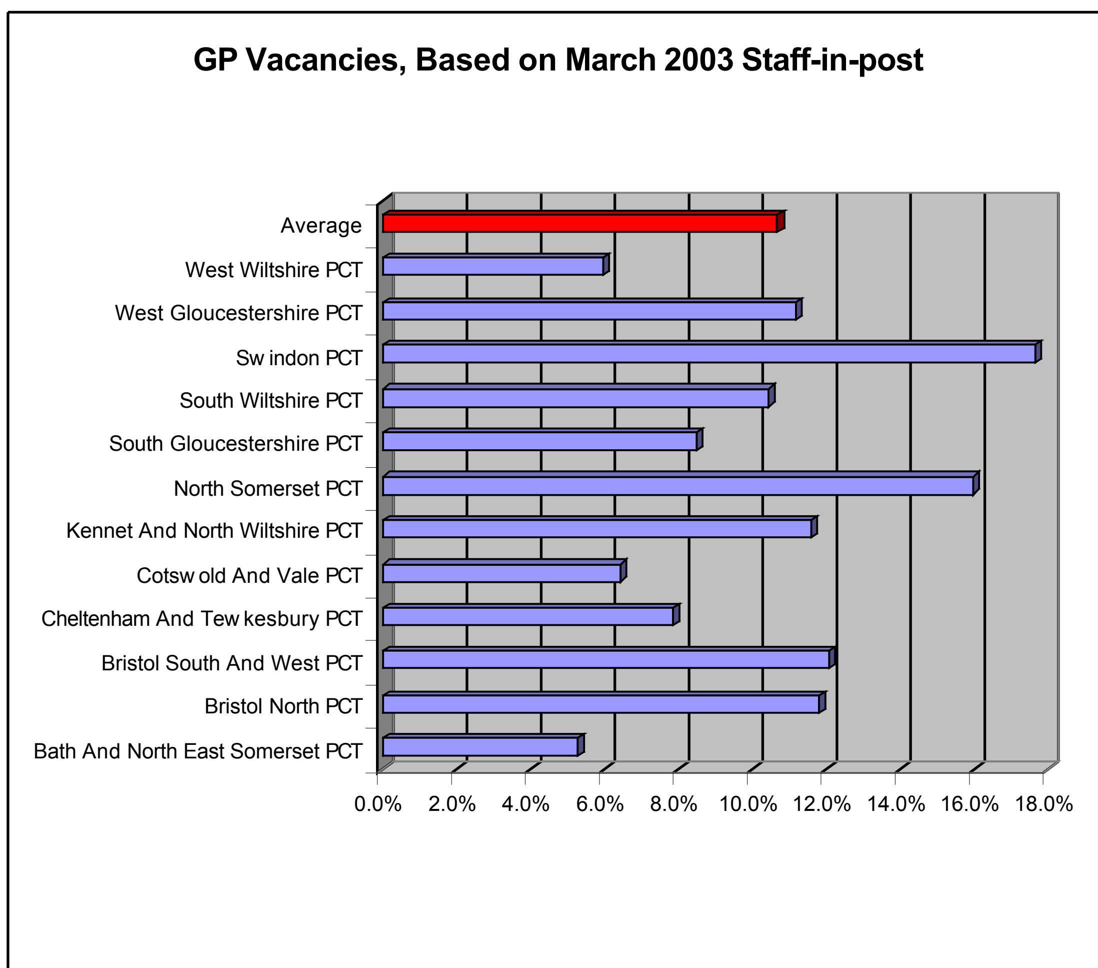
- There is a danger that health and social care organisations faced with growing staff shortages will compete against each other very intensively, resulting in upward pay pressures, unless a coordinated approach is made to the problem by employers.

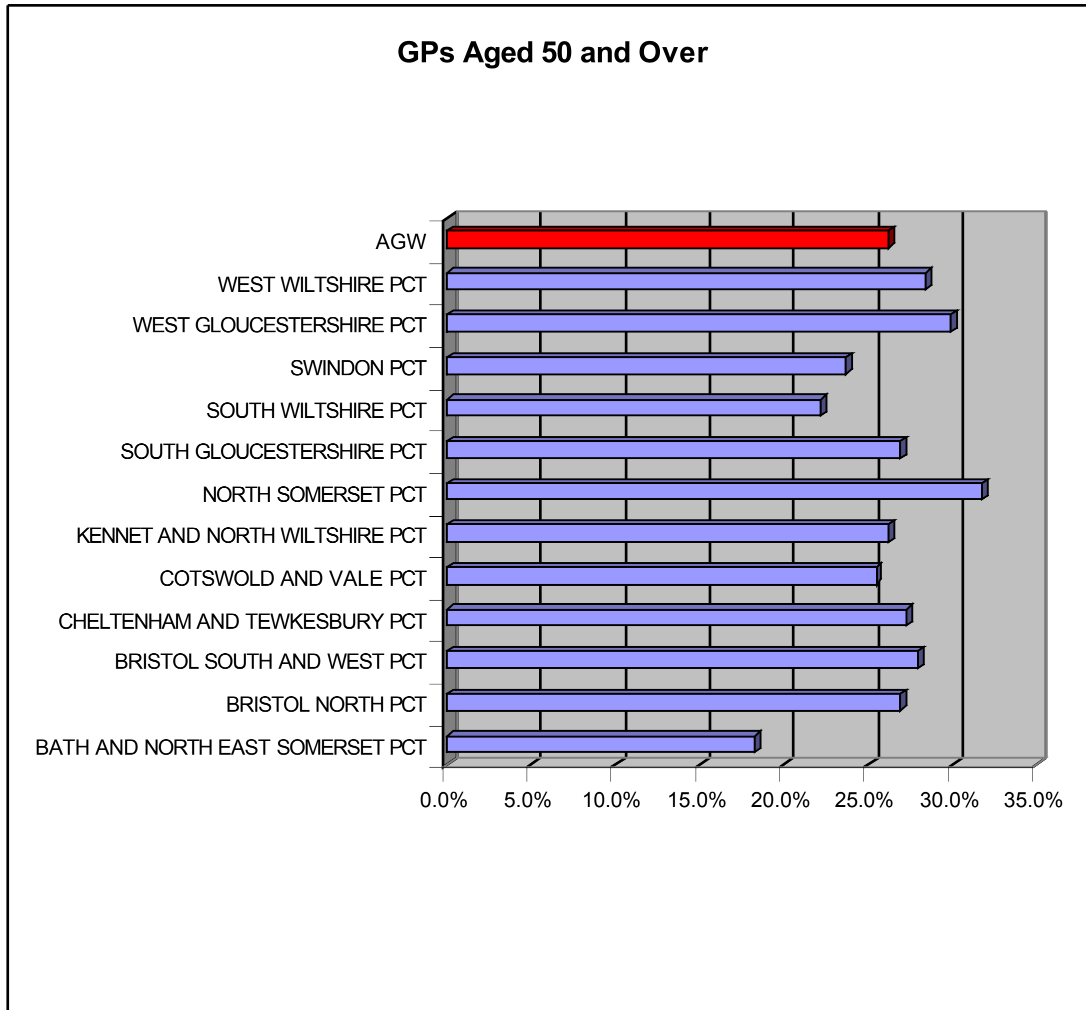
GPs

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

Diagnostic radiographers

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





Staff groups and shortages related to Long term conditions

	Significantly above ave.	Somewhat above average	Average	Somewhat below ave.	Significantly below ave.
District nurses					✓
GPs			✓		

Appendix 1

AVON, GLOUCESTERSHIRE AND WILTSHIRE LABOUR MARKETS

Bristol

Main employers by sector

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

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

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

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

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

Bristol Employment by Sector

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

Source: ONS Annual Business Inquiry 2002

Population and employment trends

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

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

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

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

Education

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

Skill Attainment Levels

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

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

Swindon

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

Economic overview

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

Service sector

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

Qualifications of workforce

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

Local downward employment trends

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

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

Gloucester

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

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

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

Document History

Role	Personnel
Sponsor	Maggie Boardman, Director of Workforce Modernisation
Client lead	Justin Riordan-Jones, Head of Workforce Information and Planning
Authors	George Blair and Sian Williams

Version	Date
1	21 November 2004

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[i] U.S. Bureau of Labor Statistics published in the February 2004 Monthly Labor Review,
[ii] RCN Report, quoted in Observer, 31 October 2004
[iii] RCN warns of fragile future of the nursing profession, Press Release, 1 November 2004
[iv] WESTEC Community Profile - Bristol
[v] Department of the Environment, Transport and the Regions, Indices of Deprivation 2000, quoted in ibid
[vi] Ibid, p.24
[vii] Ibid, p.38
[viii] Ibid, p.103