Workforce Planning Considerations for ARRS Roles.

These questions and supplied information are intended to guide PCNs in workforce planning and should be considered in conjunction with the accompanying slide set, providing information relating to each of the individual roles. There is no single approach that is likely to provide an answer to increasing capacity across primary care; however it is becoming increasingly clear that PCNs need to work more closely with acute providers in their ICS/STP, and potentially across the region, in order to come up with sustainable workforce solutions in a climate of growing demand.

Clinical Pharmacists:

How are PCNs envisioning using these?

* There may be other professions that could bridge some of the gaps/take on roles, dependent on the needs of the local population.
* Pharmacy is a fairly static workforce in secondary care, and has shown less growth than other professional groups over the last 5-6 years (as per HEE dashboard data).
* The bulk of the workforce in secondary care is comprised of the higher bandings – 7 and 8a+, which will be a source of competition for the roles in primary care. Therefore, can the system accommodate increased demand? Is there another approach?

Social Prescribing Link Workers (SPLWs):

* Supply is unknown and uncertain.
* Do PCNs envision recruiting trainees or those who have been through training?
* Given demand from these returns there is unlikely to be sufficient supply available to meet demand; however, if taken on as trainees, the main limiting factor would be capacity of training institutions to provide training to all trainees. NB Training ~7 months so fairly quick throughput, but not in time for March ’21.
* There is potential to appeal to those seeking stable employment during a period of recession, and as a springboard to other health and social care careers, but this may also mean a greater turnover of this workforce if economy recovers more quickly, or career progression not (adequately) factored in.
* PCNs also need to consider the implications of taking on trainees – who will offer on-the-job support and supervision? This will have a short term impact on clinical capacity of those supporting.

First Contact Practitioner (Physiotherapy):

* See accompanying slide pack for the latest banding breakdown in secondary care. PCNs will need to consider these will not be newly qualified staff and FCPs require a minimum of 3 years’ experience, plus additional training. There is not therefore a ready supply, which will impact on short term recruitment aims.
* A more junior workforce could be a possibility, only if adequate supervision from specialist practitioners available. If bypassing the GP referral process, they would need sufficient experience to differentiate potentially serious conditions/medical emergencies, e.g. cauda equina syndrome (commonly detected by experienced MSK PTs, but very serious implications if missed/misdiagnosed). Note that PTs are one of the most common groups of non-medical prescribers, within specific parameters, e.g. pain meds. (<https://bnfc.nice.org.uk/guidance/non-medical-prescribing.html>). When considering if a more junior workforce could be used, this should be considered across the whole region as a lack of parity will impact local recruitment, and may not be feasible in all areas. Ideally this should be nationally agreed; however, the immediate priority would be regional equitability.
* There exists the potential for split roles across primary and secondary care to support career development; although some will wish to remain clinical, common career progression is into management beyond 8a level, and more opportunities exist in secondary care. Secondary care often offers more robust progression pathways.
* Also need to consider clinical supervision - ?peer support networks/via secondary care links/split posts.

PAs:

* From trust operation plans, PA figures suggest 137.3 FTE in March ’19, aiming for 158.6 FTE in March ’20, but no updated figures available. Predicted outturn for London is updated on accompanying slides.
* Main issues are sufficient supply to meet demand across London, and attracting recruits to primary care over potentially more exciting secondary care roles. Could joint rotations be a possibility?
* In general career progression pathways for PAs are a concern/consideration, but should be factored into promotion of primary care roles.
* There is huge potential for use in primary care to free up GP time; however also need to consider supervision, particularly for new grads and impact of this on clinical time of supervising staff.

Pharmacy Technicians:

* Banding profile is given in accompanying slides, including trainees to indicate potential supply.
* Note on-the-job training offers a more immediate workforce solution, but comes with a supervisory requirement, therefore this will be limited by capacity of pharmacists to adequately support PTechs in training, with impact on their available clinical capacity.
* Low supply noted when recruiting to the Nightingale hospitals.
* Note higher banded techs will be potentially less desirable as reimbursement fee won’t cover full salary and those on higher banding are unlikely to drop bands! (But is the ESR data correct or are these pharmacists that have been incorrectly assigned to tech roles??)
* Also need to consider access to training by training institutions – is there capacity in that system to support recruitment of trainees? Are there set start dates that support the March ’21 target for recruitment?

OTs:

* There is low demand form PCNs for these, but are they aware of the full potential of this group?
* OTs can train to be FCPractitioners (with 3 years minimum experience – likely more) so may be able to free up some GP time. Likely to be suitable for those with a broad skillset, e.g. emergency medicine/specialised medicine, rather than those with highly specific specialities (neuro/ortho/oncology/MH); however, if tailored to population profile, could be extremely valuable, e.g. MH support from specialist MH OT. It would be worth liaising with RCOT for further information re. promotion and application in this sense.
* OTs can be trained as prescribers, but there are fewer prescribers compared to physios in reality.
* Good general, holistic support potential, and a natural fit for supervision of public health roles as many of these tasks are generally carried out by OTs in the absence of specific staff for signposting, etc.
* Primary care may appeal to those burnt out from fast paced acute work, or those wishing for greater flexibility and autonomy in their roles, but again need to consider career progression pathways.
* It may be possible to attract those to support into a ‘fast-track’ type development, e.g. experienced band 6 looking to progress rapidly in a defined context (primary care), but this needs careful consideration.

Dietitians:

* Similar situation to OTs, but more specific clinical work streams can be determined.
* There is potential to free up GP time through public health initiatives, e.g. weight management groups, specialised diets (heart health, diabetic mgmt., etc.), but again need to be experienced staff to spot red flags.
* Can be FCPractitioners with additional training.
* As with OT, it may be possible to attract those to support into a ‘fast-track’ type development, e.g. experienced band 6 looking to progress rapidly in a defined context (primary care), but this needs careful consideration.
* Also may be able to review nutritional support prescriptions for hospital discharges, and manage this without having to involve GP. Anecdotally, there is a lot of waste of nutritional supplements following discharge due to poor review and follow up.

Podiatrists:

* Similar situation to OT and Dietitians; can become FCPractitioners with min. 3 years experience.
* It is worth noting that a greater proportion of podiatrists are able to work in private practice, so could be more easily enticed to the stability of NHS positions if these were attractively promoted; however, they have a narrower scope of practice than other AHP professions which limits potential to free up GP time.
* Within their scope of practice, there is good potential to free up GP time – diabetic foot health, etc. and it would be worth liaising with their body equivalent to CSP/RCOT to fully determine their capabilities and potential in this regard.

H&WB Coaches and Care Coordinators:

* Similar to SPLWs, there is a potentially large supply, but this will be limited if training is required in advance of recruitment.
* Can the practices support trainees adequately? Is there sufficient access to training?
* These could work well for specific conditions/population profiles, e.g. public health programmes, such as weight loss support, in conjunction with dietitians.
* Need to consider clinical supervision. Again, may appeal to those seeking stable employment, but may be faster turnover due to limited development opportunities, or progression into other H&SC careers.
* Do the PCNs fully understand the scope of these roles?