



Role redesign: new ways of working in the NHS

Role redesign

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Abstract

Purpose – To examine the introduction of role-redesign in the NHS and highlight implications for employment relations.

Design/methodology/approach – A 12-month independent evaluation (2003-2004) of a role redesign initiative in the NHS is reported. The study followed a developmental, case-study design and included secondary data analysis, semi-structured interviews and observations at five case-study sites.

Findings – The role redesign process involved four types of change to job content: skill-mix changes; job widening; job deepening; and development of new roles. Each of these changes had implications for employment relations in terms of remuneration, management and accountability, and education and training.

Research limitations/implications – The research involves one initiative in the NHS and was evaluating a developing programme. Whilst implications are suggested for efforts at role redesign generally the research specifically relates to NHS organisations.

Practical implications – Three aspects of employment relations are identified as important when attempting role redesign: remuneration, management and accountability, and education and training.

Originality/value – This paper offers the first account of this national NHS role redesign initiative.

Keywords Health services, Employee relations, Employees, Change management, Job design

Paper type Research paper

Introduction

There is a growing trend both in the UK and internationally towards changes in workforce configuration and skill-mix in healthcare that has been driven by a range of environmental pressures and challenges (Davies, 2003). These drivers include: the need to respond to skills shortages; pressure for better management of labour costs (which account for much of overall healthcare cost); a desire to enhance organisational effectiveness and; changes in professional regulation (Adams *et al.*, 2000; Sibbald *et al.*, 2002). There is also a growing recognition of the substantial differences in structure and deployment of the healthcare workforce, which exist internationally (World Health Organisation, 2001).

Furthermore, whilst workforce configuration and skill-mix arrangements are often a product of history, precedent and cultural preconception, attempts to tackle workforce reorganisation and job redesign have experienced limited success (Payne and Keep, 2003). Redrawing boundaries between existing professional groups and established job roles has been a major organisational challenge and many stakeholders have not been convinced about the need for change (Read *et al.*, 2002; Halliwell *et al.*, 2000).

In recent years government policy has moved away from restructuring and reorganising health services towards modernising working practices in particular, and systems and processes of care, generally (DH, 2002a, b, 2003). Such modernisation



policies originated with the NHS plan which presented a ten-year plan of investment in the NHS (DH, 1999). Furthermore, it laid out two objectives for the workforce.

- (1) Specified increases in staff numbers.
- (2) Major redesign of roles for NHS staff.

“A Health Service of all the Talents” (DH, 2000) specified that role redesign, amongst other activities, should offer: greater integration and more flexibility of workers; better training, education, and regulation, for staff and better management ownership through clearer roles and responsibilities of managers. The Modernisation Agency established in 2001, included the new ways of working team whose remit involved revision of pay and staffing structures and the introduction of new and redesigned roles. The Changing Workforce Team initiated the Changing Workforce Programme (CWP) to address the introduction of new and redesigned roles in the NHS.

The CWP was a component of a wider set of reforms aimed at modernising human resource management in the NHS and making better use of the talents and skills of the NHS workforce. Its aim was to pioneer new ways of working that could improve performance of the NHS by improving access, reducing waiting times or improving service quality. Changes in jobs were important to the success of moves to redesign organisational relationships and structures across boundaries between health and other care sectors.

Much effort has been expended on health service redesign: the rearrangement of facilities, staff and patient pathways in search of more streamlined services, greater throughput and improved patient experience (DH, 2002a, b; Locock, 2001). Central to such redesign initiatives have been ideas borrowed from two overlapping traditions:

- (1) business process re-engineering (BPR) that includes emphasis on worker responsibility, multi-skilling and job variety (Leverment *et al.*, 1998; McNulty and Ferlie, 2002); and
- (2) role redesign which focuses on skill variety, task identity and significance, autonomy and feedback (Parker and Wall, 1998).

Attempts at workforce modernisation remain a highly contested area and the impact of new forms of work organisation on employees remains controversial (Appelbaum, 2002). Government, managers, professional associations, trade unions and healthcare workers all play a role in determining the skill profile of the workforce and government initiatives have been shown to work against existing professional groups (Thornley, 1996). They also work counter to traditional regulation of professional work, social closure of the professions and maintenance of their skilled status (Noon and Blyton, 1997). Social closure is achieved through shared ideologies, collective political action and through the appropriation of tools and technology of the work process that enable professionals to influence work organisation.

One role redesign initiative in the NHS, is the CWP which has sought to pioneer new ways of working using role redesign principles. An independent evaluation of CWP conducted by the authors and funded by the Department of Health is used here to explore the manner in which role redesign techniques are being applied to some areas of health service provision. The paper goes on to suggest implications for employment relations in the areas of remuneration, management and accountability and education and training.

Role redesign

BPR approaches have been criticised for their focus on new technology and their association with work intensification and de-skilling (Grey and Mitev, 1995). Role redesign “concerns the way jobs are designed or configured within the overall organization of production” (Bélanger *et al.*, 2002, p. 17) and dates back to the 1960s. Such initiatives took place against a background of trade union militancy and labour shortages and were part of an attempt to deal with rising absenteeism and high staff turnover often linked with Taylorist production systems (Payne and Keep, 2003). Role redesign initiatives were claimed to improve outcomes by increasing the meaningfulness of work whilst encouraging employees to experience responsibility for outcomes and to have active knowledge of the results of work activities. Moderating factors included knowledge and skills of the workers and motivation to adapt the role (Parker and Wall, 1998).

In the 1980s with labour surpluses and declining union power, role redesign became focused on improving organisational performance. Kelly (1992) proposed that role redesign led to improved performance through: employees negotiating changes in content (and increased output) in exchange for increased pay; employees perceiving closer links between effort, performance and valued rewards; increased goal setting motivating better performance and; improved efficiency of work methods leading to performance improvements. Parker and Wall (1998) advocated their own eight phase process for work redesign that focused on role redesign following analysis of the wider environment and initial preparation including setting pay, training and control issues. Phase one set the direction for work redesign followed by diagnostic and work formulation phases. Subsequent phases involved consideration of the wider context including pay, training and control systems followed by planning for implementation. According to this model new roles are only introduced following a pre-change assessment and are accompanied by supporting changes in the organisation. The final phase involves diffusion and efforts to sustain the change. Whilst CWP did not use this framework to guide their activities, it provides one means of analysing their approach. The impact of these type of approaches are deeply controversial with proponents arguing benefits in terms of an empowered and participative labour force and detractors arguing disadvantages in terms of work intensification and de-skilling (Appelbaum, 2002; Grey and Mitev, 1995). Proponents of BPR approaches have argued that it can be used for process reorganisation and changes in work organisation without the debilitating effects of downsizing (Leverment *et al.*, 1998).

One of the first attempts at incorporating a BPR approach to organisational change within a healthcare organisation took place at the Leicester Royal Infirmary, where an ambitious programme of re-engineering was instituted in the hope of introducing new ways of working that would improve efficiency and service quality. The programme succeeded in achieving improvements in efficiency but anticipated gains were not fully achieved (e.g. financial savings were less than predicted). Sustained changes were, however, achieved through “process thinking” (the analysis and redesign of patient care pathways). Changes were found to be highly context sensitive and the provision of effective leadership by a critical mass of clinicians involved in care was also necessary for successful change (McNulty and Ferlie, 2002).

The NHS has a significant history of ensuring fluidity of skills particularly where there are workforce shortages and a desire for cheaper labour (such as that provided by

unqualified workers). This has led to several initiatives, one of which is described in Thornley's (1996, p. 165) study of nursing. She described how nurses lost social closure of their profession following nursing shortages and showed how attacks by the government on "the nebulous character of 'skill' in nursing" succeeded. We will demonstrate that CWP engaged local workers in redesign that had a specific focus on the patient and patient outcomes and which differed from pushes for skill-mix changes in the 1980s aimed at cost containment and cuts. The CWP approach also emphasised the use of more skills and the development of competencies that had not previously been used providing a contrast to the picture presented by Keep and Mayhew (1996) and low levels of skills used in the public sector identified by Rainbird *et al.* (1999).

Research methods: a developmental evaluation

The 12 month, independent evaluation of CWP was funded by the Department of Health (conducted by the authors) and started early in 2003 using a realistic evaluation design (Pawson and Tilley, 1997). The study aimed to; analyse the development of CWP pilot sites; assess outcomes and perceived impact and; understand characteristics of successful CWP initiatives. The first phase of the evaluation involved documentary review of reports relating to this initiative. In addition, individual interviews were conducted with participants from each of the pilot sites. In total there were 30 interviews across the 13 sites. The interviews followed a semi-structured schedule, which covered the following areas: how the pilot had been initiated; stakeholder involvement; progress in role redesign; impact; future plans and; lessons learnt. The diversity and heterogeneity of the 13 pilot sites is demonstrated in Table I which outlines the aims of each pilot site, total numbers of redesigned roles and offers examples of these changes.

Phase two of the evaluation employed a case-study design to study the process of role redesign and identify examples of good practice. At the same time the study aimed to capture the impact on progress of local contextual influences and allow flexibility to explore themes as they emerged (Bromley, 1986; Mitchell, 1983; Stoeker, 1991; Yin, 1989). Four pilot sites were developed as case-study sites in addition to the fifth study which involved the CWP team itself. The CWP team case study offered a wider overview of the rapidly developing programme. The remaining four case studies were selected to illustrate varying degrees of progress in relation to individual roles; variation in type of role redesign attempted; different types of partnership arrangement; differing means of involving those receiving the service and; relevance to the wider NHS and other care sectors.

In total there were a further 64 interviews across the five case studies. Interviews covered a similar format to that of phase one, except interviews with CWP central team, which covered: links between staff and national bodies such as Royal Colleges and government bodies and; the identification of critical success factors in their role. Each interview took about an hour, was tape recorded and transcribed in full. A total of ten meetings were attended by the researchers (authors). These included a steering/reference group, a project board, team meetings and a user involvement conference. All interviews were subsequently analysed thematically, together with documentation and notes of meeting observations and role shadowing. Case study summaries were sent to pilot sites for comment/verification purposes.

Pilot site name and number of redesigned roles (total = 153)	Aims of site	Examples of redesigned role
AHPs Eight redesigned roles	To identify and test NWW ^a for AHPs and the wider healthcare team including consultant AHP roles	Included new roles for consultant podiatrist and education health worker
Anaesthesia, critical care and pain management Eight redesigned roles Care for the older person Nine redesigned roles	To implement new roles on anaesthetics, pain management and theatres To develop, support, test and implement changing roles for staff which best support the delivery of patient care and implementation of the NSF ^b for older people To introduce NWW in diabetes care that will result in improved care for patients and greater satisfaction for staff	Included new role for recovery support worker and extended role for image intensifier operator Included new role for nurse consultant and extended role for home help
Diabetes care Fifteen redesigned roles	To improve overall access to services, particularly diagnostics by introducing NWW and addressing "blocks" in care pathways	Included new role for diabetes care technician and extended role for senior diabetes nurse
Access and diagnostic services Seven redesigned roles	To improve patient access to emergency care, speed of care and patient provision, quality of care, patient and carer experience and staff satisfaction through the development of new roles and NWW	Included new role for booking clerk and extended role for district care manager
Emergency care Ten redesigned roles	To improve access and speed of diagnosis, treatment, patient and carer experiences by developing new roles and NWW which reach a balance between generalist and specialist levels of practice	Included new role for emergency care worker and extended role for emergency physiotherapists
Generalist and specialist care Nine redesigned roles	To explore NWW for health and social care teams and other workers who care for or provide services to those using mental health trusts and mental health related services	Included new role for care co-ordinator and extended roles for nurse practitioner in A&E
Mental health Twenty redesigned roles		Included new roles for support, time and recovery worker and occupational facilitator and extended role for pharmacy technicians

(continued)

Table I.
Classification of the pilot sites and examples of role redesign

Pilot site name and number of redesigned roles (total = 153)	Aims of site	Examples of redesigned role
Primary care Thirteen redesigned roles	To explore implementation of NWW in primary care with the aim of improving the patient experience	Included new role for expert patient and extended role for healthcare worker
Scientists Fourteen redesigned roles	To address the potential for solving service problems and labour shortages by developing NWW and creating new roles, and to help meet targets set out in the National Cancer Plan	Included extended roles for laboratory assistants and pharmacy assistants
SHO Twenty-two redesigned roles	Through role redesign the pilot aimed to assist in compliance with the European working time directive, improve patient care, facilitate multidisciplinary team working, improve capacity and improve working lives of staff	Included new role for consultant pharmacist and extended roles for nurses and technicians
Stroke care Thirteen redesigned roles	To improve care of stroke patients throughout their whole journey by exploring NWW across health and social care teams	Included widened role for welfare rights assistant and extended role for healthcare assistants
Wider healthcare team Five redesigned roles	To develop, test and implement NWW for healthcare support workers which improve services for patients and are better for staff	Included new roles for housekeeper and support team workers

Notes: ^aNew ways of working; ^bnational service framework

A developmental approach was used to take account of the heterogeneity and complexity of CWP interventions that precluded classical approaches (Bate, 2000). This approach was formative and prospective in nature and involved a detailed study of both the processes of the intervention and the context in which it was used (Walshe and Freeman, 2002). This type of approach is recommended for policy evaluation where programmes are fluid and fast changing, involve high levels of heterogeneity and variation and where impact is difficult to assess because of context specific complexities.

The remainder of this paper offers illustrative examples of redesigned roles in order to demonstrate how role redesign techniques were being applied to health service provision. The implications for three aspects of employment relations are then explored: remuneration; management and accountability; and education and training (full details of the evaluation, the case studies and findings of the evaluation are provided in Hyde *et al.* (2004)).

The Changing Workforce Programme

The new ways of working team was given a remit of revising pay and staffing structures and introducing new and revised roles, one element of which was the CWP. The aim of the CWP was to develop:

... new ways of working which can improve both patient care and staff satisfaction through the best use of skills. . . New ways of working in this context refers to the development of roles which are outside of traditional boundaries, which may extend to the creation of completely new types of job (CWP, 2001).

Beginning in 2001, 13 CWP pilot sites were established within NHS organisations or health economies around England. The intention was that roles would be redesigned locally under the guidance of CWP who provided project managers and workforce designers to each pilot site for the period of the pilot programme. Potential roles were identified and redesigned through the role redesign workshop (a set of materials aimed at supporting local staff in redesigning their own roles) where local stakeholders came together to redesign roles around a particular patient pathway. A phase of testing was planned to precede anticipated implementation and national spread throughout the NHS, should the redesigned role be judged a success. These attempts at role redesign were intended to challenge traditional and longstanding barriers to change directly, such as professional role demarcation, conventional team structures and hierarchies, existing care processes, and established health/social care divides.

CWP employed a contingent, emergent approach to workforce design that could be adapted and used locally. Workforce designers worked nationally as part of CWP's own team to share learning. Project managers and workforce designers worked locally, with staff from organisations involved in the pilot, to initiate role redesign. In addition, the CWP national team led work at a national level with professional bodies, education institutions and other stakeholders to facilitate and enable role redesign at a national and local level. They established a national database of information on new and redesigned roles in health and social care. They also produced printed materials and guides (Modernisation Agency, 2002a, b). More recently, they established Accelerated Development Programmes (ADP) to support speedier implementation of new roles in areas where the benefits had been tested and proven models were available to guide implementation.

The process and nature of role redesign

By the end of 2003, CWP had worked at 13 pilot sites and had generated a total of 153 redesigned roles for development of which 137 were developed beyond the initial ideas phase (see Table I, for examples and distribution). Following development, redesigned roles were tested by a small number of staff (often one staff member) who collected data about the impact of the role to support a business case for continuation of the new role. Of the 137 roles, at the end of phase one, 28 per cent had been adopted locally to the extent that further funding had been found to continue the role for at least one year. Of the 137 roles 8 per cent had been abandoned. The remaining 64 per cent of roles were in intermediate stages of development or testing by the time the pilots were due to be completed (late 2003). The largest proportion of redesigned roles involved nursing staff (29 per cent) and unregistered health care workers (31 per cent). Other staff groups included; therapists, pharmacists, scientists, administrators, unregistered social care workers, paramedics and doctors.

The role redesign process used by CWP involved four main types of change: skill-mix change; job widening; job deepening and; development of new roles. Selected illustrative examples of each type of role redesign are given here, taken from the stroke care, mental health and emergency care pilot sites. These examples demonstrate the context specific and interwoven nature of different types of workforce change advocated by CWP.

- (1) *Skill-mix changes*, involved moving tasks or roles up or down an existing hierarchy, often through role substitution. The role of “health care assistant (level 3)” was developed at the stroke care pilot site to enable health care assistants to take on a number of specified tasks from registered nurses. After training, individuals were taking on 33 tasks originally done by registered nurses, saving an average of three hours of registered nursing time a day. They were also able to delegate tasks and train and assess “health care assistants (level 2)”.
- (2) *Job widening*, in which the content of a role was expanded or enlarged, often by bringing together functions which may have been done by different individuals in the past. The role of “pharmacy technician” was extended at the mental health pilot to include visits to the ward to check charts and offer patient counselling. This role was found to reduce prescribing errors and to improve patient compliance with taking prescribed medication. Previously, technicians had only been involved in dispensing and ordering stock. The stroke care pilot illustrated the inter-relatedness of job widening and deepening changes through the role of “welfare rights assistant”. This role was deepened when existing skills were used to advise clients directly. However, the job was widened as staff were working across traditional professional divides and providing a service originally provided by a social worker.
- (3) *Job deepening*, in which the content of the role was enriched by giving the role more significant and substantial responsibilities, greater autonomy or opportunity for development. Two existing social care staff who worked in a day centre, attended by people recovering from stroke, were seconded to provide support to a group of younger stroke survivors. Although they had worked with this group before, they took on an extended role of facilitating a self-advocacy group.

- (4) *New role* creation, which combined new and/or existing roles and functions in innovative ways. A new role of “emergency care worker” (emergency care pilot) was introduced to allow nurses and paramedics, following additional training, to treat patients from the moment of being picked up by the ambulance through to and including A&E treatment.

Classification of redesigned roles was not a simple process as roles that were new in one area were already established in another, there was considerable difference in role title although work tasks could be similar. In addition, there was considerable local and context specificity of redesign. Role redesigns have been classified here under different headings solely for the purposes of providing illustrative examples. In effect, developing new ways of working often involved more than one of these skill changes. The type of role redesign was further dependent on the context as new roles created at one site, in some cases, already existed at other sites. For example, a “rehabilitation support worker for the Asian community” was a completely new role in at the stroke care pilot site. However, at the care of the older person site, a similar role was already provided, so the same role would have represented a role extension through job widening or deepening if introduced here.

Little resistance was encountered to trying out redesigned roles, which may be due to the local development of roles that increased role holders’ involvement in the process (Parker and Wall, 1998). Roles were also developed to support the provision of better services to patients by considering the process of patient care. McNulty and Ferlie (2002) suggested that sustained changes were achieved through process thinking. Here the process was the patient pathway (the route patients take through services). Proposed future developments for CWP involved national spread of redesigned roles through ADP, which would impose roles developed at pilot sites on new sites without a process of local development. Resistance was more likely at this phase of the programme as the method of introduction was totally different and could generate similar problems to those identified by Keep and Mayhew (1996) where existing skills were under-utilised.

This paper has identified the main staff groups who were involved in and affected by the proposed role redesigns and has provided examples of role redesign (for further details see Hyde *et al.*, 2004). The paper now considers the dynamic relationship between role redesign and three employment issues that emerged as important during the course of the study:

- (1) remuneration;
- (2) management and accountability; and
- (3) education and training.

Role redesign in the NHS

Remuneration

The pilot sites took a variety of approaches to remuneration that ranged from settling pay for new roles before work began to deferring decisions on pay until Agenda for Change was introduced[1]. Furthermore, although all new roles should have been evaluated for pay implications, a large number of redesigned roles were staffed through extensions of existing staff roles (53 per cent). This testing of extended roles through existing staff raised concerns about future recognition and remuneration.

For example, one role redesign was delayed because the staff group “wouldn’t do it without remuneration”. Settling pay in advance was an important factor. In contrast, some workers who were not rewarded financially reported compensations such as personal development and “doing a better job for the patient”. Whilst others expected remuneration once they had demonstrated the effectiveness of their redesigned role. The national CWP team did not engage in discussions about pay, leaving this to the local organisation to settle. They used the phrase “Working differently, not working harder” to imply that increased pay would not necessarily follow the introduction of new ways of working. However, settlement of pay at organisational level led to some anomalies. One consultant-allied health professional was appointed at medical consultant pay, which was substantially higher, because the organisation misunderstood anticipated pay settlements for these consultant posts.

At the mental health pilot site, all roles were redesigned within professional groupings (i.e. roles changed within pharmacy or within occupational therapy) and pay was settled before people took on their role. The understanding being that the trust had agreed to fund the work at that level and that if the worker accepted the redesigned role they also accepted the set pay.

Other sites were more complicated, however. At the care of the older person pilot, roles were redesigned across health and social care settings. Social services identified one role redesign involving home helps adopting health tasks that would have had pay implications for over 2,000 staff. Consequently, social services limited the redesign to specific teams. They discussed other solutions such as making separate payments for “health type work” to overcome the issue. This role illustrated complications that arise when role redesign crosses organisational boundaries. There were roles that had involved re-grading and a subsequent increase in pay. For example, education health workers (AHP pilot) were put on a higher grade to recognise their extended role across boundaries of health and education. Difficulties were also found in roles that crossed professional boundaries where there were existing pay disparities. One example of this was the emergency care worker who could be a paramedic or a nurse who were performing the same new role but who received substantially different remuneration. Settlement of pay for this role was deferred until Agenda for Change was introduced. The care of the older person pilot included NHS roles that had included financial rewards or were being “held off” by asking staff to wait for Agenda for Change. “We are hoping Agenda for Change will be the mutual solution [for organisation and workers] without it getting personal” (NHS manager).

Difficulties in determining pay settlements, faced by health care organisations are not unique to this programme (Bach, 1998) and the importance of pay for successful policy implementation has already been noted (Sibbald *et al.*, 2002, p. 11). Parker and Wall (1998) argued that remuneration should be settled prior to implementation of role redesign and some pilot sites managed this whilst others did not. Increased pay has been linked to increased performance, especially where the employee is involved in negotiating changes of role (Kelly, 1992). Remuneration for redesigned roles emerged as an important factor in role redesign and a variety of means of dealing with pay have been illustrated here. Leaving pay issues to be settled locally may store up future problems.

To summarise, the issue of remuneration did not arise where arrangements were made prior to the start of the redesigned role regarding pay, especially where someone

was appointed to a new role rather than trying a role extension within their existing work. The provision of national advice that linked local payment arrangements to national precedents for pay settlement may have resolved the pay issue as deferment appeared to be storing up problems for the future. Furthermore, whilst organisations could sustain paying one worker to work differently, the pay implications become increasingly significant where large numbers of staff are concerned, for example, where extended roles for support workers are introduced nationally.

Management and accountability

Pilot sites took a number of approaches to dealing with management and accountability arrangements for redesigned roles. Direct supervision arrangements did not appear to be an issue where roles were changed within professional grouping. Staff retained their former lines of management and accountability. Examples of these were found at the mental health pilot where redesigned roles fell within professional groupings and used traditional line management systems: the pharmacy associate and pharmacy assistant were incorporated into existing supervision arrangements and management structures for pharmacy as a whole.

Where redesigned roles involved job widening across professional or organisational boundaries, accountability routes were more problematic. For example, the emergency care worker (emergency care pilot) was working in both the ambulance service and the trust hospital. These workers had been appointed from both nursing and paramedic services and issues of accountability had not been resolved. Whereas, at the SHO pilot (Table I), one nursing role had been extended to include getting patient consent to treatment: work formerly conducted by the doctors. Accountability for taking consent was retained by the doctors with the trust board accepting responsibility for any adverse events. There was, however, more resistance to the introduction of roles that required duties to be transferred from registered to non-registered staff and extensive training packages were required. For example, at the same pilot, a radiographer assistant was sent on a two-year training course in order to extend her role to include taking plain X-ray film. There was reluctance from registered staff to handover this task to unregistered workers. Additional concerns were raised about workers taking on roles of other staff and the consequent maintenance of standards of care whilst others argued that standards would improve:

... some would argue that non-registered or different workers doing jobs are actually safer than the SHOs who are under pressure to do a lot and are only within the service for six months (SHO pilot).

Management and accountability seemed to be most problematic where roles were being developed across sectors (primary and secondary care or health and social care). For example, a role change that involved home helps supervising medication for patients in their own homes required approval from the clinical governance team of the local primary care trust (care of older people pilot). When home helps were being trained to provide additional services to clients discharged from hospital to their own homes, there were problems in supervision and accountability as they covered several nursing localities and there was no clear route for line management. One exception was the education health worker (AHP pilot) who was based in school but supervised through the school nursing system. As there were existing systems

for supervision of health workers within the school there were clear hierarchies of management to draw upon.

It has been suggested that clear routes for management and accountability should be established prior to the introduction of new roles as failure to provide clear systems can amplify existing professional tensions (Parker and Wall, 1998). Generally, there were fewer problems of management and accountability when redesigned roles could draw upon existing lines of control. Where organisational or professional boundaries were crossed, responsibility remained with the delegating professional group or was dealt with at board level. Difficulties in management and accountability that had been resolved for one role holder locally were expected to re-emerge when attempts were made to introduce roles on a larger scale perhaps amplifying organisational or professional tensions.

Education and training

Training needs were identified for all of the redesigned roles. These ranged from training sessions provided “on the job” by a local worker to two-year, university-based, training programmes prior to trying out a new role. This supports the idea of role redesign as increasing skills and contrasts with the experience of Keep and Mayhew (1996) and Rainbird *et al.* (1999) possibly because roles were developed locally with those affected by proposed changes.

In-house training was used at the mental health pilot where additional basic training was required for the pharmacy assistant role and was provided by existing members of the service.

I didn't have any mental health experience before. I had to have quite a few training sessions on mental health, competencies on the mental health side, we have had communications training. All of them have been in-house (mental health pilot).

Several sites were able to provide in-house training and some interviewees put this down to historical context, such as, the organisation having been a teaching hospital and, therefore, staff expected to provide education for each other. The education health worker offered an interesting example of work-based learning (AHP pilot). These workers received training from speech and language therapists, occupational therapists and physiotherapists in order to develop specified competencies. In contrast, some other pilot sites encountered reluctance from professional staff groups to provide training for support staff that would enable them to enhance their role. This may have happened because they were reluctant to hand over the task.

The care of the older person pilot met the education and training needs of staff on an individual basis by providing local training packages mapped onto national vocational qualifications. Interviewees suggested that CWP should be taking a national overview by looking at “wider implications of these pilots on training and education needs of home helps, support workers, health and social care workers in the future”.

The SHO pilot wished to pursue role developments through a competency-based framework that enabled them to custom build training, rather than relying on qualifications.

Educationalists will always try to invent a course with a diploma or something which is not always appropriate because some skills can be quite minor and they don't always fit into one job (CWP).

Interviewees anticipated potential difficulties with this approach as; “we could be creating a whole raft of competency assessment where there never was any need before”. They also identified a need to develop the capability and capacity to do their own competency assessment, “we have to find a way of being able to do it on the job and yet maintain safety”. As one interviewee noted:

We need to say that in this health community this standard is acceptable and we are prepared to put our money where our mouth is and we say “they can do it, we assess them, we train them and constantly monitor their performance” (SHO pilot).

Whilst Davies (2003) recommended standardised training packages as a solution to training needs, this study suggested that managers at pilot sites were less satisfied with training provided by local educational institutions as they did not fit the specific local skill requirements of their employees. It should also be noted that qualifications obtained from educational establishments enabled staff to transfer more easily across organisations and whilst this could be unpopular with managers of pilot sites it could be of considerable benefit to the workers. There was one clear example of this where emergency care workers were being approached by other ambulance services even before they completed their training.

In summary then, willingness to offer training to other staff varied according to the willingness of the training staff to hand over that part of their role. “On the job” training in competencies was generally preferred to training commissioned from educational institutions by managers and this remained a contentious issue within sites. Educational institutions are usually used by health services to provide standardised training packages that local health organisations lack the capacity to provide. Furthermore, educational institutions more commonly provide training with national transferability.

New ways of working in the NHS

The CWP initiated a wide range of redesigned roles within the NHS and with organisations in social care that appeared to address their key aims of improving access to services, reducing waiting times and improving service quality. The challenge they then faced was spread and sustainability of roles nationally. Their use of the role redesign workshop enabled local workers and stakeholders to be closely involved with locally redesigned roles. Employees and employers were able to demonstrate that role performance was improved through their involvement in negotiations, the development of closer links between effort and performance and increased efficiency of working methods (Kelly, 1992).

The proposed method for reproducing redesigned roles, through the introduction of nationally defined roles eliminates the possibility for local involvement of key stakeholders in initiation of role redesign. This local involvement appeared to play a major part in the successful design and introduction of new roles in the pilot sites. Furthermore, the plan to impose new roles nationally meant that redesigned roles would be experienced as having been enforced rather than being developed locally.

The outcomes of this study have suggested that aspects of preparation for role redesign, such as, setting pay, management and accountability, and education and training needs were addressed in various ways at each of the pilot sites. Pay was

settled at some sites in advance of the introduction of new roles whereas other sites presented a more complicated picture and yet others deferred decision-making in anticipation of the introduction of a national pay spine for the NHS (Agenda for Change). Problems around remuneration were particularly acute where pay differentials existed across organisational and professional boundaries or where large numbers of staff were affected.

Systems for management and accountability also varied. Simple arrangements were possible where existing systems could be utilized but arrangements for management and accountability presented problems where redesigned roles crossed organisational or professional boundaries. New arrangements were more easily identified where existing staff had consented to hand over a task. Local arrangements were made that are likely to be unworkable on a national/large scale. Furthermore, national level introduction of some roles has the potential to amplify existing professional tensions.

Education and training arrangements surfaced conflicts between in-house training provision, which has high local specificity, and accredited training from educational institutions, which offers workers transferable skills and nationally recognised qualifications.

CWP developed local capacity for role redesign, which would have been previously unthinkable, by involving workers in the redesign process at an early stage (through role redesign workshops). Their plan to introduce roles nationally was at odds with their original local approach. These first steps towards workforce modernisation through role redesign in the NHS have suggested some key contingent factors concerning employment relations that would apply to many organisations considering a similar programme of change.

Note

1. Agenda for Change is a proposed national pay spine for healthcare workers.

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