Role Redesign

Why Do I Need to Know?

The primary aim of planning for workforce development is to ensure that the skills of the workforce are consistent with service need and the delivery of a patient-focused service. By redesigning roles we can both respond to the new 'demand' coming from new models of care and improve the 'supply' of the workforce through an enhancement of the available labour market.

Role redesign is an integral part of service redesign, and involves redesigning existing roles as well as creating new roles. It can involve expanding the depth and breadth of roles, moving tasks up or down a traditional single-discipline ladder, and crossing traditional boundaries - professional, skill mix and organisational. Redesign may affect a whole healthcare team from support workers to the medical workforce, and may build on other initiatives which have attempted to extend or redesign the roles of particular clinical professions.

How this impacts on workforce planning

The national project known as the Future Healthcare Workforce project was set up to take a radical view and address the fundamental question: "If we were designing the workforce today for tomorrow's health service, what would it look like?"

Early findings of the project highlighted the following workforce-related problems:

Fragmentation and role demarcation

The fragmentation of the workforce into a multiplicity of professions and occupations has major implications for both the quality and cost-effectiveness of services:

- the lack of continuity in the care process
- increased delays and confusion for patients
- time wasted on unproductive activities
- too little time spent on direct care of patients
- inflexibilities in responding to peaks and troughs in the workload
- lack of clarity on accountability

Inflexible career structures

The healthcare workforce has traditionally been locked into an inflexible structure, with students being recruited to single-discipline training programmes despite the acknowledged overlaps in the requirements of the various professions.

Levels of skill

There is a significant body of evidence to illustrate that professionally-qualified staff spend a high proportion of their time on work which does not require their level of training and expertise.

Service changes

The pace of change is accelerating with the need to expand services and to re-engineer the care process as stipulated in the NHS Plan.

Labour market problems

The NHS is constantly battling with problems in the recruitment and retention of professional staff. As the demand for services increases and funding becomes available to provide additional services, this will be the single biggest constraint for both the volume and the quality of patient services.

How this factors into planning

All of the above issues led to the need to re-examine skills, roles and ways of working. At the same time, the NHS Plan and the emergence of national standards through the National Service Frameworks (NSFs) has meant that the way in which services are delivered to patients is being radically reformed.

The demand for workforce that is created through new models of care (provision, delivery and patient pathways) can be met in part by redesigning roles and developing the skills needed. Redesigned roles and ways of working will form part of the supply plan and of the action plan.

Factors to be considered when putting plans together are:

Workforce supply and productivity

New roles may be designed not only to provide more appropriate care, but also to increase the size of the available labour market in areas where 'traditional' staff have been hard to recruit. Equally, the new roles may release other staff to become more 'productive'. The new roles may release the time for more specialised or more skilled staff to work directly with those patients that need this level of expertise. In turn, this should increase the both the quality of care and the throughput of patients.

Changing skills base

The workforce plan must identify the changes needed in the skills-base arising from changes in models of care or technology.

Quality improvements

Providing a more convenient, personalised service often means a reduction in the number of different staff caring for any one patient/client. This means looking at numbers, types and deployment of staff and ensuring that any changes identified are reflected in the plans.

Costings

The redesign of roles tries to avoid unnecessary overlaps and inefficiencies. However, it can also result in the use of more specialist staff who are more expensive to employ, or in the

use of less highly qualified staff but in greater numbers. It may mean multi-skilling staff, which requires an investment in training and time.

Improved career paths

Role redesign may result in the creation of more flexible career paths, which in turn improve retention of staff and can ensure a faster response to service changes and supply problems.

Training, education and professional regulation

Redesign should always be matched with the appropriate training and education. It may be necessary to develop new occupational standards to support the education and training programmes. Professional bodies will also need to validate new practice and set out learning frameworks to ensure patient safety and to protect staff.

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How Do I?

In the NHS, the Changing Workforce Programme (CWP), as part of the Modernisation Agency, currently provides leadership and guidance to local organisations wanting to carry out role redesign. A number of projects have taken place, with the introduction of a number of new roles now accelerated across the country. At the same time, the CWP both trains and embeds support at health community/SHA level so that organisations are able to undertake their own redesign projects.

The CWP's website contains other information and databases on the subject.

Different forms of redesign

Changes to work roles may be approached from different perspectives:

Professional roles enhanced within the same discipline

This usually involves moving a task or an individual up (or down) a traditional skills ladder. It might result, for example, in the development of a specialist practitioner where the specialist takes on direct referrals from both primary and secondary care. This then reduces appointments with GPs and attendance at A & E as well as providing the patient with more joined-up care.

Professional roles enhanced across professional boundaries

Individuals extend their breadth of skills across traditional boundaries, for example a blurring of demarcations between nursing and medical staff or between physiotherapists and occupational therapists.

Reprofiling: balance between professionally-qualified staff and support workers

Traditionally, support staff were recruited to work with one professional group (for example physiotherapy helpers) but increasingly their roles are being designed to provide support for the whole clinical team. Reprofiling can also happen when tasks usually done by professionals are taken on by, for example, technicians with enhanced training which equips them to give basic treatments, do assessments, maintain records and provide education to patients and carers.

New patient-focused (or patient-centred) roles

New roles are developed by combining selected tasks (normally done by a variety of traditional roles) into one new role. These roles are designed from the patient/client process perspective and are aimed at reducing delays in the process.

New structures and criteria

The Future Healthcare Workforce project found that much of their work on new roles resulted in a three-tier structure:

- Senior medical staff and other non-medical specialists/consultants;
- Healthcare practitioners and junior doctors;
- Assistant practitioners and healthcare practitioners in training.

The project also identified common criteria to be met by a redesign of work roles:

- **fast response**: to an emergency admission or to a change in the condition of the patient post-admission;
- **improved efficiency**: to ensure that patients are not inconvenienced by delays in service delivery and that the available resources are used cost-effectively;
- **effective use of time**: to eliminate or reduce the time associated with inappropriate referrals, handovers, clerical work or in locating professional colleagues;
- **continuity of care**: staff should not 'hand off' to colleagues unnecessarily;

- **removal of barriers**: the design of work roles should not be dictated by traditional professional boundaries. However, it is important to ensure that adequate professional supervision and the right levels of autonomy or accountability are built into the new roles.

Examples of new Role developments

The Changing Workforce Programme has piloted an extensive programme of redesign projects. You can use the link at the bottom of this page to see the review of this work and the toolkits that support the development of new roles.

The earlier project, The Future Healthcare Workforce, also has a number of examples which are set out in their three project reports.

These include:

Services for Older People

The third report (published in April 2002) concentrates on services for older people. It proposes the implementation of two new roles:

- a professional role: the practitioner for older people
- an assistant practitioner role

The practitioner and assistant practitioner would work across the health and social services divide and would be responsible for delivering the majority of the service to the patient population.

The Royal College of Physicians' (RCP) proposals

The RCP report entitled 'Skillmix and the Hospital Doctor' explores the problems associated with an increasing demand for services and the large and continuing increase in emergency admissions. It concludes that: "…. conventional solutions using the current healthcare professional workforce are unlikely to meet the rising demand alone". The report explores a range of options which have been designed, in particular, to enhance the flexibility of the workforce, including:

- "A radical review of the work undertaken by doctors and other healthcare workers and the implementation of a policy of skill mix or flexible working"
- "The introduction of a new post of healthcare practitioner"

The report envisages that the new post of healthcare practitioner within acute medicine would undertake a wide range of duties:

- ordering and in some cases undertaking diagnostic tests
- introducing intravenous cannulae, flushing cannulae and setting up IV lines as directed by medical staff

- giving first doses of antibiotics and some other drugs
- prescribing from a limited formulary of drugs
- discharging patients according to agreed protocols