Identifying Successful Training Initiatives in the Hospital Sector

Final report to EPSU and HOSPEEM

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1.0 Introduction

1.1 Aims and objectives of the study

The key aim of this report is to analyse how the social partners in the hospital sector have addressed the issue of meeting new skill needs and the adaptation of existing job profiles to deal with the new challenges and requirements facing the sector in Europe. This study informed a key debate during the conference "Formalising the European sectoral Social Dialogue in the Hospital Sector" in 2006 and is intended to inform the ongoing dialogue between EPSU and HOSPEEM.

The report provides a short overview of categories of health professionals and workers. It also discusses skill needs and workforce challenges in the hospital sector. It then analyses the key trends in the evolution of the roles and responsibilities of these professions as well as the role of professional qualifications in the ability to undertake new roles. This analysis also examines the potential or existing difficulties in introducing new definitions of roles and new skills. The report will then provide examples of national initiatives to introduce new skills to health professional and workers and identify a route map on how the above mentioned issues could be addressed by the social partners in the framework of sectoral social dialogue. The report will summarise the main findings in the conclusions.

It is not the aim of this study to elaborate all existing job profiles among hospital sector staff and the training requirements for each role in different EU Member States. The emphasis of this study is on the key challenges facing the European hospital sector relating to technological, economic, social and demographic change and the way in which this is affecting skill requirements and job profiles. It provides examples of how training and job profiles have been adapted in different countries to meet these requirements in order to act as an inspiration for the social dialogue process.

1.2 The hospital sector

Hospitals are facing multiple challenges relating to significant developments in the economic, demographic and social conditions in which they operate, technological innovations and by changes in the scale and nature of the policy response to these developments. To secure workforce skills to support the implementation of changes in delivery across the hospital sector, there is a growing recognition of the need for a more efficient and effective use and deployment of hospital professionals and workers.

Assessing changing skill needs in the hospital sector is an area of crucial concern as countries strive to reform and improve the performance of their health services. The workforce in the hospital sector is particularly complex with many different professional groups with distinct roles and their own educational and regulatory structures. The new challenges brought about by recent health care reforms appear to require on the one hand a more holistic approach, brining together the skills of different professional groups, and in other areas greater specialisation and an adaptation of skills to new technologies and medical advances. As a result, it is likely that some roles will expand to incorporate additional responsibilities while others will be entirely new. The hospital sector needs to develop training and development programmes for hospital professionals and workers in order to meet these new requirements. It is therefore important to analyse how responsibilities have or will be changed and how this can adequately be reflected in training initiatives.

Work in the hospital sector revolves around effective patient care and is very labour intensive. It requires a sophisticated mix of clinical, managerial, technical and other service related inputs, which must be maximised to achieve the best possible care outcomes in line with ever evolving clinical innovations and protocols.

1.2.1 Recognition of qualifications for hospital professionals and workers

At European level, the European Commission has embarked upon a reform of the system for the recognition of professional qualifications, in order to help make labour markets more flexible, further liberalise the provision of services, encourage more automatic recognition of qualifications, and simplify administrative procedures. The proposal for a new Directive in this field aims to consolidate fifteen directives into one piece of legislation. These include twelve sectoral directives - covering the professions of doctor, nurse responsible for general care, dentist, midwife and pharmacist - and three directives which have set up a general system for the recognition of professional qualifications and cover most other regulated professions.

The Directive adopts the principle of automatic recognition for medical and dental specialisations common to at least two Member States under existing law, but restricts future additions to Directive 2005/36/EC of new medical specialisations - eligible for automatic recognition - to those that are common to at least two fifths of the Member States. Moreover, this Directive does not prevent Member States from agreeing amongst themselves on automatic recognition for certain medical and dental specialities common to them but not automatically recognised within the meaning of the Directive, according to their own rules.

1.2.2 The challenge of developing a qualified workforce

There are significant disparities between countries in how workforce development policies and strategies in the health sector are initiated and implemented. There is a need to provide the hospital sector with specific tools and methods to identify skill needs arising for the challenges facing the sector; and to support the redesign and extension of existing roles, as well as the development of new roles. In addition, there is a need to develop frameworks that increase the transferability of competence and qualifications.

2.0 Roles in the hospital sector

2.1 Professions in the hospital sector

The professions in the hospital sector include medical and non-medical staff. Medical staff includes doctors, dentists, nurses, midwives, pharmacists, biologists, psychologists, physiotherapists, occupational therapists, masseurs and laboratory specialists. Non-medical staff includes administrative, finance and accounting staff, as well as managers.

2.1.1 Medical staff

Medical staff in hospitals includes doctors, nurses, midwives, pharmacists, biologists, psychologists, dentists, physiotherapists, laboratory analysts and many other professions. Almost each of these categories, especially among doctors, dentists and nurses, is divided into specialisms. For example, in the UK there are over 60 medical specialisms among doctors as well as nurses.

Most of the medical professions are regulated. That means that in order to perform the tasks under a given role, there is a statutory requirement to hold a diploma or other occupational qualification. The number of regulated professions in the EU differs depending on the country[I].

The characteristics common to the education of doctors in the EU is the completion of a medical degree followed by a period of in-service training. Similarly, most nurse education is carried out at tertiary level, although some countries, such as Poland, still have a large number of secondary nursing school leavers[II]. In Italy, following the 1992 NHS reform, doctors and other health care professionals have more of a managerial role and to be hired by the health companies - they need to have a specialization that takes another four to five years training at University.

The content of medical training tends to be regulated at the central level whereas for some other professions (e.g. nursing in Germany) regional (*Länder*) level responsibility applies. Even in such federal systems, national benchmarks exist that serve as a basis for the education and training curricula.

In some countries, such as Sweden, the required skills and competences for each medical specialism are set by the specialist societies within the Swedish Medical Association and the Swedish Society of Medicine and are then authorised by the National Board for Health and Welfare.

2.1.2 Non-medical staff

Despite the emphasis on patient care, hospitals also employ a large number of non-medical staff to ensure the efficient running of the service. These groups include:

- *Managers.* Managerial staff are an important part of the health care workforce. In most countries managerial staff requires a general education background. However, in some countries, such as in the UK and Italy, it is considered desirable for managerial staff to have previous experience in the health care sector.

[I] For an overview of the regulated professions in the EU see European Commission's website: http://europa.eu.int/comm/internal_market/qualifications/regprof/regprofs/dsp_bycountry.cfm

[II] The recruitment to secondary nursing schools was terminated in 2004.

- *Support staff*. Support staff include the UK health care assistant (HCA), Polish medical secretary, laundry, kitchen / cooking, cleaning staff, etc. In England alone, the number of HCAs is approximately 200 000. Support staff is the second largest category in the NHS[I]. It is, therefore, a group that accounts for a large part of the hospitals' workforce. In Italy, in recent years more and more of the support services have been outsourced.
- *Administration, finance and accounting*

2.2 Role definition

The countries analysed as part of this research have demonstrated different approaches to the definition of roles in the sector. In some countries, such as in the UK and Ireland, the roles are defined very thoroughly and the importance attached to skills and their development is very high. In other countries, however, the roles are less thoroughly defined and the flexibility of taking on new responsibilities is greater (Germany, Sweden, Poland). It is of crucial importance to note that there are differences attached to skills and qualifications in general. In some countries, such as in the UK, Ireland, skills are considered to be an important part of the role and individual development.

In some countries, such as Poland, greatest emphasis is placed on vocational qualifications whereas the acquisition of key skills is considered to take place through work experience. This has both advantages and disadvantages. Having thoroughly defined roles in the sector undoubtedly helps in assessing skill needs and mapping existing skills within the sector. It also helps in human resource management. However, a disadvantage of such a rigid system is that skills and competences can go on recognised. This may lead to lower recognition of work actually undertaken and difficulties in assessing skills needs for particular professions.

It is very important to note here that in some countries the existence of specialist titles and their protection does not necessarily mean the protection of the scope of activities. In Germany, for example, a nurse can access any nursing activity, with the exception of the nursing teacher, who has to specialise. A similar situation is found in Poland. There is, however, pressure to designate spheres of competence to specialist nurses, as there is undoubtedly a value in possessing specialist training and a title.

2.3 Regulation of lifelong learning

Continuous training for many of the medical professions, including doctors, nurses and midwives, is regulated either at national or at regional or local level. As mentioned above, ongoing training in Germany is regulated at regional level, whereas this responsibility is decentralised further to the local level in the UK and in Sweden. In Italy, continuous training of doctors and other health care professionals is regulated by national law and by legislation at regional and local level. The national and local bargaining is complementary to the legislation.

Lifelong learning is often supervised by the respective professional bodies and is provided for by law. For example, in Poland, lifelong learning is regulated through the laws applying to the medical professions. At present, lifelong learning is regulated for three professions – doctors, dentists and pharmacists. In the case of nurses, continuous training is regulated up to the specialisation level. In the UK, lifelong learning is regulated by Knowledge and Skills

[I] In the UK NHS, the largest category is nursing, followed by support staff, physiotherapists, occupational therapists, etc. The least numerous group are doctors.

Agreements. At present, the Sector Skills Agreement (SSA) for the Health Sector is being prepared. The aim of the SSA is to align the employer, learning providers, the funding bodies and the government around the set of goals that will deal wit the skill needs in the sector and the training provision for health care staff[I].

In Sweden, collective agreements at national and local level provide for competence plans, to be negotiated between each employee and their line manager on an annual basis.

As regards the situation for support staff, the position is different. For example, until recently in the UK the training was focused on doctors and nurses, for whom most of the training budgets were allocated to the detriment of the support staff. At present, there are number of programmes that focus on the developing skills and competencies of assistant role in the health sector (see section 4.2.2 of this report).

2.3.1 Example – Sweden

2.3.1.1 *Doctors*

At individual level, once a year each doctor has 1 or 2 hours interview with their executive. The interview covers the employee's performance, development, need for medical training and salary review. The training needs are therefore a matter of individual planning based on an employee's performance. The costs of training are fully or partially covered by the employer. Additionally, collective agreements at national and local level provide for competence plans, which are intended to provide for annual skills development plans for each employee and are reviewed by the individual's line manager.

At the level of the profession, the Swedish Medical Association in cooperation with the Swedish Society of Medicine runs a programme to review and evaluate the quality of training programmes each year.

The reviews are also carried out by the Institute for Professional Development of Physicians in Sweden (IPULS). Currently, the Swedish Medical Association is developing a website complement (to the IPULS website) where individual doctors can check their continuing professional development[II].

A recent review of the medical specialisations was presented in 2003 to the National Board of Health and Welfare. This review included a proposal of dividing the specialisms into main and branch specialisms. Also, there was a government proposal of adding a clinical research training programme as complementary to some specialisms[III].

2.3.1.2 *Nurses*

Approximately 45% of nurses specialise 2 or 3 years after they have registered. The training is scheduled in a different ways, namely full time or part time 0.75/0.25. The nurses usually work in parallel. Due to workload constraints nurses can undertake distance or e-learning.

[I] For more information on Sector Skills Agreement see:
http://www.skillsforhealth.org.uk/ssa/about.php?page=1

[II] National Report 2004 Sweden, The Swedish Association of Hospital Physicians, AEMH 05/022, 12.04.2005, p.5

[III] Ibidem, p.5

The social partners often have an informal influence on the lifelong learning agenda. This takes place through continuous consultation within the social dialogue where variety of issues is discussed. However, there are no collective agreements at national level that would provide for the training curricula for the health care sector.

In general, there are differences between hospitals, as the local health authorities are responsible for their own competence development and training programmes. In addition, some hospitals have introduced the so-called 'career ladder', which, in short, is a programme for nurses to advance in knowledge and responsibilities. The projects under the programme are often prepared together with the social partners.

3.0 Challenges facing the hospital sector

3.1.1 Economic factors

As European societies age and the pressure towards better service delivery increases, expenditure on health and social services in constantly rising[I]. At the same time, workforce and skill shortages already recognised in several countries, put pressure on changes in human resource management in the health sector in order to achieve maximum efficiency within the available resources.

3.1.2 Social change

In the health service, as in many other public services, the public demands continuous service improvements, which require the regular updating of skills and competencies among staff. One of the changes that can be observed in health care is the trend shifting care from hospital towards community / home based care and general practices. This trend can be found in the recent reform plans of the NHS in the UK. The White Paper "Our health, our care, our say: a new direction for community services" envisages more localised budgets, and GPs having more responsibilities in terms of budgetary planning and management[II]. The reform also envisages an increased number of new operators in the health care sector, including private providers. This is expected to increase competition between the health care providers, thus pushing up standards. Greater emphasis will be placed on prevention and joined up services, such as social care and health. This will require interdisciplinary teams.

This trend is also present in Sweden and in Ireland, where care is brought closer to patient's homes. Also, health and social services are to be integrated in order to achieve a maximum efficiency and delivering the best possible quality of service[III]. This trend is also beginning in Italy, supported by the national collective bargaining.

3.1.3 Technological progress and medical advances

Technological progress is an important factor of change that demands continuous upskilling of the workforce in order to take advantage of the new technological inventions or improvements in the provision of health care service. The technological advance is likely to change the mix of jobs and occupations in the future. An example may include the advances in IT which reduced the burden for clerical staff but in turn created job opportunities in the IT field[IV].

Another important development is telemedicine which may ease the move away from the hospital and solve problems of remote rural areas in Europe (such as Norway). Moreover, changing lifestyles and much more facilities at home allow elderly and patients with chronic illnesses to be cared for at home rather than in a hospital setting.

[I] See for example: Healthcare expenditure: a future in question, OECD Observer, December 2001

[II] Our health, our care, our say: a new direction for community services, January 2006, available at: http://www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf

[III] See for example: Quality and Fairness: A Health System for You, Health Strategy, Department of Health and Children, Ireland, 2001, p.16

[IV] Nolte E., Human resources for health and health system functions: trends, opportunities and challenges, European Observatory on Health Systems & Policies, 2nd Policy Dialogue in the Baltic Countries, Vilnius, 26-27 September 2005, PPT presentation

It is also expected that the developments in particular fields of medicine, such as surgery, oncology or cardiology will lead to concentration of expertise.

The development of IT will lead to changes in working practices among health care staff as it will allow for better information sharing and education (digital libraries, online databases, distance learning, online education, etc.) and record-keeping (electronic patients' records). This might also lead to the emergence of more empowered group of patients that would not be willing to accept uncritically the model of care provided to date[I].

3.1.4 Demographic trends

Due to the ageing workforce and insufficient replacement rate between the leavers and new entrants there could be serious workforce shortages in the future. This is the case in the UK, where the retirement of 100 000 nurses is expected until 2010[II]. In Sweden, the demand for GPs has been constantly rising from 4 500 in 1999 to 6 000 in 2008. At present, there are also shortages observed within the nursing staff, in particular the specialist ones[III]. These shortages will have a significant impact on the workforce profile as the employees who will leave will be the most experienced ones. When skill shortages are severe, it may also become necessary to remodel certain roles in order to allow other professions to carry out certain tasks.

3.1.5 Regulatory / political developments

Another challenge are the regulatory and political changes that have influence on the sector. The most important developments identified were employment ceilings for professions and the implementation of the EU Working Time Directive.

3.1.5.1 *Employment ceilings*

The hospital sector in Ireland, for example, experiences problems with a shortage of skilled staff due to the employment ceiling for professions, which also include health sector. Currently, it is a large problem for the trade unions as many hospitals employ people above this ceiling. As a result, when one person leaves their job it is difficult to fill that position.

The employment ceilings lead to outsourcing of the support functions to agencies. These functions include childcare, administration and environmental waste management. It is argued by the trade unions that outsourcing and privatisation lead to bad value for money as the agency employees are paid twice as much as hospital workers. Moreover, their job is not regulated by the same sectoral regulations as for the health care sector. It is therefore difficult to ensure the same quality of service, as well as monitoring and supervision of their work. Also, outsourcing leads to a decline in skill levels among the health care workforce.

Another example includes Poland where in 2003, the number of specialised posts for doctors was limited. Those hospitals which were accredited to run a specialist training programme that would prepare young doctors for specialisation have to run competitions to fill in the specialist posts. The demand for these posts is very high as it is very difficult for doctors without a specialism to get a job. Since the demand is very high and the supply is very limited many doctors decide to work in pharmaceutical companies or other related sectors.

[I] Ibidem
[II] UNISON National Student Survey 2005, UK, p.10
[III] See: The Healthcare System in Sweden, Factsheet, available at: http://www.sweden.se/templates/cs/BasicFactsheet____6856.aspx

3.1.5.2 *Working Time Directive*

An example that sparked much controversy in the health sector was European Working Time Directive (WTD). The most important problem associated with case law associated to the Directive (SIMAP[I] and Jaeger[II]) was the on-call duty time spent on the employers' premises which should be included when calculating working time. In order to solve the difficulties caused by the SIMAP and Jaeger judgements, some hospitals have argued that they would have to employ extra staff. For example, in Germany, the implementation of the Directive would have to result in the introduction of the three-sifts' system which would require 15 000 - 27 000 additional physicians[III]. In the UK, 12 500 additional physicians would be required. As a consequence, the costs for the health care sector would increase dramatically. In order to comply with the requirements of the original Directive, some countries, such as the UK, introduced pilot programmes that aimed at testing the process of reducing doctors working time (especially junior doctors as they work longer due to training requirements). Almost all the pilots were able to increase the junior doctors' compliance with the Directive[IV].

[I] C-303/98 SiMAP v. Conselleria de Sanidad y Consumo de la Generalidad Valenciana, Judgment of the Court of 3 October 2000, Rec.2000, p.I-7963

[II] C-151/02 Landeshauptstadt Kiel v Norbert Jaeger, Judgment of the Court of 9 September 2003, Rec.2003, p.I-8389

[III] Country report – Germany, European Association of Senior Hospital Physicians, AEMH 04/029, April 2004

[IV] For more information see: Working Time Directive, Pilots Programme Report, NHS Modernising Agency, 12 January 2005, available at: http://www.wise.nhs.uk/sites/workforce/usingstaffskillseffectively/Document%20Library/1/WTD%20Final%20Report.pdf

4.0 Response to challenges

As discussed above, key challenges in terms of skills developments relate to economic, social, political demographic and technological changes. New trends and developments have led to skill shortages as well as the need for new skills. This section will outline how the hospital sector in some countries has responded to meet these challenges.

4.1 The importance of workforce planning

The workforce and skills shortages caused by the challenges outlined above demonstrate clearly the need for improved workforce planning which links an understanding of the skills in the current workforce and the availability of staff in the wider labour market with service planning. A full understanding of the current workforce - including skills and age profile, as well as reasons for retention difficulties as well as future service requirements can assist in the formulation of better skills development packages. As well as the upskilling of existing staff this can involve the remodelling of certain roles to respond to new requirements or indeed to staff shortages.

4.2 Recruitment from abroad

When faced with staff and skill shortages, health care sectors in many EU countries have sought to increase recruitment from abroad. The supporters of that solution say that foreign recruitment contributes to addressing serious skill shortages at relatively low cost. However, the opponents / critics underline the fact that foreign recruitment is not a long-term solution as it does not address the source of a problem, being the internal supply of qualified workforce. Moreover, foreign staff are likely to leave the country after a certain period. Finally, the demand for health care professionals is expected to intensify and has already overtaken supply. Consequently, it is possible that the supply of foreign health professionals may drop significantly[I]. There are also ethical issues around the problem of migration, namely developing ethical standards for recruitment and monitoring of the recruitment agencies.

Recruitment of the foreign staff can be problematic due to different standards for obtaining a qualification as well as on the in-service training. This problem is particularly important for regulated professions in the EU.

Free movement of goods, services, capital and labour is one of the core values of the European Internal Market. In the context of the free movement of labour it is therefore crucial for individuals to have their qualifications and skills recognised across the EU.

There are two regimes that facilitate the mobility of professions, namely general and sectoral regime. General system may require case by case evaluation of the diploma in order to facilitate the recognition of qualifications. Sectoral regime is based on minimum training standards and is detailed in sectoral directives. The minimum common criteria allow for automatic recognition of the qualifications. Until 2005, there were 12 sectoral directives.

[I] Skills needs in the Irish economy: The Role of Migration, p.89-90

The proposed reform of the recognition of qualifications envisages consolidation of three general system directives[I] with twelve sectoral directives[II] covering the seven professions of doctor, nurse, dental practitioner, veterinary surgeon, midwife, pharmacist and architect[III]. These pieces of legislation were merged into single text, namely the Directive 2005/36/EC[IV]. The new Directive will be effective as of 20 October 2007.

A similar process has just begun for the recognition of competences through the European Qualifications Framework. This applies in particular to the unregulated professions, to which the entry requirements are usually not rigidly defined and who have to rely on their competences much more. This finding is particularly relevant for the hospital sector, in which the large number of non-regulated occupations is represented.

The issue of cross border recruitment is the subject of more detailed exploration in another report and will therefore not be discussed further in this study.

4.3 Upgrading competencies, recognising skills and redefining roles

The consequences of the social, economic and regulatory pressures were serious skill needs and skill shortages among hospital sector staff. Two main responses to these challenges are highlighted here: the upgrading of skills of existing staff and the development and redefinition of roles. These responses will be set out in the sections below, followed by a discussion of the issues facing the hospital sector in seeking to provide staff training.

4.3.1 Upgrading competencies and recognising skills

The most important skill needs occur among non-registered and caring staff. Since until recently most training was focused on doctors and nursing staff, non-registered staff and caring professions did not have equal access to funding for training. Although the situation has changed it is still necessary to define skill requirements for these two groups that would form the basis for training programmes. In addition, it is necessary to define standards of qualifications, especially for caring professions, in order to improve the quality of service delivered by this group.

At present, most of the HCAs in the UK come from BME backgrounds. Moreover, there is increased migration among health professionals across the EU. As a consequence of the increasing diversity of the workforce and societies, cross-cultural competencies become very important and there is a need to equip staff with such skills to allow them to perform better. These skills would include soft skills, managing diversity, conflict resolution or flexibility in the workplace.

As nurses and doctors take on more managerial duties, they require training to perform these tasks. Specialist training is also required for hospital managers to adapt to the changing needs of their workplace.

[I] Council Directives 89/48/EEC and 92/51/EEC and European Parliament and Council Directive 1999/42/EC

[II] Council Directives 93/16/EEC, 77/452/EEC, 77/453/EEC, 78/686/EEC, 78/687/EEC, 78/1026/EEC, 78/1027/EEC, 80/154/EEC, 80/155/EEC, 85/432/EEC, 85/433/EEC, and 85/384/EEC

[III] For more information on the reform of the system see: Reform of the system for the recognition of professional qualifications on SCADPlus at: http://europa.eu.int/scadplus/leg/en/cha/c11065.htm

[IV] Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications, OJ L 255, 30.9.2005, p.22-142

Demographic change is set to increase skill needs, in relation to the more chronic, and often more debilitating ailments suffered by individuals with increasing age. At the same time, it will also have to address the increasing demand among patients to remain independent and receive care in their own homes[I]. The greater empowerment of patients will require additional skills from the part of the health care staff, such as pedagogical and communication skills. A growing number of older patients may result in shortages in fields like geriatrics or insufficient provision of care at home.

In Italy, laws and employment contracts have re-assessed the skills of nurses and health professionals in order to upgrade the knowledge and competence of the health workforce and create a more modern health service[II]. Other examples of initiatives aimed at upgrading and recognising skills can be found in section 5 of this report.

4.3.2 Development and re-definition of roles

Financial demands and the need for greater efficiency have resulted in a drive towards a different organisation of roles within hospitals. There is a general tendency to delegate some of the administrative and other auxiliary tasks, but also some clinical tasks to other professional or auxiliary staff. This applies in particular to nursing, whereby the roles of nurses are expanded so that they take on some of the tasks previously performed by doctors and to assistant staff, who take on the tasks previously performed by nurses. This trend is particularly visible in the UK and Sweden. Specific examples include UK clinical nurse specialists, who take on some of the responsibilities of doctors, for example in oncology or tuberculosis.

This delegation of tasks also takes place within some categories, such as registered and non-registered nurses in the UK, where the latter take on many responsibilities of registered nurses. Registered nurses, in turn, take on many administrative and management roles.

As mentioned in earlier sections, the approach towards care has changed, now embracing care provided in patients' homes. This results in the change of some training programmes. For example, in Sweden, nurses are also trained outside hospitals to provide care at patient's home.

4.3.3 Emergence of new roles

Greater specialisation and the increased delegation of tasks to different occupational groups have often resulted in the creation of new roles. In the UK, the main change of roles involves the expansion of the role of nurses in order to increase the amount of clinical and surgical hours for doctors. Also, there are new assistant roles in order to increase the capacity of more senior staff. The examples of new roles include:

4.3.3.1 *Advanced Practitioner*

This role is being developed by the Greater Manchester Strategic Health Authority over the next 3 years. The main drivers for developing the new role were:

- modernisation of the workforce and delivering better service to the patients;

[I] Swedish Health Care in an International Context – a comparison of care needs, costs, and outcomes, Swedish Association of Local Authorities and Regions, Stockholm, 2005, p.4

[II] Aran: 'Assessment skills needs of health professions in Italy', EPSU conference, Brussels 16-17 March 2006

- reductions in the number of junior doctor posts as a result of the EU Working Time Directive;
- provide professional / registered staff with opportunities for career progression and to advance their skills; and
- change of recruitment patterns due to the workforce profile (large number of people aged 30 – 40 years)[I].

The role is a senior role designed to support medical staff, who are increasingly retiring[II]. The new role is supposed to relieve the medical staff of some duties in order to increase the time the spent on clinical tasks. At the same time, the role is designed to make up for staff shortages. The examples of the tasks of the Advanced Practitioner include admission and discharge, prescribing and working between services, professions and localities.

4.3.3.2 *Assistant Practitioner*

The role is also developed by the Greater Manchester Strategic Health Authority in the framework of the 'Work, Earn and Learn' Assistant Practitioner Programme established in 2001. The programme is a 2-year training programme in which trainees learn on the job. The main motivation for introducing the role were:

- improvement of the workforce capacity and capability, as well as the quality of service delivered to the patients;
- recognised shortfall in the number of clinical staff in 2004-2005[III];
- forecast workforce shortages in clinical staff by 2088/9; and
- increase of career opportunities for support staff.
  The role of Assistant Practitioner is below the registered nurse level and is supportive to the practitioner.

Both roles are viewed as increasing the skill mix and modernising the workforce in the sector.

4.3.3.3 *Medical emergency practitioners*

In Poland, medical emergency practitioners have become important members of the ambulance teams and can perform many tasks previously undertaken by doctors. Although the role is not new as such, its development and 'use' has been recently increasing, especially in light of the preparation of a new law on medical emergency practice. It envisages a separate education path for medical emergency practitioners and regulates many issues, such as professional liability and the scope of responsibilities. The existing law on medical emergency practice has not been implemented due to its complexity, which has caused substantial problems as regards training, career path and scope of responsibilities.

4.3.3.4 *Senior nurses*

The original idea for introducing the modern matron in the UK was a survey that sought public's view on the NHS. The survey's findings showed that there was a considerable desire among the public to reintroduce the role of a matron. Historically, the matron was a person not only in charge of nursing but of non-nursing tasks as well, such as cleaning and catering. In response to the public's view, the government decided to reintroduce the role of a modern matron. The new role would be based on the old matron role and would provide for a strong

[I] Delivering the Workforce: The Mancunian Way, The reality of workforce redesign, Manchester Conference Centre, 28th April 2005

[II] The details about the role can be found at: http://www.gmsha.nhs.uk/core/dtw/advanced_practitioner_leaflet_the_advanced_practitoner_role.pdf

[III] *Delivering the Workforce – The Assistant Practitioner*, Workforce Development Confederation, Greater Manchester NHS, Learners Journey Conference, PPT presentation

leadership among hospital staff and would help ensure the best possible quality of care for the patients thus providing a single point of contact for the public.

During 2001, Great Ormond Street Hospital began work to apply this role to their hospital. The work included consultations with numerous groups, which dealt with for example with the name of the position. As there was a strong opposition from the male workforce to call a new role 'matron', it was decided that the role's name would be 'senior nurse'. The workload would include 50% clinical tasks in order to keep the nurses' clinical expertise and 50% of family and patient support across variety of areas[I]. The great advantage of the new role is the familiarity with and deep understanding of the clinical setting. The role description was very detailed and there was no misconception on the role. The main weaknesses of the new role included confusion of roles with the existing role of the ward sister.

It is expected that the new role will provide a high visibility for senior nursing staff and will also contribute to better quality of care for patients. So far, the role has been evaluated positively in terms of patient satisfaction. However, there are doubts raised as to whether the role is not coinciding and overlapping with the existing role of the ward sister.

Another important issue is the understanding of such new roles among staff. The lack of such understanding can be a severe obstacle for the introduction of a new role into the system. This can be illustrated by the example of Poland, where the role of medical rescuer is not often fully appreciated by the hospital management and it is reduced to that of a paramedic. This results in the misuse of skills and inefficiencies in hospitals.

4.3.4 Key issues relating to training provision

One of the key issues associated with new role development is the necessity to develop appropriate training provision and to generate peer support. Some roles, as indicated in the previous section, are piloted prior to being integrated in the overall skills / role framework. During such exercises it is important that the new role is understood by other members of staff and it is supported sufficiently in its implementation. In many cases the introduction of a new role (or a modification of an existing one) is supervised / mentored by more senior persons. However, as some interviewees have noted, it often happens that they are not paid extra for that task, for which they need to demonstrate additional skills. Hence, the quality of the support as well as availability of staff and willingness to take on more tasks might be reduced.

Financial support for training schemes is often insufficient or simply not available. Many heath care systems, such as the NHS in the UK or the Polish health care system, are facing significant financial problems. It is therefore difficult to allocate sufficient resources for training. Furthermore, in the UK, the problem with the funds for training is not necessarily associated with the total sums available but with their use by individual NHS trusts. Some of the interviewees claimed that in the past the funds available for training have sometimes been used to offset current financial problems of the trusts. In order to improve that situation, a more targeted approach is needed from the part of the policy-makers and more specified use for the funds is necessary.

Moreover, it is often difficult for health care management to release their staff for training as they 'lose' them from their post and often there is no one available to cover their absence. In case of the UK, the NHS is currently understaffed and experiencing financial crisis which also play an important role as regards the training investment from the part of the health care managers. Many interviewees have underlined this factor as being one of the largest difficulties in the training provision for the sector.

[I] Modernising matrons, Roundabout, Great Ormond Street Hospital, August 2002, available at: http://www.ich.ucl.ac.uk/roundabout/august02/matrons.html

Lastly, there are still managers who perceive training to be an expense rather than an investment. Some health authorities do not provide training as they are afraid that the staff might leave. However, there is not much evidence confirming this trend. Moreover, the available evidence shows that the training of staff will enhance their loyalty to a given health institution and improve their performance[I].

A very important factor is the approach to training and willingness to undertake it. Many of the initiatives, such as SKILL in Ireland (see Section 5.1) and projects initiated by Unison in the UK (see Section 5.2) prepare health care staff to go back to the classroom. Many of the staff have worked for many years in their positions but have not participated in any classroom activity ever since they graduated. It is important therefore to encourage people to return to studying and to increase their skills and knowledge. Other projects would seek methods to validate informal learning in order to ease the employment of skilled migrants in the health care workforce (see Section 5.3).

The encouragement and support given to staff from the part of the management may not always be sufficient to undertake training. In some cases the link between the upskilling and pay is very weak which acts as a disincentive to undertake additional training[II]. Some interviewees underlined that although the link between the pay and upskilling is a matter of an individual employer, they also state that in order for the training programmes to succeed they should be linked to progress at work.

An important issue that emerged during the course of the study was the significance of the intercultural competencies among the health care staff. The most typical problems that occur due to the cross-cultural barriers are unsuccessful delegation of tasks and poorer performance of the team in general. Although there exist initiatives aiming at training the health care staff in intercultural skills, there is a general difficulty in determining the scope and nature of these skills. This would serve on the one hand as a basis for designing the training courses and on the other as a set of skills that can be integrated in occupational standards and thus could be supported by training programmes and monitoring.

The delivery of training programmes in the health care sector is an important part of recruitment and retention policies, which is difficult in many countries. The UK Skills Escalator initiative has been designed to attract more workers into health sector and to allow them to progress at work and thus ensuring the right skill mix in the sector. The initiative envisages two paths of upskilling of the workforce:

- A person with a certain professional grade can expand their skills at the same responsibility level;
- A person can expand their skills with the aim of progressing to another level of responsibility[III].

The initiative also adopts a more flexible approach towards the entry requirements, which now will be complemented by cadet programmes and role conversions.

The constraints of the workload of workers and the necessity to adopt a flexible approach towards learning also shift focus to validation of informal learning which might contribute to ensuring the right skill mix in the sector.

[I] The interview with a representative of UNISON in the UK (5.04.06)

[II] See for example: UNISON Student Nurse Survey 2005

[III] For more information see: Department of Health website: www.doh.gov.uk. See also: Skills Escalator at: http://www.skillsforhealth.org.uk/workforce-1.php

5.0 National initiatives

5.1 SKILL project – Ireland

5.1.1 Background

The health service in Ireland is one of the largest public employers, with 113 800 employees in 1998. In 2003, this figure rose to 171 800, which represented the increase of 51%. In 2001, the Government launched a new National Health Strategy "Quality and Fairness: A Health System for You", which was preceded by public consultation, and which sets out goals for development. One of them is human resource development, i.e. continuous learning and continuous improvement in the skills and experiences of all staff working within the Irish health service sector.

In 2004, the Government published its Health Reform Programme that envisages large-scale organisational change in the health sector. Also, in January 2005, a new Health Service Executive was established. The project's idea builds on previous work carried out over a number of years, which include the Final Report of the Review Group on Health Service Care Staff (2004) and the benchmarking publication Recognising and Respecting the Role (2003)[I]. Both studies identify gaps in terms of the training provision and development opportunities for staff working in support grades within the health services.

5.1.2 Project aims and objectives

The SKILL project (Securing Knowledge Intra Lifelong Learning) aims to educate, develop and train support staff in the health services to the optimum of their abilities in order to enhance their role in the quality of service to patients / clients.

At present there are approximately 28 500 support staff is employed in Irish hospitals.
Support staff and support service managers include healthcare assistants, porters, catering assistants, household staff, semi-skilled persons / crafts-person's mates / maintenance persons, home supports workers / community carers, family support workers, general assistants, CSSD/TSSD technicians, therapy assistants, speech and language assistants, laboratory aides and laundry staff, etc.

The objectives of the project for support staff and support service managers are to:

- Provide an opportunity to return to learning;
- Update and extend knowledge, skills and to improve job efficiency and effectiveness, and consequently improve services to patients / clients;
- Enhance satisfaction and motivation in order to contribute more fully to the attainment of the organisational mission;
- Develop areas of expertise to progress the "skill mix" requirements of the health services having regard to workforce and succession planning issues;
- Assist in reaching full potential; and
- Guide personal development and career planning.

The project is managed by a project team that is accountable to and governed by the steering group that includes social partners. One of the first steps undertaken within the SKILL Project was to develop an agreed Competency Framework for Support Grades (set of

[I] Recognising and Respecting the Role, available at: http://www.skillproject.ie/publications/rartr.doc

competencies associated with a role), a useful tool for helping an organisation and its employees when they wish to focus on learning and developing skills and also improving performance (see the box below for details).

Competency framework for support staff

Eight core competencies include communication, teamwork, personal development, procedures, legislation and equality, person centred focus, flexibility and adaptability, technical skills, and health and safety.

Twelve role-specific competencies include: administration, food hygiene, driving, training of others, material management, care skills, sensitivity, treatment / procedures under supervision, cooking, nutrition, cleaning and laundry.

Competency pack for support staff managers

There were 10 key competencies identified for support service managers under four different headings. These include: managing the service (analysis and decision making, quality and customer focus, planning, organising and prioritising); managing yourself (change and self-development, initiative, drive and resilience); managing change (managing change / strategic thinking, managing people); and managing performance (communicating and influencing, motivating, developing and empowering, building effective relationships)

Recruitment of support staff is not regulated and training is usually based on general education. The competency pack is especially aimed at older people with basic literacy skills who lack confidence to compete with skills. Therefore, the aim of the training programme is to raise their levels of competence and confidence. Also, it is worth noting that support staff includes a fair amount of older and middle-aged workers. The classes take place during the working day and are very flexible for staff.

The project is still in its very early stages. Recently, the training needs analysis has started which comprises learning needs questionnaire issued to support staff and also the analysis of the knowledge, skills, attributes and motivation required of support staff and their supervisors to effectively carry out their roles and duties[I].

5.2 UK – Unison programmes

It is estimated that approximately 1/3 of the NHS employees are unqualified. Vast majority of them is low-paid, working at support grades and they are predominantly women, very often from different ethnic backgrounds. Despite the numerous training activities that take place in the health care sector, these groups often have little or no access to training. Approximately 40% of NHS staff receives less than 3 days of training per year. There exists thus large inequality in the distribution of training within the sector. In order to address this inequality, Unison has been working in partnership with local governments, health care or education to provide learning to these groups by brokering an arrangement between the employers and a learning provider. Since Unison is in possession of some accredited learning programmes delivered by higher education institutions it is in the position to carry out such brokering.

[I] SKILL News, Issue 1, February 2006

The courses can be divided into three groups:

- Skills for Life courses – literacy, numeracy, language and IT skills;
- "Second chance learning" courses designed for employees that have not learned since they left school;
- Professional courses – delivered in partnership with Open University, for those members of staff tat want to progress into professional grades (for example HCA into registered nurse).

The abovementioned initiatives take place in the framework of Skills Escalator (see Section 4.3.4 for an overview). The basic idea of that initiative is providing the progression opportunities for staff to enable them to climb on a skills escalator. The examples of the courses include Return to Learn and Study Skills programme.

5.2.1.1 *Return to Learn and Study Skills programme*

The main motivation for the introduction of training programmes was the age profile of the healthcare assistants' workforce, where most of the employees were 40 years or over and the student nurses started their education at the age of 26 or 27. Unison[I] has worked with different employers and Open University to design programmes that would encourage staff to return to study and to upgrade their skills. It was found that the clinical skills of the support staff were very high but since many of the staff members had not been in the classroom ever since they graduated, many were reluctant to return to learning.
The programme then focused on bringing staff back to learning through:

- Return to learn – which focused on such skills as reading and writing, learning, researching, understanding and expressing points of view, etc.
- Study Skills Programme – which was 8 – 16 weeks programme that would help develop more academic skills among the staff (8 weeks full-time and 16 weeks part-time). The programme would conclude with the short essay[II].

Both programmes prepared staff to take up nursing degrees and thus progress in their careers.

A similar programme was undertaken by the South London and Maudsley Mental Hospital, which was targeted at the administrative staff and was aimed at helping them to progress into social work degrees (up to the Master's level).

Unison is also involved in designing programmes for staff who do not want to obtain a degree yet they would not wish to lose contact with the education environment. The courses offered include for example moral, ethical and legal issues around palliative care, and aim to prepare the staff better to deal with such issues during their everyday work.

Other motivations included the changing ethnic mix of the HCAs, which now have been predominantly from BME communities. At the same time, the number of BME and Asian nurses was falling and the recruitment significantly dropped. The projects thus also aimed at encouraging BME staff to progress into nursing.

[I] Unison is Great Britain's largest trade union with 1.3 million members representing mainly workers from public sector, utilities or private contractors providing public services. For more information see: www.unison.org.uk

[II] See for example: Unison Open College http://www.unison-opencollege.org/aaa/rtl.shtml

The methodology adopted by Unison, namely brokering the arrangements between the employers and learning providers can be applied to a variety of sectors. However, there are some difficulties experienced in the independent sector where the unionisation rate tends to be very low and some employers are not willing to cooperate with the unions.

5.2.1.2 *Professional profile for HCAs*

The professional profile for HCAs was an interactive process, where the participants were asked to make a SWOT analysis of themselves and identify their strengths and weaknesses as well as the activities to be taken forward in order to improve their skills. The participants were also asked to reflect on their performance and think of ways of improving it in the future.

5.3 Sweden

5.3.1 Validation of informal learning in Sweden

The Validation Centre of Gothenburg has developed validation methodologies and offered "validation processes". At present, the Centre offers validation in the following sectors and occupations:

- Health: nurse assistant (*undersköterska*),
- Construction: bricklayer, site worker, wood/concrete construction skills,
- Technology and Production: workshop engineering, welder and electrician,
- Business: business administration.

The validation process takes place through three stages:

- Review of work experience;
- Assessment by an adviser, during which the person's knowledge and competences are assessed during for example job shadowing;
- Task, on the basis of which the person skills are validated and which is carried out under the supervision of an adviser or a vocational teacher.

The duration of the validation process varies from 1 to 8 weeks depending on the sector[I].

5.3.2 Legitimation.nu / Registered professions

The project had as its aim to provide a quicker Swedish language learning course and to help validate the qualifications of foreign physicians, as well as other health care professionals. It also provided assistance in finding job placements.

The project partners include Västra Götaland's County Labour Board, Region Västra Götaland, Göteborg University, regional university colleges and the Validation Centre of Göteborg Region. The project started in 1999 and was continued in three more phases, in 2001, 2003 and 2004 and was targeted at asylum seekers and immigrants with professional qualifications in the field of health. The 1999 phase began with the aim of reducing time required for foreign doctors to validate their qualifications. The project offered intensive, customised Swedish language training and support to prepare them for the written and practical examinations required by the Swedish National Board of Health and Welfare. The project was a great success as at the end of the project 70 out of 90 doctors found a job. The

[I] European Inventory on Validation of non-formal and informal learning, ECOTEC Final Report, 2005, p.293

2001 phase extended the scope to regulated professions and included pharmacists, dentists and nurses. The 2003 phase built upon the experiences of the previous two, this time adopting more flexible approach, for example towards people with families living far from the university centres. The participants, namely doctors and nurses, benefited from the distance learning and computer supported training. The training tools included methods of self-evaluation of the existing skills and performance evaluation. Fourth phase began in 2004, with the support of the European Refugee Fund and targeted asylum seekers with medical education.

The project was a success both in terms of quantity and quality. Most of the participants were either employed after the initiative took place or found the registration process and enculturation easier. Moreover, the distance learning approach allowed some groups, especially from remote areas, to take part in the training.

6.0 Role of sectoral social dialogue

6.1 Collection and analysis of information

Due to the complexity of the subject of qualifications, training and quality of health care the social partners should focus on the collection of information which is reliable and comparable. At present, especially in Central and Eastern European countries, there is a lack of data which makes it difficult to assess the shortages of staff[I]. Such information, then analysed, should become a basis for proposed solutions at both national and EU level.

The social partners could play an important role in sharing information on the education and training policies in the Member States as well as on the major policy developments in the field. It would also be helpful to have an overview of the education and training provision systems in each country, together with its SWOT analysis. Through this information the social partners could greatly contribute to the design of the workforce planning strategies in the sector. In addition, the social partners could help establish common standards for workforce planning, especially given the fact that it is often incoherent.

6.2 Exchange of information at European level

The information collected and the experience can be shared at the European level. It was also noted that social partners might make better use of the information already collected by different bodies, such as European Federation of Nurses[II]. Such exchange will undoubtedly benefit from the sharing of good practice examples, especially between the old and new Member States. Also: soft law approaches – open method of coordination – they could bring much more contribution

European level social dialogue would create opportunities for joint approaches of employers and employees towards workforce and skills shortages and their improved monitoring. It would also help design appropriate actions to address skill needs in the sector.

6.3 Involvement in legislative process

Social partners are well-placed to exert political pressure both at national and European level either through umbrella organisations or through sectoral bodies. Social partners can play an important role in delivering evidence and expertise to many policy initiatives, such as studies, data collection, impact assessments, etc. Such input would help draft appropriate and relevant policies both at national and EU level.

[I] See for example: The free movement of nurses and doctors within Europe provides new employment opportunities. But will it also perpetuate existing shortages? Glenn Gathercole provides the perspective of the Standing Committee of Nurses of the European Union, 14 July 2003, available at: http://www.epha.org/a/521

[II] Workshop report "Assessment of skill needs", Brussels, 17 March 2006 in the framework of the conference Formalising the European Sectoral Social Dialogue in the Hospital Sector, 16-17 March 2006, Brussels

6.4 Promotion of the lifelong learning concept

Social dialogue does not necessarily have to imply the process of negotiation of pay and conditions of work. One of the trade union's view is that the social dialogue should also provide for development of its members. The social partners would like to see their role as proactive and participating in shaping the future developments in the sector. The social partners would like to see their active role in shaping the change by being informed and consulted on the reasons for change and its implications[I].

6.5 Promotion of the sectoral social dialogue

Social partners should play an important role in promoting sectoral social dialogue in countries where such arrangements do not exist. In case of Poland, the main problem of the sectoral social dialogue is the fragmentation of trade unions and lack of an employers' organisation in the health sector. The difficulties around establishing an employers' organisation may have arisen from the fact that the hospitals and surgeries are publicly owned and are viewed as being too dependent on the State. Therefore, the social dialogue is carried out between the trade unions and the State rather than between the trade unions and the hospitals' management. Another important problem is often the lack of willingness from the part of the management to enter into social dialogue with the trade unions.
Another example includes the UK, where the independent sector, which is expected to become more important as a result of the envisaged reform, is often unwilling to introduce the idea of social dialogue.

[II] Thornley C., Still waiting?: Non-registered nurses in the NHS – an update, September 2005 in: Roles, responsibilities and awards, Evidence to the 2006/2007 Pay Review Body, Unison, 2006, p.13

7.0 Conclusions

There are several challenges facing the hospital sector. Firstly, the economic pressures to enhance effectiveness of the hospitals and health sector as such, as well as quality of service. Secondly, the concept and role of health care has evolved now embracing home care and bringing care closer to patients' homes. Thirdly, the constant technological progress and medical advances require constant upskilling of the staff and often reorganisation of work as a result of technical improvements. Fourthly, the demographic changes in the European societies, namely ageing, resulted in staff and skill shortages across the health care sector, including hospitals. Lastly, some regulatory developments, such as EU Working Time Directive or employment ceilings for professions in Ireland have resulted in reorganisation of work among different staff categories.

The staff and skill shortages are aggravated by the difficulties in recruitment and retention of new entrants in the health sector. As a result, the employers are forced to change their approach towards recruitment and retention in hospitals by changing or developing the existing roles, thus changing the skill mix in the sector. As the number of medical staff in health sector is decreasing, some of the tasks previously carried out by them were delegated to the different professional categories, namely nursing. It can also be observed that the assistant roles are increasingly important in providing essential support for nursing and medical professions. Some examples of the new roles developed recently include Advanced and Assistant Practitioner, Senior Nurse and Medical Emergency Practitioners.

In addition, the employers decide to employ foreign health care professional to cover for staff shortages. Although foreign recruitment is increasingly popular, some believe that in the long term it will not solve skill shortages problem as it does not grow the workforce from within the sector.

In order to successfully support the development of the new roles in the sector include it is necessary to provide relevant training. One of the issues raised by some interviewees was inequality in training provision among health care staff. In the UK, the example includes the relative neglect of the training needs of the support staff, which, in some countries, account for a significant share of the workforce. Another important issue is the approach towards training from the part of the health care management, that still, to some degree, perceives training as an expense rather than an investment. Lastly, due to understaffing in many health care establishments, it is difficult to release staff for training.

Another important issue which emerged is the importance of workforce planning in the sector and of ensuring its coherence at regional and national levels. One of the issues raised during the interviews was the need to focus on independent health care sector.

In the context of foreign recruitment it is necessary to ensure the transparent and efficient system of recognition of qualifications of health care professionals.

Due to shortages of data in the sector, it is often difficult to monitor the skills and even employment situation in the hospital sector. Although there are bodies that collect data on certain professions or selected elements, such as the training provision, the overall image of the sector is not complete. Therefore, the role of the social partners might include the information collection and sharing. Moreover, social partners could contribute significantly to formulating workforce planning policies or strategies. Such contribution could take place either via involvement in the legislative process or through exchange of information and good practice both at national and at EU level.

One of the challenges for the social partners is to promote the idea of sectoral social dialogue. In some countries, such as Poland, the sectoral social dialogue for health is carried out mainly between the trade unions and the State due to the lack of employers' organisation.

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