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Health Committee

Workforce Planning

Fourth Report of Session 2006–07

Volume I

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, which can be found in HC 171-II. Written evidence is cited by reference in the form 'Ev' followed by the page number; Ev x (HC 1077–II) for evidence published in May 2006, Ev x (HC 171–II) for evidence published in March 2007.

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Summary

Workforce planning for the health service is challenging and complex. The future workforce is difficult to predict: social and technological changes mean that some skills will become redundant while demand for others will suddenly increase. Basic staff numbers are hard to forecast and problems are exacerbated by the length of time required to train staff: at least three years for most health professions and up to twenty years for some senior doctors.

Nonetheless, workforce planning is a vitally important process. 70% of NHS funding is spent on staffing costs and so the effectiveness of its workforce in large part determines the effectiveness of the health service. Workforce planning is the key means for the health service to understand and anticipate the impact of demographic, technological and policy trends on future service requirements. It is also an important way of improving the efficiency of the health service. In short, changing and improving the NHS depends on effective workforce planning.

In light of its importance, the Health Committee recommended a thorough review of health service workforce planning in 1999. This recommendation was accepted and in 2000 the Government published an excellent blueprint for workforce planning entitled *A Health Service of all the talents*. In the same year, targets were set for a large increase in the number of staff employed by the NHS in the *NHS Plan*. There was also to be a significant expansion in the number of training places for clinicians.

However, the huge growth in funds provided by the Government, together with the demanding targets it set, ensured that the increase in staff far exceeded the *NHS Plan*. Many new staff were recruited from overseas. In 2005 there were signs that the NHS was spending too much. Boom turned to bust. Posts were frozen, there were some, albeit not many redundancies, but, most worryingly, many newly qualified staff were unable to find jobs and the training budget was cut.

Although the Government argued for improvements in productivity, in practice little happened. It was too easy to throw new staff into the task of meeting targets rather than consider the most cost-effective way of doing the job. Large pay increases were granted without adequate steps being taken to ensure increases in productivity in return. There were attempts to create a more flexible workforce and improve the skills of staff so they could take on more complex and responsible tasks. The results of these efforts have been mixed: in some cases, there have been few savings, in others the results have been very successful. Unfortunately, cuts in the training budget threaten what successes there have been.

There has been a disastrous failure of workforce planning. Little if any thought has been given to long term or strategic planning. There were, and are, too few people with the ability and skills to do the task. The situation has been exacerbated by constant re-organisation including the establishment and abolition of Workforce Development Confederations within 3 years. The planning system remains poorly integrated and there is an appalling lack of coordination between workforce and financial planning. The health

service, including the Department of Health, Strategic Health Authorities (SHAs), acute trusts and Primary Care Trusts (PCTs), has not made workforce planning a priority.

We cannot know precisely what workforce the health service will require in future. This means we will need a more flexible workforce. Increasing productivity is another vital goal, particularly as the rate of funding growth is likely to slow down. Employers need to make better use of the new staff contracts, particularly the new consultant contract and *Agenda for Change* to improve workforce productivity. If a health service, rather than a sickness service, is to be created, then it is crucial that the primary care workforce is expanded and improved.

Managers are a crucial component of the health service workforce. The quality of managers remains highly variable and the absence of minimum standards or training requirements is a concern. The contribution of clinicians to managing health services must be improved. Clinical training should contain a larger management element and senior clinical staff should be better supported to take on general management roles.

To avoid the boom and bust of recent years and produce a workforce appropriate for the future, we make one major recommendation: workforce planning must be a priority for the health service. We do not support further restructuring. It matters less who does the job than it is done well and taken seriously. Therefore, despite their failings to date we recommend that workforce planning continue to be undertaken by SHAs.

The 10 SHAs should take the lead on creating a better workforce planning system. Most importantly, the integration of workforce, financial and service planning must be improved, as these processes have often been very badly synchronised. In addition, more integrated planning will mean increased involvement for education providers and the independent sector. The planning system also needs to take more of a long-term view of workforce requirements and think more strategically about how to achieve them.

More time, effort and resources need to be devoted to workforce planning. SHAs must recruit workforce planners of the highest calibre and ensure that they are supported by staff with appropriate skills. Most human resources staff do not have these skills. Other organisations, including trusts and the Department of Health, must improve the quality and accuracy of the information they produce on a range of matters, including workforce forecasts, productivity and the cost of new policies. Finally, the Department of Health must stop micromanaging. In addition to ensuring SHAs have information of a high quality, they should act in an oversight capacity ensuring that SHAs are giving workforce planning the priority its importance requires.

1 Introduction

1. Workforce planning should be simple: decide what workforce is needed in the future and recruit and train it. In reality, the task is difficult and complex. The future workforce is not easy to predict: technological and social changes mean that some skills are likely to become redundant. Consider the cardiac surgeons made surplus to requirements by the introduction of vascular stents; surgeons need to acquire general skills in their education that can enable them to change speciality in mid-career. Even basic numbers are hard to forecast: we may, for example, require fewer nurses and more doctors in 10 years time. The problems are exacerbated by the length of time it takes to train staff: two to three years for a nurse, three years for a physiotherapist, about fifteen years for a surgeon. In addition, workforce planning has to be co-ordinated with financial and service plans. Unfortunately, the skills required to plan workforces are in short supply; people in human resources rarely specialise in this area and traditionally it has been a low priority for NHS managers.

2. In view of the importance of the subject the Health Committee undertook an inquiry into *Future NHS Staffing Requirements*, which was published in February 1999.[1] Many of the Committee's recommendations were accepted and the Government set out a plan for improving workforce planning in *A Health Service of all the talents* in April 2000. New structures, based around regional Workforce Development Confederations dedicated to workforce planning, were established. Emphasis was put on improving productivity and looking at whether other staff could do some of the work previously undertaken by doctors.

3. *A Health Service of all the talents* was a good blueprint, but by 2005 there were concerns about its implementation. While figures for a planned expansion of the workforce were set out in the *NHS Plan* in 2000, a range of pressures, from the European Working Time Directive to central targets, combined to cause the health service to employ ever more staff. The number of staff employed by the NHS increased by 260,000 between 1999 and 2005, an increase in workforce size of more than 24%. Over this period the number of GPs increased by 17%, nurses by 22%, consultants by 37%, staff employed in 'central functions' by 42% and in senior management by 62%. These figures far exceeded those proposed in the *NHS Plan*. Hoped for increases in productivity were not happening: it was easier to employ more people than to think about how to perform a task more efficiently. As we discussed in our report into *NHS Deficits,* in some trusts workforce planning was undertaken without reference to financial planning. New staff were employed by organisations which did not have the money to pay them.

4. Eventually, the boom turned to bust. The new Resource Accounting and Budgeting regime revealed deficits in many trusts. The deficits grew and the Secretary of State decided that the NHS should return to balance. Many posts were either removed or frozen and some staff, albeit a very small fraction of the workforce, were made redundant. Newly-qualified staff found it difficult to find jobs and big cuts were made to the training budget. The workforce planning system was not working effectively.

[1] Health Committee, Third Report of Session 1998-99, *Future NHS Staffing Requirements*, HC 38-I

5. We decided to undertake an inquiry in early 2006 when concerns about the boom-bust cycle were beginning to appear. Evidence sessions began in late spring. Not long afterwards we became concerned by the deficits, which we decided were a more urgent priority for the Committee although not a more important subject. In fact, the vital role of workforce planning became increasingly evident during our deficits inquiry. The final evidence sessions were held in December 2006 and January 2007. Our terms of reference were as follows:

> How effectively workforce planning, including clinical and managerial staff, has been undertaken and how it should be done in the future.
>
> In considering future demand, how should the effects of the following be taken into account:
>
> - recent policy announcements, including *Commissioning a patient-led NHS*
> - technological change
> - an ageing population
> - the increasing use of private providers of services
>
> How will the ability to meet demands be affected by:
>
> - financial constraints
> - the European Working Time Directive
> - increasing international competition for staff
> - early retirement
>
> To what extent can and should the demand be met, for both clinical and managerial staff, by:
>
> - changing the roles and improving the skills of existing staff
> - better retention
> - the recruitment of new staff in England
> - international recruitment
>
> How should planning be undertaken:
>
> - To what extent should it be centralised or decentralised?
> - How is flexibility to be ensured?
> - What examples of good practice can be found in England and elsewhere?

6. We received memoranda from 99 organisations and held eight oral evidence sessions, hearing from witnesses such as the Minister of State for Quality, officials including the Department of Health's Director General of Workforce, trust chief executives, academic

experts and representatives of 16 professional and occupational membership groups. We also visited California in May 2006 where we met academics, legislators and industry experts.

7. Our report considers the issues raised by the evidence under the following headings:

- Workforce developments since 1999;
- Assessment of the current workforce planning system;
- The future health service workforce; and
- The future workforce planning system.

8. We would like to thank all those who gave evidence. We are particularly grateful for the expert assistance we received from our specialist advisers: Professors James Buchan, Charles Easmon, Judy Hargadon and Alan Maynard.

2 Workforce developments since 1999

Introduction

9. Since the Committee's most recent workforce report was published in 1999, there have been significant changes to the health service workforce and to the workforce planning system. Some of the main developments are shown below:

Key workforce developments since 1999

March 1999 – Committee report *Future NHS Staffing Requirements* published

April 2000 – Publication of DH paper *A Health Service of all the talents*

July 2000 – Publication of *NHS Plan*; start of *Improving Working Lives* scheme

April 2001 – Creation of Workforce Development Confederations (WDCs); creation of NHS Modernisation Agency (MA) and National Practitioner Programme

October 2002 – Creation of Strategic Health Authorities (SHAs)

April 2003 – New consultant contract begins

April 2004 – New GP contract begins; WDCs merged with SHAs

November 2004 – Creation of NHS Employers

August 2004 – European Working Time Directive extended to trainee doctors

December 2004 – *Agenda for Change* agreement finalised

April 2005 – New pharmacy services contract begins; net NHS deficit of £251 million

July 2005 – MA replaced by NHS Institute for Innovation and Improvement

August 2005 – Start of introduction of Modernising Medical Careers

November 2005 – Secretary of State commits to achieving net NHS financial balance by end of 2006–7

March 2006 – Permit-free training for overseas doctors ended

April 2006 – New dentistry contract begins; net NHS deficits reach £547 million

July 2006 – Number of SHAs reduced from 28 to 10

10. In this chapter, we examine some of the key changes to the health service workforce and the reasons they have taken place. We consider the following areas:

- The main **reasons for workforce changes** including policy changes and significant funding growth;
- Changes in **staffing numbers**, including overall workforce size, domestic training capacity and the level of international recruitment;

- Adjustments to staff **pay and contracts** including the new consultant contract, GP contract and *Agenda for Change*; and
- The introduction of **new ways of working** including skill mix changes and other attempts to improve the efficiency of the workforce.

Reasons for workforce changes

11. In this section we look at some of the main policies and other developments which have influenced changes to the workforce. These included:

- The impact of the previous Health Select Committee report, particularly through the ***A Health Service of all the talents*** review (2000);
- The impact of **the *NHS Plan*** (2000) and the unprecedented growth in health service funding from 2000 onwards;
- The ***Shifting the Balance of Power in the NHS*** reforms (introduced in 2001) which included the creation of SHAs and Primary Care Trusts (PCTs);[2] SHAs have subsequently taken over a number of key workforce planning responsibilities from WDCs;
- The rise in **equal pay claims**, based on precedents such as the 1992 Enderby v Frenchay Health Authority ruling, which was an important cause of pay reforms, particularly the *Agenda for Change* agreement;
- **Technological changes**, for example the introduction of vascular stenting and the increasing use of automation and robotics, which have radically altered demand for particular staff groups, especially within medicine;[3]
- The effects of the extension of **European Working Time Directive** legislation to doctors in training (August 2004);
- The impact of increasing **NHS deficits** from 2005 onwards; and
- The ***Our Health, Our Care, Our Say*** white paper (published in January 2006) which set out plans to shift 5% of hospital activity into primary care.

We look at some of the most important reasons for change in more detail below.

A Health Service of all the talents

12. The Health Committee's previous workforce report, *Future NHS Staffing Requirements*, was published in February 1999. The report concluded that the NHS was "in the midst of a staffing crisis" and made a number of recommendations for changes to the workforce and the workforce planning system.[4] Recommendations included the development of a more

2 Department of Health, *Shifting the Balance of Power within the NHS: Securing Delivery*, July 2001, pp.4–7

3 Ev 26–27 (HC 1077-II)

4 Health Committee, *Future NHS Staffing Requirements*, HC 38-I, p.xi

integrated planning system, increasing medical student numbers by 1,000 per year and the introduction of a single pay system for all NHS staff. Perhaps the most significant proposal was for "a major review of current planning procedures",[5] a recommendation which the Government accepted.[6]

13. The subsequent review of workforce requirements and workforce planning procedures led to the publication of the *A Health Service of all the talents* consultation in April 2000. The proposals set out in the report included,

- The development of **a more streamlined and integrated workforce planning system** with better integration between workforce and financial planning and between medical and non-medical planning and funding;
- The creation of a National Workforce Development Board to oversee workforce planning and regional **Workforce Development Confederations** to co-ordinate workforce planning and commission education and training;
- Efforts to **increase the flexibility of the workforce** including flexible career opportunities and co-ordinated attempts to change skill mix and develop new and extended clinical roles; and
- An **increase in staff numbers**, particularly of medical staff (although the report noted that increases in numbers "will need to be accompanied by changes in the way in which they work".)[7]

14. *A Health Service of all the talents* set out a clear mandate for change to the health service workforce through reform of the workforce, particularly through increasing flexibility, and workforce growth. The proposals also set out significant changes to the workforce planning system, most notably through 'care group' workforce planning to link plans to service need;[8] and through the creation of Workforce Development Confederations (WDCs). WDCs, 24 of which were established in 2001, were regional organisations dedicated specifically to workforce issues and increased the number of staff involved with workforce planning and development. WDCs were overseen by the eight NHS Regional Offices until they were replaced by SHAs in 2002.

The NHS Plan

15. Just three months after the publication of *A Health Service of all the talents*, the Government launched the 10-year *NHS Plan* (July 2000). The *NHS Plan* set out an ambitious programme for the reform of the health service designed to expand capacity, improve access and increase the responsiveness of services. Specific service targets included reducing maximum waiting times in Accident and Emergency departments to 4 hours by

5 Health Committee, *Future NHS Staffing Requirements*, HC 38-I, pp.xlii-xliii

6 Department of Health, The Government's response to the Health Committee's report on *Future NHS Staffing Requirements*, Cm 4379, June 1999, p.5

7 Department of Health, *A Health Service of all the talents: Developing the NHS workforce*, April 2000, pp.5–6

8 Ibid, p.6—'care group' planning involves determining workforce requirements for delivering care to a particular patient group, for example cancer or mental health patients, rather than determining requirements by professional groups such as doctors, nurses or physiotherapists.

2004, and reducing waits for inpatient treatment to less than 6 months by 2005.[9] Achieving these goals required a significant and rapid increase in staff numbers. Targets for workforce expansion were set out in the *NHS Plan* and in *Delivering the NHS Plan* 2 years later.

16. Crucially, the *NHS Plan* was accompanied by unprecedented increases in the level of health spending, designed to bring UK spending levels in line with the rest of the EU. High levels of funding growth were subsequently secured until 2008 and underpinned workforce expansion targets. Funding increases also supported the *NHS Plan*'s stated ambition of increasing pay levels for all NHS staff. Health service funding levels before and after the start of the *NHS Plan* are shown in the table below.

Financial Year	Status of figures	NHS expenditure (£ billion)	Real terms increase (%)	NHS spending as % of GDP
1997–98	Outturn	34.664	2.1	5.4%
1998–99	Outturn	36.608	3.0	5.4%
1999–2000	Outturn	39.881	6.8	5.4%
2000–01	Outturn	43.932	7.8	5.6%
2001–02	Outturn	49.021	9.0	6.0%
2002–03	Outturn	54.042	6.9	6.3%
2003–04	Outturn	64.181	11.9	6.7%
2004–05	Outturn	69.306	5.1	7.0%
2005–06	Estimated	77.847	10.0	7.3%
2006–07	Plan	84.387	5.8	7.4%
2007–08	Plan	92.173	6.4	7.8%

Table 1: NHS expenditure, 1997–2008

Source: Department of Health

17. The *NHS Plan* set out clear requirement for NHS organisations to increase the size of their workforce in order to meet exacting new service goals, particularly reductions in waiting times. At the same time, major budget increases provided extra resources to recruit additional staff and to increase pay. These two developments have been the main reasons for the rapid expansion in workforce capacity (see paragraphs 23–33).

The European Working Time Directive

18. The European Working Time Directive 93/104/EC, which restricts employees to 48 working hours per week, came into effect in the UK in October 1998. In August 2004, the directive was extended to cover doctors in training, who were limited to working no more than 58 hours per week. This will be further extended in 2009 to reduce doctors in training to working a maximum of 48 hours per week. These changes are having a significant effect on workforce capacity, as junior doctors have traditionally worked considerably more than 58 hours per week.[10]

19. Equally significantly, the 2004 changes stipulated that on-call time should be counted as part of doctors' working hours, a provision which is still subject to legal challenges.[11] As a

9 Department of Health, *The NHS Plan: A plan for investment, a plan for reform*, Cm 4818-I, July 2000, pp.103–105

10 Ev 128 (HC 1077-II)

11 Q 119

result, the resident on-call system (whereby junior doctors stay overnight in hospital but are available for work) has been replaced by more rigid shift working. Such changes have in turn affected non-medical staff; nursing staff, for example, have often been required to take on additional responsibilities in response to reductions in junior doctor capacity.[12] Thus the European Working Time Directive regulations have been an important reason for the introduction of new ways of working, and particularly the redesign of clinical roles.

NHS deficits

20. In spite of the record funding increases which accompanied the *NHS Plan*, the health service has experienced increasing deficits in recent years. Total net NHS deficits in 2004–05 totalled £221 million, and this went up to £547 million in 2005-06. 6-month figures for 2006–07 show that 178 NHS organisations are currently in overall deficit (70 NHS trusts and 108 PCTs).[13] The gradual increase in the depth and breadth of deficits is shown in the table below:

Financial Year	Surplus/(deficit) reported in audited accounts (£m)	% of NHS organisations with an overall deficit
2001/02	71	8
2002/03	96	12
2003/04	73	18
2004/05	(251)	28
2005/06	(547)	31

Table 2: NHS deficits, 2001–2006

Source: Department of Health/NAO

21. The emergence of deficits has placed significant pressure on NHS organisations to reduce workforce costs. As the Committee's recent report on the subject described, cost saving measures have included job reductions, education and training cuts, and some compulsory redundancies.[14] The need for savings of this type has been increased by the Secretary of State's pledge that the NHS will achieve financial balance by the end of the 2006–07 financial year.[15] Thus deficits are an increasingly important reason for workforce change.

Staff numbers

22. The main effect of these changes was a major expansion in workforce numbers up to around 2005, followed by the emergence of deficits in 2004–05 with consequences including cuts in domestic training capacity and graduate unemployment. We discuss these developments below.

12 Q 189

13 Department of Health, *NHS financial performance Quarter 2 2006–07*, November 2006

14 Health Committee, First Report of Session 2006-07, *NHS Deficits*, HC 73-I, paras 158–165

15 Health Committee, First Report of Session 2006-07, *NHS Deficits*, HC 73-II, Q 750

Workforce expansion (2000–2005)

23. By 2000, the need to increase the size of the NHS workforce had been clearly established: the Committee's 1999 report described the "crisis" in staffing numbers. The *NHS Plan* set clear targets for expanding the workforce and subsequent funding increases ensured that money was available to increase recruitment.

Overall staff numbers

24. Between 1999 and 2005, the NHS workforce increased by 260,000, an increase in workforce size of more than 24%. Expansion was at its quickest in the period immediately after the publication of the *NHS Plan* (2000), as shown below.

Year	1999	2000	2001	2002	2003	2004	2005
Total NHS workforce (headcount, 000s)	1,098	1,118	1,166	1,224	1,283	1,331	1,365
% increase	2.5	1.8	4.4	4.9	4.8	3.7	2.6

Table 3: NHS workforce growth, 1999–2005

Source: Department of Health

25. Growth during this period was not evenly distributed across different staff groups in the health service. Growth was fastest amongst management staff (62%) and 'central functions' staff, which includes finance, Human Resources and IT (43%). Growth was considerably slower amongst nursing staff (23%), although an additional 75,000 nurses were employed during this period. The number of hospital consultants grew more than twice as quickly as the number of General Practitioners. Increases in numbers across a range of staff groups are shown below:

Staff Group	Total (1999)	Total (2005)	% Increase (1999–2005)
All	1,098,348	1,366,030	24.4%
Doctors (all)	94,953	122,987	29.5%
Consultants	23,321	31,993	37.2%
GPs	29,987	35,302	17.7%
Nurses	329,637	404,161	22.6%
Allied health professionals	47,920	61,082	27.5%
Scientific and technical	54,471	73,452	34.8%
Clinical support staff	296,619	376,219	26.8%
Central functions	73,996	105,565	42.7%
Senior management	24,287	39,391	62.2%

Table 4: NHS workforce growth by staff group, 1999 –2005 (headcount)

Source: Department of Health

26. While the *NHS Plan* was a major reason for increases in staffing numbers, the actual rate of growth significantly exceeded targets and projections for most staff groups. For example the *NHS Plan* set a target for increasing nursing numbers by 20,000 between 1999 and 2004. In fact, nursing numbers increased by more than 67,000 during this period, some 340% in excess of the original target. *Delivering the NHS Plan* (2002) set a revised

target of 35,000 additional nurses between 2001 and 2008. This target was achieved within 2 years, rather than the allotted 7, and by 2005 nursing numbers had increased by more than 53,000 relative to 2001 levels. Given the increase in funding, it was inevitable that the growth in staff numbers would exceed *NHS Plan* projections.[16] The table below provides a fuller comparison of actual staff growth relative to *NHS Plan* targets.

Staff Group	Projected new staff: 1999–2004	Actual new staff: 1999–2004	Variance
Consultants	7,500	7,329	3% under target
GPs	2,000	4,098	105% over target
Nurses	20,000	67,878	340% over target
Allied health professionals	6,500	11,039	69% over target

Table 5: Comparison of 2000 *NHS Plan* growth targets with actual workforce growth (1999–2004, headcount)

Source: Department of Health

International recruitment

27. Increases in staff numbers were achieved through a number of different approaches including increased domestic training capacity, efforts to encourage UK staff to return to work, and an expansion in international recruitment. International recruitment was one of the main means of increasing staff numbers, particularly between 2000 and 2003. As Andrew Foster, then Director of Workforce at the Department of Health, explained to the Committee,

> …if I go back to 2001–2002 when we were tasked with these massive increases in the NHS workforce… we knew that we did not have enough input of nurses and doctors [from domestic sources] to deliver the capacity that was required to achieve the main objectives of improving access. Thus we set up the international recruitment programme…[17]

28. The growth in international recruitment between 1999 and 2005 was considerable. In medicine, for example, around 60,000 doctors registered with the General Medical Council between 2002 and 2005. Of these, 31% had qualified in the UK, 16% qualified in the rest of the European Economic Area (EEA), and the remaining 53% outside the EEA.[18] The growth in the number of doctors who qualified outside the UK as a proportion of the total medical workforce is shown in the table below.

16 Ev 278 (HC 171-II)

17 Q 95

18 Ev 93 (HC 1077-II)

Year	1999	2000	2001	2002	2003	2004	2005
UK doctors qualified within United Kingdom	72.4%	72.2%	71.9%	70.5%	69.5%	67.8%	66.4%
UK doctors qualified in remainder of the EEA	5.6%	5.4%	5.4%	5.5%	5.5%	5.6%	5.7%
UK doctors qualified elsewhere in the world	22.0%	22.4%	22.7%	24.0%	25.0%	26.7%	27.8%

Table 6: The UK medical workforce by area of qualification, 1999–2005

Source: Department of Health

29. Similar trends are apparent elsewhere in the workforce. The number of overseas nurses registering with the Nursing and Midwifery Council grew from around 5,000 in 2000 to more than 15,000 in 2002,[19] and remained above 12,000 per year between 2003 and 2005.[20] Similarly, the number of overseas physiotherapists registering in the UK rose from 500 in 2000 to 1,300 in 2005.[21] Much of the recruitment of overseas staff during this period was overseen and co-ordinated by the Department of Health.[22] In 2001, the Department introduced a *Code of Practice* which prohibited NHS organisations from actively recruiting in developing countries unless prior agreement has been reached at a governmental level.[23]

Retention and return-to-work schemes

30. In its evidence, the Department of Health asserted that the growth in staff numbers resulted in part from improved staff retention and the use of return-to-work schemes to bring retired or unemployed healthcare staff back to the NHS.[24] However, it provided little evidence of the impact of these trends. On retention rates, witnesses presented a different view, arguing that rates have not improved substantially. One witness even commented that "There is little evidence that retention can be improved to a significant degree".[25] A recent survey of the nursing workforce presented a similar view, commenting that there has been "little change in [nursing] wastage rates over the last few years".[26]

31. Return-to-work schemes do seem to have played a significant role in the increase in staff numbers, however. In nursing, for example, large numbers of staff enrolled on such schemes after 1999, as shown below.

19 Q 528

20 James Buchan and Ian Seccombe, *From Boom to Bust? The UK nursing labour market review*, 2005–6 (September 2006), p.16

21 Q 954

22 Q 95

23 Department of Health, *Code of practice for NHS employers involved in the international recruitment of healthcare professionals*, 2001

24 See Ev 3– 6 (HC 1077-II)

25 Ev 239 (HC 171-II)

26 James Buchan and Ian Seccombe, *Past trends, future imperfect? A review of the UK nursing labour market in 2004 to 2005* (Royal College of Nursing, 2005), p.24

Year	Nurses enrolling on return to work schemes
1999–2000	3,287
2000–2001	4,478
2001–2002	3,762
2002–2003	3,795
2003–2004	3,463

Table 7: Nursing enrolling on return to work schemes: 1999–2004 (data not collected centrally after 2004)

Source: Department of Health

Not all of these staff will have contributed to the growth in NHS nursing numbers, as these figures include staff returning to non-NHS organisations. In spite of this, return-to-work schemes clearly played a substantial part in the expansion of the NHS workforce after 1999.

Domestic training places

32. Alongside the increase in overall staff numbers, the *NHS Plan* set targets for expanding domestic training capacity.[27] The number of people beginning training within key clinical professions increased very rapidly between 1999 and 2005, as shown in the table below:

Year	1999	2000	2001	2002	2003	2004	2005	% Increase: 1999–2005
Medicine	3,972	4,300	4,713	5,277	6,082	6,294	6,298	58.6%
Dentistry	647	672	672	711	726	722	919	42.0%
Nursing	17,692	18,923	20,610	21,736	22,815	24,069	23,651	33.7%
Physiotherapy	1,473	1,780	2,157	2,345	2,418	2,360	2,360	60.2%
Occupational Therapy	1,173	1,385	1,563	1,692	1,822	1,981	2,008	71.2%
Radiography	581	578	690	818	833	860	864	48.7%

Table 8: UK healthcare training places, 1999–2005

Source: Department of Health

33. Like the overall growth in staffing numbers, the increase in domestic training output was driven in part by *NHS Plan* targets.[28] Unlike overall staffing numbers, the increase in training capacity remained broadly in line with central targets. It is important to note, however, that increases in the number of students *entering* training from 2000 onwards did not result in increases in *output* until considerably later, because of the time taken to train healthcare staff. Therefore increases in training capacity could not be translated into increases in workforce numbers until around 2006 at the earliest in the case of medicine, and until around 2003 in the case of most other health professions. Thus the most concentrated period of growth in staff numbers, between 2000 and 2003, cannot be

27 Q 95

28 Department of Health, *The NHS Plan: A plan for investment, a plan for reform*, Cm 4818–I, July 2000, p.51

accounted for by the growth in UK training numbers; rather it resulted from international recruitment and other developments.

Workforce contraction (2005 onwards)

34. From around 2005, there is evidence of a sudden and distinct change in health service workforce trends. The growth in staff numbers came rapidly to an end and in some areas the workforce may be beginning to contract. The overshooting of workforce growth targets between 1999 and 2005 was a major cause of this problem. Workforce expansion was a major cause of the deficits that emerged in the NHS from 2004–05 onwards, which have in turn driven the sudden downturn in workforce size.[29] The direct links between unexpectedly rapid workforce expansion, the emergence of deficits, and subsequent staff redundancies, were acknowledged by the Secretary of State during the Committee's *NHS Deficits* inquiry:

> The reality is that the NHS has spent more of the growth money on additional staffing than was planned and has taken on significantly more hospital doctors and significantly more nurses…than the *NHS Plan* intended. That is why some individual organisations around the country are now having to make some very difficult decisions on their staff, including in some cases redundancy…[30]

35. In this section we describe the impacts of deficits on staff numbers, training capacity and international recruitment. The drive to restore financial balance has put pressure on all NHS organisations, whether in deficit or not, to make savings on workforce costs. Savings have been made in two main areas:

- Many **provider organisations**, who employ the great majority of NHS staff, have made direct savings by freezing or removing vacant posts, by not replacing retiring staff or, in a small number of cases, through compulsory staff redundancies; and
- Many **Strategic Health Authorities** have returned large surpluses in order to compensate for deficits elsewhere in the system (SHAs returned surpluses totalling £524 million in 2005–06); the savings required to achieve such surpluses have come mainly through cuts in education and training provision.[31]

Redundancies and job reductions

36. Estimates of the scale of current redundancies and job reductions (the removal of vacant posts from staffing establishments) have varied. A recent Office for National Statistics report estimates that the total number of NHS staff fell by 11,000 in the final quarter of 2006.[32] **Job reductions** have been announced by a large number of NHS bodies, including organisations that had recently recruited large numbers of staff.[33] A Royal

29 The role of high levels of workforce expansion as a cause of deficits in particular areas was acknowledged in Department of Health, *Explaining NHS Deficits—2003/4 – 2005/6,* February 2007, p.4

30 Health Committee, *NHS Deficits*, HC 73-II, Q 743

31 Q 1006

32 Office for National Statistics, *Public Sector Employment, Quarter 4 2006*, 14 March 2007, p.1

33 Q 6

College of Nursing (RCN) survey in August 2006 estimated the total number of job reductions at 18,000.[34] The RCN subsequently told the Committee during its inquiry into *NHS Deficits*, that up to 19,000 jobs alone were "at risk".[35]

37. The number of **compulsory redundancies** is significant but considerably lower than the number of job reductions. Department of Health officials described media reports of widespread redundancies (as opposed to job reductions) as a "gross misrepresentation" of the real picture.[36] The Department of Health announced in February 2007 that 1,446 compulsory redundancies were made in the NHS in the first three-quarters of the 2006–07 financial year.[37] 79% of redundancies were among non-clinical staff, many of which resulted from the reduction in PCT and SHA numbers required by the *Commissioning a patient-led NHS* reforms.[38] The precise impact of these changes on total NHS staffing numbers is difficult to assess, particularly as 2006 workforce figures are not yet available. However, it is clear that workforce growth is slowing down dramatically.

38. Worryingly, the Committee heard evidence that in many cases job reductions have ignored future service and workforce requirements. For example, we were told that a number of specialist breast cancer nursing posts had been frozen, in spite of the increasing demand for breast cancer services.[39] The RCN stated that,

> …the reductions in posts that we are seeing right now are not as a consequence of thought-out service change, service improvement, but rather they are a knee-jerk reaction.[40]

International recruitment restrictions

39. The downturn in workforce expansion has created pressure to protect job opportunities for UK-trained staff. This has resulted in recent attempts to constrain the level of international recruitment. In March 2006, the Department of Health and the Home Office announced an end to permit-free training for overseas medical staff.[41] Postgraduate medicine will no longer be classed as a 'shortage' profession, and so doctors from outside the EEA will only be permitted to apply for UK training posts if there is a shortage of applicants from within the UK or EEA.[42] Similar changes were announced for junior physiotherapy posts in July 2005,[43] and for general nursing posts in July 2006.[44] Although

34 *NHS Deficit crisis shows no sign of slowing down, says RCN*, RCN Press Release, 16 August 2006

35 Health Committee, *NHS Deficits*, HC 73-II, Ev 151

36 Q 4

37 Department of Health, *NHS Financial Performance, Quarter 3 2006–7*, 20 February 2006, p.8

38 Q 8, for more detailed information, see Department of Health, *Commissioning a Patient-led NHS*, August 2005

39 Ev 224 (HC 171-II)

40 Q 176

41 Q 95

42 *Extra investment and increase in home-grown medical recruits increases reliance on overseas doctors,* Department of Health Press Release, 7 March 2006

43 *An update on the dire employment situation facing physiotherapy graduates,* Chartered Society of Physiotherapy Press Release, 18 December 2006

44 *Supporting UK nurses, Band 5 nurses to be taken off Home Office shortage occupation list,* NHS Employers Press Release, 3 July 2006

the precise effects of these recent changes are not yet evident, they will inevitably lead to a rapid and significant reduction in the inflow of overseas clinicians to the NHS.

40. Department of Health officials defended the new regulations, arguing in the case of medical staff that it was necessary to restrict international applications in order to protect opportunities for UK graduates.[45] The British Association of Physicians of Indian Origin (BAPIO) was strongly critical, however, pointing out that the new regulations will have "devastating consequences" for non-EEA doctors already in training within the UK.[46] BAPIO was also critical of the "abrupt fashion" in which the changes were made, and the perceived lack of consultation over the new regulations.[47]

Domestic training reductions

41. Unlike the expansion in overall staff numbers, the growth in domestic training capacity up to 2005 remained roughly in line with *NHS Plan* targets. In parallel with staff numbers, however, there is evidence of a more recent downturn in training numbers. The Council of Deans and Heads of UK University Faculties for Nursing and Health Professions highlighted significant reductions in the number of non-medical training places commissioned by SHAs for the 2006–07 academic year. The Council stated that 10-15% cuts had been requested by 'nearly all' SHAs and that cuts were as high as 30% in some areas.[48] Detailed evidence from the University of the West of England showed cuts of more than 30% to physiotherapy and occupational therapy courses in this area.[49]

42. Widespread cuts in training commissions were acknowledged by witnesses from SHAs,[50] and by the Minister of State for Quality, Lord Hunt, who commented that,

> …we gave SHAs more discretion in the use of their budget this year…some of them have used that discretion to reduce some of the training that they finance, and that is a product of the deficit position in the Health Service. Now, my concern is to make sure that this is very much a one-off and that going into the next financial year SHAs will ensure the continuation and investment in long-term training programmes.[51]

43. However, other witnesses were much less confident that cuts in education and training intake would not be repeated in future. The Council of Nursing Deans stated that,

> My nightmare prediction is that there will be a continual raiding of the [education and training] budget unless it is ring-fenced, unless it is protected, and I think the implications of that for even the short-term workforce requirements could be devastating.[52]

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45 Q 95

46 Ev 240 (HC 1077-II)

47 Ibid—A legal appeal against the decision by BAPIO was turned down in February 2007 but has since been referred to the Court of Appeal.

48 Ev 79 (HC 1077-II)

49 Ev 288 (HC 171-II)

50 Qq 764–765

51 Q 1006

52 Q 621

As in the case of job reductions, witnesses stressed that cuts in education and training places had often taken place in order to maximise financial savings rather than because of a reduction in demand for clinical staff.[53]

Graduate unemployment

44. Another serious consequence of increasing deficits has been the increasing difficulty experienced by healthcare graduates in finding employment within the NHS. The Chartered Society of Physiotherapy (CSP) told that Committee that 68% of 2006 physiotherapy graduates have been unable to find NHS physiotherapy work.[54] The CSP estimated that in a normal year, only 5% of graduates would typically be unemployed.[55] A similar, though less acute, problem exists for 2006 nursing graduates, of whom 60% have found NHS work within 6 months of graduation compared with the usual figure of 85%.[56] Witnesses highlighted similar problems affecting midwifery, speech therapy, occupational therapy and dietetics graduates.[57] The Committee also heard fears about possible future unemployment amongst UK medical graduates and junior doctors, particularly as a result of the shortage of training capacity within the new Modernising Medical Careers system.[58]

45. Once again, the Committee heard that graduate unemployment had not occurred because staff were not needed, but rather because of the pressure to make financial savings and the failure to plan for the output of increases in domestic training capacity. For example, the CSP stated that,

> The short term impact of NHS financial deficits should not be under-estimated in considering the problems for graduates. Financial freezes have led to vacancy freezes in 2004, 2005 and 2006. Junior posts are more vulnerable to being frozen than senior posts…Unemployed physiotherapy graduates are not a symptom of over supply but of a failure in NHS workforce planning which has been unable to ensure sufficient posts for newly qualified staff, particularly in primary care.[59]

Pay and contracts

46. As well as substantially increasing workforce numbers, the health service has made changes to employment conditions for the majority of its staff in recent years. Most significantly, and in keeping with the recommendation of the Committee's 1999 report, a single pay spine has been introduced for all NHS staff, excluding doctors. Most health service staff have received substantial pay increases during this period and the growth in

53 See Q 612 and Q 621

54 *Urgent action needed to secure jobs for newly qualified physios. 7 out of 10 still out of work, says CSP,* Chartered Society of Physiotherapy Press Release 18 December 2006

55 Ev 293 (HC 171–II)

56 See Q 968 and Q 981

57 See Ev 269 and Ev 293, both (HC 171-II)

58 The prospect of overall medical unemployment was raised by Reform in Ev 258 (HC 171–II). Concerns about capacity within Modernising Medical Careers were raised by the British Medical Association in Ev 221–223 (HC 171–II). However, the Chief Medical Officer denied that unemployment among UK medical graduates was a likely prospect—see Q 109.

59 Ev 68 (HC 1077–II)

pay costs has exceeded Department of Health expectations. In this section, we examine the effects of the new contracts and the expansion in health service pay costs. In Chapters 3 and 4, we examine attempts to increase workforce productivity through the changes in working practices which accompanied the new contracts.

The new deals

47. The new contracts and pay systems introduced in recent years cover the vast majority of NHS staff as well as remuneration for services provided by independent contractors such as GPs and pharmacists. New contracts have been structured in a variety of different ways, with a range of different appraisal and incentive systems. We examine the effects of each of the new contracts below, focussing particularly on *Agenda for Change*, the new consultant contract and the new GP contract.

Agenda for Change

48. The *Agenda for Change* agreement was driven by the need for increased workforce flexibility, one of the main priorities of *A Health Service of all the talents*.[60] The switch to a single pay system also aimed to reduce the growing number of equal pay claims. The agreement was finalised in December 2004 following 5 years of negotiations between the four UK health departments, the NHS Confederation and 20 trades unions and other membership organisations. *Agenda for Change* established a single pay system to cover all NHS staff, excluding doctors, and to replace the Whitley pay scales which had been used since the establishment of the NHS in 1948. The new system is made of nine separate pay bands with a number of different pay points within each band. Staff have been moved from previous Whitley pay scales to the new *Agenda for Change* system following the mammoth 'job matching' process, which required each job role in each NHS organisation to be separately assessed and translated to the new system.[61] UNISON told the Committee that 97% of staff have now been transferred to the *Agenda for Change* pay system.[62]

49. Due to the scale and complexity of the job evaluation process, it is difficult to assess the exact effect of *Agenda for Change* on staff pay rates. However, it is clear that the majority of staff have received substantial pay increases. The RCN estimated that the new agreement would lead to average pay increases of 15.8% over 3 years for nursing staff, the largest occupational group affected by *Agenda for Change*.[63] This estimate is supported by a comparison of average pay rates for newly qualified nurses before and after the agreement, which shows that pay rates rose by around 10% in the first year of the new deal.

60 Department of Health, *A Health Service of all the talents*, April 2000, p.5

61 Q 34

62 Ev 230 (HC 1077-II)

63 See http://www.rcn.org.uk/agendaforchange/overview

Year and pay scheme	2001: Whitley	2002: Whitley	2003: Whitley	2004: Whitley	2005: Agenda for change	2006: Agenda for change
Min. salary	£15,445	£16,005	£16,525	£17,060	£18,698	£19,166
% increase	3.73%	3.63%	3.25%	3.24%	9.60%	2.50%

Table 9: Comparison of newly qualified nursing salaries, 2001–2006 - D grade Whitley minimum salary and Band 5 *Agenda for Change* minimum salary

Source: Department of Health

50. Another indication of the impact of *Agenda for Change* on pay rates can be seen in the increase in the minimum wage paid to NHS staff. The hourly rate for the lowest paid NHS staff rose from £4.85 in April 2004 to £5.89 in April 2005, an increase of more than 21% in one year.[64] The proportion of staff experiencing 'protected pay' (meaning that they have been assimilated onto the new system at a lower pay rate than previously) has been extremely low. Department of Health officials estimated that 4.5% of the 900,000 staff that have moved to *Agenda for Change* are on protected pay, an estimate confirmed by staff representatives.[65] The remaining 95% of staff have seen their pay rates maintained or, more commonly, increased.

51. The *Agenda for Change* agreement has not only brought increases in pay, but also contains significant measures to support workforce reform. Reforms include the requirement for an annual appraisal and the production of a personal development plan for each staff member, a process supported by the new *Knowledge and Skills Framework* (KSF) which accompanied the *Agenda for Change* agreement. We look in more detail at the KSF in Chapter 4.

Primary care contracts

52. There have been a range of new contracts for primary care services in recent years which have affected staff incomes and pay rates. The most significant was the General Medical Services (GMS) contract under which GP practices have operated since April 2004. New contracts have subsequently been introduced for pharmacy and dental services. The new GMS contract has brought fundamental changes to the way in which the income of GP practices is determined. Practice income is now calculated according to three main criteria: the number of patients on a practice list; the range of clinical services offered by the practice; and the practice's performance as assessed against the new *Quality and Outcomes Framework* (QOF). We consider the impact of the QOF in more detail in Chapters 3 and 4.

53. The new contract has significantly increased GP practice income. According to some reports, individual GPs can earn up to £250,000 per year under the new deal.[66] Department of Health figures show that average GP incomes have risen substantially in recent years, increasing by almost 70% between 2001–02 and 2005–06. The most substantial increase, of almost 20% in a single year, occurred when the new contract was introduced in 2004–05:

64 See www.unison.org.uk/healthcare/a4c

65 See Q 71 and Q 258

66 See news.bbc.co.uk/1/hi/health/4917454.stm

Year	2001–02	2002–03	2003–04	2004–05	2005–06
Average GP earnings	56,510	64,443	72,752	87,076	95,350
% increase on previous year	4.22%	14.04%	12.89%	19.69%	9.50%

Table 10: Average GP income, 2001–2006

Source: Memoranda from the Department of Health, Public Expenditure on Health and Personal Social Services 2006, HC 1692–i, Ev 89

54. The new pharmacy services contract was introduced in April 2005 and the new dentistry contract a year later. The pharmacy contract ensures that all community providers offer a range of 'essential' services and also allows PCTs to commission 'enhanced' services from particular providers. The dental contract replaces payment per item of service with a broader payment system based on the number of courses of treatment completed. Because of the very recent implementation of the two deals, there is little evidence to date of their impact on costs and incomes. However, the Department of Health has stated that the new dental contract will not lead to an overall increase in costs.[67]

The consultant contract

55. Hospital doctors are the only NHS-employed occupational group not covered by the *Agenda for Change* agreement.[68] Instead, a separate contract for hospital consultants was introduced, beginning in April 2003. By May 2005, 90% of consultants had voluntarily moved to the new contract, although implementation has taken longer than was originally expected.[69] The new contract aimed to link consultant pay rates more closely to the number of hours worked and to give NHS organisations more say in consultants' clinical activities through an annual 'job planning' process. We look in more detail at job planning in Chapters 3 and 4.

56. The new contract has led to a significant increase in average consultant pay. A Kings Fund study showed that consultant basic salaries rose by 17% between 2002 and 2003, when the new deal was introduced. By 2005, basic salaries had risen by more than 34% relative to 2002 levels.[70] The British Medical Association (BMA) told the Committee that average pay rises over this period had been considerably lower.[71] However, Department of Health figures for average consultant earnings show increases similar to the Kings Fund estimates, with earnings rising by more than 14% in 2003–04 and by almost 27% by 2005–06, relative to pre-contract levels.

67 *Public Expenditure on Health and Personal Social Services 2006*, HC 1692–i, Ev 93–94

68 GPs, pharmacists and dentists are independent contractors and are not employed by the NHS

69 King's Fund, *Assessing the new NHS consultant contract: A something for something deal?* May 2006, pp.7–8

70 Ibid, p.18

71 Q 297

Year	2002–03	2003–04	2004–05	2005–06
Average consultant earnings	86,746	99,168	103,648	109,974
% increase relative to 2002/3	n/a	14.32%	19.48%	26.78%

Table 11: Average consultant earnings, 2002–2006

Source: Memoranda from the Department of Health, Public Expenditure on Health and Personal Social Services 2006, HC 1692–i, Ev 90

The cost of pay reform

Overall costs

57. It is evident that pay rates have increased substantially for a wide range of staff groups as a result of the new contracts and pay systems introduced since 1999. Rising pay costs have absorbed a significant proportion of the extra money available to the NHS: in 2005–06, 47% of extra funding was spent on increases in pay.[72] The most recent estimates from the Department of Health project that £2.2 billion will be spent on implementing *Agenda for Change* by 2008–09,[73] and £444 million on the new consultant contract by 2007–08.[74] Overall spending on GP services is expected to rise by a third between 2003–04 and 2006–07, and on pharmacy services by 8% between 2005–06 and 2006–07.[75]

58. In spite of these projections of significantly increased expenditure, the cost of pay reform has consistently exceeded Department of Health expectations. Officials told the Committee that spending on *Agenda for Change* had exceeded projections by £100 million in 2004–05,[76] although subsequent information implied an overspend of £220 million.[77] Officials also acknowledged an overspend of £90 million on the new consultant contract and £250 million on the new GP contracts in 2004–05.[78] Subsequent information showed that the overspend on the GP contract was expected to remain at £250 million in 2005–06.[79] Total overspends for 2004–05 are shown below.

Contract	GP contract	Agenda for Change	Consultant contract	Total overspend
Overspend: 2004–5	£250 million	£220 million	£90 million	£540 million

Table 12: Overspending on pay reform relative to projected spending, 2004–05

Source: Department of Health

72 *Public Expenditure on Health and Personal Social Services 2006*, HC 1692-i, Ev 10

73 Ibid., Ev 91

74 Ibid., Ev 92

75 Ibid., Ev 93

76 Q 70

77 Ev 196 (HC 171–II)

78 See Q 72 and Q 67 respectively

79 Ev 195 (HC 171–II)

Deficits and pay reform

59. During the Committee's deficits inquiry, the Secretary of State acknowledged the need to improve the accuracy of pay cost projections, although she denied that overspending on the new contracts was a major cause of deficits.[80] Other witnesses disagreed, arguing that excess costs associated with the new contracts had significantly exacerbated deficits in particular organisations.[81] One witness estimated that the consultant contract alone had cost £3 million more than expected to implement within a single hospital trust in one year;[82] another commented that the combined overspend on the consultant contract and *Agenda for Change* implementation had totalled £4.5 million in one trust.[83]

60. More recently, there is evidence of attempts to control pay inflation, particularly for directly employed staff. In March 2006, the Department of Health announced that the annual uplift on *Agenda for Change* pay rates would be 2.5%, less than the 3.225% awarded in previous years.[84] More significantly, consultant pay was increased by only 1% for the first 6 months of the 2006–07 financial year, a move described as a "slap in the face" and a "betrayal of senior hospital doctors" by the BMA.[85] On 1 March 2007, the Secretary of State announced that *Agenda for Change* rates would be increased by 1.9% over 2007-8 and consultant pay increased by around 1%. There was no increase to GPs reimbursement rates for 2007–08.[86] The decision was described as "a real disappointment" by UNISON; [87] and as "a grievous insult to GPs" by the BMA.[88]

New ways of working

61. Major changes to the number of staff and to contracts and pay levels have been the dominant themes of workforce developments since 1999. In addition, there have been a number of attempts to change and improve the effectiveness of health service staff by introducing new ways of working. The Department of Health acknowledged that workforce reform has played a minor but significant role in recent years:

> …the last five years has been 80% about growth and 20% about transformation and new ways of working.[89]

80 Health Committee, *NHS Deficits*, HC 73-II, Q 817

81 Ibid., Q 187

82 Ibid., Q 189

83 Ibid., Q 187

84 *Hewitt announces 'fair and affordable' pay deals for NHS staff*, Department of Health Press Release, 30 March 2006

85 *Doctors attack government's vindictive treatment of consultants*, British Medical Association Press Release, 30 March 2006

86 *Hewitt—sensible and fair pay awards will benefit staff, the NHS and the economy* Department of Health Press Release, 1 March 2007. *Agenda for Change* will increase by 1.5% from 1 April with a further increase of 1% from 1 November, making an average increase of 1.9% across 2007–8.

87 *Health unions attack below inflation pay increase* UNISON Press Release, 1 March 2007

88 *A black day for general practice,* British Medical Association Press Release, 5 March 2007

89 Ev 12 (HC 1077–II)

Changes to working practices

62. Much of the impetus for introducing new ways of working was provided by *A Health Service of all the talents*, which concluded that '…the NHS workforce, whose commitment no-one can doubt, needs to be transformed in order to provide the sort of care which will be needed in the future.' The paper's recommendations included the need for improved team-working, a more flexible workforce, and greater variation in the mix of different staff groups (skill mix).[90] Further pressure for changes to traditional working practices came with the 2004 European Working Time Directive regulations which vastly reduced junior doctors' working hours and forced hospitals to consider alternative ways of providing basic clinical care.[91] Some workforce reforms were also introduced directly by the *NHS Plan*, notably the *Improving Working Lives* initiative.[92]

63. There have been a range of attempts to change working practices at national and local level, some of which we describe below and some of which we consider in more detail in Chapters 3 and 4. Developments have included:

- The **Changing Workforce Programme**, run by the NHS Modernisation Agency (see below);
- The **Improving Working Lives** initiative (see below);
- The reorganisation of postgraduate medical training through the **Modernising Medical Careers** initiative (see below);
- The recent, national **Productive Time** initiative which aims to increase the efficiency of the workforce, for example by reducing turnover, absenteeism and the use of agency staff;[93]
- The **Modernising Nursing Careers** scheme, launched in 2006, which aims to provide a clearer and more flexible career structure for nursing staff;[94]
- The **Knowledge and Skills Framework** which accompanied the *Agenda for Change* agreement and which aims to increase workforce flexibility and improve access to education and training;[95] and
- The new **Quality and Outcomes Framework** which creates incentives for GPs to provide particular clinical services and focuses on improving patient outcomes.[96]

90 Department of Health, *A Health Service of all the talents*, April 2000, p.5

91 Q 189

92 Department of Health, *The NHS Plan: A plan for investment, a plan for reform*, Cm 4818–I, July 2000, pp.53–54

93 Ev 8 (HC 1077–II); the 'Productive Time' initiative is considered in more detail in chapter 4

94 For more information, see Department of Health, *Modernising Nursing Careers—Setting the direction,* September 2006

95 See Chapter 4

96 See Chapters 3 and 4

The Changing Workforce Programme

64. The Changing Workforce Programme (CWP) was launched in 2001 with the aim of co-ordinating and overseeing the introduction of a number of new and amended clinical roles within the NHS. The CWP was hosted by the MA and managed a range of projects aiming to increase the flexibility of the health service workforce by training staff to take on additional responsibilities on top of, or in place of, their traditional work. In particular, the CWP aimed to introduce Assistant Practitioner roles (immediately below professional level) and Advanced Practitioner roles (allowing existing professionals to take on a range of additional responsibilities).

65. Following the closure of the MA in 2005, a small part of the work of the CWP has been continued by the National Practitioner Programme (NPP). Since 2001, the CWP and NPP have overseen the introduction of new roles across a range of service areas including emergency care, critical care and in operating theatres.[97] Examples of new roles include Surgical Care Practitioners, Endoscopy Technicians and community Emergency Care Practitioners, of which more than 700 are now working in the NHS.[98]

66. Alongside this work, there have been a range of other efforts to introduce new and amended roles.[99] Nurses in particular have taken on a range of advanced roles, for example in epilepsy, diabetes and emergency care. Research by the Royal College of Nursing shows that the number of nurses in advanced roles increased significantly from 2001 onwards.[100] Nurses in advanced roles have been widely used in response to the challenges presented by the 2004 European Working Time Directive regulations.[101] Extended roles have also been introduced within a number of other health professions, notably for physiotherapists in Accident and Emergency departments,[102] and for radiographers in image reporting.[103] Department of Health officials told the Committee that, in total, more than 100 new and extended clinical roles have been introduced in recent years.[104]

Improving Working Lives

67. Workforce reforms have also focussed on improving the quality and flexibility of working conditions for NHS staff, principally through the *Improving Working Lives* (IWL) initiative. IWL assesses the performance of all NHS organisations at providing better working conditions, for example by increasing access to flexible working arrangements and to childcare facilities, and by improving the quality of communication with staff. Since the start of IWL in 2000, all NHS trusts have achieved Practice status (showing a basic level of

97 See www.wise.nhs.uk/sites/workforce/practitioners/npp

98 Ev 10 (HC 1077–II)

99 The number of entirely new roles introduced by this work has been relatively small. More commonly, roles have been slightly amended (tinkered with, essentially) in order to increase efficiency and prevent duplication, for example through district nurses taking on some rehabilitation work in order to avoid the need for separate physiotherapy input.

100 Royal College of Nursing, *Maxi nurses. Advanced and specialist nursing roles,* May 2005, p.38

101 See Ev 178 (HC 1077–II) and Q 189

102 Ev 70 (HC 1077–II)

103 Q 256

104 Q 1046

compliance) and more than 300 trusts have achieved the more advanced Practice Plus status.[105] Submissions from key organisations such as UNISON and NHS Employers stressed the importance of IWL initiatives in achieving recent improvements in staff retention rates.[106]

Modernising Medical Careers

68. Another significant reform has been the ongoing introduction of the Modernising Medical Careers (MMC) programme, which brings significant changes to postgraduate medical training. MMC, which is undergoing phased implementation between 2005 and 2010, replaces the traditional House Officer and Registrar training grades with a redesigned run-through training programme involving two years of Foundation training followed by 3–7 years of Specialty or GP training.[107] The MMC reforms particularly aim to increase the flexibility of the medical workforce and to make the medical education and training system more responsive to future service requirements. However, serious concerns have been raised about the Medical Training Applications Service (MTAS) which is being used to implement the MMC reforms, and the Department of Health has acknowledged that there are "shortcomings" in the MTAS process. There is a clear danger that problems with MTAS will tarnish the whole of MMC.[108]

Constraints and limitations

69. The introduction of workforce reform and new ways of working has often been subject to difficulties or limitations. The most significant limitation, as we highlighted above, has been the low priority given to reform relative to workforce expansion.[109] As the Department of Health's recent analysis of NHS deficits concluded,

> Enthusiasm for making productivity improvements is diminished in an environment of rapid growth in resources.[110]

It is alarming but perhaps not surprising, therefore, that in the context of the sharp expansion in staff numbers and pay levels, workforce reform (which ultimately aims to increase productivity) has received relatively little attention.

70. Worryingly, attempts to introduce new ways of working have been badly affected by recent cuts to education and training provision in response to rising deficits. Cuts to training have affected not only undergraduate training intakes but also training for staff to

105 Ev 2 (HC 1077–II)

106 See Ev 129 and Ev 229 respectively (both HC 1077–II)

107 For more information, see www.mmc.nhs.uk

108 See Ev 10 (HC 1077-II) and paragraph 44 above. See also Department of Health Press Release, *Review of Medical Training Applications Service and selection process—Government responds to* concerns, 10 March 2007. Serious questions have emerged about the fairness with which MTAS has been implemented. However, we received little evidence on this subject and it is too early to say how significant these problems will turn out to be. On 6 March 2007, the Department of Health announced a review of the first round of MTAS applications for specialist training posts, in light of particular concerns about the fairness of the short listing process. The review is due for completion by the end of March 2007.

109 See Ev 12 (HC 1077–II) and Q 169

110 Department of Health, *Explaining NHS Deficits—2003/4 – 2005/6*, February 2007, p.6

take on new and extended roles. For example, the Committee was informed of cuts in support for upgrade training for Health Care Assistants, who are well positioned to move into Assistant Practitioner roles, and in training for specialist nursing staff.[111] Education and training cuts have also affected the implementation of the *Knowledge and Skills Framework*.[112] We comment on education and training cuts in more detail in chapters 3 and 4.

71. The introduction of new roles has also been limited by organisational changes, notably the closure of the MA in 2005.[113] As a result of this change, the Changing Workforce Programme was also closed and the smaller NPP established and hosted at SHA level. Department of Health officials acknowledged that as a result of this change the introduction of new roles,

> …has become rather more fragmented than it was and it will be more difficult therefore to coordinate…an overall pattern and there is less capacity behind it as well.[114]

The merging of WDCs with SHAs in 2004 also reduced the effectiveness of the health service at introducing new ways of working, as Department of Health officials again acknowledged.[115]

Conclusions

72. **The health service workforce has changed dramatically in recent years, most notably through the major increase in staff numbers which took place between 1999 and 2005. Rapid workforce expansion was a necessary response to the "crisis" in staffing numbers described in the Committee's 1999 report. However, the rate of growth considerably exceeded expectations, and far outstripped the targets set in the *NHS Plan*. Given the increase in funding levels, such a high level of growth was inevitable. Many new staff were recruited from overseas because of limited availability of UK staff. Eventually, many organisations recruited more staff than they could afford to pay. This was a major cause of the widespread deficits which emerged across the NHS from 2004–05 onwards.**

73. **In response to the deficits which emerged in 2004–05, the expansion of the workforce has slowed down and, in places, reversed. Overall staff numbers are now falling. Provider organisations have made large numbers of job reductions and some compulsory redundancies and many healthcare graduates have experienced unemployment. Strategic Health Authorities have cut the number of domestic training places, immediately after a period of sustained growth. During the growth phase, employers mainly increased capacity through international recruitment as they could**

111 See Q 767 and Ev 224 (HC 171–II) respectively

112 Q 327

113 Q 515

114 Q 42

115 Ev 82 (HC 1077–II)

not wait for domestic training output to increase. Now international recruitment has in turn been suddenly and sharply restricted.

74. **In parallel with the expansion in staff numbers, pay rates for the majority of health service staff have increased substantially in recent years. Senior doctors have received the most generous pay rises but the *Agenda for Change* agreement has ensured that virtually all NHS staff have benefited from increases. The costs of pay reform have been extremely high and have absorbed a large proportion of the extra money allocated to the health service in recent years. Actual costs have consistently exceeded Department of Health projections and this has contributed to deficits in some organisations. As with staff numbers, pay growth is now being curtailed with below inflation increases for all staff in 2007–08.**

75. **There have been a number of attempts in recent years to introduce new ways of working to the health service. A range of new clinical roles have been established in order to increase workforce flexibility, and there have been some efforts to improve retention, increase productivity and reform education and training. However, the scale of progress on workforce reform pales in comparison with the scale of staffing growth and pay increases which took place over the same period. Reform has also been hampered by repeated changes to organisational structures and by recent cuts in education and training provision.**

76. **There is clear evidence of a boom and bust cycle within each of these areas. The boom occurred between 1999 and 2005 as staff numbers and pay levels increased with unprecedented speed. The emergence of deficits after 2005 triggered the start of a bust phase with widespread job reductions, sweeping education and training cuts and severe pay restrictions. During both phases, workforce changes have tended to respond to prevailing financial trends, and the workforce reform agenda, articulated by *A Health Service of all the talents*, has too often been overlooked. The expansion of the workforce was reckless and uncontrolled and increases in funding were often seen as a blank cheque for recruiting new staff. Such problems raise serious questions about the effectiveness of the current workforce planning system.**

3 Assessment of the current workforce planning system

Introduction

77. As we have seen in Chapter 2, the rapid period of workforce expansion between 1999 and 2005 was followed by redundancies, vacancy freezes, graduate unemployment and widespread cuts in education and training provision. Below we examine the workforce planning system itself and how far it has achieved its aims. We consider the following areas:

- **Capacity** to do workforce planning;
- The **integration** of different elements of the workforce planning system;
- The effectiveness of the system in taking a **long-term approach** to workforce planning;
- How well the system has done in improving workforce **productivity**; and
- Whether enough has been done to increase the **flexibility** of the workforce.

Capacity to do workforce planning

78. Effective workforce planning requires organisations and individuals with appropriate experience and skills. Unfortunately, the evidence we received suggested that the health service lacks organisations and people with adequate ability and skills to undertake workforce planning effectively and has done too little to protect the resources available.[116] In particular, persistent changes to the structures and organisations involved with workforce planning, particularly the loss of separate WDCs, have undermined capacity.[117] A written submission from the Royal College of GPs summarised the problem, concluding that,

> …planning has been blighted by constant changes in the mechanisms used without giving any single mechanism time to establish itself.[118]

Regional capacity

Workforce Development Confederations

79. A number of key workforce planning functions, including the commissioning of education and training, have been concentrated at regional level. 27 regional WDCs were

116 See, for example, Ev 239 (HC 171–II)

117 See, for example, Q 680

118 Ev 168 (HC 1077–II)

created in 2001 to fulfil these responsibilities. John Sargent, former Chief Executive of Greater Manchester WDC, described the impact of the creation of WDCs:

> The changes that took place in 2001 were the first time there had really been a focus on workforce development and workforce planning in a co-ordinated way.[119]

80. The evidence from NHS Employers was also positive about the contribution of WDCs, whilst acknowledging the variation in their effectiveness:

> Workforce Development Confederations were a step forward compared to previous arrangements, though operational success varied.[120]

81. In 2004, WDCs were merged with the 28 SHAs which had been in created in 2002 as part of the *Shifting the Balance of Power in the NHS* reforms. According to John Sargent,

> …just as WDCs were starting to get on their feet, there was another reorganisation…the SHA Chief Executives… felt that it would be more appropriate if the SHAs and WDCs were merged so that there could be one strategic perspective for all functions across the new SHAs areas.[121]

82. A number of witnesses expressed concern at the effects of the decision to merge WDCs with SHAs, most notably Andrew Foster, then Workforce Director at the Department of Health:

> I also regretted the disappearance of the separate workforce development confederations who were tasked very specifically with being responsible for workforce planning and commissioning of education and training.[122]

83. Mr Foster explained that one of the aims of integrating SHAs and WDCs had been to improve the integration of workforce and financial planning, though as we point out later in this chapter there has been little evidence of such improvement. Instead, we heard that the loss of WDCs led to a corresponding loss of focus on workforce planning with SHAs more often focussing on financial and service issues. This point was made by the Council of Heads of Dental Schools:

> A recurring problem since the merger of WDCs into SHAs has been the difficulty in maintaining expertise and retaining the focus on workforce. Service imperatives subsume all others and drive the agenda. A more long-term view would recognise the vital importance of education and training the next generation.[123]

84. The Committee also heard that the merging of SHAs and WDCs has led to less involvement for independent sector organisations and higher education bodies in workforce planning.[124]

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119 Q 677

120 Ev 131 (HC 1077–II)

121 Q 677

122 Q 45

123 Ev 82 (HC 1077–II)

124 Q 794

Reduction in SHA numbers

85. In line with the *Commissioning a Patient-led NHS* reforms, the number of SHAs was reduced from 28 to 10 with effect from 1 July 2006. The new SHAs have broadly the same workforce planning remit as their predecessors but will oversee planning over a larger geographical area. The benefits of the new configuration were described by Lord Hunt, Minister of State for Quality:

> …now that we have got the new structure of strategic health authorities down to 10, they essentially cover a region. If I think of my own West Midlands region, that is an ideal area in terms of the number of staff employed, the number of higher education institutions and the number of NHS organisations, the links with the medical schools. That seems to me to be the ideal geographical area in which to sort out most of these workforce planning issues.[125]

86. However, other witnesses expressed serious concerns about the reorganisation. Dr Judy Curson, head of the NHS Workforce Review Team, highlighted the potential loss of key workforce planning personnel as a result of the changes:

> …in terms of the SHA reorganisation, there is a concern that there are very few workforce planning skills amongst SHAs and in the NHS generally…There is a very real concern that these skills might be lost as people apply for jobs, even outside the NHS, while they are waiting to see whether they do have a future in the new health authorities.[126]

87. Witnesses also pointed out that education and training is not mentioned in the strategic objectives of the new SHAs and that there is no obligation for a representative from the education sector to sit on the Boards of the new SHAs.[127] Professor Tony Butterworth of the University of Lincoln summarised the problem of lack of education sector involvement at SHA level:

> If the new SHAs have a mission which is quite tight and that is to look at the delivery of service and the commissioning of service then that is fine. If education and the provision of education is an afterthought… that would be a great shame.[128]

88. In sum, we heard serious doubts about whether the new SHAs have either the will or the skill to undertake effective workforce planning. The combination of the loss of WDCs and the reduction in the number of SHAs means that there is now far less capacity for workforce planning at regional level than was envisaged in *A Health Service of all the talents*. Instead of 28 organisations dedicated to workforce issues, the regional tier consists of 10 newly established organisations with a much wider remit within which workforce planning is at risk of being lost.[129] It is hardly surprising, in this context, that the British

125 Q 989

126 Q 40

127 Q 588

128 Q 617

129 Q 588

Psychological Society concluded that "the prominence given to workforce planning by *A Health Service of all the talents* has been seriously lost and dissipated."[130]

National capacity

89. National and collective organisations perform a range of different workforce planning functions. These include strategic analysis of future workforce requirements by the NHS Workforce Review Team, collective contract negotiation by NHS Employers and national oversight and policy development by the Department of Health. Fuller details are provided in the Annex. In this section, we consider the effectiveness of some of these national organisations.

The NHS Modernisation Agency

90. The NHS Modernisation Agency (MA) was created in 2001. Its remit was to act as a national source of information about good practice and co-ordinate changes such as the introduction of new roles through the Changing Workforce Programme.[131] Mirroring the fate of WDCs, the MA was closed in 2005 though some of its functions were subsequently resumed with the creation of the NHS Institute for Innovation and Improvement (III).[132] However, the III is a much smaller organisation than the MA with a narrow, though welcome, focus on improving productivity.

91. The Government did not provide a clear rationale for the closure of the MA. However, it is evident that the decision to close the MA was not unanimous within the Department of Health. Andrew Foster, for example, commented that,

> In my opinion, we set up the Modernisation Agency in order to give us really cutting edge, world best practice in terms of service and job design and it was beginning to do a fantastic job when it fell victim to the financial pressures of other priorities in the NHS. I personally feel we would have been able to do it better, if we still had the Modernisation Agency…[133]

92. Other witnesses agreed that the closure of the MA had led to gaps in national capacity for workforce planning. The RCN commented that the loss of the MA has meant that there is no organisation able to collect and share good practice in workforce planning and development.[134] Dr Sally Pidd of the Royal College of Psychiatrists described the impact of the closure of the MA on efforts to create new and amended clinical roles:

> …we were disappointed with the demise of the Modernisation Agency because the Changing Workforce Programme was a big driver for looking at developing new

130 Ev 51 (HC 1077–II)

131 See www.wise.nhs.uk/cmsWISE/aboutUs/AboutMA.htm for more information

132 Q 41

133 Q 41

134 Q 173

roles and extended roles and supplementary roles to enhance the overall mental health workforce.[135]

The NHS Workforce Review Team

93. The NHS Workforce Review Team (WRT) is one of the few organisations to have maintained a relatively consistent remit in recent years. WRT produces annual recommendations for planning for all of the main clinical staff groups in the health services.[136] WRT recommendations cover future recruitment levels, training numbers and other factors including the effects of changes to skill mix.[137]

94. Some of the evidence we received was positive about the contribution of WRT. The Faculty of Public Health described WRT recommendations as "high quality, timely, and useful for planning".[138] Wyn Jones commented that WRT had contributed to the improvement in workforce planning capacity and leadership at central level.[139] However, witnesses also commented that the work of WRT had failed to have a significant impact and was undermined by poor data quality and by the fact that WRT recommendations are often ignored by SHAs.[140]

The Department of Health

95. Witnesses questioned the Department of Health's effectiveness at workforce planning. As we noted in Chapter 2, for example, the Department has consistently underestimated the costs of new staff contracts. Doubts were also expressed about the Department's ability to provide strategic oversight for the rest of the workforce planning system. Anne Rainsberry, Director of People and Organisation Development at NHS London, commented that:

> …the Department of Health has a key role in setting the medium to long-term planning assumptions with which Strategic Health Authorities should plan, i.e. financial…the department could strengthen its expertise in the area of strategic workforce planning. I think that would be most welcome.[141]

135 Q 515

136 See www.healthcareworkforce.nhs.uk/workforce_review_team/wrt_recommendations/2006_recommendations.html for the most recent Workforce Review Team recommendations

137 For more information, see www.healthcareworkforce.nhs.uk/workforcereviewteam.html

138 Ev 233 (HC 171–II)

139 Ev 236 (HC 1077–II)

140 See Qq 928–9

141 Q 684 and Q 698

Local capacity

Primary Care Trusts

96. Concerns were also expressed about the ability of local organisations to contribute to workforce planning. In particular, the lack of involvement of PCTs was highlighted. Anne Rainsberry told us that,

> PCTs, if they are thinking about strategically shifting the direction of care, need to understand what that means for the workforce and appraise themselves of the plans of the providers so that workforce follows service, and at the moment PCTs, certainly in London, do not get involved in that dialogue, which I think is a gap that we must fill.[142]

97. The Committee heard that the impact of the *Commissioning a Patient-led NHS* reforms, whereby the number of PCTs was reduced to 150 with effect from 1 October 2006, had caused organisations to neglect workforce planning. Dr David McKinlay of the North Western Deanery explained that,

> A key part of our strategy has been getting out of the deanery and talking to the PCTs. Four or five of those meetings have been cancelled in the last few months by the PCTs because they did not know whether they would exist, so we have got a built-in cycle of inertia while things bed in...[143]

Workforce information

98. We heard evidence of the poor quality of workforce information supplied by local organisations in support of regional and national planning. Louise Silverton of the Royal College of Midwives described difficulties in obtaining reliable information:

> …we suffer quite badly from what local information is fed in. Heads of midwifery will ask what has been sent in about their need for midwives and a junior person in HR has looked at the age profile and decided that four will retire in the next two years and that is it. That takes no account of service changes and increased part-time working.[144]

99. Likewise the Institute of Healthcare Management noted that submissions to SHAs by local organisations "tend at best to be educated guesses".[145] Phil Gray of the Chartered Society of Physiotherapy was especially scathing, observing that because of a lack of reliable local data, workforce forecasting tended to be done "by the very scientific method of putting a wet finger in the wind".[146]

142 Q 682

143 Q 660

144 Q 929

145 Institute of Healthcare Management, unpublished memorandum

146 Q 918

Skills and training

100. Witnesses commented on the overall shortage of staff with workforce planning skills, including both technical and leadership skills, across the health service. The Institute of Healthcare Management was particularly damning, remarking that "Workforce planning in the NHS is a skill that has yet to be developed".[147] Other witnesses stressed that workforce planning jobs are not seen as important roles within NHS organisations.[148]

Workforce planning skills

101. The Committee received a submission from Thames Valley University which has recently finished teaching its first one-year Postgraduate Certificate in Strategic Workforce Planning. The course, commissioned by National Workforce Projects, provides students with practical workforce planning tools, an understanding of policy context and a network of workforce planning contacts. The course also concentrates on linking workforce planning with service and financial planning.[149] Courses of this type do not seem to be widely available; this is indicative of the stature of specialist workforce planning skills amongst health service staff.

102. Witnesses also commented on the importance of ensuring that general and financial managers understand and take part in workforce planning, rather than treating it as a separate, isolated activity. Norfolk, Suffolk and Cambridgeshire SHA remarked that,

> Workforce planning and workforce development need to be embedded as a core skill for all managers.[150]

Leadership skills

103. Workforce planning requires leadership skills to implement changes as well as technical skills to identify the requirements for change. A number of witnesses acknowledged a lack of leadership on workforce issues, including Mike Sobanja of the NHS Alliance. Commenting on the contribution of local Human Resource Directors, he stated that:

> It seems to me that the job of the HR director should be about assessing the best way in which the workforce can contribute to the service development aims of the organisation. Do they do that uniformly? No. Do they work at a strategic level? I do not believe so. Are they allowed to contribute to workforce planning sufficiently? No.[151]

104. The shortage of leadership skills was acknowledged by Lord Hunt, who commented that:

147 Institute of Healthcare Management, unpublished memorandum

148 Q 900

149 Ev 277 (HC 171–II)

150 Ev 135 (HC 1077–II)

151 Q 911

> …if you are asking me what is one of my top priorities in workforce planning, it is in enhancing leadership skills of people in individual organisations so that they lead this change.[152]

Integration of planning

105. Because of the complexity of health service workforce planning, it is vitally important that different parts of the planning system work effectively together. Workforce planning cannot take place in isolation from service and financial planning, and planning for different staff groups should be joined up.[153] Improving the integration of the planning system was one of the main recommendations of the Committee's 1999 *Future NHS Staffing Requirements* report.[154] Unfortunately, lack of integration within the planning system still appears to be a serious problem.

Medical and non-medical planning

106. A number of submissions to the Committee highlighted the importance of planning for the whole healthcare workforce rather than treating each profession as a separate 'silo'.[155] Planning for each profession in isolation inhibits innovation, for example through the development of new and amended roles, and can mean overall workforce plans do not make sense as a whole.[156] Without an understanding of changes to the overall workforce, it is impossible to plan changes to an individual professional group accurately. In particular, the importance of joined-up planning for medical and non-medical staff groups was stressed.[157]

107. The lack of integration between medical and non-medical workforce planning was pointed out in the Committee's 1999 report:

> We consider that with immediate effect there should be improved interaction between the medical and non-medical planning bodies.[158]

108. It is clear, however, that the separation of medical and non-medical workforce planning remains a serious problem. NHS London stated that,

> …the planning of medical training numbers is still carried out separately from workforce planning for all other NHS staff… These two separate approaches to workforce planning has often resulted in disjointed workforce planning for the NHS.[159]

152 Q 1042

153 See, for example, Ev 132 (HC 1077–II)

154 Health Committee, Third Report of Session 1998-99, *Future NHS Staffing Requirements*, HC 38–I, p.xlii

155 See for example, Q 794

156 Ev 218 (HC 1077–II)

157 See for example, Ev 113 (HC 1077–II)

158 Health Committee, *Future NHS Staffing Requirements*, HC 38–I, p.xlii

159 Ev 249 (HC 171–II)

109. Wyn Jones of West Yorkshire Workforce Development Confederation underlined the difficulties experienced by local organisations as a result of the centralised approach to medical workforce planning:

> Currently planning for medical and dental staff is a top-down planning model, whereas non-clinical staff planning is bottom-up…the separation of medical and dental workforce planning from the rest of the workforce remains a problem area that has not been overcome.[160]

110. Representatives from SHAs expressed particular concern to the Committee about their lack of involvement in medical workforce planning. Anne Rainsberry described the SHA role (or lack of it) in the recent implementation of Modernising Medical Careers:

> The Strategic Health Authority…have had to sign off the commissions for Modernising Medical Careers…it was a very centrally driven initiative where effectively the department, with the Workforce Review Team, would say to the Strategic Health Authority, "These are the specialties that are in expansion, there are a few that are in reduction, this is the national curriculum and, therefore, please sign here."[161]

111. A number of witnesses also commented on the division of the Multi-Professional Education and Training (MPET) levy (which is described in the box below) into separate streams for medical and non-medical training. Anne Rainsberry commented that the rigid division of funding streams inhibited the flexibility of planning at SHA level:

> The way in which MPET is currently managed needs to be re-looked at… the way in which MPET comes to us in the Strategic Health Authority is in predetermined packets and, therefore, we cannot actually implement the strategic plan because we are already committed to spending X on this and Y on that.[162]

160 Ev 236 (HC 1077–II)

161 Q 736

162 Q 698

Education and training funding

The majority of NHS education and training is funded through the MPET (Multi-Professional Education and Training) levy which totals around £4 billion per year. The size and make-up of MPET is determined by the Department of Health and funding is distributed to SHAs. MPET funding is currently made up of 3 separate streams:

- MADEL (Medical and Dental Education Levy) which funds the direct costs of postgraduate medical and dental training
- SIFT (Service Increment for Teaching) which funds the indirect, infrastructure costs of postgraduate medical and dental training and the provision of clinical placements for undergraduate medical students
- NMET (Non-Medical Education and Training) which funds undergraduate and postgraduate education and training for non-medical staff

Funding for *undergraduate* medical education and training is administered by the Higher Education Funding Council for England (HEFCE).

Planning for NHS and non-NHS organisations

112. Effective workforce planning should take account of the needs of the entire health service, rather than just the NHS.[163] This is particularly necessary in the context of the increasing use of private and voluntary sector organisations to provide NHS-funded services.[164] The increasing size and importance of the independent sector was highlighted by Peter Stansbie of Skills for Health. When asked why he thought the independent sector should play a greater role in workforce planning, he stated that:

> I think it is becoming increasingly important because the percentage of the workforce employed in the independent sector is growing… if we can do that we get some real added value in terms of the capacity that the independent sector can provide but also generally in terms of driving new roles, systems and approaches.[165]

113. However, the Committee heard that the current workforce planning system does not adequately involve independent sector organisations. The NHS Partners Network, which represents providers of Independent Sector Treatment Centres, stated that "Workforce planning would be done better if the total need of NHS patients was considered not just traditional NHS providers."[166]

163 Ev 132 (HC 1077–II)

164 See *Public Expenditure on Health and Personal Social Services 2006,* HC 1692–i, Ev 95

165 Q 819

166 Ev 132 (HC 1077–II)

114. David Highton of the NHS Partners Network explained that the merging of SHAs with WDCs in 2004 had made it more difficult for independent sector organisations to be involved in workforce planning.[167]

Workforce and financial planning

115. One of the main priorities set out in the Department of Health's 2000 consultation *A Health Service of all the talents* was to improve the alignment of workforce planning, financial planning and service planning in the health service. The paper stated that:

> Thinking about services, workforce and resources should be done together to ensure plans and developments are consistent and co-ordinated.[168]

The paper went on to call for:

> Greater integration of workforce planning and development with service and financial planning.[169]

116. We heard, however, that the integration of workforce, financial and service planning has not improved in recent years. Leicestershire, Northamptonshire and Rutland Workforce Deanery informed us that:

> Alignment [of workforce planning] with financial planning both nationally and locally has been woeful…there is still not commitment from all strategic Financial and Human Resource leads to plan jointly.[170]

117. The integration of financial and workforce planning is of vital importance for the simple reason that investment in new staff or higher pay must fit within the financial resources available. Unfortunately, it is clear that many health service organisations have failed to follow this basic principle.

Local failings

118. A graphic example of the breakdown between workforce and financial planning at a local level was provided by Andrew Foster. Mr Foster described the findings of a Department of Health investigation into staff redundancies at University Hospital of North Staffordshire NHS Trust. Mr Foster told the Committee that:

> …in the first quarter of last year there was this increase in workforce numbers which simply demonstrated the lack of integration in that instance between workforce planning and financial planning.[171]

119. When questioned as to why the Trust had recruited extra staff in spite of a growing financial deficit, Mr Foster commented that:

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167 Q 794

168 Department of Health, *A Health Service of all the talents,* 2000, p.3

169 Ibid, p.5

170 Ev 112 (HC 1077–II)

171 Q 50

> I would imagine that it is because workforce planning is done in a separate place from financial planning. The workforce planners say what work they expect to have to do, they need more staff so they start recruiting them without actually reconciling that to the budget they have available.[172]

National failings

120. The Committee also heard that the failure to integrate workforce and financial planning has affected national planning by the Department of Health.[173] As detailed in Chapter 2, the staffing growth targets set out in the *NHS Plan* were significantly exceeded for most staff groups and spectacularly exceeded for nursing staff. John Sargent pointed out that there was a significant mismatch between staffing growth targets and the amount of extra funding available to NHS organisations:

> …in 2001, the Department of Health had issued workforce expansion targets that would have increased the size of the NHS workforce in headcount terms by almost 120,000 people by 2008. At the same time, the financial settlement arising for the Department from the Spending Review settlement was sufficient to fund workforce growth about two and a half times greater than this.[174]

121. Mr Sargent was subsequently asked why the disjunction between workforce planning targets and financial resources had occurred. His assessment of the Department of Health's failings was remarkably similar to the assessment by Department of Health officials of the failings at North Staffordshire:

> I suspect, in truth, that different…sections in the Department of Health were concentrating on different aspects of the Health Service…the government policy of moving towards average OECD country levels of expenditure on health overtook some of the workforce planning targets at that time and so there was mismatch.[175]

122. As we saw in Chapter 2, the failure to integrate workforce and financial planning has had serious negative consequences for workforce planning and for the NHS in general and has been a major cause of rising financial deficits.[176]

Planning with a long-term focus

123. Workforce planning in any industry requires a combination of short-term, medium-term and long-term functions.[177] The long-term element of planning is especially important in healthcare because of the complexity of the workforce and the long training periods for some healthcare professions, notably medicine.[178] The importance of a long-

172 Q51

173 Q696

174 Ev 278 (HC 171–II)

175 Q718

176 Health Committee, First Report of Session 2006–07, *NHS Deficits*, HC 73-II, Q 743

177 Ev 120 (HC 1077–II)

178 Ev 120-121 (HC 1077–II)

term approach to healthcare workforce planning was explained by the Chartered Society of Physiotherapy:

> While needing to be flexible to fit in with changing priorities, workforce planning in health care crucially requires taking a longer term perspective. This is partly because of the time it takes to train and develop staff but also because of the time frame of emerging health trends and policy developments such as the shift of resources from the acute to the community sector.[179]

124. Unfortunately, the bulk of the evidence received by the Committee argued that health service workforce planning has lacked a consistent, long-term element. Universities UK commented that workforce planning:

> …tends to be short term, *ad hoc* interventions to redress specific shortages, rather than a wider approach that takes account of the long lead times for professional education, and the social and economic environments that concern service users and health workers.[180]

125. John Sargent pointed out that current processes for workforce planning do not encourage a long-term approach. For example, Local Delivery Plans (which bring together service plans and workforce plans for a particular organization or area) look only 3 years ahead. Mr Sargent argued that:

> Local Delivery Plans cover a period of three years. To many people this may seem like a long time in to the future; and yet in strategic workforce planning terms it is almost useless.[181]

126. We also heard that the pressure to focus on short-term priorities made it impossible for the NHS to focus adequately on long-term planning. The Postgraduate Medical Education and Training Board stated that,

> …education and training are long-term objectives and do not always sit easily alongside the short-term imperatives by which Chief Executives in the NHS are often judged.[182]

127. Most worryingly, the Committee heard on a number of occasions that recent changes to education and training provision by SHAs were motivated by financial incentives without any consideration of the impact on long-term workforce planning. Commenting on widespread reductions in SHA education and training spending for 2006–07, Professor Jill Macleod Clark of the Council of Deans and Heads of UK University Faculties for Nursing and Health Professions told the Committee that,

> There is no doubt that the underspends [on education and training]… have been put into securing some amelioration of the basic NHS deficit. That has resulted in radical cuts in commissioned numbers for this coming year… I think the implications of

179 Ev 68–69 (HC 1077–II)

180 Ev 232 (HC 1077–II)

181 Ev 278 (HC 171–II)

182 Ev 148 (HC 1077–II)

> that for even the short-term workforce requirements could be devastating… reduction in commissions is not related to the reduction in demand; it is a response to being able to raid a pot of money.[183]

This view was echoed by Professor David Gordon of the Council of Heads of Medical Schools who described cuts in education and training spending by SHAs as "eating the seed-corn for the future".[184]

128. Representatives from SHAs themselves expressed serious concerns about the impact of cuts to education and training funding. Trish Knight, of Leicestershire, Northamptonshire and Rutland Workforce Deanery, acknowledged that cuts made to date were severe enough to have a long-term impact on the workforce:

> **Dr Taylor:** We did get the Secretary of State to admit that this [cutting training provision] could only be a short term policy but we could not tie her down to how long "short term" was. How long do you think this could go on without seriously affecting the future?
>
> ***Ms Knight*:** It will affect it next year from my point of view.[185]

129. Most strikingly of all, Anne Rainsberry of NHS London agreed that long-term planning was at risk of being abandoned altogether because of short-term NHS financial problems:

> **Chairman:** Do you think that the rapid growth in staff numbers and resultant financial difficulties have caused parts of the NHS to effectively abandon long term workforce planning, for the time being anyway?
>
> ***Ms Rainsberry*:** I think there is a genuine danger of that.[186]

Planning for improved productivity

Expansion in staff numbers

130. As we described in Chapter 2, the main outcome of recent changes to the NHS workforce has been a major expansion in capacity. There have been some attempts to increase productivity and introduce new ways of working but these have been insignificant compared with increases in staff numbers. The Department of Health acknowledged this in its written submission,[187] and officials confirmed on 11 May that improving productivity was not amongst the aims of the *NHS Plan* reforms:

183 Qq 619–621

184 Q 592

185 Q 769

186 Q 758

187 Ev 12 (HC 1077–II)

> When we put more money into the NHS with the *NHS Plan* investment, we expected productivity would not actually rise. We did not anticipate that we could put all those new resources into the system and get productivity as well.[188]

131. Evidence we received was sharply critical of this approach. The Committee heard that the expansion in staff numbers should have been preceded, or at least accompanied, by attempts to improve workforce productivity.[189] Dr Karen Bloor of the University of York argued that "before planning to increase the stock of human resources it is essential to establish that the existing workforce is working effectively":[190]

> **Dr Naysmith:** …did the NHS do this prior to this rapid growth?
>
> ***Dr Bloor*:** No, I do not think it did do that, and it is contemplating further increases without doing that now as well. We have some evidence of that. There are huge variations in activity rates between hospitals, general practices and individual doctors… I do not think we really did address the effectiveness of the workforce enough before we expanded it.
>
> **Dr Naysmith:** Why not?
>
> ***Dr Bloor*:** …I do not know. Perhaps we should ask the Department of Health about that.[191]

132. The Committee heard a similar argument during its visit to California. Professor Kevin Grumbach, head of the Center for California Health Workforce Studies at the University of California underlined the short-sightedness of expanding workforce capacity without addressing the productivity of the existing workforce. Professor Grumbach stressed the importance of "not adding more sugar to your coffee before you've stirred what's already there."[192]

The new medical contracts

133. The growth in staff numbers has been accompanied by substantial pay increases for most NHS staff, as we described in Chapter 2. Senior doctors have received the most significant pay increases through the new consultant and GP contracts. As with the increase in staff numbers, witnesses argued that bringing in new contractual arrangements for senior staff without addressing overall workforce productivity was unwise. Dame Carol Black of the Royal College of Physicians remarked that:

> It would also be an enormous help if there had been some systems reform before we did all the other things like introduce a consultant contract. In fact, the system had

188 Q 89

189 Q 338

190 Bloor, K, and Maynard, A, *Planning human resources in health care, towards an economic approach: an international comparative review*, Canadian Health Services Research Foundation 2003

191 Qq 342–3

192 Professor Grumbach, personal communication

> not been reformed so consultants were paid more money but in a system which would not support more efficient working…[193]

134. Some witnesses were blunter still, arguing that the new medical contracts had led to a decline in productivity. Professor Sir Alan Craft, chair of the Academy of Medical Royal Colleges commented:

> The new consultant contract is a time sensitive contract and what it did was to identify the huge amount of work that actually was being done by consultants…and I think because of that…productivity probably has gone down in some places…Because doctors are now working to a fixed contract [i.e. with set hours and pay rates], which they never did before.[194]

135. The Committee heard similar arguments with regard to the new GP contract from Professor Bonnie Sibbald of the National Primary Care Research and Development Centre:

> **Charlotte Atkins**…their contract has meant fairly substantial pay rises for GPs. Are they doing less and getting more?
>
> ***Professor Bonnie Sibbald*:** Yes.
>
> **Charlotte Atkins:** Do you think that is justified?
>
> ***Professor Bonnie Sibbald*:** No…We conduct national surveys of general practitioners in this country, about 1,000 GPs… On average doctors were reporting a £15,000 increase in pay and a four hour reduction in their working week.[195]

136. When questioned about the new contracts, Department of Health officials acknowledged that NHS organisations had prioritised implementation of the new contracts over improving value for money. With regard to the consultant contract, Andrew Foster remarked that:

> It is fair to say that a lot of organisations put more effort into simply getting people onto the new system than generating the benefits from it… It is fair to say that many organisations, at least in the first year, did not reap the benefits that we hoped for.[196]

137. Officials also acknowledged that they did not know how well GP practices would perform against the new QOF targets, making it impossible to predict how much income would increase upon the introduction of the new contract:

> There was a great deal of uncertainty about what GPs could achieve in these areas. The GPs may have known… but the centre did not know.[197]

193 Q 338

194 Qq 222–3

195 Qq 453–455

196 Q 73

197 Q 69

Planning for increased flexibility

Skill mix changes

138. Increasing the flexibility of the health service workforce is an important and well-established goal.[198] As we noted in Chapter 2, there have been significant attempts to improve the flexibility of the workforce, particularly through changes to skill mix and the development of new clinical roles at Assistant and Advanced Practitioner level. More detail on new and amended roles is provided in Chapter 4. The Committee has heard of some success stories in this area including the development of Emergency Care Practitioner (ECP) roles. ECPs work in the community and respond to emergency calls in the same way as paramedics.[199] However, ECPs have an extended range of clinical skills and are therefore more often able to treat patients in their own homes rather than taking them to hospital. Bill O'Neill of the London Ambulance Service told the Committee that ECPs are able to manage 50% of patients in their own homes, compared with 25% for a paramedic team.[200] Peter Stansbie of Skills for Health provided an estimate of the financial savings associated with using ECPs:

> An estimate in the south west is that for each emergency care practitioner that they appoint it saves the health economy £56,000 a year.[201]

139. However, the Committee received other evidence which suggested that the quantifiable benefits of the introduction of ECPs represent the exception rather than the rule. It was argued that skill mix changes have often been poorly conceived and have not improved productivity.[202] Professor Bonnie Sibbald described her research into the use of nurses in primary care to perform tasks traditionally done by doctors. Professor Sibbald concluded that:

> …on most occasions you will not get gains in productivity or reductions in cost… when you substitute a nurse for a doctor, nurses tend to consume more resources than physicians but generate the same high quality of care output; but as they consume more resources, that eats into the savings you get in their salaries, so the overall effect tends to be cost-neutral.[203]

140. Witnesses also argued that when staff in amended roles attempt to take on extra responsibilities, these are not always relinquished by existing staff. [204] Dr Karen Bloor commented that:

> We are not always saving money or reducing the workforce but what we are doing is adding in another level of care. If that is improving patient care, that is fine, but it is

198 See, for example, Ev 219 (HC 1077–II)

199 Qq 478–479

200 Q 482

201 Q 800

202 See, for example, Ev 170

203 Q 395

204 Q 395

> important to note that certainly from research evidence they are often operating as complements and not necessarily as substitutes…[205]

141. The Committee heard that even when new and amended roles had been shown to be successful, disseminating changes across the health services remained a slow and difficult process. David Highton argued that:

> In the NHS… there are always some fantastic examples of extended roles, but it is very difficult to disseminate them across the service as a whole.[206]

142. This point was acknowledged by Andrew Foster who blamed the closure of the MA for problems with disseminating new roles. Mr Foster commented that the development of new roles had become "more difficult to coordinate as an overall pattern" since the removal of the MA.[207]

Education and training cuts

143. Most worryingly of all, the Committee heard that even when new roles have proven to be effective, recent redundancies and cuts to education and training provision have particularly targeted such developments and therefore reduced the flexibility of the workforce.[208] Breakthrough Breast Cancer and the Joint Epilepsy Council both warned about recent cuts to specialist nursing services. The former described staff in extended roles as a "soft target".[209] Peter Stansbie commented on similar cuts to training opportunities for staff in Health Care Assistant and Assistant Practitioner roles:

> It is very worrying that we heard people who are perhaps at the bottom end of the skills spectrum are going to suffer as a result of the funding cuts when what we need to do…is bring people in at that level and give them the ability to get their skills up and, indeed, move through the training. I think some of our existing systems do not help us with that.[210]

144. Representatives from SHAs confirmed that training cuts have particularly affected training for Assistant level staff and staff in new roles. Trish Knight explained:

> …we had to stop all secondment of people into training, the HCAs [Health Care Assistants] or the OT [Occupational Therapy] assistant who wants to go and do their training, which is a real shame, but that is how we have managed the cut.[211]

145. Anne Rainsberry described a similar range of cuts made by NHS London.[212] Importantly, she explained that the pattern of cuts reflected the structure of education funding and contracts rather than future workforce needs:

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205 Q 351

206 Q 803

207 Q 42

208 Q 768

209 See Ev 224 and Ev 229 (both HC 171–II)

210 Q 802

211 Qq 767–8

> The reason for that [pattern of cuts] is because of the way the MPET budget is made up. We have different levels of flexibility with different parts of the budget and therefore where we have the maximum flexibility is in the work around new roles. When you get into this urgent situation inevitably that is something that is going to be most vulnerable.[213]

146. It is clear that features of the workforce planning system itself make it more difficult to increase workforce flexibility, particularly in times of financial difficulty. The problem was aptly summarised by Professor Jill Macleod Clark:

> …the current mechanisms unwittingly are creating a situation where we are simply maintaining the *status quo*. They do not allow a flexible, more imaginative and more forward-looking approach to workforce planning.[214]

Flexible training provision

147. The Committee heard that in other areas where flexibility can be increased, such as the provision of flexible training and working opportunities, there have been few developments. This problem was highlighted by Karen Jennings, Head of Health at UNISON:

> …the commissioners of education and training are very tunnelled in their vision about where to access education and training from. There are no universities that provide part-time registration training. Now, do you not think that is bonkers? In a time when the average age of a student nurse is 29 years of age, has children, how on earth can they last on a course that is full-time?[215]

The Medical Women's Federation likewise highlighted the declining number of flexible training opportunities for doctors since the withdrawal of central funding from the Flexible Training Scheme and Flexible Careers Scheme.[216]

Conclusions

148. **There are a number of weaknesses in the current workforce planning system. Most fundamentally, there is a shortage throughout the health service of the people, organisations and skills required for workforce planning. Persistent structural changes have exacerbated this problem, particularly at regional level. The new SHAs seem to lack capacity for workforce planning even though they have a vital role to play. The removal of Workforce Development Confederations and the Modernisation Agency left gaps which remain unfilled. Local organisations have struggled even to provide accurate workforce information to support decision-making. Workforce planning appears to remain a secondary consideration for many organisations.**

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212 Qq 763–766

213 Q 768

214 Q 632

215 Q 314

216 Ev 243 (HC 171–II)

149. **Lack of integration between different parts of the planning system remains a widespread problem. The difficulties caused by the separate planning systems for medical and non-medical staff groups were pointed out by this Committee 8 years ago but have still not been effectively addressed. Medical and non-medical planning is still done by separate organisations with separate funding streams, which inhibits the ability of SHAs to plan effectively by looking at total workforce requirements. The workforce planning system has also failed to involve the private and voluntary sectors adequately, particularly since the loss of separate Workforce Development Confederations. This is a serious failing, particularly in the context of the increasing use of the independent sector to provide NHS services.**

150. **Of particular concern is the continuing lack of integration between workforce planning and financial planning. There are shocking examples of failures at local level with some organisations continuing to recruit large numbers of staff in spite of rising financial deficits. But the Department of Health has made equally serious mistakes at national level, in particular by failing to ensure that targets for increasing staff numbers were consistent with the level of funding available. Both in local organisations and at the Department of Health, workforce planning and financial planning have been done by separate teams in separate places and little has been done to bring the two processes together.**

151. **Effective workforce planning, particularly in healthcare, must include a long-term element. This has been badly wanting in health service workforce planning, partly because there is no formal long-term planning system, but more importantly because NHS organisations tend to be too focused on short-term priorities. Recent cuts to training provision and other workforce development activities have shown an especially worrying disregard for long-term workforce priorities. The Committee is deeply concerned to hear from a key workforce leader that long-term planning is at risk of being abandoned in parts of the NHS.**

152. **Increasing workforce productivity is a vital goal that has been badly neglected by the workforce planning system. The Committee was dismayed to hear that improving productivity was not an explicit aim of the *NHS Plan*. The resultant lack of focus on increasing efficiency during the recent period of rapid growth in staff numbers was reckless and unwise. We were equally concerned by the suggestion that the new consultant and GP contracts may have reduced the productivity of these vital staff groups. Pay rates for senior doctors have increased substantially without evidence of corresponding benefits for patients. This is indicative of the lack of overall focus on improving workforce productivity.**

153. **Increasing workforce flexibility is an important and related goal and some progress has been made in recent years, particularly through the development of new and amended roles. However, not enough has been done to prove that all these changes are cost effective. Even when skill mix changes have proved to be effective, recent cuts in training capacity have targeted staff in new roles and hampered attempts to increase flexibility. The current structure of education funding does not support the development of a more flexible workforce and there is a shortage of flexible training opportunities.**

154. ***A Health Service of all the talents*** **set out a blueprint for improving workforce planning through a stable system with dedicated workforce organisations and a clear focus on improving flexibility and productivity. The health service has lost sight of this vision and marginalised workforce planning. The situation has been exacerbated by persistent structural change. The system remains poorly integrated and there is a shortage of staff with the necessary skills for effective workforce planning. In light of the need for increased activity, organisations tended to throw extra workers at the problem rather than increasing the efficiency of existing staff. Even when positive changes which might improve productivity, such as the new contracts and new clinical roles, have been introduced, benefits have not been properly realised. In particular, the current wave of education and training cuts has led to a number of backward steps for workforce development. Basic problems such as the disjunction of workforce and financial planning persist at all levels of the system. Despite great efforts in some quarters, the workforce planning system is not performing noticeably better than 8 years ago.**

4 The future health service workforce

Introduction

155. In Chapters 2 and 3, we examined past developments in the health service workforce and the workforce planning system. In this chapter, we consider the type of workforce that the health service will require in order to meet future challenges. The evidence we received consistently agreed on the need for changes to the structure of the workforce and to the way in which staff work. Skills for Health argued that in light of expected policy, demographic and technological developments, future workforce requirements are likely to change radically. The organisation concluded that:

> Simply planning for "more of the same" will be insufficient to meet the challenges of the next 10 years and beyond.[217]

156. The Department of Health provided a similar analysis, stressing in particular the impact of the impending retirement of the "baby boom" generation on the health service and its workforce.[218] The Department concluded that:

> The NHS has seen a period of growth in both financial support to the NHS and the size of the workforce…The past five years has been about staff growth and the next five years will be about transformation into a flexible affordable staff mix to deliver patient centred care.[219]

157. In this chapter we focus on what the 'transformation' of the workforce envisaged by the Department of Health should consist of. We consider the following areas:

- The need for a more **productive** workforce;
- The need for a more **flexible** workforce;
- The importance of shifting the balance of the workforce towards **primary care**; and
- The need for improved **management skills** throughout the workforce.

A more productive workforce

158. In Chapter 3 we concluded that the health service has paid too little attention to improving workforce productivity. We expressed serious misgivings about the Government's argument that increasing staff numbers and staff pay were rightly regarded as more important goals than improving efficiency. The unprecedented recent growth in health service funding has led to some significant improvements in service, most notably in shorter waiting times. However, the potential benefits of much of this increased investment remain unrealised because the availability of so much extra money has made it easier to

217 Ev 219 (HC 1077–II)

218 Ev 13–14 (HC 1077–II)

219 Ev 1 (HC 1077–II)

increase capacity and activity rather than improving productivity and efficiency.[220] As Dame Carol Black put it:

> It is always easier to do what you normally do. It is easier to put another doctor or another nurse into a clinic than to take the much more difficult, both mental and cultural, things that are needed to really sit down all together and say how on earth do we change this for patient benefit. That requires much more planning. It requires that you put much more intellectual effort into this.[221]

159. More recently, as it has become clear that future funding levels are highly unlikely to keep pace with recent growth,[222] putting an extra doctor or nurse into a struggling clinic will no longer be possible. As a result, increasing workforce productivity will be fundamental to ensuring that the health service continues to improve.

160. There is some evidence that workforce productivity is now being taken more seriously by the Government. This is clear from the ambitious 'Productive Time' initiative, which aims to save £2.7 billion per year, and from the creation of the NHS Institute for Innovation and Improvement which will concentrate specifically on improving productivity.[223] In this section we look at how workforce productivity can be increased, particularly by making better use of the new staff contracts.

Measuring productivity

161. Better information is essential to improving productivity. Defining and measuring health service productivity is a complex task and we outline some of the main difficulties in the box below. However, if productivity cannot be reliably measured, then it cannot be demonstrably increased. Witnesses stressed that there is a shortage of information about productivity and that the little information that exists is rarely put to good use. George Blair of Shared Solutions Consulting commented that "the NHS drowns in data but has very little information" on productivity.[224] Dr Karen Bloor made a similar point, arguing that:

> You asked earlier about whether the NHS is an organisation prone to measuring activity rather than productivity. I would argue that until quite recently they tended to ignore both…Until we share information, until we use information, there is not the incentive to make it [productivity] better.[225]

Improving information

162. A number of different solutions were suggested to increase the amount and quality of information available to local organisations about productivity. George Blair proposed the

220 This was acknowledged by the Department of Health itself in *Explaining NHS Deficits—2003/4 – 2005/6,* February 2007, p.6

221 Q 346

222 See chapter 2

223 Ev 8 (HC 1077–II)

224 Q 336

225 Q 359

development of a "clinician's dashboard" of key indicators such as patient throughput, quality of care and quality of patient experience.[226] Dr Karen Bloor suggested making wider use of Hospital Episode Statistics to compare activity levels between organisations and individuals.[227] Witnesses also consistently emphasised the importance of making productivity information meaningful to, and usable by, clinicians.[228] There was strong criticism of the lack of investment in people and systems for improving productivity information. George Blair memorably commented that,

> The information side is not well resourced…Some analytical staff could…be easily those people first for the chop because they are not hands-on. Giving you a metaphor, in the Battle of Britain radar was crucial so that the scarce resources were most effectively deployed. There was no clamouring for scrapping the radar and having more pilots.[229]

The Better Care, Better Value *Indicators*

163. The Committee received more positive evidence about the quarterly *Better Care, Better Value* indictors published by the NHS Institute for Innovation and Improvement (III) since October 2006. The comparative indicators underpin the 'Productive Time' initiative and measure organisational performance in 15 different areas. These include direct measures of workforce productivity, such as levels of sickness absence, and of clinical productivity, such as the number of day surgery operations and the average length of hospital stay. The III provides an estimate of the money each organisations could save by improving performance in each area.[230]

164. Witnesses generally supported the use of the *Better Care, Better Value* information although some expressed reservations about the quality of data. The need for widespread dissemination of the information, particularly amongst clinical staff, was also emphasised. Sir Jonathan Michael, Chief Executive of Guy's and St Thomas's NHS Foundation Trust, commented that,

> It is very helpful information. One of the problems with the data we are currently seeing is that they are not properly case-mixed adjusted which therefore makes it quite difficult to compare one organisation with another, but all foundation trusts are looking at …productivity—the efficiency of the organisation and the way it is organised, for example the utilisation of theatres, beds and so on. That is a sensible discipline for any organisation to manage costs.[231]

226 See Q 336 and Ev 211

227 Qq 359–366

228 See, for example, Q 338

229 Q 358

230 Detailed information about the *Better Care, Better Value* indicators is available at www.productivity.nhs.uk

231 Q 891

Defining and measuring productivity

Some measures of productivity compare activity levels (outputs) with the amount of money spent (inputs). However, in healthcare particularly, this approach can be problematic. As Dr Jonathan Fielden of the BMA pointed out,

> If I am a cardiologist, the more patients that I put on beta-blockers, ACE inhibitors and otherwise, the fewer should be coming back to my clinic, so my productivity [activity relative to cost] is going down but my health outcomes are going up.[232]

Thus an alternative approach to measuring productivity compares changes in patient or population health (outcomes) with the amount of money spent (inputs). Some witnesses argued that productivity information should focus on 'outcomes' rather than 'outputs'.[233] However, other argued that in some cases 'outputs' could be used as a reasonable proxy for assessing productivity.[234]

In reality, both types of measure are likely to be used in different contexts. For example, the new consultant contract links payment with the number of units of time worked, thereby linking pay with activity. Under the new GP contract, practice income is determined partly by clinical results and patient satisfaction, thereby linking pay more directly with outcomes.

Some of these problems are evident in the most recent attempt by the Office for National Statistics (ONS) to measure the overall productivity of the health service. In February 2006, the ONS published *Public Service Productivity: Health* which contained six different assessments of NHS productivity between 1995 and 2004. Depending on the definition of productivity used, health service productivity was shown to have decreased by an average of up to 1.3% per year or to have an increased by an average of up to 1.6% per year. The six different results produced by the ONS were based on three different measures of output/outcome:

- **Unweighted** output (which shows a **drop** in NHS productivity of between 0.6% and 1.3% per year between 1995 and 2004);
- Output weighted for improvements in the **quality** of healthcare and health services (which shows change of between -0.5% and +0.2% per year); and
- Output weighted for improvements in **quality** and the increase in the **value** of healthcare over time (which shows an **increase** of between 0.9% and 1.6% per year).[235]

The 2005 *Atkinson Review* recommended that productivity measurements should be adjusted for changes in quality. However, there is continuing debate about whether the

232 Q 294

233 See for example, Q 338

234 See for example, Q 359

235 A full account of the ONS work is provided in Ev 142–4 (HC 1077–II)

adjustment for the value of healthcare should be used. The ONS recommended that their results taking account of value should be used "cautiously, pending further debate".[236]

The Government has made inconsistent use of the ONS results. In its response to the Committee's *Public Expenditure Questionnaire 2006–07*, the Department of Health wrote that NHS productivity had risen by 1.6% per year (using the results adjusted for quality **and** value).[237] However, at the evidence session on 25 January, Lord Hunt described NHS productivity as "probably level rather than plus or minus anything dramatic" (apparently using the results adjusted for quality but **not** value).[238]

The Knowledge and Skills Framework

165. In Chapter 2, we described the introduction of new contracts and pay systems for the majority of health service staff, focussing particularly on *Agenda for Change*, the consultant contract and the GP contract. In Chapter 3, we examined some of the problems with the implementation of the new pay deals; including the suggestion that the new medical contracts may have reduced short-term productivity. However, witnesses also highlighted the potential of the new contracts to be used as a lever for improving productivity in the future.[239] In this section we examine how each of the new pay schemes can be used to improve productivity.

166. The *Agenda for Change* agreement contains a number of mechanisms for increasing productivity, notably through the annual appraisal cycle.[240] The appraisal process is supported by the new *Knowledge and Skills Framework* (KSF), a vast atlas of pre-defined skills and competences which can be linked to responsibilities and pay levels for each post. The KSF covers a wider range of clinical, technical, managerial and personal competences; staff can progress in each area from level 1 to level 4.[241] Individual annual appraisals should identify which of the necessary skills are lacking or need to be improved. This information can be used to define training requirements and to set personal objectives for staff members. More detail on the KSF is provided in the box on competence frameworks below.

Productivity benefits

167. Witnesses were enthusiastic about the potential of the KSF to improve access to training and to improve the links between training and service requirements.[242] Improving access to relevant training is vital to enable staff to take on a wider range of responsibilities

236 Office for National Statistics, *Public Service Productivity: Health,* February 2006, p.1

237 *Public Expenditure on Health and Personal Social Services 2006*, HC 94–i, Q 97

238 Q 964

239 See, for example Q 964

240 For more details on the potential use of *Agenda for Change* to support productivity improvements, see NHS Employers, *From pay reform to system improvement: making the most of Agenda for Change,* 2006

241 Department of Health, *The Knowledge and Skills Framework (NHS) and the Development Review Process,* October 2004

242 Q 168 and Q 212

and increase their efficiency and value to employers. Karen Jennings of UNISON stated that,

> The Knowledge and Skills Framework is like the jewel in the crown of *Agenda for Change*. It is inspirational, in the sense that, for the first time, all staff in the NHS—from porter right through to consultant and chief executive—have the right to access education and training.[243]

168. Professor Bob Fryer, National Director for Widening Participation in Learning at the Department of Health, described the potential benefits of improving access to training for lower grade staff. He cited a close link with workforce productivity:

> The KSF, with this built-in entitlement [to annual appraisal] is a tremendous opportunity for building and growing our own workforce and that has huge advantages. There is evidence that it actually reduces labour turnover and absenteeism and raises the morale of staff, in particular what this does is actually hold out the prospect to somebody who comes in at a relatively modest level to improve their professional skills and competences and indeed their life expectancy.[244]

It is notable that these are some of the very areas targeted by the 'Productive Time' initiative, specific aims of which include decreasing staff turnover and sickness absence rates.

Current limitations

169. Regrettably, given the apparent link with improved workforce productivity, the Committee heard serious doubts about how well the benefits of the KSF have been realised to date. Karen Jennings highlighted the decline in the number of staff with professional development plans (PDPs), which detail future training requirements. She described this development as "alarming" as it suggests that the annual appraisal process which supports KSF implementation is receding precisely when it should be expanding.[245] More worryingly, Ms Jennings emphasised the impact of recent cuts in education and training funding on the ability of organisations to actually provide the training identified by appraisals and PDPs. She concluded that,

> We have one third of trusts which are in debt… when you make cuts and announce redundancies, that is the last measure. There will have been a whole raft of other measures put in place to save money. Under education budgets—we know from hearing that from our members—KSF is becoming an almost impossibility.[246]

170. Ms Jennings commented particularly on cuts to opportunities for Health Care Assistants, a staff group she described as "key to the modernisation of the NHS".[247] Representatives from SHAs confirmed that cuts in education spending have particularly

243 Q 314

244 Q 146

245 Q 314

246 Q 327

247 Q 314

affected lower grades of staff, precisely the group for whom the KSF should offer the greatest benefits.[248]

The Quality and Outcomes Framework

171. As part of the new GP contract, a proportion of each practice's income is based on performance against the *Quality and Outcomes Framework* (QOF). The practice is awarded a score based on a number of indicators covering areas including disease management, practice organisation and access to care. In 2004–05, for example, up to 1,050 QOF points were available to each practice, with up to 19 points available for regularly checking the blood pressure of patient with heart disease and 40 points for undertaking a patient satisfaction survey. In total, practices were assessed against 146 separate indicators in 2004–05. On average, practices received £75 for each QOF point in 2004–5; this rose to £120 per point in 2005–06.[249] The QOF is updated annually and changes to indicators are negotiated by GPs and NHS Employers. [250]

The impact of the QOF

172. There is clear potential for the QOF to increase the productivity of the GP workforce by linking income directly with the achievement of specific objectives, many of which relate to clinical outcomes. It also seems that GP practices have responded to the objectives set out in the QOF: practices achieved an average of 91% of QOF points in 2004–5.[251] However, as we observed in Chapter 3, Department of Health officials admitted that managers did not know how well GPs were performing against the QOF indicators prior to the introduction of the new contract.[252] It is therefore impossible to judge the level of *improvement* in GP performance in return for the substantial increases in income which accompanied the contract.

173. As we have seen in Chapter 3, some witnesses argued that the new contract has decreased GP productivity in the short term.[253] Other witness presented a somewhat different picture, arguing that QOF targets in particular had been challenging to meet and that practices had invested in additional staff in order to improve their QOF performance. Dr Graham Archard of the Royal College of GPs commented:

> I do rather take exception to your words that [QOF] targets were met so easily. Like most practices in my area, we scored extremely highly; the reason we scored extremely highly is because we worked extremely hard. We employed two full-time nurses as well to try to move this agenda forward.[254]

248 Q 767

249 See Robert Fleetcroft and Richard Cookson, *Do the incentive payments in the new NHS contract for primary care reflect likely population health gains?* (Centre for Health Economics, May 2005), p.1

250 More detail on the QOF is available at www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/QOF

251 Q 159

252 See Q 69

253 See Qq 453–4

254 Q 672

Using the QOF to increase productivity

174. It is clear that the QOF provides effective incentives for GP practices, in spite of the understandable doubts about whether it has provided value for money to date. The Committee questioned witnesses about improving the auditing of QOF submissions by PCTs but witnesses generally defended the effectiveness of the existing system.[255] Witnesses did stress, however, that PCTs need to make better use of the QOF by making targets more challenging in future. Dr David Colin-Thome, National Clinical Director for Primary Care at the Department of Health, argued that QOF requirements should be made "a bit tougher" in order to get more value from the contract.[256] Paul Holmes, Chief Executive of Kingston PCT, told the Committee that after consistent improvements in QOF performance, requirements had been made more challenging:

> For the forthcoming year…the bar has been set a little bit higher and it will be interesting to see whether we maintain the rate of improvement.[257]

Consultant job planning

175. Like *Agenda for Change*, the new consultant contract is based on an annual cycle of appraisal and objective setting. Under the terms of their new contracts, consultants' pay is directly linked to the number of Programmed Activities (PAs) worked. A PA comprises half a day's worth of activity: for example, an operating list, outpatient clinic or period of administrative work. Consultants agree the number of PAs they will work each week and what they will do in each PA in annual negotiations with their employers. This process is known as 'job planning'. As part of the annual job planning cycle, employers can also agree performance objectives with consultants. Performance against job plans and performance objectives can be used by employers to determine whether consultants receive increased pay the following year.[258]

Doubts about job planning

176. Unfortunately, as we discussed in Chapter 2, there are significant doubts about the success of the consultant contract to date. Many of these doubts have focussed on the effectiveness of the job planning process. A Kings Fund report on the new contract, published in May 2006, concluded that,

> There has been considerable variation in approach and outcome between and within trusts. Job planning for consultants has been process-driven, with cost pressures driving negotiations in some trusts…The link between job planning and appraisal of consultants is also often blurred or unclear, compounded by the fact that objective setting has so far often been weak.[259]

255 See, for example, Q 669 and Q 873

256 Q 159

257 Q 668

258 For more information, see *Consultant job planning: Standards of best practice,* available at www.nhsemployers.org/pay-conditions

259 King's Fund, *Assessing the new consultant contract: A something for something deal?* May 2006, p.ix

Witnesses from NHS Employers and the Department of Health acknowledged the variation in the quality of job planning but insisted that the standard is continuing to improve.[260]

Improving job planning

177. The Committee heard that, if effectively used, job planning and objective setting provide vital mechanisms for NHS organisations to increase the productivity of consultants. Department of Health officials commented on the importance of effective job planning and of linking consultant performance against agreed objectives with pay increases. Andrew Foster stated that,

> The other piece of leverage inside the consultant contract…is the ability to agree annual personal objectives with each consultant, for those objectives to be reviewed at the end of the year because pay progression through the scale…is dependent on meeting the job plan and delivering the agreed personal objectives.[261]

178. Other witnesses pointed out that the job planning cycle allowed employers to have a meaningful influence on consultants' clinical activities for the first time.[262] The importance of this dialogue, and the inflexibility of the previous system, were highlighted by Sian Thomas of NHS Employers:

> Before the contract if you wanted to switch the way a consultant worked between their emergency work, their planned work and their weekend work it was really an impossible thing to try to do. The contract is a framework which enables employers to do that.[263]

Dr Karen Bloor commented on the importance of the Medical Director's role in negotiating effective objectives with consultants.[264]

Measuring performance

179. Witnesses argued that performance objectives should be underpinned where possible by measurable targets. Dr Karen Bloor recommended using Hospital Episode Statistics, which measure levels of consultant activity, as a basis for agreeing job planning targets.[265] Dr Jonathan Fielden argued that objectives should be based on data relevant to the particular specialty and on measures of patient outcomes rather than simply on consultant activity rates.[266] This difference of opinion demonstrates the lack of agreed standards for local organisations to use in developing meaningful measures of clinical performance. There is a clear need for improved guidance for developing clinical productivity measures,

260 See for example, Q 288 and Q 73

261 Q 79

262 Q 227

263 Q 227

264 Q 362

265 Q 359

266 Qq 294–6

which could be provided by NHS Employers or the NHS Institute for Innovation and Improvement. Different measures would be required for each clinical specialty, some relating to activity levels and others to clinical outcomes. NHS Employers could work with the relevant Royal Colleges and other organisations to agree the best measures to use in each case. Standard productivity measures for each specialty, many of which can be based on existing data sources, would make it much easier for local managers and Medical Directors to negotiate consultant performance objectives across a range of specialties.[267]

A more flexible workforce

180. Closely linked to increasing *productivity* is the need to develop a more *flexible* workforce. Increasing the flexibility of the health service workforce has been a long-standing objective and was clearly outlined as a priority in *A Health Service of all the talents* in 2000.[268] We consider some of the definitions of 'increasing flexibility' in the box below. The importance of improving flexibility was described by Skills for Health which concluded that:

> The strategic drivers we highlight converge in two specific areas namely the need for a **more flexible workforce** (a more effective mix of people undertaking wider and different roles) and the **role of competences** as a currency and framework for addressing skills gaps…[269]

181. The Committee heard some specific examples which underline the importance of increasing workforce flexibility. The Royal College of Pathologists pointed out that lack of workforce flexibility often prevents new technologies from being introduced as staff are not able to learn new skills quickly.[270] Professor Sir Alan Craft commented that the use of nurses in amended roles was vitally important to meeting the 2004 European Working Time Directive requirements, concluding that "…if we had not had nurses taking on extended roles, we would have fallen flat on our faces."[271] Several witnesses commented on the large number of cardio-thoracic surgeons rendered obsolete by unanticipated technological changes, pointing out that problems of this type can be mitigated by developing a more flexible medical training system.[272] We consider some of the ways of increasing workforce flexibility below.

Skill mix changes and new and amended roles

182. The most concerted recent attempts to increase flexibility have involved changes to skill mix and the introduction of new and amended clinical roles.[273] The use of new and

267 Existing data sources that could be used to underpin productivity measures include Hospital Episode Statistics and the 'Better Care, Better Value' measures. More detail, including tools for measuring consultant productivity developed at York University, can be found in NHS Institute for Innovation and Improvement, *Delivering Quality and Value—Focus on: productivity and efficiency* (2006), pp.29–33.

268 Department of Health, *A Health Service of all the talents*, April 2000, p.5

269 Ev 219 (HC 1077–II)

270 Ev 261 (HC 171–II)

271 Q 189

272 See, for example, Q 44 and Q 583

273 See Chapters 2 and 3

amended roles allows changes to be made to the overall structure of the workforce, as we describe in the box below. The majority of new roles have been introduced at Assistant Practitioner level (for example, rehabilitation assistants or clinician's assistants) and at Advanced Practitioner level (for example, specialist nurses or Surgical Care Practitioners). Changes to existing roles have taken place across a range of staff groups, notably Health Care Assistants, who have developed new skills in nursing, physiotherapy and other areas.[274]

Ingredients for successful skill mix change

183. New and amended roles can have clear and measurable benefits. As Andrew Foster put it:

> It is cheaper for nurses to prescribe than doctors, and if you train a nurse to take on a significant amount of extra responsibility and pay them for taking on that extra responsibility, you have a win-win.[275]

However, as we discussed in Chapter 3, a number doubts were expressed about the effectiveness, and particularly the cost effectiveness, of work of this type. Professor Bonnie Sibbald stated that the introduction of new roles can result in "doubling the volume of service but not enhancing the efficiency of the service."[276]

184. We heard from a range of witnesses about what factors determine whether skill mix changes, such as the development of new and amended roles, are likely to be successful. The following points were most often highlighted:

- Skill mix changes are not ends in themselves and should have **clear and measurable goals** e.g. increasing productivity (for example by having specially trained workers to take blood from patients in order to allow doctors to concentrate on more complex tasks), addressing workforce shortages or improving quality;[277]
- Changes should either be justified by an existing **evidence base** or be fully evaluated (preferably quantitatively) to assess their effectiveness (for example, an evaluation of Emergency Care Practitioner (ECP) roles showed that £56,000 could be saved with the introduction of each ECP);[278] evaluation should not take place too early as skill mix changes can take some time to take full effect;[279]
- **Clinical involvement** in designing and implementing new and amended roles, rather than imposing them from the centre, improves the likelihood of success;[280]

274 Q314

275 Q 32

276 Q 395

277 Qq 393–4

278 Q 800

279 See Q 401 and Q 466

280 Q 421

- The impact of introducing new roles and extending roles on existing staff should be planned for; in particular, it is important that staff in new roles act as **substitutes not complements** and do not overlap with existing staff (as, for example, in the case of specialist nurses in primary care providing some similar services to GPs);[281]
- Planning for new and amended roles should **involve all interested parties** at an early stage, including employers, education providers and regulators where necessary;[282] and
- When new or amended roles have proven to be effective, there should be greater efforts to **disseminate** them across the health service.[283]

Department of Health review

185. Department of Health officials told the Committee that they plan to review the "100 or more" new and amended roles that have been introduced in recent years. Nic Greenfield, Director of Education, Regulation and Pay, explained that the review would aim,

> …to actually evaluate the business case to see, from the perspective of value for money, whether the patient experience and whether the benefit to the service overall has improved.[284]

What is meant by "increasing flexibility"?

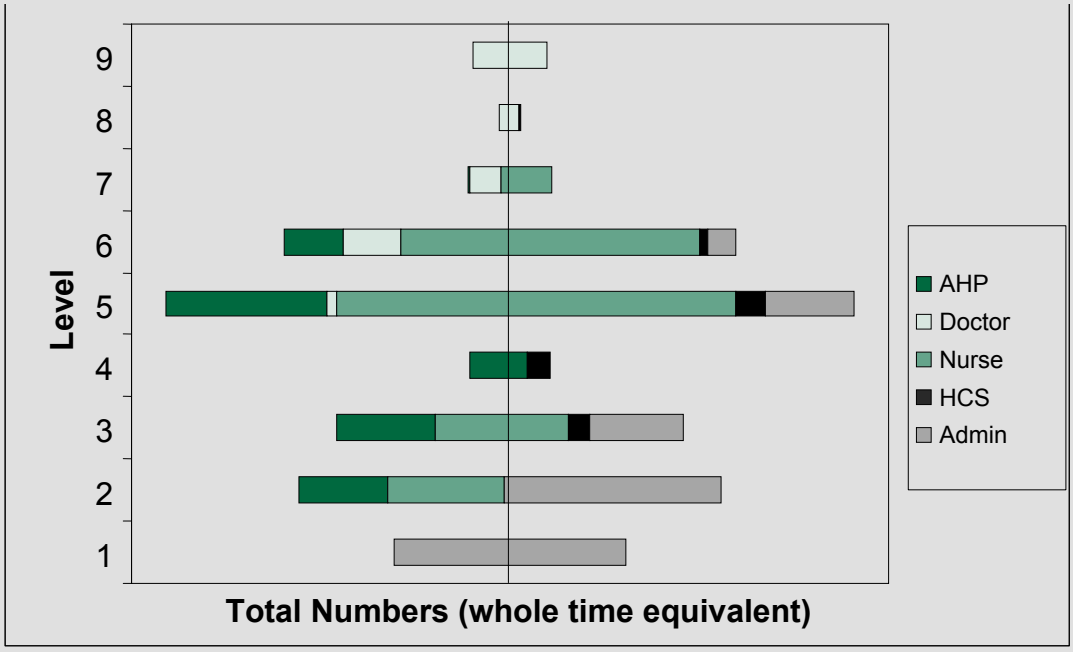
One way of defining 'flexibility' is by looking at the overall 'shape' of the workforce. For example, the diagram below (produced by the Department of Health and the NHS Workforce Review Team) shows the overall 'shape' of the health service workforce, defined by staff group and by nine different levels of seniority, which reflect the nine pay bands of the *Agenda for Change* agreement.

281 See Q 432 and Q 351

282 See Qq 529–531 and Ev 278 (HC 171–II)

283 See Q 466 and Q 803

284 Q 1046



There are very large number of staff at levels 5 and 6 (around the level of a staff nurse or junior doctor) but many fewer at levels 4 (the level of a rehabilitation assistant) and 7 (the level of a specialist nurse). Thus tasks which might be performed by a specialist nurse (level 7) will often be performed by a consultant or GP (level 9) because of the shortage of staff at levels 7 and 8. Similarly, a task which could be performed by a Health Care Assistants (levels 2-3) or an Assistant Practitioner (level 4) will often be performed by a staff nurse (level 5). It is because of these inefficiencies that the workforce can be described as 'inflexible'. It is also for this reason that many of the new roles which have been developed in recent years will fit in at levels 4 and 7 of the above diagram, thus filling current gaps and increasing workforce flexibility.

Achieving a more flexible workforce

186. Increasing the flexibility of the workforce is a complex task. This will require flexible funding and an education system geared to achieving the task. The use of competence frameworks is seen as an essential part of improving the education system.

Competence frameworks

187. One of the apparent success stories of recent years has been the development of 'competence frameworks' (which we describe in more detail in the box below); such frameworks support the development of new roles and allow workforce planners to look at total workforce requirements rather than at the needs of each profession in isolation. The importance of competences in supporting the move away from planning in professional 'silos' was emphasised by Peter Stansbie:

> … what we should use as the building blocks are the competences that people need to deliver the service that is required by the patient or the population…they are very

> powerful building blocks that will allow you to get a change to the way that you plan your workforce and then…a change to the way you deliver that workforce.[285]

188. John Sargent pointed out that the use of competences to define workforce requirements will make it easier to introduce new technologies, as in future "not all the work will be neatly parcelled up" within professional boundaries.[286] A more tangible example was provided by Nic Greenfield who argued that the use of competences would make it easier for staff to re-train in response to changes in workforce requirements.[287] Introducing flexibility of this type to the medical training system, for example, would help to prevent problems such as the current over-supply of cardio-thoracic surgeons.[288] There has been clear progress in the development of competences as the main currency for measuring workforce requirements through the *Knowledge and Skills Framework*, Modernising Medical Careers and the production of a range of national competence frameworks by Skills for Health.[289]

What is a "competence framework"?

"Competences" are descriptions of skills or qualities against which a staff member's performance can be assessed. They can be used to define the requirements for fulfilling a specific job (e.g. registered nurse) or for performing a specific task (e.g. managing a hospital ward). Because they perform both of these functions, competences can be used to translate the requirements for a particular service (e.g. a Minor Injuries Unit) into specific workforce requirements (e.g. three doctors and six nurses **or** one doctor, five nurses, three Health Care Assistants and one physiotherapist). As this example demonstrates, if service requirements are defined by competence, it may be possible to find several different workforce combinations which fulfil the requirements.

"Competence frameworks" list and categorise all of the different competences that may be required by a particular industry or organisation. For example, the new NHS **Knowledge and Skills Framework** (first published in October 2004) defines all of the competences that may be required by NHS staff (excluding doctors). There are 30 different competences ranging from 'Communication' to 'Assessment and Treatment Planning', all of which have four different levels. Each specific job in the NHS is defined by a particular combination of the 30 competences and four levels. Staff performance can be assessed against the competences relevant to their job and training needs identified. If information from individual appraisals is collated, training requirements across an organisation (or the entire NHS) can be identified. The use of a single competence framework means that there is a common language and currency for identifying and defining training requirements.

Other competence frameworks define the range of skills required to deliver a particular service, irrespective of the professional groups traditionally involved. For example, Skills for Health has produced frameworks for Children's Services and Mental Health.

285 Q 798

286 Q 713

287 Q1015

288 Q 583

289 See Qq 1015–6

Education and training provision

189. Competence frameworks do not represent an end in themselves and one of their main uses is to define future education and training requirements.[290] Unfortunately, the evidence we received suggested that the education system itself often represents a barrier to increasing workforce flexibility.[291] As we pointed out in Chapter 3, cuts to education and training funding have particularly targeted staff in new roles, specialist nurses for example, and groups such as Health Care Assistants seeking to upgrade their skills. Such cuts are worrying in themselves but also serve to highlight wider, systemic problems.

190. Witnesses suggested a number of changes which would allow the education system to support a more flexible workforce:

- Undergraduates should be more easily able to **transfer** between different training courses and the penalties for education providers who allow staff to transfer should be removed (a similar point was made with regard to postgraduate doctors);[292]
- More opportunities are needed for existing staff to **upgrade**, e.g. from Health Care Assistant to Assistant Practitioner or registered nurse, rather than all staff being trained from scratch;[293]
- Increased access to **part-time** training is required; particularly in nursing, for example, where the average age of a student is 29;[294]
- Closer links between **service requirements** and education commissioning are required so that the need for changes in training provision are recognised earlier, for example, so that the need to shift activity into primary care is quickly followed by increases in community nurse training places;[295] and
- **Funding** for education and training should be made more flexible so that innovative training opportunities are not automatically targeted by cuts (we discuss this in more detail in Chapter 5).

191. The Committee also heard that education and training requirements for some staff groups have become more academic and less vocational in recent years. Bill O'Neill described changes to training for paramedics:

> We traditionally provide our training in-house so it has not been associated with higher education…now with the standards of education that are set by the Health Professions Counsel, with the curriculum guidance published by the British

290 Q 798

291 Q 768

292 See Q 639 and Q 388

293 See Q 640 and Q 314

294 Q 314

295 Q 716

> Paramedic Association, we see ourselves in a far more higher education direction, which is right.[296]

Similarly, the number of nurses educated to degree rather than diploma level has increased in recent years.[297]

192. While they may be appropriate in particular cases, it is notable that the shift from vocational to academic training tends to reduce the flexibility of education and training provision and therefore of the workforce itself. Evidence from the Nursing and Midwifery Council highlighted the importance of maintaining a flexible approach to defining minimum professional standards.[298]

An increased focus on primary care

193. The Committee heard a good deal of evidence about the importance of improving the primary care workforce. Current health reform aims to increase the role of the primary and community care sector in the provision of services and to move towards a more preventative model of care. This approach is clearly outlined in the *Choosing Health* (2004) and *Our health, our care, our say* (2006) White Papers.[299] The latter, which includes a target to shift 5% of activity from acute to primary care, has particular implications for the distribution of health service staff. This was underlined by NHS Employers:

> "Our health, our care, our say"…sets out a new direction for NHS services which will require a shift of the NHS workforce into community settings as well as a range of other workforce changes such as an expansion of numbers of staff working in public health and new roles such as personal health trainers and care navigators… Most importantly it will require an increased focus on planning of the primary care workforce.[300]

194. A number of witnesses commented on the traditional lack of focus on the primary care workforce, relative in particular to the acute sector. Dr David Colin-Thome commented that "there basically has not been enough investment in primary care"[301] while Dr Graham Archard stated that "there is a very dramatic increase in workload in primary care, which is not being reflected in the increased workforce". The disparity between the acute and primary care sectors is also evident in changes in staff numbers: the number of hospital consultants rose by 37% between 1999 and 2005, while the number of GPs rose by only 17% over the same period.[302]

296 Q 471

297 See James Buchan and Ian Seccombe, *Past trends, future imperfect? A review of the UK nursing labour market in 2004 to 2005* (Royal College of Nursing, 2005), p.33

298 Ev 141–2 (HC 1077–II)

299 See Department of Health, *Choosing Health: Making healthy choices easier*, Cm 6374, November 2004, and *Our health, our care, our say: A new direction for community services*, Cm 6737, January 2006

300 Ev 126 (HC 1077–II)

301 Q 150

302 Health and Social Care Information Centre: *NHS Staff: 1995–2005*

Improving the primary care workforce

195. The Committee heard a number of different proposals for increasing the capacity and effectiveness of the primary care workforce. NHS Employers identified GPs and primary care specialist nurses as staff groups in need of immediate expansion.[303] Witnesses also underlined the need for staff to move between secondary and primary care and for the boundaries between the two settings to be blurred. Dr David Colin-Thome explained that:

> The other issue about more care out of hospital is that it will not all be done by primary care workers. What we are arguing about is that we need our hospital-trained staff, but working in different ways nearer the community…[304]

Professor Bonnie Sibbald predicted an increase in the number of GPs with specialist interests and specialist nurses working in primary care.[305]

196. The Committee heard that redundancies affecting clinical staff, the majority of which have occurred in the acute sector, could be mitigated by transferring staff to primary care. Josie Irwin of the RCN, commented that,

> We certainly welcome, for example, looking at ways in which we can encourage those who may be losing their jobs in the acute sector to re-train and for there to be a proper programme of transition to allow them to work in the community…[306]

197. In addition, we heard that new roles should increasingly be developed in 'intermediate care' working between hospital and community services, what one witness called the "primary care/secondary care interface".[307] An example of this was provided by Paul Holmes, who described the impact of community matrons, senior nurses who intensively manage the care of patients in the community with complex, long-term conditions:

> …one of our community matrons has 36 patients…on her caseload, and over the previous year those 36 patients accounted for 85 admissions. The average length of stay for each of those patients is ten days and that equates to 852 bed days. Over the period since they have been caring for that cohort of patients we have had no emergency admissions.[308]

The Department of Health subsequently stated that the work of community matrons in Kingston had saved £127,000 over six months.[309]

303 Ev 127 (HC 1077-II)

304 Q 151

305 Q 452

306 Q 191, see also Q 460

307 Q 472

308 Q 650

309 Ev 220 (HC 171–II)

Barriers and limitations

198. Unfortunately, the Committee also heard evidence of a number of barriers to the development of a more primary-care orientated workforce. Witnesses emphasised the lack of time spent in primary care by clinical staff during training.[310] Sian Thomas pointed out that the majority of staff continue to be trained in a hospital setting, even though the direction of policy will require an increasing proportion of staff to work in the community.[311]

199. Lack of exposure to primary care during training not only means that staff may lack the skills to work in primary care, but also that they may not wish to. As Dr David McKinlay, who has a long experience of educating GPs, pointed out, this represents a particular problem in the case of medicine:

> …there is still what has become known as the "hidden curriculum". Young doctors …are prejudiced against general practice…about a quarter of undergraduates think of general practice as a career, but the country needs half of them to be GPs.[312]

Dr McKinlay also stressed that there is a shortage of "learning environments" in primary care, such as classrooms, seminar rooms and other teaching facilities.[313] However, he acknowledged that recent pay increases had made it easier to recruit GPs to traditionally understaffed areas.[314]

200. More worryingly, the Committee heard clear evidence of a shortage of training opportunities for specialist nursing staff in primary care and that capacity has been further reduced as a result of recent cuts to education and training funding. The lack of infrastructure for training primary care nurses was described by Professor Jill Macleod Clark:

> ***Professor Macleod Clark*:** We know we need more nurse practitioners in general practice…There is no money… there is no career framework, there are no training posts.
>
> **Charlotte Atkins:** So the government's plans to move the focus from the acute sector into primary care…is completely undermined by this lack of funding of posts and career pathways within the primary care sector?
>
> ***Professor Macleod Clark*:** Absolutely, that is spot on…We had examples of SHAs…where there has been 100% reduction in the community nursing commissions this year at post-qualification level.[315]

310 See, for example, Q 150

311 Q 168

312 Q 655

313 Ev 139 (HC 1077–II)

314 Q 648

315 Qq 623–5

201. The Committee subsequently asked Lord Hunt for his comments on the shortage of opportunities for nurses in primary care. He described reports of reductions in training capacity as "disappointing".[316]

The public health workforce

202. We received alarming evidence of recent cuts to the public health workforce, another staff group with a crucial role in helping the health service move towards a more preventative model of care. A 2005 workforce survey by the Faculty of Public Health found that the number of public health consultants had fallen by 17% since 2003. The Faculty described the problem as "particularly acute in England" with only 36% of PCTs believing they have enough capacity for public health work.[317] Professor Selena Gray commented that the recent reduction in the number of PCTs and SHAs had led to a further loss of public health capacity as a number of senior staff have taken early retirement.[318]

203. As commissioners and providers of primary care services, PCTs have particular responsibility for leading the changes and addressing the concerns set out in this section. The new, larger PCTs, created as a result of the *Commissioning a patient led NHS* reforms, should have more capacity for workforce development. We discuss the role of the new PCTs in more detail in Chapter 5.

Management and leadership

204. The Committee received a considerable body of evidence about the importance of improving management skills across the health service workforce.[319] This will require both better managers and better management skills amongst clinicians. Witnesses stressed that "management" is not the exclusive responsibility of managers themselves, but should also be amongst the responsibilities of a range of other staff. As Sir Jonathan Michael pointed out,

> A ward sister is a manager because she runs a ward; a consultant is a manager because he manages his practice; and a general practitioner is a manager. Therefore, you are still separating out the definition of management in general and general management. I argue that we need to put them back together again.[320]

The management workforce

Number of managers

205. Much of the evidence we received focussed on the number of managers in the health service. As we observed in Chapter 2, the number of NHS managers increased by 62% between 1999 and 2005. However, this figure may give a misleading impression since the

316 Q 1052

317 Ev 281 (HC 171–II)

318 Q 667

319 See, for example, Ev 239 (HC 171–II), Ev 200 (1077–II) and Q 850

320 Q 851

majority of additional managers were employed in PCTs following their creation in 2001.[321] Department of Health officials told the Committee that the rapid rise in the number of managers in PCTs is now being reversed as a result of the *Commissioning a patient-led NHS* reforms. Andrew Foster explained that £250 million per year would be saved by reducing the number of managers in PCTs and SHAs.[322] He commented that such change was necessary because "the size of unit which is typically commissioning care in primary care, the PCT, has been too small".[323] Sian Thomas of NHS Employers commented with regard to recent redundancies and post reductions that "Many of the posts are managerial posts, and that is only right."[324]

206. Other witnesses presented a different view, arguing that managers tend to be soft targets when cuts are required. Mike Sobanja, for example, described the growth in the number of managers in PCTs as "desirable and laudable".[325] A written submission from Leicestershire, Northamptonshire and Rutland Healthcare Deanery argued that:

> With managerial staff it is clear they are often seen as an expendable group as each new change hits the NHS. This loss of expertise is devastating and should be halted.[326]

As well as disrupting and reducing the management workforce, recent reorganisations have affected workforce planning itself, as we observed in Chapter 3.

Effectiveness of managers

207. More important than the number of managers, however, is their quality. We heard serious concerns about variability in the quality of managers, although a number of witnesses argued that it is difficult to assess their effectiveness, particularly because there are no formal training, assessment or development requirements for managers.[327] Mike Sobanja summarised this view, stating that:

> I think that your diagnosis…is absolutely right: we do not know how well management in the NHS is doing.[328]

208. Witnesses did suggest, however, that the effectiveness of managers could be assessed in part by looking at the overall success of organisations in meeting targets and complying with Healthcare Commission standards.[329] Lord Hunt agreed that assessing the quality of the management workforce is a difficult task and acknowledged the variation in standards:

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321 Information supplied by the Department of Health showed that the number of managers in PCTs rose by 11,200 between 2001 and 2005 while the number of non-PCT managers rose by only 800, Ev 190 (HC 171–II)

322 Q 8

323 Q 22

324 Q 196

325 Q 844

326 Ev 114 (HC 1077–II)

327 See Q 849, although it was also pointed out that most NHS organisations have local arrangement for management training and development.

328 Q 850

329 See Q 848 and Q 850

> I think that there is clearly a capability issue about whether all our managers have the capability and the skills needed…It is very easy to knock managers in the Health Service but they have a hell of a difficult job to do. Many of them are absolutely brilliant…but there is clearly a variation in quality.[330]

209. The Committee heard a number of different suggestions for improving the quality of managers. The following points were amongst those raised:

- The NHS is **under-managed but over-administered**; there is a need for managers to focus more on strategic problem-solving rather than bureaucracy and chasing government targets;[331]
- NHS organisations should do more to **recruit** high calibre managers, recruiting from the private sector if necessary;[332]
- The "ad hoc" systems for **continuous professional development** for managers is a major source of variation in quality and should be addressed;[333]
- Managers need to develop improved **quantitative and commercial skills** such as contracting, negotiating, risk management and project management;[334]
- Managers should make better use of **data and information** such as Hospital Episode Statistics; many managers do not have the skills to use information effectively;[335]
- The **high turnover rate** amongst managers, particularly Chief Executives (who stay in post for an average of only 2.5 years), should be addressed as this causes disruption and damages relationships between managers and clinicians;[336] and
- Managers need improved skills in **workforce planning** itself and need to give greater priority to education and training requirements.[337]

That witnesses put such emphasis on the need for wide-ranging improvements is indicative of the current shortage of managers with adequate skills.

Clinicians and management

210. Witnesses consistently highlighted the importance of increasing the involvement of clinicians in management, both by encouraging more clinicians to move into general management roles and by improving the skills of clinicians who have management responsibilities within their existing roles. Sir Jonathan Michael, one of the few health

330 Q 1057

331 Q 840

332 Q 885

333 See Qq 836–7 and Q 884

334 Q 885

335 Q 359

336 See Q 1057 and Q 834

337 See Ev 135 (HC 171–II) and Ev 15 (HC 1077–II)

service Chief Executives from a medical background, stressed that increased clinical involvement in management would help to break down existing barriers between managers and clinicians:

> My solution…is to involve clinicians in management much more thoroughly and move towards an integrated unitary management structure where clinicians have not only clinical responsibility but responsibility for the management of the service within a defined resource.[338]

211. The Committee heard that increasing clinical involvement in the management of services would help attempts to improve productivity and to introduce skill mix changes. Lord Hunt agreed that more clinicians should move into senior management roles, stating that:

> I am convinced that alongside the excellent lay managers we have got to encourage more clinicians into senior leadership and managerial positions, and I am sure that that is the way to get greater ownership amongst clinicians for changes.[339]

Supporting clinicians in management roles

212. Importantly, the Council of Heads of Dental Schools warned against assuming that clinicians are automatically suitable to take on management responsibility. The Council concluded that:

> Clinicians are best at clinical work. A few may have the flair for management but it is wasteful to put too many clinicians into management roles.[340]

213. This point was partially supported by Sir Jonathan Michael, who warned that clinicians moving into senior management positions required effective training and support. He described his own early experiences as a Chief Executive as "like learning to swim by being thrown into the deep end".[341] A number of witnesses pointed out the role of the NHS Institute for Innovation and Improvement's *Enhancing Engagement in Medical Leadership* scheme in developing management skills amongst doctors and preparing them for leadership roles.[342]

214. The need for a larger management component within clinical training was also raised on several occasions. Dame Carol Black argued that management training should play a bigger role in medical training.[343] Mr Bernard Ribeiro, President of the Royal College of Surgeons, also commented that consultants will need to take on more specialist roles in future and argued that some should specialise in management.[344] Paul Streets of the

338 Q 833

339 Q 1057

340 Ev 83 (HC 1077–II)

341 Q 857

342 See Q 575 and Q 267

343 See Q 376 and Q 856 respectively

344 Q 569

Postgraduate Medical Education and Training Board described current work to develop consultant roles with specific management expertise:

> …there needs to be the opportunity for people to pursue medical management as a speciality…and also potentially the opportunity for doctors to take time out to do, for example, an MBA.[345]

Conclusions

215. **Future workforce requirements are very difficult to predict; for this reason, increasing the flexibility of the workforce is an important priority. In spite of the difficulties in predicting future requirements, it is clear that the workforce must become more productive, particularly since there is likely to be less extra funding available in future. There is also a clear need to increase the size and quality of the primary care workforce and to improve the standard of management across the whole workforce.**

216. **Increasing workforce productivity is a difficult goal and reliable information is vital to achieving it. In the past, although a great deal of data has been collected by the NHS, information directly relevant to productivity has been either lacking or not used sufficiently. The recently introduced *Better Care, Better Value* indicators are a good source of information about comparative productivity, although they should be improved, for example by adjusting for case mix.**

217. **Effective use of the Knowledge and Skills Framework (KSF) has great potential to improve staff productivity. The KSF can improve access to relevant education and training, and support amended roles which will allow staff to develop the skills required to increase flexibility and efficiency. However, there is little evidence that these opportunities are yet being taken. NHS organisations must make wider use of the KSF to prioritise training requirements and to offer training to staff groups, such as Health Care Assistants, that have too often been denied it in the past. In particular, the health service must do everything possible to ensure that such training opportunities are protected from short-term budget cuts. Human Resources department should ensure that the KSF becomes a fundamental tool for staff management and development.**

218. **Despite its high, and arguably excessive, cost to the health service, the new GP contract has potential to improve future productivity. The Quality and Outcomes Framework (QOF) should be used to negotiate more exacting targets for improving standards. The government should consider allowing some QOF targets to be negotiated at a local level in order to address specific local priorities. PCTs should maintain or improve the standard of the auditing of QOF returns wherever possible.**

219. **The new consultant contract has been expensive and time-consuming to implement and its impact so far on productivity has been minimal. Yet this is largely because implementation was rushed and most employers have therefore struggled to get to grips with the job planning and objective setting processes. Employers must use these processes to challenge traditional working patterns and practices, and to**

345 Q 575

negotiate and monitor demanding performance objectives with consultants. Medical Directors should play a central role in negotiating objectives and the effectiveness of objective setting should be scrutinised by Trust Boards. Failure to meet agreed objectives must constrain or limit pay progression not only for medical staff but also for the responsible Medical Director. It is only through agreeing rigorous and detailed objectives that employers will derive benefits from the consultant contract which correspond with the significant pay increases it has brought.

220. **There is a clear need to develop consistent criteria for measuring clinical productivity which would make it much easier for local organisations to negotiate meaningful performance objectives for consultants. Different specialties and disease areas will require different measures: in some cases, activity measures are a good reflection of productivity; in others, measuring outcomes is more appropriate. To this end, we recommend that NHS Employers and the NHS Institute for Innovation and Improvement work with the relevant Royal Colleges to agree standard productivity measures for each hospital specialty. Wherever possible, productivity measures should be based on existing data sources such as Hospital Episode Statistics or the *Better Care, Better Value* indicators.**

221. **Increasing workforce flexibility should be another of the main future priorities for workforce planning and development. Increasing flexibility will support efforts to improve productivity and allow the workforce to adapt more quickly to changing service demands. Using staff in new and amended roles is an important way to increase flexibility. The Committee is pleased to hear that the Department intends to review the many new roles that have been introduced and to assess their cost effectiveness, particularly as such evaluation had often been lacking or limited in the past. This review should be based on hard evidence rather than opinion; but skill mix changes should be given enough time, and done on a large enough scale, to take effect before they are reviewed. Where new roles are shown to be effective, they must be quickly disseminated across the health service. However, it is equally important that ineffective roles are rejected and that staff in new roles do not duplicate the work of existing staff.**

222. **Increasing flexibility will require a more adaptable training system which is able to respond quickly to changing requirements. The use of competence frameworks is an important element of this. However, the health service must also be quicker to change the pattern of training commissioning in response to service demands. SHAs need to do more to protect new and innovative training courses from budget cuts. Education and training provision itself must be made more flexible with more opportunities for staff to transfer between courses and more part-time courses. Rather than training all staff from scratch, more opportunities are required for groups such as Health Care Assistants to upgrade their skills and take on more challenging responsibilities.**

223. **The balance of the health service workforce must be shifted significantly towards primary care if the government's future ambitions are to be realised. Basic clinical training should involve more time in primary care. Most importantly, the health service needs to develop ways for staff to move from secondary to primary care and to work between the two sectors. Unfortunately, progress to date on achieving these aims has been limited and appears to be further threatened by recent training cuts. The public health workforce has been particularly badly affected. If the shift of 5% of**

activity out of hospitals and the adoption of a more preventative model of healthcare are to be achieved, then far more needs to be done to ensure that the primary care workforce is able to support these developments. The new PCTs should take particular responsibility for this change although there is little evidence that they are currently equipped to do so.

224. **Managers are a crucial component of the health service workforce; their importance is too often overlooked and their role has been undermined by the continual reorganisations of recent years. However, the quality of managers is highly variable and the absence of minimum standards or training requirements is a concern. NHS organisations need to recruit managers of a high calibre. They should ensure that all managers are appraised and have access to relevant training; improving quantitative and workforce planning skills should be a particular priority.**

225. **The Committee welcomes the Minister's acknowledgment that the contribution of clinicians to managing health services needs to be made more effective. This means both improving their ability to carry out everyday management tasks within their existing roles, and encouraging more clinicians to transfer into general management roles with the potential to become a Chief Executive. Clinicians need appropriate training and support if they are to take on more management responsibility. Clinical training should contain a larger management component and senior clinical roles with a management specialism should be developed, particularly for medical staff. More senior clinical staff should be trained and assisted to take on general management roles, particularly at Board level.**

5 The future workforce planning system

Introduction

226. We saw in Chapter 3 that there are serious problems with the current workforce planning system, most importantly the lack of integration between different parts of the system and the lack of people, systems and skills to do the job effectively. In Chapter 4 we pointed out the need for significant changes to the structure and make-up of the workforce in order to meet future demand. Such changes will not be achieved unless the workforce planning system itself is improved and unless the shortcomings we have highlighted are addressed. In this chapter we consider how to improve the workforce planning system.

227. The value of workforce planning is often overlooked, in part because it tends to be viewed as an abstract number-crunching process, remote from (particularly financial) reality.[346] Such a narrow and limited form of planning would indeed be of little value. However, workforce planning should in fact be the key means for the health service to understand and anticipate the impact of demographic, technological and policy trends on future service requirements. Responding earlier and more effectively to such trends is vital to ensuring the long-term sustainability of the health service. Thus workforce planning, in its broader sense, is a crucial activity which must be done properly in order to avoid future boom and bust in staff and training numbers, and in order to improve the productivity of the health service.

228. Because of the complexity of workforce planning and of the health service itself, there is no single or easy solution for improving the planning system. As Phil Gray put it,

> We recognise that workforce planning is not easy, and I have been involved in the system long enough not to pretend that it ever is a simple magic formula.[347]

Instead, improving workforce planning will require a range of steady changes by a number of different organisations. Essentially, this is about ensuring that people and systems do their job well. In particular, we examine the need for improvements in the following areas:

- Improving the **long-term, strategic** elements of workforce planning;
- Making the workforce planning system more **aligned and integrated**;
- Improving particular aspects of the **education and training** system; and
- Maximising the effectiveness of organisations at each level of the workforce planning system (Strategic Health Authorities, Primary Care Trusts, employers, the education sector and the Department of Health) and the linkages between them.

346 See, for example, Ev 277 (HC 171–II)

347 Q 918

Improving strategic, long-term planning

Introduction

229. One of the most important challenges facing the workforce planning system is to improve the long-term, strategic element of planning, something which has often been badly neglected.[348] **Long-term planning** is important because some of the changes to the shape and structure of the workforce identified in Chapter 4 cannot be achieved in one year or even three years; instead they require plans to cover the next five to ten years and beyond. In the past, long-term planning has been undermined by lack of suitable tools and mechanisms,[349] persistent organisational changes,[350] and the short-sighted pursuit of financial savings.[351]

230. **Strategic planning** is important because of the sheer complexity involved in changing the health service workforce: a range of interlocking and overlapping problems require a similar range of interacting solutions. This has not always been done well in the past. As we saw in Chapter 2, for example, the rapid expansion of the workforce after 1999 was achieved mainly through a combination of increased international recruitment and increased UK training capacity. However, international recruitment expanded so quickly that there was a shortage of opportunities for UK-trained staff once output increased after 2004.[352] There was a clear lack of alignment between the two approaches to increasing staff numbers. It is vital that the health service becomes more adept at understanding sets of problems and solutions rather than considering each one in isolation. This is what we mean by taking a more strategic approach to workforce planning.

Planning mechanisms

231. Improving long-term, strategic planning requires appropriate mechanisms to support the planning process itself. It is clear, for example, that the current 3-year Local Delivery Plan (LDP) cycle does not represent a suitable mechanism for incorporating the long-term element of workforce planning.[353] SHAs need to think carefully about how to supplement or reinforce the LDP process so that it is possible to produce workforce plans stretching at least 5–10 years ahead.[354]

Analysing demand and supply

232. More importantly, effective long-term, strategic planning requires accurate analysis of future workforce demand and supply. Witnesses stressed that analysis of **future demand** must consider the impact of a wider range of information, including the following:

348 See chapter 3

349 Ev 235 (HC 1077–II)

350 Ev 278 (HC 171–II)

351 Q 606

352 See, for example, Q 925 and Ev 278 (HC 171–II)

353 Ev 235 (HC 1077–II)

354 See, for example, Qq 749–752

- **Demographic** trends, for example the impact of the ageing of the UK population on future demand for health and social care services;[355]
- Changes in **technology**, for example the increasing use of robotic surgical techniques which will affect medical training numbers and operating theatre staffing requirements;[356]
- **Social** trends, such as the continuing rise in obesity rates, which will have implications for the public health and primary care workforces;
- Key **policy changes and central targets**, such as the 18-week hospital treatment pathway, which will require a short-term increase in surgical workforce capacity in order to reduce waiting lists and a long-term increase in information support staff in order to monitor patient journeys; and
- The **combined impact** of all of the factors described above.

233. Assumptions about **future supply** of health service staff have in particular tended to consider different problems and initiatives in isolation. Witnesses proposed that analysis should focus particularly on the following areas:

- **Demographic** trends, for example the impact of future retirement patterns (described by one witness as a "time-bomb" and by another as a "red herring");[357]
- **Legal changes**, such as the 2009 European Working Time Directive regulations (whereby junior doctors can work a maximum of 48 hours per week), which one witness estimated would cause her hospital to lose 3,000 hours of junior doctor time per week by 2009;[358]
- Changes to the **UK labour market**, for example as a result of the increasing number of people entering higher education; such information can be obtained from Labour Market Intelligence and other sources;[359]
- Changes to the **international labour market**, for example the likely growth in the number of doctors and other healthcare professionals imported by countries such as Australia and the US;[360] and
- The **combined impact** of all of the factors described above.

We discuss below how information about supply and demand should be collected, challenged and analysed.

234. The areas of focus suggested above are by no means comprehensive which demonstrates the scale and complexity of the analytical work which is needed to underpin

355 Ev 100–102 (HC 1077–II)

356 Ev 199 (HC 1077–II)

357 See Q 647 (referring specifically to GP retirement patterns) and Ev 18 (HC 1077–II) respectively

358 Q 446

359 For more information on Labour Market Intelligence, see Ev 53–58 (HC 1077–II)

360 Q 269

effective long-term planning. This is turn shows how hard it is to forecast workforce supply and demand accurately in healthcare, particularly given the long lead times from training plan to fully trained clinician. As a result, steps must be taken to increase flexibility to change workforce skills quickly. As we described in Chapter 4, such change can be achieved by the use of 'competence-based' approaches in all training, which recognise basic and progressive levels of skills and enable staff to acquire skills for new tasks in a shorter period of time.

Conclusions and recommendations

235. **Ensuring that the health service is able to respond to future service demands will require a reformed and improved workforce planning system. Workforce planning has been badly hampered by the absence of effective long-term planning and the failure to take account of the complexity of the strategic 'big picture'. Long-term planning is important because changing the structure and make-up of the workforce takes a long time, particularly in healthcare where workers take up to 15 years to train. Strategic planning is important because the complexity of workforce supply and demand mean that a lazy or over-simplistic approach to change can have serious negative consequences, as shown by current job reductions and graduate unemployment.**

236. **Some of the current mechanisms for workforce planning, such as the 3-year Local Delivery Plan cycle, do not support a long-term approach and this should be addressed by SHAs and the Department of Health as a matter of priority. Improved planning systems, however, are useless without good quality information to support them. In the past, analysis of workforce supply and demand has tended to be limited and has failed to concern itself with wider developments such as future demographic and technological changes. In future it needs to take account of a much wider range of factors, including demographic, technological and policy trends and the interaction between them. Adopting a genuinely long-term and strategic approach to workforce planning will allow planners to anticipate the need for change rather than constantly responding to it, something which is key to the sustainability of the health service.**

Making workforce planning more integrated

Introduction

237. Improving workforce planning will require the health service and the Department of Health to bridge divisions which exist between professions, organisations and functions.[361] The persistence of such divisions shows how difficult it is to achieve properly integrated planning but bridging them must be a fundamental goal of improving the workforce planning system.

Workforce, financial and service planning

238. Perhaps the most serious division that we heard about is the continuing disjunction between **workforce planning, financial planning and service planning.** Improving

361 See Chapter 3

integration between workforce, financial and service planning, described in one submission as the "Holy Grail" for the planning system, must be a major priority.[362] The following improvements were suggested by witnesses:

- Better alignment of **planning cycles** so that workforce, financial and service planning do not take place at different times of year, and particularly so that short-term financial plans cannot disregard workforce issues, and long-term workforce plans cannot disregard financial issues;[363]
- Closer working between people working in **Finance and Human Resources** departments in all organisations, bringing together the expertise of both distinct functions to inform overall service planning;[364]
- Improved **forecasting** of workforce supply and demand and of future funding levels;[365]
- Improved skills for workforce planners in understanding the **costs and benefits of workforce developments,** such as skill mix changes, which will allow organisations to become more adept at increasing productivity rather than simply employing additional staff in response to changes in demand;[366] and
- Better **oversight** of provider organisations by SHAs (or Monitor, the Foundation Trust regulator, in the case of Foundation Trusts), so that the alignment of workforce and financial planning is properly examined and challenged and so that organisations do not recruit staff that they cannot afford to pay.[367]

The use of financial incentives

239. Increasing and improving the use of financial incentives to influence workforce behaviour is another important element of bringing together workforce and financial planning and management. We saw in Chapters 3 and 4 that increasing workforce productivity is a vital goal which was badly neglected during the period of rapid recent expansion. If productivity is to be improved, incentives systems such as the QOF and consultant job planning need to be better exploited.[368]

240. Commissioners should also use contract negotiation to create incentives for providers to increase productivity, focussing on improving patient outcomes rather than just increasing activity levels.[369] The *Better Care, Better Value* indicators (which we described in Chapter 4) provide a good source of information to support the creation of measurable

362 Ev 132 (HC 1077–II)

363 See, for example, Q 387

364 Q 383

365 Q 973

366 See Q 346 for an example of the tendency to employ extra staff rather than attempting to increase efficiency, in this case in response to the 2004 European Working Time Directive changes.

367 See Qq 53–60 for an example of previous shortcomings in this area.

368 See Q 668 and Q 73 respectively.

369 See Q 380 for more information on measuring health outcomes.

incentives to increase productivity,[370] for example by reducing staff turnover or increasing day surgery rates.[371] Without improved use of financial incentives, the alignment of workforce and financial planning is likely to remain limited or tokenistic.

Planning across different staff groups

241. Another serious and long-standing problem has been the failure to plan for **overall workforce requirements** rather than just looking at the needs of each professional group in isolation.[372] This process is complicated by the different features of planning for different professions, for example variations in training times and in the distribution of staff between the public and independent sectors. However, if productivity and flexibility are to be improved, it is vital that workforce planners bridge these stubborn and persistent divides, particularly that between planning for the medical workforce and for other staff groups. Witnesses suggested that the following improvements should take particular priority:

- Increasing the role of **SHAs in medical workforce planning** by giving them a greater say in the content of training and control over the number of medical students, Foundation trainees and Speciality and GP trainees in their area;[373] SHAs also need to work together to ensure appropriate national distribution of medical staff and trainees.

- Ensuring that there is flexibility for **education and training funding** to be moved between medical and non-medical spending;[374]

- Increasing the flexibility of **education and training provision**, for example by allowing students to move between different courses (this is covered in more detail in Chapter 4);

- Ensuring that **analysis of future supply and demand**, by the Workforce Review Team at national level and by SHAs at regional level, takes account of requirements for the whole workforce rather than looking at each professional group in isolation;[375] and

- Measuring required **competences**, rather than simply counting the number of doctors and nurses traditionally needed, in order to assess future workforce

370 Q 891

371 See www.productivity.nhs.uk for more information about the 'Better Care, Better Value' indicators.

372 See Ev 258 (HC 171–II) and chapter 3

373 Q 736

374 The Committee received contradictory evidence on this point. SHA representatives stated that MPET is received in "pre-determined packets" with no freedom to move money between the non-medical (NMET) and medical (MADEL and SIFT) streams (Q 698). Department of Health officials commented that in theory there is "complete freedom" to move funding between the different streams but acknowledged that in reality there is limited scope to do so (Q 1012).

375 One witness commented that the Workforce Review Team's advice "is all predicated on continuing to train people in the same professions that there have been for many years." (Q 783)

requirements, so that a range of responses to future service demands are available.[376]

242. Professional roles and standards continue to be vital to the functioning of the health service, but there is a growing need to acknowledge the limitations of defining the workforce simply as a series of professional groups or 'silos'.[377] As John Sargent put it,

> …the competences that are inherent in particular staff groups historically are not God-given. Each of the professions has been invented by Society to meet particular needs in a particular way at a particular time.[378]

Planning across NHS and non-NHS organisations

243. Another area where improved integration is required is in planning **across the whole health service** and bridging the divide between NHS and non-NHS organisations, something which remains a serious problem.[379] This will be an increasingly important priority as the proportion of NHS services provided by non-NHS organisations increases.[380] The following changes were suggested to support improvements in this area:

- Improvements to the quality and consistency of **workforce information** from non-NHS organisations, for example by providing data to SHAs in a standardised form;[381]
- Increased involvement by non-NHS organisations in workforce planning and decision-making, particularly at SHA level, which has been lacking in the past;[382]
- Increasing the use of non-NHS organisations to provide **education and training** and developing integrated training pathways between NHS and non-NHS organisations;[383] and
- Ensuring, wherever, possible that there is **free movement of staff** between NHS and non-NHS organisations, for example by further relaxing 'additionality' rules for Independent Sector Treatment Centres so that only staff groups where the NHS has a serious, long-term shortage are covered.[384]

376 Ev 219 (HC 1077–II)

377 Q 798

378 Ev 278 (HC 171–II)

379 See chapter 3

380 See *Public Expenditure on Health and Personal Social Services 2006*, HC 1692–i, Ev 95, for evidence of the increasing use of non-NHS providers.

381 Qq 819–820

382 Ev 132 (HC 1077–II)

383 Q 821–823

384 Q 807

Involving clinicians

244. A final improvement which will help to create a more integrated workforce planning system is to increase the level of **clinical engagement and involvement** in all areas of workforce planning and development and particularly within provider organisations. We heard evidence of the need for increased clinical involvement in a range of contexts, including the design and implementation of skill mix changes, improving the quality of productivity information and managing the health service.[385] Deborah O'Dea, Director of Human Resources at St Mary's NHS Trust, summarised the importance of engaging clinicians in workforce development activities:

> At the coalface, I think clinicians have always been involved where projects have been successful. When they are not involved, projects are not.[386]

Increasing clinical involvement should therefore be a particular priority within attempts to create a more integrated planning system.

Conclusions and recommendations

245. **Workforce planning has too often been a series of isolated decisions and initiatives rather an integrated process. A number of changes are required to improve integration: most importantly, workforce planning, financial planning and service planning must be more closely aligned in all NHS organisations. This will require closer working between staff in Finance and Human Resources departments and more accurate, joint forecasting of future supply and demand. It is important that there is proper oversight across the system; the work of local organisations should be scrutinised by SHAs, the work of Foundation Trusts by Monitor and the work of SHAs by the Department of Health. The planning system should also pay much greater attention to the use of financial incentives, such as the Quality and Outcomes Framework, to increase workforce productivity, focussing wherever possible on improving health outcomes.**

246. **Planning must cover the whole workforce rather than looking at each staff group as a separate 'silo'. The persistent divide between medical and non-medical workforce planning must be addressed; SHAs currently pay for postgraduate medical training so in future they must have much more influence on training numbers and content. The Department should make clear to SHAs that money can be transferred between medical and non-medical training pots; there is currently confusion over whether this is the case. Analytical work by SHAs and the Workforce Review Team should focus on total workforce requirements rather than examining each profession and sub-discipline in isolation. The use of competences to measure overall workforce requirements will help to support this approach.**

247. **Workforce planning should take account of the requirements of the whole health service rather than looking exclusively at the NHS. Private and voluntary sector organisations should be more involved in planning at local and regional level and standardised workforce data should be available from non-NHS organisations. Free**

385 See Q 421, Q 367 and Q 856 respectively

386 Q 421

movement of staff between sectors should be permitted, expect in the case of staff groups where the NHS has serious and persistent shortages. The private and voluntary sector should increasingly be used to provide education and training and integrated training courses should be developed between NHS and non-NHS organisations. Attempts to create a more integrated planning system must be supported by increased clinical involvement, so that workforce planning and development are not regarded as back office, managerial tasks.

Improving education and training

248. Many of the improvements to the workforce described in Chapter 4 can only be achieved through changes to the education and training system. However, it is important to recognise that high-quality, flexible education and training is not an end in itself, but rather the principal means of realising workforce plans and making changes and improvements to the workforce. As Anne Rainsberry commented,

> …there is a real issue…about bringing together workforce planning for all groups, and, aligned with that, the way in which we manage commissioning of education and training. The point I would make on that is that we need a paradigm shift in that we are commissioning a workforce. We are not commissioning education *per se*.[387]

Supply and demand

249. Unfortunately, many of the problems in the education system continue to relate to mismatch between **supply and demand**, as demonstrated by recent cuts to undergraduate training commissions and high levels of unemployment amongst nursing and physiotherapy graduates.[388] Concerns have also been expressed about capacity within the new Modernising Medical Careers scheme,[389] with some witnesses predicting future unemployment amongst UK medical graduates.[390] These are serious and fundamental problems: high levels of unemployment among newly qualified staff in particular represent a regrettable waste of resources and talent.

250. The Committee heard two main suggestions for improving the stability of the education system in response to these problems: **removing commissioning responsibilities from SHAs** and **guaranteeing jobs for newly qualified staff**. We consider these proposals below.

SHA responsibilities

251. Representatives of the higher education sector suggested that responsibility for commissioning non-medical training places should be removed from SHAs and passed to the **Higher Education Funding Council for England** (HEFCE), which currently

387 Q 740

388 See Chapters 2 and 3

389 See Ev 221–222 (HC 171–II)

390 Ev 258 (HC 171–II)

commissions medical student places.[391] It was suggested that HEFCE would be more effective than SHAs at protecting education and training funding from short-term budget cuts.[392] However, other witnesses pointed out that moving responsibility away from SHAs would make it much more difficult to integrate workforce planning with service and financial planning and make it harder for NHS organisations to influence future workforce supply. Increasing workforce flexibility would also be more difficult if SHAs were to lose control of education commissioning.[393] **Given the central importance of ensuring a more integrated planning system and increasing workforce flexibility, we recommend that SHAs should retain responsibility for commissioning undergraduate training courses for non-medical staff.**

Newly qualified staff

252. Another suggestion, made by representatives of professional membership groups, was that newly qualified UK-trained healthcare staff should have **a fixed period of guaranteed employment** in the NHS. It was suggested that this would resolve the current problem of high levels of graduate unemployment and increase the stability of the training system.[394] It would also encourage employers to become more involved in decisions about education and training, thus improving the integration of the planning system. On the other hand, there is a risk that guaranteeing jobs for graduates would reduce the flexibility of workforce planning as employers would have no choice about the number of new staff recruited each year.[395] Also, given the sheer scale of the current problems affecting physiotherapy, for example,[396] it is hard to imagine that some shortages would not occur in one or two years time if jobs were guaranteed for this period. **There would be advantages and disadvantages in guaranteeing a fixed period of employment for newly trained staff; however, such a strategy has potential to improve the integration of the planning system and ensure that a cohort of graduates trained at the public's expense is not lost to the NHS. We recommend that its implications be examined in more depth.**

Commissioning and contracts

253. A number of other possible changes to the education and training system were proposed. A particular requirement was for SHAs to improve the quality of **education and training commissioning**.[397] SHAs need to give greater priority to the commissioning process and to ensure that they have staff with the skills and experience for effective commissioning.[398] They need staff who can work consistently with education and training providers to develop more flexible courses and to encourage new providers to offer

391 Q 618 and Qq 630–631

392 Q 612

393 Q 744–745

394 See, for example, Q 921

395 Q 976

396 Ev 293 (HC 171–II)

397 Q 716

398 Q 314

training places.[399] SHAs also need staff with contract management skills who can ensure that good value for money is achieved once contracts are agreed. The Government has indicated that it intends to introduce "a more robust service-level agreement between the Department and SHAs" in order to improve the standard of education commissioning.[400]

254. Improved commissioning will allow SHAs to make the most of changes to **education contracts** themselves. In order to increase flexibility and improve the alignment of financial incentives within the education system, the following changes to contracts were proposed:

- Education and training contracts need to be simplified, particularly through the development of **standard prices** for different types of training activity.[401] This would effectively create a 'tariff' for training provision to match the existing tariff for service provision. Such a tariff would make the cost of training more transparent and allow organisations that do not currently provide training to assess the costs and benefits of doing so;[402]

- Commissioners also need to ensure that contracts are more **flexible** and that particular types of training activity are not disproportionately vulnerable to cuts.[403] In the recent round of training cuts, for example, community nursing courses were often more heavily cut than general nursing courses because legal obligations limited reductions in general nursing places.[404] In future, legal distinctions of this type should wherever possible be removed so that changes to training numbers reflect future service requirements rather than contractual obligations; and

- Contracts should support and encourage a flexible, competence-based approach to the provision of education, something which we described in Chapter 4.

Student financial support

255. The Committee also heard proposals for changes to **student funding**. Both current levels of funding and systems for distributing funding were heavily criticised.[405] Louise Silverton of the Royal College of Midwives agreed with the suggestion that some healthcare students should have access to loans instead of bursaries which would be repaid automatically if graduates went on to work in the NHS for a specific period of time. There are international examples of loan repayment schemes linked to required periods of public sector employment, for example in the US.[406] The introduction of such a system would mean that students could receive more money, something which would in turn reduce

399 Q 748

400 HC Deb, 20 February 2007, Col 64WH

401 Q 1009

402 Q 763

403 See Q 768 for an example of this problem

404 See, for example, Ev 268 (HC 171–II)

405 See Q 951 and Ev 256 (HC 171–II) respectively—the National Union of Students also predicted that the cost to the NHS of supporting healthcare students will increase by £162 million per year by 2009 because of increases to tuition fees.

406 See bhpr.hrsa.gov/dsa for more details.

attrition rates.[407] It would also provide an incentive for graduates to remain within the NHS, something which could be supported by the fixed-term employment guarantees discussed above. However, such a scheme would require a short-term increase in public expenditure to finance initial loans.

Academic staff

256. Finally, the Committee heard worrying evidence, from both the medical and non-medical education sector, of recent reductions in the number of **clinical educators**.[408] One witness described current entry routes into academic posts as "serendipitous" and proposed that better career pathways should be established so that junior staff have a clear understanding of how to get the skills and experience required for an educational role.[409] Like workforce planners themselves, clinical educators are vital to the future functioning of the workforce planning system. As one witness put it,

> …without a well founded educator workforce the next generation of professionals cannot succeed.[410]

Conclusions

257. **Education and training needs to support a more flexible approach to workforce planning. In order to achieve this, we recommend that:**

- **SHAs give greater priority to education and training commissioning and ensure that they have enough staff with the right skills for effective commissioning.**
- **Standard prices be used to develop a 'tariff' for training so that new providers have an incentive to offer education and training.**
- **Education contracts be made more flexible so that if changes are required, they are determined by the future needs of the health service rather than by legal distinctions within contracts.**
- **The Department of Health and SHAs examine new approaches to student funding, for example the possibility of introducing loans to replace bursaries. Such loans should have repayment structures which reward staff for remaining within the NHS.**
- **The decline in the number of clinical academics and teaching staff for healthcare courses be addressed as a matter of urgency.**

407 Q 952

408 See Q 584 and Q 634 respectively

409 Q 634

410 Ev (HC 1077–II)

Organisational roles and responsibilities

258. Achieving the improvements set out so far in this chapter will require organisations with a strong focus on workforce planning. Repeated structural changes and re-organisations have damaged the workforce planning system, causing disruption and loss of planning capacity.[411] Further structural change therefore seems unlikely to prove beneficial. Rather than making a case for restructuring or overhauling the workforce planning system, we look at how improvements can be made in the work of existing organisations in particular by giving workforce planning a higher priority. We examine the role of:

- Strategic Health Authorities;
- Primary Care Trusts;
- Provider organisations;
- Other organisations such as NHS Employers and the Workforce Review Team; and
- The Department of Health.

Strategic Health Authorities

Introduction

259. As we described in Chapters 2 and 3, Strategic Health Authorities (SHAs) took on a range of key workforce planning functions after they absorbed Workforce Development Confederations (WDCs) in 2004. SHAs were reduced in number from 28 to 10 in 2006 but retained broadly the same responsibilities, including the commissioning of education and training. We heard serious doubts about the likely effectiveness of SHAs at workforce planning, particularly in light of the disruption and loss of personnel which followed two re-organisations in 3 years.[412] The significant cuts to education and training provision implemented by the new SHAs in recent months have done little to mitigate these doubts or to allay fears that SHAs will prioritise financial balance over long-term workforce requirements.[413] In short, SHAs have a lot to prove, both in terms of their capacity for workforce planning, and their willingness to prioritise it sufficiently.

260. In spite of these justified concerns, there are good reasons for SHAs to remain at the heart of the workforce planning system. First, while recent education and training cuts have been damaging, they have in many cases been a direct response to the Department of Health's decision to restore financial balance in 2006–7; moreover, some SHAs appear to have made genuine efforts to minimise the long-term impact of cuts.[414] Secondly, neither local nor national organisations are able to do the job. Local organisations have little capacity for or experience of workforce planning; more importantly they do not cover wide

411 See chapter 3

412 Q 40

413 Q 606

414 Qq 763–764

enough areas to plan strategically.[415] Workforce planning by central organisations has proved too remote and unresponsive in the past, something which Lord Hunt himself acknowledged.[416] SHAs, by contrast, are sufficiently local to take account of distinctive workforce requirements for their area, but large enough to bring together the different elements of the system in one place and ensure that planning becomes more joined up. Thirdly, the majority of the limited number of planners are already located at SHA level and finally, further restructuring of the workforce planning system is undesirable: it is the function that must be the priority for improvement, not the form.[417] Thus there is a strong case for SHAs to retain their current range of workforce planning responsibilities.

Key priorities for SHAs

261. The 10 new SHAs need to re-establish their workforce planning credentials and demonstrate that they are committed to long-term workforce development rather than short-term cost-cutting as a means of restoring financial balance. They also need to address the shortcomings in the current workforce planning system outlined in Chapters 2 and 3. Witnesses proposed that SHAs should:

- lead work to improve the analysis of **workforce supply and demand** at regional level; in particular they should work to improve the quality of workforce information and be more pro-active in challenging information provided by local organisations rather than simply acting as a conduit;[418]
- use supply and demand assessments to produce strategic **regional workforce plans;** these plans should be used in the commissioning of education and training;[419]
- ensure that there are forums for the **full range of relevant organisations** to participate in planning and decision-making, including education providers, medical Deaneries and independent sector providers; and
- involve themselves more in **national workforce planning**, for example working with the Workforce Review Team to establish a national overview of trends and dynamics, and influencing the content of medical training.[420]

SHA workforce planning capacity

262. In order to live up to this challenging remit, witnesses argued that SHAs need to increase the number of staff involved with workforce planning and improve the skills of current staff.[421] They will also need to improve information systems and make full use of

415 Q 657

416 Q 1018

417 Ev 168 (HC 1077–II)

418 See Q 682 and Q 973

419 Q 609

420 Q 736

421 Q 40

systems such as the new Electronic Staff Record.[422] Such changes should be a priority as investing in capacity at SHA level will represent good value for money if it helps to improve the overall workforce planning system.

263. SHAs will also need strong leadership if they are to make a success of workforce planning. The 10 SHA Directors of Workforce have a central role to play. They need to become effective champions for improving workforce planning and to lead many of the changes and improvements outlined. They should also work together to collectively assert the importance of workforce planning and development at national level. Department of Health officials commented on the importance of the new Workforce Directors and outlined plans to support them individually and as a group.[423] Such support is vital if workforce planning at SHA level is to make the improvements so clearly required.

264. **There is a strong case for the 10 new SHAs to continue to play a central role in the workforce planning system. However, there are justified misgivings about their performance to date. The new SHAs must prove their commitment to workforce planning and development as the bedrock of future financial stability, rather than a luxury which can be dispensed with in times of financial difficulty. To this end, we recommend that SHAs:**

- **improve their understanding of workforce demand and supply and the factors which influence them;**
- **do more to challenge existing assumptions by PCTs and other organisations about what workforce is required and how it can best be achieved;**
- **involve education providers and independent sector organisations in planning and decision-making; and**
- **take collective responsibility for improving planning at national level and for ensuring that NHS Employers performs its role effectively.**

Such changes will allow SHAs to produce flexible, long-term, workforce plans which should inform their commissioning of future education and training.

265. **In order to achieve these ambitious aims, many SHAs will require more staff, better training and improved information and planning systems. Whatever the requirements, SHAs must act quickly to ensure they have the necessary capacity. The 10 SHA Workforce Directors have a key role to play collectively in improving workforce planning at regional level and across the health service. SHA Chief Executives and the Department of Health's Director General of Workforce must ensure that SHA Workforce Directors are of a high calibre and have suitable training. Improving workforce planning should be one of the key performance targets for SHA Chief Executives and their progress should be closely monitored by the Department of Health.**

422 Q 1050

423 Q 1025

Primary Care Trusts

266. While SHAs must play a central role in improving workforce planning, this is not a task which they can accomplish alone. In particular, Primary Care Trusts (PCTS) must play a bigger role. Witnesses suggested that the small size of PCTs had prevented them from playing an effective role in workforce planning in the past.[424] However, with the reduction to 150 PCTs in late 2006, there is a clear opportunity for PCTs to play a more active role.[425]

Analysis of future demand

267. In particular, we heard that PCTs should work with SHAs to improve the analysis of future workforce demand.[426] As commissioners of services, PCTs are best placed to anticipate future service demands and must become adept at translating these into workforce requirements, using competence frameworks where appropriate. Only if SHAs receive accurate forecasts from their constituent PCTs can they hope to make reasonable assumptions about future workforce requirements across the whole SHA area. PCTs commission services, but SHAs must commission the workforce that will provide those services; it is vital therefore that the two sets of organisations work closely together.

The shift towards primary care

268. PCTs also have central responsibility for leading the shift towards a more primary care-oriented workforce.[427] PCTs commission all services and will therefore be aiming to move resources increasingly from secondary to primary care; this shift will only be possible if the workforce is able to support it. PCTs must give clear information to SHAs about primary care workforce requirements and particularly about gaps in education and training provision. Also, PCTs remain a major provider of primary and community care services and are therefore have direct responsibility for ensuring that these services have the right workforce to support increased levels of activity, as we described in Chapter 4.

269. **SHAs cannot achieve effective workforce planning single-handedly and must work with PCTs, which have played too small a role in the past. The new, larger PCTs are better placed to contribute to workforce planning and should ensure that they have enough people with the right skills to do so. As commissioners, PCTs must help SHAs to analyse future workforce demand and to ensure that service planning and workforce planning become integrated and complementary processes. As providers, PCTs must forecast the number and type of staff and the kind of training needed to support the move towards a more primary-care centred workforce and the shift of hospital services into the community.**

424 Q 22

425 Q 657

426 Q 682

427 Q 649

Provider organisations

270. Provider organisations, including NHS Trusts, Foundation Trusts, PCTs and private and voluntary providers, also have an important role to play in the future workforce planning system. We heard that the roles and responsibilities of provider organisations with regard to engaging in workforce planning should be similar, regardless of whether they are NHS or non-NHS organisations.[428]

Improving information

271. Provider organisations employ the vast majority of health service staff. As a result, they have responsibility for improving the quality of workforce data; this is a key priority as poor quality information undermines the current planning system. For example, recent reports of a potential future oversupply of allied health professional were criticised because information provided by employers was inaccurate or incomplete.[429] Providers can improve information partly by sharing accurate data about current workforce supply with SHAs and ensuring that new data collection systems, such as the Electronic Staff Record, are widely used.[430] As providers of primary care and community services, PCTs have an important role to play in improving the quality of information, as the understanding of workforce needs in this area is particularly poor.[431] Non-NHS providers and Foundation Trusts should provide the same types of information, and have the same access to the planning dialogue, as other provider organisations.[432]

Improving efficiency

272. As employers of most health service staff, provider organisations also have a major role to play in improving workforce productivity, particularly by achieving the savings targets set out in the 'Productive Time' initiative and measured by the *Better Care, Better Value* indicators.[433] Some of the *Better Care, Better Value* targets are based on measures specific to employers, such as reducing staff turnover, sickness absence and agency costs. Others relate to the wider efficiency of the health system, but will fall largely to providers to achieve; these include increasing day-case surgery rates and reducing average length of hospital stay.[434] In both cases, improving performance and increasing productivity will depend upon the efforts of provider organisations.

428 Ev 132 (HC 1077–II)

429 See Q 918

430 See Q 1050 for more information about the Electronic Staff Record

431 Q 8

432 Ev 235 (HC 171–II)

433 See chapter 4 for more details

434 For more information, see www.productivity.nhs.uk

Foundation Trust status

273. The government intends that most NHS providers will achieve Foundation Trust status in the near future.[435] It is important that becoming a Foundation Trust does not reduce the involvement of provider organisations in workforce planning. Department of Health officials reassured the Committee on this point, arguing that Foundation Trusts "do not have the freedom to opt out of workforce planning" and would play a similar role to other NHS providers, for example by supplying the same level of workforce information.[436]

274. However, other evidence we received gave cause for concern. NHS Employers argued that the central role of SHAs in workforce planning may be undermined by increasing conflict with Foundation Trusts, in part because Foundation Trusts are overseen by Monitor rather than by SHAs.[437] Witnesses also expressed serious concerns that Foundation Trusts are not obliged to maintain the *Agenda for Change* agreement, an important element of workforce reform.[438] NHS Employers commented that they did not know of any Foundation Trusts intending to break with *Agenda for Change*,[439] but the Committee subsequently heard that Southend University Hospital NHS Foundation Trust is planning to do exactly that.[440] It is clear that there are justified concerns about the effect of Foundation Trust status on the role of NHS providers in workforce planning and on the impact of other attempts to introduce competition to the health service. We discuss these in more detail in the box below.

275. **Acute trusts and other provider organisations have an important role to play in workforce planning and development, particularly by collecting and sharing consistent and reliable workforce information with SHAs. Providers also have the main responsibility for two goals of the highest priority: increasing workforce productivity and improving the integration of workforce and financial planning. It is vital that there is consistent involvement of providers in workforce planning, regardless of whether they are NHS or non-NHS organisations, and irrespective of Foundation Trust status.**

Competition versus collaboration

A number of witnesses to the Committee highlighted the uncertainty inherent in predicting future workforce requirements, particularly in the current policy context. For example, a number of current policies (including Payment by Results, the use of independent sector providers and the creation of Foundation Trusts) are designed to encourage competition between healthcare providers. The think-tank Reform suggested that efficiency gains as a result of competition would result in a reduction in future staff numbers of at least 10%.[441] Sir Jonathan Michael argued that market forces should

435 The original target for all NHS providers to achieve Foundation Trusts status was the end of 2008. Department of Health officials have subsequently acknowledged that this will be achieved by the majority, but not all, organizations. See *Public Expenditure on Health and Personal Social Services 2006*, HC 94–i, Q 89.

436 Q 60

437 Ev 131 (HC 1077-II)

438 Qq 212–216

439 Qq 217–218

440 Health Committee, First Report of Session 2006–07, *NHS Deficits*, HC 73–II, Q 11

441 Ev 258 (HC 171–II)

increasingly regulate workforce supply and demand, asserting that "grown-up organisations" such as Foundation Trusts should be left to determine their own workforce requirements.[442]

The Department of Health's submission took a different view, however, stressing the importance of collaboration between organisations as part of the planning process.[443] Other key organisations, including NHS Employers and Skills for Health, also argued for a more integrated and cooperative approach to planning. There is a contradiction between efforts to introduce competition and market forces to the health sector and the need for a collaborative approach to workforce planning. Without a shared and accepted vision of future requirements, workforce planning is unlikely to succeed.

Other organisations

276. There are a number of other national, regional and collective organisations (full details of which are provided in the Annex) which form part of the workforce planning system. Many of these organisations are very new and we heard little evidence about their effectiveness to date. Given their lack of proven usefulness, one option would be for the Department of Health to take back some responsibilities from these independent organisations. However, this would cause yet more disruption to the planning system, something which has done serious damage in the past.[444] Moreover, many of these organisations are so new that they have not yet had the opportunity to get to grips with their role.[445] Witnesses did not recommend a radical overhaul of these organisations but stressed the importance of them doing their jobs effectively.[446] In particular we heard that:

- In order to improve productivity, the benefits from the new medical contracts and *Agenda for Change* need to be fully realised: **NHS Employers** has much of the responsibility for achieving this;[447]
- For workforce planning to become more long-term and strategic, the quality of analysis of workforce supply and demand needs to be improved; at a national level, this is the responsibility of the **NHS Workforce Review Team**;[448]
- The **NHS Institute for Innovation and Improvement**, has an important role in increasing workforce productivity, particularly by improving the quality of productivity information through the *Better Care, Better Value* indicators;[449]

442 Qq 906–8

443 Ev 8 (HC 1077–II)

444 See Qq 41–42

445 See, for example, Ev 148–149 (HC 1077–II)

446 See, for example, Q 274 and Q 928

447 Q 274

448 Q 928

449 *Public Expenditure on Health and Personal Social Services 2006*, HC 94–ii, Q 153

- The overall quality of workforce information needs to be improved and this depends in part on the work t**rades unions, Royal Colleges and other membership organisations** which can provide expert information about particular staff groups.[450]

- As the Sector Skills Council for health, **Skills for Health** should play a central role in workforce planning. It has made good progress in writing and disseminating the 'competence frameworks' which will allow workforce planners to increase the flexibility of the workforce.[451] Given the number of organisations involved with the planning process, however, there is a need for further clarity on where Skills for Health fits in, particularly as there is little evidence that this organisation has made a wider impact on workforce planning; and

- Increasing workforce flexibility by creating new and amended roles requires greater involvement of **healthcare regulators** in workforce planning to ensure that roles can be disseminated quickly and that patient safety is maintained.[452]

277. **A number of other organisations have key roles to play in improving workforce planning. Many of these organisations are very new and it is important that they are given enough time to establish themselves before their performance is assessed In particular, we recommend that:**

- **NHS Employers ensure that local organisations have the right advice and information to realise benefits from the new staff contracts, for example by developing consultant productivity measures;**

- **The NHS Institute for Innovation and Improvement has a vital role in helping to increase efficiency, particularly by providing accurate overall productivity information for local organisations;**

- **The NHS Workforce Review Team continue to improve the quality of analysis of national workforce trends and work with SHAs, individually and collectively, to improve analysis at regional level; and**

- **The role of Skills for Health in the workforce planning system and the health service itself be clarified as there is little evidence that this organisations has yet made an impact on workforce planning beyond the production of competence frameworks.**

The Department of Health

278. The role of the Department of Health in workforce planning has been inconsistent in recent years. For example, the Department set central targets for increasing the size of the workforce and the number of undergraduate training places in 2000 and 2002 but has not set such targets since.[453] The Department negotiated the terms of the new consultant

450 Q 924

451 Ev 219 (HC 1077–II)

452 Q 528

453 See Chapter 2

contract and *Agenda for Change* but has subsequently passed responsibility for such negotiations to NHS Employers.[454] Also, the Department has remained closely involved with the planning of the medical workforce but has devolved responsibility for non-medical workforce planning to SHAs. Such inconsistencies demonstrate that there is continuing uncertainty about the appropriate role for the Department of Health in workforce planning. Below we consider what the Department's role should be.

Overseeing workforce planning

279. Witnesses argued that the Department should avoid micro-managing parts of the workforce planning system or setting central workforce targets.[455] This point was acknowledged by Lord Hunt, who commented that,

> …you cannot micro-manage the Health Service from the centre, but you have got to put your trust in people locally to do the best that they can.[456]

Instead of micro-managing, therefore, the Department should play a more strategic role by providing good quality information and overseeing the work of SHAs.[457]

280. The Department's role in **improving the quality of workforce information** can be achieved in part by contributing high-quality information to the work of the NHS Workforce Review Team (WRT) and ensuring that WRT recommendations are in keeping with future service requirements and are acted on by SHAs and other workforce planning organisations. The Department should also ensure that SHAs have a good understanding of the current and future financial position, both in terms of changes in MPET allocations and changes in the overall health service budget.[458] Without a reasonable understanding of the global financial position of the NHS, SHAs cannot carry out effective medium or long term workforce planning.

281. The Department should play a more direct role in workforce planning and development by **overseeing the work of the new SHAs**. The Department must ensure that SHA Chief Executives make workforce planning a high priority and do not sacrifice long-term workforce developments in order to achieve financial balance. The Department should support the new SHA Workforce Directors as champions of workforce planning and development at national and regional level. However, the Department must do this without interfering excessively with the autonomy of SHAs or pressuring them into achieving specific numerical targets, as has been the case in the past.[459] This is a difficult balance to strike effectively, but it is an important goal if the workforce planning system is to be improved.

282. As part of its oversight role, the Department must ensure that **Foundation Trust reform** does not fragment the workforce planning system. Foundation Trusts will not be

454 This change occurred upon the creation of NHS Employers in November 2004

455 Q 794

456 Q 1018

457 See, for example, Q 684 and Q 698

458 Q 688

459 Qq 685–6

accountable to SHAs for their overall performance, but it is vital that they continue to collaborate with them on workforce issues.[460] Otherwise, as we explore in the box above, there is a risk that cooperation within the system will break down.

283. Finally, the Department must play a more effective role in overseeing active **international recruitment** by the NHS. In view of the boom and bust in international recruitment described in Chapter 2, the Department of Health needs to work more effectively with other departments, notably the Home Office, to ensure that international recruitment is fair and consistent and that those who come to the UK in response to active international recruitment receive fair treatment and equal opportunities. The Department's *Code of Practice* on international recruitment, which received necessary strengthening in 2004, has proved effective in most areas, but there is still evidence that employers are able to exploit loopholes in order to acquire staff from restricted countries and this must be addressed.[461]

Improving forecasting

284. Another important area for the Department is improving on its poor track record for **costing national workforce changes**, notably pay reform. The significant overspends on the consultant contract, GP contract and *Agenda for Change*, which we highlighted in Chapters 2 and 3, demonstrate that the Department has consistently struggled to accurately forecast future pay costs. It is hardly surprising that representatives of SHAs expressed uncertainty about the Department's assurances that the Modernising Medical Careers scheme will not lead to an increase in medical pay costs.[462] Department of Health officials assured the Committee that changes are already being made to improve the quality of modelling and forecasting.[463]

285. On a related note, the Department must do more to ensure that the **workforce implications of new policies** are properly assessed. Witnesses consistently stressed that new policy initiatives do not always include a clear analysis of related workforce requirements.[464] As one witness put it,

> …some of their policies they actually have not really considered the financial implications of the workforce. If we take *Our care, our health, our say*, it is an excellent policy document, but actually what does that mean, not just in workforce terms but in the finances of workforce…[465]

In the case of *Our Health, Our Care, Our Say*, it is especially worrying that workforce implications were not apparently considered, given the importance of this policy for shifting activity into primary care. Again, Department of Health officials argued that

460 See, for example, Ev 131 (HC 1077–II)

461 See, for example, Q 730

462 Q 738

463 Q 1005

464 See, for example, Ev 167 and Ev 237 (HC 1077–II)

465 Q 696

improvements are being made in this area, but there was little evidence of their impact to date.[466]

286. **The Department of Health must play a more consistent role in workforce planning. We welcome the Minister's acknowledgment that the Department should not micro-manage the planning system. Instead the Department should provide effective strategic information about, and oversight of, workforce planning and development. In particular, we recommend that the Department:**

- **ensure that workforce planning is prioritised by SHAs and that SHAs employ capable Workforce Directors;**
- **provide national information, for example about future funding levels, to form the basis of SHA decision-making;**
- **issue guidance to Foundation Trusts to ensure that they play a full and consistent role in workforce planning;**
- **ensure that future international recruitment is both ethical and better managed, taking account of the number of clinicians qualifying in the UK; and**
- **improve its own ability to forecast the financial impact of workforce reforms and the staffing implications of all new policies, particularly following its consistent failure to cost new contracts accurately.**

466 Q 974

6 Conclusions

287. **In 2000 the Government published an excellent blueprint for workforce planning entitled *A Health Service of all the talents*. Figures were set for a large increase in the number of staff employed by the NHS in the *NHS Plan*. There was also to be a significant expansion in the number of training places for clinicians. However, the huge growth in funds provided by the Government, together with the demanding targets it set, ensured that the increase in staff far exceeded the *NHS Plan*. By 2005 there were signs that the NHS was spending too much. Boom turned to bust. Posts were frozen, there were some, albeit not many redundancies, but, most worryingly, many newly qualified staff were unable to find jobs and the training budget was cut.**

288. **Although the Government argued for improvements in productivity, in practice little happened. It was too easy to throw new staff into the task of meeting targets rather than consider the most cost-effective way of doing the job. There were large pay increases but adequate steps were not taken to ensure increases in productivity in return. There were attempts to create a more flexible workforce and improve the skills of staff so they could take on more complex and responsible tasks. The results of these efforts have been mixed: in some cases there have been no savings, in others the results have been successful. Unfortunately, the cuts in the training budget threaten what successes there have been.**

289. **In sum, there has been a disastrous failure of workforce planning. Little if any thought has been given to long term or strategic planning. There were, and are, too few people with the ability and skills to do the task. The situation has been exacerbated by constant re-organisation, including the establishment and abolition of WDCs within 3 years. In sum, the health service, including the Department of Health, SHAs, acute trusts and PCTs, have not made workforce planning a priority, with the consequences we can now see.**

290. **Given the pace of change, including technological developments and the unpredictable consequences of policies such as Payment by Results, we cannot know precisely what future workforce will be needed. This means we will need a more flexible workforce. There are currently many opportunities to increase productivity and obtain better value for money. There will be more opportunities in future. It is important that the workforce has the incentives to take them.**

291. **To avoid the boom and bust of recent years and produce a workforce appropriate for the future, there has to be change. However, we do not support further restructuring. Persistent reorganisation has caused many of the current problems. It matters less which organisation does the job than that it is done well and taken seriously. Therefore, despite their failings to date, we recommend that workforce planning continue to be undertaken by SHAs.**

292. **We propose one key change: workforce planning must become a priority for the health service. In practice, this means a number of straightforward but important improvements. SHAs must recruit as workforce planners people of the highest calibre and ensure that they are supported by staff with the appropriate skills. Most human**

resources staff do not have these skills. Others organisations, including trusts and the Department of Health, must improve the quality and accuracy of the information they produce on a range of matters, including workforce forecasts, productivity and the cost of new policies. Finally, the Department of Health must stop micromanaging. In addition to ensuring SHAs have information of a high quality, the Department should act in an oversight capacity ensuring that SHAs are giving workforce planning the priority its importance requires.

Conclusions and recommendations

Chapter 2

1. The health service workforce has changed dramatically in recent years, most notably through the major increase in staff numbers which took place between 1999 and 2005. Rapid workforce expansion was a necessary response to the "crisis" in staffing numbers described in the Committee's 1999 report. However, the rate of growth considerably exceeded expectations, and far outstripped the targets set in the *NHS Plan*. Given the increase in funding levels, such a high level of growth was inevitable. Many new staff were recruited from overseas because of limited availability of UK staff. Eventually, many organisations recruited more staff than they could afford to pay. This was a major cause of the widespread deficits which emerged across the NHS from 2004–05 onwards. (Paragraph 72)

2. In response to the deficits which emerged in 2004–05, the expansion of the workforce has slowed down and, in places, reversed. Overall staff numbers are now falling. Provider organisations have made large numbers of job reductions and some compulsory redundancies and many healthcare graduates have experienced unemployment. Strategic Health Authorities have cut the number of domestic training places, immediately after a period of sustained growth. During the growth phase, employers mainly increased capacity through international recruitment as they could not wait for domestic training output to increase. Now international recruitment has in turn been suddenly and sharply restricted. (Paragraph 73)

3. In parallel with the expansion in staff numbers, pay rates for the majority of health service staff have increased substantially in recent years. Senior doctors have received the most generous pay rises but the *Agenda for Change* agreement has ensured that virtually all NHS staff have benefited from increases. The costs of pay reform have been extremely high and have absorbed a large proportion of the extra money allocated to the health service in recent years. Actual costs have consistently exceeded Department of Health projections and this has contributed to deficits in some organisations. As with staff numbers, pay growth is now being curtailed with below inflation increases for all staff in 2007–08. (Paragraph 74)

4. There have been a number of attempts in recent years to introduce new ways of working to the health service. A range of new clinical roles have been established in order to increase workforce flexibility, and there have been some efforts to improve retention, increase productivity and reform education and training. However, the scale of progress on workforce reform pales in comparison with the scale of staffing growth and pay increases which took place over the same period. Reform has also been hampered by repeated changes to organisational structures and by recent cuts in education and training provision. (Paragraph 75)

5. There is clear evidence of a boom and bust cycle within each of these areas. The boom occurred between 1999 and 2005 as staff numbers and pay levels increased with unprecedented speed. The emergence of deficits after 2005 triggered the start of a bust phase with widespread job reductions, sweeping education and training cuts

and severe pay restrictions. During both phases, workforce changes have tended to respond to prevailing financial trends, and the workforce reform agenda, articulated by *A Health Service of all the talents*, has too often been overlooked. The expansion of the workforce was reckless and uncontrolled and increases in funding were often seen as a blank cheque for recruiting new staff. Such problems raise serious questions about the effectiveness of the current workforce planning system. (Paragraph 76)

Chapter 3

6. There are a number of weaknesses in the current workforce planning system. Most fundamentally, there is a shortage throughout the health service of the people, organisations and skills required for workforce planning. Persistent structural changes have exacerbated this problem, particularly at regional level. The new SHAs seem to lack capacity for workforce planning even though they have a vital role to play. The removal of Workforce Development Confederations and the Modernisation Agency left gaps which remain unfilled. Local organisations have struggled even to provide accurate workforce information to support decision-making. Workforce planning appears to remain a secondary consideration for many organisations. (Paragraph 148)

7. Lack of integration between different parts of the planning system remains a widespread problem. The difficulties caused by the separate planning systems for medical and non-medical staff groups were pointed out by this Committee 8 years ago but have still not been effectively addressed. Medical and non-medical planning is still done by separate organisations with separate funding streams, which inhibits the ability of SHAs to plan effectively by looking at total workforce requirements. The workforce planning system has also failed to involve the private and voluntary sectors adequately, particularly since the loss of separate Workforce Development Confederations. This is a serious failing, particularly in the context of the increasing use of the independent sector to provide NHS services. (Paragraph 149)

8. Of particular concern is the continuing lack of integration between workforce planning and financial planning. There are shocking examples of failures at local level with some organisations continuing to recruit large numbers of staff in spite of rising financial deficits. But the Department of Health has made equally serious mistakes at national level, in particular by failing to ensure that targets for increasing staff numbers were consistent with the level of funding available. Both in local organisations and at the Department of Health, workforce planning and financial planning have been done by separate teams in separate places and little has been done to bring the two processes together. (Paragraph 150)

9. Effective workforce planning, particularly in healthcare, must include a long-term element. This has been badly wanting in health service workforce planning, partly because there is no formal long-term planning system, but more importantly because NHS organisations tend to be too focused on short-term priorities. Recent cuts to training provision and other workforce development activities have shown an especially worrying disregard for long-term workforce priorities. The Committee is deeply concerned to hear from a key workforce leader that long-term planning is at risk of being abandoned in parts of the NHS. (Paragraph 151)

10. Increasing workforce productivity is a vital goal that has been badly neglected by the workforce planning system. The Committee was dismayed to hear that improving productivity was not an explicit aim of the *NHS Plan*. The resultant lack of focus on increasing efficiency during the recent period of rapid growth in staff numbers was reckless and unwise. We were equally concerned by the suggestion that the new consultant and GP contracts may have reduced the productivity of these vital staff groups. Pay rates for senior doctors have increased substantially without evidence of corresponding benefits for patients. This is indicative of the lack of overall focus on improving workforce productivity. (Paragraph 152)

11. Increasing workforce flexibility is an important and related goal and some progress has been made in recent years, particularly through the development of new and amended roles. However, not enough has been done to prove that all these changes are cost effective. Even when skill mix changes have proved to be effective, recent cuts in training capacity have targeted staff in new roles and hampered attempts to increase flexibility. The current structure of education funding does not support the development of a more flexible workforce and there is a shortage of flexible training opportunities. (Paragraph 153)

12. A Health Service of all the Talents set out a blueprint for improving workforce planning through a stable system with dedicated workforce organisations and a clear focus on improving flexibility and productivity. The health service has lost sight of this vision and marginalised workforce planning. The situation has been exacerbated by persistent structural change. The system remains poorly integrated and there is a shortage of staff with the necessary skills for effective workforce planning. In light of the need for increased activity, organisations tended to throw extra workers at the problem rather than increasing the efficiency of existing staff. Even when positive changes which might improve productivity, such as the new contracts and new clinical roles, have been introduced, benefits have not been properly realised. In particular, the current wave of education and training cuts has led to a number of backward steps for workforce development. Basic problems such as the disjunction of workforce and financial planning persist at all levels of the system. Despite great efforts in some quarters, the workforce planning system is not performing noticeably better than 8 years ago. (Paragraph 154)

Chapter 4

13. Future workforce requirements are very difficult to predict; for this reason, increasing the flexibility of the workforce is an important priority. In spite of the difficulties in predicting future requirements, it is clear that the workforce must become more productive, particularly since there is likely to be less extra funding available in future. There is also a clear need to increase the size and quality of the primary care workforce and to improve the standard of management across the whole workforce. (Paragraph 215)

14. Increasing workforce productivity is a difficult goal and reliable information is vital to achieving it. In the past, although a great deal of data has been collected by the NHS, information directly relevant to productivity has been either lacking or not used sufficiently. The recently introduced *Better Care, Better Value* indicators are a

good source of information about comparative productivity, although they should be improved, for example by adjusting for case mix. (Paragraph 216)

15. Effective use of the Knowledge and Skills Framework (KSF) has great potential to improve staff productivity. The KSF can improve access to relevant education and training, and support amended roles which will allow staff to develop the skills required to increase flexibility and efficiency. However, there is little evidence that these opportunities are yet being taken. NHS organisations must make wider use of the KSF to prioritise training requirements and to offer training to staff groups, such as Health Care Assistants, that have too often been denied it in the past. In particular, the health service must do everything possible to ensure that such training opportunities are protected from short-term budget cuts. Human Resources department should ensure that the KSF becomes a fundamental tool for staff management and development. (Paragraph 217)

16. Despite its high, and arguably excessive, cost to the health service, the new GP contract has potential to improve future productivity. The Quality and Outcomes Framework (QOF) should be used to negotiate more exacting targets for improving standards. The government should consider allowing some QOF targets to be negotiated at a local level in order to address specific local priorities. PCTs should maintain or improve the standard of the auditing of QOF returns wherever possible. (Paragraph 218)

17. The new consultant contract has been expensive and time-consuming to implement and its impact so far on productivity has been minimal. Yet this is largely because implementation was rushed and most employers have therefore struggled to get to grips with the job planning and objective setting processes. Employers must use these processes to challenge traditional working patterns and practices, and to negotiate and monitor demanding performance objectives with consultants. Medical Directors should play a central role in negotiating objectives and the effectiveness of objective setting should be scrutinised by Trust Boards. Failure to meet agreed objectives must constrain or limit pay progression not only for medical staff but also for the responsible Medical Director. It is only through agreeing rigorous and detailed objectives that employers will derive benefits from the consultant contract which correspond with the significant pay increases it has brought. (Paragraph 219)

18. There is a clear need to develop consistent criteria for measuring clinical productivity which would make it much easier for local organisations to negotiate meaningful performance objectives for consultants. Different specialties and disease areas will require different measures: in some cases, activity measures are a good reflection of productivity; in others, measuring outcomes is more appropriate. To this end, we recommend that NHS Employers and the NHS Institute for Innovation and Improvement work with the relevant Royal Colleges to agree standard productivity measures for each hospital specialty. Wherever possible, productivity measures should be based on existing data sources such as Hospital Episode Statistics or the *Better Care, Better Value* indicators. (Paragraph 220)

19. Increasing workforce flexibility should be another of the main future priorities for workforce planning and development. Increasing flexibility will support efforts to

improve productivity and allow the workforce to adapt more quickly to changing service demands. Using staff in new and amended roles is an important way to increase flexibility. The Committee is pleased to hear that the Department intends to review the many new roles that have been introduced and to assess their cost effectiveness, particularly as such evaluation had often been lacking or limited in the past. This review should be based on hard evidence rather than opinion; but skill mix changes should be given enough time, and done on a large enough scale, to take effect before they are reviewed. Where new roles are shown to be effective, they must be quickly disseminated across the health service. However, it is equally important that ineffective roles are rejected and that staff in new roles do not duplicate the work of existing staff. (Paragraph 221)

20. Increasing flexibility will require a more adaptable training system which is able to respond quickly to changing requirements. The use of competence frameworks is an important element of this. However, the health service must also be quicker to change the pattern of training commissioning in response to service demands. SHAs need to do more to protect new and innovative training courses from budget cuts. Education and training provision itself must be made more flexible with more opportunities for staff to transfer between courses and more part-time courses. Rather than training all staff from scratch, more opportunities are required for groups such as Health Care Assistants to upgrade their skills and take on more challenging responsibilities. (Paragraph 222)

21. The balance of the health service workforce must be shifted significantly towards primary care if the government's future ambitions are to be realised. Basic clinical training should involve more time in primary care. Most importantly, the health service needs to develop ways for staff to move from secondary to primary care and to work between the two sectors. Unfortunately, progress to date on achieving these aims has been limited and appears to be further threatened by recent training cuts. The public health workforce has been particularly badly affected. If the shift of 5% of activity out of hospitals and the adoption of a more preventative model of healthcare are to be achieved, then far more needs to be done to ensure that the primary care workforce is able to support these developments. The new PCTs should take particular responsibility for this change although there is little evidence that they are currently equipped to do so. (Paragraph 223)

22. Managers are a crucial component of the health service workforce; their importance is too often overlooked and their role has been undermined by the continual reorganisations of recent years. However, the quality of managers is highly variable and the absence of minimum standards or training requirements is a concern. NHS organisations need to recruit managers of a high calibre. They should ensure that all managers are appraised and have access to relevant training; improving quantitative and workforce planning skills should be a particular priority. (Paragraph 224)

23. The Committee welcomes the Minister's acknowledgment that the contribution of clinicians to managing health services needs to be made more effective. This means both improving their ability to carry out everyday management tasks within their existing roles, and encouraging more clinicians to transfer into general management roles, with the potential to become a Chief Executive. Clinicians need appropriate

training and support if they are to take on more management responsibility. Clinical training should contain a larger management component and senior clinical roles with a management specialism should be developed, particularly for medical staff. More senior clinical staff should be trained and assisted to take on general management roles, particularly at Board level. (Paragraph 225)

Chapter 5

24. Ensuring that the health service is able to respond to future service demands will require a reformed and improved workforce planning system. Workforce planning has been badly hampered by the absence of effective long-term planning and the failure to take account of the complexity of the strategic 'big picture'. Long-term planning is important because changing the structure and make-up of the workforce takes a long time, particularly in healthcare where workers take up to 15 years to train. Strategic planning is important because the complexity of workforce supply and demand mean that a lazy or over-simplistic approach to change can have serious negative consequences, as shown by current job reductions and graduate unemployment. (Paragraph 235)

25. Some of the current mechanisms for workforce planning, such as the 3-year Local Delivery Plan cycle, do not support a long-term approach and this should be addressed by SHAs and the Department of Health as a matter of priority. Improved planning systems, however, are useless without good quality information to support them. In the past, analysis of workforce supply and demand has tended to be limited and has failed to concern itself with wider developments such as future demographic and technological changes. In future it needs to take account of a much wider range of factors, including demographic, technological and policy trends and the interaction between them. Adopting a genuinely long-term and strategic approach to workforce planning will allow planners to anticipate the need for change rather than constantly responding to it, something which is key to the sustainability of the health service. (Paragraph 236)

26. Workforce planning has too often been a series of isolated decisions and initiatives rather an integrated process. A number of changes are required to improve integration: most importantly, workforce planning, financial planning and service planning must be more closely aligned in all NHS organisations. This will require closer working between staff in Finance and Human Resources departments and more accurate, joint forecasting of future supply and demand. It is important that there is proper oversight across the system; the work of local organisations should be scrutinised by SHAs, the work of Foundation Trusts by Monitor and the work of SHAs by the Department of Health. The planning system should also pay much greater attention to the use of financial incentives, such as the Quality and Outcomes Framework, to increase workforce productivity, focussing wherever possible on improving health outcomes. (Paragraph 245)

27. Planning must cover the whole workforce rather than looking at each staff group as a separate 'silo'. The persistent divide between medical and non-medical workforce planning must be addressed; SHAs currently pay for postgraduate medical training so in future they must have much more influence on training numbers and content.

The Department should make clear to SHAs that money can be transferred between medical and non-medical training pots; there is currently confusion over whether this is the case. Analytical work by SHAs and the Workforce Review Team should focus on total workforce requirements rather than examining each profession and sub-discipline in isolation. The use of competences to measure overall workforce requirements will help to support this approach. (Paragraph 246)

28. Workforce planning should take account of the requirements of the whole health service rather than looking exclusively at the NHS. Private and voluntary sector organisations should be more involved in planning at local and regional level and standardised workforce data should be available from non-NHS organisations. Free movement of staff between sectors should be permitted, expect in the case of staff groups where the NHS has serious and persistent shortages. The private and voluntary sector should increasingly be used to provide education and training and integrated training courses should be developed between NHS and non-NHS organisations. Attempts to create a more integrated planning system must be supported by increased clinical involvement, so that workforce planning and development are not regarded as back office, managerial tasks. (Paragraph 247)

29. Given the central importance of ensuring a more integrated planning system and increasing workforce flexibility, we recommend that SHAs should retain responsibility for commissioning undergraduate training courses for non-medical staff. (Paragraph 251)

30. There would be advantages and disadvantages in guaranteeing a fixed period of employment for newly trained staff; however, such a strategy has potential to improve the integration of the planning system and ensure that a cohort of graduates trained at the public's expense is not lost to the NHS. We recommend that its implications be examined in more depth. (Paragraph 252)

31. Education and training needs to support a more flexible approach to workforce planning. In order to achieve this, we recommend that:

- SHAs give greater priority to education and training commissioning and ensure that they have enough staff with the right skills for effective commissioning.
- Standard prices be used to develop a 'tariff' for training so that new providers have an incentive to offer education and training.
- Education contracts be made more flexible so that if changes are required, they are determined by the future needs of the health service rather than by legal distinctions within contracts.
- The Department of Health and SHAs examine new approaches to student funding, for example the possibility of introducing loans to replace bursaries. Such loans should have repayment structures which reward staff for remaining within the NHS.

- The decline in the number of clinical academics and teaching staff for healthcare courses be addressed as a matter of urgency. (Paragraph 257)

32. There is a strong case for the 10 new SHAs to continue to play a central role in the workforce planning system. However, there are justified misgivings about their performance to date. The new SHAs must prove their commitment to workforce planning and development as the bedrock of future financial stability, rather than a luxury which can be dispensed with in times of financial difficulty. To this end, we recommend that SHAs:

- improve their understanding of workforce demand and supply and the factors which influence them;
- do more to challenge existing assumptions by PCTs and other organisations about what workforce is required and how it can best be achieved;
- involve education providers and independent sector organisations in planning and decision-making; and
- take collective responsibility for improving planning at national level and for ensuring that NHS Employers performs its role effectively.

Such changes will allow SHAs to produce flexible, long-term, workforce plans which should inform their commissioning of future education and training. (Paragraph 264)

33. In order to achieve these ambitious aims, many SHAs will require more staff, better training and improved information and planning systems. Whatever the requirements, SHAs must act quickly to ensure they have the necessary capacity. The 10 SHA Workforce Directors have a key role to play collectively in improving workforce planning at regional level and across the health service. SHA Chief Executives and the Department of Health's Director General of Workforce must ensure that SHA Workforce Directors are of a high calibre and have suitable training. Improving workforce planning should be one of the key performance targets for SHA Chief Executives and their progress should be closely monitored by the Department of Health. (Paragraph 265)

34. SHAs cannot achieve effective workforce planning single-handedly and must work with PCTs, which have played too small a role in the past. The new, larger PCTs are better placed to contribute to workforce planning and should ensure that they have enough people with the right skills to do so. As commissioners, PCTs must help SHAs to analyse future workforce demand and to ensure that service planning and workforce planning become integrated and complementary processes. As providers, PCTs must forecast the number and type of staff and the kind of training needed to support the move towards a more primary-care centred workforce and the shift of hospital services into the community. (Paragraph 269)

35. Acute trusts and other provider organisations have an important role to play in workforce planning and development, particularly by collecting and sharing consistent and reliable workforce information with SHAs. Providers also have the

main responsibility for two goals of the highest priority: increasing workforce productivity and improving the integration of workforce and financial planning. It is vital that there is consistent involvement of providers in workforce planning, regardless of whether they are NHS or non-NHS organisations, and irrespective of Foundation Trust status. (Paragraph 275)

36. A number of other organisations have key roles to play in improving workforce planning. Many of these organisations are very new and it is important that they are given enough time to establish themselves before their performance is assessed In particular, we recommend that:

- NHS Employers ensure that local organisations have the right advice and information to realise benefits from the new staff contracts, for example by developing consultant productivity measures;
- The NHS Institute for Innovation and Improvement has a vital role in helping to increase efficiency, particularly by providing accurate overall productivity information for local organisations;
- The NHS Workforce Review Team continue to improve the quality of analysis of national workforce trends and work with SHAs, individually and collectively, to improve analysis at regional level; and
- The role of Skills for Health in the workforce planning system and the health service itself be clarified as there is little evidence that this organisations has yet made an impact on workforce planning beyond the production of competence frameworks. (Paragraph 277)

37. The Department of Health must play a more consistent role in workforce planning. We welcome the Minister's acknowledgment that the Department should not micro-manage the planning system. Instead the Department should provide effective strategic information about, and oversight of, workforce planning and development. In particular, we recommend that the Department:

- ensure that workforce planning is prioritised by SHAs and that SHAs employ capable Workforce Directors;
- provide national information, for example about future funding levels, to form the basis of SHA decision-making;
- issue guidance to Foundation Trusts to ensure that they play a full and consistent role in workforce planning;
- ensure that future international recruitment is both ethical and better managed, taking account of the number of clinicians qualifying in the UK; and
- improve its own ability to forecast the financial impact of workforce reforms and the staffing implications of all new policies, particularly following its consistent failure to cost new contracts accurately. (Paragraph 286)

Chapter 6

38. In 2000 the Government published an excellent blueprint for workforce planning entitled *A Health Service of all the talents*. Figures were set for a large increase in the number of staff employed by the NHS in the *NHS Plan*. There was also to be a significant expansion in the number of training places for clinicians. However, the huge growth in funds provided by the Government, together with the demanding targets it set, ensured that the increase in staff far exceeded the *NHS Plan*. By 2005 there were signs that the NHS was spending too much. Boom turned to bust. Posts were frozen, there were some, albeit not many redundancies, but, most worryingly, many newly qualified staff were unable to find jobs and the training budget was cut. (Paragraph 287)

39. Although the Government argued for improvements in productivity, in practice little happened. It was too easy to throw new staff into the task of meeting targets rather than consider the most cost-effective way of doing the job. There were large pay increases but adequate steps were not taken to ensure increases in productivity in return. There were attempts to create a more flexible workforce and improve the skills of staff so they could take on more complex and responsible tasks. The results of these efforts have been mixed: in some cases there have been no savings, in others the results have been successful. Unfortunately, the cuts in the training budget threaten what successes there have been. (Paragraph 288)

40. In sum, there has been a disastrous failure of workforce planning. Little if any thought has been given to long term or strategic planning. There were, and are, too few people with the ability and skills to do the task. The situation has been exacerbated by constant re-organisation, including the establishment and abolition of WDCs within 3 years. In sum, the health service, including the Department of Health, SHAs, acute trusts and PCTs, have not made workforce planning a priority, with the consequences we can now see. (Paragraph 289)

41. Given the pace of change, including technological developments and the unpredictable consequences of policies such as Payment by Results, we cannot know precisely what future workforce will be needed. This means we will need a more flexible workforce. There are currently many opportunities to increase productivity and obtain better value for money. There will be more opportunities in future. It is important that the workforce has the incentives to take them. (Paragraph 290)

42. To avoid the boom and bust of recent years and produce a workforce appropriate for the future, there has to be change. However, we do not support further restructuring. Persistent reorganisation has caused many of the current problems. It matters less which organisation does the job than that it is done well and taken seriously. Therefore, despite their failings to date, we recommend that workforce planning continue to be undertaken by SHAs. (Paragraph 291)

43. We propose one key change: workforce planning must become a priority for the health service. In practice, this means a number of straightforward but important improvements. SHAs must recruit as workforce planners people of the highest calibre and ensure that they are supported by staff with the appropriate skills. Most

human resources staff do not have these skills. Others organisations, including trusts and the Department of Health, must improve the quality and accuracy of the information they produce on a range of matters, including workforce forecasts, productivity and the cost of new policies. Finally, the Department of Health must stop micromanaging. In addition to ensuring SHAs have information of a high quality, the Department should act in an oversight capacity ensuring that SHAs are giving workforce planning the priority its importance requires. (Paragraph 292)

Glossary

BMA	British Medical Association
CSP	Chartered Society of Physiotherapy
CWP	Changing Workforce Programme
DH	Department of Health
EWTD	European Working Time Directive
HES	Hospital Episode Statistics
III	NHS Institute for Innovation and Improvement
ISTC	Independent Sector Treatment Centre
KSF	Knowledge and Skills Framework
MA	Modernisation Agency
MADEL	Medical and Dental Education Levy
MPET	Multi-Professional Education and Training
NAO	National Audit Office
NMET	Non-Medical Education and Training
NPP	National Practitioner Programme
NWP	National Workforce Projects
PbR	Payment by Results
PCT	Primary Care Trust
PMETB	Postgraduate Medical Education and Training Board
QOF	Quality and Outcomes Framework
RCN	Royal College of Nursing
RCP	Royal College of Physicians
SHA	Strategic Health Authority
SIFT	Service Increment for Teaching
WDC	Workforce Development Confederation
WRT	NHS Workforce Review Team

Assistant Practitioner: A non-professional trained in a particular set of skills (e.g. taking blood) used to support professional staff and generally at level 4 of *Agenda for Change* pay scales.

Competences: Measures of the skills, knowledge or experience required to perform a particular task or a particular role.

Skill mix: The combination of different staff groups or staff grades that make up the workforce or a part of the workforce.

Annex: What is workforce planning?

The terms 'workforce planning' and 'workforce development' refer to a wide range of different activities and there is no single accepted definition for either. At its most fundamental level, workforce planning is the process by which an organisation or industry decides upon the kind of workforce that it requires and will require in the future and then draws up and implements plans for creating such a workforce. In the context of the UK health service, this process is extremely complex. This annex describes some of the main activities involved in health service workforce planning and the key organisations responsible for them.

Key workforce planning activities

The main activities that make up health service workforce planning include:

- The **provision of data and information** on a range of subjects including staff numbers, training requirements and demographic, technological and policy developments;
- **Analysis of future supply and demand**, looking at how many and what type of staff are likely to be required in the future and how many and what type of staff are likely to be available;
- The **creation of workforce plans** which set out how future supply and demand will be matched, covering for example the number and type of staff to be recruited, the amount and nature of training to be commissioned and the amount and type of workforce development activity which will take place;
- Decisions about the level of **funding** which will be available to support workforce planning and development activities and how it will be distributed;
- The **commissioning of education and training**, including undergraduate, postgraduate and vocational training across a range of professional and occupational groups;
- A wide range of **workforce development activities**, including the introduction of new and extended clinical roles, redistribution of staff responsibilities, increasing productivity and efficiency; and
- **Negotiation of contracts**, including service contracts and employment contracts.

Key organisations in workforce planning

There are a large number of organisations, at national and local level, involved in health service workforce planning activities. There have also been a number of changes in organisational responsibilities since the Committee's last report in 1999. The key organisations are shown in the table below:

Organisation	Main workforce planning responsibilities
Department of Health	Oversight of workforce planning system; monitoring of SHAs; development of new policies; distribution of education funding; commissioning of undergraduate medical education.
Strategic Health Authorities	Commissioning of non-medical education and training; creation of regional workforce plans(from 2004); oversight of local workforce planning (from 2002).
Workforce Development Confederations	Commissioning of non-medical education and training; creation of regional workforce plans (until 2004).
Primary Care Trusts	Creation of local workforce plans; provision of workforce information; provision of primary care training placements (from 2001).
Provider organisations (NHS trusts, Foundation trusts and non-NHS providers)	Creation of local workforce plans; provision of workforce information; provision of training placements.
NHS Employers	Negotiation of national workforce contracts (from 2004).
NHS Workforce Review Team	National level analysis of future workforce requirements and publication of annual recommendations.
National Workforce Projects	Coordination of response to specific workforce challenges; development of workforce planning capacity (from 2005)
NHS Modernisation Agency	Collecting best practice on workforce development; oversight of introduction of new clinical roles (until 2005).
NHS Institute for Innovation and Improvement	Helping organisations to improve workforce productivity (from 2005).
Skills for Health	Sector Skills Council for health (from 2002); creation of competence frameworks.
Postgraduate Medical Education and Training Board	Organisation of postgraduate medical training at national level (from 2005).
Postgraduate medical deaneries	Organisation of postgraduate medical training at regional level.
Higher and further education providers	Provision of undergraduate and vocational training courses.
Royal Colleges, trades unions and other membership organisations	Provision of workforce information; negotiation of workforce contracts.
Healthcare regulators	Registration of healthcare staff.

Formal minutes

Thursday 15 March 2007

Members present:

Mr Kevin Barron, in the Chair

Mr Ronnie Campbell	Dr Howard Stoate
Jim Dowd	Dr Richard Taylor

The Committee considered the draft Report [Workforce Planning], proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 292 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Annex read and agreed to.

Resolved, That the Report be the Fourth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the Provisions of Standing Order No. 134.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

[Adjourned till Thursday 22 March at 9.30 am

Witnesses

Thursday 11 May 2006

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Andrew Foster, Director of Workforce, **Debbie Mellor**, Head of Workforce Capacity, and **Keith Derbyshire**, Senior Economic Adviser, Department of Health, **Dr Judy Curson**, Director of Workforce Review Team, NHS — Ev 1

Professor Sue Hill, Chief Scientific Officer, **Sir Liam Donaldson**, Chief Medical Officer, **Dr David Colin-Thome**, National Clinical Director, **Professor Bob Fryer**, National Director for Widening Participation in Learning, and **Andrew Foster**, Director of Workforce, Department of Health — Ev 17

Thursday 18 May 2006

Sian Thomas, Deputy Director, NHS Employers, **David Amos**, Director of Workforce, University College London Hospitals, **Warren Town**, Secretary, Alliance for Health Professionals, and **Professor Sir Alan Craft**, Chairman, Academy of Medical Royal Colleges, and **Josie Irwin**, Head of Employment Relations, Royal College of Nursing — Ev 30

Thursday 8 June 2006

Dr Jonathan Fielden, Deputy Chair of the Consultants Committee, British Medical Association, **Karen Jennings**, Head of Health, UNISON, and **Alastair Henderson**, Deputy Director, NHS Employers — Ev 49

Professor Dame Carol Black, President, Royal College of Physicians, **George Blair**, Managing Consultant, Shared Solutions Consulting, and **Dr Karen Bloor**, Senior Research Fellow, University of York — Ev 58

Thursday 15 June 2006

Professor Bonnie Sibbald, Deputy Director, National Primary Care Research and Development Centre, University of Manchester, **Deborah O'Dea**, Director of Human Resources, St Mary's NHS Trust, **Dr Hugo Mascie-Taylor**, Medical Director, Leeds Teaching Hospitals NHS Trust, and **Alison Norman**, Director of Nursing and Operations, Christie Hospital NHS Trust — Ev 71

Bill O'Neill, Head of Education and Development, London Ambulance Service, **Dr Sally Pidd**, Chair of the Recruitment and Retention Working Group, Royal College of Psychiatrists and **Rob Darracott**, Director of Corporate Strategic Development, Royal Pharmaceutical Society of Great Britain — Ev 82

Finlay Scott, Chief Executive, General Medical Council, **Marc Seale**, Chief Executive, Health Professions Council, and **Sarah Thewlis**, Chief Executive, Nursing and Midwifery Council — Ev 91

Thursday 29 June 2006

Professor David Gordon, Chair, Council of Heads of Medical Schools, **Paul Streets**, Chief Executive, Postgraduate Medical Education and Training Board, **Professor Elisabeth Paice**, Chair, Conference of Postgraduate Medical Deans, and **Mr Bernard Ribeiro**, President, Royal College of Surgeons Ev 96

Professor Tony Butterworth, Director, Centre for Clinical and Academic Workforce Innovation, University of Lincoln, **Professor Dame Jill Macleod Clark**, Chair, Council of Deans of UK Faculties for Nursing and Health Professions, and **Professor Sir Andrew Haines**, Health Committee Member, Universities UK Ev 106

Professor Selena Gray, Registrar, Faculty of Public Health, **Paul Holmes**, Chief Executive, Kingston PCT, **Dr David McKinlay**, Director of Postgraduate GP Education, North Western Deanery, and **Dr Graham Archard**, Vice-Chair of Council, Royal College of General Practitioners Ev 113

Thursday 14 December 2006

Ms Anne Rainsberry, Director of People and Organisation Development, NHS London, **Mr John Sargent**, former Chief Executive, Greater Manchester Workforce Development Confederation, and **Ms Trish Knight**, Director of Workforce Development and Commissioning, Leicestershire, Northamptonshire and Rutland Healthcare Workforce Deanery Ev 121

Mr Peter Stansbie, Director of Organisational Development, Skills for Health, and **Mr David Highton**, NHS Partners Network Ev 136

Thursday 18 January 2007

Sir Jonathan Michael, Chief Executive, Guy's and St Thomas' NHS Foundation Trust, **Mr Mike Sobanja**, Chief Executive, NHS Alliance, and **Ms Susan Hodgetts**, Chief Executive, Institute of Healthcare Management Ev 143

Professor Christopher Foster, Director of Workforce Planning, College of Pathologists, **Mr Phil Gray**, Chief Executive, Chartered Society of Physiotherapy, and **Ms Louise Silverton**, Deputy General Secretary, Royal College of Midwives Ev 156

Thursday 25 January 2007

Lord Hunt of Kings Heath OBE, a Member of the House of Lords, Minister of State for Quality, **Ms Clare Chapman**, Director General of Workforce, and **Mr Nic Greenfield**, Director of Workforce (Education, Regulation and Pay), Department of Health Ev 167

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42	North Western Deanery (WP 08)	Ev 138
43	Max Webb, University of Nottingham (WP 63)	Ev 140
44	Nursing and Midwifery Council (WP 69)	Ev 141
45	Office for National Statistics (WP 75)	Ev 142
46	Parkinson's Disease Society (WP 53)	Ev 144
47	Patient and Public Involvement Forum, Hull and East Yorks Hospital Trust (WP 07)	Ev 147
48	Postgraduate Medical Education and Training Board (WP 52)	Ev 148
49	Prostate Cancer Charter for Action (WP 24)	Ev 149
50	Public and Commercial Services Union (WP 14)	Ev 152
51	Reache North West (WP 09)	Ev 153
52	Brennan Wilson, Reache North West (WP 58)	Ev 154
53	Refugee Healthcare Professional Project (WP 13)	Ev 155
54	Roche (WP 49)	Ev 156
55	Royal College of Anaesthetists (WP 11)	Ev 163
56	Royal College of General Practitioners (WP 66)	Ev 168
57	Royal College of Midwives (WP 54)	Ev 170
58	Royal College of Nursing (WP 42)	Ev 175
59	Royal College of Ophthalmologists (WP 33)	Ev 182
60	Royal College of Physicians (WP 51)	Ev 184
61	Royal College of Psychiatrists (WP 71)	Ev 191
62	Royal College of Radiologists (WP 70)	Ev 196
63	Royal College of Surgeons of England (WP 28)	Ev 199
64	Royal National Institute for the Deaf (WP 18)	Ev 205
65	Royal Pharmaceutical Society of Great Britain (WP 50)	Ev 208
66	Shared Solutions Consulting (WP 03)	Ev 211
67	Skills for Health (WP 12)	Ev 216
68	The Skin Care Campaign (WP 04)	Ev 222
69	Society of British Neurological Surgeons (WP 25)	Ev 223
70	Society of Radiographers (WP 40)	Ev 224
71	Tandberg (WP 64)	Ev 226
72	UNISON (WP 62)	Ev 227
73	Universities UK (WP 65)	Ev 232
74	Wyn Jones, West Yorkshire Workforce Development Confederation (WP 41)	Ev 234
75	British Association of Physicians of Indian Origin (WP 79)	Ev 238

List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons Library where they may be inspected by Members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074). Hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

Supplementary memoranda from UNISON

Institute of Healthcare Management

Appendices to the memoranda from the Royal College of Pathology

Reports from the Health Committee

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2006–07

First Report	NHS Deficits	HC 73 (Cm 7028)
Second Report	Work of the Committee 2005–06	HC 297

Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815 (Cm 6922)
Fourth Report	Independent Sector Treatment Centres	HC 934 (Cm 6930)

The following reports have been produced by the Committee in the 2001–05 Parliament.

Session 2004–05

First Report	The Work of the Health Committee	HC 284
Second Report	The Prevention of Thromboembolism in Hospitalised Patients	HC 99 (Cm 6635)
Third Report	HIV/AIDS and Sexual Health	HC 252 (Cm 6649)
Fourth Report	The Influence of the Pharmaceutical Industry	HC 42 (Cm 6655)
Fifth Report	The Use of New Medical Technologies within the NHS	HC 398 (Cm 6656)
Sixth Report	NHS Continuing Care	HC 399 (Cm 6650)

Session 2003–04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111 (Cm 6270)
Third Report	Obesity	HC 23 (Cm 6438)
Fourth Report	Palliative Care	HC 454 (Cm 6327)
Fifth Report	GP Out-of-Hours Services	HC 697 (Cm 6352)
Sixth Report	The Provision of Allergy Services	HC 696 (Cm 6433)

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)
Eight Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 (Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515 (Cm 5611)
Third Report	Delayed Discharges	HC 617 (Cm 5645)