Reshaping the workforce to deliver the care patients need

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Chief Executive, Health Education England

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Reshaping the healthcare workforce

“It’s the workforce stupid”

NHS Employers
NHS Confederation Conference
16th June 2016

Candace Imison, Director of Policy

Twitter: @cimison
Our brief and methods

Understand the opportunities for skill mix change, as well as the challenges faced by those implementing change. Offer practical advice and guidance to national and local leaders.

Methods

• Review of academic and grey literature
• Seminar senior stakeholders with expertise in this area (June 2015)
• Survey of all local HEE offices
• Further in depth interviews senior stakeholders (Sept –Dec 2015)
• 7 case studies – spanning multiple sectors and roles
New models of care rely on significant change in the workforce

“We can design innovative new care models, but they simply won’t become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it” (Five Year Forward View, 2014)
Full potential of the workforce not being realised

Fragmented structures, overload and out-dated ways of working mean that the full potential of the most valuable resource in our health service – the people who work in it – is often not achieved.

We could work much more effectively if the barriers to collaborative team working were effectively challenged and professionals were trusted, equipped and enabled to work across the full range of their expertise.

Royal College of Nursing Scotland & The Academy of Medical Royal Colleges and Faculties in Scotland, 2015
Concerns raised by cancer patients to their Macmillan support worker

Figure 4.2: Concerns Raised (N=229)

- Tired/exhausted or fatigued: 65%
- Worry, fear or anxiety: 52%
- Exercise and activity: 42%
- Sadness or depression: 40%
- Eating or appetite: 39%
- Sleep problems/nightmares: 39%
- Getting around (walking): 38%
- Pain: 38%
- Loss of interest/activities: 37%
- Memory or concentration: 33%

“ My Macmillan worker helped me understand my feelings and emotions a bit more. They also helped me with the transition from being a cancer patient to a more normal lifestyle.”

An urgent need for change

Work needs to be done to meet patient needs ≠ Staff Mix
Numbers Roles, Skills
But for new skills and ways of working – can not rely on training pipeline alone

Current Staff Mix
Numbers
1.3 m Clinical
800k
Roles, Skills

Current training pipeline
8,000 medical graduates
30,000 nurses & AHPs p.a.

Skill Flexibility:
Role substitution Role Delegation

Skill Development:
Role enhancement Role enlargement

New Roles

Future Staff Mix
Numbers Roles, Skills
This does not diminish the importance of training & retaining staff

- 50,000 gap in NHS workforce in 2015 (PAC, 2016)
- Potential risks – loss of bursaries – non medical workforce – especially less popular allied health professional roles
- Retention – critical
  - Key driver of vacancies in nursing – rising number of nurses leaving – 6.8% (2010/11) => 9.2% 2014/15
  - Similar issues likely to be faced in medicine
Important opportunities to **extend and develop skills** in the non-medical workforce

- Expand number of advanced roles
- Extend skills – work to top of license
- Develop and expand support workforce
The support workforce: 245k – NHS, 1.16m – Social Care

“motor for the rest of the workforce”

“the big numbers that can make a big difference”

Opportunities

- Opening access through a “skills escalator” approach
- Improved patient experience and outcomes with fundamental care
- Key underpinning to the professional workforce – ameliorating workforce gaps and stress

Challenges

- Lack of role clarity
- Lack of regulation
- What is ideal patient/band 1-4 & registered nurse ratio?
- Potential fragmentation of care
“In the chronic long term conditions, actually the medical intervention is quite minimal, and so therefore there’s lots of skills and expertise across all groups of the professions that actually if they were developed and promoted, could actually ensure the health service is much more efficient than it is, and also more importantly the outcomes for patients are more effective.”

Elaine Buckley, Chair, Health & Care Professions Council
Holistic worker, Nottingham CityCare

Up-skill registered workers (e.g. nurses, AHPs) to band 4 level across each others’ disciplines

E.g. A nurse can visit to undertake a full nursing assessment, and at the same time sort out basic occupational therapy or physio issues.

Results in *more holistic care, efficient use of time and fewer referrals*

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Barriers</th>
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<tbody>
<tr>
<td>✓ Staff could see why change needed</td>
<td>✗ Professional resistance</td>
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<tr>
<td>✓ Staff engaged in change</td>
<td>✗ Time for training</td>
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<tr>
<td>✓ Good comms incl promotional video</td>
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<tr>
<td>✓ Staff in new roles acted as champions</td>
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Paramedic practitioners in primary care

GP practice in Whitstable using paramedic practitioners to do GP home visits

Success:

- Drastic reduction in home visits
- Rolling out to cover 177000 patients in MCP

But unsuccessful elsewhere in Kent – implementation lessons

Picture source: http://www.bbc.co.uk/news/uk-england-30002657
How pharmacists and paramedics can strengthen general practice

"Paramedics have taken the pressure out of the urgent care service, complementing what we as GPs do beautifully. But, ultimately, the biggest benefit is that these roles are stabilising the service and gradually making the role of being a GP more sustainable and attractive."

Mike Holmes
Partner, Haxby Group

#NHSworkforceweek
Advanced roles - Opportunities

“we have to create advanced practice roles, not just because of the shortage of junior doctors but because there’s a need to give more holistic patient care” Lisa Bayliss Pratt, HEE

Evidence - primary care
- Improved access (Martin-Misener et al, 2009)
- More frequent follow up care (Peltonen, 2009)
- Reduced hospital admissions (Griffiths et al, 2004)
- Increased patient satisfaction (Sibbald, 2009)
- Can safely substitute for GPs – range of conditions (Sibbald, 2008, 2009)

Evidence - secondary care
- Lower lengths of stay (Newhouse et al, 2011)
- More timely care (McDonnell et al, 2015)
- Provide greater continuity.
- Can safely substitute for junior doctors for a range of conditions and settings (Bohmer, Imison, 2013).
Advanced Clinical Practitioners at Sheffield Teaching Hospitals

- Developed Faculty Board for Non-Medical Advanced Practice
- 70-80 ACPs working across a range of services
- Developed first ACPs in 2006 in response to EWTD. Developed at-scale in 2012 due to lack of junior doctors

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<td>✓ £4.35 million LETB funding</td>
<td>× Retaining ACPs (pay competition)</td>
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<td>✓ Coordinated faculty approach</td>
<td>× Professional resistance</td>
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<td>✓ Strong buy-in, clinical and board</td>
<td>× Some resistance to supervision</td>
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<tr>
<td>✓ Partnerships with SHU</td>
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<tr>
<td>✓ Strong mentorship and supervision</td>
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<tr>
<td>✓ Devoted roles to manage process</td>
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Advanced roles - challenges

- Traditional lack of support and recognition of role value – can be first to be cut
- Lack of clear competence framework or recognition by regulator
- Competition for scarce skills
- Underpinning workforce gaps

We were the only organisation to have identified clear competencies for ANPs. Some people call themselves ANPs, but they haven’t done the training. That is the key.

We have just lost two paramedic practitioners to the oil industry. And there is constant demand for ANPs from GP practices who are struggling to recruit doctors…

Linda Harper, Associate Nurse Director (RCN Scotland)
Physician Associates: 250 across UK => + 1,000

Opportunities

- Improved clinical continuity
- New career pathway to attract new talent to the NHS workforce
- Improved learning and development for staff who work with PAs
- Help fill medical workforce gaps & support medical training

Challenges

- Inability to prescribe and require ongoing supervision
- Small numbers of PAs
- Lack of peer support and formal career path
Team working critical

“You have to have the basics of team-working in place in order that introducing [a new] role or changing roles will be effective”
Michael West

4 tier model for radiography

**Assistant Practitioner**
- Protocol limited tasks
- Supervised

**Practitioner**
- Autonomous practice
- Complex clinical role

**Advanced Practitioner**
- Autonomous practice
- Defines scope of others – continuous development

**Consultant Practitioner**
- Clinical Leadership
- Strategic direction and innovation

**Team-based approach** - clearly defined roles based on competences
The opportunities from reshaping the workforce

- More patient focused care
- Improved health outcomes
- More rewarding roles & happier staff
- Improved collaboration and support
- Improved recruitment and retention
- Part of a broader strategy to address workforce gaps
- Better use of resource
Also benefits for medical training and care

A question of balance
The extended surgical team

Source: RCS (2016)
Lessons for implementation

- Build roles on a detailed understanding of patient needs and necessary skills
- Strong communications and change management strategy
- Invest in the team not just the role
- Support task delegation - you may need to de-commission old roles if commissioning new ones
- Build sustainability through clear career pathways and evolve to make the best use of new skills
- Evaluate the impact of your workforce redesign
Messages to Boards

- Invest in workforce redesign, even if resources are stretched
- Create a culture of support for change – focused on patient benefits
- Ensure there is strong and dedicated leadership for change
- Implement strong supporting systems and governance structures
- Develop links with key stakeholders (e.g. HEE)
- Develop partnerships with HEIs
Messages to National Bodies

- Needs dedicated and protected investment – HEE
- More consistent nomenclature and national competence frameworks
- Need for consistent messages from system regulators – new and extended roles
- Bridge the current regulatory gap – professional and system regulators
- Help resolve legal indemnity challenges in primary care
- National research and evaluation – with guidance for local evaluation
Conclusion

• Redesigning and re-skilling the workforce is an essential prerequisite to a sustainable healthcare system that meets patient and population needs

• But – this is rebuilding the airplane while flying it

• Requires strong national support and local action
Improving our Workforce In Bradford District Care NHS Foundation Trust (BDCFT)

Kate Dale, Mental/Physical Health Project Lead BDCFT

Dr Andy McElligott, Medical Director BDCFT
Bradford District Care NHS Foundation Trust

Developing the existing Workforce
Drivers for change
Challenges
Key Learnings
Going forward
Drivers for Change

The overarching driver for employing Band 4 Associate Practitioners in community health teams was the realisation that patients with serious mental illness (SMI) were not receiving adequate physical health checks.
Drivers for Change

The introduction of CQUIN payments for improving the physical healthcare of people with severe mental illness.

In addition on 1st April 2014 new shared care guidance
Associate Practitioners

Associate Practitioners are responsible for carrying out the physical health checks. Organising Clinic including Admin Liaising with GPs/Practice Nurses and Psychiatrists and Care Co-ordinations
Assistant practitioner core competencies for physical health check

- Temperature taking
- Standard urinalysis
- Use of the Malnutrition Universal Screening Tool (MUST)
- Obtaining a Venus blood sample
- Glucose Monitoring
- Carrying out an ECG

- Heart rate recording
- Respiratory recording
- Blood pressure recording
- Oxygen saturation/pulse
- Height recording
- Weight recording
- BMI recording
- Peak flow recording
• Offer Lifestyle Advice
• Weight Management
• Smoking Cessation
• Sexual Dysfunction Advice and Support
Introduction of Associate Practitioners

• Training Developed with the Calderdale Competency Framework by Trained Facilitators
• Differentiating Band 2, 3 and 4 Skills
• Taught Practiced Competent
• Training Reviewed and Refreshed 2 yearly
• Mentors Trained within In-Patients setting and Community
Training

- Vital Sign Monitoring
- National Early Warning Score (NEWS)
- Understanding why we do what we do
- Ability to Escalate Appropriately
- Build Confidence
- Valued Workforce
Extending the Role Further
Band 4 Associate Practitioners

Phlebotomy
Electrocardiograms (ECG)
Smoking Cessation
Lifestyle Advice/Weight Management
Ensuring Patients Referred Appropriately
Results Shared with GP
Main Challenges

• Culture

• Responsibility for Results and actions (However this has been resolved)

• Psychiatrists lacked confidence for example: ECG Results Interpretation
Management of Associate Practitioners

Initially Managed by Advance Nurse Practitioner
Now Managed by Community Mental Health Team Leaders
Experiences

- Going the extra mile
- Relationships
- Education
- Support
- Standardised
- Technology
Where we are now

• Trained all current Band 2, 3 and 4 staff for In-Patient setting and Community
• All new starters during induction period
• 5 clinics in secondary care Community Band 4 Associate Practitioners running the clinics
• Rolled out in all in patient areas
Thank you very much for listening

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Please do not hesitate to contact us for further information.