The King's Fund

Time to Think Differently

Perspectives

Workforce

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Introduction

Our Time to Think Differently programme aims to stimulate debate about the changes needed for the NHS and the social care system to meet the challenges of the future. By promoting discussion, we hope to generate new thinking about innovative ways of delivering high-quality care and support health and social care leaders in their decision-making.

As part of the process, we hope to challenge assumptions about how health and social care is delivered, who delivers it and where it takes place. Our starting point for this debate is that the pressures for change, although significant, are not insurmountable, but require new thinking and fresh ideas.

This is the second in a series of four papers that aims to crystallise ideas for change in areas where, we believe, new thinking is required. The first paper focused on the NHS estate and subsequent papers will focus on the use of technology; and the role of patients and service users. The papers draw on ideas generated by seminars, discussions with experts and feedback from the Time to Think Differently programme.

We need to think differently about the workforce of a future health and social care system. This paper outlines the key challenges and suggests some priority areas for action.

The current workforce

The workforce is the primary driver of future health and social care costs: 1.4 million people work in the NHS (NHS Information Centre 2013) and a further 1.6 million in the social care sector (Centre for Workforce Intelligence 2011). Together they account for 1 in 10 of the working population and around 70 per cent of expenditure for the average health and social care provider.

One of the biggest challenges for today's professional workforce is that it was trained and developed to work in a model centred around single episodes of treatment in hospital. However, those placing the greatest demand on services, both now and in the future, are older people with multi-morbidities (both mental and physical), who need integrated, long-term health and social care.

In addition, there is a mismatch between the location of the current workforce and where care is needed. For example, while the need for home and community-based care is growing, the number of district nurses fell by 38 per cent between 2001 and 2011 (Royal College of

Nursing 2013a). As many people argued during the engagement process for our Time to Think Differently programme, there is also a pressing need for more specialist skills in primary and community care and for more generalist skills in hospital care. Across the sector, there needs to be much closer collaboration between specialists and generalists, hospital and community, and mental and physical health workers. The NHS and social care sector need multi-skilled staff to work across these boundaries.

Key challenges facing the future workforce

The challenges facing the future health and social care workforce are considerable.

Prospective workforce gaps

Across the globe, the demand for health and social care workers is growing, but the number of workers is not. The World Health Organization (2006) predicts that it will become increasingly difficult to recruit health workers. In England, many acute trusts are already finding it difficult to recruit nurses, while the Royal College of Nursing predicts that the number of nurses could fall by 28 per cent (100,000) by 2022 (Buchan and Seccombe 2011). This fall will be driven by the ageing nursing workforce, the international movement of health care workers and fewer people training to be nurses.

In social care the mismatch between supply and demand could be 1 million workers by 2025, a 35 per cent shortfall on predicted demand (Fenton 2011). In the informal workforce (unpaid care provided by friends and relatives) the gap could be even bigger. Between 2010 and 2030 the number of people requiring informal care is expected to grow by 1.1 million to 3 million, (Wittenberg *et al* 2011), while the number of people living alone and isolated from family support is growing.

While the impending shortfall in nursing and the informal workforce is widely understood, the situation with the medical workforce is more complicated. The Centre for Workforce Intelligence, the national workforce planning body in England, is forecasting an oversupply of hospital doctors and an undersupply of GPs. However, although there is expected to be a large oversupply of hospital doctors, there will be significant issues in particular specialties with emergency, geriatric and psychiatric medicine facing recruitment difficulties. Yet these are precisely the specialties where the need is greatest and growing most significantly, given changing demographics and the need for consistent 24/7 care.

Workforce redesign is needed not only because of a potentially dwindling workforce, but also because the nature of health care work is changing and the skills of the current workforce are not well matched to future needs.

The nature of work is changing

Growing and changing demand for care

The type of health and social care that individuals need is changing. The number of older people with multiple and complex conditions – the segment of the population that is already putting the greatest demands on health and social care services – is growing rapidly. Lifestyle factors, such as obesity and physical inactivity, are increasing the burden of chronic disease. In addition, there is a subtle but important change in our definition of 'illness', as medicine puts increasing focus on those 'at risk'. Finally, in health care, while developments in treatments and drugs increase our ability to treat disease and prolong life this magnifies the demand for care.

We anticipate that demand will rise for both technically less complex care (eg, home care for frail older people) and technically more complex care, as new technologies, such as genomics, metabolic testing, and computer-assisted surgery, enter routine practice. These advances also challenge the current boundaries between medical generalists and specialists. To use a sporting analogy, medicine can no longer be a racquet sport between generalist and specialist – batting the patient backwards and forwards, it needs to be a team game, generalists and specialists working together with the patient.

New medical and information technologies create new health care tasks and enable different ways of working, including enhanced roles for patients

New medical and information technologies will profoundly change the workforce: they will change what the work is, where it can be done and who does it. Technology puts power into the hands of patients and means more care can take place outside the hospital setting.

One example is the use of portable monitors for patients who are at risk of stroke and on oral anticoagulation. Instead of spending many hours attending busy outpatient clinics to have their blood monitored and medication adjusted, patients can test themselves and either adjust their medication according to a predetermined dose or call a clinic to be told the appropriate dose. Other examples include devices that remotely monitor vital signs, such as blood glucose and heart function, and intelligent devices that control household appliances. While use of these technologies can improve clinical outcomes, and make care more convenient, it is important to note that not everyone feels confident to self-medicate or will want this degree of intrusion in their daily lives. One size does not fit all. Advances in diagnostic and video technology also enable specialists to check on patients and offer advice remotely. A current example is Guy's and St Thomas' NHS Foundation Trust, which will be testing the 'eICU' system. This system uses high-definition cameras to enable consultants to check on patients from a centralised control room and alert bedside teams to and advise them on problems. This is a world in which it is the clinical information that moves not the professionals, thus expanding the geographical reach of professional expertise.

The shift towards protocol-driven care

The rapid expansion in the evidence underpinning medicine – more than 20,000 randomised control trials in the last year alone – is driving a shift to more protocol-driven care. Health problems for which there was previously no 'right' answer can now be addressed by a clinical guideline embedded in the software of a decision support tool. Medical knowledge has changed from the general to the specific (Bohmer 2009). In the future, better understanding of diseases, in particular their link to an individual's genetic make-up, will enable more individually tailored treatments. The move towards using genetic information as a part of clinical decision-making has already changed the health care workforce by increasing the demand for geneticists and genetic counsellors (Centre for Workforce Intelligence 2013).

Waste reduction/lean manufacturing techniques may change demand

In the United States, inefficient processes, overtreatment, poor care co-ordination, and other forms of waste amount to an estimated 30 per cent of all health care costs (Berwick 2011). In the United Kingdom, we believe the figure is similar. Applying waste reduction, or lean manufacturing, techniques can redesign the workflow, task allocation and physical layout of care facilities and has the potential to change the number and type of staff required. Although many organisations have already begun improving care processes using the techniques of lean manufacturing, most have a long way to go before they are truly 'lean'.

The relationship between professionals and the work is changing

Not only is the nature of work in the health and care sector changing but so too is the traditional connection between one particular profession and one particular type of work. Other professions – psychologists, optometrists, midwives, etc – have challenged doctors' hold on making diagnoses and prescribing medicines. There are also examples of non-physicians undertaking surgery. Some GPs have extended their specialist skills in areas such as dermatology and diabetes. And we have seen the creation of entirely new roles, particularly in the area of care co-ordination, where staff work across organisational and sector boundaries.

Patients' engagement with their own care and clinical decision-making has also changed significantly but still has some way to go.

Addressing the future challenges

Creating a workforce that is fit for the future is a complex challenge that requires action at both national and local level. More fundamentally, there needs to be a shift in focus to a multi-professional approach to care and a willingness to challenge the balance of the current professional hierarchy and role.

Align the workforce to work, not the other way round

The future workforce needs to be based on future work. If not, there is a risk, as we are seeing in acute hospital care, that the model of care will be driven by the available workforce, not the other way round. It is not possible to separate workforce redesign from work redesign; both need to be undertaken simultaneously. We should be driving 'collaborative practice development' not 'continuing professional development' (Albury 2013) – working across professions, not developing individual professions. Health and social care are team-based activities; the work of one team member is inter-dependent on others.

The staff we will have are the staff we already have

A common conclusion from any analysis of changing demand is a call to reform the training curriculum, particularly of doctors. However, most of the professionals who will be working in the NHS in ten years' time are working in the NHS today. Any workforce redesign needs to focus more on re-training or re-assigning/re-purposing the current workforce, so that they have the skills needed to deliver new models of care, than on the training of new junior medical staff.

Current staff need to develop the skills to care for people with multi-morbidities that span mental and physical health. But they also need to develop the skills to act as a 'partner' and 'facilitator', rather than an 'authority' and this will require significant cultural change.

Currently less than 5 per cent of the £5 billion training budget is allocated to continuing professional development while the rest is spent on securing professional qualifications (Imison *et al* 2009); this division should be reconsidered.

Develop teams, not just individual professional groups

Previous investments in workforce have been heavily weighted to individual professional groups, in particular medical and nursing staff. But clinical staff work within multidisciplinary teams and the quality of teamwork is a major contributor to the quality of patient care (Borrill *et al* 2000). Developing teamworking may be more important than developing the roles of one professional group. Medical training also needs to move away from the traditional individualistic perspective and prepare students for multidisciplinary team working.

Strong teams can also reduce dependence on any single professional group and so work can be shared. The Hospital at Night initiative is a good example of this: out-of-hours hospital cover is provided by a centralised multidisciplinary team, with the full range of skills and competencies to meet the immediate medical needs of patients. The central tenets include multi-specialty handovers; extended nursing roles (including prescribing); and bleep filtering through central co-ordination (see www.nrls.npsa.nhs.uk/resources/?EntryId45=59820). In primary care, the extended team of GPs working with primary care nurse practitioners and health care assistants is another example.

Support the informal workforce

In England, around 3 million people volunteer in health and social care (Naylor *et al* 2013), and there are more than 5.5 million informal carers (Carers UK 2012). This is almost three times the number of formal health and social care workers. We need to recognise the potential value of the extended informal workforce that includes patients, carers and volunteers. With more and more fit retirees, there is an opportunity to foster a 'social movement' to support those in need. Organisations could and should take a much more strategic approach to the support and development of volunteers.

Support and engagement of patients

There needs to be a change in culture so that patients are better supported to take more responsibility for their own care. The potential benefits of supporting patient self-care are significant. David Sobel of Kaiser Permanente argues that, as 80 per cent of health care is self-care – for example, taking over-the-counter medicines rather than seeing a GP – a community's true primary health care providers are the people themselves (Health Progress 1994). As a result, comparatively small shifts in self-care can have a big impact on the demand for professional care. Sobel argues that a 5 per cent increase in self-care could reduce the demand for professional care by 25 per cent, while a 10 per cent decrease in self-care could increase demand for professional care by 50 per cent.

However, in the future, while greater access to information and remote consultations could increase the proportion of self-care, the increase in continuous self-monitoring and identification of those 'at risk' of disease could significantly increase the need for professional care. The challenge will be support patients in a way that decreases rather than increases demand.

Reverse the 'inverse training and investment' law

In the past, too much of the workforce debate has focused on the most expensively trained workers, while the other end of the health and social care workforce has, until recently (Cavendish 2013) been largely ignored. Approximately 60 per cent of the NHS's training budget is spent on the most highly paid health professionals, doctors (12 per cent of the workforce) and 35 per cent is spent on nurses and allied health professionals, who account for 40 per cent of the total NHS workforce. Despite the fact that biggest growth in need will be in hands-on, out-of-hospital, and social care, there are no national funding streams for training the unqualified workforce, such as health care assistants, who have no real professional pathway. There is also little national investment in the social care workforce, and the national subsidy for social work training has recently been removed. While the recent Cavendish review (Cavendish 2013) calls for more formal training for health care assistants and support workers in the NHS and social care settings, it is unclear whether any national funding will support this ambition.

Staffing and workforce development have been a recurrent source of concern to regulators of social care (Centre for Workforce Intelligence 2011). As the Centre for Workforce Intelligence identified 'poor terms and conditions coupled with demanding yet sensitive tasks make social care a difficult area to recruit and retain staff' (Centre for Workforce Intelligence 2011, p 19). For staff without professional qualifications, hands-on care is challenging and risky, yet this isn't recognised in pay, and staff do not receive the appropriate supervision or development opportunities and support. This not only raises significant issues of equity in the workforce, but has significant consequences for the quality of care. As one participant said at a seminar on this topic held at The King's Fund: 'patients are being neglected by a workforce that we have neglected'. As the Cavendish review argues, there is a need to invest in this staff group by making the work more attractive, giving career development opportunities, developing a grade structure for people to aspire to, and encouraging a team approach to high-quality care, as well as providing opportunities for further training and skill building. The 'caring' role is critical to the quality of life of older and vulnerable people now and in the future.

Pay and reward strategies

A strong message from our engagement work for Time to Think Differently was that current national terms and conditions, and rigid pay scales for the different 'types' of worker are powerful barriers to change. For example, they restrict capacity to address recruitment issues in specific geographies or service area. In medicine and nursing, there appears to be an inverse relationship between the need for staff in a particular area and its attractiveness as a career choice. The basic laws of supply and demand would suggest the need for flexibility in pay scales in areas where recruitment is difficult. Unfilled posts are a major barrier to developing high-quality, patient-focused care.

Uniform pay scales also fail to align staff incentives to the type of work required, for example, incentives for population-based care that support better health outcomes or for elective surgery that drive higher throughput. There is growing evidence to support more mixed models of pay, including the opportunity to pay team incentives. Current national pay structures also reinforce the divide between primary and secondary care doctors, as well as between medical and non-medical staff. They also do not facilitate the transition between clinical and managerial roles for senior doctors. This is, however, a highly contentious area, as can be seen from the reaction to the recent attempts in the South West to develop local pay (Royal College of Nursing 2013b; BBC 2012).

Uniform pay scales have their merits too, and are fiercely defended by staff organisations and unions. Interestingly, although foundation trusts have freedoms to create their own terms and conditions these freedoms have yet to be exploited.

Above and beyond this there is a need to think much more deeply and creatively about 'non-pay' reward and engagement strategies. There is good evidence that NHS staff engagement is linked to patient outcomes (West and Dawson 2012), yet NHS staff surveys show a worryingly low level of engagement. What is it that staff in caring professions need that at present the NHS does not provide?

Support nationally, act locally

Successful workforce redesign requires national facilitation, but local action. There are lessons to be learnt from the development of extended nursing and allied health professional roles, which generated a confusing morass of people with similar titles but widely different skills, as Cavendish (2013) pointed out in relation to health care assistants. National competence

frameworks, and, in some cases, professional regulation can help to avoid this. However, professional status can also be a major barrier to changing ways of working. On the one hand, we want solutions to local problems, but on the other, some standardisation and recognition of new roles is important, particularly if we want those roles to be sustainable.

A lesson from the many workforce modernisation initiatives of the 2000s was that roles developed in isolation are difficult to sustain. Not only are these roles too reliant on individual goodwill that can then disappear when an individual leaves their post, the lack of a nationally recognised competence framework limits the capacity for individuals to deploy their skills elsewhere and build their careers. It is also important that the freedoms created by national bodies, such as the opportunities for nurses to prescribe or order x-rays, are exploited.

Support local management

The workforce cannot be completely redesigned centrally, although national policy-makers have an important role to play. Many of the issues discussed above can be influenced by local leadership and management. Effective leaders can help workers at all levels to find meaning and value in their work, promote team co-operation and collaboration, and reduce staff turnover rates. Most importantly, local leadership is pivotal in creating and nurturing the culture of compassion clearly lacking in many NHS institutions.

Local adaptations are key to success, and local leaders need support in their efforts to redesign and better engage their workforces. Effecting a smooth transition is dependent on skilled local managers, who can shape organisational culture, manage staff-side relationships, understand and account for patient and community preferences, and mobilise local educational resources.

Conclusion

The potential shortages in the formal and informal workforce faced by the health and social care system are breathtaking and will pose challenges to the implementation of new models of care. At the same time, more than 3 million people in the existing health and social care workforce need to be equipped with new skills. The scale and urgency of the task is immense. It demands action at national and local level: action that recognises the complex interdependencies between different staff groups and the work they are undertaking; action that aligns staff incentives with need; action that facilitates local innovation, but supports sustainable change. At a local level, workforce redesign will require detailed redesign of models of care and hence a high level of local management capability.

The discussion above suggests several general conclusions.

- Workforce redesign cannot be approached as an isolated topic, but should be integrated with processes for redesigning care, identifying the best site of care, and utilising technologies that facilitate alternative ways of working.
- There is currently a real risk that the workforce, in particular the medical workforce, will drive the care model not the other way round. To achieve a better alignment between the workforce and the work, workforce and service redesign need to go hand in hand. There should also be a review of current national contracts and pay.
- Workforce redesign is as much a local challenge as a national one. This means that we will have to tackle the current cultural aversion to risk and fear of failure in order to promote experimentation, tolerate variation of the quality of service around the country, and be willing to close down experiments that are not working.

- Although the most highly paid section of the workforce currently attracts most of the attention and the training budget, there is an urgent need to develop and invest in the unqualified workforce, such as health care assistants in hospitals, and care workers in the community. Given the growing shortage of informal carers we also need to consider new ways to attract and support volunteers in health and care.
- Many of tomorrow's workforce are here today. Much greater priority needs to be given to developing the skills and competences of the current workforce, and the quality of teamworking, to better meet the needs of patients today and tomorrow.
- In the future, it will be important not to be bound by our thinking regarding current ways of delivering health care. New technologies will force changes in delivery models that we have not yet thought of. Without building capacities and capabilities in our workforce for a world of continuous change and emergence of new roles and possibilities we risk being perpetually out of step and continually rebuilding our workforce to do yesterday's, not tomorrow's, health care work.

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