Briefing Paper

A Strategic Review of the Future Healthcare Workforce - Informing the nursing workforce'

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Together for Short Lives

Together for Short Lives is the leading UK charity for all children with life-threatening and life-limiting conditions and all those who support, love and care for them– families, professionals and services, including children's hospices. Our work helps to ensure that children can get the best possible care, wherever and whenever they need it. When children are unlikely to reach adulthood, we aim to make a lifetime of difference to them and their families.

We work closely with the organisations and professionals that provide important lifeline services to children and families. We support, lobby, and raise funds for children's hospices and a range of other voluntary organisations to enable them to sustain the vital work they do. We offer resources and training to help them maintain consistent, high quality care from the moment a child is diagnosed, until their eventual death, and to continue supporting families for as long as they need it.

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Introduction

This briefing provides members with a short summary of the sections of the paper – the entire nursing and midwifery workforce is considered however much of the content is relevant to the **children's workforce** and those working in the independent and voluntary sectors.

The Centre for Workforce Intelligence (CfWI) is backed by the government to become the national authority on workforce planning and development, providing advice and information to the health and social care system. Initially working with the Department of Health, their Horizon Scanning findings can be translated to their national and international project work to inform better workforce planning, in order to improve people's lives. This paper does not include particular findings from all of the nations of the UK, but neither are the implications limited to England; their value can be translated across settings.

Some thought-provoking points to be considered are set out – these are detailed to prepare the workforce for a future that includes **increased development of community services** being offered to patients. This is followed by a summary of the implications for children's hospices and children's palliative care services and some questions to consider in applying the following information:

Overview

The CfWI report considers the issues likely to shape the nursing workforce **over the next 20 years** in relation to the **transfer of care into the community** – and is the view of senior stakeholders with an interest in the nursing workforce. It will be used to inform **supply and demand modelling** in the medium and long term. The horizon scanning project within CfWI will consider 'leverage' using these findings and may widen their future scope to look at **other care pathways** to get better understanding beyond transferring care to the community. It is an analytical project that will deliver high-quality national supply-and-demand forecasts and will look at this from 1-to-5 and 5-to-20-year periods

The stakeholders were interviewed and secondary research was also done to complement where possible.

Some of the main points:

- the main nursing demand up to 2030 is likely to be the increased numbers of **older people with complex needs** requiring community care
- The major workforce supply risk is that the current approach to education and training is **not fit for purpose** in terms of large-scale transfer of care from acute hospitals to the community.

The main challenges of this include:

- planning the education and training system to train nurses to practise in a community setting
- **attracting new recruits** into nursing when more care will be community and not hospital based
- training nurses to care for older people with complex needs
- managing the changing working patterns of **providing 24/7 care** in the community
- managing the **changing working environments** for nurses providing more care in the community
- supporting programmes and continuing professional development (CPD) to increase the number of nurses moving from hospital to community settings.

  → Supply from education/training will only keep pace with new community roles if **steps are taken now.**

  → The role of the registered nurse is increasingly becoming one of case management, specialist knowledge and multidisciplinary team working and leading. Nursing is becoming increasingly '**intelligently compassionate**'.

Background

CfWI supports long-term and strategic scenario planning for the whole health and social care workforce, based on research, evidence and analysis. Some of this includes:

- The **majority of contacts** that people have with health services already take place in the community rather than in hospitals (Royal College of Nursing, 2010).
- Approximately **one third of nurses** currently work in the community, including people's homes, nursing and care homes, health centres, GP surgeries and schools (NHS Workforce Review Team, 2008).
- There is an assumption that care can be provided **more efficiently** outside of hospitals, and that **quality of care** will be improved. Whether this will hold true will be determined by a whole set of factors – such as technology, integration etc

The project asked two questions:

1. **What are the nursing workforce implications of the proposed shift of care into the community?**
2. **How is this going to affect the role of the nurse, education and training, the shape of the nursing workforce, and workforce planning?**

Findings

The future '**shapers**'[1] under consideration have been subdivided into categories:

→ technological, economic, environmental, political, social or ethical

Further details within these categories are reproduced in the following tables:

Shaper – One technological	Description and Implications
1. Technology facilitating care management and provision in people's homes	Technology will allow staff to assess, diagnose, gain specialist advice, access multidisciplinary notes from all those involved, deliver drug treatments and monitor their effects, etc. to manage and deliver comprehensive home-based care safely and effectively. This may have implications on staff training.
2. Online diagnosis and prescription (or apps) may reduce demand for staff time	This could reduce the face-to-face time patients need from nurses or GPs
3. Integrated care staff need real-time access to specialist advice	Integrated care will need staff with generalist (or cross-profession) skills, both at case-manager and hands-on care-provision levels, because people at home will have a range of caring and health issues that will cross professional boundaries.
4. There is a challenge to get systems interconnected (e.g. GP accessing EOL-wishes)	If patients have technology-based interconnecting communication systems then wishes may be acted on. If not, the default pathway is for a patient to be taken by ambulance to A&E, admitted, and to die in hospital.
5. Epigenetics, personalised medicine becomes more widespread.	Nurses 'face significant and complex challenges to integrating genomic healthcare into professional education and practice' (Task & Finish Group, 2011).
6. Electronic communications technology is often lacking for community staff.	Some community nurses lack ready access to basic computing and email facilities, let alone modern communications devices and other advanced technology that could enhance care and efficiency.

Shaper one notes: - The complexity of care may mean that technology advances cannot be adopted and their benefits not realised over the next 10 years at least. Some IT challenges remain unsolved and do not give staff confidence

In this paper - a **'shaper'** is used as an umbrella term that captures all the subjects of examination in horizon scanning, including issues, drivers, big picture challenges, trends, megatrends, wild cards and weak signals.

Shaper Two– economic	Description and Implications
The economic climate increases the drive for a more efficient workforce.	The NHS is currently working with the Nicholson Challenge to save £20 billion by 2015 - nursing is the single most expensive cost to the NHS
Economic pressures: affordability vs. choice and community care development.	This could have an effect on what could be provided versus what is provided and affordable in terms of staffing
Community care policy lacks implementation clarity (re funding, training etc.)	What staff training is needed and how does the current system need redesigning? How will the required changes be achieved? These things are not clear.
Nurse numbers may fall as 20 years of constraint replace decades of growth.	There could be budgetary constraint even after 2015. This could lead to a slowdown or reversal of past trends for annual increases in numbers of nurses employed.
More care delivered in the community may reduce overall health costs	Though it has long been thought that greater care in the community reduces hospital stays etc and reduces cost – it depends however on the level of current unmet need: more staff contacts with patients in their homes could lead to a greater volume of care provided at the same or greater overall cost.
More efficient deployment reduces workforce costs per patient.	There has been managerial focus on this method of reducing costs for years, so it is unclear how much more can be achieved
Patient-held budgets, allowing people to choose and pay providers, become more widespread	This could have a wide range of effects, most of which are uncertain. For example, will it lead to care deficits due to unrecognised needs that then need to be met via emergency intervention (therefore increasing overall nursing demand)? Or, alternatively, it could better match actual need and thus reduce overall nursing demand. People could choose to buy more social care than nursing, or care from cheaper suppliers (e.g. more HCA care).
Marketing by providers will increase.	This may impact on nursing in a number of ways – it could lead to a diversification of employers with differing terms and conditions, role requirements and career pathways. It could be that more people buy social care or cheaper healthcare, rather than pay for highly qualified nurses with specialised knowledge and experience.
Richer skill mix could improve outcomes and reduce overall costs	It has not yet been proven that a workforce with more degree-level entrants and richer skill mix increases the quality of care, improves outcomes and ultimately reduces costs

Shaper Two notes: - Economy factors may affect other shapers too such as affordability of technology.

Shaper Three – environmental	Description and Implications
Domestic price rises and poorer diets	The health consequences would increase demand for nursing.
Epidemic of new forms of healthcare-associated infections.	Increasing demand for nursing if numbers of cases rise
Major epidemic or national disaster – lack of response plans.	The effects of a major epidemic or other national-scale disaster on the nursing workforce is difficult to achieve, and local plans are not currently coordinated at a national level

Shaper Three notes: - Environmental shapers were not were not seen as the most influential with regard to nursing in this project.

Shaper Four– political	Description and Implications
The current approach to education and training is not fit for purpose in terms of transfer from acute to community.	Nurses typically undertake pre-registration education for three years with mostly hospital placements, and then work in hospital for some time (and undertake specialist training) before considering a post in the community. Thus there is a time lag of at least five years and usually longer between providing new pre-registration places to working in the community
A step change may be needed to the rate of shift to community care	Growth in community-located nurses over the past 20 years has been about the same as the acute hospital growth rate. A big change in patterns is required in order to transfer services, let alone meet the policy objective to 'transform'.
Community care moves may continue to be sporadic, piecemeal, local developments.	Services tend to be locally developed, patchy and not available everywhere which depresses overall demand for community nursing. The future may therefore see increased demand.
The care practitioner role appears, working across traditional professional boundaries.	As more complex care is given in the community, there is a need for specialist knowledge: heart disease, stroke, cancer, asthma, diabetes, neurological, etc. But specialists need to be generic as they will work across the traditional professional boundaries (nurse, doctor, therapist, social worker). This could happen at both registered and assistant practitioner levels.
Proactive case management needs rapid development to progress integrated care.	Experienced, skilled community nurses or specialist outreach nurses should be naturally suited to excel in this role. Are there enough of such nurses in the supply pool? These nurses often identify their own CPD based of their skills of identifying need in their patients – which gives them the skill set of hybrid hospital-community outreach roles.
More understanding of care pathways to plan services and workforce	There are many factors that affect services needed, time taken for each patient, skill level needed, travel time, shift patterns, availability of back-up and advice). More information is needed about these factors to estimate the workforce required and therefore costs.

'Any qualified provider' makes education and workforce planning more difficult.	This could lead to a more diverse range of providers, including from the private sector. This could make it harder to make decisions about education numbers and placements, and result in many aspects of workforce planning becoming harder to coordinate.
There is a 'protecting our professions' response	Protectionism can have pros and cons: it could slow down beneficial change; or alternatively could protect patients and the public by retaining safe and proven ways of working.

Shaper Four notes: - If the future remains one of local response to policy, it is unlikely that policy aims will be fully achieved within 20 years.

Shaper Five– social	Description and Implications
Lengths of stay continue to reduce in acute sector.	Acute hospitals are likely to want to continue reducing lengths of stay. This will push ever more acute need/demand into community settings and increase the intensity of work for staff.
Better outcomes increase survival and thus increase the demand for nursing.	Over the last 20 years the percentage surviving has more than doubled
Increasing population (all ages) increases demand for nursing workforce.	Even if the need for 'nursing-per-person' stays the same, there will be an increased demand for nursing: the likely growth rate in NHS activity is expected to continue to outstrip population growth, adding further to the overall demand for nursing care.
Consumers expect and demand more	The public expects and is willing to pay for ever more care (whether costs are met via taxation, efficiencies, private payment or insurance).
There could be changing disease profiles	New diseases could emerge that have different effects on nursing as a profession in the way that the emergence of HIV radically changed nursing in a number of ways such as in workforce protection procedures,
There are fewer newly qualified nurses due to education intake reductions	The number of places in pre-registration education has declined; in the total numbers of places rather than applications.
24/7 community care becomes the norm and changes the current role of nursing.	Many nurses work in the community because the work is often 9-5, Monday-Friday - more care in the community will require a 24/7, 'virtual ward' approach requiring the kinds of recruitment, retention and deployment approaches used by hospitals. Factors such as hours of work and working alone rather than in busy ward teams may have an effect on community nursing recruitment and retention along with the age structure of the workforce and retirement patterns

Shaper Six – ethical	Description and Implications
People with complex needs, demand integrated care.	The demand for improvements in the coordination of care will become louder and more urgent over the next 20 years. This may affect nursing numbers, skill mix, approach, and locations
The shift to community could mean more people with unmet needs	Moving more acute care into the community is not without risk. Staffing levels, good prioritisation/ scheduling of visits, telehealth and e-monitoring will all need to be well utilised to reduce this risk.
There is a transfer of risk to patients and families	Risks currently taken by the NHS are shifting onto patients and carers. This may increase nurses' role as trusted advisors but it is uncertain how
There is an increase in self-managed care and lay carer involvement	The impact of trends towards more carer and patient management of care on nursing could be wide ranging and uncertain
The majority of people are keen to reduce time spent in hospital	This is a fundamental demand driver that changes the levels and type of demand in the different care settings.
Person-centred care could become even more of a priority.	Care should be personalised yet reports continue to emerge about extensive shortcomings. In future this may be expressed more strongly; 'Intelligently compassionate nursing'
There is an internet information overload – so trust and reliance on nurses increases	Information may become so unreliable, inaccurate and confusing that people may turn to trusted sources like nurses and ask them to assist and advise when making choices
No one receives the healthcare that could fully benefit them.	There will never be enough nurses available or employed to provide all the possible care to everyone with any kind of need or enough time or funding to deliver all they could for every one of their patients. Nurses can never do everything possible.

Conclusion from the report

- Far more nurses will be needed with skills and knowledge in complex case management (assessment and diagnosis, coordination across professional boundaries, and prescription skills) and advanced specialist practice knowledge in care delivery. Currently, there is no readily available **supply pool large enough** to meet this need
- The Nursing and Midwifery Professional Advisory Board (PAB) – a board of clinical professionals who provide expert advice on nursing and midwifery workforce planning– is assessing the **post-registration career framework** as a priority, and could thus advise on the necessary CPD changes.
- The main nursing workforce challenge to 2030 will be **commissioning** and making changes to the **education and training** system so that it can create the required high-level community nursing capacity in time to meet demand.
- The role of the registered nurse will increasingly become one of **advanced practice**

Next Steps and Implications for the Children's Palliative Care Sector:

- Next steps for the CfWI will include the Nursing and Midwifery programme working out who is best placed to **influence** these shapers – if that is possible at all
- If managing shapers is not possible then the CfWI will look at how their effects can be **mitigated**
- The intention is to move the learning from this project into other pathways broader than moving nursing into the community

Together for Short Lives would welcome your comments on the following questions and whether you would welcome further discussions with colleagues about the aspects of future workforce planning that it contains.

We would especially like to hear if your organisation or is planning to develop **more flexible working** including delivering an increased service in the community and whether you think the detail in this paper is reflective of the challenges and conditions that you predict.

Questions to consider:

1. Are you currently provisioned to offer nursing in a community setting as well as a building-based service?
2. Are you considering this as a development in the future of your service?
3. Which of the shapers in the above categories currently gives you cause for challenge or concern? (these could be technology, electronic information sharing, availability of training, caseloads, 24/7 cover, commissioning of services)
4. What are you doing to mitigate the effects of the shapers above?
5. Are you linked with the Workforce Development Officer of your **Local Education and Training Board (LETB)** to discuss current and future nurse training - links to LETB websites below:

   → East Midlands
   → East of England
   → Yorkshire and the Humber
   → Wessex
   → Thames Valley
   → North West London
   → South London
   → North Central and East London
   → Kent, Surrey and Sussex
   → North East
   → North West
   → West Midlands
   → South West

Please reply to:
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