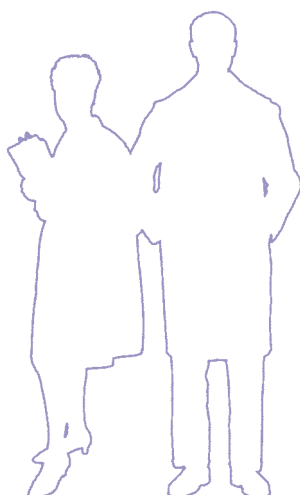


Tomorrow's workforce:

Commentaries on the future of skills and employment
in the UK's health sector

Skills for
Health



better **skills**
better **jobs**
better **health**

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Tomorrow's workforce:

Commentaries on the future of skills and employment in the UK's health sector

Foreword

By John Rogers

Chief Executive, Skills for Health



In the autumn of 2009, Skills for Health invited a number of leading academics and health sector commentators to develop their thoughts on what they see as the main skills and employment challenges confronting the health sector in the next five to ten years. They were asked to write freely from their perspectives drawing largely from their academic and professional interests and to speculate on how the health sector may respond to these challenges.

These commentaries therefore represent the views of the authors themselves, and not those of the institutions they work for, nor of Skills for Health. Similarly, the commentaries do not represent policies of any government within the United Kingdom.

The commentaries form part of Skills for Health's strategy to provide not only robust statistics on the shape of the sector's workforce and skills needs, but also to develop forward-looking skills and labour market intelligence. Alongside Skills for Health's scenario planning and forecasting exercises, the commentaries seek to identify the drivers for change that we see affecting the sector now and in the future.

As we enter a new decade, we anticipate that these commentaries will provide food for thought for anyone working in the United Kingdom's health sector, as well as those closely associated with people development. The commentaries suggest that there is a broad consensus, that change within the sector is being driven by a range of short and long-term factors.

- In the short to medium-term, the world economic crisis which hit the UK economy from 2007 and the resulting public sector deficit will focus the minds of politicians and the electorate on what level of health care services are 'affordable' from public funds. It is clear that ongoing increases in spending as seen over the previous decade are unlikely to be seen again for some time

- The commentators also highlight a diverse range of longer-term trends which are shaping the sector. These include demographic changes, innovations in health care provision, the rising incidence of patients with long-term conditions and the expectations of patients themselves

Commentators agree that these two broad areas will require significant changes in how services are delivered in the health sector and the skills required to do this. There is also consensus that the sector cannot simply do more of the same and will have to reshape its approaches to care in order to deliver more within finite resources.

Just how these forces will act out in reality only the future will tell. However, each commentator provides a sense of what they feel will be some of the main initiatives that health care employers may adopt. Importantly, each commentator focuses on a range of possible future employment and skills needs required to help ensure that we develop a future health service that deals effectively with these drivers for change.

These commentaries are intended to stimulate debate about the future of employment and skills in the health sector. If you have any observations on the themes raised and would like to get in touch please contact the Labour Market Intelligence team on 0117 922 1155. Please contact us also if you would like to get involved in developing our future-oriented research, either in the form of participating in one of our forward thinking events, or writing a commentary yourself.

A handwritten signature in black ink that reads "John Rogers." The signature is written in a cursive style with a long, sweeping underline.

About Skills for Health

Skills for Health is the Sector Skills Council for the UK healthcare sector, encompassing the National Health Services, independent healthcare providers and voluntary organisations. It exists to help the sector develop a skilled, flexible and productive workforce, to improve the quality of health and healthcare.

Skills for Health fulfils its role in a variety of ways. These include:

- Understanding and representing healthcare employers' skills needs
- Developing tools and solutions that enable effective workforce planning, design and transformation
- Working with healthcare employers to use these tools and solutions effectively in developing a skilled, flexible and productive workforce

Skills for Health was relicensed by the UK Government in 2009.

Skills and Labour Market Intelligence

As part of its remit, Skills for Health develops high quality, accessible, skills and labour market intelligence for the UK health sector. Our primary focus is on the current and future skills needs of the sector, including those working in the NHS, independent and voluntary sectors.

Our skills and labour market intelligence is developed within a network of 25 Sector Skills Councils who together cover over 80% of the economy. As part of the network, Skills for Health is able to develop its understanding of how the health sector labour market

behaves in relation to the rest of the economy. We are also subject to thorough quality audit by the National Audit office.

Our labour market intelligence can be divided into four broad areas.

1. **Baseline national and regional industry specific intelligence**

Skills for Health develops a range of regular assessments of the current and future skills needs of the health sector. These are developed using key national sources, including amongst others the Labour Force Survey, Annual Business Inquiry, National Employer Skills Survey, Higher Education Statistics Agency as well as a range of industry intelligence and bespoke surveys, consultation activities and industry sources.

Skills for Health is developing a range of outputs, many of which are freely available on our website and include:

- Annual Sector Skills Assessments
- National LMI reports and associated research
- Regional LMI briefings and associated research

- Quarterly Policy, Research and LMI Bulletin
- Key Findings from the 2008 Skills for the Workplace: Employer Perspectives
- Relevant Findings from the 2007 National Employer Skills Survey for England

2. Research themes

Skills for Health undertakes research into a range of themes which are designed to address gaps in our knowledge and raise the ambitions of employers, to raise the level of skills in the sector and adopt new ways of delivering healthcare.

Themes that have been and are currently being addressed include:

- Understanding ‘turnover and wastage’ in the health sector
- Understanding productivity and performance
- The ‘third sector’ and the volunteer workforce
- Migration (Attracting Talent Stage 1 and Stage 2)
- The development of the independent sector and small enterprises

3. Developing foresight

Skills for Health also uses a range of creative approaches to help employers in the sector anticipate the future of work and skills in the sector. These include:

- Tomorrow’s workforce: Commentaries on the future of skills and employment in the UK’s health sector
- Rehearsing uncertain futures: scenario planning for the future of health care in the UK

4. Labour Market Intelligence online tool

This online tool is a free service offered by Skills for Health. It provides access to health sector statistics on areas including employment, skills, labour demand, training and demographics. Users can view the information in published reports or in an online database. In common with Skills for Health’s UK perspective the data covers England, Scotland, Wales and Northern Ireland, as well as individual areas within each region. In addition, it includes the public, independent, and voluntary and community healthcare sectors.

Service Line Staff Planning: Management force for the future?

Nick Bosanquet

Professor of Health Policy, Dept of Bioengineering, Imperial College

***“The era of picked soldiers and selected crews has arrived.”
De Gaulle, the Army of the Future. 1936.***

Manpower planners deal in numbers, re-assuring when the lines point upwards: managers want performance, initiative and high morale. The challenge is that of meeting increased workload and a more varied workload with a workforce which is likely to have a smaller number of hours available for direct care – and less for hours involving 24/7 care.

The workload pressures are partly from changes in clinical programmes and new innovations: but other forces will also impact. First there is the increasing number of doctors with a further shift to come in terms of an increasing number of senior doctors compared to those in training. They will tend to generate more demand for tests and medical procedures especially under pressure. We are likely to have the same dynamics as the US system. Within the USA spending on imaging rose 20 per cent a year between 1999 and 2006. Scans per 1,000 insured persons have risen from 85 to 234 in the USA since 1999. (Bosanquet 2009).

The availability of doctors and of diagnostic equipment will also create major pressures. The famous increase in capital investment and staffing to end under funding does not create a static and possibly serene situation – instead it creates a major change in professional and patient expectations.

As a result of the time lags for investment much of the new equipment and staffing is coming into full use only after the funding increase slows down or stops. Thus the NHS will be facing an increase in workload driven by this new powerful force of expectations just when the old solutions are not there. The days of the low spending Scottish consultants who dominated the NHS in its first 20 years are long gone.

Second there will be demand for higher treatment rates. As services become better run and more effective so referral thresholds are likely to change. Through increased clinical willingness to intervene and increased patient demand this is already clear in such diverse areas as renal dialysis and cardiac surgery. Thirty years ago there were only a few hundred people alive with end stage renal failure. Now there are over 80,000 either with transplants or on dialysis with scope for further expansion for treatment of people in their 80s and 90s.

The third force will be that of pressure to improve services in neglected areas of care. There are already a long line of strategies and must-dos. The strategies include the cancer reform strategy (a 90 per cent increase in radiotherapy fractions recommended),

and the National Dementia strategy (assessment centres and care programmes in every PCT area for 2 - 300 new patients a year).

The NHS will be under pressure to deliver a long list of quality improvements. Increased information creates a greater requirement for action.

- Management of chemotherapy. A recent review showed that only 30 per cent of treatment courses were being delivered to an acceptable standard. The number of treatments has risen by 60 per cent and the number of oncologists by 80 - 100 per cent – but the gains in quality have been weak
- Care programmes for rheumatoid-arthritis
- Improving end of life care with more home support
- Speeding up operations for fractured neck of femur
- Diagnostics within hours for patients who have had TIAs

NHS managers face the problem of raising productivity with a workforce which is ageing. The pension scheme will be a big incentive to stay on. Lower turnover – as older workers have much less tendency to change jobs – will mean a diminishing number of vacancies and less recruitment of younger workers. In effect the expanded number of trainees from the past seven years is now coming into a very different internal labour market where there is likely to be a net reduction in vacancies.

Pay will become more age related. There is serious danger that capable younger staff will find their promotion blocked and even if they are promoted will find the management job as painful and frustrating, as staff set in their ways – a bit like elderly pets on sofas – become difficult to move or motivate. Any employer will value the contribution of older staff in competence and experience – but moving forward, service also needs younger staff who supply elements

of drive, ambition and contact with changing culture and requirements. An ageing workforce will have particular problems in adapting to more customer power in a customer led, and more personal service. It is not all one way – there are some older workers who may want the opportunity to be leaders and mentors but in general an ageing workforce will present problems both for cost and for motivation.

The NHS workforce will diverge from workforces elsewhere in the economy as it will be one of the last to be based on lifetime tenure, final salary pensions and national pay systems. Others will have greater flexibility and more use of locally determined performance related pay. It may well be that some more able younger staff will want to take more risk and to move into jobs in the private sector which will offer greater freedom and the chance of much higher pay. There is a danger that in a system with static funding and major management problems the NHS will lose young leaders.

The NHS is the last practitioner of national manpower planning on a gigantic scale. The full effects of the recent increase, particularly of doctors, have yet to come through. The number of medical graduates will rise from 3,000 in 2000 to 6,000 in 2011. Thus the NHS is double banking. It did not wait for the expansion of training to recruit more staff – so now for the next 20 years it will have two streams moving up in career grades. The net effect will be to increase the number of senior doctors relative to junior doctors.

The House of Commons Select Committee in its excellent report on manpower planning rightly pointed up the complete lack of contact between financial and manpower planning. (House of Commons Health Committee 2006/07) In the past this produced a situation in which the NHS recruited far more staff than it could afford to pay. The danger in the future is rather different – that there will be a slow rise in the cost of

staffing both through greater seniority and through the higher proportion of doctors. Before the recession the Department of Health projected a 3.2 - 3.7 per cent real terms growth in the medical pay bill from 2004/05 to 2030/31 with a rise in the pay bill from £9.5bn to £21.7 - £24.7bn. (DH 2006/07)

All this leaves a massive job for local managers – who are being asked to deliver a more flexible, customer focused service at lower cost just when the health workforce is becoming less flexible and much more expensive. For the next five years they are likely to face a 20 per cent rise in demand with 5 per cent rise in funding and a reduction in staff hours. (Kings Fund/IFS 2009) They can learn from the experience of new service activity labour markets which have developed. For example budget airlines have shown that it is possible to use IT so that every step of the process is digital. They have done this by using smaller software providers rather than large IT contractors. They have also succeeded in training and motivating a high quality workforce or limited cost.

Skills for Health has made a very good start as the first body in the history of the NHS to try to develop more integrated training which employers want rather than simply planning manpower in separate groups and then leaving the employers to make the joins. But it has a massive challenge to find ways to help local managers to deliver on new kinds of service.

1 Service Line training. The challenge is now to align financial and staff training and to develop the training which will contribute most to the health enterprise. The key question is what training will contribute most to quality. At present the main effort of Skills for Health seems to be to train people at lower levels for aide and assistant roles. These are important roles but are they the ones which will contribute most to the goals of the enterprise? We need to give power to service

leaders and give them the budgets to carry out the training programmes which will make most difference to them. Indeed some of them may want to devise training programmes for themselves as the ward Manager Programme developed in the mental health service.

2 Invest in The Ten year Group. In most occupations it takes 10 years to produce an employee who can solve problems – as opposed to working for 20 minutes and then asking what to do next. The NHS does not do much to recognize these local cadres and managers. A key element in service line manpower planning would be to develop programmes which would help these groups to raise their capabilities. As the Select Committee showed (p.64) the health service has many staff at levels 5 and 6 around the level of a staff nurse or a junior doctor but many fewer at level 4 (rehabilitation assistant) and 7, the level of specialist nurse. The NHS is making progress in training more staff for level 4 but there is a much less clear focus on level 7 – but these jobs for local managers are vital to enterprise success. We need some very urgent research on relative productivity contributions but it is highly likely that level 7 - 8 (from platoon to battalion commander) will be crucial. They have to turn aspirations into service. These are also the vital levels for financial management and for getting value for money at which actual activities and budgets can be logged together. It is there that an effective manager can make a real difference to service quality and staff morale.

The NHS faces an enormous challenge in developing the band 7 role. It is at this level that the professional demarcations really block action. In just one example a new manager in a London teaching hospital tried to change an ingrained pattern of sickness absence. She receives threatening anonymous note – how

Skills for Health has made a very good start as the first body in the history of the NHS to try to develop more integrated training which employers want rather than simply planning manpower in separate groups and then leaving the employers to make the joins.

dare you interfere with our sick – and is soon off sick herself. Managers at this level face the full weight of system inertia and do not have the revitalizing effect of day to day contact with patients. They also have to contend with the powerful culture of blame by which all too often there is a witch hunt for culprits and little praise for good performance. It is also at this level that the NHS pay structure is least help. The focus has been on pay at entry grades and at level 4 – on the mass rather than on the incentives to the minority who make things happen. They are also the group most affected by the tax system. The float down of the 40 per cent tax rate has brought many more into the higher rate tax paying group. They also have to pay additional pension contributions if they earn more. Becker many years ago identified a particular problem of public sector pay structures that pay more than the going rate for entry level jobs – while giving little career progression. (Becker 1957) The NHS pay structure may have an acute case of Becker's syndrome.

3 Priority for small investments to raise worker capability. Staff capability depends on the ability to communicate and to move forward on process. The political mantra stresses that front line staff are holy while back office are bad: The ability of front line staff to give the service depends on support from further back – even on the original front line

of the Western line infantry were only a third of the total by 1918. Some of these investments could be in communication. Much of the NHS is still the wrong side of the digital Rubicon. Most individuals and businesses now use IT as a guidance system in which their core business can be managed. The NHS is still struggling to get out of the silos. The fading out of Connecting for Health gives a great opportunity to develop the communication which local service managers want rather than the system which the politicians think they need. The focus should be on what will contribute to service quality. The sooner we delegate budgets and decision-making to local managers the better.

Strengthen the role of Foundation Trusts in skill and manpower development. Foundation Trusts have not yet played a very distinctive role in developing staff and more and more decision making seems to be passing to the SHA. The SHA as with NHS London is playing a very useful role in raising value from the training budget (£1.1bn in the case of NHS London) but they are not actually running the services. Foundation Trusts will soon be the main employers. They are responsible for their own decisions, but on manpower there are few signs of what they regard as vital for the business. Should they for example be given the freedom to develop early retirement programmes so as to allow accelerated promotion for younger staff?

Focus on service needs not macro-economics. There will be strong pressures to push the NHS into the role of an economic primer of the pump. In some cases this will divert scarce resources for management and training into activities which may help the wider economy. The NHS training priorities are not to increase the number of people in entry level jobs – they are to develop the capability of the team already there to deliver better services, to shift the training spend from the future to the current workforce through continuing personal development funding.

The recent trebling of the number of apprenticeships has all the appearance of a top down decision. The NHS local agencies and trusts had decided on 1,500 apprentices; now they are suddenly being ordered from above to devote time and effort to devising training for 5,000 entry level jobs. Such a sudden move may in fact lead to a good deal of disillusionment and rising drop out rates and it is also difficult to fit in with the commitment to greater competition and outsourcing. It may also have an opportunity cost in diverting funding and resources from the 10 year group.

Free up funding for investment in staff capability. The NHS could offer a generous early retirement programme to employees who are away on long term sickness or barely performing when they are there. A 5 per cent reduction in staff numbers would create resources for investment in skills.

Increase the scope for joint training between the NHS private/third force providers – and social services. Skills for Health is showing a welcome new approach in working with employers across the health sector. There is great scope for shared training programmes and already some examples of joint developments.

In summary the NHS faces a challenge in developing a more effective workforce. Most of the culture and many of the systems contribute to lack of flexibility and retard productivity. There is big problem of alignment between the aim of a more customer orientated, high quality service and the reality of the forces which are shaping the pay and job structure.

Service line staff planning offers the opportunity to develop local incentives which can make use of the great talents and abilities which are there in NHS. The NHS has attracted a whole new generation of staff – but there is a danger that the most able and highly motivated will drift away over the next few years

unless we can develop new incentives and a more positive local approach.

The NHS is now moving from the myth that improvement in service quality depends on spending large amounts of money. Many of the quality problems (for example in chemotherapy) could in fact be solved in weeks if local service teams were given the freedom to manage and to develop their own plans for the new more flexible service future.

Heavy recruitment has brought in a new generation of able young people including doctors on special courses for graduates. If the NHS is to retain and use this ability it has got to give back real responsibility to local health teams. Unless it restores the local sense of control and achievement many of the most able people will more off into other careers which offer less security but greater recognition.

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The Real Challenges for the UK Nursing Workforce

Professor James Buchan

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UK nursing is entering a difficult period, when it will have to address underlying challenges whilst also dealing with the immediate impact of recession. This article sets the nursing workforce context and looks at some of the key nursing workforce challenges facing the UK against a backdrop of labour market and NHS funding change.

The recession will impact by altering supply and nurses' labour market behaviour – some nurses will extend the hours they work, others will try and re-enter the labour market, and there will be an increase in applications to pre-registration nurse education. Indirectly it will impact on demand for NHS nurses because NHS funding is constrained by fiscal tightening of public sector finances¹.

The NHS Confederation has termed this fiscal impact as “the greatest ever leadership challenge for the NHS”; it has highlighted that “with little or no cash increase from 2011/12 the NHS will need to plan for real term funding to fall by 2.5 - 3 per cent per annum... it is unavoidable that this will also translate into fewer staff”^{2 3}. Recent press speculation and “leaked” reports have suggested that foundation trust plans could lead to the cut of 16,500 nursing jobs⁴, and that overall there could be a cut of one in ten NHS jobs⁵.

Other current policy changes will have a major impact on the nursing workforce, notably the Nursing and Midwifery Council (NMC) announcement in September 2008 that nursing would become an all graduate entry profession by the mid-part of next decade⁶ has significant implications. The all graduate entry route (already a factor in Wales) raises major questions of future education commissioning, workforce planning, and the skill mix of the profession.

The current UK nursing workforce

The starting point for any assessment of workforce policy in nursing is to scope the current workforce. In March 2008 there were 676,547 qualified nurses, midwives and health visitors registered with the Nursing and Midwifery Council (NMC). This represents the “pool” from which all employers must recruit.

The NHS is the main employer of nurses in the UK, but nurses also work in a range of other jobs and sectors. Data on employment in other sectors is limited and has reduced in coverage, quality and completeness in recent years.

NHS workforce data from the four UK countries shows significant but variable levels of overall nurse staffing growth have been achieved over the period 1998-2008 (Table 1; some caution is required in interpreting data as definitions vary in the four countries and across time).

Table 1: Whole time equivalent and per cent change in the NHS qualified nursing and midwifery workforce, 1998 to 2008, four UK countries (September)

(Note: Scottish data is not directly comparable over time)

	1998	2008	% Change 1998 - 2008
England	247,238	315,410	28
Scotland	35,245	41,453	18
Wales	17,278	21,426	24
Northern Ireland	11,247	13,941	24

Note: Data for England includes bank nurses; data for other three countries does not. Scotland data for 2008 is not directly comparable with that from 1998 as data collection was re-calibrated using Agenda for Change bands – 2008 data is for bands 5-9.

Sources: Buchan and Seccombe, 2009; England: non medical staff census, The Information Centre, NHS. Northern Ireland – DHSSPSNI; data is for March; Scotland data – ISD Workforce Statistics; Wales – Stats Wales. Note: per cent Figures are rounded.

The UK countries all reported significant staffing growth over the last ten years. This headline percentage increase in the four UK countries reflects government investment in funding more nurse education places; implementation of policies to improve retention and returners, and (mainly in England) a commitment to a policy of active international recruitment up to 2006.

The staffing numbers across the UK lead to some recorded variation in staff: population measures – see Table 2 below.

Table 2: Qualified Nursing Staff (WTE) per 10,000 population and Live Births per Midwife (WTE): Four UK countries, 2007

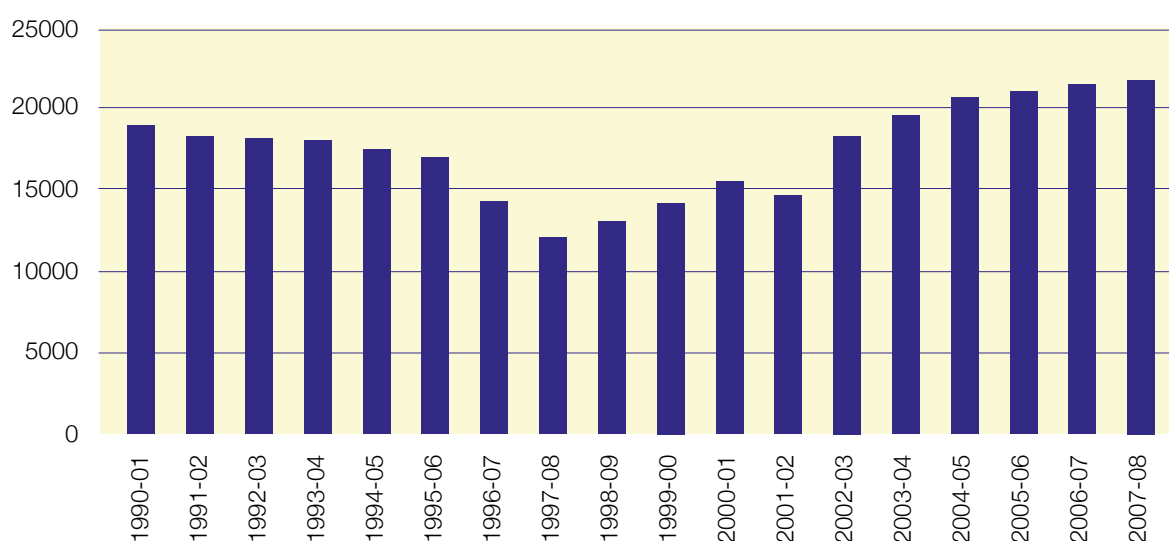
	WTE nurses per 10,000	Live births per WTE midwife
England	58	35
Northern Ireland	78	27
Scotland	73	24
Wales	72	28

Source: Northern Ireland Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk/workforce_census_march_2008_web.pdf

The supply of nurses and midwives

UK governments have their hands on the major policy levers to increase or reduce the future supply of nurses and midwives, through allocating funds for pre-registration nurse education, through making decisions on how much funding to allocate to employing nurses in the NHS, and to broader migration policy which impacts on international recruitment levels. One critical question will be how tightened NHS funding impacts on the future level of intakes to pre-registration nurse and midwifery education. History suggests that short term cuts to funds for intakes will be one policy response.

Figure 1: Number of new entrants to the UK nursing register from UK sources, 1990/1 to 2007/8



Source: NMC/UKCC.

In the late 1990s the governments in the UK increased funded intakes to pre-registration education of nurses and midwives, as part of the overall approach to increasing the workforce. This came after a period of marked decline in funding for nurse education places in the early 1990s. The pattern of decline and growth is shown in Figure 1. There was then a significant upward trend between 1997/98 and 2007/08 as increased funding for pre-registration places led subsequently to more “new” nurses coming out of pre-registration education in the UK with the new intake from UK education hitting 21,600 in 2007/08.

The latest data suggests that nursing continues to attract potential recruits to home based training. UK-wide statistics from UCAS on the number of choices made by applicants show a substantial rise both in nursing degree choices (up 20.7 per cent to 59,895) and nursing ‘other’ choices (up 17.5 per cent to 50,155).⁷ Figures released by UCAS at the end

of August 2009 report increases in the numbers of acceptances for both degree courses (up 23.5 per cent to 7,301) and diploma courses (up 20.4 per cent to 13,139)⁸.

The ebb and flow of international recruitment

In the period between the late 1990s and middle of this decade, the UK, particularly England, was actively recruiting nurses from a number of countries. However the use of international recruitment has declined rapidly in recent years.

This is not because there are fewer potential recruits from other countries. It is because a series of self imposed policy changes have made it much more difficult for non EU nurses to enter the UK. In 2005 the NMC instigated a much tougher (and costlier) programme for overseas nurses intending to practise in the UK. Then in 2006 the main entry clinical grades

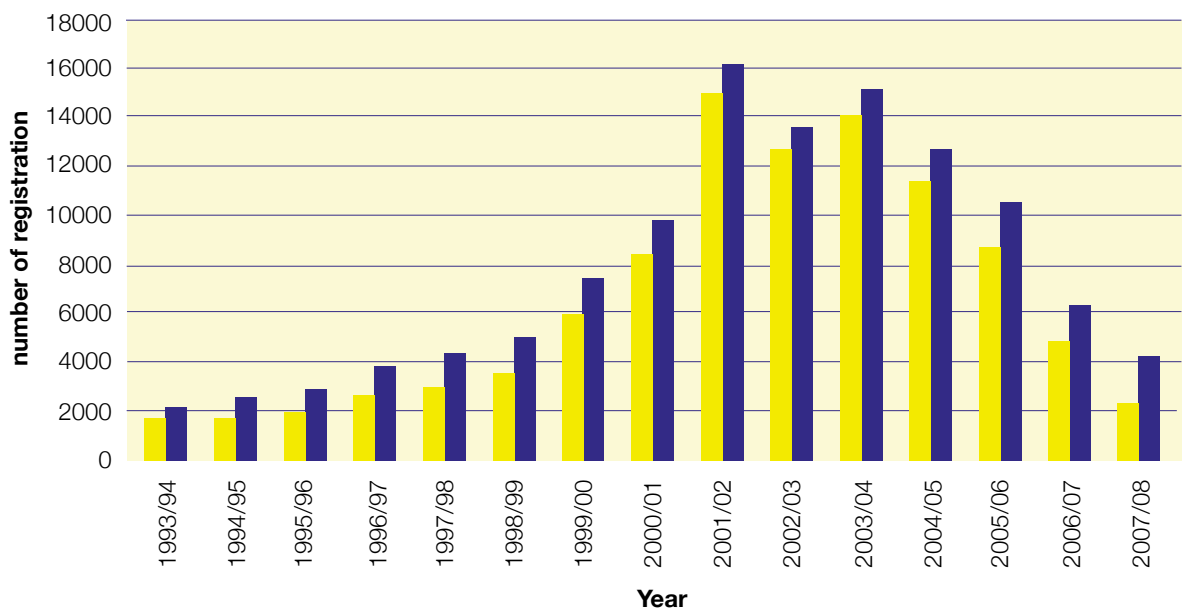
in the NHS were removed from the Home Office shortage occupation list. Thirdly, in 2007 the NMC then also raised the English language test requirements. Finally, in 2008 the shift to a points based work permit system has reinforced the government policy of making international recruitment a more difficult option for employers. Currently only some specialities of experienced nurses, such as critical care and theatre nursing are likely to qualify for entry.

NMC data shows that in a 10 year period the UK has shifted from low level international recruitment activity in the late 1990s to very high levels of recruitment in the early part of this decade, back down to low activity

in recent years (Figure 2). (There are limitations in using NMC data to monitor the inflow of nurses to the UK, because it registers intent to work in the UK, rather than the actuality of working.)

In 2002 more than 16,000 international nurses were registered; in 2007/08, just 4,000. The overall marked decline in international nurses has also masked another important trend that the UK is now proportionately more much more reliant on nurses registering from the EU. EU nurses are not subject to the same constraints on entry to the UK as are nurses from other countries, and this is a factor in this relative switch in the pattern of source countries.

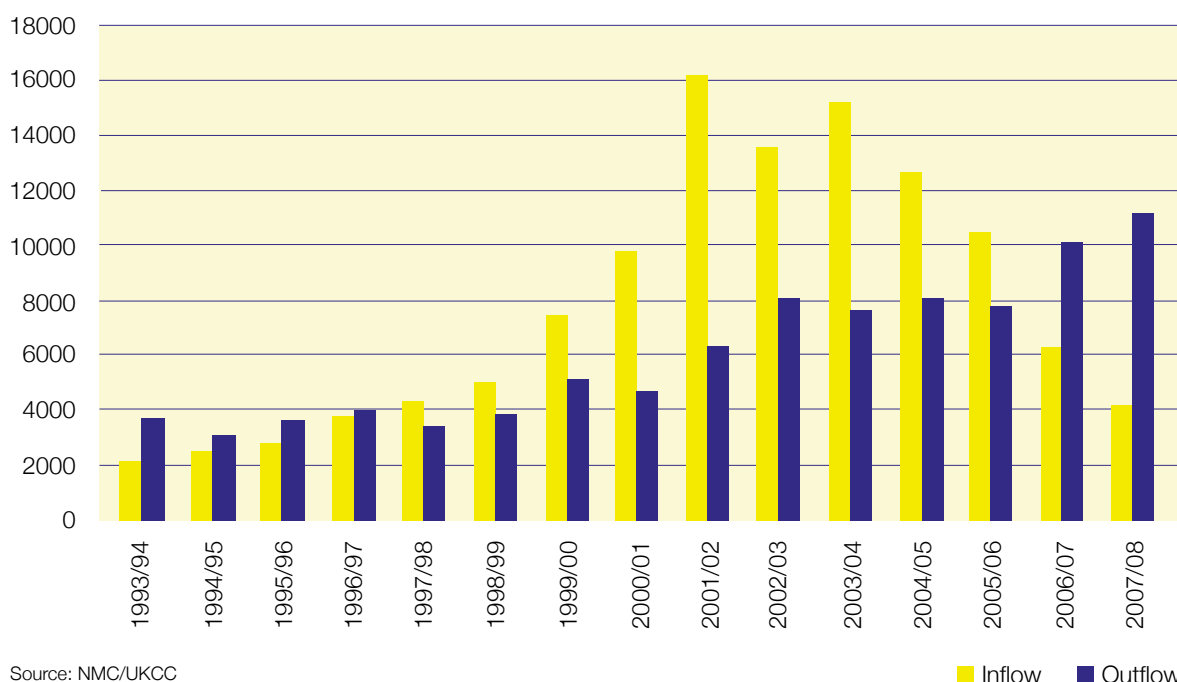
Figure 2: Admissions to the UK nursing register from EU countries and other (non EU) countries 1993/94 - 2007/08



Source: NMC/UKCC

■ Non-Eu ■ EU

Figure 3: “Inflow” and “Outflow” of nurses from the UK 1993-2008



Source: NMC/UKCC

These self-imposed changes to regulatory and general migration policy have contributed to a situation where the UK is moving from being an active recruiter of nurses to a passive “source” of nurses to other countries. In 2007/08 there were more than 11,000 verification requests from UK registered nurses as part of their process of applying for a job in another country. This was at its highest level in the last twenty years and continues a recent upward trend. Figure 3 shows the trend in annual numbers of nurses applying for verification to nurse abroad (“outflow”) alongside the numbers from other countries registering to practise in the UK (“inflow”).

The underlying challenges

The nursing and midwifery labour market impact of recession may take some of the pressure of the supply side, in the next few years, but it will not change the underlying trends. Modelling conducted by the NHS

Workforce Review Team in 2008 forecast that if current training commissioning levels were maintained there would be a slight decline in overall NHS nursing numbers across the period 2007 to 2016⁹. This assessment is not dissimilar to the results of scenario modelling undertaken for the RCN in 2007¹⁰.

The Workforce Review Team has also recently published its annual assessment of NHS workforce issues in England¹¹. It highlights the need for vigilance in keeping training intakes at necessary levels and sets out a range of “suggested mitigation strategies” to improve recruitment, retention and deployment of nurses and midwives. These include “SHAs to consider increasing current commissioning levels in light of the latest WRT forecasts”; “Employers to ensure that nurses have the appropriate clinical and leadership skills to deliver new ways of working”;

“PCTs and employers to increase availability of community placements, including in nursing homes”; and “Recruitment initiatives to encourage nurses to work in a primary care setting”.

Against this backdrop of changed nursing labour market conditions and tight NHS funding, there are several key nursing and midwifery workforce challenges that can be identified which will have to be addressed by policy makers in the next few years. The first is the ageing of the NHS nursing workforce. The second is the shift from acute to community/primary care. The third is the planning and policy implications of all graduate nursing, and the related issue of the development of the use of the assistant practitioner.

Dealing with the ageing of the workforce

The UK registered nursing and midwifery population, as with many others in the developed world, is ageing.

In 2008 less than one in 10 was aged fewer than 30, whilst one in three was aged 50 or older. Figure 4 shows the shift of the age profile of nurses on the UK register over the 12 year period 1997-2008. More than 200,000 nurses on the register were aged 50 or older in 2008.

The impact of recession may delay the retirement of some nurses, and attract others back into the labour market. Even so, larger cohorts aged 50-plus are moving into retirement age over the next few years. Nursing homes, practice nursing and NHS community nursing will be particularly vulnerable to the impact of ageing and retirement. Nurses working in NHS community nursing services have a markedly older age profile than other registered nurses; the age profile of “other” community nurses is also older than that of registered nurses working in the acute sector (Figure 5). This means that the impact of growing retirements will hit the community sector earlier and harder¹².

Figure 4: Age profile, UK nursing Register 1997 and 2008

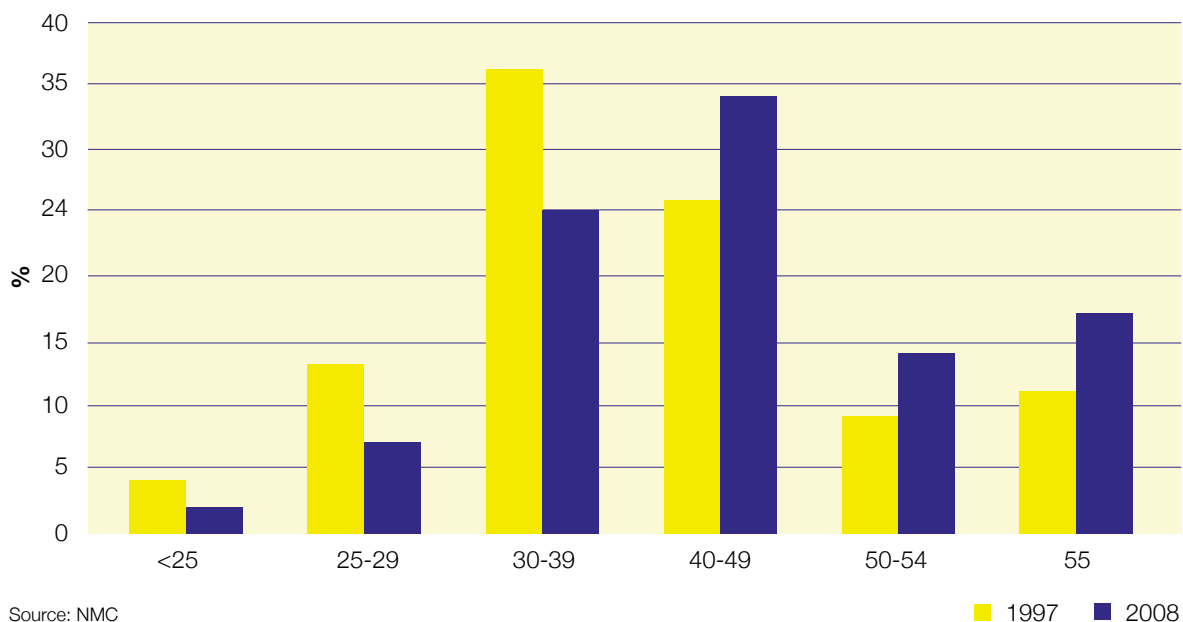
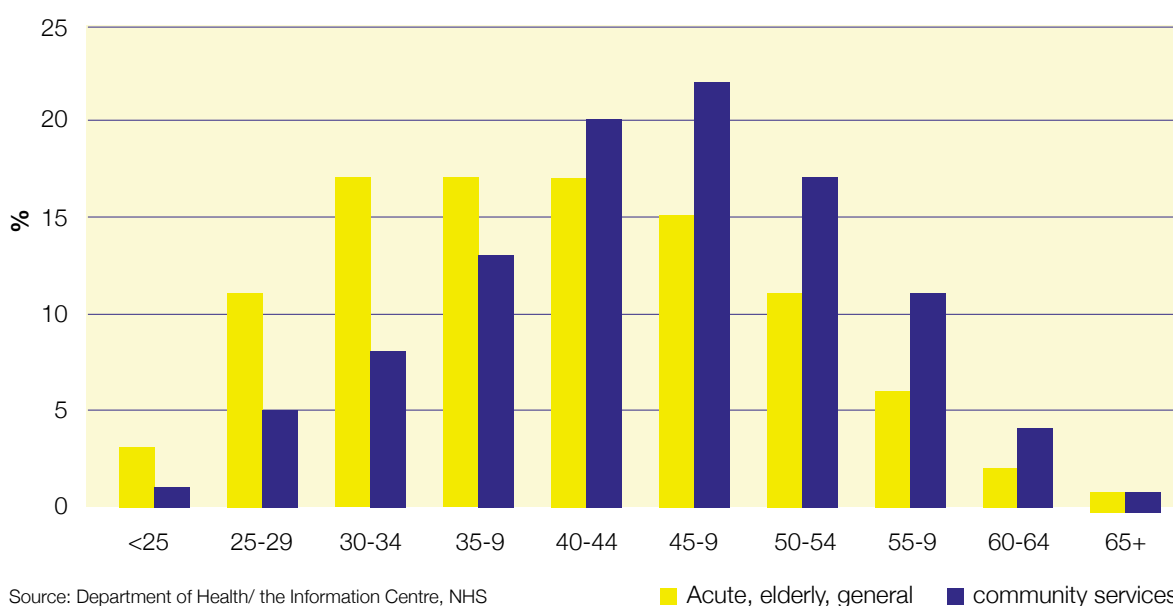


Figure 5: Age profile, NHS nurses acute/care of elderly/general and community services, England Sept 2007



There have been a series of policy research papers in recent years which have focused on the issue of the ageing nursing workforce^{13 14 15}. These papers have argued that more needs to be done to ‘age-proof’ employment policy and practice in the NHS and other sectors to encourage the retention of older nurses at work, and that pension provision has to be made more flexible to support a more phased approach to retirement. The ageing of the nursing workforce is impacting just as there is increasing debate about the possibilities of continuing final salary pensions in the public sector.

Supporting care to community

A policy shift of resources, care delivery, and staff to community/primary care and away from acute care has been a major focus in recent years. Generally the workforce planning and development issues related to this shift of focus have been given insufficient

attention. Community nursing will carry a major responsibility for delivering any change and growth in this sector, yet, as highlighted above, the community nursing workforce is particularly vulnerable to the impact of ageing.

One related factor is the scope for increased deployment of nurses in advanced roles in community/primary care. A Cochrane systematic review on the scope for using nurses in advanced roles in primary care concluded that, on the basis of the limited available research, “In primary care, it appears that appropriately trained nurses can produce as high quality care and achieve as good health outcomes for patients as doctors”¹⁶. One recent review for the Scottish government¹⁷ reported considerable scope for nurses to work in advanced roles in community care as part of supporting the shift in balance of care. The workforce strategy for London¹⁸ estimated

The workforce strategy for London estimated in 2008 that 22 per cent of nurses were based in a community setting and that this should increase to 40 per cent within the next decade as well as a doubling in the number of advanced practitioners over the next five to eight years and a “potential 29 per cent” growth in the number of assistant practitioners.

in 2008 that 22 per cent of nurses were based in a community setting and that this should increase to 40 per cent within the next decade as well as a doubling in the number of advanced practitioners over the next five to eight years and a “potential 29 per cent” growth in the number of assistant practitioners¹⁹.

Despite these policy objectives and growing evidence base, there is little evidence as yet of any step change in the pattern of deployment of qualified nurses in favour of primary care. In 1998, 14 per cent of qualified nurses, midwives and health visitors were recorded as working in “community services” in the NHS in England. After 10 years of policy commitment to shifting care to the community, this figure had only improved by the smallest of margins. In 2008, 16 per cent of qualified staff were reportedly working in community services²⁰.

Clearly there will have to be more investment in specialist bridging training for hospital-based and other acute sector nurses who are interested in working in the community sector, and there will have to be further efforts to establish community oriented pre- and post-registration education courses to increase the supply pipeline.

Skill mix and all graduate entry

The move to all graduate entry for nursing was based on education led arguments that nursing must become a graduate profession to meet the needs of complex care delivery in an increasingly fast paced health care system which demands flexible, responsive and highly skilled practitioners. Moving to an all graduate route will have to be planned with consideration to levels of applicants, education capacity, and future mix of staff and staffing levels.

NHS Employers noted recently that the move will bring challenges for workforce planning, and is likely to stimulate employers to look to make more use of assistant practitioners²¹.

Skills for Health have been conducting a scoping exercise of the role of Assistant Practitioners (AP) as part of a process to determine core standards (which were published in November 2009). The scoping exercise noted significant variation in the role of the AP, and that APs were normally paid on band 4 of Agenda for Change. It reported “The overwhelming message we have found from all regions is very positive about the introduction of Assistant Practitioners.”²². The drive to all graduate entry is therefore likely to be a major contributing factor to growth in the deployment of the new role of assistant practitioner.

These challenges will have to be met, irrespective of the level of constraint on NHS funding. And they will have to be met across a time period when the underlying trend was for a potential reduction in NHS nursing numbers, due to ageing of the workforce and the collapse in international recruitment. There is no doubt that the next few years will be the most difficult for decades for the planners and policy makers who have the responsibility to sustain an adequate, productive and motivated nursing workforce.

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The healthcare we want?

Debating the future of employment and skills in the United Kingdom's health sector

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This paper provides a high level overview of some of the factors impacting on the health sector in the United Kingdom. It begins by identifying the main drivers of change; continues by exploring the implications of these drivers for health services provision; and concludes by discussing funding prospects and the workforce implications. The paper is intended to be a 'think piece' contribution to current debates about the future direction of health care and the implications for the workforce.

It should be emphasised that the way in which these implications play out is likely to vary in the four countries that make up the United Kingdom in view of the powers available to the devolved governments to shape the direction of health care. In the scope of this paper, it is not possible to explore the impact of devolution in detail.

Drivers of change

The main drivers for change in health care can be summarised as follows:

- **demographic change:** people are living longer and the balance between young and old is shifting in favour of the latter. The ageing population will require increased NHS spending of around 1 per cent per annum in coming years (Appleby, Crawford and Emmerson, 2009)
- **the shifting disease burden:** premature death rates from cardiovascular diseases and cancer have declined but chronic conditions such as diabetes, asthma, COPD, heart failure, arthritis and mental illness have become more significant. Infectious diseases like swine flu are likely to have an impact in the future, although the timing and extent of impact are uncertain

- **risk factors:** progress has been made in reducing cigarette smoking but new challenges like overweight and obesity have arisen and there are also concerns about alcohol misuse and changes in sexual behaviour
- **health inequalities:** the health gap between more and less affluent groups in the population remains, and may become wider as a consequence of the recession and its impact on employment and public spending
- **public expectations:** increased levels of per capita income and educational attainment have contributed to rising public expectations of the NHS both among younger people and people in middle age and those approaching retirement
- **medical advances:** new forms of diagnosis and treatment have contributed to long term improvements in population health, and developments in genomics, stem cell research and other fields hold out promise for the future, with implications for future spending on health care
- **resource availability:** NHS spending has increased rapidly in the last decade and is now over £100bn. Funding is expected to become much tighter in future and this will require the NHS to deliver much greater annual improvements in productivity than has historically been the case (Ham, 2009)
- **globalisation:** health care in the United Kingdom is increasingly affected by international factors such as workforce mobility and European legislation

Implications for health services provision

Current models of care reflect the legacy of decisions taken during the lifetime of the NHS. These models are centred on the provision of specialist treatment services to address the main burden of disease in

the second half of the twentieth century, namely cardiovascular diseases and cancer. Acute hospitals have come to play an increasingly prominent part in the NHS as successive governments have sought to make available effective treatment for people affected by these life threatening conditions.

Demographic changes and the shifting burden of disease require these models of care to be reassessed. With premature deaths from cardiovascular diseases and cancer continuing to fall, and with chronic conditions becoming more significant, a reorientation is needed to meet the needs of people with these conditions. At the same time, there needs to be an increased focus on the prevention of ill health through a renewed effort to tackle major risk factors like overweight and obesity.

As far as service provision is concerned, a high priority will be to meet the needs of the increasing numbers of older people in the population. While many of these people will live long and for the most part healthy lives, others will require support from both the NHS and social care. This includes services for older people with dementia and other chronic conditions to enable them to live independently in the community for as long as possible.

The model of care needed in the future is likely to encompass:

- **prevention of ill health:** action at the population/ community level and in relation to individuals to identify people at risk, address risk factors and fully engage the population in bringing about further improvement in life expectancy and in the quality of life. This includes action to reduce the health gap between more and less affluent groups

- **supported self care:** action to enable individuals, carers and families to make healthy choices and to continue to play a major part in looking after themselves when they become ill or are diagnosed with a chronic condition. This includes the use of assistive technologies in the home and training programmes to provide people with the confidence and skills to manage their conditions
- **enhanced primary care:** action to reduce variations in the quality of primary care provision and to provide additional services out of hospital. This includes the development of polyclinics as well as increased collaboration between practices in federated arrangements to enable patients to access diagnostic and specialist outpatient services closer to home. It also encompasses the greater provision of intermediate care such as hospital at home schemes
- **integration of care:** action to link primary care teams more closely with specialists and health care with social care to ensure patients and users receive care that is effectively coordinated, and that reduces duplication and hand offs wherever possible. This is likely to be facilitated by the development of the electronic care record and of IT systems that connect different parts of the care system
- **high quality and safe specialist care:** action to rationalise acute care in fewer hospitals and to concentrate specialist services in those centres able to deliver the best outcomes. Services currently provided in acute hospitals will be increasingly unbundled with some diagnostic and outpatient services provided in primary care, and many inpatient services delivered in step down facilities such as community hospitals and nursing homes

Many of these characteristics have been described in much more detail in health policy documents during the last decade (Scottish Executive, 2005; Welsh Assembly Government, 2005; Secretary of State for Health, 2006) and there is a large measure of consensus among policy makers on how services need to be reoriented. The workforce implications include:

- a strengthening of the public health workforce to enable priority to be given to prevention e.g. through the use of health trainers and community health workers
- more emphasis on primary care staffing, particularly non-medical staff to ensure effective use of nurses, AHPs, health care assistants and other members of the primary care team
- greater flexibility in the workforce e.g. to enable more integrated working between primary care teams and specialists, particularly in the case of people with chronic conditions and older people with complex needs

Policy options

Making a reality of this new model of care requires the right levers and incentives to be in place to enable more care to be provided closer to home. Current health reforms in England were designed primarily to improve patients' access to hospital services and these reforms will continue to suck more resources into hospitals unless there is a change of direction.

World class commissioning and practice based commissioning are intended to enable more priority to be given to prevention and enhanced primary care but to date their impact has been limited. The default setting in the NHS is strongly oriented to acute hospitals, and an effective countervailing power is lacking to challenge the dominance of these hospitals and to facilitate the emergence of a new model of

This will happen in a context in which both the numbers of staff employed in the NHS and their pay have increased significantly in recent years. As various independent studies have shown, the new contracts for consultants and GPs and the Agenda for Change reforms have accounted for a substantial proportion of the extra resources allocated to the NHS.

care. Proposals have been put forward to give GPs real budgets with which to commission care but it is not clear that this will be more effective than practice based commissioning in supporting new priorities.

What this suggests is that if the NHS in England continues along its current trajectory then there will be an increasing disconnect between the needs of the population and the services that are provided. Just as generals are always at risk of fighting the last war, so too the NHS will be addressing the main problems of the last century rather than the new problems of the current century. This is where there is the opportunity for learning from the natural experiments that are emerging in the four countries of the United Kingdom.

The reforms being pursued in Northern Ireland, Scotland and Wales appear to offer potential for bringing about the shifts that are needed in moving to the new model of care. A common concern in these reforms is to emphasise the importance of prevention and primary care and to reorient services to meet the needs of an ageing population in which chronic conditions represent the main burden of disease. This is being pursued through integrated systems that rely on planning rather than competition to bring about the necessary changes.

In the next stage of NHS reform, the impact of these different arrangements on models of service provision need to be evaluated to understand better what levers and incentives are most likely to produce the desired changes.

Funding prospects

The global economic recession means that funding for the NHS and social care will become much tighter after the end of the current spending review in 2011. Although there is some uncertainty as to whether there will be real cuts in spending or very small increases, there is no doubt that the NHS will have to deliver much greater annual improvements in efficiency than has historically been the case if the costs of the ageing population and medical advances are to be met. With around 70 per cent of the NHS budget being spent on pay, it is inevitable that the use of the workforce will come under increasing scrutiny.

This will happen in a context in which both the numbers of staff employed in the NHS and their pay have increased significantly in recent years. As various independent studies have shown, the new contracts for consultants and GPs and the Agenda for Change reforms have accounted for a substantial proportion of the extra resources allocated to the NHS. What is more, there is little evidence that the promised benefits of the new contracts in terms of improved productivity have been realised (NAO, 2007, 2008, 2009). It can therefore be expected that health ministers (of whatever party) will take the opportunity to argue for both pay restraint and for a demonstrable return on the investment that has been made.

The silver lining in these developments is that after a period of unprecedented expansion in budgets, staffing and services, funding constraints will enable much more attention to be given to workforce reform. As the review undertaken by the Health Committee (2007) found, workforce policy between 1997 and

2006 was dominated by doing more of the same rather than doing things differently. This approach is not sustainable in the much more challenging financial times that lie ahead.

Workforce implications

How these issues are resolved depends in part on changing patterns of workforce employment. While the involvement of the independent sector in the provision of care to NHS patients has increased, and encouragement has been given to social enterprises and third sector organisations, most staff continue to be directly employed by NHS organisations under the terms of contracts negotiated nationally. NHS Foundation Trusts have so far been slow to use the freedoms they have to negotiate changes to these contracts and this means that government retains a major role in setting the direction of workforce policy.

Issues likely to receive attention include:

- **pay:** there will be moves to either freeze pay or negotiate pay reductions, perhaps in return for agreements with trades unions to avoid compulsory redundancies
- **pensions:** there will be moves to renegotiate the NHS final salary pension scheme e.g. to close the scheme to new entrants and/or to move to pensions being based on average earnings
- **staff numbers:** there will be moves to reduce the number of staff employed through vacancy freezes, voluntary redundancies, and reduced use of agency/locum staff, as well as negotiation on working hours
- **sabbaticals/career breaks:** there will be moves to negotiate opportunities for staff to take career breaks and sabbaticals on reduced pay
- **productivity:** there will be moves to tackle variations in productivity between key groups

of staff such as doctors and nurses e.g. through improved job planning, appraisal and clinical excellence awards

- **skill mix:** there will be moves to substitute expensive staff with less expensive staff where this can deliver productivity improvements without compromising quality of care e.g. the use of AHPs and specialist nurses in place of doctors and emergency care practitioners in urgent care. This is linked to the increased use of team working and greater flexibility in the workforce
- **co-opting patients and users:** there will be moves to enhance supported self care (see above) recognise the important part played by patients and users (alongside carers and families) in the delivery of care. There is significant potential to take this further and in so doing to learn from experience in other sectors (retail, banking, airlines, etc) where customers have become co-workers

How these issues are resolved depends in part on the negotiating stance of trade unions. In some other sectors the unions have often been willing to make pay sacrifices in return for job protection. There are some indications that public sector trade unions are less inclined to do this and are more concerned to protect pay, especially for staff on low wages. The willingness of unions and employers to negotiate on these issues is likely to be tested to the limits and may result in conflict of a kind not seen in the recent history of the NHS.

Linked to these issues is the question of what will happen to staff completing their training and entering the NHS at a time when fewer posts will be available. The prospect of surpluses and possible redundancies among both clinical and non-clinical staff will strengthen the hand of government and employers in negotiating on the above agenda. At the same time, it will raise questions about the wisdom of training staff for posts that may not exist. This may result

Current Productivity Opportunity

	Q1 07/08	Q2 07/08	Q3 07/08	Q4 07/08	Q1 08/09
Reducing Length of stay	£820,161,000	£839,062,000	£892,013,260	£852,032,063	£1,004,953,563
Increasing Day Care Rate Surgery	£14,723,000	£14,865,000	£15,076,623	£13,149,427	£16,694,233
Reducing Pre-Operative Bed Days	£509,765,000	£528,383,000	£587,676,824	£443,864,071	£711,648,468
Managing Variation in Surgical Thresholds	£62,619,000	£74,789,000	£72,931,685	£90,760,502	£91,268,446
Managing Variation in Emergency Admissions	£270,731,000	£220,202,000	£248,146,793	£369,864,502	£335,599,086
Managing Variation in Outpatient Appointments	£239,304,000	£260,038,000	£260,038,000	£260,038,000	£260,038,000
Percentage of Low Cost Statin Prescribing	£75,960,800	£68,483,990	£67,868,014	£57,494,680	£72,739,733
Reducing DNA Rate	N/A	N/A	N/A	N/A	£189,386,091
Reducing Follow Up Appointments	N/A	N/A	N/A	N/A	£232,069,328
Managing 14 Day Re-admission Rates	N/A	N/A	N/A	N/A	£99,558,080
Total	£1,993,263,800	£2,005,822,990	£2,143,751,199	£2,087,203,245	£3,013,955,027

- New Indicators
- Growth in activity
- Changes in coding

in a reduction in training places until demand and supply return to some kind of equilibrium, once again demonstrating the complexities of workforce planning in health care.

The drivers of change impacting on health care will also have implications for the content of training programmes. In an environment in which team working and workforce flexibility will become more important, pre-registration and basic training

programmes will need to be adapted to equip staff with the skills needed in future.

The productivity opportunity

The scope for improving productivity has been demonstrated by the Better Care, Better Value indicators developed by the NHS Institute for Innovation and Improvement. These indicators use routinely available NHS data to illustrate variations in performance in areas such as length of stay and

day case rates. Recent analysis has suggested a 'productivity opportunity' for the NHS in England of the order of £3bn based on the top quartile of performance (see p 25). As well, there is scope for improving productivity in the community services.

Service line reporting has been developed to enable clinical teams in NHS Foundation Trusts to become more involved in improving performance. Under service line reporting, services are organised into distinct and relevant business units, and each unit is able to compare the cost of providing services with the income it earns. This kind of analysis provides the basis for examining ways of increasing income and/or reducing expenditure e.g. through the more effective use of staff. In some cases, NHS organisations are strengthening information systems to develop patient-level costing to better understand opportunities for improvement.

In primary care, practice based commissioning provides similar opportunities for groups of practices to work together to improve efficiency. Although practice based commissioning has yet to engage more than a minority of enthusiastic GPs in reviewing the use of resources, there is anecdotal evidence that it can make a difference. Examples include reducing the use of hospital services through more effective management of demand in the community e.g. by strengthening the links between primary care team and community health services to avoid inappropriate admissions and to enable people to live independently in the community.

A common feature of service line reporting and practice based commissioning is the involvement of clinicians in leading the search for improvements in performance. This reflects analysis showing that the most important opportunities for productivity improvement relate to variations in clinical practice

Service line reporting has been developed to enable clinical teams in NHS Foundation Trusts to become more involved in improving performance. Under service line reporting, services are organised into distinct and relevant business units, and each unit is able to compare the cost of providing services with the income it earns.

rather than management costs and back office functions (Ham, 2009). By providing clinical leaders with information about their services and appropriate incentives, service line reporting and practice based commissioning enable front line staff to take the lead in enabling more value to be delivered with the resources available.

Interdependencies and threats

The NHS does not exist in isolation and many of the workforce implications listed above mirror changes already taking place in other sectors. A number of related interdependencies are worth noting and these pose potential threats to the NHS:

- **the recession** will have an impact on the demand for NHS services with rising unemployment likely to result in increased levels of physical and mental illness
- **cuts in local government spending** and a tightening of eligibility for social care support could also increase pressure on the NHS e.g. by making it more difficult for people to live independently at home, and by increasing delayed transfers of care in hospital

- **a collapse in the private residential and nursing home markets** e.g. in highly leveraged companies unable to renegotiate debt burdens, could place further pressure on both hospitals and community services
- **future tax increases** introduced to help finance the public debt taken on to deal with the recession may result in a reduced propensity on the part of high earners to continue funding a universal and comprehensive health service that they perceive is being used disproportionately by people on low incomes (and who in turn are most affected by the recession)
- **NHS solidarity** may be further undermined by continuing and perhaps increasing differences between socio-economic groups in their willingness to change their behaviours and lifestyles in line with public health advice
- **NHS coverage:** limiting the scope of the NHS benefits package by defining a set of core services that would continue to be covered and requiring individuals to pay directly for services outside the scope of the package
- **private funding:** incentivising middle and high income earners to take out private medical insurance along the lines of the approach adopted in Australia that resulted in almost 50 per cent of the population taking up this option (current levels of cover in the United Kingdom remain around 11 per cent)
- **partnership funding:** implementing a model of partnership funding in social care in which the costs of care would be shared between the state and the individual, along the lines set out in the recent green paper
- **competition:** making it much easier for independent sector providers to provide services within the NHS in order to drive down costs and improve productivity, as favoured by the Conservative Party. Over time this would have the effect of transferring more of the responsibility for negotiating controversial workforce changes to the independent sector

Radical alternatives

To make these points is to recognise that the post-war settlement that gave birth to the NHS may be fundamentally challenged by a set of financial circumstances without precedent in the lifetime and experience of most people in the United Kingdom. Although all major political parties have expressed their continuing support for the NHS, the possibility of radical alternatives coming on to the table should not be discounted. These alternatives include:

- **user charges:** increasing existing charges such as for prescriptions and extending charges to other areas e.g. visits to the GP or hospital specialist or for hospital stays. Another option would be to extend the principle of top up payments for experimental drugs introduced following the Richards' review to other expensive new technologies

While none of these alternatives is new, the view that 'a crisis is too good an opportunity to waste' may mean that some of them are actually taken up this time round.

Conclusion

A key message of this paper is that long term trends (the drivers of change) and short term imperatives (impending financial constraints) point in the same direction. The NHS needs to implement a new model of care to meet changing population needs and to live within much tighter budgets. This model of care

has to give much higher priority to prevention and enhanced primary care and to support a rationalisation of hospital services.

After a period of unprecedented expansion, the next few years will be characterised by the search for significant productivity improvements. With 70 per cent of expenditure going on pay, attention is likely to focus on the workforce with a range of options up for consideration. Both government and NHS organisations will be exploring ways of achieving more with less and realising the benefits of the new contracts introduced in recent years.

As this happens, it is likely that there will be an increasing focus on variations in performance. Service line reporting and practice based commissioning will be used to tackle these variations with the emphasis on clinical leaders driving change, supported by timely and accurate information and incentives. One of the consequences is likely to be new ways of working with serious attention being given to skill mix and flexible working.

The recession will add to the pressures facing the NHS and a series of threats have been identified. It is likely that radical alternatives will come onto the agenda in relation to the future funding of care, the scope of NHS coverage and the role of the independent sector. The post-war settlement on which the NHS was based will then be challenged, although the policy consequences are difficult to predict at this stage.

August 2009.

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Tomorrow's workforce?

A perspective on employment and skills in the United Kingdom's health sector

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Introduction

The health sector is in constant evolution as medical science advances and new technologies are adopted. The surprise over the last 50 years is how little traditional patterns of working and service provision have changed in this context. 21st century medicine is being delivered using structures and processes that have changed little since 1948 and the inception of the NHS. However, in the next 10 years a number of factors may combine to disrupt traditional practices and challenge the way in which health professionals work.

What are the main challenges to the health sector?

Economic Trends

The factor likely to drive greatest disruption to current healthcare delivery is the prospective squeeze on healthcare funding in the UK. From 2011 onwards the health sector will be operating in much harsher financial environment. In contrast to the past decade, during which healthcare funding enjoyed continuous expansion, with average rates of annual growth of around 5 per cent, the prospects now are for a prolonged period of low growth if not reductions in health spend.

In addition to the immediate impact of the economic downturn there are longer term adjustment issues for health care. Health spend in the UK, in common with other developed countries, has grown faster than the wider economy and as a consequence taken a growing percentage of GDP – growing from 4 per cent to nearly 10 per cent in the last 40 years. If the current trends continued, by the end of the century, most of the OECD countries would be spending half of their GDP on health. This is not sustainable. The health sector will need to do more for less, substantial productivity gains are needed.

Demography & Epidemiology

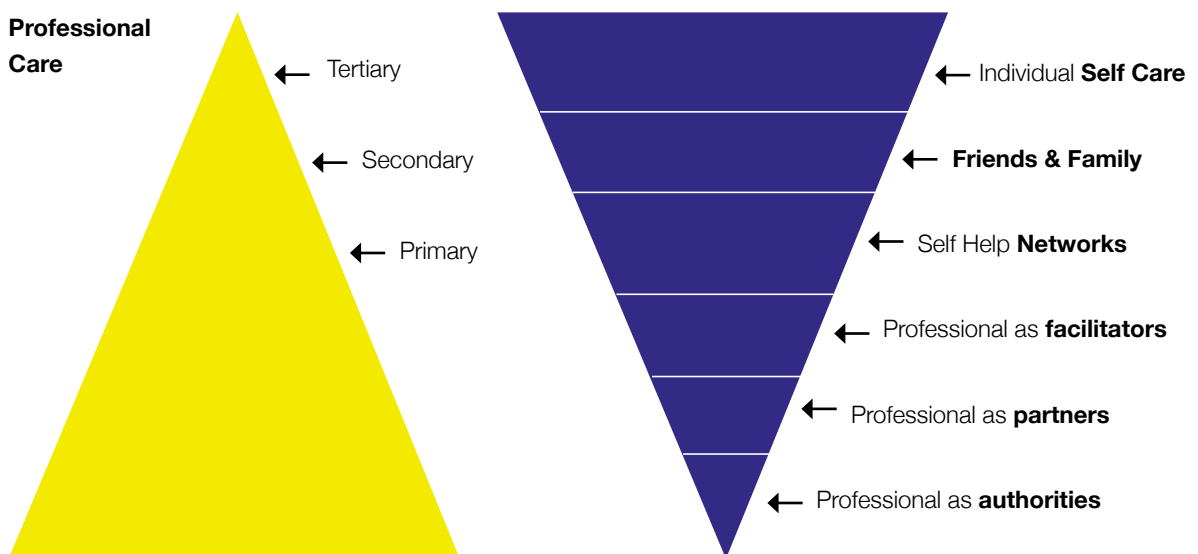
While resources are constrained, demographic and epidemiological trends signal an increasing demand for health services.

The overall rate of growth in the population is expected to be relatively small, but the population is ageing. The Government Actuary's Department predictions suggest that while the population of England is expected to rise by just under 3m (5 per cent) by 2015 to 54.3m, the over - 75 population is predicted to grow by 500,000 to 4.5m (+13 per cent) by 2015. This will mean greater numbers of age-related disorders and disabilities (including mental health disorders such as dementia and depression). In addition we are likely to see the consequences of the rising rates of obesity and alcohol consumption in the health of the population. Nearly a quarter of people living in the UK are

classified as obese, up from around 15 per cent 15 years ago. This will mean more diabetes, more hypertension, more heart disease, more liver disease, more musculoskeletal problems. The burden of chronic disease will be considerable and the major driver of health and social care demand.

The public health agenda, including issues such as obesity, will also demand far greater attention. There will also be a continuing threat to public health from communicable disease such as pandemic flu, and diseases such as SARS, West Nile fever and Ebola virus, as well as the likely emergence of other new diseases. The steady increase in air travel and migration escalates the risks from all communicable disease. Finally, the effects of global warming are likely to precipitate more frequent heat waves in the UK, with health impacts particularly on vulnerable older people.

Industrial age medicine needs to transform to Information Age Health care



Source: Jennings, Miller and Materna - Changing Health Care, Santa Monica: Knowledge Exchange, 1997

Patient Expectations

The population has increasing technological sophistication and capacity to access information on health and healthcare. The increased access to healthcare information is changing the nature of the doctor-patient relationship. The vision laid out in 1997 by Jennings et al (see p 30) is still to be fully realised, but describes well the potential change in balance of power and control between professional and patient. Part of this change is the increasing importance and role of self care and the opportunities for people to “co-produce” their care in the same way that they now manage their own financial affairs.

Finally, as the baby boomers age, there will be particular demands on services for the elderly, not only as a result of their comparatively unhealthy lifestyles – and greater numbers – but also because this generation of older people will have higher expectations than previous ones.

These future increases in demand alongside the tight economic constraints, suggest improved productivity and gains in efficiency will be essential.

Medical & Technological Advances

One way to deliver improved productivity is to make better use of new medical and information technologies. For example, digital capture of diagnostic test results and electronic prescribing systems can reduce errors in prescribing and diagnosis. If clinical information is shared digitally between professionals duplication of clinical effort can be avoided. Technologies such as automated analyses – medical devices that can self monitor and call upon expert/professional help automatically – allows clinicians to manage people better at home, avoiding costly hospital admissions. However, a frequent challenge for the health service is not the lack of new, cutting-edge ideas and inventions, but the historical

failure to adopt, diffuse and implement knowledge and technologies. The hope is that the new financial imperatives may encourage more rapid adoption.

Over the next 10 years the future development of new medicines are likely to result in incremental rather than step changes. The newer types of biologic therapies such as those that are gene or stem cell based will deliver their greatest benefits over a longer time – 15 years or more. Advances in genetics will drive increased use of genetic screening. This raises ethical issues for clinicians and society.

Labour Force

The future composition and working patterns of the healthcare workforce present a number of challenges to the health sector in the UK.

The traditional reliance on the junior doctor as a mainstay of service provision is under particular threat as a consequence of their reduced working hours; the new model of medical training; and the recognition that higher quality and more efficient care is delivered by more senior doctors. The UK is relatively unique in the reliance it places upon doctors in training to deliver care in hospitals. In other countries medical training is more centralised.

There are two further features of the workforce that are worthy of note but we can't be sure what their impact will be. The healthcare workforce is ageing alongside the wider population. If the workforce is fit and retires later this will not be a problem, but if not, we could see significant gaps in the workforce. Some are already predicted in the community nursing workforce. The other issue is the increasing feminisation of the medical workforce, the net impact of this on participation and productivity rates is uncertain.

How will these challenge current provision or the current trajectory of provision?

Changes in junior doctor working hours, training patterns and advances in medical technology are likely to continue to drive centralisation of emergency and 24/7 services and a decentralisation of elective and office based services. The rate at which this happens will in part depend on political will. Current consultation requirements and public opposition can make service change lengthy and costly. Specialist hospital care is likely to become more differentiated. The local general hospital will no longer be a comprehensive provider of care but will be a part of broader network of health and social care providers. Costly admissions to hospital will be avoided where possible and lengths of stay minimised. The pressure on resources will result in a much greater need to demonstrate value from clinical interventions, such as surgery, and high-cost drugs. The primary locus of care will shift further from hospital to community.

We are likely to see larger, multi-disciplinary primary care teams. Some may work out of traditional health centres, others may move to more community-based facilities as part of an integrated health, social and education community resource. There is likely to be increasing co-location of health and non-health services to maximise access and improve utilisation of costly estate. In these facilities there will be an increasing focus on helping patients help themselves and on promoting health and wellbeing. Web-based communication will enable informal peer support to play an increasing role, especially for those with long-term conditions.

Professionals may work increasingly in multiple and/or new types of organisation for example: more clinically specialised organisations or integrated provider organisations for office/community care. The traditional division in the UK between the private

and public healthcare is likely to continue to be broken down with a more diverse provider mix.

What would be the consequences if the sector continued doing things the way it has always done?

There will simply not be the resources to meet future demand if the current pattern and process of care is not changed significantly. If the gap between demand and supply is not bridged through productivity gains and new models of care – in the first instance the current geographic variation in care delivery would probably widen. In due course the key principles of the NHS are likely to be threatened, that is: a comprehensive service, available to all, free at point of delivery. There could be attempts to exclude service areas from NHS provision, and/or introduce co-payments or means testing for some services, as is already the case for dentistry and optometry.

How would we need to redesign the health sector workforce and ensure it has the skills to deliver health care which meets the challenges ahead?

The challenges described above suggest a number of significant changes in the skills required by health professionals and the way in which they are trained.

Delivering and demonstrating value

The extreme pressure on resources means that professionals will need to demonstrate value in the care they deliver. There will be growing pressure for them to take on leadership roles and be accountable for spending. This will not only require *leadership and managerial skills but the skills to innovate and improve the process of care.*

Team working will become the norm. The greater focus on team working means that as well as needing *team-working skills*, professionals will need to define their unique contribution to the team. The pressure

upon doctors' time and the importance of rapid accurate diagnosis for efficient use of resources means that doctors are likely to focus on their role as diagnostician and care planner rather than as an administrator of treatment.

Coping with the exponential rise in information and knowledge

The exponential rise in medical knowledge means that professionals will need to make much greater use of information technology to support clinical decision making. Professionals need to be expert *knowledge managers and navigators*. The increasing engagement of patients in their own care may mean that professionals also support patients to navigate clinical information more effectively.

Supporting self care – enabling patients to be co-producers of care

Professionals will need to have the skills to *help engage patients in their own care*. This will be challenging as different patients will have different skills and capacities and professionals will need to be able to adjust flexibly to this.

Clinical teams will need to help patients navigate their way through a complex care system and support them in their transition between one provider and another. There is likely to be an increasing need for clinical teams to be expert at *navigation and support across clinical pathways*.

Promoting improvements in public health

There is a growing demand for professionals to promote health as well as treat illness. This will increasingly include *genetic counselling* as they speak to patients about the relative risk of disease created by an individual's genetic make-up.

Managing the rising burden of chronic disease

Rather than dying from disease, patients are living with disease, and as they get older, people will often have more than one disease, frequently a combination of social, physical and mental health problems. There will be *an increasing need for generalists and generalist skills*.

Adapting to technological change

Technological change is likely to drive changes in the demarcation between primary, secondary and tertiary care. The pressure to deliver specialist care in the community may drive a separation between *“hospitalists”* (physicians expert in managing patients in hospital setting) and new office-based specialists who would work along side General Practitioners in the community. Clinical roles will need to be flexible and able to adapt to changing technologies. *Continuing professional education and development* will be of increasing importance.

What might be the barriers against making these improvements? How could we overcome them?

There are a number of barriers to these changes: some are created by current patterns of training; some by current demarcations in professional roles and responsibilities; and some by the way the system currently operates. It is noteworthy that health systems across the world struggle with innovation and reform.

Barriers within current professional training

1. Focus on the bio-medical model

Current training programmes, particularly for doctors, focus on the bio-medical model. Little is taught about the way healthcare is delivered and the way in which technological innovation might support different ways of practice. We need healthcare professionals to be innovators

in process redesign as well as clinical innovators. Managers are too removed from clinical practice to effectively drive this type of innovation.

2. **Professionals as authorities rather than facilitators**

Also implicit in current training programmes is the assumption that the professional is the authority and source of medical knowledge. Professionals need to be taught how to effectively engage patients as “co-producers” of their health and care. They also need to be equipped with the skills to work effectively with clinical decision support tools and to continually seek out new knowledge and build on the knowledge gained in their original training.

Barriers within current professional practice and demarcations

3. **Lack of senior generalist skills within a hospital setting, lack of specialist and diagnostic skills and capacity within community setting**

Patient needs have changed yet clinical practice has not. This has left a deficit of generalists – able to manage older patients with multiple co-morbidities in a hospital setting – and a deficit of specialists and diagnosticians able to manage those with chronic disease in a community setting. Waiting for new recruits to provide these skills is unlikely to deliver the change rapidly enough. Professionals need to be facilitated to work across primary and secondary care and greater attention paid to ensure staff in both settings have the appropriate skills.

4. **Poor understanding of the wider system by professionals**

Professionals, particularly in primary care, face a confusing and complex array of services in

secondary and community care. Little attention is paid to equipping these professionals with the skills and knowledge needed to navigate patients through this. As a consequence patients can feel unsupported and vulnerable and resources can be wasted as a result of inappropriate admissions or referrals.

Barriers within the current English health system

5. **Separation between primary, community and secondary care**

The separation between primary, community and secondary care – the legacy of the original NHS settlement – does not facilitate integrated patient-focused care. Patients experience multiple handoffs between professionals and clinical and organisational incentives are not aligned to deliver high-quality cost-effective care. Community services have suffered particularly from a lack of attention and input from primary care. There needs to be much greater strategic alignment between the different organisations and the professionals that work within them.

Conclusion

A combination of factors mean that the NHS is about to face the most challenging period in its history. It could provide the opportunity for the NHS to tip from “industrial age medicine” to “information age health care” or it could threaten our capacity to provide a comprehensive health service, available to all on the basis of need and free at the point of delivery. Equipping the workforce with the appropriate skills will be critical to which of these two outcomes is achieved.

Candace Imison

August 2009.

Do We Need a Leadership 2.0 in Healthcare?

A Commentary

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Introduction

In the current climate of public sector deficits, the health sector is being asked to do ‘more for less’. Improving sector performance and skills utilisation through greater levels of engagement among staff has been singled out as one of the most effective ways of achieving a return on investment in human capital. Yet, recent research on staff engagement, a key aim and driver of healthcare delivery and policy, shows that the sector itself is ‘a suitable case for treatment’.

One of the common themes to emerge from recent research projects are the poor perceptions by staff of senior leadership teams with respect to key issues such as delivering patient care, communications and managing change effectively. Though healthcare leaders are taking steps to address these problems, there is still strong evidence of a lack of ‘honest’ signals – by which we mean novel, credible, authentic and sustainable signals – from senior leadership teams that staff interpret as they and patients really matter.

In this commentary, firstly, I outline and discuss recent research into engagement in the UK health sector, including work conducted by ourselves in Scotland. Secondly, I propose that doing nothing about these poor perceptions of senior leadership among staff can

only lead to future problems in attracting, engaging and retaining talented people in healthcare, including those senior managers and clinical leaders on whose shoulders doing more with less rests. Thirdly, I outline and evaluate some of the current solutions from new leadership theory for a revised form of leadership – distributed leadership, responsible followership and transformed management 2.0. While all three show promise, there are some significant problems attaching to them.

So what can be done? The analysis suggests that a better worked out theory of distributed leadership may help. It also suggests that we need to incorporate doctors more in leadership teams and help them become effective members of senior management teams, though there is still resistance among them

to be incorporated into this process because of the arguably unrealistic assumptions of leadership impact generally. We may also need to develop in staff at all levels the notion of 'responsible followership', because leadership is based on the interaction between leaders and followers. All of these factors may combine to signal greater 'honesty' in the messages sent out to staff and prospective staff concerning the novelty, credibility, authenticity and sustainability of leadership and employment in healthcare.

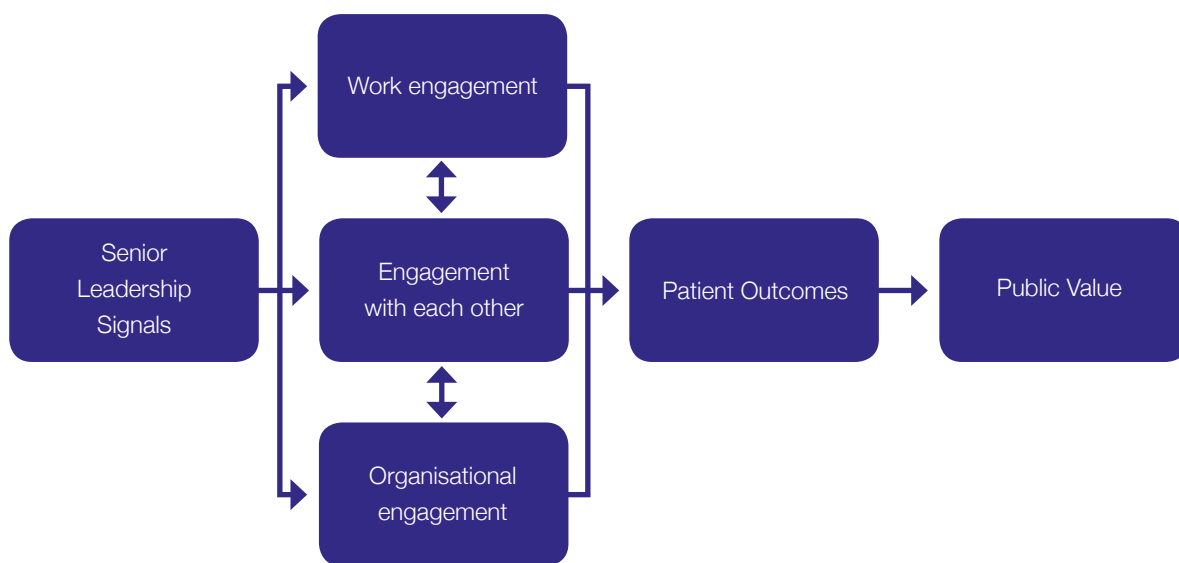
The Problems of Senior Leadership in Healthcare

Recent research suggests that the healthcare sector throughout the UK has difficulty in creating a reputation as an employer of choice. This applies externally regarding its image among potential recruits¹. It also applies internally, revealed by consistent problems with staff engagement. Engagement is a complicated concept, which is often poorly defined; as a result, it is not particularly well measured in healthcare, or other industries for that matter. Nevertheless, and with good reason, it is thought to be a key driver of healthcare performance and of a willingness among staff to implement change. Staff engagement is also seen as an end in itself because it provides key psychological benefits to those working in the service. Both factors are at the heart of sustaining and improving the corporate reputation of the NHS as a whole and as 'employers of choice'. The basic assumption underlying this belief is of a public sector equivalent of the so-called 'service-profit chain', in which there is deemed to be a clear line of sight between satisfied employees, satisfied patients and other stakeholders in the healthcare system, so resulting in greater public value (Martin & Hetrick, 2006, Bushfield & Martin, 2009; Bennington & Moore, 2010). Though over-simplified, this chain provides a good starting point for a conversation (see Figure 1 on next page).

Staff engagement is also seen as an end in itself because it provides key psychological benefits to those working in the service. Both factors are at the heart of sustaining and improving the corporate reputation of the NHS as a whole and as 'employers of choice'.

Our recent research has identified three critical levels or types of engagement in managing the reputation of the NHS (Martin, Pate & Bell, 2009). The first is *work engagement*, which addresses the questions: to what extent do staff display *vigour or energy* in their jobs, to what extent are they absorbed or immersed in their work, and to what extent are they dedicated or involved in their work and feel a sense of significance and pride in what they do (Schaufeli, Bakker & Salanova, 2006) As might be expected, positive answers to all three sets of questions have been shown to positively predict the key outcomes in the delivery of healthcare services. The second is organisational engagement, (more properly called *organisational identification*), which is concerned with the extent to which staff identify with their employers as an organisation and with NHS as a whole. Here we are referring to the extent to which staff see working in the NHS as a key element in shaping their answers to three questions: 'who am I' (does working in the organisation express my personal identity), how attached do I feel to my NHS employer (do I feel a sense of psychological ownership), and do I share the values and aims of my NHS employer (Edwards & Peccei, 2007) The third is *engagement with each other*, otherwise known as relational coordination (Hoffer Gittell, 2009). The impact of high performance HR (and leadership) systems on objective evidence of patient care has been found to be strongly influenced by the extent

Figure 1: A Revised Service-Profit Chain for Healthcare Showing the Links between Leadership Signals and Different Levels of Engagement



to which various groups of staff involved in the patient journey see the need for themselves and others to collaborate effectively and for them to behave in ways that demonstrate such collaboration.

The first point I want to draw from this diagram is that is that all three levels of engagement are inter-related and *necessary conditions* of effective healthcare and the reputation of the NHS. It is possible, but unlikely that organisational engagement will be sustainable if staff do not experience engagement with their jobs and with each other. The second is that staff experiences and perceptions of senior leadership are among the most important influences on all three types and levels of engagement and organisational behaviour and, indeed, misbehaviour (see Figure 1). The third is that these experience and perceptions of senior leadership teams are largely negative. Although they are improving, they are nowhere near the levels to which employers aspire (see Box 1).

The impact of high performance HR (and leadership) systems on objective evidence of patient care has been found to be strongly influenced by the extent to which various groups of staff involved in the patient journey see the need for themselves and others to collaborate effectively and for them to behave in ways that demonstrate such collaboration.

Box 1. Evidence from Recent Research in UK Healthcare on Engagement and Leadership Impact

Evidence from a large-scale survey of 9,000 staff in the NHS in England (IPSOS/Mori, 2008) found that three key factors were not perceived to be delivered to any great extent – ‘I understand my role and where it fits in’, ‘I feel fairly treated with pay, benefits and staff facilities’ and ‘senior managers are involved with our work’. The research concluded that staff did not feel they helped to provide high quality patient care to any significant extent, and that these last three factors were important causes of this problem.

The Healthcare Commission (2008) surveyed 290,000 employees in England and Wales. Retrofitting findings onto the three levels of engagement, it can be concluded that engagement with each other was low with – 90 per cent reported working in teams but only 39 per cent reported their teams to be effective; only 44 per cent of all staff felt that healthcare professionals and managers worked well together; only a quarter of staff felt their managers involved them in important decisions and only a third felt that managers involved staff in important decisions. On organisational engagement with their Trusts, less than a third of staff were satisfied with the extent to which their Trust valued their work, less than half believed their Trust communicated aims clearly, and only 44 per cent felt their Trusts were committed to helping staff achieve work-life balance.

Our own study of reputation management and engagement in the NHS in Scotland in 2008/09, based on forty in-depth focus group interviews and a re-analysis of 50,000+ responses to an

attitude survey data conducted in 2006 and 2008 reflects these findings in England and Wales. The three most important and valuable factors influencing their perceptions of the delivery of psychological contracts were – the *reward-effort bargain*, *opportunities for development* and training, and *effective leadership and support*. After fairness over pay and the Agenda for Change procedures, the most important negative perceptions focused on senior leadership support, and the lack of openness, honesty and trust which could be placed in them to act in employees’ interests. Like the Healthcare Commission report, line managers were seen in a positive light. Senior managers, however, were deemed to be too remote, too concerned with the political and financial agenda, and not particularly interested in patient care except when expressed by targets.

This last finding was supported by further questions on the images of employees of their employers. Health Boards (the employers in Scotland) were not seen as particularly as patient-centred organisations or employers of choice – a strategic workforce aspiration of NHS Scotland. Instead, staff saw their organisations as dominated by power, politics and financially/target driven senior managers, and as divided by professional and local identities and interests, especially among non-clinical grades but also by nurses. The 2008 staff survey broadly corroborated these findings, though it showed that dissatisfaction was much more marked among lower paid groups, which have less control over their work. In contrast, higher paid and managerial staff felt more satisfied.

Our main conclusions from these data showed some deep divisions in organisational culture which would prevent cooperative change in the future. Combined with research from other countries on organisational culture change in healthcare, the negative perception of senior leadership, organisational and professional politics is an important barrier to engaging NHS employees in Scotland because of relatively widespread feelings of cynicism towards Government targets and target setting, the ‘real’ agenda of senior managers as opposed to the rhetoric of ‘staff being out most important asset’, and staff perceptions of a lack of professional respect from senior leadership.

The Perspective of Senior Leadership

There is nothing surprising about these conclusions since evidence on the low esteem in which senior managers in healthcare have been held has been around for some time. However, what one sees depends on where one stands. The limited evidence we have on senior leaders’ perceptions of the problems of healthcare tells the story from a different angle. Probably the best insights come from Blackler’s (2006) study of chief executives in the early part of this decade. So critical was this study of the dysfunctional consequences of targets and their impact on chief executives that it was even quoted in the Sun newspaper.

Before undertaking his research, Blackler expected to find evidence of ‘heroic’ leaders of the kind romanticised in the business press and business books. Instead, he found *‘that popular image of an empowered, proactive leader did not match the reality of senior leaders’ roles in public sector organizations in the English NHS, at least between 2000 and 2002...’*

General managers were introduced into the Service in the 1980s, which led to widespread budgetary reforms and an increase in power of senior managers, largely, it seems, at the expense of senior clinicians.

However, by the time of this study ‘senior politicians in the UK had become suspicious of the abilities of public sector managers in general, and those within the NHS in particular, to deliver the reforms that they had deemed essential’ (Blackler, 2006:1). Blackler conducted a series of interviews with 25 of the most reputedly successful NHS chief executives during a three year period between 2000/02. His findings recorded the pressures to which they were felt they were subjected:

‘... rather than being given the scope to help lead the reform of the NHS, chief executives were treated as little more than conduits for the policies of the centre. The interviews illustrate how undermined and demoralized many of them came to feel’.

Career low points came under the heading of political battles with doctors, chairmen and other staff, broader political problems in the NHS, personal criticism from the public and having to make difficult decisions over resources, etc. Career high points were in providing services that would benefit patients, such as turning round a failing hospital and launching new initiatives or hospitals, winning staff and organisational development battles, especially with clinicians, building strong management teams, and in participating on a national stage on strategic policy-making.

Blackler concluded that it was questionable whether these chief executives were leaders at all in the sense of having any real discretion over decision-making. This led him to also question whether such lack of discretion and the way in which chief executives were subject to control could do anything other than feed through negatively to frontline staff as a service

characterised by change for the sake of change and conflict rather than the delegation of power and authority, partnership working and consistency of messages about what was required.

So, although attributing the problems to a different cause, it seems that staff perceptions of their senior leaders closely reflect the views these leaders have of themselves and their positions in being weak (despite having control over substantial resources?). And, perhaps, this was a perspective that chief executives and their teams communicated intentionally and unintentionally during moments of stress and difficult decision-making through their actions and inactions. We concluded in our report on the Scottish NHS that many staff rather unfairly criticise senior leaders because the majority, including senior medical staff, had little or no contact with senior managers, in part a result of the size and geographical spread of some Scottish boards but also because some staff wished to remain at a distance to pursue their career and patient care ambitions more or less untrammelled by concerns for targets and management problems. We further suggested that because effective leadership is contingent on the abilities of followers to fully apprehend the complexities of public sector management: a convincing explanation for the negative views held of senior leadership by many staff may reside in their unrealistic expectations of what leaders in the public sector can actually achieve in a highly politicised, stakeholder-driven environment, especially when compared, inevitably unfavourably, with the largely media-created 'celebrity' leaders in the private sector.

Nevertheless, we also concluded that such expectations and 'definitions of the situation' are real in their consequences and need to be addressed for significant change to be implemented in achieving healthcare reforms and creating public value.

Explaining Their Explanations

The above analysis takes us so far, but can we dig deeper into these perceptions of senior managers and staff on the problems of leadership? There are at least three lines of argument from leadership theory that come together to help explain the low regard in which leaders appear to be held and, indeed, hold themselves. The first concerns definitions of the problems leaders face, the second is in how we as followers attribute cause to success and failure, the third concerns our implicit theories of how leaders should look and act.

These problems have been elaborated by Keith Grint in a document he and I wrote for public sector leadership in Scotland (ESRC/ Scottish Government, 2009). His analysis was that we can't solve 'wicked problems' through proven management 'process' approaches. Like other researchers in leadership, Grint (2008) has grounded the distinction between management and leadership in a division between certainty and '*tame problems*' and uncertainty and '*wicked problems*'. Tame problems may be complicated, like many medical procedures, but are resolvable through the application of previous knowledge, experience and by following more or less sequential or systematic procedures. In other words, there is only a limited degree of uncertainty surrounding such problems and thus they are associated with conventional scientific/ scientific management solutions. So, tame problems can be likened to puzzles, for which there is always a rational management answer – better planning, organising and controlling. This seems to be very much the perspective of politicians, who view targets and output control as the solution to managing healthcare problems and, perversely, the perspective of many staff who see solutions to such problems in healthcare in the same way they see solutions to their football clubs' problems when things go wrong – sack the manager! (Kuper & Szymanski, 2009).

Wicked problems, however, are more complicated than tame problems but, importantly, are also more complex. Unlike tame problems, they cannot be removed from their environment, solved, and returned without affecting the environment. Good examples here are that systemic consequences of the new consultant and general practitioner contracts, consultants' distinction awards schemes, 'Agenda for Change', or implementing equal pay. Moreover, there is no clear relationship between cause and effect in the sense that we can build causal models and apply these logics in a linear fashion. Instead, such problems are often intractable and indeed irresolvable: we simply cannot manage complex organisations and problems such as those evident in a health service purely on the basis of scientific management, operational research and measurement, as was fashionably thought in the early 1900s, again in the 1970s and now in the new millennium, by imposing bureaucratic controls and simplified measurable targets on senior managers. As Grint argued, with an ageing population, better medical knowledge and techniques that can intervene and maintain life, a potentially infinite increase in demand but a finite (and now probably declining) level of resource, there cannot be a purely scientific solution to the problem of health provision and, by extension, to the leadership of such a service.

Thus leading a health service organisation is fundamentally about facing up to wicked problems and asking the right questions. But conventionally we associate leaders with precisely the opposite – the ability to solve problems, act decisively and to know what to do. In recent years, we have become conditioned into a 'romance' with such heroic and/or charismatic leaders, especially by a celebrity-hungry press business press and 'airport' business books that have put forward a case for commander-style leadership borrowed from the military and transformational leadership borrowed from the

drift in the political sphere towards presidential-style 'democrats'. Though there is some evidence that transformational leaders can have an impact and that commander-style leadership may be necessary in crisis, research has shown that it is by no means certain that these types of leaders can impact positively in the majority of cases in which leadership is required, especially in a public sector environment. This is because the wicked problems that leaders face, especially in the public sector, often require the exact opposite of acting decisively: they cannot know what to do for the best in an increasingly unknowable and complex world that requires the exercise of wisdom rather than rationality (Weick, 2001) by admitting to 'known unknowns' (to borrow from the unfortunate Donald Rumsfeld who won the 'Foot in the Mouth' award in 2003 for his inelegant elaboration of this insightful expression of wisdom).

In short, we cannot solve wicked problems; we can only learn to live with them and learn to ask the right questions by engaging with the 'wisdom of crowds' and transferring authority to the collective to help resolve them. What often happens, however, is that the pressure to act decisively often leads us to try to solve the problem as if it were a tame one – and if you only have a hammer in your toolbox, every problem becomes a nail. Maybe leaders in healthcare understand this conundrum only too well; as a result, inaction or what might be seen as passing the buck by passing on ownership and responsibility for the decision to politicians and other groups is what staff see. And, given that we often attribute reputational success and failure to leaders according to how well they service our material aims and match up to our expectations of trust and reliability (Love & Kraatz, 2009), it should be of little surprise that many public sector employees have a negative view of their leaders, especially when these same leaders have a negative view of themselves as victims, or seek to avoid making difficult decisions over intractable resource issues.

Linked to these arguments are two further explanations, one of which we have already touched upon. The first lies in how we attribute causes to what we observe and sometimes commit the fundamental ‘attributional error’ of giving too much weight to individuals, often leaders, and too little weight to the situations and contexts in which they act (Rosenzweig, 2007). Second, our conditioning over the last two decades and associations of leaders causes us to develop *implicit theories* about what such leaders should look and act like. *Attribution theory* tells us that individuals develop relatively simple explanations for the behaviours and outcomes of leaders, often leading them to over-attribute cause to personal characteristics such as charisma, decisiveness and even height and under-attribute to contexts. What frequently happens, however, as in the case of some well known examples of outstanding business performances over the last few years have illustrated only too well, is that we often attribute success to a simple cause – usually leaders’ personal abilities, which are likely to be the same personal abilities that led to failure. The romance with heroes and subsequent vilification of these self same heroes characterise this attribution. Thus, it can be argued, leadership is as much a property of followership as of leaders. Perhaps even more controversially, leaders are truly a creature of followers in one important sense: not only do we make negative attributions of public sector leaders who cannot match up to the private sector models but, as Kellerman (2008) has argued, we cannot have bad leaders without bad or irresponsible followers. More of this contention later.

The Problems of Doing Nothing

From the above analysis, one might be forgiven for concluding that leaders only matter in an NHS context in a symbolic sense or as Government appointed delegates at the ‘bargaining table’. As we have seen, there is evidence to support these views

but not only from the public sector. Reasonably good evidence has shown that the vast majority of football managers make very little difference to the success of their football teams (Kuper & Szymanski, 2009), a conclusion supported by a sharp scholarly pin aimed at the romance with leaders ‘bubble’. Pfeffer and Sutton’s iconoclastic book on ‘Hard Facts, Dangerous Half Truths and Total Nonsense’, concluded:

“Scholars who conduct and evaluate the best peer-reviewed studies argue over how much leadership matters and when it matters most. But when they set aside their petty differences, most agree that the effects of leadership on performance are modest under most conditions, strong under a few conditions, and absent in others.”

“Studies from leaders... show that organisational performance is determined largely by factors that no individual – including a leader – can control.”
Pfeffer & Sutton, 2006 (p. 192).

However, like many recent scholarly works on the subject, they recognised that bad leaders can have a very negative impact. Barbara Kellerman (2004), from the Kennedy School of Government in the USA, has been at the forefront of this research, contending that we could learn as much about leadership from bad leaders as good leaders. Her model placed bad leadership on two axes, ineffective leadership and unethical leadership. Kellerman then examined the ongoing costs of bad leadership and the benefits of its study. She argued that bad leadership has a lingering and multigenerational effect, and that

organisations needed to identify and understand patterns of human behaviour and bad leadership so that they will better be able to deal with it – earlier rather than later.

The main point we can deduce from these data and arguments is that staff engagement is not contingent on the fact of leadership and its actual impact on performance but on employees' subjective experiences of leaders and leadership. Whether right or wrong, it is their definition of the situation that becomes real in its consequences. And what evidence suggests on this issue is that staff tend to place their senior leaders on the ineffective end of the axis, though there will be always be claims of incidences of unethical leadership such as bullying and a lack of concern in patient care. And, as Kellerman has pointed out, such incompetence is likely to have damaging long term consequences on the three levels of engagement we identified earlier, and, through them, on organisational performance and public value.

Possible Solutions

New Models of Distributed Leadership and an End to the Romance with Leaders

Perhaps the most widely touted solution to these problems and others facing the NHS is distributed leadership. Spillane (2006) argues from his research that distributed leadership is best thought of as the product of interactions among leaders, their followers and features of their situation, such as how they use knowledge, routines and procedures to address complicated questions. In an interesting metaphor, Wilkinson (2007) has likened this process to a dance – think 'Strictly Come Dancing' – in which professionals eventually guide the celebrities to sometimes highly skilled performances, but only if they last the course. This is leadership practice par excellence because it illustrates that the eventual performance is not only or even mainly about the leadership skills of the professionals but rests with the celebrities and in

the interaction between 'leader' and 'follower'. The endgame in this contest is really for the follower to become leader, though in the minds of the public they are leading already because of their (sometimes dubious) celebrity status and, paradoxically, willingness to acknowledge and display their lack of skill, which is a sign of wisdom that senior leaders sometimes lack (Edmondson, 2008) (you may note some parallels here with the public trust placed in doctors as the authoritative leaders of the NHS in the court of public opinion, and the ease by which governments can curry favour with the public and media by attacking professional managers).

Distributed leadership, however, can take a range of forms and metaphors, not just those revealed by dancing analogies. These range from one end of a continuum where the leader is broadly in charge to the other end in which (a) leadership is either *shared collectively* among two or more leaders who work separately but interdependently, as in cricket, or (b) *collaboratively*, where the work is shared among colleagues who work together, as in a football team, or (c) *in coordination*, where one team leader may pass on work to another in a sequence during the course of completing a project, as in a relay race.

In these forms, distributed leadership is believed to be fundamentally different from the romance with charismatic or commander-style leaders because it requires organisations to think, act and behave in quite different ways from the hierarchical *bureaucratic model* that characterise many organisations operating in simple, unchanging environments, the *professional bureaucratic model* that used to characterise healthcare prior to the introduction of professional managers (Mintzberg et al, 2009), or even the managed professional bureaucracy that is now claimed to dominate the sector – the overlay of managers and managerial values on professional (mainly medical) power (Ham & Dickenson, 2008).

Distributed leadership, however, is not easy to implement because it is usually only possible in receptive contexts for change, which include receptive social and cultural contexts, organisational structures and perspectives on power and control. It also relies on the ways in which such change is introduced, who it is introduced by, the dynamics of teams, and the position and status of potential leaders within the organisation. One good example of how distributed leadership evolved in a particular trust, which turned out to be the most successful of three being compared for cancer care is beautifully documented by Buchanan et al (2007). Although, these researchers

claim this successful trust was an illustration of no-one in charge, the description and analysis of the research fits well with distributed leadership (see Box 2).

Buchanan et al conclude that what was striking about this case was just how distributed leadership really was, how leadership migrated over times from national to regional to local levels, and how the changes were driven and sustained by partnership pairing, cores of four and fluid supporting roles at different times. They also highlighted the lack of project management, or no-one in charge, as a potential positive because project management may result in a lack of leadership sustainability when projects come to an end.

Box 2: An Example of No-one in Charge or Distributed Leadership in Healthcare (based on Buchanan et al (2007))

In this paper, the successful organisation of prostate cancer treatment in an acute trust that had no particular advantages over two others helped it meet all nine key targets for 'star rating' (indeed, according to conventional change management theory, one of the other trust would have been predicted to be more successful). Moreover, during the period of much of the research during 2002/03 the hospital experienced five changes of chief executive! According to Buchanan et al (2007), what appeared to have happened is that given heightened expectations of performance targets and standards of care that cancer services were expected to achieve, and the articulation of goals and priorities, a complex process of distributed

change began to take place in the absence of the usual sine qua non of change management – implementation planning or project manager appointments. The trust had some advantages over the other two, in that lead roles were filled, prostate services were the responsibility of an innovative and interested directorate for surgery and urology, and the cancer network that developed was seen as a valuable resource. Importantly, according to the researchers, it also had no shortage of distributed change champions who were left to get on with things. And, in comparison to the other trusts in which involvement in management was regarded as 'burdensome' by doctors or was something to be 'distanced from', doctors and other clinical staff in this trust were 'actively involved in trust and cancer network roles related to service improvements for prostate cancer' (p 1,084).

Responsible followership

These last points resonate with another model widely proposed in the public sector – responsible followership. Indeed, the above discussion more or less depends on it. Kellerman (2008) has described a typology of followership based on their level of engagement. She sees good followers as actively supporting effective and ethical leaders and responding appropriately to bad leaders. Bad followers, on the other hand, are seen as making no contribution and supporting the wrong types of leader. In ‘Followership’, Kellerman has classified followers into five categories according to their level of engagement, from detached ‘isolates’ and neutral ‘bystanders’ to active ‘participants’, full-blown ‘activists’ and committed ‘diehards’ (see box 3).

According to Kellerman, isolates and bystanders go largely ignored but they are the ones who make bad leadership possible. Through their passivity and indifference, they implicitly support those in positions of power and influence and, in doing so, make it possible for bad leaders to stay in power. As we

have noted, these kinds of followers are probably over-represented among doctors, a point to which we return in the final section because they are so critical to achieving organisational change in the Service. On the other hand, Kellerman argues that, depending on the ends they and the organisation pursue, participants, activists and diehards are more likely to be good followers, so providing the energy and resources for distributed leadership. As the work of Buchanan et al illustrate, good followers are in some way involved in the groups and organisations of which they are members. Good followers also support effective and ethical leader, but oppose as far as they reasonably can, or provide a check on ineffective or unethical leaders.

A Transformed Management 2.0

This last point about ethicality leads us nicely into recent calls for a transformed management 2.0. Hamel and Birkinshaw from London Business School organised conference in 2008 for an invited group of thirty five leading management scholars and practitioners at Half Moon Bay, California in May

Box 3. Kellerman's Classification of Followers (Kellerman, 2008)

Isolates – Isolates are completely detached, scarcely aware of what is going on around them and do not care about leaders or respond to them. However, by being passive they provide tacit support to status quo.

Bystanders – Bystanders disengage from the organization, watching from the sidelines almost as an observer. They go along passively but they offer little active support.

Participants – Participants care about the organization and try to make an impact. If they agree with the leader they will support them. If they disagree, they will oppose them.

Activists – Activists feel more strongly about their organizations and leaders and act accordingly. When supportive, they are eager, energetic, and engaged.

Diehards – Diehards are passionate about an idea a person or both and will give all for them. When they consider something worthy, they becomes dedicated.

Box 4. The Ten Most Important 'Moonshots' (adapted from Hamel, 2009)

- 1 Ensure that the work of management serves a higher purpose – companies need to articulate a purpose beyond making money.
- 2 Fully embed the ideas of community and citizenship in management systems
- 3 Reconstruct management's philosophical foundations to be adaptable, innovative, inspiring and socially responsible, as well as operationally excellent
- 4 Eliminate the problems created by hierarchy, including privileging experience over new ideas, giving followers no influence over their leaders and undermining the self-worth of individuals
- 5 Reduce fear and increase trust to increase commitment, remove a fear of failure and promote knowledge sharing
- 6 Reinvent the means of control to encourage innovation as well as risk management
- 7 Redefine the work of leadership so that they are not seen as grand visionaries, all-seeing decision-makers and disciplinarians to become architects and facilitators of employee collaboration
- 8 Expand and exploit diversity to increase the variety of ideas, options and experiments in organizations
- 9 Reinvent strategy-making as an emergent and option-laden process rather than top down, one-size fits all plan
- 10 De-structure and disaggregate the organization to remove barriers to innovation, personal fiefdoms and to create fast-moving, reconfigurable structures that can intercept opportunities and reflect dynamic environments

2008. Participants created an ambitious agenda for management innovation in the face of increasing criticism of leadership and management teams who helped cause the recent financial services-led crisis. This agenda resulted in a need to 're-orient management from compliance to creativity, from flogging efficiencies out of existing resources to generating new ones', from zero sum management to positive sum games. In short, the call was for management 2.0 to focus on innovation, employees and other stakeholders rather than on costs and shareholders.

What management 2.0 looks like is detailed in an HBR article by Hamel (2009) resulting from the Half Moon Bay conference. The consensus was that organisations needed to articulate a purpose beyond making money, to ensure distributed leadership and strategy-making rather than the traditional top-down model, fostering community and citizenship and building trust. None of these ideas are new and speak to the legitimacy dimension of the corporate reputations agenda that has also been a sub-text of many courses taught in business schools, but one that has been relatively muted until Enron. So what do companies that seek to embrace management 2.0 have in common? Twenty-five ideas were proposed with a general consensus that the first ten were the most important (see Box 4).

Conclusions: Possibilities and Problems

From the above discussion, there seems to be an emerging consensus of opinion among practitioners and leading academics on the need for a new leadership 2.0, rather than management 2.0, combining the ideas of distributed leadership, responsible followership and exhortations for more innovative, ethical, people-centred and stakeholder-centred organisational architecture and management. These seem to be laudable aspirations, appear rational in the light of longstanding health sector problems, have some basis in evidence, and, importantly, reflect the contemporary private and public sector zeitgeist following the reputation ‘spillover’ from bad leadership during the financial services crisis.

Yet, there are unresolved issues surrounding these ideas, especially when governments need to hold senior leaders accountable to the public and have them take ownership for problems they believe they are paid good money to solve. The first is the still rather nebulous notion of distributed leadership, which was recently the subject of a symposium at the British Academy of Management (Sept, 2009). At this session, all speakers criticised the concept for its vagueness in meaning what you want it to mean. The most important conclusion from the discussion was that distributed leadership is sometimes used as rhetoric to draw attention to some problems but to hide others. This last issue was re-visited a number of times, often formulated in the question: was distributed leadership a rhetorical device used by leaders to avoid ownership of problem and deflect blame?

This notion of distributed leadership as rhetoric helps us understand an underlying problem with the leadership agenda generally and distributed leadership in particular, for there is little doubt that some groups of staff think rhetoric rather than reality is characteristic of much leadership activity in healthcare, and helps

explain why doctors in particular are reluctant to become involved in management. This underlying problem lies in the common assumption of all three solutions discussed in the previous section is that they are rooted in unrealistic *unitary* organisational assumptions – that healthcare is essentially characterised by a common cause and common spirit (‘we’re all in it together, kicking into the same goal’), that different interests and conflict are essentially unnatural, and that problems arising in healthcare are open to solutions such as enlightened leadership and sophisticated human resource management or, when it is clear that people are making mischief, a dose of directive leadership. This turn to unitary assumptions about how organisations really are (or, more likely, how they should be) became part of the political and business culture in the 1980s in Thatcher’s Britain, when leadership first appeared on the agenda in business schools and private sector organisations (until then, no one really spoke about leadership seriously). Yet, these assumptions have not really been part of the history and culture of healthcare management, except perhaps for a short while following the introduction of ‘managerialism’ as part of reforms in the 1980s, which were really an attempt to re-engineer the culture of healthcare organisations. Nor are these unitary assumptions perceived to hold true in the experience of most staff, certainly as measured by the data we cited at the beginning of this paper.

So, perhaps a more realistic starting point might be to assume pluralism still forms the bedrock of healthcare – perhaps a dirty word these days, but one that better characterises many healthcare organisations, as arenas of naturally competing but legitimate interests, which can only be resolved when everyone gets something of their aims through mutual accommodation. Thus professional and non-professional staff will typically follow their legitimate interests, inevitably conflicting with those of managers

and other groups from time to time, especially when governments and managers seek to get more for less or to reduce their power, status or autonomy.

Old fashioned pluralism became a tainted philosophy because governments and leaders implicitly and explicitly believed that strong professions, while good for professionals and perhaps good for patients in the short run, may be the cause of the ‘British Disease’ as applied to healthcare – low pay for the many and lower levels of productivity than could be reasonably expected given the unit of resource invested, and of less-than-rational organisational solutions and institutions which are designed to further the interests of powerful professions more than the corporate or public good. These beliefs, no doubt, underpin the long term strategy, whether planned or emergent, intended or unintended, to reduce the power and autonomy of hospital consultants and influence of large hospitals, the latter of which serve the interests of powerful professionals at the expense of patients and those whose job it is to control resources. Seen in this light, unitary solutions to pluralist cultures will always find difficulty in working because of the shaky bedrock on which they attempt to construct elaborate but unsustainable structures of control. There is little wonder that many professionals are reluctant to become incorporated by crude attempts at unitarism, with its hearts and minds campaigns, ‘cult’ of the customer, and unreflective human resource management and organisational development, often borrowed wholesale from industries such as food retailing and financial services. Doctors, in particular, are reluctant to cross the line in the sand between management and clinical work, especially when there is little incentive to do so and, often, a greater incentive to remain a loyal (or disloyal) opposition to put the interests of patients (or even themselves) first.

Credibility, authenticity and sustainability are only achieved through meaningful and prolonged involvement with clinical professionals and other staff, which is a message that any rhetoric of a new leadership 2.0 should send out.

So, let’s assume pluralism is a better, though less optimistic and fashionable, story to work with, as evidenced by current and repeated low levels of engagement from various studies. Let’s also assume, we’ve tried sophisticated HR and its ‘stablemate’, transformational leadership, only to find them wanting because the more things change, the more they stay the same. Admittedly, to use the football vernacular, this is a big ask for management professions and interest groups which have grown substantially in numbers and influence on the back of unitarism. What, then, can be done? The classic pluralist dictum going way back into time to the 1960s is that managers ‘can only regain control by sharing control’, wisdom that rather takes us back to a form of partnership working which involves all professions, most importantly senior clinicians and other disengaged professionals in whom the public trusts more than managers to look after their interests. This partnership would need to be supported by a model of distributed leadership not only concerned with sharing the cake and disseminating the rhetoric of the wisdom of crowds, responsible followership and management 2.0, but also backed by significant attempts to give doctors and other professionals an important say in designing the cake to increase as far as possible its size – what we used to know as integrative bargaining. It would also mean that professionals need even greater encouragement, job resources and the removal of micro and macro political blockages to become more engaged in their work and with each other. High quality education with

prestigious qualifications in clinical leadership may be one such incentive to encourage more doctors and other senior clinicians into management. Creating the opportunities to influence policy, resource allocation and to face up to wicked problems, however, will always be necessary to make use of their education, help them develop into responsible followers and, eventually leaders 2.0.

If, as is likely, healthcare organisations are unable to buy into unreconstructed pluralism – a ‘we’ve come too far to turn back’ mentality – or even if they could and would, above all else senior leaders need to send out honest signals about their intentions, problems and attitudes to distributed leadership, including signals that also point out to isolates and bystanders the consequences of their inaction. Signalling theory as applied to leadership has as its central concern the honesty of signals, especially as interpreted by receivers, the costs associated with communicating honestly, and the possibility of faking honesty. For leaders’ signals to be perceived as honest by receivers, they need to appeal to novelty, credibility and authenticity, and sustainability (Van Riel, 2003). The more staff see these qualities in senior leaders’ signals, the more likely they are to buy into the messages of change. Novelty is important to make employees feel distinctive from others, an inevitable element in professional competition, which, however, provides a built-in incentive to fake honesty in the form of a rhetoric-reality gap. Credibility, authenticity and sustainability are necessary to create feelings of legitimacy among staff. By legitimacy, I’m referring to the beliefs their employers are interested in higher values rather than treating them as hired hands, focused on patient and public value, and trusting and valuing their staff to deliver these. I’m also referring to legitimacy in the sense that the potential employees buy into this message rather than the weak and mixed signals that seem to characterise the image of healthcare as an employer in the labour market.

Credibility, authenticity and sustainability are only achieved through meaningful and prolonged involvement with clinical professionals and other staff, which is a message that any rhetoric of a new leadership 2.0 should send out. Nevertheless, they may come at a cost, which may mean relinquishing control over official corporate communications channels, in which employees have less faith. Research has shown that many people have turned to the internet and Web 2.0 for credible information about prospective employers and, indeed, their own employers, especially from employee blogs and employee social networking sites (Martin, Reddington & Kneafsey, 2009). The costs of signalling are also high when the signals are of strategic importance and often bound up with major handicaps, such as a previous track record of dishonesty, faking or communicating weak and inconsistent messages. Luckily, honest signals are not always so costly, especially if there is a convergence of interests between the signaller and receiver. This can happen when key employees clearly understand that their interests are intimately bound up with those of organisations, or if leaders find them hard-to-fake (because of the existence of an informed opposition), or impose high costs on dishonest leadership (which is currently the case in healthcare). So, for senior leadership teams in healthcare to be seen as honest, which as I have argued has major implications for all levels of engagement and through it valuable patient and public outcomes, they need to think about re-imaging or re-branding themselves to take into account all or some of these ideas – perhaps starting with some serious reflections by managers themselves. However, those professionals who remain isolates or bystanders are also culpable, and the lessons of responsible followership may need to be aired and be pressed home more forcibly.

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- Endnote 1. For example, our own recent but as yet unpublished research suggests that the healthcare sector in Scotland has a relatively weak overall image as a potential employer among further education students and experienced postgraduate management and science students.

Employment and Skills in the UK

Bryan Stoten

Chairman, NHS Confederation

The headline reads:

“Health: NHS Staff in Crisis – the NHS is facing serious difficulties because it is failing to retain staff.”

The article continues: “A report suggests that more than three-quarters of all hospitals are struggling to keep and recruit nurses and midwives at all levels. The problem is worse for basic rate nurses and specialists in intensive care and care of the elderly. 82 per cent of hospitals are having problems in finding experienced occupational therapists and physiotherapists.

“The government has already pledged to recruit an extra 15,000 nurses and increase by 6,000 the number of training places, but the Conservatives question where these extra nurses come from.”

The NHS Confederation, which wrote the report, went on to attribute the cause of this crisis to “overall workforce shortage, lack of career opportunities, difficult working conditions, a feeling of continuous change, increasingly difficult and growing workloads and a feeling that NHS professions are undervalued”.

The tone of ‘Crisis in the NHS’ is familiar but the date of the news report is 17 September 1998. Since then the Health Service has increased its spending by 40 per cent in real terms and increased the number of nursing staff by 80,000.

Now the McKinsey Management Consultancy recommends to the Secretary of State for Health that the NHS should slash its workforce by around 10 per cent or 137,000 staff.

Well a decade is a long time in the NHS.

When we wrote *‘Falling School Roles and the Management of Teachers’* we were only too aware of the falling birth rate. The ‘demographic time bomb’ we predicted, would go off shortly and leave public services denuded of staff whilst the commercial sector would be forced to rely on immigrant labour to continue to trade.

Yet it seems the apocalypse never happened. As then so now I would enter a plea for a little calm. It could be argued that as a society we over-educate and over-train our workforce. Whilst that is an unfashionable and unpopular view nonetheless it is the case that we do have 250,000 qualified nurses and 100,000 doctors in the community but not practicing their skills in the NHS. That is true of other professional groups also.

The availability of skill, when it is needed, is likely to be far more flexible than our media or indeed our advisers and consultants choose to suggest.

The fact that the NHS seems to be constantly on a media precipice informed by the twin myths of low pay and staff shortage is however based on little evidence.

Whilst it is the case that in local circumstances significant numbers of staff may need to be recruited or indeed reduced, in reality where such circumstances arise the wider health economy appears able to absorb surpluses or indeed make up shortfalls. Overall staffing numbers, despite the much reduced birth rate, have steadily increased in the NHS specifically and in the public sector generally. Indeed by the middle of last year 29.6m people were in work across the UK, close to the highest figure on record.

Rather our interest here is in three rather different issues:

1. Over the next 10 years the demand for the provision of healthcare is likely to change in fundamental ways:

- High technology specialities, especially those associated with neurosciences, orthopaedics, endocrinology and cancers will become more concentrated in large units able to access significant technical support. They will need to be associated with medical schools characterised by their own commitment to research and development activities. In large part they will become the primary provider of inpatient facilities, offering major trauma, major invasive surgery, providing a high technology hub for diagnostics and imaging

- General hospital care, especially offering day surgery, diagnostics and imaging linked to a major tertiary centre but with restricted inpatient facilities, will form a secondary care penumbra around the tertiary centres while
- Lord Darzi's vision of primary care will, in large measure, be realised with increasingly specialised General Practitioners whose continuing professional development will be geared to the speciality research of their local medical school with increasingly sophisticated but non-medically qualified clinical staff working out of a facility offering minor surgery and scanning facilities linked to the specialist diagnostic skills available in the regional tertiary centres. Serving populations between 25,000 - 50,000, these 'bed-less' hospitals will increasingly be able to offer the bulk of non invasive care
- The inevitable consequence of the fiscal crisis confronting public sector funding over at least the next half decade will open the minds of healthcare policy makers to the views of health economists who are now forensically able to identify the benefits to be derived from significant health innovations and medical developments. The focus of decision making will shift from the individualised considerations of NICE determining the viability or otherwise of high value clinical interventions for a handful of patients toward the fundamental re-examination of the balance of healthcare investment. This investment is confronted with the huge downscaling of CHD morbidity as against the increasing burden of the chronic diseases of diabetes, dementia, COPD etc.

This shift of focus may be helped by the early findings, following the introduction of the Smokefree Workplace and Public Places legislation showing – on the face of it – a significant reduction in heart attacks and demand for coronary care.

2. Those processes will lead inexorably toward a service unable to resist the logic behind Derek Wanless' 'fully engaged scenario' and the current commitment expressed by the Secretary of State that prevention strategies must be moved to the heart of any national health strategy away from the shadows of good intentions and marginal funding. This shift of focus may be helped by the early findings, following the introduction of the Smokefree Workplace and Public Places legislation showing – on the face of it – a significant reduction in heart attacks and demand for coronary care.
3. From 2011 onward, for at least half a decade, the labour force in general and the healthcare system in particular will experience the loss of the baby boomers, currently making up the senior levels of nursing, medicine and general management. This process coming at the same time as a downward pressure on public service spending while appearing fortuitous will require a fundamental shift in the delivery of healthcare. The process will occur, of course, alongside the re-emergence of large numbers of unemployed but generally poorly skilled benefit claimants of working years. Despite calls to roll back the consequences of Project 2000 in nursing education and to re-establish the role of the matron in hospital management the reality will look very different. Scarce, highly skilled experience will need to be eked out in the most efficient and

effective manner. The skill mix which extends from the highest levels of medical sophistication through to basic levels of housekeeping and empathetic care will need to be calibrated with much greater attention to maximising the value to be derived from staff highly skilled but scarce on the one hand and semi or unskilled but more plentiful on the other. It will be necessary to bring in to work experience people of working age who find themselves in the second or even third generation of non-employment. That will undoubtedly take us down one route or another which parallels the Welfare to Work schemes developed under the Clinton administration in the US.

None of these changes can occur without state organisation at a time when the demand for a smaller state will be vociferously expressed. Whilst such demands may result in a reduction in the services provided through the public sector they will not be likely to emerge simply through the dynamic of the marketplace. The role of the public sector as planner, organiser and facilitator cannot be ignored although the necessity of the state taking on the role of provider may well diminish. That itself however will require a fundamental change in political culture. It will no longer be sufficient to boast about how much of taxpayers' money has been reinvested in creating jobs and extending services and benefits. Raising and spending public money has always been the easy part – and, the evidence suggests, the unproductive part too. Using the public sector rather to plan and organise for those things that can be done collectively rather than individually is both more difficult and potentially more rewarding. Adjusting to that new role, however, will be challenge enough for the next episode in the development of the NHS.

So we have significant changes in our employment environment:

- The post-war baby boomers will disproportionately reduce the public sector workforce at precisely the moment when public spending will also experience cuts
- The demand for specialists rather than generalists will require greater investment in continuing professional development of high quality
- The fall in the working age population will force recruitment and the development of the social care skills of a section of the population with limited cultural experience of such employment. The potential workers are going to be an unaffordable burden on a benefit system under pressure. Their numbers, however, are required to address the burden of an ever falling ratio in the population between carers and cared for.

Flexibility in the retirement age will help, though the high salaries of the most senior staff will be unwelcome in a period of financial restraint. Part-time working with appropriate pension protection may resolve this difficulty.

The enhanced role of professional accreditation already underway will allow for greater enhancement of traditional CPD programmes.

Flexibility in the retirement age will help, though the high salaries of the most senior staff will be unwelcome in a period of financial restraint. Part-time working with appropriate pension protection may resolve this difficulty.

But most challenging will be the development of measures to encourage both the work ethic and caring facility required by an expanding aged population whose personal income is diminished and whose social care support is likely to be limited. Nonetheless across the NHS, schemes for the long term jobless have shown successful results. The NSVQ schemes offering qualifications, for the first time, to workless claimants have successfully found employment for 80 per cent with appropriate training. The necessity is there and the demand will only grow.

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In 2004 he was awarded a CBE for his services to the National Health Service.

Candace Imison

Candace Imison is Deputy Director of Policy at The King's Fund. She came to The King's Fund from the NHS where she was Director of Strategy in a large acute trust. Candace previously worked on strategy at the Department of Health between 2000 and 2006. While at the Department of Health Candace worked extensively on workforce issues including leading the workforce strand for the Wanless review and leading a workforce modernisation programme, Hospital at Night. More recently she has led the King's Fund contribution to the Royal College of Physicians work on the future doctor and is about to publish a report for The King's Fund on the future of workforce planning.

Graeme Martin

Graeme is Director of the Centre for Reputation Management through People (CRMP) in the Department of Management at the University of Glasgow, where he is also course director for the Masters in Clinical Leadership run in conjunction with the Royal College of Physicians and Surgeons of Glasgow. He also teaches and holds visiting appointments in Sweden, the USA, Italy and Australia, is a member of the scientific committee of IDRAC business school in Lyon, and has been instrumental in recently establishing a Centre for Employer Branding and Reputation Management at Peking University jointly with the University of Glasgow. Graeme has undertaken a number of projects for the NHS in Scotland and regularly works with senior managers and directors in the Scottish health boards.

Bryan Stoten

Bryan Stoten is Chairman of the NHS Confederation, Chairman of NHS Warwickshire and Director of the Tobacco Control Collaborating Centre. He worked at the Health Services Management Centre and the Institute of Local Government Studies at the University of Birmingham and is Chief Executive of PMA, an independent public health research organisation.



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