Of the NHS’s 1,241,325 workforce...
656,004 are professionally qualified clinical staff
587,647 are non-clinical staff

Clinical staff
- 114,427 doctors
- 362,920 nurses, midwives and health visitors
- 159,548 scientific, therapeutic and technical staff
- 19,349 ambulance staff

Non-clinical staff
- 327,482 support to clinical staff
- 215,165 infrastructure support

The NHS could not do any of its work without them

IT’S TIME TO PAY THEM SOME ATTENTION
It’s time to bring the hidden half million out of the shadows

The HSJ/Serco Inquiry Into Maximising The Contribution Of “Non-Clinical” NHS Staff began our work in March 2016, with five workshops and a range of sessions at HSJ Summits at venues across England to explore the issues for this inquiry with a broad range of NHS colleagues.

We produced an interim report in May (tinyurl.com/hjdyxgp): its findings were refined and reviewed at subsequent sessions. Those sessions broadly endorsed that interim report’s findings, while making helpful additions and suggestions of emphasis that extended and strengthened our findings.

This final report relies hugely on the contributions of all those who attended the workshops or submitted good practice case studies, which are available on the inquiry website’s dedicated “best practice” page (tinyurl.com/jjx6267). These participants’ advice, comments, examples and insights are vital to the value of this final report. Thank you all. Any errors or omissions are due to the author alone.

How do you hide half a million people? Call them “non-clinical staff”

Over half a million (587,647) of the 1,241,325 NHS staff work in the vital range of fields that support clinical care. The diversity of their jobs is significant.

Any effort to exhaustively catalogue the many categories of role under the non-clinical umbrella wouldn’t add huge value. As well as key services provided by cleaners, cooks, porters, gardeners and maintenance colleagues, there are administrators at all levels, switchboard colleagues, IT staff, security staff – as well as those in communications, finance and HR.

There are receptionists, including those in GP practices. There are mortuary staff. And there are medical librarians (who really, really hated not being mentioned in our interim report). Commissioning support staff matter, too. Nor can we possibly forget the staff who handle arguably the key litmus test issue of the local NHS: car parking.

The NHS could not function without all these people’s contributions.

What’s in a name? Quite a lot

These “support to clinical” and “infrastructure support” staff (using the HSCIC NHS Workforce Survey definitions) have traditionally been referred to under the unhelpful catch-all label of “non-clinical” staff.

It’s a terrible concept and an even worse name, professionally defining them negatively: as what they are not. We wouldn’t describe women as “non-men”. This polarisation makes as much sense as calling a chef a “non-waiter”. One participant in our workshops that helped shape this report recalled a letter they received working at a university, which began “Dear non-administrative member of staff...”

The term also suggests that for all the rhetoric about teamworking, there remains a gap and hierarchy between clinical and non-clinical staff every bit as polarising and unhelpful as those between and within the clinical and medical professions.

One aim was to come up with a better name. Nothing leapt out: “ancillary” seemed dismissive; “support” had unwelcome connotations of subservience. “Associates”, “partners”, “facilitators”, “enablers”: the options seemed either clumsy, cumbersome or confusing.

We concluded that it would be better to just call all NHS staff... “staff”. In fact, we should do away with the generic terms of “clinical staff” and “non-clinical staff”. Obviously, when we refer to doctors, nurses, radiologists or any other professional group, we should keep those words. But the habit of banding NHS staff into “clinical” and “non-clinical” groups is divisive and reductive. It creates a hierarchy where no hierarchy is helpful, and we should stop using those terms. It may only be a semantic barrier, but words matter. We have job titles, professional qualifications, governance and even HR departments to see that the right people are doing the appropriate roles.

The division that the “clinical/non-clinical”
dichotomy describes is absolutely real. At one workshop, a participant described visiting one ward team who proudly announced that they had named photographs of every single member of the ward staff team up on the wall.

When this visitor looked at these photographs, they politely pointed out that the ward clerk and receptionist was not up there, despite their vital, patient- and public-facing role. This full-time “non-clinical” member of staff had become invisible when their clinical colleagues thought about the ward team. That needs to change.

The policy context

Over recent years, a remarkable consensus has formed in NHS policy that the service’s future must be one of planning and providing person-centred care on a health and care economy-wide basis, delivered by clinically led multidisciplinary teams working together with patients beyond the traditional organisational silos.

These themes inform and illuminate the Five-Year Forward View strategy, and all subsequent major policy initiatives.

It all sounds attractive. Yet although this narrative has developed alongside an aspiration to get clinicians involved in changing care planning and provision, it has tended to include very little or nothing about the contribution and the value of 587,647 of the NHS’s 1,241,325 staff.

As the NHS trudges on towards the end of a decade of rising demand, with a 33 per cent rise in the number of people aged 85 and over in the last decade, funding increases have felt homeopathic in comparison to the long-run average of 3-4 per cent a year. The problem is compounded by long-term poor workforce planning and training shortages, highlighted in the National Audit Office’s critical report.

Do we have a plan for changing service provision to adapt to need? We don’t just have a plan: we’ve got 44 of them! The emerging sustainability and transformation plans are, at the time of writing, the subjects of arm wrestling between the leaders of the 44 STP health economy footprints and NHS England and NHS Improvement.

NURTURING OUR PEOPLE

Serco employs thousands of staff in NHS hospitals and many more in hospitals in other countries. We provide the widest range of services from estates and hotel services to pathology, procurement, contact centres and back office processes.

Our cleaners, catering staff, porters and those in many other support roles have direct daily contact with patients and their families. They can and do have an impact on patient experience and care; they can and do help release clinical staff from non-clinical activity; they can and do help make more effective use of hospital facilities and clinical assets.

So what have we learned from this sometimes “hidden army”? First of all, something about safety and care. The NHS can’t deliver the safest possible care unless this body of people is mobilised to think and behave with this as their top priority.

They are invaluable “eyes and ears”: in the wards and in all parts of the healthcare system. We think it important that they are recruited, trained, enabled and encouraged to prioritise the safety and care of patients. We want them to speak up and play a positive role.

Many of these roles are not highly paid, but we think they should be decently paid for what they do and with the right employment terms. If we did not offer sick pay, would we find unwell people turning up for work? Could we expect such staff to exhibit the behaviours we want?

Of course not. That’s why Serco will not join any race to the bottom in the remuneration of staff for the service roles we provide to the NHS.

We also find that where our support staff are provided with the right equipment, systems and information they can have a positive impact on the patient experience and the life of doctors, nurses and allied health professionals. Modern hospitals are busy, very pressured environments, clinical staff are spread thinly.

Often, patients see and interact with our staff more than they do with clinical professionals. Good patient administration can help patients and their carers make better sense of their journey through the health and care system. It can help make clinics and the wider care system more productive. It can remove some of the frustrations that clinicians and others feel when the process surrounding clinical care is ineffective or broken.

Investment in staff, good operational processes, equipment and technology is just as important in support services as in clinical care. Of course, the NHS prioritises the latter. In this age of austerity, it is not surprising that investment in the former can be overlooked, but both are required for the delivery of safe care and a good patient experience.

Historical divisions

We know that there is a good body of evidence to support the fact that happy patients recover more quickly. Our staff go the extra mile for the people in their care: for the porter it is a real person they are moving, not a case; for the caterer it is presenting food that is appealing person they are moving, not a case; for the person they are moving, not a case; for the caterer it is presenting food that is appealing, knowing that if they eat it will speed recovery. We know that there is a good body of evidence to support the fact that happy patients recover more quickly. Our staff go the extra mile for the people in their care: for the porter it is a real person they are moving, not a case; for the caterer it is presenting food that is appealing, knowing that if they eat it will speed recovery.

The 21st century healthcare system needs to stop creating divisions and understand that a great patient experience is one where they recover due to clinical intervention and better care.

This can only be achieved by a seamless, multifunctional, committed team, who care enough to get past the historical professional divisions to make a real difference to patients, their families and each other.

Ian Crichton is chief executive of Serco Health
Key conclusions

Non-clinical staff don’t feel they’re being listened to, and feel they’re being bypassed in conversations about change

1. End second-class citizen status for staff whose jobs are not clinical: this is a point for everyone.

All participants agreed that overall, the NHS could do much better at valuing all its staff. Those not in clinical roles, however, tend to be more undervalued. Some NHS organisations involve and value their staff in these roles well and consistently (and we had the pleasure of visiting a few) but it isn’t universal.

The value of clinical staff in the NHS scarcely needs stating (although junior doctors might currently disagree). Contrastingly, their colleagues can seem and definitely feel rather invisible in discussions about workforce, training and policy.

Participants with experience in the private and third sector observed that this division between “clinical” and “non-clinical” staff, in terminology and status, would not seem to be or be acceptable.

The negative consequences of this two-tier approach in the NHS are absolutely real. One participant described an induction session, at which a new non-executive director asked his neighbour what job he was starting. “I’m working in Estates,” came the reply. The NED’s response: “Oh, never mind!”

Even a relatively senior, highly trained finance officer recounted having been told by a clinician whom he’d asked about clinical markers for a stroke project: “Don’t worry: you’re here to get and crunch the numbers – we do the rest.”

One question that emerged was how organisations can get these staff members’ voice into the board (beyond finance, which has director-level representation). Inevitably, this seems an issue for HR teams and for staff-side representatives.

There could be an important role here for non-executive directors – to seek perspectives from these important staff as well as from their clinical colleagues to take from ward to board.

One factor that participants identified as contributing to a “second-class” status for these staff is the ongoing impact of political rhetoric, most recently from the Lansley reforms about “investing in doctors and nurses” and “cutting bureaucracy”. As one workforce director suggested: “If we map the contributions of these staff, we could show positive changes to care pathways and outcomes.”

Realistically, it may be a while until we see the politician who will laud hard-working estates staff or medical secretaries. Yet it would be right and smart for both sector leaders and the NHS media to point out that healthcare is delivered by teams, all of whose members matter. Silo-isation is a problem within and among the medical professions: one the NHS should stop emulating.

Participants discussed an unhelpful tendency for staff in these roles to be made “the other”, observing that although clinicians may tend to be complimentary about these colleagues with whom they work directly, “the other lot over there” are ripe for criticism and disdain. As one colleague observed, “everyone complains about switchboard staff, but I went to do that work for one day – and I’ll never complain about them again: it’s a really tough job.”

2. Improve NHS culture by maximising these staff members’ motivation.

People enjoy work which has meaning. We need to tell these colleagues’ professional stories internally and externally, to make the value of these staff and their teamship visible. Failing to engage these groups of colleagues means missing their insights into care gaps and inefficiencies: this is an untapped resource.

Participants repeatedly observed that experience, interviews and staff surveys show the importance to these staff that their work helps and benefits people: they are loyal and valued drivers. That is a high intrinsic motivation. There’s a famous anecdote about John F Kennedy visiting NASA, and asking a janitor carrying a broom what he was doing: the janitor replied: “I’m helping to put a man on the moon.”

That sense of widely shared purpose is one the NHS at its best does well – but could often do better.

As the NHS plans radical changes in provision with the Carter efficiency review, the 44 sustainability and transformation plans and footprints, success regimes, devolution in Manchester, new care models plans, its chances of success will need considered, consistent, credible and sincere engagement with all its staff groups.

Several participants described their organisation’s progress with moving from competency-based staff recruitment (ie relevant NHS experience) to values-based recruitment. This change is challenging, and clearly at first more time consuming, but produces a better and professionally happier calibre of staff.

3. Patient experience.

Most of us are, thankfully, not sufficient consumers of healthcare that we will become expert in judging its quality. We can, however, relate to the aspects of our experiences of service that are not clinical – the environment, cleanliness, politeness, orderly queueing and functioning systems.

Consumerist analogies are not always helpful or illuminating, but these are aspects of what we recognise in other parts of our lives as customer service.

The contributions of these staff to patient experience are huge. They are also significant drivers of the general working environment.

A workforce which is treated respectfully, whatever their job title or role, is going to make the organisation a happier place to be, for both staff and patients, as well as safer – as the work of Michael West and colleagues has shown. The staff can (and in well-run organisations, do) play a role as extra eyes and ears for patient safety. Porters can spend a lot of time with patients. Organisations should ask all their staff whether they feel they can speak up about safety and quality issues, and if they do, are they listened to – or victimised?
A lot of this workforce is low-paid (and may remain so) but their input is vital.

Many of these staff’s jobs are in bands 1-4, and career progression may be relatively limited. Likewise, training opportunities (discussed later) may be few. But there could be opportunities for organisations, with the new government policy for and levy on apprenticeships. Moreover, as care redesign will inevitably involve greater use of technology, we will have to adequately resource training staff in its use: not traditionally an NHS strength.

Job design is an issue for these staff: one chief executive noted: “I’m an HR professional by background, and I’m always profoundly shocked by the lack of organisation and role design competence. If we really got to grips with that, it would transform thinking. We’re doing work around productivity, which will lead to growth investment in non-clinical staff. How much appraisal do these staff get? Not much, would be my bet.”

Participants suggested that this can best be recognised by proper emphasis on getting what training there is right, and on internal and external recognition programmes for good performance. The sense of vocation is no less strong in these staff, and good organisations already recognise and value this.

Many of these staff are also of black and minority ethnic backgrounds. The data from the Workforce Race Equality Standard survey, revealing that staff from BME backgrounds are less likely to access training or have career progression, show how much progress remains to be made on this important and mandatory equality agenda. In a chief executive’s memorable words: “It’s interesting comparing the NHS staff survey data for this group with the publication of the WRES data. This is about discrimination in the deepest sense”.

Doing Carter and STPs right – can we job plan across an STP footprint?

The Carter efficiency review was much discussed: reactions ranged from those impressed by its working process to those who perceived it as likely to be used in a heavy-handed and centralising manner, or feared it would not understand why certain organisations invested differently in higher skill mixes for certain services such as imaging, HR or estates.

A finance director observed: “Carter could be useful if we set up a mature environment in which to discuss it. It shouldn’t be just a benchmarking tool. But vaguely consistent measurement can tell us things.”

The emergence of sustainability and transformation plans (STPs) as the vehicles to drive change during the course of this inquiry changed perspectives: some participants suggested that this was “about control totals rather than Carter”.

Changes in service provision will involve all NHS staff working in different ways. It was not obvious to participants that there had been extensive consultation, formal or otherwise, with staff working in this essential (albeit non-clinical) roles. In one participant’s phrase, “fundamentally, transformation will come from the non-clinical work”.

A chief finance officer observed “we have one hell of a challenge ahead: this half of the NHS workforce can make change much easier and massively increase our chances of success”.

There were other optimistic notes: one CCG leader highlighted that their local health economy’s shift to more sustainable ways of working had been greatly led by equal participation in service redesign between colleagues from all disciplines, and with crucial contributions from IT colleagues in standardising and data sharing.

Too often, NHS metrics still tend to be about cost rather than value: the Carter efficiency review data on the cost of a meal per head, rather than the value to a patient’s wellbeing and recovery of a good quality meal and its contribution to a swifter ability to leave hospital. Likewise, we tend not to get data on the relationship between cleanliness of acute settings and prevented infections.

Until we connect the value of some of these roles with clinical value, decisions will be all about cost, and not about how to use the valuable resource of these staff. We need to think of these staff groups as a valuable resource, not a problematic cost.

**CASE STUDY: FACILITIES MANAGEMENT STAFF**

As part of Serco’s Safe, Caring and Successful strategy within their health business, managing director of Serco Health Ian Crichton commissioned ExperienceLab (Serco’s in-house service design and customer experience experts) to undertake a research and service design project focusing on the role of their soft facilities management staff.

We know these support staff spend considerable time interacting with the patient (housekeepers may interact with a patient three to four times more frequently than clinical staff) and clinical teams. As such, the brief was to explore the role of the soft FM staff to maximise the value of the patient and clinical interaction time, with a lens on imparting patient wellbeing (speeding recovery) and supporting the clinical staff.

To really understand the environment and ensure that the service design emerging was practical, ExperienceLab spent significant time engaging with soft FM staff, clinical staff, carers, management and the patients at six different hospitals across England and Scotland. The structured approach taken was qualitative in nature, totalling engagement with more than 200 individuals and spending more than 600 hours at the front line.

In advance of the in-context research, ExperienceLab conducted broader baseline research to understand, collate and synthesise existing academic and sector research available. This provided insights into work that has been done in this area previously.

In addition, it provided clear tangible evidence that:

1. Social support and interactions with patients increases positive mental attitude which, in turn, has a direct faster recovery (including shorter, peripheral interactions in a health setting).
2. Providing additional support to clinical staff will ease the ever-increasing pressure on this group which in turn will impact on clinical staff positivity.
3. An improvement in clinical staff positivity has a direct impact on reduced mortality rates, reduced accidents and improved financial performance.
4. The first phase of the project is now complete, the key findings being:
   - There is significant opportunity for the soft FM staff to have a positive impact on patient wellbeing and on clinical staff satisfaction.
   - It will not happen simply through small incremental changes as it requires a culture shift of all parties involved in the shaping and delivery of soft FM contracts.
   - There are a number of practical recommendations emerging that will have demonstrable positive impact that Serco will be taking forward to prove the model.
   - Taking an approach which centred on real engagement with frontline staff and patients, and provides evidence for and legitimacy to a number of “one team” concepts – whose presence in rhetoric but absence in practice have been lamented within the health sector for a long time.

Phase two will focus on the findings and how these can impact service delivery model to positively impact the hospital environment, moving the commissioning of services beyond a commodity buy (which will be a race to the bottom) and into a space where it directly contributes to both patient recovery and clinical staff positivity.

Gavin Sambles is director of Serco ExperienceLab
In terms of ‘happy’ patient experiences of receiving care, much of this is influenced by the person on reception; whether systems work properly; whether clinical staff have the right information; whether the environment is clean atmosphere and environment will be more likely to achieve the win-win of inspiring confidence in patients and having a positive effect on staff morale.

Why non-clinical staff are undervalued
Paul Myatt points out that in the wake of the Francis inquiries into Mid-Stafts, the regulatory and political emphasis on safe levels of clinical staffing draw workforce directors’ attention. “Clinical staff numbers are what regulators come and count. So in the main, HR directors’ attention is paid to clinical staff: if their organisation lacks enough of them, there are impacts immediately for quality, regulation, media attention – and of course, poorer outcomes.”

All participants agreed that another key factor was a reluctance to describe the value of “backroom” non-clinical staff, informed by political and media hostility towards NHS bureaucracy and bureaucrats.

Unison’s deputy head of health Sara Gorton suggested that “we’ve become reticent to talk about the budget spent on non-direct patient care. We’ve collectively failed to make the case for the value of this work and workforce, when actually it’s the way we can help improve productivity. “I recently had treatment at King’s: I thought I’d get good clinical care (and I did), but what most impressed me was the admin systems support. The care was across four or five departments, and it was very obvious that their administrative managers were talking to each other, and understood how the other departments worked.”

Managers In Partnership chief executive Jon Restell agreed that a perceived threat of Daily Mail-type manager-administrator-bashing “has made us reluctant to draw attention to the non-clinical care spend. And there’s lots of good work to promote: from the porter who makes time to talk to a frightened patient to the clinical coders and finance staff – we should value these as important occupations, as well as simply being jobs”.

Skills For Health head of research and evaluation Ian Wheeler pointed out that undervaluing non-clinical staff “is part of the whole discourse of the Andrew Lansley agenda of the last six years, about getting rid of backroom staff, who have been framed and perceived as waste. And that’s ludicrous: without good non-clinical colleagues and their systems, clinicians won’t know who they’re supposed to be treating for what and when”.

Mr Wheeler added that his impression is that non-clinical staff increasingly feel like their value is beyond doubt: the challenge is how to support, promote and shout about them.
We have one hell of a challenge ahead: this half of the NHS workforce can make change much easier and massively increase our chances of success.
If we want to ‘Get Carter’, we need to get the value of support and non-clinical staff

outsiders: “They don’t feel they’re being listened to, and feel they’re being bypassed in conversations about change. Which is bizarre, because many non-clinical staff are very experienced people, who’ve been in this sector for a long time, and who know how to make change work successfully. “And they know what doesn’t work, too”. Director of workforce for University College London Hospitals Foundation Trust Ben Morrish observed that it can be attractive to focus on brands which are easier for the public to connect with, such as doctors and nurses. He added that there are various other unhelpfully “broad brush” and negatively framed names in the field, like professions allied to medicine and allied health professionals “which were scarcely appropriate for the healthcare delivery of 1996, let alone 2016. We need to be clearer about our language for describing people who provide services of fundamental patient benefit”.

Discussing the value

Dean Royles, executive director of HR and OD at Leeds Teaching Hospitals Trust, and former chief executive of NHS Employers, concurs with the bureaucracy-bashing analysis: “Once non-clinical staff become a professional part of the workforce, they get lumped into a populist demonisation of bureaucracy: ‘Oh, they’re not front line, so they’re not essential to NHS running’.

“To get the best out of this part of our workforce, we need to present this as an area in which people would want to work. So we have to get the national PR right about these jobs, and that ranges from thinking fully about talent management, job desirability, downstream to things as basic as having the right job descriptions.”

Mr Royles concludes that “non-clinical support staff are vital to all services, but I don’t think they’re often remembered by policy makers. What would help would be to highlight more those non-clinical support roles as central to patient care. These are jobs where people should be valued, get satisfaction and in which they can train and develop careers.

“Many of us know that in the NHS we have great access to training and development opportunities, but wouldn’t have known this from outside the NHS. So this needs to be communicated: non-clinical staff make a big contribution: they’re not bureaucrats, time-wasters and pen-pushers”.

Andrew Prince, development director of the Serco Global Healthcare Centre of Excellence and a non-executive director of Frimley Park Hospitals Foundation Trust, observes that “the metrics still tend to be about cost rather than value: the Carter efficiency review data on the cost of a meal per head, rather than the value to a patient’s wellbeing and recovery of a good quality meal and its contribution to a swifter ability to leave hospital. Likewise, we tend not to get data on the relationship between cleanliness of acute settings and prevented infections.

“So we’re yet to connect the value of some of these non-clinical roles with clinical value. Until we can make that connection, decisions will be all about cost, and not about how to use the valuable resource of these staff.”

Paul Myatt agrees that the case for the value of this part of the workforce should be made
more strongly: “We should say that improving your non-clinical support workforce could make your (expensive and scarce) clinical staff more productive with efficient administration – getting the right level and quality of staff to support your clinicians to do great jobs.”

MIPS’s Jon Restell reflects that the real need for better appreciation of these staff is among those charged with workforce planning: “Intermittently, we discuss with Health Education England the 0.01 per cent of the NHS training budget for non-clinical staff, and depressing, nothing changes.

“Look through the vanguards’ work and the Carter efficiency review: it’s riddled with requirement for skilled non-clinical staff in procurement and integration. Where is a supportive plan for developing and retraining those staff, in the way you’d have for clinical staff if you were redesigning cancer services?

One of the vanguards’ staff pledges was that: ‘We will engage clinicians, on values of programme.’ Just engage clinicians? Until that changes, we’ll make little headway with politicians or others.”

Healthcare Financial Management Association chief executive Paul Bridgford agreed that “a great deal of what’s needed to achieve the Carter efficiencies is highly skilled work. If we want to ‘Get Carter’, we need to get the value of support and non-clinical staff.

Visibility and integrating teams

Sara Gorton described Unison’s attempt to increase the visibility of this staff group: “Our ‘One Team’ campaign was about getting members in non-clinical roles to describe to clinician members what they do, and large numbers said that their colleagues in their own trust had no idea what they did and what their contribution was.”

Ben Morrin highlights UCLH’s efforts to get an integrated ethos among staff from the point of arrival: “Two thousand staff join us each year, and in their first week, all the different groups come in together, and sit together at lunch and dinner, and talk together. Which helps a lot, but is only the start.

“Another priority for us is to share and champion great administration’s contributions; it’s about showing the value at its point of impact. So when we successfully recruit 700 nurses that we need, we’ll celebrate that success with those who benefit. Part of responsibility for that is on the non-clinical colleagues: that customer relationship drives how we work together.”

Serco’s Andrew Prince suggested that part of solving the value and visibility issue might be to get patients to help us explain this group’s importance.

“Quite a lot of these staff have extensive contact with patients – cleaners and caterers are always around, and can and do give exceptional service. Patients write in sometimes, and say ‘that porter was really caring, and went above and beyond the call of duty’, and maybe we need to lift that feedback into more public use.”

Feeling valued

The HFMA’s Mr Bridgford presented startling data from their recent finance staff census and members’ survey. While 89 per cent of respondents felt they did a valuable job for their organisation, answers on how they felt valued were stark. A total of 78 per cent felt valued by their line managers; 48 per cent by the board and 46 per cent by clinicians. When responses moved to what government, the public and patients think, 10 per cent felt valued by government and 5 per cent by patients.

Finance staff reported high levels of motivation: 71 per cent saying they really value working in NHS and public sector ethos and 60 per cent saying they see their primary role as trying to improve patient care.

Yet while 64 per cent say they would like to spend the rest of their career in the service (despite mounting pressure on their teams and the most challenging financial operating environment to date), many fear that the constant change and reforms mean they won’t be able to fulfil these ambitions, with only 47 per cent expecting to continue to be employed by the NHS until they retire.

Workforce planning

The NHS consistently has what we might politely term “issues” with clinical workforce planning, and much the same is true of the non-clinical workforce. Dean Royles says there is “no strategic oversight of the non-clinical workforce (which goes well beyond support roles, if we think about engineering and IT).

“This is a non-commissioned workforce. This is about half of the NHS workforce, and it’s one where by and large, the market dictates supply and there are professional regulations, training and qualifications in such fields as HR IT, finance, etc.

“For clinical staff, our efforts to predict workforce have tended to see us lurch from problem to problem as the care delivery model changes. Planning of that kind has not really happened in the non-clinical workforce: you do get some specialisms, such as IT, but the market responds relatively quickly to changes in demand.”

Unison’s Sara Gorton reflects that “rather than celebrate jobs and roles, perhaps we should celebrate skills. It’s interesting that in the NMC vanguard work, what’s at the forefront is moving away from traditional specialist roles: not from specialist to generalist, but expecting multi-specialisms. The parallel ability for non-clinical colleagues to analyse, are we providing good value? We need non-clinical staff to be able to answer that question

Non-clinical support staff are vital to all services, but I don’t think they’re often remembered by policy makers

November 2016 HSJ/Serco Inquiry on Maximising the Contribution of NHS Non-Clinical Staff
change and influence, whether in rostering, setting up payroll, changes in OD: these are all skills we can describe, and maybe that’s an important labelling job”.

**Scarcity and career desirability**

Dean Royles’ view, informed by his time running NHS Employers, is that policy makers tend to have “a very London-and-South-East-centric belief that non-clinical or support staff are hard to come by: a parochial view of the labour market world.

“So any policies we do get tend to be about how to deal with recruiting people with, say, long-term conditions or criminal records, or the long-term unemployed and those not in education, employment or training. These are very evident in south-east England’s workforce planning, which is quite reliant on a wider EU/international workforce.

“By contrast, where I work in Leeds, the non-clinical jobs in the NHS are seen as good, desirable and stable jobs. In Leeds and Sheffield, the NHS has a good choice of staff”.

**Mystery training**

Dean Royles concludes that consequently, “the national policy focus tends to be assuming it’s hard to attract and recruit non-clinical staff, and there’s been very little attention to training and development and career prospects. There’s the occasional bit on apprenticeships.

“The policy landscape is always London-centric, where it is hard to recruit, so we’ve seen very little on encouraging non-clinical staff to move on in their careers with training and development opportunities. It shouldn’t be hard to support. Those in bands 1-4 end up doing 70 per cent of hands-on care.”

Skills For Health’s Ian Wheeler adds that “the cycle of workforce planning often does not take account of clinical support workers, and tend not to receive the training and development they should do. Skills For Health in this major, including clinical and non-clinical support staff. In practice, you get what can feel like almost a clinical apartheid, where the clinical registered workforce get a lot of attention.

“Our paper looking at the healthcare support workforce used the Labour Force Survey data to split clinical and non-clinical workforce, and we found some suggestion investment in admin skills in the NHS is less than in the private sector.

Skills For Health’s study also found that non-clinical staff receive substantially less training overall.

This report also found that “only a quarter of admin and secretarial workers received training and development in the past 13 weeks, compared with almost half of the workforce overall, and a significantly lower proportion of administrative and secretarial occupations are qualified at NQF level 4 and above”.

A second Skills For Health paper, Mr Wheeler adds, analyses the ‘hourglass-shape’ of the workplace: “the healthcare sector is good at developing high-level clinical registered skills; then you have lots of staff at the bottom, and a thin wedge in the middle through which people pass as their careers progress. What we need is to expand the high-skilled, flexible and responsive intermediate workforce”.

The NHS is mostly, Mr Wheeler suggests, “not creating high-quality intermediate jobs – where people could be working at a very high-quality level. We consistently see this in the UK economy as a whole, and so unsurprisingly it’s reflected in parts of healthcare, and in the divide between the clinical registered and non-registered workforce. Healthcare is becoming increasingly data driven. Who can get hold of, manage and maximise patient data? The processing and flows of this data, going forward, will be increasingly important”.

This presents challenges: NHS Providers’ Paul Myatt observes that some HR directors already complain about challenges in recruiting sufficient IT staff within the pay bandings of Agenda For Change.

Mr Myatt also suggests that employers “should address motivations beyond quality and finance: think about having an engaged workforce; about development opportunities to build careers (including non-clinical ones). And we need to be more forward-thinking on patient experience: NHS staff, including non-clinical staff, could perhaps benefit from specific training in customer service skills, so patients feel well treated rather than brusquely-treated”.

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**SUPPORT WORKER OCCUPATIONS BY UK COUNTRY**

<table>
<thead>
<tr>
<th>Country</th>
<th>Clinical support</th>
<th>Cleaners/cleaning</th>
<th>Administrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>17%</td>
<td>2%</td>
<td>14%</td>
</tr>
<tr>
<td>Scotland</td>
<td>17%</td>
<td>3%</td>
<td>11%</td>
</tr>
<tr>
<td>N Ireland</td>
<td>21%</td>
<td>7%</td>
<td>9%</td>
</tr>
<tr>
<td>Wales</td>
<td>18%</td>
<td>4%</td>
<td>16%</td>
</tr>
<tr>
<td>UK</td>
<td>17%</td>
<td>2%</td>
<td>13%</td>
</tr>
</tbody>
</table>

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**Total support workforce as a % of health sector workforce**

<table>
<thead>
<tr>
<th>Country</th>
<th>England</th>
<th>Scotland</th>
<th>N Ireland</th>
<th>Wales</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>36%</td>
<td>34%</td>
<td>49%</td>
<td>42%</td>
<td>37%</td>
</tr>
</tbody>
</table>

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**Source:** Labour Force Survey, 2014, ONS

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Ian Wheeler adds that “without great administration, though it may not stir the passions, most aspects of healthcare are more difficult. So many NHS complaints are customer service-type complaints”.

**Gender and diversity**

Ben Morrin highlights the importance of remembering gender and diversity and inclusion for this workforce. “Most of the NHS workforce is female, and the majority of junior doctors. (It was interesting that in the contract dispute row, it was only men doing the negotiations). This area is fundamental to workforce development thinking. If the same old faces try to design the workforce of the next 10-20 years, it may not be different enough”.

Paul Bridgock notes that while 62 per cent of the NHS finance workforce is female, only 26 per cent of finance directors are female, and Ian Wheeler adds that support workers are more likely to be part-time (and women are statistically more likely to work part-time).

**Working differently**

The workshop session focused attention on how changes in the NHS landscape may affect this staff group. UCLH’s Ben Morrin says that the impact of the Carter efficiency review’s proposed administration spending cap of 7 per cent by 2018 and 6 per cent by 2020 implies an urgent need to review how organisations collaborate and work together.

“Can London’s NHS justify having 80-90 HR departments? Probably not... they’re likely to be fewer and bigger shared functions, which can mean a better service for patients. The STP footprints also imply some potential reconfiguration.”

Unison’s Sara Gorton suggests that “widening the NHS employment footprint could work on many fronts. Some specialist functions like IT may benefit from going to scale. The Carter recommendations need skills to drive technological innovation, like e-rostering and proper booking systems.”

Those kind of functions don’t need either to be small or England-wide: we’ll need to find a balance. That begs the question of how we get buy-in to participate over wider footprints, and give staff the security they need. Many of our members talk about their fears of instability, of cuts, of services contracted and moved, and that funding streams might just dry up.

“The ability to move some money around in the new STP footprints may free things up and allow bolder decisions. Perhaps there’ll be new conversations with staff, where employers may say ‘we can’t say where you work in five years time, but we know we’ll need your skills, so we will guarantee you work if you’ll commit to stay with us?’”

Ben Morrin suggests that “if we map the contributions of these staff, we could show positive changes to care pathways and outcomes. UCLH is a clustered organisation: run by clinicians, led by four medical directors, and it’s the most empowering place to work – a big part of which is the quality of respect and commitment to roles that we’re discussing here. This is about trust, which depends on the quality of personal relationships, line management support, and being there when team members have tricky moments.

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Without good non-clinical colleagues and their systems, clinicians won’t know who they’re supposed to be treating for what and when **Ian Wheeler**

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**Comparison of training received by support and non-support workers in the health sector**

<table>
<thead>
<tr>
<th></th>
<th>Support</th>
<th>Non-support</th>
</tr>
</thead>
<tbody>
<tr>
<td>65%</td>
<td>35%</td>
<td>55%</td>
</tr>
</tbody>
</table>

Source: Labour Force Survey, 2014, ONS
“However provision will be organised in future, we should recognise that if we ask staff to give up their own, known team to run services differently and at greater scale for a population, it comes down to one point: trust in line management and individual manager, and ultimately in the chief executive. Without that trust, plans for change will be deeply flawed.”

Skills For Health’s Ian Wheeler adds that other obstacles to progress are the quality of appraisals; a dearth of information about NHS productivity; and the consequent failure to link the contribution of good processes, system analyst skills and operation skills.

Serco’s Andrew Prince reflects that we lack clarity about the required skills. The skills needed for traditional and notionally competing healthcare foundation trust-type organisations are more decentralised ones: those needed to redesign provision across the 44 STP footprints are more integration/transformational skills; yet Carter envisages centralising, efficiency-driving skills.

Sara Gorton adds that this probably means equipping clinical staff with some of the process and change management skills traditionally seen as those of support/admin staff. “Timing and depth of staff engagement are crucial. All the current big picture changes, even vanguard innovations, feel as if they’ve been foisted on the system from above.

“So some of the skills – transformational skills, ability to lead change without disrupting clinical influence, and be integrators and facilitators of systems – risk being bolted on mid-way. There are many good examples of clumsy behaviour of both HR and local trades unions to poorly-thought-through proposals, which could have been thought through and problems anticipated if staff were involved early. It’ll be interesting to see if NMCs vanguards really engage staff about system design”.

HFMA’s Paul Briddock reflects that as clinical behaviour and choices drive spending the vast majority of budgets in the NHS, to change these decisions, “we need intelligence, and with good-quality information, so we can challenge inappropriate clinical decisions.

“The ‘Two sides of the same coin’ work HFMA did with the Academy Of Medical Royal Colleges, NHS Confederation and Faculty of Medical Leadership and Management highlights the need for really good-quality intelligence. Non-clinical support staff are the ones with benchmarks, metrics and ability. They are vital to give a solid foundation on which to challenge clinical performance, outcomes, and also examine patient satisfaction in different ways. Are we providing good value? We need non-clinical staff to be able to answer that question.”

Culture club
All participants agree that over-directive, target-driven NHS approaches forge a negative working culture, too often driven by fear and blame. Serco’s Douglas Ritchie suggests that changing how we run any system “will fail unless we can change behaviour. You can’t enforce change from policy, you must get commitment to new organisational ways of working and flexibility.

“We have to understand that people deliver all this, and if we don’t tap into their motivations, then behaviours will have an impact on outcomes for patients, the public and staff. Where we work with the NHS, we spend a lot of time with our own colleagues to get the behaviour right.

“My background’s in construction: on building sites, it’s a requirement to speak up if you see unsafe practices, and maybe we need to promote that as a value in the NHS for all staff”. MIP’s Jon Restell agrees, adding “maybe this inquiry should be not just ‘the nuts and bolts of non-clinical workforce planning’ but also describe a new, more positive working culture that we want to see”.

Sara Gorton suggested that changing culture and working patterns is also a systemic issue: “By its very nature, commissioning and contract functions are usually in an individual organisation’s best interest to draw close and keep their own identity and competitive edge. Now, we need to share culture across
The basis of culture is in consistently clarifying and communicating what organisations value and reward.

organisational footprints, and get people to work in roles with more utility.

“Maybe we have to think more creatively, as with the Social Partnership Forum work on pensions for a wholly (or mainly) NHS workforce to access NHS pension scheme, and a commitment to some passport for learning skills – more could be done to map this.

“The key for me is to go back to the original NHS Constitution, and revising those commitments to staff. It may not be politically palatable: the government’s certainly still keen on the constitution commitments to patients and the public.

“But our debate suggests that we probably need well-designed jobs, and opportunities for skills and development. We need to look at the people who’ll be potentially running the system in twenty years’ time, and say ‘these are some of the skills you’ll need, these are where you can find training and help, and we’ll move you around the system in your career to benefit you with the right experience’.

UCLH’s Ben Morrion suggests that “the basis of culture is in consistently clarifying and communicating what organisations value and reward. For this part of the NHS staff community, and perhaps for quite a bit of it, it seems we’re not quite there. The culture we’re seeking local and nationally needs to be informed by our description to the wider community of the health and care outcomes we want. Local government’s had to be innovative at doing this.

“Secondly, we need conversations about the way to unite local focus of culture of my organisation, as we seek to balance in our part of the London STP footprint, but also to contribute and inform the national culture – pay development, training, learning, people management 2015-20.

“Staff need to be open when they see bad practice and do something about it without fear. When that’s in place, that’ll be a sign of a good culture: when someone’s done something wrong, staff won’t just throw their hands up and walk away. In my part of this workforce, we regard supporting and promoting those who confront bad practice as just decent line management, which we think is as important as patient experience”.

HFMA’s Paul Bridgock adds that “a frustration of many of our members is that they feel they’re working in organisational silos. We need to think across pathways, but we’re managed and regulated in organisational silos, and mentally and culturally, once people are in those, it can be very hard to get from one silo to another. The old regional health authorities moved staff around like chess pieces to give them broad experience, but after the advent of FTs, we’ve seen that much less.

“That’ll create new challenges: some of the most important finance roles over the next few years will be in commissioning, but the most experienced finance people are in FTs. If you’ve only worked in a commissioning background, the move to a provider role is hard. I’m not sure that transferability is there, or that senior managers have given finance staff a much more diverse view of overall system working. And there are potential problems with accountability lines through those channels. Bottom-line accountability for providers is to TDA/Monitor, and for commissioners to NHS England. And that causes frustration around joint working”.

Serco’s Andrew Prince concludes that “we need to focus on continuity: the 44 STP footprints are a real opportunity to create new locus of planning and funding transformation to redesign care pathways. How will we reconcile individual financial reporting by organisations with redesigning care pathways across STP footprints?”

UCLH’s Ben Morrion agreed that reconciling these financial and redesign requirements “presents system leaders with a national unlocking opportunity”.

Find out more
Health Foundation (2016) – Fit For Purpose? Workforce Policy in the English NHS
http://tinyurl.com/hqvx8nz

Skills For Health workforce papers
http://bit.ly/1WF5bXY
Other obstacles to progress are the quality of appraisals; a dearth of information about NHS productivity, and the consequent failure to link the contribution of good processes, system analyst skills and operation skills.
During the work contributing to this Interim Report, participants agreed that some simple self-assessment questions might help organisations and system leaders to focus on the issues around the non-clinical workforce. These are the questions.

**QUESTIONS FOR ORGANISATIONS**

- How valued do our support/non-clinical staff feel? How do we know this; who feels most valued and who least; and what do we do about this?
- Do we understand the value these staff provide, and not just the overhead cost they represent? How do we measure it?
- Do we help these staff understand how they contribute to patients’ experience, outcomes and good use of resources? How can we be sure?
- How do we provide career development opportunities and skills aligned to future needs of the organisation/system? How are career development plans organised to ensure we get the staff we need at the right time?
- What are our measures of job satisfaction and staff engagement, and how do we plan to enhance attention of HSJ readers on their value, at a time of economic stress getting more intense?
- How are we actively challenging upwards to system leaders around the strategic vision for this part of the workforce?
- How does our board present its views on the value of these staff internally and to the wider world, articulating and celebrating contribution of this group? If the answer is by awards, what is the ratio of celebration of clinical/medical staff to non-clinical staff?
- How will we evaluate (in a proportionate but meaningful way) emerging new support roles?
- Given the Carter agenda on cutting the cost of back office, how will we evaluate the impact of taking staff down a couple of grades on service, colleagues, outcome for staff and public and patients?
- Carter and procurement – fantastic, but where is national procurement expertise and leadership and change in behaviour, and procurement development plans locally? Where are workforce, skills etc?
- What are the implications of choices based on lowest-cost in staff engagement and quality?
- Are we involving these staff and getting the best value from their contributions and insights into how to improve care?

**QUESTIONS FOR SYSTEM LEADERS**

- Do our narratives about change highlight the importance of all parts of the NHS workforce, including those who support and enable the work of clinicians?
- How are we ensuring providers and commissioners are collaborating to develop this part of the workforce in tandem with reform plans?