The Future Workforce of the NHS

Introduction

This report synthesises discussion at the conference track ‘The Workforce and the Professions in Health’. The NHS workforce is under great pressure to change from a variety of sources. The Labour Government has pledged to reform the NHS and sees workforce change as central to a more patient-centred workforce. There is widespread recognition that even if ambitious targets for expansion of the workforce are met they will not be sufficient to meet projected levels of demand (quantity and quality) for healthcare by 2020. Simply increasing staff numbers will not make the NHS more patient-centred. The NHS needs to work differently, the question is how to best go about it.

An opening informal discussion noted the diversity of current influences. It is not only Richmond House driving change. The EU, for example, is an increasingly important external influence. The working-time directive forced reorganisation of work. There are also societal pressures for change. There has been a general erosion of public trust in all professions, from scientists to teachers. People are less likely to acquiesce to traditional sources of authority and take professionals at their word. They want to be more involved in the choice of the care they receive, and to be more informed generally. They are said to be more consumerist in outlook and want services tailored to their needs. The concerted central drive to reform the professions was emphasised. The Government has a clear vision of what it wants: more interdisciplinary and flexible working unconstrained by professional demarcation.

Can the planned reforms deliver a patient-centred service?

Circumstances prevented the formal presentation of the opening paper by Rachel Lissauer of IPPR. Her paper underlines the centrality of workforce development to governments’ modernising agenda but points to a key contradiction. On the one hand, government values the professions and seeks to “place them in the driving seat”, but on the other displays a very strong determination to ‘shatter old demarcations’ and overcome the restrictive practices and traditional professional boundaries in order to provide patient-centred care. The paper lays down the challenge that the health system as presently conceived is failing to develop in order to meet patients’ needs in the round. Because patients’ requirements have been ‘classified and packaged in the basis of their clinical diagnosis’, Lissauer argues, medicine remains placed above other professions in a way that neglects and undervalues public health and health promotion. Generating a real sense of responsibility for the wellbeing of a local community in PCTs and focussing on care ‘not as a clinical episode but as a continuous healing relationship’ requires more fundamental change. She thus calls for a major conceptual shift to promote genuinely radical reforms. Another important theme of her paper is that deeply embedded professional values and identities can work against change and a new concept of professionalism is needed to underpin this. She makes the point that change is
not progressive in itself. It is not inevitable that it will improve the problems of fragmentation of services or the poor communication that may be inhibiting the quality of care. The Institute of Public Policy and Research's future health worker project, due to report in December 2002 is likely to explore some of these themes further.

**New relationships between nursing and medicine: strategic review of roles or substitution of skills?**

Anne Williams of the University of Wales drew work she had completed for the Wanless Report¹ and examined innovation at the boundaries between nursing and medicine in primary care. Her paper notes growing support for the idea that professions need to work together more effectively and emphasises that this is an important influence on the quality of care provided. She suggests boundaries are changing through the one-way transferral of skills from medicine-to-nursing rather than by working in a more strategic way.

She also suggests that across the boundary some important issues can be seen differently, for example, ‘continuity’ and the way patients’ ‘first contact’ should be managed. Some nurses worry that the proliferation of specialists will create a more fragmented process of care. This raises issues around continuity and is in tension with a wish among nurses to take a more holistic approach to healthcare. Interestingly, GPs' think nurses do a better job caring for routine chronic care, such as asthma, but they too fear that transferring the management of certain patient-groups disturbs continuity. They worry they will only see some of their patients in a crisis.

**Neglect of the care assistant role**

While nursing takes on more roles traditionally the jurisdiction of medicine, who does the things they used to? The Wanless report suggests healthcare assistants will. It is one of the less widely reported recommendations in his report. Wanless’ calculations mean 140,000 healthcare assistants will be recruited. It is not a surprising suggestion, but Carole Thornley from Keele University argued that it was an unrealistic one. It misunderstands the root inequalities that are involved.

The Government and employers' interest in examining skills and competences is at the lower end of the workforce hierarchy. Health Care Assistants are a very cheap source of labour. Pay is increasingly determined locally, not by national negotiation, making care assistants more flexible, or vulnerable, depending on your view, to management power. The stress on local determination of role is an important reason why the role is not clearly understood. It is also one of the reasons the NHS does not know how many healthcare assistants it has and why their demographic profile and skills are not well understood either. Commonly thought of as young, in practice, most are mature women. They have a lot of

---

caring experience, on average 12 years. They learn on the job and teach themselves off it.

The NHS faces a number of challenges in developing its vision for a large and well-motivated workforce of healthcare assistants. A re-evaluation of skills and work is required, as is an understanding of ‘hard’ and ‘soft’ contributions of the role, and establishing which is to be emphasised most. The role of Health Care Assistant needs to become a more attractive career before 140,000 people rush to join it.

What is it like to work in a newly constructed role?
Alisa Cameron of the University of Bristol and Abigail Masterson who runs an independent consultancy, have completed work on innovative roles in nursing and in the allied health professions. Findings suggest that the excitement, prestige and challenge of new roles is balanced by uncertainty and the isolation of being unique. Because a role isn’t clearly understood “no one knows what training we need”. What is done is done in-house and is very ad hoc. There is little interest in the emerging professions within higher education, and few courses are available. People have concerns about their future career. If the innovation is isolated within an organisation, might a person be fulfilling a role that doesn’t exist elsewhere? People fear they are departing from a recognised career structure. Innovations that encourage more generalist roles do not fit well with specialist roles advertised elsewhere. There is a sense in which working as a generalist might harm your career.

There is a lack of clarity about the new roles being created, and there is not always a good understanding amongst colleagues of what new roles mean. Some colleagues are liable to feel that role changes are unnecessary. If the NHS wants fully to remove barriers between professions and have a flexible workforce, these writers argue, it faces a number of complex challenges related to competence, accountability and regulation. A greater focus on professional standards across healthcare roles is needed. This will not be straightforward. If new roles are not professionally accountable and are locally determined, there is greater onus is on the employer. The problem is that people in senior positions are often unaware of these issues.

How do specialists respond to pressures to change?
If the trend in workforce roles is towards greater flexibility and greater substitution, what does that mean for people who have developed careers by acquiring specialist knowledge through long training programmes? Central initiatives on a number of fronts are forcing changes in specialist care. Jenny Gallagher of King’s College London examined the experience of Oral and Maxillofacial Surgery (OMFS), a medical specialty with its roots in dentistry, as a case study for the implications of professional changes for the future specialist workforce. OMFS as a specialty has increasingly overlapped with Otorhinolaryngology [ENT] and Plastic Surgery - both medical specialties that share a skill base. The introduction of Service Frameworks and the commissioning of Cleft Lip and/or Palate Surgery, Head and Neck Cancer
surgery and Facial Trauma Repair are initiatives that cut across specialties, creating competition for patients, particularly in complex cases. Thus current health policy initiatives are fuelling contests between these specialties.

Complicating the picture further, the introduction of specialists in Surgical Dentistry present a challenge to OMFS in the field of high volume routine care in a manner that is contrary to the traditional development of specialties.

Specialisation is a dynamic process, shaped by context and negotiation of power with the state, public, patients and other professional groups. Power is central to the division of labour and is core to the re-engineering of roles. The power of single specialisms to determine the future appears to be in decline and tensions are high. How can these tensions be resolved? Possible solutions proposed by specialists include: multidisciplinary working in existing surgical specialties or the creation of super-specialties. However, multidisciplinary working may present a challenge as specialists both have a narrowly defined field of surgery and require a large population base. In routine cases, tensions may be resolved through a new hierarchical relationship between specialists or the re-provision of specialist care in High Street surgeries.

**How well-developed is the vision of an interdisciplinary workforce?**

Jan Savage of the RCN Institute was unable to join the discussion, but her abstract chimed with the notion that there is tension between aspirations for more interdisciplinary working and the reality of deep pockets of specialist knowledge. As knowledge is both a source of power and identity, working more collaboratively may require some relinquishment and reconstruction of both. Much policy is based on an assumption that people will work in interdisciplinary teams. But this overlooks the different systems of expert knowledge held by individual team members and the role of expert knowledge in maintaining professional identity. Furthermore, in the drive for evidence-based-medicine, ‘evidence’ is drawn from basic sciences of medicine with little recognition of other forms of knowledge such as those associated with sound clinical judgement. ‘This kind of privileging of one knowledge system over another would seem to be detrimental to genuine multidisciplinary decision-making.’

**Changing relationships between traditional medicine and complementary and alternative health interventions**

Philosophical differences also underpin differences between traditional medicine and growing demand and supply of complementary and alternative interventions. A paper from Geraldine Lee-Treweek of the Open University and Sarah Oerton of the University of Glamorgan notes how far apart the two approaches are, but also how quickly, relatively speaking, the two have moved closer. As recently as 1986, a BMA report talked about CAMs as alien to the NHS, as a world of small private clinic or home-based amateurs and charlatans practising without an evidence base. CAMs were thought to pander to the lifestyle concerns of a minority. But only seven years later, in 1993, the medical establishment’s view had softened to the point where it acknowledged and
sought to accommodate certain therapies. The growing interest of NHS staff in alternative therapies aided acceptability, as did its growing popularity with the public.

There are more alternative practitioners, and more courses, and there is growing disillusionment with traditional conceptions of health. But there are still significant obstacles to relating CAMs to mainstream health services. There is no single body over-seeing student training in new therapies and while the government would like to see more provision and the development of self-regulation, the different organizations that represent CAMs have resisted calls for common regulation. There is perhaps some competition as to who is the legitimate voice of CAMs and there is little sense of a collective identity. One suggestion is that tensions might be improved through more fully incorporating CAMs into the NHS regulatory framework. In practice, professionals draw on different techniques. What would it mean for regulation if a physician chose to practice acupuncture to relieve pain? The lack of consensus on what constitutes adequate knowledge is a barrier to a more formalised system of training. There are also deep problems in forging a common knowledge between complementary and alternative approaches with mainstream medicine. There is not a great deal of research on alternative approaches and barely any links to established research institutions. Nor are there many incentives for new or further research. More fundamentally, each has different orientations to health, what it is and how it can be improved.

Conclusion: hopes and fears for the future workforce

Reading across the different papers presented and the discussion, the tensions that characterise the current state of the workforce cannot be ignored. Their further exploration is key to creating a healthy division of labour in the NHS. There is a great deal of support for more collaborative working, but as ever the devil is in the detail of implementation. Identity is an important issue. If policy requires people to work in new roles, it also requires them to think differently about the role they play as well as who they are in the organisation and clinical team. The successful development of roles will require the leaders of professions, nationally and locally, working with colleagues in other disciplines to reconfigure health services.

The discussion covered many topics. These ranged from control and regulation of complementary therapies, to medical specialisation and the “swampy lowlands” (as described by Alison Kitson, using Donald Schon’s term) of the formal and informal renegotiations around medical, nursing and allied health professions. Three key themes stand out: power and who has it, the need for a clear framework for local innovation and the centrality of evaluation to reform. Within each are both hopes and fears.

(1) Power: who has it?
It is important to understand who is driving reform and who is not. A hyperactive government has spent five years pushing through radical change.
There is a fear reform is narrowly concentrated on system redesign rather than on the content of new roles and professional relationships within the workforce. To bridge this gap, it is to be hoped that leaders of the health care professions and the NHS together begin to engage in debate, scenario planning, evaluation and research on the best way to change behaviour. There is also a need for much greater engagement between the leaders of the professions in thinking through new roles and the relationships between them.

(2) Innovation
Innovation is already widespread, but there is some concern that the process of reform is fragmented and efforts are isolated. The various strands of policy require a more role-orientated assessment of the how people should undertake work across the boundaries of doctors, nurses and healthcare assistants. A more strategic and coordinated approach to local innovation, with evaluation at its heart, may enable local teams, units and organisations to feel they can adapt and adopt frameworks that ensure greater ownership.

(3) Evaluation
'Safe innovation' was a concept repeated used by participants. Evaluation and assessment should be integral to every project. Evaluation is also needed to explore tensions and unforeseen consequences as well as better understanding the quality assurance role of the centre in local innovation, particularly around important areas such as accountability, competence, risk assessment, job satisfaction, cost and clinical effectiveness.

Final thought
It was pointed out that not very many men or medics joined this stream of discussion. An alternative session on finance proved more attractive. Can anything be read into that? Finance always gets more headlines than workforce issues in the NHS. The NHS, said Wanless, faces two central problems: it is under funded and needs to work in new ways. The latter received less attention, but as Wanless recognised, finance alone will not modernise the NHS. The central challenge is to work differently. Until this receives adequate attention, the aspirations for a patient centred, responsive and effective service will not be fulfilled.

Reference
**Papers Presented**


Cameron, A and A, Masterson (2002). *Is there an invisible revolution happening within the clinical team?*
