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Shaping a vision for a ‘New Generation’ workforce

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Introduction

Putting patients and carers at the heart of a modernised service is a key objective of the Government’s agenda for reforming health and social care. This will mean providing services in which the divisions and demarcations between professions are set aside in the face of the overwhelming need to work differently and collaboratively in the interests of the patient.

A dramatic shift in the scale of skill mix changes will need to take place if the Government’s vision for NHS and social care is to be realised. This paper explores some of the issues surrounding the shaping of a vision for a new generation workforce. Key to this vision are the principles of learning together and developing new educational pathways and routes for new role configurations. Learning together in both the pre qualifying stage of professional education and subsequently is taken as crucial to opening up the potential for future workforce modernisation. The answer does not lie in multi-professional learning in which large numbers of students are taught together in the same space or about the same topic without necessarily learning with or about each other. The emphasis must instead be placed on interprofessional learning, in which professionals learn with and from each other in order to enhance collaborative working.

This paper explores the policy context for educational and workforce reform. It draws upon the experience of establishing the New Generation Project to illustrate the potential for achieving radical reforms of education programmes that place interprofessional learning at their core. It suggests that educational reforms must be part of whole-systems-change rather than simply add-ons to existing programmes. Our recommendations focus upon the roles of Workforce Development Confederations in leading reform and address the implications for the regulation of the health and social care workforce that begin to emerge from changes in roles and skills-mix.

1 The New Generation Project is a partnership between the University of Southampton, the University of Portsmouth and the Hampshire & Isle of Wight Workforce Development Confederation. The Partnership reaches across ten health and social care professional programmes; three faculties; two universities, and the health and social care organisations that support student learning in practice. In January 2002 the Project was identified as one of the four Department of Health leading edge sites for taking forward common learning.
Policy context: the need for change

The reform agenda

The United Kingdom (UK) health care system has undergone marked structural changes over the past twenty years. The development of a primary care led NHS, the introduction and subsequent removal of quasi markets and the aspirations of the NHS Plan have all raised significant challenges for the service. The demands of quality and cost drivers in both the NHS and social care have created additional pressures for providers to meet, whilst delivering on a broad range of throughput targets (Department of Health 2000a). The NHS Plan has heralded the introduction of national standards through the National Institute of Clinical Excellence (NICE), the development of local Clinical Governance arrangements and the establishment of the Commission for Health Improvement (CHI) to monitor standards. The development of an appropriate and flexible workforce is critical to the delivery of the improvements in services sought by the Government. The delivery of National Service Frameworks, Health Improvement Plans, waiting list targets and the Working Time Directive for Junior Doctors all depend upon workforce design and development.

Workforce projections

No profession can be viewed in isolation: each has a territory of practice that interconnects and often overlaps with that of other professions, managers and non-professionals. The codification of and access to knowledge and the understanding of procedures has gradually opened up provision to other professions and service providers. As such the division of labour of labour in health and social care could be seen as in a constant state of flux. The scale of the workforce challenge facing the NHS has been set out clearly in the report led by Derek Wanless on behalf of the HM Treasury ‘Securing our Future Health: Taking a Long Term View (Wanless 2001). As the report makes clear:

*Health and social care are labour intensive services. The health service employs more than 1.25 million people in the UK. Social care employs between 875,000 and 1.25 million people, depending on which staff groups are included. Combined, the health and social care sectors employ one in ten of the working population.*

Yet in the face of the projected expansion in the number of health care professionals in training there remains the fundamental need to reconsider the skill mix of the workforce in relation to patient need. Over the next two decades radical changes in health and social care roles are inevitable. Indeed they are essential if there is to be any chance of meeting the increasing demand for health care, particularly in the context of an aging population, multiple pathology, complex health and social, enduring and chronic ill health. Here again this will require that health and social care professionals to have a far greater mutual understanding and respect for each other if patient focused services are going to be delivered.

Health care teams in the future are also likely to comprise a greater variety of skill levels. It is inconceivable that the increased demand for health and social care can be met using the current skill mix. The development of Foundation Degrees, initiated by the
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Department for Education and Skills, for example, will see the emergence of an ‘intermediate professional’ in health and social care. These opportunities to provide a different range and level of services will have far-reaching implications for the scope of exiting professional territories of practice.

The Bristol Inquiry

A defining moment in creating a focus for radical change in the NHS has been the Bristol Inquiry into the deaths of children undergoing cardiac surgery at Bristol Royal Infirmary. The findings of the Inquiry, chaired by Professor Sir Ian Kennedy, have provided a strong lever for the modernisation of the NHS. In accepting the recommendations of the Kennedy Report, the Government recognised the need for a new relationship between government and the NHS and between the NHS and patients.

The Inquiry brought into stark relief the consequences of professional groups socialised into behaviour patterns and working relationships that maintained a pervasive order based on a medical hegemony. The process of socialisation had created a social order of professions which itself became resistant to questioning and change. A diversity of patient and interprofessional perspectives can often open up new possibilities for change. However, the maintenance of the status quo through persistent social norms and values often acts to *nullify the sought after advantage of diversity* (Pascal, Millemann & Gioja 2000).

The findings of the Inquiry made clear the need to ‘broaden the notion of competence’ in the preparation of health care professionals. The inquiry team suggested that

> One of the most effective ways to foster an understanding about and respect for various professional roles and the value of multi-professional teams is to expose medical and nursing students, other healthcare professionals and managers to shared education and training (Kennedy et al. 2001).

To this end they recommended that a number of pilot projects should be developed in universities to take forward the radical reform of pre registration education by bringing students from differing professions together to learn.

In its response to the Inquiry’s recommendations the Department of Health identified ‘that there should be more opportunities for different health care professions to share learning and that more emphasis should be placed upon the non-clinical aspects of care, such as communication skills, in the education, training and development of those working within the NHS’. To support this there was also a commitment to ‘improve the regulation, education and training of health care professionals’. As a result, in it’s lifelong learning strategy, ‘Working Together – Learning Together the Department committed itself to ensuring the implementation of ‘common learning’ in all pre registration programmes across all Higher Education Institutions in England by 2004 (Department of Health 2001). The Inquiry identified a range of areas that it viewed as crucially important to the care of patients, which should be reflected as a basis for common learning.
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Fig 1. Broadening the Notion of Competence: Six key areas

- Skills in communicating with patients and with colleagues;
- Education about the principles and organisation of the NHS, how care is managed, and the skills required for management;
- The development of teamwork;
- Shared learning across professional boundaries;
- Clinical audit and reflective practice; and
- Leadership

For the Inquiry, enabling undergraduate students to learn together was identified as a vital stage in creating different relationships for the future:

*Education in the areas which we have highlighted must become fully integrated into the undergraduate curricula of relevant courses. They must be much more than mere ‘add-ons’, tolerated as extraneous burdens on what some might see as the ‘real’ clinical curriculum. It is in the formative years of undergraduate education that attitudes are forged and skills imparted which shape the quality of engagement with patients for years to come.*

**The case for modernising health professional education**

From the Bristol Inquiry and the subsequent Department of Health strategy for lifelong learning (Department of Health 2001), the policy imperative to promote interprofessional and shared learning in all pre registration programmes for health care practitioners has been significantly advanced (Department of Health 2000b).

Clarity of language is important, and the definition of interprofessional education that the rest of this paper uses is that from the Centre for the Advancement of Interprofessional Education (CAIPE)

*Interprofessional education occurs when two or more professions learn with, from and about each one another to facilitate collaboration in practice. It is a subset of multiprofessional education during which professions learn side by side for whatever reason (CAIPE 1997).*

The future preparation of students should involve developing a better understanding of differing perspectives on the same world of health and social care. With this comes the potential for recognition of the respective jurisdictions of practice, developing flexibility, open-mindedness, reducing prejudice and stereotyping, building mutual respect and understanding of the common world of patient centred care. Blurring of role boundaries and recent policy initiatives including the proposed Department of Health review of the health care workforce and proposals outlined in the Agenda for Change document, all support the need for radical review of current approaches to educating health care professionals.
The New Generation Project: A whole system case study

Over the last decade the University of Southampton, and within it the Faculty of Medicine, Health and Biological Sciences, has been committed to developing a model of interprofessional learning and teaching for all health care professionals in partnership with key stakeholders. As a result of this long-term vision the New Generation Project was established in 1999. The Project has since expanded and evolved to become a partnership between the University of Southampton, the University of Portsmouth and the Hampshire & Isle of Wight Workforce Development Confederation. The Partnership reaches across ten professional programmes; three faculties; two universities, and the health and social care organisations that support student learning in practice. In January 2002 the Project was identified as one of the four national ‘leading edge sites’ for taking forward common learning.

The Project will develop a Common Learning Programme (CLP) based on external reference points, including relevant subject benchmark statements, the national qualifications frameworks for higher education and, where appropriate, the requirements of professional and statutory bodies and employers. The CLP will identify the knowledge, skills and competencies amenable to share interprofessional learning and assessment. It will be integrated into all 10 professional pre qualifying programmes within the Project. The CLP will result in every student experiencing both interprofessional and profession-specific learning in each year of their programme. This will involve radical curriculum review and culture change, enhanced delivery of innovative learning approaches and the evolution of new programme pathways and health professional outputs. It is anticipated that the New Generation model will, once well established, enable efficiency savings in education delivery and offer value-added components in relation to responsiveness, flexibility and transferability within roles and improvements in recruitment and retention.

Graduates of ‘new generation’ programmes will start to enter professional practice from 2006 onwards. It is anticipated that they will have the knowledge, skills, competences and attributes required to deal with the complexity of modern health and social care delivery, and patient/client and societal expectations. The programmes will be specifically designed to ensure that they:

- Recognise that patient/client needs must shape services
- Respect and understand the role and contribution of other professionals to health and social care delivery.
- Be predisposed to working in interprofessional teams.
- Demonstrate effective teamwork skills focused on meeting patient/client needs.
- Be equipped to play a confident and equal role as a member of interprofessional teams.
- Recognise that the changing nature of health and social care means that roles and boundaries will develop and change over time.

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2 Medicine, Midwifery, Nursing, Occupational Therapy, Pharmacy, Physiotherapy, Podiatry, Radiography (Diagnostic), Radiography (Therapeutic), Social Work
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The combination of interprofessional and profession-specific learning experiences will cross-traditional boundaries. Approaches to learning will give depth and breadth to each student’s knowledge (theoretical and clinical) through the application and integration of profession-specific knowledge to shared inter-professional learning. The resultant diversity of problem solving opportunities used by students will develop their ability to work within the changing health and social care environment and give them the key transferable skills necessary to the management of both clients and carers and their own career progression.

Implementing reform: Opportunities and challenges

The New Generation Project’s approach to inter-professional education arose out of an appreciation that the ability of existing professionals to function effectively in the future will require education, training and human resource investment supportive of the delivery of patient-focused care.

The following section identifies a series of policy recommendations that will need to be addressed if the Government’s commitment to reform in the NHS is to be delivered. These recommendations are by no means exhaustive, but illustrate the complexities involved in realising and delivering a modernised NHS system.

The need for whole system change

Workforce roles that at present do not exist, and cannot be predicted, will emerge as a result of technological change, breakthroughs in knowledge and consumer demand for accessible and responsive services. Developments in the area of diagnostics, investigations and simple operative procedures already illustrate the workforce possibilities that can emerge. Knowledge is a key driver in change; even minimal changes in knowledge can shift the jurisdictions of practice, creating a ‘different version of a common reality’ (Berger & Luckmann 1985)

It is evident that the implications of change in health and social care roles and the ability of existing professionals to function effectively in the future will require education, training and human resource investment supportive of the changes. The integration of ‘common learning’ requires a greater emphasis on issues of flexibility, multi-professional teamwork, competency and skills acquisition and problem solving, whilst maintaining the integrity of relevant knowledge base acquisition.

At present, many of the necessary changes to the educational preparation of the health and social care professionals are occurring as a result of adding on to existing programmes. This neglects the necessary whole system curriculum and practice development reform needed to ensuring that programmes equip individuals with the necessary capabilities for the future.

Conditioning the environment to develop its receptiveness to change will require considerable work. Creating role models of good practice is vital. Service providers now operate in an environment that is dominated by a growth in technology, increasing demands for services, faster information and knowledge flows and more active and discerning service users. As the codification, expansion and transfer of knowledge grows
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so the access to knowledge to enable service change will expand. Processes of innovation in practice will develop new solutions and patterns of practice. This will in turn generate new knowledge and new approaches to care. Preparing undergraduate students together has an important role to play in enabling students to develop the capacity and capability to constantly think differently about ways of working and delivering care. Innovation is itself autocatalytic: outcomes and expectations inform new partial solutions, but the need to constantly evolve the service is clear.

Investment in whole system cultural change requires strategic direction and investment from the Department of Health as well as involvement and evaluation by the NHS Research and Development Unit.

Current performance targets measure numbers of additional staff being recruited. This emphasis contradicts attempts to introduce whole-systems change in the way that staff work. In future, Performance Assessment Frameworks should focus on a specification of outcomes rather than inputs, thereby promoting and encouraging new developments in workforce deployment to effectively meet patients’ needs.

The outcomes specified by all pre-qualifying programmes as necessary attributes for health and social care professionals should include: comprehension of the need for patient-centred care and the capability to continually question the concepts that shape the practices of health and social care.

Workforce Development Confederations

Defining a fit-for-purpose workforce

The House of Commons Select Committee on Health (1999) explored a wide range of issues that impact upon the workforce challenge facing the NHS. Amongst its recommendations was a call for an integrated planning system and joint training which should incorporate a national overview, providing a ‘national strategy for workforce planning’ which should bring a ‘sense of consistency and cohesion’. Many of the recommendations of the Select Committee are reflected in the NHS Plan, with responsibility for the design and planning of the NHS workforce now residing with the Workforce Development Confederations. The Confederations will play a key role in developing a workforce fit for the future, and the conditions that will support that change.

Through the establishment of these organisations, the integration of workforce planning, service and financial planning within the health service is just beginning. It would be logical to involve social services as part of this approach.

Health and social care workforce planning, funding and regulation must be combined to ensure a whole system basis for workforce design and investment decisions. An immediate way forward would be to pilot integrated workforce planning in several, selected health economies.
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Workforce Development Confederations must invest in the development and commissioning of new programmes that support the delivery of an appropriate workforce, for example Foundations Degree.

Ministers must offer encouragement to Workforce Confederations, primary care practices and Trusts to develop a critical mass of new roles if skill-mix changes are to have a tangible impact on service delivery.

Practice based learning

The development and integration of interprofessional learning in both the classroom and practice requires a shift in emphasis in practice-based learning. Practice-based interprofessional learning has been identified as being more effective than theory-based in generating positive behaviour and organisational/patient outcomes for example increased patient satisfaction (Freeth, Reeves, & Goreham 2001; Koppel & Reeves 2001). Practice learning represents a vital element of all the health and social care programmes across the New Generation Project. Therefore the capacity within provider organisations to facilitate this learning defines both a limit to growth and a limit to quality in terms of each programme. Aligning the modernisation agenda in service and education is an essential prerequisite for ensuring suitable practice based learning. The responsibility for ensuring adequate placement capacity and quality is now a joint responsibility between the Workforce Development Confederations and universities, who must ‘ensure sufficient numbers of high quality practice placements, provide experience for health care students in training and to support inter-professional education in practice settings (Department of Health 2001).

Workforce Development Confederations must work closely with service providers and Universities to develop appropriate work-based learning.

Currently, there is little training and few incentives for staff to support learning in practice. A common framework should be developed for the training of practice staff participating in work-based learning. This should establish a system of fair reward for staff supporting work-based learning and must be linked to incentives, appraisal and Performance Assessment Framework.

There is currently little information about placement capacity to feed into strategies of workforce planning or to inform an assessment of the scope for increasing student numbers. Clear analysis of placement capacity across whole health economies must be undertaken and this information should systematically inform and define the capacity for growth of local Higher Education Institutions.

Generating an evidence base

In the context of the prevailing ‘evidence-based’ agendas the need to provide empirical support for the value of interprofessional education is increasing. As Barr et al (Barr et al. 2000) captured in their review of the developing evidence base Persuasive though
arguments in favour of interprofessional education may be, evidence to substantiate them are elusive’ (pp15). It is vital that research investment is identified and directed towards this policy area (Zwarenstein et al. 2000). The evidence available to date does suggest that the greater the integration of interprofessional education into the wider curriculum the more positive the effect on attitudes to interprofessional collaborative working (Barnes, Carpenter, & Dickinson 2000). (Horsburgh, Lamdin, & Williamson 2001). The (Parsell & Bligh 1999) studies available are all largely atheoretical, based on short term interprofessional inputs and have used outcome measures which address short term affects only, often immediately post intervention. Very few studies provide evidence of longer-term outcomes, in particular on professional practice (Cooper et al, 2001). Most evaluations have been more concerned with student satisfaction than meeting external requirements (Barr, et al, 2000).

The ‘evidence-based’ dilemma that will be faced in the promulgation of interprofessional learning, as with all innovation, is that of change to the existing order. The dilemma simply put is that without innovation evidence cannot be developed. Yet the mantra of the ‘evidence-base’ could potentially become a constraint to the innovation necessary to address the significant workforce challenges faced by the future of health and social care.

At present, funding arrangements to support innovative work as part of the modernisation agenda are ad hoc. Yet research and evaluation into the methods and outcomes of interprofessional learning will be key to taking forward the Department of Health’s long term vision of the healthcare workforce. Research costs and the costs of evaluation for inter-professional learning programmes must be consistently built in to assumptions about the resources requirements of modernisation.

The need to challenge existing responsibilities

The status quo is rarely identified as an option for the future (British Medical Association 2002). Yet many of the practices in health and social care are steeped in the vestiges of the last century. The considerable complexity of modernising the workforce and the processes and systems of pre registration education is coupled with a backdrop of professions and organisations that often seek to defend themselves against change (Humphris & Masterson 2000).

The changes and flexibilities sought from the workforce raise fundamental questions about how far reformers are willing to go in challenging the existing medical hegemony (Cameron 2000). Cameron suggests that many of the new roles that have emerged in the non-medical professions reflect a ‘subtle transfer of power within the medical profession from the acute to primary sector’ (pp20). As a consequence, General Practitioners exercise considerable control over the work of other professionals and will, with the establishment of Primary Care Trusts (PCT’s), have increasing political and economic leverage. If the investment targeted at the NHS is to generate the radical reform to which the Government suggests it aspires, then spheres of responsibility for clinical decision making in practice must be firmly on the agenda. The present clinical responsibility for patient care is based on the traditional medical model. If changes are to be patient-
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centred, then the issue of clinical responsibility needs also to be on the table, along with the notion of ‘demedicalising’ areas of intervention.

The British Medical Association (BMA) in setting out its recent vision of the future healthcare workforce recognised that in primary care ‘the first point of call for most patients could be a nurse practitioner’, who would guide the patient to other relevant services including a general practitioner, community pharmacist, family welfare worker, a benefits advise worker, or a combination of these (British Medical Association 2002). To deliver the BMA’s model of provision would require a systematic approach to the development of the present and future workforce, to include the skills of team and interprofessional working. However, although this report offers a new model of provision in primary care, it fails to consider the options for differing roles or service providers.

The BMA report is the most recent illustration of a professional group recognising the very significant workforce challenge that the service now faces in health and social care. However, such changes should be viewed in the context of Cameron’s caution about the willingness to see radical reform to the existing hegemony.

| Clinical responsibility for patients has hitherto been based on the traditional medical model. If there is to be meaningful change in workforce deployment, issues of clinical responsibility need to be reconsidered. In future, all consultants, whether nurses, therapists or doctors, will need to be legally responsible for the clinical decisions they take. |

Regulation
The protection of the public through the regulation of the workforce that cares for vulnerable people is a legitimate and important function. The modernisation of regulation is an essential process to provide a framework that is relevant and responsive to contemporary society. Any new arrangements must command the respect of the public, ensuring transparency and public understanding. The present system of regulation provides limitations and constraints on practice for a range of professions. The issues highlighted in the Kennedy Report related to interprofessional education would be more effectively addressed through an effective regulatory framework that incorporates all the health and social care regulatory bodies.

If modernisation is to deliver radical reform, the regulation of professions and their territories of practice must be within the scope of real reform. The proposed Council for the Regulation of Health Professions must be empowered to build and manage a framework of self-regulation that can accommodate new and emerging roles, consider the concept of the ‘licensed practitioner’ and support the delivery of interprofessional learning in all pre registration programmes. In considering again Cameron’s (2000) reflection on the emergence of new roles, it is evident that the regulation of practice of one profession may be a constraint on the practice of others; one obvious example would be sub-optimising the new consultant roles in nursing, midwifery and health professions.

The present systems of professional registration are beginning to embrace the challenges of enabling the delivery of interprofessional education. The New Generation Project has
systematically engaged the regulatory bodies in a dialogue to enable the delivery of the project vision. The delivery of ‘common learning’ will require that the existing rules and regulations will need to develop a degree of flexibility if the Department of Health’s requirements are to be delivered. It seems likely that the relationship between Government and regulators will be tested by the need to create the conditions to enable the delivery of policy commitments in the NHS Plan.

Professional regulatory requirements must recognise and define standards for interprofessional learning and practice as a legitimate part of programme requirements.

The emergence of new roles resulting from the DfES development of Foundation Degrees will, in the health and social care sectors, raise the possibility of ‘licensing’ intermediate workers as a means to provide protection for the public without necessarily registering practitioners with existing regulatory bodies. The Government must address this as a matter of urgency to provide clarity to the public and to ensure a safe standard of practice.

The changes proposed with the establishment of UK Council for Health Regulators must encompass social care and have in place mechanisms to recognise and codify new roles and deregulate roles that over time are no longer required.

The global context

The education and workforce challenges in health and social care are not confined to the UK. Across many developed health care systems there is recognition of the need to develop interprofessional learning (Leathard 1994). For over twenty years the World Health Organisation has promoted the need for interprofessional working and learning (World Health Organisation 1988), encouraging examples of innovation across North America, Sweden, France the Netherlands and the United Kingdom. Gradually a number of organisations have emerged to galvanise the efforts of early adopters. In the UK the Centre for the Advancement of Interprofessional Education (CAPIE) has to date been a leading organisation. On a wider European basis the European Network for Development of Multiprofessional education in Health Services (EMPE) was established in Sweden in 1987 (Goble 1994).

Concerted approaches to the development of interprofessional learning in undergraduate health and social care programmes raise the prospect for European wide regulatory changes to enable a common vision to develop and be delivered in the context of the free movement of labour across Europe.

Conclusion

This paper has set out to explore the implications of shaping a vision for developing a new generation of health and social care professionals in which learning together in undergraduate professional education is a pre requisite for opening up the potential for future workforce modernisation. The longer-term, ongoing reform of both services and the workforce in health and social care will require a workforce who can themselves
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drive the changes necessary to deliver patient centred services. This will require a capable to continually question the underlying concepts that shape the practices of health and social care.

The Workforce Development Confederations will be key to driving through the reforms necessary to enable the delivery of the NHS Plan. The Higher Education sector has a significant role to play, working in partnership with the Confederations and service providers, to enable the radical reform of education programmes to place interprofessional learning at their heart.

Interprofessional learning should not be viewed as the end, but as a means to evolve and redesign the relationship between health and social care professionals and the needs of the population embracing, as this does, the constant debate about workforce and skill mix. Systems of health care and the requisite workforce can be viewed as living systems that need to respond to the changes in the external environment in order to continue to be appropriate. The regulators of the health and social care workforce will need develop a culture of responsiveness, protecting the public whilst enabling innovation in role development.

We can be certain that there is no inevitability about any model of delivery, each will only be a partial solution over time. Those who reflect nostalgically on the times defined by an hegemony shaped by a dominant group, could potentially see the encouragement of interprofessional learning as inherently subversive to that order. In many senses it is, because the workforce model of the past will simply not meet the demands and needs of the future. Developing mutual respect and understanding from the outset by the various professions is a step on the journey. Certainty is dead, and in turn the ability to deal with uncertainty becomes the key characteristic of groups and individuals who survive.
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