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PERSPECTIVE

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Developing the future research agenda for the health and social care workforce in the United Kingdom: Findings from a national forum for policymakers and researchers

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Abstract

There is a gap between healthcare workforce research and decision-making in policy and practice. This matters more than ever given the urgent staffing crisis. As a national research network, we held the first ever United Kingdom (UK) forum on healthcare workforce evidence in March 2023. This paper summarises outputs of the event including an emerging UK healthcare workforce agenda and actions to build research capacity and bridge the gap between academics and decisionmakers. The forum brought together over 80 clinical and system leaders, policymakers and regulators with workforce researchers. Fifteen sessions convened by leading experts combined knowledge exchange with deliberative dialogue over 2 days. Topics ranged from workforce analytics, forecasting, international migration to interprofessional working. In the small groups that were convened, important gaps were identified in both the existing research body and uptake of evidence already available. There had not been enough high quality evaluations of recent workforce initiatives implemented at pace, from virtual wards to e-rostering. The pandemic had accelerated many changes in

skillmix and professional roles with little learning from other countries and systems. Existing research was often small-scale or focused on individual, rather than organisational solutions in areas such as staff wellbeing. In terms of existing research, managers were often unaware of accepted high quality evidence in areas like the relationship between registered nurse staffing levels and patient outcomes. More work is needed to engage new disciplines from labour economics and occupational health to academic human resources and to strengthen the emerging diverse community of healthcare workforce researchers.

KEYWORDS
evidence, healthcare workforce, knowledge mobilisation, research impact, staffing, United Kingdom

Highlights

- Gap between research and practice persists despite crisis in healthcare staffing
- Need to bring leading workforce researchers and health leaders together
- Dialogue is needed to exchange best evidence and identify knowledge gaps
- Design to optimise relational work in evidence interpretation and impact

1 | INTRODUCTION

The gap between available knowledge on the healthcare workforce and those who need it matters more than ever. The World Health Organisation projects a shortfall of 10 million health workers by 2030[1] and every country has experienced shortages of key workers, exacerbated by the shock of the recent pandemic. In England for example, recent analysis suggests an overall workforce supply-demand gap of around 103,000 full-time posts or around 7% of estimated demand.[2] Latest figures show a vacancy rate of 8.9% for all healthcare staff in England, with higher levels for some groups such as registered nurses, and historically high rates of workforce exit.[3] Addressing the workforce crisis is the number one challenge for most healthcare systems.

Yet relevant research findings often fail to reach those who make workforce decisions in healthcare. Human resource managers in hospitals rarely look to research for help with important questions, from understanding changes in labour markets to the impact of new forms of shifts and rostering. Changes during the pandemic identified new areas of uncertainty with rapid redeployment of staff, shifts to remote working and new clinical pathways implemented at pace. At the same time, questions of how best to support staff under pressure and equity challenges in a diverse workforce came to the fore. These were pressing questions but workforce research rarely featured in public debate or healthcare decision-making. The chasm between practice and research was marked.

2 | CHALLENGES IN WORKFORCE RESEARCH

There is little evidence of workforce research influencing healthcare policy and practice and this is partly due to longstanding problems of research investment, capacity and community. Research on workforce and service delivery has experienced historic underinvestment compared with other areas of health and healthcare. Less than 3% of total United Kingdom (UK) health research funding is devoted to applied organisational research.[4] Researchers working on projects related to healthcare staffing come from various different disciplines, from labour economics and analytics to management or organisational behaviour and sociology. Funding opportunities are growing but have been scarce in the past. There are few development opportunities for early career researchers to work with those in other disciplines as future leaders of workforce research. Individuals rarely define themselves as 'workforce researchers' and identify as a coherent research field. While meeting the central definition of Haas' epistemic community (in a different context of international development) as "professionals with recognised expertise … and a common policy enterprise",[5] it is difficult to characterise workforce research as a coherent field of scholarship or knowledge generation.

Just as there has been an under-supply of research and researchers on workforce topics, there have also been difficulties in synthesising and sharing knowledge. The lack of a defined workforce community or body of knowledge, as noted above, means that research is often dispersed and locked in disciplinary or professional silos, from medicine and nursing to organisational psychology and labour economics. Conference proceedings, academic journals and other outputs are often restricted to single fields and may not be easily identified by standard keywords and indexing terms. There has been an explosion of published research in this space recently; a quick MEDLINE search by the authors indicated the number of (general) workforce related publications in the health literature in 2022 had almost doubled in 3 years. But relevant evidence is not always identified or brought together, rarely featuring in policy briefings or guidance.

3 | BRIDGING THE GAP: A FORUM FOR POLICYMAKERS AND RESEARCHERS

There is an urgency then to close the gap between researchers and decision-makers in healthcare workforce. As a national network, Health Services Research UK (HSR UK) convened the first ever UK forum on health and care workforce evidence in March 2023. The purpose of this 2-day event was to bring together a wide range of researchers with clinical and system leaders, policymakers, regulators and others to discuss available research and gaps.

Designing this event, HSR UK drew on a rich theoretical and empirical evidence from many scholars on what works in mobilising research and making better links between research and policymakers in areas from public health to education and criminal justice.[6] Over 20 years ago, Jonathan Lomas described the 'linkage and exchange' activities of a Canadian health research foundation,[7] refined further by Graham and Tetroe emphasising feedback loops and dynamic interaction between researchers and users.[8]

Lomas' work is useful in illustrating practical activities from roundtable meetings with policy-makers to identify research gaps to mediated efforts to identify and synthesise relevant evidence in a form which decision-makers could use. A key principle was the shared nature of learning and two-way flow of insights and knowledge between researchers and service leads. This leans into the notion of collaboration which "shifts the emphasis from 'push' and 'pull' models, where researchers disseminate findings or where decision-makers seek research, towards deliberative decision-making that blurs the distinction between those who produce knowledge and those who use it".[9]

The 2-day forum was designed as an invited closed roundtable event. This was to allow genuine dialogue in small groups and two-way exchange between policymakers and researchers working together to interpret and

understand findings and identify important gaps in the collaborative way highlighted by Lomas. The small expert planning committee identified a wide range of individual stakeholders in several rounds of personal invitations.

Fifteen topics were selected of maximal interest to those making workforce decisions (Table 1). Session chairs were identified as experts in their field. They were asked to lead discussion in small groups, presenting an overview of what was known and strength of evidence, exposing controversies and gaps in knowledge and asking participants for views on importance and relevance of future research. Session chairs were also asked to prepare reading lists with three to five landmark research or seminal papers for each topic circulated in advance. These resources, together with slidepacks for each session were available on a platform to all participants before and after the event. Each session also had an early career researcher to act as rapporteur as a development opportunity.

Plenary sessions included contributions from workforce policy leaders in the UK as well as comparative learning from the more established Canadian Health Workforce Network with a recently published strategy setting out evidence-informed solutions to healthcare staffing crisis.[10] There was also brief plenary feedback from chairs on main issues arising from each session as these were held in parallel, so participants could only take part in a third of all sessions.

4 | WHAT DID WE LEARN AND WHERE ARE THE GAPS?

Eighty one people attended - 43 workforce researchers from a range of relevant disciplines and thirty eight decision-makers at national and local levels from the service, policy, regulatory and professional bodies. There was rich discussion and debate, identifying some areas which were 'known knowns' to researchers, such as robust high quality evidence on the relationship between registered nurse staffing levels and patient outcomes,[11] but not well known to healthcare managers. There were also a number of areas where evidence was limited.

4.1 | New roles and shifting boundaries

Research struggled to keep up with the growing number of roles designed as solutions to address shortages in (often) medical workforce, with inconsistent definitions and scopes of practice in different associate and advanced practitioner roles[12] as well as support workers, and a tendency to rush to implement and scale up such new roles without good evaluations. Evidence on impact and degree of substitution remained mixed and often difficult to interpret.[13] Some areas were contested with differing views from participants on the benefits and costs of further shifts in existing professional boundaries. Transferable learning from evidence in other sectors, from law to education and police, on the role of paraprofessionals was under-used. Some areas of workforce were problematised by political debate, such as the value of professional nursing care or the balance between academic knowledge and practical experience in nurse training, whereas other issues, such as the degree of variation in grademix in medical staffing[14] received less attention. Participants noted the value of ethnographic research in understanding issues of

TABLE 1 Session topics at workforce forum.

- Workforce data and analytics
- Equity and diversity and discrimination
- Recruitment, retention and leaving
- New ways of working including flexibility, digital health
- Levels of staffing and impact on outcomes
- Pay and reward strategy
- Research funding and setting future agenda
- Management and leadership
- Skillmix and new roles
- Workforce policy and planning for future needs
- Interprofessional working
- Staff wellbeing and burnout
- Bullying, harassment and whistleblowing
- International workforce and migration
- Developments in professional regulation

professional identity and team cohesion and how this plays out in interprofessional teams of different kinds,[15] as well as the gap between 'work as imagined' and 'work as done'.[16]

We know much less about workforce in areas that are difficult to research, such as community-based lone workers including homecare staff, paramedics or community nurses. Other important gaps included research into non-patient facing support staff, such as laboratory scientists, logistics, portering and cleaning services, administrative workers, estates and IT support staff.

4.2 | Changing labour market

Structural shifts in the labour market with greater outsourcing, casualisation and precarity, as well as generational changes privileging flexibility and part-time working had not yet been properly investigated, and the recent major shift towards remote working driven by the pandemic had not been evaluated at all. Initiatives by employers to boost recruitment and retention, from apprenticeships to team-based self-rostering, were rarely evaluated. Some healthcare organisations had personalised rewards and incentives for staff but the impact of this on satisfaction and retention were not known. Other important gaps in what was researched included workforce education and training, from approaches to interprofessional learning and simulation to developing generalist skills to address growing number of people with complex and multiple needs.

4.3 | Career pathways and decisions to stay

Both in policy and research terms, there has been more attention to date on training and recruitment than retention and return to work, but there is a need for studies to explore career decisions and pathways and individual behaviours over time. For instance, we know little about the longterm impacts of international recruitment, for individuals or for organisations and healthcare systems. There has also been more focus on those who leave than those who stay,[17] with potential for positive deviant approaches to examine high-performing organisations with low turnover and high rates of staff engagement. Given high levels of international recruitment, there was not enough attention to learning from positive examples of organisations with good onboarding, induction and integration with the domestic workforce.

4.4 | Staff wellbeing and support

Research in areas of staff wellbeing had focused largely on individual-focused interventions, from mindfulness to resilience training, rather than organisational or system responses which remained under-researched.[18] Similarly, there was a lack of evidence on organisational level culture changes to prevent or minimise bullying,[19] including team-based interventions with a focus on fostering psychological safety, reducing authority gradients and creating specific moments for voice. More is known about the problems, patterning and risks than on solutions at an organisational or microsystem (team) level.

The interaction of racism and discrimination with other factors relating to bullying and harassment needed more exploration as well as ways of creating more inclusive work environments. There was reasonable evidence in the UK of higher levels of referral for minoritised staff to regulators and local disciplinary processes[20] but less understanding of underlying causes or mitigations. Differential impact of policy and practice on healthcare staff from ethnic minority groups was a recurrent theme. This included higher levels of risks, exposure and harm during the pandemic[21] but the effects of different staff wellbeing or retention interventions was unknown or the extent of pay and progression gaps along ethnicity lines.

5 | OPENINGS FOR NEW RESEARCH AND AGENDA-SETTING

Participants identified opportunities for research, including the existence of robust UK health datasets from electronic staff records and surveys held by health care organisation to data on registrants and career pathways held by professional regulatory bodies. This provided opportunities for longitudinal research, enabling researchers to track medical practitioners for instance from application through foundation training and beyond.[22] We need more cohort studies to understand what works for different professionals at different career stages in terms of widening access, the value of training and initiatives to boost retention. In terms of data, there were still important gaps in workforce data in primary and community care, for agency and bank staff and across independent and voluntary sector. More effort was needed to support better linkage of data, with easier ways to link various workforce dataset with patient-level data on activity and outcomes. Participants agreed for the need for more standard datasets and definitions on workforce and for a secure data environment to enable better sharing of data for forecasting, planning and research. Other countries like Sweden enjoyed more open data and registries.[23]

Participants raised the need for horizon scanning to anticipate challenges and solutions for future workforce. This ranged from use of artificial intelligence and automation with impact on current staff and posts to point of care testing and other advances which changed where care was delivered, and by whom. Implications and impact on workforce were rarely factored into new technologies and the pandemic illustrated radical disruptive change affecting systems and staffing.

Current research funding was often piecemeal and poorly coordinated although there had been positive UK initiatives to commission workforce research in targeted areas, such as evaluations of new staff roles.[24] While context was important with national regulatory, policy and pay frameworks there were also opportunities for international collaboration and comparative system evaluation on some key workforce issues. The influential RN4Cast programme for instance provided data on nurse staffing levels and relationship to patient outcomes in nine countries across Europe.[25] There was a need for more strategic and programmatic agenda setting to identify priorities. Participants noted that any future exercise to prioritise areas of research need should pay attention to who and how this was done, with risk of capture by dominant voices and competing stakeholder interests.[26]

6 | DISCUSSION AND NEXT STEPS

This was the first attempt in the UK to bring together researchers and healthcare workforce policymakers or service leads at a national event. Over 80 people took part in a 2 day event with rich discussion in parallel sessions led by experts. This provided an opportunity to review the state of evidence, identify where evidence was strong and weak or missing and start to prioritise the most important areas for future research.

Over half the participants were researchers, with reasonable coverage of the main areas of expertise and input from leading investigators in workforce research. We also had good engagement and participation from a wide range of senior policymakers and NHS leaders, though it was more challenging for those with operational responsibilities to free up the time to attend a 2 day meeting.

There was a lack of patient and public voice at the event, which in retrospect was a limitation of our approach. It was recognised that those receiving care would also have relevant and important views on aspects like impact of remote working, new staff roles or continuity of care. This would be an important element in future activities.

This event was not designed as a formal consensus building exercise in terms of recommendations and future research. This was the first bridging event of its kind and future activity might include more structured forms of agenda setting or debate.

The in-person nature of the event was important, including a dinner and opportunities to network over 2 days. This element is critical given what we know of the social life of knowledge[27] and the relational aspects of exchange. The event generated collaborations between participants on research projects and activities. This includes future

plans for a programme of research webinars for human resource leads and managers at healthcare organisations, led by HSR UK in partnership with a service network identified at the forum.

The role of HSR UK in driving this forum was important, acting as a dynamic mediator between service and research interests. Key activities included shaping a compelling programme and identifying authoritative experts and persuading them to commit to active work in shaping and leading sessions and preparing curated resources. The challenge is to keep the momentum going. Lomas emphasises that linkage and exchange should be seen as a process not a discrete event, with focus on building and maintaining relationships.[7] This is difficult for a small institute. But as a research network, HSR UK is exploring options from creating a special workforce interest research group at its annual conference to organising focused research exchange events on priority themes. These are all ways of building and supporting a community of practice in healthcare workforce research. It will be good to track these activities and add to a growing body of evidence[28–30] on the role of intermediary bodies in strengthening use and usefulness of evidence to decision-makers. High quality and relevant research is needed as never before to support national and local decisions on how to make the best use of their greatest asset—their workforce.

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CONFLICT OF INTEREST STATEMENT

Cat Chatfield is salaried director and Kieran Walshe and Tara Lamont unpaid trustees of HSR UK, the organisation which ran the forum described in this paper.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

ETHICS STATEMENT

Not applicable.

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