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'Riding the bumpy seas': or the impact of the Knowledge Skills Framework component of the Agenda for Change initiative on staff in intermediate care settings

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Abstract

This paper explores the compatibility of the recently modernised NHS pay structure, 'Agenda for Change' (AfC) with the workforce flexibilities arising within intermediate care services in the NHS in England. The findings reported here were an unanticipated outcome of a larger, Department of Health (England) study which explored the impact of workforce flexibility on the costs and outcomes of older peoples' community based services. The research coincided with the introduction of AfC, and, as such workforce flexibility was a strongly emergent theme from focus groups which involved 11 teams as part of the larger study. In principle, it appears that both intermediate care and AfC should support the concepts of interprofessional working, blurring of role boundaries and role substitution, however the findings from this study suggest otherwise. In particular, intermediate care was described as a largely non-hierarchical service structure where staff roles expand horizontally to take on a broad plethora of generic tasks. In contrast, AfC promotes a hierarchical framework for career progression which recognises and rewards defined skills, expertise and responsibility. From this perspective, AfC was seen to reward specialisation rather than generalism, and had difficulty differentiating between and rewarding staff with broad generalist roles.

Key words: agenda for change, intermediate care, knowledge skills framework, NHS

Introduction

This paper draws on data derived from a larger, Department of Health funded research project which explored how, and with what impact, workforce substitution and specialisation is influenced by workforce change policies in the context of older peoples' services (Nancarrow *et al* 2008). The research setting was intermediate care services (IC) for older people in the NHS in England. When analysing the staff interviews from this study we noticed an emergent theme around staff experiences of their newly implemented pay structure, 'Agenda for Change' (AfC). This was not a primary focus of our research, however, the strength of the staff reaction to AfC permeated so many of the themes that we considered this a topic worthy of separate examination. This paper draws on our data and published literature to explore the compatibility of AfC with the working processes of intermediate care.

Background and Historical Context

Both intermediate care and AfC arose as part of the New Labour NHS Modernisation agenda. Intermediate care was a major a service reform designed to prevent avoidable admissions to hospital and / or facilitate timely and appropriate discharge from hospital. The goals of AfC were to break down traditional staff barriers and facilitate patient centred care; to reward equal work with equal pay and ensure promotions based on competence, performance and responsibility; and to simplify and modernise the conditions of service.

Intermediate care is defined as 'Those services which will help to divert admission to an acute setting through timely therapeutic interventions which aim to divert a psychological crisis or offer recuperative services at or near a person's own home'(Vaughan and Lathlean, 1999:1).

Intermediate care services are primarily targeted at older people. The introduction of these services in 2000 has resulted in widespread service restructuring across England. There is no single model of intermediate care, rather the policy around intermediate care has been interpreted and applied in various ways according to the needs of the local communities (Barton et al 2005). Nancarrow (2004) identifies the value of using intermediate care as a lens through which to explore the changing landscape of care, including workforce changes, arguing that most intermediate care services have evolved in the context of the NHS 'Modernisation' philosophies of care which include joined up, flexible, seamless, patient centred care and interdisciplinary working (Department of Health a,b).

Agenda for Change (AfC) is a single pay system for the NHS which was introduced in 2004 based on *Agenda for Change – Modernising the NHS Pay System* (Department of Health 1999). It applies to all staff employed directly by the NHS with the exception of doctors, dentists and some senior managers. AfC sought to tackle pay, conditions, career structure, patient care, and overall quality of service by undertaking a vast reconfiguration of the way NHS employees are assigned by job role and competence. The AfC replaced the previous 'Whitley Council' NHS pay system.

Within AfC, employee pay is structured around nine pay bands with salaries ranging from £11,135 to £83,546. Employment conditions, including working hours, overtime and annual leave have been harmonized across the workforce. To arrive at a specific pay band, all NHS staff have undergone a 'job evaluation' which examines 16 factors associated with each job (for instance, knowledge, skills and responsibilities), and allocates a score to that job which results in it being allocated to one of the 9 pay bands. Each post is then linked to a national profile, or locally evaluated.

Staff progression is linked to the demonstrable application of staff knowledge and skills, using the Knowledge and Skills Framework (KSF). The KSF is a single framework that is used as the basis of staff review and development which defines and describes the skills required by staff to deliver their job competently. The KSF forms the basis of the pay and career progression strand of the AfC.

This new harmonized pay system removed the historical links to specific professional groups, and made it easier to design and reward new jobs that cross traditional professional boundaries, and reward greater responsibilities. Thus, in principle, AfC should support workforce flexibilities within the context of intermediate care. Intermediate care has seen the rapid and, in some cases, engineered introduction of new roles, particularly ‘support worker’ roles (Nancarrow et al 2005). Additionally, intermediate care demands that strict role boundaries are erased in favour of more flexible and generic skills. However the data that emerged from our study found that there are some incompatibilities between the two initiatives.

In this paper we focus on the exploration of staff feelings, generated via focus group interview, on their reaction to the implementation of the AfC, and specifically on the KSF. We juxtapose the need, within intermediate care services, for a flexible workforce, able to fulfil different roles and complete varying tasks with the hierarchical structures imposed by the KSF and ask whether the two systems are in fact compatible.

Methodology

Focus group interviews were held between November 2006 and September 2007 with 158 staff from 11 of the 20 participating teams. The purpose of the interviews was to explore staff perceptions of the impact of different staffing, organisational, and management models on the workforce. For some teams, more than one focus group was undertaken to ensure all of the team members were able to participate. Separate telephone interviews were also conducted with four team managers.

We had originally intended to undertake focus groups with all of the participating teams (N=21), however after interviewing the first 11 teams, no new themes were emerging. The 11 teams represented a diverse cross section of the overall study sample in terms of team size, host (health or social services) and geographic location.

The focus groups covered the following topics:

- The aims and objectives of the service
- The way the team is organised
- Roles and responsibilities of different staff members
- Benefits and difficulties of the current staffing models
- Challenges to delivering the service
- Working relationships between different types of staff members

All focus groups were tape-recorded and transcribed verbatim and analysed using the Ritchie and Spencer Framework approach (Ritchie and Spencer 1995) . The qualitative data analysis package NVIVO(Version 7) was used as an administrative tool.

A coding framework was established based on *a priori* issues which arose from the original research questions (listed above) and literature review, and formed the basis of the interview schedule. One researcher developed the initial coding template using codes which were derived from the *a priori* themes, and *in vivo* codes arising from the interview data. Two other researchers independently coded two additional transcripts using this template, and compared their findings with the original coding framework. The three researchers compared their findings to reach consensus on the final coding framework, and subsequently developed a coding 'glossary' to define all of the codes in order to help increase consistency of coding.

Results

This study reinforced previous findings that intermediate care is conducive to the implementation of policies around joint working and shared roles. IC is characterised by an interdisciplinary team approach to care and as such staffing is organised to facilitate interdisciplinary team working. Joint professional visits, multidisciplinary team meetings, being based together in a common physical space and the sharing of professional skills were all identified as important organisational aspects of interdisciplinary team working, and these facets of care were largely seen as being positive.

'...there is lots of joint working, joint visits, joint goal setting and I think it is very much a team approach, as opposed to disciplines and slices of different intervention.' [Team 3]

Staff acknowledged that the sharing of skills between professional groups allows them to be more responsive and flexible:

'I think one of the most positive aspects of the service since it began has been the flexibility of the staff to change and to try all new ways of working. If it hadn't have been for that we wouldn't be doing what we are doing now.' [Team 13]

Indeed the majority of teams perceived role sharing as essential to 'get the job done';
'... there is no defensiveness or possessiveness about roles because there is more than enough work to go round...' [Team 3]

And although generic working implies the sharing of professional skills, it was also acknowledged that each professional still had expertise to offer:

'And we also recognise that we all have, even though we've got a wide generic middle of calm, we've also got our own specialities at either end.' [Team 7]

However the price for these initiatives, within the intermediate care setting at least, is a lack of clear career progression opportunities, particularly for higher grade staff. This was compounded by the lack of training and development opportunities available in several teams. Additionally, it appears that AfC does not reward generalism, which is in direct conflict with the blurring of roles and flexible working practices which are so well illustrated in intermediate care teams.

Flat team structures and limited career progression opportunities

The data reinforced the non-hierarchical career structures within intermediate care, and the lack of opportunities for specialisation.

*'There is very little career progression, there is no career progression in IC. You can go for the next band if one comes up and that's it. There are not specialisms to go for, it is a specialism in itself, you can argue that, but that's not being reflected for any of us under Agenda for Change. So as a career move it is not a very good one. So that's how I see it'.
[Team 5]*

This is then offered as a potentially divisive move capable of disrupting the morale which informally holds teams together in the face of more formal mechanisms for unity. One of the respondents gives this account, which highlights both the flat career structures within intermediate care and the additional spin off of this which is to not acknowledge or reward the additional management responsibilities.

*'...from my point of view I came in as a grade H and I was the most senior in the team as the manager. I'm actually banded at 6 along with all the rest and with all my physios and OTs so where do I stand in the structure now? I have nowhere to go really from a management point of view but I – technically I'm managing all my band 6s but I'm a band 6 as well, but I've been told that's OK, that's how the Agenda for Change works. It doesn't necessarily mean you're going to get a higher – even though technically financially I've been dropped'
[Team 1].*

Rewarding generic roles

Staff described the generic nature of their work, suggesting that having a broad range of generic skills should be recognised as a speciality in itself, however the KSF does not appear to acknowledge or reward this skill breadth.

'I wish there was a word for it, because it really worries me, this word generic, because it seems to me that's terribly specialist, is to have a broad range of skills, it is as specialist and as expert as somebody who is looking at just one condition and we haven't got a word to capture that have we really? A sort of generic specialist, no that's interesting.' [Team 2]

'Some people have come in on higher grades and are disease specific whereas we're expected to know every disease under the sun at a lesser grade. It's a bit of a touchy subject that, isn't it?' [Team 12]

'I think as well, since joining [the team], the main thing for me is I have become more and more specialised at being more and more general.' [Team 14]

However, the expectation that staff will have ever expanding generic roles can come at the expense of the maintenance of specialist skills by staff.

...to have staff that were at the right level for what we're wanting them to do to free up the people that have got these specialist skills to do things so that they don't become de-skilled because personally in my role, I think that if I continue down that line I've got a very big risk of becoming de-skilled because I'm doing things that I don't need to do because if I don't do them they don't get done. [Team 13]

It appears that there is a need to balance the broad repertoire of generic skills with the need for specialist skills in intermediate care. Staff with specialist skills need to be provided with the opportunities to use and develop these skills, which will also introduce the opportunities for career development that staff are missing.

Inconsistencies in staff grading

Despite attempts by AfC to ensure equity of pay on the basis of the job evaluation process, there was evidence within our study that several staff felt that the grades had not been awarded fairly or consistently.

'There is inconsistencies in the grades of physios and OTs particularly, at band 6 and 7 and 8 - across the Trust...and there is inconsistencies throughout really, so that makes it quite difficult and I think people haven't mentioned it because they have got over the anger of it all, but it is still a big problem in terms of recruiting..' [Team 3]

Some staff perceived that they had fared worse than their hospital counterparts.

The acute side of hospitals did a lot better than we did out in the community. I think it's reflected in how the community in some respects is seeing community working. [Team A]

These perceived grading inequities were also seen to create a barrier to recruitment and retention of staff into intermediate care services.

F I mean our physio's just leaving...

I And why is that?

F Because she was a senior 2 and got band 5, she was actually doing 3 jobs, she was based in the hospital, she was based in the resource centre and 2 afternoons at the COPD clinic that she'd done for 12 months, and over an hour a day travelling to work and the same going back was a little bit much for her, applied for a job in Leeds and she's got a band 7, senior 1.

I So from a 5 to a 7?

F Yes. And if she'd have stayed with us she'd have got nowhere, she'd have stayed on 5.

[Team 7]

Recruitment and retention

The AfC was not only introduced to reward flexible working but also to address issues around retention and recruitment, however staff explicitly blamed AfC for some of their recruitment difficulties.

*'A lot of it is to do with Agenda for Change and we cannot recruit the staff that we need'.
[Team 7]*

We heard senior professional staff suggest that the only way to advance their career would be to move out of the IC setting , for example,

'Once you have fallen out of the hospital system where you can progress your career, it is not easy to go back.' *[Team 1]*

Additionally, the inequities were seen to create tensions within teams

I: Does it create tensions?

R: (laughter)

R: We still love one another!

R: (laughter) [Team N]

Even given that the reported laughter was genuine the fact remains that the question was not answered and the tension that the interviewer suggested was possibly being released in this exchange.

Role boundaries and flexibility

The role boundaries and functions which in staff groups formerly delineated the one from the other are almost entirely absent in the way IC is practised. Role substitutions reinforce the elasticity that the KSF requires, and was generally seen as a positive aspect to the structure of the teams, however it clearly puts a strain on the teams in terms of increasing their workload.

'In terms of our service when we think that the therapy team, the load on us in terms of patient care and our remit with the patients on the service, didn't change, but when the nursing side of the service was pulled out or the role that they historically used to manage, just kind of got thrust onto us, while we were already – as in any service you get peaks and troughs, but we were already fairly stretched in our busy times then, so suddenly we went from just doing the therapy care to managing the health care support workers, managing their one to one supervision, managing their off duty and being responsible for their shift allocation and everything like that, which is an enormous – I think it was a real strain at first because I certainly didn't come into the job expecting to be doing that'. [Team 2]

Recognising and rewarding changing roles

A further difficulty in the application of the AfC arises out of the shifting nature of IC.

Bridges, Fitzgerald and Meyer (2007) describe in their study how role boundaries and actual practices of the role they explored continued to shift well after the role had been accepted and embedded into routine practice in the service. How then can the AfC, which has taken a snapshot of job roles and competences, deal with a moving target? Bridges *et al* suggest that by its emergent nature the new role they studied continually moved away from the established norms to the point where there was less meaningful comparison to be made between the previous and emergent job descriptions. This is again likely to cause confusion

and uncertainty for incumbents but will also mislead staff applying for positions where there is an apparent discrepancy between the role, competence and rewards.

The focus groups provided plenty of detail on the porous and elastic role boundaries that staff negotiate in their daily practice. According to one contributor

'I mean I've been doing this job for about two years so I think the job that I had initially was very different to what it is now.....' [Team 6]

One of the support workers (SW) we (I) interviewed suggested that the harmony between role and performance that the KSF seeks was still some way off.

SW Well I take blood, the support workers are a very mixed group, we all have our areas, but I very rarely get to do it and they will put nurses in the same day as I go in to take a blood, it's quite.. and we've all got skills that perhaps we could use a little bit more.

I So you've been trained to take bloods but you don't take bloods?

F Well I do when I initiate going in to do it myself, but if I didn't make the move forward..... all the support workers have got skills in different areas that perhaps aren't used as much as they could be. [Team 5]

With reference then to the literature and to the thoughts and feelings of the staff what does this mean for the future of the flexible workforce in the modern NHS?

Discussion

The findings of this study reinforce the areas of potential compatibility of AfC with the delivery of intermediate care services. Indeed, the flexibility of the workforce in intermediate care means that it should be the ideal setting in which to implement a harmonised pay structure. However, as the results have shown, there are several areas of tension or incompatibility between the two approaches.

The non-hierarchical nature of intermediate care does not lend itself well to the application of a hierarchical career structure. When intermediate care staff expand their repertory of skills, they tend to become more generic, blurring the boundaries between their own roles and those of their colleagues. To progress along a career structure in AfC requires the application of the Knowledge and Skills Framework which recognises the application of expertise and responsibility. Yet, expansion within intermediate care means taking on a wider range of generalist tasks at the expense of maintaining specialist skills. Taking on a broader generic role is less easy to reward under the KSF. But as one participant pointed out, genericism should be valued as a skill in itself. This notion was further reinforced by the perception that hospital based staff have greater opportunities for career progression, when hospitals typically operate under far more hierarchical structures.

It is important to point out that the flat career structures are not a result of the AfC, and research preceding the introduction of the AfC described similar barriers to staff progression within this setting (Nancarrow, 2007). The application of a uniform pay structure within intermediate care services has highlighted, and possibly reinforced the flat structures across

all professional groups. Additionally, because the structures for promotion do not exist in intermediate care, the roles become difficult to differentiate. What is unclear is whether it is possible to retain the benefits of the non-hierarchical structures of intermediate care whilst introducing career structures along generic pathways.

By acknowledging and rewarding specialisms, AfC inadvertently reinforces a unidisciplinary model of care. Typically, within intermediate care, staff without a professional qualification were grade 4 or below while professionally qualified staff were grade 5 and above. One team had made an exception to this, with a grade 5 'assistant practitioner', however within all other teams, career progression from a grade 4 to 5 was a large hurdle, linked to the attainment of a professional qualification. This is not a fault of AfC, which was designed precisely to allow this kind of progression, but a problem with the infrastructure to support flexible career development outside traditional professional structures. The creation of a new type of grade 5 'generic' role which may be appropriate within intermediate care requires a great deal of innovation from the local service, with the support of the appropriate training institutions. In the absence of a clearly delineated manager to drive this type of initiative, it is unlikely to happen. Instead, within intermediate care, career progression is still seen to be linked to increasingly narrow expertise which is linked to a specific discipline, or taking on management responsibility.

This study has also identified some potential inequities in the application of AfC. For instance, one team did not differentiate between the grade of the manager and the rest of the team, which appears to not reward or recognise the additional management responsibility of that staff member. Staff also highlighted several perceived imbalances in the allocation of grades between apparently similar jobs, but in different settings. It may be that by adopting a

uniform pay structure, AfC has thrown into focus differences in pay that were previously cloaked behind the uniprofessional Whitley Council pay awards.

In essence there is a tension apparent between the old ways represented by the Whitley Council pay scales and the recent modernisation agenda where there is an emphasis on flexibility. The development of IC and the flexibility necessary to deliver it to an ageing population highlights a point of issue: in an attempt to promote fairness and then to enhance patient care, the KSF demands the presence of a career structure and hierarchy. Against this the nature of the job necessitates a more plastic approach. Can the two positions be reconciled, and what does this mean for the future of AfC and the workforce?

The disquiet expressed by staff in the focus groups with regard to their career prospects should surprise no one. It has long been anticipated. Rushmer & Dowling (2000) picked out *Towards a New Way of Working* (DH, 1998) as a document that called for the 'flatter' career structures. Rushmer & Dowling (2000) further note that while these 'flatter structures' may well function to encourage employees to 'cluster' in teams and while this in itself may have beneficial effects in care delivery they nevertheless 'offer little chance of promoted posts in the traditional sense' (2000:2297). They progress their argument by suggesting that 'development' might be replacing promotion as a career move as the NHS seeks more generalist practitioners (2000:2298).

The move from the Whitley Council rates through the grading exercise of the mid 1980s to the present banding system introduced via the AfC suggests a gradual process of moving away from universal and foundational certainty. In this respect the NHS may be described as adopting a more 'postmodern' stance as it reinvents itself to cope with the demands of a post industrial age.

As the emphasis in health care has moved from providing acute and critical care to managing long-term conditions the shape of the workforce has had to alter. This flexibility that is sought in providing healthcare can be achieved in several ways. The AfC, paradoxically, attempts to introduce flexibility by adopting a hierarchical structure. Within intermediate care, there is plenty of room for manoeuvre within the bands as staff perform a variety of roles and tasks. But there are few opportunities to progress between bands because of the non-hierarchical structures of intermediate care.

Conclusions

The implementation of AfC is still relatively recent, therefore our study only represents a snapshot of one period in its evolution in one setting. Additionally, this study only reports the findings from 11 teams, which, whilst we believe that this reflects a fairly representative sample of intermediate care teams, it may not be represent the views of all intermediate care services.

We found that attempting to overlay the hierarchical structure of AfC on top of the flat intermediate care structure does not achieve the original goals of AfC. However, what is not clear from our findings is whether it is the intermediate care structures that need to adapt to embrace the new career framework, or whether the AfC needs to be altered be able to recognise more 'generic specialisms'.

It appears that staff in intermediate care, on the one hand, value the benefits that a flat career structure brings, of generic working and role blurring, but on the other, suffer from the lack of career development opportunities themselves, and in their ability to retain and recruit staff.

The non-hierarchical team structures appear to work well in the delivery of intermediate care services, and it may be that forcing this group of services into a hierarchical framework will impair the delivery of care. If applied correctly, AfC has the potential to facilitate the types of career development opportunities desired by staff, however this is likely to require both innovation from the services to create these hierarchies, and support from appropriate educational bodies.

This study has reported on unanticipated findings arising from interview data which were collected to answer other research questions. As the AfC was not the primary focus of the larger study, we did not specifically explore this area in depth. Respondents were never asked to comment specifically on their attitudes towards pay and conditions. They were nevertheless vocal in expressing their concerns. This in itself suggests that more attention needs to be paid to the subjective emotions of the workforce who are asked to undergo major modifications in respect of their employment. Had the AfC been the main focus of this study, we would probably have obtained a more detailed and nuanced understanding of the impact of this significant initiative and we suggest that there is a need for more research in this area.

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Traditionally, health care delivery has been defined and dominated by established professional and paraprofessional groups (Larkin 1983; Friedson 1988). Workforce shortages, alongside an increasing focus on patient centred care, call for a labour supply that is able to respond to the needs of patients, rather than one characterised by practitioners who are constrained by professional role definitions and traditional organisational hierarchies (Calpin-Davies and Akehurst 1999; Department of Health 2000; Department of Health 2004). Despite decades of protection of professional titles and roles, it is well documented that some forms of care can be delivered by more than one type of practitioner (Richardson, Maynard et al. 1998; Cooper 2001; Booth and Hewison 2002). For instance, in many countries, nurses have compensated for doctor shortages by expanding into traditional medical roles such as prescribing and minor surgery (Richards, Carley et al. 2000; Appel and Malcolm 2002). The UK has introduced a number of policies and programmes to address workforce shortages, resulting in the development of a range of new flexible models of workforce development and delivery (Department of Health 2000; Department of Health 2002; Department of Health 2002; Changing Workforce Programme 2003; Changing Workforce Programme 2003; Department of Health 2004; Department of Health 2004).

