

**The impact of workforce flexibility on the  
costs and outcomes of older peoples'  
services:**

*A policy and literature review*

**August 2006**

Prepared by

*Susan Nancarrow, Anna Moran, Alan Borthwick, James Buchan*

Project team (alphabetical order)

*James Buchan, Simon Dixon , Pamela Enderby , Caroline Mitchell, Anna Moran, Susan Nancarrow, Stuart Parker*

© 2006 SchARR (Sheffield School of Health and Related Research), University of Sheffield

ISBN 1 900752 56 5

Published by the School of Health and Related Research, University of Sheffield

SchARR Report Series No: 01/1

## **Acknowledgements**

We would like to thank the members of our executive steering committee for their advice and input;

Jayne Andrew, Rosalyn Eve, Frances Evesham, Nigel Mathers,  
Gillian Parker, Bhanu Ramaswamy, Fiona Shield, Bonnie Sibbald,  
Jan Stevenson.

Address for correspondence

Dr Susan Nancarrow  
Trent RDSU  
University of Sheffield  
ICOSS Building  
219 Portobello  
Sheffield  
S1 4DP  
[s.nancarrow@sheffield.ac.uk](mailto:s.nancarrow@sheffield.ac.uk)

# Executive summary

## ***Purpose and approach***

The purpose of this review is to;

- Examine the key policies and other factors impacting on workforce change in Community and Intermediate Care Services (CAICS) for older people.
- Develop a model that describes older peoples' community and intermediate care services given the complexity of the interventions
- Examine extent and impact of workforce change resulting from policies
- Examine impact of and relationship between a range of organisational structures on service and user outcomes.

The review has been structured into six chapters to address these goals:

- Chapter 1 presents the purpose of and approach to the review
- Chapter 2 explores the policies that have impacted on workforce change
- Chapter 3 describes the history and sociology of the professions and the socio-historic factors leading to the current configuration of the workforce
- Chapter 4 reviews the literature on workforce change. The first section is a review of reviews around workforce issues. The second section specifically examines the key issues that are pertinent to intermediate care.
- Chapter 5 systematically explores the components of intermediate care to present a framework for the evaluation and comparison of intermediate care services
- Chapter 6 concludes the review and provides recommendations.

Because of the complexity of the questions being asked within each of the chapters, each one uses a different methodology to address the specific questions. The methodologies are embedded within the respective chapters.

The key findings are as follows;

## ***Key policies that have impacted on the workforce***

The modernisation of health and social care following the 1997 general election stipulated the need for high quality, person centred care that extended across health and social care boundaries. The goals, together with the size of investment required in both capital and human resources, were expressed within the NHS Plan <sup>1</sup> with the details of service improvement at specialty level, set out in the National Service Frameworks <sup>2,3</sup>. These documents emphasised the need for and outlined systems that would support:

- *User centred care* where service user needs and opinions are central to the organisation and delivery of care.
- *Patient choice* whereby patients may choose from a 'national menu' of services provided by a choice network of providers nationally and locally.
- *Health focussed* service delivery that engages people in living healthier lives

- *Quality care* through introduction of national guidelines and frameworks, clinical governance and best practice, excellence bodies such as NICE and SCIE, amalgamated regulatory bodies such as the General Social Care Council and the Council for Regulation of Healthcare Professions, enhanced access to education and training and new methods of education and training such as Inter-professional Education.
- *Timely access* through set targets such as the 4 hour Accident and Emergency turnover time.
- *Efficiency and sustainability* through new financing mechanisms such as payment by results, structural changes such as creating Primary Care and Foundation Trusts and commissioning changes such as primary care Practice Based Commissioning and joint ventures with the independent sector.
- *Care closer to home* through shifting of resources and expertise to Primary Care Trusts.
- *Partnership working* through legislation enabling local authorities and health authorities to share resources <sup>1 4 5</sup>.

Specifically, the modernisation reforms impacted on Older People's services through:

- Targeting ageism;
- The introduction of 'intermediate care' which supports older people through their illness trajectory by integrating and utilising services as identified by patient needs <sup>6-8</sup>;
- Legislation enabling health and social care partnerships to form and share resources to deliver intermediate care and to encourage more seamless care for older people <sup>4 9</sup>;
- Targeting and improving the management of long term conditions and those with complex needs through 'Expert Patient' roles, improved access to multidisciplinary rehabilitative support from health and social care and through the introduction of the community matron role <sup>3 10 11</sup>.

Policy that has targeted the NHS workforce encompasses a range of themes which include:

- *Increasing staffing numbers* through increasing undergraduate training places, international recruitment strategies, attracting new staff into the NHS and encouraging return to practice non-practicing staff <sup>1 12 13</sup>;
- *Improving staff retention* through new career pathways, pay systems and the working lives standard<sup>14-18</sup>;
- *Introducing new roles* such as assistant practitioners, consultant therapists and support workers in intermediate care through the changing workforce programme, accelerated development programme and the national practitioner programme <sup>1 19-21</sup>;
- Developing *new ways of working* such as role sharing and blurring of professional boundaries <sup>1 20-22</sup>;
- Improving *workforce planning* through communication with education bodies, introduction of workforce confederations and workforce care group teams <sup>1 10 15 23-26</sup>; and
- Improving the *quality of the workforce* through greater access to training, education & continuing professional development, introducing more rigorous clinical governance and professional regulation <sup>1 4 10 27-35</sup>.

## ***The history and sociology of the professions***

This section of the review highlights the importance of the historical development of the professions and the relationship between different professional groups. It also reinforces the socially constructed nature of the professions. In particular it highlights the social and historical constructions of the workforce, rather than being based on any form of 'evidence'.

- Health care division of labour is shaped by the relationship between professional groups and the state, and between the different professions themselves.
- Medicine has been pre-eminent in the health care division of labour. It was the first health care profession to enter into a partnership with the state placing it in an advantageous position to take ownership of newly introduced technologies (such as anaesthetics and antibiotics), as well as being able to take an important role in shaping the other health care professions as they evolved within the health care division of labour.
- There are different theories about the nature of professionalism. Much of the recent theory paints the professions as opportunistic and even predatory groups whose aim is to ensure that they are able to take on high status work, whilst preventing encroachment on their task domains by other professional groups. Additionally, professions have had to respond to changing circumstances and ensure that they are in advantageous position with respect to other professional groups.
- The model of 'professional closure' describes the way that the professions have attempted to control their task domains and role boundaries within the health care division of labour. Larson (1977) describes the 'professional project' in which the professions as constantly seeking to establish and maintain a 'market monopoly, social status and work autonomy'. However, this is at odds with recent government policy which aims to increase role flexibility, and recognise and reward individuals' skills and competencies rather than professional titles.
- The reinforcement of professional roles requires the support of 'powerful elites', predominantly the government, through the provision of protective licensing and legislation which stops rival professions undertaking these tasks. However professional roles are also reinforced through organisations, employers, other professional groups and the public.
- Professions have, until relatively recently, been given the privileges of autonomy, ability to regulate themselves, and in some cases, high pay, in return for offering their skills and knowledge to society.
- However, the traditional models of professionalism have faced a number of challenges recently. The introduction of managerialism, or New Public Management has reduced the importance of the special relationship between the professions and the government, replacing it with new systems of accountability, such as clinical governance, which examine individual performance. Accountability is moving from an implicit model of collective governance to explicit forms of demonstrating individual accountability. The new general practice and consultant contracts are one example of this change.
- The government has actively introduced a number of mechanisms which undermine medical dominance including non –medical prescribing; extended scope practitioners; the new consultant contracts; nurse-led walk in centres;

European working time directives; proposals to introduce physician assistants; and nurse practitioners.

- Increasingly informed consumers are also challenging traditional models of health care delivery, such as the new models of the 'expert patient' and NHS direct.
- The health care workforce is currently undergoing unprecedented change. It is not clear how these changes will impact on the future workforce or the structures and hierarchies within the workforce.
- Despite the growing evidence of workforce change, it still appears that professional hierarchies exist. Those practitioners with extended roles have not gained the status or rewards that were traditionally attached to those tasks. For instance, non-medical prescribers do not have the status or income of doctors, the traditional gatekeepers of prescribing.

## ***Workforce change – the evidence base and relevance to intermediate care***

This chapter is presented in two sections. The first presents a review of systematic reviews on the evidence underpinning health workforce change generally. The second section examines the literature around workforce and staffing that has arisen specifically from intermediate care services.

### Section 1:

The majority of the evidence around staffing relates to nurse and care assistant, or nurse – physician substitution. Little of the existing evidence can be clearly translated into community based, multidisciplinary, intermediate care services.

There are a number of drivers for workforce change including skills shortages; productivity improvements; cost containment; quality improvement; technological innovation; and health sector reform.

The main approaches to introducing workforce changes include:

- skill substitution (eg doctor – nurse, qualified health professional – care assistant);
- role extension for existing practitioners (eg consultant nurses and allied health professionals, extended scope practitioners) and
- the introduction of new types of workers

Additionally, informal workers, such as carers and volunteers are widely used, however little is known about their effectiveness.

The evidence base underpinning each of these approaches is variable, and in some cases contradictory. This is confounded by the use of a range of different outcome measures and experimental techniques. Additionally, many staffing and skills mix studies utilise routinely collected indicators (eg length of stay, bed occupancy rates, mortality rates), and the majority are collected in secondary care projects. Thus, the current scope for evidence based evaluation of workforce change in community and intermediate care services is less advanced than secondary care projects.

### Section 2:

Of 391 papers identified in the search around staffing in intermediate care, 91 papers were found to be relevant for this section. Of these, the majority are descriptive or position statements. A small number of surveys and audit data are available. No hierarchy of evidence was employed due to the paucity of experimental data. The key findings are;

- There is evidence of new roles within intermediate care, particularly the growth of support worker roles.
- There has been growth in the roles of support workers in these settings. Support workers undertake a variety of tasks which seem to be dictated by the team structure and purpose.
- The majority of intermediate care teams are multidisciplinary, and there is some documented role overlap in intermediate care settings.
- There are roles for the voluntary, private and social care sectors in delivering intermediate care, although the impact of these roles on services users is yet to be explored.

### ***Defining intermediate care***

Intermediate care is heterogeneous group of services which form part of a complex system of health care delivery. The literature points to highly different constructions in the ways of delivering these types of care, yet there are few studies evaluating intermediate care that are considered to be 'good quality' in the traditional sense of an RCT. Those that do exist point to few measurable differences in outcomes between the 'usual' models of care and the intermediate care service.

The lack of standard definitions or classifications of intermediate care services makes it difficult to compare services and / or outcomes. Existing intermediate care taxonomies incorporate a combination of purposes, functions and structures, yet within these taxonomies, there is little to unite the services in terms of a range of service attributes, which means that they have little value as a basis for analysis or comparison.

The purpose of this chapter was to provide a framework which identifies the key domains of service delivery and organisation which may impact on the outcomes of the service. The framework will also provide a basis for comparison of services and to help guide service commissioning and development. We propose that all intermediate care evaluations should describe, in detail, their context in a comparable way, so that other services can learn from and / or apply the findings from these studies.

We utilised a qualitative (template) approach to explore the way that intermediate care services have been described across 17 key documents, evaluations and reports to develop a service description template.

The six domains that describe intermediate care services are;

1. Context
2. Reason for the service
3. Service users
4. Access to the service
5. Service structure
6. The organisation of care

The **context** refers to the social, political and organisational setting in which the intermediate care service is delivered and provided; for instance, services have different funding bodies; serve different types of populations (eg urban or rural); may be hosted by a range of different types of trusts.

The **reason for the service** refers to the justification behind the introduction of the various intermediate care services, such as 'bed blocking' and unmet needs of the community.

The **service users** refer to the actual or potential users of the intermediate care services and were defined by services in three ways; the socio-demographic and medical profile of the client group; Target population for the service; and individual service user needs

**Access to services** includes the pathways used by the service user to access the intermediate care service, as well as the eligibility criteria used by the service to regulate entry to the service. Access is described in terms of the referral source; access point or system; patient eligibility criteria; and patient exclusion criteria.

The **service structure** refers to the actual operational and organisational details of each individual service. The service structure and organisation and includes the setting or location of care; setting; staffing; average or target duration of input; professional lead and team organisation.

The **organisation of care** refers to the components that go together to make up the individual intervention from the perspective of the client or patient and includes the actual intervention; duration of individual client input; organisation of input; and intensity of input.

These domains form the basis of a template for service comparison and evaluation which is provided in Chapter 5 of the report.

## ***Conclusions***

Intermediate care staffing changes are taking place in a wider context of workforce change and evolution, and new ways and philosophies of delivering care. The current policy initiatives aim to improve health service capacity and productivity with a view to achieving measurable outputs. Increasing workforce efficiency has been a primary focus of the policy agenda. The implications for the workforce are still emerging, and include substantial changes to existing roles, the introduction of a range of new roles, and currently, redundancies for staff in a number of trusts.

Most of the literature on workforce substitution reinforces the notion that certain occupations have jurisdiction over particular tasks (and in some cases, over other professions). However, these jurisdictions are almost solely obtained through political influence and social positioning, not through research evidence that these practitioners are the best people to do the job. Agenda for Change, and the Skills for Health Competency Frameworks have attempted to alter this approach so that rewards are competency, not strictly profession based.



Yet 'good' research attempts to use positivist approaches to demonstrate whether one type of practitioner can effectively substitute or delegate roles to another type of worker to achieve an equal or better outcome. Alternative research methods are required to demonstrate workforce effectiveness and recognise that changes to the workforce configuration are dealing with a range of complex variables which include:

- The best evidence about the way to perform a particular intervention (which is largely non-existent);
- The competencies, skills and knowledge necessary to perform or deliver those interventions;
- An appreciation of the social and political boundaries that prevent particular groups from either performing a particular intervention or developing competencies that may be seen as the 'turf' of another professional group;
- The organisational setting or context in which the workforce change occurs.

The majority of existing workforce studies are unidisciplinary, or focus on the relationship between two different types of workers. However, intermediate care services are largely multidisciplinary. Therefore it is difficult to directly translate the findings of the existing research into intermediate care services.

Intermediate care is complex group of heterogeneous services involving many different agencies, staff and organisations. The wide variations between services makes service classification, and therefore comparison difficult. Yet despite enormous variations in models of intermediate care services, there are few clearly measurable differences in outcome between different types of services. This may indicate that the outcomes measures used in intermediate care evaluations are not appropriate, or not sensitive to change between different types of interventions. Alternatively, it may indicate that despite the diversity in the ways of delivering care, the outcomes are largely similar.

There is little empirical evidence available to support the best way of staffing or organising an intermediate care service.

## ***Recommendations***

There is insufficient evidence to draw firm conclusions about the contribution of different staffing models to patient, staff and service outcomes in community and intermediate care services for older people.

There is a need to replicate workforce studies that have been undertaken in secondary care settings which have involved multivariate analysis on components of care (including staffing) and compare these with a range of patient, staff and service outcomes.

There is a need for more descriptive contextual information on studies investigating intermediate care services to facilitate comparison and description.

Research is required which provides an understanding of the input of whole team roles, rather than necessarily the contribution of individual practitioners.

Further research is required about the roles and contribution of different types of practitioners in intermediate care, and the impact of different models of skill mix on intermediate care services.

Local evaluations are valuable in understanding the context of the workforce dynamics in intermediate care, however there is a need for large scale, comparative studies to explore the impact of a range of variables on patient, staff and service outcomes (including costs).

The routine collection of outcome measures or indicators, similar to those used in secondary care studies, would facilitate more straightforward evaluation of the impact of different service changes (such as workforce changes).