

**Final Report**

**COMPREHENSIVE REVIEW  
OF THE  
PODIATRY WORKFORCE**

**REPORT OF THE  
PROJECT GROUP**

*23 December 2002*

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## **EXECUTIVE SUMMARY**

In September 2001, the DHSSPS commenced a series of uni-professional workforce reviews, which, over the period of one year, would cover the main clinical professions within the HPSS. There were a number of drivers behind the initiative and these included, the publication of the Hayes Report on the future of Acute Hospital Services and the DHSSPS consultation document 'The Employer of Choice'. Both documents highlighted the urgent need to put in place structures that will support workforce planning within and across all of the HPSS Professions. While it was determined that the initiatives, at this stage, would be taken forward on a uni-professional basis, the information and recommendations from this work would provide an important baseline in terms of developing workforce planning within HPSS across service sectors and professions.

### **Introduction**

The document presented sets out a comprehensive review of the HPSS Podiatry profession. The review was undertaken during the period April-September 2002 and was co-ordinated by a Project Group, which comprised of representatives of the DHSSPS, providers, education, commissioners and staff side. The content of the report includes background details (including terms of reference), the project methodology, and a detailed profile of the current Podiatry workforce, a projection of the supply and demand for podiatrists within the HPSS workforce over the 5-year period 2003-2007 and recommendations to address issues arising from the review.

### **Background**

The principal focus of the review was to provide the DHSSPS and service providers and commissioners with information concerning recruitment and retention issues within Podiatry and a projection of supply and demand within the profession. This information is vital to assist the Department in developing strategies that will ensure that the correct numbers of professionals are trained, in place and working effectively to offer the maximum benefit to patients and clients.

In considering the above, it is also important to review the current health policy context for the delivery of health and social care services in the future. A number of strategic documents have been reviewed and highlight the focus now being given to the delivery of high quality accessible care, with the development of the HPSS workforce being key to achieving this.

## **Terms of Reference**

1. Provide a profile of the current Podiatry workforce in Northern Ireland, including:
  - Numbers employed, specialism in which employed, grading distribution age and gender balance.
  - Working conditions and patterns, grading and distribution.
  - Continuing professional development opportunities.
  
2. Provide an analysis of current and future recruitment and retention issues, including:
  - Remuneration
  - Career development and specialisation
  - Career breaks / leaving the profession
  - Working arrangements
  
3. Provide a prediction of the future supply of podiatrists over the next 5 years within the workforce and demand, including:
  - Number of podiatrists required meeting service demands
  - Specialism distribution

This review will focus on providing a qualitative report and was not required to examine economic issues or carry out detailed feasibility studies.

## **Methodology**

The following methodology was employed:

- Audit of current workforce identifying the staffing profile and characteristics. This baseline information was primarily gathered from existing information held within the Department and at Trust level on the Human Resource Management Information Systems, and supplemented as possible by the respective professional bodies.
  
- Background research conducted to identify future and current trends impacting upon the staff and involved a keyword and heading search of relevant professional databases; policy document review; a review of Trust and commissioner strategies to identify proposed service developments or changes and a review of benchmark data sources.

- Consultation with stakeholders involving extensive consultation, through 14 key informant interviews and 7 focus groups.
- Analysis of data gathered to develop a workforce model to aid the prediction of supply and demand of the workforce over the period of 2003 - 2007.

## **Key findings of the review – supply and demand issues**

### **Supply Issues**

#### ***Current Staffing Profile***

- The Podiatry workforce represents a total headcount of 179 in Northern Ireland (March 2002).
- The ratio of headcount to whole time equivalent for this work force is 1.2:1.
- 77% of the workforce is female with 23% male.
- The age profile of the Podiatry workforce shows that only 1% fall within the 55 + category and that 60 is the ‘eligible’ age for retirement within the general Podiatry profession.
- The data indicates that 95% of the workforce is under 50 years of age and 69% are below 40 years of age.
- The grade breakdown of podiatrists within Northern Ireland workforce identifies that 32% are at Senior I grade and 52% are at Senior II grade and only 1% at the basic grade level.
- The total number of current vacancies within this profession was identified as 7, which equates to 3.9% of the workforce.

#### ***Recruitment and Retention***

- There are currently no issues with regard to recruiting to training places at the University of Ulster with the application to places ratio 5.5:1
- The attrition rate for Podiatry students is 22% based on a three-year period.
- On average 73% of new graduates do not enter the HPSS sector in Northern Ireland, due to a lack of posts. Data indicates that only 1

graduate in each of the last 2 years took up employment within the N.I HPSS due to the lack of posts available.

- Final year students expressed a strong desire to take up employment in the NIHPSS but indicated there were poor job opportunities.
- Staff requests are increasing for work-life balance practices and it is estimated that currently this accounts for a loss of 1% of the Podiatry workforce per annum and the trend is likely to increase.

### ***Private Sector***

- There is a demand for Podiatrists within the private sector and graduates often gravitate towards this employment when unable to gain employment within the HPSS.
- A considerable number of Podiatrists work in a dual role between the private sector and the HPSS.

### ***Career Progression***

- Lack of career opportunities and progression is a significant factor in demotivating the work force. There is a limited career path beyond Senior I level when often the only available promotional route after Senior I is into management, which has very limited opportunities.
- There are very few basic grade posts within the Podiatry workforce (a total of 6 at March 2002) and these numbers have decreased by 57% since 1998 (from 14 Podiatrists).
- The majority of Podiatry posts - 31%, are at a Senior I level, with 51% of posts at Senior II level, which in total accounts for 82% of the workforce.

### ***Lifelong Learning***

- Difficulties are encountered in ensuring Continual Professional Development for post-graduate staff both from a time and funding prospective. Time out often has a detrimental affect on contract and indicative volumes, which complicates workflow patterns and the ability of managers to release staff for training.
- There are current issues indicating the need for a change in the undergraduate clinical placement system and a requirement for Trusts to consider improved way of facilitating clinical placements.

### ***Under representation***

- There is a lack of representation at corporate and strategic levels for the profession, which correspondingly means a lack of inclusion in the decision and communication process within Boards and Trusts.

### **Demand Issues**

Demands, which will alter services provision, have been identified within the context of the review.

### ***Service Developments***

- The development of a Diabetes specialist post Royal Group of Hospitals Trust.
- The delivery of a Podiatry Service within the context of Regional Brain Injury Unit.
- The provision of Podiatric Surgery within the HPSS.
- The Podiatry contribution to the Health and Social Care Groups.
- Role extension of the Podiatrists into both the clinical specialist and consultant role.

### ***Skill Mix/Workforce Review***

- A significant amount of podiatrist's time can be spent on administrative and clerical tasks.
- Some tasks undertaken by podiatrists do not require professional skills and there are opportunities to further allocate tasks to assistant grades eg decontamination of equipment.
- Podiatry assistants could be employed to meet some of the requirements identified as current demand in the clinical service.

### ***Operational difficulties***

- A considerable element of the clinical service time has now been allocated to "high risk" category patients. This prioritisation shifts the emphasis of service provision to leave a significant gap in the ability to

deliver a clinical service to lower risk patients. These pressures have resulted in lengthening clinical waiting lists within the podiatry service.

- Pressures experienced within the Podiatry Service results in lengthening clinical waiting lists for new patients attempting to access the clinical service for the first time.
- An increase in patient awareness of Patients Charter, rights access to services, increasing expectations and complaints systems causes pressure on the operational service delivery.
- An ageing growing population with increased referral activity patterns, compounding clinical complications and increased dependency, are causing pressure on the clinical service.

## **Projected Supply and Demand Conclusions**

Conclusions were drawn and assumptions made concerning the future profile of the workforce and supply and demand projections have been detailed in Section 7 of this report. They have been developed into a workforce model to predict the requirement of the Podiatry workforce over the period 2003 - 2007.

All data presented has been gathered from discussions with the project group, key informant interviews, HPSS Project Support Analysis statistics and current business cases.

## **Supply Conclusions**

Supply conclusions are based on assumptions made during the consultation process and the projected supply of podiatrists has been calculated between 2003-2007. These are profiled in the table below:-

**Table: Projected Supply of Overall Podiatry Workforce in NI (2003-2007)**

Supply	2003	2004	2005	2006	2007
Total available to NIHPSS	12	15	15	15	15
Total leavers of NIHPSS	5	6	6	5	5
Total current/potential numbers in NIHPSS	172	179	190	201	211
Projected potential numbers in NIHPSS	179	190	201	211	221
<b>Potential net increase (decrease)</b>	<b>4%</b>	<b>5%</b>	<b>5%</b>	<b>5%</b>	<b>5%</b>

## Demand Conclusions

The demand for Podiatry professionals has been presented at three category levels:

**Category 1:** This refers to capital and service development, which have already been agreed in which the workforce requirements have been identified, and have the associated funding approval.

**Category 2:** This refers to service developments that have been identified via the key informant interviews and project group that are likely to be supported over the next 5 years, although resources have yet to be identified. This includes educational requirements at both under and postgraduate's levels including continual professional development, time required to facilitate students on clinical placements, elements of health promotion, role development and meeting clinical governance.

**Category 3:** This refers to additional demands within the current and future services, identified via the key informant interviews and project group that do not have funding allocation. This includes referral waiting lists and clinical service demands that cannot be met within existing resources.

For the initial purposes of this workforce plan the combination of Categories 1 + 2 has been adopted. These categories include agreed resourced capital and service plans with identified workforce requirements and those that are likely to be resourced within the 5-year plan. The following table illustrates the impact of these demands including the current vacancies within the projected workforce.

**Table: Projected Demand Figures in headcount over the 5-year workforce plan for Podiatry population within Northern Ireland.**

Workforce requirements	2003	2004	2005	2006	2007
Vacancies	7	5	2	0	0
<i>Category 1 (capital &amp; service requirements, with identified resources)</i>	0	2	-	-	-
<i>Category 2 (current and future demand likely to be resourced)</i>	6	4	5	1	1
<b>Total</b>	<b>13</b>	<b>11</b>	<b>7</b>	<b>1</b>	<b>1</b>

**Demand Category 3** has been explored in depth in Chapter 5 of the report.

## Supply v Demand Conclusions

The following table illustrates the overall increase (decrease) in the numbers within the workforce over the 5-year plan.

**Table: Profile of projected supply against demand by headcount for the 5-year plan.**

Key Factors: Supply v Demand	2003	2004	2005	2006	2007
Potential additional numbers in NI HPSS	7	9	9	10	10
Potential total workforce in NI HPSS	186	195	204	214	224
Vacancies	7	0	0	0	0
Demand Categories 1&2	5	6	5	1	1
<b>Total over (under) numbers in workforce</b>	<b>(5)</b>	<b>3</b>	<b>4</b>	<b>9</b>	<b>9</b>

It can be seen from the above table that the supply of Podiatrists available to the NIHPSS should meet the demands of Categories 1&2 by year 2 of the workforce plan when taking into account the current vacancies (7).

## **RECOMMENDATIONS**

The timescale for the implementation of the key recommendations outlined below is twelve months to coincide with the follow up review.

### **Workforce Planning**

- Now that the workforce planning process is established it is recommended that the Project Board should be retained to review supply and demand on an ongoing basis. It should utilise the information gathered in the review building and expand on it, taking into account such factors as the impact on the workforce, of role extension, specialisation, capital plans and service development business cases.
- The Project Board should ensure that there is a consistent and targeted approach to gathering relevant supply and demand data and manpower recording processes.
- The Department should review the activity data collected from the Allied Health Professions at Trust level. Professional managers should review management data collection from the current information systems and ensure the systems are maximised to their full potential. The aim of these reviews will be to provide a more comprehensive management information collection, which will aid the workforce planning process.

### **Recruitment & Retention**

- All employers should put in place policies to incorporate planned induction, consolidation and mentorship programmes for all new staff and review the effectiveness of these in a quantitative and qualitative manner.
- Employers and the profession should put in place a consistent approach to the implementation of work-life balance policies and procedures and this should be factored into workforce planning.

### **Utilisation of the available Workforce**

- Trusts should carry out further work into the possibility of reallocating non-clinical responsibilities to other health care workers including Podiatry Assistants.
- A co-ordinated approach between the professions, employers and the DHSSPS should take place with regard to workforce planning of

Podiatry, particularly in relation to role extension and development issues.

- Commissioners should work closely with Trusts to clearly specify the required podiatry clinical service provision within the existing resources.
- Consideration should be given by Commissioners and Trusts to defining how patients access the service with the aim of achieving better control of demand and workflow focused through appropriate clinical channels.

### **Education & Development**

- The UU and Trusts should work together to agree best practice for undergraduate clinical placements that ensures students are fully prepared for a clinical working environment
- All Trusts with Podiatry services have been surveyed (DHSSPS May 2002) with regards to the existing numbers of clinical placements and the maximum numbers that may be accommodated for each training year. Further discussions should take place between DHSSPS, Trusts and the University to establish a more comprehensive way of providing undergraduate clinical placements. There should be solutions found to the barriers identified to ensure Trusts can accommodate the number and quality of clinical placements required.
- Statistics indicate a high attrition rate and a high number of repeat year students within the undergraduate course. The reasons for these should be identified and explored with the view to improve outcomes and graduate numbers. These statistics should be monitored by the University of Ulster and reviewed on a regular basis by the DHSSPS.
- There should be an increased focus placed on Continuing Professional Development (including leadership development) and all employers should ensure that the recommended hours provision is accounted for through the workforce planning process.
- The Podiatry profession should become actively involved in the Centre for Postgraduate Continuing Professional Development for Allied Health Professionals. The NI Podiatry profession should identify its training requirements and contribute to planning for these needs.
- Employers should ensure training is available for all staff that will be required to provide mentorship or coaching support as part of their role.

- The Department should take forward the development of the AHP's Consultant role to acknowledge the high levels of clinical expertise within the profession.

### **Further Review of the Workforce**

- The Project Group should be convened initially on an annual basis to review and update the workforce plan.
- Trusts should review the skill mix of their Podiatry workforce to ensure it has the most appropriate combination of staffing grades to meet the needs of the clinical service. This review should also ensure that entry-level posts are maintained so there is a continued flow into the workforce of new graduates.
- The Project Group should be mobilised to take forward where appropriate any recommendations emanating from the workforce review.
- Trusts should review with its Podiatry Service the demands of Category 3, as identified in this report, and ensure that any agreed increase in service is included in any future service development plans.

### **CONCLUSION**

This Podiatry workforce review can be only viewed as a starting point, or baseline for further work to be carried forward. This includes the development of an action plan to take forward the recommendations outlined above. The models presented in the report will need updated and refined on a regular basis to continue to inform decision making and priorities concerning the investment in the NI HPSS Podiatry workforce over the five-year plan.

## **1. INTRODUCTION**

An in-depth review of the Podiatry workforce in Northern Ireland took place between April and September 2002 and was co-ordinated by a Project Group, which comprised of representatives of the DHSSPS, HPSS commissioners and providers, education and staff side. The report includes:

- A background to the project
- The project methodology
- A summary of the recruitment and retention issues arising from the review and a projection of the supply and demand for podiatrists over the next five years within HPSS.

The report concludes with a list of recommendations, which seek to contribute to the addressing current and future workforce issues within the NI HPSS Podiatry workforce.

The Department of Health, Social Services and Public Safety Northern Ireland's aim of the review is to develop strategies that can assure the correct numbers of podiatrists are in place and working in the most effective way to offer optimal benefit to the overall healthcare team and the patient.

### **1.1 TERMS OF REFERENCE**

The following specific terms of reference were applied when carrying out this review:

Provide a profile of the current Podiatry workforce in Northern Ireland, including:

- Numbers employed, grading, distribution, age and gender balance.
- Working conditions and patterns.
- Continuing professional development commitments.
- Provide an analysis of current and future recruitment and retention issues, including:
- Remuneration.
- Career development and specialisation.

- Career breaks/leaving the profession.
- Working arrangements.
- Provide a prediction of future supply over the next 5 years and demand for podiatrists, including:
  - The number required meeting service demands.
  - Specialism distribution.

The requirement for this piece of work was to review issues at a generic, strategic level and provide sound conclusions and recommendations relevant to the workforce as a whole. This review was not required to examine economic issues or carry out detailed feasibility studies.

The aim of the report is to provide a starting point and baseline for workforce planning which could then be built on and expanded through future analysis and focus using identified workforce representatives at all levels throughout the sector.

## **1.2 METHODOLOGY**

The methodology for the review focused on consulting with those within the current workforce, across the geographical regions of Northern Ireland. The views of under graduate students were also sought as they represent a substantial part of the future supply of the workforce.

All representatives were identified by the Project Board, Appendix 1, set up to manage this review.

The methodology adopted for this review contained the following:

- Key Informant Interviews: Semi-structured in-depth interviews were carried out with 14 key representatives, Appendix 2.
- Focus Groups: 7 focus groups were held made up of a representative mix of disciplines, grades and primary and secondary sector employees, Appendix 3.
- Literature Review and Desk Research: A comprehensive literature review was undertaken and it was key that these references were utilised to inform the project, Appendix 4.

## 2. CONTEXT

It was important to set this review within an appropriate context before carrying out any data gathering to inform the design of pertinent survey tools and ensure relevancy of conclusions and recommendations. This necessitated looking at the current situation with regard to the wider Health Policy context and the roles that podiatrists could play within this.

### *Health Policy Context*

The overall aim of the Department of Health, Social Services and Public Safety is to improve the health and well being of the people of Northern Ireland within the resources available. It seeks to achieve this in ways which:

- Are fair and equitable, targeting resources towards those in greatest need
- Listen to the views of users, carers and the public.
- Continuously improve the quality and clinical excellence of services
- Stimulate and support the formation of partnerships across all sectors to promote and improve health and well-being.

It must also seek to increase the effectiveness of clinical intervention. That is to maintain or improve health and to secure the greatest possible health gain from available resources. Those HPSS employees, which fall within the Allied Health Professions, specifically Podiatry, are key to achieving this overall clinical effectiveness and essential to develop strategies that can ensure the correct numbers of these skilled employees are in place, working on an integrated basis and in the most effective way, offering maximum benefit to the health care team and optimal patient and client outcomes. Sir Maurice Hayes has further reinforced this in the Acute Services Review consultation document (May 2001) (1) where he states that the DHSSPS, in consultation with the service, should as a matter of urgency undertake an assessment of service needs and the skills and staff required to deliver these services efficiently and effectively. The report also stressed that there is the need to build up adequate contingency or even over supply of adequately prepared professionals so as to ensure that there is no repeat of difficulties of the past.

It is within this context that the workforce review for Podiatry is set.

### ***Great Britain and Northern Ireland Context***

The strategic focus outlined above was first detailed in ‘The New NHS – Modern and Dependable’ (2) which set out the Government’s vision for the National Health Service (NHS) in England. The Government plans for NHS modernisation are intended to ensure a high quality, national service that is clinically sound, cost-effective and equitable. This was emphasised by Alan Milburn, speaking at Farnborough Hospital on 13 October 1999, saying, “By the time we finish our 10-year programme of modernisation, the NHS of 1948 will be unrecognisable. It will remain true to its values but they will be delivered in new and modern ways”. The NHS white paper (3) and subsequent quality consultation document (4) identified requirements for consistent, high quality care throughout the health service and all health organisations, including primary care. This will mean that all areas of healthcare, including Podiatry deliver care to the patient in the most timely and most cost effective ways possible.

In line with the above, the Northern Ireland Executive in its Programme for Government 2001-2004 (5) identified “Working for a Healthier people” as one of its priorities and has stated that “we will work to reduce waiting lists, implementing new management arrangements, and recruiting additional front line staff”.

The Programme focuses specifically on the following:

- Reducing preventable diseases, ill health and health inequalities.
- Ensuring that the environment supports healthy living and that recreational facilities are improved.
- Modernising and improving hospital and primary care services to ensure more timely and effective care and treatment for patients.
- Enabling those who suffer from disability, chronic mental or terminal illness to live normal lives.

The Programme commits the Executive to the following actions, which affect podiatrists directly:

- Providing 40-50 extra specialist medical, nursing and other staff to improve treatment of people with breast, lung and colorectal cancers.
- Addressing workforce shortages in the health service.

The document 'Priorities for Action' (6) details the DHSSPS planning priorities for 2001-2002, in the context of the Programme for Government as outlined above. It states the objectives, and targets that will ensure their achievement. In meeting its responsibility for setting strategic direction, overseeing the delivery of the health and social services, the DHSSPS has set targets for Boards and Trusts. These include:

- Increasing capacity, improving flexibility and responsiveness to meeting continued demand.
- Improving access to services, particularly reducing waiting lists.
- Tackling shortages of skilled staff, particularly in hard-pressed specialist areas. This includes not only increases in the supply of qualified staff but also measures to improve recruitment and retention of staff within the HPSS.
- Developing partnerships with other statutory and voluntary sector organisations.

### *Secondary Care*

In the provision of secondary services, the Acute Hospital Review Group Report 2001(1) is the most recent document to address the structure of the HPSS as a whole in Northern Ireland. The Report highlights key recommendations, which include:

- To significantly shift the balance of care from secondary care to primary care.
- To provide acute hospital services that are consultant delivered rather than consultant led.
- Primary care organisations should be given the responsibility for the commissioning of community services and non-regional hospital services in the context of the strategic plan.

### *Quality and Primary Care*

These principles outlined above have been reinforced in the context of Northern Ireland in the recent Consultation Paper, "Best Practice – Best Care" (7). This paper, published in April 2001, focuses on the three interlocking strands of setting standards (improving services and practice), delivering services (ensuring local accountability) and improving monitoring and regulation of the services. In addition, identifying new ways for health professionals to be involved in the delivery of NHS services has been a key

principle identified in the Consultation Paper “Building the way forward in Primary Care” (8), which clearly sets out a number of priority areas for development in primary care relevant to this review.

In Northern Ireland these proposals have been supported by the ‘Allied Health Professions’, which includes Podiatry. The position paper ‘Primary Care – Professions Allied to Medicine’ (9), endorses the priority given to breaking down traditional boundaries so that all care professionals use their skills in the most appropriate way to treat and care for people, the development of new and innovative models of service delivery and the support of emerging new professional roles. However in order for this to happen it is argued that there must be greater representation of the Allied Health Professions to influence the decision making process in strategic planning, policy formulation, commissioning and in the general management of the HPSS (10).

### ***Public Health***

In the UK, public health strategies have recently been produced for Scotland (Working together for a Healthier Scotland 1998) (11), Wales (Better Health – Better Wales 1998) (12) and England (Saving Lives: Our Healthier Nation 1999) (13).

In Northern Ireland these key issues are reinforced in the strategic documents “Investing for Health” (14), and “Well into 2000: A positive agenda for Health and Social Well-being” (15) which underpin the government’s vision for the Health Service. The proposals encourage professions to work with the community to promote health and well-being rather than focus on the treatment of ill health. Podiatry has a key role to play in health promotion starting from childhood on.

### ***The Podiatry profession***

The Society of Chiropodists and Podiatrists came into being in 1945 when 5 British chiropody organisations amalgamated. In 1954 the examinations of the Society were approved by the Ministry of Health for National Service appointments. The Society continued as the examining body for the purposes of State Registration when the United Kingdom Parliament formally acknowledged the professional status of Podiatry under the Professions Supplementary to Medicine Act 1960. This gives a considerable degree of professional autonomy to Podiatrists, enabling them to maintain their own professional discipline, set standards of conduct and Code of Ethics, and to set standards of education and training for entry into the workforce.

In 1993 the Society of Chiropodists added the name Podiatrist to its title reflecting the use of the term throughout the English-speaking world.

There are currently 8,500 members and students registered in the UK with the Society of Chiropodists and Podiatrists. (16)

## **SUPPLY ISSUES**

The NI Podiatry Workforce has had minimal growth in recent years. Northern Ireland had 141.29 WTE podiatrists in posts at March 1998, a total of 149.8 WTE in March 2002, an increase of 5.7% over 4 years. The issues associated with the supply of podiatrists are detailed in subsequent paragraphs:

### ***Remuneration***

The pay structure for podiatrists provides Basic, Senior II, Senior I, Chief IV, Chief III, Chief II, Chief I and Area Chief Grades. Clinical grades are identified at Basic, Senior II and Senior I. From Chief IV to Area Chief as well as Senior Management II are considered to be at a managerial level. Often the Chief IV grade has a high clinical input with a managerial element. Agreement was reached however during 2001/2 on the introduction of Allied Health Professions Consultant Posts in England and Wales.

The salary structure is the same as that applied to the other Allied Health Professions of Occupational Therapy, Physiotherapy, Orthoptists, Dietitians and Radiographers with pay awards determined by the National Pay Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine. The Pay Review Body recommended a 3.7 per cent increase to basic pay and some allowances in 2001/2. Discretionary Points were consolidated into the pay scales, introduced as a mechanism for staff to achieve recognition for having developed their role and skills. Staff are eligible for discretionary points after serving one year at the top of the scale. (17)

Like other NHS professions, the remuneration of podiatrists will come under new arrangements proposed under Agenda for Change. The timeframe for introduction of these arrangements within NI HPSS has not yet been determined.

### ***Recruitment***

There is evidence to suggest that the recruitment issues for podiatry commence at undergraduate level within the UK as a whole. A report in Podiatry Now in May 2001 suggested "Schools across the UK are almost universally struggling to recruit students on the podiatry degree course and ultimately into the profession." (18) In its 1999 Annual Report, the Society of Chiropodists and Podiatrists documented the problem of falling numbers of applications to podiatry degree courses, concluding that between 1996 and 1999 there had been a 29% reduction in the total number of applications. (19) The situation led to the establishment of a Task Force who produced and distributed entirely new

recruitment material. In addition, a careers speakers network was set up during 2001 for members attending careers conventions. In addition, podiatry was promoted as the NHS Career of the month for September 2001.

Statistics from the Department of Health Vacancy Survey indicated that at March 2001 there were 40 podiatry vacancies in the United Kingdom. This represents a vacancy rate of 1.5 per cent. In Northern Ireland at 31<sup>st</sup> March 2002 there were 7 podiatry vacancies (3.9%).

The shortfall in the number of podiatrists required was recognised beyond doubt in the NHS Plan. (20) The Plan highlighted a commitment to increasing PAMs numbers, suggesting that by 2004 there would be:

- Over 65,000 more therapists.
- 4,450 more therapists in training.
- New therapist Consultant posts.

### ***Retention***

Professional and occupational burnout is a recognised syndrome amongst health care professionals. A recent study of burnout and work stress in newly qualified podiatrists in the NHS indicated that 100% of the 172 sample exhibited high levels of emotional exhaustion and de-personalisation. The report indicated that the key work stressors identified were too much work, isolation, patients' lack of understanding of the job, and lack of career structure. (2000) (21)

A report published in Podiatry Now (February 2002) indicated that for podiatrists, a lack of recognition for their work and role within the NHS could be a frustrating and demoralising experience. (2002) (22)

### ***The Role of the Private Sector***

Evidence presented to the Select Committee on Health in England indicated that 5,000 State Registered Podiatrists are employed in the private sector. Over 50% of the nation's statutory regulated podiatric workforce therefore, is self-employed, (2000) (23). However there is a no accurate way of establishing the number of dual workers i.e. these staff that work both in the private and public sectors.

### ***Education and Training***

A number of strategic documents review education, training and development for health professionals in England and Wales (2001) (24). Educating and Training the Future Health Professional Workforce for England (2001) concluded that achieving the planned expansion set out in the July 2000 NHS

Plan depends on increased investment in teaching staff and accommodation at higher education institutions; achieving value for money in the provision of training courses; a reduction in student drop out rates and a larger number of good quality practice placements.

The reports also note the availability of suitable practice placements as a critical limiting factor on the number of training places that can be commissioned and that given current staffing levels, most hospital departments are close to or have already reached their capacity for supervising students. In England there have also been problems with recruitment and retention for undergraduate places, with an average 20% under recruitment against available places, and student attrition rates ranging from 6 to 10%. The NHS Executive's Human Resource Performance Framework (2000) (25) includes targets to reduce attrition rates, with the 2000/01-intake non-completion rate of pre-registration training not to exceed 10% for allied health professionals nationally.

In Northern Ireland the overall number of university places for podiatry is 18 per annum. In addition, the attrition rate is higher in Northern Ireland than in England and Wales, with average attrition rate of 22% per course (based on figures from UU over the last three years).

### ***Family Friendly Policies***

In England and Wales, this is documented in the third Report of the House of Commons Select Committee on Health (1999) (26). In considering NHS workforce issues the report details the government's commitment to introduce a range of family friendly policies including childcare facilities, flexible hours and job share opportunities and the fact that the NHS operates a comprehensive 24-hour service provides opportunities. There is therefore a need to be flexible so that an employer can assist staff to 'marry their work and out of work responsibilities'.

## **DEMAND ISSUES**

Understanding the current and future demand issues within HPSS as they relate to podiatrists is essential in projecting future requirements for staff. The issues associated with the demand of podiatrists are detailed in subsequent paragraphs:

### ***Societal Changes***

The Department for Education and Employment, Employers Skills Survey Report (2000) (27) highlighted that there has been steady growth in demand that is expected to continue in the medium term, for the services of Professions Allied to Medicine. Factors contributing to this demand include ageing

population, rising expectations of patients and government reforms including a move towards care in the community, more integrated multi-disciplinary services and the introduction of clinical governance. The report identifies that the picture within HPSS is one of changes in technology and ways of working requiring staff to have a greater range of skills and a higher level of skills. The NHS plan has recognised the above and sets out a clear commitment to AHP's staff, with over 6500 more therapists and other health professionals to be employed by 2004 and the introduction of new therapist consultant posts. The NHS Plan identifies the need for 250 Consultant therapist posts by 2005.

### ***Legislative Changes***

Special Education Needs and Disability Bill (2003/4) - This new legislation which is likely to be passed by the Assembly in 2003/04, will provide more opportunity for parents to opt to place their children in mainstream schools with the recommended support required, rather than within a special school. (The Bill will remove 'economic grounds' as a reason for Boards not recommending placement of special needs children in mainstream schools). This will potentially have logistical and resource implications for podiatrists specialising in podopaediatrics who may be required to provide services to children placed in scattered mainstream schools.

### ***Service Demands***

According to evidence presented to the Select Committee on Health, at any one time 3,700 full-time equivalent podiatrists maintain 2,250,000 active cases. At present access to podiatry varies widely across the UK. In many areas, only those at highest risk receive access to treatment. In other areas, podiatry care continues to be provided along the traditional line of the 4 priority groups who retain the associated right of self-referral, pensioners, children under 18 in full-time education, expectant mothers and disabled. Both those at high risk and those who maintain the right to self-referral will impact upon the demand upon podiatry services in the future:

- **Ageing Population:** Their average life span is increasing by about 2 years every decade (28). OPCS data suggested that 16% of the population are aged 65 and over. The number of people in this age category has also increased by 16.15. % during the last 10 years. Nationally 87% of podiatry provision goes to pensioners. Furthermore, 45% of all pensioners receive NHS podiatry care. (2001) (29).
- **Diabetes:** The World Health Organisation's report 'The World Health Report 1997' indicated that by 2005 cases of diabetes will double globally (1997) (30). Where podiatrists are involved in the care of patients with diabetes, the number of amputations is reduced by 40%, saving the NHS at least £60,000 per patient. (2002) (23). The National

Service Framework for Diabetes (2001) (31) indicated that a core of highly skilled NHS podiatrists would be required. Standard 10 of the National Service Framework states that:

“All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.”

It goes on to indicate that:

- All young people and adults with diabetes should receive an annual surveillance for lower limb complications and should be managed in line with the latest evidence.
- All those identified as being at increased risk of developing lower limb complications should be referred to a foot protection programme;
- All those who develop swelling, redness, discolouration, pain or ulceration of their foot should be referred urgently (usually within 24 hours) to a multi-disciplinary foot care services.

CREST Guidelines for the management in Northern Ireland of the Diabetic foot (1998) (32) states that “early detection and surveillance for foot problems reduces the incidents of diabetic foot disease. Poor management can be implicated in 1/3 of the foot complications of diabetes mellitus, resulting in very significant morbidity and mortality. The Saint Vincent Declaration, (1989) includes targets for reducing the complications of diabetes. Systematic and regular foot care has been shown to reduce the risk of chronic ulceration and amputation in the lower limb by 50% or more. Admission for diabetic foot/leg disease is the single largest component of hospital bed usage by people with diabetes. Almost half of all diabetes related admissions are for lower limb disease”. “In Northern Ireland 60% of all major amputations are related to diabetes”.

- **Children’s Services:** Research funded by the Department of Education and Employment identified those caseloads and waiting lists were highest for under 4’s. This will include the increasing number of children diagnosed with autism and children with special needs. There is also increasing emphasis on the need for significantly more early intervention services within Podiatry, brought about by initiatives such. as Surestart.
- **Education Services:** The increased demand for podiatry services within educational settings is evidenced by figures provided by the South Eastern Education and Library Board. During the period 1985 to 2001, there was a 114% increase in the number of children attending special schools in the area (604 to 1291). Between 1997 and 2001, the number of children with a statement of special education needs

increased by 14% (2592 to 2943). In addition, a significant number of children with special education needs do not receive a statement, but are supported through specialist inputs within mainstream education. The Warnock Report states that at any time 20% of school age population will have special needs and approximately 2% will have a statement.

Furthermore, the numbers of children in full-time education up to the age of 18 has increased. If the right of self-referral remains this will impact upon the demand for podiatry services.

- **Cancer Services:** The NHS Cancer Plan (2000) (33) and the Calman-Hine Report (1995) (34), in United Kingdom, were published with the aim to create a network of cancer care within England and Wales so that every patient wherever he or she lives, receive a uniformly high standard of care. In the Government's strategic document 'Investing for Health' Northern Ireland (2000) (14), it states that, as the second most frequent cause of death men have a 1 in 6, and a women as 1 in 8 chance of dying from the it before the age of 75yrs. The Campbell Report (1996) (35) was a key document as it showed that treatment by specialist, multi-disciplinary teams leads to better outcomes for patients. To ensure that all people with the disease have rapid access to cancer services the report also outlined for the need for current services to be re-organised. The implementation of the report will provide one regional cancer centre, at the Belfast City Hospital, and four additional cancer units, one for each Board area. To progress the development of Cancer Units and the Cancer Centre in line with the Campbell Report, is one of the key objectives within both the 'Acute Services Review' (2001) (1) and 'Priorities for Action' (2001) (6).

### *Service Developments*

A number of service developments are likely to impact upon the demand for podiatric services. They can be outlined as follows:

- **Prescribing Rights:** The Health and Social Care Act 2001 contained enabling legislation to extent prescribing rights to other statutorily registered groups of healthcare professionals, including podiatrists.
- **Nail Surgery:** A recent survey published in Podiatry Now of 350 patients in a mixed urban-rural health board indicated that both the majority of GPs (63%) and users (81%) supported an expansion of podiatrists providing nail surgery. (29)
- **Podiatric Surgery:** According to the Society of Chiropractors and Podiatrists a 'growing number of Trusts are showing an interest in

setting up podiatric surgical units and NHS commissioning officers have been identified at regional level to progress developments.’ (2001) (19)

- **Biomechanics/Gait Analysis:** In May 2002 the Health Services Audit commissioned a Review of Disability Equipment in Trusts in Northern Ireland. Podiatric Biomechanics and Orthotic provision was included in this review. Result indicated that in terms of NI Trusts, Causeway H&SS Trust and Homefirst Community Trust demonstrated innovative practice with regard to Podiatric Orthotic provision which included formal tendering in accordance with good practice guidelines and audit work that demonstrated clinical effectiveness. The report recommended that Trusts should liaise with Commissioners to determine the scope for the funding of future provision of Podiatric Orthotic Services that meet the needs of the local population in a timely manner.
- **Podopaediatric:** Podopaediatrics is a specialist service for children and involves assessing and detecting problems of the feet and lower limbs, which may affect children in later life. Referrals to this specialist service have grown over the past 10 years and successful outcomes have been identified in prospective Audits undertaken by Causeway H&SS Trust Podiatry Services since 1998. Results in the NI Review of Disability Equipment in 2001 recommended that Trusts should liaise with Commissioners to determine the scope for the funding of future provision of Paediatric Podiatric Orthotic Services that meet the needs of the local population in a timely manner.
- **Rheumatology:** As stated in the Guidelines for the Management of the Foot in Rheumatic Diseases (North West Podiatry Services, Clinical Effectiveness Group 2002), rheumatological diseases can be disabling, cause pain, deformity and loss of function. In rheumatoid arthritis, foot involvement has been reported to occur between 50-80% of patients (Michelson et al, 1994, Kerry et al, 1994) with the degree of disability progressing with the course of the disease. The majority of patients with systemic sclerosis often present with foot problems (Sai-Kousel et al 2001) and it is recognised that foot care is important in preventing major foot pathologies and amputations. The role of the Podiatrist in the orthotic management of other rheumatological diseases such as juvenile chronic arthritis has also been highlighted as being essential (Helliwell and Woodburn 1998) both for the reduction of pain and the improvement in foot function. Although at less risk from serious foot problems, patients with osteoarthritis may benefit from podiatry interventions (Keating et al, 1993).

The broad philosophy of podiatry management is to relieve pain, maintain function, prevent or minimise deformity and reduce the risk of ulceration. Podiatry services should provide a specific service for the

diagnosis, assessment and management of foot problems associated with rheumatic diseases. The role of the Podiatrist in the Rheumatology team is recognised as a vital component in the integrated care given to patients by the multidisciplinary team (SIGN guidelines 2000, Widdow 1998). Increasingly Consultant Rheumatologists are requesting specialist foot care services for their patients (Williams 2001a) and it is suggested that the Podiatrist is a key practitioner in the management of patients with musculoskeletal disease (Beeson 1995, Jacobs 1984). However in both primary and secondary care less than 25% of patients with O/A and less than 45% of patients with RA are informed about podiatry as a possible treatment or service (BLAR Standards of Care 1999).

Currently in Northern Ireland there is only one full time dedicated podiatry clinical specialist in Rheumatology (at Senior I grade). This Podiatrist works as part of a multidisciplinary rheumatology team at Belfast City Hospital.

### ***Continuous Professional Development***

In the UK, although there has been no statutory requirement, the code of professional conduct makes it clear that all podiatrists must continue to maintain and advance their knowledge and skills throughout their careers. The Society of Chiropodists and Podiatrists Code of Conduct states ‘Practising members must undertake continuing professional development in accordance with such guidance that is issued by the Society from time to time.’ In February 2001 the Faculty of Podiatric Medicine, endorsed by the Council, introduced a new CPD framework for all members continuously to improve the quality of service to patients through encouraging the uptake of CPD. The policy recommends that members will be expected to complete 15 core credits and 15 general credits over a three-year period. One hour of activity equals one CPD point. It is the responsibility of the practitioner to maintain a record of CPD activity. (2000) (36). It is anticipated that this will eventually become a mandatory requirement with the establishment of the Health Professions Council (HPC) on 17 April 2002.

Evidence based practice through good quality audit and research is vital if podiatry is to develop as a profession. A recent report completed by the Research and Development Office in Northern Ireland found that the ratio of podiatry staff involved in research was 1:14, and only 1% of podiatrists surveyed had a master’s degree. The report concluded that much more needs to be done to support PAMs in this area. (2001) (37).

### *Skill Mix*

A recent survey published in Podiatry Now of 350 patients in a mixed urban-rural health board indicated that both GPs (59%) and users (61%) were supportive of the trained and supervised Foot Care Assistant grade to provide basic foot care (29).

### 3. KEY FINDINGS – DATA ANALYSIS

This section details the key findings of the analysis of the workforce profile information.

#### Workforce Demographic Profile

Available information was compiled of the current demographic profile of the Podiatry workforce of Northern Ireland to use as baseline information. The key sources utilised are highlighted below:

- The DHSSPS Project Support Analysis Branch sourced from-
  - HRMS – current HR system in use by the Trusts across Northern Ireland.
  - PMIS – current HR system in use by the Department at a regional level.
- DHSSPS – Workforce Questionnaire, May 2002.
- University of Ulster – Students statistics.
- Society of Chiropodists and Podiatrist Annual Report 2001.

#### 3.1 CURRENT UK PROFILE OF THE PODIATRY WORKFORCE

Information contained in the Society of Chiropodists and Podiatrists Annual Report (2001) would suggest that nearly half of all registered Podiatrists work in NHS only. However approximately 27.05% work in private practice, with 12% working in both and NHS and private practice.

**Table 3.1.1: UK Breakdown of Podiatry Employment Sources**

<b>Sector</b>	<b>Headcount</b>	<b>Percentage</b>
Dual NHS & Private Practice	852	12.00
Private Practice & Community	475	6.7
NHS & Community	75	1.06
NHS & Private Practice & Community	200	2.82
Private Practice only	1919	27.05
Community	223	3.14
NHS Only	3351	47.23
<b>Total</b>	<b>7095</b>	<b>100</b>

*Source: Society of Chiropodists and Podiatrists Annual Report (2001)*

### 3.2. CURRENT REGIONAL PROFILE OF THE PODIATRY WORKFORCE

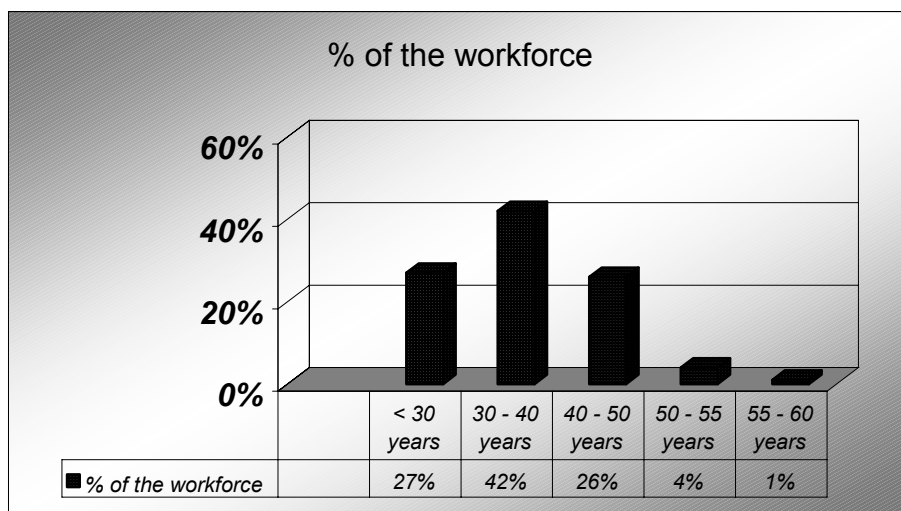
In Northern Ireland there are currently 179 state registered podiatrists working in the HPSS (13 Trusts) in N.I.

Of these 23% are male and 77% are female. There has been a slight decrease in the number of males within the workforce over the past 4 years (28% in 1998, compared to 23% in 2002).

In addition, 2 Trusts are recorded as employing 4 podiatrist bank staff (these staff may also be employed permanently within other Trusts).

The source of this information is the DHSSPS Data Base.

**Graph 3.2.1: Age Profile: Podiatrists- March 2002**



*Source DHSSPSNI (March 2002)*

The data indicates that the vast majority (95%) of the current workforce is less than 50 years of age and 69% are under 40 years.

### 3.3 FULL TIME/ PART TIME PROFILE

The number of podiatrists working part time has increased quite significantly over the past 4 years, from 49 in 1998 (30% of the total workforce) to 68 in 2002 (39% of the workforce). Overall the workforce has grown minimally by 5.7% (from 141.29 WTE to 149.8 WTE) over the period 1998 – 2002.

### 3.4 HEADCOUNT TO WHOLE TIME EQUIVALENT BREAKDOWN

Based on the available data, information can be presented on the ratio of current numbers of full time to part time podiatry staff, shown as actual headcount to whole time equivalent.

**Table 3.4.1: Headcount to WTE ratio**

Total Headcount	179
Total WTE	149.8
Headcount/WTE	Headcount = 1.2 WTE

*Source: Trust Questionnaire*

The figure indicates that for every WTE podiatry post, the equivalent of 1.2 are staff employed within the service.

### 3.5 WORKFORCE PROFILE BY GRADE

An analysis across all HSS Trusts of grade profile of the podiatry workforce is detailed in the table below.

**Table 3.5.1: Grade Profile by Headcount**

Grade	F/T	P/T	Total Headcount	% Of total
Basic	2	0	2	1%
Senior II	51	40	91	51%
Senior I	33	23	56	31%
Chief IV	10	3	13	7%
Chief 111	8	1	9	5%
Chief 11	3	0	3	2%
Area Chief 2	3	1	4	2%
Senior Management II	1	0	1	1%
<b>TOTAL</b>	<b>111</b>	<b>68</b>	<b>179</b>	<b>100%</b>

*Source: HRMS*

The table indicates that the highest proportion of staff is graded at the middle and upper clinical grades (i.e. Senior I and Senior II) 31% and 51% respectively.

In relation to support staff for the podiatry, only 2 assistants were recorded as working within HPSS throughout NI in March 2002.

### 3.6 VACANCY ANALYSIS

The workforce questionnaire forwarded to service managers provided details of the vacancy profile at March 2002. The analysis of the vacancies is detailed below.

**Table 3.6.1: Vacancies by Headcount**

<b>BOARD</b>	<b>FULL TIME</b>	<b>PART TIME</b>	<b>TOTAL</b>
EHSSB	2	1	3
SHSSB	0	0	0
NHSSB	0	3	3
WHSSB	0	1	1
<b>Total</b>	2	5	7

*Source: Trust questionnaire*

All of the seven identified vacancies at March 2002 were permanent posts.

#### *Vacancy Analysis / Total Workforce Numbers*

The information from the workforce questionnaire at March 2002 indicates current vacancy rate of 3.9% within the HPSS Podiatry workforce. This is calculated by headcount as follows:

Staff in post	172
Vacancies	7
Total workforce	179
Vacancy % rate	3.9

*Source: Trust Questionnaire*

### 3.7 RECRUITMENT AND RETENTION OF STAFF

Managers were asked within the questionnaire to identify the number of staff they had been able to recruit from universities or employers outside of N.I. The figures provided indicated that on average (across the last 3 years):

- 8 graduates from universities outside of N.I. was recruited to NI HPSS (average of 2 per year).
- 11 qualified staff returned to the N.I HPSS workforce after working as therapists elsewhere (average 3 per year), a number of these will have trained within N.I.

In relation to retention of staff, managers returned the following information:

- 13 staff left the HPSS workforce during 1999 – 2001. (This equates to approximately 7% of the workforce)
  - None of the above retired
  - 8% left for family reasons
  - 23% left to take up a post outside of N.I.
  - 31% left to take up a post in the private sector
  - 38% left for other reasons

*Source: Trust Questionnaire*

The DHSSPS has also been able to supply information on podiatrists leaving HPSS for reasons other than retirement during 2001. The figures provided have informed the development of the supply projections detailed in future sections of the report.

### **3.8 UNDERGRADUATE EDUCATION**

The degree course for Podiatry is three years in duration and is located on the Jordanstown Campus of the University of Ulster in Northern Ireland. Qualification grades for entry into the course are a B, C and D at Advanced Level education. Applications to training places are a ratio of 5:5.1.

Based on information provided by the University of Ulster the table 3.8.1 provides details of anticipated number of undergraduates entering the degree course over the next 4 years.

**Table 3.8.1: Estimates of students qualifying from UU over the next 5 years**

<b>Entry Year</b>	<b>Student Places</b>	<b>Graduation Year</b>	<b>Graduate Numbers</b>
<b>2000</b>	<b>18</b>	<b>2003</b>	<b>10</b>
<b>2001</b>	<b>18</b>	<b>2004</b>	<b>13</b>
<b>2002</b>	<b>18</b>	<b>2005</b>	<b>13</b>
<b>2003</b>	<b>18</b>	<b>2006</b>	<b>13</b>
<b>2004</b>	<b>18</b>	<b>2007</b>	<b>13</b>

*Source: University of Ulster*

### 3.9 ATTRITION RATES AND DESTINATION OF GRADUATES

The University of Ulster have provided details of the attrition rate for each intake of students and the first employment destination of graduates.

The details indicate an average attrition rate of 22% based on figures produced over the last 3 years.

The following table details the occupation by destination of graduates 6 months post graduation from 1999–2001.

**Table 3.9.1: Destination of University of Ulster Graduates**

<b>Destination</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>
<b>NI HPSS</b>	6	1	1
<b>NHS</b>	0	2	0
<b>Private Practice</b>	3	3	4
<b>Commercial Sector</b>	2	0	2
<b>Education Sector</b>	2	1	0
<b>Others</b>	2	1	0
<b>Total Graduates</b>	15	8	7
<b>% Students not entering NI workforce</b>	60%	77%	86%

*Source: University of Ulster*

The figures indicate that for 1999 only 40% of students joined the N.I. HPSS workforce immediately after graduating from the University of Ulster. This figure decreased to 13% in 2000, and increased slightly to 14% in 2001. In both 2000 and 2001 the highest number of graduates joined private practice, with 57% doing so in 2001.

These figures may well reflect the lack of job opportunities for newly qualified graduates within the NI HPSS.

The figures provided in this section will inform the future supply projections for the workforce.

## **4. KEY FINDINGS IN KEY INFORMANT INTERVIEWS AND FOCUS GROUPS**

### **4.1 SUPPLY ISSUES**

This section provides details of the views expressed throughout the 14 key informant interviews and the 7 focus groups, which involved 32 podiatrists and 5 University of Ulster podiatry final year students. Many of the issues raised by different individuals were consistent and provided valuable information, which has informed the development of the recommendations and conclusions, contained in the report.

#### **4.1.1 University of Ulster Students and Graduates**

Students involved in the undergraduate focus group raised a number of issues, which were of concern in the recruitment of students to the undergraduate course and the profession. The focus group participants highlighted the need to “raise the profile of the profession” both in secondary schools and within the service itself. As one student implied, “Not many people know about the course, or even the name ‘podiatry’. If you say you’re a podiatrist people think you cut toenails.”

Participants in the University of Ulster focus group acknowledged the high attrition rate on the undergraduate course. They explained that the likely cause of this was factors to do with the course provision and structure. Students pointed to the fact that the course had moved location twice in the last 5 years. The majority of key informants also highlighted the lack of practical clinical placements as a major contributing factor. However, the students did not raise this as an issue.

Participants within the University of Ulster and professional focus groups indicated that the frustration upon graduating was the lack of full-time permanent posts in Northern Ireland. As one student suggested, “There is no work in the Health Service in Northern Ireland and when there is it is only maternity leave or part-time cover”. The lack of full-time permanent positions resulted in students looking at the private practice option, employment in Boots, Scholl or employment in NHS in England or Scotland. One student highlighted this issue suggesting, “Because we can’t get a job in the NHS, we look to private practice but we’re just doing bits and pieces.” The focus group participants highlighted the frustration that they felt with this. The feeling amongst the group was that there was demand for work for podiatrists but no jobs. One student said, “When you’re out on clinical placement the service waiting lists are very long. There is work but no jobs.”

#### **4.1.2 HPSS Recruitment**

Nearly all Trust Managers interviewed indicated that they had not been experiencing difficulties in recruiting staff over the last 1-3 years, largely because of the lack of new posts available. The majority of key informants highlighted a reduction in the number of applicants applying for posts at all levels and staff recruited were largely from Northern Ireland.

A minority of key informants indicated that difficulties might be experienced in the future in recruiting staff to specialist posts in renal and oncology, and recruiting staff to positions at Chief IV level, where it was perceived that staff were not keen to take on additional responsibility for no difference in salary to that of a Senior I.

#### **4.1.3 Temporary Posts**

Most Trusts were employing temporary staff for cover for secondments, maternity leave, acting up arrangements and pilot projects, such as those in primary care commissioning. Agency staff usage was non-existent.

#### **4.1.4 HPSS Retention**

The majority of Trusts did not have difficulty retaining staff, and reported that they had a stable workforce. A minority of Trusts reported difficulties retaining temporary and Basic Grade staff who left for reasons of a permanent contract or promotion. A small number of informants did envisage some difficulty retaining staff in the future because of the better terms and conditions offered by private companies such as Boots and Scholl, and the upgrades which had occurred in Homefirst Trust which, it was perceived, would draw staff to this Trust.

#### **4.1.5 Family Friendly Policies/Career Breaks/Return to Practice**

Many respondents in the key informant interviews reported increasing requests for flexible working. The average number of requests for flexible working, at each Trust, per annum, was two. Almost all of the key informants interviewed reported taking a flexible and positive approach to requests, provided the requirements of the service were met. The requests for flexible working were reported as relating in the main to reduced hours because of family commitments, staff were tired of the system, unpaid leave after maternity leave, term-time working or to take up some private practice.

Five out of 11 Trusts interviewed indicated that they had experienced requests for career breaks. Evidence from the interviews did however indicate that in the main staff returned to the Trust following a career break.

#### **4.1.6 Private/Voluntary Sector**

The majority of key informants indicated that there was a demand for staff to work in private practice. The majority of Trusts indicated that staff did not leave their HPSS post to work in the private sector, but instead operated a dual role, with some staff requesting a reduction in HPSS hours to do so. However, there is currently no means of collating evidence as to the numbers involved in private practice whose substantive employment is in the HPSS. The influence of private practice was reported in almost all of the focus groups sessions. The attraction of private practice was highlighted as the ability to increase income levels, as one participant suggested, “Verrucae have educated my son.”

Three Trusts mentioned the growing influence of private companies such as Boots and Scholl to attract staff.

None of the Trusts reported the demand for podiatrists in the voluntary sector.

#### **4.1.7 Working Hours, Terms and Conditions**

Key informants indicated that staff worked 36.5 hours per week, with a minimal amount of evening clinics being provided. Fifty per cent of Trusts had staff who worked overtime on a regular basis, with half of these Trusts reporting paying overtime and the other half offering time off in lieu.

Many respondents in the interviews and focus groups indicated that working hours, terms and conditions was a key area of concern and impacted on the recruitment and retention of staff. Participants were particularly frustrated by the salary on offer and the current use of Discretionary Points as a means of extending the career structure of podiatrists.

The most common area of concern was the salary package on offer to podiatrists. Focus group participants highlighted the fact that they perceived that the level of pay did not reflect the level of responsibility and the level of risk associated with the work, for example, those patients at risk of amputation.

The current use of Discretionary Points to extend the career structure of podiatrists was seen by almost all participants in the focus groups as bureaucratic. Staff also reported distaste at having to prove on paper what they did, which was time-consuming in itself. As one participant in the focus group suggested:

“You had a lot of hoops to go through, a lot of paperwork.....An awful lot of people didn’t bother.”

#### **4.1.8 Career Progression**

The lack of career progression and a formal structure for promotion was perhaps the most vehemently expressed issue in both the key informant and focus group participants. The lack of career progression was noted at all levels. The reasons for this were documented as being three-fold: the lack of formal structure for promotion caused by the definitions of Whitley Council not being updated to meet clinical changes and the lack of recognition of clinical specialist (Chief III), the resulting static workforce, and the fact that there has been no new posts in podiatry for a number of years.

Focus group participants highlighted the limited opportunities for newly qualified graduates, because of both the lack of Basic Grade posts in the system. Focus group participants and key interview informants pointed to what they described as the resultant “temporary merry-go-round.” Limited opportunities to progress to Senior I from Senior II were also highlighted. One focus group participant highlighted this issue in, “I’ve been sitting at Senior II for 22 years. I’m going downhill rather than uphill.” Another participant suggested that the limited opportunities to progress to Senior I was because of the lack of appropriate infrastructure: “Senior I’s have to become a Senior I for something, but we don’t have something. It’s through luck or spending time being trained privately. There is no investment in Senior II training.”

The limited opportunity for career progression once at Senior I level was also highlighted. It was reported that an active decision was made at Senior I level as to whether staff wanted to leave the clinical route and become a Manager. It was highlighted that becoming a Manager was becoming less appealing because of the additional responsibility and the limited pay differential between Managerial and clinical grades.

Key informants also indicated that the creation of Clinical Specialist posts at Chief III level were required. The opportunity to continue along a clinical route would be more appealing, as one focus group participant suggested, “You’re clinically dead after Senior I.”

#### **4.1.9 Continuing Professional Development (CPD) and Research**

Both interview informants and focus group participants highlighted lack of resources for continuing professional development as a key concern. All staff acknowledged the importance of CPD in terms of ensuring their ability to perform and meet the demands of the service.

The main issue raised by both the key informants and the focus group participants was one of limited funding per person per Trust, and the lack of parity in funding across Trusts.

Staff also reported problems with getting time off to go on courses or to attend conferences which was often linked to lack of resources to ensure contracts and indicative volumes were maintained.

A further issue was the provision factor. Staff participating in the focus groups and the majority of key informants pointed to the lack of a co-ordinated, regional approach to training, and the lack of provision by both the Professional Body and School of Podiatry at the University of Ulster. Staff participating in the focus group highlighted the fact that the Managers had got together in a Forum to provide some Regional courses, which had improved the training situation.

Accessibility to relevant courses was also highlighted as an issue. Staff indicated that they were often required to go to England for specialist courses in areas such as diabetes and biomechanics.

The majority of key informants also made reference to the fact that the requirement for future re-registration will increase the demands for continual professional development and make it mandatory.

## **4.2 DEMAND ISSUES**

All respondents expressed concern about the inability of HPSS to meet the demand for podiatry services both currently and into the future.

### **4.2.1 Current Services**

The evidence from the interviews suggested that key areas of current unmet need/demand for podiatry services are as follows:

1. Diabetes
2. Renal
3. Vascular
4. Acute services
5. Podiatric surgery
6. Paediatrics
7. Rehabilitation
8. Health Promotion
9. Stroke Services
10. Elderly Care Services
11. Physical Disability
12. Learning Disability
13. Oncology

#### **4.2.2 Administration**

The majority of focus group respondents indicated that paperwork and administration were taking up more and more of qualified podiatrists time, which was reducing the amount of patient contact time. The amount of time spent on clerical tasks had evolved out of the increasing need to document all aspects of the podiatrist's work because of increasing legislation, litigation, Parliamentary questions and audit and performance review. Few podiatrists felt that they had access to adequate clerical support, and half of all focus group participants felt that a significant proportion of the administrative work could be reallocated to administration staff if there were appropriate numbers.

#### **4.2.3 Increased Focus on CPD**

Both the key informants and participants in the focus group sessions highlighted the increasing role of continual professional development, given the likely introduction by the new Health Professions Council of a requirement for a minimum number of CPD days to be undertaken by qualified staff, and the growing emphasis on clinical governance within HPSS organisations.

#### **4.2.4 Provision of Undergraduate Clinical Placements**

The current system of student clinical placements was one of the key concerns of Managers participating in the key informant interviews, with all of the Managers acknowledging practical clinical placements were a necessary pre-requisite to complete the educational cycle and transition into employment.

Eight out of the eleven Trusts interviewed provided observational clinical placements, although one Trust was not providing the placements in the current year. The majority of Trusts supported observational placements in the students' first and second years of the course, with only one Trust providing third year placements.

All of the key informant interviews expressed concern over the current clinical placement structure and organisation, and acknowledged that there was a need for a formal review. The key barriers to the provision of clinical placements were expressed as being the lack of practical placements, lack of funding for the placement providers, lack of funding for staff acting as supervisors, lack of training for staff acting as supervisors, the current workload of staff, and lack of accommodation for students.

Managers involved in the key informant interviews expressed concern that the current system reduced the clinical abilities of qualifying graduates. They recognised this system could be enhanced and improved upon. Although the graduates had a good theoretical foundation, the lack of practical clinical

placements meant that they were less well equipped for working in the clinical setting.

Managers identified the value of the clinical tutor role if a new system was to be introduced for undergraduate clinical placements.

#### **4.2.5 Increasing Patient Expectations**

Both interview and focus group participants pointed to the fact that patients were more knowledgeable about their rights through increased availability and access to information. Focus group participants also indicated that patients were not well informed about the role of Podiatry, which caused particular frustrations for staff. This can be supported by a recent survey published in Podiatry Now of 350 patients in a mixed urban-rural health board, which indicated that only 5% of users were aware of the education level of Podiatrists, whilst only 17% were aware of the difference between State Registered and Non-State Registered Podiatrists. (2001) (25) Focus group participants highlighted however that patients were pleased by the outcome of the service of Podiatry, once they were aware of the service that a podiatrist could provide.

For the majority of focus group participants the main issue was the expectation of over 65 year olds of a right to a service, and the issue of self-referral. This is supported by a recent survey published in Podiatry Now of 350 patients in a mixed urban-rural health board, which indicated that 65% of users and 87% of GPs supported the abolition of self-referral. (2001) (25)

#### **4.2.6 Role Extensions**

Examples of where the role of Podiatry has had an impact or could in the future are detailed below:

- Podiatric Surgery
- Health Promotion & Prevention
- Teaching of students on clinical placements
- Clinical Specialist roles in wound care, biomechanics, podopaediatrics, falls clinic, rapid response, rheumatology, vascular, A&E nail surgery.

#### **4.2.7 Skill Mix**

Only one of the 11 Trusts interviewed employed Foot Care Assistants, this Trust employed 2 WTE Assistants. A second Trust also employed a technical instructor grade. Those employing assistants commented positively on the contribution they made to service delivery. Most of the respondents in the key informant interviews and focus groups welcomed the role of the assistant, with some presumptions. Staff indicated that the Foot Care Assistant role must not be employed instead of a qualified podiatrist, and that there must be clarity

around the role and function of the assistant. Possible roles for the Foot Care Assistant were highlighted in the key informant interview and focus groups as charting, dressing/undressing patients, applying surgical dressings, basic foot care and hygiene, health promotion, decontamination/sterilisation of instruments and clerical and administrative tasks.

The issue of inappropriate skill mix was also highlighted for the professional staff. The issue most commonly expressed was that the majority of clinical specialist posts were graded at Senior I level, and should be graded at Chief III. In addition, a number of key informants also expressed concern at Senior II undertaking Senior I tasks. The fact that the profile of patients had altered in Trusts towards high-risk patients had also resulted in staff at Senior II performing at a higher level. It was expressed that as a result in one Trust was Senior II staff successfully requesting upgrades to Senior I and this may have a knock-on effect on other Trusts.

On the managerial front, Managers highlighted the fact that there was a flat managerial structure, therefore limiting the ability for deputisation, delegation of tasks, and succession training.

#### **4.2.8 Changing Service Provision**

Participants in both the key informant interview and focus group sessions highlighted ways in which they envisaged the provision of podiatry services changing and/or developing in the future. These can be outlined as follows:

- Changing the clinical profile to high risk cases – a recent survey published in Podiatry Now of 350 patients in a mixed urban-rural health board, indicated that both users and GPs supported increased priority status for people with diabetes (2001) (25)
- Reducing the number of domiciliary visits
- Educating carers
- Educating GPs with regards to inappropriate referrals
- Providing orthopaedic triage clinics
- Providing health promotion projects, such as the Delta Project for children in schools.

#### **4.2.9 Societal Factors**

The majority of respondents highlighted the following societal factors as necessitating an increase in demand:

- **Ageing Population** - advances in medicine have resulted in people living longer and this has resulted in an increase in demand for podiatry services.

- **Increased Dependency** - it is now recognised that those who receive the clinical care are generally more dependant than before and this brings about a more resource intensive podiatry service.
- **Medical Technology** - advances in medicine and technology have resulted in people with certain complex conditions surviving longer than previously and requiring an increased input from the podiatry service.
- **CREST guidelines** – in NI approximately 39% only of people with diabetes per 100,000 population on arrival receive assessment of their foot health as set out in CREST guidelines for Wound Management.

## **5. WORKFORCE SUPPLY AND DEMAND PROJECTIONS**

The Project Board agreed a set of assumptions around key supply and demand factors that are and will affect the Podiatry workforce within the NI HPSS in the next 5-years. These assumptions were then used to formulate a model from which certain predictions around projected supply and demand could be calculated. The key assumptions utilised have been outlined.

### **5.1 SUPPLY PROJECTIONS**

The supply figures have been gathered by reviewing trends over the past 3-4 year period, presented in the data supplied by the DHSSPS, University of Ulster and Podiatry Managers from within the service.

The supply of Podiatrists within the NI workforce is in the main determined by:

- The existing employees currently available in the workforce;
- Students graduating from the University of Ulster;
- Students returning to work in NI after graduating from a University outside of NI;
- Professionals leaving the workforce (through retirement, leaving for personal reasons, career breaks etc).

#### **5.1.1 Supply assumptions for those Podiatrists entering the workforce**

There is a total of 179 podiatrists within the current HPSS workforce. On average 10-13 students graduate each year. An attrition rate of 22% for students on the University of Ulster course for podiatrists has been included in the graduate statistics.

The supply of graduates entering the workforce in N.Ireland HPSS has been averaged at 26% of the final numbers qualifying. This is based on destination figures supplied by the University of Ulster over the three-year period 1999-2001. In real terms therefore 74% do not take up their first post within NI HPSS. However, in the last year (2001) only one graduate took up post within NIHPSS. This is an indication of the low number of available entry-level posts within Podiatry NI HPSS. It was the view of the Project Group that the employer of choice for graduates was the NIHPSS and it was only after failure to identify such a position that employment was sought elsewhere eg the private sector.

The view from Podiatry Managers in the Project Group and evidence gathered from the key respondents interviews indicated that there would be the equivalent of two qualified podiatrists p.a. entering the overall Northern Ireland HPSS sector from outside of Northern Ireland. This has been projected to remain static over the 5-year workforce projections included in the report.

### **5.1.2 Supply assumptions for those leaving the workforce**

In regards to retirees, an assumption has been made by calculating the numbers retiring based on earliest eligible retirement age (ie 60 years). Therefore as all podiatrists over 55 years at present have been assumed as leaving the workforce over the next 5 years. This equates to 1 podiatrist. Evidence from the DHSSPS Project Support and Analysis Branch would support this assumption.

Included in the retirement figures will be a small number of staff retiring due to incapacity. This has been recorded as one over the period 1999–2002. Therefore the assumption has been made that 1 podiatrist over the course of the 5-year plan might retire due to incapacity.

Based on anecdotal evidence from the key informant interviews and feedback from the project group, it has been suggested that, at present, 1.75% of the total workforce capacity is lost over the 5-year period due to an increase in the uptake of part-time working and work-life balance policies. Evidence shows that podiatry is a young workforce with 69% of staff under 40 years of age. This is the age group in which more requests for life/work balance occurs.

Based on anecdotal evidence from the key informant interviews and feedback from the project group, it has been estimated that the number of podiatrists leaving the HPSS sector will be 4 each year [for reasons other than retirement/medical].

## **5.2 DEMAND PROJECTIONS**

It is difficult to obtain accurate data concerning the exact future quantifiable demand for Podiatrists. This is mainly due to the fact that there is little specific information available on projected resource investment within the service over the next 5-years. The professional managers have expressed concerns regarding the lack of past growth and investment in podiatry posts balanced against the significant demand which was identified by the project group in terms of waiting lists, inability to meet clinical guidelines and clinical service areas which the profession recognise they cannot give a commitment.

### **5.2.1 Demand Assumptions Utilised**

The demand projections for additional podiatrists required within the HPSS over the next 5 years have been identified in the following categories:-

### **Category 1**

This refers to capital and service development, which have already been agreed in which the workforce requirements have been identified, and have the associated funding approval.

### **Category 2**

This refers to service development that have been identified via the key informant interviews and project group that are likely to be supported over the next 5 years, although resources have yet to be identified. This includes educational requirements and both under and postgraduates level including continual professional development, time required to facilitate students on clinical placements, elements of health promotion, role development and meeting clinical governance.

### **Category 3**

This refers to additional demands within the current and future services, identified via the key informant interviews and project group that do not have a funding allocation. This includes referral waiting lists and clinical service demands that cannot be met within existing resources.

#### ***Category 1***

*Capital and service requirements with identified workforce requirement, which have had funding approval.*

Four posts were identified within this category over the 5-year plan:

- Diabetes specialist post RVH (1 WTE)
- Brain Injury Unit (1 WTE)

To meet the needs of **Category 1** a total of 2 WTE Podiatrists have been identified.

#### ***Category 2***

*Capital and service requirements identified by the project group that are likely to be resourced within the 5-year plan.*

Within this category the project group identified the following demands over the 5-year plan:-

- it is suggested the time spent on Continuing Professional Development should equate to 36.5 hours per podiatrist per annum. This translates into an additional 3.5 WTE podiatrists.
- there is a requirement for protected time allocated to students by podiatrists during their clinical training in respect of adequate mentoring and support. It is suggested this should equate to 6 hours per week per student over the course of their clinical placements. This allocation will require an additional 0.5 WTE podiatrist.
- Areas of role extension and workforce requirements for podiatry were identified as:
  - Podiatric surgery development (2 WTE)
  - Clinical specialist in wound care, biomechanics, falls clinics, rheumatology, vascular – neurology, A&E nail surgery (4 WTE)
  - The Consultant Podiatrist role (2 WTE)
  - Participation in the newly established Health and Social Care Groups (2.25 WTE)

The total workforce requirement of **Category 2** is 14.25 WTE Podiatrists. It is important to use the figures presented in Category 2 as a baseline and to recognise the need for review to be carried out to refine them in order to provide the most accurate projection.

### **Category 3**

*Current and future demand/unmet need with no identified funding.*

The professional podiatry managers considered the areas of clinical unmet need and current demand on Podiatry services throughout the NI HPSS. After exploring and identifying the requirements within Category 3 they prioritised the need. This report will only identify the prioritised need. This has been divided into three distinct areas:-

- **CREST Guidelines.** In 1998 CREST published guidelines on wound management, which clearly outlined good practice in the management of the diabetic foot. At present a Joint Diabetes Task Force is reviewing and developing the CREST guidelines on Diabetes. To achieve this aim, a strategy for the implementation of these multi-disciplinary guidelines has been developed. As part of this process the Task Force is identifying the workforce requirements to fully implement the strategy. A consultation document emanating from the Task Force's report on its findings by December of 2002. The implementation of both these CREST guidelines will have significant implications within NI Podiatry Workforce as it is estimated that it may require in total an additional 52 WTE Podiatrists. This estimate only takes into account the current

diagnosed incidence rates of diabetes and not the predicted rise in these rates over the next 5-10 years. In NI currently there are 40,000 diagnosed diabetics with a possible additional 25,000 not yet diagnosed within the current population. Diabetes UK predict that these figures will double by 2010.

➤ **Clinical High Risk Patients** “High-risk” refers to people with a systemic disease process, which results in significant foot pathology. High risk conditions could lead to serious foot pathology and ultimately will impact on the person’s morbidity and mortality. These conditions include:-

- Vascular Disease
- Renal Dysfunction
- Diabetes
- Neurological Conditions
- Compromised Autoimmune Disorders

The requirement for podiatry provision to these patients would be 8 WTE Podiatrists. This has been calculated using existing waiting lists statistics which are in excess of 10 weeks.

➤ **Patients with significant Podiatric Pathology.** Current Podiatric waiting list statistics indicate that some people with significant podiatric pathology in the absence of a medical condition wait an average two-three years to be seen. Based on current waiting list information the workforce requirement to address this clinical area would be 8 WTE.

The benefits of Podiatry treatment of these clinical groups are:

- decrease incidence of ulceration and infection
- allow developmental progress
- decrease in amputation rates
- reduction in further treatment/rehabilitation
- reduction in bed occupancy for these groups
- increased independence

➤ **Duties associated with staff side representation.** The group considered that the time spent regionally had substantially increased in recent years. This time spent reduces the provision of the clinical service which the group assessed as equating to 200 hours per annum (1 WTE)

To meet the prioritised clinical need in **Category 3**, as identified by the professional managers in the project group, a total increase of 69 WTE Podiatrists would be required.

### 5.3 SENSITIVITY ANALYSIS

In an attempt to explore the percentage growth and investment that would be required in the Podiatry Workforce to meet the prioritised clinical services of Category 3 a sensitivity analysis exercise was undertaken. The analysis consists of three scenarios, 10%, 30% and 40% growth levels of the Podiatry workforce.

The table below indicates the number of podiatrists that would equate to each scenario growth level.

**Table 5.3:1: Scenario 1, 2 & 3 and percentage increase of Podiatrists indicated in each growth level.**

Scenario	Current Head Count	Increase Head Count	Total increased Workforce
1. Increase by 10%	179	18	197
2. Increase by 30%	179	54	233
3. Increase by 40%	179	72	251

These percentage growths were applied to Category 3 (current demand and unmet need with no identified funding within the Podiatry Clinical Service).

#### Scenario 1

An overall increased growth of 10% to the existing podiatry workforce equates to a total of 197 staff, an increase of 18 podiatrists. At this level of growth the Podiatry Service would be able to provide clinical services for unmet need/current demand areas identified within Category 3 for patients with the following conditions:-

- vascular disease
- renal dysfunction
- diabetes
- neurological conditions
- compromised auto-immune disorders

It could also provide a limited clinical service for patients with significant podiatric pathology based on current waiting lists.

#### Scenario 2

An overall increase of 30% to the existing podiatry workforce would equate to an increase of 54 podiatrists giving a total of 233. At this level of growth a

clinical service could be provided that would allow the podiatry service to meet all the CREST guidelines on wound management and diabetes care.

### **Scenario 3**

An overall increase of 40% to the existing podiatry workforce would equate to an increase of 72 podiatrists giving a total of 251. At this level of growth a clinical service could be provided that would allow the Podiatry Service to meet all the CREST guidelines on wound management and diabetes care as well as providing a clinical service for high-risk patients with:

- vascular disease
- renal dysfunction
- diabetes
- neurological conditions
- compromised auto-immune disorders

It could also provide a clinical service for patients with significant podiatric pathology based on current waiting lists. The time identified by the Project Group associated with staff-side representation regionally would also be met within this growth.

In conclusion the Podiatry service would require a 40% growth to meet all the prioritised clinical requirements identified by the Project Group and the service managers within Category 3 (unmet need and current clinical demand).

## 6. CONCLUSIONS

### 6.1 PROJECTED SUPPLY OF PODIATRY WORKFORCE

In using the previous assumptions based on our consultation process the projected supply of podiatrists has been calculated between the years of 2003-2007. Highlighted are relevant podiatry supply issues table (6.1.1), which utilises elements of supply figures based on feedback from respondents and literature review. For the purposes of identifying actual numbers required in the workforce the figures have been converted to headcount based on the headcount to WTE ratio for the profession, which is 1.2:1.

**Table 6.1.1: Projected Available Supply in Headcount of Overall Podiatry Workforce in NI (2003 - 2007). NB [ ] indicates a decrease**

Supply	2003	2004	2005	2006	2007
Return to practice	0	0	0	0	0
University of Ulster Graduate Figures	10	13	13	13	13
Entering N.I. from elsewhere	2	2	2	2	2
<b>Total supply available to enter NI Workforce</b>	<b>12</b>	<b>15</b>	<b>15</b>	<b>15</b>	<b>15</b>
<b>Those leaving the Workforce:-</b>					
Retirees [inc. incapacity]	0	1	1	0	0
Family friendly lost capacity	1	1	1	1	1
Leaving Podiatry	4	4	4	4	4
<b>Total leaving NI Workforce</b>	<b>5</b>	<b>6</b>	<b>6</b>	<b>5</b>	<b>5</b>
Total current/potential workforce	172	179	190	201	211
Projected potential workforce	179	190	201	211	221
<b>Potential Net Increase (Decrease)</b>	<b>4%</b>	<b>5%</b>	<b>5%</b>	<b>5%</b>	<b>5%</b>

The number of graduates stated in this table equates to the total supply and not just those taking up employment within the NIHPSS. It should also be noted that although these Podiatrists may be initially available to the NI Workforce not all of them may wish to take up employment within the HPSS.

The graduate figures are based on the present average attrition rate during the course of 22%.

Areas that could have an effect on the supply equation have been noted:

- Euro/Pound Equilibrium - could have the effect of decreasing the supply of the Podiatry workforce in the Northern Ireland marketplace.

Consideration should be given to the effect of the recently announced strategy for the health service in the Republic of Ireland.

- More effective utilisation of the available workforce - as the evidence in this report and historical data shows there is some potential for a more effective utilisation of the available workforce either by a re-allocation of certain duties to non-qualified staff, an increase in the whole time equivalent ratio, an increase in the amount of qualified podiatrists returning to the workforce.
- The University of Ulster increase its intake and subsequent output of graduates. At the moment all information suggests that the recently increased intake will remain static for the foreseeable future.

In conclusion, based on the above analysis and assumptions a prediction that the supply of the overall Podiatry workforce over the course of the next 5 years has the potential to increase by up to 20%.

## 6.2 DEMANDS FOR THE PODIATRY WORKFORCE

Based on information gathered during the project from key informant interviews, the Project Board, relevant policy documents, specific educational, capital and service developments, with associated staffing implications, have been identified over the 5-year plan (2003-2007). For the initial purposes of this workforce plan the combination of Categories 1&2 have been adopted. These categories include agreed resourced capital and service plans with identified workforce requirements and those that are likely to be resourced within the 5-year plan. In order to estimate the demand numbers of professionals these summary figures have been profiled on table 6.2.1.

**Table 6.2.1: Projected Demand Figures in headcount for the Podiatry Workforce 5-year Plan**

	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
<b>CATEGORY 1</b> Capital and service requirements that have allocated resources:-						
Diabetes Specialist (RVH)	-	1	-	-	-	1
Brain Injury Unit	-	1	-	-	-	1
<b>SUB TOTAL - HC</b>	-	<b>2</b>	-	-	-	<b>2</b>
<b>CATEGORY 2</b> Current demand that are likely to be resourced in 5-year plan						
Extended role:-						
Podiatric Surgery	1	-	1	-	-	2
Student Training	1	-	-	-	-	1
CPD	1	1	2	-	-	4
Clinical Specialist	1	1	1	1	-	4
Consultant Role	-	-	1	-	1	2
HSC Groups	1	2	-	-	-	3
<b>SUB TOTAL - HC</b>	<b>5</b>	<b>4</b>	<b>5</b>	<b>1</b>	<b>1</b>	<b>16</b>
<b>CATEGORIES 1&amp;2</b>	<b>5</b>	<b>6</b>	<b>5</b>	<b>1</b>	<b>1</b>	<b>18</b>

The demand for additional podiatrists over the 5-year plan for Category 1 is a headcount of 2 and for Category 2 is 16. The total demand for categories 1&2

is 18 Podiatrists in headcount over the 5-year plan as identified by the project group.

### 6.3 SUPPLY V DEMAND FOR THE PODIATRY WORKFORCE

In order to estimate the numbers of additional professionals required over the course of the next 5 years the summary figures of supply and demand have been profiled.

**Table 6.3.1: Profile of projected supply against projected demand over a 5-year period by headcount.**

<b>Key Factors</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Total Supply Available to NIHPSS	12	15	15	15	15
Total leavers in NIHPSS	5	6	6	5	5
<b>Net Supply</b>	<b>7</b>	<b>9</b>	<b>9</b>	<b>10</b>	<b>10</b>
Vacancies	7	-	-	-	-
Demand Category 1	-	2	-	-	-
<b>Over (Under) Supply</b>	<b>7</b>	<b>7</b>	<b>9</b>	<b>10</b>	<b>10</b>
Demand Category 1&2	5	6	5	1	1
<b>Over (under) supply</b>	<b>(5)</b>	<b>3</b>	<b>4</b>	<b>9</b>	<b>9</b>

From the previous tables it can be concluded that supply balances with demand for podiatry-staffing levels at each of the two categories presented apart from year one of the plan.

### 6.4 CONCLUSIONS ON SUPPLY AND DEMAND

It can be seen from the figures presented that the total supply of podiatrists available to the NIHPSS should meet the demands of categories 1&2 (agreed and resourced capital and service plans) by year 2 of the workforce plan when taking into account the current vacancies (7). These forecasts are made with the assumption that the supply available to the workforce remains constant. It should be noted the supply figures have the potential to be increased with an improvement in the attrition rate of the Podiatry Degree Course.

**Table 6.4.1: Projected supply workforce numbers available in headcount after accounting for demand categories 1&2. NB ( ) indicates a shortfall**

<b>YEAR</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Project numbers over (under) supply	(5)	3	4	9	9

Subject to securing investment the provision of a clinical service for some of the identified needs of Category 3 could be considered in years 2, 3, 4 and 5 of

the plan. This includes referral waiting lists and clinical service demands that can not be met within the existing resources eg meeting the standards of clinical practice identified within the Crest guidelines.

The figures identified by the Project Group should be taken as a first attempt and a baseline, which will require further in-depth discussion and challenge to refine and produce the most accurate statistics.

## 6.5 SENSITIVITY ANALYSIS SUMMARY

A number of scenarios have been presented to analyse their impact on the clinical service provision identified in demand Category 3 of prioritised unmet need/current demand, which has no identified funding.

Scenario 1: Increasing the percentage of Podiatry posts in Northern Ireland by 10% and considering which elements of the clinical service indicated in Category 3 could be achieved.

Scenario 2: Increasing the percentage of Podiatry posts in Northern Ireland by 30% and considering which elements of the clinical service indicated in Category 3 could be achieved.

Scenario 3: Increasing the percentage of Podiatry posts in Northern Ireland by 40% and considering which elements of the clinical service indicated in Category 3 could be achieved.

**Table 6.5:1: Sensitivity Summary Impact of Increasing % of Podiatry Posts within NIHPSS**

Scenario	Additional Podiatrists Headcount	Potential Additional Clinical Service Provision
1. Increase of 10%	18	Clinical “High Risk” patients within identified patient groups
2. Increase of 30%	54	Meet CREST guidelines on wound management and diabetes
3. Increase of 40%	72	Clinical “High Risk” patients within identified patient groups and meet CREST guidelines on wound management and diabetes.
<b>Total existing Workforce (2002)</b>	<b>179</b>	<b>Present service delivery</b>

The above table profiles and summarises the impact of increasing the workforce in the three scenario stages on the prioritised clinical service areas of unmet need and current demand identified by the Project Board in Category 3.

## **7. RECOMMENDATIONS**

The timescale for the implementation of the key recommendations outlined below is twelve months to coincide with the follow up review.

### **Workforce Planning**

- Now that the workforce planning process is established it is recommended that the Project Board should be retained to review supply and demand on an ongoing basis. It should utilise the information gathered in the review building and expand on it, taking into account such factors as the impact on the workforce, of role extension, specialisation, capital plans and service development business cases.
- The Project Board should ensure that there is a consistent and targeted approach to gathering relevant supply and demand data and manpower recording processes.
- The Department should review the activity data collected from the Allied Health Professions at Trust level. Professional managers should review management data collection from the current information systems and ensure the systems are maximised to their full potential. The aim of these reviews will be to provide a more comprehensive management information collection, which will aid the workforce planning process.

### **Recruitment & Retention**

- All employers should put in place policies to incorporate planned induction, consolidation and mentorship programmes for all new staff and review the effectiveness of these in a quantitative and qualitative manner.
- Employers and the profession should put in place a consistent approach to the implementation of work-life balance policies and procedures and this should be factored into workforce planning.

### **Utilisation of the available Workforce**

- Trusts should carry out further work into the possibility of reallocating non-clinical responsibilities to other health care workers including Podiatry Assistants.
- A co-ordinated approach between the professions, employers and the DHSSPS should take place with regard to workforce planning of

Podiatry, particularly in relation to role extension and development issues.

- Commissioners should work closely with Trusts to clearly specify the required podiatry clinical service provision within the existing resources.
- Consideration should be given by Commissioners and Trusts to defining how patients access the service with the aim of achieving better control of demand and workflow focused through appropriate clinical channels.

### **Education & Development**

- The UU and Trusts should work together to agree best practice for undergraduate clinical placements that ensures students are fully prepared for a clinical working environment
- All Trusts with Podiatry services have been surveyed (DHSSPS May 2002) with regards to the existing numbers of clinical placements and the maximum numbers that may be accommodated for each training year. Further discussions should take place between DHSSPS, Trusts and the University to establish a more comprehensive way of providing undergraduate clinical placements. There should be solutions found to the barriers identified to ensure Trusts can accommodate the number and quality of clinical placements required.
- Statistics indicate a high attrition rate and a high number of repeat year students within the undergraduate course. The reasons for these should be identified and explored with the view to improve outcomes and graduate numbers. These statistics should be monitored by the University of Ulster and reviewed on a regular basis by the DHSSPS.
- There should be an increased focus placed on Continuing Professional Development (including leadership development) and all employers should ensure that the recommended hours provision is accounted for through the workforce planning process.
- The Podiatry profession should become actively involved in the Centre for Postgraduate Continuing Professional Development for Allied Health Professionals. The NI Podiatry profession should identify its training requirements and contribute to planning for these needs.
- Employers should ensure training is available for all staff that will be required to provide mentorship or coaching support as part of their role.

- The Department should take forward the development of the AHP's Consultant role to acknowledge the high levels of clinical expertise within the profession.

### **Further Review of the Workforce**

- The Project Group should be convened initially on an annual basis to review and update the workforce plan.
- Trusts should review the skill mix of their Podiatry workforce to ensure it has the most appropriate combination of staffing grades to meet the needs of the clinical service. This review should also ensure that entry-level posts are maintained so there is a continued flow into the workforce of new graduates.
- The Project Group should be mobilised to take forward where appropriate any recommendations emanating from the workforce review.
- Trusts should review with its Podiatry Service the demands of Category 3, as identified in this report, and ensure that any agreed increase in service is included in any future service development plans.

### **CONCLUSION**

This Podiatry workforce review can be only viewed as a starting point, or baseline for further work to be carried forward. This includes the development of an action plan to take forward the recommendations outlined above. The models presented in the report will need updated and refined on a regular basis to continue to inform decision making and priorities concerning the investment in the NI HPSS Podiatry workforce over the five-year plan.

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## APPENDIX 1 - PROJECT BOARD MEMBERS

### Workforce Planning Group – Members

NAME	TRUST/HOSPITAL
DAVID BINGHAM, DIRECTOR OF HUMAN RESOURCES	Department of Health Social Services & Public Safety
JOYCE CAIRNS, DEPUTY DIRECTOR OF HUMAN RESOURCES	Department of Health Social Services & Public Safety
DOROTHY JEFFREY, PROJECT DIRECTOR	Department of Health Social Services & Public Safety
FIONA HODKINSON	Department of Health Social Services & Public Safety
BRONAGH MONAGHAN, CHIEF PODIATRIST	Belfast City Hospital Trust
COLIN FULLERTON, CHIEF OF SCHOOL OF PODIATRY	University of Ulster, Jordanstown
MARGARET MOORE, PODIATRY MANAGER	Sperrin Lakeland Trust
MICHELLE TENNYSON, PODIATRY MANAGER	South & East Belfast Trust
SADIE SOMERVILLE, PODIATRY MANAGER	Armagh & Dungannon HSS Trust
ANNE CLARKE, SENIOR MANAGER, PODIATRY SERVICES	Causeway HSS Trust
COMMISSIONER REPRESENTATIVE – DR. PAMELA HANNIGAN	Northern Health & Social Services Board
JENA MUSTON	Beeches Management Centre
FRANK GALLAGHER	Regional Staff Side Representative
ROY HAMILL, PODIATRY MANAGER	Homefirst Community Trust. Braidvalley Hospital Site, Ballymena

## APPENDIX 2 – KEY INFORMANT INTERVIEWS

<b>Representative</b>	<b>Organisation</b>
Mrs Julia Shaw	Royal Group of Hospitals Trust
Michelle Tennyson	South & East Belfast Trust
Mrs Shirley Blair	Homefirst Community HSS Trust
Margaret Moorehead	Ulster Communities & Hospital Trust
Margaret Moore	Sperrin Lakeland Trust
Mr Roy Hamill	Homefirst Community HSS Trust
Mr David Fenton	Down Lisburn Trust
Anne Clarke	Causeway Community Trust
Mrs Sadie Sommerville	Armagh & Dungannon HSS Trust
Mr Martin McLoughlin	Newry & Mourne HSS Trust
Bronagh Monaghan	Belfast City Trust
Mrs Joy Steenson	Armagh & Dungannon Trust
Mr Colin Fullerton	University of Ulster
Mr Frank Gallagher	Regional Staff Side Representative

### APPENDIX 3 – FOCUS GROUPS

<b>Group</b>	<b>Location</b>
<b>1</b>	NHSSB-Homefirst Staff
<b>2</b>	NHSSB-Causeway Staff
<b>3</b>	WHSSB
<b>4</b>	SHSSB
<b>5</b>	EHSSB-Mater & BCH Staff
<b>6</b>	EHSSB-DLT, UCHT, SEBT, NWBT
<b>7</b>	Final year – UU Students

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Website: [www.cpsm.org](http://www.cpsm.org)