

Changing Workforce Programme

The NHS Plan highlighted the need to look at new ways of working to improve patient care and ensure good use of skills. This in turn will help with the plans to increase staff numbers, by ensuring greater job satisfaction. The Changing Workforce programme has been set up to help the NHS and associated organisations do this. There is a great of good practice that can be shared and many areas where potential changes need more intensive investigation and support. Please note that throughout this document the term health care is assumed to include relevant care by other bodies, such as social services or the independent sector

The term new ways of working covers four types of change:

1. Moving a task up or down a traditional uni-disciplinary ladder – eg consultant giving care previously covered by doctors in training
2. Expanding the breadth of a job – eg rehabilitation practitioner across traditional professional divides, some of CNOs 10 roles
3. Increasing the depth of a job – eg nurse and therapy consultants
4. New jobs, combining tasks differently to before

The activities fall into three main areas:

1. Pilot test sites

These will be 10-12 test sites for specific areas where new ways of working could help solve service problems. These sites will receive support from the Changing Workforce Programme to explore a theme, which covers one, or more of the types of new ways of working.

The purpose is to test fully the potential for different ways of working, identifying and overcoming the blocks to successful implementation both in the test site and throughout health care. The themed projects overlap, and lessons will be shared between them. However they will each focus on an issue of major significance in health care at present, where there is a recognised need for change.

Common underlying principles in the work

Each pilot will be different, but there are certain principles, which will apply in all our work

- ◆ All changes to roles will be based on the use of care systems, pathways and protocols to ensure clarity, accountability and safety.
- ◆ The work will build on evidence of good practice, identified by other developments e.g. NPAT collaborative, partnerships and action on programmes;

the Clinical Governance Team; Primary Care Development Team; Beacon Sites and other schemes which identify excellence in health care.

- ◆ Close links will be maintained with other relevant Human Resource developments such as Agenda for Change (the new pay system), Improving Working Lives and improving diversity in the service.
- ◆ All job design will take account of the need for continuing personal and professional development and lifelong learning. Educational programme design will enable accredited modular progression within and between qualifications
- ◆ The term health care is intended to include social care and other agencies when and where appropriate

Success Criteria

Success will be measured by:

- ◆ improved patient care, each project to set targets at outset e.g. decreased patient handovers;
- ◆ enhanced job satisfaction and staff retention;
- ◆ contribution to the skills escalator concept, i.e. that experience and training for one post enable one to move to higher levels with credit for previous achievements;
- ◆ reduced vacancies and staffing turnover for reasons other than promotion or family reasons.

Support from the CWP for the Local Project

- ◆ Facilitated thinking time
- ◆ Resources to “oil the wheels” e.g. locum cost cover, meeting costs
- ◆ Information and research support
- ◆ Action at national and regional level to unlock the blocks
- ◆ Support in dissemination of project outcomes

Each pilot will have a Workforce Designer from the Changing Workforce Programme, who will work about 75% of their time on the test site, with the rest of their time enabling change in other parts of the service. This will enable them to keep up-to date and bring in ideas from elsewhere to the pilot, as well as supporting introduction of new ways of working throughout the service.

There will be a part or full-time project manager for each pilot who will work at a range of levels according to local need. This person will co-ordinate activities of project participants, meetings, timetables, and undertake a number of tasks associated with implementing the change.

Each project will work differently and funding levels and use may vary. Resources will be available to free up the time of clinicians and support staff involved in the delivery of care, to enable them to explore, plan, trial and implement the changes. In addition there will be some funding for administrative costs such as meetings and special printing. A central pool will be kept for unforeseen costs. The objective is

however to pilot approaches that can be easily introduced by other organisations and not require further pump priming.

Each test site will have a steering group to both help local people with the work and ensure that key stakeholders are involved. This would include relevant medical colleges and other professional bodies, workforce taskforce members and product champions. These steering groups will have a role in clearing the external blocks to change, but most importantly need to be enthusiasts for the work, acting as a sounding board, generating new ideas and encouraging those involved in implementation.

There will be an expectation from the projects for sharing:

- ◆ replicable models and good practice database;
- ◆ detailed testing of boundaries;
- ◆ examples and evidence for supporting national changes in education and training, regulation, pay systems, accreditation, continuing professional development and lifelong learning.

The work will roll out in three phases, each taking nine to twelve months as follows:

Detailed exploration and implementation of site themes

During this phase detailed work will be undertaken to:

- ◆ analyse the health care problems which could be resolved by new ways of working;
- ◆ ensure clear protocols exist for the work and develop them if not;
- ◆ redesign the system of care if needed, using work from other modernisation teams;
- ◆ explore examples of new roles elsewhere to see what can be learnt from others;
- ◆ design job descriptions and new kinds of person specification for the new posts, to allow flexibility;
- ◆ clarify accountability and other organisational matters;
- ◆ appoint people into the new jobs.

During this first phase we will also develop a review mechanism to ensure lessons are learnt as we proceed. There will be joint work between the pilots, both as a support and an audit mechanism.

We will pay particular attention to ideas that were difficult to implement, or which were blocked, analysing the reasons and developing actions to resolve them. Lessons, however small, will be shared beyond the pilot as soon as there is reasonable evidence of success.

Application of themed learning to all sites in pilot group

During this second phase we will build on the confidence acquired locally around new ways of working, to encourage each site to implement roles from other pilots or to explore additional new roles. The aim will be to get the whole “organisation” to

develop an approach to the delivery of health care, which is based on integrated care pathways, local care protocols and best allocation of staff skills.

We will also at this stage be well into clearing the blocks at a national, or indeed local level, having gathered enough information from phase 1 to be clear about what needs to change, and enough evidence to “prove the need and argue the case”. This, in turn, will enable us to implement some ideas during phase 2 that may have been blocked in the first phase. Changes needed in the education systems will be emerging by this time, and we will work with colleagues to encourage these developments.

Dissemination throughout the NHS

The first part of this third phase will be to publish the learning from the pilots in a comprehensive fashion. Elements of the learning will already have been shared through the database and advisory service (see below). A programme will be set up to enable all Trusts to implement the new ways of working identified within the pilots areas. CWP workforce designers will work with local Modernisation teams to do this.

Progress on site selection:

- ◆ SHO Equivalent Roles, linked to SHO training review and impact of changed hours in doctor’s contracts - Leicester Hospitals, Trent Region
- ◆ New Roles in Diagnostic Care, to be linked to the access taskforce – Hartlepool Trust, Northern and Yorkshire Region
- ◆ Emergency Care, links between paramedics and A&E to help winter/trolley waits. Site to be determined – hopefully within Eastern Region - will link to current emergency service review and testing of new models of emergency care
- ◆ Medical Support Staff , e.g. technician/assistant at NVQ3/2 year foundation degree level – Portsmouth Health Economy
- ◆ Anaesthetics Team, exploring new roles within anaesthesia, critical care and pain management – Burton, West Midlands Region
- ◆ Primary Care, building on developments of PCDT to further test new roles. Site to be determined linked to GP specialists, PMS pilots, PCDT and Primary Care Workforce review.
- ◆ Mental Health, testing the new roles identified in the NSF and NHS Plan. Pilot Site chosen in partnership with Workforce Action Team of the Mental Health Taskforce - Northumberland Mental Health Trust with North Lakeland Healthcare NHS Trust, Northern and Yorkshire Region
- ◆ Cancer/Scientists, exploration with one of the cancer sites on whether laboratory and scientific tasks can be organised differently to resolve service problems caused by labour shortage, discussion in hand with Chief Scientist and Cancer Taskforce Team Bristol, South West Region
- ◆ Therapy Consultants, pilots on range of possible roles- Salford, North West Region and one other
- ◆ Stroke Care testing across health and social care teams Bradford, Northern and Yorkshire Region
- ◆ Generalist/specialist – testing impact on service delivery where new ways of working reaches the balance point between generalism and specialism – Central Middlesex and Kingston Hospitals London Region.

- ◆ Diabetes- to develop new roles associated with improving the NSF, when published.

2. Removing the Blocks - Creating the right “climate” for new ways of working

We are aware of a number of blocks to change already. The pilot sites, and work with providers generally will give us more information. These blocks to implementation have a range of causes, such as anxiety, history, territorial and protectionist behaviour, education and training, regulation, information systems, rewards, including pay, management understanding, leadership, workforce planning systems, disjointed initiatives.

In all these areas the CWP will work to remove the blocks, operating in a range of ways, and participating in the work of others to ensure new ways of working are helped and not hindered by their actions. In some aspects we will play a lead role. This work is and will be mostly undertaken by the Director and the two programme leaders. There are two more costly/time-consuming pieces of work within this category

- ◆ Protocols work - to ensure a robust database for the reallocation of tasks so that clinical accountability and safety are clear.
- ◆ Education pilots - support to two major projects to try to ensure that services and education changes take place together – probably one will be in Southampton where they are most advanced in common learning programmes – the other should be somewhere less advanced so we can test potential in the weak sites.

Much of the work in this section will involve acting as an advocate of new ways of working and seeking opportunities to support these developments which may not be apparent at present.

3. Support to all in NHS to achieve new ways of working.

At the same time as the above it is important to build on the enthusiasm of staff and local modernisation teams to implement new ways of working, without waiting for the outcome of the pilots. A great deal of change can be achieved, particularly in categories 1,2,and 3 of new ways of working by harnessing local ideas, and helping people implement them without making the mistakes others have made before them. Some of these may turn into pilot sites as models of good practice in implementing new ways of working. We aim to:

- ◆ establish and maintain a data base of good practice;
- ◆ develop a standard approach to implementation of new ways of working – known as the toolkit - to be used on a self help or facilitated basis – based on lessons learned in previous implementation;
- ◆ work with up to 100 Trusts/Clinical Networks per annum using the toolkit, data base and supporting local change agents – ideally want to reach all in three years;
- ◆ use lessons from these to continue to enlarge the database and inform work in section 2 above;
- ◆ offer advisory services to those keen to implement new ways of working.

4. The Toolkit

The toolkit is currently being tested. It enables a Trust, clinical network and other similar groups to tackle up to 10 service problems by reviewing whether reallocation of tasks can help resolution. It builds on other activities that have made recommendations about better systems of service delivery and encourages thorough problem analysis prior to generating solutions.

The major part of the process is a one-day workshop involving a series of exercises and activities and culminating in an action plan to be taken forward by small service based groups. Board level commitment is essential to effective use of the toolkit. The process can be facilitated by the Changing Workforce Programme (CWP) staff, or can be run by a CWP trained local facilitator.

The intention is that changes achieved through the first round will lead to a cascade effect in the organisation, with the workshop repeated for other problem areas.

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