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Health Committee

Workforce Planning

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Footnotes

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Supplementary memoranda from UNISON

Institute of Healthcare Management

Appendices to the memoranda from the Royal College of Pathology

Oral evidence

Taken before the Health Committee

on Thursday 11 May 2006

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess
Charlotte Atkins
Mr Ronnie Campbell
Jim Dowd
Sandra Gidley
Anne Milton
Dr Doug Naysmith
Dr Howard Stoate
Dr Richard Taylor

Witnesses: **Mr Andrew Foster,** Director of Workforce, **Ms Debbie Mellor,** Head of Workforce Capacity, **Mr Keith Derbyshire,** Senior Economic Adviser, Department of Health and **Dr Judy Curson,** Head of Workforce Review Team, National Health Service, gave evidence.

Q1 Chairman: May I say good morning and welcome you to the Committee? May I ask you to introduce yourselves and your positions for the record please? May I start with Dr Curson?
Dr Curson: I am Dr Judy Curson. I lead the Workforce Review Team which is an expert group of NHS staff providing national analysis and modelling of workforce in the health professions. We work on behalf of and make recommendations to strategic health authorities.
Ms Mellor: I am Debbie Mellor. I am head of Workforce Capacity in the Department of Health where my remit is ensuring that the workforce planning and the supply and demand are effective.
Mr Foster: My name is Andrew Foster. For the last five years I have been the Director of Workforce at the Department of Health. As of last week, I have moved onto a new role, but I did not want to miss the pleasure of meeting you all just one more time before I went. If I could have the opportunity in a moment just to say a few opening remarks, I should be grateful.
Mr Derbyshire: I am Keith Derbyshire. I am a Senior Economist Adviser in the Department of Health. I have worked on workforce issues in the past and am currently working on productivity.

Q2 Chairman: May I welcome you all? This is the first session of our inquiry into workforce planning. Mr Foster, you said that you would like to say a few words first, by all means do.
Mr Foster: I am actually particularly grateful to this Committee which in 1999 undertook a review of workforce planning which identified a series of weaknesses and failings and led to a major overhaul from a document produced internally by the Department called *A Health Service of All the Talents* and then to a restructuring of workforce planning which has become more robust year on year. I should not like to pretend by any means that we have a perfect workforce planning system now, but we have the closest thing to a balance between demand and supply for healthcare staff that we have ever had, as measured by the lowest vacancy rates for most of the main professions that we have ever had. I am very pleased that the Health Select Committee is going to focus on us yet again, because I am sure that we have further improvements to make, which we plan anyway, but it was the impetus from you in 1999 that pushed this much more to the forefront of the NHS planning systems and has been a real benefit.

Q3 Chairman: Thank you very much. I wonder whether any of my colleagues here were actually on the Committee at that time; I was not.
Mr Foster: Debbie Mellor was part of the team that provided help last time as well.

Q4 Chairman: Let us pursue how that report and the subsequent actions got round. You have probably seen on the news this morning that we are being lobbied by NHS workers again today here in Parliament. I suppose many people out there, members of the public, would ask the obvious question. A few years ago we were told the NHS was short of staff, yet now we seem to be making people redundant. Why is this?
Mr Foster: The headlines are a gross misrepresentation of what is really happening. For the last five years we certainly have had a remarkable increase in the number of staff. It is about 200,000 increase in staff in just the last four years and the last figure, the last year for which we have accurate records, is the year which finished September 2005, which showed that there was a further 34,000 increase in staff last year. This year, many organisations are having to make sure that their workforce plans are aligned with their financial plans and many are announcing intentions to reduce the number of posts in their organisations. However, when you plough beneath almost every single one of those headlines, they are reductions in numbers of posts, not making actual staff redundant. Typically, we did a poll of this when we had a HR conference in Birmingham the week before last, where about 1,000 HR managers were present and typically, the ratio of actual compulsory redundancies to the headlines is

about 1:100; so in organisations making 300 post reductions, three compulsory redundancies. There are one or two exceptions to that, but for the very large part this is to be achieved through natural turnover rates, typically 10% in any organisation in a year, through reduction in reliance on agency and temporary staff and not through making actual staff redundant and particularly not clinical staff.

Q5 Chairman: May I ask you about nurses in particular? The NHS Plan set the target of expanding the nursing workforce by 20,000 nurses between 1999 and 2004. Recent evidence shows that the nursing workforce in fact grew by 68,000 during that period. Why did this actual expansion so greatly exceed the target expansion?
Mr Foster: Well, the NHS Plan target said at least 20,000 nurses and then it went on to roll that target forward in a series of two further documents which had a target going up to 2008. Yes, we have very significantly exceeded the targets that were set and that is really based on the needs of local organisations to meet the demands of the access targets, increasing the capacity necessary to reduce waiting times and to improve quality through delivering the national service frameworks. So the main reason is that the figures that were in the NHS Plan and the subsequent documents were minimum targets and they do explicitly say that.

Q6 Chairman: I accept that they were minimum targets, but the plan in 2000 has been overshot, for want of a better expression, by 340% as far as nurses are concerned. It seems to me that when you talked earlier about this issue of workforce plans having to come into line with financial plans, most people would ask why workforce plans were not in line with financial plans, or the other way round, in the year 2000 when the NHS Plan was first published. Why do we wait while there is this perceived crisis? I accept, looking at these figures, I do not disagree for one minute, that the actual job losses are far below what has been grabbing the headlines in the media. What grabs the headlines in the media grabs the public as well. Why were we not having financial and workforce plans working alongside one another logically for the last six years?
Mr Foster: For the last five years we have had workforce and financial plans which have worked alongside each other quite comfortably, as witnessed by the fact that the NHS has achieved its targets and stayed within financial balance until the last year, 2005–06, when there were well-publicised significant difficulties. I accept that there was a degree of over-heating in the system just in this last year, where people clearly have taken on more than they could afford and there is some evidence of that, for example in North Staffordshire, which is one of the organisations with the biggest problems and has announced 1,000 job reductions, where it actually took on 300 extra staff in the first quarter of last year. The integration of financial and activity planning has not been as good as it might have been everywhere. For example, if you take last year's planning process, there is a challenge in the system that was created following the last HSC report so that organisations submit workforce plans at the beginning of the year and in April 2005 organisations submitted workforce plans which totalled an increase of approximately 6%. These were then challenged by the central workforce planning process and they were told that those did not really match up with the financial environment that they were entering. As a result of that, the plans were redrawn and predicted a 2% increase in the workforce in 2005–06, which is in fact very similar to what was achieved when you look at the September 2005 census figures. It is a system which has worked relatively well for four or five years, but has just slightly over-heated in the last year.

Q7 Chairman: Does this scenario of over-heating, as you call it, help to explain the current trend towards deficits and redundancies in parts of the NHS? Is that basically what you are saying?
Mr Foster: Yes. The NHS does have deficits in 2005-2006. Two thirds of the money that we spend is on staff and therefore, in order to bring it back into balance, clearly staff numbers have a very significant part to play. Thanks to the very high turnover rate that happens naturally every year, we have the opportunity to do that with minimum redundancies.

Q8 Anne Milton: Notwithstanding that the nursing workforce has expanded more quickly possibly than intended, the number of central administrative and management staff has grown more quickly still. In fact these figures in front of me show that nurses as a whole have gone from 30% of the workforce in 1999 to 29% of the workforce, whereas the support staff and senior management have grown quite substantially as a percentage of the total workforce. Can you justify that?
Mr Foster: I can explain it and I can also point to what is likely to happen by the time that you get the next set of figures. Broadly speaking, what has happened over the last five years is that we have brought a level of management into primary care that was never there before. So the creation initially of primary care groups and then primary care trusts, each with their own management teams, is an attempt to introduce management into primary and community care that was never there before. If you look at the level of management in NHS acute trusts, you will see that there has been no growth at all, or only growth which is proportionate to the total increase in the size of organisation; so the significant growth has come in primary care. As part of the manifesto commitment last year, the Government announced their intention to reduce £250 million out of management costs, a process which is now working its way through with the reduction in numbers of strategic health authorities and primary care trusts so that by the time you get the next set of results, you should see a reduction in that figure which will bring it much more into line with the rest of the workforce.

Q9 Anne Milton: I have to ask you, because I think the public would want to know, what the management in primary care has been managing?
Mr Foster: It has been managing the change in the system which seeks to prepare for less care to be delivered in hospitals, more care to be delivered in primary care settings and in the patient's home. It is managing that pathway of the patients.

Q10 Anne Milton: You are going to have to have another go Mr Foster, because I do not think that anybody reading this would be entirely clear what you mean by that.
Mr Foster: What I would really like to do is ask you to ask that question again in the second half of our session when we have Dr David Colin-Thome present, who is the Tsar of national primary care and who will be able to give a better answer than I can.

Q11 Anne Milton: It has been management for primary care, for practices and district nurses and . . . ?
Mr Foster: It is also commissioning. It is also allowing GPs, on behalf of patients, to plan services and giving them the management support that they need to do so.

Q12 Anne Milton: Right; so the managers have been helping the GPs.
Mr Foster: Yes.

Q13 Mr Amess: What you have just said is just barking mad. I am trying to reflect on it. We have more staff in the primary care trusts to sort things out because of the way the practices with the hospitals are changing and at the same time we are reorganising primary care trusts, we are going to cut down the numbers, we are going to streamline the numbers. This is an absolute shambles. This is not planning: this is just all over the place. I am sorry, but what you have just said to the Committee just does not make any sense whatsoever. You want us to leave it alone until 11.15am when the Tsar comes in and I realise you have moved on to another job, but you were the guy. You started off praising us for what we did in 1999, but honestly you could do a little bit better in trying to expand on what you said earlier, just to make sense. The general public are not idiots.
Mr Foster: Okay. One thing I said was that we want a trend whereby people are treated less in hospitals and more in their homes and in the community; I do not think anybody would disagree with that. We said we have a trend where we want to have the patient experience in primary care better managed; I do not think anybody would disagree with that. We would say that we have reached a point where we recognise that this had resulted in a disproportionately high management cost going into primary care, so there is now a correction of the order of £250 million to concentrate that into a smaller number of larger organisations carrying out the same task; I do not think anybody would disagree with that. You have all of those three trends working at the same time which is a complex set of changes to manage but each of the three are things which I think people would agree with.

Q14 Anne Milton: I just want to come back on one thing. The managers are for primary care and yet the number of GPs as a percentage of the workforce has gone down from 2.7% to 2.6%. The number of practice nurses, which I should say, if there is an increasing emphasis on primary care, you would expect to have gone up, but that has gone down. It is hard to understand this.
Mr Foster: If you look at the community nursing figures, what you are seeing is a much greater flexibility here.
Ms Mellor: The community nursing figures have been going up steadily year on year and we now have over 100,000 community nurses working in primary care.

Q15 Anne Milton: It is not whether they go up or not, it is what they represent as a percentage of the total workforce. That is the crucial thing. The fact that they have gone up or down is not quite the point. It is the fact that as a percentage of the total workforce those numbers are going down.
Ms Mellor: In community nursing, the numbers are going up.
Anne Milton: No, you are not listening to what I am saying: as a percentage of the total workforce, not the actual numbers.

Q16 Dr Naysmith: Are you saying there has been an expansion in primary care trust management staff or in primary care delivery in the primary care setting?
Mr Foster: I am saying that there has been definitely an increase in the number of primary care trust management staff and the plan is to shift care from secondary care to primary care.

Q17 Dr Naysmith: Not many people would disagree with that. What are the primary care trust managers doing for primary care that was not being done before?
Mr Foster: Commissioning is the main answer to that.

Q18 Dr Naysmith: Do you mean commission things at a primary care trust level?
Mr Foster: Commissioning integrated care between secondary and primary care. The secondary care are provider organisations: they do not plan the whole patient pathways; they do commission the services; they do not decide what is delivered where, that is the role given to PCTs as advised by the experts, the GPs.

Q19 Sandra Gidley: Let me get this straight. We have had an increase in primary care management over five years, the agenda you have just mentioned about moving care close to home and all of the other rhetoric, I would perhaps agree with, but I have seen little movement in that over the last five years. What I am struggling to understand is how services have been improved for patients; not the man on the

Clapham omnibus, but the man in Clapham hospital's bed. There seems to have been no corresponding increase in workforce in primary care, which I could understand if this increased number of managers was delivering. So how has this actually improved for the patient? Can you give me a practical example, because I am struggling to get my head round this?

Mr Foster: In answer to the two questions here, what you have seen in the last five years is slightly more growth occurring in the hospital sector than in the primary care sector and the benefits to patients you can demonstrate in terms of the dramatic reduction in waiting at every level of the system from A&E to outpatients to inpatients to cancer care, the improved clinical outcomes in terms of reduced death rates from coronary heart disease and cancer and the emphasis of shifting into primary care has been a plan for a while which is now really being given much more impetus by the White Paper, *Our Health, Our Care, Our Say* and through the creation of the new GMS contract which has a much better quality control of primary care. You can demonstrate the quality outcomes in primary care as measured through the quality and outcomes framework which is used to remunerate GP practices. So you can see demonstrable benefits there. The real stage of transfer from secondary to primary care is about to begin.

Q20 Sandra Gidley: But the demonstrable benefits you talk about are because you are actually paying GPs to deliver certain services and they deliver if they are paid. I cannot see how that is linked to the increase in management.

Mr Foster: No, but you asked me what the demonstrable benefits were of the increase.

Q21 Sandra Gidley: The demonstrable benefits of the increase in management and actually most of what you said was related to secondary care, the reduced times for operations. Basically we welcome all that, but I cannot see the benefits in primary care.

Mr Foster: You cannot just stop doing some practices in a hospital and start doing it in primary care. You need to manage the transition, you need to manage the patient flows and you need to manage the training of the staff who will apply the extra skills. So there is a management task in changing from something which is predominantly hospital oriented to something which is delivered much more in the home.

Q22 Sandra Gidley: But you also said that there is a lot more impetus to this care close to home and we are now reducing the managers. What have they been doing for five years?

Mr Foster: The managers have been changing to an environment where there is a greater level of management in primary care, but in response to the workforce statistics that we have seen about the disproportionate growth, what we have found is that the size of unit which is typically commissioning care in primary care, the PCT, has been too small. The big hospital trusts have been powerful organisations and have not been able to be sufficiently bossed around by the PCTs. The plan now is to have a smaller number of much more powerful PCTs, with greater powers of commissioning, building on the work which has been laid to shift from secondary to primary and strengthened by the direction set out in the White Paper.

Q23 Sandra Gidley: So will the current changes mean a reduction or an increase in the number of managers working at primary care level?

Mr Foster: It will mean a reduction. The next workforce figures you will see will show a reduction of managers working in primary care trusts.

Q24 Sandra Gidley: I have never seen a single organisation that has resulted in large-scale management redundancies.

Mr Foster: It is required. The £250 million manifesto commitment saving is disaggregated to each strategic health authority so that it has to be achieved at PCT level. The process of reducing from 300 PCTs to a number which has yet to be announced, but something of the order of half of that, will result in £250 million of management savings and that will show through in next year's figures.

Mr Amess: Would you agree that it does not look very good? Nurses in 1999 30% fallen to 29.6%, bureaucrats 6.7% up to 7.7%, senior management 2.2% up to 2.9%.

Chairman: I was going to put that question back to Debbie Mellor because what Anne Milton was pursuing and what you have just said there is that there is no contradiction. If some parts of the workforce are expanding by a few percent that does not really say there are not more people working in that particular area. That is basically what our witnesses are telling us about these differentials that there are in the tables we have seen.

Q25 Dr Stoate: At the risk of being politically incorrect, I would have to say that the health service has been woefully under-managed for generations and in fact I have to say that some of the management increases in primary care have been very welcome. I am not talking about the number of administrators but the number of managers, and I really mean managers, is actually extremely welcome and has actually knocked some sense into what has been an extremely disparate sector of the health service for far too long. What I want to move on to is your memorandum which indicates that the focus over the last five years has largely been on expanding the workforce and the memorandum goes on to say that over the next five years, it is going to focus on the transformation of the workforce. Perhaps you would like to explain what that means?

Mr Foster: The NHS Plan of 2001 produced by Alan Milburn started off with an analysis based on a variety of consultations but one of them was asking the public what they wanted to see. The number one thing that the public said that they wanted to see in 2001 was more staff better paid. What has really happened over the last five years is precisely that.

More money has gone into pay, the numbers have increased by about 200,000 and we have introduced new systems of remuneration which are designed to increase the flexibility and productivity of the system. We have achieved the input targets. We are now shifting to looking at the output targets.

Q26 Dr Stoate: That is my point. We are seeing the extension of numbers; now we want to see the transformation of the service. I want you to explain how that is going to happen.
Mr Foster: Exactly. Mr Derbyshire on my left is our expert in productivity and I shall pass it on to him in a moment. Broadly speaking, there is a series of measures which have been well described by the former Modernisation Agency of high impact changes which require you to redesign the way services are delivered so that you reduce the length of stay in the hospital sector, you do as much work as day case procedures as you can, you adjust the skill mix of your team so that the work is done by the person who is safe to do the work but is most economically efficient. For example, some years ago you might have seen a doctor taking a blood sample from a patient, then we have had phlebotomists who have been trained to do it, then we have had nurses who have been trained to do it and now we have healthcare assistants who are trained to do it. So the same procedure can be carried out much more economically, effectively by somebody who is a member of the team and who can then be remunerated for taking on extra responsibilities. So that redesign of services and redesign of skill mix will enable us to get a higher output or productivity.

Q27 Dr Stoate: Are you confident that will happen? All of that sounds lovely in theory and I am quite sure that is the intention, but are you convinced that is actually what is going to happen?
Mr Foster: That is what is already happening and what we want to do is to accelerate it.
Mr Derbyshire: If we go back to the NHS Plan in 2000–01, then the decision was made to increase the inputs into the National Health Service by a significant and sustained amount and a lot of the increase in inputs was the increase in labour force which we have seen achieved. Over the past five years the output of the NHS has increased more or less in line with those inputs. What we should like to do is further increase the rate of improvement of the output of the NHS as fast as the increase in the input.

Q28 Dr Stoate: Could it not be said though that it was somewhat reckless to expand the workforce massively without sorting out the outputs as a priority right from the beginning? All we are left with then are the charges, which we have heard from many members of the Committee today, of a massive explosion in management, but seemingly not enough to show for it yet. Is that not the charge that it is too easy to levy at you?
Mr Derbyshire: There was a risk with the rapid expansion of the NHS that not all of the increased resources would be deployed on improving patient health. The question about managers is not what the increase in managers has been, but precisely what they have done to facilitate improved health outcomes.

Q29 Dr Stoate: That is exactly the question. What have they done? It leaves open the question. We have seen the massive expansion, we can look at the huge input into the health service, but can you honestly say that enough has changed to justify that?
Mr Derbyshire: In aggregate terms, we can, and working with the ONS and the Atkinson review of *How to Measure Government Outputs*, if you move away from crude measures of what the NHS produces in terms of patient treatments and begin to look at the quality and the health benefits those treatments deliver, then output has risen in line with inputs. Then there is a micro question about whether the mix of inputs is correct. Andrew made the point about PCT managers that maybe the organisations themselves were badly configured; they were perhaps too small for the role that they have gradually been evolved to do and we are putting that right for the future. One of the underlying reasons for their smallness to begin with was to work together in a community of GPs to organise services at primary care level as well as commission from secondary care.
Mr Foster: On the point you made right at the start of your question about management, if you do patient surveys or if you even think anecdotally of the instances you know of where friends or relatives of yours have been using healthcare systems, by and large the time that they spend with the clinician is excellent; they have a fantastic service. It is their travel through the system that is often unsatisfactory and it is more management of the pathway that is needed and better management and that is really what we are trying to achieve in line with international best practice. We spend less than 3% of the NHS pay bill on managers and that compares well with anywhere else in the world.

Q30 Chairman: May I just ask you about this issue of transformation? We are all very well aware of what the public's attitude was to the NHS Plan: more staff and better paid. In a recent interview that you gave to the *British Journal of Healthcare Management*, when you were talking about the workforce side of this, you said that we have to lose 1940s ways of working and need a more flexible workforce with more patient-centred care. Did you genuinely feel that there were still 1940s ways of working in the National Health Service? Not in whole, but in part or in whole?
Mr Foster: Yes. I have given one example already, which was taking blood samples. Take another example, prescribing. We now have nearly 10% of the nursing workforce doing some form of prescribing. Several years ago only doctors prescribed. Now that is about really dramatically changing the division of labour within the workforce and allowing people with appropriate training to carry out tasks which they are perfectly skilled to do. Nearly 10% of the nursing workforce is a very large amount of transformation indeed, but that hides a

plethora of exciting new roles. In any healthcare organisation you visit you will not only find these extended roles, people doing tasks that they did not do before, but you will find some completely new roles. We now, for example, have approximately 800 emergency care practitioners who are people who will deal with sick and elderly patients in their own home, avoiding them being admitted to hospital, which is not just an economic benefit to the system, it is infinitely preferable for the patients themselves. We could go on to give you countless examples of new roles in the therapies, in science, GPs with special interests, which are really about the transformation of the workforce away from the rather rigid silos of apples and pears, nurses, doctors and so on that there used to be.

Q31 Anne Milton: Would you expect the pay to go with it? Doctors at one time prescribed and they were the only people who prescribed, then nurses extend their role and start prescribing. Would you expect, say, if you took nurses, that they would get increases in remuneration to reflect that?
Mr Foster: Yes.

Q32 Sandra Gidley: The accusation is that they become a cheap labour force. It is cheaper for nurses to prescribe than it is doctors.
Mr Foster: No. 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. You have a better opportunity for the nurses.

Q33 Anne Milton: You would expect pay to increase with the extension of role.
Mr Foster: That is exactly what Agenda for Change is designed to do. It is actually to incentivise people to take on added responsibilities and pay them more for it. If you look at the pay bands of Agenda for Change, band five is a newly qualified nurse, band six is probably a ward manager but then you see nurse endoscopists, cardiac theatre nurses and a whole range of extended roles at band seven and above reflecting the fact that they have taken on extra responsibilities.

Q34 Anne Milton: There is some concern about that within some of the professions within the NHS. It is not so much an increase but equivalent pay scales that they are looking for.
Mr Foster: The whole system is based on a very complex job evaluation scheme which took seven years to develop but working in partnership with the trade unions. It is probably the most thoroughly tested job evaluation scheme anywhere in the world and is widely regarded by the trade unions as a very successful joint development.

Q35 Chairman: Are there any practical measures beyond Agenda for Change that workforce planners are using to get this transformation in terms of maybe skilling?
Mr Foster: Yes. May I broadly say that we recognised that in workforce planning there is a degree of bottom-up: how many people are going to be retiring over the next few years? There is a degree of top-down: what are the major changes in demography, technology, international immigration? Then what we do is some skill specific analysis: what are the skills we need for cancer services of the future? Rather than saying we need to commission so many more nurses or so many more physiotherapists or whatever, we are looking at the competences that we require as an added input to workforce planning. Judy sits at the heart of this complex web, so may I perhaps ask her to answer that?
Dr Curson: You are asking about what workforce planners can do to support transformation.

Q36 Chairman: Yes, practical things beyond Agenda for Change.
Dr Curson: One of the issues is that as workforce planners we can come up with plans. It is down to trusts and to service managers in the trusts to implement those and that can be an issue with new roles. For example, graduate mental health practitioners, where a new role was developed which crossed the boundary between social work, OT, nursing. Sometimes it can be difficult to convince service managers in trusts who are under a lot of pressure to take on new roles and to work in different ways, so one of the things is for workforce planners not to work in isolation and come up with great dreams of wonderful new roles that will make a difference, but to ensure that that is embedded in the way people work locally and that they actually want the roles and are going to know how to use them. A number of projects are going on nationally and at local level to try to support people to make those changes so that workforce planning does not take place . . . We have talked about it not taking place separately from financial planning, but it is actually very important that it is not separate from service planning because otherwise there is a risk that workforce planners come up with new roles and then no-one wants to employ them.

Q37 Jim Dowd: There has been a significant number of changes in workforce planning in the last five or six years. I just mention the National Workforce Development Board replaced by the Workforce Programme, the Workforce Numbers Advisory Board replaced by the Review Team. Why have there been so many changes and surely they are more disruptive than beneficial?
Mr Foster: What you are describing are not fundamental changes, these are evolutions. So for example, you talked about the Workforce Programme Board and its predecessor the National Workforce Development Board, there was really a sort of modest adjustment of the membership of effectively the same body to make sure that we had better representation from strategic health authority management. There is no fundamental change going on there.

Q38 Jim Dowd: Are you saying then that was because the SHAs developed over time and the relationship needed to change?
Mr Foster: Yes; exactly. The original National Workforce Development Board was a stakeholder board which sat at the pinnacle of the workforce planning process and we recognised that we needed to get a better buy-in from the strategic health authority management. That is why that changed.

Q39 Jim Dowd: Then of course the SHAs were reorganised.
Mr Foster: And then the SHAs have been reorganised, but all that will mean is that there will be different individuals, but we will still have the SHAs represented within the process.
Dr Curson: I would echo some of that; a lot of it has been evolution. My team used to make recommendations on medical workforce to a body called SWAG. It then made recommendations to the Workforce Advisory Board and now we go to the Workforce Programme Board. Basically the team has been doing very similar work with the same group of stakeholders over that five-year period, so it does feel more evolutionary than revolutionary in that sense, although I accept that there have been a number of changes.

Q40 Jim Dowd: What about the disadvantages of this reorganisation?
Dr Curson: Certainly 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 and that is one of the reasons National Workforce Projects have actually set up the first training programme for workforce planners. 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. We are putting as much support in place as we can to ensure that people are retained and once the new people are appointed we shall be providing information packs for example and offers to help and advise them on where they can get information and so on if they are new to workforce planning. It is a concern, but one that everyone is actively addressing.

Q41 Jim Dowd: Mr Foster, the Chairman mentioned your interview with the *British Journal of Healthcare Management*. In that you describe the closure of the Modernisation Agency as a terrible mistake. I should say in passing that, as the Director of Finance at Lewisham Hospital was poached specifically to work for the Modernisation Agency, it was a particular blow locally to learn that it was being closed. If it was such a mistake, what are you doing to redress that and why was it closed?
Mr Foster: I should perhaps make it clear that I was giving an interview in a personal capacity and I have not actually seen this interview yet; I was not speaking officially on behalf of the Department, as you will probably appreciate. 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. The work that was being done, indeed by some of the people who are advising this Committee, to accelerate, define and expand new roles, to develop a competence-based workforce, has lost some of the impetus behind it as a result of the disappearance of the Modernisation Agency. The new NHS Institute has taken over some of the former roles of the Modernisation Agency, but it is a smaller body, it does not have the same capacity to influence job redesign at ground level, so we are going to have to devolve the initiative to do that to NHS organisations themselves more. I personally feel we would have been able to do it better, if we still had the Modernisation Agency.

Q42 Jim Dowd: What about the impact on programmes like the advanced practitioner programme?
Mr Foster: Exactly. The programmes themselves remain, so out of the former work of the Modernisation Agency much has been retained and devolved to organisations like Skills for Health, the Sector Skills Council, to the NHS Employers or to some individual strategic health authorities. However, it has become rather more fragmented than it was and it will be more difficult therefore to coordinate as an overall pattern and there is less capacity behind it as well.

Q43 Jim Dowd: In conclusion, are you saying that the benefits which it offered were clear but were just too expensive?
Mr Foster: I am saying that the decision which was taken to remove the Modernisation Agency came just as the Modernisation Agency was really beginning to accelerate and deliver benefits. If we had waited another six or 12 months, we would never have removed the Modernisation Agency.

Q44 Dr Taylor: I am afraid I cannot be terribly quick because I am just totally and utterly confused. We already know there have been something like 30 reorganisations of the NHS in the last 20 years. We are now getting organisation after organisation with acronyms, all differing, which come for a few months and disappear again; I am completely lost. We have got the National Workforce Development Board, the Workforce Numbers Advisory Board, the Modernisation Agency, NHS employers, none of which still exists. Then we go over the sheet of our brief and we have Workforce Development Confederation, we have them being made co-terminous with strategic health authorities, then them merging. How does anybody know what is happening and what is going on? It strikes me as utterly ridiculous.
Mr Foster: May I separate those out? One is about structures of the NHS overall, so the move from PCGs to PCTs and then reducing the number of PCTs, the reduction in the number of strategic health authorities, previously directorates of health and social care, all of that is one set of things which

I am happy to talk about if you like. In terms of workforce planning, the conclusion of your committee in 1999 was that we were not sufficiently sophisticated and it is hugely complicated. You will know as well as anybody how difficult it is to do medical workforce planning. Take an example like cardio-thoracic surgery where during the period of training of a cardio-thoracic surgeon the technology has changed so dramatically that we do not need what we started off the training with. So we need an ever more sophisticated set of arrangements which does mean setting up specific bodies with the right expertise. I apologise for the use of acronyms, it is because they tend to have such long names to represent the combination of expertise that they are representing, that we do reduce them to these acronyms. For each of those bodies and for the evolution of each of those bodies, there has been an extremely good reason, as outlined by Dr Curson, about getting the system ever better year on year, albeit that I fully accept that it will never be perfect.

Q45 Dr Taylor: May I go back to the combination of the workforce development confederations and strategic health authorities? Is that not going to dilute the effectiveness of planning? How are you going to make sure that planning at strategic health authority level becomes really competent?
Mr Foster: Again, I have expressed in that article that I regret the disappearance of the Modernisation Agency and 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. The reason for incorporating them into strategic health authorities goes back to some of the issues we were talking about earlier on, about better integration of workforce planning with finance and activity planning and the view which won the day, accepting that there are arguments on both sides, was that it would be better to locate the workforce planning and training commission functions absolutely inside the strategic health authority, so that what was a separate workforce development confederation now becomes an integral part of the strategic health authority to improve the integration of planning. That is the logic behind that.

Q46 Dr Taylor: Do you think with the reduction of 28 to 10 that they will be able to cope?
Mr Foster: Dr Curson has already outlined her concerns that there is a risk of loss of talent. On the face of it, we shall have more numbers of people than we need posts for, so there should be a surplus, but there is always a danger in reorganisations that the best people go quickly and therefore we may have some short-term problems. I am sure that Judy and her team will be doing their best to compensate for any short-term friction with a view to restoring a much stronger system under the 10 new strategic health authorities.
Dr Curson: From our perspective as the Workforce Review Team trying to work with the 28 health authorities, what appeared to happen was that when the WDCs were brought with the health authorities, and I can understand the rationale about integrating workforce and financial and service planning, although we regretted it at the time, when that happened what appeared was that some health authorities retained a much stronger workforce and workforce planning function than others. Our hope is that with the 28 coming down to 10 they will all have equally strong strategic workforce functions which have been set down as one of the functions of the new health authorities.

Q47 Dr Taylor: And that is a hope?
Dr Curson: That is a hope.

Q48 Dr Taylor: Will it come true? What can you do to make sure it does?
Mr Foster: We cannot say at this stage because the detailed arrangements of the structures of the new strategic health authorities are still being worked out. I should very much hope that this Committee in its conclusions on this process would have something to say on this, because you were very influential last time.

Q49 Charlotte Atkins: Mr Foster, you were speaking earlier about redundancies and you seemed to be taking a somewhat blasé view about redundancies. I have to say that sitting in North Staffordshire—and you mentioned my local hospital—we take a less relaxed view about redundancies. You particularly mentioned my local hospital and you spoke about 300 extra staff being recruited in the first quarter. Can you elaborate a bit more about that?
Mr Foster: First of all, I was by no means being blasé about redundancies. Everybody who works in human resources and workforce would say that they are the very last measure that any organisation should ever take and we have been very clear on a series of other things that can and should be done first before compulsory redundancies are even contemplated and far from being blasé, I was simply pointing out the contrast between the headline numbers that are being banded about as job cuts, which are in fact reductions in numbers of posts and not redundancies of individual people. So far from it.

Q50 Charlotte Atkins: So you would expect in North Staffordshire we are still talking about over 500 redundancies?
Mr Foster: Yes. I also said that there are two or three exceptions of which I am aware of organisations where the level of cut is so great that there will be more significant numbers and regretfully North Staffordshire is on of those two or three organisations. But, the example that I gave, which really follows the investigation that has been taking place into why North Staffordshire found itself in this situation that it is, did reveal 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.

Q51 Charlotte Atkins: What was the justification for taking on these extra 300 staff?
Mr Foster: I do not know the answer to that, because I have not asked that question. 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.

Q52 Charlotte Atkins: So who is responsible for linking up the issue of workforce planning with the financial resources available?
Mr Foster: Following the last sitting of the Committee on this subject, the publication *A Health Service of All the Talents* made the point that there is a level of responsibility at every stage in the system. There is responsibility inside a provider organisation for integrating its planning, there is a responsibility at the level of the strategic health authority for challenging and ensuring that those figures are collected and then there is a responsibility nationally for us to aggregate the strategic health authority plans. I gave you the example of last year when we aggregated the first of the strategic health authority plans and it demonstrated a 6% increase in workforce planning which we said did not make sense in the financial environment. There is a challenge at the higher levels of the pyramidical structure, but the fundamental responsibility for planning lies at local level in each provider organisation.

Q53 Charlotte Atkins: What worries me, and you have already spoken about the strategic health authorities and how of course they are going to be reduced in number, while even in the smaller scale, is when you have the Shropshire and Staffordshire Strategic Health Authority with a vast hospital, the University Hospital of North Staffordshire, in its patch, which did not pick up on the fact that workforce was being recruited not centrally by the University Hospital, but by each separate department and there was no central control, which you indicated, with that 300 extra staff just recruited with no reference to the financial implications.
Mr Foster: Just as I have indicated that under the new structure there are responsibilities at every level of the NHS, when something goes badly wrong, as it has done in North Staffordshire, there is a degree of responsibility at every level.

Q54 Charlotte Atkins: So the responsibility lies with the strategic health authority, it lies also with the management of the particular hospital.
Mr Foster: Inevitably.

Q55 Charlotte Atkins: But the reality is that the hospital management, in the case of the University Hospital of North Staffordshire, go off and get plum jobs whereas the staff, the very committed, dedicated staff of the hospital end up with their P45s.
Mr Foster: Yes, and partly as a result of that and other stories, the system has been strengthened further this year. I do not know, Debbie, whether you want to outline the information we are now proposing to collect from each organisation?
Ms Mellor: We started last year. There was a challenge process where we sat down with the SHAs and we looked at their workforce and their finance plans and on the back of that we decided we needed to collect a bit more data. So we started collecting some workforce data around the numbers of staff in post in various groups and across the total workforce and the pay bill and the agency costs that were associated with that. We are going to strengthen that system in the current financial year by making sure that we have a joint collection process which actually will bring together, within the financial information management system, FIMS, which previously has collected financial data only, a financial dataset alongside a workforce dataset, so that we can actually track these linkages and analyse them. Then we can feed that back and we can help both the strategic health authorities, in terms of the information that is available to them, and individual trusts by making sure that we have good benchmark information which they can then use.

Q56 Charlotte Atkins: But if this process started last year, why was it the case, just before Christmas last year, well into the year, that it was still not clear in the University Hospital of North Staffordshire what the deficit was, what the financial situation was, just before in fact the whole board of the hospital resigned?
Mr Foster: My understanding of that, and this is somewhat second-hand, is that the challenge process happened. The strategic health authority visited the trust board and asked it to explain how it proposed to deal with the financial situation that it faced, did not get a satisfactory response and that is why the board resigned.

Q57 Charlotte Atkins: What worries me is whether the strategic health authority only visits the hospital once a year?
Mr Foster: That is really what I was inviting Debbie to explain, how we are now going to be collecting information on a monthly basis so that capacity to challenge is served by an information dataset and you will have that information much earlier.

Q58 Charlotte Atkins: Who will verify those figures? That is the other issue. There were conflicting figures washing around in North Staffordshire, none of which was verified. Who is responsible for verifying this?
Ms Mellor: It will be the SHA who will be responsible for verifying the figures which come up from their patch.

Q59 Charlotte Atkins: The very organisation that did not pick up on this problem last year.
Mr Foster: Or, alternatively, the organisation which did pick up on the problem, but rather later than we would have hoped.

Q60 Mr Campbell: What is the current formal role of NHS foundation trusts in the local workforce planning? It is in the nature of these trusts basically to integrate the workforce development through the local development plan. Has that been happening in the foundation trusts?
Mr Foster: By and large, yes. They have a duty of cooperation, so there is a duty to contribute to workforce planning. Although they have many freedoms, they do not have the freedom to opt out of workforce planning. So by and large yes, they have been contributing well to the whole system.

Q61 Mr Campbell: Are they actually working well within the health service economy? Are they contributing?
Mr Foster: Yes.

Q62 Mr Campbell: Does the workforce work in the same way as it works elsewhere in the hospital trusts?
Mr Foster: Debbie may want to give you more detail, but the fundamental workforce information is a common set of workforce information which foundation trusts have to give us in exactly the same way as all other organisations, so that we can have integrated workforce planning for a whole strategic health authority.

Q63 Mr Campbell: Are you telling the Committee that there is not much difference between the foundation trusts and a normal hospital which is not a trust?
Mr Foster: In this specific respect, yes.

Q64 Mr Campbell: In workforce planning,
Mr Foster: Yes.

Q65 Mr Campbell: May I ask you the same question in relation to the independent sector? We see the growth of the independent sector rising very fast in places. Is the same thing happening there? Are these people on board as well with the planning of the workforce?
Mr Foster: Again, that was a change that was made following *A Health Service of All the Talents* where workforce development confederations were established with the explicit duty of setting up stakeholder boards which involved independent sector providers as well as NHS providers. I do now know whether Judy or Debbie want to comment on further strengthening which has taken place?
Dr Curson: It does rely on cooperation. The independent sector is not required, for example, to participate in electronic staff records, which is only one of the ways that we collect data, but my contacts with them, both at national and at local level, have shown that they do want to cooperate because they are dependent on the same staff that we need and generally there is enthusiasm for cooperation, although recognising that they are in competition and that some issues are commercial in confidence. At this stage I am cautiously optimistic that we shall be able to continue to workforce plan. Clearly one sector where we have not had very good data has been the nursing home sector which is very disparate, which has been in the independent sector for many years and which does employ a large number of nurses; it has more beds than NHS hospitals. We are very hopeful that we shall continue to get reasonable data but it is not consistent and they are not bound by the same systems that the NHS is.
Ms Mellor: In the recent White Paper it was recognised that we do need to have more integrated workforce planning across health and social care. One of the things that we committed to do was actually to work with local government to try to bring the workforce planning arrangements, particularly in social care and the independent sector, and particularly the independent sector nursing homes which have been more difficult, within the system.

Q66 Mr Campbell: The danger with the independent sector, as we found out before, is that the training is not as good in the workforce as it is in the health service itself and it is a little sore which needs to be put right; their training methods or their training in general is not as good for the workforce. I do not think they plan it very well either.
Ms Mellor: It is varied. It was particularly an issue in the first wave: how they were set up and how training was written into the contract. The people who were organising that have learned from that first experience and now training is included in the contracts. Again, it does need people to work together locally because often, if you take, for example, orthopaedic surgery, what is offered in the independent sector is a very important part of the routine joint replacement surgery, but it is not the full range of orthopaedic surgery and therefore a training programme both needs that independent sector provision in order to train staff, but equally the independent sector needs the NHS, so it is about cooperation, having rotational programmes across the two in order to do good training.
Mr Campbell: As long as we have our finger on the button.

Q67 Sandra Gidley: A lot of NHS workers have had new contracts and you have submitted information showing how much that has cost, but it is quite alarming to see an annual overspend of £250 million on the new GP contracts, £220 million on Agenda for Change and £90 million on the new consultant contract. Why does there seem to be a consistent pattern of significant overspend and what will be done to redress this?
Mr Foster: The answer to that question differs for each of those three contracts so I shall try not to give an over-long answer. In relation to the GMS contract, that was created with a built-in ability to overspend if quality targets were exceeded and of the £250 million overspend £150 million is accounted for through over-achievement on quality. I do not want to make over-achievement on quality sound like a bad thing because obviously it is not. What this means is that by the objective criteria which are independently established as the best measures of what primary care could contribute to improved

health outcomes, we have done better. For that overspend, we do have something in return. The rest of the GMS contract overspend principally relates to setting up the new out-of-hours scheme. It was very difficult to predict what number of GPs would retain an out-of-hours responsibility, how many would transfer them to cooperatives and what alternative arrangements could be put in hand in collaboration with secondary care providers, drop-in centres and so on. Obviously it is very important to have a fully comprehensive out-of-hours service and that is why that has over-spent. Do you want me to stop or go on to the other two?

Q68 Sandra Gidley: It might be useful to just question something at that point. It seems to me that when GPs have been offered money for doing something, they usually try to maximise their salary; not just GPs let us be fair, anybody would do that. Certainly in conversations with my local primary care trust leads they said they knew that their local doctors would get their acts together and they all achieved just over 99% in my home town, which was much greater than anticipated. There is a little bit of a head-in-the-sand over that. How was the prediction made? What basis was used? Was it plucked out of the air? Was it based on previous changes? Why was it so out of kilter as a result?
Mr Foster: Again, I was not directly party to that but I understand that it was a negotiated figure. There was evidence from the academic centres that were drawing up the criteria about what the current level of performance was and therefore what might be achieved. There was a desire by the GP negotiators to set the bar as low as possible. There was a desire by the Department negotiators to set the bar as high as possible and in the end there was a negotiated figure.

Q69 Sandra Gidley: But how did they know what was going on? I find it difficult to find any baseline figure for what was actually being achieved.
Mr Foster: I would prefer to transfer that more detailed question to Dr David Colin-Thome when he comes later on, but I understand that a university was allocated to collect the data and to ascertain the baselines.
Mr Derbyshire: Could I just make a point on the GP contracts? There was a great deal of uncertainty about what GPs could achieve in these areas. The GPs may have known, and your GPs may have known, but the centre did not know. Having the contract out there which rewards the activities of GPs, we now know how effective that can be and we now know how relatively easy it is to achieve certain levels. We can recalibrate the GP contract using the incentive structure to achieve more outcomes in future.

Q70 Sandra Gidley: I am not knocking the increased output; I welcome it. It is just a shame that we could not have set the bar a bit higher, as you said. If we get started on out-of-hours, we will be here all day, because I can go on about that forever, so perhaps we should move on to Agenda for Change.
Mr Foster: The situation at present is that we do not know yet exactly what, if anything, Agenda for Change has cost over the estimate. We have a series of very important sources of information though and the most important one is that we did test Agenda for Change for a year in 12 early implementer organisations and, at the end of that, we were able to analyse 36,000 pay records which demonstrated that on average the cost of Agenda for Change had been accurately estimated. The second piece of information we have is a sample which took place partway through last year when roughly 40% of staff had been assimilated onto the new system, which was estimating an overspend of approximately £100 million and possibly some extra costs relating to replacing staff who had added holiday entitlements. This was an estimated study and our experience is that organisations which are asked to estimate costs tend to err on the cautious side so that when their financial year-end comes along, they cannot get criticised for having got it wrong. The third is that we are now getting a series of anecdotal reports from organisations which have analysed the introduction of Agenda for Change this year and they range, as reported in *The Guardian* last week, from Bedford Hospital Trust, which believes that it has over-spent by £1 million, to Leeds Hospital Trust, which is the biggest trust in the country, which has implemented within budget. If you put all of the available information together, it suggests that there may have been an overspend of the order of £100 million, which I deeply regret, but getting an overspend of £100 million on a pay bill of £30,000 million is about as close as you can get to landing on an aircraft carrier on a sixpence and is infinitely better than the last time we tried to do this on the nurse grading scheme where there was just a complete loss of control. Although there has been an overspend, it has been fantastically close to what was intended.

Q71 Sandra Gidley: But with Agenda for Change a proportion of staff had a decrease in salary. Has that not been demotivating? Do you think that is acceptable?
Mr Foster: In the early implementer sites 8.5% of staff required pay protection. Nobody has actually had a decrease in pay: some people's pay marks time until inflation catches up. On the early implementer sites it was 8.5%, but then, working with the Modernisation Agency and others, we found opportunities for those members of staff to take on extra responsibilities to move to a higher pay band. To give you an example of this, you could find a medical secretary whose job evaluation would allocate them to pay band three, which would mean that they would be moving to a lower pay rate than they had previously been on. So then there was a national project to design an advanced role for medical secretaries who would take on administrative work currently done by consultants, for example maintaining their clinical governance records or their records for revalidation. This enabled the post to take on extra roles and responsibilities to move it to band four, so that those

staff did not have to face a pay reduction and again is beneficial to the whole system. It is still more economically efficient for the medical secretaries to do that work than for the much higher paid consultants to do the work. The figure that we now have for the 900,000 or so staff that have now gone fully onto Agenda for Change is that only 4.5% of staff have required pay protection and it has been a hugely complex system with 650 different jobs or grades. It would never have been possible to give everybody a pay increase, or if we had done, it would simply have cost a huge amount more. Getting it down to 4.5% requiring protection has been another very good achievement.

Q72 Sandra Gidley: Could we then finally finish with the consultant contract overspend of £90 million?
Mr Foster: The consultant contract overspend, on the basis of returns from individual organisations in the year 2004–05, was £90 million and the principal reason for that was that a higher number of programmed activities was given to consultants than had been expected. The whole agreed negotiation with the BMA presumed that we would be able to reduce the average working week of a consultant to about 47 hours and thus they would get 10.7 programmed activities of four hours each. The actual outturn was just over 11.1 and that difference of half a programmed activity per consultant explains the vast proportion of the £90 million overspent. Because of that overspend there was an adjustment to the tariff price which providers received in 2005–06 which was actually higher than £90 million and therefore the consultant contract overspend, which we know has reduced in 2005–06, because most organisations have negotiated a small reduction in programmed activity, is not part of the financial pressures that have been experienced in 2005–06, because it was more than picked up in the tariff price.

Q73 Sandra Gidley: The King's Fund Report yesterday was very critical of the implementation and you have talked about programmed activity, but there seems to be an opportunity missed to link pay to increased performance. Do you agree with that criticism?
Mr Foster: 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 and it was a difficult and complex task to negotiate. This is not something you do at a national level; you effectively have 30,000 individual local negotiations with individual consultants. It is fair to say that many organisations, at least in the first year, did not reap the benefits that we hoped for. They have then been supported in a process of job plan reviews which have been taking place this year, and are going to be given much better data, which Mr Derbyshire may want to talk about in a moment, which will enable us to use the mechanisms of the contract which is about transparent job planning, but also about setting objectives for individual consultants which would give us much greater optimism that these tools will be used more effectively in future years.
Mr Derbyshire: Just to back that up, with the new tools and levers of the new consultant contract we want to give the NHS more benchmark information which can actually show at consultant level what the relative performance of their consultants is compared to their peer group in the same specialty. That actually will not only incentivise the managers to begin to ask questions but the consultants themselves will be interested to know where they are in the national distribution of productivity.

Q74 Sandra Gidley: Is that not available now?
Mr Derbyshire: No. It is going out this month.[1]

Q75 Dr Naysmith: Mr Foster, you said that you ran pilots for the Agenda for Change people in a dozen or so different places.
Mr Foster: Yes.

Q76 Dr Naysmith: Did you think of running pilots for the GP contract and the contract for the consultants and if not, why not?
Mr Foster: We would have liked to have run pilots for both the consultant and GP contract, but we were not able to agree that with the British Medical Association in each case. We did the closest thing we could do to that which was desktop exercises and dummy running in real organisations, to see in theory what this would mean. Inevitably that does not provide you with the same quality of data as when you actually practically test it.

Q77 Dr Naysmith: So are you saying the GPs held out against doing a pilot?
Mr Foster: I was not involved personally in the GPs' negotiations but in the consultants' negotiations I certainly wanted to have actual piloting and they would not accept that.

Q78 Dr Taylor: It has been a great disappointment to me; I have missed out throughout my career. When units of medical time came in I was stopping being a junior doctor and stopped being a consultant long before these came in. Just going back to the GP contract very quickly, one of you said the GP contract rewards activity. Points have been made to me by GPs that the QOFs really were too easy and they were doing them in any case and all this has meant is that they have ticked boxes to show they are doing it. Have you any proof that they are doing things now that they were not doing before?
Mr Foster: I should really prefer to have Dr Colin-Thome answer that because he will be better able to do it. In relation to the first portion of you question, Debbie Mellor is also responsible for the return-to-practice scheme where retired practitioners can receive suitable training and rejoin.

[1] *Note by witness:* The consultant productivity data may be released later than May in order to be issued with other benchmark information currently in preparation

Q79 Dr Taylor: No, I am not tempted at all. Just going back to the consultant contract and job plans, in a previous inquiry not all that long ago we were horrified to discover that a relatively small proportion of consultants actually had job plans even though they had been in existence for years, long before this new contract. Are all consultants now fitted up with job plans and does their pay depend on that?
Mr Foster: Yes, all consultants now have job plans and it is a condition of agreeing a job plan to be able to go onto the new consultant contract in the first place, so in that sense, yes, it is linked to their pay. The other piece of leverage inside the consultant contract which has generally not been used as well as it might 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, which sadly you were not able to enjoy when you were a consultant, is dependent on meeting the job plan and delivering the agreed personal objectives.

Q80 Dr Taylor: Could you give us some examples? What would these personal objectives be? To do more operations, see more patients in outpatients? What are they?
Mr Foster: They could be quantitative objectives, they could be related to the data that Mr Derbyshire has described will be available on productivity information, they could be related to service improvement and quality improvement, they could be related to redesigning, multi-disciplinary working. The real objective, what we really want to do here, is to ask each NHS organisation what they are trying to achieve, probably the best resource available to them to achieve that is their consultant, so let us put into their job plans what their contribution is to what the organisation is trying to achieve.

Q81 Dr Taylor: Would it not have been easier just to go for a fee-for-service contract and why was that not done?
Mr Foster: As I am sure you know, that is a very big question and fee-for-service is generally out of favour throughout the world where it is being used because fee-for-service tends to incentivise inappropriate behaviours and tends to lead to loss of control of the finances of the system.

Q82 Dr Taylor: Was it seriously considered or was it discarded right at the beginning?
Mr Foster: In the initial stages, over all of the contracts, we looked at the possible reward systems which were available throughout the world and in the case of the GMS contract what we have come up with is something which is a world leader in linking pay to system quality and what we come up with in Agenda for Change is another world leader which rewards people for developing their personal skills in line with what the organisation is trying to achieve.

Q83 Dr Taylor: Will the new contract encourage people who do a lot of day surgery?
Mr Foster: That is an example that you could put in. If we know that the national average day case rate for some particular procedure is 85% and we know that a particular consultant is doing 70%, you can put into a personal objective an agreement that that should rise to 85%.

Q84 Dr Taylor: Could that extend to lengths of stay?
Mr Foster: Another really, really good example of precisely what you should do, yes.

Q85 Dr Taylor: Finally on changing roles, has there been any evaluation of any possible disadvantage of changing roles? I am thinking really of junior doctors no longer having to take blood, which was one of the best ways of making sure that you could always get a needle into a vein. Now they are losing out on that practice. Has there been any evaluation of any disadvantages of these sorts of changes?
Mr Foster: I am not aware of any evaluation of disadvantage, although the Hospital at Night project, which has looked at the reorganisation of services and roles at night and weekends, seems to have demonstrated very, very large benefits indeed in terms of quality of patient experience, allowing junior doctors' training to be better delivered because they spend less of their time working at night and a reduction in the procession of faces that you have if you are sadly admitted to a hospital at night. Anecdotally one hears of the type of problem that you hear, but I am not aware of a whole-scale evaluation.

Q86 Chairman: You talked about the pay bands in Agenda for Change. Is it your knowledge that any pay bands for nurses have been moved to a lower rate of pay through Agenda for Change?
Mr Foster: I do not know personally of that, but given that there are 400,000 nurses, it is possible.

Q87 Chairman: It is quite possible that that would have happened and the scene you described earlier may not be the case in some instances.
Mr Foster: I certainly know that where protection has had to occur, the more common areas where this has happened have been in administrative and clerical and managerial jobs.

Q88 Chairman: Not in nursing staff?
Mr Foster: I am not saying that there are not any, because I do not want to give you the wrong impression, but I certainly have not heard of many instances of nurses being banded lower than their current pay.

Q89 Jim Dowd: Briefly, after that tale of woe of Dr Taylor's thwarted clinical career, may I just ask you one question on productivity? There is a problem with productivity right across the British economy, public sector, private sector et cetera. The ONS recently brought out a report showing six different indicators of productivity in the NHS. You chose to adopt one of those six which coincidentally or incidentally was the one which showed the highest figure. (a) Why did you choose that? (b) Is it not

important to have a durable and broadly accepted measure of productivity within NHS staff at all levels?

Mr Foster: I am in the fortunate position of having the best expert in the Department next to me, so I shall pass it over.

Mr Derbyshire: The answer to (b) is easier than the answer to (a). The obvious answer to (b) is that we do need a better measure of what the NHS produces, not just in terms of the number of treatments but the health benefit which accrues from those treatments and also the patient experience of going through the system. Waiting times of six months have gone down significantly and that is of value to people. The physical facilities in which they are treated has value for people, as does the amount of time they get to speak to the consultant. We need to bring all those things into the measure of output before we can actually have a proper debate about whether productivity is rising in the NHS or not and the ONS, under Sir Ron Atkinson, did work with the Department of Health to improve the measure of output that we had previously which was about the cost of the number of treatments. Over the long run, that has been increasing by about 0.5% to 1% per annum in terms of productivity. 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. What we do have is a significant increase in output and outcomes and the ONS measure does give a range of the level of output growth over the NHS over the last five years. Yes, the Department published the high one as being the best available, but they also included the others and explained the different methodology to make it transparent.

Q90 Dr Naysmith: Mr Foster again. We have had a number of submissions from education providers indicating that they do not think they are sufficiently involved in workforce planning; sometimes they say they are involved too late or not at all. What do you think we can do about that? Do you agree with that and do you think there is a plan to address it?

Mr Foster: This was one of the identified weaknesses in 1999 and again, when workforce development confederations were established and required to set up their stakeholder boards, they were required to have representatives of education on those boards to address that issue. I am interested that that is what the educational institutions have submitted to you in evidence. In my five years in the Department I have had no complaints from educational institutions to me that they do not feel they have been adequately involved. It may be that there are some local instances where relationships have not been as good as they might be, but, again, it seems to me that that is another opportunity for this Committee to recommend to us that we identify any shortcomings and look to strengthen them.

Q91 Dr Naysmith: Perhaps we will pursue that a bit more with the people who have said that to us. Do you think there is any role for the independent sector as far as education and training are concerned?

Mr Foster: Definitely; yes. Mr Campbell asked some questions. When you say the independent sector . . . ?

Q92 Dr Naysmith: I do not necessarily mean providing—

Mr Foster: There are the existing private hospitals. There are nursing and residential homes, which is a very large sector. There is the first wave of independent sector treatment centres that the Government commissioned where we are not explicit about training and then there is the second wave where we are explicit about training. Yes, it will be absolutely clear that they must provide that.

Q93 Dr Naysmith: You see it only in terms of the second wave.

Mr Foster: We are requiring it in the second wave.

Q94 Dr Naysmith: Is there a chance you will be extending it more widely?

Mr Foster: Yes. For each of those sections of the independent sector we have different levers available to us and the strongest lever available to us is where it is our money which is commissioning the services, thus we can require it in the wave two contracts. We should also like initially to encourage it to be introduced into the wave one contract and then when they are up for renewal at the end of their five years, we shall obviously have the opportunity to extend to them as well.

Q95 Mr Amess: Witnesses, we are anxious to wrap up this session because we have had enough. So very, very quickly, recruitment from overseas. We all know what went on, we have lots of doctors and nurses and others, marvellously handled, very, very successful and now we have people here, educated here, who cannot get jobs or are losing their job et cetera. First of all, from one of you a comment on that approach and has the Department done any work to see whether taking staff from the developing world has in any sense damaged those countries? If you do have some work on it, is the Department trying to cover up releasing that information? Try to say something to make it more interesting at the end.

Mr Foster: I shall hand over to Debbie in a moment because she has led in this area, but if I go back to 2001–02 when we were tasked with these massive increases in the NHS workforce, we knew how many people we had already commissioned to come out of training, we knew approximately what the average retirement rate was and we knew approximately what the average return rate was, in other words people who have had a career break. When we put all those things together, we knew that we did not have enough input of nurses and doctors to deliver the capacity that was required to achieve the main objectives of improving access. Thus we set up the international recruitment programme with the international code of practice which still remains, as I understand it, the best in the world, which means that we only recruit actively from countries where their governments agree for us to do so and that has

been the biggest single contribution to achieving the workforce capacity that we have needed over the last few years. Now we face a situation where funding growth begins to reduce, where a balance between supply and demand is much closer. The numbers coming out of domestic training, because we have been investing in that year on year, are increasing. We are becoming less and less reliant year on year on staff from overseas and many of them came over here with fixed-term contracts of two to three years which are now not being renewed for that very reason. We have to balance the obligation we have to our home grown-students, the workforce planning needs of having the capacity to meet the demand in the system, and the international duty you have in the countries from which these staff have come. As we said earlier in response to questions, workforce planning is a very difficult art to get right, but as of where we are now, we have the nearest to a balance than we have ever had.

Ms Mellor: You asked two questions, one was about unemployment. There certainly have been problems with doctors, a lot of them from the Indian sub-continent, who have come here, who have taken the exams, got their GMC registration and have not then been able to get into the NHS. What happened was that, on the back of the NHS Plan and the work that we were doing around international recruitment in the medical side, which was focused very much at consultant level and for GPs, a sort of message got out that England was expanding and needed doctors. Although we have worked very hard with the British Council, with our High Commissions in the Indian sub-continent and with the GMC to get out some very clear messages that there were limited recruitment opportunities in the NHS, there has been a large number of doctors who have come over here over recent years speculatively hoping that they would get in and I am afraid a lot of them have been disappointed. One of the things that we have done, apart from trying to get these messages out, is that we have actually looked at the system that we have got in place with the Home Office around work permits. We recently changed the permit-free training arrangements so that we have brought into line with the way that all other professions and staff groups are treated the way in which we operate work permit arrangements for the medical profession. That has been very helpful in sending out a very final and clear signal that actually it is sensible to check on what the job opportunities are before you go through the difficult and expensive process of getting onto the register and coming over here to find jobs. We are introducing, to support the Modernising Medical Careers, the MMC process, and the new arrangement for training doctors, a new centralised web-based recruitment system which will give us a much simpler and more cost-effective way and more sensible way of getting doctors into the various training programmes. It will also help us manage the flow and the routes into the NHS for international medical graduates and it will make sure that there is a sensible, clear, open route which does not have them coming over here speculatively. I am hoping that we have made improvements there. The second question you asked was about the ethics of what we are doing and what the impact had been in developing countries. We are the only developed country which has actually developed policies and practices and an ethical recruitment code of practice to try to manage international recruitment. We have certainly made clear that, within the NHS to start with, we did not want to see active recruitment from developing countries with vulnerable healthcare systems and we worked hard with the independent sector and with the recruitment industry to revise, improve and extend that code so that it covered our partners in the independent sector and was also supported by the Recruitment and Employment Confederation. You asked what we are doing in terms of having an understanding of the way in which this is having an impact in developing countries. I have to say we have built up a very close working partnership now with DFID and we are also working with the World Health Organisation—you will have seen their recent report which flags what we are doing around ethical recruitment—and with organisations like the International Labour Organisation and the IOM. There are several programmes which are being taken forward to look at the impact in various, particularly sub-Saharan, African countries to see what the impact is and what can be done to help those local healthcare systems address some of the push factors which are fuelling the emigration from their countries. I am not quite sure that we have any secret information that we have not published anywhere. We do have a Memorandum of Understanding with South Africa and we have a lot of discussions and debates with them.

Mr Amess: So no cover-up. Thank you very much indeed for your comprehensive reply.

Q96 Chairman: My colleague wants to ask you a specific question in relation to EEA doctors. May I first ask you about this issue of working within the code of practice with the independent sector? My understanding is, and correct me if I am wrong on this, that if somebody came in from a country that we would not directly recruit from because of the weakness of their healthcare system, it does not mean to say that they could not work within the independent sector for a length of time and then be recruited by the National Health Service. That length of time is six months. Is that correct?

Ms Mellor: It has certainly happened and we do know that within the independent sector there has been quite a level of recruitment and some of that is from the developing countries that we would not like to see and some of that indeed has been the basis of our discussions with countries like South Africa.

Q97 Chairman: But there is no statutory regulation which could stop them doing this, so if they do not volunteer to cooperate, then it does not get done. Is that correct?

Ms Mellor: Yes, but, as I say, we have worked with the Independent Healthcare Federation and with the Recruitment and Employment Confederation to try to extend our code of practice. What will actually

really help us to address this issue is that the Nursing and Midwifery Council have brought in new arrangements for the training of nursing recruits from overseas and what that requires is that they have to go through a period of training within a higher education institute. That is quite a costly process and it is going to be a very difficult process to do if you do not have an employer fully backing you and being prepared to fund it. That will make the kind of opportunistic individual immigration a little bit more difficult for the individuals because it will be more difficult to organise and it will be more costly to do. The real answer to this is that we have supply and demand matched far more, particularly in nursing, so I would hope that even those bits of the independent sector that are not aware of and are not complying with the code of practice would find that they can actually recruit far more easily from within the UK or indeed from within Europe without the additional expense and difficulty of going to the Philippines or South Africa or Ghana or Kenya.

Q98 Chairman: Do you have regular meetings with DFID about these issues?
Ms Mellor: Yes.

Q99 Dr Stoate: It is obviously very good news that we are now producing more medical students of our own and more medical graduates; that is obviously very welcome. Nevertheless, we have relied on the NHS for generations, on the good will and the hard work of huge numbers of doctors and others from the Indian sub-continent who come here and work tirelessly for the NHS for a long time. I have been contacted by a significant number of doctors who now have recently found out, for whatever reason, and these are non EEA graduates, that they either will not be able to get a job, they are not eligible for a job and that the current job when it finishes will not be renewed, that they will not be allowed to complete their training and, obviously for good reasons, they are pretty upset. How has this been allowed to happen? Why was there not a much more planned and orderly transfer once we knew that we were beginning to produce our own graduates in sufficient numbers?
Ms Mellor: We started looking at the work permit arrangements and the need to have another look at that last July, when we started to talk to the Home Office and also to the deans about how the whole regime—

Q100 Dr Stoate: But that was last July, that is less than a year ago and now these people have received letters from their trusts saying they cannot complete their training, they can finish their current post, they are not going to be allowed to apply for posts which come up. That is a very short timescale for someone to rearrange their entire life.
Ms Mellor: There may be some lack of awareness of the way the changes have been implemented and we are trying to make sure that the guidance which NHS employers have issued on this actually gets to the parts of the organisations that really need to understand it. We are very clear that in introducing this change we needed to have some transition arrangements, so we worked very carefully with the Home Office, who were very helpful and who agreed that we would have transitional arrangements. So anybody who is in training will be able to switch into a work permit from the permit-free arrangements, so that they will be able to complete their training.

Q101 Dr Stoate: May I just clarify that. Are you saying that they can not just complete the current posts that they are employed for in the trusts, but they can complete their entire training? This is not what I am getting from many of these groups.
Ms Mellor: This is a very complex area. Medical recruitment is complex and the work permit rules and the immigration rules are equally complex. Rather than me trying to give you an answer now in a couple of minutes, perhaps I might write to you and set out the exact transitional arrangements. If I may just confirm, yes, the arrangements that we put in place are that there will be transitional arrangements so that people who are in training programmes will be able to complete those training programmes and international medical graduates will be able to apply for posts, but, in common with everyone else in the UK economy, we shall in future have what is called a resident labour market test, which means that we have to check that we cannot fill that post already with somebody who is a UK doctor or, if they are suitable, a doctor from the EEA.

Q102 Dr Stoate: I should like this clarified because it is causing a significant amount of upset to a lot of highly motivated people who have based their lives and their careers on what they thought was their prospect and now it is not. I should very much like proper clarification on that.
Ms Mellor: Yes; certainly.

Q103 Chairman: We should be very grateful for that, but just tell us in your written answer whether or not somebody who is actually in training is different from somebody who is actually in the country looking for training. This might be an area that you could give us a few views on as well.
Ms Mellor: Yes.
Chairman: Okay? May I thank you all very much indeed for coming along and helping us in our first session in what is going to be quite a long inquiry? Thank you very much indeed; you have certainly been very helpful.
Jim Dowd: Could we just add our very best wishes to Mr Foster who has been a regular attender over the past few years?

Q104 Chairman: Absolutely. I understand you are joining us in the North West.
Mr Foster: Indeed; the best part of the country.
Chairman: Thank you very much.

Witnesses: **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 **Mr Andrew Foster,** Director of Workforce, Department of Health, gave evidence.

Q105 Chairman: Good morning. May I welcome you all to the first session of our inquiry into workforce planning? May I ask you for the record just to introduce yourselves?
Professor Fryer: My name is Professor Bob Fryer. I am the National Director for Widening Participation in Learning, that is I look after the learning of the non-professionally qualified staff in the NHS.
Dr Colin-Thome: Dr David Colin-Thome, National Clinical Director of primary care and a GP for some 35 years.
Professor Hill: Professor Sue Hill, Chief Scientific Officer of the Department of Health with lead responsibility for healthcare scientists.
Mr Foster: Andrew Foster, until recently Director of Workforce.
Sir Liam Donaldson: Liam Donaldson, Chief Medical Officer for England and the UK Government's Chief Medical Adviser.

Q106 Chairman: I hope Andrew that you now have a copy of your interview. I asked that you be given a copy of it. There will not be any questions in this half which directly relate to it. I am sorry about that; we assumed you would have seen it. May I start by asking the first question to Sir Liam Donaldson? May I also say I am very pleased to have you back here in your role as Chief Medical Officer? The last time you gave evidence to this Committee you made some impact in relation to the subject matter that you were championing. I just hope that this Committee's report and any subsequent actions were helpful in championing your cause and I am very pleased indeed at the way things are progressing.
Sir Liam Donaldson: Thank you Chairman. I do not intend to make any impact today.

Q107 Chairman: In 1999 this Committee was advised that an oversupply of doctors was highly unlikely before the year 2020. We have received evidence from the NHS Employers that there is currently a 7% oversupply of doctors and that this will rise to 12% by 2009.[2] How did this occur and is this a desirable scenario?

Sir Liam Donaldson: My own view is that I do not really accept the assessment that there is an oversupply of doctors. Even if you look forward to those distant time spans that you have mentioned, we shall still be lower than the OECD average. When I came into post in 1998, we were above Turkey, but otherwise we were the lowest OECD country for doctors per head of population. We are still behind and I do not see ourselves as producing an excess of doctors at all, indeed with demographic trends, with the fact that we shall have a 70% female medical workforce in the next few years, with changes in technology, with greater specialisation, we are still going to need a lot of doctors.

Q108 Chairman: You heard the last couple of questions we had in the previous session. It is very difficult to relate to OECD levels and ratios about doctors to population as opposed to the actual needs of doctors within the system. Clearly this inquiry is going to be looking at the needs of different levels of clinical and others caring in the healthcare system. Is there no sort of optimum level within our system as opposed to saying that, if it is different to the OECD level or it is still lower than the OECD level, then there is still a need for doctors? Is that not quite the way we should be looking at it?
Sir Liam Donaldson: There are several benchmarks that you can choose. The most difficult benchmark is to predict future need which has always been unpredictable in the past. I have a fair amount, through representing the UK on the World Health Organisation, of insight into other healthcare systems and even at an impressionistic level, it is clear that many other healthcare systems are able to provide faster care than we do at the moment with a skilled competent doctor. We do pretty well and we are improving but the basic infrastructure of care in this country, which includes the number of doctors and nurses, is still expanding and it needs to expand further.

Q109 Chairman: You do not think with the expansion of medical schools that medical unemployment is inevitable?
Sir Liam Donaldson: No, I do not think so at all.

Q110 Chairman: Presumably at other grades as well, in terms of nursing and things like that.
Sir Liam Donaldson: I do not know so much about nursing, but as far as medicine is concerned, I do not think we shall see that. We have never seen it so far.

Q111 Chairman: Do you think that anybody who goes to medical school in this country and after very many years becomes a doctor, at whatever level, has a right to have a job within the system?
Sir Liam Donaldson: Yes, they do in the first instance and then, after that, it depends on how well they do their job and how well they perform and so on. But yes, the aim is to give every graduate a post to go into at the time of their qualification.

Q112 Chairman: Should that be under all circumstances?
Sir Liam Donaldson: Well, unless there are concerns about somebody's competence, health, conduct and provided that they want to have a job. As you know there is a small number of medical students who, having graduated, go into other professions. Obviously there is a small proportion like that, but

[2] NHS Employers have subsequently submitted a correction to its written evidence on this point. The evidence should have stated that there are currently 12% more Foundation level medical training posts available than there are medical students graduating in the UK each year. If current trends continue, this figure will fall to 7% by 2008–09, increasing the risk of an overall oversupply of medical graduates.

as far, for example, as this forthcoming summer is concerned, we expect to be able to put all our medical graduates into the first year of what is now called a foundation programme, which will take them through two years uninterrupted of basic medical education, which will be of a more educationally based nature than has been the case in previous years.

Q113 Chairman: If it was the case in this more transparent health service that the Government and the general population desire to know the costs of the National Health Service, as opposed to what it spent, if we are moving to payment by results, if I were running a trust and I had an option of either setting on two doctors directly from medical school, in their next phase of training as it were, and spending money from my budget to do that, as opposed to saying that I have a target to meet from my budget, maybe for elective surgery or something, and under those circumstances I have to spend the money on the patient and not on the doctor, would that be unacceptable?

Sir Liam Donaldson: There is a lot wrapped up in that question. Obviously, we want patients to be seen by skilled, competent doctors, but at the same time most chief executive officers of hospitals would know that if they do not invest in the future, then they will not have high quality doctors in the future. You do need both. These fears of expediency on the part of hospital chief executives are often talked about, but I have yet to meet one who would dilute the quality of training in their hospital, the quality of research and all the other things which eventually contribute to high quality patient care.

Mr Foster: I just wanted to talk about medical unemployment and to link it to the previous session where Debbie Mellor was talking about overseas graduates. In so far as there is medical unemployment in this country, that is where it is; it is for the several thousand who came here on spec without specific jobs hoping that they could find ones easily. That is where the medical unemployment lies. Because there were several stories last year about unemployment of UK graduates, the GMC conducted a study of the last three cohorts which found that the problem is absolutely tiny. Of the 2005 graduate cohort, there were six unemployed and four of those were not actually looking for jobs. Of the 2004 and 2003 graduate cohorts, there are about 20 and 30 in each case who are currently unemployed but generally that is because they are looking for a job that geographically suits them and have not been able to find it. Those numbers are absolutely tiny. So UK graduate medical unemployment is not really an issue.

Q114 Dr Stoate: The Royal College of Physicians have told us that the number of doctors receiving specialist training under Modernising Medical Careers is likely to exceed the number of posts ultimately available. Is that true or not?

Sir Liam Donaldson: We do not know what the number of specialist posts will be in 10 or 12 years' time. The Royal College of Physicians have been very supportive of the Modernising Medical Careers programme, they are helping us in the planning, but, as you well know, there are great changes in medicine occurring all the time. For example, it takes 12 years to train a cardiac surgeon. Within the last five years, the developments in treatment of heart conditions, with the possibility of minimally invasive treatment, has meant that we are probably now going to have heart surgeons in excess of the numbers that we shall need. So a 12-year training programme and a five-year change in technology which has transformed the position for that particular specialty and I could give other examples. You have to keep these things constantly under review. If you settle on a figure now that you are definitely going to need in 12 years' time, then we shall see problems in the planning of the specialist workforce.

Q115 Dr Stoate: Do you see a contradiction though between that and the answer you last gave. You could not see any realistic chance of unemployment in medical graduates and now you are saying that as we cannot possibly predict what we are going to need, then we may not need these graduates which we are currently training.

Sir Liam Donaldson: No, I am talking about the balance between specialties. There are 59 specialties. If we have 59 rigid boxes all with a number in them for 10 years' time and then we sit back and do something else until the clock ticks round, then we shall have problems. We have to evaluate the need specialty by specialty, but on the whole, given the position internationally, the trends in the burden of disease, the growth of technology, the feminisation of the workforce, I think we shall need more doctors.

Q116 Dr Stoate: That is true, but if someone has done a specialist training programme, then that trains them to be a specialist in a particular area or field. If that is no longer required, then we may have an overall matching number of doctors, but if people with very specific higher training cannot then get a job in that specialty because it does not exist anymore, for example, then that is unemployment surely.

Sir Liam Donaldson: I do not think so. We need to take a more flexible approach. I cannot believe that the excess of cardiac surgeons that we would have, if we just simply sat back and waited, would mean all of those doctors were made redundant. They will be able to adapt the skills that they have gained in surgery and in the diagnosis of heart disease and treatment of heart disease into other specialties. For example, vascular surgery, operations on blood vessels, is a specialty which is going towards, not exactly disappearance but almost so. Now radiologists can push wires and tubes into those same blood vessels and do the treatment that would in the past have required a full-blown operation. We have to keep all of these things under review.

Q117 Dr Stoate: Just to go back to my first question, so the Royal College of Physicians is wrong, there will not be these specialist trained doctors who are going to have no jobs to go to. That is what they are saying to us and you are saying they are wrong.
Sir Liam Donaldson: If they are saying it in such black and white terms, then that is not right. If they are expressing a general concern that we need to get the specialty training right for the future, and they themselves have had ideas about redefining some of the specialties within the medicine, it is something that we need to work with them on and we do work with them. I do not mind them making provocative statements from time to time because that keeps us all on our toes.

Q118 Dr Stoate: They keep us amused as well. Just a final point. What will the impact of Modernising Medical Careers be on the non-training service posts, which the Royal College of Anaesthetists have called the so-called "failed doctor" grade? That was not my expression that was theirs. What do you see happening in that situation?
Sir Liam Donaldson: We shall probably see fewer of these posts which are really designed within local organisations to meet a service need because we are going to see an expansion of training posts following on from the medical school expansion. I do not like that description, and neither do you by the way you asked the question, but we do have to remember that there are many doctors today, for family reasons or work/life balance attitudes, who do not necessarily want to go on to become principals in general practice or consultants. For example, some of the most talented doctors in the country are in such posts in very specialised areas of practice. For example, I know of a radiologist who is very expert in the ultrasound diagnosis of certain conditions, who, although a staff grade, has cases referred to her from consultants because they regard her as the best opinion in a particular field. We must not regard these posts as posts which are not valuable and do not have a future; they do and they are very important.

Q119 Dr Taylor: Can we come on to the European Working Time Directive? Can you bring us up to date: In 2004 the aim was 58 hours. I cannot remember what happened about those European cases and time on-call counting within those hours. What is the state with that?
Mr Foster: In 2004 there was a reduction to 58 hours but the main impact of 2004 was that the rest aspects of the directive came into play, as interpreted by the SiMAP/Jaeger judgments, which are the two that you are referring to, which effectively meant that we could no longer staff hospitals with doctors who were resident on-call. Instead we had to move to a pattern of shift working. What has happened since is that there have been many, many attempts within the European Union to revise the Working Time Directive laws as they apply to rest and at this stage no agreement has yet been reached. There is a lot of consensus that SiMAP/Jaeger are having an unhelpful effect in some medical specialties and there is a common desire to overturn it, but it is intertwined with several other issues of the opt-out and so on. The next stage is a meeting in June under the current Austrian presidency which is going to hammer out yet another attempt to produce a compromise solution to it. At the moment we are still stuck with it. The next phase of the Working Time Directive is in 2009, when we have to reduce doctors' and trainees' working to 48 hours a week. That in itself will be a very, very big challenge, even more so if we still have not resolved the SiMAP/ Jaeger issue. It underpins some of the comments that Sir Liam was making about workforce planning. Clearly, if you currently get 56 hours from a junior doctor and in future you get 48 hours, that drives a need for greater numbers.

Q120 Dr Taylor: Is there still the concern among some junior doctors about the lack of training even at the 48-hour level?
Mr Foster: Yes, we have received concerns from various specialties that because of the change to shift working, they have to spend an increasing proportion of their work at nights and weekends when they are not typically being trained by consultants. Some of the logbooks from surgeons and anaesthetists in particular show that they are getting less direct training than under the previous system. We have a project called Hospital at Night which is designed to correct this and the best examples show that by cross-cover between medical specialties and by enhancing the roles of non-medical staff, we can go back to having most of the trainees available during the daytime and we can improve their training.
Sir Liam Donaldson: There are also some very innovative new teaching methods in some specialties. For example, in radiology we now have three academies around the country, one in Norwich, which I visited last Friday, which train the young doctors on digital x-ray images in a databank. Rather than sitting as an apprentice in hospital looking at one x-ray at a time, they are able to have a databank which includes abnormalities and findings from images all over the world and they are taught specifically and they are given feedback on their competency. In some of the skill-based specialities, it is possible to use techniques of simulation to fill in that gap which, as you rightly point out, because of the lower hours of exposure in a conventional training, mean that people do not see as many patients as they would have in the old days.

Q121 Dr Taylor: Is there any answer for junior surgeons and the worries that by the time they become consultants they will probably have done relatively few of the sorts of operations they will then have to go on to do?
Sir Liam Donaldson: Probably the main solution would be to look at those technologies of simulation which, as you know, in minimally invasive surgery are now quite advanced.

Mr Foster: In addition to that, what the Hospital at Night project tells us is that there is very little, almost no, actual surgery which needs to be done or should be done at night in hospitals and yet we have a lot of surgical trainees on-call at night. By providing suitable cross-cover arrangements, you can return to the situation where the high proportion of their time is available during the day where they can get those experiences of operations.

Q122 Dr Taylor: Can you forecast whether the aim is going to be, to cover the 2009 problem, to employ more doctors or to shift the work that doctors do more onto other staff like the nurses?
Mr Foster: This will vary according to the geography of an organisation. There are certain critical masses for some specialties that you have to maintain, so in some cases, in rural and remote hospitals, you can only resolve this by increasing the number of doctors. The best practice in large hospitals is to do exactly what you say, to have better cross-cover arrangements between the medical specialties and to enhance the roles of non-medical staff.

Q123 Dr Taylor: Does the affordability of this by 2009 worry you?
Mr Foster: Yes, it will be part of our spending review bid for next year to recognise the costs that are applied by it.

Q124 Jim Dowd: I just want to come back to Sir Liam on this question of training. I saw a release from the BMA a year or so ago saying that medicine is the most socially exclusive of all higher education or degree courses. The only one that was more socially exclusive was veterinary medicine. If you are from a manual household background, you are 200 times less likely to get a course in medicine than you are if you come from a professional or A-B group background. Given the fact that it is so divisive and exclusive, given the fact that the technology is changing the nature of the training, one of the reasons that it is as divided as it is, is because very few people, other than from a relatively prosperous background, could contemplate training for seven years, 10 years, 12 years. Are you taking the opportunity to change the courses, obviously in concert with the great gatekeepers of the royal colleges, to ensure that you can reduce courses as technology changes, which, at the same time, will encourage people from non-traditional backgrounds to come into medicine? One of the big problems we have with the health service is that it is actually almost entirely middle class practitioners and almost entirely working class patients.
Sir Liam Donaldson: It is a very, very important area and it is one which has always concerned me. There has been a change towards a more balanced entry of medical students to medical school. We are certainly well represented now in some ethnic minority groups, although not the Afro-Caribbean community where the entry levels are very, very low. The social class differences are still quite marked as you have pointed out. We have done a lot of work with medical school deans, particularly in the new medical schools which have been established over the last few years, and I chaired the committee which established them, to lay down criteria so that for them to be successful in being awarded more places they had to improve access to disadvantaged groups. It is very important, it is important for doctors to have insight into the communities that they are serving. We are trying to do as much as we can, but to some extent it means going back into the education system earlier on to make sure that those students have the opportunity to get the right qualifications at GCSE and A-levels to get in. It is possible to get into medical school with other sorts of qualification now as well and certainly the new medical schools, Peninsula would be an example, University of East Anglia another example, they do have a much more diverse range of students than they have had in the past.
Mr Foster: There has been some research carried out which demonstrates that one of the biggest problems is that students from poorer backgrounds or from certain ethnic minorities, not all ethnic minorities, do not perceive that they have the chance to become a doctor; they really think they are excluded. Some of these more modern medical schools that Sir Liam has described are doing out-reach activities where existing working class medical students go out to schools and say "You can do it. I have done it" and that has been demonstrated to be one of the most articulate ways of breaking down that particular problem.
Professor Fryer: There is evidence that the real issue is not simply the level of the A-levels that students from non-traditional backgrounds get, but the wrong ones too. For example, chemistry is often a lack. Some medical schools around the country are now working with local further education colleges and with local schools to put in, at no cost to the student let me say, that additional training so that they can get the qualifications in the relevant areas. It has been very responsibly done because they are very keen not to take students from disadvantaged backgrounds and then get them into a system where they fail. There has been a scheme, for example, with London FE colleges working with the University of Southampton specifically to target Afro-Caribbean students where the FE college plays a key role in preparing them for entry into medical school. We could give you some data on that.

Q125 Chairman: Are you aware, not the new schools, that the Sheffield Medical School has links with comprehensive schools in South Yorkshire, one in my constituency in Dinnington, where they actually visit and chat to the head about the brighter pupils in there who may have no links at all with the medical profession on a family basis at it were, but are taken out and encouraged to go into medical school through our current education system. That seems a very sensible approach in terms of this issue of the social class and medical education.

Professor Fryer: There are many examples of that around the country and I want to say that the medical profession themselves have been very good in doing mentoring and coaching and indeed it would be good to see this as part and parcel of NHS organisations, seeing themselves as exemplary employers, reaching back into the education system to raise aspirations, to provide information and to work alongside the young students. That has been happening and where it happens it is extremely effective.

Q126 Jim Dowd: The note I saw from the BMA did admit that this was an area where they were just not doing well enough. That was the tone of it rather than anything else.
Professor Fryer: There is still a long way to go.

Q127 Dr Naysmith: We have spent a lot of time this morning, as we usually do, talking about doctors and nurses and allied professionals, but actually the section of the workforce which is growing fastest of all is the scientific workforce. I have one or two questions for Professor Hill to answer in that area. What are these staff doing and do you think the numbers are going to continue to grow?
Professor Hill: We now know more about the composition and the roles which are undertaken by the scientific workforce than we did. For example, we now classify the healthcare science workforce into 51 disciplines and they are grouped into three broad-brush divisions: life sciences, which include genetics; physiological sciences are those that work predominantly in clinically facing specialties like cardiology, respiratory medicine; and those in physical sciences and engineering, from the medical physicists supporting imaging and cancer treatments for example, through to clinical engineers, who are engineers who design equipment or work and develop rehabilitation-type solutions, to maxillo-facial prosthetists. In terms of the numbers employed within the workforce, there has been an increase of 5,814 over the 2001 baseline. We have done a lot of work to collect more detailed information on the scientific workforce through the introduction, for example, of the T-matrix which is the scientists' specific part of the Department of Health census which is collecting information on 18 disciplines in six employment grades as well as the rest of the disciplines in the more aggregated data. To provide us with more information in terms of the age, profile of the workforce, the future planning arrangements for the scientific workforce, we are working with three strategic health authorities on a more detailed workforce project, that is Trent Strategic Health Authority, North Central London and Greater Manchester. That is giving us a greater insight across the totality of the workforce.

Q128 Dr Naysmith: So they are clearly a key section of the workforce and you think they are going to increase in numbers in the future.
Professor Hill: They are a key section. The recognition of their contribution to healthcare is growing and the importance, for example, of many of the scientific disciplines in delivering the 18-week access target by better diagnostic service provision, is obviously driving some of the changes. In terms of the workforce profile for the future, we shall need to increase the workforce but not necessarily more of the same. There needs to be a greater focus on the scientific workforce skills which are required to deliver service functions as opposed to the old traditional routes and associated with that will be more assistants and associates, which will reflect the increasing automation in some parts of the workforce, the demand for higher types of low clinical risk activities. Equally, there will be the requirement for more advanced and consultant practitioners to support the advances in science and technology and the need for more specialist advice and interpretation.

Q129 Dr Naysmith: Just before we go into that in a little bit more detail, I used to teach scientists in that category before I became an MP. One of the things that they always used to tell me was that they were not paid nearly enough money. Mr Foster, you were talking in the previous session about Agenda for Change. Have they significantly improved under Agenda for Change?
Mr Foster: As Professor Hill has said, there is no simple answer to that because there are 51 different specialties. However, the job evaluation scheme is designed to recognise the complex range of skills, knowledge and environmental difficulties that people have to face. Yes, their skills are properly recognised in the new job evaluation scheme and many of them have benefited considerably, particularly in terms of the starting salaries for laboratory staff.

Q130 Dr Naysmith: I am glad to hear that. When talking about this group of staff, is the increase a result of the development of new roles or is this just employing more people in existing roles?
Professor Hill: There is a combination. There is no doubt some of the work that we have done to introduce a new career framework for healthcare scientists has focused the scientific workforce on the development of new roles, that is both from a national perspective in some of the work that we have been doing, but also locally to meet local service requirements. The bulk of the increase we have seen to date has probably been in more traditional roles, but we are seeing a change in the profile towards more new roles being commissioned and funded.

Q131 Dr Naysmith: One of the things that we have frequently heard in this Committee in the past is that the NHS is pretty slow at taking advantage of new technology and, even when it comes in one bit of the National Health Service, it often does not spread very quickly to other parts of the NHS. Could that be partly due to not taking advantage of new

technologies because of workforce shortages? Is that a possibility? You may not agree with what I said in the first place, but it has certainly been said in this Committee often enough.

Professor Hill: The evidence we got from the functions which are undertaken by the Healthcare Science Workforce is that they are adopting new technology. For example, they have been our key drivers in the adoption of new *in vitro* diagnostics for example and some new diagnostics which support, for example, cardiac physiology interventions or indeed more handheld portable-type investigations in respiratory physiology. So this workforce has been a leader in terms of adoption of new technology. Our challenge is actually how we can use the skills and talents of the Healthcare Science Workforce to help the rest of the workforce adopt new technology. Indeed, we are working on a competence framework, based on the healthcare science competences which might be applicable across the wider healthcare team, around adoption of new technologies.

Q132 Dr Naysmith: One of the things which has been said to us by some of the companies who manufacture some of this new equipment is that they would like perhaps to get involved in training National Health Service staff. One can understand from their point of view why it would be a good idea, but it is also possible that they could bring about change more quickly, if this happened. What do you think of that idea?

Professor Hill: Yesterday I was just out at the Medtronic Training Centre in Switzerland looking at the type of simulated training that they are providing for interventional cardiac devices as well as training some of the cardiac physiologists, for example in interpreting echo-cardiography. There has been quite a substantial uptake in England by both the medically qualified staff and the scientific workforce in accessing training solutions provided by the independent sector and that is quite common across a number of the different healthcare science disciplines.

Q133 Dr Naysmith: So that sort of thing is something that you would be happy to encourage.

Professor Hill: Yes. In terms of the future and the way in which technology is advancing, there will be a need both for us to reflect the ability to respond to that technology in both pre- and post-registration education and training programmes, but also in solutions with the independent sector and other providers of such training on highly specialised pieces of equipment.

Q134 Dr Naysmith: I have one final question to do with the fact that biomedical sciences are a key diagnostic group within the National Health Service but the training of them is not within the control of the Department of Health. Is that something which is a problem, or is it something which worries you?

Professor Hill: We are modernising pre-registration education and training for both of the two currently regulated healthcare scientist groups, the clinical scientists and the biomedical scientists, to make them more fit for NHS purpose. That is being done in conjunction with educational providers and in a separate stream of work we have discussions ongoing with the Department for Education and Skills on how we might drive changes in the funding and the arrangements for the delivery of these new NHS fit-for-purpose programmes in the future.

Mr Foster: This is an inevitable difficulty when you have graduate professions which contribute employees to many different industries. It would be difficult for the NHS to say they insist on monopolising it. It is the collaborative arrangements which Professor Hill described which really are our best bet.

Q135 Mr Amess: Professor Fryer, it is your job apparently to devise and implement a strategy to improve access to learning across the NHS. How are you doing? Please do not be immodest.

Professor Fryer: The first thing we are going to do is build on the success which is there already. By comparison with the rest of the British workforce, this is the most highly qualified and highly skilled workforce in the country. Just to give you an example, there is a big concern in the country about the numbers of people qualified at what is called level two or above, about the equivalent of five GCSEs. 80% of the NHS workforce is already qualified at that level or above. So the first thing is to build on success. The successes also include a very innovative scheme which was introduced as part of the NHS Plan to provide dedicated money year on year for unqualified staff either to acquire NVQs or to use what was called an individual learning account to get other money. This is not year zero. This is not the Pol-Pot regime, we are starting and the NHS has much higher aspirations for the qualifications of its staff than does the rest of British industry because it wants to get a very, very professional staff. Specifically what this means is also attending to things which do need improving. One of the areas needing improvement is around literacy and numeracy levels. We know that this is a problem across the British economy and indeed in health and social care generally we more or less match the challenges which are faced in the rest of the British economy, that is that about one fifth of all adults have some problems with literacy and almost 50% have some problems with numeracy. How we have been tackling that is to work very closely with the Department for Education and Skills and with local education providers to put in place specific programmes which are aimed at healthcare staff. All the evidence around the world shows that if you actually build literacy and numeracy into the local work and personal circumstances of people, it is much more effective, so we have started in that direction. Secondly, there are possibilities for progression. For example, we are currently already recruiting about one fifth of our nurses from

healthcare assistants. Healthcare assistants form one of the largest sections and one of the fastest growing sections of the workforce and we have provision in place whereby healthcare assistants can get financial support to undertake their training so that they can progress into nursing. In fact we have set an ambitious target of systematically moving that up to 25%. That would be a second area in which we are doing some work. A third area in which we are doing some work is that we are trying to reach back into the labour market, both amongst young people and in socially-deprived communities, to get training levels up so that when people enter the workforce they have higher levels of training, in very close collaboration with the Department for Work and Pensions and with Jobcentre Plus so people do not lose their benefit while we bring them up to a threshold of qualification. Those are just three examples of how we are doing this.

Mr Amess: You have already answered the second half of my question, so I am going to give you A++.

Q136 Dr Taylor: That is encouraging. I am delighted to hear that you are encouraging healthcare assistants to go on to become fully qualified nurses. We have been given some figures. We have been told that £4 billion is going into the Multi-Professional Education and Training Levy and that more than half of that is spent on medical training when doctors only account for 9% of the workforce. Is that right?

Professor Fryer: It is not quite accurate.

Q137 Dr Taylor: Please correct the figures we have been given.

Mr Foster: The figures you have been given are correct, but this is really about how we fund doctors in training. A large part of that actually pays their salaries. Rather than paying their salaries through their employers, because they are doctors in training their salaries come through these training budgets.

Professor Fryer: If you take the length of time a doctor needs to be trained, part of that training has to be covered by them still earning some money.

Q138 Dr Taylor: That is why it is such a very large proportion, because it is training. I am with you. On the surface it looks very unfair, but in fact . . .

Professor Fryer: No-one would argue that it is yet as fair as it might be, but there have been considerable improvements and the gains have been year on year and we want to see that continue to make sure that the appropriate levels of funding are made available at each level of the career framework of Agenda for Change. Sir Liam was talking earlier, for example, about Modernising Medical Careers. That means smarter and newer ways of spending the money we have so that there is more money to be spent across the board. We do not see any decline in standards in training doctors and other clinical staff, but things like the digital learning and the e-learning have allowed us to release resource so that other people can then have additional training. Most of the training at the lower end of these scales does not take so long, but there is still the issue, if you want to remove people from the workforce so they can do this training, of backup costs. What we are trying to do there is develop a systematic approach to work-based learning and to e-learning so that you do not have the double cost of both the education and the backup.

Q139 Dr Taylor: May I ask about these conferences which are advertised so widely? The *Health Service Journal* every week has three or four glossies and for a day conference the typical cost is £440.63. Who pays for that? Are you paying for that? Are you getting value for money out of it or are these conferences an entire waste of time and making money for somebody else?

Professor Fryer: I am not going to generalise about conferences. First of all, the conference world is a market world and education is a very big and growing market; in fact probably now the fastest growing market for conferences.

Q140 Dr Taylor: Who pays that £440.63?

Professor Fryer: It is a combination. Very often it is local organisations which pay and local NHS organisations will have policies on what sorts of conferences and what sorts of benefits they expect to derive for their organisations and their patients. So they might pay. Sometimes individuals pay. Very rarely does any payment come from the centre or from the money we reserve for training for the staff that we have been talking about.

Q141 Dr Taylor: It is all a local decision.

Professor Fryer: It is largely a local decision.

Q142 Dr Taylor: Would anybody keep an eye on value for money for that? Who should it be?

Professor Fryer: It should be the local managers who sanction the attendance. There should be reports back from conferences and the benefits should be spread. There is a bit of a culture in the country—and this is nothing to do with the NHS—of people seeing conferences as an individual benefit and not as a corporate benefit. We need to ensure that we are much choosier about who goes to what conference and be clear what the benefit is. You cannot generalise: some are extraordinarily valuable; some, quite frankly, I would not spend the time of day on.

Q143 Dr Taylor: Any comments? Am I alone in being worried about these?

Mr Foster: We have worried about them in the Department of Health from time to time. You occasionally see an overseas conference which has a very large number of UK delegates going to it and you wonder why it should be beneficial that so many go. There are waves from time to time of carrying out exactly what Professor Fryer described: much tighter local arrangements to make sure the value for money is being achieved. There is no doubt that the conferences have the potential to supply good training on the issues of the day from the experts

who know what they are talking about and are much appreciated. There was a conference yesterday addressed by Sir Liam on MRSA, which I think in fact was free of charge to delegates but which was extremely well received.

Q144 Dr Taylor: Free of charge? That is excellent. How did they manage that?
Sir Liam Donaldson: I did not actually speak at it. I do speak at most conferences, indeed it is probably years since I sat in the audience at a conference and it would be the greatest pleasure if I could have the opportunity not to be the speaker for once.

Q145 Chairman: In view of what you said earlier about the issue of numeracy and literacy of the workforce, do you feel that the proposals for extended vocational training from 14 to 19 in secondary education and in further education, potentially higher education, have any implications for the NHS?
Professor Fryer: Very, very important implications. In fact I have been talking to Lord Leitch precisely about this. As the largest employer nationally and locally we have a great interest in what goes on in schools. Indeed it is very difficult for any employer to correct what does not happen in schools. That is a national issue. It is extraordinarily difficult and it is much harder for us to correct it. We are very keen to see the development of the combined routes both academic and vocational; indeed some would argue that healthcare is *par excellence* an area where you need both academic and vocational aspects of work. The healthcare scientists would be a very good example and I would argue indeed that surgery does; it needs certain of the skills which are much more associated with vocationalism. We are very keen to work very closely, very keen to see the new vocational certificates being very much geared towards the NHS. We have our Sector Skills Council, Skills for Health, which takes an active interest in that and no doubt they will talk to you about that when they come. I work very closely with the Sector Skills Council.

Q146 Chairman: Could you tell us what will be the role of the knowledge and skills framework in improving education and learning in the NHS?
Professor Fryer: The particular advantage of this is that it affords an opportunity. Every year there is an entitlement in the NHS and, again, that makes it almost unique amongst British employers. There is an entitlement to an annual appraisal and interview and discussion on your personal development with your manager. Out of that can come a personal and learning development plan. The huge advantage of the knowledge and skills framework is that you can look at what you need to do, where you need to develop and be trained and if necessary get additional credit qualifications in order to progress through that career ladder. The knowledge and skills framework, with this built-in entitlement is a tremendous opportunity for building and growing our own workforce and that has huge advantages. Some of the issues we discussed in the first half in terms of recruitment can be counteracted. 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, because higher qualifications in education are closely associated not only with material life chances in the way of money, but mental health, wellbeing, participation in the community and so on. The knowledge and skills framework is a tremendous tool. What we want to do is to support local managers in getting the most out of it. Year on year we can see improvement, but there is some way to go.

Q147 Chairman: Is it likely to be hampered by other areas of the Agenda for Change like the job-matching process and things like that?
Professor Fryer: It is not necessarily likely to be hindered by other processes. What it does require is that in that dialogue between local managers and their staff, which goes on annually, those managers themselves have a very clear understanding of the service delivery and the service improvement that the body as a whole is trying to achieve and therefore what their future needs may be. It cannot be done in isolation. It needs those people to have a clear understanding about the priorities and the challenges which their healthcare organisation is facing.

Q148 Chairman: Do you believe that the constituent parts of the National Health Service, including representative bodies of the workforce, have endorsed the knowledge and skills framework?
Professor Fryer: They were involved in designing and testing it and developing it. I should say that the representative bodies, the trade unions and the professional bodies, including the royal colleges—do not exclude them—have been very, very positive about the whole notion of widening participation and progression. What we need to do now is year on year show the improvements. They have been very supportive of it and Andrew can no doubt talk about how they helped to design and build it and test it.
Mr Foster: The knowledge and skills framework really is the centrepiece of the pay system. As I said earlier on, it really is quite a unique pay system which rewards personal development with pay development which aligns the two. The knowledge and skills framework was designed over a period of a five-year negotiation, working with the trade unions and professional bodies in the NHS and you would not find a single one of those bodies which would come here and say anything negative about it except that it must be implemented properly. If you analyse somebody's learning needs and fit them into their knowledge and skills framework then you have to be sure you can follow through delivering the learning and training which is required by it. For the last 12 months we have been getting people onto the

Agenda for Change and as of March we had 99% of the non-medical English workforce being paid under Agenda for Change, but that is only the start of it. Now we have to get all the benefits out of the knowledge and skills framework and align the learning needs of individuals with the service needs of the organisations.

Q149 Charlotte Atkins: Earlier on Mr Foster you passed the baton to your colleague Dr Colin-Thome on primary care. Maybe we ought to ask the question first of all which Mr Foster was having some difficulty answering. What exactly do managers in the primary care sector do? That was one of the questions with which Mr Foster was having some difficulty.

Dr Colin-Thome: It depends at what level. There are two levels. There is one at the primary care trust level, which is not really primary care; it is the organisation which funds the whole health service. They have a key role there in making certain that resources are allocated and so on. There has also been a growth in management at general practice level. One of the tests for us in general practice is to have our practice better organised. Sometimes, although the doctors and nurses can be good at their clinical work, they are not effective at running an organisation and making it more effective. For instance, if you look at one of the drivers in the new GP contract the quality and outcomes framework, it is about getting systems in place for people with long-term conditions, chronic care. That takes a different mindset than is often around amongst clinicians. At PCT level they have a significant function and, as you know, we are halving the number, which I know in your area has caused some issues. We are halving the number so there will be a smaller number of PCTs because you can have a critical mass of people working together for one organisation. At practice level there is a significant need not to grow a lot more, but to have better quality managers and in some practices they did not have much management at all. Perversely, the quality and outcomes framework, which will give better clinical quality to patients, needed better management.

Q150 Charlotte Atkins: I think you are right in saying that PCTs are going to be halved as opposed to reduced by two thirds, if the feedback I am getting is correct. There is a move by the Government, rightly in my view, because I think my primary care trust does an excellent job, to shift from secondary to primary care. However, what we are seeing in terms of workforce is that it does not seem to be paralleled by an increase . . . Obviously there is an increase in staffing at primary care level, but there seemed to me to be more of an increase in hospitals. For instance, if you look at nurses, there is an increase in nurses in hospitals but not as large an increase in practice nurses. Similarly, if you look at the increase in consultants, there seems to be a disproportionate increase in consultants as compared with GPs. Why is that?

Dr Colin-Thome: That is historic. I do not want to criticise previous ideas, but there basically has not been enough investment in primary care. It has taken a long time to recognise that primary care is the biggest provider of clinical care; we do about 85% of all the consultations. International evidence has also been gathered by people such as Barbara Starfield and locally by Brian Jarman that increasing the number of primary care professionals, including doctors, makes a difference not only to the satisfaction of people with the health service but makes it more cost effective and now there is some actual connection with better outcomes. In one sense it is probably our fault by being, so-called, independent contractors. The health service has focused on the salaried end of organisations such as community nurses and staff in the hospitals and left primary care independent contractors a bit adrift. What I welcome about the policies which really have happened in the last 15 years is the greater focus on primary care, but the investment has not followed. That is maybe the reason for the lurid headlines about how much we are paid in primary care now. It does seem to have worked, because there has been a huge growth in doctors in general practice; an increase of about 1,000 a year in the last three years. That is head count rather than whole-time equivalents. In the last four or five years there has also been a growth of something like 18,000 nurses, of which only 3,000 or so are practice nurses.

Q151 Charlotte Atkins: That is the point, the proportion, in terms of the percentage increase in practice nurses, is far less than nurses overall and that is a concern. You focused on GPs, but clearly the work of primary care is heavily carried out not just by GPs but by practice nurses, by health visitors, by community matrons, people like that who are making a vast difference in the quality of primary care and the experience of the patient.

Dr Colin-Thome: That is where the biggest growth has been, in community nurses who are not employed by GPs; they are community-based staff. The issue for us then, and sometimes we have not been good at working with organisations outwith the people we employ, is how does the registered population, which is quite unique in British general practice, be the population base to look after communities, rather than just about general practice and its own organisation. If you look at the general growth of community nurses, it has been about 12,000 in the last five years. These are community-based staff that will do some of the work. It is not all going to be done by general practice. The other issue about more care out of hospital is that 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. For instance, some of the community matrons will traverse primary and secondary care and work with social care to get a better package of care. It is not just "Let's shut the hospital and give it to primary care", it is increasingly about where the care takes

place and some of that will be our secondary care colleagues, including especially nurses rather than consultants, doing some of that work.

Q152 Charlotte Atkins: Obviously in terms of the increased role that nurses are taking on that makes a lot of sense. Can you just answer one question about the redundancies in the secondary care sector, in the hospitals? Would you put that down at all to the increase in resources going to the primary care sector or would you see it more as a function of the primary care trust holding their acute hospitals to account and in fact defining where their residents, their patients, will be treated?
Dr Colin-Thome: It is a consequence of the realisation that in Britain, compared with a lot of equivalent healthcare systems, we put people in hospital, which modern medical care and healthcare do not lend themselves well to. For instance, because of the work of community matrons, these are case managers who are nurse trained—

Q153 Charlotte Atkins: Managing emergency admissions much better?
Dr Colin-Thome: No, they are actually managing people with complex long-term conditions, with co-morbidity, the group of people, not that many, who often have more than one chronic illness. The crude figures are that about 5% of our population account for 42% of all the bed days. The international evidence on case management is that you can often reduce emergency admissions, though the evidence is sometimes not clear. The biggest difference they make is shortening lengths of stay, because people can go home early and that will have a big impact. If a lot of patients with chronic long-term conditions are the biggest inhabiters of hospital beds and we can shorten their lengths of stay without affecting, in fact improving, their wellbeing and their life quality, then we do not need as many beds as we have traditionally had. It is often where care is taking place. The issue which is going to be interesting is that out of the redundancies not many were fully directly employed nurses. What will happen is that there will be more growth in primary care, because more care will be done and things like practice-based commissioning will be driving some of that. It is where care takes place. Some of the more lurid headlines about sacking are really just saying that we are using resources not very appropriately by keeping people in hospital unnecessarily when their care could be done better in community settings. Just as a very practical example, I am doing some work with the teaching hospital in Manchester where they have asked me to be their lead primary care adviser for the hospital. I can do it part time along with my other commitments. What we have come up with is that the hospital and the PCT, without getting in the way of contestability and choice and all that and being transparent, are saying they want a joint venture around urgent care and long-term conditions so we can rationalise where the care takes place and have fewer headlines. You will find more and more growth of that much more imaginative working. If you look at the acute hospitals project, of which I was a member, about reshaping the future hospital, there is a move to say that care could be done in different ways. That is a generally accepted view now.

Q154 Charlotte Atkins: How do we make sure that the education facilities of the NHS follow the staff? The impression we get is that a lot of the education and training takes place in the secondary area. How do we make sure that the innovative things which are happening in primary care are backed up by education resources? I should be interested to know how much clinical training is available in the primary care sector and what the proportions are, how much per head someone in the primary care sector gets in terms of training as compared with the acute sector.
Dr Colin-Thome: I cannot help you there.
Mr Foster: I do not have that information available.

Q155 Charlotte Atkins: Could you let us have it?
Mr Foster: What I can say is that the post-registration training monies are held by the strategic health authorities. They are not held by the trusts or the PCTs. The strategic health authorities can direct those monies to support what is generally trying to be achieved. In this case what is generally trying to be achieved is a transfer of work from hospital settings to primary and community care settings and there are plentiful examples of where staff are being trained to do that. I went to Epping Forest a few weeks ago and saw a team of staff who had previously been nurses working in the hospital who are now providing step-down arrangements in the community for the people Dr Colin-Thome identified, the over-75s who have the most frequent admissions to hospital. They were now being looked after by a case manager, either in their own homes or in a community hospital. This was a much better service from the patient's point of view and was much more efficient from the whole health economy point of view and was an example of where posts will be transferred from secondary settings to primary and community care settings.
Dr Colin-Thome: Also our community nurses are trained in community settings; we have a post-graduate degree. Practice nurse training is within the gift of general practice and I have to admit that sometimes that varies. The drivers of the contract which looks not just at clinical care, and therefore they have to have an expertise to do this well, but also at the organisational standards we are setting about having work plans and so on for our staff on which we have to be measured, will drive better training in general practice as well. Many practices do excellent training, but there are accusations of variation, though of course all our community nursing services are trained. Some of the community matrons are nurses coming from hospitals who might have emergency knowledge and can work well across, but they still need some training and we do

have some training programmes for our community matrons and we have produced a competency framework and so on to get that training.

Q156 Charlotte Atkins: Who is making sure that the health authorities are performing equally well across the country? There has been a huge variation in the ability of strategic health authorities to perform.
Sir Liam Donaldson: On medicine it is pretty standardised. There has been a major shift at both the undergraduate and postgraduate level to introduce more time in general practice and that is determined by national curricula. I do think there has been a massive change over the last 10 years in medicine. As far as nursing is concerned I guess it would be more determined by local practice.
Dr Colin-Thome: Yes.

Q157 Charlotte Atkins: To be honest, I am not quite so interested in doctors and nurses; I am actually more interested in the overall workforce in the NHS because very often it is these people, certainly community nurses, but other staff as well within the NHS, the carers, people like that, who are the ones who have the most contact with the patient.
Dr Colin-Thome: The training which some of the work people like allied health professionals, physiotherapists, have in hospitals is relevant to what we want in community settings. In the White Paper we have made quite a significant commitment to training programmes for carers, which we focused on earlier. I actually lead on the long-term conditions programme for the Department of Health and that is a significant part of our strategy because we recognise that most care is informal or self-care and both the patient who has the condition needs to be given more training programmes, which we are doing with things like the expert patient programmes and the diabetes programme, but also we need to be committed to carers.
Professor Fryer: You are quite right that there is a whole range of people within the team and healthcare assistants form a very large group, a fast-growing group in the workforce—
Dr Colin-Thome: Including in primary care.
Professor Fryer: As longevity increases and we know that not only is there a small proportion of the population which makes huge demands on the service, but actually it is age-related too in those last 10 years of life, healthcare assistants become very important and if you want evidence of what happens when you do not get it right, have a look at the research which was done on the Paris heat wave and the Chicago heat wave. Very often it was this level of skill and expertise and training that was lacking. I spoke early on very positively and I am feeling very positive about what the NHS is doing, but there is a lot more to do. The White Paper was extraordinarily honest. There is a sentence which the Secretary of State put in her recent White Paper, *Our Health, Our Care, Our Say* which said that sometimes we find that the least well-served communities in terms of healthcare are served by the least well-trained staff. We do need to do more. The obverse of me saying that 80% of the staff in the service are at level two or above—if I put it the other way round—is that we find that 28% are on level two or below. When the NHS staff survey, which is a very important source of information, suggests that up to one fifth of staff claim they receive no training at all, we all in this room know who they are without having to ask. We are doing well, there is this shift, healthcare assistants are an important component of that change and we need to do much more. Anything your Committee suggests that we need to do more for those staff will have me throwing my hat in the air.
Dr Colin-Thome: If you are looking at chronic diseases, it is unfortunate more of us are getting these, but it is a vehicle for working better together, one of the things we are going to work on with not just with our secondary care colleagues but social care colleagues who have many of those skills we lack. This is not about a healthcare system on its own and long-term conditions management is the practical way that that can be demonstrated. Some of the most effective ways of not needing to admit people to hospital include having social care input.

Q158 Sandra Gidley: You mentioned lurid headlines about wages and I want to bring you back to those. Whilst the press will always pick on the sensational, you cannot get away from the fact that there is a £250 million overspend on the GP contracts and they are figures supplied by the Department. Why did it go so wrong?
Dr Colin-Thome: I do not know that it went wrong.

Q159 Sandra Gidley: From the GPs' point of view it probably went exactly right.
Dr Colin-Thome: The trouble is that the contract is quite unique, because it is the world's largest quality-based contract that anybody has attempted. What our trade union, the BMA, the Department and also our expert panel estimated—because we had no baseline data—was that we would hit about 75% of the quality points. Some people might say that we did better because it was too easy, but actually there has been quite a significant investment in people such as healthcare assistants and nurses. It is actually quite hard to get to 91%. There was enough money, given that PCTs have had a huge increase in their allocation. So they did have money to compensate for that, but we did overachieve and that is to our credit. If you look at things like chronic disease, which amounts to 50% of the points, we know that better care systems for people with chronic conditions will increase longevity as well as quality of life. There is a drive to do that. The other issue which is interesting is that it was not uniformly spread. Some PCTs actually balanced. Maybe they had made a better assessment, maybe they had baseline knowledge of what their GPs were doing but some managed to balance their books and not overspend. It is a global sum. The other interesting thing is that the overspend or underspend or whatever bore no correlation to the QOF scores. It was not as though the biggest overspenders were

where the practices had the highest QOF scores. It is interesting that one of the issues we are trying to look at is how local health organisations, who are much more knowledgeable about local conditions, can make an assessment of both the needs of their communities, but also the capability and capacity in their local organisations. That is what the new PCTs will have to do in spades to have that knowledge. Wrong maybe, because it is hard often to allocate and to know exactly the monies you require, and you could equally argue that about out of hours care, but again there was huge variation in PCTs about how they spent their money, so in a global sense you might say we got it wrong, but it is local organisations which obviously have to have a better assessment. What is fantastic now is that the GP contract has given us that baseline and now that we are doing it with all that effort, we are going to try to make it a bit tougher so that it is about continuous improvement.

Q160 Sandra Gidley: You say there is a baseline, but it is quite difficult to assess what more is being delivered because I have seen reports which say that what has actually happened is that the good GPs are just getting paid more for what they delivered anyway and with the GPs who perhaps needed the biggest kick the improvement has not been quite so great. Hospital episode statistics have been collected since 1987, but there are no parallel statistics for GP activity. Is anything being done to address this imbalance?

Dr Colin-Thome: The quality and outcomes framework now does that. All we had were patient contacts, but now two things have come from the contract. One is that it is much easier to put this information on the computer, because it is really hard to track patients if you have paper-based records. One of the side benefits is that we have a fantastically better database of what patients have got wrong with them. That is number one to build up for the future. Two, we do have quite key markers now about the effectiveness of care. What the QOF people did, quality outcomes framework people did, including our expert panel, was look at process measures which were easy to measure because they would fit a contract, but which you know will lead to outcomes. That is why a lot of the clinical points were for things like diabetes and heart disease and stroke because we have better evidence that those measurements lead to better health outcomes. That is what they did. It was not that good doctors were not doing good things; it was that we managed to raise the level of all our patients rather than the variation because there was a more systematic—

Q161 Sandra Gidley: Would it not have been better to have had a year of base-lining to find out what was actually happening in practice so that you could actually see whether you were getting better value for money in the end?

Dr Colin-Thome: In a scientific sense yes, but the real issue for us was that we were desperate to get more investment into primary care because the number of GPs' had remained flat for years and the number of consultants was growing. One of the negotiation points was how to get more money into primary care to make it a much more attractive career and that seems to be working in the early days and that certainly ought to work if you look at the same sort of event which happened in 1966 with the contract. The second thing is what we were determined not just to give lots of money but at least to try to link it with a quality based contract. In an ideal sense it would have been better, but on the other hand there is some urgency to invest more in primary care and that seems to be benefiting. It would not have been ideal, but often a negotiation contains a lot of different issues which you are trying to address and that was what we came up with. At least now we have this baseline. What we are going to do is introduce new facets and we do not have a baseline for that, but at least it is a start. Often people collect better data when they have some incentives to do so and that means that the database will be much tougher and more accurate. After all, we do get reviewed at practice level by our PCTs to check that we are not doing things correctly. In an ideal sense I would agree, but there was a whole package of reasons why we were investing more into general practice, not least the fact that since we have better outcomes and better effects for the health service from primary care we needed more people in primary care.

Q162 Dr Naysmith: May I comment on something you said? You said that some PCTs in some parts of the country came in on budget and therefore they maybe estimated better what the cost of the contracts was going to be for PCTs, but actually what happened in the PCTs where that happened was that they postponed development and investment plans that they had planned for that year and they have now had to postpone them or give them up so they could come in on budget. That is what they tell me.

Dr Colin-Thome: That is the job of a manager really: to manage that resource and set priorities.

Q163 Dr Naysmith: Of course. All I am saying is that it was not because they estimated better what the contract was going to cost.

Dr Colin-Thome: Some might have done, because they may have had a better shot at assessment. If you look at some of the personal medical services, PMS, 40% of GPs, the PCTs had a clear view, as a sort of exemplar, of what practices could achieve, because they had local contracts. You are right in some senses: you manage a budget by setting out the priorities and one of the biggest priorities for the best hit for your pound is actually investing in primary care. There is an international evidence base to back that.

Q164 Dr Naysmith: I am not disagreeing with anything else you have said, that is the only bit you said that I disagree with.

Dr Colin-Thome: That is what a manager does. If there are some issues you have to prioritise, you may have to delay others.

Q165 Dr Naysmith: They had carefully budgeted for developments they intended to put in place this year and they could not do them because the contracts came in at slightly more than they expected.
Dr Colin-Thome: Right; yes.
Chairman: May I thank you all very much indeed. May I also thank you and some other organisations for contributing to our written evidence which has now been published and will be available for people to look at. We have had quite a long session this morning and thank you Andrew Foster particularly for being involved. Thank you all. This is the first public session of a very long inquiry which I hope will come out in a few months' time with some guidance in terms of where workforce planning should be going in healthcare in general; not just in terms of the National Health Service but where we all often need to have different forms of healthcare. Thanks again very much. Sorry about the lateness of the hour; these are becoming far too predictable now.

Thursday 18 May 2006

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess	Anne Milton
Charlotte Atkins	Mike Penning
Mr Ronnie Campbell	Dr Doug Naysmith
Jim Dowd	Dr Howard Stoate
Sandra Gidley	Dr Richard Taylor

Witnesses: **Ms Sian Thomas,** Deputy Director, NHS Employers, **Mr David Amos,** Director of Workforce, University College London Hospitals, **Mr Warren Town,** Secretary, Alliance for Health Professionals, **Professor Sir Alan Craft,** Chairman, Academy of Medical Royal Colleges, and **Ms Josie Irwin,** Head of Employment Relations, Royal College of Nursing, gave evidence.

Q166 Chairman: Good morning. Thank you for coming to the second evidence session on our inquiry into workforce planning. Could you introduce yourselves for the record?
Ms Irwin: Josie Irwin, Head of Employment Relations for the Royal College of Nursing.
Professor Sir Alan Craft: Alan Craft, a paediatrician in Newcastle but my present position here is as Chairman of the Academy of Medical Royal Colleges.
Mr Town: Warren Town, and my day job is Director of the Society of Radiographers, but I am here in the capacity of the Secretary of the Alliance for Health Professionals.
Ms Thomas: Sian Thomas, Deputy Director for NHS Employers, which is the employers' organisation in the NHS.
Mr Amos: David Amos, Director of Workforce at University College London Hospitals NHS Foundation Trust.

Q167 Chairman: May I say before we start the session that, sadly, we have lost one of our parliamentary colleagues who died last night. He was on the Opposition benches and at least three members of this committee will be leaving for a short period of time during this session in recognition of that event. I start with the first question in relation to the trends in workforce supply. This is purely an extension from the session we had last week. This question is probably for all of you in turn. There has been a number of development in the NHS workforce since 1999, including rapid increases in staff numbers and some workforce reform. Could I ask you individually what you believe have been the major successes and failures of the past few years.
Ms Irwin: One of the major successes in the last 10 years has been, from the Royal College of Nursing's perspective, to increase the numbers of nurses in the UK NHS workforce by some 85,000 since 1997. However, one of the issues which you will have read in our evidence is that the quality of workforce planning in the UK means that we do not know where all those nurses have gone; we do not know how many of them have stayed in the UK; we do not know how many of them have stayed in the NHS. That is an issue in terms of workforce planning because, right now, and I think our evidence has highlighted this, we are in a situation of global shortage in respect of nursing staff and other countries, such as the United States and Australia, are proving to be attractive draws to those people. In terms of other challenges, because you have asked the extent to which things have been done well or not, we also have an issue in respect of the whole workforce, but more particularly in respect of nursing and ageing. For example, at the moment there are about 100,000 nurses aged over 55, so set to retire within the next 10 years. Another issue about workforce planning in the UK is that we do not know very much about the retirement behaviour of these nurses: when they are likely to retire, what sort of things might influence them in terms of retiring now, except that we do know, for example, that the uncertainty generated by some of the NHS reforms is causing people to wonder if they would like to retire now. The overall point I am making is that there is a degree of uncertainty in workforce planning that means that the success of importing new numbers of nurses into the UK is challenged by not knowing enough about what has happened to them once they have entered the workforce.
Professor Sir Alan Craft: From the medical point of view, there has been a large increase in the number of doctors working in the NHS, and this is partly in home-grown doctors; we are increasing the number of medical students and the output from medical schools is increasing. We have also had a large increase in the number of international medical graduates coming over the last few years and they have been encouraged to come. We have also had a significant increase in the number of European doctors coming, particularly in 2004 from the new accession states; we had quite a big influx of doctors from the former eastern Europe. We have had quite a large increase in the medical workforce. There has been a big recognition over the last few years that we cannot go on as we always have done with the pattern of medical health care. There is a variety of matters driving us to look at what we do, particularly in specialist practice but also to some extent in general practice. All the Royal Colleges are looking at how they can provide a workforce fit for the future. The problem is that we have a lag time between looking at what the future is and training anybody for that, which can take anywhere between

eight and 10 years. By the time you get to eight to 10 years, that has probably changed anyhow. One of the things that we are building into all our training systems is flexibility so that people are capable of adapting to whatever it is they are going to have to do in 10 years' time. We recognise that there are an awful lot of things that doctors do that other people could do quite nicely and probably better to some extent. We have welcomed the advanced roles that nurses have taken up. We are generally supportive of health care practitioners, medical care practitioners, social care practitioners. We are a bit concerned about what you call them. In general, we are very keen on them but also very keen that they should be part of a medical team. We are a little concerned that they may be working in isolation. Things have changed greatly and they will change more over the next few years but planning is difficult.

Mr Town: With regard to successes for AHPs, there have been a number of innovations on extending roles, taking on extra responsibilities and working with non-qualified staff to extend their roles. These measures would allow the AHPs to develop their specialist skills and take over roles at a higher level. There have been failures in that there has been no indication that there has been an associated increase in the levels of recruitment or levels of staff to the service. The fact is that at the present level we anticipate that at best we can stand still, but we cannot innovate without that extra number of staff. The current round of uncertainty about finance will do no good either because, in truth, the jobs being cut are going to be junior jobs. That does not allow the seniors to take on extra roles that they tend to do as extra responsibilities. Like others, one of our major problems is that within all the AHPs there is an indication that many will retire within the next 10 to 15 years. Without an increase in numbers at the lower levels, there will be a shortage of skills in the more qualified and more experienced grades. This may be exacerbated, we do no know, if the pension debate is not settled.

Ms Thomas: I agree with many of the comments made by my colleagues, and that is the difficulty of coming near the end. I would like to make a few points on behalf of NHS Employers. I have no doubt that, from an employers' perspective, if you look back over the last five or 10 years, we have made huge improvements in the number of people working in the NHS and certainly that has had a demonstrable impact on patient care. We are very clear that the numbers of people working in the service now compared to 10 years ago has dramatically changed and the gap between the number of people we need and the number we have is now much narrower than it was. Certainly, there is a new set of challenges and I think that has been described by my colleagues.

Q168 Chairman: The increase is the success in all this as far as the NHS is concerned. The failure side, in a sense, is that it has probably not been terribly coordinated in terms of finance.

Ms Thomas: That is certainly true but the integration between finance, workforce and what the service wants can always be improved. In some parts of the country that challenge is graver than in other parts. We are seeing that the vast majority of employers are now able to plan better and coordinate their working teams because of that huge increase in the number of people. The challenge for the future is that most of our people have been trained in a hospital setting; we need to improve the vast majority of their training when the shift in care is towards more primary care working. Also, new roles bring on new sets of challenges, as my colleagues here have said, around integrating the team, making sure there is a competence framework. That has been put in place in the Knowledge and Skills Framework that we have, to deliver all of that. There is a platform to secure for the future and to overcome some of these challenges.

Mr Amos: Perhaps I could add something from the personal perspective of someone who was an HR director in London in the mid to late Nineties. We have seen a transformation in the health care labour market, particularly in London. I know the situation then was a factor that prompted your committee to do the work it did. In headline terms, back in London at UCLH we have seen a growth in the workforce, which you and colleagues have acknowledged. There has been a very substantial reduction in the number of vacancies. Many trusts now have talent pools, as they call them, of people who want to come to work and who are waiting for the advert to be placed. We have seen a reduction in turnover and reductions in areas such as temporary bank and agency working. Overall, we have a far more diverse workforce than we have ever had. I say that as a massive, positive tribute to NHS and other health care providers which have recruited and developed staff. There is much more we can do in that area. That is a very significant feature of the couple of hundred thousand people working in the NHS in London. It indicates the great potential that the NHS has if it continues to take advantage of the talents and potential of the individuals working in the NHS. In terms of prospects, as your committee has already acknowledged, we need to work out how we can get more from the NHS and from other staff working in health care (I know that is a central part of your inquiry) and to make sure that we get staff in the right place within NHS organisations. Within my trust, for example, we are working increasingly with day cases rather than inpatients. We need to move staff between sectors. That is one of the key characteristics of what is changing at the moment.

Q169 Dr Stoate: You have always said quite clearly that there has been a huge increase in the workforce of the NHS. None of you seem to have disagreed with that statement. What we find so frustrating and mystifying on this committee is why that huge increase in staff does not seem to have been accompanied by the necessary measures of reform. Why has reform been so slow, given the huge increase in staff?

Ms Thomas: It is true to say that reform is now more of an issue than perhaps it was five or 10 years ago. It is definitely true to say that we have new polices which employers are implementing. The career framework was not in place five years ago to enable people to shift between the sorts of jobs we did. I think we could give you many examples where within the NHS people are doing things differently with community matron roles, lots more specialist nurse roles and emergency care practitioners. Those measures are beginning to change the way that patients receive care along the route of referral, but we need to do more.

Q170 Dr Stoate: We have plenty of examples of best practice. We have been sent lots of memos and we have spoken to many people about best practice. Why is best practice still only best practice and not normal practice? Why is it that the NHS is so slow to reform as an organisation?
Mr Town: Going back to the point about the increase in staff, yes, there has been an increase but, as I said before, certainly for the AHPs, that is a standing still; it is not moving matters very far forward. Equally, as long as the Government introduces new plans, new ideas and new strategies, we have to meet those demands as well. That may be ISTCs or it may be admission to a patient-led NHS. We then have to develop new plans and put those plans into practice, but if we are only standing still with the staff we have, we are not going to make the innovations that you think are going to happen in the NHS. I have one word of caution and it is a health warning for one particular area of staff where there has not been an increase but a dramatic shortage of staff, and that is in cancer care with radiotherapy. That is definitely a problem. Also, the increases in themselves must be planned in association with the outturns of how many are leaving and how many are not taking up posts. In physiotherapy, for example, there have been increases but there are also physiotherapists not taking up posts because there are not any posts, and that means losing people.

Q171 Dr Stoate: I accept that but there are examples where there have been massive increases in certain sectors of the NHS and yet that still has not been accompanied with enough reform. Perhaps Professor Craft might be able to help us.
Professor Sir Alan Craft: One of the problems is that the NHS is not a national organisation. Deliberately, it has been devolved to lots and lots of smaller things. You are right that there are some good examples of good practice and new innovations in some places but not far away they are doing things in the old-fashioned way. When the Modernisation Agency was in existence, they had regular documents coming out about sharing good practice. My own college, the Royal College of Paediatrics, produced a very influential documented called *Old Problems Need Solutions.* We had case studies about how it had been done in different places and that has helped to reorganise and improve services all over the country. You are right that there is a lot of sharing to be done. If the best practice was universal practice, things would be much better.

Q172 Dr Stoate: They would. We find it difficult to understand why that should be. Turning to something else, the number of non-clinical staff has risen just as fast as clinical staff. Is that justified?
Ms Irwin: May I pick up your previous point and contest what you have said about there having been no reform?

Q173 Dr Stoate: I did not say there was no reform but that it was too slow and it is not widespread enough.
Ms Irwin: The point, as articulated by Professor Sir Alan Craft, is that there are all sorts of examples of good practice occurring at local level, all of which have contributed to the targets set by Government being achieved. The problem is that the Modernisation Agency has been abolished. One of the things that this inquiry is highlighting is the lack of robust workforce planning. What we do not have is an agency that collates that evidence of good practice. Returning to the question that you have asked about the numbers of support staff in the service, that in itself is evidence of people working in new and different ways, of working as teams to change the way the patient moves through the service. In itself, that may be a good thing, so I would contest that as well.

Q174 Dr Stoate: I have not really heard answers that I am satisfied with. You all come up with good reasons why things have not changed but those have not satisfied me as to the need for radical reform in the NHS. Last week, Andrew Foster told us that he thought the workforce planning system was overheated. Surely that is more of an understatement than anything else? Surely we should expect the NHS to reform, given the huge amounts of resources going in and huge increases in staff numbers? Surely the Government has a right to expect this reform? Why is it taking so long? I do not think any of you have really addressed that issue.
Ms Thomas: Perhaps it would help to describe one of the roles of NHS Employers in trying to share best practice with employers. We are a year old. We are new in our role but increasingly over the last years that is exactly what we have been doing. The examples I have given you are in things like the emergency care practitioner, midwifery, chronic disease management, respiratory care and health care sciences. We are doing huge amounts of work in those areas. There is not enough time to sit here and describe them all to you. Some of those are replicated nationally. Nurse prescribing, for example, is a national reform in the way that that profession implements its practice. I think it is true to say that we are on a huge journey. It is quite right to say that we need to get on with delivering all the changes needed, and that is certainly what we are doing. Our role is to try to help employers share where they can what they do best and to learn from that.

Professor Sir Alan Craft: I want to return to this and to say that it is not all our fault. People on your side of the table have a role to play as well. The biggest problem in reorganisation and redesign of services is the local MP who wants to continue to have his hospital doing the same thing it has always done, to have its maternity unit, its A&E unit and everything else, which we know in the modern system they cannot have. I think there is a great deal of education to do on your side of the fence as well.
Dr Stoate: That is a good answer.

Q175 Charlotte Atkins: Recent reports about NHS redundancies have suggested that the vast majority of job cuts are reductions in posts rather than in personal redundancies. I know that obviously the RCN has been running their *Keep nurses working: keep patients safe* campaign. What is your view? Is it mostly about posts and not actual real redundancies?
Ms Irwin: Shall I respond to that first as I think Charlotte mentioned the Royal College of Nursing campaign. We have actually been very clear from the outset of the campaign, which we embarked upon in the autumn of last year, that we are concerned about posts being lost from the service. We started mapping the numbers of nursing posts that trusts were shedding as a consequence of reorganisation in the autumn of last year. More recently, we have seen, with the advent of turnaround teams going into trusts just after Christmas, for example, those post losses also being redundancies. For example, on Monday of this week a set of redundancies was announced through a Section 188 notice in Nottingham. I think we ought all to be as concerned about the loss of posts as of individuals. In respect to nursing, I draw to the committee's attention some evidence which we have included in our written evidence. We know, for example, that the nursing workforce is very stretched, that on average a nurse works six extra hours in excess of the normal working hours each week, and that is a day a week. That is indicative of nurses working at full stretch. The loss of posts and the loss of agency temporary staffing resources all add to that workforce stress, and therefore the impact on the patient. Yes, the focus is on posts, but I would say that that is as concerning as the loss of individual jobs from the service.

Q176 Charlotte Atkins: Are you saying therefore that it would not be possible or advisable for management to look at the mix of nursing skills and just change the mix? Are you saying it has to stay as it is?
Ms Irwin: No, I am not saying that. One of the problems about what is happening now, though, is that the workforce changes and the loss of nursing posts is not as a consequence of an all-out change of service design or a service improvement but much more a knee-jerk reaction to the deficit situation. I know that the committee will be having a separate inquiry into deficit. No, I think it would be a misinterpretation of the RCN's campaign if it were to be seen that we are arguing against any effective mix of skill, but it is highlighting the fact that the posts that are being lost from the service at the moment are not part of that. It is a knee-jerk, short-term reaction to the deficit situation.

Q177 Charlotte Atkins: Since 1999, we have had something like 75,000 extra nurses. Are you suggesting that pre-1999 patients were not safe? The title of your campaign is *Keep nurses working: keep patient safe*. Does that indicate that before 1999 patients were not safe?
Ms Irwin: No, not at all, and our focus right now is on the consequences of ill-thought out reductions in posts as a consequence, say, of a knee-jerk reaction to financial deficits rather than thinking through service improvements. Those 85,000 nurses that have entered the UK from 1997, in our view are all being effectively used and deployed in improving patient safety and patient care.

Q178 Charlotte Atkins: What your campaign seems to imply is that these reductions in posts will actually put patients at risk, whereas in fact overall there has been a substantial increase in the number of nurses in the NHS?
Ms Irwin: There has been, but the point that I am making is that because of the crudity of workforce planning, as I have said before but to repeat the point, 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. There is no thought-out rationale to bring health care assistants into the mix, for example. The challenge is to patient care because, as I have already highlighted, the nursing workforce is so fully stretched at the moment. If there are ill-thought out reductions in posts rather than effectively thinking through a proper skill mix, that will inevitably impact on the quality of nursing care that a nurse can give. I would like to use the words "quality of nursing care" very carefully rather than "patient safety".

Q179 Jim Dowd: On that point, and you have said it a number of times, you used this horrendous cliché about a "knee-jerk reaction" to deficits. I would like to know what you think should be done about the deficits, other than the Government ladling out more money. My local trust went through a realignment of services to live within its budget, which then implied a certain surplus of individuals. Why is it that this obsession with posts, and in local government terms it is the establishment, only exists in the public sector? In the private sector, you just live within the budget and employ the people you need to do the job; there is no such thing as posts and establishment.
Ms Irwin: I apologise if I used a cliché but perhaps I can use different language. The example that you have just set out would appear, without knowing all the detail, to be a good example of looking at ways in which a budget deficit can be addressed and thinking about sensible ways of realigning the service in order

to do that. The RCN's concern is about losses of posts where the service reduction is ill-thought out and the posts—

Q180 Jim Dowd: Where has that happened?
Ms Irwin: That has happened in a number of places. It is well-documented across the UK.

Q181 Jim Dowd: It was in one or two places.
Ms Irwin: I do not have the details off the top of my head. I do have a list with me which I am happy to make available to the Clerk subsequently. To return to the key question you asked, which is why is there an obsession with posts, I think that we have to be concerned, do we not? The RCN's annual employment survey, which we submitted as part of our evidence to the Review Body, highlighted that 25% of the nurses that we surveyed, and it is a statistic exam survey, said that they were concerned that their workload meant that they were not able to deliver the quality of care that they would like to deliver. From the patient's perspective, clearly we have to be concerned that if posts are reduced that will further add to the nurses' workload and that in turn has an impact on the quality of patient care.
Mr Town: The AHPs have not so much been subject to redundancies yet. If it were in, say, radiotherapy, then the last person to leave should please turn off the light because there would be no-one left. Our problem is that there are a number of frozen posts within the establishments. Those frozen posts are not being taken up.

Q182 Charlotte Atkins: You are taking about frozen posts because of the deficit?
Mr Town: Yes, because of the deficits.

Q183 Dr Naysmith: Do you mean newly frozen posts?
Mr Town: Yes, the job freezes.

Q184 Dr Naysmith: I remember being in the Health Service just a few years back and going round and visiting hospitals and nearly every establishment I visited had empty posts that were being kept empty in order to keep within budget. Nowadays, meaning in the last 18 months, this is virtually absent. You are saying it is starting again, are you?
Mr Town: It is starting again and it started in the middle of last year. We have noticed that a number of our members within the AHPs have been subject to frozen posts; in other words, job freezes, so that there is no-one going into the vacant posts. One of our constituents, the Chartered Society of Physiotherapy, conducted a survey and found a reduction in vacant posts at a time when there are graduates coming out ready to go into posts. These are new graduates, and it costs £28,000 to train someone. If they are not going to go into a post, where are they going to go? If they do not go into the NHS, they will go somewhere else. If you are not going to put people into posts but you want to reduce waiting lists, you want to reduce waiting times, then you cannot have it both ways. A high proportion of the junior posts, the posts that are being frozen which are not being filled, are the ones that do the majority of the work. In physiotherapy the juniors do most of the work. In radiography, it is the juniors who do most of the work and a lot of the out-of-hours work as well. In truth, by job freezing, you are also impacting upon the quality of the care that should happen in the NHS. So people are being diagnosed but they are not then necessarily being treated because there are not sufficient people in the jobs to do treat them.

Q185 Charlotte Atkins: So we have very few actual redundancies. I wonder if the employers' organisation would like to come in here because clearly there have been huge numbers identified, including in my own North Staffordshire University Hospital. The actual numbers of compulsory redundancies, although obviously there will be some natural wastage over time, is not as great, but still I have to say that is very serious and very serious for the individuals concerned. I am also a bit concerned about the RCN campaign. I appreciate you are a nursing-only organisation but the implication is that only nurses jobs are important and the rest are not. I would like the employers' organisation to come in here.
Ms Thomas: I will make three very important points, and then I will ask David Amos to talk from a local perspective about his own situation and his understanding. The first thing to say is that obviously patient care is paramount. Any trust board that makes a decision to go through an exercise to review its workforce in the way you have seen people do takes that into account. We, the NHS Employers, did a recent survey on the ground with employers to understand what the situation is. I think it is disingenuous to say that the only reason for these changes is deficit. There is a whole raft of reasons, many of which we have talked about today. The world is changing. There is a world of technology. That is what we do: we review what our workforce is doing, what our skill mix needs to be, and we do that every day. That includes how many numbers of people we need.

Q186 Charlotte Atkins: Are you saying that the NHS deficits are being used as a sort of smokescreen for reorganisation within hospitals?
Ms Thomas: No, I am not saying that. Only this week we heard of an example in Nottinghamshire. I spoke to the Director in QMC at Nottinghamshire who has just announced over 1000 posts will be going from that organisation, but they are merging two big hospitals together. They have always planned to do that. They will be more efficient by doing that. They want to redesign their services. The second point is that there are many types of change and certainly some of them are not about taking whole posts out of an organisation but doing the very thing people have described as skill mixing. Now that we have reached this equilibrium, many organisations are narrowing gaps between supply and demand. Now they have to articulate what their optimum balance of flexible to permanent staff should be. It is safe to say that at this time that really

is an important issue for many employers because we now have many more people who want permanent jobs. I would like to say something about graduates. This is not to say that any individual situation is not important; of course it is important and the number of compulsory redundancies in our survey was very minimal. A significant minority of people are going through what are very difficult times. Some of those local situations, and there is a handful, are more challenging than others. We, the employers, want to do everything we can to make sure that every graduate, particularly in nursing as a profession and as an example and physiotherapy where we know there is an over-supply of graduates, gets a job this year. We will be working in partnership with the RCN and the Chartered Society of Physiotherapy to overcome some of those issues. We met recently with 40 physiotherapy professionals and the CSP to discuss that very issue six weeks ago and we have an action plan in place to overcome some of those problems. We will do a similar thing for nurse graduates and find innovative ways in which we can take all those graduates into the workforce wherever we possibly can. It cannot be right that we train people who then cannot get a first entry job in the service.

Q187 Charlotte Atkins: It has been suggested that up to 10,000 nursing students graduating this year may face unemployment.

Ms Thomas: We have not seen any evidence of a figure anywhere like that. Currently, we are conducting our own review of the local situation.

Mr Amos: The evidence, as I see it on the ground and I know it is our experience at UCLH and Barnet and Chase Farm and at trusts across London, is that, with some considerable effort, they are able to take on all the nurse graduates that are forecast to come out this year. That was certainly the case earlier on this year and last year. At Barnet and Chase Farm, for example, it is estimated that there will be 80 nurse graduates coming out later on this year. They are all going to be taken on. That is also the case for UCLH. It is important to recognise that that is done in partnership with the individuals, with departments and staff side representatives working hard to find perhaps in the first case temporary appointments before permanent placements can be made. In line with a general observation around the headlines currently being portrayed, we need to hold our nerve; we need to take the situation very seriously but to actually look at what is going on on the ground, as Sian has indicated. I wanted to give you one other example, which I think illustrates the amount of reform going on, where staff, staff side representatives, technology and training are helping to deliver reform. At UCLH and number of trusts we have introduced technology for the transfer and storage of radiological images, formerly known and loved as X-ray films. That has transformed the working lives of clinicians and vastly improved the quality of patient care in all settings in acute care. That has had a dramatic effect on people who, often for decades, have worked in hidden basement areas filing X-ray films. In our case, and I know it is true right across the NHS, we have worked with those individuals as we have not wanted to make them redundant, We have given them training and trial periods in other roles. I am glad to say that we have found them work. For those individuals and their colleagues, that is a huge amount of reform. It may be difficult to calibrate at this level and at a national level but, through commitment and hard work on the part of everybody (the individual, their representatives and their line managers) we can pull off that reform which is good for staff and patients, and good for cost-effective care.

Professor Sir Alan Craft: I want to go back to how you started this by asking the nurses whether the quality of care has deteriorated in spite of having an extra 30,000 or 40,000 nurses.

Q188 Charlotte Atkins: It is 75,000 since 1999 and up to 85,000.

Professor Sir Alan Craft: It is important to recognise that the delivery of health care has changed dramatically.

Q189 Charlotte Atkins: Has it changed for the better or for the worse?

Professor Sir Alan Craft: It has changed for the better. Nurses are doing a lot more things and have helped to restructure the NHS, particularly through things like the European Working Time Directive crisis that we had. If we had not had nurses taking on extended roles, we would have fallen flat on our faces. It is very difficult to look at one particular bit of the Health Service in isolation. We are all now incredibly dependent. Physiotherapists are taking on roles doing things like physiotherapy-led back pain clinics that is freeing up orthopaedic surgeons. It really is difficult to look at each of the different bits in isolation.

Ms Irwin: I wanted to flag one of the dangers, to return to a point being discussed with colleagues about the student intake this year. There are indications, particularly from the West Midlands and the East Midlands, of real difficulties about graduate students of nursing getting their first jobs. Whilst I think it is reasonable to say that there should not be an expectation necessarily that an individual should get a job where they have trained, we have to recognise that the majority of nursing students these days are much older than they were. The average is 29. Many of them will have local ties, children and partners with jobs in the local community. The danger is that if we lose this year's intake or this year's graduate cohort because of the short-term difficulties that the NHS is experiencing, added to what I was describing right at the outset of this inquiry about the ageing of the nursing workforce, there is a danger that this short-term blip will become a bigger problem for the future. I would like to highlight that to the committee and make the additional point that workforce planning somehow has to capture that. Our concern is that it is not and that the short-term blip that we are experiencing now will turn into a bigger problem for the future.

Q190 Charlotte Atkins: What should Government do about it then?
Ms Irwin: In our evidence, we have set out ways that the committee might ask the Government to look at improving workforce planning. We have described models that exist in Scotland, for example, which is a much more all-embracing model of workforce planning that also looks to social services, for example, in terms of getting information. Our solution, and the solution we would like to suggest to the committee, is that there is a much more robust way of looking at the workforce from a national perspective by incorporating the UK perspective and being much more robust at local level too.

Q191 Charlotte Atkins: That is fine for the long term but what about the short-term deficit, for instance in my own local hospital, the University Hospital, in North Staffordshire?
Ms Irwin: My colleague, Sian Thomas from NHS Employers has already alluded to some discussions that are about to be embarked upon in partnership with the trade unions. We welcome 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 where we know, for example from your inquiry last week, that there is a shortage of skills in community staff. We want to embrace that change and work with NHS Employers to deal with that short term.

Q192 Charlotte Atkins: That would require transitional funding, which is unlikely to come from the National Health Service.
Ms Thomas: Perhaps I could give an example of where we need to build on the success of what is already happening. When we met with the physiotherapists, for example, and I hope we are able to embark on some of these ideas in partnership with the RCN, we heard that in community services in particular we have perhaps been too narrow in our thinking about what physios can do in the community and what supervision they need in their roles. I think we can overcome some of those issues by placing perhaps more junior professionals into the community with better supervision so that the transition is easier for them.

Q193 Charlotte Atkins: But that would have to be funded by the primary care trusts. If they are already in deficit, how do they fund that?
Ms Thomas: It is certainly true to say that there are many deficits in the primary care trusts as well. However, many of them have told us that they are working on designing new ways of patient care in the community. There certainly are examples of where new technician roles, community matron roles and junior district nursing roles, are changing the way they work. I think that will evolve over the next year to 18 months as the White Paper is implemented and those models of care will be seen to be happening. All the announcements about post reductions have been in the hospital sector. It is only right that that happens if care now needs to be delivered in the community.

Q194 Charlotte Atkins: If the primary care trusts cannot come up with the extra funding, how do they transfer to the community?
Ms Thomas: The challenge for them now is to redesign what their workforce does and how it looks and to change the way those people work.
Ms Irwin: To support what Sian Thomas has just said, there are all sorts of examples where nurses are working in different ways with associate practitioners in the community. The fact that associate practitioners are then able to be paid in a different way because of the change to the pay system through *Agenda for Change* has meant that people who would not previously have done those jobs have been attracted to them and primary care trusts have then been able to save money because they have not had to fork out for agency staff costs. There are small examples like that which, aggregated up, could become quite powerful in terms of not costing primary care trusts extra money to make changes.

Q195 Chairman: Could I ask a specific question about this whole area before we move on to something else? It was said a few weeks ago in the public domain that the safety net was being withdrawn from NHS patients. Was that an unfortunate expression or is it evidenced? Does anybody have any evidence that the safety net is being withdrawn from patients because of the current situation?
Ms Thomas: We certainly have had no evidence in our survey with employers that there has been detriment to patient care from these changes. There is certainly change but no evidence that was presented to us by local employers.

Q196 Jim Dowd: To take the other side of that coin for a moment, do you have any view on the idea that a lot of the reductions have been accompanied by assurances, and I am generalising here, that that will not have an effect on patient care? What were these people doing before then?
Ms Thomas: Can I qualify that by saying that the reductions, in the vast majority of cases, were in non-clinical roles and in roles, as David has described, where people were supporting teams; the way those services are now being delivered has changed. Many of the posts are managerial posts, and that is only right. The evidence we have is that there are minimal reductions in patient care and, where that happens, it is through closure of beds because people are staying in hospital a lot shorter time, or there are more day case operations instead of people staying in overnight. Those sorts of examples mean that it is only right to move those jobs to another part of the health system. I hope that helps you.
Ms Irwin: I said earlier that there are issues and concerns about the quality of care. I challenged a comment made about concern for patient safety. We certainly have some anecdotal evidence, and some of

that was talked about in the lobbying session last week, that specialist nurses are being withdrawn from services that they provide. For example, a specialist nurse who may be delivering arthritis care or rheumatism care, traditionally Cinderella services, or providing care to elderly patients is being required to work within a more general setting. Whilst it would not be fair to say that that compromises patient safety, it certainly has an impact on the quality of care being provided.

Chairman: I am sure that unfilled posts bring a tremendous amount of pressure on people working inside the service. I have no doubt in my mind at all about that but that is a big leap from then saying that we have no safety net. The concept of a safety net being withdrawn from under patients is something beyond that. I was concerned to hear that. Obviously, if there is evidence out there, we would like to know about it. At this stage, we have no hard evidence; it is only anecdotal.

Q197 Anne Milton: I declare an interest because I am a member of the Royal College of Nursing. I just wanted to challenge what you said, Ms Thomas, and apologise because I might have missed this if it came up earlier. To say that there will be no damage to patient care is a desperately glib statement. I am thinking about what Josie Irwin said. There is one line about "nobody dying because of . . ." The trouble is that in the quality of patient care the scale is huge from the very best and highest quality of care down to what is just about adequate. I have to challenge the statement that patient care will not suffer. I think you have to say what that means. It needs to be qualified.

Mr Amos: That is one way of describing it. It is seen in two ways. I would go a step further and say that the whole point of reform is to improve the quality and volume, if I can describe it in that way, of patient care. I know that is what boards and organisations are determined to do whilst making sure that they listen to staff and staff side representatives, local MPs and others for views on those changes. I think it is the prospect of change that brings uncertainty and worry and makes people sometimes think the worst. I do not say that glibly or that those are not legitimate concerns. We need to distinguish between those two prospects. What does the prospect of change feel like? We are getting some headlines about worries as to what that might mean for patient safety and working lives. The determination is to manage that change in a way that does not reduce patient safety but delivers on the real objective, which is to improve working lives. That is a good end in itself but it is a means to an end to improve the quality of patient services and the overall volume of services that the NHS and other health care providers can deliver.

Q198 Anne Milton: Mr Amos, I think it is very easy to dismiss the concerns of a workforce about reform as being about self-interest and say that nobody likes change and that is why they do not like it while missing the fact that a lot of professional staff are raising valid concerns about reform.

Mr Amos: My sense on that is that if you acknowledge that that is the case, then you can do something about it. That includes staff side representatives and staff themselves. I think you are right; if you dismiss it, then you can get into a situation where people get seriously de-motivated and leave and you do put safety and other matters in jeopardy. As leaders, if you acknowledge that is how people react to change, and it happens to all of us whether we are front line staff or not, then you can do everything in your power to work with staff, consult, communicate, listen and give support and training, certainly in the midst of change in the early days of post-reform, in order to make sure that you meet the concerns expressed here this morning.

Q199 Anne Milton: Mr Amos, I think you and I need to go away and have this argument outside the committee.

Mr Town: I think there is a difference between releasing the safety net and what is detrimental to the patient in the longer term because if patients are left to wait for their treatment much longer than they expect, then there is an immediate detriment. If there are not people there to take the responsibility for diagnosing or providing a therapy service to them, they will suffer. That is the one point that you made quite eloquently and one that we would endorse. It concerns our members quite a lot and is a frustration for them.

Q200 Dr Naysmith: You will welcome very much the change in waiting times that has taken place over the last few years and the reduction in waiting times must have made a huge difference to patients.

Mr Town: The evidence we have at the moment is that the outpatient waiting times have doubled.

Q201 Dr Naysmith: We need proper figures on that. You have talked quite a lot about physiotherapists already and that is a good example of allied health care professionals. That is quite a big and interesting bunch of people. There is something quite interesting about physiotherapy. The Chartered Society of Physiotherapy put in figures to suggest that currently there are 1500 vacant physiotherapy posts in the NHS. Despite that, one-third of those who graduated last year did not get jobs in the National Health Service. There could be a couple of explanations for that. One is that we are training too many physiotherapists and these vacant posts are not really needed or, two, that cuts are taking place because of the financial deficits.

Ms Thomas: My sense from working with the Chartered Society recently with the people we met as I described, and we are implementing our action plan on this, is that there are probably three or four key things going on for the profession. One is that clearly there is a demand, as one of my colleagues said, for physiotherapists who are more senior and more skilled to start taking on roles that previously were done by, for example, doctors. There is now a framework in place to enable some of that to happen; for example, triaging patients before they have to get into an acute setting. There is a time lag

in the training that is needed for these graduates to get up to that skill level. That is one issue. The second issue is that the number of vacancies that we have seen in physiotherapy certainly has not decreased at all. One reason for that is because there is a demand for more of the senior people, and we are tracking that. One of the things we have agreed with the CSP is that we will do some work with employers to help fast-track some of these graduates who cannot get jobs into some of those more senior roles.

Q202 Dr Naysmith: There is another group of these professionals that I know something about, clinical psychologists. People suffering from mental illness often say that they really would like talking therapies rather than drug therapy. That is a very commonly expressed view and yet they sometimes have to wait months to see a psychologist. Why is it that we cannot switch resources from one part of the service that people say they do not like so much into another one for which people are making a demand?
Ms Thomas: Perhaps Josie Irwin could help me out here, but I think the talking therapies plans are all about what kind of health care professionals can take on that work. It may not just be about psychologists but also about what mental health nurses can do to help deliver those sorts of care for patients. Certainly, we as employers are working with the Chief Nursing Officer on various plans. It is not normally the kind of area that mental health nurses perhaps in the past have worked in but we would like to see that extended.

Q203 Dr Naysmith: This is something that has been around in mental health for quite a long time. For the last five years, these people have been saying that and yet we do not seem to be moving towards that kind of service.
Ms Irwin: I do not need to help my colleague out because she has articulated very clearly the innovative thinking that is going on right now to try to develop the roles in order that things can be done much more quickly.

Q204 Dr Naysmith: So you think that is one of the answers then?
Ms Irwin: Yes.
Mr Town: There is the issue on financial deficits. Historically there have been a number of short-term posts for physiotherapists when they graduate but, with the deficits, those posts are not going to be created and therefore there is that particular loss. It is also important to recognise that a number of overseas-qualified physios are coming into the workforce as well. In the last three years, 6,000 new overseas-qualified physiotherapists have entered. For example, in London alone, the physio departments rely on an Australasian workforce. I have just come back from Australia where they are cutting back on their workforce, and so there will be a problem with that as well.

Q205 Dr Taylor: Before going on to medical employment, I want to go back to quality of care and insert just a bit of realism. Today, before this meeting, I have just had two complaints. One was from a friend across the river that an elderly person has been in hospital for quite some days and the nurses have been camped round the nurses' station rather than actually nursing. I get these sorts of complaints at home about lack of continuity of care, lack of communication between patients, doctors and nurses. One has got to put an air of realism into this. It is absolutely marvellous that nurses are taking on lots of extended duties and doing other things but is not the quality of actual bed-side nursing care suffering tremendously?
Ms Irwin: I said earlier that one of the employment surveys that we carry out on an annual basis has indicated that 25% of nurses felt that they were not able to deliver the quality of care that they would like to be able to deliver. Of course we would have to be concerned about that. It is difficult, though, to respond to the kind of anecdotal information that you have just provided. It is very important to say, in response to any concern that has been registered such as you describe, that that is challenged by the patient in that particular setting.

Q206 Dr Taylor: I have got to get back at Sir Alan on the dig that all MPs, particularly me, are protecting their interests. I have been trying to tell the Government for a long time how to get away with mergers and my message is falling on deaf ears. There are ways it can be done. However, going on to medical employment, in your submission, Sian, I think you say the expansion in medical school places since 1997 has led to the over-supply of doctors rising from 7% to 12% by 2009.[3] The Chief Medical Officer last week told us that medical unemployment is highly unlikely. Would you agree with that? What is your projection based on?

Ms Thomas: Our assessment of the situation is that, given where we were a number of years ago, we certainly now have a situation where we have many more home-grown doctors. UK graduates have improved significantly. There now is a supply to the entry level posts for doctors. We want to see all doctors get their first job in the NHS. Certainly, if we embark on training doctors through medical school, that should be what employers seek to do. There is an issue about how many doctors in the future we will need. There are all sorts of complicated dynamics around that. One is that the medical workforce now has far more women in it, and so what will the contribution of those people be in the next 20 years? The second is as we have described: the setting in which people are working is changing, so we may need to mix the specialisms and the settings between hospital and community. The third issue is the impact of the Working Time Directive. All of those three things together are now being

[3] NHS Employers have subsequently submitted a correction to its written evidence on this point. The evidence should have stated that there are currently 12% more Foundation level medical training posts available than there are medical students graduating in the UK each year. If current trends continue, this figure will fall to 7% by 2008–09, increasing the risk of an overall oversupply of medical graduates.

analysed. Our view is that it would be a good thing to have a modest over-supply of doctors. It is something we have never had. We think that that happens in every other profession and there is not any reason why it should not happen in medicine. There were days when people did not put an advert out for a consultant because they knew they would not get an applicant. That obviously cannot be right when we are trying to deliver patient care. We want applicants; we do not just want one but a number so that we have a choice. That drives up competition, which drives up quality, in our view. We are certainly not saying that we want to see unemployed doctors. I think that ought to be made very clear. As a group of employers, we are not saying that. We are saying that we are in a global market here; doctors will have choices about which country they want to work in now more than ever before. Our view is that there will potentially be a modest over-supply, but more work needs to be done to understand exactly, in 2020 and 2030, what the true scenario will be with all of these new graduates that we now have in the marketplace.

Professor Sir Alan Craft: Could I add that it is extraordinarily difficult to predict what we actually do need because of all the reasons that have been said? We now have 70% of medical students are women and even the men want to work less than full time. We have desperately been trying to get our number of doctors up to the European norm but even that is a false comparison because the way that they practice medicine in European countries is completely different. They have under-employed—they do not have unemployed doctors, at least not many, in France, Germany, but they have doctors that certainly do a lot less than doctors in this country do just because of the way that they practise in primary care, primary care specialists are often under-employed compared to what they are in this country. So I do not think we should be driving ourselves to get up to the European norm, we should be trying to provide the number of doctors we need for the service that we think we will need in 15 years' time. If anybody can predict that with accuracy then they are better than we have been doing for the last 50 years.

Q207 Dr Taylor: Do we have any idea how many unemployed doctors there are in this country at the moment, taking those from abroad as well?

Ms Thomas: We might be able to give you some data.

Professor Sir Alan Craft: There was a big fuss last year about the number of newly qualified doctors who did not get first jobs. In fact it was slightly more than we usually have but every year there are about 80 to 100 of our graduates who do not get a job, either because there is not one geographically that they can get, or because they do not want one—there are quite a number of people who deliberately do not want one and opt out for a while.

Q208 Mike Penning: So you go to medical school, spend all that time and all the state funding is there and they do not want to be a doctor?

Professor Sir Alan Craft: Which takes you right back to how do we get the right people into medical school, and that is another challenge.

Q209 Dr Taylor: How do we square this apparent excess of doctors with the College of Physicians' census in 2004 that shows many specialities have tremendous numbers of unfilled posts in them, particularly geriatric medicine and palliative medicine?

Professor Sir Alan Craft: Because in order to fill them you need to train people and that training takes seven years. So once you spot where the difficulties are you then redirect your needs into those specialities, providing you have some sort of national planning.

Q210 Dr Taylor: And how do we get flexibility? At the moment we are told that cardiac surgeons are going to have to be retrained to do other jobs. How do we get flexibility into workforce planning?

Professor Sir Alan Craft: I think what you have to do is to get flexibility into doctors' training. I do not know about the other healthcare professions. What we have to do is to make sure that all doctors have a generic training and then they have a bit of specialist training on top of that to do whatever it is, but also to recognise that they will probably not be doing that for all their life, that they may well have to be retrained. The cardiac surgery one is a very good example of the fact that we thought we knew what cardiac surgery was being done and what would be done for the next 20 years, when all of a sudden a new medical innovation came along which said it could all be done by radiologists, but we do not have enough of them. So we have too many cardiac surgeons and not enough radiologists.

Chairman: Could we move on to pay schemes? Ronnie Campbell.

Q211 Mr Campbell: Now we have seen an increase in staff and reasonable pay—I will not say it is brilliant but it is reasonable to what it has been—do you think the Agenda for Change and the new medical contracts is providing a better deal for clinicians? Do you think it has provided a better deal for clinicians?

Professor Sir Alan Craft: From the medical point I cannot speak for Agenda for Change, but from the medical point of view there are two new contracts. The GP contract has provided a much better life for GPs—they have got rid of all of their night work and, if you read the Press, they have all increased their salaries by a significant amount. One of the problems with that is that a lot of the nighttime work has actually been moved to hospital and the funding has not gone with that. So for the GPs themselves it has been good but for the service it probably has not been as good as all that. From the consultants' point of view they had a new contract as well, which is a work sensitive contract, and that has had a mixed reception. It has been very divisive in places.

Q212 Mr Campbell: Do you think it is a better deal for the patients as well as the taxpayer?

Professor Sir Alan Craft: I think the out of hours care for general practice; the primary care is not such a good deal as they used to have.
Ms Irwin: I think from the Royal College of Nursing perspective that the new Agenda for Change and the pay system is a very good deal indeed. It has to be good, does it not, I think, to have introduced into the NHS a proper job evaluation system which does mean for the first time in the NHS there is equal pay for work of equal value? The job evaluation system, by the way, also for the first time probably recognises the work of nurses in that it is capable of measuring caring skills. What Agenda for Change also does, through the knowledge and skills framework, by providing a way of measuring competence and a way of ensuring that nurses can develop in their roles, is to provide enormous potential both for the nurse to progress in her career and also to improve the quality of care that she is providing to patients. I think evidence that Agenda for Change is already working Agenda for Change has just been implemented. However, in evidence that we submitted to the pay review body last year, we were already showing signs of improved recruitment and retention as individual members of staff waited for their Agenda for Change outcome, and that has to be a very important marker in terms of improving quality of care to patients. So it is a good thing for the individual member of staff but it is also good for the patient.
Mr Town: Endorsing most of what Josie says but with some degree of caution—which I seem to be doing a lot today—is that we are beginning to see problems in relation to Agenda for Change working in partnership with some employers refusing to engage in partnership, the most prominent ones being the Foundation Trusts, and one particular Foundation Trust has already stated that its board is legally liable therefore whatever decisions need to be taken will not be taken in partnership, and therefore we begin to wonder how Agenda for Change will operate within Foundation Trusts. The other difficulty we would see is that if the deficits continue to increase then the potential for using the knowledge and skills framework and for the job evaluation system to operate may also come under pressure as individuals do progress and therefore are entitled to move into the job evaluation scheme and therefore may increase their potential earning, but will an employer be able to pay for that and will they therefore start looking at rationing?

Q213 Mr Campbell: As you say, Mr Chairman, Foundation Hospitals that are employers have a better system in Agenda for Change.
Mr Town: No, I said that they do not have to operate within Agenda for Change.

Q214 Mr Campbell: Then which system are they operating?
Mr Town: At the moment they are operating with Agenda for Change but they have the option not to.

Q215 Mr Campbell: Have they taken up that option?
Mr Town: Not so far.
Chairman: We have some specific questions on Agenda for Change a bit later on.

Q216 Sandra Gidley: Is that not a real concern though if the aim is to move to all Foundation Trusts eventually?
Mr Town: Absolutely, and the concern was always expressed when Foundation Trusts were established, and a number of organisations, including the radiographers and some other allied health professions, were trying desperately to put the Agenda for Change terms and conditions as a minimum standard within the Bill that introduced Foundation Trusts, but the government refused.

Q217 Mr Campbell: The Chairman has said Agenda for Change is coming up later on, so I will go on to my next question. What is happening with the improvement of productivity through the pay reforms?
Ms Thomas: Can I respond to the pay agenda? It is a broad comment about pay reforms that overwhelmingly they are good deals for patients, employers and the staff themselves. Next week at your Committee we have brought some experts to deal specifically with some of your questions about the pay reform. I would like to respond to the issue about the collegiate of health employers, including Foundation Trusts, and our view is that this is a fantastic framework. It is a world class knowledge and skills framework in healthcare, and we even have private sector employers looking at the knowledge and skills framework and saying, "This is a great framework, we are adopting it," so I would say that there is no doubt that if anybody chose not to they would have to have a pretty good pay framework as an alternative.

Q218 Mr Campbell: Can you give us some examples?
Ms Thomas: We have no examples where people are not adopting Agenda for Change. The final point is about partnership working, which is to say that one of the biggest things to come out of Agenda for Change is the fantastic partnership working with staff organisations, and we would see that as one of the major improvements.

Q219 Mr Campbell: But there are no examples for seeing the productivity coming from pay reforms?
Ms Thomas: On the issue of productivity, what you mean by productivity we would describe, as employers, productivity as helping people in the individual teams and the individuals themselves to take on more work or do things differently to enable improved patient care to happen, and our view is that the knowledge and skills framework is the perfect framework to enable that to happen safely because those competences can be managed.
Ms Irwin: I would just add to what my colleague has said, in terms of actual practical on the ground examples of where Agenda for Change is beginning to make a real difference in delivering services differently, improving patient care and improving outcomes in a value for money way—because I think

that is what you are driving at—my colleague's NHS Employers' website in fact has a number of examples as Trusts work them through appearing, and one I would like to refer to, which I highlighted earlier, one NHS Trust in the southwest of England where they have introduced associate practitioners to work alongside community mental health nurses—a different way of working—which has enabled them to reduce enormously the agency bill that they were having to pay for qualified nursing staff and at the same time improve the access of patients to the mental health service. We will see more of those examples as it was only March this year that Agenda for Change was fully implemented across England.
Chairman: Can we move on now to consultant contracts, Sandra Gidley.

Q220 Sandra Gidley: The consultants appear to have done very well and what we are trying to establish in this Committee is whether the NHS is getting as much out of the contract as perhaps could have been achieved. The success of the contract from a patient point of view probably revolves around the introduction of effective job plans, and a few years ago we know that there were very few in case. Is it not the case that the job plans that have been developed to date have been somewhat inconsistent and not of the standard that we might expect? How would this situation be addressed?
Professor Sir Alan Craft: Really you should be asking the BMA and not me, but I will answer it as best I can.

Q221 Sandra Gidley: Why should I be asking the BMA?
Professor Sir Alan Craft: Because they are the people who are responsible for terms and conditions of service, not the Royal Colleges.
Mike Penning: You must have a view.

Q222 Chairman: Let Sir Alan answer the question as best he can.
Professor Sir Alan Craft: I am excusing myself because that is the terms and conditions, which is the union's job, which is the BMA's job. 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 a lot of that is now being squeezed out of the system, that consultants are being told that they must work their contracted hours, whether it is 10 sessions, 11 sessions or 12 sessions, and I think because of that—to go back to Mr Campbell's point—productivity probably has gone down in some places.

Q223 Sandra Gidley: Productivity has gone down? Can you clarify why you think that?
Professor Sir Alan Craft: Because doctors are now working to a fixed contract, which they never did before. They also have to fit in with the contracts of everyone else.

Q224 Sandra Gidley: So are you saying that a consultant does not put the six hours extra a week that we have been told a nurse does?
Professor Sir Alan Craft: They do, yes, but they used to put in a great deal more than that in the past. Most doctors are still working way above their contracted hours, yet because of the system the productivity has probably gone down compared to what it was before.

Q225 Sandra Gidley: Can you give me a practical example of that because I cannot quite understand how we are paying more, we have a set contract and you are saying that productivity has gone down?

Q226 Professor Sir Alan Craft: Most consultants were probably working 60-odd hours a week, which is probably too much. The standard working week has now gone down to 10 sessions, which is probably slightly less than 40 hours a week, and if you want any more than that then contractually the employer has to pay you to do that. But employers have been working towards reducing everybody to the minimum number of contracted hours; therefore for each individual consultant you are getting less. In the long run it will be safer for patients because that work still has to be done so you have more consultants doing that work, but each of them are doing less hours than they were in the past, and you will get better consultants because they are working 40 hours a week instead of 60 hours a week.

Q227 Sandra Gidley: It has been put to us that we were not always clear what consultants were actually doing before and that the job plans are a chance to clarify this, but maybe we do not have the data on it?
Professor Sir Alan Craft: I think that you are now much clearer, you have to be much more explicit about what you are doing in every session of the week. I think the myth that was around was that a lot of consultants were abusing the system by spending quite a lot of time at the local private hospital, and I think that has been shown to be a myth; the vast majority of consultants were working way above their contracted hours, and that is now explicit in the contract. That is the situation.
Ms Thomas: The first thing to say is that our evidence next week will give fuller answers on this point and there is also a report shortly due out by the consultant contract implementation team on exactly some of these issues, which I would commend you to read. But overall we have to say that job planning has improved an understanding about what our consultants are doing and how to manage the flexibility between the types of work that they do. 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. Some employers are implementing that better than others, which is what we would expect, and our role is to help people with that. I think the other thing that has been missed in the point here is that we have increased the consultant workforce, so it may well be that doctors' hours have come down in some of those roles but that is because in some specialities the

consultant workforce has increased significantly. I do not know if David would like to give a specific example?

Mr Amos: As a general observation and a specific illustration I guess that with a reform of this nature you do not always get it right the first time, but I think what we have is a platform, and I am sure that this Committee could make some suggestions that through negotiation with the BMA and others the new consultants' contract, which is now in its third year, can be improved in order to meet the objectives that it set out to do. I would say that you need to remember what it replaced, and we now have a currency and a method for a dialogue with 30,000 colleagues across the NHS in a way that we never had before with the existence of a more 1940s, 1950s style employment contract. The currency I think is good for the organisation, good for patients, good for the individual to be able to agree objectives, to be able to agree priorities, to be able to agree what personal professional development and support those individuals need in order to do their day job and if they need to change in order to do tomorrow's job what needs to happen. I think you are already starting to see that across the NHS. I know that employers will have views on how we can improve the contract to deliver more on the original objectives, but we can now have a dialogue and agree objectives and standards and, as I said, I think that is good for the individual patients and the organisation as a whole in a way that we could never do before.

Q228 Sandra Gidley: As an employer do you think that the government probably missed a trick when negotiating the consultant contract because they spurned the idea of a fee for service contract, which is something that might have improved productivity?

Mr Amos: That is maybe one of the things that needs to be considered, but having observed negotiations at the time I am pretty sure it was very unlikely that that would have been accepted.

Q229 Sandra Gidley: Should it be a case of what the consultants will accept?

Mr Amos: I think when you are making such a dramatic change you do need to carry people with you and the important thing is to make sure that it hits the overall objectives in terms of improving patient care and improving recruitment and retention. As I said, if you remember what it replaced it does represent a massive step forward in terms of where we were four or five years ago.

Ms Thomas: Could I just add that one of the things that we are doing in NHS Employers at the moment is that within these contracts helping employers improve the way they have implemented them and will continue to work with them, and I do believe that within the current consultant contract there is every way that we can try and improve those, and certainly some employers we have brilliant best practice to show that they are exemplary in the way they have done that and others need more help.

Q230 Sandra Gidley: How is that being shared because the NHS is traditionally appalling at sharing best practice?

Ms Thomas: What has just been said is that through our organisation and through our website we have just established a Medical Workforce Forum in NHS Employers, which for the first time we have over 100 employers engaged in that and they are in dialogue about the vast range of medical workforce issues we have talked about here today, including the consultant contract, and getting employers together like that has never happened before on some of these issues, it has normally been the Department of Health and the BMA and the profession, and for the first time we have had an organisation with a voice, that is the employers' voice, to implement the very things that you are describing, and that is what we aim to do.

Mr Amos: Just to add, we may have something in the jargon—and I will explain the acronym in a second—PA for service, Programmed Activity, which as you know makes up the consultant contract, and in discussion with individuals we can now give levels of PA either on a temporary or a permanent basis for part-timers above six and full timers above 10 on the basis of delivering either a specific quality of service that is not there before or a specific volume and I am sure we can find many examples of that, and that is probably quite a good way of testing what a measure of fee for service feels like, what effect it has and whether that can be extended in order to get greater benefit for patients.

Q231 Sandra Gidley: So are we actually tracking what improvements and what increased activity we are achieving, and how is that being done?

Ms Thomas: We are collecting evidence of best practice and case studies of best practice and we are very happy to send a note to you of some examples of those.

Q232 Sandra Gidley: That is just evidence though, I am talking about so that we have a global picture.

Ms Thomas: Centrally?

Q233 Sandra Gidley: Yes.

Ms Thomas: It is not our role to collect central data on such issues.

Q234 Sandra Gidley: Whose role is it?

Ms Thomas: It may be a question to put to the Department but it would not be for us to collect. We would certainly help employers benchmark. For example, a group of Trusts we have just gone to in psychiatry are benchmarking between themselves the very thing that David has talked about, which is in a geographic patch and they have worked together, benchmarked how many PAs they are all giving their psychiatrists against how much agency staff they are bringing in in psychiatry, to see if they benchmark well within one another, but our role is to help local people do things for themselves and improve things for themselves. If you are asking

about a national collection of data, that is not something that we would do, but maybe something that you should consider as a Committee.
Mr Amos: We are certainly happy at a local level within organisations as part of the business planning what organisations are setting out to achieve to look at the level of PAs by speciality in connection with what individuals, clinical teams and the acute hospital as a whole is trying to achieve. As Sian has indicated, the Association of UK Teaching Hospitals is doing some benchmarking work on precisely that issue.

Q235 Dr Taylor: You have talked about changing practice, Sir Alan. Can the clinical excellence awards be used as a tool to make people change practice, for instance to increase day surgery rates? Is that what they are designed for? What can they be used for?
Professor Sir Alan Craft: I think the local discretionary points are there to award local innovations in practice, people who have done more than they might have done to improve local services, then they would be rewarded by local discretionary points. The clinical excellence awards are where there has been innovation at a higher level than that. They would certainly reward people for that but I do not think that they should be used to drive innovation.

Q236 Dr Taylor: So what is there available if people are still doing, for example, cataracts as inpatients or anything like that? What tools do employers have to enforce change there?
Ms Thomas: As David described, within the consultant contract there are two or three main levers you have as an employer. One is the job plan itself, which describes on a day-by-day basis where somebody is, what they do and what type of work they are doing.

Q237 Dr Taylor: So that would actually say that it was a session for day surgery rather than inpatient surgery?
Ms Thomas: Absolutely. The second thing is every year that job plan is reviewed so it is not a static thing, and it can be reviewed at any time by both parties. So once a year is a minimum and then more frequently if some innovation came in or some standard came in and a Chief Executive saw that their Trust was an outlier within a certain level of practice it could call for a job plan review with its clinician. The third thing is the objectives and the standards, as David said, which is each clinician is now expected to have some objectives through the years. So if you were not doing day surgery because your competence would not allow that to happen you certainly would not want to make somebody do it at the next day, but your objective would be to help that clinician move towards that goal.

Q238 Dr Taylor: Has the system been going long enough to show that that is happening?
Ms Thomas: Some employers embraced that from day one; others are taking longer, and as David said we are seeing that happening all through the contract and our job is to make sure that share the best across the service.

Q239 Anne Milton: Can I come in on a couple of points? I think you said that it was not NHS Employers' responsibility to collect data?
Ms Thomas: No, I said central data. We have not been asked by the Department and we certainly would not see our role to collect from the service data for performance management or policy purposes. What we are doing is collecting data and sometimes we are collecting that from large numbers of employers to enable employers to improve what they are doing and to benchmark their work. There already are organisations that do that job, and I think you heard from one just last Thursday, Workforce Review Team and Workforce Planning Teams at SHAs collect data for that purpose. We would not see ourselves as replicating the work of other bodies.

Q240 Anne Milton: So you feel that it is being collected elsewhere.
Ms Thomas: I do not know if the particular point that was raised is collected nationally and it is not our role to understand why or where that should happen, but maybe you should ask the question.

Q241 Anne Milton: But you represent the employers?
Ms Thomas: We do.

Q242 Anne Milton: And employers are interested in outcomes of data?
Ms Thomas: Yes, for a benchmarking purpose. Nationally we have not to date—and I am not saying that we might not in the future—employers at the moment are not asking us to collection national data from all of them on service specific issues. We may well do that at some point but not at the moment.
Chairman: Could we move on to the questions on Agenda for Change? Charlotte Atkins.

Q243 Charlotte Atkins: From your earlier comments all of you seem to be quite positive about Agenda for Change. The Department of Health suggested to us that no professional group or union coming before the Committee would be critical of Agenda for Change. Do you have any criticisms at all of the agreement?
Mr Town: I find that a bit difficult because the Society of Radiographers rejected Agenda for Change but then took a pragmatic approach to work with it, so saying that no one would be critical of it is actually not true.

Q244 Charlotte Atkins: Can you give us the reason for your criticisms then?
Mr Town: The main reason from our own membership was the increase in the hours from 35 to 37 and a half without any guarantees or additional earnings that were associated with that increase.

That was the main reason for our members' rejection. What we achieved through discussion with the Minister was that we would monitor and look at the impact of Agenda for Change on our members' earnings and if there was any evidence that there would be a loss we would have to go back to the Department and talk to them about making good that loss. That was the agreement we reached with the Minister.

Q245 Charlotte Atkins: Can you define loss?
Mr Town: Financial loss.

Q246 Charlotte Atkins: Monetary loss spread over the extra hours?
Mr Town: Yes. Our major concern at the moment is that although there is a lot of talk about how the Agenda for Change has been rolled out and it is finished and it is implemented, it has not—not in radiography, for example. Only between 8% and 10%, is our estimate, have been matched of that number and a higher proportion are already appealing. So we are finding it very difficult at the moment to say that Agenda for Change is working well and it is difficult to say that it is not working at all. We can only say that we are still working our way through, having our members moved on to the terms and conditions or to be matched or job evaluated under Agenda for Change.

Q247 Charlotte Atkins: So is radiography the only area within the allied professions which is problematic?
Mr Town: As far as I am aware.
Ms Irwin: Notwithstanding Warren's members' concerns about the impact of Agenda for Change on staff across the NHS I think it has to be said that it is an amazing achievement that 1.3 million staff have been moved across on to new terms and conditions in the space of 18 months, and that the quite high levels of protection which were initially anticipated have not been realised. The concern might be, as I think Warren highlighted in an earlier contribution, that the financial difficulties that the NHS has entered right now may cause some difficulty in terms of full implementation of the knowledge and skills framework and the development of competencies and the development of skills to improve patient care, and there is slight concern that that may be compromised. But overall I think the contribution that Andrew Foster made last week was correct in him saying that the majority of the trade unions would celebrate the introduction of Agenda for Change, and we do, and it is an enormous logistical exercise and an enormous achievement in terms of the fact that it has been achieved through partnership, which has not been achieved in any other area of the public service so far as I am aware.

Q248 Charlotte Atkins: Is this just because the vast majority of nurses have seen an increase in pay? Maybe you could give us an indication of a grade D nurse, what sort of average rise in pay in percentage terms that nurse would have achieved?
Ms Irwin: I do not have the figures in front of me so I have to delve in the depths of my memory, but I think looking at an average staff nurse moving from grade D to band 5 we are looking at something of the order of a £3,000 pay increase.

Q249 Charlotte Atkins: Per annum?
Ms Irwin: Per annum. But it is not just the pay increase itself that is important, it is the potential to progress, and what Agenda for Change does is introduce across all staff—not just the nursing staff—longer pay bands, the potential to progress, the potential for higher earnings and also, more importantly perhaps, the motivator to enhance skills and develop and work with other members of staff in the same sphere.

Q250 Charlotte Atkins: So a staff nurse getting £3,000 extra a year is really just the starting point?
Ms Irwin: Yes.

Q251 Charlotte Atkins: They can then progress to make even bigger increases in pay?
Ms Irwin: Yes, and that goes right the way up through each of the pay bands and it is applicable to other groups of staff, not just nursing.

Q252 Charlotte Atkins: Have you had any complaints about grade compression? Both grade D and grade E nurses, as I understand, will be assimilated on band 5?
Ms Irwin: There are some localised concerns which are being played out through requests for reviews which are allowed through the Agenda for Change process, but we certainly have not seen any evidence of a real difficulty around compression. Where there has been compression it is usually local and generated by the particular management motivation of that Trust.
Mr Amos: I know, as Josie has indicated, that a number of specialist E grade nurses are getting into the band 6 level and that is in recognition of their experience and skills and what they deliver at a level that is different from a non-specialist E grade, and I think that is quite a good example of how compression has been avoided and skills and experience have been recognised, and the potential for those individuals to deliver at that level and to take on more responsibility, which Agenda for Change allows. I just want to make one point about Josie's recognition of celebration. I think the celebration will be complete when we look back and say in one to two years' time—and I ask the Committee to give us time to do this—which is to demonstrate that we have a return on the investment that is associated with Agenda for Change. I think that will come in a number of ways and I am sure you will hear next week. But that is getting more from the million who have gone through the Agenda for Change process in terms of them as individuals taking on more responsibility, either within their classic professional roles or that have traditionally been dealt with elsewhere, and crucially how we can now create new roles either at local individual healthcare organisation level or across local labour

markets or even nationally in order to be able to deal with many of the issues that we have been discussing this morning. So in order to give a full answer to your question it is not that we know the answer, but we need one to two years in order to be able to get that return on investment, which I know across London and elsewhere staff side, staff themselves and obviously employing organisations are extremely keen to set out to achieve.

Ms Thomas: Just a point to illustrate it. I think your question was about are there any parts of Agenda for Change that could be improved and David has explained very well that we need more time and we need to spread the benefits of Agenda for Change. A very real example, the day before yesterday, of how Agenda for Change will enable patients to receive better care, is that we won an award in the NHS for the most popular graduate scheme and we have moved in a year from being eightieth for healthcare science engineering and information technology to being second, beating the world's best employers, and I think we have to be proud that we have a public service that has the top graduates of 40 universities that were surveyed, who say that healthcare is the second most popular career. Okay, we would want to be number one but I think to move from eightieth to second in a career like healthcare science where we need those graduates has to be commended, and we should all really be proud of that. We certainly are and it is demonstrable evidence that best graduates going through the system now see a fairer pay system and a better career framework for them, and I think that is classic evidence of that.

Q253 Dr Stoate: The *Daily Mail* must have missed that headline—I do not remember anything about that!

Ms Thomas: I will give the *Guardian* a plug because the *Guardian* surveyed 80,000 undergraduate students in 40 universities.

Q254 Anne Milton: I am having problems here because I was at the RCN panel last week—and I apologise for my question being rather broad—but you are painting a picture that I do not recognise, and I do not think I am alone around this Committee. Both Sian Thomas and David Amos are painting a picture and yet we had a lobby from the RCN last week. If it is all so good why is everybody telling us who is working in the NHS that it is not very good? I acknowledge that there are some good things and I think Agenda for Change is a good thing, although I would have brought junior doctors in on this as well, it has to be said.

Ms Irwin: Shall I come back in on that because you are obviously asking your question in the context of the—

Q255 Mike Penning: It is not just the RCN.

Ms Irwin: No, the bigger lobby last week. The question was about Agenda for Change and there is no doubt across the piece, as I said, that Agenda for Change is felt to be broadly a good thing by all staff. However, even the feel good factor about Agenda for Change is beginning to be tinged by the sorts of difficulties that the NHS has recently encountered, and it is that which was reflected in the lobbying activity last week, and a concern that everything that has been achieved through the implementation of Agenda for Change will be stymied because of current financial difficulties, so with the knowledge and skills framework the numbers of appraisals that might be carried out, the development and training that might be provided would be cut as a consequence of the financial difficulties, and therefore the potential unleashed by Agenda for Change would not be realised. So it is not quite fair to say that that is not what you have been hearing, what you have been hearing is concerns about the NHS writ large and not about Agenda for Change.

Mike Penning: No, that is not true.

Q256 Anne Milton: Mr Town is jumping up and down in his seat—I can feel it!

Mr Town: There are a number of salient points. The radiographers rejected it but there was a clear view that the long-term effect of Agenda for Change is a benefit. That was not an issue; the issue was around the hours, as I have said, but also about the commitment from the Department to both fund and support the process of Agenda for Change, and I think in recent weeks, in recent months, that has also become an issue, and in many ways it may be that Agenda for Change is now suffering from project fatigue and that people are beginning to lose sight of what they are trying to achieve because they are trying to put so much in place at the same time with so many competing ideas, so many competing policies. But there is inevitably a short-term problem—when I say short-term I would go a bit further than two, I may go as far as five years—because many of our members who are in radiography, who have already accepted extended roles before Agenda for Change came in and have used their opportunities to enhance their earnings are now on protected salary. That in itself is a major problem because individuals then do not see any benefit in moving anywhere further whilst they remain on a protected scale. So if ultra-sonographers have extended their role and do reporting, if radiographers have extended their role and do reporting, have increased their earnings, they are then stuck on a protected salary because they have already moved on from Agenda for Change as it stands at the moment. That is part of our evidence to the pay review body for the next period but it is still a problem and that is part of the issue that we have seen amongst our own members who have said, "I have gone through all this, I have worked very hard and now I feel I have been kicked in the teeth."

Q257 Chairman: The Department of Health last week told us that the amount of staff on pay protection is some 4.5%; is that correct?

Mr Town: Overall. Our estimate at the moment is 40% of radiographic staff that we have had matched.

Q258 Chairman: You do not dispute it is just 4.5% nationally, as it were?

Mr Town: Nationally, yes.

Q259 Chairman: At this stage?
Mr Town: Yes.
Chairman: Clearly all Agenda for Change has not been implemented yet. If we move on, Jim Dowd.

Q260 Jim Dowd: A quick look at training—and I know this was referred to earlier in passing. Agenda for Change and also Modernising Medical Careers encourages the cultivation of "competencies" as the essential building blocks for both training and career development. For anybody in any particular order, (a) has that been useful, is it a welcome development; and (b) has it provided additional flexibility amongst the workforce?
Ms Irwin: Very useful and is beginning to provide that flexibility. The concern, though, that I go back to, the NHS' own annual staff survey showed for 2005 that there was a reduction both in the number of appraisals that had been carried out, which obviously is an annual interview that identifies development needs, and also there had been a reduction from 2004 in the number of what are considered to be quality appraisals, ie that go through all the processes and are supported by development funds and so on. So the potential has begun to be realised and I repeat what I said earlier, that there is a concern that the financial difficulties that the NHS has encountered present the challenge to continued progress of the initiative.
Professor Sir Alan Craft: From the medical point of view it is very important. All the colleges are developing competency-based curricular with competency-based assessments built into them, and I think it will be important for the future and it will give more flexibility so that you know what competencies people do have from what they do not have, and you can actually give them targeted training to get them. The one issue which is coming up is the time to do the competency-based assessments, to do the appraisals, and I think that is probably greater than was initially thought would be necessary, and building in the time into people's job plans to do the training and assessment is something which the NHS has to take seriously and has not taken seriously in the past.
Mr Town: The allied health professions have used continued professional development for many years and the problem, as has been as identified in CPD, is having the time and the money in order to achieve the objectives and the targets that are set. At the moment there are very few care set outlines for allied health professions and it is very difficult to establish to what extent that will have impact for the immediate future.

Q261 Jim Dowd: Would it be a vehicle by which we could transform surplus cardio thoracic surgeons into paediatricians—into geriatricians?
Professor Sir Alan Craft: You could not transform them into paediatricians, that is very difficult. You need to look at what skills they have and if they are surgeons they need to be redirected building on the competences that they already have.

Q262 Jim Dowd: This is probably specifically for you, Professor Craft. Has it led to a shortage in training posts?
Professor Sir Alan Craft: A shortage in training posts? No. The training posts have increased.

Q263 Jim Dowd: Sorry, medical training posts.
Professor Sir Alan Craft: The medical training posts have increased over the last few years.

Q264 Jim Dowd: What about the growth in the numbers of staff grade doctors in recent years? How can we improve the status of staff grade doctors?
Professor Sir Alan Craft: That is a huge issue, particularly for things like the European Working Time Directive. Trusts employ huge numbers of SASG doctors—Staff and Associate Specialist Grade doctors or Trust doctors, call them whatever they want to—there are a lot of them in the system. What we are doing with Modernising Medical Careers is trying to assess their competencies and see where they fit in comparison to people who are being trained so that we actually know what their competencies are and can employ them accordingly to their competencies, but also if they want to move up in their career you actually know where they are and what competencies they need to progress.

Q265 Jim Dowd: The increase in the numbers of them, though, has that been a positive development or a negative one? What does it reflect?
Professor Sir Alan Craft: It was an essential move to actually cope with the Working Time Directive. It would have probably been better to go for fully trained doctors but you cannot pluck fully trained doctors off trees, it takes time to train them. So as a short-term measure it was probably good; as a long-term measure I think that the NHS needs to know the competencies of the doctors that it is employing so that they can give appropriate care to their patients, and we do not know that at the moment. But we are working towards it.
Ms Thomas: Could I just make two points from an employer's perspective? I agree entirely with everything that has just been said by Sir Alan, and that is about the challenge of the infrastructure issues, which I think is what you were alluding to. We have these frameworks but there are clear challenges on infrastructure. One is our concern—and I know it is a concern in the education world—around the clinical educator challenge, so are there enough clinical educators to train all of these people? Two is enabling people to build time into their busy jobs for this role. And the third is around the protection of funding. So where we have funding for learning and development all of us commissioners and employers need to find ways in which we protect that as far as possible.
Professor Sir Alan Craft: Could I just add to that the importance of the NHS taking education and training seriously and not raiding the education budget when times get tough.

Jim Dowd: I was going to ask a previous question about the substantial and significant growth in health commissions at university places for health-related posts in the last six years, which have gone up overall by something over 40% and in some cases 70% but I will not go into that now.

Q266 Dr Taylor: We have covered the extended roles but I wanted to ask Sir Alan, in your submission you say, "We recognise that there will be an increase in multi-professional working, however we are clear that healthcare teams should be led by medical doctors." Obviously I feel strongly about that as well but I would like you to justify it to some of our colleagues.
Professor Sir Alan Craft: I think it is important that doctors are trained differently, doctors are trained to deal with uncertainty, and I think particularly for the healthcare practitioners and other professions they can work very well once you know what the diagnosis is, and they can work down algorithms and patient pathways and all sorts of things. But it is when uncertainty comes into being that people need to know when they are uncertain and know where and how to ask for help, and that is usually from the medical side of things. So we are very keen that there should be a team looking after patients and that there is always a medical person within that to ask for help if needed.

Q267 Dr Taylor: Do the doctors require extra training to take on that leadership role, or is it something that they have always done?
Professor Sir Alan Craft: It is something that they have always done but they do need extra training to do that and we are working with the Institute of Improvement and Innovation to improve the leadership and management skills of all doctors, starting at undergraduate level.

Q268 Dr Taylor: What are the feelings of the other professionals?
Ms Irwin: I think from our perspective Sir Alan just said that when things go wrong the advice and assistance would usually be provided by the doctor within the team, and I think the key word there was "usually". We would argue that there is potential for the leadership to be provided elsewhere within the team and for that leadership to be provided by a nurse. Not always, but there are circumstances in which that would be highly appropriate.
Mr Town: I would agree that there are other avenues and other alternatives and it is a matter that we see it as equal partnership within that team. It may be that within AHPs the consultant roles may take that lead as opposed to a medical consultant. There are a number of changes taking place in the NHS and in the way that the healthcare team operate and the care pathway is structured, and I think we need to reflect on what is the best for the patient, not necessarily best for the professional group that is involved.

Q269 Chairman: Can I ask you what I think is probably the final question? A lot of this workforce, new staff employed since 1999 in the National Health Service, has been recruited from abroad—this is employed as opposed to coming here for training purposes. Do you think that this is a sustainable strategy for the Health Service workforce?
Ms Irwin: Just to respond on that, initially the look to overseas countries to provide nursing staff was a short-term stopgap measure which quickly became embedded because of shortages and supply not coming through from university places because the previous administration, prior to 1997, had drastically reduced it. I think one of the sad facets of the current situation is that there are currently 37,000 internationally recruited nurses waiting for adaptation placements in order to qualify to work as registered nurses in the UK, and they cannot get an adaptation, either because the Trusts cannot free up the capacity to provide them with a mentor, which is a consequence of the current situation, or they do not have the money to provide the development opportunity. In the future there is going to be increasingly a pull from the US and Australia, for example, that have their own particular difficulties, that may mean some of the internationally recruited nurses hop from the UK to Australia or the US. So I have a very large question mark over the sustainability of that as a means of procuring qualified nursing staff.

Q270 Chairman: Sir Alan?
Professor Sir Alan Craft: I do not think that we should be relying on international medical graduates for the future. I think it has been wrong that we have denuded quite a lot of countries, particularly African countries, of people that they desperately need, and I think that the new immigration rules that have just come in will stop all of that. I do not think that we will ever be self-sufficient within the UK for our workforce but I think that we would hope to be self-sufficient within Europe, and given the freedom of movement and the fact that English is spoken by virtually every doctor in Europe that many doctors will come here. The challenge therefore is to make sure that there is some equity in the standards across Europe and that is a whole other ballgame. The one thing I think we should do and which has been lost with the new immigration laws is the opportunity for countries like Sri Lanka and many other countries in developing their workforce, where they have always sent people here for two years of targeted training before they can become a consultant. The new immigration rules have stopped that happening so they are now going to Australia or the United States, and I think in the long-term in terms of the UK influence worldwide we have missed a big trick there.
Mr Town: Very quickly, most of the points have been made about the need to be ethical about overseas appointments. A key element of an AHP qualification is that it is transferable and you do work within a global market, but you cannot expect that your own healthcare system will be propped up simply by importing from abroad. Individuals come

from abroad for a number of reasons, not necessarily to enhance the NHS but maybe to enhance their own benefits or to ensure that they are able to sustain their own families overseas. What is needed is a sustainable workforce planning for the NHS which can also incorporate any overseas employment and assist with overseas employment.

Ms Thomas: What I would say is given the change in the diversity of the workforce we agree with the comments that Sir Alan made, that going forward we would hope to see that Europe sustains a healthcare workforce for itself in the future, but we would always have a mix, is our view. I think on the point about workforce planning, there is no perfect committee structure or planning structure which will ever be able to overcome these challenges of the time lag and the complexity of the healthcare world that we are in, but it needs to happen at all levels and effectively at the employer level and effectively at the national level and probably something in between, and if we can get the mix between social care workforce planning and healthcare workforce planning between the independent and public sector I think we are better placed now to do that given that we are at this point of the investment in the workforce being much better. We would certainly want to urge the Committee to let us see that continue and not have this feast and famine which we have had in previous years.

Mr Amos: Just in a nutshell, I should declare an interest as the person who led on international recruitment nationally from the period that you have described. Clearly less reliant, but I think we should welcome a labour market scenario where we continue to welcome in colleagues from abroad to bring in their skills and experience perspective, either on a short or longer-term basis, but also to encourage and not panic if NHS workers go abroad as well. International recruitment in and out flow did not start in 1999, and that is good for us as an employer and in the service for staff to go abroad for a time to develop their own skills and experience and then to bring those back to the NHS.

Chairman: Thank you all very much indeed for coming along and giving us evidence. Sorry about the overrun, but thank you very much indeed.

Thursday 8 June 2006

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess	Mike Penning
Charlotte Atkins	Dr Howard Stoate
Anne Milton	Dr Richard Taylor
Dr Doug Naysmith	

Witnesses: **Dr Jonathan Fielden,** Deputy Chair of the Consultants Committee, British Medical Association, **Ms Karen Jennings,** Head of Health, UNISON, and **Mr Alastair Henderson,** Deputy Director, NHS Employers, gave evidence.

Q271 Chairman: Good morning. Could I welcome you to our third session in relation to our inquiry into workforce planning and ask you to introduce yourselves and your organisations for the record.
Ms Jennings: Good morning everybody. My name is Karen Jennings and I am the National Secretary for Health in UNISON. UNISON is the largest trade union in the Health Service, representing over 450,000 staff right across the piece, other than doctors and dentists.
Mr Henderson: I am Alastair Henderson. I am Deputy Director of NHS Employers, the employers' organisation for NHS Trusts. I am particularly responsible for pay and negotiations.
Dr Fielden: I am Dr Jonathan Fielden, a consultant anaesthetist with an interest in intensive care medicine. I am Deputy Chairman of the Consultants' Committee of the BMA and also the Chairman of Negotiators.

Q272 Chairman: Thank you for coming along. Dr Fielden, we are now paying our consultants a lot more as a result of the 2003 contract. Why have we not seen more improvements in return for this extra pay?
Dr Fielden: I think you have seen improvements in return for the extra pay. The hours that consultants are doing are now properly rewarded and recognised. There are tools available within the contract to ensure that job planning allows consultant time to be focused for the best benefit of patients, and you have the tools to engage consultants at trust level in the objectives and direction that trusts need to go. There are other tools there. Some trusts—my own, for example, and there are many others around the country—are using it very well and very successfully. Others—and in an organisation as big as the NHS I suppose you would expect this—are not using those tools as well as appropriate. Those tools are there to be used and we are there to help them.

Q273 Chairman: We were told by the Academy of Medical Royal Colleges that the short-term impact of the new consultant contract has been to reduce the productivity of the consultant workforce. You are saying, Dr Fielden, that that has not happened, certainly in some areas. Do you agree with that statement?
Dr Fielden: I would not agree with the statement. Having said that, we would have to ask what you mean by productivity. You asked the Department what they meant and they came back with a whole range of productivity measures. I think the Department has to decide what measure of productivity it is talking about and then we can come back to answering that question. The contract was about recognising the workload that consultants did, appropriately remunerating it and giving the tools for engagement between employers and employees, and I think that is what the contract has done and will allow that relationship to develop.

Q274 Chairman: Mr Henderson, do you have any comments on this?
Mr Henderson: Yes, indeed. I think it is important, both with the consultant contract and the *Agenda for Change,* to recognise what they can and cannot deliver. The consultant contract is a contract of employment; *Agenda for Change* is a pay system. By themselves they do not result in improvements to services; they are tools to be used. As such, I think they can be tools that can either be a hindrance or a help to organisations making changes. I am pretty clear, both with the consultant contract and *Agenda for Change,* that compared to what we had before they are huge aids to organisations making changes. Specifically on the consultant contract, my colleague David Amos, who came to you a couple of weeks ago, described in what I think was quite a nice way that we now have a currency and a method for engaging with consultants that we did not have before, a currency with which we can talk about how their work is planned, how their work is delivered, and we can talk about how work needs to be changed, if it does. I think that is now beginning to happen in the NHS.

Q275 Chairman: Andrew Foster, who I know has left the post, came here and he said to us that he believed a lot of organisations put more effort into simply getting people onto the new system than generating the benefits from it. Do you think, Mr Henderson, that the implementation of the contract was rushed?
Mr Henderson: I do not know about being rushed. I think just on 90% of consultants are now on the new contract—and remember it was their choice to do that. I think it is important to recognise that it was

not implemented in a uniform rate or manner across the NHS—and that is probably not surprising. I think it is true that to start with there was probably as much attention paid on the process of putting it in and the process of job planning rather than the content—and, again, that is not necessarily surprising. There was a huge amount of activity going on and the transactional job of getting the new contract in of itself was a major task and organisations did understandably concentrate on that to start with. In the second/third round of job planning, we are seeing organisations, now that the structure and the machinery is in place, concentrating on how you use the job plans, how you develop them. I think we are seeing more and more of that.

Q276 Chairman: Are you saying, basically, that we are seeing more benefits from it now than we were with the initial implications?
Mr Henderson: Absolutely. I think that is happening all the time. I think there is a range of examples of benefits and of ways that it has been used. There are a number of examples one can find of job plans that now have team job planning which provides cross-cover across various specialities. That has happened in anaesthesia, in paediatrics, in radiology. In Plymouth Hospital, I know they have introduced, through a contract, annualised hours and team job plans in their colorectal team. That has meant that they have now not had any cancellations of clinics due to consultants' annual leave (which was something that used to happen) and they have 100% utilisation of sessions. Bart's would tell you that their team job planning has helped them deliver their A&E targets. Hampshire Partnership Trust, as well, developed evening services there for consultants. That developed, over time, through better job planning, through better dialogue between consultants and managers to sit down and work out how they do that best. That is going to develop over time.

Q277 Dr Naysmith: Dr Fielden, could I ask you a question to do with the negotiation stage of the contract. Andrew Foster told us last week that he wanted to run a pilot scheme but the BMA refused even to consider it. Is that true?
Dr Fielden: My recollection is different: that the piloting was refused at higher level.

Q278 Dr Naysmith: Higher level in the Department of Health?
Dr Fielden: Yes, at either ministerial level or higher.

Q279 Dr Naysmith: Why would Andrew Foster say that when he was in charge of the negotiation?
Dr Fielden: I am not sure on that. From our position, we felt that there may or may not have been some benefit of piloting, but actually it was better to bring out the contracts across the board. To our recollection, we did not refuse piloting.

Q280 Dr Naysmith: Would it be true to say you were not enthusiastic about having a pilot?
Dr Fielden: I do not think we felt, on this particular aspect, that it was going to be the best way of bringing in this contract. There was a choice aspect, where the consultants went across to it, but job planning should have been done from 1991, so it was not a radical change. The increased clarity that was brought in with the contract was going to bring that in and then reward and recognise the hours and work the consultants were doing.

Q281 Dr Naysmith: You are probably aware that there were job plans long before this new contract was agreed.
Dr Fielden: Yes.

Q282 Dr Naysmith: And we have had evidence before this Committee on many occasions that hospital administrators did not take up the question of job plans with consultants because they would know that they would be told where to go. That sort of thing has been said two or three times before the Committee. Might it not have been a good idea to see what effect the new contract would have on job planning before we actually agreed it?
Dr Fielden: As I say, we did not feel there would be a substantial benefit of piloting in this particular example. Our recollection from the time is that piloting was also not something that was pushed centrally. I believe the issue of piloting ideas with doctors goes back even as far as Ken Clarke. It was felt that you would not pilot things because doctors would wreck things, and therefore you pushed things in. I would not agree with that, but we believe the pressure to pilot came from other sides.
Mr Henderson: I was involved with Andrew in the consultant contract negotiations through both stages—an assortment of delightful BMA negotiations, phase 1 and phase 2 of them. We were keen to talk about piloting and it was something that we were not able to progress. It is not the easiest thing to do to get a pure pilot. That is a slight difference in some of the *Agenda for Change* piloting of new pay systems, with some of what was proposed there, but I think it was something that we did wish to explore.

Q283 Dr Naysmith: Do you regret it not having happened?
Mr Henderson: It might have been nice to have some sort of pilots, yes, though one of the important things about the contract that I think is most important is the potential cultural change that the contract implies. That takes place over time. That is always quite difficult to get in a three-month pilot. It might tell you something about how *x* payment system works, but you are probably unlikely to get information on what the cultural changes mean with the workforce.

Q284 Dr Stoate: We are talking about very large sums of public money and we cannot even agree on who did and did not want a pilot. I am very concerned about what I am hearing. I would like to explore further Mr Henderson's statement earlier on in the session about gradually getting improvements

and things sorted out with the new consultant contract and things gradually coming into place and seeing improvements over time, but we were told quite clearly by David Amos that rigorous job planning and objective setting are crucial to the end benefits of the contract. Should this not have been sorted out before the contract rather than hoping it would all come right a year or two afterwards?
Mr Henderson: As was said, there should have been job planning in the NHS before. Frankly, I think it was very patchy. I do not think it is surprising that having a good and rigorous system of job planning and appraisal is something that develops. I do not think it does land fully formed in one go. It is something that you do on an annual basis and hopefully you get better at. I am not saying that you do not want it as good as possible first time round, but you do get better at it. Both managers and the doctors involved in the process will begin to understand the process better and will be given to understand how to get more benefits out of it. The fact that it is an improving process is unsurprising.

Q285 Dr Stoate: I think the taxpayer has a right to know why, for example, a 49.4% pay rise between 2001 and 2005 for consultants was not backed with rigorous improvements in productivity and job planning before that very large sum of money was spent.
Mr Henderson: As Jonathan has said, there is a whole series of measures on the success. I think that introducing what I have talked about—this new currency, this new dialogue for consultant—is a benefit that has been worthwhile. I think we have seen improvements in service and I think we have seen improvements in the management of consultants and the way that consultant time is managed, and that is going to take some time.

Q286 Dr Stoate: But we cannot even agree on what productivity is. Sir Alan Craft has told us that he thought productivity would go down; Dr Fielden has told us he thinks productivity has gone up. All I do know for certain is that there are huge amounts of public money being spent. We do not seem to be getting very far in terms of even deciding what has happened and why.
Mr Henderson: By what you measure productivity, yes, there is a whole series of things. There is, of course, straightforward output of consultants, which is a subject of considerable debate on which I know your advisers have some keen views as well. I was talking to Jonathan Michael, the Chief Executive at Guys and Thomas's, saying that the way he has been viewing that as an organisation is not just productivity in terms of throughput of operations, important though that is, and contact with patient time, but it is about also the use of consultants in their teaching, in their research, in their clinical audit and clinical governance. It is ensuring that the contract is used for full and getting all the benefits of that as well. That single productivity measure is then quite difficult to work out what you want.

Q287 Dr Stoate: It is a very long answer but it does not really reassure me. Let me put a more straightforward question. When will job planning and objective setting be fully operational to improve productivity?
Mr Henderson: I think it is. Job planning is fully in. It will continue, year on year, to continue more benefits.

Q288 Dr Stoate: I am still not convinced that we have got very far. The money has gone in, job planning seems to have partly gone in and productivity possibly is improving—but we cannot even agree on that. I simply want to know when taxpayers can say, "We've got our value for money."
Mr Henderson: Job planning is in. Job planning and objective setting is happening in every organisation. It is happening to different degrees of success, but it is getting better each year. I think the public can say they are seeing improvements from the consultant contract.
Dr Stoate: Thank you.

Q289 Anne Milton: Mr Henderson, I wonder if I could ask you to do the "man in the pub" test. Anybody reading this transcript—and I have some sympathy for what Dr Stoate was saying—would not understand a lot of the words you use. I wonder if you could explain what "currency and method for engaging consultants" means to the man in the pub. Is it surprising that it was not there before, really?
Mr Henderson: Yes, it is surprising that it was not there before, but it has not been. The way that organisations engaged with consultants over the past has not been terribly—

Q290 Anne Milton: Man in the pub, who does not talk about engaging.
Mr Henderson: Fair enough.

Q291 Anne Milton: I think it means something physical rather than intellectual.
Mr Henderson: There has to be a proper way that trusts manage the work of their doctors, like they manage the work for all their other staff. That did not always happen in the past. This contract provides a better way of planning the use of consultants' time, so that what they do can tie in with what the local organisation wants, so it can deliver the best form of services for local patients that is most appropriate, so that we are using the consultants time most effectively and the best way to deliver services for patients.

Q292 Anne Milton: So a management tool for encouraging—forcing if necessary, and I know you do not like that word—consultants to do what management wants them to do to produce better outcomes—I mean, I do not mean to be prejudicial—to produce better outcomes for patient care.
Mr Henderson: Yes, indeed.
Dr Fielden: It gives you the tools so they can have that discussion.

Q293 Anne Milton: Tools, meaning?
Dr Fielden: The framework. You have to sit down on at least an annual basis. You have the blocks of time, you have the objectives for supporting resources, the aspects to a discussion that you must go through to ensure that what a consultant is doing and when they are doing it is appropriately focused on what the trust needs for patients and what the current doctors feel they need for patients. One of the reasons that did not happen before is that the trusts were concerned that the closer they look, the more they realise consultants are doing. As we shared with you in previous sessions here, the hours that consultants were doing were substantially in excess of the old contract. They continue to be in excess of the new contract. The closer you look and the harder you try to force people to do things, the more they are likely to react and say, "Okay, you do not get this bit for free if you are not going to treat me like a professional." I think one of the reasons the trusts avoided it for so long is that they realised what a huge amount was going on—and the closer you look you reveal even more.
Anne Milton: Thank you.

Q294 Dr Taylor: Back to productivity. We have really only talked about activity, which is the easy part of productivity to measure. We can easily measure FCEs, the outpatient scene, but what about health outcomes? What measures are there to include a measure of health outcomes in these contracts?
Dr Fielden: I think it varies a lot between trusts and the amount of data they are actually using. We would certainly advocate, and we are advocating in the information we put out to consultants and into the public domain, "You should be including all aspects of how best to improve care for patients as part of the information that informs your job planning process." Let me take an example of myself in intensive care. There is clear evidence of the benefit of patient outcome of having more consultant time on the floor in the intensive care unit throughout the day and into the evening and night. That presence improves the quality of care and outcome for patients in intensive care. My job plan now allows us to focus more consultant time in intensive care for those patients and we are seeing benefits in the improved care of patients going through our unit. Similarly, in A&E.

Q295 Dr Taylor: What are your measures of outcome coming out of the ITU?
Dr Fielden: Survival. In intensive care terms, survival.

Q296 Dr Taylor: So that is easy.
Dr Fielden: You can then map it in. You can then, if you like, look at quality of care outcome as well. We have managed to ensure that our follow-up clinic in intensive care is properly focused within a job plan, so that we can make sure the morbidity aspects related to intensive care are also looked into. We have examples around the country, in obstetrics and paediatrics in Plymouth, where they focus their emergency work into a week. That allows separation of the emergency/elective workload, which, as Alastair has already mentioned, means you get less cancellation of elective work but also a greater fully-trained presence, like consultants, in for emergencies, which improves outcome. There are multiple examples of that. If you are measuring just fixed consultant episodes going through in cardiac surgery, for example, they are going to go down because our radiologists have got particularly clever at boring out arteries, so the number going through is going to go down. 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 is going down but my health outcomes are going up. I think you have to throw the productivity question back to them. If I may come back to Howard Stoate's comment about a 49% increase, I think that is an interesting figure to quote because the hours in the contract went up from 35 to 40 for the base hours and there was a small rise associated with that. The majority of the increase in that period of time was because you are paying for the extra hours that are being worked. Most consultants are being paid now for about 44–45 hours of work, which means that trusts can guarantee and decide on which hours they want to be done and focus that for patients, rather than it not being paid for and then maybe or maybe not being done. So the majority of that increase is, if you like, paid-for overtime.

Q297 Dr Stoate: This was in a report from the King's Fund. They said consultants' basic pay rose by 49.4% between 2001 and 2005. That is not from us, it is not from Government. That is from the King's Fund.
Dr Fielden: The King's Fund report was limited to five trusts in London. Everyone pretty much recognises it is a very limited report. Those figures focused on the early years. The biggest pay rise in the contract was for consultants in the first few years. That is partly a recruitment measure and partly a factor that junior doctors' salaries had increased and therefore there was a need to increase consultants' salaries, otherwise you would have juniors taking a drop in salary before they went in to taking much more responsibility. That was an appropriate increase. If that increase was high, the increase at the end, to retain doctors, was higher. In the middle, it was about 4.5% or 5%, if you look at it, until you add on the additional paid overtime. The King's Fund report was fairly choosy with how it picked its figures because I think it gave them the headline to give them the publicity they wanted.
Chairman: We are going to move on to the *Agenda for Change*.

Q298 Mike Penning: I will speak to my friends from UNISON, who must have felt a bit left out for the last 10 minutes or so. The Committee has heard that about 4.5% of staff so far have moved on to *Agenda for Change* contracts on protected pay. Is that a figure which you understand is correct?

Ms Jennings: That is a figure which we would support. It has been produced through partnership with the Department of Health. It is a figure which is rather supported—in terms of, we were expecting a larger number to be on protected pay. As a result of developing better job profiles, we have been able to reduce that figure down to 4.5%.

Q299 Mike Penning: Which are the areas of professional expertise which have been most affected by this? Many of us have been written to, in my case by the pharmacy profession and senior nurses. Are there other areas which have been affected dramatically by this?
Ms Jennings: I think the group that has been affected most by this is the admin and clerical sector, medical secretaries and so on. I think they have begun to improve in the bandings that they have achieved as a result of looking at better job development programmes and the profiling of them.

Q300 Mike Penning: Is that because of the difficulty in looking at their job descriptions and fitting into certain bands, or is it just because of the way that admin in the NHS has expanded so much over the years and we do not quite know what pay they should be on?
Ms Jennings: I think it is a combination. Also I think the panels that were implementing and assimilating the staff needed additional advice and information about where to place those staff, so that they were not demonstrating any bias towards clinical staff and therefore not fully understanding the role of the admin and clerical staff.

Q301 Mike Penning: Are UNISON happy with the way the appeals procedure is working for those who have suffered? I have had correspondence from constituents whose pay has dropped. Is the appeals procedure working well or are there teething problems there as well?
Ms Jennings: It appears to be working well at the moment. We are not getting complaints through. Because it is done in partnership, I certainly think that the mechanisms for appeal are much better than they were under the previous pay and grading system, the clinical trading structure. I think we have learned a great deal about how to work in partnership and to ensure that there is a fairer process in place.

Q302 Mike Penning: Mr Henderson, from the employers' side.
Mr Henderson: The protection is less than was first thought. It is important to remember that protection does ensure that nobody's pay drops at all. I mean, it may stand still but it does not drop. I think Karen is right, our view is that probably the majority where protection is, is in admin and clerical roles.

Q303 Mike Penning: And a 4.5% is something that you see as well? We have heard slightly higher figures, so I am interested in confirming what you think.
Mr Henderson: Yes, I think that is about the figures that I am picking up. The estimation was that it could be up to 9%, but I think it is less than that. It is running at around 4.5%.

Q304 Dr Taylor: The people who have been in touch with me have been people in the more senior grades. Is it fair to say that they would mostly, if we are talking about nursing, be in the RCN rather than in UNISON. I am talking about nurse consultants, nurse specialists. A large number of those I think are on standstill, which is quite hard. I know it is not as bad as a pay reduction but it is quite hard when your pay suddenly sticks and other people, who are probably doing not much more than you, are on an increasing range.
Ms Jennings: UNISON represents a broad family, including senior nursing staff. We have 240,000 members. I think the important thing to remember is that *Agenda for Change* is about an equal value pay system and it has a rigorous process of determining where individuals are assimilated to. Our evidence is not necessarily that senior nurses are suffering more than other groups of staff.

Q305 Dr Taylor: Those who are being made to standstill were probably being paid too much before, is that what you are saying?
Ms Jennings: No, I have not said that. I think if they are standing still then they have been properly evaluated and are being paid what they should have been paid.

Q306 Dr Taylor: Do you have physios and occupational therapists?
Ms Jennings: We have occupational therapists.

Q307 Dr Taylor: Have they been affected?
Ms Jennings: Occupational therapists have, indeed, been affected. In our submission to the Pay Review Body evidence, we are concerned that the recruitment and retention of occupational therapists is very worrying—in fact, I think they are the second largest occupational group that continue to have major shortages. There are some concerns for highly skilled technical staff to go on to gain access to education and training on occupational therapy. We believe it would be helpful, in that case, if recruitment and retention premia were utilised to enable better recruitment of occupational therapists, because they do not feel they have done as well out of *Agenda for Change* as other comparable groups.

Q308 Dr Taylor: Is it, again, the more senior occupational therapists who feel hard done by?
Ms Jennings: I think it is across.

Q309 Dr Taylor: I think Mike mentioned pharmacy. What about pathology, the path lab technicians—the medical laboratory scientific staff?
Ms Jennings: I think there is still a lot of work to be done on their job profiles. It is a continuing process, looking at the job evaluation scheme and developing profiles for those particular schemes. We are trying

to look at a family of job descriptions and profiles which will enable a better career development and better career structure for those groups.

Q310 Chairman: Is there any evidence at all, both Karen Jennings and Alastair Henderson, that *Agenda for Change* has been used for cutting costs in any trusts that may not have spending problems?
Mr Henderson: Not that I have seen at all. I am not sure how, particularly, it might be. There has been a rigorous process of job evaluation, of putting people on to new schemes. I have not heard that as a complaint.
Ms Jennings: I think it is a very interesting question and it is certainly something that was used in previous pay systems to depress the grades that existed. Generally speaking, that has not been the case. However, I think there has been some industrial strife in the ambulance service, in particular, where it has been felt that a blanket grading of certain staff has been brought in to depress costs and we are trying to look at mechanisms to overcome that. I think that is a claim that could be made there.

Q311 Chairman: Mr Henderson, do you want to add to that.
Mr Henderson: I think there have been some anxieties for ambulance staff to have. It is slightly ironic that ambulance staff overall have done particularly well out of *Agenda for Change*. Often in a pay reform it is a comparative evaluation, that you may have done well but you perhaps did less well than you thought you ought to have done. With the allied health professionals, it is an average £3,500 gain that people were making, and, with nurses, over £4,000 around each of the grades was the average gain that was being made.

Q312 Chairman: On the issue of Foundation Trusts, I think in theory they do not have to endorse or take on board *Agenda for Change*. Do you feel there is any threat that that may happen at some stage in the future?
Ms Jennings: When the Foundation Trusts first came into being, clearly Alan Milburn was making promises that in the Foundation Trusts' five-year business plan they would have to include *Agenda for Change.* It is not clear that that has to be the case with subsequent secretaries of state. It certainly is not a requirement within the legislation. Of course the regulatory body for Foundation Trusts does not have a mandate over pay and terms and conditions of service. We do have concerns about the future of the continuing of *Agenda for Change* in national bargaining as the roll-out of Foundation Trust Hospitals takes hold. We have tried to have meetings with the Foundation Trusts' network, to no avail because they do not want to meet on a collective basis. That sends early alarm bells in our collective heads around the future of collective responsibility around pay and negotiations, and we have examples of some trusts which are departing already from pay and terms and conditions of service, particularly, for example, around admin and clerical staff. That is happening in London in some Foundation Trust Hospitals where they are having some difficulty recruiting and retaining their staff.

Q313 Dr Stoate: If we are moving towards all hospitals being Foundation Hospitals by 2008, which is the Government's stated aim, then surely *Agenda for Change* is theoretically dead, so why bother with it? If all hospitals become Foundation Hospitals and Foundation Hospitals do not have to stick to *Agenda for Change,* then what is the point of *Agenda for Change?*
Ms Jennings: The experience under the Thatcher years was that when trusts were legally allowed to set their own pay and terms and conditions of service, the vast majority did stick with the national terms and conditions of service because it made huge sense not to replicate that negotiating at a local level. But I do think we did see at that time some maverick trusts and renegade trusts which did move away. If that begins to happen, particularly as it becomes more and more competitive, we are going to see, I think, more industrial relations problems and differences between staff and how they are trained.
Mr Henderson: I think Foundation Trusts but all other organisations have the right to do different terms and conditions and they are legally allowed to. I think Karen is right, *Agenda for Change* does provide a framework, and an attractive framework, but it does provide an awful lot of flexibilities as well. That was all part of the purpose. I do not see at the moment much due from foundation or other trusts to want to do it because they have a system that they can use. Also, it is not the best use of everybody's time to reinvent wheels if there is a good framework there.

Q314 Charlotte Atkins: Moving on to the new Knowledge and Skills Framework provided by *Agenda for Change*, we have had glowing reports from various witnesses. Is it really as good as it seems? I see from the UNISON evidence that you are calling for the ring-fencing of learning and skills budgets, so clearly you do have some concerns about the whole training agenda.
Ms Jennings: Thank you for that question. 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 to education and training. Alarmingly, in the Healthcare Commission's report it indicated that less people this year had professional development plans than last year, so something is going wrong in terms of that access assessments in relation to their education and training. Also, because of the trust debt situation, I know we have had alarming headlines about redundancies and job cuts, but, when a trust does that, it goes through the whole system of what you can cut elsewhere. So there is a whole range of other mechanisms to save money before you then announce, as well as that, staff redundancies, and the big chop is in education and training, without a doubt. We are seeing that right

across the country. In fact, we have a letter from I think the South West London Strategic Health Authority that has written to all trusts saying there will be no money for NVQ training, there will be no money for seconding healthcare assistants, there will be no money for post-registration training—and we are talking about a large number of trusts. In fact I have the letter here, so you are very welcome to see that, but it is saying that there will be no cash allocation to trusts, there will be no new healthcare assistant secondments, there will be no new full-time AHP secondments, there will be no funding for seconding registration students, there will be no funding for EN conversion, there will be no NVQ funding. If you look at where staff are being developed at the moment, where the biggest growth is, where the richest pool for recruitment into professional education and training is, it is healthcare assistants. UNISON's own healthcare assistants' surveys have repeatedly shown that 80–90% of healthcare assistants want to gain access to education and training, want to develop themselves to a high level, and want to go on to do nursing, occupational therapy, or whatever it is, ambulance paramedic training. We are going to cut that source of potential recruitment which is key to the modernisation of the NHS—absolutely key—if we have nurses that are shifting up and up-skilling and therefore needing more hands-on staff. Could I mention, on this skill-mix element, that 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? We would like to see—which is something UNISON has developed with the Open University and NHS Professionals—a true skills' escalator, where you are providing education and training to healthcare assistants, enabling them to gain access to pre-registration programmes and going on part-time courses—and you find that the attrition rate is way in excess in full-time courses than part-time courses. We have to ask Strategic Health Authorities, who commission the education and training, to start to open up their eyes to better opportunities for that. It is much more cost-effective. Just think about the money you are losing all the time.

Q315 Charlotte Atkins: Presumably you have put this to the Department of Health, have you?
Ms Jennings: We have put this to the Department of Health.

Q316 Charlotte Atkins: What sort of response have you had?
Ms Jennings: I wrote to Patricia Hewitt earlier in the year expressing my concerns about the potential lack of money for education and training and the answer that I had to that was that they had not set the budget yet. We have made numerous approaches to the Department of Health about looking at widening the opportunity and the access for pre-registration training and to look to develop part-time courses. There is a bit of a stranglehold, I think, between the Commission in this and the higher education institutions.

Q317 Charlotte Atkins: Are the NHS Employers very much in favour of the UNISON approach here? Presumably it would increase productivity if you can train the existing workforce to take on more responsible roles, as encouraged by *Agenda for Change,* rather than taking people in who might decide health is not really their thing and they will leave and hence you waste all that time.
Mr Henderson: Absolutely. That is a core part of *Agenda for Change* since we started. That is a core part of the KSF and there are good examples of that. In Dartford and Gravesham there is an example of a ward administrator who has taken on more roles, in terms of admission of patients, and is doing that. Developing those people—and Karen is absolutely right, those people who work in the NHS normally want to get on and move on—is an entirely sensible thing to do. I think KSF will be a real benefit in doing that.

Q318 Charlotte Atkins: One thing that the Committee is a bit concerned about is that the Knowledge and Skills Framework has not been implemented until after the job evaluation. Were there any other approaches considered rather than just doing that process whereby job evaluation happens first and then the Skills Framework? Surely, the Skills Framework and the training element of it should have been put in much earlier.
Mr Henderson: I think it is. I think we now have about 85% of KSF outlines, about 55% of full KSF. My understanding is that it was really just in part practical terms that you could not have done that before. There is a cycle for the KSF which starts coming in from this October. The task of implementing the whole new job evaluation pay system was pretty hard. I am not sure whether it would have been possible to do it altogether, but it is now coming in.

Q319 Charlotte Atkins: Clearly, this is key to productivity.
Mr Henderson: Absolutely.

Q320 Charlotte Atkins: The idea that somehow this is constrained by the budget seems to me a false economy.
Mr Henderson: As you will know, there are a number of organisations who have severe financial difficulties. I am not sure that in those positions there is necessarily any one particular bit of the budget that has to be *per se* immune if there are savings to be made. But I would quite agree with you, and I think most trusts would agree, that it is clearly short-sighted in the long term to take money out of the training, but that is not going to happen with the KSF.

Q321 Charlotte Atkins: Have we not heard earlier that huge amounts of money have gone into staffing, and, whatever level of staff, we are fearful that we are just not getting the productivity gains that we should be getting out of the vast sums of money that have been rightly invested in staff. Surely it is a very, short-term expedient then to start cutting the training, which is absolutely vital if we are going to get the true productivity gains out of our investment.
Mr Henderson: One trust, I think Central Cheshire Primary Care Trust, has told us that one of the things, interestingly, the KSF has allowed them to do is to make better use of their training resource budget. Perhaps in the past it was slightly random and training went to some of those who maybe put their hand up and seemed very keen on it rather than necessarily those at whom it was most directed. The KSF, this PCT tells us, has allowed them to work out where the best need is and they have said it has made better use of their training budgets there.

Q322 Charlotte Atkins: But are they also cutting the overall budget?
Mr Henderson: I have no idea about that particular organisation.

Q323 Charlotte Atkins: The important thing is—and I would hope the employers are going to make very strong representations to acute trusts and to PCTs—that training should be absolutely key here. We are going to get the productivity gains that the Government and we as consumers of the Health Service have a right to expect.
Mr Henderson: I think that is right. Remember, the NHS's training budget is absolutely vast and still huge sums are being put into that. We are just saying that I am not sure individual organisations would support ring-fencing budget A or budget B, because there are equal calls for a particular cancer budget or whatever. There has to be then some flexibility, and clearly no trust is going to want to cut off its nose to spite its face by cutting back training, but, if you are making financial savings, you have to have flexibilities of where to use them.

Q324 Charlotte Atkins: Training is just seen as an easy pot, is it not, to cut?
Mr Henderson: Not just in the Health Service but across organisations, that has been the case. I am not sure that is the case in every organisation. I think there is increasing recognition of the importance of that, but I am saying that there are organisations that would not want, if they are having to balance their books, their hands tied precisely about where they do that.
Ms Jennings: I wonder if I may introduce that there are major, major reforms. It is a continuous process in the NHS, as we know, but with Our Health, Our Care, Our Say and the migration of the workforce from secondary care into primary care, we are going to need to see a step up in the investment in education and training. Also, with the demographics that face us, we are going to have to make sure that we have enough staff in the NHS to keep going. We have a third of the nursing workforce due to retire in the next five to 10 years and where are we going to get them from if we do not start to grow our own. As I said earlier, we need to make sure that we do not disillusion those healthcare assistants, those who cannot get any access to education and training. They have that glass ceiling at NVQ Level 2, and yet there are all these amazing developments that they are getting involved in now. And it is not just healthcare assistants who support nurses: you have physiotherapy support workers, occupational therapy support workers and speech therapy support workers—all of them working in the community to get older people out of hospital—who require education and training. They can go on to assist those professionals, such as the occupational therapists that we spoke about earlier, going on to grow that workforce. It is absolutely crucial, if we are going to have that world-class healthcare service that we keep talking about.

Q325 Chairman: Would you leave us that letter that you have there.
Ms Jennings: Yes. Absolutely.

Q326 Dr Taylor: I would like to congratulate Karen on her tremendous defence of the healthcare assistants and the training, and to wonder if this sudden cut in the training budget is anything due to the Government's deficits and its attempt to minimise the deficits.
Ms Jennings: Dr Taylor, I think it is to do with that.

Q327 Dr Taylor: That is where they found the money.
Ms Jennings: We have one third of trusts which are in debt. One third of NHS Trusts that we know are in debt. As I believe I said earlier, 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.

Q328 Mr Amess: Let us not quote my namesake any more. UNISON said that *Agenda for Change* ". . . has fostered a partnership between Health Service managers and employees" and everyone thinks this new partnership is wonderful. I would be delighted if someone would quickly tell me when I have finished what we mean by "this partnership". Obviously when people are given more money they are absolutely delighted. Look at Members of Parliament: we are all delighted when we get our extra little bit of money, so we are all bound to say this is fantastic. But, in reality, it would appear that the Government now feels that this has been rather an expensive arrangement in hindsight. What do the Panel think about that?
Ms Jennings: I think there are some extraordinary examples of partnership—from even before *Agenda for Change* came into being. If I may give you an example of the London Ambulance Service. That was a service that was on its knees and it was about to be disaggregated, disbanded and reorganised

elsewhere. A visionary chief executive and a visionary branch secretary came together and provided the solutions for the London Ambulance Service. They were then at the cutting edge of how an ambulance service should model itself. They introduced appropriate responses; in other words, technicians, paramedics, going out on bicycles, motorbikes, cars and, indeed, helicopters—you did not need to go out in an ambulance truck every time—and also a range of different skill mixes, so you do have the ambulance technicians, you do have the paramedics, you do have the researchers. The benefit realisation is that there are good industrial relations—because it was appalling before that—and response times were improved upon and came in under what the response time targets were. You now have the reconfiguration of the ambulance service based on that incredible model of partnership. Again, this is an ambulance service that has worked through *Agenda for Change* fairly peacefully as well. There are many, many other examples of partnership that I can give you. Clearly, when you come up against a situation where there are deficits and difficulties, I think it is incumbent upon the chief executives and the board to work with the trade unions to ensure that they find joint solutions to it. What is unacceptable is when there are announcements about redundancies and job freezes and they have not spoken to the branch about it. I think the Department of Health did not demonstrate itself very well as a role model for partnership last year when it parachuted in the reconfiguration of Primary Care Trusts and Strategic Health Authorities. I think they have recognised and apologised for that and have attempted to move on to make sure that there is closer collaboration and information. We want to see a lot more consultation out of the Department of Health before decisions are taken and we hope that we will move on from that position.

Mr Henderson: If you think that introducing a pay reform unit brings benefits, brings everybody rushing out in gratitude, please let me put you right on that. What I think we mean by the partnership that really has worked well for *Agenda for Change,* and I think, in large places, with the consultant contract implementation as well, is with management and staff representatives genuinely tackling problems and the issue together, and finding that it is in their benefit to seek a solution together rather than have what may have been rather more adversarial approaches before. In another example from the example Karen used of the Ambulance Service, the National Blood Service, the Blood Authority, which had a history of pretty poor relations, has introduced *Agenda for Change* on a joint basis that has improved things for the staff and has improved the service enormously. When we talk about that, I think it is about cooperation, behaving as grown-ups, to address problems together. I think you are right, that it is easier to do that when you are doing something nice. It is more of a challenge when you are doing something less nice, like potential workforce reductions. I think that will be a test, but I am confident that in a number of places relations that have developed will mean that those are addressed on a "nobody wants to do that" basis but will be dealt with jointly and on a grown-up basis. Behaving as a grown-up, I think, is what partnership is about.

Q329 Mr Amess: Some vicious attacks have been made upon the consultants. They are not all playing golf on the golf course, are they, Richard? That is an unfair caricature, so can we have your version.

Dr Fielden: I think it has always been an unfair caricature. Without a doubt, there is clear evidence of the huge amount of work consultants deliver for patients within the NHS. Partnership, I think, has been aided by the consultant contract substantially. The tools are there for that adult and often difficult discussion. I think we are seeing the number of programmed activities for consultants now being focused down, the overall numbers coming down, so that they really are focused on the hours that are needed for patient care. In trusts where the trust management are working in partnership with their consultants, you see dramatic improvement. My own trust has gone from deficit last year to predicted surplus this year. That is because we worked very closely with our senior managers and the consultant body, through improving our A&E to deliver all the A&E targets 98% of the time; bringing in a clinical decision unit that has dramatically changed emergency medicine; improving intensive care; separating the elective and emergency workloads—so that we can really focus the skills that we have to where the patients need it. That works where you have partnership. Unfortunately, that partnership is often put under stress by often centrally driven, short-term financial measures. Where that partnership is then fractured, you have organisations that continue to fail and they cannot address those difficult decisions. The consultant contract, in particular, does give you the tools to do that, but very often centrally driven short-term measures mean that that partnership is fractured.

Ms Jennings: As we increasingly move into situations where there are retrenchment measures taking place within trusts, some of our branches are telling us that they are starting to lose their facility time and time off to be able to do the necessary trade union activities to participate fully in partnership. I think it would be helpful for the Committee to think about that and to make comment on that, because if we want to continue with an NHS that celebrates the partnership that it has and the relative industrial peace that it has, we need to make sure that there is proper trade union time and facility time for them to participate in the activity.

Q330 Mr Amess: Although it is tempting, I must not prolong this session. I think the answer was that you think the money that you have is reasonable. As you know, we are having an inquiry into deficits and these things can be teased out there. Specifically to UNISON, given that you welcome this spirit of partnership: Do you think what is happening at the moment with jobs being lost is going to sell this?

Ms Jennings: Thank you for the opportunity to come back in again. Since the NHS ten-year plan, the NHS has made great strides on investing in the workforce, on the human resources agenda, on very valuable equal pay system. I think it has set the standard for all others to follow. I think the more recent reforms are very worrying in terms of the unravelling of that cohesion of the NHS. I do believe that the trust debt situation is going to impact badly, but I think the trust reforms more than the existing debts at the moment are going to have a great impact. On the outsourcing of services, the supply of services, the outsourcing of community services, although we have had a retraction of the statement from the Department of Health that all PCTs will divest themselves, it is quite clear that the direction of travel remains the same and there appears to be a favouring of the private sector, influencing the development of the private sector. It is that which concerns us in relation to the harmony of the NHS, the solidarity across the NHS, and also we do not think it is cost-effective or cost-efficient. I think a lot will be undone in terms of the national bargaining and the human resources agenda in relation to that.

Q331 Mr Amess: Finally you got the money, you got it quickly, but there is the impression that the changes which the Government wanted to working practices has not been entirely secured. Is that unfair?

Mr Henderson: No, I do not think it is unfair. As you described, it is changes to working practices and culture, and changes to working practices and culture do not happen overnight, nor can we expect them to. There are more and more examples of these benefits coming through. That tap is going to come more and more on stream, to mix a few metaphors.

Ms Jennings: There are more changes than are being reported and I do not think enough is being done to measure the benefits of those changes. Alastair mentioned earlier, for example, the NHS Blood Service which has made huge changes in terms of benefits realisation. It is now a 24 hour, seven day a week service. It has improved its recruitment of transport services to such an extent that the service no longer has to rely on couriers and that has saved them £2 million. Who is talking about that? Who is talking about those savings that are going on? If you look at what Primary Care Trusts are doing in relation to developing skill mixes, bringing in support staff to work with district nurses, occupational therapists, and so on, they are keeping people out of hospital longer and those benefits are not being measured in terms of costs. That really does need to offset some of the other concerns we have around productivity and the overspends in some Trusts.

Q332 Mr Amess: Are the consultants going to do what the Government want them to do?

Dr Fielden: The consultants are focused on what they need to do for patients. If what the Government wishes to do is in line with what patients need, and that increasingly is focused on a local level, then those two visions are aligned. Coming back to the contract, I think that does give the tools to ensure that at local level the Trusts and consultants can ensure they deliver for patients in the most appropriate and value for money way. Unfortunately sometimes Government whim and short-term policy changes mean we cannot do that and it gets in the way.

Mr Amess: We have three splendid advocates for their cases.

Chairman: Could I thank all of you for coming along this morning and helping us with this particular session. We are now going to move on.

Witnesses: **Professor Dame Carol Black,** President, Royal College of Physicians; **Mr George Blair,** Managing Consultant, Shared Solutions Consulting; and **Dr Karen Bloor,** Senior Research Fellow, University of York, gave evidence.

Q333 Chairman: First of all, could I thank you for coming along and helping us with this inquiry. This is our third session today and I know some of you have caught the flavour of the last session we have just finished. Could I ask, for the sake of the record, that you introduce yourselves and your organisations.

Professor Dame Carol Black: I am Carol Black, currently President of the Royal College of Physicians. I am also a rheumatologist and work at the Royal Free Hospital.

Dr Bloor: I am Karen Bloor, a Senior Research Fellow at the University of York in the Department of Health Sciences. I am also a non-executive director on Selby and York Primary Care Trust.

Mr Blair: I am George Blair, Managing Consultant at Shared Solutions Consulting. I am also a director of the HR Society, which is an interest group with special interest in workforce planning where I have spent much of my working career.

Q334 Chairman: Once again, thank you for coming along and helping us. Could I begin by asking a question to all of you. The think tank Reform has argued that if the NHS focuses on improving productivity then it will be able to the reduce the size of its workforce by 10%, describing this as a realistic medium-term outcome. Is this a credible or desirable scenario?

Professor Dame Carol Black: Thank you for that interesting question. Could we reduce the workforce? If we did increase productivity, and it depends how you define productivity and I would put into that not just efficiency but quality which is very important, then you may certainly be able to reduce it a little. If you bear in mind the other counter-factors, for example the European Working Time Directive, you are going to have people working a shorter time, consultants as well as doctors in training, so you are going to need a workforce to cope with that. Patients' needs are

increasing so you have to balance that. We have an ageing population. We seem to be also increasing the diseases which come from our own behaviour, such as obesity, poor sexual health, and excessive alcohol consumption. If you balance these things, if you factor in that you would like to improve quality and you wish to meet the needs of patients, I am not at all convinced that you are going to reduce the workforce requirement spread across the different health care professionals by a great amount.

Dr Bloor: I looked at the Reform Report and it was an interesting report and had some useful points to make, but at times it lacked a really clear evidence base.

Q335 Chairman: It was more theoretical.

Dr Bloor: Yes, I think so. That 10% seems to be a rather ambitious target. The NHS, and healthcare in general, is a labour-intensive industry; it is about caring, and it is always going to be difficult to make the level of productivity improvements that would generate that kind of staff saving, particularly in the context of some of the demand factors that Carol mentioned.

Mr Blair: Across the board 10% to me sounds very much like the approach that everybody has to make 10% across the board savings this year, when there are certain areas that can make substantially more than 10% savings with the right sort of investment and other areas where there is much, much less scope for doing so. I think a more interesting question would be what is the scope to increase productivity and what timescale and what sort of investment is needed. In some areas there is considerable scope, particularly where technology changes. If technological changes are properly anticipated and planned for, and organisational structures are changed, then you can make much more in those areas. There are some good points made about other areas which are inherently labour intensive. For instance, a district nurse visiting an old person in their home perhaps a 10% saving in their time may not be a good idea.

Q336 Anne Milton: To come on to what you said that this is just about saving money, it is a rather theoretical look at different ways of treating the workforce. The idea that you put more investment in fewer people, I would be interested to hear your views. What we are talking about is working smarter. You are right, Dr Bloor, that the NHS is about caring but that is not just about numbers. There is a sense that we all run around doing lots of activity but not necessarily achieving very much, therefore if you invest in your workforce and get them to work smarter maybe you could reduce the workforce.

Mr Blair: Let us be specific. If we look at pathology, there are huge changes there with capital investment. The non-urgent work could go to big centralised automated laboratories and save a huge amount, so that is an area where much more could be achieved and that is an example of working smarter. I am very keen on that notion of working smarter in those sort of specific areas. The other thing about working smarter, the NHS drowns in data but it has very little information. By information I mean information, and particularly for clinicians, which is there in one document which pulls things together. I would argue the most useful thing, if we are talking about productivity, is to involve clinicians in it. The earlier discussions were about you have had the money, have you delivered. I think there is another question, how do we encourage you. Clinicians are very keen to improve the quality of care. Let us have quality of care indices included, and that would involve clinicians a lot more. Quality can also impact on costs through hospital acquired infections. In order to support your view about working smarter, I would say it is crucial that information needs to be presented very much better, and its for clinicians because they are the ones who effectively will deliver productivity. If it is other organisations pointing out the naughty boys and girls, perhaps that is needed to some extent but that is not going to motivate anybody. I am very much in favour of what is called elsewhere a dashboard of key indicators, so that in one document a whole range things to do with throughput, quality of care and quality of patient experience are there on the wall for clinicians and they monitor it themselves. That would be the sign of success. That is what, for instance, in terms of working smarter, Toyota have been brilliant at. They are the world leader in terms of improving productivity because they get their staff to monitor what they do over a wide range of activities and drive down waste. We need to present this in a way which is meaningful for clinicians not just meaningful for management consultants.

Dr Bloor: I think your question was more investment in fewer people.

Q337 Anne Milton: That is right, but feel free to expand.

Dr Bloor: That statement lacks a real evidence base. As George says, there are some areas of the Health Service where that might be the case. There is some quite interesting research evidence from the States that looks at the appropriate level of training of nurses and whether a more highly trained nurse gets clear patient outcomes, reduced mortality, reduced readmissions, reduced unnecessary complications, that kind of thing, so there is some evidence that better trained people, even fewer better trained people, can be more effective than increasing the number of people. There is some evidence that contributes to that, but in general to say more investment in fewer people across the Health Service is a bit of a sweeping generalisation.

Q338 Anne Milton: It is a very big statement, but what you would suggest, if I summarise, is more work needs to be done and there is early evidence to say that might be worth it.

Dr Bloor: I am a researcher or I would say that.

Professor Dame Carol Black: I will restrict myself to talking about doctors working smarter if that is what you ask. It would be difficult to think how you would change, at the moment, the hours they are working. If you are saying we will have fewer doctors

but make them work longer hours, certainly for physicians they are already working about 59 hours a week so you could not really have fewer of them working longer. The things that would be extremely helpful, for example, would be if we could separate more appropriately acute admissions and our more elective work because most of us are schizophrenically trying to do two things. We try to look after the ever increasing acute medical take, and we are trying to do out-patient work, endoscopies, et cetera. That means you are trying to do two jobs so you are probably not terribly smart at either. If we do develop this speciality of acute medicine appropriately, then that would help us be smarter. We would be smarter in our work if we had our diagnostics better arranged, if we did not have to stop at 5 o'clock being able to get a CT scan, for example. 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 not been reformed so consultants were paid more money but in a system which would not support more efficient working. The final point I would like to make is about data, which has been brought out before. Doctors are really interested in data that relates to outcome and are not interested in data for data's sake. If you want us to work smarter and you want to engage us, then it has to be for patients' benefit. It has to have relevance.

Q339 Anne Milton: Loaded at the front end, as you say. Could you be more specific on systems reform?
Professor Dame Carol Black: Perhaps I could use my own speciality as an example. I am a rheumatologist and the flow of patients through the rheumatology department in which I have worked for many years could be greatly enhanced. We bring people back to do all sorts of investigations, we send them upstairs to get their blood tests and they wait an hour and a half up there, they come down and might need a knee X-ray so they come back with that. They come to me in a clinic that is already ongoing and already working behind time. If you go to some hospitals in other countries, they have worked out how patients flow around systems. They have made it possible for us to work more efficiently. I am sure you could take any speciality, often the X-rays are missing, the notes are often missing and then you scrabble around for that, so it is all about how you provide the actual environment in which you could make us work smarter.

Q340 Anne Milton: I find it enormously frustrating listening to what you have to say. It is a continuing theme of a lot of these evidence sessions that I listen to something that has been going on for 20 years. It seems so utterly simple, does it not, to work out how to move patients around a hospital, be it an acute admission or an elected admission, or out-patients or in-patients. Why do you think it has not happened? With all your experience, why has nobody ever got to grips with it?
Professor Dame Carol Black: I am probably giving you a fairly local feel and I could be quite wrong but it is rather about living in silos. The consultants have lived in their silos, put their heads down and do their clinical work but we have not communicated well. A huge amount of this has been about communication with doctors, managers, other health care professionals, the clinic clerk. We have just not had the right environment, and perhaps the right drivers, to get us together to say this is what would be so much better for patient care. We have managed to do it, for example, much better now in acute care, the A&E end of the hospital. There is a much better throughput. It requires local doing, because I do not think this is something the centre can actually do. It will vary with geography and with the people who work in an environment. As president of the College I have travelled a huge amount to many hospitals in the country and I see some hospitals that do it extremely well. There are very good examples out there of where this has been looked at and tackled but spreading good practice in the NHS seems to be remarkably difficult.

Q341 Anne Milton: Something we all want to happen, for 10, 20, 30 years, is just not happening even though we all want it to happen.
Professor Dame Carol Black: There are examples of where it has happened but it is how do we get that. It is about getting people to actually be singing to the same hymn sheet.

Q342 Dr Naysmith: Before we go into my questions I will pick up on what has been said. There are some really good examples of the flow improving. There are a couple of good examples in my own constituency relating to breast cancer in women where they come in the morning, have a biopsy, and by the evening they have had the results of the biopsy and, if necessary, counselling. That all used to take days before. It can be done and it ought to be done, but, as you say, it is more often in the acute sector that it gets done like that. I wanted to talk about what you were talking about before but in the context of the large increase in staffing that has taken place in the National Health Service since 1999. I want to start with the quotation from Dr Bloor's written evidence to us that "before planning to increase the stock of human resources it is essential to establish that the existing workforce is working effectively". From some of the things that have been said already, and maybe you could expand a little bit, did the NHS do this prior to this rapid growth? You have indicated that maybe you think it did not, but why did it not do it?
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. There are huge variations in activity. Admittedly some of these measures are quite crude and do not pick up overall productivity, including the quality measures that Carol has mentioned and that are obviously desirable, but there are some substantial

variations, and largely unexplained variations, in what people are doing and what different organisations are doing. I do not think we really did address the effectiveness of the workforce enough before we expanded it.

Q343 Dr Naysmith: Why not?
Dr Bloor: I guess it comes back to the discussions we were having on the last point about lack of communication between different organisations and between different teams within an organisation. There were some interesting points made in the Reform Report about the difference between primary care and secondary care on this kind of responsiveness issue. They were saying there was a different mix of staff in primary care compared to secondary care, but it was also a difference in the responsiveness of those staff to different situations as well. It is a small example, but as a non-executive I visit local general practices to look at their patient satisfaction questionnaires. By the time I go, they have the results of the questionnaire. In one of my local general practices there was a point about a children's play area and where the letter box was. The GP I was discussing this with said they had had that comment on one questionnaire and they had re-organised the children's play area and moved the letter box. I thought in a hospital or a PCT, or even the University of York, that small change would take months of deliberation and sub-committees. It is sometimes easier for small organisations to move and respond faster than bigger organisations where there are the silos that Carol mentioned. In terms of why we have not made sure that the workforce was working more effectively before expanding it, I do not know. Perhaps we should ask the Department of Health about that.

Q344 Dr Naysmith: I am using Carol's example of a rheumatology clinic and going off for tests and coming back. With the expanding workforce, you could either, find a cleverer way of doing that and get more patients through faster in a better way or you could just run another clinic if you have more staff in the same old-fashioned way. Why do we not do the first thing I mentioned and try to look at more intelligent, cleverer ways of doing the same sort of thing without getting more staff to do more of what has gone on before?
Dr Bloor: I do not have good evidence for this but I wonder whether it might be about empowering teams within organisations to make those kind of changes. I cannot believe that the rheumatology service that Carol describes could not sort that kind of thing out if they were given the freedom to do that. I wonder whether there is a role for saying what a team is and empowering them to make small changes, sometimes small changes at the margins, to improve effectiveness. Some hospitals do that and some do not.

Q345 Dr Naysmith: The problem with this is the increases in pay, and all that sort of thing, have followed behind the increase in the workforce. It would have been better the other way around, as already mentioned. Do you think that is the case? We should have looked at all of this before introducing *Agenda for Change*, or is it part of *Agenda for Change*?
Dr Bloor: Some of the variations that we have seen are emerging as a result of the contract changes and we will get better information in the future because of some of the changes that have been introduced. Perhaps we did not know, and could not have known, some of those issues earlier.
Mr Blair: I think there are other issues to do with bottlenecks. The NHS has so many different staff groups, some of who are key for diagnostics. Professor Black has already made a crucial point about the use of scanners which are crucial for this. Whilst overall you can see big increases in staff, we have had additional scanners, but we do not have enough staff to use them. That has a negative effect on productivity, spending more on capital but not getting commensurate output from it. There are quite fundamental strategic issues if you want to look at productivity and improve it and say where are the bottlenecks in the NHS now, in five years time, and how can we plan for them. Diagnostics is a crucial area. How do we incentivise people to introduce skill mix faster? There are assistant practitioners being introduced, an excellent role, very useful, and yet I would argue that the pace of innovation is too slow for our needs. It is predictably slow because that is what happens when something new is introduced. I would argue that we need to think what is important, what do we need to happen, and what can we do to incentivise those service managers who do new and difficult things.

Q346 Dr Naysmith: Do you think what is missing are incentives to do it?
Mr Blair: In that particular example, yes, because it was very well project-managed that assistant radiographer programme nationally and there was money invested in education and training. I would argue that for a busy service manager it might be interesting to wait and see what their colleagues down the road do and how successful it is. Why should somebody dive in straight away if they are very busy. We should reward them by some means of additional monies for training, development, or to spend on the staff appropriately to attend conferences so that people see some rewards if we want to get people to do more. I do not necessary mean money in their pockets, I mean money for their clinical areas.
Professor Dame Carol Black: 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. People are so busy trying to meet the workload they have that it seems the easiest thing, I suspect, to say if we employ another person that we will send another X patients through the system. Of course that is not the best way to think about it.

When the European Working Time Directive came upon us, what people did was employ more doctors because that is what we had to do, but that did not give much time for constructive thinking about anything else.

Q347 Dr Naysmith: That leads on to what was going to be my next question. Have there been other changes since 1999 which have had an effect on productivity? The European Working Time Directive could have had the effect of making the existing workforce work shorter hours but more effectively but you say we just employed more doctors.
Professor Dame Carol Black: We simply had to. Our doctors in training really deliver a huge amount of service. When you did the calculations if we literally did not employ more pairs of hands you would not have been able to fill the rotas. You would not have had human beings to do 24 hours a day. It was not a question of those people working smarter.

Q348 Dr Naysmith: With the existing workforce and the additional ones that you needed, the numbers overall could have been reduced if we had the existing ones to work smarter.
Professor Dame Carol Black: You still have to cover. Maybe what they do within the hours they are there we could say could they work smarter, but it is a fact of life that to keep patients safe you are going to have to have an adequate level of cover. We are just about down to the bare bones now. We could not really reduce night cover medically any further.

Q349 Dr Naysmith: There has to be a minimum.
Professor Dame Carol Black: Most hospitals have worked very hard to try and meet the European Working Time Directive and have pared down their night cover to a considerable degree.

Q350 Dr Naysmith: My final question was going to be something slightly different but it comes in now quite well. When we were in California we had a session with Bob Brook, one of the directors of RAND Health, a thinking out of the box organisation, coming up with lots of interesting suggestions which I could put to you now. He suggested where some things could be done more cost effectively. For example, not everybody who was performing cataract surgery had to be a fully qualified surgeon, and you could do this kind of thing using highly trained technicians but not necessarily people who had gone through full medical and surgical training, and probably ophthalmological training as well. That is very much out of the mainstream thinking but it is a possibility. It is a very routine thing and you can learn to do it. Things like reading mammograms which do not require full medical training, could some of the things that radiologists currently do be outsourced to areas in different parts of the world where they do a mechanical read and send back the reports? Obviously this is looking very much into the future, but are things like that not considered rather than just employing more doctors?
Professor Dame Carol Black: I hesitate to comment about surgery so I am not going to offer you a comment on cataract surgery, but if I look into a world I know much better, physicianly medicine, there are many things that people other than doctors could do. We know that and we are fully supportive of extended roles of medical care practitioners. In fact, our College, along with the general practitioners and the University of Birmingham, has written the curriculum for the medical care practitioners for the Department of Health so we do not have a problem with that. People can work to protocols, so if this is a protocol driven exercise, which you are implying surgery is, that is fine, but when you train a doctor you do have excess knowledge. You have that knowledge which you only use may be 10% to 15% of your time but my goodness is that valuable when the difficult cataract comes up or the difficult mammogram. I would suspect your family, as much as for mine, would like to know that the person looking at that mammogram would be able to cope with the 15% when you need the extra knowledge. It is a way to go to a certain extent but you have to be very sure that you do not disadvantage a patient by reducing that extra knowledge which, in any profession, you get but you do not use all the time. You should not underestimate the value of that.

Q351 Dr Naysmith: Dr Brook was advocating it, not necessarily me. How about the other two in the context of what has happened since 1999?
Dr Bloor: Professor Brook has some fascinating ideas. There is evidence that some of these tasks can be done by other individuals. There has been a recent large trial of nurse endoscopy which demonstrates that nurses can do most of the endoscopies that are within their protocol. There are complicated ones and that is where you need a doctor, and there are also training issues which Dame Carol can comment on in a more informed way. There are some tasks that can be done by people other than doctors. The American evidence is quite contradictory on this. A lot of the time what they call non-physician clinicians, people who are not doctors, are brought in and can do tasks, can see patients and do it well but they tend to operate as complements to doctors rather than as substitutes. 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 important to note that certainly from research evidence they are often operating as complements and not necessarily as substitutes.

Q352 Dr Naysmith: They could theoretically increase the throughput if what they are doing is hanging around waiting for the occasional emergency.
Dr Bloor: I am sure they could.
Mr Blair: I very much like your international approach rather than saying certain things are happening very dramatically how can we respond. There are sometimes changes in response to crisis measures. It is fascinating looking at the States

where nurse anaesthetists have had a much more advanced role than they have had in England for something like 25 or 30 years, and the question is would that be useful to introduce here. I am surprised that that sort of thinking does not take place a lot more often. I know when German operating teams came to Britain there was real consternation that they have fewer roles. Quite often it was the consultant, another skill mix, that had a wider role which meant that you had fewer workers. They had expensive people, fewer of them, but doing more things. I would see more the point about there is lots we can learn from other countries, they have done certain things that we have not for 20 or 30 years, let us evaluate to see to what extent we can bring that to Britain.

Professor Dame Carol Black: Could I make one correction? We have nurse anaesthetists.

Mr Blair: But to the sort of standards that the Americans work, which is virtually on a par with consultant anaesthetists. It is very much more advanced practice. I did not make that point well enough. We do have them but in Britain it is a much more junior role compared to America. Thank you for that correction.

Dr Bloor: It is important to target your most expensive resources, and in the NHS that is our doctors, our consultants and our GPs. It is important to target those resources where they are needed most, and if there are some of these tasks that can be done by other people then that might be more efficient but it is not necessarily going to save money.

Q353 Dr Naysmith: Do you think the Royal Colleges are obstructing developments in this kind of area?

Professor Dame Carol Black: Emphatically no, certainly not in the last four years. If you think about our workforce unit and the work that we have done, we have provided figures, and very useful figures, to the Department for many years. We have worked in very close collaboration with them on the workforce requirements within our 28 specialities. We have always tried to be reasonable there and to work it out and we now have a very good relationship. The fact that they use our figures would indicate that they do have faith in them and believe in them. We have, over the years, had an increasingly more efficient workforce unit. As far as medical care practitioners or extended roles, the interest really started in the Royal College of Physicians under my predecessor, Sir George Alberti, because it was during his time that we had our first Working Party on skill mix. We have been very supportive of skill mix. What we are not supportive of, and I would indeed hope you would not be supportive of, is having a lot of additional practitioners who do not work to national standards. You require that your doctors are all trained to national standards, that we have competencies which are assessed and then we have continuing professional development. The only caveat we would put to extended roles is that it ought to be on a national basis so you can move anywhere in the country with those qualifications. You would like a medically qualified person to have competencies against which you would be assessed, and presumably in some ways you would be revalidated. That is just one more example that there has been a change. I would not like to tell you that 25 years ago perhaps there would have been such an open door to these changes, but I think we have been very welcoming. All our specialities, for example endoscopy and gastroenterologists, have worked very constructively with nurse-led endoscopy. Certainly in my own speciality we have physiotherapy-led spinal clinics and nurse-led clinics. If you look at any of the medical Royal Colleges they have all been endeavouring to embrace this.

Q354 Dr Naysmith: Some people would suggest some of your fellow college presidents have been less progressive in this area than you have. I am sure you will not want to comment on that.

Professor Dame Carol Black: Of course it is variable, and some people find it more difficult to change than others and have memberships and fellowships whose views they have to consider. We have all been moving down a road, some of us faster than others.

Dr Naysmith: We now have thoracic surgeons results on the internet.

Q355 Chairman: There has been a debate around areas like the limitation of types of surgery in treatment centres in terms if you only have one or two joints, as opposed to three, four, five, six or seven joints. The profession has had comments about that. Not that every surgeon has to be all singing all dancing, but I know in terms of the potential changes for training there has been a heavy debate that should not happen and we should not restrict. Would you agree with that in general terms, I do not mean in any specific area?

Professor Dame Carol Black: You mean the work that could be done within an ISTC?

Q356 Chairman: Yes, in the sense that some colleges have commented that it is restrictive in terms of what they can and cannot do because you are looking at probably one or perhaps two knee joints and that is it, whereas in quite a lot of orthopaedic surgery you have a wider choice than what is in treatment centres. Do you think that has been an issue?

Professor Dame Carol Black: I do not honestly think I have enough information to give you a considered answer. It has not been something that has been in the forefront of my own college. What we would feel about Independent Treatment Centres is we would like the people who work in them to be appropriately qualified and perhaps rotate through the units in the NHS. As physicians if we develop ISTCs for gastroenterology or diabetology, it would be to everybody's advantage, especially if they are going to be teaching ISTCs, that those people working in the ISTCs could rotate through the NHS hospital. It would better collaboration and very reassuring to the doctors who work within the NHS. It would be a possible way to go that might improve some of the fears and worries that are around.

Chairman: That is probably for another inquiry. I will move on to the David.

Q357 Mr Amess: I am not going to ask Mr Blair if you are comfortable with your name, or if you are the result of a glorious union between George Bush and Tony Blair, and ask you about the collection and use of information about productivity. You said it needs to be improved, could you expand on that and tell us what it is you want to collect?
Mr Blair: My perspective on a national level is that we must improve quality indicators to fully engage consultants. For it to work, it has to be real for clinicians at different levels. For instance, a radiologist would have some different indicators or measures for him or her than there would be for a surgeon. All that sort of thing needs to be thought through. The other thing that needs to support that information, information is only useful if people use it. What I was wondering is at what point does a nurse, a doctor or a physiotherapist enter a discussion like this about working practices and working smarter. There are all sorts of tools and techniques that can be used. Where do they learn that? When do they learn that? I am not at all clear how that happens, I would argue that for information to be really effective that needs to be underpinned.

Q358 Mr Amess: Do NHS organisations tend to measure activity rather than productivity? Is there any evidence of this trend?
Mr Blair: The honest answer is it varies enormously. The NHS has suffered very badly from old information systems that do not talk to each, produced by different functions at different timescales. The information side is not well resourced, so if there is any time for economies because those are the sort of areas that are very vulnerable. Perhaps that is an issue to put to you. Some analytical staff could easily be called men in suits, or women, but they 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. We need to have a debate where there is more local investment in making information work for the clinicians and give them information, less data, less frequently, but something which they have been involved in, their colleges have been involved in the various measures, because they will differ.

Q359 Mr Amess: We will certainly reflect on the advice you are giving us. Finally, Hospital Episode Statistics (HES), how useful are they in measuring productivity or is it all a waste of time?
Dr Bloor: Hospital Episode Statistics are an administrative data set. They are a routinely collected data set about patient episodes. They were not designed to measure doctor productivity or productivity of the health workforce at all. They are far from ideal as a measure of productivity but I think that they do have a role. 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. We can get very tied up in quality measures and in trying to find an ideal measure of productivity that adequately takes into account patient case notes and quality of care. We can get paralysed by that. I would argue that there is a role, and we have done some of this recently at York for the Department of Health, to share information about crude activity levels adjusted where we can for differences in patient case mix. Despite its inadequacies, and there are many, it can act as a catalyst for developing those better indicators. Until we share information, until we use information, there is not the incentive to make it better. I would argue that Hospital Episodes Statistics does have a role in producing something that is better than nothing. I will expand on that if there is more time.
Professor Dame Carol Black: I would say that as far as HES data is concerned one of the things we have tried to do for clinicians through our Informatics unit, which is in Swansea, is to encourage them to use that data. They can come and we will help them burrow down into their own data. We do bear in mind that it does not do out-patient work, it does not tell you anything about the telephone calls a doctor makes, anything about management, anything about all our other activities, but I think clinicians do need to learn how to use what we have got. We have had increasingly better uptake. People have learnt quite a lot about themselves when they have burrowed down into this data. It is what we have at the moment but we would like to see it made much more sophisticated and that is what is needed.
Dr Bloor: The out-patient data is developing and it is in process. I think Dame Carol's college has been leading this question of clinicians looking at their own data, validating their own data and beginning to use it. That can only be a benefit.

Q360 Dr Naysmith: Following up on this Hospital Episode Statistics, no matter how crude it is if you use it to measure consultant activity you find huge variations between the amount of "work" that is reported by using that statistic between different consultants. Why does that happen? If it is as crude as that and not of any use, then we should not use. It must be telling us something.
Dr Bloor: Yes, it does, but it is a very partial picture. At the moment the distributions that we have produced have been on in-patient episodes not including out-patients and not including any real measures of quality or outcome. That is where we really need to focus our efforts in developing better patient outcome measures. There is huge variation. Some of that can be explained, some of that can explained by differences in patients and case mix. Severity of patients differs and I do not think that is always adequately adjusted for. The only adjustment we could make was by HRG and tariffs which is an imperfect adjustment for case mix. There are differences in the consultants, their age, their gender, their contracts, their other interests, their other responsibilities, they might be medical directors, they might be clinical leads, they might be teachers and trainers, they might be researchers. There are differences at consultant levels and there

are differences between Trusts, and perhaps the access to operating theatres might create differences in productivity.

Q361 Dr Naysmith: Do you think it is misleading?
Dr Bloor: No, it is a basis for discussion.

Q362 Dr Naysmith: Between whom?
Dr Bloor: I would not use it as a performance measure, but I would use it if I was a medical director of a Trust. I would use it to have a conversation with my consultants around job planning and appraisal. If there are bottlenecks that are being created that limit consultant productivity in some area, then that would be discussed and hopefully resolved. I would use it if I was involved in job plans and appraisals in that way. I might even use it in clinical excellence awards.

Q363 Dr Naysmith: You could use it to measure and theoretically increase productivity as a partial measure?
Dr Bloor: You could use it as a basis for discussion. I do not think it is an overall measure of performance. It is a very partial picture but it does give some transparency.

Q364 Dr Naysmith: How do the discussions you are talking about begin? "Dr So-and-so, it looks as if you are not doing as many episodes of activity as someone further along. Can you explain to me why?"
Dr Bloor: Yes. There may well be good reasons why Dr So-and-so is not doing as many episodes and it might be that he is a clinical lead or medical director or something like that.

Q365 Dr Naysmith: Presumably the management would know that?
Dr Bloor: Yes. If, for example, you have a group of ophthalmologists and they are all doing a relatively similar amount of episodes per year. If you are then faced with a national distribution that puts all of those in the lower quartile and says that in other hospitals other consultants are doing twice as many episodes per year, that is a reasonable question for a manager or a medical director to ask what is creating these episodes.

Q366 Dr Naysmith: It is probably useful for that purpose as well, comparing between Trusts.
Dr Bloor: Yes.
Professor Dame Carol Black: To add to that and give you a very practical example, if in a Trust where you have surgeons who do transplant surgery or highly complicated surgery where there may be quite a lot of complications post-surgery, the people who look after those complications, because they are usually metabolic, will be the physicians. You might in a hospital like that find, although it is never recorded, your physicians spend all day keeping "Mr Smith" alive and well post-surgery from medical complications but that is never recorded anywhere. That doctor has actually spent that day interacting with and on behalf of their surgical colleagues. You have to know what is the hospital case mix. What is it doing? What might its doctors be asked to do that is not recorded through the data that we do collect? It is about using this data intelligently.

Q367 Dr Naysmith: Is that why the impression has got around in some quarters that the medical profession is resisting this kind of productivity measure?
Professor Dame Carol Black: The medical profession does not resist data collected appropriately, in which let us hope they have had some say in what is being collected, if it is related to outcome. Doctors are quite hungry for that sort of data and they certainly are prepared to look at that. They have been quite resistant in some cases to look at HES data, but it depends how you are going to use this HES data. You have to use it intelligently and appropriately and know what its limitations are.

Q368 Dr Naysmith: Is there any indication that this resistance is likely to increase? Is the situation getting better, in other words?
Professor Dame Carol Black: I think if we improved our quality of data, it would certainly get better. What frustrates a lot of doctors at the moment is this hoped-for improvement in IT. We would like to get there and we would like to be able to have this data as that would make a difference to what we could look at and what we could do.

Q369 Chairman: I have a question for Mr Blair. In your submission, you commented on the "complete lack of clarity regarding who is responsible for trying to improve productivity", and you recommend that the NHS trusts should have a dedicated lead for productivity. How would you see this role working and is not productivity, if not a matter for all the workforce in any institution, certainly a matter for the managers of the workforce?
Mr Blair: Certainly it is a matter for managers, but I think it has not had an adequate focus and I think many of your questions really point to that, that some organisations were historically well resourced, others were poorly resourced and resource in the past was purely incremental, so there were no rewards for improving productivity historically. I think there needs to be more focus on it. I think it is for all organisations to try and answer that question and come up with their own solution. You are quite right that it would vary locally, but my sense is that productivity does not just include financial measures, "How are we doing financially?", but there is a whole wider range of issues and going on to things like hearts and minds, that brings in working practices, it brings in human resources. I think it goes back to what we were hearing earlier about silo mentality and I think there needs to be a productivity group. I think that would be a better way to develop that idea which somebody convenes and is responsible for with all the various inputs. I do not see examples of that, although admittedly some trusts perform very well. When I circulated my paper, one wrote back to me saying, "Oh, we've done this, George", so I do not want to imply that

there are not examples of very good practice, but I think a lot more could be done to pull together a whole range of people to look at this in a more consistent way across an organisation.

Q370 Chairman: Perhaps I could ask the other two witnesses, do you think we should have dedicated people in NHS organisations looking at productivity or should it be managers having time to do this, as it were?
Professor Dame Carol Black: My personal view is that you have got the people there who should be deeply involved with this. You have got clinical directors, you have got clinical leads, you will have senior nurses and you will have managers, and really if you put another person in there, you take the responsibility away, I think, from the people who should be deeply concerned about productivity, so I would like it to be the people who are delivering the care. Of course that does require time and that might be a factor, but again if we had better data, if Connecting for Health was working well, then that would again help.
Dr Bloor: I am inclined to agree with Dame Carol on this. I think if you have a person who is director of productivity or whatever, it might feel like it is their job to deal with productivity and not everybody else's. I would be inclined to give it to the medical director.

Q371 Chairman: We have been taking evidence sort of in this area and a number of written submissions we have had to the inquiry commented on the lack of integration between financial activity and workforce planning in the NHS. Indeed in one of the earlier sessions we had about this was this issue about what has effectively been the over-recruitment certainly beyond targets that were set and now there are the problems that we have in some areas of NHS organisations with over-expending, as it were. Whether these are related or not, we will be looking into at a later stage. Do you think that improving productivity really should be a way of helping to integrate this sort of planning process of workforce planning and the economic activity in institutions as well?
Dr Bloor: Yes, I think it should actually. I think it should certainly be integrated into the workforce planning, that productivity should be an integral part of workforce planning. I guess it is particularly obvious now that workforce planning and forecasting and financial planning and forecasting have not necessarily been done together when we have got a finance squeeze and also people coming out of medical school and business school and those expansions in the workforce have been substantial, so it has perhaps focused the mind on that mismatch, but yes, I think more attention to productivity, more integration of productivity into workforce planning should help to address that.
Professor Dame Carol Black: I think had we taken it from the point of view of a pathway of care for a patient and said, "If you have a certain condition, what sort of health intervention do you need? What kind of workforce do you need to create? Do you need a nurse, a physiotherapist, a doctor? What do you need", we might then have been able to start to think together about the shape of the workforce. Rather, we have increased nurses, physiotherapists and doctors, but we never said, "What do you require along a pathway of care?" and I think that would have been a much better way to have approached it. Then we could have employed the workforce that, as far as we can see, and it is always difficult to see what you are going to need 10 years down the road, but we could have surely made it more appropriate to what the pathway indicated. I think we did not do any of that thinking in any of that planning.
Mr Blair: I would like to come in about the planning process, my experience of previous local delivery planning processes. We get central guidance from the Department, there is a finance bit, an activity bit and a workforce bit and there is this sense that they are experts providing for their needs. Then it comes at strategic health authority level and they think, "How can we pull this together? How can we make this meaningful and easier for our trusts to contribute to?" and then each of them will try to come up with some sort of approach and some produce quite good spreadsheets and then they cascade that down. Then you get somebody in finance usually, somebody looking on the service side and somebody in the workforce all with their own spreadsheets, all trying to communicate. I have had quite a lot of experience of budgets now being cut for whatever reason, so finance reduce their figures, but the message has not gone through to HR because it is done in such a fragmented way that that particular trust passes on to the strategic health authority and the Department the demand for staff that even then it cannot afford, so that whole planning process lacks integration all the way through. I know that there have been attempts to change it, but I think we need a lot smarter thinking. It is very easy to write software nowadays where you can feed information in, and I think what is necessary is for them to be planning software where, if you have got this money, you reduce the budget and, therefore, you have got to reduce the staff accordingly and you cannot just send effectively three different submissions stapled together.

Q372 Chairman: We had one submission to this inquiry which said that the alignment between workforce and financial planning was "woeful". I assume from what you have said, Mr Blair, that you would agree with that?
Mr Blair: Yes.

Q373 Chairman: Not in all cases obviously.
Mr Blair: That is right, but there are too many cases of that, yes.

Q374 Dr Taylor: Going back to improving productivity, Carol, you said that the people on the ground who do this are the clinical directors and the clinical leads. How well do you think they are prepared for this job?

Professor Dame Carol Black: I would have hoped that somebody who takes on the role now of the clinical director, a medical director or a clinical lead would certainly have got some of the necessary training to be able to think and do this. I think it is about sitting down together. I do not think there is magic in this. If you think of productivity as quality as well as just efficiency, then I think you will engage doctors, so I think it is about getting people to work together.

Q375 Dr Taylor: One thing, I think, some of us were quite impressed with in California where we have been is that they pick out what they call 'emerging medical leaders' early on and actually train them. Are we actually doing any formal training in medical management because, I quite agree with you, in my day you picked it up as you were going along, but I am not sure that is the best way to do it?
Professor Dame Carol Black: That is an exceedingly good question and it is something that we have all been very aware has been missing in the training of the average doctor. I think, for example, BAMM has done a very good job of training at the level of people who are committed—

Q376 Dr Taylor: The British Association of—
Professor Dame Carol Black: Yes, the British Association of Medical Managers, when people have committed to becoming a medical director or a clinical director and they are already down that road, but what we have not been good at, and it is now changing, is how you get into both undergraduate and postgraduate education the skills that will allow you to be a clinical leader and to have medical management skills so that this is spread much more across, I would not say all consultants, but that you are getting this ability into the consultant body. There is the emerging leaders network which has just been set up in the Department of Health which is now seeking to identify such people and we have all been asked to offer names, so there is a young emerging leaders network, there is work from the NHS Institute for Improvement and Innovation with the Academy of Royal Colleges to really now start getting programmes out there. It is perhaps a bit late in the day and we should have done it earlier, but it is—

Q377 Dr Taylor: But it is coming.
Professor Dame Carol Black: We have had a very good programme with middle managers and young consultants going for the last year in which they have done problem-solving together. They have come from the same trust, the clinician has identified the manager and together they have had to bring a problem that needed a solution, so they had to do some systems reform. It has been actually riveting in showing how people can work together and they have increased productivity in each of those projects. There was, almost without exception, increased productivity if you put quality into that, so I think a lot is happening now.

Q378 Dr Taylor: Will this help to cut down the barriers between the silos because this is one of the awful things, that there are so many barriers?
Professor Dame Carol Black: Yes.

Q379 Dr Taylor: Obviously clinical directors and doctors in management have got to work very closely with managers. Do you think central targets have driven a split between managers and doctors where they contrast? I think it was Dr Fielden who said that doctors and managers would work well together as long as the aims were the same. Have government targets tended to drive these apart?
Professor Dame Carol Black: Well, quite a few of those targets would be things that a lot of doctors would think were not unreasonable. We might not have designed them in quite the same way and we might have wished to modify them, but I think managers and doctors do have the same aims which are to improve the care for the patients in their institutions. I think managers are under quite different constraints from the centre and I think it adds tension, but one would hope it might enable doctors and managers to understand each other better and perhaps to be able to work together more effectively.

Q380 Dr Taylor: Coming back to quality, which is what we all desperately need, how should data relating to quality and to outcomes be collected? Have any of you any ideas?
Professor Dame Carol Black: Could I just give you two examples of perhaps the way it has been collected through the Royal College in the national stroke audit and the myocardial infarction audit, both of which were national audits set up by the Royal College's Evaluation Unit. The important thing about those audits was that they involved clinicians right from the beginning. They helped design the programme, they fed their own data in, they knew the data were safe and they were going to be compared with each other, but you had managerial buy-in because 100% of the acute hospitals in this country participate, so you had hospital buy-in, you had doctor buy-in, they could see where they were and nobody wants to be bottom of the list. Therefore, I think you can do it effectively as long as you plan it properly and it is on a topic that people think to be important. Improving door-to-needle time improves mortality, so no doctor is not going to want to do an audit that actually does that, but it is getting it aligned to appropriate patient outcomes.
Dr Bloor: I think there are some really interesting developments in this kind of outcome measurement within individual specialties, so, as Dame Carol mentioned the myocardial infarction audit, there are also joint registers and that kind of thing and cancer registers that are developing lots of quite detailed information about patient outcome, but within clinical specialties. What I would like to see in addition to that is something generic that we can use across specialties, something like EQ5D or SF36, one of these measures—

Q381 Dr Taylor: Help! You are going to have to expand on that.
Dr Bloor: I am sorry, it is a generic measure of quality of life. EQ5D is a simple five-question scale basically asking how you are with five very simple questions and it has a kind of thermometer where you can locate your own state of health on one day. It has been used across clinical trials in all kinds of different areas, but it has not been used to routinely measure how patients are doing in the NHS. A different quality-of-life measure, SF36, is one developed by the RAND Corporation, and I believe you visited them recently, and that has been used in BUPA as part of their everyday routine data collection in patients, so they give patients these questionnaires before they are admitted and then again six months later and they see whether there is a difference; they see essentially whether patients are feeling better six months after their operations. It is not rocket science. I think we could add that level. I think the bottom-up development of real detailed clinical measures is essential, but I would quite like to see that generic measure of simple health, how is a patient feeling, on top of that.

Q382 Dr Taylor: So the best measure of outcome is to ask somebody how they are?
Dr Bloor: Yes.
Mr Blair: I do not have anything to add to that. There were some good answers there.

Q383 Charlotte Atkins: We have heard that workforce planning in the NHS has traditionally focused just on measuring and controlling staff numbers, and that is what everyone tends to focus on whether they are going up or going down, so how do we get the NHS instead to focus on the whole issue of productivity and closer links between the workforce and financial planning because it seems to be woefully lacking at the moment?
Mr Blair: I think there is quite a trick with regard to finance people. I think there would be real value in getting finance people to have a great understanding of the workforce issues. I have been involved a huge amount in workforce planning training and training HR people and some of them are not sufficiently networked in with finance people and what I thought was that we have not been thinking, I would say, widely enough, so broadening finance thinking with regards to the workforce, because that is where most of the money is, would be incredibly useful, so that would be one thing I would suggest, a key target audience.

Q384 Charlotte Atkins: It seems amazing to me that it has not happened already. Given that the NHS spending is largely about employing staff, I would have thought that the two were so intimately involved and connected that you could not do financial planning without knowing exactly what the workforce implications were.
Mr Blair: Well, if that were so, how come there is the issue I have presented with the scanners, that you have scanners which are switched off at five o'clock and the finance director is quite happy to sign off, "Yes, we need more"? I am not saying that they are not needed further down the track, I am not saying that we are doing well nationally compared with other countries, but clearly there is a lack of think-through and particularly an understanding of where the bottlenecks are in the hospital. I think it goes back to this silo thinking and I think that probably is one of the issues which is again coming up and hitting us in the face.

Q385 Charlotte Atkins: Does it not say something about the quality of our financial planning within the NHS when they are just turning off a scanner at five o'clock and then thinking about needing more scanners because they have got several which they have turned off at five o'clock?
Mr Blair: I am wondering whether that is further down the system and that the people in finance are quite removed and will not really know much about clinical things, so I think the NHS is really like a sort of vast old clock with lots of different cogs which do not always mesh in with each other and what are sensible decisions at one point. For instance, if you are the manager of a radiography department and all of a sudden you are offered a new piece of equipment and you know that next year it will not be on offer, you are going to say yes, so that is a sensible decision for that manager, but it is not necessarily sensible for the whole NHS or perhaps for the finance of that hospital to do so, so what we are left with are people in a fragmented system making what, in their individual cases, are sensible decisions, but collectively they do not add up. It is that collectivity, how to make the NHS, even within trusts, a more holistic sort of organisation which is key.

Q386 Charlotte Atkins: So is this happening anywhere? Are there changes anywhere which are approximating to what you are saying needs to be done?
Mr Blair: Please, with something as large as the NHS there are all sorts of areas of excellence. I have come across a few, but I cannot sit here and tell you the scale of what the good practice is and where it is.

Q387 Charlotte Atkins: Maybe you could let us know because I think we obviously ought to be looking at good practice and, from what you are saying, it does not seem to be hugely prevalent.
Mr Blair: Let us say, there are too many examples where it is clearly not there. I think that might be a better way of putting it.
Dr Bloor: Just to go back to your question about the disjointedness of financial and workforce planning, I think it is partly just timescale. We make a decision to increase medical school intake in October and we are making a decision to increase the medical workforce in 10 or 12 years' time and the financial plans are not that long, so there is a problem there. I think that Dame Carol's earlier example about looking at pathways of care and integrating workforce planning, not looking at the medical workforce on its own, not looking at the nursing workforce on its own, that really needs to happen and there are examples of this. The Australian

Medical Workforce Advisory Committee and I believe the Canadian systems as well have made much more of an effort to integrate their overall workforce planning techniques, although sometimes they still take out medics as a separate case which I think we probably need to stop doing.

Q388 Charlotte Atkins: Well, that is one of the issues, is it not, Dame Carol, that the medics often are taken out as a special case and do not see themselves as part of the overall workforce in the NHS? Would they be willing to embrace this more inclusive change?

Professor Dame Carol Black: I think that you now do see examples and I think you can see it in some of the Royal Colleges in the sense that they are embracing medical care practitioners and they are bringing into their colleges either through associateships or affiliateships non-medically qualified colleagues. I think just one other thing perhaps to put into the equation somewhere is that we are feminising certainly the medical workforce and that does have an effect on numbers and how it is going to pan out in the future. Remember, even though you may have numbers, they are not all whole-time equivalents, so you see a large increase in the number of GPs, but how many are whole-time equivalents? There are lots of different factors and perhaps the one thing we have really been thinking about recently is how flexible we could make the physician workforce. I cannot talk for other specialties, but we really have to try and make it as flexible as possible because we do not know really what the needs necessarily are going to be. We can say we are all going to live longer, we are going to have more chronic disease, we think it is going to look like this and we need to work with colleagues in the community, but we somehow have got to build much more flexibility into the workforce to be able to move laterally, and that is quite a challenge, but one I think we have got to face.

Q389 Charlotte Atkins: Do you think that the medical profession is likely to embrace this flexibility? It has not always been known for its flexibility.

Professor Dame Carol Black: I think you have got to start very early on with the young and try and get them to see the world in perhaps a different way. If you just take planning in the 65 specialties which we have in this country, it is, I think, fairly obvious now that, even if you qualify in medicine and you are guaranteed perhaps your foundation course, you may have to be flexible about doing a specialty that was not your first choice. Years ago you were going to be a neurologist and that is what you went for absolutely 100% and you wanted to work in London. Well, it is quite possible that now you might have to think about perhaps being a geriatrician or a clinical geneticist and you might go and work in Manchester. I think it is that sort of flexibility—

Q390 Charlotte Atkins: Or indeed having more than one specialism. I was talking to a consultant in my own local hospital, North Staffordshire University Hospital, who was pointing out that when you have consultants who are just pure specialists in one field, therefore, you overnight have to employ several consultants to ensure that everything is covered. It seems to me that you are talking about flexibility, but how about the medical profession looking at a range of specialisms rather than just one pure specialism?

Professor Dame Carol Black: Well, we are doing that, for example, with the College of Anaesthetists, the College of Emergency Medicine and the intensivists in how we could devise a much more "composite training" and then the opportunity to work either in the emergency room or you may want to spend some time in the acute admissions ward, you might even wish, as a physician, to be able to spend time on the intensive care ward. Now, this is in these four specialties and it is quite reasonable and easy to start with these. We obviously need to extend that idea and perhaps you might see yourself acquiring an additional competency, so, if you were a respiratory physician, but your trust required a special skill akin to your specialty we may in the future devise competencies that you can acquire post-CCT competencies and that would be another way of extending your skill base and being more flexible.

Q391 Dr Naysmith: A general physician maybe!

Dr Bloor: Well, there are two conflicting trends here, are there not, because you have got this need for flexibility, but you also at the same time have the drive towards sub-specialisation and more and more sub-specialisation where we have two or more orthopaedic surgeons who do not focus on the ankle, and that kind of thing is happening more. I think the sub-specialisation is perhaps limiting the flexibility, and perhaps there is a difference between surgery and medicine, but there seem to be kind of conflicting trends here.

Mr Blair: Picking up the point about the 65 specialties and given the need to plan for that many, without doubt some of those plans will be proved wrong by events. I think the issue is not so much to be surprised by it, but to try to identify that early on. I heard in 2003 about cardiothoracic surgeons and that was just a workforce planner, not somebody involved in medicine, so the word was on the street that that was a problem area and I think we all ought to have a recipe of what we do if there is a specialty with substantial over-supply, what the process is for rapidly retraining people, some sort of accelerated scheme so that it is not as if, "Oh dear! We got it wrong". Well, life is like that for something with so many changes and with the planning over such a long timescale, so I think there is much greater need for contingency planning and also looking at scenarios, looking at the impact of technological change much more widely and advertising that on

the Net, "These are the views of changing technology". That would be very useful to share to involve people like surgical manufacturers of equipment because what they are designing, in three or four years' time people will be using, so there is a great deal of value to be picked up from intelligence from that source as well, so we need a great deal of flexibility and not to regard it as, "Oh, we've got too many of these people. Oh, we've got it wrong". We need to have the flexibility to sort them.

Chairman: Well, could I thank all three of you very much indeed for this session. I suspect it will be next year before you see the outcome of this inquiry, but thank you very much.

Thursday 15 June 2006

Members present:

Mr Kevin Barron, in the Chair

Charlotte Atkins	Dr Doug Naysmith
Mr Ronnie Campbell	Mike Penning
Sandra Gidley	Dr Richard Taylor

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

Q392 Chairman: Good afternoon. Would you like to introduce yourselves?
Ms Norman: I am Alison Norman. I am here as a member of the Board of NHS Employers, but I am also Director of Nursing at Christie Hospital in Manchester.
Dr Mascie-Taylor: I am Hugo Mascie-Taylor; I am also on the Policy Board of NHS Employers. My day job is Medical Director at Leeds Teaching Hospital Trust.
Professor Sibbald: I am Professor Bonnie Sibbald, a professor of health services research with the National Primary Care Research and Development Centre in the University of Manchester.
Ms O'Dea: I am Deborah O'Dea. I am Director of Human Resources and Organisational Development at St Mary's Hospital in Paddington, and I am also President Elect of the HPMA (Healthcare People Management Association).

Q393 Chairman: Once again, welcome. Can I ask a general question to all of you, but I hasten to add that if what you want to say has been said, you do not have to repeat it. Changes to skill mix and the development of new and extended clinical roles such as specialist nurses is currently very fashionable in the National Health Service. Can you tell us why this has happened, and what is the evidence base for these types of changes?
Professor Sibbald: I am happy to comment on this, at least from the perspective of primary care. There are three main drivers of this change. The first is the presumption that one can save costs by using nurses as opposed to physicians. The second is that one can enhance the quality of healthcare by adding specialist nurses and others to physician teams. The third driver is medical workforce shortages, either nationally, regionally or locally.
Ms Norman: I agree with Bonnie, but would add to that. The liberation from the nursing point of view in terms of what nurses traditionally did and what they are now doing came in 1992 when the regulatory body introduced scope of practice which basically enabled nurses to build on the basis of their professional training and education and to go into other roles. Over that period of time there has been a tremendous development, both in terms of specific specialist roles; but also generically, for example the nurse practitioner—those in primary care and those in acute hospitals—who can enable first contact with patients and speed up the process of care and support. Some medical shortfall has driven some change, but, equally, it has been the need to enable patients to get early and efficient access to care, and to ensure that patients get continuity. One of our problems is that in relying on doctors in training to provide much service contribution, you do get discontinuity. A specialist or advanced practitioner nurse within the team can provide sometimes the one bit of consistency that a patient with an illness over a long period of time will get.

Q394 Chairman: Andrew Foster gave evidence to us on 11 May, and he said that redesigning the skill mix will enable us to get higher output or productivity. Do you agree with this, and is there evidence that these changes are cost-effective? I know that Professor Sibbald has a view about that. Do you agree that it is going to get higher output or productivity?
Dr Mascie-Taylor: I would absolutely agree with the drivers that have been set out to you. Given the drivers, which essentially are the existence of various facts, then they predict the answer to your question, because if it is the only or the best way of doing it, it would have the effect that you are talking about. The danger would be if one undertook skill redesign for less good reason, and then it might not have the desired output. I suppose my point would be that if the employer takes the view that that is the optimum way of achieving a desirable, then it will work. If it is done for other reasons—and there are various other reasons why it might be done—then the outcome is less certain.

Q395 Chairman: Can you give us an example of the reasons—just one?
Dr Mascie-Taylor: Certainly. There is a mix here of employer ambition and professional ambition, and it is necessary, if you want to achieve changes in the skill mix, to have both of those; but sometimes the balance is in favour of professional ambition as opposed to the needs of employers; and the appropriate and correct balance needs to be put into that if the desired effects on productivity and quality are to be had.
Professor Sibbald: The research that we have reviewed in primary care suggests that on most occasions you will not get gains in productivity or reductions in cost. The reason for this is that at least

in the research setting, 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. We also know that without very tough management strategies, when you add a specialised nurse to a physician team in the expectation that the doctor will delegate away elements of that care to the nurse, physicians tend to continue with their previous activities, so the nurse is then as it were doubling the volume of service but not enhancing the efficiency of the service.

Ms Norman: There are other elements obviously around patient quality and patient safety, for example protecting junior doctors particularly from being thrown into the front line in the way that traditionally they were, often in areas where they may not have had the opportunity to gain expertise—and I would cite particularly out-of-hours use of experienced nurses who are often the first port of call for dealing with patient care. In my own hospital, which is a specialist cancer hospital, our out-of-hours nurse practitioners probably are in a significantly better place for the specific cancer problems for patients than the doctors in training who may also be part of that night-time team. Although efficiency and cost-effectiveness has to be important to us, the issues of patient safety and ensuring that people who are not fit for purpose in dealing with those patients' needs are not put in a position where they have to, must equally be important to a concerned employer.

Q396 Sandra Gidley: Is there a flip side to that? As a patient, I would probably want the most experienced person, but it has also been put to us that the situation you are describing actually reduced training opportunities for junior doctors. How do we make sure that doctors have access to training and make sure that there is expertise and safety for the patient?

Ms Norman: You make an important point. In my own place of work we have to undertake a lot of invasive procedures with patients and give them drugs. One of my concerns is that, to be honest, nurses have almost entirely colonised that area of work and do it very well; and it is important that we have to remember that doctors have to be able to understand that too. This is essentially around the practical skills that doctors have. There may be a need to balance the learning needs and protective learning time for doctors in training and their exposure to practice, but in a way that does not expose patients to being practised on, and supported. There may be particular times when that balance is not quite right. I think that within individual hospitals and in discussions with medical trainers you need to ensure that doctors get that exposure as well.

Dr Mascie-Taylor: I agree with that and support it. It goes back to the point I was making, that one needs to decide at the outside what the objective is. Is it quality; is it quantity; is it cost reduction; is it improved training; what exactly is the purpose? The employer needs to drive that and drive it effectively, and then good things can be achieved in a number of those areas although not necessarily all of them. It is perfectly possible, and should be the case, that competent nurses, trained doctors—there is absolutely no reason why doctors cannot learn from people other than doctors. If it is set up in that way it works well. If the training of doctors and indeed any other professional is ignored, it will not work well. It comes from the same point: what is the purpose of this, and how do we set it up in such a way to make it work?

Ms O'Dea: The experience in our trust is that where you involve the clinical professionals, doctors and nurses, senior doctors and nurses, at the coalface, in the redesign of these roles, it works extremely well. If you hand them down and tell them how things are going to change, it tends not to. They take into account that the juniors will need training. I can give you a couple of very good examples. Currently, we have nurse practitioners that take the place of SHOs on the rota. Professor Lesley Regan, who was involved in the design of this, tells me that not only does this vastly improve patient care because of the continuity, but also it assists in teaching the juniors that are still coming through. She is very keen to continue with that practice. Equally, we have nurse practitioners working alongside doctors in the care of TB patients, and the studies have shown that those patients comply with the drug regimes far more when they are seeing the nurse practitioners. It is very difficult to put a cost on that or a saving, in terms of productivity; but there is a very clear benefit in terms of patient care.

Q397 Chairman: The think tank Reform gave evidence to this Committee and they said that the NHS should have more investment in fewer people—and they were talking about a percentage reduction in the workforce; that with the right investment there could be a better National Health Service. Do you think there is a risk that skill mix changes means that we are dumbing down the NHS workforce?

Ms Norman: This is the point that Hugo has made. Dependent on the motivation and the big picture that you are looking at of skill-mix change, it can be enormously enabling as well. It can enable somebody with more advanced or developed skills to be able to devote time to that. Often, those criticisms of the NHS in terms of the people who are non-clinical, who are clerical administrative staff—I see little purpose in one of my highly qualified nursing colleagues doing work that one of our clerical colleagues could do better, in order to enable that nursing colleague to spend time with patients, and managing his or her team of colleagues. Equally, at the other end of the scale, properly trained and qualified assistant practitioners, who can undertake very important aspects of the fundamental care of patients, for example ensuring patients who need assistance with eating are provided with that

assistance, are fundamentally important. It is all about the quality of management and the way that you deploy the art and science of skill mixing.

Q398 Mike Penning: Can we develop a little more the effectiveness of changes. How well do the current workforce planning structures in the NHS encourage work on skill mix and role redesign? The leading part of this is, how could it be improved? Nothing is perfect, so how do we move on from here?
Ms Norman: The way that it can be improved is building on what has worked very well in the past, for example the work of the Modernisation Agency previously, and increasing the new Institute for Innovation and Skills, in supporting good initiatives and enabling other organisations to follow on. That is a key role for NHS employers as well. One of the major criticisms of the NHS is that you have a very good idea in Shrewsbury but do you do it in Stafford?

Q399 Mike Penning: Everybody is re-inventing the wheel, all around the NHS?
Ms Norman: Yes, or, rather more worryingly re-inventing the flat tyre, which can also happen. Often we learn more from people's mistakes than we do from their successes. It is about giving people the tools to undertake the work within their own context and environment, and sometimes the use of drivers. There is no doubt that bringing down access times for patients has been a real driver for change. Sometimes it has felt like quite hard work, but it has been a very good thing in liberating our thinking and our ideas about what essentially is a team endeavour in healthcare. You do need to work with a team to get these ideas into place and working properly.

Q400 Mike Penning: Individual teams in different parts of the NHS, even though they may be doing exactly the same job, are not developing at the same speed; they may be doing very well but there is no continuity throughout the NHS.
Ms Norman: I think there is more than there was because of the work that has gone on, for example, through collaborative projects, in cancer care for example. The cancer collaborative has provided us with a really clear framework, and indeed in terms of measuring our performance in cancer you jolly well need to respond to that toolkit if you are not actually delivering. There is no doubt that there is still work to do. Within organisations you will find some things that are day-to-day working practice, and other teams might be less open to it, so you need to do your own internal work on that.
Dr Mascie-Taylor: Locally, to encourage employers very strongly to look at the most effective way of performing their functions, so support from the centre for local employers, taking on these issues and working with the professions locally. As has already been said, that produces far more ownership and far more likelihood of success than some imposed directive. The difficulty with that is that it produces lack of symmetry, and one has to accept a degree of lack of symmetry if you want to empower local people. The balance is, I think, with empowerment rather than looking for symmetry, which hopefully addresses—

Q401 Mike Penning: Is not the problem with that though that if you do not have symmetry, you increase the postcode lottery in healthcare?
Dr Mascie-Taylor: Yes, there is an absolute balance to be struck—I agree with you. You cannot necessarily always have both. You have to have some of both. I would go for empowering local employers to work with local people, but set a balance, because there is a national role which seems to me about offering examples of good practice to employers and helping them learn from them and providing evidence that they work, that is they achieve that which they set out to achieve, and they do not achieve other things—so to be clear about that. I think that nationally it would be useful for more departmental support explicitly for employers; and, again in that balance, slightly less engagement with individual colleges, which have a vital role in training, education and good-quality service delivery; but they also have another role, which is about the interests of their members.

Q402 Mike Penning: The drivers that Alison was referring to, so a sympathetic driver rather than a target-driven driver.
Dr Mascie-Taylor: Yes, but these are all balances, are they not? I agree with you that we should avoid postcode lotteries when we can, but you have to do this at a local level if it is to work. The trick is to have a fairly light touch from the centre about specifics, and a strong drive from the centre about supporting and enabling employers as opposed to dealing with endless professional bodies and, if you like, picking up too strongly on their vested interests.

Q403 Mike Penning: Is there a light touch coming from the centre?
Dr Mascie-Taylor: It varies.

Q404 Mike Penning: That is a politician's answer!
Dr Mascie-Taylor: This would be the last place for me to blame politicians!
Professor Sibbald: The situation in general practice and primary care outside the acute sector is much more challenging. There is a need to have a clarity of objective as to why you are changing skill mix. This has been said before. It is a solution to a problem, so you need to analyse your problem carefully to know whether a particular skill mix change is right for your organisation—and it may not be. That goes to your point that there needs to be local variation. The second point has to do with good human resources, skills and management, which are not think on the ground in primary care. They are small self-employed businesses generally speaking, and they do not have the kind of input that enables them to make complex skill mix changes to support the process of change very easily. It is difficult for me to see how that can be altered. It needs to be addressed. The third thing that is different about primary care is that often changes in skill mix happen much more

rapidly than in the acute sector, partly because they are small organisations and are less tightly managed and regulated; and that often means that you have employers, employees—nurses in particular—taking on new and expanded roles, without yet having an educational infrastructure to support that change. That is where there needs to be a much more responsive educational system to keep pace, as it were, with the changes going on in that.

Ms O'Dea: I would agree with Dr Matthew Taylor that the important balance here is between the local ownership—without that these things just do not work—and central regulation, I suppose, of how we consider whether these things have worked or not. I have seen some very good practice. South Tees in particular has a very good practice around deciding that things have not worked and stopping them; and I would like to see some more of that. There is good practice from the employers' organisations, their large-scale workforce team, sharing best practice. Within that also we need to ensure that people implement that best practice in the way it was intended, and do not over-egg the jobs that people are not qualified to do. I think that I would recommend that the Institute of Innovation and Improvement and the Employers' Organisation need to set a framework for us around the testing of these jobs, and ensuring the safety of these jobs and that they work. That is where the centre comes in; it is in setting frameworks and doing some education.

Q405 Mike Penning: That is very interesting because it sounds very *ad hoc* as to what best practice is being shared at the moment; so would you say that the NHS is good at piloting these sorts of projects, and are they pulling together the information well enough and distributing it throughout the NHS so that everybody does not re-invent the wheel every five minutes, and so that you can share the best practice in a more sympathetic way rather than moving on, as we discussed, with a postcode lottery system?

Ms O'Dea: It is the "not invented here" syndrome that tends to be the problem, rather than the centre saying, "let us pull this together". It is a need for local ownership, and that is the balance that we have to get right.

Q406 Mike Penning: Where you have got local ownership and somebody is doing it quite well, with best practice and so on—is that being drawn into the centre and then distributed back out correctly, with the correct amount of information; or is it done *ad hoc* throughout the organisation?

Ms O'Dea: I think it is a mixture. In the large-scale workforce team, for example, the alternative support worker has proved very popular and has been a very successful initiative. It has been taken up by NHS employers, and they are supporting local employers in implementing this new role. Those initiatives are excellent. We have to make sure that the others are tried and tested and really do achieve what they set out to achieve in the organisations that are testing them, before we get over-enthusiastic about sharing that practice. We often share it before we have really tested it.

Q407 Mike Penning: Is the funding there to do this, or are you robbing Peter to pay Paul to get this funding? Is the funding coming down from central government to allow you to do that?

Ms O'Dea: There are some national workforce projects that are fully funded to go out and pilot, for example, what we ought to be doing around team-working; what we ought to be doing around the European Working Time Directive. However, local employers will see their own needs and will invest in improvements that they believe benefit their patients and their staff.

Q408 Mike Penning: Many local employers in the NHS are in deficit, so there is quite a difficult decision to be made here, surely, as to whether there is a funding need or not; and if it is left completely up to the individual trust or individual strategic health authority and they are in deficit, it is not going to happen, is it?

Ms O'Dea: As I said, there is a mixture. There are some central initiatives, but there are also local people who want to make changes for the better within their own organisations, and they will continue to find the money to do that if they believe that will improve—

Q409 Mike Penning: I wish they could find it in my part of the world!

Professor Sibbald: You asked about the evidence base for change. As a researcher, my evaluation is that there is a wholly inadequate evidence base to support most skill-mix change—that people for example believe that nurses would save money when substituting general practice; and the evidence base is that that does not happen. My view is– as I would say, as a researcher—that we need more research!

Q410 Mike Penning: More research, more money, of course!

Professor Sibbald: Also more money for the research.

Dr Mascie-Taylor: In terms of mechanisms by which people learn, some of it can usefully be through a national centre, but a great deal of it is horizontal, and some of it is international. There are a number of mechanisms, all of which work in different ways. In terms of evidence base, it is crucially important if we are to convince various groups of professionals of the need to change. Finally on resources, there is resource, but if one were to compare the amount of resource to the resource that drives clinical change, it would be far less. Less resource goes into service change than into clinical change.

Ms Norman: What we need is the opportunity for there to be a framework whereby good practice could be disseminated, and an ability within the organisation to have organisational development resource to bed it in. That is something that traditionally NHS organisations have not been terribly good at. It is something that often gets

squeezed first in times of difficulty. Where it does work, if I could give an illustration—the emphasis that was driven to some degree politically some years ago, around enabling non-medical people to prescribe, which is now coming into play—if you like it was a political idea that was enabled through the NHS system and the strategic health authority. However, it is down to individual organisations to make sure that they have planned how that will be implemented and that they are careful about who goes to do the course, and that they are then able to work in practice. An illustration of how well that can work: we have a consultant in palliative care, a nurse in my organisation, who works closely with the Macmillan community specialist nurses in Manchester. We believe we are getting evidence (a) that because of the prescription of opiates, pain-controlling drugs, by that nurse prescriber fewer patients are having emergency admissions, and less use is being made of our out-of-hours GP locum or on-call systems. That has got to be better for patients. What I would love to be able to do is to have Bonnie come and research this because I do think there is a dearth of research into some of the changes that we are making, and it would be good to be able to demonstrate that.

Q411 Mike Penning: It is quite interesting that you use the analogy of palliative care, which is outside the NHS in most cases. We draw down on them enormously—the Macmillan nurses and the hospice movement in general. It would probably be great to see Bonnie come in and do some analysis on that, to show what is going on.

Ms Norman: The NHS of course does fund it. In terms of Macmillan, they give their name and their money for three years. The name stays but the NHS often, or the individual hospice, picks that up.

Q412 Mr Campbell: When we talk about spreading innovation within the National Health Service, because we have heard in evidence that it is always a bit slow on the take-up when it comes to that sort of line, can we learn anything from the independent sector on innovation? Can they teach you anything? Is there anything there? We are told in evidence that the private sector is better than the NHS at innovation. Do you have any evidence of that?

Dr Mascie-Taylor: I am absolutely not familiar with the evidence that it is better than, but absolutely open to the idea that the private sector innovates well. I would argue that in certain areas the NHS innovates well. I do not see a lot of point in which is better at it. I think they do it differently. What might be really helpful would be for me to look at the freedoms the private sector has to innovate. If one accepts, for the sake of argument, that the private sector innovates well and maybe better, what is it that allows it to do that? I think it is about the fact that it is often in limited areas of business as opposed to global business. It therefore can direct its workforce more appropriately. It is often less constrained. It has a limited area of activity, and far greater managerial freedom. It is less heavily directed, less heavily regulated, and less heavily target-driven. If you accept your thesis that it is good at it or better at it, you have to look at what are the factors that allow it to be good at it or better at it. My view would be that it is about limited rates of activity, greater managerial freedom, and probably less power amongst individual professions and unions.

Ms Norman: We can also learn lessons from the "not-for-profit" sector. If you look at organisations like the Marie Curie Cancer Care and Macmillan, those organisations are very close to what people want and how people are feeling; hence they come forward with services that meet those needs. The fourth point to add to Hugo's very excellent list would be being close to the patient and to the community; and perhaps the NHS has not always been as good at that as it needed to be.

Dr Mascie-Taylor: That is because they often in a necessary but limited area.

Professor Sibbald: I would say that NHS general practices—and the important thing here is that they are independent contractors into the NHS—are some of the best innovators in the world, and they adapt to change extremely quickly. I am thinking here of general practice-based counsellors as an example—mental health counsellors. There were about 12 in the country in 1980; by 1992 a third of general practices had one on site; and by the late 1990s more than 50% of general practices had them on site. The other point I would make is that the extended multi-disciplinary teams in general practice in this country are thought to be the best model by other Western developed countries around the world—so the United States, Australia, Canada, France and New Zealand. They are all looking to our model of care as to the way they want to move in their country.

Q413 Mr Campbell: Will payments by results make it better to get innovation from the Health Service—or is that a tricky question?

Dr Mascie-Taylor: A really tricky question!

Ms Norman: It will if it works.

Dr Mascie-Taylor: You could construct it in such a way that it might. If you are going to use a quasi market system to drive change, the changes which it produces will depend absolutely on the ability of the market-makers to drive change. I do not think any of us know, on this side of the table, quite how that market will be constructed, and therefore in what way it will drive us. We await with interest.

Professor Sibbald: I would say again the difference between the acute and the primary care sector is that payment by results will reward the acute sector for activity and volume, so it is a volume-driven thing. People have an interest in doing more, which is a desirable thing in some respects. In general practice however the payment system there is paid for performance and is about quality of care produced; and that is only a segment of income that is balanced by capitation and other basic fees. That blended payments system, as it is often known, is thought by most academics at least to be the best possible balance in terms of achieving high-volume and high-quality care.

Q414 Dr Naysmith: The Modernisation Agency was scrapped a couple of years ago. We had some evidence here that that might have been a loss. Andrew Foster, for instance, said that the skill mix projects had become more fragmented as a result of the loss of the Modernisation Agency. Do you agree with that?
Ms O'Dea: I think there is a gap that needs to be taken up by organisations like NHS Employers. We have to use the infrastructure that we have now to co-ordinate it in the absence of the Modernisation Agency.

Q415 Dr Naysmith: Do you think it was doing a good job in this area?
Ms O'Dea: I think it raised the profile of these sorts of things across the sector in a way that that profile had not been raised before.

Q416 Dr Naysmith: Do you think you will have to find some other organisation to fill its place, or to do the role that—
Ms O'Dea: I think the needs may be slightly different now, but I think there is still a need for some central framework around some of this, as we have been talking about this morning.

Q417 Dr Naysmith: What has been the impact on the National Practitioner Programme? Do you think it gave the wrong message, that it was not really a priority?
Ms O'Dea: I think that where these innovations were started they have continued. What is really important was that people locally started to think about what was the best way to deliver care. We have a plethora of examples to show that where that continued, it continued very well. It served its purpose extremely well in getting local people to change the way they were practising.

Q418 Dr Naysmith: Dr Mascie-Taylor, do you think it has meant fragmentation and giving the wrong messages—scrapping it?
Dr Mascie-Taylor: I think the Modernisation Agency played a useful role. As I indicated earlier, there are many ways in which people learn, and one of those ways is through a central body, and the Modernisation Agency in part was that. I do not think that is the only way of doing it. I cannot see a great deal of point in getting into a debate about whether it was the right or wrong decision; more important is the need to look to the future and recognise that the centre, the national body, has a role, not the only role, in producing useful change and innovation, and also in producing the research that would support it. How you want to badge that is a secondary question that I would be happy to talk about, although I do not consider myself particularly expert. If, as often appears to be the case, there is a perceived need to change a national organisation, it is sometimes easier for the service if what it does changes, whilst its name does not. What is particularly disruptive is when its name changes and what it does does not!
Ms Norman: The Modernisation Agency was a turn-around team for practice, to help practice be fit for purpose and be able to meet different challenges. We continue to need that kind of supporting service.

Q419 Dr Naysmith: Where is it coming from now?
Ms Norman: As Deborah said, I think NHS employers can help fill that gap. There has been space left, and we need to find ways of filling it. If we need finance turn-around teams, as is happening quite a lot in the service, we also need that kind of support to help us turn around services and to get that spread of good practice. I do believe—I probably would say this, would I not—that NHS employers can help with that, along with some other organisations.

Q420 Dr Naysmith: They have got lots of other NHS employers who have lots of other things to do as well; how can it be made a priority, if it should be a priority?
Ms Norman: I think its priority would be brought about because unless we get service delivery right, we will not manage our finances properly within the Health Service; we will not manage quality properly and we will not manage access properly. Really, it is about modernising the way we do things and ensuring that people are being employed appropriately, both for patient care and also for their own job satisfaction. Sometimes organisations need something outside themselves to assist them with dealing with those issues. Interestingly, we are just spending money on bringing somebody who has got their training in the Modernisation Agency and is now working independently, to come and help us with our radiology waits in our organisation. In times gone by, I suspect that we might have got that service free!

Q421 Dr Naysmith: We also had evidence suggesting that the Modernisation Agency's approach was sometimes too simplistic, and also that it did not involve clinicians enough. Were those two criticisms fair? We are talking about an agency that has now been scrapped, and that is fair enough, but we are learning lessons for the future as well.
Ms O'Dea: We are, but a great deal of good came out of the Modernisation Agency. You have just heard that we are still employing people who were trained by them and a lot of us have received a lot of training and a lot of excellent tools, and took that out into the field. Most of the work that I have ever been involved with, with the Modernisation Agency, gave me tools and attributes to take out and work with our clinicians. At the coalface, I think clinicians have always been involved where projects have been successful. When they are not involved, projects are not.

Q422 Dr Naysmith: Do you agree with that, Ms Norman?
Ms Norman: Yes, I do. Sometimes it is difficult to engage clinicians of any discipline, in something that feels theoretical and abstract. If you can show people

it makes a difference to the lives of their patients and their working lives, that is when you really get hearts and minds.

Q423 Dr Naysmith: So you think that if the agency trained enough evangelists to go out there and spread the word . . .
Ms Norman: There can never be enough evangelists.

Q424 Chairman: Is there any contradiction between national evangelists and local ownership?
Ms Norman: I think it is about a really good franchise, is it not? You sometimes need help outside of yourself, and that is what the external resource can give you. However, you have to have the capability, confidence and desire to drive that locally. You cannot just take a solution from one place and apply it without customising it.

Q425 Chairman: You do not think there has been a reluctance to listen to evangelists, on the basis that "your model does not fit here"? It seems to me that there is no great national plan, although we might have a National Health Service, about how we should run GP practices, because the needs of different communities are so divergent in many instances.
Dr Mascie-Taylor: I do not think I would take the view that all general practices should be run in the same way, because, as you point out, the needs of their populations are very different. Importantly though, general practices, just like secondary services, should be run in a way which benefits the patient as opposed to benefiting the people providing the service. If there is an area here that should be tested, it is what is the function of the organisation, not the need for symmetry, but a need for an absolute focus on the function. Then the form follows that function.

Q426 Dr Taylor: Can I go back to some areas of concern, some of which has been touched on, the first of which is the training of doctors. With the almost universal use of phlebotomist at the moment do medical students get practice with taking blood during their training?
Dr Mascie-Taylor: They do.

Q427 Dr Taylor: Enough?
Dr Mascie-Taylor: Well, is it ever enough? They do get that practice, and indeed doctors in training get that practice. I have to say that the amount of practice that I had as a junior doctor far exceeded my requirements. There is a difference here between that which is necessary for training and that which is necessary to provide a service. The important point is, let us discriminate between the two and let us not use people for service where it is inappropriate, but equally let us recognise that they have to be trained. If you are clear about the purpose, you come to the right answer.

Q428 Dr Taylor: As far as putting up drips, do they still get enough practice with that, even though the nurses are doing most of that now?
Dr Mascie-Taylor: In part, the answer to your question is that nurses are doing most of it. The difficulty I think is that with the particular patient where the nurse practitioner may fail—what was then inappropriate is to let the doctors do it when they are less skilled at it. I have absolutely no difficulty with nurses or indeed any other group of people becoming skilled in areas where traditionally doctors were skilled. My view is that if it is a particularly difficult access problem then you might need to call on the skills of a particularly skilled doctor, for example an anaesthetist, rather than making the assumption that any doctor can do it simply because they happen to be a doctor.

Q429 Dr Taylor: That is absolutely right. One of the first examples of skills mix, which was absolutely crucial, was the introduction of ward clerks, which took away paperwork from both doctors and nurses. With deficits will there be a threat to this sort of post?
Ms Norman: One can never predict what pressure might do to people's common sense, but I would certainly resist that in my organisation, should it be the case. I would hope NHS employers can assist organisations that are in difficulty, and that we could manage what may, I hope, be a short-term financial difficulty well, so that we do not throw babies out with the bathwater or do things that cost the organisation more money or cause dysfunction.

Q430 Dr Taylor: You would also be protecting nursing assistants, the people who feed the patients who need to be fed.
Ms Norman: I think what one has to have at the heart of the whole thing is where the patient experience comes in and the degree to which organisations can be as concerned about evidence of good patient experience as they are about the financial bottom line. That has always been a hard balance to achieve. For organisations which aspire to be successful foundation trusts, for example, they will not prosper if the evidence about patient experience—and we have national surveys now that can tell us if people do well or not—if those surveys suggest people are doing badly, one of the questions in the national survey is, for example, whether you got the help you needed with being fed. If you find yourself falling to the bottom 20%, I would hope the commissioners of your services would take an interest, and, more importantly, that you would be interested in dealing with that.

Q431 Dr Taylor: Can you expand a little bit about nurse practitioners improving continuity of care? One of the complaints I get consistently, particularly about in-patients, is because of shift systems and continuity of care goes by the board. Are nurse practitioners in a position in hospitals to assist continuity of care?
Ms Norman: I think they are. We have a system which is very common in many hospitals, where you have a group of colleagues who work out of hours, supporting the medical teams, forming the first line of support. They will be on duty for a period of time

during the week, and some patients will see them quite frequently. Sometimes you may consider the patient gets discontinuity because they may get a different person. I suspect what is important to that patient is that the nurse on the ward gives a proper brief and hand-over; and if that patient is in pain or requires the siting of a cannula or they require the commencement of treatment, my view is that what the patient wants more than anything else is that that happens quickly and competently. We obviously have to be concerned about not fragmenting the care that patients get, but often it is efficiency, speed and quick response to the need. If I can give you an illustration of where this works well; we have colleagues working with teams, largely in the out-patient setting, called nurse clinicians, who effectively do the work that registrars used to do. So we now have a colleague working in a firm or practice who has her own out-patients' clinic; she works alongside the professorial team; she undertakes quite invasive procedures for patients; and she is somebody who, particularly for patients who have survived the treatment but may require further intervention—she is the continuity that has been there for a decade. That is what nurses can very often add to the party for the patient, if you like.

Q432 Dr Taylor: The point that Professor Sibbald made was that in some cases where nurses are taking over work, doctors are not giving this up. Can you give us some examples of that? What sorts of things were you thinking of?
Professor Sibbald: Nurses and doctors both dealing with minor and self-limiting illness in patients who are on same-day appointments in general practice—coughs, cold and flu. Instead of surgeries being arranged with some sort of triage for those patients that are directed to the nurse, both the nurse and the doctor will continue seeing those patients. Those types of problems are almost limitless in the population. If you offer the places, the patients will fill them up!
Dr Mascie-Taylor: On continuity of patient care, we can no longer rely on particular staff working very long hours. We have not yet fully replaced that. We have to look at single sets of notes—multi-disciplinary team working and IT solutions. It is a real problem.

Q433 Dr Taylor: Single sets of notes between nurses and doctors and all professionals, including psychiatrists?
Dr Mascie-Taylor: If appropriate, yes. There may be some difficulty at the margins.
Mike Penning: They would have to be handwriting experts!

Q434 Dr Taylor: So, single sets of notes. Are we really coming towards that, whereby nursing and medical notes are being combined?
Dr Mascie-Taylor: We are undoubtedly moving in that direction. We need to move more quickly. More importantly, it reflects an attitude of mind that what matters is not which profession you are in, but that we are caring for the same patient and the information can be shared. That is the challenge. The challenge is not a physical set of notes; it is the attitude that underlines multiple sets of notes. You can drive that through IT solutions as well as in a number of other ways, which we can discuss if you wish.

Q435 Dr Taylor: How are improvements in technology affecting skill mix?
Ms O'Dea: Sadly, a number of my staff find themselves jobless this week because of NHS jobs, which was absolutely marvellous. We have saved hundreds of thousands of pounds by having jobs on the Net rather than having to advertise them, and by linking our workforce systems directly into the NHS jobs network, so that we do not have to re-key. Nobody has to photocopy bits of paper or run round the hospital handing them out. I will end up with a group of staff that are more senior, and more professional staff and less junior staff. We are having to redeploy those staff, but that one action will have saved the NHS hundreds and hundreds of thousands of pounds through technology.

Q436 Dr Taylor: Can you think of any clinical technological advances that have reduced—
Ms O'Dea: PACS. It is fabulous in what it does. Not only has that reduced the need for hundreds of people in dungeons in hospitals to run around and try to find films, and then try to get them to the right place at the right time; but it also means that doctors have access to those images immediately the patient is there, and anywhere for teaching. It is fantastic!

Q437 Dr Taylor: How generalised is PACS now?
Ms O'Dea: It is increasing.
Dr Mascie-Taylor: It is becoming more generalised. It is an expensive system to put in, and I think one of the difficulties with PACS is that—

Q438 Mike Penning: Where there are deficits. Where there are financial problems, it is not coming through.
Dr Mascie-Taylor: It is not simply deficit; it is about the cost of—

Q439 Mike Penning: But it is a real problem.
Dr Mascie-Taylor: It is a problem, but then in medicine in its broader sense you will spend whatever money is available. The skill of management is to make the best use of resource. PACS drives through quality of care. What is less clear about PACS is that it will cut cost, so again we need to be clear about the objective. If you are looking to improve quality of care, PACS will do it; if you want to reduce costs, it will not. It is the same discussion about skill mix: what are you trying to achieve?

Q440 Sandra Gidley: We heard from some people that there is a feeling that specialist nurses and particularly nursing specialist roles are becoming increasingly specialised and narrow in focus. Is this a good thing generally? The other thing that has been put to us is that they often do not like having to

perform the basic nursing skills. The phrase has been used before, but are nurses too posh to wash these days?

Ms Norman: The challenge for nursing is that they have got to be able to wash and they have also got to be able to perform specialist roles in terms of role substitution for doctors and the needs of patients in the service. I do not think we can do one or the other; we have to be able to do both. I would say that it would probably not be the best use of nurses in developed roles to have them washing patients as well. For example, I told you about the example of our nurse clinician. I do not think it would be a good use of her skills to have her looking after the personal care needs of one of our in-patients. However, I think that personal care needs in patients are as important. The trick that we have to pull off is to ensure that within the nursing workforce you have a proper spectrum and that you value all the component parts of that. In terms of the point at the heart of your question, we often get very seduced into discussions about specialist roles, when we also need to be very concerned about the support and training for the unqualified staff who are working alongside the professionally qualified nurse, and maximising the contribution and the ability of the band 5-staff nurse. You need those people to be good at managing resources and be optimal in the range of clinical skills they have got.

Q441 Sandra Gidley: I would like to challenge your use of the word "unqualified". I think people working alongside nurses in those roles would feel they have a qualification of some sort. It may not be a nursing qualification, but I do not think the word "unqualified" is fair.

Ms Norman: I apologise; I should have used the word "unregistered"; but equally we are very fortunate in Manchester; we have benefited from the work of the strategic health authority in setting up a very excellent assistant practitioner programme. The key thing for organisations is that you do not invest in colleagues and train them and support them to a qualification which is a foundation degree in fact, for those colleagues in Manchester, and then have them coming back and doing exactly the same job. You have to enable them to develop that.

Q442 Sandra Gidley: Professor Sibbald said when talking about the change in skill mix that it was very difficult to see that any cost-savings had been achieved because of the different ways that nurses consumed resources, and that the evidence base is not there to show cost-saving. With the new clinical roles, such as medical and surgical care practitioners, is cost the only option? Are we improving productivity or improving the service we give to the patient? Has any work been done to show that it is not just cost, but that we can provide a better service through skill mix?

Professor Sibbald: In general practice nurses can add quality to the care, so it is cost-neutral and they are adding quality. For example, patients tended to rate their satisfaction with their practitioner more highly when that practitioner was a nurse as compared to a doctor. Part of the reason for that, we think, is because nurses were less productive in offering longer consultations with patients and they were seeing them more frequently; but that was something that was very much valued by patients. We also know that nurses tend to give more information and advice to patients, which is again something they very much appreciate. We know too that nurses working for example managing chronic disease clinics in general practice—that that is a model of care that improves the quality of care for those patients, compared with the situation where the physician tried to do that with a routine consultation. Adding quality to care is something that nurses can do.

Dr Mascie-Taylor: Looking at the question slightly differently, if you look at the targets that the NHS has now broadly achieved, if you look at the A&E target, where the targets that we now have largely met would be the envy of many Western countries—they have been met because of changes in the skill mix in part. A bit depends on what you regard as evidence, but the NHS would not have responded in the way it has and increased its capacity to deal with things more rapidly if it had not entertained many changes in skill mix and many changes in systems. There is pretty good sense of increased productivity in that sense. A lot depends on the nature of the evidence you are looking for.

Professor Sibbald: A pre-requisite for a skill mix is that you have a large population to serve of relatively undifferentiated conditions, or at least there is a high volume of a particular thing; because that is the only situation in which you can sustain this ever-increasing specialisation and role differentiation, both among physicians and between physicians and nurses. That model of care then drives the system towards having larger, more complex teams, and that means that if you are not going to expand the volume of care, you are getting fewer general practices because they have to be bigger and more complex; and that model of working is not necessarily efficient, let alone cost-effective for example in rural settings, with low population densities. The question of whether skill mix can improve productivity goes inherently to the nature of the patient population you are serving. I would also add that there are costs that we have not talked about yet clearly here today, of having larger and more complex teams. If before you had one, say, general practitioner that managed all the problems in his or her presenting patients; and now you have to have the physicians, the receptionists and three nurses each dealing with a particular kind of chronic disease—cardiovascular, muscular-skeletal—then you get a problem with the co-ordination of care. There is a management cost to having larger and more complex teams that also needs to be considered.

Q443 Sandra Gidley: Do teams need to be doctor-led? Some of the submissions from doctor organisations have said that is very important to retain. Are they just defending their own interests or are they really necessary?

Ms Norman: Where you have a consultant physician-led service I do not think it is inappropriate for the doctor to be the team captain. Preferably they do not need to play all the roles, and many people do not have much problem with that, but there may be issues where you are spear-heading new services where there may not be physician involvement and that is where that kind of approach and attitude can stymie it. In years gone by in some of the primary care developments, nurse practitioners for homeless people and things like that, that kind of attitude did create barriers to those developments.

Dr Mascie-Taylor: This may not be popular with my colleagues but in a multi-disciplinary team people should bring to that team their expertise. Somebody in that team needs to have expertise in leadership but it may or may not be the doctor.

Sandra Gidley: That is very refreshing.

Q444 Dr Taylor: The European Working Time Directive, could we have met it without the extended roles of nurses?

Ms Norman: Absolutely not.

Q445 Dr Taylor: How will we cope with the 2009 requirements?

Ms Norman: We will have to become even more clever in terms of the point made by your colleague about ensuring that as nurses colonise roles previously undertaken by medical personnel that we do not abandon the important things that nurses do.

Q446 Dr Taylor: What scope is there for extending the roles of other people, such as physios, OTs and MLSOs?

Ms O'Dea: I am fortunate enough at St Mary's Hospital to be chairing a group with about 15 consultant medical staff, a group of nurses and some others, to look at how we are going to maintain the quality and safety of patient care 24 hours a day, 7 days a week, 365 days a year, with all of the changes that we are going to face in modernising medical careers, modernising nursing careers, with my own Trust loosing 3,000 hours of junior doctor time a week by 2009. I would like to agree with Dr Mascie-Taylor that our local consultants are actually telling me we are not being radical enough on your thinking. They are very keen indeed to do this in a multi-disciplinary team-led way rather than a doctor-led way, and these are consultant themselves. We are going to ask Professor Michael West, who has done a lot of the work around the links between multi-disciplinary team working and reduction in patient mortality, to come along and work with that group so we understand exactly how to design a workforce that enhances the use of the multi-disciplinary team. That is a physician-led request. We have supported those doctors with a leadership programme to ensure that they had the skills and access to the work that has been previously done around the creation of new roles, including the work previously done by the Modernisation Agency, so that they can define what the need is as a multi-disciplinary group of very senior professions and they have the skills and the knowledge to look at what other people have done and say is that going to fit here or is it not.

Dr Mascie-Taylor: Could you give us an idea of the sort of extra things physios, for example, could take on?

Ms O'Dea: In our own Trust we have some physiotherapy-led clinics and out-patients rather than having people constantly see orthopaedic surgeons. Those sorts of things prove very popular. We are beginning to understand the skills and knowledge that are going to be needed to bridge that 3,000 hours gap, and only after we have done that will we define from where those skills and knowledge should come, from which of the professions. Something that both Alison and Hugo said earlier is you start by looking at what you need to treat the patient. You put it into a block and say these are the knowledge and skills we need at this time of the day to ensure we have quality and safe patient care. You then redesign the roles around those looking at what other people have done, looking at what the nursing profession, the physiotherapy profession and the medical profession brings, and then decide where those roles can only be done by professionals and where those professionals need some additions to their current role in order to take this forward.

Professor Sibbald: If the problem you are trying to address is a medical workforce shortage, then the obvious solution is to have more doctors. There are other strategies for doing that and I know this committee has, and will, consider those things. The reason for me making that point is as we change skill mix and develop very new roles for nurses and other health professions, they are not going to go away in the future when we have an adequate supply of physicians. You need to think in the long-term about whether the effectiveness, efficiency and quality added through these changes that we might make for a short-term need will be sustained into the future. I do not see a lot of evidence one way or the other about that.

Q447 Dr Taylor: Thank you for that warning.

Dr Mascie-Taylor: When asking what is the work to be done, too often there is an assumption it is work that needs to be done by a specialised doctor, which is usually not the case. What is the work to be done and who do we have available to do it, that will drive some change in skill mix. Finally, a point you made, sometimes for highly complex services where you do require large teams of technically driven people you have to be prepared to take hard decisions about centralising services.

Q448 Chairman: A number of Accident and Emergency Departments have changed their process so patients are now seen by a consultant as soon as they arrive in order to speed up the decision making, and the quality of decision making is a lot better for that. Does this not show that one of the important things is where we deploy skills as well as what skills we have? Would you agree with that? Would any of you think this could go beyond A&E and into other areas, certainly in the acute sector?

Dr Mascie-Taylor: I think the crucial thing in A&E is to recognise that doctors in training should be providing less of the care and be receiving more training. They are not fully trained and the rate of decision making is probably too slow. If a decision needs to be made by a doctor, the consultant is the one best equipped to do it. The specific of your question is who sees the patient at point of entry to the department. There are two ways of doing it: either a very experienced triage nurse or a very experienced doctor. Either of those will work and neither is right nor wrong. What does not work is lack of experience or lack of a system which triages patients. You need the right person in the right system but you do not have to be dogmatic about what is their background.

Q449 Chairman: Could you extend that into other areas within your hospital in terms of people with more experience seeing patients earlier or quicker?
Dr Mascie-Taylor: I do not have the evidence but my intuition is the more quickly patients are seen by an experienced member of staff, whatever their background including doctors, the quicker will be their treatment, the more appropriate, the better the quality of care, and the more productive it will be. That is not surprising as it is the same as in any other walk of life: the experienced professional will do better quicker.

Q450 Chairman: What might be surprising is we are actually having this conversation. As far as patients are concerned, most of them would think they would see the top people when they are taken into A&E. In some instances they do, where it is an obvious situation coming out of a motor car accident or something like that. Otherwise, is this deemed to be a part of training of doctors as opposed to other things? You do not see a consultant when you first go into A&E so why is that?
Dr Mascie-Taylor: It is in part because of the very varied nature of problems that present at A&E, many of which can be dealt with by people other than a consultant, and part by a relative lack of consultants. If we had the financial and human resource capacity to have every single patient seen by a consultant as they arrived in A&E, I suspect what we would see is some increase in quality of care, some increase in rapidity of care, and a very substantial increase in cost.

Q451 Charlotte Atkins: Professor Sibbald, we have already heard from you that your research has shown that using nurses in place of doctors is cost neutral. You were saying it improved the quality in terms of patient care, but your research showed that nurses are more likely to refer patients to hospital. Why is that, and does that mean that patients are less likely to receive appropriate care if seen by a nurse?
Professor Sibbald: They were not universally more likely to refer but there were, in a sufficient numbers of studies, that you got a small effect in that direction. The short answer to your question is the appropriateness of those referrals was not investigated so I cannot directly answer your question. I can indirectly answer it by saying that the health outcomes for those patients were not altered, either more favourably or the reverse, through that referral, and the cost of that referral was taken into consideration in this overall determination that nurses were cost neutral.

Q452 Charlotte Atkins: Do you think there will be any impact by GP commissioning on this process?
Professor Sibbald: The most likely effect of GP commissioning, as it was with fund holding, is some marginal change in where they direct patients in the acute section and a big effect in terms of moving services out of hospitals and into the community, and in particular into their own general practices where they can provide a wider range of care. Generally speaking, the way they have expanded service, the range of service provision and practices, is to hire more specialised nurses to undertake that work.

Q453 Charlotte Atkins: What proportion of current primary care work is done by GPs? This is obviously in view of the fact that their contract has meant fairly substantial pay rises for GPs. Are they doing less and getting more?
Professor Sibbald: Yes.

Q454 Charlotte Atkins: Do you think that is justified?
Professor Sibbald: No.

Q455 Charlotte Atkins: I am very sorry that we do not have one of our members on the committee here today because he is a GP and I am sure he would have wanted to come in there.
Professor Sibbald: I can say on what basis I give that answer. We conduct national surveys of general practitioners in this country, about 1,000 GPs. We surveyed the same panel immediately before and immediately after the contract. We asked them to report their hours of work and their pay. On average doctors were reporting a £15,000 increase in pay and a four hour reduction in their working week. We have a panel of 45 practices where we do detailed investigations of quality of care and we have been following this panel since 1998. What we can see is there has been an increase in the quality of care steadily over this period of time, and the new contract seems to have added further value to that, so we are getting something for our money.

Q456 Charlotte Atkins: This extra four hours they have to play with, I assume they were not donating that to the work of the local Primary Care Trust?
Professor Sibbald: I do not have an answer to that.

Q457 Charlotte Atkins: When was your research done?
Professor Sibbald: The after survey was conducted in the autumn of last year, and the before in the spring of 2004.

Q458 Charlotte Atkins: You were saying you think that with GP commissioning there is going to be more activity within the community, if not within GP surgeries themselves. What changes to skill mixes are required when that happens? Obviously it is emerging, it is happening now, but what are the changes in skill mix we need to do now to meet that challenge?
Professor Sibbald: This, and the most recent White Paper reforms as well as the new contract, will reinforce a trend that has been evident very strongly in general practice from at least 1990, which is that you are going to get larger more diverse teams of health professionals. In particular, you will see greater role differentiation amongst GPs within a practice, so partners become more specialist in particular areas at the expense of being generalist in all areas. You will have more nurses employed in practices, and those nurses will have more specialised roles than they have had in the past. Pharmacists are another health profession which plays an increasingly prominent role in primary care delivery in minor illness management, to medication review and in repeat prescribing, among other things.

Q459 Charlotte Atkins: Will this be at the cost of patients not being able to see their GP, which some patients value?
Professor Sibbald: Yes. That trend has been evident for a very long time. As the size of the team increases, the opportunity for patients to see the doctor of their choice, or indeed the nurse of their choice, declines. That is widely known to be true and has been shown across Europe in studies. We know too that patients value continuity of care, so they do not like that change, but the question is what are they willing to trade-off for that. Many patients are quite happy, as was suggested earlier, to see any professional who is competent to deal with their problem quickly and simply, but the most vulnerable patients are the ones who most often value continuity. People with serious and ongoing problems, particularly of a psychological or distressing nature to them, prefer to see the individual with whom they have built a relationship. What I cannot say is globally what impact that will have on the quality of their care, as the evidence base for that, although extensive, is divided as to whether loss of continuity has a negative and damaging affect or not.

Q460 Charlotte Atkins: Hopefully if we have this one set of notes in primary care as well as in acute care we might overcome that problem. Given that a number of nurses are likely to be made redundant in some acute settings in hospitals, what scope do you see for these nurses going into primary care from hospital settings?
Professor Sibbald: There is considerable scope. The tradition has been for general practice to be staffed by nurses who first worked in hospitals and later in their careers moved out into the community for a wide variety of reasons. I would say there is every opportunity for them to do so.

Q461 Charlotte Atkins: Lastly, do you think that primary care generally has had enough of a priority in terms of role redesign? The whole of the medical system seems to be geared up for hospitals and not so much primary care. Is that changing or are we still seeing that the focus, in terms of innovation and role design, is at the hospital level?
Professor Sibbald: I would say two things. Where general practice loses out is in access to good human resource management expertise and skills which are much more available in acute trusts. On the other hand, I think that their degree of distance on the innovation front has been an asset to general practice. They are small businesses. They are usually quick on their feet in terms of making skill mix changes, often leading them in the country. I do not think that they suffered in terms of innovating in terms of roles within practices but they could do with more HR skills.
Chairman: Could I thank you all very much for coming along this morning. I am sure your evidence will be invaluable when we come to draw up an inquiry at some stage, very likely at the end of this year or the beginning of next year. Thank you for your evidence this morning.

Witnesses: **Dr Sally Pidd,** Chair of the Recruitment and Retention Working Group, Royal College of Psychiatrists, **Mr Rob Darracott,** Director of Corporate Strategic Development, Royal Pharmaceutical Society of Great Britain and **Mr Bill O'Neill,** Head of Education and Development, London Ambulance Service, gave evidence.

Q462 Chairman: Thank you very much for coming along. Could you, for the sake of the record, give us your name and the organisation you represent?
Dr Pidd: I am Dr Sally Pidd, Associate Dean for Workforce at the Royal College of Psychiatrists. I am also a practising clinician in the North West of England.
Mr Darracott: I am Robert Darracott, Director of Corporate Development at the Royal Pharmaceutical Society of Great Britain, the professional and regulatory body for pharmacists.
Mr O'Neill: I am Bill O'Neill, Head of Education and Development for the London Ambulance Service.
Q463 Chairman: Thank you very much for coming along. This is our fourth evidence session on Workforce Planning. Your organisations have all recently been involved with changes to skill mix and the development of new and extended clinical roles. How effective are current workforce planning systems in helping to make these changes?
Dr Pidd: The mental health professions as a whole have worked very hard over the last few years to

look at new ways of working in mental health. This was led initially by concerns about psychiatrists and their roles. People were finding increasingly that consultant psychiatrist roles were becoming over-extended and they could not deliver an adequate service, and because of those concerns a national steering group was set up to look at new ways of working for psychiatrists which has moved into now looking at new ways of working in other mental health professions as a whole. That work went alongside the work of the Mental Health Care Group Workforce Team which has now been disbanded. That is of some significance because that Group had an overarching remit to look at the mental health workforce as a whole and make recommendations, for example for increasing commissions for clinical psychologists or training numbers for psychiatrists. With that joint remit of looking both at the numbers needed and then at the changing roles not only of psychiatrists but other mental health professionals, the Mental Health Care Group Workforce Team was able to tie together quite well the planning aspect for the service as a whole. With the demise of the Mental Health Care Workforce that has been lost to some extent. To balance that, the changing remit of the Workforce Review Team to cover not only doctors, which it initially did, but all other relevant professions, it remains to be seen how that works out. In a time when we have seen a huge development of new roles in mental health, particularly in response to the NHS plan and the working out of the National Service framework for mental health, it is a critically important time to get the workforce planning right, both from the top down and from the grass roots up, when so many roles are changing, in order to deliver a service. There are some things where central control has its place, but in looking at changing skills mix you have to start down at the service level.

Mr Darracott: We very much welcome this opportunity to come and talk here today because workforce is a particular issue for us at the moment and we have spent time looking at that. Pharmacy is a little bit complicated because the majority of pharmacists delivering service on behalf of the NHS, or to NHS patients, are employed in the private sector which makes workforce management a little more complicated. You are right to highlight the fact that we have, in both secondary care roles and in primary care now increasingly, pharmacists moving into more clinical activities and, therefore, extending their roles into those areas. We have been working with the Department of Health and the Welsh Assembly government on developing a workforce planning model which covers both the NHS and the private or community sector, which, rather than providing any answers, supported the need for some of the changes which have been proposed in recent legislation, particularly with regard to skill mix within the pharmacy workforce. The planning model, which hopefully we will be launching to the world at some point very shortly when we have dotted the "i"s and crossed the "t"s, highlights the gap that currently exists, which everybody felt was there in the first place but we now have some evidence and a rather robust model for that. The workforce team have also made some recommendations as to how pharmacy needs to adapt to resolve some of those issues. It is fair to say that while it has highlighted the gap there as well, some of the recommendations we have already seen starting to happen. For instance, the move from an essentially manipulative activity in the supply and provision of medicines into working more closely with patients about medicine as utilisation. What we are seeing now is the start of automation, and the greater involvement of automation both in the secondary and also primary care sector. One of the suggestions that comes out of the workforce model is we need to look at different ways of doing existing tasks, and we welcome the opportunity to talk to you about it.

Mr O'Neill: We are in a slightly unique position in some respects in so far as the major impact for us has been the introduction of the role of ECP (Emergency Care Practitioner).

Q464 Chairman: We will go into some detail about that. It is about this overall workforce planning system that we have at national level and the helpfulness that has been.

Mr O'Neill: The reason I mention that is because that has been, in many respects, the catalyst which has led to us look at the rest of our workforce. To be honest, we are still in a "what about the rest of the workforce" situation at the moment, and it is hard to describe it without bringing the ECP into it.

Q465 Chairman: Maybe that would be a good way of doing it. What I was trying to probe was whether the workforce planning systems inside the NHS particularly are well funded or should be better funded or better allocated in terms of where funding goes to which body. I do not know if you have any firm views in that area, or maybe you could pick it up later on. Let us move on.

Q466 Mike Penning: If you feel you want to answer that question later on, that is fine. How can we encourage individual organisations and managers to do more work of this type to move this on?

Dr Pidd: This is where there is a need for national work to filter down, and to filter down effectively, to local organisations. If I give some examples from mental health, the New Ways of Working group, which produced its final report last year, demonstrated that it is possible to pilot different ways of working and then to evaluate those pilots, but then you need a mechanism for disseminating the results of those pilots, of changing roles, for example changing the role of pharmacists to be involved in clinical activities within mental health. For that work to be overseen by a national body, in this case the National Institute of Mental Health, you then need a mechanism for disseminating that out to areas and then encouraging that down to local level.

Q467 Mike Penning: Are you saying those mechanisms are not in place at the moment?
Dr Pidd: They are in place at the moment through the regional development centres, but I think often to take those results and implement them locally there often needs relatively small pump priming monies, for facilitators for example, if you are looking at changing the skill mix within a team. If I give another example, one of the outputs of the New Ways of Working Group has been the development of a creating capable teams toolkit which enables local teams of any sort, be it in children's services or community mental health teams, to examine the local needs, the local skills, and the local skill mix to see if the service could be redesigned to produce better outcomes for patients. Service users are a part of implementing that. The work has been done at a national level to produce this toolkit, but in order to implement it locally you may need some skilled facilitation and some time.

Q468 Mike Penning: Would money be the driver for this to happen?
Dr Pidd: I do not think it is a lot of money; it is often a small amount of money.

Q469 Mike Penning: Clearly it is not coming through now?
Dr Pidd: It is not coming through in the way it perhaps needs to. I think a lot of learning from the national pilot sites in New Ways of Working both for psychiatrists, advanced practitioner nurses, and so on, is not getting down quickly enough.
Mr Darracott: I think we are in the process at the moment where there are some key building blocks in place. If you look at the community pharmacy side for a moment, there are proposals in the Health Bill which will enable some of these skill mix things that may be need to happen in the community to take place. We need some legislative change. There are some long-standing provisions by which pharmacist's responsibilities in community pharmacies require them to be present, there is a physical presence aspect, and some of the proposals in the Health Bill take us a little bit further forward on that. We welcome the opportunity to talk about flexibility because as pharmacists do get into more clinical roles, either spending more time with individual patients within the pharmacy itself or outside the pharmacy location, then you need some flexibility to sort out the problem of the physical presence which has been a feature of the law for some years. We are really looking forward to discussing the regulations that may fall out of that. We are in the process of actually doing something about it, which means sorting out some of the legislative aspects. There then comes a point at which we need to really highlight to the profession at large what those new possibilities are, how people who start to take those opportunities can use them and how that improves services for patients. It is incumbent upon us all to highlight that to the profession. With all of these things you are looking at people working a particular way for a long time. Some of these opportunities are quite different ways of working and we need to highlight that. I am not saying it is necessarily a matter of funding. We have a new pharmacy contract in the community which is bringing about some of these new roles anyway, but there is a legislative issue there. In the secondary care sector we are still coming out of the finishing of the completion of the Agenda for Change programme. That has left us with some issues that still need to be resolved and I can discuss those at some length. We are waiting to see how that all falls in place. There are one or two key things coming up which I would highlight at this stage which are pinch points in the system, and they are rather further back in the generation of a pharmacist than the actual service delivery, in the sort of training programme. Pharmacists currently are trained as scientists so the funding stream for pharmacists is through HEFCE, so science funding as opposed to clinical funding. As pharmacists get into more clinical roles, there is a question mark about how that training is funded, particularly the exposure of pharmacy students and pharmacy at the pre-registration level to patients and how that is facilitated. If you just have a science funding stream, there is little provision within that for clinically based training.

Q470 Mike Penning: It is a very tight gateway, is it not?
Mr Darracott: The higher education institutions have a range of ways of dealing with that but it would help if some of that was looked into.

Q471 Mike Penning: Perhaps we can come back to that. What about the ambulance service?
Mr O'Neill: That comes into the issue for us as well. We had the publication last June of the Ambulance Service Review from the Department of Health. That, alongside with the work that has been conducted by the Ambulance Service Association employers and the British Paramedic Association, is giving us far more of an idea of where we are going in terms of our skill mix and the way that we implement some of that. I am trying not to touch on ECPs yet, but for us the issue is about how we get that funding. We traditionally provide our training in-house so it has not been associated with higher education which has been gradually coming in over the last decade I would suggest. Certainly now with the standards of education that are set by the Health Professions Counsel, with the curriculum guidance published by the British Paramedic Association, we see ourselves in a far more higher education direction, which is right. We do not want to throw the baby out with the bath water and move away from the in-house apprentice route, but we are scratching our heads, to some extent, how we are going to fund this because nothing seems to be coming to light. No matter which way we turn, we seem to be getting some blank faces in terms of how to make this transition.

Q472 Mike Penning: You get that from politicians sometimes. Have these new workers in these new extended roles replaced existing workers or have we

put a whole new tier in? Have we kept the existing workers and put in a whole new tier of skilled workers.
Dr Pidd: In mental health they have largely come in alongside existing practitioners, so within community mental health teams there has always been a mix of social workers, community nurses, doctors and occupational therapists. New workers coming in, for example working more on the primary care/secondary care interface, is a new layer if we are talking about gateway workers or graduate workers.

Q473 Mike Penning: They have not replaced but there is a whole new layer.
Dr Pidd: They have not replaced them in function, but one of the workforce issues has been that as new roles have been identified the existing workforce have moved into them which has sometimes left gaps.

Q474 Mike Penning: Have people then come in to fill those places so there is an increase in provision?
Dr Pidd: Certainly within mental health services the new roles have enhanced the service. For example, there is no shortage of psychology graduates interested in moving into clinical work. There have never been enough training places for clinical psychologists which has left a gap in the service. We have now created a new role for psychology graduates to come into the mental health workforce in a primary care setting gaining skills, and doing this at a time when the notion of the skills escalator within the NHS means that people are coming in and can progress along different career pathways than used to be the case.

Q475 Mike Penning: We will go on to ECP quickly, but I do not know if it affects you.
Mr O'Neill: It is too early to say because we are not sure the extent to which the introduction of this new role is going to impact on numbers of other roles we have.

Q476 Mike Penning: Your main problem will be funding, as you just discussed.
Mr O'Neill: Yes.
Mr Darracott: In pharmacy, as an example of the secondary care sector, some of the new roles pharmacists have gone into have followed a recognition that medicines are important parts of the health care system. There is a lot money spent on them, and the appropriate use of the pharmacy skills around use, and the use of the medicines, if you invest more time and energy in that as part of the clinical team, then you end up with better outcomes for patients. In terms of what the pharmacist does there, the additional parts of those roles really have taken over some of the roles that might be elsewhere in the team. They are carving out a role in independent prescribing and this will save time elsewhere in the system. As to what the pharmacists were doing which now allows them to do these new roles, that has largely been delegated to more technical staff.

Q477 Mike Penning: It does not look as if you have increased your workforce but have delegated skills around so the skill base has increased within the existing staff.
Mr Darracott: The roles around the supply of medicines have been largely delegated to technical staff, yes.

Q478 Charlotte Atkins: You have been incredibly patient but you can now tell us about emergency care practitioners, what they do and how they fit into the emergency care workforce.
Mr O'Neill: I think it would be fair to say that I can only really tell you how they work within London. It would be fair to say how they work in other areas of the country is not necessarily the same as the way they work in London. One of the issues that we do have is there does not seem to be a consistency in what is understood as an ECP across the country. In terms of what they do in London, they effectively support both our operational response to 999 calls and are given the opportunity to work with other local health care providers to be able to help with some of the out-of-hours work, et cetera. The way it is working at the moment is we do not have anybody who has come through the ECP programme fully trained and out the other end; they are all in what you might call a development stage.

Q479 Charlotte Atkins: How long have you had these?
Mr O'Neill: The current cohort are in their second year. They will end up with a diploma working through St George's at Kingston University. I have to be somewhat vague about some of this because some of it is quite vague in terms of why it has been planned the way it has been planned. If that sounds like I do not know what I am talking about, to an extent this whole thing grew up outside of the auspices certainly of my department and my remit within the organisation. It was kept in this vacuum and developed there and we are now picking up some of what may have been mistakes that were made along the way in trying to develop this role. We do have a situation where, at the moment, there is a lot of development time with our ECPs and not a great deal of operational time. That is something we are trying to address and pull that back around. We are not seeing the effectiveness we might have expected to see at this stage, but it would also be fair to say that the evidence is not telling us anything other than they are being as effective as could have been projected at this point.

Q480 Charlotte Atkins: It always amazes me that within the Ambulance Service nationally there is loads of innovation going on in particular areas and it is not taken up by other ambulance services. What is the overall rating of your ambulance trust in terms of stars?
Mr O'Neill: Two.

Q481 Charlotte Atkins: You are hoping that these ECPs will help increase your overall performance.

Mr O'Neill: Yes.

Q482 Charlotte Atkins: Can you tell me, at this stage, what sort of percentage of emergency admissions your ECPs are enabling you not to take to hospital?
Mr O'Neill: Of the calls that they attend, the non-conveyance rate is about 50% as opposed to about 25% for a traditional ambulance response.

Q483 Charlotte Atkins: Michael was asking earlier about funding, so presumably there would be an overall saving to the Health Service because you are not taking them to hospital because it would cost you much more per patient to do that. Presumably that is where some of the savings will come to develop this particular role.
Mr O'Neill: I believe it costs about half of what it costs for a patient to go through the Emergency Department; the range is between £24 and £29 per patient visit by an ECP as opposed to around £55.

Q484 Charlotte Atkins: £55 seems a bit low to me.
Mr O'Neill: Those are the figures I have seen in the research.

Q485 Charlotte Atkins: You say in your evidence that ambulance staff do not have medical advice routinely available, but in some ambulance trusts they do have medical advice routinely available, do they not?
Mr O'Neill: There are varying forms of advice. I think every operational ambulance person would be able to pick up a phone or radio and get medical advice. We have someone on duty 24 hours a day who is able to pick up on the kind of calls that crews call in and say "I need help with this."

Q486 Charlotte Atkins: Do you have a team centrally to which your ambulance crews can ring who are experienced in the whole area of emergency service? They ring in and will get the advice so there is routine medical advice available?
Mr O'Neill: It is not used routinely but used for those situations where the crews feel themselves stumped and do not know how to proceed.

Q487 Charlotte Atkins: You do not use a Telemedicine system?
Mr O'Neill: No.

Q488 Charlotte Atkins: I know some ambulance services do use that and are able to get from the patient the status of the patient and feed that straight back to the medical team, so they work on that very effectively. I am surprised, given the challenges faced by the London Ambulance Service, that that is not routinely done in London.
Mr O'Neill: It is done for certain conditions. For example, the new policy we have for direct admission into cath labs for people who have confirmed heart attacks, there is that back and forth communication going on, but for the majority of calls, unless the crew make a decision that this is something they need advice on, then it is not done routinely.

Q489 Charlotte Atkins: You do not use the technology available to give information to the medical team back at base?
Mr O'Neill: The medical team as such is going to be one person who is an on-call medical adviser.

Q490 Charlotte Atkins: We have already spoken about the 25% decrease in the number of people taken to hospital, but in the meantime A&E departments are having increasing numbers of patients going to A&E. What do you think the potential is for this particular development to reduce A&E admissions?
Mr O'Neill: The target for our service is to reduce the number of patients we take to A&E by 200,000 per year within the next five years.

Q491 Charlotte Atkins: What percentage is that of your present admissions?
Mr O'Neill: About a quarter.

Q492 Charlotte Atkins: What plans do you have, given we have had the review of the Ambulance Service, to learn from other innovative practices in other services?
Mr O'Neill: Now that we have got fewer services with the amalgamation of ambulance services across the country, that should be easier to achieve. It would be fair to say traditionally it has been very difficult to share practice among ambulance services. That has increased with the publication, several years ago, of the new joint Royal Colleges' Ambulance Liaison Committee Practice Guidelines. We saw people coming together from ambulance services, more so than we saw before, to share good practice and set a national standard. We have started to do that a great deal more than we did 10 or 15 years ago and I can see it continuing to do that.

Q493 Charlotte Atkins: I am quite surprised by that response because you had this star rating system, which presumably is in place to ensure that excellence is recorded and presumably learnt from. At the moment, apart from that Committee you are talking about, there is no way of improving on the performance which exists in individual ambulance services.
Mr O'Neill: I think the Ambulance Service Association is a means by which we do share some other good practice, and certainly in terms of what we are looking at around skill mix and what the shape of the workforce needs to look like in the future, that kind of area is something we do quite well. In terms of ambulance education, we have improved a great deal in terms of sharing the way we do things amongst ambulance services. In the past there were enormous differences between what we do in London and what other services did, even just around the length of the training courses. That has

improved a great deal so despite my focusing on the development of the practice guidelines there are other areas that we have shared good practice.

Q494 Jim Dowd: You said that with ECPs, what you described as the non-conveyance rate went up from 25% to 50%. The savings thus indicated do not go to the LAS, do they?
Mr O'Neill: No, not necessarily.

Q495 Jim Dowd: In fact, it might cost you more to have that rate.
Mr O'Neill: In some respects yes, and in some respects no. As far as it will cost us more to train these advanced practitioners, but then we are only sending one person as opposed to sending a double-crewed ambulance. At the moment we are unable to say.

Q496 Jim Dowd: I readily accept it is far better in terms of service, and far better for the tax payer who pays the bills for all of them, but within the labyrinthian complexities of the NHS finances you also have this target of 200,000 over five years. Was that self-imposed or was that agreed with the acute trusts?
Mr O'Neill: It was self-imposed to an extent in so far as it was based on us looking at outcomes for patients who we take to A&E and being able to safely judge that those patients could have actually got definitive care or been as safely left at home rather than being taken to A&E. It is based on the actual outcomes of our patients.

Q497 Jim Dowd: To follow up Charlotte's point about why the increased non-conveyance rate has not reduced attendances at A&E, I realise you are only speaking for London but can you give us an indication normally what proportion of A&E attendees are brought by ambulance?
Mr O'Neill: I do not know.

Q498 Dr Taylor: I am a bit confused about the training of ECPs. You start with paramedics and then you give them extra training. Is this standardised throughout the country or does it vary from ambulance service to ambulance service?
Mr O'Neill: It varies, in some cases hugely.

Q499 Dr Taylor: Certainly that is the impression. You said this was a three-year training.
Mr O'Neill: Two-year university based training.

Q500 Dr Taylor: Is that day release or night release?
Mr O'Neill: Basically they are full-time ECPs.

Q501 Dr Taylor: You lose them for two years full time.
Mr O'Neill: The programme is two years long. We get between one and two days operationally out of them depending on the student themselves. There is a lot of flexibility.

Q502 Dr Taylor: How does this fit with regulation? Your paramedics are regulated by the Health Professions Council. We believe there are nurses in training as ECPs as well.
Mr O'Neill: Yes, some.

Q503 Dr Taylor: Surely the training should be regulated by somebody.
Mr O'Neill: It will be, I believe, but at the moment it is not. The British Paramedic Association would like to see the regulation brought in under the respective regulation for each different profession who is involved in this programme.

Q504 Dr Taylor: A separate bit in the nursing to do that.
Mr O'Neill: Nursing for nurses, and paramedic for paramedics. I know there are other opinions that there should be separate regulation for ECPs, and to the best of my knowledge that has not been decided on yet.

Q505 Dr Taylor: Your people in training are not yet out on the road as ECPs?
Mr O'Neill: No, but they are regulated as paramedics.

Q506 Dr Taylor: On the medical back-up that you think they should have, your paramedics who are giving thrombolysis presumably are connected to a cardiologist?
Mr O'Neill: We do not use thrombolysis in London.

Q507 Dr Taylor: Because you are able to get them to a centre to consider re-vascularization quickly enough.
Mr O'Neill: Yes.

Q508 Sandra Gidley: Before I move on to the questions I was expecting to ask, can I just pick up on that. If you have different bodies regulating the same role, could you not end up with differences between the regulation depending on whether they were ultimately regulated by the nursing body or the paramedics?
Mr O'Neill: I have to be honest, this is not a specific area in which I am involved.

Q509 Sandra Gidley: I have some questions for Rob Darracott, and I need to put on record that I am a member of the Royal Pharmaceutical Society. The written evidence commented that the role of pharmacy technicians and assistants has been extended in recent years. You alluded to this earlier but I would like some clarification. Has extending the roles of non-professional staff made the overall pharmacy workforce more productive or differently productive?
Mr Darracott: In so far as I think that extending the roles of technical staff allows the pharmacist to do different things, I think it has extended the overall activity of the pharmacy profession as a whole.

Q510 Sandra Gidley: The submission also says that there is a predicted gap between supply and demand of pharmacists. Does that mean it would become more important to have more technicians or other pharmacy staff that are not actually pharmacists?
Mr Darracott: That would be one way of plugging the gap, because a significant part of the role of the pharmacy profession is the supply of medicines and you could see that could be fulfilled in some way by various forms of automation. That is one way of dealing with that. Automation in itself is not the answer because machines are only as good as the people who are operating them. It does change the balance of what is required but also the productivity goes up in terms of the actual handling of the medicines themselves. With 700 or 800 million medical prescriptions a year being generated in the NHS, that is a continuing growing burden of purely technical activity outside of the cognitive activity that goes alongside it.

Q511 Sandra Gidley: The submission seemed a little bit cautious about extending the roles of junior staff and I wondered why that was. Is it a sort of doctor/nurse situation where sometimes you get doctors wanting to hang on to their traditional roles? Do you have pharmacists feeling threatened by pharmacy technicians taking on extra roles?
Mr Darracott: I am sure there is an element of that within the profession. The submission is a little cautious because we are in a period of change. We are regulating technicians at the moment only a voluntary basis and we are expecting to have the statutory authority to do that shortly. We are in a process of change anyway, and before we get to the point where we have statutory regulation of pharmacy technicians I think it is right to be cautious as to what we will do. The other thing we have embarked upon in the last six months is a major review of our education policy in how we regulate the education of pharmacists and the education of pharmacy technicians. The statutory regulation of technicians really means that we need to take a fresh look at how we regulate the education of technicians. Something may then fall out of that. The key to all of this is to identify the sort of scopes of practice. You have the scope of practice of pharmacists changing as they explore and go to new areas, something which has been supported by policy documents from the Government here but also in the devolved administrations. There will be a knock-on effect into exactly how we define what actually is the technician's scope of practice.

Q512 Sandra Gidley: You mentioned legislative change earlier and the Health Bill has provisions for changing the way that the community pharmacy particularly is supervised, so instead of the current situation we have the pharmacists continually on the premises. That could actually change. Does that not mean that there is a greater need for regulation of technicians? What are pharmacists going to be doing if they are not on the premises?
Mr Darracott: First of all, I think the regulation of technicians is an important part of that because any of the changes which are suggested may come about as a result of the Health Bill will, if the pharmacist is going to do other activities, either on the premises, which means they are not in a position to directly supervise the supply of medicines, it will require that activity, if that activity is going to carry on without their direct and personal supervision, to be done by somebody who is trained to do that. I would expect the pharmacist not to leave patients in that position without that being the case, but I think having regulated technicians is part of that package. So whilst we welcome the flexibility that the Health Bill offers and we look forward to the discussion on the regulations, I think there are two other things which we will be very mindful of. First of all, that any new system ensures that patients' safety is not compromised; secondly, that one of the things we have talked about often in office, that pharmacists are readily accessible health officials. I think what you have alluded to is that if we are allowing the flexibility for pharmacists to undertake activities outside of the pharmacy then there is a question, therefore, about how access to that service is going to be maintained. So in developing those regulations I think we need to be very mindful of both of those points: that patients' safety will not be compromised if pharmacists are undertaking other activities, which I think fundamentally requires the regulation of other practitioners within the pharmacy setting, and secondly that we do not throw the baby out with the bathwater and lose the access to the pharmacy service which is currently available out there now, right now, walk-in off the street and there it is.

Q513 Sandra Gidley: You mentioned earlier that the role of pharmacy was changing and one of the suggested questions, which I thought was rather unkind—I will read it out, and I do not expect you to answer it—"Are not most pharmacists over qualified for many of the tasks which they actually perform given that prescribing is mostly done by doctors and the majority of drugs are pre-packaged?" I think that displays a lack of knowledge, personally, about what pharmacists do do. I just wanted to put that on the record. Would it be fair to say that the new contract gives pharmacists a lot of opportunities to provide different services, but how is that actually benefiting the patient when a lot of those services are just extensions of what is happening maybe in a GP's surgery or could also be provided by nurses?
Mr Darracott: I would answer your initial question by maybe saying I notice that the NHS workforce survey says that there is a 65% increase in the pharmacy staff in the last 10 years in hospitals, and I say about time too. I think what is very important is that what we are starting to use now for the first time is the very expensive training that pharmacists get in the use of medicines, and pharmacists are uniquely qualified to deliver that service. Frankly, my view is that if those services are delivered by anybody else because of the complexity of modern medicines then actually we are not doing right by the

patients, and that the extended role begins to use for the first time, in a fuller sense, the very training that pharmacists spend five years acquiring.

Q514 Sandra Gidley: I have to say, if I felt that my training had been used I probably would not be sitting here today, I would probably still be a pharmacist; so I have to concur with that. Finally, practice-based commissioning: will pharmacists get a look in? Is there an opportunity for pharmacy or will it be dominated by GPs?
Mr Darracott: It should be but the earlier signs are not good. I think that is partly just the way things are but also partly because of the pressures within the service generally. But I think there is scope there and if other health professions do not recognise and help that along, then I think they are also missing a trick actually.

Q515 Dr Naysmith: Dr Pidd, I want to explore what this role extension and substitution that we have been talking about has meant and potentially could mean in the future for mental health services. You have already mentioned—and you have also written in evidence that you have submitted to the Committee—that there is a shortage of psychiatrists in the UK. So to what extent have mental health services compensated for this shortage by extending the roles of other groups? Again, you have already mentioned clinical psychologists this morning, and the New Ways of Working Report, which I think you yourself authored.
Dr Pidd: Undoubtedly one of the drivers for new ways of working for psychiatrists was the chronic shortage; we have historically had vacancy rates of 15%-ish for psychiatrists, which remains stubbornly stuck almost whatever we do, and it seems that we have so far failed to bridge that gap. That has meant pressure on psychiatrists and their working practices. So I think some of the driver for looking at how mental health services as a whole can be provided does come from that starting point. But I think there is also recognition that psychiatrists have not always been doing things that only psychiatrists, only people with medical training could do within the mental health workforce; and also a recognition that we work within multi-disciplinary and multi-agency teams. Therefore, looking at the skills at each of those members of the team and how they can be enhanced to provide a better use for the service users and carers I think has underpinned all the work on new ways of working. Because alongside that we were disappointed with the demise of the Modernisation Agency because the Changing Workforce Programme was a big driver for looking at developing new roles and extended roles and supplementary roles to enhance the overall mental health workforce. So I suppose it has partly been to make up for the lack of fully trained psychiatrists, but I think it has also enabled us to think more critically about what it is that each member of the mental health workforce can bring to the care pathways of patients.

Q516 Dr Naysmith: It is interesting, is it not, that when talking about the Choice Agenda—and we are not here to talk about the Choice Agenda today—people do suggest that one of the things that people using mental health services would like would be the ability to chose their main worker, whether it is the psychiatrist or clinical psychologist or a social worker or a psychiatric nurse, and that ought to be a driver too, ought it not?
Dr Pidd: Yes, I think it certainly is. I think one of the problems about changing roles is that patients' expectations sometimes do not match the workforce changes that take place because often people say that they would like to spend more time with their psychiatrist, whereas in fact under the CPA arrangements the person they are probably likely to see most of is their care coordinator, who may be from a number of different disciplines but is unlikely to be a doctor. So I think there is something about respecting patients' choice but also trying to provide them with a rationale for why seeing a psychiatrist is not perhaps what is needed on a weekly or a more regular basis, and seeing somebody from another discipline can meet their mental health needs in a better way.

Q517 Dr Naysmith: Have psychiatrists been reluctant to give up tasks that have normally or traditionally been allotted to them, to other staff groups? Has there been a reluctance in the profession at all?
Dr Pidd: It is always very difficult to generalise because psychiatrists are not known for being like sheep, which are all of a same mind. There is undoubtedly a hard core of psychiatrists, probably of an older generation, who have a very clear idea what their role is and do not wish it to change. I do not think that is true of the majority of psychiatrists. We have all trained in multi-disciplinary settings and very much see our role as to be part of a team, whether it is an inpatient team, a community team, an Assertive Outreach team. So certainly amongst the younger generation of psychiatrists there is an expectation that their role is very different from that of a psychiatrist who had their own huge caseload which did not really interact with anybody's caseload at all.

Q518 Dr Naysmith: We have been told that the new role of Graduate Mental Health Practitioner has not been particularly successful in the sense that few local services have made use of them. Is that true in your experience?
Dr Pidd: I am surprised that that is what you have heard.

Q519 Dr Naysmith: It was the head of the National Health Service Workforce Review, Judy Curson, said that.
Dr Pidd: It is a relatively young role and so I think it is perhaps unfair to make judgments at this stage about it. I would guess most services have only had the experience of graduate workers over the past two or three years. Also, I think when graduate workers were first introduced there was not a robust

framework within which they could work, so I think some graduate workers were placed into primary care as a sole practitioner, and really with quite a limited remit, without perhaps enough backup from other services. But I think with the development of primary care mental health services, which I think is going to continue apace in the coming years, the graduate workers will be working alongside clinical psychologists or nurse specialists with CBT skills; they will be working alongside counsellors, they will be working alongside community psychiatric nurses who are doing rapid screening and triaging of patients, as well as offering short-term intervention. So I think the graduate workers will find their place, and I think it is one of the problems of workforce planning and workforce changes that sometimes not enough time is given for new roles and new services to bed down before a judgment is made as to whether they are going to be effective or not.

Q520 Dr Naysmith: That is very helpful. How do the STR workers—and for the audience and for the note taker I had better say what that stands for, "support, time and recovery" workers—fit into this?
Dr Pidd: I think they are fitting in extremely well. The idea of support, time and recovery workers came very much from service users and carers identifying that what they needed more of were people who could given them hands-on time helping them in activities of daily living, negotiating their way through the benefits system, perhaps facilitating their use of occupational activities and therapeutic activities. We have always had within the healthcare system a huge number—they used to be called unqualified staff—of non-professionally qualified staff, who have had a variety names, and care assistants and support workers have been part of the mental health service for as long as I can remember. I think the introduction of the STR workers has added a professional dimension to what they do; they are not just the people who run around doing the odd jobs to support people. But for many users of mental health services they are their first port of call and their main support, their main advocate. So I think STR workers—although I think the numbers that were suggested in the NHS plan were fairly artificial—in fact is one of the groups that has been quite enthusiastically embraced because there was a ready pool of people already working in other roles, for example, as OT assistants.

Q521 Dr Naysmith: So would you say that they have improved productivity in the service?
Dr Pidd: I think it is difficult to define what productivity is in these terms. I think if we are talking about the quality of patients' lives then undoubtedly STR workers have enhanced the quality of patients' lives, their ability to access facilities that everybody else does. Certainly in terms of social inclusion agenda, for example, I think STR workers may not recognise that is what they are doing, but think effectively that is what they are doing—that they are acting as a bridge between the world, which many people with severe and enduring mental health problems find quite a frightening place to negotiate, and they are facilitating their re-entry.

Q522 Dr Naysmith: It is certainly something that you would want to encourage?
Dr Pidd: Yes, I certainly think so because the role of medication, for example, in the treatment of mental health services is only a relatively small part for people—it is a vital part—but making sure that they can access housing benefits and recreational activities certainly promotes the recovery model and that is absolutely vital.

Q523 Dr Naysmith: Finally to round all this up, we started off talking about the shortage of psychiatrists and you mentioned all those other people who make up the team, but there must be variation in availability from one part of the country to another in how these teams are made up.
Dr Pidd: Yes.

Q524 Dr Naysmith: Do you think that people adopting new roles is sustainable into the future in order to compensate for the shortage of psychiatrists? We will probably need more psychiatrists in the future rather than fewer, given what is going on.
Dr Pidd: I think we probably need at least the number that we have at the moment, if we were fully recruited to them, partly because of the changing demands. For example, when the new Mental Health Bill finally surfaces that will undoubtedly place more demands not just on psychiatrists but on other mental health professionals as well. But I think in terms of the sustainability of new teams, from a workforce-planning point of view one of the difficulties has been that a lot of the top down instructions about the composition of teams and how many functional teams you need for areas was predicated on urban areas. So I come from, relatively speaking, a rural area and it does not match very well. So I think there is a need to ensure that there could be local variation to meet the local services, but also making sure that areas which are struggling, either for financial reasons or for recruitment reasons, are having difficulty; that there is some mechanism in terms of the oversight of the Strategic Health Authorities or the reformed PCTs, the larger PCTs, to ensure that services are still commissioned with an equality of access to all these different professionals rather than areas that already have those services continuing to have them and other areas struggling.
Chairman: Could I thank you all very much indeed? Could I just say to Mr Darracott that one of the roles we do play around this table is being the devil's advocate on occasions—we do not expect witnesses to take everything personally? Thank you very much indeed for coming along and helping this morning.

Witnesses: **Mr Marc Seale,** Chief Executive, Health Professions Council, **Mr Finlay Scott,** Chief Executive, General Medical Council and **Ms Sarah Thewlis,** Chief Executive, Nursing and Midwifery Council, gave evidence.

Q525 Chairman: Good afternoon, I am sorry we have started a few minutes later. Could I ask you, for the sake of the record, to introduce yourselves and the organisation that you come from?
Ms Thewlis: I am Sarah Thewlis, Chief Executive at the Nursing and Midwifery Council.
Mr Scott: I am Finlay Scott, I am the Chief Executive at the General Medical Council.
Mr Seale: I am Marc Seale and I am the Chief Executive at the Health Professions Council.

Q526 Chairman: Thank you very much for coming along and to help us. Could I declare my interest, as I am currently a lay member of the General Medical Council? Could I ask an opening question to all of you? How are regulators helping to develop a workforce that is fit for purpose for the 21st century, as opposed to just developing more of the same?
Ms Thewlis: You have three regulators here and one of the things as a team—and I think we do work collaboratively across it—is very much looking at seeing regulation in its broadest context and not just seeing it dealing with unfitness to practise issues. So very much looking at the individual registers we keep and making sure that people who come on to those registers are capable of what we call safe and effective practice. We all do that in very different ways because obviously we have different professions that we work with, but I think very much when you are working at workforce planning it is about making sure that people that come on to the register are competent—but that is obviously something that the individuals themselves have responsibility for—and also to work with employers. At the Nursing and Midwifery Council as a new body we have worked very hard with employers about making sure that we can provide a flexible workforce. I am sure we will go on to some more detail, but just for the record there was some conversation about the emergency care practitioners and I think it would be helpful to say what our position on that is, and I am sure that Marc will come in and do some of the detail. Some of those people who are nurses, who have gone into emergency care practitioners, one of the important things to say is that if people are on a professional register then obviously they have signed up to a professional set of standards and a Code of Conduct by which they are regulated. So I think the argument about who regulates them is probably a secondary point. The important thing is that somebody regulates them, and I think one of the discussions that we are going to have for the review of non-medical regulation is looking at some of these emerging roles that come out and how those get managed. But I would very much want to put it on the record, I would not want you to think that there are people out there doing things and nobody is actually controlling that.
Mr Scott: Good afternoon. To answer your question, to recall that we have four statutory functions, although to read the Press and listen to the radio and television you would often think it was only one, namely dealing with doctors who are impaired. The other three functions, that is Standards, Ethics, Education and Registration, all help us to contribute to the shaping of the workforce through influencing not only undergraduate medical education and training, but also the attitudes, the ethics and principles that doctors take to their work day by day and, as with the Nursing and Midwifery Council and other regulators, the very direct control over who joins our register from outside the UK and the EEA. In addition we ensure that we always consult widely on any proposals that we wish to make. For example, when we laid down new guidance in 1992 on the undergraduate medical curriculum that was the result of extensive work involving others, and as we are revising that at the moment again we are ensuring that we fully involve representatives of the public, employers, and of course representatives of the profession, to try to ensure that the public's expectations of doctors can be reflected in the way that the doctors of today are educated.
Mr Seale: In addition to the points that Sarah and Finlay have raised, I think one of our roles is very much to ensure that regulation is not a constraint for development of the healthcare system in terms of what individual practitioners can do. The Health Professions Council also has a specific role in advising the Secretary of State of which new professions should become statutorily regulated, and that, I think, is vital in terms of protection of the public. I think the last thing is that all three of us have participated in the Foster and Donaldson Review and we are eagerly awaiting the outcome of that because I think that will that enable the regulators to be fit for purpose as we move forward into the existing century.

Q527 Chairman: Could you tell us, as well as setting professional standards—and it probably relates to what you have just said, Marc—should regulators be involved with regulating the activity levels and clinical outcomes of professional staff? Is it more than just setting standards?
Mr Scott: Volume levels, I am absolutely convinced, are no concern of the regulator; the regulator is clearly concerned with the quality of outcome. I think that is a different dimension. First of all, can I explain that we have found it helpful to think of regulation in terms of a four-layer model, the four layers being personal regulation, which reflects the set of values, ethics and principles that every professional—not just doctors—should take into their work; a team-based regulation, reflecting the fact that, in our case, doctors increasingly work as part of teams and not on their own; workplace regulation provided by employers and other healthcare providers; and finally national regulation is provided by us and by, say, the medical Royal Colleges. Our role in terms of the quality of outcome is to lay down broad principles through our core guidance, *Good Medical Practice*, which influences how doctors approach their interaction with

patients and their relationships with colleagues. The definition of specific standards in relation to outcomes is best left to those with specialist knowledge, and that is generally not the province of the GMC in our case but of the medical Royal College and faculties. So our job is to work with the medical Royal Colleges to ensure that those standards are available and understood by the profession, and in the event that allegations are made by doctors on the lowest of the standards, to draw in appropriate expert help in making a decision as to whether that is true or not.

Ms Thewlis: I think building on from that it is the whole issue of what evidence individual practitioners will produce as far as when they are coming to re-register. At the Nursing and Midwifery Council, building on our successor body, the UKCC, we have something called PREP, which means that every three years people have to produce whatever evidence they have done to make sure they have kept themselves up to practice. We accept that we have to do some work on that and it is not as robust as it should be, but I think that there is an important philosophical point that people recognise that they do not just get on to the register and stay there for life and are only taken off if there is some sort of misconduct or lack of competence within that, and I think very much what we are looking to do—looking at some of the work that the GMC have done—is looking at how we can accept the four-layer model that Finlay talks about, and recognising that we, as the regulator, have a part in that along with things such as are happening on a local basis and also with individual teams, rather than actually just producing something and expecting somebody to do that completely independent of what is happening within the workforce. One area that I think is quite a good example is some of the work that we have done with the Royal Pharmaceutical Society around extended prescribing, where very much if you are looking at that spreading across a wide range of professions, looking at what are some of the core standards that we should all work together around, how you can train people to actually take on the extra responsibility as far as prescribing is concerned, and I think that is a good example of where you can see regulation working across the regulators, seeing how we are looking to improve patient care.

Mr Seale: The only other point I would like to add is that while we are a regulator of health professionals and not the environment those individuals work in, under our standards of conduct and performance ethics our registrants are also required to only undertake action if it is safe and effective, and therefore we would not expect a registrant to be working in an environment that they thought was unsafe, whether it was to do with, let us say, infection control, or indeed the workload was so heavy that they could not deliver appropriate healthcare. So in a sense we do indirectly have an influence on the working environment of those registrants.

Q528 Charlotte Atkins: Sarah, your evidence stated that the involvement of regulators in workforce planning is "vital but frequently overlooked". Can you give us some examples of that happening, please?

Ms Thewlis: I think a good example would be the whole area of international recruitment. I joined the Nursing and Midwifery Council in 2002 and obviously I think there had been a policy direction about looking to increase capacity within the whole of the NHS, but I do not think anybody had a discussion with the regulators about what that was going to mean about people coming on to the register. So just to give you some figures, in 2000 we were looking at about 5,000 people coming on to the register, and then at the peak in 2002 it was up to 15,000 that were looking to come on to the register. The system—and I think this is partly a responsibility for us as regulators—is really looking at some of the trend analyses and how really we could have looked at a different way of how we were going to handle some of those applications; and what we wanted to do was to make sure, as the regulator, that we could actually say, "Yes, safe and effective practice," and I think some early discussions would have been quite helpful around that. That is the first point. The second point would have been around some of the treatment centres that people were looking to build in. We are driven by legislation—that is what you do when you are a regulator—and one of the things we are not able to do is to actually offer temporary registration, and I think part of the thing with the overseas teams that were coming over was that that was one of the things that they were looking to do. But I think if they had had a conversation with us at the beginning then we could have said, "We cannot deliver on that, we are not able to do that. We actually have core European standards where people have to have met some minimum competences and unless they have done those it is no good you telling us that this is a fantastic nurse. If they have not delivered around the core European directive we are really sorry, we cannot help." So those were two examples I would give you.

Q529 Charlotte Atkins: Thank you for that. It sounds a bit as if you are poor wilting flowers, waiting to be asked. I have to say that you are regulators and you do not look the sort of person to me that is a wilting flower.

Ms Thewlis: I think you are right, and that is one of the things where, in fairness, individually we have all worked with the respective Departments of Health at a much earlier stage. But you are quite right, I think sometimes regulation did see itself as rather isolationist and maybe did not get involved, but I think all three of us now recognise that we do need to work more closely with employers and actually get there at the beginning. Around some of the new roles' work, what I saw happening was the regulator was dragged in at the end and said, "Would you approve this?" which really is not terribly helpful because I think regulation needs to be there at the beginning and work with employers; and also what the policy direction is that you are looking to drive forward. The third bit in that is really looking at where education fits within that because I think that

at the NMC we have responsibility for quality assuring education, which our predecessor did not. So I think it is important that there is a very active dialogue because to actually change educational programmes takes quite some time. So I think from the policy direction it is important that the regulator does have responsibility for education in the way that they do at the GMC, but that was new for us. You are right, we cannot afford to be wilting flowers and I would not say we are.

Q530 Charlotte Atkins: Finlay and Marc, are you punching your weight as regulators or are you sitting back and wilting?
Mr Scott: We are certainly not a wilting flower; where I come from you do not survive if you are a wilting flower! In fact our experience, perhaps because we are a longer established body, contains really good examples of cooperative working with the Departments of Health, and I can particularly mention the Department of Health programme for recruitments of specialists internationally. We were involved in that from the outset and very successfully so. Also, when the ISTC programme was first launched we were involved in that from the outset to ensure that registration was not an impediment and that those who were proposing to tender for ISTCs understood our requirements. So there have been quite good examples. On the other hand, I think that some of the current controversy around international medical graduates who have been unable to find jobs might have been avoided if there had been a clearer national picture of workforce requirements which could have been communicated to IMGs who were thinking of coming to this country. So I would say that it was more of a mixed picture with some success but some work still to be done.

Q531 Charlotte Atkins: So the GMC are getting their slice of the action. How about the health professionals?
Mr Seale: I think it is very important as a regulator we work with all our stakeholders, I think particularly in healthcare where in fact you are beginning to get a very different Scottish NHS and also I think Wales is beginning to go in a slight direction. So it is important that we have good contacts with the four different administrations. I think also that some of our professions, for example chiropodists and pharmacists, over 60% of them do not work in the NHS but work in the private sector, so it is important that we influence that process. To give you an example, with a new profession coming on stream, emergency practitioners, I think it is vital that when those individuals are trained they can work anywhere in the NHS, and one of the roles as a regulator that we must do is ensure that those skills are transferable throughout the UK and you do not end up with a situation that somebody who trains in Kingston finds that they cannot work in Cardiff because their training has been very different. So it is very important that we are brought in at an appropriate time, but at the same time we are not seen as a blot on the system.

Q532 Charlotte Atkins: It just seems a bit odd from the evidence we had earlier—and I think you were in the audience to hear the evidence.
Mr Seale: Yes.

Q533 Charlotte Atkins: On the emergency care practitioners it did seem somewhat vague. It has been developed in London and I know it has been developed elsewhere within the country, and that must be a concern for regulators, is it not?
Mr Seale: Yes. I listened to the discussion that you had a few minutes ago on this particular subject and maybe I can give you some background information that might be of some assistance? In essence it is a new emerging profession, there are very few people currently on courses and there are a number of courses that have now been set up. What essentially is happening is that the people who are going on those courses are already regulated because they are either nurses or indeed they are paramedics. So in a sense we can wait for a short period of time because those individuals will be regulated when they go back into the workforce because we regulate by protection of title, and the principle is that as long as you are educated and you are working within your scope of practice your Code of Practice comes into play. The issue coming down the road is that at some point these new courses will want to recruit people who are not necessarily nurses or paramedics and therefore if they are not statutorily regulated when they finish their courses there will be nobody to regulate them, there will be nobody setting standards of training, conduct and ethics, et cetera, and, more importantly, we will not be able to protect the public because of the outside regulation. Again, if we go back to Foster and Donaldson, certainly in the Foster review, coupled with the themes that we discussed, there is an issue about how do we regulate these new professions and how do we set standards, et cetera? Hence the desire to see the results of those two reviews as soon as possible.
Dr Taylor: Going on with that, I am a bit alarmed because I was under the impression that there were emergency care practitioners actually working in my area and I think in Charlotte's as well.
Charlotte Atkins: They are not called that; it is a slightly different role—certainly not the university training in Staffordshire.

Q534 Dr Taylor: No, there is certainly no university training in my part. So should you not already be involved in the regulation of the training of these people who are seen as absolutely crucial with loss of emergency services across the country? Should you not, and the NMC as well, as nurses are going to be in this role too?
Mr Seale: How we currently treat a group like this is that we would regard it as a post-registration qualification in those individuals who have already qualified as a paramedic or a nurse, have gone through their training and in very small numbers are now going out into the workforce. But the ideal situation is that they should be regulated at the post-registration level and that we should set the standards of that level. It is one of those issues that

we want to move ahead but currently we are working for developments within the Department of Health on these other two reviews.
Ms Thewlis: I would concur with what Marc says. I think one of the things that we talk about being on a professional register is about ensuring that people work within what we call their scope of practice. So obviously people do not extend into areas where they are not competent, so I think that is the first bit. But as Marc said, one of the bits that we are waiting for is obviously what is going to come out from the Foster Review, because these emerging roles will have some clarity around the system that we are going to need to take this forward.

Q535 Dr Taylor: In your evidence you make a distinction between extension of existing roles and the establishment of new roles.
Ms Thewlis: Yes.

Q536 Dr Taylor: Will the ECPs be new roles or extended roles?
Ms Thewlis: I think that is one of the things where it is talking about not tying things down so tightly that you do not have a flexible workforce, and I think that is one of the things where we are very conscious that sometimes regulation is seen as a barrier to progress rather than actually something about where you can manage it going forward. I have given you two answers on that one really, Dr Taylor, because I think some of it you will see where it is just an extension of role, whereas some of it you will actually say, "No, this is a significant jump that you are talking about, it is something different." What we are very keen on at the Nursing and Midwifery Council—we are having discussions with the Department of Health at the moment—is actually having what we call an advance practice part of the register because I think there is that step change where you are saying, the individual has moved on to do something at a higher level than their initial training. I think some of the roles that we are talking about, particularly if you have responsibility for total patient care, that that is very different from doing the normal nursing that you would do. So we are having very fruitful discussions, I hope, with the Department of Health about having this level. Almost in the same way that the GMC has the Specialist Register, then we are looking at something along those lines. What we would be doing would be having a set of broad competencies where we would work with some of the specialist areas around particular clinical areas where obviously we would need to take their input because it is not our responsibility to set up the detailed clinical standards, but we are responsible for the competencies.

Q537 Dr Taylor: So nurse consultants, nurse practitioners, nurse specialists would all be in this?
Ms Thewlis: They could, and one of the things from a public protection point of view is that none of those titles that you have just mentioned are regulated or protected, so anybody could call themselves one of those where they have perhaps done a two-week course or they may have done a Masters level of education. But the difficulty is, if you say, "I am a nurse consultant" or "I am a nurse practitioner" a member of public would think that must mean that you have some sort of training. That is why, from a public protection point of view, the NMC feels very strongly that there should be a regulated part of the register where you could only use that title if you got to a certain level of competence. We have a little bit of a joke about this as to what is the longest name you can get for a title for a job that you are doing, will it fit on the name badge?

Q538 Dr Taylor: I find that surprising. So some people who are labelled as nurse consultants probably are not?
Ms Thewlis: It depends how you define what a nurse consultant is.

Q539 Dr Taylor: How do you define it?
Ms Thewlis: We actually talk about nurse practitioners and we have worked with the Royal College of Nursing, we have worked internationally—because obviously nursing is a very global profession—looking at setting a series of what we would call competences, that when you have reached that level there should be some protected title that comes with that to allow yourself to call yourself that. I think from a public protection point of view, when people use the word "doctor" of whatever they have a kind of understanding that that means you have done some sort of training, that you are safe, and "We think it is okay, we trust you."

Q540 Dr Taylor: I have to declare an interest, one of my daughters claims to be a nurse consultant! I shall have to chase her up on this! Thank you very much. You have already covered the point about regulation not being a constraint and rather being a facilitator. The last question is to Finlay. Is it right to say that the medical profession has become more regulated than other professions recently?
Mr Scott: I think if you ask most doctors they almost certainly would say so. I think the serious point is to recognise, as we have tried to do through our four-layer model, that doctors are not only regulated by the GMC but regulation takes different forms, including regulation of where they work or their employer. I think the aim has to be, whether it is in the context of revalidation or any other initiative by the GMC, to ensure that we can achieve the desired impact with the minimum burden. I think some of the thinking that has been emerging over the last 12 or 15 months around risk-based regulation from the Hampton Report, is extremely helpful, and it will enable us in developing revalidation, once Ministers have made their decisions, to approach revalidation on a basis that allows us to target much more closely the effort required to be confident that a doctor is up to date and fit to practise. That is why, as part of our ongoing programme of reform and modernisation, we are proposing to collect scope of practice data about doctors who hold a licence to practise so that that data can both be made available to employers

in the context of workforce planning and to members of the public, and will also inform our approach to regulating individuals and groups of doctors.

Q541 Dr Taylor: Sorry to backtrack, can I just go back to the emergency care practitioners for one moment because I am still not clear? Are Marc and Sarah saying that you would keep nurse emergency care practitioners under your regulation and ambulance trained ones under your regulation?
Mr Seale: I think the issue of who regulates them is completely irrelevant. I do not think that regulators should be having turf warfare between who regulates. What is important is that they are regulated, and whether you put them all in the nurses—or indeed if the dental regulator was to regulate them—it does not matter, as long as they are regulated.

Q542 Dr Taylor: So somebody will do it?
Ms Thewlis: Yes.

Q543 Dr Taylor: Who?
Ms Thewlis: Without wishing to second guess what is coming out of the Foster Review, they have talked about this concept of almost having a host regulator. I would see the emergency care practitioners, Marc would have responsibility around the education and the quality side of it, and there may be some nurses who take the decision that they want to actually not be regulated by the Nursing and Midwifery Council now, but they would rather be regulated by the Health Professions Council. If they did not make that decision and we had a fitness to practise issue that came up where somebody had concerns about the standard of care, then obviously within our legislation we are able to bring in what we would call an expert witness of due regard for somebody saying, "Is this appropriate care that is being given?" So I think that is the sense we want to get across—that, as Marc says, it is not who does it; it just needs to be done. I think one of the things that has been very helpful, I hope we have given a sense that we do actually collaborate and we do not have turf wars around this, because I think the public need to know that there is an effective system of regulation in there and we have part responsibility for that—the individual profession does—but, as Finlay said, there are other groups as well.
Mr Scott: The same issue arises in relation to other groups such as surgical care practitioners and medical care practitioners. Essentially there are two models that have been on the table. One is where you would have a single regulator responsible for any one of those groups and then individuals who were already registered with another regulator would have a choice of double registration or of switching their registration. The second model, which is the one that Sarah has just touched on, is where you have a lead regulator but those who are already regulated, ie registered with another regulator, could remain regulated in that way, and then their existing regulator would take the standards from the lead regulator. It is not a very easy concept to describe, but I think it is fair to say on balance that it is the one that the community of regulators thinks would work most effectively.

Q544 Chairman: By implication that would mean that probably the statute that covers all your three areas of regulation may have to be a bit more flexible at the moment.
Mr Scott: Perhaps it would help if I tried to illustrate what I was clumsily trying to explain? If you take, not emergency care practitioners but, say, surgical care practitioners, as has already emerged from the evidence both from us and others, there are essentially two sub populations—those who qualify perhaps as nurses or some other healthcare profession and those who, from the outset, seek to qualify as a surgical care practitioner. One model is that, say, the GMC would be the lead regulator for surgical care practitioners, but nurses who went on to qualify as surgical care practitioners could choose to remain regulated by the NMC. We would lay down the appropriate standards under that model. In that the event that the nurse, now surgical care practitioner, had her or his competence challenged the NMC would handle that in accordance with the standards that we had laid down.
Mr Seale: It might be useful to link this debate back to workforce planning. What is going on—and it is beginning to accelerate this change—is the traditional model of doctors, nurses and physiotherapists is beginning not to work, because I think what is happening is that new skills, new technology, new drugs, et cetera, start off in a very small group of individuals who are skilled in doing that and gradually that skill goes down through the workforce. At the same time you can actually now come into the workforce at a particular level with that new set of skills and what the regulators have to do is to capture those new individuals with the new skills as it trickles down through the system. Currently it is not quite working correctly but I think all the regulators want to see it work effectively. That will mean that as demands are put on the workforce those skills could then flow through the individuals.
Chairman: Thank you very much for that. We are likely to have this inquiry running to later this year if not into next year, so if you have any further thoughts in this area please do not hesitate to contact us and we will be more than happy to receive them. Can I thank all three of you for coming along, and I am sorry about the delay.

Thursday 29 June 2006

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess
Charlotte Atkins
Mr Ronnie Campbell
Sandra Gidley
Dr Doug Naysmith
Dr Howard Stoate
Dr Richard Taylor

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

Q545 Chairman: Good morning. I am sorry; we are a few minutes late. Could I ask you, for the record, to give us your name and the organisation that you are from?
Professor Paice: My name is Elisabeth Paice. I am the Dean Director of London Deanery and the Chair of COPMD, the Conference of Postgraduate Medical Deans.
Professor Gordon: I am David Gordon. I am the Dean of the Faculty of Medical and Human Sciences in the University of Manchester and I am here in my capacity as the Chair of the Council of Heads of Medical Schools.
Mr Streets: I am Paul Streets. I am the Chief Executive of the Postgraduate Medical Education and Training Board.

Q546 Chairman: I understand our other witness, Bernard Ribeiro from the Royal College of Surgeons, is presently in a cab shortly to be with us. Could I, first of all, thank you very much for coming along to give evidence to us today on what is our fifth day of our evidence taken in the inquiry into workforce planning. A question for Mr Streets and Professor Paice: the new system of specialist medical training begins in the summer 2007. Nine thousand five hundred specialist training posts will be available, but the BMA estimate that 21,000 doctors will compete for these posts. Why is there such an apparent shortage of specialist posts and what will happen to those who cannot get a training place?
Professor Paice: At the moment the September 2005 census shows that there are 21,000 people in SHO (Senior House Officer) level posts. Those posts are funded one way or another. Many of them are educationally approved SHO posts, some of them are locally funded, trust doctor posts, which are not educationally approved, and the census is not able to distinguish between the two; but do we know that there were 21,000 people in posts at that time. If you like, that is the stock. Five thousand of those have been reconfigured into Foundation Year Two posts, which start in August this year and will continue, so actually the 21,000 is now reduced by 5,000 to 16,000. Of those 16,000 posts, as I say, it is not totally clear exactly what proportion are locally funded, but the majority of those 16,000 are educationally approved SHO posts, which would fit very nicely into the specialty training programmes of the future at three levels: the first year, the second year and the third year. It would, therefore, be possible, with the existing resources, to fit all of those 21,000 people into all of those four years of posts. The question then is whether or not you have the specialist training opportunities and, indeed, the requirement for all of those people in those posts to go through to complete training, either to be a GP or to be a consultant, and that is a decision which has to be made for the long-term because you certainly cannot start people down a training pathway if you cannot complete it. The likelihood is that the capacity to train is there. It is a decision to be made whether the commitment is there to take people through.

Q547 Chairman: Have you anything to add to that, Mr Streets?
Mr Streets: It might be helpful for the Committee to understand that it is PMETB's responsibility to set standards, maintain standards and promote and develop Postgraduate Medical Education. We have no due restriction over numbers, but in terms of this debate we can work with the deans in order to ensure that people can fit into training beyond the first year, and that is one of the things that Professor Paice has referred to.

Q548 Chairman: Basically, are you saying, Professor Paice, that UK-trained doctors do not face a genuine threat of unemployment?
Professor Paice: I do not believe that there is any need for the output of the UK medical schools to face unemployment and not be able to complete their training. We have moved from a phase where we encouraged a great deal of international recruitment, and I do not think that is sustainable. Of that 21,000, we know that nearly half were not UK graduates, so there is a balance to be struck there.

Q549 Chairman: You have mentioned the issue about the new Foundation Training Programme. Will doctors in all Senior House Officer posts have equal access to specialist training posts or will it be reserved just for the new foundation training programme?

Professor Paice: No, the idea is that that body of people who are in the SHO posts will have the opportunity to compete for the training as GPs and training as specialists, not just the Foundation Two people.

Q550 Chairman: Could I just welcome Bernard Ribeiro. We understand you have been spending some time in a cab?
Mr Ribeiro: Thank you very much, Chairman. My apologies for being late.
Chairman: No problem.

Q551 Dr Stoate: I would like to explore one final point. The BMA is saying, openly, that there will be significant unemployment amongst doctors because of these new changes and they are predicting that vast numbers will emigrate to other countries. Is this realistic or simply crying wolf?
Professor Paice: It depends how you describe "doctors". At the moment there is unemployment amongst doctors in the UK, and it is something which is very concerning. A lot of the unemployed doctors are doctors who have come to this country to train, have taken PLAB and are unemployed, and that is a situation which I do not think anyone finds acceptable. It would be quite wrong to say there is not unemployment amongst doctors in the UK, there is, but that may be a different thing from saying that looking to the future, with the changes which have already been put into place about access to permit free training, there is a plan in the future to organise things so that there are unemployed UK graduates, which there is not.

Q552 Dr Stoate: I still do not feel much happier, because the BMA are saying that there will be large numbers of unemployed doctors as a result of these changes. Are you saying that this is not going to make much difference or is going to make much difference?
Professor Paice: As I say, I think that it is important to say what you mean by "doctors". There is not enough training capacity and, indeed, need in the UK to train every doctor who has come and taken PLAB and has come to this country looking for training to offer training to everyone. It just is not there. If you are saying, is there going to be unemployment amongst doctors? The answer is, no, there is no intention to train every doctor that comes to the country seeking training, but I am having to make a distinction between plans for the output of UK medical schools and plans for the very, very intense interest there is in coming from various parts of the world to seek training in the UK, and there is not the capacity to meet that demand.

Q553 Dr Stoate: So you are saying that UK trained doctors coming out of our medical schools in this country will not face unemployment but many people who are coming into the country who are given training might? Is that a better way of putting it?
Professor Paice: I would have to say that those people who are unable to compete in that market, those UK graduates who find themselves unable to enter into open competition successfully, as the vast majority of UK graduates would, may be unemployed. Nobody could guarantee that every UK graduate will be offered a training programme—that is not possible—but the plans are being based on the intention to offer an appropriate number of training programmes for the UK output. Is that a reasonable way of putting it?
Dr Stoate: That is much clearer. Thank you.

Q554 Sandra Gidley: You seem to be saying that it is unacceptable that a doctor would do a degree course and then not be able to access further training.
Professor Paice: No. I guess what I am saying is it would be wrong to plan to produce medical graduates and to say, "The plan is we will have a cull and we are not planning for a third of them to progress." After a six-year undergraduate training programme, which is broad and deep and expensive, it would be wrong to plan for people not to be able to train further in the postgraduate field and make themselves useful.

Q555 Sandra Gidley: So we actually need fewer university places?
Professor Paice: No, I do not think so. I think we need all the doctors that we are currently training. There has been a recent review of this looking at the projections over the next ten, 20, 30 years, looking at the demographics of the doctors being produced, looking at the participation rates that are predicted, looking at the skill mix for the future and the needs of the country for the future, and careful discussion as to whether we needed more medical schools or fewer medical schools, and the conclusion was actually at looks as if we have probably got it about right at the moment.

Q556 Dr Naysmith: I am going to turn to another aspect of this training. There has been a recent survey in which 62% of doctors who were surveyed (and it was a large survey, more than a thousand doctors of all different grades and skills and so on) felt that patient safety had worsened as a result of the recent changes to postgraduate training. What are your comments on that? Do you agree that is a valid judgment?
Mr Ribeiro: We presented evidence last time on the basis of what we had surveyed following the European Working Time Directive, and it really is a combination of the impact of what the EWTD has done since 2004. What we found for our survey was that 83% of the respondents felt there had been a reduction in the continuity of care and, as a consequence, in the quality of care which they felt they were able to provide to their patients, and that was our college survey. When you talk about patient safety, doctors in a professional sense have a real desire to see the job done and not to leave a case until they are satisfied it is properly done. The restriction imposed by time-based working, which what the European Working Time Directive does, leaves

many doctors with the unsatisfactory situation of having to hand over to somebody else to manage the case, and I think it is this sense that gives rise to the question of patient safety. In terms of risk to patients *per se*, I suspect that that would be subjective in terms of how that is reported.

Professor Paice: I think it is very difficult in a period of change for people to see how things can work in a new world. People are very used to what they do and change seems risky. My own personal view is that the reforms, particularly the reforms around the Working Time Directive, which will hopefully put an end to sleep deprived doctors, will do nothing but good for patient safety. I strongly believe that doctors do not learn well when sleep deprived, nobody else learns well when sleep deprived, and there is good evidence to show that what you do learn at night when sleep deprived following that learning experience is not retained. So, the first thing I would say, putting an end to sleep deprivation can do nothing but good for patient safety. The second thing I would say is making sure that the training is structured, that competency is assessed, that supervision is in place before people are allowed to do things unsupervised can do nothing but good for patient safety. What is absolutely critical is that people get the experience that they need, and one of the things I think that we have to do with the new reforms is to make sure that that happens, because there is no doubt about it, surgeons cannot learn unless they are able to practice and see what needs to be seen, and that means moving away from a system in which trainees have been seen perhaps as deliverers of service that you have to train in order to get them to come and work for you and into a system where trainees are there to learn, where the learning is available, at the times when it makes sense for them and in the centres where the clinical cases are there for them to learn on, so that when their learning is done in a streamlined way and a little bit quicker than we do it now, they come out as specialists and general practitioners who are competent, experienced and able.

Q557 Dr Naysmith: I am not sure whether you are saying that the judgment expressed by these doctors was correct and you are doing something about it or whether you disagree with that judgment?

Professor Paice: We are talking about reforms which are still in the pipeline, and so I am saying I think they are wrong, I am sure they are wrong, that patient safety will suffer in the future if we get the training right, but if left to serendipity and opportunism, I have absolutely no doubt that there will be problems.

Mr Ribeiro: Can I come back on that. I entirely take that aspect. I think where we have been concerned in our projections is over the time that will be available. Currently trainees are clocking up something of the order of about 17,500 hours in the current Calman system of training that they have towards the end of the training. Our calculations were that with the onset of the EWTD (48 hours by 2009) that will lead to a reduction down to something like 6,000 hours of training time. As a consequence of that, our college has actually extended the period of training with this new arrangement to anything between—

Q558 Dr Naysmith: That aspect has been sorted out?

Mr Ribeiro: Part of that aspect has been sorted out by virtue of the fact we have extended the training from six years of specialty training to about seven to eight years, but it is important to realise that a lot of practice and experience that we have is going to be based on competences, and those competences will determine that somebody is competent to practice, but it actually needs a lot of experience before somebody can practice independently and in a professional and safe way.

Q559 Dr Naysmith: So there is a danger that people will not get that experience unless you make absolutely sure?

Mr Ribeiro: While I accept everything that Professor Paice has said about working at night and the problems, and we have looked at that, and perhaps I could return to that later and the work that we are doing in the college on the separation of emergency/elective care, what I would say is that, recognising that problem, we have extended the period of training to take account of that. We are also, within our college, developing courses for our current trainees which will look at some of the problems that come in delivering care. Trainees as well as consultants need to have training in the effective handover of the skills that they have acquired, and these are part of the things that we are doing, and we are developing courses to make sure that they are fully aware of this.

Mr Streets: Clearly, we cannot bury our heads in the sand. The Working Time Directive is with us and it will have an impact on training, and you can juxtaposition, as Professor Paice has, the past, where people worked 120-hour shifts, with the future where they will be not be able to that and question whether actually that was safe for patient safety too. The key for us is that we must make more explicit some of the things that have been implicit in training, and that is about standards for curricula, standards for assessment and the standards in which training is taking place, and PMETB is a part of that working alongside MMC and the colleges and the deaneries. The danger is that if we do not do that, we will just need to continually extend the length of time that people train, and that will probably lead to less flexibility, and, as this Committee has considered previously, one of the things that we need to more towards is more flexibility. We think there needs to be a move towards much more explicit standards for the situation in which training takes place, and PMETB is a part of that.

Q560 Dr Naysmith: The same survey found that, as a result of *Modernising Medical Careers*, 63% of junior doctors felt that the quality of training had worsened. Is that something that you are prepared to address? What do you think of that? The junior doctors themselves felt that training had worsened?

Professor Paice: Yet, *Modernising Medical Careers* is not yet implemented. The Foundation Two programmes start in August, the new run-through grades start in August 2007.

Q561 Dr Naysmith: So what we are talking about is really things that have happened that have got nothing to do with changing medical careers?
Professor Paice: I am not sure what they were referring to.

Q562 Sandra Gidley: My question is to Mr Streets. There has been a change in the way doctors train, and you now have the two-year foundation course split into the F1 and the F2 year, F1 controlled by the GMC and F2 under PMETB. Would it be more sensible to have the whole lot organised by one organisation?
Mr Streets: You could take that view. There is a logic behind what has been proposed, because the GMC is responsible for the registration of doctors and doctors are registered at the end of F1 (Foundation Programme One). PMETB is responsible for all specialist training that takes place after that, and that is where the cut takes place. What is important is that we work closely with the GMC, and we have a joint group working with the GMC, for example, looking at how we get a quality-assured foundation programme. We also have a joint group which is looking at how the outcomes of foundation training will be looked as a whole. I would like to reassure you that we are working very closely with the GMC. It might be better if it was one or other of us, but there are reasons why, from a statutory perspective, the GMC needs to be responsible for the first year of foundation programmes where people are signed off.

Q563 Sandra Gidley: Could you clarify why the GMC does need to be involved at that stage?
Mr Streets: It is about the registration process for doctors. Doctors are registered at the end of their first year post medical school.

Q564 Sandra Gidley: Why does that mean that they have to completely oversee? Why can they not just assess what has gone on, or is it just easier to do the two alongside?
Mr Streets: Professor Gordon may want to come in on this because it is very much his territory in terms of what happens after medical school.
Professor Gordon: The position is that the Medical Act defines the responsibilities of the GMC and then the PMETB takes over thereafter, but the delivery of medical education up to qualification, normally five years from admission to medical school, is directly what we do, but we remain responsible for our students to ensure that they are getting good experience and training and education for that next year until they are fully registered. We are very happy to have that responsibility, because we believe very strongly that there needs to be a continuum in the medical education process from admission to medical school right through to higher training and, indeed, to continuous professional development. I think it is a pity that we have divisions at any point, but obviously one body cannot deal with everything right the way through. There is another important point in there, and that is that in the development of the foundation programme and the later stages of MMC there has been a lot of thought put into the educational content of the curriculum, but some of our students have commented that maybe that has not been as joined up as it might have been. They have found themselves in the first foundation year being taught about things that they felt had adequately been covered in medical school. So, I think, yes, there needs to be much better "joinedupness".
Mr Streets: It might help the Committee to know that the Chair of the GMC Education Committee, which is responsible for this, is also the Chair of PMETB, and that is Professor Ruben, so in that sense it does help in terms of coordination between the two bodies.

Q565 Sandra Gidley: Does he get paid twice?
Mr Streets: You would have to ask him that.

Q566 Sandra Gidley: Mr Ribeiro, there has been some comment that the additional training requirements of the new foundation programmes actually put a further strain on consultant time. Is this a justified comment?
Mr Ribeiro: I was actually in the north-east yesterday talking to some consultants, and I asked them that very question because they had got some foundation trainees with them, and I got two different answers, which was that there were some consultants who felt that they put an inordinate amount of strain on them in terms of the extra time to do the assessments, and so forth, and others, who clearly have had some training in this, who were able to organise their work in such a way that they felt that they could accommodate it in the time that is available. That is a foundation programme. Once you add the M*odernising Medical Careers* group, which will start in 2007, to it, I think Professor Paice actually has the figures of what it actually means in terms of time, but we do anticipate that for the assessments that will need to be done, and there are a series of work-placed assessments that do need to be done, it will add extra time to a consultant's working. What we have been trying to do, working with the deans, is to develop a framework that will allow to us have regional schools of surgery for us and for medicine and for the other specialties, and within these frameworks we will actually define the responsibility of the various people who are going to undertake training, and it may be that not every single consultant will have a responsibility for training *per se*. I think all consultants have an obligation to train, but in terms of responsibility for supervising and organising the training and the assessment of trainees, this may have to be done by consultants who have been selected, trained and picked to do it. I do not think it is just a matter of every consultant having to have that responsibility; that is one of supervision.

Q567 Sandra Gidley: You have just mentioned in terms of assessment as to how much extra time it would be. Are you able to quantify that?

Mr Ribeiro: This is what I hope the Postgraduate Medical Deans will be able to tell you, because they did actually do that sum before they made the bid for extra monies for the foundation programme.

Professor Paice: We certainly did look at how much it would cost or at least how much time it would take to do the various assessments, and I will apologise, I do not have the figures in my head but I am happy to send them along. I would actually say the trouble is when you think about the future in terms of the now, you some time get things wrong. Yesterday I went to a presentation by the National E-learning Alliance, which really opened my eyes to what modernising education should look like and already does look like for radiology, where you join an on-line learning management system, where the things that you need to learn, the films, et cetera, are brought up to your own laptop in the comfort of your own home. You do a lot of the training in your own time and the outcome so far appears to be that trainees who have this available to them are volunteering to take the exams a year early, passing them, moving ahead at a far greater rate and also going into the clinical environment (and this is the important bit) to meet with their consultant already well prepared, well informed, having had the opportunity to do some virtual learning and are then able to benefit from that expertise, and that is very expensive specialist time, rather than the old apprenticeship model. What we need to do is modernise, not just medical careers but modernise the content and the delivery of education, and that is expensive, but by no means unaffordable, as an overall vision for the way we train specialists in the future without just simply doing one-to-one teaching.

Q568 Sandra Gidley: Is the consultant as trainer model slightly outmoded then, because it seems we are expecting them to be trainers, managers and clinicians and you cannot necessarily expect everybody to have all three of those qualities?

Professor Paice: Not only that, but you need huge opportunities for people to practice skills which are not everyday skills. The high fidelity simulator environment where you have everything which looks jolly like the real thing and you are faced with emergencies, five emergencies in one day that might take you five years to experience in real life and have someone observe how you carry out everything from the procedures, to the thinking, to the team working, to the resource management, to the human factors. That is the kind of learning which is available, and I think patients would be surprised to discover that it is not available for every trainee on a regular basis.

Mr Streets: Professor Ribeiro is probably right that not all consultants in the future will train, and it is interesting perhaps for the Committee to juxtaposition general practice training where GPs are selected as trainers and remunerated as trainers compared to hospital training where that is not the case. Clearly, there is an issue here about how trainers are incentivised to be trainers and, indeed, how trusts are incentivised to provide training. This Committee previously has looked at ISTCs, for example. The first wave of ISTCs were not rewarded for training, the second wave will be, and that is very important from our perspective; but what is more important in all of this is that there is a culture of training and education embedded in the NHS. That is actually pretty important to us because that is the only way that consultants will be released for this work, and that means chief executives being measured just as much on their ability to provide a workforce for the future as delivery today, and that is one of the central problems that we have to address as we move forward in implementing MMC.

Professor Gordon: Just a small point, I noted your expression of surprise at this degree of multi-skilling amongst the consultant workforce.

Q569 Sandra Gidley: It is not just surprise, it is disbelief.

Professor Gordon: You have to have to remember that 7% of all hospital doctors are actually clinical academic staff employed by universities and they, in addition to doing clinical work, at the highest level and, of course, patient safety is paramount, also teach and do research, and we expect their research to be of international quality as well, so there are a lot of people working very hard.

Mr Ribeiro: One of the issues in the workforce is this question of consultant expansion, and one of the reasons we have been very keen to drive that is because we felt that we would be moving towards a consultant base rather than a consultant-led service. So, we will inevitably end up with many more consultants than trainees, and we have estimated that the ratio would be something like five consultants to every one trainee in the future. So, with that sort of ratio, it is inevitable that consultants will have to develop different skills. Some will develop skills as managers, some will develop skills as educators and trainers, some will develop research and academic skills, some will have technical skills that actually determine their future and the trust will appoint people on the skills that they actually present. On the question of the interaction between trainer and trainee, one of the things that our colleges have been doing, with support from the Department of Health, is to develop a new web-based curriculum, and as regards the work on this our college, which is an intercollegiate surgical web-based site. I think is a first, and in fact there has been a lot of interest from countries outside the United Kingdom in what we are doing. The intention with this is actually to have a conversation, as Professor Paice has said, through the web-base with your trainee to actually set them objectives, see whether they will be able to meet those objectives and then to critique it and decide how they are progressing. It is not all about necessarily a face to face, and we must be aware of technology. One of the things that we are criticised as a profession is that we are obstructers of change. Actually the medical profession has been one of the

greatest innovators of change, and we have actually undertaken this in the development of this new curriculum.

Q570 Dr Taylor: Going on with the content of medical training, it is obvious that undergraduates have got to have the scientific and the clinical training. Some of you have mentioned other aspects of the NHS. How important is it at student level (and really to Professor Gordon, I think, first) that they are taught about the NHS itself, about relationships with managers, with other professionals?
Professor Gordon: You have to remember that we are educating medical students for a lifetime career rather than just training them for a job, and that career for most of our graduates, of course, will be in the UK but many of them will work abroad, some of them will be overseas students who, once they are fully trained, will return home. Education for a lifetime career, potentially worldwide, means that the NHS is a very important element, but it is not the sole element that they need to understand. Nevertheless, it is very important that, certainly before qualification, our students understand how the NHS works and how they can interact with the service, more importantly, how they interact with their professional colleagues in other disciplines and learn to work together in a team. I think most undergraduate medical curricula are quite well advanced in making sure that that understanding is in place. The GMC Education Committee would be on our backs if we did not.

Q571 Dr Taylor: So at undergraduate level that happens. As one moves up the scale, on one of our visits recently when we went to visit Kaiser Permanente, we learnt that fairly early on they pick out what they call "emerging medical leaders". At what stage does that happen in a career? Is it left until somebody becomes a consultant or are there steps before then?
Professor Gordon: It is a subject of great interest to us, for a number of reasons, not least, for example, that it is surprising that more people do not put themselves forward to become deans of medical schools, and we are particularly concerned that more women do not put themselves forward to become deans of medical schools, and we are working with the Leadership Foundation for Higher Education on that problem. We see it as something that extends much earlier in people's careers and, indeed, we are looking into ways in which, right down to medical student level, there will be some people who will be interested in developing their leadership skills, and there is some work being done at the University of Leeds Medical School on this.

Q572 Dr Taylor: More and more doctors have to be medical managers. What is the college doing about that?
Mr Ribeiro: Again, in the submission that was given by both Professor Dame Carol Black and Sir Alan Croft, reference was made to young emerging consultants, as you have said, and also reference was made to the fact that the Academy and the colleges are working very closely with the Institute for Improvement and Innovation, because we see that one of the major deficiencies, which I am sure you experienced when you became a consultant, is that you were trained to be a physician and a surgeon, and I was plainly trained to be a surgeon, you were not trained to manage, and we picked that up during our early consulting years. I remember having a three-day refresher course on how to deal with managers and how to deal with management in the early days. We would hope that that would be part of the curriculum, and one of the things that has come in our curriculum is adopting the GMC's seven principles, one of which does involve the acquisition skills of management. So, within the training programme, we will actually be teaching this and training in those skills.

Q573 Dr Taylor: You are talking about the future. Is it there now?
Mr Ribeiro: Currently, it is there in the curriculum that we have developed now. We would hope, and we are encouraging our trainees, that all trainees in the current Calman programme would be encouraged and move to the new curriculum. We would certainly expect those Calman trainees who are in year one to four to adopt the new curriculum. We cannot force them to do so, they were appointed under different terms, but we would certainly expect them to adopt those principles.

Q574 Dr Taylor: Would there be any move to pick out people who show promise in this and push them forward?
Mr Ribeiro: In what way?

Q575 Dr Taylor: To push them forward to take on more of the management, more of the leadership role if they looked to be the sort of people who would do that.
Mr Ribeiro: The model I was suggesting to people is that to be employable as consultants it is not good enough just to have the skills of a doctor, they will have to, at a point, demonstrate that they have added value to that trust, because I think in the future what we as colleges have done is produced a cohort of trainees with a certificate that says, "You are accredited to practice as a consultant." We have not armed them with anything else. What I think we now have to be cognisant of is that we are in a market place now, and trusts are going to function on the basis of contracts, commissioning, PBR, all those things which will determine that they have a workforce to deliver the agenda that they have been given, and I think we have a responsibility as colleges now to develop that workforce.
Mr Streets: Your question was broad on content but you fell specifically on medical management. PMETB has said it will look at what the content and outcomes of all curricular should be in order that we can look at the core content, and one of the aspects that we will look at is medical management. We have specifically indicated this. We think there are three levels at which this needs to take place. There needs to be a compulsory component of medical

management which is within the CCT itself for everyone, but also there needs to be the opportunity for people to pursue medical management as a speciality post CCT, and, as previous people giving evidence to this Committee have said, we have encouraged the work of the National Institute for Innovation and Improvement to look at this specifically, and also potentially the opportunity for doctors to take time out to do, for example, an MBA. Having just come from the NHS Confederation Conference, there is great deal of talk about the need for clinical engagement and clearly to date one of the issues has been clinical engagement; but I think it is interesting that the Committee has not looked at, which for me is one of the major drivers of content in the future of medical education, at the different kinds of relationships between patients and professionals as heralded by things like a patient-led NHS, and if one looks at moves towards the co-morbidity of patients in the future, older patients requiring a very different kind of relationship with their doctors, I would suggest to the Committee that that is perhaps the major change that we need to look at in medical education and how we get that right.

Q576 Dr Taylor: "A different relationship with their doctors"?
Mr Streets: If I can use diabetes, which is the example I know very well, good diabetes physicians were moving to a model very much where it is a partnership between patient and professional making joint decisions around care.
Dr Taylor: Thank you.

Q577 Dr Stoate: According to Mr Ribeiro, *Modernising Medical Careers* is going to introduce for, the first time, this idea of competences in the currency of medical training. Do you think this will help to improve flexibility of a consultant's career?
Mr Ribeiro: I think there have been some who have felt that a trainee who has been proved to be competent in one particular area, for example taking gall bladders out, might be able to provide a service to the NHS by doing a service list of gall bladders. I think you have to see it in context. The training is the training in the whole, and just ticking a box to say, "I am competent to do gall bladders", is not what we are about. Certainly in general surgery we would expect our trainees to end up being more than just competent to manage the emergencies; they must be able to be competent in their own speciality, plus the ability to manage the general emergencies, and that is a big task because it involves expertise in all the sub-specialties within general surgery.

Q578 Dr Stoate: I have got an even bigger question. Given that the role of surgeons if likely to change very radically over the next ten, 20 years, are we training the surgeons now with the right competence to be flexible in the future, given that their role is going to change enormously?
Mr Ribeiro: I have used the expression that one has to learn to be light on one's feet, and I think that we all know the dangers that came from Tagamet, the drug that got rid of ulcer surgery, you will no doubt ask me questions about cardiac surgery and drugs that get rid of the need for cardiac surgery. You have got to be light on your feet. If you do not have a good, broad base to your training, you will be never be able to reposition yourself into another specialty.

Q579 Dr Stoate: Is the current training under MMC going to do that or not?
Mr Ribeiro: This is one of the things that we have done. We have started from a premise that we were here to try and shorten training and improve training educationally, and we felt that we could do that and the time-frame for that was suggested that this could be done in six years, indicative years. However, the confounding factors of the European Working Time Directive and all those things made it absolutely clear that this was not achievable in that time frame, and what we have in surgery done is insisted that we have a core two years, what we call a core specialty two years, where these generic foundation skills and surgery will be learnt. I think it is very, very important that people do not go straight into their specialty, but that they do have exposure to other specialties in the first two years of starting, because they will be coming out of a foundation programme, many of them, with no exposure to surgery. It is quite possible to apply for a surgical post, believe it or not, with the way things are structured, without having done a surgical job other than your first foundation year.

Q580 Dr Stoate: Before I bring Professor Gordon in, the cardiac surgeons that you quite rightly brought up, and I wanted to talk about, would not be required probably at all. That may be a broad statement, but as we know them today, in 20 years time, if it is foreseeable that cardiac surgery will be a thing of the past, what in your view will happen to those cardiac surgeons? Are they going to be trained today to have any role in the future?
Mr Ribeiro: In fact, the Cardio Thoracic Society has done a survey of its Fellows to find out what they would actually do, and I have got the results tucked away here somewhere, and what that actually showed was that 50% of those surgeons would be prepared to continue in cardiac surgery in non-consultant grades if necessary. That is the determination. They have trained to this high level of expertise and they do not want to throw that away. All of them would naturally like to stay cardiac surgeons.

Q581 Dr Stoate: But is there going to be any cardiac surgery for them to do is the point I am making?
Mr Ribeiro: Well, yes and no. We talk about statins, we talk about stents, but stents can fail, and we do not know what the long-term is. In fact, in terms of research, we do not know what the long-term results are going to be for cardiac—

Q582 Dr Stoate: Can I stop you there. Are you hoping there will still be a role for cardiac surgeons and that stents will fail and we will still need cardiac surgeons, or are you—

Mr Ribeiro: No, no, no. Do not forget, the explosion in cardiac surgeons came about through the National Service Framework, I think it was under Milburn's time, which suggested that there should be an expansion, and, unfortunately, that expansion coincided with the drug treatment.

Q583 Dr Stoate: That is my point?
Mr Ribeiro: The point is that, that workforce will now have to be redeployed. We should avoid making those sorts of mistakes in the future by, as I said, making sure people are light on their feet and can move into other services, and it is quite clear that 20% of the people surveyed were prepared to consider other surgical jobs and the rest would have had to redirect themselves to radiology or whatever.

Q584 Dr Stoate: Professor Gordon, what do you think about this?
Professor Gordon: I would very much like to echo Mr Ribeiro's point about lightness on the feet. I think medical knowledge and the practice of medicine change unimaginably in a lifetime career, and the kind of medicine that we saw in medical school is now history. The point I want to make is that one of the places where innovation in clinical care comes from is from the academic world. A good example is that when the HIV epidemic began there was no-one who knew how to treat this disease, and the first specialists in Aids all came from clinical academic infectious disease who had the flexibility and the background knowledge to be able to move into this new area. It is very important that we maintain that scale and flexibility of academic activity. We are very concerned, because the numbers of clinical academic staff are declining. We have published this morning our annual survey of clinical academic staff numbers, and we have enough copies of this for the Committee, which we will leave, and it shows that the total number of clinical academics has fallen below 3,000 for the first time. That is at a time when research is expanding and medical student numbers are expanding and the world is growing, and we are trying do what we do with fewer and fewer people, and so it is very important that, whatever the root causes of that decline, they are addressed because we will not be able to be flexible on our feet in the future if we do not have these people.

Q585 Dr Stoate: A final point to Mr Streets. Do you envisage that the Royal College exams in future will be scrapped as a result of these competencies or will we continue to have some sort of parallel system of Royal College exams and competencies determining someone's fitness to practice?
Mr Streets: There is likely to be both, in fact, because there is no doubt that within the CCT as it stands there will be college exams as part of the assessment process, but the arrival of PMETB has enabled people to be assessed on competence, using a mechanism called Article 14 which has enabled us to look at somebody's training experience, qualifications and assess them as equivalent to a day-one consultant. In relation to the broader point you made, I would just like to make a comment on flexibility, because our belief would be that there is not enough flexibility in specialist training at the present stage, and we will work closely with the colleges on this. One option for us would be to look at a core and options approach within training so that people can flex what they do within a training programme. We think we need to see training and education more as a continuum and perhaps we need to look what is within the CCT and what is after the CCT. There are contractual issues there, because it is quite difficult at the moment for doctors to take time out to train, from a financial perspective we need to look at that, but most important of all, what we need at national level is a strategic approach towards this that looks five, or ten, or twelve years ahead. At the moment we do not have that, and that is the missing link. It is very difficult thing to do. We cannot predict the future, it is very evident in terms of technological change and many of the things you have considered, but we do need a strategic approach towards thinking about what the medical workforce should look like in 10 years' time.

Q586 Charlotte Atkins: Professor Paice, we saw the integration of the Workforce Development Confederations and Strategic Heath Authorities back in 2004. What impact has that had on the provision of postgraduate medical training?
Professor Paice: I do not think that integration made a difference to postgraduate medical education and training. I do not think that integration made a difference.

Q587 Charlotte Atkins: Obviously, one of the issues as well is the whole issue of the number of Strategic Heath Authorities being reduced down to 10. Do you feel that that will have an impact, adverse or otherwise? I will bring Professor Gordon after you have spoken.
Professor Paice: I think one of the things which is a concern to anyone who is engaged in postgraduate medical or undergraduate medical education is whether this reduction in size, or at least a reduction in the number and increase in the size, of the SHA will make a difference to where education sits on the board or in the structure of the SHAs. It was a feature of the 28 SHAs that there was an educational presence on those boards, and clearly with the new structures that may well not happen. I think it is absolutely critical that postgraduate medical and dental education feature within that board structure.

Q588 Charlotte Atkins: Do you think that the postgraduate deaneries will not have the same sort of relationship with the SHAs given that they are going to be reduced to ten? Is that your concern?
Professor Paice: I do not think it is necessary for that to happen. I think it could be, and, indeed, certainly in London, where we had five SHAs and one London Deanery, I am extremely hopeful that the relationship may improve as a one-to-one relationship. So, I do not think that is necessary at all, it is just a question of making sure that education is up there.

Professor Gordon: We are actually very concerned about these changes in the documentation about the strategic objectives of the new SHAs. There is not a single mention of education or of research, and I should mention parenthetically, and you may note, that the Healthcare Commission also makes no mention of education or research in its core developmental standards. To echo Professor Paice's point, there is now no obligation to have a representative from higher education on the board of an SHAs because there is actually a statutory instrument before Parliament at the moment removing that, and that means that there will be no membership as of right on each SHA making sure that tri-partite mission of education and research alongside patient care is fully met, and I think this is very important indeed. We cannot really sensibly leave decision-making about how much resource and how much effort goes into education to local decision-making in SHAs where there is no-one with a flag, so it is a very serious problem.

Q589 Charlotte Atkins: Mr Streets, do you want to come in on that?
Mr Streets: Yes. We would welcome moves towards integration if it really means that chief executives of strategic heath authorities are going to prioritise training and education, and the proof of the eating will be in the pudding, and actually it is difficult to see how they will, given the other priorities they are going to be facing. We need strong deaneries if we are going to have good education, but the key goes back to the point I made earlier about national strategic leadership for medical education looking beyond the next year or two, and it will be fine for them to be integrated locally within SHAs, providing it was in the context of national leadership of medical education, really thinking beyond the next year or two, and it is difficult to see how strategic heath authorities will be able to do that. Indeed, one would not want 10 different approaches towards that, you need one national approach to that.

Q590 Charlotte Atkins: Interestingly enough, you made a comment about ISTCs and the fact they were going to be training in phase two. I think some evidence we received yesterday indicated that that was very much down to the deaneries and it would not necessarily be a contractual obligation?
Mr Streets: There is no doubt that deaneries are absolutely critical to the delivery of medical education, and they must ensure that training provided in ISTCs is equivalent to that that would be provided in an NHS hospital.

Q591 Charlotte Atkins: Do you think that will happen?
Mr Streets: It is a question you could ask Professor Paice about.
Professor Paice: Only if there is the funding for it, because there is one thing that is absolutely clear about ISTCs and that is that they will do what it is that they are incentivised to do financially.

Professor Gordon: I think it is important to point out that it is very difficult when the education and training levy within the SHA budget is not actually really ring-fenced, as we think probably it should be.

Q592 Mr Campbell: As we know, education and training funding is basically supplied by the Strategic Health Authority, but last year it had a surplus of 500 million. You have got to wonder why. Did this really affect any training and education, and the second question which follows on from that, was it prevented from spending that money because of the defects in the health economy elsewhere?
Professor Gordon: That is a question for the Department of Health, but I think it is quite likely that financial problems in the delivery of patient care may have to be bailed out, in the present circumstances, using money that should be for education and training, not just for postgraduate education and training but also the money that underpins the additional hospital and primary care costs of training medical students. The Department of Health has recently very clearly ring-fenced its R&D money and we believe strongly that the education and training money should be equally firmly ring-fenced, because if it is not it will be raided, and that is actually eating the seed-corn for the future.

Q593 Mr Campbell: The big question is: is it being raided now or is it going to be raided?
Professor Gordon: We believe has been raided now.

Q594 Mr Campbell: It has been?
Professor Gordon: My information is that it has been.

Q595 Mr Campbell: So it is going to affect training and education?
Professor Gordon: Yes. Certainly there is evidence in the reduced number of places commissioned in nursing. You have got Dame Jill Macleod Clark coming later, so you may be able to ask her about that.

Q596 Dr Taylor: We have had evidence about nurse training, but, as far as you are concerned, the deficits have not yet affected medical training.
Professor Gordon: No, but there is a process going on to look at the scale of the element of SIFT (Service Increment for Teaching) that actually supports undergraduate medical training to suggest that there might be a common rate and that rate might well be much less than the true cost, we believe. Certainly in many centres it will vary from one centre to another. So, we are very concerned about the process that is going on to review the levels of SIFT, and we believe that that could have a severely adverse effect on undergraduate medical training.

Q597 Dr Taylor: Somehow the Government have found £765 million to lesson their deficits, and that would appear to have possibly come from the training budgets. Have you any evidence that that is the case?
Professor Gordon: Not directly, no, I have not.

Q598 Dr Naysmith: We are going on, finally, to the question of diversity. It seems to be fairly well recognised that a disproportionate number of doctors are female, white or Asian and middleclass. How can we encourage more working class men into the medical profession?
Professor Gordon: The Committee members probably do not know the huge amount of work that medical schools do in trying to ensure the appropriate diversity of their intake. We have teams of staff and our students go out into primary and secondary schools. In my own centre we are involved in every school within a certain radius in Greater Manchester and we talk to children, we endeavour to find those who would have the aptitude and the ability and encourage them to come in. Sometimes they are dissuaded by other factors, particularly financial ones. It is very difficult if your parents are looking forward to you entering the paid workforce very early on and you are going to be a student for many years, and there, I think, obviously bursaries and other things can help in that way. The other development with which the Council of Heads and Medical Schools is involved is that of the UK clinical aptitude test. This is designed to test innate ability rather the kind of abilities that can be trained for and shown in public examinations, and it will also be looking for qualities such as integrity, empathy and resilience. So, we are looking for the basic qualities that the young man or woman has rather than what they have been coached to do in school, and about 75% of all medical and dental schools will require students to take UK CAT, and we believe that this will be a great help in picking out young people from all backgrounds who have the right ability and then we are very keen to get them through.

Q599 Dr Naysmith: The Chief Medical Officer told us when we were discussing this subject that new medical schools had been more successful in this than other medical schools, the older, more established traditional ones. Should it not be those ones that they were really trying to get the sort of people you were talking about?
Professor Gordon: I would be interested to know Sir Liam's data on that point. I come from quite an old medical school and we are working very hard.

Q600 Dr Naysmith: Maybe it is misquoting him a little bit. What he said was that they recognised the importance of it and were trying much harder than the others. I think that is what he really meant.
Mr Ribeiro: Can I follow up on that? We have worked very hard with the Department of Health over the last 20 odd years to increase the number of consultant surgeons, and, in fact, we have had in the last 10 years a 60% increase in consultant surgeons. What we have noticed in that time is that the number of female consultants starting with them has increased from a point where we used to have something in the order of about 50 or 60 female consultants to 220, and that is still only 6% of the surgical workforce and there is a lot of work to be done to get that right. On the diversity side, I think I heard it quoted, and I cannot remember, in some of the evidence that was given, of I think Sheffield Medical School. One of the members of our council, Mr Andrew Raftery, who is the Dean for Admissions, has indeed instituted a system whereby they go round all the local schools, and the local comprehensives and so forth, to make the point that medical training is a worthwhile thing to do, and what we as a college now feel is that, in order to recruit our workforce in the future, for which we will need to rely on the female workforce to maintain the surgical workforce, we will have to go into the medical schools, actively go into the medical schools, promoting surgery as a career for everybody to do. The question of diversity is quite a tricky one. You are right to say that there are increasing numbers of Asian women in surgery, in fact 25% of the female intake at medical school is almost all female Asians in that context, but there is not the same amongst the Afro-Caribbeans, and the question is: why? We were recently in the West Indies, in Jamaica, doing a course there. A lot of their bright and very able young people go to the States for their training because their role models are in the West Indies. What we need are West Indian role models who are getting on into medicine. Without those role models, in the same way as women if we do not have women consultants as role models, you will not recruit.

Q601 Dr Naysmith: While I have you in front of me why do you think it is that surgery has always had this reputation of not having many women in it? Why has it been unattractive for women?
Mr Ribeiro: I think because it was the perception—and I will give you a very good example—of long hours, hard work and physical activity. That is no surprise that the percentage of women doing paediatric surgery is about 23% whereas the percentage doing orthopaedic surgery is less than 3%, and there is perception for orthopaedic surgery that you have to be a big, strong second row rugby player before you can do the surgery, and these stereotypical things do put people off, and I think that what we are realising is that women now drive heavy goods vehicles because technology makes it possible for them to steer a vehicle and turn it on a sixpence, and in the future these specialities which have been thought to be male preserves will, with the aid of technology, be open to all.
Mr Streets: If I may make two very brief points on that. One is the flipside of the Working Time Directive, of course, as it will encourage more women into the medical workforce because it becomes more possible to run a medical career alongside a work-life balance, and what the evidence from the BMA is telling us is that doctors, both male and female, want a better work-life balance and that is one of the reasons why 60% of general practice

registrars are women because they think in general practice they can achieve a better work-life balance. In terms of role models I think Professor Ribeiro's point is absolutely right and one of the things we hope Article 14 will do is to enable more people who previously have not been able to get through the assessment systems of colleges and others, to access the specialist register because of their experience, and what we are seeing through Article 14 is the doctors who previously would not have been able to become consultants are now eligible to apply. Many of those are from South Asia and therefore may become the role models of the future for some of the diversity issues we are talking about.

Q602 Sandra Gidley: I was very, very struck, particularly with you talking about Asia, by the statistic we were given, which says that 19% of new medical students were Asian in 2001, while Asian people made up 7% of the UK population. Are the Asian students homegrown or are they overseas students who come and are very attractive to universities because they pay full fees?

Professor Gordon: These are home grown. We are looking at a very strong demand for medical school places from school leavers of ethnic Asian origin, but UK home grown, and they are chosen purely on their aptitude and merit, and of course they are excellent students. The point is absolutely, though, why do we not have working class male students who have the ability, applying in the right numbers, and we do not know. We are trying.

Chairman: Could I say that on the Sheffield Medical School I understand that it has one link with one secondary school in my constituency and not the other four? Could I thank you all for coming along this morning and giving us evidence on these points? Thank you very much.

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

Q603 Chairman: Good morning. Can I ask you if you can give us your names and organisation just for the record, please?

Professor Sir Andrew Haines: I am Andy Haines; I am Director of the London School of Hygiene and Tropical Medicine and a member of the Universities UK Health Committee.

Professor Butterworth: I am Tony Butterworth; I am a nurse by profession. I offered evidence in my capacity as a director for the centre at the University of Lincoln, but I have a previous career as a WDC Chief Executive.

Professor Macleod Clark: I am Jill Macleod Clark and I am Professor of Nursing and Deputy Dean of the Faculty of Medicine and Health, University of Southampton, but I am here in my capacity as Chair of the Council of Deans for Nursing and Allied Health Professions.

Q604 Chairman: Thank you very much for coming along. Could I ask Professor Butterworth a question, please? In your written evidence you stated that the previous "boom and bust" approach to workforce planning has largely been resolved over the past five years. How do you reconcile this with the current reductions in training places for nursing and other professions? And how can we avoid another "bust" phase?

Professor Butterworth: When offering the evidence I think it was clear that the work of the then Strategic Health Authorities, the National Workforce Review Team and the WDCs had ironed out what had been quite a serendipitous approach to workforce planning, and I think that we had both geographic expertise across the country through the SHAs and the WDCs, and we are beginning to work intelligently with the hospitals and health communities in such a way that we were trying to join together workforce requirements with what they said they needed to deliver by way of service. We have not fulfilled that completely, by any means, but at least it was a step in the right direction. I think the immediate difficulties are occasioned by financial problems rather than a lessening of the requirement for the workforce number.

Q605 Chairman: Can I ask the other two? Your submissions stated that training places have been cut by up to 30% for 2006–07. Is this the start of another "bust" phase in your view, or has the planning hiatus which has been described been resolved?

Professor Macleod Clark: If I can answer that? I think it is definitely a very dangerous position in which to find ourselves. The overall reductions in commission numbers across the country are about 10%-plus and that is in Nursing and Allied Health Professions, but in certain areas they are much, much higher than that. For instance, the University of West England has a 26% reduction in nursing numbers for this year, and a 31% in physiotherapy and the University of East Anglia has a 27% reduction in nursing and a 28% in physiotherapy. That is hugely greater than the "bust" cycle we saw in the 1990s where we had about a 20% reduction over a period of five years. You can see that if these figures were maintained for just one more year they would be much greater than those.

Q606 Chairman: Do you have anything to add?

Professor Sir Andrew Haines: Just to echo what my colleagues have said. I think it is very difficult for Higher Education Institutions to cope with this amount of variability and it really makes long-term strategic planning almost impossible. At the recent meeting of the UK Health Committee I was rather struck, looking at my colleagues around the table, by

the dismay that they were expressing and the difficulties of forward planning of an HEI, which has quite a major commitment to the Health Service. I think it really makes the relationship very difficult and very fraught. As we have already heard, education and training is always susceptible to short-term pressures around finances and what we need really is a much more long-term and strategic view, and I think that will be greatly welcomed by the Higher Education Institutions.

Q607 Chairman: Do you think that cuts in training places are a response to financial deficits in other parts of the National Health Service?
Professor Macleod Clark: I think without doubt, and we do have some quite clear evidence that that is the case, that the Strategic Health Authorities in finding contributions to the financial deficits have raided the education budgets and they have particularly notably raided them in the Nursing and Allied Health Profession, NMET end of that budget.

Q608 Chairman: If you have that evidence already could I invite you to send it in?[4]

Professor Macleod Clark: Indeed.
Professor Butterworth: As a case example, when I was a Chief Executive of the Trent Workforce Development Confederation we would handle a budget of about £56 million a year for education and training of the professions other than dentistry and medicine. The Strategic Health Authorities had a budget of £7 million and therefore savings had been found from somewhere which was clearly not all from their own coffers, I think.
Professor Macleod Clark: If I could add to that? For instance, in the Avon Gloucester and Wiltshire Strategic Health Authorities there is a record from the board meeting of a £10 million saving on the NMET budget, which has gone into the deficits.
Chairman: Thank you for that. Howard Stoate.

Q609 Dr Stoate: Professor Clark, just a follow up to that. You said in your submission that the link between workforce planning and education commissioning is non-existent at least and tenuous at best. That is pretty alarming. How do you think we can put that right?
Professor Macleod Clark: I think what is very clear is that current mechanisms are not working and they are not working for a number of reasons, notably because there is no joined-up thinking and we do not have a national integrated workforce plan. The devolution of responsibility to Strategic Health Authorities has not been successful because it then puts those decisions at the vagaries of issues like financial deficits, and we need a joined-up picture. I think although our medical colleagues, as evidenced in the previous session, do have some problems they are nothing compared with the problems that we have for the Nursing and Allied Health Professions, and that is partly because there is a bigger national picture for medical manpower planning. So I think that an integrated approach is needed and there are also real issues about the fact that we do not have similar funding streams and that is a nonsense.

Q610 Dr Stoate: What would you do about it? How would you improve the situation?
Professor Macleod Clark: We would have an integrated workforce plan at national level with long-term strategic planning, not too much anxiety about do we exactly get the numbers right because I do not think anyone can ever do that. But we do know that we will need more health and social care professionals over the next 10 to 15 years and not less, and we do know that we need to be flexible in the types of professionals that we produce. So that means that you have to have the big, broad joined-up picture, and I also think that we need to have joined-up funding streams because if you have separate funding streams each of those is vulnerable and if they are not ring-fenced for education they become increasingly vulnerable.

Q611 Dr Stoate: Is there a case, for example, to have a similar system for non-doctors as we have for the medical profession?
Professor Macleod Clark: Yes, indeed there is.

Q612 Dr Stoate: Would the other two agree with that?
Professor Sir Andrew Haines: Yes, I would. I think that the arrangements for the medical profession work reasonably well, and I think also one could draw the distinction between the money being handled by HEFCE where it is relatively protected from these kind of short-term vagaries and the money being at the mercy of the SHAs, where inevitably it is going to be sacrificed for short-term emergency spending; it is always going to be raided for that purpose. So I think the point we would like to make is that there needs to be ring-fencing for the NMET budget, that this may be better done by removing it from the day to day vagaries of short-term financial considerations, and that one needs to look carefully at the medical model to see whether it actually is more generalisable to the non-medical professions.

Q613 Dr Stoate: Do you have anything to add to that, Professor Butterworth?
Professor Butterworth: I think that the original ambitions, which I described before, to try and link workforce planning to the delivery of service were good; I think it is the best idea to be able to do that, and although it was only partially successful I think that ambition needs to be pursued further such that it is not a separate exercise, workforce planning, from the delivery of service. You have an excellent expert national workforce review team who can give you technical advice and then take advantage of that at a local level. The discontinuity that we see at the moment, the difficulties of re-establishing new Strategic Health Authorities, has taken one eye off the ball for that, I think at the moment.

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Q614 Mr Campbell: Did the introduction of Workforce Development Confederations improve the workforce planning relations between the Health Service and higher education providers?
Professor Butterworth: I left the higher education sector to become a Chief Executive of the Workforce Development Confederation and assumed that there would be rooms full of people with that expertise, but in fact there were not. We spent quite a lot of time encouraging and developing people with workforce planning expertise that we could draw from both the health and educational sector, and I think that they did seek to make a difference between the health and the knowledge economy, and I think it was a step again in the right direction.

Q615 Mr Campbell: What has been the impact between the Workforce Development Confederation and the SHAs? Has there been an impact of that merger?
Professor Butterworth: In Trent I held an executive appointment on the Strategic Health Authority so that allowed me to bring to their agenda at their board meetings educational matters across all the professions, which was very helpful, because they could then build in those things to their strategic requirements, so that entrée between institutions in higher education and the health strategic planners I think was significantly important.
Professor Macleod Clark: I would say from the experience of our constituencies that the continual change that has gone on has been undermining. There has been a failure to have continuity in some of the people who we have been working with in partnership, a dilution of the expertise, which I think was pretty slim to start off with, and notably I think there has been a tendency to put a huge amount of resource into micromanaging the educational contracts, as opposed to developing a strategic long-term partnership to discuss the kind of workforce that is required locally. It would be an interesting test to see how much it actually costs to deliver this NMET education programme through the Department of Health mechanisms, if you were to compare it with the process that is used for medical students and for social work students. So our perception is that whatever changes have occurred the processes are not becoming better, they are becoming more disruptive and the partnerships between Higher Education Institutions and the SHAs have been undermined, and notably there is now no Higher Education Institute representative on the new Strategic Health Authority boards.

Q616 Mr Campbell: Do you think that the reduction of SHAs from 28 to 10 will make it better for education in the future?
Professor Macleod Clark: I think that the problem goes back to how I answered a previous question, that I do not believe the mechanisms that are in place at the moment are the right mechanisms to predict and work with Higher Education Institutions to produce the workforce that we need for the future. So that simply reducing the number of SHAs will not help in its own right.

Q617 Mr Campbell: Does anybody else want to say anything?
Professor Sir Andrew Haines: Just to reinforce the point that I think that education and training is the victim of the constant reorganisation of the NHS without necessarily a very strong evidence-base behind it. One can see that in some areas, for example in London, having one SHA might be advantageous in terms of strategic planning across London, but a real issue is first of all the pace of the reorganisation, also whether or not Higher Education Institutions are going to be properly represented on the SHAs and the indication we have at the moment is that they will not be, and that seems to us a real lost opportunity in terms of engaging the higher education sector.
Professor Butterworth: 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, over which they have some control, that would be a great shame. I felt that perhaps within the 28 it was more focused, more purposeful, but they will become smaller and more beautiful and specifically focused in the business they will do. So there is a danger that education becomes an afterthought out of that strategic planning exercise.

Q618 Chairman: Should it be taken out of their hands?
Professor Butterworth: If it were properly thought through in such a way. I think it would be quite easy to do that, you could take it away from Strategic Health Authorities, but you would have to secure it in some other way and still have that interlocation with strategic planning somewhere. We could not ignore the Strategic Health Authorities and their mission to deliver services.
Professor Macleod Clark: I think again that the medical model does work with a funding stream through HEFCE and indeed in Scotland the non-medical funding scheme is being channelled through the Scottish Health Higher Education Council. So I think there is a real potential to shift the way in which the funding is managed for the non-medical education budget.
Professor Sir Andrew Haines: I would just say that I think it is going to be very difficult for 10 SHAs to really develop a national perspective on workforce development on education, so although there may be an argument for regional relationships between the NHS and HEIs, which we would welcome, as I say, that does not really deal with the whole issue of national planning and we need to look at the broader strategy, not just what is happening in the UK but also what is happening on the international stage. If you look, for example, in North America, it is quite clear that the USA is going to be importing more health professionals in years to come and that is going to have implications for the UK. We have been traditionally a major importer and certainly when I go around the world I get a lot of feedback about the UK's role importing many people from low income countries, and while we have tried to

improve that situation in recent years I think we still have a responsibility to make sure that we do not adversely impact. That is not the sort of thing that we can do at the SHA level, that is the sort of thing that needs a national view.

Q619 Charlotte Atkins: Professor Clark, the Strategic Health Authorities last year underspent by more than £500 million. Clearly this must have had an impact on education and training and would you like to tell us what your experience is?
Professor Macleod Clark: Yes, I think it refers back to the answer to the first question. There is no doubt that the underspends and more 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 and we have ample evidence that it is precisely those pots that have been raided, as I said.

Q620 Charlotte Atkins: So ring fencing does not work?
Professor Macleod Clark: There is no ring fencing for that element of the budget. It has been token and indeed we have had a correspondence with Lord Warner, in which he again said that there would be no ring fencing for the year to come either. This is why I think we are in a very dangerous situation.

Q621 Charlotte Atkins: So what do you expect to happen in the coming year?***Professor Macleod Clark:*** My nightmare prediction is that there will be a continual raiding of this budget unless it is ring-fenced, unless it is protected, and I think the implications on that for even the short-term workforce requirements could be devastating because what we do absolutely know is that for instance that reduction in commissions is not related to the reduction in demand; it is a response to being able to raid a pot of money.

Q622 Charlotte Atkins: Professor Haines, did you want to come in?
Professor Sir Andrew Haines: Only to add that from the perspective of my own institution we obviously have concerns around public health and there is a similar picture there—40% reduction in planned recruitment and public health training for 2006 compared with 2005, and academic public health also showing a decline. That is another point that is important to make, that if you allow the clinical academics, the nursing academics to decline, if you do not sustain them then of course you have lack of capacity to train people in the future. So, again, we need to iron out these fluctuations in demand and the fluctuations on financial pressures to Higher Education Institutions, otherwise we erode the base of the institutions.
Professor Macleod Clark: Can I give you an example to bring it to light? From the Avon Gloucester and Wiltshire SHA again, the SHA set the WDC a savings total of £10 million to contribute to achieving a balanced LDP and to avoid cost shifting to the service. This meant further reductions in education commissions had to be made, and we have many examples that we could give you.

Q623 Charlotte Atkins: Overall do you think that too much is spent out of the NHS education and training funding used for medical training, as opposed to other forms of training?
Professor Macleod Clark: I think there is a disproportionate spend. It would be quite inappropriate to say there is too much and the argument could well be there is far too little spent on the non-medical education training budgets. The disproportion is quite striking in terms of the numbers of qualified nurses and Allied Health Professions in the system and the amount of money that is spent, particularly in their continuing development and education, and that which is spent for the medical post-registration training, and this lies at the core of the problem about our inability to reform the healthcare workforce because there are no ring-fenced monies for continuing professional development in Nursing and Allied Health Professions—or there are very few—and they are not linked to career pathways nor to trainee posts. I would give you the example of GP trainees where there is clearly a very obvious funding route; there is an obvious career route and ring-fenced monies to secure the future workforce in that domain. We know we need more nurse practitioners in general practice—first point of contact. There is no money, there is no ring-fenced money, there is no career framework, there are no training posts. Just to give you a tangible example, you ask about the disproportion. There are 127,000 nurses and Allied Health Professions currently studying part-time and the amount of money that is being invested in that is about £1,200 per student. In contrast, there are 35,000 posts for medical post-registration training and there is £40,000 per student allocated to that budget, and that is just one example, and we can give you others.

Q624 Charlotte Atkins: So the Government's plans to move the focus from the acute sector into primary care, therefore, 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; that is the real problem, and it is why I come back to the fact that the current mechanisms for both commissioning and funding a non-medical education area is really not fit for purpose.
Professor Butterworth: If I may pursue the example briefly? I quoted previously the funds available in Trent for the impact levy and of that we would have 5% or 10% for innovation, creation and retraining. If that has been withdrawn in order to balance other deficits then that opportunity to retrain and make people fit for purpose in other settings, in a primary care setting has gone and that immediate support is no longer there.

Q625 Sandra Gidley: Professor Clark has moved on to the point I wanted to raise, but you mentioned the percentage cuts in nursing intake but it is not quite clear how the reductions in budgets have affected the ongoing postgraduate nursing training. It is not entirely clear to this Committee how the services and the courses are commissioned anyway and it might be useful if you could outline how it works. Who decides what courses are needed? You have alluded to the fact that some are just not being commissioned and it seems very airy-fairy; are you able to put a bit of meat on the bones?
Professor Macleod Clark: Yes. I think it is an extremely good question. In theory the WDD reflects the needs of its Health Service provider constituents and should take a view from those Trusts and other providers what is required in the future. In reality there are pressures from the centre to meet targets in terms of numbers and that is quite a compelling motivator, I think, for those working at SHA level, and in reality the decisions that are made do not seem to necessarily concur with the requirements of individual Trusts. So just to put some flesh on that for you, you ask about post-qualification training, we know that there is a real need for more nurses in the community. We had examples of SHAs in the West of England, with one of them where there has been 100% reduction in the community nursing commissions this year at post-qualification level, and we could find you many more if you would like those. The same is true for post-qualification in the Allied Health Professions, particularly in physiotherapy.

Q626 Dr Taylor: This is really some of the most helpful evidence about the deficits that we have because we have been trying to get to the bottom of where the money has gone. Professor Butterworth, in your submission you said, when funding is tight, as now, the first casualty is CPD. Has basic nursing training been affected or is it all the CPD side?
Professor Butterworth: There are two opportunities to support the educational enterprise. One is initial registration programmes, which is, as Jill described, managed in that particular way, supposed to satisfy the needs of the health economy. Continuous professional development is slightly different. There is some resource held centrally through the Strategic Health Authorities and some is held by the Trusts themselves in smaller proportion. So it is really hard to get a full picture of how badly that has been affected, but certainly some of the evidence offered here shows that difficulty that people are now experiencing, particularly if it is a government enterprise, to move so much more care into the primary care setting, and the opportunity to make people fit for purpose for that is quite badly affected through these changes.

Q627 Dr Taylor: Can you just repeat the percentage of the Trent SHA money that comes from the training budget?
Professor Butterworth: This is for two years ago, so I have not been in that position for two years now. Approximately £56 million and of that about 10 would be available for creating new courses, encouraging people to move into community focused posts, things of that sort. The rest was fixed on education commissions with the seven universities we did business with.
Professor Macleod Clark: I think the answer to your question is that the reductions in the commissions are most definitely in pre-qualification and pre-registration as well as post-qualification. So that is where the numbers are that we derive for your two examples of 26% reduction in the West of England and a 27% reduction in East Anglia for nursing and 31% and 28% respectively in physiotherapy, pre-registration for this coming year. So there is no doubt that it is impacting across the piece. And there is absolutely no evidence that that is not related—coming back to Sandra's question—to the demands or the requirements of the Trusts, quite the reverse. We have examples in my own patch in Hampshire where, for instance, our local Trusts have been asking for graduate nurses because it is quite expensive to turn a diplomate nursing into a graduate after they have finished training, and yet the commissions have doggedly been for diploma level as opposed to graduate. So the answer to the question about is there a tie-in between what is needed in a local community and what is commissioned we have geographical examples of where that is not the case.

Q628 Dr Naysmith: I had been intending to explore Avon Gloucester and Wiltshire and the effect on universities in the West of England, which is located in my constituency, but Professor Clark has brought out almost all of the points that need to be brought out there because I had been well briefed beforehand by Professor West.
Professor Macleod Clark: Perhaps I could expand upon the question?

Q629 Dr Naysmith: I was going to say that his letter to me, which brought all this out has been circulated with today's papers and I am sure it is going to provide a body of evidence for some recommendations when we come to make recommendations because it is clearly quite a devastating picture of what has happened.
Professor Macleod Clark: And we do have other evidence we can let the Committee have. On that particular example, though, I think it is important, coming back to the post-qualification and career pathways within community nursing, that would be a programme that was supposed to produce your next generation of school nurses, community nurses, health visitors, and all the conversion programmes for nurses who want to be retrained to go into new posts. So it comes back to the workforce design and reform issue, and there were no intakes in your patch for those courses.

Q630 Dr Naysmith: I agree with Richard that this is really very important evidence and I am sure it will underpin some of the things we recommend. Just a couple of tidying up points, you recommended

that HEFCE should take over the funding. Would that work? Have you looked very closely to see that HEFCE would be able to do it?

Professor Macleod Clark: I think there is no reason in theory why it should not work. It would have to be handled and managed quite carefully because there are notable differences around bursaries, and at present the inability for universities to charge top-up fees, so there are differences in the way in which those programmes, currently commissioned from the Department of Health, work to the way that HEFCE normally does its business. But there are examples and social work would be another one, which works extremely well under HEFCE model.

Q631 Dr Naysmith: So HEFCE would have the expertise?

Professor Macleod Clark: They have the expertise and it is our belief that it would be much more cost effective.

Q632 Dr Naysmith: The other thing you have already touched on as well is the question of education funding in primary care and public health. What changes do you think would need to be brought in to enable that to be done properly?

Professor Macleod Clark: I think we must develop a mechanism for proper career pathway tracking, trainee posts and the ring fenced money to go behind that. In the absence of that we will not achieve a workforce reform shift, it just will not happen, because 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.

Q633 Sandra Gidley: Professor Clark, the average dropout rate for the United Kingdom university courses is 14% but in nursing the average rate is 25%. Why do so many nursing students drop out and should we be doing more to try and retain them?

Professor Macleod Clark: There are two things. The way in which dropout rates are calculated across the university sector generally, and the way in which they are calculated by the Department of Health are very different. So it is impossible to make a direct comparison. Our view is that the attrition rates in Nursing and Allied Health Professions are very varied. For instance, you will have a higher attrition rate in learning disabilities nursing than you will in adult nursing. You will have a higher dropout rate in radiography than you will in physiotherapy. So it is quite difficult to lump it altogether because there are big discrepancies. If you use a similar methodology to the higher education model then it looks as if the Nursing and Allied Health Profession attrition rate is very similar to other vocational or technical courses like engineering. So, again, the general figure that is produced at HEIs covers a multitude of courses, students on very different routes, and if you compare like with like, which is students who are undertaking courses leading to a vocation, profession involving some coursework which is in practice, then those would be the proper comparative figures. There is no doubt that Nurses and Allied Health Professions have a tougher time at university than many other students; they have to work harder, they have to do practice, they are often older so they have other commitments. I think over 30% of recruits into nursing are now in their 30s and above, so you know that they will have other challenges and pressures that will make it more difficult. One of the things that is very worrying for us is that we know now, because of the problem about the lack of job opportunities that is looming, that many students are deciding that if they are struggling they do not want to stick with it because why would they if they are not going to get a job at the end of it? So we do not really believe that the figures for nursing, Allied Health Professions are that much higher than other students in similar circumstances, but now we may see a much greater hike in attrition because of these current factors.

Professor Butterworth: It is known that one of the factor that mitigates against people dropping out is if they have good placement experiences, if they are content and cared for where they have those experiences by nurses and others who have been prepared for that role, and that lack of capacity to invest in that now compounds that difficulty, so the people you would want to make the students' experience a happy one need that adequate preparation. The reductions in funding may just work against that to worsen that particular thing, I think.

Professor Macleod Clark: I think that is right. There was a very good move to create clinical placement facilitator posts for Nursing and Allied Health Professions and those have all been eroded in this last round of cost cutting, and I think that that again is very short-sighted, but it comes back to the fact that the mechanisms for funding for non-medical education do not contain the processes for supporting a funding stream for the placement experience. So there is no money that follows the students into practice, unlike in medicine.

Q634 Chairman: Professor Butterworth, your submission highlighted the shortage of healthcare educators in the UK. How serious is this problem and what is being done to address it?

Professor Butterworth: There is some work underway to at least uncover some intelligence about that further. The United Kingdom Clinical Research Collaborative has commissioned some work which we are leading to look at what that looks like. That work for us has all the characteristics of the total nurse workforce. Also 25% of it is in the ages of 50 and 55, and the resolution to that in part is to make a career as an educator or as a researcher attractive. It is often serendipitous as to why people go into careers as educators or researchers, and to craft those pathways such that it is seen as a good thing to do and to be helped into those pathways, there are some quite easy ways to do that and we are about that business now. It is necessary to seek some investment to make that happen, to make sure that the next generation of educators are in place, first of all to deliver those new programmes, which we have

talked about in the process of giving evidence so far. So it is a cause for great concern. Senior appointments at universities, for example, often have very poor shortlists because of lack of available candidates at the moment, and that is an increasing difficulty reported by a number of universities, but there is some work underway to try and address the difficulty.

Q635 Dr Taylor: I think my questions are rather academic because of the lack of funds, but I will ask them just the same. We have been told that there are really no part time nursing courses in the UK. Is that correct?
Professor Butterworth: That is not correct.

Q636 Dr Taylor: Could you elaborate because it would seem to me that if 30% of the people coming into nursing are over 30, and certainly healthcare assistants who want to go on and become nurses are in the older age group, there have to be part-time courses, so what part-time courses are available?
Professor Macleod Clark: We believe that there are currently about a dozen part-time courses offered in nursing across the UK and some in the Allied Health Professions. One of the difficulties again is the commissioning pattern because they have to be commissioned; you cannot run a course in a Higher Education Institution if you are not commissioned to run it.
Professor Butterworth: Might I give an example? In Lincolnshire, which I used to have some responsibility for, where it is difficult to recruit people into posts because of the rural nature of the county, I commissioned a nurse registration programme with the Open University, that was largely work-based and quite flexible and had part-time opportunities. So there are mechanisms to do that if the commissioners are willing to do it.
Professor Macleod Clark: If I could give you an example? In one area in the UK part-time occupational therapy commissions have again been cut by a third for next year, so this will be a good example of where we make this rather bold statement about there being a disconnect between the commissions and the service requirements. Most universities have a part-time option on the stocks, but you cannot deliver it if you are not commissioned, so we cannot look at what we have in terms of a local potential workforce and offer that course unless we are asked to deliver it. And there are also issues because it is not necessarily cheaper to run a part-time course. There are sometimes additional expenses, students may need more support, but there would be a standard price for a course and some universities may feel it is simply not possible to deliver a quality course.

Q637 Dr Taylor: Would that standard price be greater for a part-time course than a full-time course?
Professor Macleod Clark: It would be extended over a longer period of time so the student would need a bursary over a longer period of time, and there are additional costs to a university when supporting a part-time student over a longer period of time. So it may be that that would be a disincentive if the price of that provision was not adequately costed.

Q638 Dr Taylor: So the responsibility is entirely with the commissioners rather than the providers?
Professor Macleod Clark: Yes, we are absolutely clear that the provision of part-time courses is there but it is not being commissioned.

Q639 Dr Taylor: That is very helpful. Talking about flexibility, are there opportunities to change between different healthcare training courses, or if you are on a nursing course you have to stay with that and you cannot cross over?
Professor Macleod Clark: No, within a university it is always possible to change course. The extent to which you might need to start again or get some advanced standing and accelerate your progress through another course would vary according to circumstance. But we come back to the commissioning because if I were to talk of my own patch we are given a target for student nurses, physiotherapists and Allied Health Professions, and there is a positive disincentive to get students to swap between courses if you have to pay a penalty, as indeed universities do, for having an attrition rate over a certain level, and at the moment it would be counted as an attrition from a nursing course, even if you were adding it to a physiotherapy course. So that comes back again to Sandra's question.

Q640 Dr Taylor: Is it common for healthcare assistants to want to go on and train as nurses or is it unusual?
Professor Macleod Clark: Common. But, again, it is one of the areas that has suffered because of this cost saving exercise because again they are more expensive—it comes back to the part-time route. They need support because they have been on salaries before and that money has been radically cut this year.

Q641 Dr Taylor: So that would be an example of a part-time course, the healthcare assistant going up to registering.
Professor Macleod Clark: Some of them will do a part-time course, some of them will do a full-time course, and the Open University runs a part-time version, which many healthcare assistants take.
Chairman: Could I thank you all very much indeed. Could I say, Professor Clark, that the statistics that Sandra used earlier were given to us by the National Union of Students and not by the NHS! I do not know if that is relevant or not, you are a better judge of that than me! Thank you very much indeed for coming along.

Witnesses: **Dr David McKinlay,** Director of Postgraduate GP Education, North Western Deanery, **Dr Graham Archard,** Vice Chairman, Royal College of GPs, **Professor Selena Gray,** Registrar, Faculty of Public Health and **Mr Paul Holmes,** Chief Executive, Kingston PCT, gave evidence.

Q642 Chairman: Good morning, could I welcome you to this evidence session. Can I ask you if you would introduce yourselves and the organisation that you are from, for the record. Could I start with you, Professor Gray?

Professor Gray: I am Selena Gray and I am the Registrar of the Faculty of Public Health, and I am also Professor of Public Health at the University of the West of England.

Dr McKinlay: I am David McKinlay and I am the Director of Postgraduate General Practice Education in the North Western Deanery, a part-time GP in the Ribble Valley and I retire in eight days on the anniversary of 37 years' service in the NHS.

Dr Archard: Good morning. I am Graham Archard and I am the Vice Chairman of the Royal College of General Practitioners and also Chairman of the Professional Executive Committee of the South and East Dorset PCT. I represent the RCGP today.

Mr Holmes: Good morning. I am Paul Holmes; I am Chief Executive of Kingston Primary Care Trust and was formally Chief Executive of the South West London Workforce Development Confederation, which subsequently became part of the South West London Health Authority, where I was the Workforce Development Director.

Q643 Chairman: Once again, thank you for coming along. Could I ask a question to all of you? The primary care workforce has expanded more slowly than the overall NHS workforce in the past five years. How much of a problem is this?

Dr Archard: It has quite a radical effect. The complexities of secondary care are such that some of the work has had to be shifted towards primary care, and that is inevitable because of additional workloads in secondary care. To reflect the additional workload in secondary care there has been quite a dramatic increase in the number of consultant places to accommodate that increased workload. Add to that of course secondary care is also subject to the European Work Directive, such that particularly junior hospital staff are perfectly reasonably working far less hours than historically they would have done. The obvious knock-on effect of that has been that a significantly increased amount of work has been shifted towards the primary care sector. There has not been a comparable rate of increase in the workforce in the primary care sector and so inevitably there has been a problem in accommodating the additional workload, which is moving towards the primary care sector. This is not just in general practitioners but in all healthcare professions, such as nursing, physiotherapy, pharmacy and so on. So there is a very dramatic increase in workload in primary care, which is not being reflected in the increased workforce.

Professor Gray: I think in terms of public health we are clearly very concerned that the public health workforce certainly has not grown at anything like the extent of the secondary care workforce, and yet we know the demands on public health are increasing, with chronic disease management, illness, the Wanless Report, there are increasing demands across health protection, health improvement and service quality improvement—the three domains of the public health practice—and yet we have a workforce that clearly is not growing and we are in danger of losing people through various reorganisations at the peak, sometimes, of their professional careers.

Q644 Chairman: Your submission, Professor Gray, did point that out to us. Do you really think that this will be made worse by the reduction in the number of PCTs and SHAs?

Professor Gray: I think we are very concerned that the current reorganisation does not lose yet more health professionals, and there clearly is the opportunity, with the merger of PCTs, in theory, to create larger, more robust public health teams. But we are anxious about the safeguards that are put in place to protect the public health workforce and to make sure that people are not lost along the wayside. I think we need proper guarantees that those posts are not going to be lost.

Dr McKinlay: The difference in the ratio between GPs and specialists is quite dramatic. I used to give talks in the late 1980s and talk of an average health district and it was a quarter of a million people, 50 consultants, 100 GPs, 100 junior doctors and about a million consultations of which only 20,000 would have finished up in hospital. The ratio now is equal and so it was two GPs to one consultant, and it is now one-to-one. Then I think the other point that may be helpful to add is that the impact of the various reorganisations on young doctors on training is sometimes not appreciated. I set up the East Lancashire training scheme and in 1989 there were 130 applicants for four places on that scheme and in 1991 there were three applicants for four places on that scheme. As far as we were able to work out there was the 1990 contract which gave young doctors in training the idea that they were just going to push paper around for fund holding and not have time to see patients. At the same time there were the Calman reforms that gave young doctors the idea that they would all become consultants in six or seven years, and six or seven years later they found out that that was not the case. Then finally, in my own local area, there was a dramatic shift in the way that the University of Manchester trained its students and it kept them all close to the university, and to stereotype it we used to counteract two weeks in the concrete jungle with two weeks' hunting and fishing in the Ribble Valley, and the peripheral experience, the Ribble experience was taken away to keep the students close. Those three factors dramatically affected recruitment in East Lancs., and it took us most of the 1990s to turn that around.

Mr Holmes: If I could give you a very local perspective from South West London? It is not a general pattern if we look at it by individual profession, so, for example, across five PCTs in

South West London during the period from 2000 to 2005 we saw a 23% increase in the number of general practitioners. Conversely, the number of practice nurses remained very stable during that period; there was a very small reduction of just under 2% in the number of practice nurses. And there was 100% increase in the number of healthcare assistants to a total number of just under 100, and that was quite significant because we did not have healthcare assistants in place in 2000.

Q645 Chairman: Dr McKinlay, you said that there was a severe crisis of GP numbers in the North West.
Dr McKinlay: Yes.

Q646 Chairman: First of all, how has this been addressed? Also, could you tell us has the recent growth in GP numbers been inconsistent across the UK?
Dr McKinlay: I think there has always been a north-south divide and within our actual area there is a microcosm of the London versus the rest scenario because Greater Manchester medical school is the focus of training, and I am afraid still, although less, we are all trained in tertiary care and we all work in secondary and primary care, and I do see that modernising medical careers as an opportunity to actually change that to some degree. East Lancashire is very severely affected, but even we have difficulty in persuading a large PCT like Morecambe Bay. Lancaster is an extremely popular market town—very difficult to get doctors to go to Barrow-in-Furness in the same area, so you get a microcosm within a small area. The Ribble Valley, where I work, is a bit of an oasis in the desert; it is relatively easy to get doctors to come to a nice market town like Clitheroe—it is not so easy to get them to go to Burnley.

Q647 Chairman: Effectively the increase in GP numbers is inconsistent but historically they always have been inconsistent in terms of GP ratios with patients.
Dr McKinlay: I think that is right but the problem is that it is going to be compounded by the retirement time bomb. Again, it is a slight stereotype but the survey we did in 1999 of all the doctors of over 50 in the North West, the doctors who have gone to the under deprived area were very often doctors from overseas, they came and they tried to get on in the hospital service, realised that at that time there was a glass ceiling and moved into general practice, and when we surveyed them the older GPs told us that they were going to go on working because they did not have the pension rights because they had been junior doctors in the hospital for a long time. For the younger GPs, the worrying thing from our survey was that the 50 to 55 year olds said, "We have our ISAs, we have our pensions, we are going to go when we are 55 to 60." And the other issue with retirement is that the doctors working in the Health Service now tend to be full-time with long hours. The workforce that is coming through to replace them is a strongly female workforce, but it is not just the female doctors who want to practise part-time it is male doctors as well.

Q648 Chairman: If you have a need of more doctors in a place like Clitheroe, has anything that has happened in recent years, particularly the new contract, been able to give the PCT powers to induce people to go and work there more than being able to in the past?
Dr McKinlay: I realise that the new contract has had a lot of bad press in terms of finance but we have just undergone a recruitment round for general practice and I think it has had an extremely positive effect. The combination of the publicity, which in my own experience is wrong, of high salaries for GPs, but probably more the out of hours issue because the most important aspect with GPs really was to spend your lifetime providing a service 24 hours a day had become unsustainable because of the expectations of patients. Twenty years ago, when I was out of my bed at night, it was either to deliver a baby or to see a seriously ill patient. I stopped doing out of hours nine years ago when I became director because I could not be in the Valley all the time. But even nine years ago you get called out every night for relatively trivial problems, and I think that is about the expectations. The patients that need our support and have the serious problems are the very elderly and they have always had a low expectation of care because they remember before the Health Service. I had a patient who died aged 101 two or three years ago, and her notes were like this (indicating a small amount). I have patients who are 16 and their notes are like this (indicating a large amount) and by the time they have something really wrong with them the Health Service is going to be groaning.

Q649 Charlotte Atkins: Mr Holmes, and in fact Dr Archard as well might like to comment on this. We have seen the *Our Health, Our Care, Our Say* called for a 10% shift of activity from secondary primary care. Clearly, that is the way we are going, but what kind of changes in the workforce do we need now to achieve that shift?
Mr Holmes: If I can give you some very practical examples of the sorts of changes that we have implemented in Kingston recently to respond to the shift of care into primary care settings, and I will give you two specific examples? We have a small number of community matrons within the Primary Care Trust and the work which the community matrons are doing is to develop an approach to individual patient care, which is called case management model. We have an assessment tool, and the acronym for it is PARR, which stands for Patients at Risk of Readmission, and basically through the process of assessment one can identify a cohort of patients whose history indicates that if they have a range of long-terms conditions there is a higher risk if they hit a crisis point at some point that they will tip into A&E and possibly subsequently into secondary care admission. The work which the community matrons do is that they each carry a caseload and they work with the GP, they work with

the secondary care clinicians, and they develop a very comprehensive care plan to support individual patients, very much with an emphasis on supporting and helping an individual patient to recognise the symptoms, the signs of when they are likely to hit a crisis point. They provide support and advice to individual patients, and to give an example of the impact on that—and it is early days yet—

Q650 Charlotte Atkins: My own Primary Care Trust does a lot of work in this field and has been incredibly successful.

Mr Holmes: It is very impressive and it is early days, but just to give an example one of our community matrons has 36 patients of the type I have described 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 10 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. So it is an indication of the impact of that sort of change.

Q651 Charlotte Atkins: Dr Archard, would you like to comment?

Dr Archard: The 10% saving is very readily achievable when we look at what might be achieved as far as the shift in the work, as far as things like outpatient procedures and so on into primary care. Everything comes down, of course, to resourcing or human resources in the end. There are a number of ways in which this can be achieved and the most important of course is skill mix. While in an ideal world you would be able to recruit other members to the primary healthcare team to extend that work the reality is that we still do have a great shortage of other healthcare professionals, such as nurses, pharmacists and so on. I am very fortunate in my patch in as much as I live in a fairly well heeled area so it is not difficult to get hold of nurses to join the team, and as a consequence of that we have a very large number of nurses and a very small number of doctors by choice. In our particular practice we have over double the usual amount of patients per practitioner in our area because we are able to recruit nurses. The sort of areas in which we are trying to make some sort of headway into this sort of area is slightly different. Although there are community matrons in our area we are also trying a rather different tack, which is a liaison sister, which is some work that we are doing with the National Health Service Institute, which looks at nurses who are specifically dipping in and out of vulnerable people, usually the elderly, to try to reduce admissions to hospital and once in hospital to go into hospital to facilitate discharge, but unlike community matrons, who have a caseload, these nurses actually dip in and out and have a changing caseload. That is not a substitute, that is an addition to the community matron role, but it is something that as yet has not been explored very widely, but it is something which needs to be explored. The other obvious way of addressing the issue, of course, is with general practitioners with special interest, but because of the shifting balance of work towards primary care practices commonly are not very keen on general practitioners moving general practice with a special interest role because that will obviously remove them from the coalface of work at the practice, which leaves the remaining partners to do a great deal more work. So consequently there is a bit of a hiatus here in as much as a number of people would like to be general practitioners with special interest but they cannot move on in that direction. A third way of moving this forward as far as GPs are concerned is a fairly embryonic model which I am trying to introduce at the moment called a practitioner with extended knowledge, which would be that this would be somebody who had probably historically had a lot of clinical experience in a particular area when they were in hospital practice and as a consequence of that has maintained that interest but is not of the sort of level that one might expect from being a general practitioner with special interest. But this knowledge could be used within the practice; in other words, it would not take referrals from other practitioners outside the practice but would certainly look at areas within their own practice. These sorts of skills can be relatively quickly brushed up so that work could be shifted away from hospitals to the practice without having very much of a detrimental effect on the workload within the practice.

Dr McKinlay: If I could add that areas of deprivation are not just with GPs, they are with the whole primary healthcare team. I think the mean that is quoted for practice nurses is 2.3 per GP; but in Cumbria and Lancs it is one nurse to 2.3 GPs.[5] So we have difficulty in recruiting all the way around. The other thing is, in practices that have developed the skill mix it is already factored in. I think most of the first QOF round that took off have really been delivered by good practice organisation, including practice nurses through chronic disease management and things. So I am a little bit sceptical about skill mix being the panacea for everything; I think developing practices have already been working on skill mix for a very long time.

Q652 Charlotte Atkins: We have had a lot of publicity about all the redundancies in the acute sector. Do you think that these redundancies are needed to achieve the changing structure of the NHS workforce overall, the balance between the acute sector and primary care?

Dr McKinlay: I think it is vital that resource follows activity into the primary care sector and I think the nature of the Health Service of the future is that it should be well delivered at a primary or an intermediate care level. I do not think it is for me to decide how that resource shift comes about. It seems to be probably short-sighted to cut the coalface workers, but I am not qualified to answer that. I was very pleased to see in the new White Paper support for the community hospitals, but they need to be adequately resourced. We spent £100,000 of our

[5] *Note by witness*: This should read "I think the mean that is quoted for practice nurses is one per GP but in Cumbria and Lancs it is one nurse to 6.7 GPs".

fund holding savings on putting X-ray facilities into our community hospital and that enabled a large number of consultants to come and start delivering outpatients in the community hospital and saved a lot of patients a lot of journeys but also improved the service.

Q653 Dr Stoate: I would like to pick up something that Dr Archard was talking about, GPs with extended knowledge. GPs have always done that. In my own practice, for example, I have a partner who is very good at dermatology, a partner who is very good at minor surgery and I do a lot of joint injections, and we have always referred people to each other. But does the Royal College see this a much more formal role with perhaps some way of actually providing resources to do it, or do you just see an extension of what is already going on?
Dr Archard: I think it is a bit of both really. As you say, most practices do have these areas of extended knowledge within their practice team, and it is not just GPs of course, it is nursing colleagues as well. It is purely the fact that we all know, as practising doctors, the sort of skills that one has on leaving hospital practice are very soon lost, which is a disaster and a waste of enormous resource, and if we could look at the training structures, such that those people who have those interests are nurtured through their career in general practice to maintain that knowledge, that would be helpful. While there are those such as me who was a registrar in ophthalmology at one time—and I know very little ophthalmology now but perhaps more than the average GP—it would not take very much to bring me up to speed at a much higher level than I currently am at because these things come back very quickly, as you know. If we were able to put that resource into those people who do have this bit of knowledge it would take very little to really bring those people up to speed really quite quickly, and this might provide a facility to accept some of the work that is coming from the secondary care.

Q654 Dr Stoate: Is that not something the College could be involved in? Could you envisage, for example, a diploma type of qualification for GPs with extended knowledge in particular areas, and the College might be overseeing that as the educational overseer, if you like, of general practice.
Dr Archard: Certainly the College should look very carefully at this sort of thing and there is no doubt that the College, as you are probably aware, is run on a faculty basis and in some faculties it is already being undertaken in as much as there are local certificates in knowledge of a particular area, which may take between three and five days training to bring people up to speed again. This is not national but certainly it is something that the College is looking at and it is something which I think the College could be encouraged to undertake even further to undertake these sorts of diplomas.

Q655 Dr Stoate: To me that would be an extremely worthwhile thing to do. I want to move on to Dr McKinlay and talk about whether you think there is too much emphasis in medical training on the specialist workforce at the expense of a primary care workforce?
Dr McKinlay: I think there is some recent evidence—it is not published yet, I have been supporting a young doctor who started looking at these issues when he was a student and he is now doing it in the FI—that there is still what has become known as the "hidden curriculum". Young doctors, undergraduates are prejudiced against general practice and the danger is that if they get a bad experience on their general practice attachment then that reinforces that prejudice. So we have evidence from an evaluation we did of giving PRHOs GP experience. In that, 55% of them who had not made their mind up before did opt for general practice once they had experienced it, and this is one of the great opportunities of modernising medical careers to make sure that every doctor has some experience of general practice in their foundation programme so that they are making a more informed choice. A charismatic lecturer was often the reason we made our career choices to graduate level and that is not good practice. The study seems to suggest that about a quarter of undergraduates think of general practice as a career, but the country needs half of them to be GPs.

Q656 Dr Stoate: Do you think the MMC might put some of that right?
Dr McKinlay: I do, once it is bedded in; if it is allowed to. I do not have figures for elsewhere but it seems from the publicity I am seeing that certain deaneries are going to make the expected cuts in their allocations by hitting general practice. I have worked with a Dean who is general practice centred and we will have over 90% of the Foundation II doctors going through general practice in the North West, but the funded aim for the first year is only 55%, although it is expected that it will be for everybody in due course. We have a particular problem with timing.

Q657 Dr Stoate: Mr Holmes, with the reduction of PCT numbers from 303 to 152, do you think that will have an effect on workforce planning in primary care?
Mr Holmes: Prospectively, yes. In London I think it is unlikely because in London the number of PCTs has remained stable. Outside of London, the experience which we typically have is of PCTs serving relatively small populations and therefore in terms of the management resources to support the work of the PCT in some cases is struggling, and to develop specialist management skills in areas such as workforce planning. So I would hope that there is potentially a positive outcome from the amalgamation of PCTs into monitoring areas in terms of being able to share those scarce resources.

Q658 Dr Stoate: I appreciate that there is a management sharing and obviously you get greater expertise, but do you think that there may be some loss of local focus with PCTs, for example, becoming

much larger geographically. Do you think that that might make it more difficult or less difficult for them to plan workforce needs in their area?

Mr Holmes: Workforce planning takes place at a number of different levels. The level of the individual practice, for example, very, very practical workforce planning takes place, as you will be well aware, on a day-to-day basis as staff working in practices deploy their resources. If we think about longer term workforce planning—and your example of GPs with specialist interests is a very good example—to date in my personal experience that has often depended on the individual interests of individual practitioners and where those services are then delivered will often be dependent on where those GPs are practising. If we think about a more coordinated approach to development of such practitioners—and a good example in my own PCT is diabetic care—through the process of practice based commission 27 of the 29 practices are signed up to a model of diabetic care which they would like to develop, which is their initiative, and they want to develop a hub and spoke approach to diabetic care with one practice in each of four localities, providing up to level 2 diabetic care. To enable them to do that, we need to develop GPs with specialist interests in each of those four central surgeries. So it is a good example of where there is a potential by planning over a wider area where there could be a more coordinated approach to workforce planning.

Professor Gray: I think there are some concerns that some of the issues that you heard about in the last session with SHAs taking money from the levies that that will affect both public health training and GP registrar numbers. There is some evidence that some of those things are seen as easy targets for savings and the numbers have been cut, so we have got four regions that have not got any public health training. I know there are regions where GPR numbers have been cut and again, not related to demand but related to balancing the books.

Q659 Mr Campbell: What changes to the education funding systems are required to ensure that a greater proportion of resources go to primary care?

Dr McKinlay: I could start with what was the basis of my evidence, that there was an extremely effective initiative three or four years ago but it was not from the levies, it was from the workforce group where £30 million was invested through the deaneries in capital premises to develop training capacity and that produced about 650 new training slots across England. That was so successful that we tried to keep it going in the North West with the co-operation of two SHAs. We have spent about £2 million and we have created the numbers that were in my evidence: 29 new GPRs, 37 new foundation 2s but also 29 undergraduates and postgraduate nursing. In order to access this fund, our would-be training practices need to develop a multi-disciplinary approach and the SHA has supported this on the basis that it is for allied health professionals as well. If we are putting funding in to provide a seminar room for teaching, that room is not just to be occupied for the two hours a week that the GP registrar is getting his tutorial, it has to be in use all the time. Our strategy to deal with these problems has been three-fold. It has been to get out and talk to the PCTs, to produce the guide for the PCTs that I mentioned in the evidence, 'The gardener's guide on how to grow and keep your own GPs', and to invest in the capital. I think it has been a really good bang your buck for the NHS and the other thing is that patients benefit because there is some evidence that training practices are quality assured to a high standard and so the patients probably get a better service as well.

Q660 Mr Campbell: What about your comments in your submission that there is a shortage of education facilities in primary care. You mentioned that in your submission. Can that be addressed?

Dr McKinlay: We are addressing it and that is the way in which I was just mentioning it, capital outcome. There was a second tranche of money for primary care, £108 million a little while ago, that did not require a consultation with the deaneries. I surveyed my other fellow directors and with one exception, which was South Yorkshire that came to light only later when I shared this evidence with them, the deaneries were not consulted and that money had not been used to develop training capacity, which is a shame. There is a small sum of money called the Primary Care Development Fund that is out there now which again requires consultation with the deanery. They are very small sums and it is also deprivation weighted so some areas that could provide more training would not get that funding if they are considered to have enough doctors. In the North West six of the bottom 15 PCTs are in my patch so we would be very keen and we have pushed a lot. When you mention re-organisation, I have been around for a while and there has been roughly re-organisation every two years and there is a period of limbo while we are settling in. A key 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 before the next.

Q661 Dr Taylor: I want to go back to redundancies, first in primary care management and then possibly in public health too. Mr Holmes, obviously there is going to be a tremendous reduction in the number of PCT staff when we cut them. Do you think redundancies are mostly going to be in managers or will they be in people who are working on commissioning?

Mr Holmes: The people who work on commissioning largely are managers working within primary care.

Q662 Dr Taylor: I put that badly, direct service managers as opposed to those who are coping with commissioning.

Mr Holmes: I think it more likely that the redundancies would come in the range of corporate functions within Primary Care Trusts. There are a wide range of corporate functions so, for example,

in addition to commissioning there would be information technology support provided to practices and performance management of contracts, the actual administration of contracts, financial functions and human resources, et cetera. It is that range of functions where the bulk of redundancies would fall. The provision of community health services provided by Primary Care Trusts is a relatively small proportion of the business of the Primary Care Trusts and effectively it is an operational management service which needs to be supported.

Q663 Dr Taylor: Do you think the economies that are forecast will be made? Cutting the PCTs by half, is that going to cut the staff by half or are lots going to have to go and continue to work for the bigger PCTs?
Mr Holmes: I think we will see a significant reduction in the overall number of managerial and administrative staff within Primary Care Trusts. I could not venture a figure to you.

Q664 Dr Taylor: Do you think there will be an overall saving?
Mr Holmes: I think there will be, yes.

Q665 Dr Taylor: In our inquiry into changes to Primary Care Trusts, we did get a statement from the Department of Health that public health departments would be excluded from the £250 million cost saving exercise. Is that being borne out? Do you hear of public health doctors who are likely to be made redundant where you lose a Primary Care Trust that has got its own Director of Public Health or an area like mine where you are going to lose three Primary Care Trusts and three Directors of Public Health, do you get any inkling that there are going to be redundancies there?
Professor Gray: The statements made by the Department of Health are very helpful. I think what is not completely apparent is the mechanism by which they are going to make sure that happens. We have got a series of recruitment rounds taking place now with various guidance which does not give any guarantees that these posts will not be lost. What we want to see is a very strong line from the new SHAs and the regional directors of public health to make sure that the existing capacity is protected. We know from our survey that only 36% of the current ones feel that they have got enough people to do the job. We cannot afford to lose anyone in this round.

Q666 Dr Taylor: Are most PCT directors of public health applying now for the one job that still exists?
Professor Gray: Yes, in the next few months they will be going through that process.

Q667 Dr Taylor: We have heard of one SHA Director at least who is resigning in complete frustration to all the changes. Are there any more that are going?
Professor Gray: A number of the top tier, the regional directors of public health and the strategic directors of public health, who are currently going through the appointment round, have chosen to take early retirement or not to go through the process.

Q668 Dr Naysmith: Mr Holmes, as you are well aware there have been new contracts in Primary Care for doctors, dentists and pharmacists and there were lots of ideas behind these contracts but they were supposed to improve productivity and quality at the same time. In your experience, have they done that?
Mr Holmes: The dental and pharmacy contracts have only very recently been implemented, it is too early to say what the impacts will be. In relation to the GP contract, again I can provide you with some local evidence. The scores, as evidenced by the quality and outcomes framework, are uniformly higher across my own PCT, so 91% of the available points have been attained by the practices within Kingston and that compares very similarly with the national average. We have seen, in the first two years of the quality and outcomes framework within Kingston, a 5% increase in the number of points which would indicate that there are improvements in quality. For the forthcoming year, or the year we are in now, the bar has been set a little bit higher and it will be interesting to see whether we maintain the rate of improvement.

Q669 Dr Naysmith: The QOF targets, being met and met much higher than expected, cost the NHS about £150 million nationally and some people are a little bit cynical about whether that quality of improvement has been reached and some suggest that there should be changes to the contracts to make the GPs work harder. Now, having been married to a GP for a long time, I know that many GPs work very hard but it does seem sensible that if these targets were met so quickly and so easily maybe you need higher and more demanding targets. Is that your view?
Mr Holmes: Certainly as I said earlier, Dr Naysmith, for the current year we are seeing the targets being somewhat stiffened. The process of assessing the performance of individual practices is a very robust process in my own PCT. It entails a combination of PCT managers, non-executive directors who are specially trained for the purpose and clinical advisors going into practices. One of the benefits we are learning from this process is that they are identifying where there are particularly good examples of good practice and are able to then share that learning across the Primary Care Trust. We should also remember that the quality and outcomes framework is not just about performance of individual GPs, it is about performance of the whole practice team and the more effectively the team work, the more likely their performance will be strong.

Q670 Dr Naysmith: Do you think that the contract is delivering value for money?

Mr Holmes: Again, I think it is too early to say. I think we need to allow a longer period of time to assess whether we secure continuous improvement over that period of time.

Q671 Dr Naysmith: I agree with what you said about dentists, it is too soon to say about dentists, but with pharmacists it was last year that the contract was renewed and there has been a lot of talk about things. Do you think there is going to be delivery of some of these things that have talked about, pharmacies having places you can basically drop in and discuss aliments with pharmacists and so on. Is that beginning to happen?
Mr Holmes: It is, we have seen some good evidence of an extended range of services being provided by practices. For example, in my own patch we have pharmacists who are now offering needle exchange services and safe needle disposal services, advice to individual patients, assessment of patients and something that we are particularly proud of in Kingston is last year we asked all pharmacists who contracted with us to support six public health campaigns during the year and they did that very effectively.

Q672 Dr Naysmith: Do either of the other two general practitioners want to comment on what has happened since? It has been widely misunderstood in many places. It is a question of quality and value for money really.
Dr Archard: The first point is that the very term Quality and Outcomes Framework would imply, and I think correctly, that all those practices which are achieving a high return on their points which is, as we have already heard the performance has been significantly greater than initially anticipated, is a demonstration first of all of quality because those markers were agreed markers between the profession and the department. These were markers of quality, not the only markers but nevertheless they were markers of quality. By achieving high standards in that, that would demonstrate that quality has improved. The second thing is that this is an outcome as well and by improving the quality of patient care, our outcomes should also be improving. It will not be in the first year but on the long-term basis, outcomes will have improved. When it comes to productivity, this rather depends on what you mean by productivity. If you mean by that the number of patient contacts, then there is no doubt that patient contacts have increased dramatically within the primary health care in order to achieve the outcomes framework in as much as seeing patients more frequently, ensuring that people are chased up more for their regular reviews as well as for ongoing conditions. I do rather take exception to your words that 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. We had practice meetings on a weekly basis to try to move the agenda forward. We had meetings with our patient group to try to find ways of encouraging patients as well to adopt the standards and so on and so forth. If my practice is anything to go by, and I have no reason to believe it is not, then it was far from achieved easily, it was achieved by extremely hard work.

Q673 Dr Naysmith: Why then do you think there was this junction between what the Department expected to happen and what did happen?
Dr Archard: There is an old adage which says if you want a GP to do something write the instructions on the back of a cheque, I do not think that is necessarily true but nevertheless there is some incentive there.

Q674 Dr Naysmith: Some people would take exception to that statement!
Dr Archard: If you do provide resources in the form of a financial reward that means, as in my case, we were able to employ two full-time nurses and that resource enabled us to employ those people in order to achieve that quality objective. Without that resource, we would be unable to do so and that is why, the Government put their money where their mouth was and said in order to achieve this quality we need to put some money in. They put some money in perfectly appropriately and as a consequence that was reinvested in a big way by the primary care. Every single member of our practice team, from the most junior receptionist to the most senior nurse had a cut in the QOF and that is the case with a vast number of practices, everybody benefited from the QOF, everybody was a team member and it is because of that team approach, which has been encouraged by the QOF, that we were able to move forward. I have no doubt at all that, even with the higher setting of the level in the next year the performance will increase yet further.
Dr McKinlay: I strongly support everything Dr Archard said, I have just one or two other small points. The risk here is to personal and continuing patient care which is much valued by patients and I think that has been put at risk by what are essentially incentives to fragment the service. This is reflected in us having a cancer network, a vascular disease network and a diabetes network. My patients have diabetes and vascular disease and they are pretty depressed about it so which of the silos do they get fitted into? Primary care is one of the great benefits of the NHS and the patients need their advocate and their guide to the NHS more than they have ever needed them. If I get through next Tuesday's surgery, I will have got through my career without being sued, I do not think that is ever going to happen in the future because of the changing culture. When I mentioned my concerns about the retirement workforce, there was a follow-up study to mine done in South Yorkshire by Dr Pat Lane—and the Chairman might be interested because Rotherham was included in that—it was clear that the same factors that were operational, revalidation, litigation and turning up the burner on the QOF in the wrong directions, ie more hoops, would have a

detrimental effect on the people who are going to retire. It would seem that we are looking at about 15% of GPs in the next two to five years, there were one or two studies. There was a straw poll done the other week by one of the GP newspapers which said 17% in two years; the South Yorkshire survey suggests 22% in Barnsley and Doncaster and 14% in Rotherham and 10% in Sheffield we are in that sort of area but if we make life harder for a lot of GPs who feel they are working harder, it will affect retirement. The other bit of anecdotal evidence is that my team tell me that the gap between training and non-training practices has narrowed substantially. I have got people going out to advise non-training practices how to become training. We have had quality assurance of training practices for a long time. I have always defended the strengths of the independent contractor status because it gave us the flexibility to deliver a local service but the downside was that you got some unacceptable practice, you have got an unacceptable face. That independence has gone so I think this framework has great potential to redeliver the quality and it was not always back of a cheque. For years GPs were paid to do cervical smears and the cervical smear rates did not respond as we wanted so it is not just about money, I think the culture has changed towards quality.

Q675 Chairman: Can I have a supplementary on that. South Yorkshire has always had very high levels of GP patient ratios, I know 15 years ago it was the highest in England and Wales, that has changed a little bit now. I asked the question earlier about whether or not the new contract is likely to change in terms of getting GPs to come and work in places because we have on my border the constituency which has got the United Health Care preferred bidder in there to GP practices. One of them, as I understand from the MP there, has been empty for years and we could never deliver a GP to come and work in these mining communities or ex-mining communities that we represent. Is it to be helped that we are going to be able to get the National Health Service to provide us with more GPs than what it has done for the last 60 years, particularly with our health inequalities?

Dr McKinlay: If the PCTs have the resource and the flexibility to make it attractive. This is why our strategy is grow your own. There is evidence from a London study that people do settle near where they train. I am afraid disparity was mentioned about where GPs are trained, there was this idea a few years ago, which I was trying to rebut, that people would train in Brighton and work in Blackpool, it does not work like that. I think the MPC did quite a good job over the country, it had problems with London, but the Medical Practice Committee had its incentives like initial practice allowances to get people to set up in new towns and in deprived areas and over a number of years, they did quite a bit to improve it. It would be better local solutions but they need to be able to put together a package that is attractive. One of our other strategies is to get bright school kids and give them good quality work experience in general practice before the consultants in the teaching hospitals poison their minds and that has worked quite well in some of our deprived areas.

Mr Holmes: I would totally endorse Dr McKinlay's comments. When I was working in the South West in the workforce development, we put a huge amount of effort into both retaining and attracting GPs, and I fully concur with Dr McKinlay's comments about the importance of hanging on to the trainees who you have. We spent a lot of time working with groups of GP registrars to find out exactly what they were looking for in a first job and did our utmost to work with PCTs to ensure that some of those aspirations were met. At the other end of the scale we did a lot of work with GPs nearing retirement who did not necessarily want to keep on day in day out—Dr McKinlay may be an exception—running their surgeries but were very interested in, for example, areas of work such as mentoring, supporting and developing GPs. We did our best to encourage that and to enable those people to stay in the workforce longer. I think you have to work really, really hard at it.

Chairman: Could I thank you all very much indeed for coming along to this morning's session, and we have not run too far over this week I am pleased to say. Can I thank my colleagues for that as well, I hasten to add. Thank you very much indeed. I suspect it is going to be 2007 before this report comes out in any shape or form but it is a bit of a moving picture. Your assistance has helped us greatly this morning, thank you.

Thursday 14 December 2006

Members present:

Mr Kevin Barron, in the Chair

Charlotte Atkins	Dr Doug Naysmith
Mr Ronnie Campbell	Dr Howard Stoate
Sandra Gidley	Dr Richard Taylor

Witnesses: **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, gave evidence.

Q676 Chairman: Good morning. Could I welcome you to the evidence session this morning? For the record, could you give us your names and the positions that you hold?
Ms Rainsberry: Anne Rainsberry, Director of People and Organisation Development NHS, London.
Ms Knight: Good morning. I am Trish Knight. I am presently Director of Workforce Development and Commissioning at Leicestershire, Northamptonshire and Rutland Healthcare Workforce Deanery.
Mr Sargent: My name is John Sargent. I am currently working as a Workforce Development Consultant and I was formerly Chief Executive of Greater Manchester WDC.

Q677 Chairman: Welcome to what is now the sixth session in our inquiry into workforce planning. We have had bit of a gap, recently which was filled with the deficits inquiry that has now been published. I wonder if I could start by asking some general questions about the organisation of NHS workforce planning. Regional Workforce Development Confederations were created in 2001, following the Committee's last inquiry into workforce planning. In 2004 WDCs were merged with Strategic Health Authorities. Why did this happen and what has been the effect of this merger on workforce planning?
Mr Sargent: The changes that took place in 2001 was the first time there had really been a focus on workforce development and workforce planning in a co-ordinated way, not least because workforce planning was always seen as a bit of a back-office function that was not taken seriously enough in many people's minds, especially those of us who believed in WDCs. A lot of progress was then made between 2001 and 2004, but what happened was that, almost just as WDCs were starting to get on their feet, there was another reorganisation, this time the one that created, not the current wave, but the previous wave, the 28 Strategic Health Authorities, who had almost identical footprints across the country WDCs. (There were 27 and then 28.) The background to this was that the SHA Chief Executives, through their meetings with the Chief Executive of the NHS, felt that it would be more appropriate if the SHA and WDCs were merged so that there could be one strategic perspective for all functions across the new SHAs areas, and that, of course, has evolved into the 10 SHAs very recently.

Q678 Chairman: How many jobs were lost when this merger took place? What kind of skills were lost? Has there been any replacement of those skills?
Ms Rainsberry: Is this the change when the WDC—

Q679 Chairman: Yes.
Ms Rainsberry: In London very few were lost at that time because, when we formed the 28 Strategic Health Authorities, there was also reorganisation of the Primary Care Trusts that preceded the current one and, therefore, effectively, there was a degree of job creation at that stage; so skills were redistributed rather than lost. Obviously, under the current reorganisation that is slightly different.

Q680 Chairman: You would not have thought that the skills were lost, they were just elsewhere, as it were?
Ms Rainsberry: Yes.
Mr Sargent: With one possible rider, and a very personal one in a sense, that what was lost were nearly all the WDC chief executives, many of whom were very experienced people who had been chief executives and directors through their careers who then finished up, as with myself, retiring early. So that was a loss, I would suggest, and there were some very talented people around the country who are no longer available to support this and give the leadership perhaps at regional, SHA or WDC level that many of us feel would have still been useful.
Ms Knight: One thing that the WDCs should be remembered for is that, for the first time, you really got an alignment between workforce planning and the commissioning of non-medical education. They were really making a difference in that area.

Q681 Chairman: Of course, we have now had the change from 28 SHAs down to ten. Do you think that the new SHAs will have the right people and skills for effective workforce planning and will workforce planning be a priority for the new SHAs? I have no doubt you will have seen some stuff that has been in the media that we brought out in our deficits inquiry and earlier in this inquiry as well.
Ms Rainsberry: In my view, the answer would be, "Yes", to all of those questions. In London we have a Board director who is responsible for workforce, which is myself. We have a team which has strengthened the whole level of strategic workforce planning which in the previous workforce

directorates, which were the successors to the WDCs and the SHAs in London, relied predominantly on relatively junior staff to undertake workforce planning. We have certainly taken the opportunity in London to address that and have made very senior appointments in order to take that forward and, in terms of our planning frameworks that recently have been published, we have taken the opportunity to integrate workforce with an action service planning—so commissioning and provider development.

Q682 Chairman: So you think that PCTs should have a role to play in this work?
Ms Rainsberry: Definitely. If we are to make a reality of *Commissioning a Patient-led NHS*, then commissioners, PCTs, if they are thinking about strategically shifting the direction of care, need to understand what that means for 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.

Q683 Chairman: Would you suggest that PCTs should be given responsibility as opposed to being asked?
Ms Rainsberry: I would not say responsibility, if you are meaning devolving MPET and so on, but I think the way in which we work with them as stakeholders to commission services and to commission education should be the same. The same forum should be used in the way that we do that.

Q684 Mr Campbell: Moving along a little bit, Chairman. What role should the Department of Health play in workforce planning? For example, should medical training workforce growth targets continue to be determined centrally?
Ms Rainsberry: My view is 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, ie financial. Generally, if you take *Your health, your care, your say*, looking at what planning assumptions at a high level we should be taking into account, Strategic Health Authorities should plan within that. What I would say is that the way in which planning for the medical workforce and rest of the workforce is done in two different silos, one set being done by the department with HEFCE and the others with the SHAs, is very divisive and mitigates against us being able to think more flexibly about redesigning the workforce; so that is something I would want to see.

Q685 Mr Campbell: We were told some time ago by the WDCs that they were pressurised by the Department of Health to meet the National Health Plan workforce growth targets regardless of local needs.
Ms Rainsberry: Yes, I was in a regional office at the time. I do remember that. I think that is true.

Q686 Mr Campbell: That is a fair assessment of what occurred?
Ms Rainsberry: Well, not pressurised, I think there was obviously some work done nationally which identified that this was the level of growth that was required and, therefore, a tension was created where, in the longer term, we required that growth (indeed, actually we have got over-supply now, but we needed that growth), but in some parts of the country that created a pressure where that growth was not necessarily affordable.

Q687 Mr Campbell: Is there any way of avoiding that sort of interference?
Ms Rainsberry: Of the department?

Q688 Mr Campbell: Of the department.
Mr Sargent: I do think that there is more that can be done around this. I certainly believe, and I agree, the department has a very important role. I think it has a key leadership role in shaping what should happen. The best example I can give you is that all of us knew back in 2004 that another Spending Review was coming, and most people can guess roughly what it might turn out like, and it certainly will not be growth in money terms of 7.3% that we have seen during the Spending Review. When you bear in mind there is a four-year lead time to get one more or one less registered nurse, or anybody else (it is more for doctors, of course), there is a very strong argument that back in 2004 the Department of Health should have been anticipating the most likely scenarios within the next Spending Review, the commissioning changes should have been flagged up by 2004 and reductions should have been occurring from 2005 onwards in anticipation of the next Spending Review. Furthermore, if we are serious about looking at changing roles and getting more flexibility in the workforce, there is an argument that that should go further and some of the resources released should go to developing existing members of the workforce, many of whom receive little investment in their development at all.

Q689 Dr Naysmith: Could I just explore some of that before we leave it. What you said, Ms Rainsberry, is really quite incredible. You were saying the centre was pressurising organisations (and you said that is what happened) to take on staff when they knew they could not afford to pay these staff, which would inevitably mean either cuts in some other parts of the service or it would mean they would eventually be in deficit. Is that what was really happening?
Ms Rainsberry: No. I think the question was put to me, "Were they being pressurised?", and I said there was a tension that was created.

Q690 Dr Naysmith: You said, "Yes, that's right."
Ms Rainsberry: Yes, there was a tension that was created.

Q691 Dr Naysmith: No, you said, "Yes, they were being pressurised"?
Ms Rainsberry: Yes, but the tension that was created was that the department has a legitimate role in saying over the long-term we need this level of supply. In-year a health economy may well have

financial pressures where they feel they are not able to commit to that, and they would interpret that as being pressurised into making commitments that they feel they cannot make in-year, whereas the longer-term strategic perspective would suggest that they do need to make this commitment. So I can understand that the parties involved, certainly on the ground, would have felt that there was some pressure to do things which they felt they could not in the short-term commit to.

Q692 Dr Naysmith: Were they not justified in feeling like that? Were they not justified in saying: "Look, we have not got the finances this year to take on these extra staff or take on these responsibilities, so we are not going to do it"?
Ms Rainsberry: I think at SHA level, and at the time you are talking about it would have been regional offices, there was always some brokerage in understanding that issue and understanding whether there were other areas of the health economy, other organisations, who could take additional commissions.

Q693 Dr Naysmith: Do you mean they expected they might be bailed out at the end of the year, because they had made it clear—
Ms Rainsberry: No, I think at a regional level you had a responsibility to see, where there were particular financial pressures for organisations or health economies, whether across a region you could meet the necessary growth in workforce supply but without putting pressure on particular organisations. That would be a sort of response you would take at a regional level.
Dr Naysmith: We will probably return to this.

Q694 Chairman: We were trying to tease this out with previous witnesses in both this inquiry and also in the deficits one. We were told by the Secretary of State that trusts who had overspent should not have employed people if they could not afford it, but what you describe to me here is a direction, effectively, saying that you must.
Mr Sargent: I think we must draw the distinction also between members of staff and students. What we are essentially talking about is the commissioning of student numbers.

Q695 Chairman: As opposed to post numbers or jobs?
Mr Sargent: Absolutely.
Chairman: Thank you for that.

Q696 Dr Taylor: I think you have all implied that the Department of Health's job is to take a view of long-term priorities. It seems to me they have made a bit of a mess of it. Are they capable of taking that on? How should they be changed so they do it a bit better, or am I being excessively rude about them?
Ms Knight: I think what we have seen is that in 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, and that is where I think they should be leading us.

Q697 Dr Taylor: Do you think it is possible for anybody to predict what doctors you will need in 12, 15 years' time? Is it an impossible task?
Ms Knight: I think in terms of doctors it probably is impossible, but what we should be able to predict is the types of skills and competences that you are going need in that time span. You will never get it exact—we can never get it exact; it is not an exact science—but we should be able to make some fairly broad statements about the type of skills and competences we need.

Q698 Dr Taylor: Would you limit the Department of Health's role to this long-term priority setting, and, if you do that, how would you split up the other jobs between the Strategic Health Authorities and PCTs? At the moment it seems to me very muddling and to find out what bit is responsible for what is extraordinarily difficult?
Ms Rainsberry: My view would be that the department could strengthen its expertise in the area of strategic workforce planning. I think that would be most welcome. A number of the things that are impacting on the workforce at the moment, the European Time Directive is one example, have been known about for many, many years, and the impact of that could be modelled as some of the demographic changes. So I think we could make a real contribution at that level to doing that. I think the role of Strategic Health Authorities is to do what it says in the name, which is to lead the strategy for a health economy, and that must include workforce strategy. In order to be able to do that, we have to have the ability to plan the total workforce, not parts of the workforce. The way in which MPET is currently managed needs to be re-looked at—there is an MPET review, which you will be aware of—which means that at the moment, at its crudest, we could integrate service financial workforce planning at a Strategic Health Authority level, and we are planning on doing that; but 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. I think with Strategic Health Authorities (we have got 10 now) there is a real opportunity to provide proper leadership at that level within the over-arching strategic framework which the Department of Health should be providing. That would be my vision.

Q699 Dr Taylor: We are told at the moment it is the department that determines the size and the distribution of the MPET levy. Should they continue to determine the size, or does that not rather tie you, as a Strategic Health Authority, into what you do if the size is decided for you?

Ms Rainsberry: Yes, I think that would need to be a dialogue. I think you need a bottom-up from Strategic Health Authorities, a strategic overlook from the Department of Health and a dialogue where we agree between us what it should look like.

Q700 Dr Taylor: At the moment it is very much top-down?
Ms Rainsberry: Yes, we are given an allocation.
Mr Sargent: It should be a function of integrated service workforce and financial plans, which would be put together by the 10 SHAs and then 10 discussions with the Department of Health. At the end of the day, if the MPET was not enough or, indeed, too much (whichever way it was) to match up to those 10 plans, then you do need another discussion and the SHAs then ought to be able to say, if MPET is not enough to do what you want for the whole of your plans, if that is the way it turns out, then the plans should be amended until they are properly integrated and affordable.

Q701 Dr Taylor: We heard in the deficits inquiry that a great deal of pressure was put on Strategic Health Authorities not to use all their MPET money?
Ms Knight: It might be worth just saying what the effect on the budget cuts with us has been; and that has been our inability to actually second people into training, which is a way that we have found very effective. If you take a healthcare assistant and you second them through training, they stay with you and they are a very effective professional. What has happened with the MPET cuts is that we have had to totally stop being able to do that.
Ms Rainsberry: I think this particular year it has been quite unusual, the size of the reduction and the timing of it, and because of the way the MPET budget is constructed, you have very little room for manoeuvre at Strategic Health Authority level once you are in that situation. Having said that, the role of the Strategic Health Authority is to balance the competing objectives that we are given. So, the big number one, of which you are aware, is to balance the books, and we have to make decisions about how we do that along with all of our other obligations and priorities. I hope (and I can say I think in London this is the case) that we tackled that in a way which did not store up longer-term problems for MPET. We looked to see how we could make reductions without having to reduce the stock programmes that people were already on and things like that.
Mr Sargent: That does highlight a strategic dilemma, if we are honest about it, because if the money available to deliver the future workforce is squeezed through short-term pressures, then where is the changed workforce of the future going to come from? In particular, if we are currently training more people than we need for jobs that are paying more than they need to be if you look at the jobs differently and we do not invest in developing the ones who could deliver the work at an affordable price, then the focus on the short-term "balance the books" actually misses a very important trick here, that that money would be better invested in a longer-term view, taken within a proper strategic approach, which would develop the people we need at a price we can afford to pay as a country from the overall sums voted by Parliament to support the National Health Service.

Q702 Dr Taylor: Who should be deciding, and at what level should it be decided, that public health is just as well advised upon by non-medically qualified advisers, who would be a lot cheaper than public health doctors?
Mr Sargent: It is not particular public health doctors I was thinking about.

Q703 Dr Taylor: No, that is what I was thinking about!
Mr Sargent: But they are a good example too. It is looking at what competences do you need and what is affordable to deliver the quality of service that is deemed appropriate. The big numbers (and in truth they are not in the public health doctors) are in delivering care in wards, in health centres, and so on. If all the money goes into, for instance, registered nurses, doctors or even public health doctors, then it is not there, where the system is now, to support, say, the development of more skilled health care assistants, assistant practitioners. That is where the really big numbers are and that is where the big savings are, the current savings on the financial side, in terms of balancing the books in the longer-term.

Q704 Dr Taylor: As the NHS are relying more and more on the third sector, do you as a group have any input into planning workforce requirements in the third sector or do you take that into account?
Ms Knight: I think that is a very important point. You mentioned about workforce planning being done by PCTs, but I think actually workforce planning across health communities is really important and is the one area where we have actually had to concentrate in order to incorporate all the providers of healthcare, whether they be independent sector, private sector, social care; and that is going to be a difficult task because the data systems are very different, and the like, but it is something that, as workforce planning needs, we have got to tackle.
Ms Rainsberry: I think it is already happening. In London this year, because we have been very alive to the issue of the financial position in London, therefore trusts are holding vacancies—the real risk of potential newly qualified nurses, for example, not being able to gain employment—we have had very productive discussions with other sectors about providing employment, either on a short-term or medium-term basis, because all the evidence is that if a nurse, for example, once qualified, does not get into nursing within a certain period of time, we lose them completely. So we have been very keen to work with other partners to try and secure them into the healthcare workforce and, hopefully, back into the NHS.

Q705 Chairman: Trish, you mentioned one of the White Papers that has been published by the department, *Our health, our care, our say*, which suggests that the mode of travel is from the acute to primary and then, within that, pro health issues as opposed to ill-health issues which dominate the scene of healthcare in this country. Why have we not seen shifts in issues about public health personnel in the way that we have done with the acute sector in the last few years? What are the implications for these White Papers? Should we be seeing movement in public health professionals?
Ms Knight: Yes, I certainly think we should.

Q706 Chairman: Why are we not?
Ms Knight: I think because it is a complex workforce, because it covers all organisations. It is not just a health issue, this is an issue for local authorities, environmental health and the government offices and, therefore, to plan that workforce is very tricky because no-one really takes responsibility for that planning. There was an attempt, I think nearly six years ago, to do a national public health workforce plan, but I think it fell on affordability because when you look at numbers it is fairly difficult. I think what we have to do is to use some of our existing workforce and to change the way they work. Let us take health visitors, who at the moment tend to focus on individual clients. We need to change the way they operate to actually look after the population and to be a public health specialist in the true sense of the word.

Q707 Dr Naysmith: We have talked quite a lot about the lack of integration of workforce and financial planning in response to the series of questions that Richard asked, but I think Anne said this has been a very special year, a very unusual year in some ways, and we have seen a lot of over-shooting of past workforce growth targets, particularly this year, which has resulted in serious financial problems in various parts of the service. Are you aware of there being better planning by some SHAs and WDCs than others, and, if so, how did some of them manage to do their planning and their integration better than others?
Ms Rainsberry: Being fairly new in post, I am not aware of the performance of other Strategic Health Authorities.

Q708 Dr Naysmith: Why were SHAs and WDCs as a whole unable to prevent this overshooting of targets in some cases producing financial problems?
Mr Sargent: I am not entirely sure which targets you are referring to. Are you talking about the workforce expansion targets?

Q709 Dr Naysmith: Yes.
Mr Sargent: There are a couple of things. First of all, the workforce expansion targets were just for workforce, and it brings us back to this baseline issue that actually, if you look at all the workforce targets that ever were over the years from 1999 to 2008, I think you will find it comes to something like 116–120,000, but if you look back a good few years at the amount of money that was available and negotiated between the Department of Health and the Treasury, you would find that it would pay the wages of many more people than the workforce expansion target. So I do not think there has been a case of overshooting the workforce expansion target. What there has been of late, specifically with regard to the students, is that the students that are being trained in significant numbers did not anticipate the financial problems that surfaced last year and still do not fully anticipate the changes that most people would expect in the wake of the next Spending Review.

Q710 Dr Naysmith: Before you go any further, can I read you some figures. Between 1999 and 2004 the variants from the targets that were set, and they were all achieved but for consultants, actually except for consultants it was 3% under target, but for GPs it was 105% over the target, for nurses it was 340% over target and for allied health professionals it was 69% over target. That was not just students.
Mr Sargent: What I am saying is that the student numbers, first of all, took a while to build up in anticipation of the very large growth of monies that were put into the delivery of service in the NHS. There is a four-year lead time. So what was happening, colleagues round the table and round the country were building up the commissions, and the Department of Health was on the case, but that took time to work through. In the years you refer to, that was when the demand for more staff was at its height and then there were concerted efforts (and the Department of Health worked incredibly hard at this) to bring in things like "return to work", international recruitment, and so on, because the money they had available for service delivery did then outstrip the supply. The supply has since caught up.

Q711 Dr Naysmith: One of the things you said earlier is that Strategic Health Authorities had this sort of balancing act to perform. It was you, Mr Sargent, that said that?
Ms Rainsberry: I think it was me.

Q712 Dr Naysmith: I am sorry, it was you. We have not done a very good job of balancing these things out, have we?
Mr Sargent: I think there are significant constraints, as we have said, and that is why you are looking at this, but by the same token let us not forget that over the years, despite all the figures we can band about, the number of people who have qualified and been through training and not found jobs is relatively small and the problems are relatively short lived, and vice versa. So, whilst we can be very critical and think there are a lot of improvements and that is what we should be doing, by the same token I think it is wrong to be over-critical, because in a lot of ways the system has worked relatively well for many years. My belief is that the strategic change is a remedy, but we do need to move on and we do need some fundamental changes now to respond to the challenges of the future.

Q713 Dr Naysmith: What are the changes that we need to see?
Mr Sargent: Two in particular, and they are linked. The first one is a real move towards strategic workforce planning which takes place within a properly integrated approach to workforce financial and service planning; and the other thing that comes with it is that the world we are moving into, the strategic drivers we already know about, let alone the ones we do not, means to me that the healthcare employer of the future will have to be at least significantly dependent on a more flexible workforce than currently, and that means that we would need to start planning the services in part around the competences that are needed to deliver the sorts of services that we are looking for. That does mean new roles in a whole lot of ways—it is starting to happen already, but probably considerably more so—and it does mean that not all the work will be neatly parcelled up within the professional boundaries that we have seen historically, because the explosion of knowledge and technology just by itself means that it is going to be increasingly difficult to sustain.

Q714 Dr Naysmith: That is all very important, but given that that is 70% of the costs of the National Health Service and running the National Health Service workforce, is it not a bit daft that financial planning and workforce planning are not much more closely linked together?
Mr Sargent: I would agree that historically it could have been a whole lot better. I also feel significant strides have been made, but to answer your point directly—"Is there still some way to go?"—yes, I believe there is.

Q715 Dr Naysmith: What is the barrier to it happening? It happens in big private firms, private companies?
Ms Knight: Maybe we could see the deficit as actually an opportunity to drive this, because you will only manage the deficit by managing your pay bill, and if we have proper, good workforce development and HR practices coming out of that, because they have got to manage their pay bill, and a real look, as John says, at what their workforce need is, then maybe we will see an opportunity coming out of the deficits which we had not really realised to actually link financial and workforce planning.
Mr Sargent: Specifically, I have a personal view on at least part of the answer to the very valid question you raise. I think what lies behind a lot of this is essentially a cultural issue whereby HR and workforce issues are seen in many trusts, PCTs and other organisations as a second order of priority, because the short-term imperatives—balance the books, waiting lists targets and so on—compared, as I was saying, with a four-year lead time to get one more or one less nurse, make it hard to reconcile and get your head round as something that is really important when there are all these short-term issues on your desk. I think one of the key things we need to address is to try and get a cultural change that sees this as key and part of that integrated approach.

Q716 Dr Naysmith: In our recent deficits inquiry we came across two or three trusts where the finance director was referring to the board that they were in financial difficulties and at the other end of the organisation they were still recruiting and putting out adverts to recruit staff. That seems barmy, does it not, Ms Rainsberry?
Ms Rainsberry: Yes, it does seem barmy. I read your report. One of the issues that was referred to in your report about deficits, one of the pressures, is the new pay arrangements (ie the unit cost for the people that are being trained and are coming into the workforce has gone up). Equally, the amount of work we are doing is increasing, and therefore, if you do not redesign your services and you do it in the old way, then the yearly cost is going to become higher and higher. I think there is a danger in just seeing workforce planning as the Holy Grail to everything. I think workforce planning at a national level leads to informal workforce strategy, which will be about balancing supply and demand, but what we tend to do then is just assume that education commissioning is the way in which we balance supply and demand, and that inherently will cause financial problems. I think what we need to do at a national level is understand what other elements we are anticipating. This is where I come back to the planning assumptions that the department have set within a strategic framework. How much are we planning to close that gap through productivity of the existing workforce, for example, or creating new roles within the existing workforce, and so on? If we are able to join up nationally all the different elements for workforce strategy rather than just looking at education commissioning in a silo, I think that would be extremely helpful.

Q717 Dr Naysmith: Finally, one of the things that is immediately cut when any National Health Service organisation gets into financial difficulties is the developmental activities of the workforce, which are referred to by some as expensive luxuries. That must be wrong too. What would be your view on that?
Mr Sargent: I absolutely agree. You would hope that the programme of investment in the development of the staff is within the strategic framework and, if it is and that is what goes, it is crazy, because you may hit a short-term target, like balance one bit of this year's books somewhere, but we do have a responsibility collectively to deliver the healthcare of the people of this country for future years, and that means developing the staff who are able to do that. So, unless it is put back very quickly— I do not think it matters if it was three months taking it and it was definitely put back next year, if you are looking over a ten-year period, but if it is just take, take, take, then that is very short-sighted.
Ms Knight: I would like to add that I think Strategic Health Authorities and the Deaneries have a responsibility to have some kind of performance management of the trusts and organisations about what they are doing around education and development, a proper agreement that they will go on educating staff.

Q718 Sandra Gidley: A question for John Sargent initially. In your written submission you talk about the mismatch between the workforce figures predicted in the NHS plan and the level of funding growth. Why did that mismatch occur, do you think?
Mr Sargent: I suspect, in truth, that different, as it were, sections in the Department of Health were concentrating on different aspects of the Health Service. I think (and it is true of most organisations in my experience) if you have got a lot of people effectively working on different projects, the analogy is, if you throw a rock in a pool, there are ripples and you have got to think where the ripples land. I think, in part, what happened there was the Department of Health did very well, relative to other departments, on the financial settlement side and I think that the workforce targets were up. When people were looking at that in the Department of Health, it was also functioning physically, "How many extra people can we develop through the systems as they are?" So there was always going to be tension if you expressed it in, "How many extra numbers of wages can we afford to put on the payroll", and compared that with how many extra people physically did you think you could put in, because most people, do not forget, in the NHS complain those workforce expansion targets were too high and could not be met. In fact, as somebody else has said this morning, they were significantly over-met in total at the end of the day, though not necessarily in the individual silos. So, I think there was a lesson learned there, if you like, that the government policy 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. I think a lot of that has been learnt and it is being brought together now.

Q719 Sandra Gidley: Why was all the money spent on workforce rather than drugs? We all hear tales of drug rationing, et cetera. Why was it all poured into that stream?
Mr Sargent: It was not all poured into that stream.

Q720 Sandra Gidley: Why was so much more than necessary poured into the workforce stream?
Mr Sargent: I do not believe it was. As somebody said this morning, it is about 70%, but actually relatively more is going into drugs. If you look at the growth type money, over the current Spending Review, it has been about 7.3%, on average, real growth money, and yet the workforce has only gone up the order of about 4% a year. So, relatively, we have been putting more into the non-workforce areas.

Q721 Sandra Gidley: If you look at the demographic profile of the workforce, there are a lot of nurses in particular coming up to retirement. Is it the case we have got a short-term blip while we produce a mode, if you like, but that in a few years we will be glad of all the extra people that are around now?
Mr Sargent: Again, my own view is that the most important thing that is needed is that strategic dimension. Look at the people who still apply in very significant numbers and get turned down in significant numbers for jobs like healthcare assistants: they are the people who we know have got a lot of talent, incredible talent a lot of them, and can be developed further. We know that the numbers are down, but there is enough evidence on that to show that we can grow those people. If you grow those people over the interim period, then the adjustment to the number of registered professionals that we need, if you took the numbers down as people are suggesting now, is sustainable when you go from 10 to 15 years hence. I think that the trick is not just to look at the established professions but to look at the opportunities to make a real strategic change which makes the NHS affordable and means that the shape of the workforce is one that can be delivered, but it can only be done if you look at it over a ten-year period, and, in answer to your question, if that is done, then I do not believe that we are storing up a problem for the future that we would then be under supplied in, say, 10 years' time.

Q722 Sandra Gidley: Can I understand what you are saying, because there is a lot of broad jargon there, if you like. You seem to be saying that we can get a lot of what we get now on the cheap.
Mr Sargent: I am not.

Q723 Sandra Gidley: By not fully training nurses.
Mr Sargent: Absolutely not.

Q724 Sandra Gidley: But training other people in different ways.
Mr Sargent: Not at all. What we have just had, amongst other policies, is Agenda for Change, and Agenda for Change is absolutely designed to ensure that people get developed appropriately according to the needs of patients and the services in which they are treated. Inevitably, if you introduce a new system, there has got to be a transition. Inevitably there has been a high cost of moving people from the old pay system onto the new, an effect on their old jobs. What I am saying is that the pace of change is such that we need to rethink some of that and redesign services around what patients need with all the new knowledge, technology and drugs and so forth, look at those competences and design the roles in a way that is both effective and cost-efficient, because at the end of the day the services do have to be delivered within the money that is voted through by Parliament.

Q725 Sandra Gidley: So you are assuming that we know what the structures will be like in 10 years' time.
Mr Sargent: No, the essential point about competences is that it is not as constraining as many of the ways that we have designed things in the past. If you develop somebody with, if you like, 100 competences, if the world moves on, what we ought to be saying to them is, "Look, we only want numbers one to 90", if that is how things move in five

years' time. "What we would like you to do is instead develop yourself to pick up numbers 101 to 110. We are only going to still pay you for maybe 100. We want one to 90 plus 101 to 110", and those 10 will be the ones that make a difference to be able to respond to the changing world rather than starting all over again.

Q726 Sandra Gidley: So you are actually talking about flexibility more than anything else?
Mr Sargent: Absolutely.

Q727 Sandra Gidley: If the Department of Health had such a great problem in aligning its workforce planning and its financial planning, is it surprising that other organisations probably did not get the help they needed or did not have the expertise they needed to make sure that the two ran in tandem?
Ms Rainsberry: The Strategic Health Authorities?

Q728 Sandra Gidley: Yes.
Ms Rainsberry: I think it is a function of a fragmented system rather than the capability of the organisations to do the job, as I said earlier. What we have just been talking about there is the need to, on the one hand, have the balance of getting a much greater focus on the long-term strategy and what are the fixed points that we know are happening within the demographic changes that you mentioned, and, on the other hand, how do we build in flexibility. We know our needs may change quite rapidly, and the infrastructure and the budget and the way in which we manage the workforce and commission education training is inherently very inflexible. Therefore, what we need to do is to make sure that we have got the overall direction of travel right but that the way in which we set contracts with education providers, the types of education and the access to that training also builds in flexibility, and the way we can use the budget also allows us flexibility and so I think we need both. I think if you have that, then the organisations like Strategic Health Authorities are best placed to bring together service commissioning with financial priorities and workforce, because that is essentially their role.

Q729 Sandra Gidley: They have not done it very well in the past though. What needs to happen to make them more effective?
Ms Rainsberry: I think (a) they need to have the right capability at the right level to perform that role (and I can say it from my own experience, certainly, and this is picked up, I think, in healthcare and all its talents) and traditionally these functions have been done by quite junior staff and I think that needs to change, but, more importantly, once you have got the capability, you need to have the tools to deliver the plan, as I said earlier, at a Strategic Health Authority level. We can produce a health strategy for London, we can produce a workforce strategy for London which looks at how we are going to shift workforce to primary care settings, etcetera, but if we are constrained by the way in which the budgetary system works, it means that we cannot actually implement that plan. I think it is understanding what are the causes of that. I would not necessarily just follow through to say it is the fact that the organisations were not capable of doing it; it is whether they were in a context where they were able to deliver it.

Q730 Chairman: Before we move on to other aspects of workforce planning, I want to ask you a couple of questions about how we have traditionally filled some skill gaps in the United Kingdom, particularly around nursing, by the employment of nurses from other parts of the world, particularly the developing world. What do you think about the ethics of filling skill gaps with nurses like that? I was told that the National Health Service never directly employ a nurse from the developing world, but if they come and work in the independent sector for six months, then they will take them on. Is that right?
Ms Rainsberry: There is obviously a code which has been published by the department in terms of ethical recruitments, and we would expect all employers to abide by that. I know that there are cases where that has not happened, and certainly I have been involved in cases where we have had to address that. I think what is in issue now is that, as John has said, as the supply of nurses is coming through there is an issue where we have international recruits who are in post where we need to effectively manage that through so that the national supply can get work, and that is not quite as straightforward as it might seem as not renewing your work permit. A lot of these international recruits have very valuable skills in specialist areas like renal medicine, for example, or ITU where you have had gaps, and your newly qualified cannot go into those areas. So it is quite a complex strategy that is required to manage that through, but it is important that we do and that we do it sensitively as well to those individuals who have come from abroad.

Q731 Chairman: Does the code recognise that, or is that just about recruitment?
Ms Rainsberry: That is just about recruitment in terms of—

Q732 Chairman: Trish, have you got any views on this?
Ms Knight: No, I would just echo what Anne says. We have had that supply and we should recognise that they have given us good service. That would be my comment.
Mr Sargent: Slightly different in one sense, in that this was a big issue if you go back to the early 2000s. In my case, I was in Greater Manchester in 2001. We did the analysis, and it was clear there was going to be a gap—our best was about 2,000 people short amongst the healthcare employees—and so what we did was to try and take a strategic view of that and set off on a programme which we called "delivering the workforce", which was an attempt to grow our own people (up to 2,000 assistant practitioners), over a five-year period, to try and fill that gap by making opportunities for people who probably would not otherwise have work opportunities in and around Greater Manchester and to try and see that

through, and that meant a whole lot of other changes. There were still international recruitees into the Greater Manchester health economy, do not get me wrong, but we could see it coming, and it brings us back to this point again, that you do have a strategic view of it. There are things that you can do to avoid some of the other problems, but you do need to be there to take those decisions and stick with them and see them through over a strategic period if they are to have the impact that they are intended to.

Q733 Chairman: I do not know if any of you have had direct responsibility for recruitment in this area. Was there any difference between recruiting somebody from a country that actually trains nurses effectively for export to earn credits, like the Philippines, as opposed to many countries in Africa and the Caribbean that can ill afford to lose their nurses but do so because of the attraction of coming and working in an English speaking country and being able to earn sums of money far in excess of what they can if they stayed at home? Has there ever been anything that you have looked at?
Mr Sargent: I am unaware. Certainly, in my experience, in the parts of the country I worked in, it was well co-ordinated between people locally and the Department of Health and it did follow the ethical recruitment policy. I have no doubt, equally, that if somebody dug they would be able to find somebody somewhere who had come through another route, but in terms of what we were trying to do alongside the Department of Health, it was absolutely to make sure that it was from two countries in particular. You have mentioned one, the Philippines. India was another one, and that was more complicated because probably they needed many of the people themselves, but they were coming here in droves anyway, so we needed to find some way to make that both ethical on the one hand and recognise what was happening, and work was done to bring that to a reasonable conclusion.

Q734 Chairman: Anne, have you anything to add?
Ms Rainsberry: No, I would agree with John. I think it was something that was well co-ordinated by the Department of Health with appropriate government to government agreements with the Philippines, India, and so on, and at that time that we are talking about regional offices worked very closely with the Department of Health to ensure, as much as they could, that constituent employers were working within that framework and recruiting as part of those agreements.
Ms Knight: I think it might be worth mentioning that previous to actual international recruitment, we had a period when an awful lot of people from the likes of Zimbabwe were coming across to do their nurse training prior to the changing of the regulations. We had an enormous amount of people who had come for whom we paid for training, so that gives us just another slant, but those recruits are coming through now as well.

Q735 Chairman: We have a lot of doctors coming into the system on a short-term two or three years getting experience that they take back again, and I think that is all to the general good of the individual countries they come from. You would accept that, would you not?
Ms Rainsberry: Yes.
Chairman: We are going to move on to some other areas of the nature and quality workforce planning.

Q736 Dr Taylor: Can we move to integration of workforce planning, in particular to Anne in the first instance, because in the summary to your document you said, "The evidence points out that the planning of medical training numbers is still carried out separately from workforce planning for all other NHS staff". Could you summarise a brief list of the problems that that causes?
Ms Rainsberry: Yes, certainly. I will give you a very live example: *Modernising medical careers* would be an example that is current. The Strategic Health Authority, within the last week or so, have had to sign off the commissions for *Modernising medical careers*, and that is a big deal for us because, effectively, as you know, it is, on average, a seven-year run through training programme, so in London we are seriously committing those funds for seven years. In that discussion we have to look at what are the programmes that are being commissioned and also what our view as a Strategic Health Authority is in terms of the sorts of things people have been discussing, such as *Your health, your care, your say*. Effectively what we have done with *Modernising medical careers* is take existing programmes and put them through into the sort of MMC framework, and the way in which we have had to do it has been constrained by the fact that the training numbers have been determined nationally. I think if we had a freer hand as a Strategic Health Authority and a bit more time, I have to say, we probably would have wanted to take slightly more strategic view about (a) the composition of the run through training in terms of interplay between acute and primary care settings and (b) the type of training that was being commissioned so that we had the right balance coming out. As it was, 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 expansion, there are a few that are in reduction, this is the national curriculum and, therefore, please sign here." Of course, that is a massive amount of our budget, and I think that if we really are to think about new models of care—end of life or beginning of life or emergency care—we need to look at those, look at what that model looks like, look at what workforce is required to deliver through those sorts of models of care across all parts of the Health Service, and then design the workforce to deliver that, and doing it in silos does not allow you to do that.

Q737 Dr Taylor: Having committed that amount for seven years, does that rob the non-medical training part of your money?

Ms Rainsberry: No, it has not in London. Basically it has meant that the money that is already committed through MADEL is continued to be committed.

Q738 Dr Taylor: So you have not had to move stuff out of NMET into MADEL?
Ms Rainsberry: No, we have not. Coming back to my point about workforce strategies, as distinct from workforce planning, one of the issues and risks we discussed as a Strategic Health Authority Board was the fact that the new pay scales, for example, for doctors moving on to MMC are yet to be agreed by NHS employers. We are advised that they will be cost-neutral, we are working on the basis that they will be cost-neutral, but obviously, if they are not, the amount of money that we have just signed the cheque for could be larger. Those are the sorts of things that we have to try and manage.

Q739 Dr Taylor: We all know the department's record of making contracts cost-neutral is not very good. You have got three recommendations at the bottom of your paper. Are those what you would like to see?
Ms Rainsberry: Yes.

Q740 Dr Taylor: Could you take us through those very quickly?
Ms Rainsberry: Yes. I feel I am repeating myself, but, firstly, I think there is a real issue, as I have just described, 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 with that, we are commissioning a workforce. We are not commissioning education *per se*. I think from my perspective we need to be able to understand what workforce we need and use the budgets available to deliver that. We need more flexibility with that. The last point is just to re-emphasise the need to have a much clearer strategic direction at departmental level on the workforce with clear, longer term planning priorities within which the strategic health authorities would then deliver the integration, because I think they are best placed to do that.

Q741 Dr Taylor: Turning to Trish, we gather that in your part the medical deanery has merged with the SHA. Is that right?
Ms Knight: The medical and the non-medical deaneries have merged. The old WDC and the medical deanery have merged. We are in the process of merging two deaneries across the patch which will again remain as what is called a healthcare workforce deanery. My fears about that are that the non-medical side gets swamped by the issues around the medical side. There is a real need for strategic leadership of non-medical education.

Q742 Dr Taylor: At first sight it looked a good thing but there might be some disadvantages?
Ms Knight: Yes, I think that would be fair.

Q743 Dr Taylor: Is this happening in other parts of the country?
Ms Knight: I am aware that is has happened in the West Midlands. It is the proposed direction of travel that was outlined in the paper from the Department of Health. One of the other fears is that it divorces workforce planning from education to a certain extent or it can do. The skill that we may be losing is the ability to translate a workforce development plan into a plan for education. That is a skill that is very scarce.

Q744 Dr Taylor: HEFCE funds medical undergraduate education and MPET does virtually everything else with NMET, MADEL and SIFT. The MPET things are under the pressures that the NHS has. HEFCE seems to be very cheap to run and not under attack, so why should we not be pushing that everything goes to HEFCE?
Ms Knight: We would have to be careful. It is an option that needs to be looked at and examined. The problem I would see is that the NHS as a whole would have less influence on the education that was provided. We would have less influence on producing this workforce that we wanted.

Q745 Dr Taylor: Should undergraduate nurse training go to HEFCE?
Ms Knight: I think it is an option that should be looked at but it needs to be looked at with that proviso, that we do not lose the link between what the NHS requires and what the universities deliver.

Q746 Dr Taylor: It is not an automatic response from any of you?
Mr Sargent: No. You are quite right that HEFCE does pay for medical undergraduates. However, there are still the deaneries and these link very closely into workforce needs in the medical arena, however well or not so well assessed. That is not the case for everything else that HEFCE funds where effectively they are funding undergraduate programmes. In most cases if you are going to be an engineer, an accountant or whatever you start your professional after. The risk is if you put nurse training responsibilities and education responsibilities that way is there anybody who has a clear eye on commissioning the workforce needs of the future health service of this country. If HEFCE were to go about it the same way they do for most other programmes, we could either have big shortages or big surpluses.
Ms Rainsberry: I would agree with John.

Q747 Dr Naysmith: Mr Sargent, in your written evidence you said that local delivery plans are not a suitable tool for workforce planning because they only cover a three year period. I think you have already hinted earlier that there is evidence that the National Health Service is starting to develop longer term workforce plans. I wonder what you think the timescale should be for these plans if it is not three years.

Mr Sargent: You are quite right. The three years is difficult because for most of the people who come through the traditional programmes the minimum period is three years so the commissioning decision was taken a year before that. The first time you can begin to influence change is in the fourth year, which is the year after the plan finishes.

Q748 Dr Naysmith: That is not much good then, is it?
Mr Sargent: That is just the LDP. My own view is if you believe that the service and patient requirements are such that significant modernisation is required, it is folly to try and do it overnight and certainly within the three years. I think you do need a much longer strategic perspective on that. Your question was exactly how long. My own view is that unless you have a reasonable run through over 10 years to make an impression on the overall shape of the workforce, you just cannot do it because the numbers are so huge. I quote the example I know best which is through my colleagues in greater Manchester who have significant experience now of putting assistant practitioners into the workforce. There are now over 600 of them. Their assessment is that 15% on average of work that is done in clinical teams could be done now by assistant practitioners. If you tried to move to that nationally, even over 10 years, you would so destabilise schools of nursing. Going back to a question that somebody asked, if you took the numbers down you would need them back again, say, in 10 years' time and you would have lost the expertise to do it. I think a minimum of 10 years is required. In some cases, you need to look at a programme that probably goes to 15 years. That is not to say that you set it in tablets of stone. I believe that as new knowledge comes along each year you can incrementally change it so what maybe you think is 15% this year could be 14% next year or 16%. Because you can only bring people through a year at a time, I do not think that is disastrous at all. Quite the opposite. I think you need a clear strategic direction, a view over 10 to 15 years, and then keep revising it as better knowledge and experiences come through.
Ms Knight: What we have to be very careful about is a boom and bust. Any changes in commissioning decisions should be done gradually, not in great step changes. There is a real danger at the moment that because of the financial problem you just cut commissions to save money and I think we have to guard against that.
Mr Sargent: A very important point in this is the gearing effect. Roughly 5% of the healthcare workforce retires or otherwise completely leaves work in a year. That is five in 100. When we have been in a period where we have seen workforce growth at, say, 3% to 4%, that sounds like a fairly low number but it is three or four students on five, so that is why we have seen the 60%, 70%, 80% growth in numbers. It is quite difficult to deliver very small numbers in workforce changes because even very small changes in the whole workforce level have major implications in the numbers in percentage terms, when we look at the commissions. If you try to make the sorts of changes I referred to over short periods of time, the numbers at the commissioning will take the end of the scale either down to nearly zero at one end or put such intolerable strains on the other that you really do need a longer term view if you want sustainability.

Q749 Dr Naysmith: The Department of Health in their evidence told us that the new Integrated Service Improvement Programmes (ISIPs) will help to ensure that workforce planning is more effective and better integrated. They think it will; do you agree?
Ms Rainsberry: Not on its own I do not think. An ISIP is an extremely useful tool by which health economies can pull together the integration of finance, service and workforce, but I think it needs to be done in the context of an overall strategy for that.

Q750 Dr Naysmith: How does it tie in with local delivery plans?
Ms Rainsberry: I would see it as a delivery mechanism of the plans. If the local delivery plan is saying, "This is what we are going to deliver in healthcare outcomes", there will be certain areas within a health economy that will require parties to sign up and to give specific attention to A&E waits or whatever it might be. I think ISIP is extremely useful in targeting and integrating resource around those areas but I do not think it is the answer to all the things we have been discussing this morning.

Q751 Dr Naysmith: How is it affected by the need for the financial stringency that we spent such a long time talking about to start with?
Ms Rainsberry: It would have to take into account that there is always a balance between what you want in workforce terms and what you can afford.

Q752 Dr Naysmith: You are saying it will help but it is not the answer?
Ms Rainsberry: It will help in making those decisions—ie, in framing those decisions. If I want a certain number of staff of a certain level and a certain qualification, that is going to cost me a certain amount of money. I know that sounds basic but it is getting organisations to look at that and to understand that I can either do it in this way and it will cost that much or that way and it will cost this much. I think it is useful in that way but as a delivery mechanism for the overall plan for a health economy.
Ms Knight: The one thing it does do is to make people think outside organisational boundaries and that really helps.

Q753 Chairman: We have been told that clinical engagement is vital to the effectiveness of workforce development activities such as skill mix change. I wonder if I could ask Anne and Trish if they agree with that notion and what you are doing if you do agree with it?
Ms Rainsberry: If you are going to work through on the timescales that John has been talking about and if you take *Your Health, Your Care, Your Say*, and look at what that is going to mean in models of

care and how that might play through to the configuration of services and workforce then you need to work with clinical colleagues to understand the workforce element. If we are going to provide care in that way, what will that mean for the workforce? That is absolutely key. You then have a second set of discussions which are, "That is our ideal model of how we would like to deliver something" and the discussion we have just had about ISIP which is, "How does the ideal balance with the money we have and the timescales and so on?" That is where I think sometimes tensions can be caused in those relationships. You have to make judgment calls about how you are going to deliver but clinical engagement and understanding what skills you need in order to deliver a particular model of care are key.

Q754 Chairman: Would you agree with that?
Ms Knight: I would agree and I would add also that we have seen quite a lot of attempts at new ways of working that have not been sustainable because they have not had proper clinical engagement. Some of these new ways of working are far better if they bubble up from the bottom rather than getting imposed from the top. We have an example at the moment within pathology where they came to us and said, "What we want is assistant practitioners to underpin our biomedical scientists and we would like a foundation degree developed for them." It was definitely their engagement, their initiative, and I am sure it will be sustainable.

Q755 Chairman: Would you say overall clinical engagement is crucial to the overall success of workforce planning and development, as opposed to just care which is pretty obvious?
Ms Rainsberry: Yes. At its most basic level workforce planning is an estimating exercise, forecasting, and you cannot do it in a vacuum. If you say, "We are going to provide this type of care in this sort of volume" you need some clinical input to understand what skills and volume of skills you require to deliver that. Getting an estimation of what you need right is absolutely fundamental.
Ms Knight: I do not think you can do workforce planning without understanding where the service is going. The only people who can tell you where the service is going are the clinicians.
Mr Sargent: My personal view is that it is quite a sophisticated mix of top down and bottom up. Clinical engagement runs through that. Top down is the overall strategic direction. The Working Time Directive is coming. All these things are coming and they are going to impact on you and your teams. Our best guess in overall terms is it might look something like this. Would you like to have a go with you and your colleagues? What does it really mean for you? You have the engagement through the clinical teams and they will have some brilliant ideas about how to address that that the people at the top down will not have thought of. Then you need the discussion in the middle of it and it can be quite tricky because inevitably, if the top down and bottom up do not meet first time round, there does need to be a discussion because if the bottom up comes up with something that is either totally unaffordable or you could not possibly run a course to do that or whatever it might be, that is the way to do it. You get the clinical engagement and quite a sophisticated mix of strategic top down and bottom up with real team engagement—not just the doctors, by the way, but all the team members, because if you change the role of anyone in the team, by definition, you change the role of all the others.

Q756 Chairman: We have been told that the prominence given to workforce planning by *A Health Service of All the Talents* has been seriously lost and dissipated. Do you agree with that? If so, why has this happened and what can be done about it?
Ms Rainsberry: Can you expand on the question?

Q757 Chairman: People tell us that the document *A Health Service of All the Talents* is not focused any more.
Ms Rainsberry: It has lost its direction?

Q758 Chairman: Yes. 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.

Q759 Chairman: Do you think it has happened?
Ms Rainsberry: I do not think it has happened but there is a genuine danger of that if you do not have the proper strategic focus around it, where people at the right level are making the right decisions about the interplay between needing to achieve financial balance in year and also understanding the need to ensure the future workforce supply. Sometimes, there is a risk that the pressure to balance the books in some areas can mean that people focus only on that and therefore do make some short term decisions. The department and the Strategic Health Authorities need to act as the counterbalance to that so that we are maintaining the right direction and so that the way in which those short term measures are taken does not fundamentally affect the longer term direction, which is I think what John was saying earlier.
Mr Sargent: There are a couple of other differences that are worth reflecting on. WDCs were set up as member organisations, whereas SHAs are effectively performance management organisations. In my time in Greater Manchester, we went out of our way to be a member organisation so that it was not the WDC chief executive who was doing A, B and C. We tried to get the engagement so that the members own what comes through their WDC rather than it being something that is done to them. We tried very hard to make sure that amongst those members were the employees from the non-NHS part of the sector. There is a risk that the NHS can be too introspective and not give as much attention as it ought to to that section of the healthcare sector.

Ms Knight: I would echo Anne's point about the strategic issues around workforce planning because I am very aware that there is an awful lot of extremely good, longer term workforce planning going on in provider organisations in Strategic Health Authorities, but it is making sure strategically it still has a place.
Ms Rainsberry: Strategic Health Authorities are fundamentally changing their role to strategic commissioning organisations and moving away from performance management. If we genuinely have a role around understanding, getting the maximum health gain for the money spent on behalf of the population—in my case, London—the workforce has to be integral to that. It is not commissioning education; it is commissioning a workforce that is going to deliver that health gain.
Chairman: That might be an appropriate opportunity to move onto issues around education and training.

Q760 Dr Taylor: We have just touched on SHA services and the MPET budget. I want to try and dig a bit further into this. In the year 2005–06 we know that the gross NHS deficit was 1.27 billion and it was reduced to about 500 million because of SHA surpluses, largely. How did that affect the MPET budgets in your two areas, thinking of Anne and Trish? Were you at any time instructed that you had to hold back on the MPET budgets to allow your SHA to have a big surplus or was that not the case?
Ms Rainsberry: I cannot answer because I was not in post at the time. I can talk for this year but not for 2005–06.

Q761 Dr Taylor: Trish, were you about that year?
Ms Knight: We had discussions around how to best manage the MPET budget within the financial envelope that was given to us and the Strategic Health Authority was very open to trying to maintain the education budget. We are perhaps fortunate with the Strategic Health Authority but they were very open to maintaining it at the level we had.

Q762 Dr Taylor: In your area they were able to maintain it, were they, pretty much?
Ms Knight: Pretty much, yes.

Q763 Dr Taylor: Going on to 2006–07, the figures we have for London, the total MPET allocation for 2005–06 for the five London SHAs, was 886 million which was 86% of the total SHA budget. For 2006–07, you are taking a cut of 60 million down to 826 million. How is that going to affect the workforce and the training?
Ms Rainsberry: As a bit of context on that, at the beginning of the financial year we knew that there were discussions in the department obviously about the devolution of central budgets and MPET is one. We were planning for a reduction of between 5% and 10%, somewhere in the middle. It ended up being 10.4% for London, which is quite substantial. It is a £96 million reduction for London. We had a number of criteria that we used in London to make some decisions. First of all, we had to honour all our legal obligations. Where we had contracts with education providers, we needed to honour those. We took a decision that we were not prepared to pull the plug on any programmes where people were in training. That was not the case throughout the country but that is the decision that we took in London. We also did not want to take decisions which would result in other partners getting in a position where they would have redundancies. That was our ideal. The amount of money we had to save and the point at which we had to save it, which was August this year, clearly made it very difficult so we took some decisions. There was some activity that we could defer to next year. For some of the infrastructure costs around the further roll out of MMC and things like that we agreed with the deanery we could do some things next year rather than this year. We effectively shifted the costs. In London the way in which some of the allocations out to trust is not necessarily equal and we took the opportunity to equalise some of the allocations across London. Through that, we saved some money. Also, we took a view on MADEL that typically there was a 1% vacancy factor across London. We had always funded at 100% rather than 99%. We did things like that to find the additional money, which we felt were things that were not going to irrevocably undermine our future direction.

Q764 Dr Taylor: You were able not to stop any people who were already in training courses?
Ms Rainsberry: Correct. We did reduce the numbers of future commissions by a small amount.

Q765 Dr Taylor: From what you said, you think that was not the case across the country. Some people did have to be cut in training courses?
Ms Rainsberry: My understanding is that but that would be general discussion I have overheard. I could not give you an example.

Q766 Dr Taylor: You have had to cut, for example, healthcare assistants who want to upgrade?
Ms Rainsberry: Yes. We have had to reduce the amount of funding we put into that. We have talked to our education providers, trying not to get to closing down programmes completely, to try to treat this as a short term measure in order to deliver. A lot depends on what we can deliver in terms of our financial control target for London and we are obviously working very hard as a strategic health authority to deliver what we have said we will deliver so that we do not store up further problems for next year.

Q767 Dr Taylor: Trish, have you had the same sort of range of cuts for 2006–07?
Ms Knight: Yes, we have. I can only really answer for the NMET part of the budget, the non-medical side. For the NMET part of the budget, we have done much as Anne illustrated. We have made sure that anything we were contractually obliged to do through the universities we have maintained. Anything where it would have been a loss of infrastructure within the universities if we stopped

it, like community nursing training, we have maintained. We had to stop all secondment of people into training, the HCAs or the OT assistant who wants to go and do their training, which is a real shame, but that is how we have managed the cut. It does raise an issue though that what we have cut is the salary support to trainees. Maybe one of the solutions to the problem around the education budget is that whole issue of how we support people who are in training. We should examine it in great detail. It is a very complex area because trainees are supported in a lot of different ways but it needs a complete re-examination. That is my belief and it could enable the MPET budget to stretch further.

Q768 Dr Taylor: We are right to interpret this as the lower grade you are in the staff hierarchy the worse these cuts affect you?
Ms Knight: Yes.
Ms Rainsberry: The reason for that 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.
Ms Knight: The pot of money that is totally cut is the one that was supporting the National Vocational Qualifications. That has gone completely. We have managed to support them for this last year but we will not be able to support them next year and that is hitting the most vulnerable, lowest paid group.

Q769 Dr Taylor: We did get the Secretary of State to admit that this 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.

Q770 Dr Taylor: We have already had it 2005–06 and 2006–07 so if it goes on to 2007–08 it is a disaster?
Ms Knight: "Disaster" is perhaps strong but it is storing up problems for the future in that we do not have the funds to develop the workforce that needs developing.
Ms Rainsberry: It has been a very positive move this week that the operating framework for the NHS has been published earlier than ever I can remember it being published. I think that does give us much greater certainty within which to plan.

Q771 Dr Taylor: You trust that it will not change?
Ms Rainsberry: I do not want to get cynical, but I hope that that is the case. In London we want to get to a position where we are able to invest in these programmes again next year. We are not able to say to the Committee that is what we will be able to do because we have just started our planning round, but that is certainly our intention. That is what we would like to see.

Q772 Dr Taylor: You have had it earlier than usual?
Ms Rainsberry: Yes.

Q773 Sandra Gidley: You said there had been cuts to learning support. I was not quite sure whether that was cuts in numbers or the support packages that individuals had reduced in some way. Are you able to clarify that?
Ms Knight: It is the support packages. There are quite a lot of trainees, particularly within the health care scientists group. Their salary is supported while they are training and it is that area that I think needs examination because it is inequitable at the moment. Different people get different amounts and it suggests that we should look at a much more flat rate for those people. This year we tried to rationalise it a bit but we have not made a sea change, which is what I think we need.

Q774 Chairman: You spoke about vocational training. Is this going to impact on the agenda for change?
Ms Knight: I am not quite sure. I am not an HR expert. I presume that if an individual member of staff was going to go through an agenda for change gateway and they requested vocational training and were unable to get it, that would be a problem.

Q775 Chairman: They would not go through Agenda for Change? Presumably they would not get the requisite increase in salary?
Ms Rainsberry: It links to the knowledge and skills framework and obviously progression through the pay bands on Agenda for Change is to do with the acquisition of additional knowledge and skills.

Q776 Chairman: If somebody has agreed their individual training package under agenda for change, are we saying it is potentially going to be disrupted?
Ms Rainsberry: Potentially, it shifts the burden onto individual employers to try and meet that obligation to those staff.

Q777 Chairman: Meet the increase in salary or meet the training?
Ms Rainsberry: The training.

Q778 Chairman: Could we see a situation where you could get the increase in salary without the training or the qualification?
Ms Rainsberry: That is not the premise on which Agenda for Change operates.

Q779 Chairman: I know it is not but I am wondering if this has a negative impact on that premise.
Ms Knight: I do not know. I would expect not.

Q780 Chairman: Hopefully.
Ms Rainsberry: Hopefully.

Q781 Mr Campbell: John, you argued in your submission that there are about 25% more nurses entering training than the health service can employ once they are qualified. Can you expand?

Mr Sargent: If you remember, we have 5% of the workforce retiring each year so we need five students to cover them. We have had a period where we have had growth of 3% to 4% so we would have five, plus three or four students, eight or nine. That is in a period when money growth has been 7.3%. We have had 3% to 4% workforce growth. If we are going to see money growth—the Chancellor will no doubt determine in due course—some people will guess that maybe the figure might be in the order of 3% to 4%. If that were proven to be a good guess, the affordable workforce growth comes down to perhaps about $\frac{1}{2}$%. That means the NHS needs five newly qualified students plus a half for the growth instead of the eight to nine they have now. That is where the difference comes in. It is this gearing effect I was talking about. If you anticipate that in 2008 the service can afford to grow its workforce by the order of $\frac{1}{2}$%, those students are already in and there are too many of them. That is the point I am making. Just to get it back in balance so that roughly the ones who do qualify, by and large, can find a job, we need to reduce the commissioning. We needed to have done it a couple of years ago in truth but certainly now it needs to come down to probably of the order of 18,000 fairly immediately. I guess from what colleagues have said it probably will be when you add them up this year but not as a result of a strategic run through argument and analysis of this as a response to the reductions that we talked about in the last series of questions.

Q782 Mr Campbell: What you are saying is that we are training too many staff?
Mr Sargent: We are at the moment, yes. Absolutely.

Q783 Mr Campbell: The National Health workforce review team said in a recommendation that for the current, 2006, commissions to be maintained at the same level as we have now through 2007 and 2008, they do not seem to be picking up what you are picking up.
Mr Sargent: Their methodology is different for this purpose in two crucial ways. First of all, they assess that number based not on affordability but the number of people needed to deliver the amount of activity that meets the other Department of Health targets to get waiting lists down and so on. It is not predicated on what is affordable. What I have given you comes back to the financial envelope that is available to support the workforce. The WRT are looking at the numbers to deliver what they believe, after an allowance for improved productivity, would be needed to do everything else that the service is being asked to do. The other key difference between what I have been saying and the way they look at it is they do not take any account of developing new roles. Their advice is all predicated on continuing to train people in the same professions that there have been for many years.

Q784 Mr Campbell: Would you agree with that?
Ms Knight: Yes. We have to remember that we are not just training for the NHS in this. We need to remember that we are training for independent care homes, for the independent sector, and that broader picture needs to be played into this. I would like to pick up on Sandra's point earlier about the fact that there is this retirement bulge coming. The average age of nurses is in the region of 44. That retirement bulge is going to come in five to 10 years and I am not sure we have fully absorbed that.
Ms Rainsberry: I would agree. I know the workforce review team take an awful lot of guidance and evidence from the Royal Colleges in terms of what we should be doing in terms of medical workforce. From a Strategic Health Authority perspective, we have very little input into that but we are certainly accountable for delivery of financial balance. I see that process as being somewhat at odds with what we are being required to do.

Q785 Sandra Gidley: A lot of professional training these days takes the form of a full time degree course. Should we be making training more flexible and is the full time degree course the best way to go?
Ms Knight: I am sure we should make it more flexible. We have been trying in our patch to do that bit by bit. Unfortunately, one of the stumbling blocks that we have come across is the regulators because we wanted to put in a part time nursing course at one of our universities and they wanted me to say exactly how many part time people I would want to commission each year. My response was, "I do not know but if a person presents and wants to go part time I want them to be able to do a part time route." That was not acceptable.

Q786 Sandra Gidley: Which regulator is this?
Ms Knight: The Nursing and Midwifery Council.

Q787 Sandra Gidley: That is surprising. You would think that an organisation predominantly female would be much more sympathetic to flexible working, to make a sexist point.
Ms Knight: We cannot state how many people are going to want to do part time as opposed to full time. We have to be very flexible about the numbers but be able to provide both courses.
Ms Rainsberry: There is a link to the ageing population in England in that I can see that the numbers of younger people we are going to be able to get on to programmes are going to be reducing and therefore there is an urgent need for us to provide different forms of access. People who want second careers are probably going to become a substantial part of that so it really is quite important that we are able to influence the delivery.

Q788 Sandra Gidley: We were told by Karen Jennings of UNISON that the average age of a student nurse is 29 and she has children.
Mr Sargent: That is true.
Ms Knight: The other avenue which we should definitely be looking at is graduates who want to enter the health service. The other area that we should be really making our education flexible for is 16 to 19 year olds who at the moment cannot get on to full professional training until 17 and we lost a lot of people in that way.

Mr Sargent: I think the specific words were around a full time degree course. I would agree with what has been said on the full time versus part time but we need to remember that in England at least the majority of the numbers we are talking about are not on degree courses. They are on diploma courses and are student nurses mostly. There are routes through. 15% now, or thereabouts, of the students do not come through the normal routes; they come through access routes normally developed as health care assistants and so on. We probably need to do rather more of that. We also need to recognise there are pressures in some areas for nursing to become a degree profession, as has already been decided I think in Wales. It brings us back to some of the other things we have said about planning for the whole workforce in an integrated way. It may mean we do need to think about a degree profession for nurses but perhaps not as many nurses.

Q789 Sandra Gidley: Why do nurses have to have degrees?
Mr Sargent: They do not have to at the moment.

Q790 Sandra Gidley: You said maybe we do need to think about it. It is quite interesting because I think there is pressure from within the profession itself that to be regarded as professional they need to have a degree. I want to go into hospital and receive the right treatment at the right time.
Mr Sargent: That fits because if you go down the line I was suggesting before you will look at the other competences needed. You will finish up with a section of the workforce which you could term assistant practitioners. The ones that you have who are fully registered nurses you would want to have a range of highly developed sets of knowledge and skill to within that team setting. The extra knowledge and skill that they can get from getting degrees will complement the other areas I am talking about in the whole clinical team.

Q791 Sandra Gidley: You do not think certain health professionals have become too academic in recent years and not practical enough?
Ms Rainsberry: I think it is about getting the balance right. If you look at something like MMC, the amount of time that doctors in training will have for service delivery is reduced. That does mean you need to look at other roles that can take on those activities. Therefore, you do need highly trained nursing staff. The question is in what quantity do you need them and what are the other things that need to be done like the basic nursing care. How should that be provided?
Ms Knight: The issue is around the difference between the people who are going on to do a diploma as opposed to doing a degree and the way they are funded. It is stifling any development because the diploma student comes with a bursary. The degree person has a non-means tested bursary and that is why you are getting far more doing a diploma than a degree.

Q792 Sandra Gidley: I had this at my surgery the other week. Somebody who thought she was doing a good thing by taking a nursing degree felt she had done the wrong thing when she looked at colleagues she did not think were being trained that much differently. This is quite common.
Ms Knight: Yes, this is true.
Chairman: Could I thank all three of you? We hope that this report will be published in the first quarter of next year. I do not know exactly when at this stage. Thank you.

Witnesses: **Mr Peter Stansbie,** Director of Organisational Development, Skills for Health, and **Mr David Highton,** NHS Partners Network, gave evidence.

Q793 Chairman: Good morning, gentlemen. Could you give us your names and the positions you hold for the record, please?
Mr Highton: I am David Highton. I am the managing director of Clinicenta, an ISTC bidder, and I am representing the NHS Partners Network which is an alliance of independent sector providers, providing NHS care.
Mr Stansbie: I am Peter Stansbie. I am director of organisational development for Skills for Health, which is the Sector Skills Council for health.

Q794 Chairman: You both represent non-NHS organisations which have an important role to play in workforce planning for the health service. What is your assessment of the current arrangements for workforce planning?
Mr Stansbie: We are talking about workforce planning, not education planning. That is a really important distinction. Secondly, health probably has the most complex workforce in the country. It is about two million people across the UK. Roughly 80% of that will be in England. Around 400,000 of those work outside the NHS. Those staff run from the ubiquitous porter to the ubiquitous brain surgeon. You have a huge range of skills there. In general up to now, workforce planning has produced the number of staff that we need until recently reasonably within the funding that is available. It is based mainly on looking at planning for education and for the registered group of staff in the health sector and based on existing groups and existing practices. What we are all saying is that what has suited us in the past probably will not suit us in the future with changes to technology, to systems and all the demographic changes that we are seeing. I think we do need to see a significant change to make sure that we get a strategic plan for our workforce and that education and training are employer led and follows what is needed to deliver care for the patient and better health.
Mr Highton: From my standpoint, there are two factors, one probably emphasising what Peter just said. The professional identities and the registered

professions are very dominant in how the workforce is organised. They provide a recognisable currency by which employers can recognise a group of skills and competences but there is a down side to their strength in that it makes it very difficult for new job roles to emerge based on a different mix of key competences. Therefore, the planning has tended to be an incremental change from the past rather than perhaps taking a more fundamental look at how those competences might be organised in the future. The second thing is what was covered largely in the previous evidence I heard about the way the use of performance targets at the micro level sought to influence local workforce planning. As a subset of that, the merger of WDCs and SHAs has made it harder for the non-NHS bodies to access that dialogue. The move from a membership organisation to a statutory authority has made it harder for that to happen.

Q795 Chairman: If I ask about changes you would like to see, presumably you think it should be more strategic and the educational training should be employer led as opposed to led by other institutions and representative bodies?
Mr Stansbie: Absolutely. "Employer led" is in some ways code for saying that the best people who can determine what workforce is needed to deliver what the patient needs or indeed what the public need in terms of public health are the employers, the people who are actually delivering that. This has to be led by the strategic need of the sector. It really is important to say that the sector has a single workforce. I know this is about England but there is a UK workforce in health and that will always be the case. Of course, although the NHS probably takes about 80% of the workforce in health, that workforce moves into the independent sector, into the voluntary sector and vice versa. Our view is if we can make sure that our planning is delivered to meet the needs of the patient and the sector through the employer that gives us the best chance of getting a flexible workforce and a workforce that can deliver what is necessary and that keeps up with changes in technology and systems. Those changes have been huge in the last 10 years and I suspect will continue to be huge in the next 10 years.

Q796 Chairman: Do you agree with that, David?
Mr Highton: Yes. Employers are generally quite good at anticipating future innovations and future changes that are going to happen over a longer time frame; whereas the institutionalised workforce planning tends to produce incremental growth targets from a base which starts to get rather fossilised. I think there starts to be a tension and the difficulty of getting over professional boundaries sometimes hampers employers in implementing sensible innovations.

Q797 Chairman: We took evidence abroad with this Committee a few months ago now and one of the things that was put to us by a member of a leading organisation in America was that a surgeon who does cataracts should be a brilliant surgeon who does cataracts and does not have to be anything else. Would you agree with that?
Mr Highton: There are aspects of care delivery which, if someone becomes an expert in quite a narrow focus, mean they do not necessarily need all the training to be a generalist. On cataracts, it would be possible to train someone to be very good at phaeco-emulsification without them necessarily having gone through all the medical training earlier in their career. My own company is linked with the teaching hospitals in Canada and they train respiratory therapists to be anaesthetic assistants. In theatre, for minor operations where the patients are conscious but have had some sort of local or regional anaesthesia, there is a consultant supervising the whole suite of four or five theatres but the individual monitoring the patient in the theatre is not a doctor but an anaesthetic assistant. The equivalent in the US would be nurse anaesthetists. In Canada, they have gone through a different training route. Those things are not really prevalent in this country and in my experience would be considerably resisted by the medical workforce.
Chairman: I was going to say, "Could it happen here?" but I think you have answered that question.

Q798 Dr Naysmith: What you are outlining is a rather different approach to training and workforce planning and the needs of the employer being paramount rather than professional little empires and so on which is what we have been talking about this morning. Mr Stansbie, in your written evidence you explain that Skills for Health aims to improve the flexibility of the workforce and to encourage the use of competences as the currency for workforce planning. We have already touched on that. Would you like to say a little bit more about it? Why is this approach important?
Mr Stansbie: First, we are not suggesting—nor is anybody else—that we throw the baby out with the bath water. We need very skilled professionals and we will continue to need those. What we are saying is that 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. If you identify those competences then you can start to identify different ways of providing the workforce that can deliver that effectively, timely and in the right location. What we have seen and what we are seeing is all of those three things change. The effectiveness changes, the location changes, you get new drugs and new approaches. If you cannot have that flexibility your workforce, if you are not careful, is always chasing the changes rather than having a workforce which has the competences to deliver what is needed at that time. I do not think health is that different from all the other industries in this country. We like to think it is and that health is always special, but all of the industries in this country and indeed across the world are facing these challenges. For us, competences are no more a panacea than every other thing that you can talk about, but they are very powerful building blocks that will allow you to get a change to the way

that you plan your workforce and then, more importantly, a change to the way you deliver that workforce.

Q799 Dr Naysmith: How much progress in your organisation have you made in this? Do you have evidence that it is effective and proving effective and popular with the workforce?

Mr Stansbie: It is not an exact science. I guess you find that in workforces generally. We estimate we have mapped around 70% of the core competences in health so there is still some way to go. Even with those competences, we have already had very significant success. I will mention some examples because they are always best. We looked at breast screening and developed competences in breast screening that allow associate specialists to be developed who are not radiographers or radiologists. That allowed the breast screening service to deliver something like 40% more breast screening. It also allowed the highly skilled radiologists and radiographers to use their skills better so they were not doing things that other people could do. A quote from one doctor on that was that they simply could not have met their target for breast screening had those new posts not been there. Those competences that we developed are national. They are UK-wide, so those competences are now being used across the UK. Perhaps the most striking example in terms of money, if we want to talk about money—

Q800 Dr Naysmith: It is quite important.

Mr Stansbie: Absolutely. It is emergency care practitioners, where we have worked with Sir George Alberti on this. We have developed competences for what are called emergency care practitioners. These are people who are skilled in dealing with emergencies. They are rather different to paramedics and doctors and nurses. They may come from any of those backgrounds. 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. If you estimate—again, I am using Sir George Alberti's figures, not ours—that we need perhaps 1,000 to 2,000 of those in England, you are talking about savings of £50 million to £100 million a year. What are those savings? You do not actually save that money in health. It is simply about using that money more efficiently. That is on the money side. The real gain is that people are getting treated effectively, more appropriately and where they need to be treated. Those are things that happen across the board. I had to smile this morning because we have also done a lot of work in public health and our competences were used to make sure that specialists in public health could be people other than doctors. In Swansea we have just used those competences to map the whole public health workforce. It is a huge workforce. That looks not just at health but social care, the voluntary sector, the leisure sector and all of those things. I think they are very powerful.

Q801 Dr Naysmith: Perhaps the most interesting thing about all this is that these priorities and what you are talking about now were set out in *A Health Service of All the Talents* in 2000, a National Health Service document; and yet if that is true—and I think probably you would agree that a lot of the stuff was that was in there—why has not the health service made more progress in implementing these changes?

Mr Stansbie: They have made a lot of progress. The examples I have given are small examples. This morning there were other examples given, I hope using our competences. It does take a long time to change the health service, partly because of the length of time it takes to train people, a minimum of three years but for doctors and most nurses a lot more. The other thing is there are very big cultural issues in health. The public need to feel secure and safe and have to be secure and safe. The natural pressure is to make sure that all of the things you are doing are ultra safe because doctors, nurses, physios and OTs, the longstanding professions, have a history of that. For the newer work, it does take a long time. The other thing is that—blowing the trumpet for Sector Skills Councils—we were only licensed in 2004 as a Sector Skills Council. We are licensed by the Department for Education and Skills and one of 25, so we only started this in 2003, in fact, and our predecessor bodies were not in the mainstream. We have been very heavily supported by all four health departments, by NHS employers and by the independent sector. That is why I think the whole issue of employers driving this gives us a real chance to make a difference.

Q802 Dr Naysmith: That is very helpful and it is very encouraging to hear that is beginning to happen but in a positive way, are there any features of current workforce planning structures that make the approach you describe easier or more difficult to achieve?

Mr Stansbie: I think we are moving. Our Sector Skills Councils are working regionally in England now and bringing employers together at that level. I really do think this issue of getting things coming from the bottom as well as from the top is crucial to it. Some of the existing mechanisms, which quite naturally concentrate on existing professions, as David has said, incremental changes to those existing professions and on some of the education you need for that, could change and could change effectively. Again, I think it is about building on that and making sure that we can use all of the skills we have got across the workforce. 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, particularly given demographics, 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. We are all trying to make some changes in this and that would be a big change if we could make it.

Q803 Sandra Gidley: David, you talked about the huge potential for increasing flexibility by using staff in extended roles. Who is best at this, the independent sector or the NHS, and why?
Mr Highton: I do not know, and bear in mind I am only talking about the part of the independent sector that delivers NHS care; I do not know very much about private hospitals. I think, because of the point Peter made about the ability to retain public confidence, the way our contracts work probably does limit our scope slightly, so for instance we can only utilise doctors who are on the specialist register. Therefore, I think generally the ISTC companies have not implemented all of the overseas innovations they might have done because it is reflecting the Department's concern about the ability to ensure the public have confidence. It is easier to tend to replicate what has happened rather than bring in too many new things. Certainly, I know that the companies in the network which are involved in the diagnostic contracts tend to utilise the radiographer changes that Skills for Health led over the last few years, I think those changes will come in. Advantages ISTCs could have in that certainly so far they have tended to be greenfield operations, so that you are not encumbered by having a change management process from somewhere you would prefer not to be starting, you do at least have the opportunity to start something new and, therefore, you can design in new ways of working right from the beginning instead of having to persuade people that it is a sensible thing. I think the other thing is that increasingly in the second wave of contracts we are seeing contracts where in order to keep the care local, in line with the new White Paper, we are seeing some quite small centres, so there might be only seven or eight staff delivering something very local, and obviously for the independent sector there the ability to multi-skill those staff to do a number of tasks outside traditional boundaries would be very attractive. I think probably we could not hold up a lot of evidence yet to say we have done all the innovation that perhaps we would like to, but I think that is certainly the direction of travel. In the NHS, from my experience, there are always some fantastic examples of extended roles, but it is very difficult to disseminate them across the Service as a whole.

Q804 Sandra Gidley: What needs to happen to realise this huge potential then?
Mr Highton: I think that the competences that Skills for Health have developed need to sit alongside qualifications, particularly vocational qualifications, that are recognised by employers and therefore portable between employers. Historically, there have been issues where employers made up their own competency frameworks and a member of staff moved 50 miles down the road to another employer and they would not have necessarily recognised what the previous employer had done. I am a very strong supporter of Skills for Health, because it gives recognisable currencies between employers. With the strength and public recognition of the existing professions, the scope is at the assistant practitioner level using vocational qualifications and at the advanced practitioner level, where people have a professional registration and then are able to acquire new skills, perhaps from other professions, to expand their range and flexibility to their employer, I think it would not be realistic to say that one could replace the registered professions. We need to adapt them at the margin, ie the level perhaps just below assistant practitioner and the level above where people could acquire a new and wider range of qualifications.

Q805 Sandra Gidley: Is there anything you want to add?
Mr Stansbie: I think I would agree with what David said. There are good examples in the NHS and good examples in the private sector. Just recently we had a meeting hosted by BUPA with 10 of the big private independent hospitals and they are very keen to use the work that we are doing. The good thing about that of course is, again, the commonality and transferability so that you can move between different parts of the sector and UK. I think increasingly we are moving to a mixed economy and from our point of view what is important is that transferability is there so that the skills are in the workforce at all levels and we can use them to deliver what we need for the patient. There is a real potential. The other thing of course to say is, as you have said all morning, the workforce is 70% of the costs and, therefore, it is critical that we get this right. Also, my personal belief is that in health it is a personal issue and, therefore, the workforce are the people who look after the people. We have got to get this right and make a difference. I do not think it is either/or, it is both and the potential to move across is what is really important.

Q806 Chairman: Do you think that skill mix changes are cost-effective? Have you any evidence of that?
Mr Highton: I think they certainly can be cost-effective if they are planned well and, as the Health Service moves perhaps to having fewer large acute hospitals and more care being moved out into settings, work that perhaps might be done by doctors in large acute settings can be done by other professionals in the other settings, but you need to train staff to be able to do some of those extended roles. Obviously the out-of-acute hospital settings will not necessarily be able to have the same 24/7 medical rotas which large hospitals have got and therefore one has to find other ways of covering the care in a way that the public will retain confidence in. I think the challenge for the whole health care sector at the moment is to retain public confidence in the set of changes which are likely to happen.

Q807 Chairman: When we looked at ISTCs in our report obviously the additionality affected any sort of cross flow of workforce between the independent sector and the NHS but we are told that will alter in phase two. We are not sure how many will go ahead with current press reports. Do you envisage that will affect this skill mix change, that you could see somebody coming in and operating a little bit

differently in the independent sector and then potentially going back to the ways that they have operated before? I do not mean operation, just the way that they worked before.
Mr Highton: I think the additionality has been relaxed somewhat in the second wave. Clearly, the additionality rules relate back three years to when the demand was outstripping the supply and therefore it was felt important to demonstrate that the new capacity was not draining or poaching from the NHS. I think we have now moved into a situation where the supply is probably outstripping the demand, certainly at the newly qualified level and work permits are now required for the newly qualified nurse grade equivalent, yet, companies like mine will still have contracts that have additionality clauses relating. I think there is a catch up needed, there is a realignment needed of the additionality clause and our submission said that ultimately we think we should move to a free labour market. I think we understand why it was needed three years ago, I think we are less clear why it is needed now.

Q808 Chairman: It is not clear at this stage. We did visit an establishment which was BUPA in Redwood and they had a situation where the National Health Service and BUPA staff were working alongside one another on elective surgery teams. Do you think that is likely to happen in any phase two ISTC?
Mr Highton: I think, speaking for my company, we expect that to happen in some of the centres that we have got, that a proportion of the staff will be transferred from the local hospital and a proportion will be new staff employed by us and we would expect them to work alongside each other effectively, which I think is a management challenge we feel sure we will be able to deliver.

Q809 Dr Naysmith: To do some training as well, that has got to come into it.
Mr Highton: Absolutely. There are two types, the first one required in the contract is, if you like, we are making sure that we offer training capacity, so 35% of our theatre lists have to be offered up for training and then obviously, as an employer, we will invest our own funds in the continuing professional development of our own staff. There are two types there, one that we are funding and the other we are providing the capacity for junior doctors and student nurse placements which the existing system can utilise but we are certainly pleased to be doing that.

Q810 Dr Taylor: Following up on that, I think you said in Canada you had got integrated training going already. Is that what you said?
Mr Highton: The hospital group in Canada, the University Health Network in Toronto that we are partnered with, utilise maybe four theatres with a block group so there is a consultant anaesthetist putting in the blocks but in the theatre there is an anaesthetic assistant monitoring the patient. There is a doctor present but there is not a doctor in each individual theatre.

Q811 Dr Taylor: I thought you were referring to training issues.
Mr Highton: I was talking about service issues there. Those respiratory therapists that they have in the hospital who want to become anaesthetic assistants do go through a provincially accredited training system.

Q812 Dr Taylor: There are some specialties which still remain on the additionality list, like orthopaedics and anaesthetics. Can you see those being eroded and you getting more integration on both sides?
Mr Highton: I think anaesthetics is very difficult because I think the current workforce planning, and the reason it is recognising the shortage speciality, assumes the current paradigm. Unless there is an acceptance, I suspect at a national level involving the Royal College, that paradigm can change, then the workforce planning will carry on much as it is at the moment. If every anaesthetised patient, whether general or local, has to have a doctor present then the current paradigm will continue. I do not think it is in our power as an employer to change that.

Q813 Dr Taylor: Picking up on Peter's point about emergency care practitioners, was the figure you said £56,000?
Mr Stansbie: Yes, that was an estimate from one of the south-west ambulance trusts, that is £56,000 savings to the health economy and that did not include any savings in bed days. It did include a significant saving in people having to go to A&E, a significant saving in terms of mileage and transport costs. Then the extrapolation is the number you get. These are not our figures, this was a trust working these out, even if they are 50% too high, it is still very substantial savings.

Q814 Dr Taylor: At the moment, who is doing the training of the ECPs?
Mr Stansbie: It is a local training scheme using our competences and, of course, the beauty of that is that becomes a transferable scheme because our competences are recognised and transferable.

Q815 Dr Taylor: Which budget does the training for ECPs come out of?
Mr Stansbie: I would guess it is MPET but I am not an expert in those budgets locally.

Q816 Dr Taylor: If it is MPET it could be targeted like everything else?
Mr Stansbie: It could.

Q817 Dr Taylor: I think one of you implied that it was difficult for new jobs to appear. Is that because with the cut in NHS training budgets it is the innovative training courses that get cut first because they have to go on with the old ones?

Mr Stansbie: I think there are a number of issues about new jobs and new roles. First, we are quite conservative as a health sector and therefore—and I think it was said this morning—you have got to get clinical buy-in to this. I want to stress that clinical buy-in is about the whole clinical team and that takes time and by far the best way of getting it is from the bottom up. Secondly, some of our systems and processes mean that even when you have identified the jobs, the competences and everything else then you have still got quite a lot of work to do to make that a reality. Thirdly, the education and training which we deliver is still quite bound by what education provides, both further education and higher education. I think John Sargent was saying in Manchester when they tried to build a very substantial scheme for assistant practitioners, they realised how long it took to get the education sector up to delivering that number of people. I think you have got all three of those things as factors.

Q818 Dr Taylor: Are either of you qualified to say whether the independent sector are better at preserving training budgets if they are hard up, or have they not been hard up?
Mr Highton: I think part of what we do is provide capacity for the NHS budget to utilise the work we do for the post-graduate doctors to train on and also to provide places where pre-registration nurse placements from the universities can take place. We are contractually bound to deliver that training capacity, it would be the budgetary situation within the NHS that decides how much of it is taken up. I think in terms of our own continuing professional development budgets, it is clearly in our interest to continue to invest in the development of our own staff but it is like any business, every bit of expenditure is up for review annually, of course.

Q819 Charlotte Atkins: You both argued in your written evidence that the independent sector should play a greater role in workforce planning. How might that be achieved and why do you think that is important?
Mr Stansbie: I think it is becoming increasingly important because the percentage of the workforce employed in the independent sector is growing and, therefore, we would be most unwise not to take account of what is a growing percentage of the workforce. In terms of how that is done, it is even more complicated than in the NHS because a lot of independent sector providers are very small and, therefore, it is about how you can make sure that you are hearing those voices and bringing what they are saying to the whole issue of the workforce. The way we are approaching that is we have something called a "Sector Skills Agreement" which all Sector Skills Councils are developing which is basically an agreement of how you develop skills in the sector and we have one of those for each of the UK countries including England, which is actually agreed. It is a set of deals, but we are taking that one stage further and looking at doing regional skills agreements. I think it is at regional level that we stand the best chance of involving the independent and voluntary sectors. It will not be perfect and I do not think any of us would pretend that, but it does, I think, give us the opportunity at a more local level to listen to what the needs and requirements are and also about how we can use the independent and NHS parts of the sector together and, indeed, the voluntary sector. The voluntary sector is not insignificant and some of the big employers in the voluntary sector are quite substantial in local settings, so it is about bringing all of those together. Of course, 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, so that is what we are hoping to do. That is from our point of view, as a Sector Skills Council. There is then an issue about how we bring that together with people, like WRT, National Workforce Programmes, the Department of Health and others, who are very big players in the workforce planning scene. I wish I had all the answers, but we have got some of the questions I think now and we have started to put some mechanisms in place which can help, simple things, like working with David, the Independent Healthcare Advisory Services, the regions and having meetings with the private sector, as we had the other week, hosted by the private sector is a big move forward from where we were.

Q820 Charlotte Atkins: You are not aiming to include all the smallest organisations, just the main players?
Mr Stansbie: We have to do that, I think, through representative bodies because if you move to some of the nursing homes, for example, they are very small indeed. For example, we have a council of employers and other stakeholders that advise us and we have representative bodies for the independent sector, the voluntary sector and the nursing home sector on that.

Q821 Charlotte Atkins: David, you have suggested in your submission that clinical staff would derive particular benefits from training in the private sector. Why do you say that?
Mr Highton: I think the advantage ISTCs have, for instance, is that the work we do is more planned and predictable than if the same work is done within a hospital setting because we are sort of isolated from the day-to-day pressures of the emergency flow. Because we have got a more predictable workload we can provide a more predictable training platform for certain bits of a doctor's training; the doctor also obviously has to learn how to deal with the unselected emergency take. We feel quite strongly, and from my discussions with the deanery in London where we are involved, we will probably be part of a training attachment to an NHS hospital rather than saying a trainee will come to us.

Q822 Charlotte Atkins: So you are talking about a supplementary role rather than a central role?
Mr Highton: Yes, but I think it is making sure that part of their training week they come to us is very effective and we believe the way we deliver our care

will enable that to happen. I do not want to say it is more effective than the NHS, I think it is a good training opportunity because it is less likely to be amenable to service disruption.

Q823 Charlotte Atkins: It is really the setting rather than training itself you are talking about?

Mr Highton: Yes.

Chairman: I think that is it. Gentlemen, could I thank you very much indeed for coming along and helping us this morning. As I said earlier, we hope to publish in the first quarter of next year; but somebody has whispered in my ear it may be a bit further than that, we will wait and see. Thank you.

Thursday 18 January 2007

Members present:

Dr Doug Naysmith, in the Chair

Mr David Amess	Mike Penning
Charlotte Atkins	Dr Howard Stoate
Jim Dowd	Dr Richard Taylor
Sandra Gidley	

In the absence of the Chairman, Dr Naysmith was called to the Chair

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Witnesses: **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, gave evidence.

Q824 Dr Naysmith: Good morning. I am Doug Naysmith. I am standing in for our Chairman who is on important parliamentary business elsewhere in Europe and has taken with him our chief clerk. We are very pleased that you have come along this morning. We have a lot of questions for you. I ask you to introduce yourselves for the record.
Mr Sobanja: I am Michael Sobanja, chief executive of NHS Alliance.
Ms Hodgetts: I am Sue Hodgetts, chief executive of the Institute of Healthcare Management.
Sir Jonathan Michael: I am Jonathan Michael, former consultant physician and chief executive of Guy's & St Thomas' NHS Foundation Trust. I am also chairman of the Association of University Hospitals which has provided written evidence to the Committee. I am chairman of the board of the Foundation Trust Network.

Q825 Dr Naysmith: That just emphasises that there is a lot of expertise available to us today. We are very grateful to you for coming. I start off with the Griffiths inquiry, with which I am sure all of you are familiar, which concluded in 1983 that if Florence Nightingale was carrying her lamp through the corridors of the National Health Service today she would almost certainly be searching for the people in charge. Perhaps the question is: is it that different today? General managers were brought in to address this problem. Have managers succeeded in taking charge of the National Health Service over the past 20 years?
Sir Jonathan Michael: I suspect it depends on how you define "being in charge", but in terms of accountability there is no doubt in my mind about the accountability which rests with the board of an organisation and specifically the chief executive of an NHS organisation.

Q826 Dr Naysmith: You will not venture an opinion. Is it much more obvious now who is in charge than it was in 1983?
Sir Jonathan Michael: I would say that it is much more obvious. The 1998 or 1997 Act established clinical governance and gave the boards of NHS trusts specific accountability not only for things like finance but also clinical quality and outcomes of the organisation, whereas previously perhaps there had been some uncertainty as to management's accountability and responsibility for clinical matters. That legislation made very clear that responsibility rested with the board and chief executive of the organisation in particular.

Q827 Dr Naysmith: What other benefits have resulted from knowing who is in charge?
Sir Jonathan Michael: Clear accountability is important. I suppose that I am an example of somebody who has moved from the clinical side of the divide, if there was one, to the management side. I do not believe that fundamentally there is a divide between the two. Members of the NHS who are working in a management capacity have just as much interest in accountability for the quality of the service provided to patients as do clinicians. I am of the view that the much talked about differences are over-hyped and we all share a common interest.
Ms Hodgetts: In terms of common interest and benefit for patients, that is what all of us are working towards. Accountability has been very clearly outlined by Sir Jonathan. I would add that working together is of utmost importance for both present and future provision.
Mr Sobanja: The notion of the accountable officer seems to be extremely important not only in terms of clinical governance but also in lines of reporting which are now much clearer in the health service. Previously, that was done through chairmen of health authorities; now it is from Strategic Health Authorities directly to the chief executive and ultimately to Parliament. I think that makes a difference. The comments I add in respect of primary care relate to the nature of the management task. Colleagues and Sir Jonathan have been involved in the management of an institution—if he will forgive me—which is slightly different from working, as Dr Stoate will know, with a range of independent contractors in primary care where there is no line management relationship. That probably magnifies the comment about the management task not being the sole territory of managers particularly in primary care. Where this works well and effectively it is about partnerships and shared objectives and goals. As to the benefits, I start from the point that the health service is an improved service now compared with, say, 10 or 12 years ago. Whilst not

all of that is attributable to management, managers have played their part in reduced waiting times and the introduction of national service frameworks and new contractual arrangements, by and large achieving 48-hour waits in general practice. To say a word about practice managers in that regard, if one takes the implementation of the QOF, which in my view increased standards in primary care, there is little doubt in my mind that at that level and in PCT managers have played their part in enhancing services to patients.

Q828 Dr Naysmith: Would it be a reasonable assumption—perhaps you could give a yes or no answer—that a number of the objectives of the Griffiths report and inquiry of 1983 have been implemented and are relatively successful?
Sir Jonathan Michael: I would say it was.
Ms Hodgetts: I would agree.

Q829 Dr Naysmith: It is widely perceived that managers are in conflict with doctors and other clinicians particularly over the control of reform. Is that an accurate perception? If so, why is it that managers and clinicians tend to come into conflict over this?
Mr Sobanja: It is not the case that managers and clinicians in the widest sense, including doctors, nurses, physiotherapists and others who deliver services directly to patients, are always in conflict. There is a chequered set of relationships across the country. For me, where that conflict exists it is probably something to do with the background and culture arising from the training of both disciplines. Most clinicians are trained and brought up with the ethos of doing the best possible for the patient in front of them. I think that is right and proper. Most managers are required to take a wider perspective about how to get the greatest benefit for a group of patients, whether it is a registered list or resident population. Inevitably, it involves managing some sort of trade-off on priorities. That can create tensions in the relationship. There are other elements such as managers sometimes being seen as instruments of political policy which clinicians may not find acceptable or even desirable, but at the heart of it is the individual versus the population leader.

Q830 Dr Naysmith: You have set out very clearly the problem. What is the solution? How do you resolve it?
Mr Sobanja: To my mind, the resolution is always centred on good communication and sharing the vision and understanding of what we are here for. If I take the introduction in primary care of practice-based commissioning, which I understand the Committee may wish to consider later, around the country in too many instances there has been a debate about its introduction without considering what we are trying to achieve by using that mechanism. Where managers and clinicians are able to come together and answer the latter the process of implementation and introduction is so much easier because there is a shared view and objective.

Ms Hodgetts: Anybody who has been watching the BBC and listening to Sir Gerry Robinson will be very aware of some of the tensions, some stronger than others, between clinicians and managers. It is important for managers to gain credibility with clinicians. While there is not any particular way in which managers are subject to certain forms of training, that gap will not really be closed. Until managers become subject to a more rigorous compulsory CPD programme that will be an issue that adds to the tensions between managers and clinicians.

Q831 Dr Naysmith: For the record, what does "CPD" stand for?
Ms Hodgetts: Continuing professional development. Clinicians have extremely rigorous training followed by extremely rigorous CPD, whereas managers do not have to have any specific qualification and are not subject to any particular CPD, unless they are part of an organisation that demands it. Organisations across the piece in terms of national health organisations are erratic in terms of how they ask manager to become qualified. Until we have something that is specifically for managers we will not bridge that gap.

Q832 Dr Naysmith: Is there any programme or anything else in existence to make that happen?
Ms Hodgetts: Members of the Institute of Healthcare Management are subject to continuing professional development, but that represents only a proportion of managers across the NHS.

Q833 Dr Naysmith: Sir Jonathan, you have experience of this side of the line in senior positions. The turnover rate among management staff is much higher than among clinical staff, particularly consultants. Do you think the fact that senior managers move on and have a relatively short lifespan at the top, whereas clinicians tend to stay there forever, has any effect on what we are talking about? That is an add-on to what has already been asked.
Sir Jonathan Michael: First, I agree entirely that the focus of an individual clinician is the patient in front of him or her at the time and the focus of a manager, whether clinical or non-clinical, tends to be the wider group. It may be a department or a whole organisation. Sometimes that is the source of tension between the two. My solution—I would say it, would I not?—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. In our professional and personal lives we all have to work within constraints in terms of a resource envelope or a legislative or regulatory framework. The same applies to clinicians. My view is that it is easier if you empower clinicians to be responsible for running services, but to have that responsibility they must accept accountability. That is my solution. It does not always work easily.

Q834 Dr Naysmith: I have to interject to say that as a Member of Parliament for Bristol thinking back to the so-called heart baby scandal as revealed in the *Evening Post* the idea of clinicians turning into senior managers was not an entirely happy one, without going into it in great detail.
Sir Jonathan Michael: I entirely accept that. I make two comments. First, it predated the legislation which gave the management and organisation formal legal accountability for what was happening on the clinical side to deal with that particular issue where the chief executive denied responsibility but also the ability to interfere or intervene in poor clinical practice. Second, I remind you that that clinician who was the chief executive also suffered personally as a result of that failure. To return to the question about turnover, it is a big problem. To give you an example, when I was appointed to the University Hospital in Birmingham in my former role I was the fourth chief executive of that organisation in five years. I was given the opportunity to leave a 30-year tenure consultant's position for the insecurity of an NHS chief executive's job. I think that is something which causes senior clinicians to think twice before they move to a full-time managerial role.
Mr Sobanja: If I may refer to the interface between management and clinicians in primary care, I urge the Committee to consider the role of the professional executive committee within trusts. That is currently the subject of consultation by the Department of Health. That is meant to be the central forum that handles the interface. The alliance has done a fair amount of work on this in terms of publishing the work behind the consultation document on the question whether or not the professional executive committee is truly executive, advisory or representative and its relationships with the board and management team. Unless all of those things and others are crystal clear the scope for conflict and confusion abounds. It seems to me that that is critical in primary care.

Q835 Dr Naysmith: Is the high turnover rate for senior management something about which we can do anything or is it part of the way that things will have to work?
Sir Jonathan Michael: I hope it is something that would be amenable to improvement. One of the problems is that if you have specific personal accountability as head of an organisation every time there is a potential problem there is a risk that accountability may result in the departure of whoever is leading that organisation. Many healthcare organisations are dealing with pretty difficult services and functions that will not always work well and have satisfactory outcomes. I am not trying to defend poor management or clinical practice, but the downside of accountability resting very firmly with an individual on behalf of the organisation is that in event of organisational weakness or failure there is likely to be a need for that person to take responsibility.

Q836 Dr Stoate: I think we are getting to the nub of the problem. From what I understand you to say, there is no formal interpretation structure for NHS management and no formal CPD or continuous assessment of any sort. The simple question is: how do we know if any managers are any good at all? Who objects?
Ms Hodgetts: Within the organisation hopefully there are professional development plans which are fulfilled and people work within a structure whereby there are checks on managers who meet targets and have some CPD in progress, but you cannot guarantee that that happens right across the board.

Q837 Dr Stoate: It is totally ad hoc?
Ms Hodgetts: It is ad hoc if you look across the board; it is not necessarily so within an organisation.

Q838 Dr Stoate: Therefore, you hope that the organisation has these structures but it does not have to have them?
Ms Hodgetts: One hopes.

Q839 Dr Stoate: Obviously, the number of primary care managers has increased dramatically over the past few years since the introduction of PCTs. I would like to draw a working distinction between management and administrators. I think that we have a lot of administrators in Primary Care Trusts but I think there are very few managers. How can we tell the difference?
Mr Sobanja: I think it is extremely difficult. The "numbers" argument is an interesting one. At one stage we had health authorities and family health services authorities and some would argue that FHSAs were administrators and literally about managing the reimbursement of contracts in primary care. When they were merged with health authorities it was extremely difficult to count any sort of numbers of managers or administrators in primary care because they became that group. In 1999 with the introduction of 481 primary care groups we were able to see clusters of numbers around primary care managers and administrators, often using the senior manager grades which included many of the administrative and clerical grades at the time. Numbers have fallen because of the rationalisation from 481 to 303 PCTs and now to 152. To get to your question about whether you can count the difference between those involved in administrative and management functions, my answer is no, although management functions will not be confined to those in purely managerial grades because there are people employed within PCTs who are clinicians carrying managerial responsibilities. If I take that still further into general practice, as you know clinicians are at the heart of management there as well. I do not think it is possible to make sense of the numbers in the way you seek given the currently available data.

Q840 Dr Stoate: In that case would it be fair to say what I have been saying for some time, that the NHS is chronically under-managed and over-administered?

Mr Sobanja: I entirely agree with that.

Q841 Dr Stoate: What are we to do about it?
Mr Sobanja: We have to be clear about the nature of the management task, who is responsible for doing that, make sure it is not a label attached to managers alone, which very much echoes Sir Jonathan's point about shared responsibilities, and get away from box-ticking on targets and targets for their own sake and think about issues relating to health outcomes and those which matter for patients. We should focus management's efforts on those issues.

Q842 Dr Stoate: When Primary Care Trusts were set up should it not have been obvious that there were not enough people with the right skills to fulfil the huge number of administrative jobs created?
Mr Sobanja: I think that is a reasonable assumption. However, many of the tasks attributed to Primary Care Trusts were completely new. The whole business of commissioning in a proper sense remains poorly understood and defined in many cases. Currently, there is a move towards the introduction of plurality, as it is often put, and some sort of market discipline. I hear expressions like "market shaping" and "market making" as well as "market operation". As a health service manager of 30 years, I have no experience in that discipline. I am not quite sure whether anybody really knows what it means, never mind the skills necessary to carry it out.

Q843 Dr Stoate: There has been reform right across the piece; it is not just in primary care but also in secondary care. Why is it there has been a massive boom in administrators in the primary care sector, which I believe has caused a fair amount of difficulty and confusion, whereas in the secondary sector there has been only a 3% increase in managers and yet they also have had to cope with quite a large amount of reform and change? How come you have managed to do so much with only a 3% increase in administration when primary care has had such an enormous boom and variable results?
Sir Jonathan Michael: I do not think I am in a position to comment on what has happened in primary care, but I accept that there is a significant advantage in having a clear line management accountability regime within an organisation. Within an organisation such as mine it is clear that clinicians are employees of the organisation in the same way as I am and there is a line management relationship between all of us. That applies to all of the administrative as well as clinical staff. In a way, I think it also helps to manage resources appropriately, including administrative resources. It may be that that more compact management structure allows us to look very carefully at processes and functions with which we try to manage the number of staff required to do them. If you have a handle on those processes and can simplify them you can manage the organisation more efficiently.

Q844 Dr Stoate: Why is it that primary care has not been able to do the same? Perhaps you are not the best person to answer that. Mr Sobanja, why has not primary care been able to handle the same types of changes with the same structure?
Mr Sobanja: I think you need to look at the reference period. The Griffiths report and the institution of management structures in the hospitals were well bedded down up until 1999. Since then we have seen the introduction of the role of management in primary care which is quite different from anything that has gone before. If for example you take the implementation of the new types of contracts for general practice, a great deal more skill and management effort needs to go into that. I am not absolutely convinced that in this regard we are comparing apples with applies. The development of Primary Care Trusts and practice management means that there been greater growth in the management function in primary care that is both desirable and laudable. Whether or not it has been matched by outputs is an entirely different question.

Q845 Mike Penning: If we can move on to management roles and responsibilities, perhaps we can look at general managers rather than go through the whole gamut of the management side. What should be the functions performed by general managers in the NHS, and how well does the current management workforce within the NHS meet those qualities and standards?
Ms Hodgetts: I think that a good manager has a unique role to play, particularly in healthcare management. That is quite different from general management because it has to bring together several facets of management within the context of health care. One is to understand and implement the political agenda and the work that clinicians do and how to support them to do their job properly, but the most fundamental point is to make sure that patients get the best possible service and combine those three unique factors within a management context with a limited resource. That is the role of a good manager. Whether they come up to standard, which I think is the second part of your question, is dependent on the skills and support around them and whether they can work effectively in their organisation with the tools that they have.

Q846 Mike Penning: Within the large NHS general management structure what percentage of managers are stepping up to the plate and performing that function and what percentage are failing? Would it be 50% or 60%?
Ms Hodgetts: That is a very difficult question.

Q847 Mike Penning: That is why I ask it.
Ms Hodgetts: I think it is an impossible question for me to answer.

Q848 Mike Penning: If we have no ability to judge how well the management is doing how do we know how the NHS and the general managers are performing? This was considered by Griffiths in 1983. It is guesswork, is it not?

Ms Hodgetts: If you look at the targets that managers have to fulfil you can base your assumption on whether they have met the targets, and maybe they are doing a good job. If you go back to the point made earlier you can hit the targets and miss the point in terms of whether they are still being good managers.

Q849 Mike Penning: Many of the vital functions that you said a good manager should have do not fall within any of the present target structures. We have structures from central government which it is said should be performed, but many of the vital roles that you said a general manager would need do not fall within those criteria. How will you continue to judge general managers in the future?
Ms Hodgetts: I think that comes back to having a solid and formal continuing professional development structure for managers that makes sure they are competent to do the job.

Q850 Mike Penning: Therefore, it is far from perfect at the moment?
Ms Hodgetts: Far from perfect.
Mr Sobanja: I agree with my colleague about CPD. To go back a little, if you want to look at the percentage of managers who are being effective I suppose you can go back to the report of the Healthcare Commission. Look at those organisations that were seen to be succeeding or failing in different areas and attach management results to it. It would not be perfect but it would be as close as one could get. As to CPD, every health organisation is supposed to have a performance appraisal system in place for all members of staff including managers. I used to be a health authority chief executive. I have views upon the adequacy of that performance appraisal because it can be anything from a quiet chat with the chairman over a cup of coffee to something far more demanding. It seems to me that it has to be far more demanding. If I go back to the question, we need to institute something like a 360 feedback around managers particularly in primary care but across the board. That would give us an opportunity to assess how well managers were working with their colleagues, peer groups, clinicians and staff, as well as fulfilling the line management function directly up to the Secretary of State and so on. We simply do not do that well at the moment. I think that your diagnosis, if I read it correctly, is absolutely right: we do not know how well management in the NHS is doing.
Sir Jonathan Michael: I am slightly less pessimistic about whether we can measure. Although I merely accept the Secretary of State's comments that the NHS is not a business I see the component parts of it as businesses. I am in the healthcare business. As an organisation we have to deliver the objectives of the organisation within a framework of standards, resources and regulation. It is possible to measure the outcome of that activity and the organisation, whether it meets its objectives, activities, financial targets and quality standards. Therefore, you can measure the organisation and its effectiveness. The question is whether that reflects on the managers within that organisation, but there must be some relationship. The other element is how that is achieved, because certainly from my point of view it is the behaviour of managers as well as their performance which is important and needs to be measured.

Q851 Mike Penning: With that in mind, is this lack of understanding of the full role of general manager, perhaps from within the NHS, contributing to the lack of understanding outside the NHS as to what managements do within the service? I include Members of Parliament. There are different management structures within my local trust and I do not have a clue about them. If we can firm up this understanding of the structure and accountability it will help in understanding accountability.
Sir Jonathan Michael: It depends on how you define management. 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.
Mike Penning: I would probably agree with that.
Dr Taylor: I think we have a unique opportunity to explore the life of a consultant in management, a medical director and a chief executive. I should inform the Committee that I have a slight interest in that Sir Jonathan helped me many times with renal matters when I was a hack general physician and he was a proper kidney specialist. Sir Jonathan, you have told us a little about the difficulties of moving and the loss of security. What made you decide that you would give up a very satisfying career in renal medicine and go this way?

Q852 Sandra Gidley: Clearly, it was not!
Sir Jonathan Michael: It clearly was. I enjoyed my clinical practice. The reality is that at the time I made the transition we were having some significant difficulties in Birmingham in terms of the organisation of which I was part. I was a clinical representative on the management team having been the elected chairman of the staff committee at the time. Therefore, I had been participating in the management structure in a professional advisory role. When it was clear that a change needed to be made I was asked to take on a more formal management role. Interestingly, as a clinician it allowed me to make a move from dealing with individual patients to helping a larger group of patients but by stepping back from the direct clinical role. I think that it is a very satisfactory and fulfilling transition from a clinical to a managerial role.

Q853 Dr Taylor: As chief executive in Birmingham and more recently in London, have you had a medical director under you, as it were?
Sir Jonathan Michael: Yes. As you will know, the legislation requires that there be a doctor on a trust board. I briefly thought about whether I could fulfil that legislative requirement but the reality is that you would need to separate the two roles. I do not think

it is easy to be the medical director working with a medically qualified chief executive because there is a temptation to try to do both roles.

Q854 Dr Taylor: But does your previous experience make it easier for you to communicate with the medical side of your workforce who are the people responsible for spending most of the money?
Sir Jonathan Michael: Undoubtedly it does. First, you understand the language; you have what may be described as domain knowledge, which is helpful. Second, I suppose that I am a classic poacher turned game-keeper. I have done most of the things that my clinical colleagues may wish to do to me and I have learned the tricks by changing roles, which is helpful. Sometimes it is easer to give uncomfortable messages to clinical colleagues if they feel that you have been there yourself.

Q855 Dr Taylor: Should we really be trying to get clinicians to play a much bigger role in management?
Sir Jonathan Michael: Yes.

Q856 Dr Taylor: How?
Sir Jonathan Michael: You have to look at the managerial training within the clinical training of nurses and doctors. I am not talking just about doctors in terms of clinical managers. At the moment, I think there is relatively little managerial training in the already quite crowded curriculum of both undergraduate and postgraduate trainees, but I think it needs to be strengthened. If you go back to my business analogy, clinicians are fee-earners. People do not come to our hospital to see me; they come to see clinicians, so they are fee-earners who also generate cost. They need to be involved and to understand their involvement. At the moment, I think that comes very late in clinical training.

Q857 Dr Taylor: How did you get training to take on all that you took on? Did you just go into it and learn as you went along?
Sir Jonathan Michael: I suppose it was like learning to swim by being thrown into the deep end. I just had to do it, but I do not recommend it. To go back to the early issue about training, I do not think it is a good way to do it. I would endorse the idea that much more structured management training is helpful.

Q858 Dr Taylor: When we went to California we discovered that it had a system of picking out promising young consultants who might take on a management role and pushing them in that direction with training. Is that something we should be recommending here?
Sir Jonathan Michael: In my own organisation there is a structure which gives management roles to clinicians at a relatively early stage. We have developed a training programme to try to give them the competencies necessary to allow them to fulfil their role.

Q859 Dr Taylor: Do you go as far as to say that you can be a consultant with a special interest in management doing quite a good proportion of your clinical work but trained for that special interest in management?
Sir Jonathan Michael: That is certainly a model I have seen in Australia where clinicians can go off into formal clinical management training at SHO level. I think there are advantages in having been an active clinician for some time. Having the tee-shirt, as it were, and having done it yourself does help, whereas having a medical qualification per se but never having practised as a doctor or nurse is not quite the same.
Ms Hodgetts: There is some hope on the horizon in helping clinicians to manage in terms of work being done by the NHS Institute for Innovation and Improvement by way of a pilot scheme for the introduction of a management module into the core training of doctors in the future. Therefore, just for your information something is starting to happen.

Q860 Dr Taylor: At what stage in their careers does that arise?
Ms Hodgetts: That comes right at the beginning as a core competence.
Mr Sobanja: In terms of primary care, I think there is a pressing need to see a career development pathway associated with developmental training for clinicians of all backgrounds, be it general practitioners, nurses, physiotherapists and so on—all of my colleagues who work there—who are often associated with the management task through the professional executive committee but given very little support and development to undertake that role. For example, one of the difficulties facing general practitioners coming out of practice and perhaps going part-time in order to fulfil management positions is what they do when the structure changes or their faces do not fit any more. There is no career pathway and it may well be that back at the practice their jobs have been taken or altered and they are out on a limb. There is very little incentive for some clinicians to get involved in management if there is no clear pathway in front of them. Having said that, there are advantages in having clinicians in management but that is not the total story. We want the best people whatever their professional background which means encouraging all managers, not simply one group.

Q861 Dr Taylor: Have any general practitioners done what Sir Jonathan has done?
Mr Sobanja: Yes.

Q862 Sandra Gidley: It was said earlier that the reason there are more managers in primary care is that they are taking on new jobs, mainly commissioning. Did we have the right people with the right skills at the time? How effective has PCT-led commissioning been over the past five years?
Mr Sobanja: I think it was in 1990 that I was appointed director of commissioning in a health authority. I observed at the time that I did not know what the job was, and I do not know that much

better what it is now. I can offer an opinion on the nature of commissioning and what it should be, but I think there has been a lot of confusion about it over the years, particularly in terms of whether or not we have a provider-led service or commissioning-led service and how much commissioning should be related to the needs of local communities, which was apparent when we had 481 primary care groups. It is less apparent now we have 152 PCTs, the largest of which has a population of over 1.2 million. Relating the PCT to local communities will not be easy. I think that the history of commissioning has been remarkably variable. Without doubt there have been successes around the country in terms of reshaping and redefining care, which I take to be the basis of commissioning, understanding local needs and being able to articulate those needs into service requirements and securing those services. If we go into the area of comparative performance we are very poor in assessing it and evaluating the health outcomes attributable to commissioning. My bottom line is that commissioning has been a bit of a curate's egg. It is immensely variable round the country and commissioning is yet to demonstrate that it makes the real difference that we thought it might when it was first introduced in the 1990s.

Q863 Sandra Gidley: It is all up in the air now anyway because we have changed the system. We have practice-based commissioning, which is often referred to, quite worryingly in my view, as GP commissioning. GPs are not trained in commissioning. Should we be training GPs to perform this role, or are there challenges in the new system that is being introduced?
Mr Sobanja: I think there are new challenges. There are different aspects of practice-based commissioning. First, it covers a very broad spectrum. On the one hand, one can be a practice-based commissioner if one receives information about the consequences of one's referral patterns for other behaviours as a clinician. I echo your sentiment about it not being GP-focused alone. On the other hand, one can be a practice-based commissioner if one is designing or redesigning services and making a real difference to patients. One has those two aspects in the continuum. Second, there is a debate which I do not believe the Department of Health or ministers have yet resolved; that is, whether the introduction of practice-based commissioning means the shifting of commissioning responsibility from PCTs to practice-based organisations, be they localities, clusters or whatever name it is, or is practice-based commissioning to be the whole system's healthcare commissioning by PCTs through groups of practices for designated populations? Somebody has to commission primary care and look at the continuum. I would tend towards the latter. I do not believe that a view of the world which says that the time of PCTs is up is right because of practice-based commissioning. I think that the job of commissioning primary care as part of the whole system of care makes it potentially more challenging. To take just a minute to explain it, I am referring to a PCT giving a group of practices £10 million to manage diabetes care for their registered population. They have to provide what needs to be provided and that which they cannot or do not want to provide they commission from a third party. That might be another group of practices, a hospital or some other entity. In that sense, practice-based commissioning is far more like sub-contracting and the primary responsibility for managing all-round care for patients rests with that practice cluster. That issue has not been resolved. I am not sure about the Government's intent with regard to that and until then I do not think the role of PCTs is clear.
Dr Naysmith: I do not think we should go too far into this subject because we were focussing on how to get a trained workforce.

Q864 Sandra Gidley: That was the point I intended to follow up. What training is provided to managers to manage this? In the past there was a system which in some respects they were ill-qualified to administer. We have changed the system completely, and it seems that there are huge training needs that may not be being addressed. Is that a fair comment, or are the skills transferable?
Mr Sobanja: I believe it is a fair comment even though there are some transferable skills. If one has not been clear about the true nature of the task it seems to me that one cannot then do a retraining analysis followed by a gap analysis and put things in place. That is not to say there is not any training on commissioning because Ms Hodgetts has mentioned some of it in connection with the NHS Institute for Innovation and Improvement. There have been other courses about commissioning and so on, but I argue that it is pretty patchy and ad hoc round the country, to coin a phrase used earlier.

Q865 Dr Naysmith: Ms Hodgetts' body language did not quite agree with a couple of things.
Ms Hodgetts: Some generalised statements have been made. Some training is available, but I agree that it is ad hoc. There are some pilots in place around vocational training schemes for practice managers which includes an element of commissioning. We are very much at the beginning of looking at how we can disseminate that across the country.

Q866 Sandra Gidley: To put the cat among the pigeons, do managers in PCTs tend to be less experienced and competent than those in acute trusts? Would anybody like to answer that? Perhaps one cannot generalise.
Ms Hodgetts: I cannot generalise.

Q867 Jim Dowd: Referring to Dr Stoate's point about the growth in managers in PCTs compared with acute trusts, which is a five-fold increase in less than four years, how much of that is due to the introduction of PCTs compared with the relatively stable number of acute trusts? If that is the case, do you think too many PCTs were established at the outset?

Mr Sobanja: I think that a fair amount of it was to do with the expansion in the number of PCTs and those groups, although undoubtedly one element is the expansion of the functions within them. As to whether too many PCTs were established, I think the problem is that if we go back to primary care groups the reason for breaking up health authorities was two-fold. There were 95 health authorities when I was a health authority chief executive. The argument was that we needed to get closer to local communities and local clinicians. That was the basis for setting up 481 PCGs. Undoubtedly, those PCGs of which local clinicians had more ownership, including general practitioners, also got closer to local communities. If you place that emphasis upon it there probably were not too many. If you then get into the question of economies of scale around contracting, shared functions and payroll and all the things people think of as being at the forefront of managers' minds then there were probably too many. There is a real dilemma here in understanding the nature of the job. Personally, I regret the reduction to 152 for the reasons I have just mentioned. The management task is about health improvements in local communities and it should remain focused there. It has to be done in an efficient way, but I think there are problems in doing that and there is bound to be a cost.

Q868 Jim Dowd: Do you think that one PCT per borough in London is an efficient use of resources?
Mr Sobanja: No.

Q869 Jim Dowd: Are there too many or not enough?
Mr Sobanja: There are too many. If you look at experience around the country and the population served, the conclusion that you need 31 PCTs for the population of London, even though the density is greater, leads me to believe that that is too many and should be reduced.

Q870 Jim Dowd: Has the introduction of GP contracts changed the role of PCT managers?
Mr Sobanja: I think it has because the previous contractual arrangements based upon the red book were about reimbursement for services provided, paid for in part by capitation and in part through a fee per item of service. The introduction of arrangements around GMS, PMS, CPMS—all of the five variants to secure primary care medical services—means that there is now a requirement to commission general practitioner services and other services. I think that that alters the job very considerably. In the past one needed someone in the back office who knew the book very well. The data came in and whatever people did they were reimbursed for. Now you need people who are thinking about what should be provided in primary care, how it links up with secondary care, what the transition points are and making sense of that. It is in my view a much more skilled job.

Q871 Jim Dowd: Earlier you mentioned the qualities and outcomes framework. Has QOF given PCT managers more control over GPs?
Mr Sobanja: "Control" is an interesting word. The way I put it is that it has legitimised an area of clinical activity. What was often a no-go area for managers is become a "go" area to challenge and to seek justification for clinical activity. I do not recognise general practitioners being controlled by managers as something to do with reality.

Q872 Jim Dowd: Or as controllable in many cases?
Mr Sobanja: Your conclusion, sir!

Q873 Jim Dowd: Should managers have a greater role in auditing QOF returns from local GPs?
Mr Sobanja: The QOF returns are audited, but for some behind that question may lie an assumption that the QOF is a money-making machine that is being used by general practitioners. I do not believe that that is the case. Undoubtedly, the quality and outcomes framework has been responsible for increasing the standard of primary care medical services right across the UK, and it should be commended for that. That has come at a cost. In my view, the audit arrangements which involve practice-based visits and so on are perfectly adequate at the moment. One might have a look at one or two areas such as exception reporting and so on, but I believe that they are fringe activities and not things that require a heavy-footed approach which would undermine the relationships between managers and clinicians at the cost of services to patients.

Q874 Dr Naysmith: I do not want to let Sir Jonathan off the hook completely. I know that he is not involved in GP practices and primary care, but some of the things done under QOF now are things that are currently in acute hospitals—there are moves to expand them in future—for example, monitoring and managing diseases outside in the community which in the past would have meant visits to acute services to see consultants or members of their teams. Will this have an effect on you as a manager in acute services?
Sir Jonathan Michael: Yes, it will have an effect, but my preference would have been to move away from the old-fashioned paradigm which separates community from institutional care and think more about integrated care pathways, particularly for those patients with chronic disease. If one looks at mental health, there is an integrated delivery pathway which includes where appropriate both institutional and community care. I think that progressively we will move different disease groupings into a similar model. It is then a question of who co-ordinates that integrated care pathway as well as who delivers it, or who contributes to its delivery. Potentially, it can have an effect, but the optimistic view is to say that we can also have a role in delivering an integrated care pathway in a community setting.

Q875 Dr Naysmith: Is the interaction between community and the acute services being co-ordinated?

Sir Jonathan Michael: It is something that is being discussed and developed locally. It is possible given the regulatory framework within which we work, so it is up to individual organisations and PCTs to agree what is the appropriate way of handling it. There are already examples in this country and quite a lot of discussions going on that are focused on specific disease pathways.
Mr Sobanja: To give you an idea of scale, the alliance has a network of 285 consultants working in community and primary care settings who meet for the exchange of ideas and so on. It is not a tiny minority.

Q876 Charlotte Atkins: Moving to management training skills, what does the NHS actually do to get a management workforce that is fit for purpose?
Ms Hodgetts: In terms of the whole NHS one has the graduate training scheme which currently has about 400 students participating in it. That is where the NHS has harnessed a great deal of intellectual capital. As I am sure you know, a lot of those graduates will go into senior posts within the NHS. What is quite interesting is that the graduate trainees who become senior managers are these days less inclined to go into chief executive posts for the reasons we have discussed, namely the short-termism associated with those kinds of posts. That is what the NHS does formally. Informally, there are local arrangements. There is nothing formal for general or healthcare managers per se.

Q877 Charlotte Atkins: You referred to the graduate management training scheme, and there is the gateway to leadership scheme. Are they effective? Obviously, they are there for new entrants into the NHS. What is done for all those managers who have been at various levels for 20 or 30 years? Do they get any systematic training to make them more effective?
Ms Hodgetts: It is systematic only if it is supported within the organisation, not across the board.

Q878 Charlotte Atkins: Therefore, it is ad hoc and depends very much on what each hospital or Strategic Health Authority does?
Ms Hodgetts: One would hope that within a good organisation that would happen.

Q879 Charlotte Atkins: You would hope, but does it happen?
Ms Hodgetts: One hopes it does happen.

Q880 Charlotte Atkins: Can anyone tell me whether or not it does happen? Hopes are fine, but we have just seen TV programmes that tell us very often it does not.
Ms Hodgetts: If I look across at the membership of IHM and at senior, middle managers and first line managers there is a diverse response to that question. Some people say that they have had a fantastic opportunity within their organisation and have had a lot of training to help their careers; others say that they have been limited by lack of support and training in their careers. There is a real continuum of experience in the range of managers.

Q881 Charlotte Atkins: Therefore, there is no systematic approach?
Ms Hodgetts: There is not a systematic approach across the country; it is a bit of a postcode lottery.
Sir Jonathan Michael: In a way, your question is predicated on assumptions that the NHS is a single organisation but it is not; it is a virtual organisation made up of a whole range of different bodies. As part of a strategy, at the moment we are seeing greater decentralisation rather than greater centralisation. The implication is that responsibility for training and delivery and matters like that is that of the component parts of the organisations that sit within the NHS. It seems to me that the NHS has a responsibility or interest in making sure that there are training opportunities for people, such as the graduate management framework. Maybe there are not enough of them, but ultimately it is for the organisations to make sure that the staff working within them get professional training and have the competencies required to do the jobs.

Q882 Charlotte Atkins: I recognise that the NHS is obviously an organisation made up of many parts. Having said that, given there are national pilots targets and everything else one would have thought that training might possibly have an impact on meeting targets and making the workforce more effective. What worries me is that from what you say it very much depends on the effective management of those different parts, and what we are talking about is the training of those managers.
Sir Jonathan Michael: But that is a consequence of a policy that moves towards a decentralised model, and I think that is a better way of doing it than having a totally centralised structure and trying to run everything from Whitehall. Given the size of the organisation and workforce, one will not manage a training programme for over one million staff from one point in the organisation.

Q883 Charlotte Atkins: If you look at the area of education, at least you would have much more stress on leadership. While we are talking about these issues, can you tell me whether there are enough integrated training opportunities for clinicians and managers so that they understand the different points of view coming from those two roles?
Sir Jonathan Michael: There is some but probably not enough. In working practices clinicians and managers are working very much together and therefore are learning about the particular perceptions of managers and clinicians. My belief is that we need to see more integration and the use of clinicians in management which will help. Are there integrated training programmes? I suspect that there are not many. There are multi-professional training opportunities certainly at undergraduate level and at various stages of postgraduate training, but I suspect that they are relatively limited.

Ms Hodgetts: There is medical and management training that comes together at national level in that courses are put on around the country, but again they are for people who want to turn up as opposed to compulsory courses. There are opportunities to bring both managers and medics together, but again it is about people who want to do that as opposed to people being directed to do it.

Q884 Charlotte Atkins: The graduate management training scheme involves both clinicians and others, does it not?
Ms Hodgetts: Yes, it does.
Mr Sobanja: It seems to me that at the heart of it is Ms Hodgetts' point about continuous professional development and performance appraisal. I entirely take Sir Jonathan's point that one does not want a centrally managed or administered scheme, but we have an arrangement within general practice and with nurses which operates for 35,000 GPs under which there is a system requirement to have an annual review and for development opportunities to be identified. One of the principal points is that it is a matter of career development as opposed to a retrospective look at how one has done and one needs to separate out the two. It seems to me perfectly possible to say that managers should have the benefit of a similar type of experience, even if that is to be administrated, managed—however it is put—locally and met within local criteria and against local needs, but there is no such system of which I am aware.

Q885 Dr Taylor: Ms Hodgetts, towards the end of your written submission you say that there is a key skill and knowledge deficit in moving from public service models to a market-led model. You go on to say that developing commercial skills now forms a key part of your programmes. Can you explain what you mean by "commercial skills"? What grades and types of staff need them? Are they in PCTs or trusts?
Ms Hodgetts: It is about the NHS moving towards a mixed economy of providers in a contracted for environment. Bearing that in mind, there will be an increasing need for an improvement in terms of skills like negotiation, contracting with people and managing risk. We can learn a lot from the private sector in terms of those skills. Compared with the NHS, the commercial sector is more nimble, flexible, takes more risks and is more responsive to quick changes in direction, but it is profit-driven. Currently, the NHS is not profit-driven. Therefore, in public sector terms delivering to budget would be the closest we could get in terms of that definition. The commercial skill is very much about being a lot more astute in terms of contract management, project management and working to an agreed and non-negotiable timescale, which is not always the case—often it is elongated, and so forth—to get things done in an efficient and effective manner.

Q886 Dr Taylor: What grade of managers would you be training? Would you go down to clerks in the accounting departments?
Ms Hodgetts: No; it would be more senior management.

Q887 Dr Taylor: So, it would be senior management?
Ms Hodgetts: It would be senior and middle management.

Q888 Dr Taylor: Since the market came in has there been an explosion of staff necessary to drive both the commissioning side and the providing side.
Ms Hodgetts: I think we come back to a previous question that Mr Sobanja answered. There has not been an explosion; there has just been a redirection of staff. Some of them perhaps have not got those new skills that are needed in the new environment.

Q889 Dr Taylor: You are producing the training programmes now hopefully to give them those skills?
Ms Hodgetts: We do have some training programmes, yes.

Q890 Dr Taylor: Sir Jonathan, in your experience of foundation trusts have you needed more managers or managers with different skills?
Sir Jonathan Michael: I agree with Ms Hodgetts in terms of the range of skills required. Another issue that I think is important is an understanding of an assurance framework for an organisation which is the wider aspect of making sure the governance, risk management and so on of the organisation is assured and it is doing what it should be doing and what it says it is doing. As to a more commercial approach, this is linked back to my view that we are running a healthcare business and, therefore, we need to understand the dynamics of that business broken down to the individual subsets of the service we deliver. Therefore, teams need to understand what we call service line accounting and what income is generated by the work that they do and what costs are being generated. Whether they are making effectively a theoretical profit or loss is a fundamental discipline in the new world, although we are not generating a profit as such. Those are important skills, but it does not mean that you need an increase in the number of managers. To go back to a point made earlier by Dr Stoate, we have talked a lot about increases in management, but I think the NHS remains under-managed. There may be an excess of administrative burden and functions, but the management costs of my own organisation are only 3.5%. That is an organisation with a turnover approaching £700 million per annum and 9,000 staff. If you look at comparable organisations in the private sector, their management costs are significantly higher than that.

Q891 Dr Taylor: I cannot remember whether the department's paper *Better Care, Better Value* applied to foundation trusts, but it showed that a large number of acute trusts were not performing to the best on length of stay and length of admission

to hospital before operation. Is that the sort of thing you have addressed automatically in your foundation trust?
Sir Jonathan Michael: It is the sort of thing that we are addressing. 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 what I describe as 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.

Q892 Dr Taylor: Do you think you get enough data for management purposes?
Sir Jonathan Michael: We produce the data. The data that come back to us are produced by us in the first instance, so it is coming round a loop. What it helps us to do is provide comparative benchmarking data.

Q893 Dr Taylor: As a foundation trust are you better at that than other organisations?
Sir Jonathan Michael: I think the financial disciplines required of a foundation trust encourage us to do that slightly earlier, but the same financial requirements apply to all NHS organisations. I think that foundation trusts are just a year or so ahead.

Q894 Dr Taylor: I think one of the witnesses mentioned managers from the private sector having commercial skills. Should we be using more of them?
Ms Hodgetts: I am not sure that we should be using more of them, but we should be making sure that our own managers have those kinds of skills.

Q895 Dr Taylor: That is what you would prefer?
Ms Hodgetts: Yes.

Q896 Sandra Gidley: It was said earlier that managers should be managing health improvements but also that they were under siege in some respects. Do they focus too much on implementing change and too little on making improvements? Is it just poor management or the pressures of the current system?
Ms Hodgetts: If you look at the amount of change that has occurred over the past 20 years—we have had at least 10 Secretaries of States in that time, a number of junior ministers have been involved and a number of changes have been forced upon managers—no doubt they are distracted by that. The consequence is that there is a parallel process of trying to think about what you have to do in terms of the political agenda and what has to be done in terms of the organisation, making sure that we get the essential patient care whatever management that needs. The changed management process is bound to be a distraction.

Q897 Sandra Gidley: How do you say those three are balanced?
Ms Hodgetts: They are not. I think the distraction is the constant change. We could do with a period of calm to imbed some of those good policies that need to be maintained and followed through, as opposed to being suddenly changed again as a result of another governmental directive.

Q898 Sandra Gidley: We live in a particular NHS culture where everything has to be evidence-based. Are managerial decisions evidence-based?
Mr Sobanja: No. I think it is particularly difficult because of the shifts to which Ms Hodgetts has referred to collect evidence particularly when new arrangements are not piloted and the political ambition is such that we go full tilt into one thing and then go full tilt into another without necessarily evaluating the outcomes, particularly in patient care. Many management decisions and processes are not evidence-based, unless one considers experiment in practice as being part of the evidence, which sometimes it is. There are evaluations of some things, but in terms of overall management processes I believe there is relatively little research and evidence as to what works.

Q899 Sandra Gidley: Would that go for the acute section as well?
Sir Jonathan Michael: Yes, to a certain extent. Clearly, individual management decisions are probably not evidence-based, but if you look at the performance of an organisation you can take a cumulative view of management decisions. If that organisation is delivering quality of care against its objectives and requirements it is likely, one would hope, there is some relationship between that fact and the management decisions made within that organisation.

Q900 Mr Amess: I was an MP when the Griffiths report was first published, and I certainly do not think that the Florence Nightingale issue has been addressed at all. Our workforce planning inquiry is not exactly setting the world on fire, and I do not think that the naff questions that I am about to ask will add too much to it. Therefore, if only one of you answers yes or no I shall be content. Is workforce planning seen as a distinct and valuable career path for NHS managers—yes or no?
Mr Sobanja: No.

Q901 Mr Amess: What kind of people tend to go into workforce planning?
Sir Jonathan Michael: I do not think we should criticise those of our colleagues who try to look at the workforce needs of an organisation, but I go back to my earlier comment to Charlotte Atkins: is one trying to manage this across the whole NHS? My organisation is looking at its workforce needs within the organisation, and that is a manageable thing to do. To look at it across the whole of the NHS, particularly if one is looking at clinical workforce where the training programmes are prolonged, the sub-specialty outcomes of training

may be very complicated and multiple and the needs of patients change and the science on which one bases that care change quite quickly, it is a very difficult job. I argue that perhaps we should not try to be so specific in terms of workforce planning across the whole of the NHS. I think we are trying to be too specific, but to criticise those who are trying their best would be unfortunate.

Q902 Mr Amess: As a supplementary, Anne Rainsberry of NHS London told us at our session on 14 December that she felt a lot of this work was being done by junior staff. Do you agree with that and, if it is a problem, how can it be addressed?
Sir Jonathan Michael: I am not in a position to comment as to the staff doing the actual work.
Mr Sobanja: There are some very senior people in workforce development confederations which have moved into Strategic Health Authorities, so to suggest that this work is being undertaken by junior staff is in my view wrong. Whether or not it is joined-up work is something on which I would focus attention. For instance, is it reconciled back to PCT development plans, commissioning intentions and trust development plans and their intentions? Is it reconciled back to affordability and likely sources of supply? It seems to me that whether or not it is being undertaken by junior or senior staff is the single failing of workforce planning on which I would put my finger.
Mr Amess: Is there any significance in the fact that my colleague Dr Taylor seems to have a bag underneath his desk which sports the NHS Alliance logo, or is it just a coincidence?

Q903 Dr Naysmith: Perhaps I can rescue the situation. There is an important point underlying the naff questions that Mr Amess has just been asking. Perhaps I can turn round these questions a bit and ask: is workforce planning possible? Can we do it? I say that in the light of a BMA press release this week from which one would think all hell was about to break loose. Two years ago we did not have enough doctors; now we have too many, and in two or three years' time we will not have enough. If one reads that press release carefully it appears that the whole of the National Health Service is about to collapse. Can we plan for things like this or not? Is it possible?
Ms Hodgetts: I think workforce planning is essential if one thinks of the kinds of budgets that one is working with, particularly the MPET budget in terms of the training of our clinicians, for example. I think that the mismatch has happened due to the lack of communication between national and local planners. We have people with a very high level of skill in workforce planning, for example on our workforce review team, and we also have people working locally in workforce planning but who do not have those skills. The question is how we have the conversation between the two and think about the way we are revising and reviewing the way we work at the same time. It is complex, but not to do it would probably be foolish.

Q904 Dr Naysmith: Are you saying that it is not working terribly well?
Ms Hodgetts: It has not worked terribly well. I hasten to say that I think we are improving as we learn and reflect on what has gone wrong in the past and see how we can make it better in the future.
Sir Jonathan Michael: I would perhaps err on the side of doing less or doing something less specific and keep it at a fairly strategic level for the country as a whole and the NHS in the wider sense and allow individual organisations to have more responsibility for their own workforce planning. Clearly, there is no point in an organisation such as mine planning that it will need a certain number of nurses if nobody is training nurses in this country. There needs to be some workforce planning, but to try to manage it to the specific level that we have been is fraught with difficulty and almost guaranteed not to succeed. You cannot ignore the relationship between workforce planning and terms and conditions of employment. In the same way that I believe workforce planning is fundamentally something that organisations need to do, I would like to see a move away from national unitary contract negotiations on terms and conditions to something that is linked closer to the requirements of local organisations.

Q905 Dr Stoate: The present situation is pretty hopeless because, to pick up an earlier point, it is totally piecemeal and is not joined up at all. That point has just been reinforced by Sir Jonathan who says that he is perfectly happy to do workforce planning in his own organisation, but that is exactly the wrong way to go. First, the BMA says that there are 10,000 too few GPs; now it says there are no jobs for GPs; then it says there are not enough cardiac surgeons; now we have cardiac surgeons with nothing to do and it is all dreadful. We get into a ridiculous situation where we have literally boom and bust in all sorts of professions at different times, but if we allow each individual organisation to plan for itself no one will take a strategic decision as to how many doctors, nurses or physiotherapists to train. We are then told that 70% of physiotherapists coming out of colleges this year cannot find jobs; five years ago you could not get a physiotherapist for love nor money. We are dogged by unjoined-up mechanisms. We have heard evidence that workforce planning is very poorly integrated with financial and service planning. Is it because financial and service planning managers do not pay enough attention to workforce issues?
Mr Sobanja: I believe that the system does not pay enough attention to integrating those things. If you look at the performance management arrangements in the health service, whether they are through Strategic Health Authorities or elements undertaken by the Healthcare Commission, they do not seek specifically to measure or manage that degree of integration. I am nearer Ms Hodgetts' point than Sir Jonathan's. I think there has to be a national system. It will always be an art rather than a science. The particular problem in the health service is that training lead times are sometimes extremely long, but that means you have to look further out and

have a vision of what the service looks like. The failure to articulate what the service may look like in five to 10 years' time makes workforce planning extremely difficult. Currently, the vision is that there will be a 5% transfer from the acute sector into primary care. Will that be undertaken by general practitioners or pharmacists, nurses, physiotherapists or whatever else? People will say that it will be a mix of that. Unless you have a service planning view of what the service looks like—one of the key roles of a PCT locally is to articulate that view—you will not get anywhere in terms of meaningful workforce planning.

Q906 Dr Stoate: That is exactly my point. I recently wrote a pamphlet for the Fabian Society arguing that 10% ought to be transferred from secondary into primary care, but somebody needs to have that strategic vision; otherwise, we are all chasing our tails. Nobody knows how many practice nurses or what other skills in the field of healthcare assistants we need in 10 years' time. It seems to me that nobody is making those big decisions and we just lurch from year to year with boom and bust of every description.

Sir Jonathan Michael: You could argue that the reason we lurch backwards and forwards is that to try to do centralised workforce planning is impossible. Therefore, one needs to take account effectively of market forces in terms of employment. If people wish to go into the legal profession there is not a structured workforce planning arrangement which says that there should be a certain number of litigation experts in this particular sub-discipline. If people want to become lawyers they will make a judgment about where they see career opportunities matching their interests. I think that we need to move more in that direction. It does not, however, mean that you do not have a national overview about the likely number of doctors, nurses and other clinical professionals who are required.

Q907 Dr Stoate: But that will not do. If, for example, in five years' time one suddenly decides that one needs 10 more pharmacists in one's hospital and there are not any because nobody has bothered to train any pharmacists five years ago what will you do?

Sir Jonathan Michael: As with any other grown-up organisation we will recruit them from elsewhere.

Q908 Dr Stoate: From where will you recruit them—other countries?

Sir Jonathan Michael: If need be. We do not have the focus of a parochial organisation. We recruit from overseas as well as from this country. Other people recruit those we train to work overseas.

Q909 Dr Stoate: Let us save money and close all the pharmacy schools and recruit all our pharmacists from Europe. We have to have some idea of how many pharmacists to train in the next 10 years.

Sir Jonathan Michael: That is the sort of strategic workforce planning that I think is sensible. I agree with that.

Dr Stoate: My view is that we do not have a medium to long-term view of how many pharmacists we will need in five, 10, 15 or 20 years, which is the problem.

Q910 Jim Dowd: Have we not allowed the royal colleges to make the whole clinical business, if you like, far too specialised and their role as gatekeepers is limiting scope? You mentioned the parallel with lawyers. You train lawyers and they then decide what they want to specialise in at a basic level, but the royal colleges, and the BMA for that matter, have traditionally resisted all that; they jealously guard their role as the gatekeepers and definers of what is a qualified clinician.

Sir Jonathan Michael: They are responsible for defining the competencies required for the training within disciplines, but the wider question is: do we need to have the sub-disciplines? The reality is that clinical practice is changing and the answer is that you no longer have a generic surgeon who will open your head, belly and chest. You would prefer to have a sub-specialist who is trained to do the specifics. That is one of the complexities.

Q911 Mr Amess: I was in recruitment for many years. We have seen a ridiculous rebranding of the job title "personnel officer" or "personnel manager" to "human resources director", as if it means anything different. In general, what do you think of the quality of these personnel officers, managers, human resources directors, whatever you want to call them? Are they making a real contribution to workforce planning, or are they just interested in the conditions of the workers?

Mr Sobanja: My background is such that when I entered the service there was no such thing as "personnel", never mind HR management. My first substantive post in the health service was as a personnel manager before it turned into HR. I have some interest in this area. 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. That does not mean to say there are not some very highly skilled and efficient HR persons out there. Are they allowed to contribute to workforce planning sufficiently? No.

Ms Hodgetts: I believe that over the past few years anybody involved in HR has had a very difficult job, bearing in mind consultant contracts, Agenda for Change and the European Working Time Directive. All those things have merged together and caused a tremendous amount of skilled work to implement all those changes. There must be a degree of skill to be able to deal with all those particular changes. My experience in dealing with HR managers is that they tend to be more operational than strategic, to

reinforce Mr Sobanja's point. At the same time, there are some stunning directors of HR who perhaps have been brought in from the private sector but are still contributing a great deal to the development of organisations.

Dr Naysmith: We will draw this session to a close. We have gone down some interesting byways this morning and have received a lot of valuable information from you. Thank you very much for your contribution.

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

Q912 Dr Naysmith: Good morning. I welcome you to the Select Committee on Health. At the start of the session I apologise for the absence of Kevin Barron, our Chairman. He is on important parliamentary business elsewhere in the world and cannot be with us today. If you listened to the previous session you will know that we allowed it to stray rather widely, but we have you with us today to talk particularly about your colleges and the society. We will focus particularly on your problems and the matters you have put to us in writing. You all represent staff groups which face particular challenges with regard to workforce planning. What are the most important problems facing your organisations and the clinical groups you represent? Before you deal with that, for the record perhaps you would introduce yourselves.

Ms Silverton: I am Louise Silverton, deputy general secretary of the Royal College of Midwives. I have been a midwife for some 28 years and have delivered in excess of 1,000 babies, so if anybody needs any advice on that I am available.

Professor Foster: I am Professor Christopher Foster, director of workforce planning at the Royal College of Pathologists. I am also the George Holt professor of pathology at the University of Liverpool, having been trained in both this country and the United States of America.

Mr Gray: I am Phil Gray, chief executive of the Chartered Society of Physiotherapy. I have been involved in industrial relations, healthcare and workforce matters for the best part of 25 years. I was previously director of labour relations for the Royal College of Nursing.

Q913 Dr Naysmith: There are problems for all of the professional groups you represent.

Professor Foster: Dr Naysmith, perhaps I may answer that question at the very beginning. You asked what the major problem was. Perhaps I may say that the way the college was invited or not invited to be present here exemplifies exactly the problem with pathology, that is, profile and perception. Not only within the lay community but also within much of the medical community there is a profound failure to understand the role of pathology across all the specialties, what it does and what it contributes and how it is fundamental in underpinning the vast majority of the medical activities that go on in this country from the time that a person presents.

Q914 Dr Naysmith: Therefore, do you think that there is a problem in the way we have introduced it?

Professor Foster: The fact we were not invited to be present right from the very beginning so that our written submission was not included in the book which was published meant that no profile of pathology was included. I think that that absolutely exemplifies a major problem with healthcare in the United Kingdom.

Sandra Gidley: It is up to organisations to be proactive. We do not specifically invite anything from anybody, as I understand it.

Q915 Dr Naysmith: It was not a question of issuing individual invitations.

Professor Foster: But the answer is profile. If there is not a profile, whether it is in the medical school or in the community, we are unlikely to attract large numbers of people who want to come into pathology, whatever be the specialty. Without a profile it is unlikely that the lay community outside understands what it is we do.

Q916 Dr Naysmith: You probably are unaware that I was a lecturer in pathology for 25 years at the University of Bristol Medical School, although I am not medically qualified. As you will know, you can be a pathologist without being medically qualified. Therefore, there is some knowledge around the table as to how important pathology is.

Ms Silverton: We have a similar problem in midwifery. We put ourselves forward to be here, but many people think that we are nurses; we are not. We are the senior professionals present at in excess of 65% of births in the UK. We work with women from the point of pregnancy up until four to eight weeks after birth. We find ourselves with a very serious problem. Three years ago the Government recognised that there was a significant shortage of midwives; they put in place a six-point action plan to address that shortage. We had some increase in midwifery numbers, but we find ourselves now in a position where midwives, for whom there is a need, cannot get jobs when they complete their training. We have an increasing birth rate and medicalisation of births. The make-up of the child-bearing population with immigration has changed markedly. We also seek to implement government initiatives with respect to the manifesto commitments and the maternity standard within the national service framework. There is no sight at all of any work on the requirements for additional midwives and training for those midwives who are

currently in post to take on new roles in relation to being the first point of contact in pregnancy and to work in non-medicalised units, be they midwife-led or at home. We think that we have really serious problems. We hear that because of the financial cuts some areas seek to stop all post-natal care. What is happening? On the one hand, the Government say that midwifery is important; it is there at the start of life; they want the best possible care for mothers and babies, and yet nobody is paying any attention to midwives.

Q917 Dr Naysmith: Do you know of any workforce planning in this area?
Ms Silverton: As a college we have done a lot of workforce planning, and there is also a workforce planning tool called Birthright-Plus, which is supported by the Government, that will tell you how many midwives are needed in a particular setting for a particular population and will also deal with the skill mix. Many units have done that, but what they have not done is to say, "We are 20 midwives short. Let us go and get midwives." We know that this is costing the NHS money, because shortage of midwives leads to poorer care and maternity services are a major contributor to litigation costs. It is very foolish to be skimping on midwives and not giving women access to the care they need, coming poorly prepared to labour and seeing the result in intervention rates.

Q918 Dr Naysmith: We will come to some of these matters later on. Mr Gray, your written submissions state that allied health professionals are being subject recently to poor guesswork, not workforce planning. What is your justification for that statement?
Mr Gray: Many of the comments that I have to make would apply specifically to physiotherapy but also to many of the allied health professionals who have significant problems: speech and language therapy; occupational therapy; radiography to some extent; dietetics and healthcare science. There are common problems. We have big problems in workforce planning which we believe has been subject to poor guesswork. Starting with the position that has been reflected already in the previous discussions, only three years ago there was a very serious shortage of physiotherapists. Interestingly, the history over the years was that planners grossly underestimated the number of physiotherapists that would be required and the demand that the jobs have created has exceeded that—hence the reason why the year before last we ended up with a situation where we had difficulties filling 1,500 vacancies in physiotherapy. 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. The problem arises where the occasional long-term vision gets lost by short-term demands and is buried by them. For example, we believe that there is a complete lack of resource going into properly assessing these groups. The reason I say that it is a guesstimate for AHPs and healthcare science is that a week ago the *Health Service Journal* released a document from the Department of Health which appeared on the front pages of most national newspapers announcing predictions of 3,200 too many consultants, too few junior doctors, too few nurses and—this is a wonderful one—that by 2010 there would be 16,200 too many allied health professionals, healthcare scientists and technicians. When one looks—I have seen the document—there are no data, evidence or breakdown. What one has is a series of long-term forecasting done by the very scientific method of putting a wet finger in the wind; in other words, it is a guesstimate; there is no evidence to back it. There is a lack of resource to look at that long-term need. It needs to be done and can be done because, for example, the medical sub-specialties devote a lot of resources from the Department of Health and others to doing precisely that. We believe that there is a real problem about lack of follow through. It is one thing to commission future workforce. Once one has taken in those students, paid for by the taxpayer and commissioned by the NHS, there should be a contractual responsibility to ensure that the service does some thinking about what to do with the people who have been commissioned. All too often that does not happen. It almost appears as though six months or two months before or afterwards there is a sudden rush and people ask, "What should we do with these people?" They have not planned it. We believe that there is a genuine and scandalous waste of highly committed and talented people, 30% of whom are mature students with second careers who come into physiotherapy as a result of advertisement by the Government. They now feel very let down and a significant number feel betrayed.

Q919 Dr Naysmith: That has probably obviated the need for one or two questions later on. Professor Foster, do you have any general points to make at this stage?
Professor Foster: To an extent I endorse what I have just heard, but I think that pathology is in an almost unique situation in that we span not only the medically trained pathologists but also, in terms of our responsibilities—mine is that of the director of workforce planning—the clinical and bi-medical scientists. You will probably be aware that under the Knowledge and Skills Framework led by Sue Hill, with whom we have co-operated very closely, there is a strong move to look at the career pathways of all three groups. We look at the roles and what will be necessary not only to deliver pathology as we understand it today but to scan the horizon and identify new technologies that need to be introduced. We look at how to devolve responsibility sideways from groups currently practising or taking responsibility for certain of the tests to other groups so they can be performed perfectly competently, whilst allowing those with other training, for example medical training, to become more patient-interactive or interfaced in an appropriate manner, or to be at the cutting edge in terms of developing technologies through a new understanding of disease processes. Here is an

ongoing education component, if you like, which affects the medically and scientifically trained which I think is of paramount importance in the development not only of pathology but all medicine and the delivery of healthcare.

Q920 Jim Dowd: Ms Silverton, I think you referred to an increasing birth rate in this country. I thought that in common with most of Europe, certainly northern Europe, we had a declining birth rate.
Ms Silverton: We did have a declining birth rate; it declined from 1996, but we are now back up to 1996 levels. There has been an increase of about 8% over the past five years. The increase is greater in London because it has a younger and different population. There are far more non-UK-born women who come with their own needs. We will face significant problems because we find that with PFIs maternity units are smaller; each time they are replaced they become smaller. Women are told that they will be going home four or six hours after birth, essentially whether or not they like it. That puts increasing pressure on midwives. I also echo what my two colleagues have said about people being encouraged into midwifery. The average age of student midwives is 33 and 75% of them have dependents. Having been trained over three years at a cost in excess of £45,000, they find there are no jobs for them. With respect to the six-point plan for midwifery, that was cut off at the end of 2005 and nothing has replaced it.

Q921 Jim Dowd: That is linked to the next question which involves Mr Gray. Is it the contention of either or both of you that anybody trained in a medical school has an automatic right to a job in the National Health Service?
Ms Silverton: My answer is that anybody whose training has been paid for by the NHS should work first and foremost for the NHS. I say that because 99% of births in the UK take place in the NHS. The market in private maternity care is very small; the number of births undertaken by independent midwives is 0.07%, so from a midwifery standpoint my answer is yes.
Mr Gray: We do not say that people have an automatic right to a job. What we do argue is that in terms of trying to ensure that a huge investment by the British taxpayer is not wasted it makes sense to think about giving new graduates something like a one-year job commitment, after which they are on their own and they have to look after themselves. We understand that in medicine there is effectively a two-year guarantee of employment after qualification, and in Scotland there is something like a one-year guarantee for nurses. There are precedents for that. However, after that there should be no commitment. The primary issue is how to deliver better and more effective and efficient patient care. The issue as to whether or not we need them is predicated on that patient need.

Q922 Jim Dowd: A former Secretary of State for Health came up with the idea, again from the point of view of protecting the taxpayers' investment, of requiring all trained doctors to spend a minimum period with the NHS. I hear that that got absolutely nowhere, largely because of the opposition of the royal colleges of which you may understand I am not a fan.
Mr Gray: The Chartered Society of Physiotherapists is not one of the royal colleges and it takes a different view. We estimate that the cost to the taxpayer per physiotherapist, taking purely NHS figures, is probably in the region of £30,000. If the estimated 1,300-odd physiotherapy graduates of last year's output still do not have a job that is a loss of something like £40 million, which is a huge waste. The real issue here is that we are hit by short-termism which is substantially to do with financial deficit reduction. To be clear, financial deficits have not just been hitting in 2006, though in that year it was much worse, but, as you found in your previous investigation into NHS deficits, it also hit 2005 and 2004. That hits significantly jobs that junior physiotherapists can do. It is often in those grades where there is the greatest turnover, so those are the posts that fall vacant and become frozen when the portcullis comes down. What is not centrally featured in that are the needs of patients. We know from our own evidence that waiting lists particularly in outpatient physiotherapy, which are hidden because they are not recorded substantially in the 18-week wait assessment, are going up significantly. The evidence we have put before you shows that in some cases it is going up to something like four months. That guarantees that people end up not getting their injuries at work dealt with quickly and effectively; they end up on incapacity benefit and with a huge amount of employer cost in sick pay, but the failure of joined-up thinking does not link the cost or saving to the NHS compared with the cost to the employers, the cost to the Department for Work and Pensions and the lives of the individuals affected in that way.

Q923 Jim Dowd: We also discovered in our deficits inquiry that as a proportion of total NHS spend the deficits in 1997 were much higher than they are today, or in recent years.
Mr Gray: Yes.

Q924 Jim Dowd: Turning to the royal colleges, we received evidence from the NHS Partners Network to suggest that the role of workforce planning should be to meet the business expectation of commissioners and not the diktats of the royal colleges. Do you agree with that proposition? What role do you think the colleges currently play, and how can it be improved?
Professor Foster: As the representative of the Royal College of Pathologists perhaps I may answer that. You have not provided any evidence for the stance you have taken. I have already said, and can demonstrate, that the Royal College of Pathologists, far from being defensive, is playing a very proactive role in interacting with members of the Department of Health across the board. We look not only at our own members—in other words, the medically trained members—but we also integrate the professional bodies of clinical scientists and

members of the IBMS to look at the totality of workforce requirements, so there is no protectionism there. We certainly do not defend medics against scientists and technicians. The evidence which is demonstrable is completely contrary to what you suggest.

Ms Silverton: For the record, although we are the Royal College of Midwives we are not a medical college and we do not control the numbers that come into our profession; they are commissioned by the NHS. At the moment we have a situation where people have been commissioned to come into midwifery to meet shortages but they cannot get any jobs. If we take the University of Salford as an example, last year 34 midwives got jobs; this year 12 did and there are unfilled vacancies, which means that women in labour find that no midwife is caring for them. One midwife is running between three and four women at the same time. It is not that we are protectionist; it is to do with the quality of care and women not being able to see midwives because there are not any.

Mr Gray: I do not wish to comment on the royal medical colleges, but in the case of the allied health professions and physiotherapy we genuinely start by looking at patient need and what is required to improve the delivery of service to patients all over the country. An example of good connectedness of both vision and decision was the NHS plan in 2000. Quite a lot of work was done on that at the time and immediately after in trying to forecast the then changes in policy and direction of travel. One result was a government decision announced several times in Parliament that the workforce in physiotherapy over 10 years would increase by 59%, that is, about 8,000 additional staff. We were approximately half-way through that process when it changed, despite the fact that since then there have been many other policy proposals and changes, not least of which is the increasing elderly population, the changes in the delivery of community services and the need to be responsive to patient choice. Clearly, all of that indicates a need for an increasing number of physiotherapists. Our problem is not one of defensiveness but short-term cuts leading to long-term problems in the delivery of healthcare.

Q925 Jim Dowd: This Government has put more money in the health service than any other and the judgment is that collectively we are approaching the point where the nation is making its maximum investment in healthcare provision generally. I do not think that we can increase its share of GDP much beyond what it is. You refer to short-term cuts, but this is just financial discipline, surely?

Mr Gray: We have no quarrel at all with and warmly acknowledge the very substantial commitment and investment that the Government have made and the way in which things are being delivered. The shortening of waiting lists in which physiotherapists and other HPs have played a significant part is an exemplar of what has happened in that respect. It is not a question of the money disappearing into a black hole; it has delivered much higher levels of care, but that does not detract from the damage which has been done as reflected in the report of the Health Committee on NHS deficits in terms of short-term decision-making. If I am being completely cruel about it, the short-term decision is almost one where they plan to produce more physiotherapists, and most of the senior decision-makers you talk to will acknowledge the continuing need for those physiotherapists, but the service will say to those graduating, "We are terribly sorry. We did intend to do this but it is just not convenient at the moment." For people who are very bright, able and committed that is disillusioning, but those same people have the opportunity to go somewhere else. The average physiotherapy student going onto a course has the same high A-level score that is required to get into medical school. If those same bright people do not find jobs in the NHS they will eventually find jobs not just in McDonald's and short-term positions where they are now but in the City and in companies that will use them outside healthcare. In a couple of years' time we will be scratching our heads and asking what the heck happened to all the physiotherapists.

Q926 Jim Dowd: Our local McDonald's in Forest Hill closed down last September.

Mr Gray: That was not because of the physiotherapists, hopefully.

Ms Silverton: We recognise that significant money has been put into the NHS. However, when one looks at the proportion of that money spent on maternity services it has fallen from 4% in 2000–01 to 3% in 2003–04.

Q927 Jim Dowd: But in cash terms it is a much higher figure, is it not?

Ms Silverton: I agree, but when one looks at the significant increase in the number of nurses in the NHS, which is 20% to 25%—the Department of Health does not disaggregate midwives from its nursing figure—the increase in midwives is less than 5% and they have been asked to do much more in screening, meeting disadvantaged groups, assisting breast-feeding mothers, dealing with domestic plans and with an increase in the birth rate.

Q928 Jim Dowd: The NHS workforce review team works with you and other organisations. Is it effective and useful? Is it of any benefit?

Mr Gray: I believe that the workforce review team does a good job but within severe limits. Its work is now much more effective in looking at the supply side; in other words, how many staff are in the service, how many people are coming in and what is the likely wastage rate from the service and so on, but there are still big gaps. For example, in physiotherapy and other AHPs the system does not collect any information about the speciality and grade mix. It can tell you how many physiotherapists there are but not how many senior ones there are, and it certainly cannot tell you how many of those seniors are involved in delivering care for older people. There is a gap on that side but the bigger gap is on the other side. I make very clear that workforce planning is inherently very difficult. If it was easy

everybody would be doing it. From conversations that we have had with them—I respect their expertise—their big gap is the forecasting of demand. First, experience shows that when you start off with decisions at local level, where they have to be, you have to take account of the population's needs. We are told by the workforce review team that we cannot really deal with patient needs; all we can deal with are expressed demands from employers. Whether they reflect the needs is quite another matter. Second, the information that they get is extremely poor. In our evidence we have cited the fact that we got so irritated by the last set of figures from the workforce review team—again, this is not their fault; they get it locally and from SHAs—that we made a Freedom of Information Act disclosure. First, we demanded from every SHA all their figures on physiotherapy workforce demand. We were appalled. Out of the then 28 Strategic Health Authorities, 11 put in no information. Five were the London SHAs, the largest employers in the country, and there was no information from them leading to future projections. Second, a number of the SHAs had no physiotherapy breakdown; they had an AHP figure. That is a bit like saying that a physiotherapist is a radiographer, is a pathologist, is a dietician, is a biomedical scientist. Of course they are not; they are very different and need to be looked at differently. When short-termism comes in the problem is compounded. At a purely practical level, when people fill out forms in trusts and indicate how many nurses or physiotherapists they will need in five years' time when faced with very big short-term financial directions their horizons are reduced. Whether it is a junior person in an HR department filling out that form—frequently in the past it has been—or a senior one, the inclination to do the digging and true investigation that is needed is not there. For all these groups, the medium size and smaller professions, in the health service there is a major gap in terms of information for the future. With the best will in the world, the workforce review team with all its skills is handicapped by that lack. They tell us that they simply must reflect what the SHAs tell them they believe they need.

Professor Foster: I agree that there is a big problem in the Strategic Health Authorities in terms of commissioning. We work very closely with the NHS workforce review team on almost a continuous basis. Until last year the WRT made recommendations about the NTNs—national training numbers—required in the various pathology specialties to be able to maintain the services as they saw them expanding, but there is no mandatory element there. Strategic Health Authorities can choose either to accept or ignore that advice, and they will not put money into training if they have budget deficits elsewhere. As we have seen in the past year, the MPET moneys have been unbundled and are no longer ring-fenced and so there is a very real risk that training will be compromised. The other element at the start of the discussion was the difference between numbers. I believe that part of the problem of workforce planning in the United Kingdom is that for too many years we have concentrated on whether we have replaced the numbers of individuals there at particular levels in the past. Bearing in mind what I said earlier, the Royal College of Pathologists is looking holistically not just at the medical workforce but also the scientists and technicians. We put together a group under my chairmanship which also involved the NHS workforce review team, the Audit Commission and the Keele clinical management group. The reason was my desire to develop an algorithm by which we could look at the workload of individual laboratories around the country. What is the amount and type of work and what is the expertise required to deliver on the work that is coming in? As clinical services develop, as they should, and are underpinned by pathology then one can predict the types of people one needs. In that integrated manner one can not only transfer skills between the groups, as Sue Hill wants to do, but look also at joint training and education, about which Charlotte Atkins asked in the previous session. At the moment we are hampered by the way the Strategic Health Authority particularly does not interact with us and commissions work. We think that that is too naı£ve, restrictive and parochial.

Q929 Dr Naysmith: In pathology about 10 years ago one of the things that was happening was the privatisation and out-sourcing of pathology services, not so much clinicians but the other two strands that you talked about at the beginning. Has that continued apace, and will it not have an influence?

Professor Foster: Of course, privatisation is something that has come to the fore both through pathology modernisation and, more recently, discussions around the Carter report. At the end of the day, one needs to specify which type of pathology one is talking about. If one is running a private clinical chemistry laboratory where there is a very high automation rate compared with manpower and one can run machines 24 hours a day 365 days of the year one benefits by taking on work from almost any source because it becomes more efficient. One cannot do the same with histopathology, for example, or something that requires a much higher manpower/unit workload ratio. Looking at the latter, the number of histopathologists available in the country who are able to report is relatively small. At some point during the day they need to stop what they are doing and take a rest. That is where the European Working Time Directive comes in. When that is fully implemented it will be illegal to work 40 hours a week in the NHS reporting histopathology and then to do another 40 hours elsewhere. I believe that that was where Sir Jonathan Michael was naı£ve in saying that one would just recruit from outside. The Royal College of Pathologists tried to do that on a number of occasions. We do not believe that it is legitimate to take pathologists from, say, third world countries where they should be employed more effectively. We have stopped that as a policy. But in addition those people are not there and we need to train them. The money needs to be put in early

because there is a lead period of something like 13 years between identification of the need for a pathologist and the training of somebody who has those skills and can practise independently.
Ms Silverton: We work extremely closely with the workforce review team and it has been quite a satisfactory arrangement. However, 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. We have also been hit by what is, I suppose, the double-whammy of two routes into midwifery. There is the three-year route which is paid on a bursary, and in England there is an 18-month route post-nursing. Those people are paid from the NHS salary bill. The number of commissions in some areas has been cut by up to one third, which means that in 18 months' time there will be a third fewer student midwives coming out. We have some suggestions. We would like to see all units use the Birthrate Plus workforce tool every three years or when they reconfigure their service and change their model of care. We would also like to see the information on workforce numbers for midwives disaggregated from that for nurses. We are talking about 24,000 whole-time midwives in England and hundreds of thousands of nurses. We just need to be able to produce specific figures.

Q930 Charlotte Atkins: I think we are all agreed that the number of staff in the NHS has massively increased. There has been an increase of about 24% between 1999 and 2005. From what you have said, I suspect that if I asked you about staff numbers in your own areas you might not be able to give me exact figures. Ms Silverton said that midwife numbers had increased by 5%.
Ms Silverton: There was an increase of 896 between 1997 and 2005, so it is an increase of less than 5%.

Q931 Charlotte Atkins: I do not know whether Mr Gray can give a comparable figure.
Mr Gray: In physiotherapy the increase has been just under 5,000 since 1999, which is about 33%.
Professor Foster: As to pathology, yesterday I obtained the figures and compared them with data from the health and social care information centre on the web. Overall, the increase is 5.2% but that also includes a deficit of something like 3% in chemical pathology and 16% in immunology, so there has been a fall in some sectors. Overall, there has been no increase greater than 8%.

Q932 Charlotte Atkins: What would be the overall increase?
Professor Foster: It is 5.2%.

Q933 Charlotte Atkins: What I would like to ask you, not so much about your own areas because obviously the increases are relatively small, is whether you think the increase in staff numbers has been effectively managed within the NHS.
Professor Foster: Do you mean within pathology?

Q934 Charlotte Atkins: I was going to ask you about your own sectors but also your impressions of the increase in staff outside those areas.
Professor Foster: I do not think I have the data to be able to tell you the position outside my own sector, and it would be presumptuous for me to try to do that.

Q935 Charlotte Atkins: In that case, perhaps you could comment on your own sector.
Professor Foster: I think that pathology, which is very much a self-motivated group of specialties straddling science and the medical/clinical field, has been over-managed to focus upon delivering service with relatively little resource. We accept that there has been an expansion, but what you have not asked about is the expansion in the workload. Laboratories generally work on a geometrical expansion of 13% per annum, so if you set that against an overall arithmetic change of 5.2% in workforce numbers the disproportion, irrespective of the increase, is enormous.

Q936 Charlotte Atkins: What about the deficit areas that you talked about? You said there was a 16% deficit in immunology. What impact has that had?
Professor Foster: It is enormous. One hears in the media frequently that accurate diagnoses and investigations are being long delayed, not because the individuals concerned are not working to the maximum but because there is a mismatch between the resource and their workload.
Ms Silverton: With respect, unfortunately it has been very badly managed. The six-point plan came in with a great trumpet fanfare and there were lots of things about continuing professional development for midwives. That ended totally at the end of 2005. There is now no funding for midwives' return to practice or for adaptation of overseas midwives who could gain entry to the register and who are far fewer than in nursing. The total number of midwives, which is the number that the NHS likes to use, has increased slightly. However, now 55% of midwives work part-time, whereas in 1997 the figure was 43%, so they are delivering fewer hours and fewer babies. The manifesto demands have not been looked at with respect to resource requirements. Given the increase in older mothers who need more midwifery care and the number of teenage mothers, I think the whole thing is a bit of a mess. We probably need to go back to the drawing board and have a look at what can be done to manage this. In about 2000 the Secretary of State said there would be 100 consultant midwives. As of 2005 there were 50, since which time there have been redundancies and an even further reduction in posts. I am afraid that payment by results does not help because the basis on which the costings have been made locally is flawed and it appears that all trusts want to do is reduce the number of midwives as much as possible. We have seen some very significant increases in the number of healthcare assistants. The college is much in favour of having appropriately prepared maternity care

assistants as part of the team, but our evidence is that they are being used to substitute for midwives. Birthrate Plus shows that for an average DGH you can substitute approximately 9% of midwifery time primarily in postnatal care, but you cannot substitute anywhere else without loss of quality of service.

Q937 Charlotte Atkins: Mr Gray, in your evidence you wanted to focus on heads of content as well as head count. Therefore, when you answer the question about your particular area perhaps you can also elaborate on that issue.
Mr Gray: I take a different view from Ms Silverton in that in terms of employed staff it has been managed very well and has been very successful. There is a different answer, to which I will return, when we come to the issue of how well the large number of unemployed graduates has been managed. Just looking at what has happened to the additional staff employed, it has worked tremendously well in terms of prevention and treatment, real innovation in the way services are delivered and the locality in which they are delivered. They are highly productive changes that have reduced waiting lists and improved the delivery of care. To quote just a couple of examples, for the past several years in physiotherapy there have been more and more places, but still not all—the Prime Minister did not say that about exactly the same issue a few years ago—on orthopaedic surgeons' waiting lists. That has resulted in something like a 70% reduction in their waiting lists which are the longest in the NHS. That is done by experienced specialist physiotherapists reviewing the whole of the waiting lists and directing up to 70% of the people on those lists either into physiotherapy or other forms of treatment and allowing the other 30%—people who are likely to benefit from surgery—to go forward. That saved a huge amount of time and money. As to the delivery of services for older people, there has been a significant expansion in relation to the national service framework that came out in 2003. We can always think of lots more things that can be done, but in terms of physiotherapists' contributions to enabling people to get out of hospitals and hospital beds reasonably quickly and restoring their ability to go back to their homes and normal lives, not ending up unnecessarily in nursing home care with the huge cost that that involves, they have played a big part in that. One of the recent developments is in patient self-referral systems, enabling patients as part of patient choice when they have an injury to refer themselves directly, instead of going to a GP, to a physiotherapy service. Referring to the *Health Service Journal* awards that took place only a few weeks ago, physiotherapy self-referral systems in Scotland got the prize for the best innovation in terms of access. There have been a lot of very significant changes, but there are gaps. One classic gap is the lack of joined-up government. A major issue about which the Government are concerned is how to reduce the number of people on incapacity benefit. How does one reduce the 680,000 people who go onto that benefit per year? One answer is to try to provide treatment for those people who are on incapacity benefit, but a much better one is to decide how to get rapid access to effective treatment. Patient self-referral systems do that. Unfortunately, although the Department for Work and Pensions and the Government overall want that the NHS is not investing in it. Joined-up government would help.

Q938 Dr Taylor: Before I go on to deal with training funding I just want to reassure Mr Gray that we are aware of a huge lobby of unemployed physiotherapists. Ms Silverton, in your evidence you said that perhaps there were some newly-qualified midwives who were not able to get jobs. Do you have any idea of the numbers? Is it a major problem?
Ms Silverton: That has become an increasing problem since September of last year. It is quite hard to find out. In Salford in 2005 35 midwives got posts. The University of Salford trains for a number of the Manchester hospitals. This year 12 have got posts and we understand that there are sufficient vacancies for all of them. As a proxy, in November and December of last year we had 350 fewer moving from student to core membership. That is indicative of the fact that it is a major problem. I think that we might have been much happier with the Government on how things had been done if, like the physiotherapists, we had had an increase. We called for 10,000 more midwives which would have been an increase of a third; we have had just under 5%.

Q939 Dr Taylor: To go back to training funding, in the deficits inquiry that we have just undertaken we were horrified to find how training budgets had been affected so severely. It relates particularly to non-medical rather than medical training. Turning to Professor Foster, obviously pathology includes medically trained doctors, clinical and biomedical scientists and other staff. Is the difference in the training funds available for the medically qualified and the others very obvious to you?
Professor Foster: I think that that depends on the individual specialty. Across the board we are short of funding, but the landscape has changed this year. Medical training was protected by the MPET levy but it is no longer, so we will not see the effects of that. In any case, we have faced a shortage of people wanting to come into pathology because within the undergraduate medical curriculum in the majority of schools pathology is no longer a core component. This comes back to my comment at the beginning. If there is no profile you are hardly likely to want to choose such an occupation for a future career. The answer to your question is that when you compare the scientists and medics the factors affecting recruitment are very different. The quality of non-clinical scientists and technicians who predominantly are now recruited from universities—so they are graduate entrants—is extremely high. The problem until recently, which I believe Sue Hill is trying to address, is that there has been a mismatch between the time to registration and its requirements and the funding available for registration so that numbers of the non-clinical

scientists would come in at the required four years but they would do three years. They would not get money for their final year before registration and would leave and go into industry, which would mean a huge drain on resources from the NHS. We estimate that it would amount to somewhere between £80,000 and £100,000 per person dropping out at that point. The funding has been there but it has not been structured correctly in terms of career structures, and that is being addressed. On the medical side, the problem is lack of profile so we are not recruiting because we have little or no presence across the board in the undergraduate medical curriculum.

Q940 Dr Naysmith: Professor Foster, one of the matters you referred to in your submission was the need for flexibility in the whole pathology workforce. How does that tie in with what you have just been talking about?
Professor Foster: As I said at the beginning, what we do in the college is to look across the three sectors—the medically trained, the non-clinical scientists and the technicians—and consider two questions. First, is there work being performed by one of those sectors that should be performed by another? We do not see that as being static but constantly in flux. Many things which only a few years ago would have been done only by medically trained persons for whatever reason have now been cascaded down and are being done perfectly competently by clinical scientists or those at a technical grade. I am not being pejorative when I use either of those terms. At the same time, we are looking towards core training so that within those training grades we will have medically trained young pathologists together with non-clinical scientists in training and biomedical scientists or technicians taking core components of their training simultaneously.

Q941 Dr Naysmith: What I am trying to get at is whether you ever come across a situation where you cannot implement new technology and the barrier to it is the lack of adequately trained staff?
Professor Foster: Yes, we are facing that. One of the current drives is for pathology modernisation. My committee on modernising pathology careers and blue skies horizon scanning for available technologies that can be introduced finds that we can bring in new technologies and train individuals only if we have time allocated in order that they should undergo education and take time away from delivering the service within all of the sectors of pathology. It is too tightly tied between the activities of the pathologist or scientist at the bench, microscope or wherever and the delivery of service and there is no slack whatever. Any slack that there might be is perceived to be non-economic. I believe that that view has to change, because to take in individuals, transfers skills and bring in new technology so there is constant evolution and education must be an investment for the future. We do not have that at the moment.

Q942 Dr Taylor: I think you said that the specialties within pathology were differently affected. If you take biochemistry as an example, is it right that there are very few medically qualified biochemists working now?
Professor Foster: Not entirely. This is very interesting. We go back to what I tried to say earlier about different roles. In many ways within the college it is probably inappropriate to keep people who are medically trained within the laboratory, unless they want to do that as a career, so that the clinical skills that they have gained are not used and developed for the management and care of patients. When we were at the Westminster together chemical pathology was, if you like, a fixed entity, but it has now changed. We now have specialties like clinical chemistry and metabolic medicine. There are those trained in the deep science and understanding of the chemical bases of diseases who are perfectly competent and who are beginning to manage patients and use those skills, devolving the strictly laboratory non-clinical skills to non-clinical scientists. That is a very good example of one of the matters to which I referred earlier.

Q943 Dr Taylor: You also said that the workload was going up by 13% per annum.
Professor Foster: We use 13% as a pretty good geometrical figure; in other words, the 13% next year is based on the 13% that has already occurred this year.

Q944 Dr Taylor: It would seem that as a result of a lot of technological changes the actual demands for staff, even though the workload is going up with increased automation, might even be going down?
Professor Foster: That is correct if you look at the groups. It depends on how you want the medically trained pathologists to interact, let us say. There is no doubt that within medicine pathology harbours a deep understanding of the science of medicine. Since pathology and science is no longer taught as part of the undergraduate curriculum pathologists are the only people who still retain that information. The motto of the college of pathologists is that it is the science that underpins healthcare. If one looks at how many medically trained staff one needs to run an increasingly automated service the answer is relatively few compared with the increase in workload, but one needs more scientists and technicians. On the other hand, if one looks at histopathology where one needs interpretation and a deep understanding of the clinical relevance of the observations one needs far more; one needs to keep expanding those.

Q945 Dr Taylor: Has the decline in the post-mortem rate had an effect on reducing the workload?
Professor Foster: Not so much in terms of the workload, because the surgical material that is coming in is going up enormously, but as far as concerns feeding hard data and information into medicine and management of patients and the critical evaluation of clinical procedures and how patients are managed, I think that we are in an

appalling situation. One of the most fundamental audits of the effectiveness of clinical services has just been cut away from underneath us.

Q946 Dr Taylor: So, post-mortems are no longer used for training medical students?
Professor Foster: No. I understand where your question comes from. I tried to answer the question at one level, but I believe that the deep implication which I have tried to explain when I talked about the science—you now ask about autopsy—is the fundamental understanding of disease. Our understanding is not static; it is not that which was present five, 10 or 15 years ago; it is evolving so that there are new types of management, sub-divisions of diseases and the development of biologically appropriate ways of treating or not treating patients. Malignant disease, cardiovascular disease and metabolic disease are all affected.

Q947 Dr Taylor: One of the witnesses mentioned payments by results. Should there be an element in the tariff for training? At the moment I believe that it is funded separately, is it not?
Ms Silverton: There should be, certainly with respect to continuing education for midwives. Last year's survey showed that 70% of midwives received fewer than two days' training each year, and 36% got time off but had to pay for and organise their own training. It has become far worse. A survey that we did just before Christmas showed that 40% of units had cut their training budgets, and in 20% of cases the cut was 100% and there was no training at all. Two of those units are doing some training using endowment and charity funds. We are not talking about having a nice day off; we are talking about mandatory training for midwives that affects lives. For example, if one thinks of the assessment of foetal heart rate and the practising of drills when things go wrong in labour wards, unless one practises them when something goes wrong one does not know what to do. For some of these things one has to do it once a year or twice a year, and they are being cut. What does that do for quality of patient care? There is a shortage of midwives. We want to introduce the midwife as the first point of contact. We want midwives to move from hospitals into midwife-led units. They are skilled and competent midwives but currently, to use an analogy, they are driving an automatic car. If one gives them a car with gears they need to learn how to drive it. They understand road sense but they have to feel confident about doing it. There is no backfill for them. How on earth will they deliver an agenda set by the Government, which we fully support, that puts women at the centre of care and planning it? I am now beginning to despair.

Q948 Dr Taylor: Is one answer to have payment by results and alter the tariff?
Ms Silverton: It needs a proportion for funding and training, in the same way as the Birthrate Plus tool kit.
Mr Gray: I add that there is a need to widen that because the government are looking at changes not only in the provision of services by current NHS providers but also by diverse other providers. We need to make sure that there are elements built into that and that the independent sector, which will be increasing in future, plays an active role both in commissioning and sharing responsibility for providing post-qualification training for others.

Q949 Dr Naysmith: We feel that we sorted that out, or at least contributed to it in our report.
Mr Gray: But we and AHPs have seen training budgets slashed. The answer to the earlier question is that there should not be two separate budgets for medics and non-medics; there should be a single one determined according to need. We cannot have a beggar-our-neighbour situation; if budgets are being slashed they hit everybody.

Q950 Mr Amess: We are coming to the end of this fabulous evidence session. In a way, it would have been interesting if our three witnesses could have shared the platform with our three previous witnesses, and even more so if we could get you back to share the platform with ministers at the end of the inquiry, but perhaps that may not be possible. Ms Silverton, you have delivered over 1,000 babies which is an incredible achievement.
Ms Silverton: For the benefit of the inquiry, I should say that most of them were in Scotland. As you can tell from my accent, I am a Scottish midwife.

Q951 Mr Amess: When you retire perhaps you will write a book on it. I am sure that, like *Dr Finlay's Casebook*, it would be interesting. You said that the bursary for midwifery students had been increased to £10,000. Can you explain to the Committee why? Can you also tell us whether you think that other healthcare students would benefit from bursaries? I am sure that they would. How important do you think these bursaries are in persuading people to enter the service?
Ms Silverton: It was two years ago that we launched our campaign for a bursary of £10,000. I am sure that we should be looking at increasing it now. It is a nice round figure, but one needs to look at the issue of a non-means-tested bursary. The profile of student midwives is quite different from many other groups that come into healthcare. The average age of students is 33 and 75% of them have dependents, so they have experienced childbirth themselves and then they come into midwifery. They struggle very hard on the bursary; they do not have university holidays; they are looking at six to eight weeks' holiday a year. It is very hard for them to work as well as be students. They are delivering service and are working shifts in hospitals and in the community and they are on call. Those with dependents have their own homes so they have to keep their homes running. The way that the bursary is currently calculated means that if their partners earn more than £13,000 or £14,000 a year they are regarded as contributing and often they find themselves on those salaries subsidising someone who receives £5,000 or £6,000 a year. There are very silly rules. Because of the nature of midwifery and there is not a maternity unit everywhere many find that for a period of their

training they move from their home unit to another one. If they choose to avail themselves of accommodation at the second unit that is not reimbursed; if they choose to drive each day it is. We find that midwives drive from Plymouth to Exeter and back each day and try to keep their families going. The peak time for midwives to drop out of training is towards the end of the second year. We have invested £30,000 in them and they have invested a lot of time, and for them often it is the straw that break's the camel's back.

Q952 Mr Amess: You are Scottish and probably for those reasons loans would be a big disincentive?
Ms Silverton: We would like to look at that. We would not rule it out. Perhaps a loan that is automatically repaid after a certain time if they have given service in the NHS might be a way round it. That would keep midwives working and contributing to the NHS, and it might galvanise the minds of those who commission training to try to sort out some continuing practice for them when they qualify. But they are a scarce resource. Most of the people who come into midwifery regard it as a second career; they have very good transferable skills. We have midwives with PhDs who come into midwifery because they want to look after women. It is a shame that they cannot get jobs, and we need to address it.

Q953 Mr Amess: I do not have a quote for Professor Foster to comment upon, but he should not regard it as a sleight because he certainly made his presence felt at the start of this session. I have a quote for Ms Silverton and Mr Gray. Ms Silverton, you spoke about skill mix changes in midwifery to combat budget pressures rather than as a way to improve care. What is your evidence for that?
Ms Silverton: The evidence is that the council of deans of the nursing and midwifery programmes have done extensive surveys on education commissions. The fact is that commission numbers have been reduced despite the forthcoming NSF and the requirement for more midwifery time, and hospital managers have said to us that they are cutting the number of 18-month student midwives simply to reduce the salary costs and are spending salaries on those who are directly delivering care. More worryingly, we find that where a healthcare assistant has been seconded to do three-year training—that is a well-known route into midwifery—there have been major problems in re-employing them once they have qualified because there is no money for that. Some of them have found themselves qualified as midwives but are still paid as maternity care assistants.

Q954 Mr Amess: I am not a QC, so I shall let you off with that answer. Mr Gray, you said there was no evidence that change in roles would reduce demand for existing staff overall. Does this mean that staff in new roles are creating another tier of care rather than replacing more expensive staff?
Mr Gray: No. We think that the very clear evidence is that physiotherapists are relatively inexpensive, are productive and clinically effective and deliver major changes in care. Within that, skill and grade mix matters. The problem is: what is happening with that? At the moment we think there is a danger that an almost inverted pyramid will appear with very few junior posts and many senior ones being created. One significant effect that emerges from it that the Committee may look at is the tendency towards lazy workforce planning. We have been very successful in demonstrating through research and elsewhere the effectiveness of this change in roles. The tendency of NHS trusts has been to seek senior physiotherapists rather than junior ones with a complete lack of connectedness. They have commissioned so many in previous years, but what are they doing about creating jobs for those juniors to enable them to become progressively the seniors of tomorrow? Instead, what has happened in physiotherapy—the comment by the chief executive of St Thomas' about the abandonment of workforce planning and leaving it to market forces raise more than one or two questions in my head—is that we have been drawing in from overseas increasingly large numbers of very able physiotherapists. Our survey showed that in 1999–2000 the state registration body registered 500; in 2005 that went up to 1,300, which was an increase of well over 200%. They were filling the gap which is demonstrated by that statistic. The qualified physiotherapy workforce between September 2003 and September 2005, according to the Department of Health's figures, increased by 2,000. The increase in student numbers over the same period was about 500. Where was the gap filled? It was done by drawing in people from overseas. When as part of that we are pulling in people from poor African countries—large numbers from Zimbabwe, South Africa, Zambia and Nigeria—with comparatively few physiotherapists to treat their needy populations to start with then lazy workforce planning and free market forces become a scandal, because on the other side this year we have 1,300 graduates who do not have jobs and next year we may have a larger number. We have another 200 graduates coming out in the first three months of 2007. I think it is crucial to plan that investment by the taxpayer properly and productively in the service instead of simply looking for short-term lazy solutions. Therefore, skill and grade mix really matters.

Q955 Dr Naysmith: My experience is that there are quite a lot of antipodean physiotherapists. How long do some of these overseas physiotherapists stay employed by the National Health Service? Do you have any figures?
Mr Gray: Yes.

Q956 Dr Naysmith: I suspect that it would be a relatively short period for Australians and New Zealanders.
Mr Gray: Australians, New Zealanders and some South Africans—not others—used to come here in sizeable numbers on holiday work permits. They would work primarily and substantially for agencies

doing temporary jobs. The recent figures we have seen show a falling off in that number. Since the Department of Health and the Home Office removed junior grade posts from the shortage list which enables people to get work permits there has been a reduction in those numbers, but the opportunity for people from overseas occupying senior posts is wide open and there are still very sizeable numbers of those. There is turnover, but our evidence is that very substantial numbers from other countries, including African ones, stay and do not go back home after a short time.

Dr Naysmith: I interrupted Mr Amess.

Mr Amess: I think you have made your case extremely well. I am sure that what you have just described will be seen in many other sectors.

Dr Naysmith: I thank all three of you for your contribution this morning. We have heard some very interesting statements and comments. We hope that our report will be published before Easter; if not, certainly very shortly after it. You will be able to read your contributions and our deliberations in that report.

Thursday 25 January 2007

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess	Mr Stewart Jackson
Charlotte Atkins	Dr Doug Naysmith
Mr Ronnie Campbell	Mike Penning
Jim Dowd	Dr Howard Stoate
Sandra Gidley	Dr Richard Taylor

Witnesses: **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, gave evidence.

Q957 Chairman: Good morning. Could I welcome you to what is now our eighth evidence session, we think our final evidence session, on our inquiry into workforce planning. I wonder if I could ask you, for the sake of the record, to introduce yourselves and the position that you hold.
Ms Chapman: Clare Chapman, the Director General of Workforce for the NHS.
Lord Hunt of Kings Heath: Lord Hunt. I have ministerial responsibility for workforce planning.
Mr Greenfield: Nic Greenfield. I am the director of education, regulation and pay and was the acting Director General of Workforce for the last eight months.

Q958 Chairman: Welcome, and welcome back, I think, in your case, Lord Hunt. You are back into the fold of the National Health Service as a Minister now. I am sorry you are in at the deep end. I know you have not been around for the vast majority of our inquiry. Nonetheless, I have no doubt you have been well briefed on what sessions we have had up-to-date. Can I begin by looking at the issue of the workforce since 1999? *The NHS Plan* and the major growth in the NHS budget led to what has been unprecedented workforce expansion between the years 2000 and 2005. Was the cost of the rapid expansion of the NHS workforce explicitly assessed at national or regional level?
Lord Hunt of Kings Heath: Could I, first of all, thank you, Chairman, for your warm welcome. I am looking forward to working with the Select Committee again. I think my last appearance was about four years ago when we discussed the issue of NICE, so some things do not change. Of course, the huge increase in staff that we have seen in the Health Service—over 300,000 more people now working in the Health Service—has been an absolute integral part of the implementation of *The NHS Plan*. Without it we would not have been able to develop services or reduce waiting times and all the other new developments that are taking place in the Health Service, so, clearly, that has to be seen as an integral part of the overall planning. I think, if the implication of your question is the extent to which workforce planning and actual planning and service planning are all integrated, my answer to you would be (and I am in my third week, so I am giving you a general view of how I think things have gone) that historically the NHS has found it very, very difficult to integrate those functions. I think, if you look back over 20, 30, 40 years, historically what has happened with the workforce is that there has been a see-saw effect: at times in history you have expanded training places, large numbers of staff coming in, the Health Service did not have the money to employ them, the tap was switched off and then you went from one situation to another. I have no doubt that the Select Committee will want to ask about some of the challenges that we face with the workforce at the moment, but the fact is that we are much better balanced than I believe the Health Service has ever been. We have addressed the issue of the large-scale shortages that were apparent in the NHS in the 1990s. Of course there are issues and challenges, and the whole point about workforce planning, the work that is going to be done, is being done at the department and also at the local level, is trying to make sure that we do match, as far as is possible, supply and demand of staff with the finance available and the service developments. I am not saying that we do not have some issues and problems at the moment, but I do think overall, compared with where we have been, we are in a much better position to deal with them.

Q959 Chairman: I do not dispute at all, I do not think anybody would, that the recruitment (a) was probably necessary and (b) did go ahead. What we really would like to question is in the *National Health Service Plan* there was a plan for job growth, if you like, or employment in different grades. I have got in front of me a comparison of targets growth in *The NHS Plan 2000* and the actual growth (and this is between 1999 and 2004) for consultants was actually under target in that particular year. The projected new staff was 7,500 and it was actually 7,329. All the others—GPs, nurses and allied heath professionals—were over recruited, GPs by over 100% more than what it said in *The NHS Plan,* Allied health professionals 69% over target and nursing 340% over target. If we had a national plan that said we want growth in National Health Service jobs at the level *The NHS Plan* did, who is responsible for these over-recruitments (for want of a better expression), certainly well above target, that did actually take place as opposed to what

we assume was planned to take place? Is it the responsibility of Richmond House, SHAs, foundation trusts, hospitals or PCTs? Where is the responsibility in meeting these targets on jobs and increasing staff.

Lord Hunt of Kings Heath: Chairman, clearly different parts of the system have different responsibilities. At a national level, ministerially I now have that responsibility. The team that you see before you is clearly responsible for strategic direction and overall leadership. Equally, a lot of these decisions have to be made at local level, and that is why we think that the role of the new Strategic Health Authorities is going to be so important in the future. They have to look at long-term trends, they have to work with individual trusts to see what the likely demands for future staff are. They then have to work with higher education institutes and they do have to take a long-term position. The job that the Department of Health has in relation to leadership is to monitor the work of the SHAs, making sure that it all adds up to coherence and that we do get the right number of staff in the right places. I would have to say, Chairman, that my experience again at the NHS is that, whilst you will never get an absolutely perfect match, what we are trying to do is to make sure it is as good as possible.

Q960 Chairman: Does not 340% over target on nursing suggest that some NHS organisations—I am not saying all—felt that this was really a blank cheque that they had been given in terms of recruiting? Would you say that was the case?

Lord Hunt of Kings Heath: In relation to the specific question, my understanding is that these targets were floors not ceilings, so in a sense they were setting a minimum level.

Q961 Chairman: Why bother then?

Lord Hunt of Kings Heath: We are learning, are we not, by experience, and what is happening is that the NHS is getting more and more information about staffing, about staff requirements. The aim of workforce planning, which I am determined to see is effected, is that we do get better and better at predicting the long-term requirements and then that we ensure that we are training the right number of people and that those people are then able to be used by the Health Service. It is not perfect, but it is getting a lot better, and I think that the new relationship that we are developing between the department and the Strategic Health Authorities will ensure that it will get better still in the future.

Ms Chapman: Can I make a point to illustrate that. Coming from outside, one of the first things I looked at was the vacancy rates, because if you have got high numbers of vacancy rates it always affects the amount of service that can be delivered to patients. On nurses it looks like around 2001 the vacancy rates were running about just over 3%, about 3.4% from recollection, and in the last set of numbers in 2006 that had come down to 0.9%.

Q962 Mike Penning: That is because you have cut the posts? You cannot do this comparison, because it is not factually correct. If you cut the posts, you do not have the vacancy rates.

Ms Chapman: I understand your point, although actually the key thing is the trend, and what that is actually showing to me is that there is work going on around recruitment to make sure that you have got posts filled to ensure the delivery of service, and that will be adjusted by SHAs dependent on their plan for the year.

Q963 Chairman: Does anybody else have anything to add on that?

Mr Greenfield: On the issue that you raise about the growth of posts, I think it is important to note that we do look at the costs of workforce as a routine part of the CSR process in order to get our resources for the next three-year cycle of government, we assess the costs of pay reform before we embark upon it, very clearly, and have done so, but we have grown the service significantly, as the Minister has explained, and the vacancies have reduced, the size of the workforce has increased significantly and the service to patients, above all, has increased markedly.

Q964 Chairman: I think the issue around the table is that we took evidence in and around these issues on other inquiries and found that different things were being said at different times. Could I just finish on my opening session. This issue about *The NHS Plan 2000*, there was nothing in it about productivity. You have quite rightly pointed out, Mr Greenfield, that you need to take into account costs and everything else, but in reality evidence that we have taken in other inquiries has shown that staff costs have been grossly underestimated and, as a consequence, have led to some of the problems that there are currently inside the National Health Service in terms of funding and problems with overspend. It is an extraordinary situation, I would have thought. First of all, *The NHS Plan* does not talk about productivity, and yet we have just allowed this situation to happen where I think 70% of current National Health Service costs are costs of employing people, and we have had all these overshoots in the three grades that I have told you, some quite dramatically. Clearly it has affected how the National Health Service is running and clearly it is likely to have affected the productivity of the National Health Service as well, or is that too crude a measure?

Lord Hunt of Kings Heath: First of all, productivity is important, no question about it, and, as you probably know, Chairman, the ONS have done various calculations in relation to productivity. I think, looking at the different calculations, one can say that the productivity figures are probably level rather than plus or minus anything dramatic. I would also say to you that my understanding is that the general trend in healthcare worldwide is actually a reduction in productivity, partly because of the cost of drugs and other of the features that tend to increase costs as the years go ahead, but we are, of

course, committed to increasing productivity. The contracts that you have referred to are very strong foundations, I believe, for increasing productivity in the future, because what they are doing essentially is tying rewards for staff with outcomes in terms of what patients get from the service. I would also say that the productive time targets that have been set for the NHS are reckoned to deliver about 2.7 billion per annum in efficiency savings by 2008. That is through reductions in length of stay, reductions in do not attend, reductions in agency spend, reductions in staff sickness, so that in fact the Health Service is doing a lot to improve its efficiency. We can do more. I think that the conditions are there to enable us to do it, but I am certainly not complacent about the issue of productivity.

Q965 Sandra Gidley: I want to challenge you on your assertion that because the drugs budget is rising that means productivity falls. The amount of money may be increasing but the proportion of the NHS pot that is spent on drugs has actually decreased; so how can you assert that that has had an impact on productivity?
Lord Hunt of Kings Heath: I am not a technical expert on how productivity is worked through, I confess. I was referring to other countries.

Q966 Sandra Gidley: You seemed to be extrapolating.
Lord Hunt of Kings Heath: No. I certainly would be prepared to let the Committee have further details of other countries where productivity has gone down. My understanding is the reason for that is in relation to drug costs; I am not at all complacent about the issue of productivity. Clearly, from the taxpayers' point of view, if you put a lot more money into the Health Service, you want something out of it. I think that looking at what has been achieved in the Health Service, in terms of better services, more access, reduced waiting times, we are getting a hell of a lot out of what has been put in. Can we do more in the future? Yes. What is one of the ways to do it? It is, in fact, to do what we are doing with staff: to reward them for the contribution they make, to give them greater skills, use the skills to better effect, and that is what we are seeking to do.

Q967 Mr Jackson: I can understand, Minister, that you want to look forward and not back, but if I can gently take you back to the Chairman's original question, which was about accountability, it seems to me what you have said is that you had a target with respect to workforce planning in *The NHS Plan* in 2000 which you took no notice of, effectively, and you did not have a target for productivity. If I can come back to Mr Greenfield's point about planning of costs, salaries, wages, there is a £540 million overspend on that, so I would not think that is something that one could necessarily put aside, but I would say, just on one example, Chairman, briefly, in terms of the use of resources, the BMA told us recently that there will be possibly 3,200 consultants for whom there will not be posts. If you look at the cumulative investment that the NHS has made in those consultant posts, that is an enormous waste of resources. Can I ask you to respond to that: why you had a target you took no notice of and yet in respect of productivity you had no target at all?
Lord Hunt of Kings Heath: My understanding in relation to workforce targets in *The NHS Plan*, as I have said earlier, is that those were floors rather than ceilings. In other words, it expressed the minimum that we wanted to get to. I would just refer you to the situation in 1997 and 1998 and the crisis that the NHS faced in terms of shortages of staff. We had to take quick and decisive action, and that has happened. As a result of that, we now have a huge number of extra staff in the Health Service. Of course there are always going to be issues about how you make sure that the supply of staff, by and large, matches the availability of jobs. Clearly that is part of our function in workforce planning. I am not complacent about that. Clearly, in your previous sessions you have met colleagues who have identified some of the issues that they are now facing, but what I would say to you is that the position of the Health Service now in relation to its workforce is hugely strengthened compared to the absolute difficulty of the situation when we had such shortages. What we have to do is to build on that. Of course we need to make sure that the number of staff we have, and those we want in the future, is matched with the amount of money that is available and with the service planning requirements, but that is not an easy task, that is a very complex task, particularly in the context of the Health Service, which is continually changing because science and technology is making huge changes in the potential Health Service and in the kind of service that needs to be operated. So there are lot of factors that have to be considered, but I would come back to you and say that we are in a much stronger position to deal with those issues than we were 10 years ago.

Q968 Dr Naysmith: First of all, Lord Hunt, may I say it is a pleasure to see you back in front of the Committee. You referred to the inquiry we did on NICE, and it was a good and interesting inquiry and we got some very good stuff out of it, not least by your concise and useful answers, so maybe we will have the same sort of thing this morning as well. In respect of what you have been talking about with Mr Jackson, nonetheless, despite what you say about the National Health Service now being in a strong position, because of recruitment levels and pay levels, which have both grown much more rapidly than planned, this is a major cause of current National Health Service deficits quite clearly—we can argue about the balance although it clearly is—and these deficits have led to redundancies, graduate unemployment and major cuts in funding for training. There is no other way of looking at this other than to say that it is a spectacular failure of NHS workforce planning, which we have been trying to do.
Lord Hunt of Kings Heath: I would argue with your words "spectacular failure". There is no question that the requirement on the NHS to eradicate deficits has led to NHS organisations having to

make some difficult decisions. However, this is tempered by the work that is being done to make sure that the impact on the staff and patient services is minimised. If you take, for instance, the issue of compulsory redundancies, no-one, and certainly not me, would ever take lightly anyone having to be made compulsorily redundant. From the figures I have got, which relate back to September last year, we reckon that 903 redundancies have occurred, 736 were non-clinical, 135 nurses and 11 doctors. As I have said, I could never take lightly any compulsory redundancies, but they are a relatively small number and clearly the NHS has done everything it can to ensure that they are minimised. As regards the employment of newly qualified staff, again there are issues. From the figures that I have got, overall we reckon just over 60% of newly qualified nurses have now found employment from the cohorts that came out last year.

Q969 Dr Naysmith: You are not saying that the workforce planning has worked, are you? It is a mess.

Lord Hunt of Kings Heath: It is not a mess. Clearly what has happened is that, because of the need to deal with the deficits, there have been some short-term decisions that have had to be made. What the Health Service is doing, and has been doing, is to ameliorate those issues as far as possible, to ensure that, for instance, where nurses are finding it difficult to find a job, they are given advice about where vacancies may be, but I see this as a very short-term issue. The more long-term proposition is that the NHS will have an ability to identify trends and issues where either you have got a shortage or you have a surplus of staff and is able to take action, and that, of course, is what is behind the work that is being done at the moment.

Q970 Dr Naysmith: We now seem to be moving into another phase where the NHS is contracting following its far too rapid expansion. How long do you expect the contraction phase to last?

Lord Hunt of Kings Heath: I would draw your conclusion that in terms of where there have been reductions in staff posts you have to put that in the context of over 300,000 extra staff now being employed in the Health Service. My own expectation is that the issues that we face this year are very much one-off issues, that we expect the NHS overall to come back into financial balance at the end of the financial year and that that will place the NHS in a much better footing for future years. Clearly changes are taking place in services all the time, there is redesign of services going on, reconfiguration proposals, which will always lead to changes in the number of staff that will be required in the integral parts of the NHS—that will never go away—but our requirement on the Health Service, particularly on Strategic Health Authorities, is to ensure that workforce planning does sit consistently with financial planning and service delivery, and that is what we will be aiming to do.

Q971 Dr Naysmith: I know we cannot blame it on you, because you were not there when all this was happening, and whether we call it a mess or not is a matter of judgment, but you are going to have to sort it out. What lessons can we learn from this boom and bust cycle that we are in now?

Lord Hunt of Kings Heath: The first thing to say to you is that what you describe as boom and bust is much less than traditional boom and bust in the Health Service. The scale of numbers of staff we are talking about, although, of course, significant for every individual concerned, is much smaller than some of the acute problems the Health Service has faced in the past.

Q972 Dr Naysmith: Are you saying it has grown faster than at some times in the past?

Lord Hunt of Kings Heath: No, I think if you look back in history, for instance, the early 1990s when there was a huge reduction in nursing training places that led to acute shortages, we are not in that position. We are in a much healthier position than that. The key lesson, and it is very much for Strategic Health Authorities and their local leadership, is that they have to pull in the three elements of workforce planning, finance and service delivery, to plan for the long-term, to make sure that the training commissions that they are now commissioning actually do fit in with the long-term plan of the health system. Those are the key lessons. It is the job of the department and myself to monitor the performance of SHAs to make sure that that happens.

Q973 Dr Naysmith: Ms Chapman wants to come in. I am sorry, I cut you off. I wanted to pursue that with the Minister.

Ms Chapman: I just wanted to respond to your point about both the workforce planning being a mess but also what are the lessons learned: because again, I think, coming from outside, whilst a three-week insight needs to be understood as being first impressions, I have worked for two world-class companies and there are some things that I noticed coming in. I managed to get into some hospitals before I started to work in December, and what I did see was that the way that they had managed to build up their services and build up their workforce actually showed that they were doing a number of things right. Any organisation that can build up its workforce by 300,000 in the period of time we are talking about shows that there is a lot of effort going into making sure that people match the aspiration of services, but I do think there are some lessons to learn when you compare what we are doing in the NHS to what goes on in world-class companies, and I think there are three things you have to get right. You absolutely have to get your forecast right. Any business that wants to get good availability on any supply chain, whether it is people or products, has to have a good forecast. I think that there is good forecasting going on on the base business, but when we change what services are being delivered I think

there is a faster way that the NHS could be responding to translating that into workforce demands.

Q974 Dr Naysmith: You are talking about a more flexible workforce, are you?
Ms Chapman: Indeed. If there are different services required, actually working through, through the SHAs, as the Minister described, what are the implications for the workforce needs to be done quickly and well, and I have seen some evidence of that being started with recent policy changes. The second thing you have to get right is flow. I think where workforce planning is a once-a-year activity, what you tend to get is too much central planning. Where you have got flow being created, because workforce planning is a dynamic process built into the management process, and this is where you will get the true link to productivity, I think that what we have got through the creation of the 10 SHAs is actually the forums to enable that bottom-up and top-down planning to come together as part of a management process with the appropriate finance data. The third thing you have got to get right is it has got to be simple. Because there are so many moving parts, the more complex it is the more opportunities there are for a supply chain to go wrong, and I think that what has been identified in the report commissioned by Lord Warner last year is that there are some things that we could do to simplify it, which I know is being worked on right now. I think there are genuinely some lessons to be learned, both internally and externally.
Lord Hunt of Kings Heath: Can I ask Mr Greenfield to come in?
Mr Greenfield: On the issue: has workforce planning been a spectacular failure, it is very easy to draw such a conclusion, wrongly, in my view, when we have the difficulty we have at the moment for those 903 people who have been made redundant compulsorily, which we would all wish to have avoided; but I think we have to go back to the late 1990s, early 2000s, when what we had were vacancies which were relatively high—4.7% vacancies in the medical profession in consultants in 2003—where, because of our wish to meet the growing aspirations of patients, we needed to expand the workforce rapidly, and we have invested in that. We have recruited internationally to meet those demands and we have reduced vacancies now for doctors to 1.8%, for nursing to around 1% from over 3%, so that has been hugely successful, and even the unfortunate 903 redundancies, which we seek daily to try to minimise and avoid, has to be borne in mind by the fact that we have around 2,500 people turnover each week in a workforce of over 1.3 million and an annual turnover of about 130,000. This is the third biggest workforce in the world.

Q975 Charlotte Atkins: Clearly, as Lord Hunt says, we do not want to see any redundancies in the workforce, and certainly the figures you have given give the lie to what has been in the press, but representing an area like North Staffordshire, where there has been a concentration of redundancies, the impact on that community, particularly if you are talking about nurses, who possibly trained knowing that they had a good opportunity of getting a local job, because nurses are not that flexible if they have got children, are married and their husband's cannot move jobs, they are not hugely well paid and, therefore, there is a big issue there. Clearly, if they have just qualified, should there not be some sort of guarantee of, say, a year's work within the NHS? Otherwise they are in a position (and many of them are looking at going to Australia and so on) of having not worked in the NHS and, therefore, they are not able to market themselves very effectively. I know that the ideal would be not to have those redundancies, but given what does happen in the NHS, given that it is such a big organisation, should we not at least guarantee some of sort of experience within the NHS so that we hold faith with our staff who have committed themselves to working in the NHS?
Lord Hunt of Kings Heath: I do very much understand the question, and, of course, I know that the rate of redundancies in the hospital you are talking about is higher than in many other hospitals, which I think reflects some of the longstanding challenges that the hospitals face.

Q976 Charlotte Atkins: And the poor management?
Lord Hunt of Kings Heath: Well, I hope now that we do have effective leadership in the trust. I am not convinced that a cast-iron guarantee is the right way forward. Another national target, I guess it would mean, in terms of instructions to the Health Service. I also think that, if you were actually to insist that an individual trust actually had to take on so many places, it would constrain them in the kind of decisions that they have to take. There are also issues about if you guarantee, say, one year, what happens to those people at the end of the year? So I think it is much better that we encourage the NHS to ensure that locally there is flexibility so that as many nurses as possible are employed: because, clearly, there is absolutely no point in training nurses to be nurses if they are then lost to the system. Indeed, one of the past problems of nurse training has been the high attrition rate during training or, indeed, at the end of it. We clearly want to reduce the attrition rate; we want to make sure that nurses who are suitably qualified are able to come into the NHS. We have obviously had this very short-term problem this year. What we are learning from that is that there is much that the NHS can do to try and ameliorate the problem. Some of them have developed joint appointments with the independent sector; others have offered part-time appointments and then an opportunity to work in the trust bank; so people are trying to find ways through. I accept what you say, that some nurses can only accept a job locally, but we do think that better career advice can be given to those newly qualified nurses if they are finding problems. There are still vacancies for newly qualified nurses throughout the country, and I think if we can give better career advice we ought to be able to, because some people can be encouraged perhaps to think of specialties that they had not thought

about. There are lot of lessons we can learn. I have been encouraged by the way NHS bodies are seeking to sort these issues out, but I am not convinced that simply having a quota, which is what I think would follow from that guarantee, is really the way forward.

Q977 Charlotte Atkins: You mentioned specialities there. Is it not the case that specialist nurses or advanced skills nurses, epilepsy nurses, cancer nurses, are in fact more likely to be at risk in terms of the workforce cuts than others? It is not just the newly qualified; it is actually the specialist nurses that are particularly vulnerable when a hospital is downsizing.

Lord Hunt of Kings Heath: I do not know if my colleagues have got figures on that and if they are available. I would be very disappointed if a specialist post of that sort were being unduly singled out in terms of decisions being made by an individual trust. Of course specialist nurses have an awful lot to offer in terms of the special skills that they can use and, indeed, looking at the way the NHS is going, our whole programme has been about encouraging nurses to develop their specialist skills, but I hope, if that is occurring, it is very much a one-off in relation to today's circumstances and that will not be a trend.

Q978 Charlotte Atkins: I am certainly aware of advanced skills nurses in North Staffordshire who have been made redundant?

Lord Hunt of Kings Heath: Can I ask Mr Greenfield to respond?

Mr Greenfield: I am not aware of the specific numbers or particular problems on specialist nurses. I will go and have a look at that and come back to the Committee in writing,[6] but I think the point worth making is that of the 903 redundancies, broadly 80% of them have been on non-clinical staff and only 135 around the country have been on nursing staff, including specialists; so it tends to be a very local decision depending on the configuration that is required for the service to be well-founded for the future. What I draw attention to is that you talk of a guarantee. What we are trying to do as a first step is to promote a much stronger partnership working between the higher education institutions which actually look after these students as they rotate from trust to trust, even in primary care, to do their training and to introduce them to improved opportunities, which may not be in the traditional teaching trust, where many of them, frankly, have always looked first because they get structured supervision, they feel more comfortable in that environment, but we have opportunities in the voluntary, independent and private sector who also employ significant nurses, we have significant vacancies and opportunities in social care, and so we are trying to look at those. David Nicholson, the Chief Executive of the NHS, wrote out at the tail end of last year to promote and require Strategic Health Authorities to look collaboratively at this responsibility, and we have been delighted with the response we have had from NHS employers, from the HEI institutions and also from the trade unions to try to work that through to come up with really practical solutions to solve these problems.

Q979 Dr Naysmith: On the question of specialised nurses, I know that in some parts of the country (and it has happened probably in Bristol) specialist nurses are being asked to fill vacancies on general wards and are not being funded to carry on with their specialised function. There is evidence for that. I think it has been mentioned here in one evidence session as well. It may not be the case that people are not funding specialised nursing posts, not cutting them, but they are being redeployed in other areas, and that is quite worrying.

Lord Hunt of Kings Heath: Can I repeat that we will do some more work on the information we have relating to specialist nurses and come back to the Committee. In terms of the future for specialised nurses, individual trusts are not going to achieve the kind of service change that we need to achieve if they do not use specialist nurses and their skills. If there are instances where this has happened, it is very much my hope that this was a very, very short-term decision in relation to the requirement to get rid of the deficits this financial year. I would be concerned if there were long-term trends in this area. It is, of course, a matter which I would expect Strategic Health Authorities to monitor in their own localities, but perhaps we can go back and see what information we have got on that.

Q980 Mike Penning: First of all, can I say for those of us who have listened to other evidence on this Committee on our deficits inquiry and have had problems with deficits in our own constituencies, and I certainly do not recognise the figures that have been given to this Committee today about redundancies and job losses in my own trust. The chief executives sat at the end of this table and told us there were 750 job losses, in one way or another, going to come from my own trust when they closed the hospital. Can I say to Lord Hunt, at the end of the day you are in charge of this. If you were a chief executive of one of the world renowned companies that your colleague worked for before and you trained a huge amount of staff, got them qualified, invested in those people and then for 40% of them you did not have a vacancy at the end of it, I think your head would be on the block because you would have just wasted a huge amount of your shareholders' money (in this case taxpayers' money) and broke the hearts of many dedicated health workers.

Lord Hunt of Kings Heath: On the 40% figure.

Q981 Mike Penning: I was going on your 60%.

Lord Hunt of Kings Heath: I would say to you that my understanding is that approximately, in a normal year, 85% of nurses qualify and would find jobs.

Q982 Mike Penning: We are not in a normal year, are we?

[6] Ev

Lord Hunt of Kings Heath: No, but—

Q983 Mike Penning: You said 60. That means 40% have not, and that money has been wasted and those people's careers have been affected?
Lord Hunt of Kings Heath: That is right, but I am trying to make a comparison between what might happen in years previously and the current year. The NHS is a huge organisation, 1.3 million people. Ensuring that everything fits together—

Q984 Mike Penning: It is your job.
Lord Hunt of Kings Heath: Absolutely.

Q985 Mike Penning: Or your predecessor's job, in your case.
Lord Hunt of Kings Heath: And it is a fantastic job and the NHS overall is getting much better at pulling these things together: training, jobs availability, resources, service, development, but we are talking here about a huge number of separate organisations. We are talking about a lot of individual people. We are talking about a lot of higher education institutions. So pulling all that together and then ensuring—

Q986 Mike Penning: It is your job.
Lord Hunt of Kings Heath: It is my job, and I am delighted to do it. What I am saying to you is that it is a very complex job. The Health Service is getting better at it. I am determined that we will get better in the future, but I think that, if I were to look back at our stewardship of the NHS over the last 10 years, my conclusion would be: what was the great problem of the NHS in 1997? It was that we had a huge shortage of staff. We no longer have that problem. So, in terms of the big macro picture, we have dealt with it. We are now dealing with the issue of trying to ensure that long-term planning meets service requirements. We are doing that, we will continue to improve, that is why we are developing our workforce capacity, but I would ask you to reflect on where we are now.

Q987 Mike Penning: I will say exactly the same to you as I said to the Secretary of State, and it is for the Chairman to stop me if he wishes, that this Committee does not go along party lines, it is not a party political broadcast as to what happened then and what is happening now, it is what is happening today. We are looking at workforce planning. You keep reverting back to 10 years ago.
Lord Hunt of Kings Heath: With respect, you did ask me to compare the NHS to a large organisation. What I am saying to you is that the big issue the Health Service has faced for many years was a chronic shortage of staff. We have overcome that, and I think that I would much rather be judged on that had we dealt with the mega problems the Health Service faced. I believe we have.
Mike Penning: 40% of nurses that are trained are not getting jobs.
Chairman: David, can we move on.

Q988 Mr Amess: Congratulations, Lord Hunt, on your reappointment and congratulations on overcoming the obstacle that you do not appear to be Scottish!
Lord Hunt of Kings Heath: I have a quarter Scottish in me.

Q989 Mr Amess: There we go. Just as an aside, it was ironic that you reminded us about the inquiry into the National Institute for Health and Clinical Excellence because, unlike my colleague Doug (but we are not going to fall out about it), we were making different remarks about that inquiry, but we will see what happens with the next inquiry. Whether or not the situation is a mess at the moment, the evidence that the Committee has heard, as far as I am concerned, is worrying. Of course, you and your officials will have read the evidence session last week when we had representatives from the midwives, the pathologists and the physiotherapists here. I did suggest how wonderful it would have been to have had a joint session with your good self and them together. It may be that these were three areas we plucked out who were having difficulties, but knowing those three professions, as I do, I am a little concerned. The final thing, before I get on to my questions, I do not know about my two colleagues, but I am not the least bit wounded by your veiled attack on the last Government in the last century. I would simply say that our inquiry is into workforce planning under the present Government and, as such, workforce development confederations were the main means of delivering the goals set out in *A Health Service of all the Talents*. Given that was the case, why were they disbanded after only three years, a change which was actually opposed by the department's workforce director?
Lord Hunt of Kings Heath: I do not know about that, but I do think that it made sense to pull workforce planning right back in the centrality of what leaders of health services are responsible for locally, and now that we have got the new structure of Strategic Health Authorities down to ten, 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 work planning issues. Should you off-shore it into a confederation or is it better to place responsibility and accountability on the SHA and the chief executive? I think it is much more sensible to place direct responsibility on the Strategic Health Authority. We have to ensure that they do the job properly; we have to ensure that they have the capacity; but to me it makes an awful lot of sense to pull it together with the SHA's role in finance and service delivery and planning. In a sense the question that I was asked by the Chairman at the beginning is: do we pull all these things together? I think the answer is that at the SHA level that is the place to do it. So I do not think we have anything to apologise for in making those changes.

Q990 Mr Amess: Thank you for your honest answer. I think Mr Greenfield is busting to shed some light on this.
Mr Greenfield: I was one of the WDC chief executives in the largest one in North Central London and, as the only member of the panel who was there at that time, I think that we have to look back and note that WDCs were a welcome addition to the structure because they brought a new and stronger focus on workforce, but the reality was that they were conceived a year or two before Strategic Health Authorities. Had the Strategic Health Authorities been in place when WDCs were formed, I would have strongly argued (and I know my colleagues would have done the same) that the right place for the workforce was not in a separate silo but was integrated strongly with service and financial planning, and it was that timing of the restructuring which did not enable that at the time. Most of the WDCs were harmoniously co-located or brought together with the SHAs, as indeed I did with mine in North Central London, and they were the stronger for it. I think the Minister's point about the integration of service, finance and workforce planning is the one that we must keep to the fore.

Q991 Mr Amess: So it was not a mistake disbanding them?
Mr Greenfield: I think when you use the word "disbanding" that tends to be a little bit misleading. What has happened with many of them is that they have been integrated into the new Strategic Health Authorities, and we are absolutely key that the SHAs are going to have a fundamental role around workforce strategic development.
Lord Hunt of Kings Heath: To put it very simply, the organisation has changed but the kind of skills that they develop, the experience of working with all these different bodies that have to sort out workforce planning at a local level, has not been lost, but having it clearly the responsibility of the chief executive of the SHA as one of their key priorities, it just makes much more sense to do it that way.

Q992 Mr Amess: So it would be wrong for us to take the view that in the closure of them, demonstrated by 2004, the NHS had badly lost sight of workforce planning priorities as set out in the year 2000? It would be wrong for us to draw that conclusion.
Lord Hunt of Kings Heath: Certainly I would not draw that conclusion. I think it is much better to put it in the mainstream management. The last thing we want, and we have seen this before, is you take a specialty function like HR workforce planning and you put it to one side as a kind of silo. This does not work unless it is right there in front of the chief executive as one of their key responsibilities.

Q993 Dr Stoate: Can I bring you back into the fold and wish you well with your very challenging brief. Looking back over the last few years since I have been in this House, I remember when, at the end of the 1990s, the BMA and others were saying that we were between five and 10 thousand GPs short of what we absolutely needed to provide a good service. The Government responded by increasing the number of registrars and now the BMA is saying, "Oh my goodness, there is an awful lot of possible unemployment amongst GPs." Similarly, we were 400 cardiac surgeons short, so the Government quite rightly upped the training for cardiac surgeons, and now the Royal College of Surgeons tell us that there are unemployed cardiac surgeons and the future looks pretty bleak for them. The question I want to ask is that the Government is open to the criticism that we are too caught up with short-termism and political expedience rather than taking the long-term view. How do you respond to that?
Lord Hunt of Kings Heath: I am very surprised that you could accuse the Government of that.

Q994 Dr Stoate: I did not accuse the Government, I said the Government was open to the charge of that.
Lord Hunt of Kings Heath: I think I need to get back to the House of Lords, Chairman! It is interesting, the comments of the BMA, which probably one would expect from the BMA but it does show one of the issues. Why workforce planning is not easy is simply the huge long lead-time and the years it takes to train a consultant. How do you ensure that we know today what kind of Health Service we need in 15, 20 years' time? Of course the answer is that we have some ideas but no-one here could predict, could they, the exact type of Health Service we are going to require in two generations time given the pace of medical science and technology. We can make assumptions and we have to have a system which keeps in touch with what is happening and can make adjustments, and that is what we have now got in place, but, with hand on heart, I cannot say to the Committee that I can guarantee for all time that the decisions we make now will ensure you have absolutely the right number of GPs or pathologists or midwives in 10 or 15 years' time. That cannot be done, no one could do it, but what we can do is try and get it as accurate as possible and that is what we are really seeking to do. That is why we are continuously getting figures from the Health Service about future trends so that, where you do identify either potential shortages or surpluses of staff, you do try and make adjustments as quickly as possible. The traditional NHS route has been to wait for the crisis to happen, then make the adjustment, the adjustment is too sharp and then you have an opposite reaction in another five or six years, and that is what we have got to stop. We are always going to have, there are always going to be, some discrepancies between people available and places, but what we have got to try and do is get those discrepancies as small as possible.

Q995 Dr Stoate: I appreciate that obviously, that predicting exact future workforce requirements is an impossible task, but just to go further in being devil's advocate, last week Sir Jonathan Michael, CEO of Guy's and St Thomas' NHS Foundation Trust, actually told us that we should not be going down this road of central planning at all, but we should leave it entirely for local organisations and in that it should be entirely led by the market. He put forward

what sounded a perfectly reasonable case for saying, "Let the market decide. Chief executives up and down the country will work out their own needs, will recruit according to need and the market will provide those needs". He made that case. Personally, I do not agree with that case, I think that is a recipe for very great difficulties, but I just wonder what you think about it.

Lord Hunt of Kings Heath: Well, I have got great respect for Sir Michael and he has done a great job, but I do not agree with him on this matter. I do not think you can simply have a free-for-all where I suppose you would depend on the universities to decide how many people they were prepared to train and then it would be up to each individual organisation to simply do the best they could. I do think that very rigid centralised planning is not appropriate. Actually, the NHS has tried that. Historically, it has tried it and it has not worked, so what you have got to do is to establish a national strategy with a lot of accurate information and then you have got to get ownership at local level, and that is why the role of the Strategic Health Authority working with the individual trust is so important. My job essentially is to make sure that Strategic Health Authorities do look at the long term, that they do not get into short-termist approaches, and to ensure, as far as possible in terms of, say, training commissions, that we do forecast as exactly as possible the numbers that are required. I do think of course you need to give individual trusts flexibility, and that is our problem with a guarantee, for instance, that every nurse who is qualified or physio could be guaranteed a 12-month job because I do not think it is right for us to sit in Whitehall and to determine that the individual trust has to do it, but I do think that, as part of the National Health Service where we want much more devolved authority, actually workforce planning is one of those bits of the architecture that sits in terms of national leadership and it is essential to carry on with that.

Q996 Mike Penning: Lord Hunt, we have seen evidence and we have been given evidence that planning is poorly integrated with financial planning and the service planning when it comes to workforce planning. Do you accept this criticism?

Lord Hunt of Kings Heath: I think there are clearly going to be instances where it has not been as good as it should have been. I believe that it is getting better and I hope, from what I have said this morning, that you will understand that I want to make sure that the three elements are pulled together as tightly as possible. That is what the Strategic Health Authorities are charged with doing.

Q997 Mike Penning: The NHS as a whole and the Department you are a Minister of are partly responsible for this poor planning?

Lord Hunt of Kings Heath: I do not think I accept your word "poor" planning. I think I said that there clearly may be instances where workforce planning, finance and services do not completely dovetail together.

Q998 Mike Penning: That is fascinating because in the Department's evidence on workforce planning and education planning, it actually says there that workforce planning lacks integration with finance planning, so your own Department's document agrees with me, not you.

Lord Hunt of Kings Heath: I am not sure that I read it that way. I think clearly we have identified that we need to do better and I am not running away from that at all. What I am really saying here is that workforce planning in the Health Service is in a hell of a better state than it has been before. Of course there are instances where it is not working as well as we would want it to work and we know that people have had to make some short-term decisions this year because of the financial deficit. That is not in question, but the—

Q999 Mike Penning: Let us help you a little bit, Minister. Would you agree that the Department of Health is equally to blame for failing to accurately predict the workforce planned expansion and the cost of it, especially when it comes to central negotiation of contracts? Are you going to take any blame in the Department at all for the contracts which were imposed on the trusts which has cost them so much money?

Lord Hunt of Kings Heath: Well, the Department clearly played a major role in the contracts and of course I accept responsibility for what the Department has done.

Q1000 Mike Penning: But the financial planning which has caused so many problems, especially for trusts which are having severe financial problems, these contracts were imposed, they did not negotiate them, but centrally they were imposed and that was not integrated into workforce planning.

Lord Hunt of Kings Heath: No, although, to be fair, NHS trusts, through NHS employers, also played a key role in the contract negotiation, so I do not think it would be fair to say that the NHS—

Q1001 Mike Penning: I did not say it was only them. I specifically said it was joint.

Lord Hunt of Kings Heath: In relation to the contracts, as the Committee knows, the costs of those contracts were underestimated and it is a factor in the financial deficits that trusts are facing at the moment, but I would also say to Mr Penning that the fundamental principle of the contracts is vitally important in ensuring that we reward staff in relation to the work that they do for patients. I do think they are a good foundation. They are subject to adjustment. We have seen, for instance, in the GP contract the adjustments that were made last year which have been very helpful in terms of what has been received for the money spent, but all of these contracts actually do give the NHS a much better prospect of realistic discussions with clinicians about the work they do and about ensuring that that work fits into service developments. Whatever the issues about the cost overruns, these contracts were a huge change and they are a much better foundation on working with doctors in the future, they really are.

Q1002 Mike Penning: I think everybody would agree that quality staff need quality pay and they need to get the benefits that they so rightly deserve, but, because of the cost overruns, that has had a huge knock-on effect on others within the workforce within the NHS which has caused problems with workforce planning and you have got the redundancies, et cetera, et cetera. All I was saying was surely, right at the start when this first came in, there should have been better integration and better work done centrally because at the end of the day the Department and the ministers are in charge of the NHS, that is what they are there for, so that we should not have got into this position in the first place?

Lord Hunt of Kings Heath: If you are saying, "Are there lessons to be learned from contract negotiations?", the answer is of course, but there are always likely to be lessons learned when you are bringing in a huge change in the way doctors in particular are contracted with the Health Service. Have we learnt those lessons? Are we seeking to develop the use of those contracts in a way which is positive for the Health Service? The answer is yes. For instance, if you take the consultant contracts, the job plans of the consultants are open to review on an annual basis and that is happening and the GP contracts are open to annual negotiations in relation to the quality requirements, so I believe the Health Service is learning, and we are learning, from what happened with the introduction that we will be getting more and more out of those contracts in the future.

Mr Greenfield: I think that the issue about lessons to be learned is absolutely fair and the consultant contract was the first contract that we negotiated. By the way, I did not recognise the figure of £540 million overspend.

Q1003 Mike Penning: Well, I did not use that.

Mr Greenfield: It was used earlier.

Q1004 Mike Penning: I think you will find it was my colleague next to me, but I am sure he will back it up afterwards.

Mr Greenfield: The figure, as I understand it, for the consultant contract was £90 million which is a very large figure, but, when we look at it, one 40th of 1% of the consultant pay bill is £4 billion. Our pay bill is £34 billion a year.[7]

Q1005 Mike Penning: You are into an argument I did not make, to be fair, Mr Greenfield. I did not make that argument with the Minister at all, so you are raising something which I did not even raise.

Mr Greenfield: The point I wanted to make about lessons learned is that we were acutely concerned that our forecasting of those costs was not as accurate as we could possibly make it, so we are working with the NAO to try to look to see if we can improve the modelling. We immediately fed back, we did not wait, we fed back immediately the lessons learned to have stronger piloting for Agenda for Change which was a much bigger pay deal, we piloted it thoroughly in 28 separate trusts and indeed we suspended the implementation of one of the elements which we are still working on because we were not sure of the costings, so the point I am making is that we do learn the lessons, we are committed to piloting and to improving our modelling and we are working with what we consider are experts to take that forward.

Mike Penning: You have done a very political thing there, you have answered a question I did not even ask. That is brilliant!

Chairman: It is not known for people to ask questions that they should not have asked as well, Mike, though I do not mean you particularly.

Q1006 Sandra Gidley: Now a change of tack to education and training. You will be aware that this year there have been cuts in the budget. In one submission we had, it said that the general range was 10 to 15% and in some cases large reductions of up to 30% are being proposed for some programmes. Does this reduction concern you at all?

Lord Hunt of Kings Heath: Well, you probably know that we gave SHAs more discretion in the use of their budget this year and that 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, so it is a fact of life that SHAs have had to deal with a very difficult situation. I think it was inevitable in that circumstance that training had to bear some of the cost of that, but I do not want to see that happen again. I do want to see SHAs highly committed to training and education in the future.

Q1007 Sandra Gidley: I do welcome your honesty and candour which is sometimes not something we see, but you said earlier that the Strategic Health Authorities should have some responsibility and take a long-term position and, as the Department, you obviously monitor the Strategic Health Authorities, but clearly, if you cut by 30% one year, you cannot then expect a school to suddenly find the staff to train again the next year. It places an almost impossible burden on the schools that have to plan as well. Is there any plan from the Department to try and smooth this out and ensure that these measures are a one-off? You say you would like to see it happen, but you cannot just devolve the responsibility, I do not feel.

Lord Hunt of Kings Heath: I think it is fair to say that the experience of SHAs differs, and you quoted a figure of about 10% which we think is about right overall. The second thing is yes, they have had to make very difficult decisions this year, but clearly my role and that of the Workforce Directorate is to

[7] The witness later contacted the Committee to clarify this information as 'only 1 quarter of 1% of the total pay bill of £36 billion a year'.

make sure that that does not happen again and that SHAs do have their minds on the long term. We will monitor that, I can assure you.

Q1008 Sandra Gidley: Why is education and training funded as a separate activity anyway and could not some form of training be funded in other ways, such as using a payment by results system?
Lord Hunt of Kings Heath: Well, it is interesting. I think historically the case for ring-fencing training and education was to make sure that the money was spent on training and education of course. On the other hand, it must make sense to devolve as much as possible to the NHS at the local level and that of course is why we allowed SHAs to have more discretion, and I intend to continue to allow SHAs to have discretion because I think they are well capable of making their own decisions. Our job is to monitor that to make sure that they do continue to invest appropriately in education and training, that they do plan for the long term and we all make sure that that happens, but, given the size of the job at SHA level in terms of the negotiation which has to take place between a lot of individual organisations and higher education institutions, I think it is much better that we do give them a greater deal of discretion, but then checking up that they use it appropriately. I think that is perhaps the developing role of the Department and its relationship to the NHS which is to give as much authority as possible, but having the ability to step in when you think decisions are being made which actually detract from an overarching national strategy on education and pay.

Q1009 Sandra Gidley: Nic, I get the impression that you want to say something.
Mr Greenfield: The issue of PBR is about what price you charge for things and particularly having a standard national price adjusted for the market forces factor in different communities to reflect their local cost of living primarily. The issue that we are looking at at the moment, or begun looking at, is whether the way we currently fund education and training is consistent with reform and that work is ongoing and we will be looking at it over months, but we have made some progress towards, for example, the introduction of a benchmark price in the last couple of years for all of our education, contracting with the higher education sector to take the issue of price out and to be fair to both the NHS and to the higher education sector, but the issue that the Minister makes quite rightly is that it is not so much about the price, it is about the volumes of activity and ensuring that they are consistent with our long-term workforce plan.

Q1010 Chairman: Evidence has been given to the Committee by the Chartered Society of Physiotherapy that, we have been told, last year 70% of graduates were unemployed. Obviously this is something which is not very tradeable in the marketplace if you have done a degree course in that. It was described to us as a "scandalous waste" of public money. What do you say to that?
Lord Hunt of Kings Heath: Well, I am concerned about the specific position of physiotherapists. They do a hugely valuable job and, speaking as if I had my former DWP hat on in terms of promoting health in the workplace, the role of physiotherapists in early intervention, preventing some people from having to go off work on incapacity benefit is absolutely critical, so I am concerned about the position of physiotherapists. There is to be a summit of NHS employers, my Department and professional staff organisations in a couple of weeks' time to see what more we can do to try and deal with these issues, but I can assure you that I do take this one very seriously and am doing everything I can to make sure that we deal with it because I think physiotherapists are absolutely vital to the future of the Health Service. Some of the things that we are looking at are seeing if more posts can be developed in community and primary care and looking at whether more temporary posts can be created. There is also the problem that there are a lot of basic-grade physiotherapists who are not applying for more senior posts where there may be vacancies and we will also be discussing whether we can have some accelerated programmes so that we can move these basic-grade physios on to more senior posts and then create vacancies, but it clearly is a big issue and we do want to tackle it.
Chairman: I think we would appreciate it if you could keep us in touch on that as a committee.

Q1011 Mr Campbell: I would like to welcome you to your post, Lord Hunt. I am sure that it is better than the last one you had in the Child Support Agency!
Lord Hunt of Kings Heath: I was hoping no one would mention that!

Q1012 Mr Campbell: In 2002, there was a full review of education and training. It was recommended that the three separate elements of the training budget should be integrated into one single budget. What happened to this? Did this just fall by the wayside?
Lord Hunt of Kings Heath: I think I am going to have to defer to Mr Greenfield to answer that.
Mr Greenfield: I believe what you are referring to in your comment about the budgets is that traditionally we have split the funding for undergraduate medical education, known as SIFT, the service increment for training, the medical postgraduate budget, known as MADEL, the medical and dental education levy, and also the budget for non-medical education and training which includes a budget for staff development. It is true that those were tightly ring-fenced and separate in the past. Since the 2002 arrangements, we have merged them so that there is now complete freedom from one to another, but still, in the way that we calculate the allocation to each SHA, we do base it on a bottom-up approach which takes account, for example, of the number of undergraduates and medics in medical school, dental school and planned commissions, so we use it to allocate the resource, but we do not restrict the way the resource is spent.

Q1013 Mr Campbell: Is it working better than the old system because there was a lot of criticism of the old system and that is why a lot of witnesses came forward, saying that it should have been put into three, so is it working properly? Is it working better than the last one?

Mr Greenfield: I think the freedom is certainly helping, but I think there is still a measure of inevitable inertia because a lot of the budgets for education and training are not funds which you can switch easily from one to another. For example, if you had a certain number of undergraduates in medical school, they are there for five or six years and you have to keep funding them and similarly with postgraduate medical education, so there is a large and overwhelming majority of all of those budgets which is committed and the room for flexibility is probably in the order of 5 to 10%.

Lord Hunt of Kings Heath: It must make more sense to give greater flexibility because we want SHAs and their constituent bodies to take on much more responsibility for ensuring that the workforce planning does indeed fit with finance and service priorities, so clearly the more flexibility we give to them, the better. Our job then is to make sure that it hangs together in terms of a national strategy.

Q1014 Dr Naysmith: The expectations are often that people will proceed along a track and once you start on a track, you carry on to the end, which might be becoming a heart surgeon or something like that. Do we not need much more flexibility both in the education system as well and in the way people are trained and also with the workforce being prepared to decide maybe, "We've got too many heart surgeons. I will have to switch to becoming a GP"? Building in the education a system of flexibility and the expectation in people who start off on long medical careers and other associated careers that they may have to change as well is vitally important for the future.

Lord Hunt of Kings Heath: I think that must be right and, as I was saying earlier, it would be very difficult today to say with certainty that in 20 years' time what are the medical specialties that we are going to need. When you think about some of the huge developments that we have seen, for instance, new drugs which come along, it may mean that certain procedures are no longer required. We do not know what that might be. What I think we have to do is ensure that professionals who are highly trained, highly skilled and experienced in taking difficult decisions, if that does happen, they are not suddenly left in a siding, that the Health Service is able to use their skills to the full, but develop them in other professions. It may be that Mr Greenfield might like to comment on how we are developing that professionally, but, as a matter of principle, you must be right.

Q1015 Dr Naysmith: It also means that you must interact with the education establishments so that they are flexible and provide part-time courses and in-work training courses to move into other areas, and there is not a lot of that at the moment.

Lord Hunt of Kings Heath: I think again Mr Greenfield will come on and speak, but he talked about inertia. I think you are right, the traditional approach might be, "How many places? Here's the money", and clearly part of the reason we want SHAs to take this as being one of their top priorities is to start to think through with the higher education institutions in their own patch how in fact you can develop a much more flexible workforce, how you can ensure that maybe the competencies people are developing are ones which can be used to change courses, if they have to be changed, but a much more sophisticated approach. Perhaps I could ask Mr Greenfield to comment.

Mr Greenfield: I think we recognised the concern that you have outlined which is about people progressing through one career and then finding there is no opportunity for them perhaps because of a technological change, such as is the case with cardiothoracic surgeons, and then having to come down a snake and climb a very long ladder. Our vision of the future for that is to move towards a workforce which is based on competencies rather than exclusively on professions, although we would still place very high regard on professions because those are fundamentally what people want to join, but we are working, for example, in the medical profession with the MMC, the Modernising Medical Careers Programme, and all of the royal colleges that represent the 58 different specialties in medicine to identify competencies at each stage of progress, so we will make the snakes a little bit shorter and enable people who are displaced or frankly want to make a change of career to move more quickly and easily into a different career. We are also working with Skills for Health to define the competencies for the whole workforce including non-medics.

Q1016 Dr Naysmith: When you say you are working on it, I hope that does not mean you are just thinking about it, but that things are actually happening.

Mr Greenfield: We have curricula which are being approved by PMETB at the moment to support Modernising Medical Careers, some have already been approved, for example, a GP curriculum, and I think most of those will have been approved this year.

Q1017 Mr Jackson: I want to try and focus on real-life experience in the next question. Given the financial stringency that the NHS will be under from 2008 and given the rather belated, I think, admission that there has been endemic failure of the system to co-ordinate properly financial and service planning with workforce planning, do you think it is wise to give Strategic Health Authorities, who have not got a good track record in education and training, such a big role in workforce planning for the future?

Lord Hunt of Kings Heath: Well, allow me, if I can, to pass over your words "endemic failure". I do not believe that is the position.

Q1018 Mr Jackson: Your own document, as Mr Penning pointed out, does very gently allude to the fact that, "The workforce planning lacks integration with financial planning and with service planning".
Lord Hunt of Kings Heath: I do not recognise the words "endemic failure" in that, but, coming to the substantive question you have asked, is it wise for us to give more authority to Strategic Health Authorities, and I cannot anticipate the next Comprehensive Spending Review, as you have done of course? The answer must be yes because, whatever the financial position of the NHS in the future, there are hugely difficult judgments to be made about how it should be spent, where services should be delivered, how they should be delivered and what are the staff required. Now, what is the alternative? The alternative is that at the centre we decide all this centrally. We decide on all the training places that are required and we simply issue edicts to the Health Service that they have to fit in with that. Having now spent my second term at the Department and my whole career in the Health Service, I just know 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. The way you do that is you actually give them as much discretion as possible, but then you monitor them against the national strategy, and that is what we are doing and I am convinced that is the way to do it.

Q1019 Mr Jackson: That would be a more convincing argument, Minister, had there not been this sort of Maoist cultural revolution of reorganisation that we have had over the last 10 years, establishing bodies, getting rid of them and putting them back. That is less convincing, given the situation we have had up to now, if I may say so. Can I move you on to a supplementary question—
Lord Hunt of Kings Heath: Can I answer that because it is a very important question which you have raised. It is always good to be called a Maoist and my branch Labour Party would be very surprised to hear that, I might say!

Q1020 Mr Jackson: So you are saying there has not been an enormous amount of organisational change in the Health Service since 1997? Is that your contention, Minister?
Lord Hunt of Kings Heath: The history of the Health Service since the 1970s has been one of a huge amount of structural change and, frankly, I think it would have been better over that whole period if we had had less structural change. Is the structure right now? I think it is because what we have got is a situation where we are encouraging practice-based commissioning, so we are giving GPs much more ability to determine the services on behalf of their patients, on Primary Care Trusts, I think 70% of Primary Care Trusts are now coterminous with the local authority area and that makes a lot of sense in terms of the interrelationship between health and social care and other issues, and on the Strategic Health Authorities, the 10 cover a region and, whilst those regions will not be totally self-sufficient, they are large enough with medical schools to actually ensure that you have got a total provision of health services for everyone living there, so I do think we have got the right structure and that is why I think the discretion we want to give to SHAs is also right.

Q1021 Mr Jackson: As you touched on medical schools, could I briefly just draw your attention, and you may have seen the evidence, to the evidence by Professor Sir Andrew Haines of Universities UK who said with respect to education money as it, "being at the mercy of the SHAs, where inevitably it is going to be sacrificed for short-term emergency spending". How do you react to that comment?
Lord Hunt of Kings Heath: I think it is wrong. SHAs know that working in close collaboration with medical schools is part of their strategic leadership role. We have made clear to them that we are going to monitor them in terms of their long-term planning. Long-term planning in relation to the workforce means a very close association and working relationship with universities and other higher education institutions. I think that is far too bleak an assessment and I do not believe it will happen. What we have seen this year has been a response to a difficult situation, but that will not continue in the future, and we will monitor SHAs against it.
Ms Chapman: You asked for a real-life discussion and it struck me that, when I went out to the West Midlands just before Christmas, what I did see was that a way of doing workforce planning and making very sensible decisions, linking it both to what the Service needed as well as affordability, was going on there. Is it wise to give that responsibility devolved down? From that example, it suggests to me that there are places where we can define what good looks like around the work that happens at both the SHA and the trust level. Do I think that we have got that level of standard across the Service? Again first impressions would be no, but my sense is that it is not a will gap. There are a lot of trusts that actually want to get better at this and it is more of a skill gap than a will gap. As the Minister said, given the structures that we have now got, I think it is beholden on us to focus on building skills to do this rather than reorganising because I do not think the reorganising will solve that problem, but I do think there are examples of what good looks like.

Q1022 Mr Jackson: Are there people on those boards who are tasked with making sure that education and training is protected because the drive now is towards financial issues and financial imperatives?
Ms Chapman: Sure.

Q1023 Mr Jackson: That is my concern.
Ms Chapman: What I saw on that board was them making a decision that linked their training money to their workforce plans, so they were being data-driven and informed by the numbers of people that needed to come out of it as opposed to, "Oh, there's a budget. Let's use that to plug any gaps". It was a very sensible discussion and a very informed set of decisions that they took.

Lord Hunt of Kings Heath: Just on the issue of accountability, clearly the chief executive of the Strategic Health Authority is accountable to the board for making sure that this is done in the appropriate way and they will be held accountable.

Q1024 Dr Taylor: Lord Hunt, it is good to see you here, although I am very sorry you are no longer battling with the CSA.
Lord Hunt of Kings Heath: I am not sure I am!
Jim Dowd: Nobody will be soon because it is going!

Q1025 Dr Taylor: This is really just to put a little detail on the previous question because we heard right at the beginning of this inquiry way back in May from Judy Curson, the Head of the NHS Workforce Review Team, that there was very grave concern about the lack of workforce planning skills and that one would probably lose them with the mergers down to smaller numbers of SHAs. Can we be assured that all 10 new SHAs do have a director of workforce at board level?
Lord Hunt of Kings Heath: I do not know the specifics. Do you know the answer to that?
Mr Greenfield: I can tell you that the arrangement that we have agreed with the SHAs is to define that workforce is a key responsibility which must have a nominated lead at board level. In some cases, it is a dedicated director of workforce and in other cases it is merged, for example, as a director of workforce and nursing, but we are well networked to them all. I can also confirm that not all appointments have yet been made because these are infant organisations. Indeed, there is an appointment process later this week for one of those key posts and five strong candidates.
Lord Hunt of Kings Heath: Perhaps I can say that my answer to Mr Jackson is that the person we will hold accountable has to be the chief executive. Perhaps I could ask Clare Chapman to comment because one of her roles is to increase, and develop, capacity in the general HR workforce function.
Ms Chapman: I met with the workforce directors of the SHAs last week and it was very clear that there was a call from them to make sure that, rather than having 10 different approaches, we actually codify what good looks like and then do some skill-building around it. Otherwise, what is going to happen is that it is going to take quite a long time to learn the lessons of how to do it well. Partly I think it is, "Let us get the right people in", and, as Mr Greenfield mentioned, participating in the appointment process tomorrow for one of those roles, and I think the main aim would be to get the right people in those roles and then make sure that we do the appropriate monitoring.

Q1026 Dr Taylor: Can I expand on the difficulties faced by SHAs a little bit. Lord Hunt, you have said workforce, financial and service-delivery planning have got to be combined and you, Ms Chapman, have said that the forecasts must be right. Even though Lord Hunt does not want to micro-manage centrally, there have been an awful lot of changes demanded centrally, particularly if you are thinking of sudden edicts to have independent sector treatment centres that perhaps are not needed, but do these changes demanded centrally not make these forecasts almost impossible?
Lord Hunt of Kings Heath: No, and on the issue of ISTCs, I think it is absolutely right, first of all, that they were developed to increase capacity and then it is also right that we do encourage innovation and that no one should feel complacent in the NHS because they do need to feel that there is contestability. Are there implications for the independent sector providers in relation to workforce planning? The answer is yes. You will probably be aware that, in relation to the treatment centres, there are certain restrictions based on the staff that those ISTCs should recruit. Longer term, do we need to take account of the independent sector in relation to workforce planning? I think the answer must be yes and indeed, if we have more pluralistic provision of services and, incidentally, of course not just health services, but social care services too, in the social care field there is clearly a huge proportion of people employed by independent statutory agencies, clearly we need to have that in mind and we need to have a strong relationship with those providers to make sure that at the end of the day we are producing enough people.

Q1027 Dr Taylor: I think some of the complaints we have heard have been where independent sector treatment centres have not, if you have really examined NHS capacity, actually been needed and, therefore, this does take work away from the NHS workforce who could have done it, and this is going to affect staffing levels.
Lord Hunt of Kings Heath: Clearly those are considerations that have to be taken into account in the development of the programme, but I think, as I have said earlier, that there are two things here. One is increased capacity and we have needed to increase capacity, but also we should encourage new people to come in to provide services; that is how you get innovation. We do have to acknowledge complacency amongst NHS organisations, so I think of course there may be some tensions over staffing, but we have done our best to make sure that in the first tranche there would be no impact and I think in the second tranche it is to make sure that you protect the shortage specialties, so we are trying to do that in a way which has less impact on the staffing issue.

Q1028 Mr Amess: Anne Rainsberry, the Director of People and Organisation Development at NHS London, as a representative of Strategic Health Authorities, expressed frustration that they are financially accountable for postgraduate medical training, but have no influence over the number of trainees or the content of training. Would you answer that charge please in 50 words?
Lord Hunt of Kings Heath: I cannot answer on the actual details, but I am happy to write to the Committee on it. As a general point, part of the deal really with SHAs is, "We are placing a lot of responsibility on to you and we expect you to sort

out some of these very difficult issues. The other side of the coin is that you then play an integral part in the decisions we make at national level in relation to workforce planning issues", and that is how we want it to work in the future.

Mr Greenfield: The content of the postgraduate medical curriculum is the statutory responsibility of the PMETB, the Postgraduate Medical Education Training Board, which is independent, but has responsibility to take account of affordability and employers' views, and they could be fed into that. On numbers, part of the workforce planning process, which we do engage SHAs in, is to determine the number of posts for postgraduate medical students, so I would not accept what she has said without clarifying it.

Lord Hunt of Kings Heath: Perhaps we might just follow this up with a written response.[8]

Mr Amess: If you could, please.

Q1029 Mr Campbell: Recently you conducted a full workforce planning inquiry of all the aspects of workforce. What were the changes and what was the outcome of that?

Lord Hunt of Kings Heath: I think that this is the review by Lord Warner.

Q1030 Mr Campbell: Yes.

Lord Hunt of Kings Heath: I think that one of the principal conclusions is what we have been talking about in the Committee today, that, to make workforce planning as successful as possible, we have to make sure that—

Q1031 Mr Campbell: If I can give you some of the big issues which have just been mentioned before, they were integration between the workforce and the service planning, the lack of clinical engagement with the workforce, the education and training investment "blighted" by short-term financial considerations, that sort of thing, and that is the sort of thing obviously we are looking at and that really is the whole gamut.

Lord Hunt of Kings Heath: You have described my agenda for the future. Those are the very issues which we have been debating. We have learnt a lot of lessons—

Q1032 Mr Campbell: But Lord Warner has not come up with anything? He has looked at it, but he has not come up with anything?

Lord Hunt of Kings Heath: No, I do not think that is fair at all to my esteemed predecessor who might have been before you today, but for his decision to retire. He set in train this review. It has brought forward those conclusions. Our job, the people here, is to make sure that we get on and ensure that the Health Service is able to meet them. Clearly, the discussions that we are having with the Strategic Health Authorities, this is all designed to make sure that we do achieve what the outcome of the review suggested.

[8] Ev

Q1033 Mr Campbell: So Lord Warner's inquiry still continues? Basically, that is what you are saying.

Lord Hunt of Kings Heath: Basically, the outcome of his inquiry is setting the agenda for our work at the moment, yes.

Q1034 Mr Campbell: And will this Committee have an input into that?

Lord Hunt of Kings Heath: We would be very interested and obviously the conclusions of the Select Committee will be considered very carefully. It is not as if we have got a hard-and-fast, "We have had the review, that's it". Workforce planning is an ongoing process and we will certainly take account of everything the Committee says of course.

Q1035 Mr Amess: That was, by the way, the killer question, so we are going to look very carefully at your answer to that particular question now you have answered it! We had an interesting debate this week in the House about MRSA where an awful lot was said about the productivity of the NHS workforce. Do you think it should be a key priority, given the current NHS financial position, the productivity of the NHS workforce?

Lord Hunt of Kings Heath: You mean improving productivity?

Q1036 Mr Amess: Yes.

Lord Hunt of Kings Heath: Yes, absolutely. I think, as I have said, that the changes to the contract, Agenda for Change as well as the doctor contracts put us in a much better position to improve productivity. There is clearly a real challenge for the leadership of NHS organisations to chase down productivity. I think that the work which has been done on productive time shows great promise, but we need to do much more than that. Again I would say that one of my priorities and that of Clare Chapman and the Chief Executive is to enhance leadership skills within the NHS in order to engage with clinicians and to make productivity improvements, so it is absolutely the right thing to do and we are going to do it.

Q1037 Mr Amess: So the work that you have in place, the measurement of productivity, will actually be clearer now that you will measure productivity?

Lord Hunt of Kings Heath: Again I think earlier I promised to write to the Committee in terms of our assessment on productivity because of the rather technical nature of how we describe it, but absolutely, and I think the Secretary of State has made it clear that we want to see improvements in productivity. I do think that the work on productive time does show that we are getting there. I have no question at all, in terms of the big challenges that the Health Service faces in the future, that we have to drive up and we have to have more productive working. We have to go for it, yes.

Q1038 Dr Naysmith: Dame Carol Black told us that the National Health Service tends to put extra resources into performing more activity rather than thinking it through and thinking about how these

activities can be performed more efficiently. Do you agree with that and do you think we can break the deadlock if you do? How would you see about doing that?

Lord Hunt of Kings Heath: I cannot pretend to be an expert in clinical procedures, but, if one is looking at where we want the Health Service to go, it is to take a much more integrationist approach. We talked earlier about physiotherapists and it is certainly my belief that the more physiotherapists and the earlier that the physiotherapists can treat the patients, the more likely it is that they can get better without having heavy interventionist work. Now, I think there are any number of examples where, in an holistic approach to patient care, you do try to intervene as early as possible rather than simply being concerned about the number of operations you do, and it is exactly where we want to be.

Q1039 Dr Naysmith: I can think of just one situation which I know quite well and it is to do with stroke. It is quite clear, and there is lots of evidence to suggest, that, apart from the necessity to get stroke patients scanned to decide what sort of stroke they have had, once we have got to the stage where that is happening routinely, there is a lot of evidence to show that the sooner you get physiotherapy and other things like speech therapy and so on involved, it makes a huge difference to the outcome. Clearly, if we can do that efficiently everywhere in the country, which we do not have to do at the moment, that will save a heck of a lot of money in terms of aftercare and so on for stroke patients.

Lord Hunt of Kings Heath: You have described also the issue with people on incapacity benefit.

Q1040 Dr Naysmith: Yes, it is exactly the same.

Lord Hunt of Kings Heath: For far too long people get on to IB and, once they are on it, often very many people stay on it for years, yet, if you could have got early intervention right from the start, you would have prevented them getting on incapacity benefit in the first place. We know the life and health outcomes of people on IB are very, very poor, so it is a no-brainer really, and the more we can get upfront investment as early as possible, the better. That is why, if I may go back to the issue of physiotherapists, I am concerned about the position and why clearly we need to do everything we can to try and resolve it. I think there are other examples where early intervention helps. Of course NICE, in some of the guidelines that they have been producing, give very good guidance to the Health Service in that regard and I would expect NICE to continue to do that.

Q1041 Dr Naysmith: It also relates to what we were talking about earlier about needing a flexible workforce and being able to build in this ability to change as needs change.

Lord Hunt of Kings Heath: Yes, and I think in Agenda for Change, for instance, on which almost all the non-medical and dental staff have now been assimilated, is an approach which actually encourages that by measuring the job evaluation process. It does allow you to reward people for the skills that they bring and it does allow you to encourage and incentivise people to develop their skills into the kind of flexibility that you want if you are going to get the kind of change in service provision which you have suggested.

Q1042 Dr Naysmith: So is changing the culture a priority in the National Health Service then? Everything cannot be a priority, I know that.

Lord Hunt of Kings Heath: Everything is a priority, but, thinking about the scale of the challenge, let us pay tribute to the staff of the NHS; they have done a hell of a lot in the last few years and we have seen a lot of improvements. We now have to kind of step up a bit because, if we are going to meet the real challenges, the demographic challenges of the future, more monies come in, but we have be smarter at the way we do things. That means a change in culture. The job of those of us responsible for workforce planning is to take these incredibly committed and skilled people and give them every opportunity to enhance their skills, develop their skills and use them to the fullest. That of course is about a change in culture, but I think that we also need to give our leadership at the local level every support and encouragement to lead that process. That is why, 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

Ms Chapman: If what you are striving after is efficiency, then I think that flexibility that you talked about is important. I am absolutely sure though that the other piece is about engaging staff because inevitably the people who know how to redesign it so that it is most efficient are the staff themselves. What I saw before Christmas, going round a cancer unit that had just been redesigned by the staff, was that both the physical layout as well as the way the treatment was being delivered was more satisfying to work in because people actually felt they were wasting less time, it was far more effective for the patients because they were not waiting around so much and overall, when you looked at the productivity of the whole unit, it was improving, so, as part of the leadership challenge and, as you mentioned, Minister, the culture, I am completely sure that engaging staff to find those efficiencies is absolutely the right way to get at them fast.

Q1043 Dr Taylor: I am very glad you have said that; it is absolutely crucial. I really want to go on with flexibility a little bit. We have heard a lot about the advantages, but what are the disadvantages of flexibility? Are there any?

Lord Hunt of Kings Heath: Do you mean in terms of individual members of staff or of the Health Service?

Q1044 Dr Taylor: In terms of the ability of staff gaining competencies in other things and doing other things.

Ms Chapman: I have a general point to make on that and that is that my experience is that one of the big satisfiers at work is the opportunity to get on, so

often flexibility is one of the ways that you make sure that you provide that ongoing challenge for people in the workforce. I think that where flexibility can be combined with a career ladder so that it is genuinely an opportunity to get on, then it is positive. Where it can be negative is where you actually get a dilution of skills or your get confused roles and that is where I think it requires very careful working through because what you do not want is everyone doing everyone else's job because (a) that is not satisfying, and (b) it is not productive. What you also do not want is people doing roles that they are not prepared for. I think flexibility has to come with quite thoughtful work around both of those areas.

Lord Hunt of Kings Heath: Of course paramount must be patient safety in that sense. The issue about people doing jobs for which they actually do not have the competency is a very important factor here.

Q1045 Dr Taylor: So, as a way to promotion, I would agree, that is absolutely brilliant to look at it like that. One of our witnesses previously pointed to some disadvantages and said that, ". . . 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".

Lord Hunt of Kings Heath: Well, I am not sure that we have evidence of that. I will certainly find out whether there are some indications, but I suppose in a sense nurses, when they are given greater clinical discretion, tend to work under protocols and my understanding is that nurses work very well within those protocols, so I am surprised by that and I am not sure that that is borne out in practice, but I will see whether the Department has any information about that.

Q1046 Dr Taylor: I think the only illustration I can give of that is if nurses are doing screening clinics, then they would have a whole battery of investigations that perhaps, if it was done by a doctor, they would reduce the list. That has been suggested.

Mr Greenfield: I think that the evidence we have of the different application of skill mix at the moment is very patchy. One of the streams of work that we have identified the need for within our productivity agenda is actually to look at the 100 or more new roles that we have introduced and 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. Where, frankly, we have an overwhelming business case, a good example is the emergency care practitioner which has enabled us to reduce pressure on primary care, convert the ambulance service from what many people perceive as a patient transport service to actually a front line of first-contact healthcare; that would be a strong case. However, in some of our other new roles, the case is not well understood, not well made and it is that sort of evaluation that we need to do, to assess the business case and then promote it through the SHAs so that the commissioning reflects what is proven.

Q1047 Dr Taylor: Yes, emergency care practitioners, we have had a lot of evidence to say how effective and accepted they are. Turning to healthcare assistants, increased training for them towards promotion is absolutely crucial, yet these appear to be one of the groups that are hit worst by the cuts in the training budgets. This is why I was so pleased to hear you, Lord Hunt, say that these cuts were one-off cuts because your predecessor at a previous session implied that this was going to go on for some time.

Lord Hunt of Kings Heath: Let me just comment on that. Of course the SHAs have to make their own decisions within the framework that I have already suggested. I cannot say that an SHA in the future will not make some reductions in some training places because clearly they have to make their own judgments. What I am saying is that, as a broad response, we have had to deal with a very, very difficult situation this year in terms of financial deficits and that has meant that SHAs have had to make some very difficult decisions. We expect SHAs to get back on an even keel and that short-termist decisions in relation to training, et cetera, will not have to be made. What I agree with you about healthcare assistants is that they do a fantastic job and also there has been great success in helping healthcare assistants, who have a lot of experience, in training to be professional nurses, and clearly we would not want to inhibit that. I can assure you that one of the key planks that we will be monitoring SHAs on in the future is their ability to be able to progress those staff. I cannot say to you that there will not be any changes in the future in terms of number of healthcare assistant places for nurse training, but I can say to you that I have always considered that healthcare assistants know what being in the Health Service is like and they have all that experience of working with patients, so they are ideal people to then, for those who wish to, encourage to become nurses.

Q1048 Dr Taylor: So you will feel able to put some pressure on SHAs to protect those sorts of training posts?

Lord Hunt of Kings Heath: I have no problem at all about putting pressure on SHAs and, if anything, ministers have to be very cautious about that. What I have said is that I want to give them as much discretion as possible because I think ultimately that is the only way you get the harmony between money, services and staff, but their commitment to long-term workforce planning, including encouragement of existing staff to go in for training, particularly in relation to healthcare assistants, is one of the important indicators that we will monitor them on.

Q1049 Dr Taylor: Can I just come back to another example of flexibility downwards, which has been mentioned already, and this is where we come back to the specialist nurses. What is going to be so

difficult for you in giving us more information about this is to discover which specialist nurses are being actually employed part-time and doing ordinary nursing duties. So we really would like this information but it is going to be very difficult to get, and we do not just need the numbers that have been made redundant because redundancies are a very small proportion of the staff reductions because most of the reductions are vacancies that have been frozen where people have left, so when you do look at specialist nurses somehow we want you to cover all those groups of staff reductions.
Lord Hunt of Kings Heath: We will do the best we can to get the information that is available. Again, I say I do not think that it will be in the long-term interest of individual organisations to impact on the ability of specialist nurses to do the job. In terms of the future and in terms of our debate about the need to be able to change the services to meet new circumstances, they are just the sort of people that we need to encourage.

Q1050 Dr Taylor: But I am sure we have all got anecdotes that for part of their time they have been shoved on to a ward to do the basic nursing.
Mr Greenfield: It is perhaps worth also pointing out that historically our access to that level of detail of information of the workforce of 1.3 million has been very patchy and the bureaucracy of actually obtaining such information is significant. However what we are doing at the moment is rolling out a new electronic staff record system. We have it in place now for over 505,000 staff, almost 300 separate organisations, and by the end of this month we hope to have it out to over 600,000 staff, and it will be fully rolled out by April 2008. The level of detail within that system will help local management to actually identify the skill-sets that it has and we would hope support their more effective and efficient use and it will also enable us to access details of the current workforce from a central data warehouse which will improve quite significantly the information and the timeliness with which we can provide it.

Q1051 Dr Taylor: This is more up to schedule than the whole of the NHS IT system?
Mr Greenfield: This is a separate programme which is on target and on budget.
Dr Taylor: Brilliant.

Q1052 Charlotte Atkins: The NHS plans to move 5% of hospital activity into primary care and increasingly the Government wants to ensure that healthcare is delivered locally, but we have heard from the Council of Nursing Deans that this move is very much undermined by both lack of funding and career pathways within the primary care sector. What would your comment be on that?
Lord Hunt of Kings Heath: I am disappointed to hear that because clearly we are committed and we are going to make sure that primary care does more work in the future, it can do more work in the future, and indeed I would argue that the GP contract is one of the foundations for ensuring that that happens. I am not aware of problems in relation to career—I assume this is for nurses in primary care—

Q1053 Charlotte Atkins: Absolutely, we are talking about nursing deans here, yes.
Lord Hunt of Kings Heath: Certainly it is something that I would be very happy to look into.

Q1054 Charlotte Atkins: I hope you will because certainly the impression I get and indeed those of who campaign hard about our Primary Care Trusts do see that within the primary care structure there is not a great career path for nurses or indeed for other staff. Yes of course you have the GP contract, but primary care is more than just about GPs and clearly there is a whole range of professions and allied occupations which are crucial within primary care which do not seem to get the recognition that they do in hospitals. It is very much again hospitals being the tail that wags the dog.
Lord Hunt of Kings Heath: The reason I mentioned the GP contract is because of the way it rewards GPs for their patient performance and use of nurses can be very much an integral part of that. We all know I think from personal experience just how much more is done in the primary care setting by nurses. I also think that the development of people like community matrons and other specialties is an indication of what can be done, so it is disappointing to hear if nurses in primary care feel that they are not being recognised or do not have career pathways. I am certainly very happy to look into that and perhaps come back to the Committee in that area.

Q1055 Charlotte Atkins: Can I pick you up on the community matrons; certainly within my own patch they do a great job but, as I understand it, the evidence does not demonstrate that they do substantially reduce, for instance, emergency admissions into hospitals. Is that not the case?
Mr Greenfield: I believe you had the Chief Executive of Kingston PCT here and my understanding of the evidence he presented was different to that, so I would have to go back and look at the evidence of the impact of community matrons on admissions.

Q1056 Charlotte Atkins: I have not read the evidence but I understand that what tends to happen is that those community matrons tend to find additional jobs that have to be done within the community rather than actually reducing the amount of admissions into hospital. I would certainly be interested to see your evidence on that to see whether that is in fact the case.
Lord Hunt of Kings Heath: My experience of talking to many nurses working in the community is that they are thoroughly enjoying the extra responsibilities that they have been given. I just mention nurse prescribing as one excellent example where their abilities have been recognised. There are so many new opportunities for nurses in the community, so many areas in which they are developing that I would have thought that it does present opportunities and, if anything, I have come

across many nurses who have left hospital and gone into the community because they feel they are given so much more autonomy in the community, which is a lesson perhaps that hospitals can learn in relation to their own staff, so it is disappointing to hear that. As I say, I would like to look into that and perhaps come back to you on it.

Mr Greenfield: I am familiar with some of the work we already have in stream in this area. I think it is true that traditionally when nurses have graduated from diplomas or degrees they have tended to go into the trust environment and we have had work going on in this area in Camden and Islington PCT where they have developed programmes that help support the initial placement straight into primary care, safely and well supported. We have also got through the Chief Nursing Officer a programme recently launched in the last quarter of last year which is about modernising nursing careers and within that there are workstreams that include defining more clearly the career path in primary care, which I think has traditionally not been the case, but also recognising many of those posts in primary care are not NHS employed, they are GP employed, which adds a complexity, and also to support the move for nurses and other professionals out of large acute trusts to provide care closer to home, which is consistent with the direction of the White Paper. That last stream of work is only just beginning but it is one of our priorities.

Q1057 Mr Campbell: We were told by some of our witnesses the other week that the quality of managers is highly variable and that there were no minimum standards for them. Of course, there are no minimum standards for MPs but at least we are assessed every four years!

Lord Hunt of Kings Heath: I think chief executives would say that they are assessed because of course one of my concerns is the rapid turnover rate of chief executives in the Health Service. There are clearly some issues here about leadership. I have put this down as one of the areas that I particularly want to focus on, as has the Chief Executive of the NHS. There is a sense in which the great NHS tradition has been to have administrators, they then began to be called managers, and I think that there is clearly a capability issue about whether all our managers have the capability and the skills needed to drive through some of the changes that we want to see. 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, and you have had one or two appear before you, but there is clearly a variation in quality. There are issues about what kind of people ought we to recruit at a young age into the Service. There are issues about the graduate training programme and whether that is fit for purpose. These are the matters that we want to look at. David Nicholson, the new Chief Executive of the NHS, who was chief executive in the West Midlands, had started a programme in the West Midlands of identifying about 160 future leaders and starting a very intensive programme with them. He now wants to develop that throughout the country. The interesting thing about the West Midlands programme is that a lot of clinicians have been identified and are taking part in it. 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. You had Sir Jonathan Michael before you in a previous session and he, surely, is the kind of role model that we would wish to see developed in the future.

Q1058 Mr Campbell: One thing that was in the news last week was where they were going to put business managers into schools; would that apply to hospitals?

Lord Hunt of Kings Heath: The Health Service has gone through various phases of encouraging people in from outside. Some Members will recall when in the early 1990s a lot of Service people came in for a brief period of time. I very much welcome people from other fields coming in. Clare Chapman's appointment from Tesco to the Health Service is an excellent example of that and we want to see more of that happen. It is not as if one would say everyone needs to come from outside. We have got a lot of highly skilled people who we want to grow and develop but yes, let us get people in from outside as well, people from social services also have a lot to offer, and let us remember that this is a hugely challenging task.

Q1059 Mr Campbell: In many ways it is a team job as well. You have got managers who will be clinicians and you have got managers like yourself, Clare, and it is a team effort really—I would have thought that anyway.

Lord Hunt of Kings Heath: You do not really have a completely hierarchical managerial set-up where the chief executive can simply tell clinicians and everyone to go and do what the chief executive wants. Clearly the chief executive has to set the framework and the job plans for consultants are a very good way in which the chief executive can have a grown-up discussion with individual clinicians. Running a hospital for instance, it is a highly complex organisation, you need to do it with great skill, there is team work, but in the end you have to hold the chief executive accountable for what happens in that institution, and what we need to do is to make sure they have got the tools of the job to discharge that accountability. I wonder if I could bring Clare Chapman in to give some more specifics about the kind of programmes that we want to develop in this area.

Ms Chapman: One of the things that the Chief Executive has asked me to look at as a priority is what are the things that a manager or chief executive need in order to succeed in their role. If we are very clear on that then in the same way that we had the discussion just a moment ago you can make sure that those experiences are actually achieved and the standards are assessed as part of that. I am completely sure from the few people I spoke to before Christmas that managers would welcome

that too because I think people thrive when they are clear what is expected of them and also they get the skills at the right time. I think as a matter of priority it is let us be clear what people need in order to succeed in those roles and then let us work with the managers themselves to make sure that that is programmed in.

Q1060 Chairman: I am interested in your plans for attacking the high turnover rate of chief executives. Have you any plans for attacking the high turnover rate of ministers?
Lord Hunt of Kings Heath: I will try and stay here for as long as possible!

Q1061 Dr Stoate: At least the current Minister does not have to worry about being re-elected!
Lord Hunt of Kings Heath: Not yet!

Q1062 Dr Stoate: I have worked in the Health Service for a long time, as you know, and I have been saying for many years that the NHS is chronically under-managed and chronically over-administered. In this inquiry and in the previous one on NHS deficits, I have been very disturbed by the enormous variation in quality among managers. You have mentioned a couple today who are obviously first-class but we have also seen evidence of managers, frankly, who have been extremely underwhelming. We heard from PCTs when we had evidence on the NHS deficits inquiry and some of them seemed to have lost complete control over their finances and seemed to think that was just the way it is. My worry is that there is no set down qualification to be an NHS manager, there is nothing specific about the chosen requirements, they have not got to be revalidated or reassessed every five years. Obviously they are assessed by their boards and they can be removed if they do not perform, but that usually only applies to the chief executive. My concern is that there remains far too much variability and far too much unpredictability and in the end, let us be honest, it is the Government that pays the political price when an institution fails in its duty to manage adequately the money that it has been given.
Lord Hunt of Kings Heath: I do not disagree with your analysis of a variation in the quality and expertise of the managerial cadre and clearly I have already stated that I see that as one of the areas where I have a great interest in sorting this out. What I am clear is that the reduction in PCTs and in Strategic Health Authorities is very important in terms of ensuring that you have got a smaller number of organisations with greater expertise. There is no question that we need to enhance commissioning skills. On the hospitals side too, we need to make sure that the managers we have got do have the right skills and expertise for what I am sure you would agree is a very demanding job. I hope I can reassure you that we do see this as important. The fact that David Nicholson has a good track record in actually resolving some of these problems in the West Midlands, where I would say that by and large we have a very good health system, indicates that we are going to take this seriously, and we do very much accept the points you make.
Ms Chapman: Can I just make a point on that, in terms of that variability I think you described brilliantly what needs to be done, which is define what is needed and make sure that you design the programmes and experiences to get that. One of the things that really attracted me to the NHS was the size of the talent pool. One would assume given over one million people that within that number there are some extraordinarily good managers or people who have got the capability to be extraordinarily good managers. The issue is spotting them, so as well as the development programmes that the Minister has just described and you have outlined, I think it is also pretty critical to make sure that it becomes a priority not just to engage staff but also to do some very active talent-spotting because if we do not have the talent with over one million people then many companies have got a number of problems.

Q1063 Dr Stoate: It is not just talent-spotting; it is ensuring that those who do not meet the grade are either re-trained very quickly or moved somewhere else because it is very disappointing when a local institution can effectively let down the entire local health economy and ministers have very little control over that situation, but certainly the local Members of Parliament know it and they very often pay the price.
Lord Hunt of Kings Heath: I think it is also worth pointing out that the system reform of incentivising hospitals that do well through payment by results is clearly designed to get the levers in to reward good performance and penalise poor performance, so hand-in-hand with managerial improvement goes the system that we are developing.
Mr Greenfield: Perhaps I could offer some comment too about work that has been going on with the foundation trusts to monitor where they have been developing programmes to assess fitness for purpose for transition into foundation trust status, and as part of that the tests are about the executive and non-executive quality of the teams. We have been developing work mirrored around that to support the development of PCTs in a fitness for purpose assessment which is about our reconfiguration and by reducing from just over 300 to around 150 we are assessing them for fitness to practise which includes the assessment of management skills.
Dr Stoate: As long as you are tough on the outcomes because we do not want the fitness for purpose problems that the Home Office has had. Clearly there is no question that some PCTs in the past have not been fit for purpose and I am now hopeful with the configuration that that should be a thing of the past.

Q1064 Chairman: Could I ask you how we determine the future NHS workforce. The think-tank Reform has told us that they believe that what the NHS needs is a smaller but more highly skilled workforce. The Chief Medical Officer giving evidence to us told us that the UK medical

workforce should be expanded as it is still smaller than the OECD average. You may be tempted to say that they are both right but I just wondered how is the future size of the NHS workforce going to be determined when we have these not necessarily conflicts but issues around about what should happen in the NHS?

Lord Hunt of Kings Heath: That is really our collective responsibility here before you today to determine how to do this in the future. I think it is very much about trying to ensure as far as we can what the likely future requirements on the Service are, to make sure that we produce the numbers of staff that are required to meet those requirements but then to have the flexibility to make adjustments if it looks like the figures are not bearing this out or there are big changes in practice in the Health Service. As I said earlier, no-one could sit here and say with confidence that we know exactly what the workforce requirements will be in 10 or 15 years' time, but we can make as reasonable an estimate as possible building on all the experience we are developing. As I say, the key thing there is the monitoring, making sure that we have got up-to-date information, making sure that we are in close discussions with Strategic Health Authorities, and then being able to make the adjustments, and that is really what we seek to do.

Q1065 Chairman: Can I ask you about something that we have briefly touched on this morning but not in any great detail. It was mentioned earlier about where there have been gaps in the workforce in the past that overseas recruitment has been a way of bridging that gap. We come really to the issue of the ethics of doing this, particularly recruiting from the developing world which in itself has far less of a structure of formal healthcare than certainly we have in this developed economy that we sit in now. What are your views on that not so much in terms of the past but in terms of the future?

Lord Hunt of Kings Heath: I would of course refer to the ethical policy that we adopted in relation to international recruitment. Essentially much of that international recruitment was to help us deal with the immediate, short-term shortages in staff. What is now happening (and we have seen some of the products of it in terms of the issue with nurses and physiotherapists) is we are becoming self-sufficient so that would suggest that we have much less requirement for international recruitment in the future.

Q1066 Chairman: What about the issues, and I am talking not so much about nurses at this stage but the issues of doctors and potentially surgeons who will come here not to work permanently but come here for probably six months or even up to two years, where they would actually be working inside the National Health Service and be salaried but also effectively getting skills and then after their term taking those back to the developing world. What does the Department think about that? If we are going to have a market-place of doctors, is that likely to end?

Lord Hunt of Kings Heath: I will ask Mr Greenfield to comment in detail, but as a general principle I would draw a distinction between going abroad to bring in staff to deal with vacancies that we have here and of course what is absolutely essential is the continued link between our NHS and healthcare services overseas because in terms of UK plc it is absolutely critical that we keep that link. Would you answer on the technicality?

Mr Greenfield: As the Minister has pointed out, we are moving from significant dependence on international medical graduates (for whom we have been very grateful) to more self-sufficiency, which is fairly unique within the modern world. For example, we understand America and some other English speaking countries are currently planning to train doctors to provide 75% self sufficiency. I can also confirm that we were approached by the Royal Colleges to say that they wanted us to protect the arrangement for people to come here from other countries for short periods of, say, up to two years so they could develop specialist skills and so that we could maintain our professional reputation in the world for very strong medical training and give them skills to take back to their communities, and we have agreed those arrangements with the Home Office and that scheme will continue.

Q1067 Chairman: That has been agreed, has it, because the Home Office are currently out for consultation on a migration advisory committee that they are setting up and that quite clearly could interfere if it is not sensitive to the needs of what I would loosely term assisting the developing world in enabling that to happen. Could I move on to nursing because this is an area where I was told by ministers many years ago now that there is no direct recruitment of nursing from abroad in terms of what I would call the sensitive and the developing world, and that could be the Caribbean and it could be many African countries as well, but that does not stop somebody coming in and working for six months in the private sector and then coming into the National Health Service. As opposed to that, we have got countries like the Philippines which trains nurses so they can be effectively exported, for want of a better expression, and earn money and send it back home. What is going to happen in the future in these particular areas?

Lord Hunt of Kings Heath: I think it is worth saying—and you mention Philipino nurses—clearly the number of nurses who have come into the UK in the last few years has been large and they have been incredibly helpful in dealing with the shortages, but we have this express desire to make the UK more self-sufficient. That is where we are at the moment. We have been discussing the issue of newly qualified staff and we are seeing the impact on self-sufficiency, so inevitably as a general point we are going to rely less on overseas staff in the future.

Q1068 Chairman: If there were nursing grades that were coming for the type of training we are suggesting surgeons or doctors may be doing for the short term to improve their skills and then to take

them back, then presumably they would be looked after as well, would they? I do not know if that is the case, Minister, I have to say, but I just pose the question in view of the assistance that we can give to other parts of the world.

Lord Hunt of Kings Heath: The general point is this: clearly we are going to reduce the number of people coming in, but what we do not want to do is inhibit the kind of exchange programmes which are helping developing countries. Equally, as I have said, because the UK's health position, our pharmaceutical industry, our medical devices industry is so strong, from a UK plc point of view it is essential that we continue these international links and we want people from overseas to look to the NHS as a model for them to review, look at, and take back to their own country.

Mr Greenfield: We have recently in the last six months asked Lord Crisp, a previous Chief Executive of the NHS, to undertake some work with colleagues in government to look at the impact of our changed ethical policy to international recruitment and the impact of greater self-sufficiency on those developing nations, and I understand his report is due in the springtime.

Jim Dowd: But these are all peripheral activities of the Health Service, are they not, they are not mainstream activities.

Chairman: But important in terms of elsewhere in the world. We should have done a bit of housekeeping before you came in which we did not do and that is that the Committee should agree that we publish the written memoranda that we have had on our Patient and Public Involvement inquiry that starts next Thursday; is that agreed? Minister, could I thank you and your two colleagues very much indeed for coming along and giving us what hopefully is going to be the final session in this inquiry. We hope that we will have the report out by about Easter, we are looking at the logistics of it at this stage, so you can take it away along with other reports that you have got to look at and hopefully employ it in workforce planning in the National Health Service.

Supplementary evidence submitted by the Department of Health (WP 01A)

INTAKE AND YEARLY GROWTH RATE DATA 1990–2005 ENGLAND/UK (WHERE AVAILABLE)

This data has been collected from a variety of sources including some of unknown quality. The reliability of the data is not guaranteed by WRT and should be treated as indicative only.

Sources: DH Medical/Dental intakes spreadsheets
WRT proformas 2005
1995–96 National workforce balance sheet for 1996–97 commissioning
DH NHS Executive NHS workforce in England 1982–92
HEI student data 2004—first year full-time first degree.

	1990	*1991*	*1992*	*1993*	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*
NURSING																
Commissions (England)			16,934	14,175	12,666	13,770	15,670	14,985	16,057	17,692	18,923	20,610	21,736	22,815	24,069	23,651
Yearly rate of increase				−16.29%	−10.65%	8.72%	13.80%	−4.37%	7.15%	10.18%	6.96%	8.92%	5.46%	4.96%	5.50%	−1.74%
PHYSIOTHERAPY																
Commissions (England)			830	925	915	982	1,087	1,344	1,346	1473	1,780	2,157	2,345	2,418	2,360	2,360
Yearly rate of increase				11.45%	−1.08%	7.32%	10.69%	23.64%	0.15%	9.44%	20.84%	21.18%	8.72%	3.11%	−2.40%	0.00%
OCCUPATIONAL THERAPY																
Commissions (England)			838	842	910	939	958	1,107	1,135	1,173	1,385	1,563	1,692	1,822	1,981	2,008
Yearly rate of increase				0.48%	8.08%	3.19%	2.02%	15.55%	2.53%	3.35%	18.07%	12.85%	8.25%	7.68%	8.73%	1.36%
RADIOGRAPHY																
Commissions (England)			662	639	585			535	586	581	578	690	818	833	860	864
Yearly rate of increase				−3.47%	−8.45%			−8.61%	9.54%	−0.73%	−0.58%	19.41%	18.47%	1.93%	3.23%	0.37%
MEDICINE																
Intakes (England)		3,191	3,263	3,374	3,515	3,486	3,594	3,749	3,735	3,972	4,300	4,713	5,277	6,082	6,294	6,298
Yearly rate of increase			2.26%	3.40%	4.18%	−0.83%	3.10%	4.31%	−0.37%	6.35%	8.26%	9.60%	11.97%	15.25%	3.49%	0.06%
Intakes (UK)	4,311	4,320	4,449	4,531	4,778	4,699	4,833	5,062	5,069	5,302	5,610	6,115	6,752	7,596	7,883	7,898
Yearly rate of increase		0.21%	2.99%	1.84%	5.45%	−1.65%	2.85%	4.74%	0.14%	4.60%	5.81%	9.00%	10.42%	12.50%	3.78%	0.19%
PHARMACY																
Intakes (UK)					1667	1,694	2,163	1,866	1,768	1,920	1,970	4,105		2,346	2,565	
Yearly rate of increase						1.62%	27.69%	−13.73%	−5.25%	8.60%	2.60%	6.85%		11.45%	9.34%	
DENTISTRY																
Intakes (England)		631	665	680	705	670	722	668	633	647	672	672	711	726	722	919
Yearly rate of increase			5.39%	2.26%	3.68%	−4.96%	7.76%	−7.48%	−5.24%	2.21%	3.86%	0.00%	5.80%	2.11%	−0.55%	27.29%
Intakes (UK)		849	902	907	947	896	941	898	868	883	920	922	958	983	1,000	1,210
Yearly rate of increase			6.24%	0.55%	4.41%	−5.39%	5.02%	−4.57%	−3.34%	1.73%	4.19%	0.22%	3.90%	2.61%	1.73%	21.00%

Department of Health

May 2006

Further supplementary evidence submitted by the Department of Health (WP 01B)

SECTION 1

Transitional arrangements for International Medical Graduates (IMG) entering into the UK health system

1.1 The details of the changes to the immigration rules, including the transitional arrangements have been attached in annex 1 for information.

1.2 Transitional arrangements apply to those IMGs who were on a recognised training programme when the announcement was made on 7 March 2006, or who had been offered a place on such a programme before that date.

1.3 We recognise the need to offer opportunities to train doctors from developing countries in the UK, in skills they cannot get in their home countries. We have agreed a way forward with the Home Office. A new category for Medical Training Initiatives, has been introduced as part of the Training and Work Experience Scheme, which will enable overseas doctors to train in the UK for a up to 24 months and leave the UK with enhanced skills and understanding.

1.4 It should be noted that IMGs will still be able to train in the UK but they will now need to meet the criteria of one of the employment categories of the immigration rules such as the work permit requirements. Work permits will be granted for posts for which there were no suitable UK or EEA candidates (the process of ensuring this is known as the resident labour market test).

SECTION 2

Managers in Primary Care Trusts

2.1 The Health Select committee asked for clarification on the number of managers in Primary Care Trusts, reasons for the above average increase in this staff group and a description of the roles carried out by them.

2.2 Table 1 shows the overall growth in the number of staff in the NHS, in PCTs and the number of PCTs each year as at 30 September.

	2001	*2002*	*2003*	*2004*	*2005*
Total NHS Staff (headcount)	1,166,016	1,223,824	1,282,930	1,331,087	1,365,388
Staff employed by PCTs	76,792	201,408	220,852	238,087	253,337
Of which managers and senior managers	2,577	9,941	11,660	12,815	13,780
Number of PCTs	164	303	303	303	303

Challenges faced by PCTS 2001–05

2.3 PCTs were set up in 2001 to carry out the following three key roles:

— to purchase care for local communities from hospitals and other local providers;

— to directly provide services such as community nurses; and

— to work with local agencies to tackle health inequalities and improve public health.

2.4 In fulfilling these roles PCTs have faced many challenges including:

— managing 75% of the NHS budget to buy and provide services on behalf of their local population;

— creating incentives in primary care including implementing a new contract for over 32,000 GPs that will improve the quality of patient care;

— preparing for a new contract for nearly 10,000 community pharmacists;

— managing over 300 million procedures by GPs and practice nurses every year;

— successful implementation of Agenda for Change and improving financial planning across the health care system;

— working with local government to provide joined-up health and social care;

— building effective relationships between acute and primary care to achieve service redesign;

— managing the largest-ever investment in IT to improve access to healthcare and patient outcomes;

— ensuring recruitment and retention of a workforce which has the capacity, skills, diversity and flexibility to meet the demands on the services it provides, including primary care services; and

— managing the public health agenda to prevent illness, promote health and reduce health inequalities across the country in accordance with National Service Frameworks as described below:

2.5 National service frameworks (NSFs) are long-term strategies for improving specific areas of care. They set measurable goals within set time frames. NSFs:

— set national standards and identify key interventions for a defined service or care group;

— put in place strategies to support implementation;

— establish ways to ensure progress within an agreed time scale; and

— form one of a range of measures to raise quality and decrease variations in service, introduced in *The New NHS* and *A First Class Service.* The NHS Plan re-emphasised the role of NSFs as drivers in delivering the Modernisation Agenda.

2.6 Each NSF is developed with the assistance of an external reference group (ERG) which brings together health professionals, service users and carers, health service managers, partner agencies, and other advocates. ERGs adopt an inclusive process to engage the full range of views. The Department of Health supports the ERGs and manages the overall process.

2.7 The rolling programme of NSFs, launched in April 1998, covers:

— Conorary Heart Disease.

— Cancer.

— Paediatric Intensive Care.

— Mental Health.

— Older People.

— Diabetes.

— Long-Term Conditions.

— Renal.

— Children.

— Chronic Obstructive Pulmonary Disease.

— Involvement of the Pharmaceutical Industry.

The Role of Managers

2.8 The real test for improvements in the NHS is not the number of managers it employs, but the outcomes for patients. For example:

— PCTs nationally reported that 99.9% of patients could be offered an appointment with a GP within two working days.

— Figures for March 2006 showed that waiting lists were below one million for the 38th successive month.

— The development of more NHS Walk-in Centres has increased choice and convenience for patients. There are 72 NHS walk-in centres currently open across the country and a further 17 are currently in development, bringing the total number of centrally-funded NHS walk-in centres in England to 89.

2.9 Managers are a key part of the success of improvement in services provided by PCTs. They manage the talented, hardworking people who make up the NHS, controlling the finance and providing the equipment, buildings and services needed to deliver effective healthcare to nearly 60 million people. Managers oversee the renewal of ageing healthcare premises making them fit for the future. Extensions to surgeries and health centres make it possible to develop one-stop shops that house a range of healthcare professionals and new services. PCTs act as a catalyst to redesigning the services available to patients in these state-of-the-art premises. Where patients would once have had to travel to the district general hospital for treatments such as podiatry or physiotherapy, often they now need go no further than a GP surgery. By working collaboratively alongside clinicians and acting as enablers to make changes happen, managers play an essential role in connecting those services provided by the PCT and those services commissioned elsewhere.

2.10 Managers fulfil a wide range of functions within PCTs. They work closely with frontline staff enabling them to concentrate on the delivery of high quality services for patients. Much of their work is invisible, but it is crucial to the organisation and to patients. Taking HR and workforce as an example, managers:

— look at the bigger picture and put plans in place to ensure that their organisations have the staff with the appropriate skills and knowledge to deliver all the services provided by the PCT;

— have responsibility for the day-to-day management in improving working lives by working closely with clinical staff on issues of recruitment and retention, sickness and absenteeism—all matters that affect service delivery;

— ensure staff get the training they need to deliver a high quality service for local people; and

— work closely with education and local authorities to provide opportunities that will attract people to the area playing a significant role in sustaining local communities.

PCTs 2006 and beyond

2.11 From October this year the number of PCTs will reduce to 153 from 303. The reduction, as part of Commissioning a Patient-Led NHS, is expected to result in administrative savings of £150 million to be invested in patient care. As workforce data is collected each year as at 30 September it is likely that most of the reductions will not be seen in published data until Spring 2008.

2.12 The new PCT structures will:

— Save money by streamlining management and administration to provide better value for money so greater resources can be dedicated to patient care.

— Cut out unnecessary bureaucracy by bringing together administration services and reducing the duplication of administration, human resource functions, accounts and hospital contract negotiation teams.

SECTION 3

Community Nurse Numbers

3.1 The table below sets out the growth in the primary and community sector since 1997 compared with growth in the number of nursing staff working in other areas and the total NHS workforce.

	1997	*2004*	*2005*	*Increase 1997–2005*	*% Increase 1997–2005*	*Increase 2004–05*	*% Increase 2004–05*
Total NHS Workforce	1,058,686	1,331,087	1,365,388	306,702	28.9%	34,301	2.5%
Nurses working in primary or community care settings	77,249	102,364	105,753	28,504	36.9%	3,389	3.3%
Other nurses	241,607	295,151	298,408	56,801	23.5%	3,257	1.1%
Total Qualified Nursing staff	318,856	397,515	404,161	85,305	26.7%	6,646	1.7%

3.2 As shown in the table, the percentage growth since 1997 in the number of nurses working in primary or community care settings is 13.4% above that of nurses working in other areas and 8% above growth in the total NHS workforce.

3.3 The table below provides a detailed breakdown of the growth in the community sector since 1997.

NURSES WORKING IN PRIMARY OR COMMUNITY CARE SETTINGS
1997–2005 HEADCOUNT

	1997	*2004*	*2005*	*Increase 1997–2005*	*% Increase 1997–2005*	*Increase 2004–05*	*% Increase 2004–05*
Community Matrons	..	..	267	..	..	..	..
District Nurses	14,150	12,827	12,067	−2,083	−14.7%	−760	−5.9%
Health Visitors	12,410	13,303	12,818	408	3.3%	−485	−3.6%
School Nursing Service Nurses	..	2,409	2,887	..	..	478	19.8%
of which:							
Nurses with a school nursing qualification	..	856	943	..	..	87	10.2%
Other Qualified Community Services Nurses[1,2]	1,219,338	33,020	35,218	15,880	82.1%	2,198	6.7%
Sub Total	**45,898**	**61,559**	**63,257**	**17,359**	**37.8%**	**1,698**	**2.8%**
Practice Nurses[3]	318,389	22,144	22,904	4,515	24.6%	760	3.4%
Total	**64,287**	**83,703**	**86,161**	**21,874**	**34.0%**	**2,458**	**2.9%**
Community Learning Disability Nurses	3,226	3,752	3,748	522	16.2%	−4	−0.1%
Community Psychiatric Nurses	9,736	14,909	15,844	6,108	62.7%	935	6.3%
Sub Total	**12,962**	**18,661**	**19,592**	**6,630**	**51.1%**	**931**	**5.0%**
Grand Total	**77,249**	**102,364**	**105,753**	**28,504**	**36.9%**	**3,389**	**3.3%**

3.4 Although there have been decreases in the number of district nurses and health visitors between 2004 and 2005, there has been significant growth in the overall number of nurses working in primary and community care settings in both 2004–05 of 3,389 (3%) and since 1997 of 28,504 (37%). Many of these nurses are working in general practice, while others staff new delivery models such as intermediate, and hospital at home teams.

3.5 Many of these nurses working in the community have specialist expertise in areas such as diabetes, palliative care and tissue viability. As well as seeing patients whose needs are complex to meet, they also advise, teach and support other nursing and GP colleagues to improve overall standards of care. There are also nurse practitioners who provide first contact care in GP surgeries or other settings, and the new clinical role of community matron was implemented to case manage those with multiple, long-term needs.

3.6 The Department recognises there is a need for nurses with specialist skills and knowledge in caring for and promoting the health of people in the community. There will be many opportunities for nurses working in the community and demand for more specialist and advanced level skills, especially in light of current reforms to move more care out of hospitals and improve the public's health. New approaches to child health, end of life care and models for addressing long-term conditions mean we need to re-visit the roles, responsibilities and training of the community nursing workforce. The Department will be working with others to review career and education strategies for nursing in the community to ensure the workforce evolves in order to deliver the vision outlined in the White Paper. This work forms a strand of Modernising Nursing Careers.

Section 4

Clinical Training in Primary Care

Post Registration

4.1 The majority of investment in post-registration training for existing staff is funded through MPET levy monies held by Strategic Health Authorities (SHAs). SHAs invest this money to develop the skills and competencies of staff in primary and secondary care according to local workforce and service priorities. The DH does not collect information on whether staff benefiting from this resource are from primary or secondary care. However, across the country PCTs have increasingly been involved in directing this investment, which had historically largely been spent on staff in secondary care.

Specialist Practitioner Community Nursing

4.2 SHAs also invest workforce development funding in specialist practitioner community nursing programmes, which lead to a degree or postgraduate diploma. These programmes are for qualified and (usually) experienced nurses and lead to a further professional qualification as a Specialist Practitioner able to lead the development of services in the community. Spending on these programmes has increased in recent years.

	2003–04	*2004–05*	*2005–06*
Community nursing			
Spend £m	48.6	58.3	60.6
Student Population	1,910	2,160	2,245
Community Specialist Practitioner			
Spend £m	8.2	10.6	14.7
Student Population	350	450	620

SHAs are also investing MPET funding in developing and funding training programmes for modern matrons.

Medical Training

4.3 Costs of training doctors in primary care are funded through MPET in a similar way to funding provided in secondary care. In 2005–06, funding of £232 million was provided to support 2,786 GP Registrar posts and 125 GP PRHO posts. In addition, from 2006–07 funding will be provided to enable 55% of second year Foundation Programme doctors to spend up to four months in primary care settings.

Undergraduate Training

4.4 MPET funding is provided to support the training of undergraduate doctors and dentists in both primary and secondary care through the SIFT (Service Increment for Teaching) levy. These arrangements are negotiated locally between SHAs, Universities and GPs however funding will generally be allocated on a similar basis to the funding paid to secondary care providers (about £220 per student week).

SECTION 5

GP Contract Costs

5.1 DH response to HSC request for follow up data that details *the estimated additional cost of the 2004 GP contract in 2004, 2005 and the estimate for 2006 (this to include and separately list the cost of alternative out of hours coverage)*.

5.2 The introduction of the new General Medical Services (nGMS) contract was underpinned by a three-year deal, ending in 2005–06, which guaranteed a 36% increase in resources (available to all primary care contractors in England, including those that fall under the national GMS contract arrangements), from £5 billion in 2002–03 to £6.8 billion in 2005–06. Negotiators agreed to measure increased investment in Primary Medical Care Services, in the three-year period ending 2005–06, through a mechanism known as the Gross Investment Guarantee (GIG).

5.3 Evidence from PCT expenditure returns shows that Primary Care Trusts have also made available additional resources to secure the range of services and improvements in care to meet national and local priorities. The overall increase in resources is now forecast to total between 40–50% for the three-year period, based on an estimated spend on Primary Medical Care Services of around £7.7 billion in 2005–06. Final audited information on 2005–06 contract spend will not be available until the Autumn.

5.4 The estimated cost of implementing the new GMS contract is given in Table 1 below. The introduction of the contract was underpinned by a three year deal ending in 2005–06. From 2006 onwards, the contract will be annually reviewed and is the subject of negotiations with GPC. Negotiators have agreed there will be no uplift to any existing element of the contract for inflation or cost pressures in 2006–07.

Table 1

EXPECTED COST OF IMPLEMENTING NEW GMS CONTRACT

Financial Year	*Cost £ billion*
2003–04	5.8
2004–05	6.9
2005–06[1]	7.7
2006–07[2]	7.7

[1] Estimated cost subject to validation/agreement with GPC.

[2] The increase in spending over the period 2003–04 to 2006–07 is largely due to increased investment in the Quality Outcomes Framework (c £1.1 billion) and Enhanced Services (c £0.5 billion).

5.5 Table 2 provides a breakdown of the GIG against outturn covering 2003–04 to 2005–06—the agreed coverage period for the GIG. From 2006 onwards, GIG arrangements no longer exist.

Table 2

FORECAST ACHIEVEMENT AGAINST GROSS INVESTMENT GUARANTEE (GIG)

£ billion

Financial Year	*GIG*	*Outturn*	*Over*
2003–04	5.6	5.8	0.2
2004–05	6.2	6.9	0.7
2005–06[1]	6.9	7.6	0.7

[1] Forecast outturn, ie still subject to validation/agreement with GPC.

5.6 The England GIG agreed with the General Practitioners Committee (GPC) is detailed in Table 1, against which current figures indicate the GIG for all years will be significantly over-achieved, ie more spend than was guaranteed.

5.7 The Gross Investment Guarantee (GIG) is the mechanism by which minimum levels of investment is guaranteed for Primary Medical Care services in the three-year period ending 2005–06. The England GIG agreed with the General Practitioners Committee (GPC) is detailed in Table 1 against which current DH forecasts indicate the GIG for all years will be significantly over-achieved, ie more spend than was guaranteed, for each of the three financial years.

5.8 The GIG comprises of expenditure on the following elements:

- Global Sum payments for core services (including Minimum Protection Income Guarantee).
- Quality and Outcomes Framework.
- Enhanced Services.
- Primary Care Trust Administered Funds (eg payments for locum cover, seniority, dispensing).
- Premises (capital and revenue expenditure).
- IM&T.
- Out of Hours.
- Personal Medical Services (PMS) contracts.

5.9 Whilst arrangements were put in place to determine minimum levels of investment guaranteed for the three year period ending 2005–06, the new GMS contract did not formally commence until 1 April 2004.

5.10 The 2004–05 over-spend against the GIG was some £700 million of which £250 million are in the main attributable to additional costs arising from the new GMS contract:

- Circa £150 million due to over-achievement of the QOF.
- Circa £100 million due to pressures on the OOH service.

5.11 Whilst citing the above over-spends, the remaining balance is predominantly due to an increase in the level of investment in PMS contracts, over and above that initially assumed at the time GIG was set. Work is still ongoing in investigating this further.

5.12 We currently estimate in 2004–05 that PCTs are having to manage a financial pressure of £250 million as a consequence of resourcing the contracts. Final audited information on 2005–06 will not be available until late autumn 2006.

5.13 PCT forecasts for 2005–06 indicate a similar over-spend as that reported for 2004–05, ie £700 million. DH assessment is that the QOF and OOH services will exceed allocated resources by similar amounts to those experienced in 2004–05.

5.14 Looking across all three years of the deal: In England the final costs of providing Primary Medical Care Services over the three years 2003–04 to 2005–06 was some £1.6 million more than the amount originally guaranteed to GPs.

5.15 Measurement of spend against the Gross Investment Guarantee should not be confused with spend against resources allocated to PCTs.

5.16 DH currently does not have available information from the NHS on the forecast spend on the GP contract 2006–07 position.

Quality Outcomes Framework (QOF)

5.17 High levels of achievement in the quality and outcomes framework are to be congratulated. It shows we have a system in place that motivates General Practice to provide high quality evidence-based clinical care. This benefits the vast majority of patients and improves health prevention in ten of the most common long-term illnesses as well as impacting on the wider NHS; for example, fewer avoidable hospital admissions due to better chronic disease management.

Out-of-Hours

5.18 Increased spending on Out-of-Hours shows that PCTs are maximising use of their unified budgets in order to establish integrated networks of unscheduled care provision so that when patients contact out-of-hours services they can be assured that their clinical needs will be consistently met through fast and convenient access to care, delivered by the most appropriate professional in the most appropriate place.

5.19 Less than 5% of GPs provided their own out-of-hours (OOH) care to patients before new general medical services (GMS) contracts were introduced. OOH opt-outs were a key feature to improve GPs working lives through ending 24-hour responsibility for their patients.

5.20 Under the GMS contract, where a GMS GP practice opts-out, it will surrender 6% of its global sum funding, equivalent to around £6,000 per average GP.

PMS practices surrender an equivalent amount. If every practice in the country opted-out, this would amount to some £180 million. In addition:

— There is a ring-fenced Development Fund of £91.2 million.
— £14 million to support PCTs facing the biggest challenge in developing out -of-hours services.
— £33.4 million to support the development of urgent care services.
— £3 million to support the OOHs exemplar programme.

5.21 Taken together these resources of up to £322 million will be available in 2005–06 to help fund PCT provision of out-of-hours services. The majority of OOH provision is provided under Alternative Provider Medical Service (APMS) contracts.

5.22 Patients continue to receive a safe out-of-hours service that also needs to meet new national quality standards such as access through a single phone call.

SECTION 6

New Contracts Information

Agenda for Change Costs

6.1 The committee requested information on the budget for 2004–05 or the over-spend (or under-spend) for 2005–06.

6.2 The original funding envelope for Agenda for Change from 2004–05 to 2006–07 is set out in the Table below.

6.3 Monitoring of the costs of Agenda for Change in 28 sample sites in 2005 suggested that in the first 12 months from October 2004 to September 2005 direct earnings costs exceeded those originally estimated by 0.5% of the Agenda for Change paybill, or around £120 million a year in cash terms. In the same period, this data suggested that the indirect costs of replacing additional hours and leave arising from Agenda for Change exceeded those originally estimated by at least £100 million a year. However, these indirect costs are based on trust estimates rather than actual payroll records, and are susceptible to management action. Analysis of subsequent 2005–06 accounts data for non-Foundation Trusts suggests that Hospital and Community Health Service pay costs overall have been running at less than our original assumptions (5.2% overall against our original 5.8% assumption.).

6.4 In addition, from October 2005, a significant minority of staff who were previously on their scale maxima, or on spot salaries, will have gained access to some further pay progression. This was allowed for in the cost estimates below. But whether actual experience of progression is more than expected, or less than expected, is not known, and we are currently considering what further information and analysis is necessary to measure this.

6.5 There are also a number of benefits from the pay reform which will arise over time and are not taken into account in the analysis above. One example is that the net effect of harmonisation of working hours on nursing hours (37.5 hours per week) will be to gradually increase the total hours available to the NHS, including hours available from key groups such as radiographers.

6.6 It is also important to note that it will become increasingly difficult to separate out costs due to the new system from other changes as time goes on.

ESTIMATED COST OF IMPLEMENTING AGENDA FOR CHANGE

Year	*Cumulative total £ million*[1]
2004–05[2,3]	490
2005–06	950
2006–07	1,390

[1] Totals rounded to nearest £10 million.

[2] Original envelope figure. This was subsequently reduced to £480 million.

[3] A further £30 million in non-recurring funding was made available in 2004–05, primarily for the transitional costs of the change in pay systems—such as backfill for staff assisting with job evaluation.

SECTION 7

Consultant Contract Costs

7.1 The Committee requested information on the budget or projected variance for 2005–06 or 2006–07.

7.2 We invested additional, recurrent funding to meet the costs of the consultant contract. This investment, a total of £250 million, was introduced over the three-year period from 2003–04 to 2005–06.

7.3 Representations from trusts in late 2004 suggested that the costs of the consultant contract had exceeded plans by as much as £150 million, mainly due to higher levels of programmed activities decided by local trusts. We uplifted the tariff for 2005–06 by this amount.

7.4 Evidence obtained subsequently, however, from the DH consultant contract survey (on data as at October 2004), suggested that while the levels of programmed activities were higher than expected, the difference suggested an excess cost of the order of £90 million rather than £150 million.

7.5 Data from the October 2005 DH consultant contract survey has shown a further reduction in average programmed activities from 11.17 in October 2004 to 10.83 in October 2005. It has also shown a reduction in the proportion of consultants receiving on-call supplements, which had also been cited as a cause of cost pressures.

Department of Health

27 October 2006

Annex 1

POSTGRADUATE DOCTORS AND DENTISTS
those granted leave as a postgraduate doctor or dentist prior to 3 April 2006

Below is guidance about the effects of these changes on those who were granted leave as a Postgraduate Doctor or Dentist prior to 3 April 2006. There is guidance on:

- The effect of the changes.
- Those granted leave as a Postgraduate Doctor or Dentist prior to 3 April 2006 who will not meet the new requirements.
- Transitional Arrangements—Senior House Officer and equivalent grades and Foundation Programme/Pre-Registration House Officer Year.
- Transitional Arrangements—Specialist Registrars and equivalent Grades.

The effect of the changes

Prior to 3 April 2006, the category for Postgraduate Doctors and Dentists enabled non-EEA doctors and dentists to train in the UK at the following levels:

- Foundation Programmes.
- Basic Specialist Training—this refers to Senior House Office (SHO) and equivalent grades.
- Higher Specialist Training—this refers to Specialist Registrar and equivalent grades. The General Practice Vocational Training Scheme (GPVTS) is also considered as higher specialist training.

Since 3 April 2006, only those who have studied in the UK and are taking a Foundation Programme will meet the requirements. Those in Senior House Officer or Specialist Registrar posts (or posts at the equivalent grades of either of these) will no longer be eligible for a grant of leave as a Postgraduate Doctor or Dentist, and those undertaking a Foundation Programme (or Pre-Registration House Officer year) will only be eligible if they studied in the UK and meet all the other requirements.

These doctors and dentists can continue to come to the UK, but need to meet the requirements of the relevant part of the Immigration Rules, such as the work permit system. Work permits can now be granted for posts at all three levels.

Those granted leave as a Postgraduate Doctor or Dentist prior to 3 April 2006 who will not meet the new requirements

- Any leave granted as a Postgraduate Doctor or Dentist prior to 3 April 2006 will continue on the same conditions. The leave remains valid and the conditions of leave remain the same.
- This means that they can continue to train in relevant posts, including completing ongoing posts and taking any relevant new posts, while their leave remains current and valid.
- However, an extension of stay as a Postgraduate Doctor or Dentist can only be granted if the new requirements are met.
- The switching provisions remain effective—therefore those with leave as a Postgraduate Doctor or Dentist who want to work in the UK can switch into leave as a work permit holder, highly skilled migrant, business person or innovator, if they meet the relevant requirements.
- They can also switch into leave to undertake a period of clinical attachment or dental observer post, if they have the relevant observation post arranged and meet the remaining requirements.
- Anyone who does not qualify under the new Rules for leave as a Postgraduate Doctor or Dentist, and who does not switch into an appropriate alternative category, will have to leave the UK when their leave expires.
- Transitional arrangements are in place for doctors and dentists offered a recognised training post before 7 March 2006 who do not have sufficient leave to complete the post. These relate to the employer obtaining a work permit without having to go through the resident labour market test. All the other normal requirements remain, including all the other work permit requirements and the normal restrictions on switching.

Transitional Arrangements—Senior House Officer and equivalent grades and Foundation Programme/Pre-Registration House Officer Year

- These transitional arrangements apply to applicants:
  - who were offered a place on a Foundation Programme or a recognised training post as a Senior House Officer (or equivalent grades) prior to 7 March 2006; and whose post is due to commence on or before 4 August 2006; and
  - who, because of the changes to the Rules which took effect on 3 April, no longer meet the requirements of the Immigration Rules for Postgraduate Doctors and Dentists; and
  - who do not have sufficient existing leave to complete the post on offer (whether or not they currently have leave as a Postgraduate Doctor or Dentist—they may be abroad, or in the UK with leave in another category).
- If these requirements are met, then the employer can apply for a work permit for the post on behalf of the migrant and will not have to show that they have advertised the post to the resident labour market. All the other normal requirements remain in effect. If the work permit is granted, the migrant will need to apply to switch into leave as a work permit holder and meet the relevant requirements of the Immigration Rules for that category.
- Therefore, the transitional arrangements are of interest to employers who have gone through the recruitment process and offered a training post to a non-EEA national before 7 March 2006 without carrying out a resident labour market search.

— As stated above, the transitional arrangements apply to any non-EEA doctor or dentist who has been offered a place either on a Foundation Programme or a recognised training post at a Senior House Officer or equivalent grade. This applies both to those in the country and those overseas, as long as they have been offered a relevant training post before 7 March 2006 and meet the other requirements.

— The changes to the provisions for Postgraduate Doctors and Dentists were announced on 7 March 2006. Therefore any migrant who has been offered such a post on or after 7 March 2006 should have been fully aware when they were offered the post that they would not qualify for leave as a Postgraduate Doctor or Dentist to take up that post. Employers should equally have been aware of the new requirements.

— The transitional arrangements only apply to recognised training posts. Any other posts (including Trust Doctor posts, which are not recognised training posts) will not benefit from this concession and the normal work permit provisions apply.

— The transitional arrangements only apply where the posts on offer commence on or before 4 August 2006—which is the start of the next rotation period.

— We have set up these transitional arrangements to enable the employer of any doctor or dentist who was offered a relevant place prior to 7 March 2006 to be granted a work permit without needing to advertise the job to EEA nationals first (the resident labour market test). All the other requirements of the work permit system must be met, and further details of the work permit provisions are available on the Working in the UK website. Once a work permit has been granted, the doctor or dentist will need to apply to switch into leave as a work permit holder.

— If the applicant does not fall within these transitional provisions, then they can still come to or remain in the UK as a work permit holder. However, the employer will need to show that all the normal work permit requirements are met (including that the post has first been advertised to the resident labour market).

Please note: there is no exemption to the normal switching provisions. Therefore a doctor or dentist who is already in the UK with leave in a category which does not allow switching into leave as a work permit holder, but who wants to benefit from these transitional arrangements, will have to leave the UK and apply for entry clearance in the normal manner. This includes those in the UK with leave as a Visitor or leave as the dependant of another migrant, where there is no provision for them to switch into leave as a work permit holder.

Further information on the work permit process is available on the Working in the UK website at www.workingintheuk.gov.uk.

Transitional Arrangements—Specialist Registrars and Equivalent Grades

— Those with existing leave as a Postgraduate Doctor or Dentist.

— Many Specialist Registrar programmes last for five years. Under the previous provisions, leave as a Postgraduate Doctor or Dentist could be granted for a maximum of three years at one time. Any non-EEA national in a Specialist Registrar programme would therefore need more than one period of leave as a Postgraduate Doctor or Dentist in order to complete their programme.

— In recognition of this, there is a concession for anyone who has existing leave as a Postgraduate Doctor or Dentist to take up posts at Specialist Registrar or equivalent grades to switch into the work permit system without their employer needing to advertise the job to EEA nationals first (the resident labour market test). All other work permit requirements will still apply.

— This concession will only apply to applications made before or on 31 December 2006. As the work permit system involves a two stage process, this means that the employer of an eligible migrant will need to apply for a work permit before 31 December 2006 in order to benefit from this concession.

— Employers can apply for a work permit after 31 December 2006, but the application will not be considered under the concession and the resident labour market test will apply where relevant.

Further information on the work permit process is available on the Working in the UK website at www.workingintheuk.gov.uk.

— Those who have been offered a recognised training post as a Specialist Registrar, but who do not have leave as a Postgraduate Doctor or Dentist.

— We recognise that the changes to the provisions for Postgraduate Doctors and Dentists also affect employers, who may have gone through their normal recruitment procedure and offered a training post to a non-EEA national as a Specialist Registrar without testing the resident labour market.

— Therefore the same transitional arrangements apply to those who have been offered a recognised training post as a Specialist Registrar before 7 March 2006 as to those who have been offered a place on a Foundation Programme or a recognised training post as a Senior House Officer (or equivalent grade).

— Further details are available above (Transitional Arrangements—Senior House Officer and equivalent grades and Foundation Programme/Pre-Registration House Officer Year) but to summarise this concession applies to those:

  — who were offered a recognised training place/post as a Specialist Registrar prior to 7 March 2006; and

  — whose post is due to commence on or before 4 August 2006; and

  — who, because of the changes to the Rules which took effect on 3 April, no longer meet the requirements of the Immigration Rules for Postgraduate Doctors and Dentists; and

  — do not have sufficient existing leave to complete the post on offer (whether or not they currently have leave as a Postgraduate Doctor or Dentist—they may be abroad, or in the UK with leave in another category).

If these requirements are met, then the employer can apply for a work permit for the post on behalf of the migrant and will not have to show that they have advertised the post to the resident labour market. All the other normal requirements remain in effect. If the work permit is granted, the migrant will need to apply to switch into leave as a work permit holder and meet the relevant requirements of the Immigration Rules.

— If the applicant does not fall within these transitional provisions, then they can still come to or remain in the UK as a work permit holder.

— However, the employer will need to show that all the normal work permit requirements are met (including that the post has first been advertised to the resident labour market).

— Please note: there is no exemption to the normal switching provisions. Therefore a doctor or dentist who is already in the UK with leave in a category which does not allow switching into leave as a work permit holder, but who wants to benefit from these transitional arrangements, will have to leave the UK and apply for entry clearance in the normal manner. This includes those in the UK with leave as a Visitor or leave as the dependant of another migrant, where there is no provision for them to switch into leave as a work permit holder.

Further information on the work permit process is available on the Working in the UK website at www.workingintheuk.gov.uk

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Further supplementary evidence submitted by the Department of Health (WP 01C)

PURPOSE

1. This note updates the Health Select Committee on progress with the review of workforce planning, education and training. The review was commissioned in July 2006 by Lord Warner, Minister of State for Reform. In summary the purpose of the review is to:

— consider how workforce planning and commissioning strategies can support health reform and the implementation of the White Paper "Our Health, Our Care, Our Say";

— look at what works well in the present arrangements;

— identify what does not work well and any gaps;

— consider how we can improve systems and relationships; and

— consider how we can strengthen partnerships.

METHOD

2. Our approach has been to meet internal and external stakeholders across health and education. We held a major stakeholder event in October and have followed that up with meetings with universities and the Department's Workforce Programme Group. We have also worked closely with DfES as agreed with Bill Rammell, Minister of State for Higher Education and Lifelong Learning. It is vital that we also represent the views of Strategic Health Authorities (SHAs) and we are currently in the process of consulting them.

3. We have conducted the review at a time when concern about funding education and training in the NHS has been heightened by the need for the NHS to achieve financial balance and because of a policy shift in DH where educational budgets have been assigned to SHAs without ring-fencing in order to provide maximum local flexibility. This has helpfully engaged the key players but we also note that short-term concerns that the review is a cost-cutting exercise have inevitably coloured what is a longer-term look at education, planning and commissioning.

Health Reform: Implications for the Workforce

4. The NHS workforce strategy until recently has focussed heavily on increasing service capacity, recruiting more staff and reforming pay. This has seen major policy development with increases in the number of doctors and nurses, international recruitment, pay and contractual reform for a number of staff groups including Agenda for Change with its attendant Knowledge and Skills Framework.

5. After a long period of unprecedented levels of investment targets there is now a strong focus on financial sustainability in the NHS. We also expect the next spending review settlement for health to be tight. The "More Staff, Working Differently" motto much used about the NHS workforce no longer has the relevance it did. However, "Working Differently" remains an important theme.

6. Health Reform policies and "Our Health, Our Care, Our Say" will change the way care is delivered:

- patients will be able to access more services closer to home;
- there will be closer working between health and social care;
- there will be greater plurality of provision and greater patient choice;
- payment by results will profoundly affect decision-making; and
- there will be stronger emphasis on public health and self-care.

7. This array of reform demands that we re-assess our workforce strategies to make sure they respond effectively to these developments. We also accept that we need to do better on public/patient involvement in the training and development of health professions and the wider workforce. A greater patient-focused approach would see a more flexible workforce dedicated to a more flexible response to patient need. There are opportunities here too to put a greater and much-needed accent on inter-professional education and training not least through more responsive development processes for curricula at all levels. In particular, we need to recognise the need to develop common elements on leadership, management and clinical engagement in curricula.

Consensus: Planning

8. Consultation with stakeholders has highlighted a number of issues. In terms of planning there is a consensus that:

- it can be very complex with variable quality;
- it is by its nature often long-term in its focus, however, this means it can be unresponsive to service needs;
- much of the information produced by the existing systems is not reliable;
- it works better for the larger professions but is more difficult for smaller specialties and disciplines;
- there is a lack of strategic approach to the wider workforce;
- at all levels, nationally, SHA, PCT and trust, workforce planning lacks integration with financial planning and with service planning;
- too often workforce planning appears reactive and is not used to lead change;
- it is often done at a junior level in organisations which suggests it is not taken seriously enough; and
- clinicians are often not effectively engaged.

9. Not everything is negative though. At present:

- we have a better match between supply and demand than ever before;
- variations are much less than other countries;
- most medical specialties have a good match between supply and demand; and
- the system has been able to reply to shortages.

Consensus: Education

10. The issues around education, training and funding are closely linked with planning.

- investment and innovation is blighted by short-term financial considerations;
- loss of ring-fenced budgets has brought about uncertainty and damaged relationships with higher education (HE);
- the MPET formulaic system doesn't sit well with a world of plurality of provision;
- working relationships between the NHS and HE are not effective at all levels;
- there is no consistent approach to commissioning;
- there is no formal conduit for service providers to influence national commissioners or regulators;

— there is a lack of support for innovation and new roles—HE not always responsive/innovative enough, NHS not always good at articulating what it wants; and
— the approach to student support is incoherent and counter-productive.

Action in the Short-term

11. There are a number of areas where we need to focus our attention to make progress in the short-term.
— The need for more effective working relationships between SHAs, the NHS and HE at all levels.
— A national workforce planning overview function, but with a more strategic local approach to workforce planning with greater integration between service, financial and workforce planning. This might be achieved through:
  — promotion of shared best practice nationally;
  — identifying and sharing best practice at SHA/HE partnership level;
  — strengthening the role of Workforce Review Team (WRT) and SHA ownership of WRT;
  — extending to other professions the national quota system (which we use with the Higher Education Funding Council for England (HEFCE)) for medical and dental undergraduate education—with strengthened input from SHAs; and
  — identifying workforce as a key measure of assessment in PCT Fitness for purpose frameworks and Whole Health Community Diagnostic tools.
— Formal conduit for service providers to influence national commissioners or regulators.
— A more consistent approach to commissioning with a view to addressing financial instability.
— A strategic approach and investment in the wider workforce.
— Support for innovation and new ways of working (including new roles) in the NHS and in HE.

Action in the Medium-term

12. Some issues are not easily solvable and will require more detailed consideration and consultation with stakeholders in order to develop options for change that respond to existing concerns but will also be flexible enough to stand the test of time.
— Implementing improved funding arrangements under the MPET Review—to incentivise education and training.
— Reviewing and addressing student support anomalies.
— Changing the structure and content of undergraduate courses to improve the competence-base and to improve links with employer needs and inter-professional learning.
— Addressing variations in unit costs—mapping funding flows to achieve more transparency and VFM.

Further Options for Change

13. It is clear that there is scope for incremental improvements in existing arrangements, particularly in terms of the relationships between NHS and education planners and commissioners including their mutual responsiveness. However, incremental improvements may not reflect the nature and pace of system reform where there are major shifts in provision into the community, the emergence of foundation trusts and an increasingly plurality of health provision.

14. We need to look beyond incremental change and examine more basic change based on a market approach. How in a more open, fluid and devolved system can we best secure a well-motivated workforce in the right numbers and of the right quality and capability?

15. Areas to explore might include:
— Transferring responsibility for healthcare professional training directly to HEIs and HEFCE.
— Transferring responsibility for career decisions to students by moving to a loan system.
— Influencing overall supply by targeting loans at students in disciplines where HEI decisions and self-funding lead to market failures.
— Whether a market system would see employers invest in training and development to provide specialist skills.
— Potential for postgraduate training and development funding to be invested across all employers through the tariff.
— A variation on the current system of MPET funding would provide employers with bursaries to support FP, specialty and GP training.
— A bursary system reflecting current training patterns and funding to avoid instability.

— Incentives to invest in post-graduate training to meet the primary aim of modest over-supply. Bursaries might provide SHAs with a strong lever for driving change. Some bursaries could be available to develop specialist skills in other shortage areas, for example, healthcare scientists and public health.

— A new and different role for HEFCE. Options include a "HEFCE for Health" along the NHS Education for Scotland model or a system similar to the Training and Development Agency for Schools.

SUMMARY

16. Consultation with stakeholders continues, in particular with SHAs and employers. As demonstrated above, we have identified a wide range of issues where changes are required. The next phase of work over the coming months will see the development of a range of detailed options to address these issues. The Health Select Committee will be kept informed of progress.

Department of Health

December 2006

Further supplementary evidence submitted by the Department of Health (WP 01D)

MEDICAL WORKFORCE PLANNING 2005–30

1. This paper brings together analysis of the future demand and supply of the medical workforce including analysis of:

— The impact of recent medical school expansion on medical supply—there will be more doctors in training to find jobs for;

— The implementation of Modernising Medical Careers (MMC)—a higher proportion of medical care will be delivered fully-trained doctors;

— The European Working Time Directive (EWTD)—doctors in training working hours could be lower;

— The impact of reduced flows of International Medical Graduates (IMGs) on medical supply—there will be more job opportunities for the increasing number of UK graduates;

— Future reduction in workforce participation—a lower contribution from each doctor, creating need more individuals;

— Costs and affordability of growth in the medical workforce;

— Changes in skill mix—potential affecting the demand for doctors but lacking hard evidence and comparative costs;

— Estimates of demand for healthcare—demographic trends suggest a higher demand.

BACKGROUND

2. Recent expansion of medical school numbers will mean the medical workforce will continue to expand for the next 30–40 years until a steady-state is reached. The larger medical workforce will mean the service will have capacity to meet growing demand for healthcare whilst gradually reducing reliance on IMGs. As UK graduates progress through specialty training, the workforce will be more richly skilled than at present, and average labour costs will therefore increase commensurately.

3. Over the coming decades factors like the EWTD, trends to more part-time working, the growing "feminisation" of the workforce, and demands for a more satisfactory work-life balance could have a negative impact on the supply of doctors.

4. Other factors, such as implementation of MMC or future changes in skill mix add further uncertainty to medical workforce planning.

MEDICAL WORKFORCE SUPPLY

5. The shape and composition of the medical workforce is likely to change in coming years.

— Recent increases in the UK medical school intake will enable the service to become more self sufficient in doctors, reducing reliance on IMGs, whilst still increasing the overall size of the workforce.

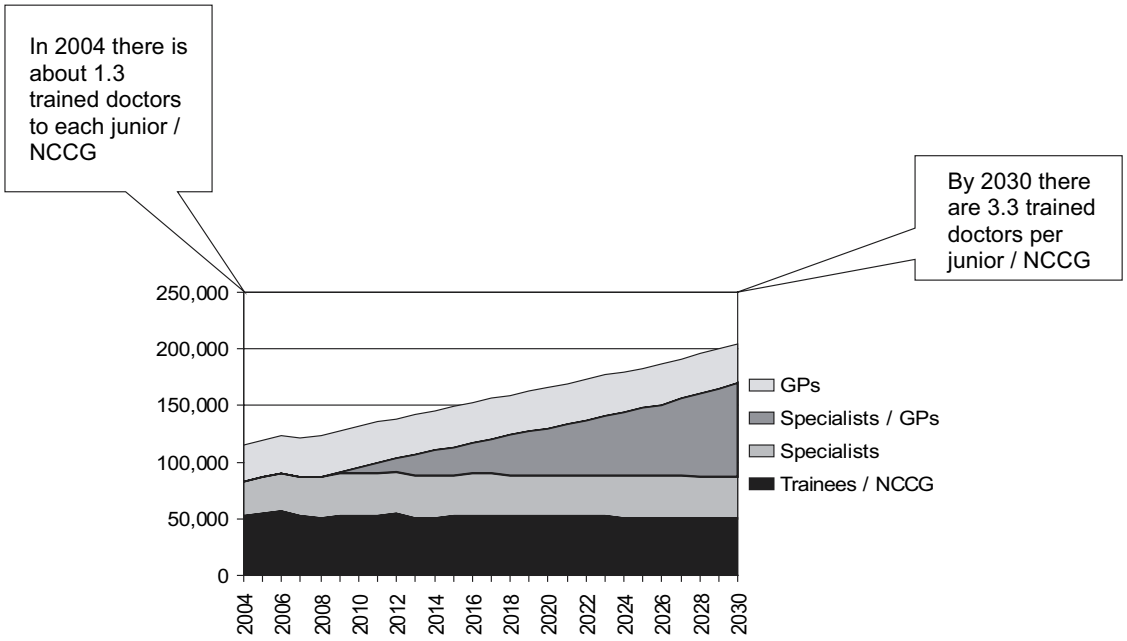
— As the expanded UK workforce progress through specialty or GP training, we will have a richer medical skill mix than present. This implies however, that service currently delivered at junior level, will in future be delivered by fewer, more efficient specialist doctors.

6. The Workforce Review Team (WRT) have modelled a number of medical supply scenarios. The "central" scenario is set out below.

- Average annual growth in headcount (HC) trained doctors (CCST, CCT and GPs) 2005–30 is projected to be about 3.8% per annum. The number of trained doctors will continue to grow until about 2040.
- WRT project no growth in total numbers of juniors/non specialist career grade doctors. A small increase in trainees is offset by a decline in numbers of career doctors.

7. The changing composition of the workforce implies a radical shift in the way service is delivered. Service currently delivered by doctors in training will have to be performed by other healthcare professionals—specialist doctors and non-medical staff. The chart below sets out the changing medical skill mix over time. A key question is whether the service is prepared for and wants the changing size and skill mix of the medical workforce.

Chart 2: Composition of the medical workforce 2004 - 2030 (Headcount)



KEY ASSUMPTIONS:

- 2,500 training posts for GPs each year.
- No flows of IMGs.
- Total entrants into the system = UKGs + headroom.
- Specialty training places for all UKGs + headroom.

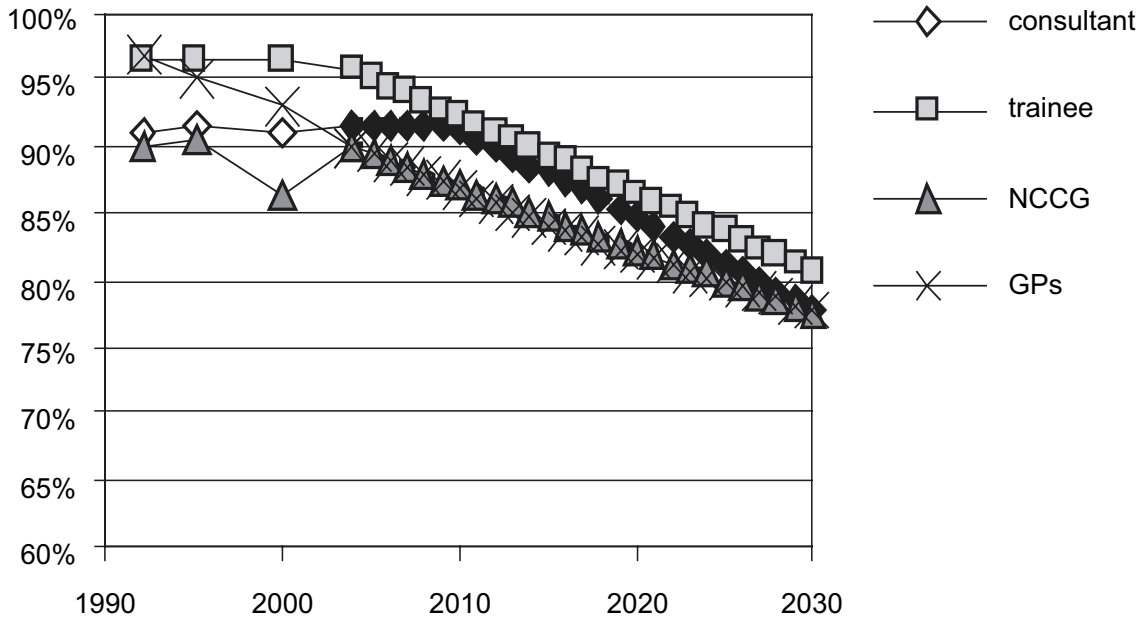
PARTICIPATION

8. Changes in the working culture may affect future participation of the medical workforce.

- Some of the current stock of doctors trained by working 60+ hours per week, whereas doctors in training are currently limited to an average maximum working week of 56 hours, which will reduce from 2009 to a maximum of 48 hours. It is possible that when future doctors in training complete specialty training they will expect to work less than current consultants do.
- It is asserted that in the past consultants have worked longer than their contracted hours "for free", in future, they may only work their contracted hours, which will lower participation.
- A growing feminisation of the workforce may reduce overall participation as doctors take career breaks or work part time to have children.
- There is a growing societal trend (for men and women) towards more part time working and taking career breaks.

9. The chart below shows projected participation rates for GPs, consultants and career doctors and trainee doctors used in the analysis. The projections take into account past trends in participation and likely reduction in hours worked. They project a relatively quick decline in participation.

Chart 3: Trends and projected participation of the medical workforce (whole time equivalent rates)



MMC

10. The MMC reforms will change the training and career pathway for doctors. Though the framework for the new career structure has been agreed, there are several key factors that remain to be determined. These will affect projected medical supply:

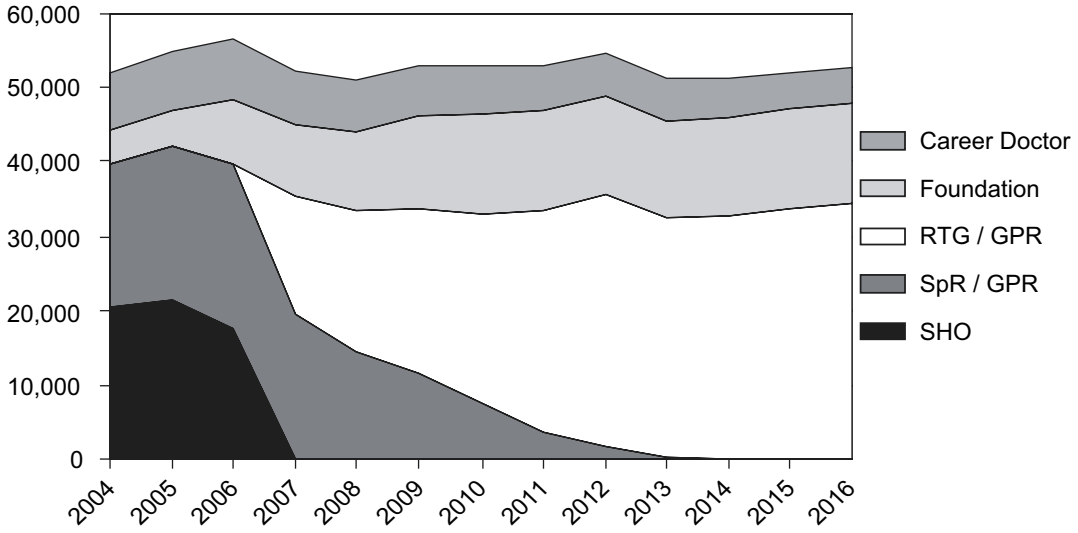
- The average length of specialist training in a competency-based system is hard to predict (six to eight years).
- The proportion of doctors with a Certificate of Completion of Training (CCT) will increase and will deliver a higher proportion of medical care. This may knock on to future demand.
- The pay/cost/contribution of MMC doctors.
- Whether there will be enough specialist and GP places for current SHOs and the future contribution of IMGs.
- How many doctors will take up Fixed Term Specialist Training Appointments (FTSTA).
- How many doctors will become Non Consultant Career Grades (NCCGs) and not progress to CCT.

11. To start examining some of these issues the WRT have produced 28 supply scenarios by varying some of these and other assumptions (though many more scenarios are possible).

12. The assumptions used as our current central supply estimate are as follows and is shown in chart 3 above:

- No further IMG flows.
- 20% of current SHO posts (about 4,000) are cut. These could include some of the 8,500 IMG SHOs.
- Average length of specialty training of seven years.
- No flows into FTSTA or career grades.

Chart 4: Composition of the trainee and career grade medical workforce up to 2016 (Headcount)



13. The precise role of MMC trainee and specialist doctors is likely to change. This means that their productivity is likely to be different. Analysts from DAT and WRT canvassed service experts to estimate the relative productivity of MMC and current doctors; this is set out in the table in the appendix. The relative productivity reflects (1) the relative amount of time each grade of doctor spends providing service rather than doing other activities (such as providing training, being trained or administration and management) and (2) the relative expertise of each grade of doctor. The assumptions are however debatable and represent our current best estimate for modelling purposes.

— Run Through (RT) doctors are assumed in the scenario to be much less productive than SpRs. This reflects the belief that specialty training for MMC doctors might focus on learning rather than providing service.

— CCT doctors are assumed to be slightly less productive than CCST consultants to reflect different levels of training and expertise.

— Foundation programme year 2 doctors are assumed to deliver no service, unlike current SHO level 1. Experience is now however showing that is assumption undervalues the contribution of F2 doctors.

14. The relative productivity of doctors enables us to translate demand modelled under the current medical workforce structure, to demand expressed as numbers of MMC doctors.

Working Time Directive

15. We model the impact of the EWTD by crudely assuming it will reduce the amount of time that juniors are available to work from a maximum of 56 hours to 48 hours (about a 14% drop in the available supply of doctors in training). In practice, Trusts will adopt various strategies such as service redesign to meet growing demand in the context of the EWTD.

16. The analysis assumes that the EWTD is an additional demand pressure—ie additional doctors will be required to deliver the projected demand for healthcare following the introduction of the EWTD. New Deal contract monitoring shows that a third of doctors in training are already working a 48 hour week. By 2009, when the EWTD is fully implemented, it adds about 5,000 registrars and SHOs to demand, though Trusts will not simply employ more junior staff to manage the EWTD.

Skill Mix Substitution Between Doctors and Nurses

17. The current evidence base for using non-medical staff to substitute for medical staff is equivocal. There is evidence that skill mix changes either improve patient outcomes and patient experience, but there is little evidence that the changes are cost effective in hospital settings. However, in primary care there is evidence that practice nurses can cost-effectively substitute for GPs.

18. A recent review by DAT identified many new or extended roles. As these roles are new, there is little evidence on their cost effectiveness or impact on demand for medical staff. New roles included:

— Advanced practitioners such as Medical Care, Surgical Care, Anaesthesia Practitioners who work alongside qualified medical staff;

— Emergency Care Practitioners;
— Consultant Allied Health Professionals;
— More assistant practitioners to work with AHPs;
— Medical assistants and Administrative assistants to work with doctors;
— Modern Matrons.

19. Apart from assistant practitioners and Consultant AHPs the new roles cannot be identified on the census[1] so it is difficult to assess their current impact on the delivery of healthcare.

20. The modelling assumes that in the long term growth in practice nurse consultations will be faster than for GPs, as practice nurses perform an increasing proportion of primary care activity. It is assumed that by 2030 practice nurses could do about 44% of all primary care activity, up from about 38% now.

Workforce Demand

21. Growth in demand for health services is driven by many factors:
— An increasing population. Total population growth is projected to be about $\frac{1}{2}$% per year.
— An aging population. The population growth of the over 65s is projected to be about 1.8% per year.
— Changing culture and lifestyle that affect morbidity. For example, incidence of obesity are rising, smoking rates have fallen but may have levelled off.
— Changing public expectations. Rising living standards mean growing patient expectations.
— Greater medical advances increase the range of treatments available.

22. We have modelled various scenarios around healthcare demand (set out in more detail in table 1).
— The lowest assume demand for healthcare increases only as a result of demographic growth.
— Past trendsin activity can be taken as an indication of future demand for healthcare. Trends in growth of activity have been significantly above demographic growth.
— The Wanless review modelled activity up to 2020 around different scenarios. These all projected activity growth some way above recent trends.

23. Our central assumption on healthcare demand is activity to follow Wanless projections up to 2020 then revert to past trends.

Table 1

KEY ASSUMPTIONS—DEMAND SCENARIOS

Scenario 1: *Demographic growth only*	This scenario assumes that growth in demand for healthcare will only come from demographic growth. Current activity rates per person will continue, ie the impact of changing morbidity and patient expectations will be zero. This is a low growth scenario as historically activity rates per person have been rising faster than population growth. — Low secondary care growth (0.8%) — Low primary care growth (0.7%)
Scenario 2: *past activity trends continue*	This scenario extrapolates forward past (1990–2003) trends in activity. — high growth for secondary care (2.5% per year), — moderate growth of primary care activity (1.2% per year).
Scenario 3: *Wanless activity growth assumptions—Fully engaged*	This scenario extrapolates forward long-term (2015–20) activity growth assumptions used in the Wanless review of 2002. — high life expectancy; — high improvement in health status; — high growth for secondary care activity (3% per year); — 2.0% per year growth in GP primary care activity + practice nurse activity set at 3.3% per year growth.

Medical Demand and Supply

24. We model demand and supply separately for trained doctors (specialists and GPs) and trainee doctors/NCCGs. Demand is expressed in MMC workforce grades. Any gap between workforce demand and supply is presented as numbers of CCT doctors. Charts 5 and 6 show supply and demand below.

[1] Modern Matrons can be identified on the census from 2005.

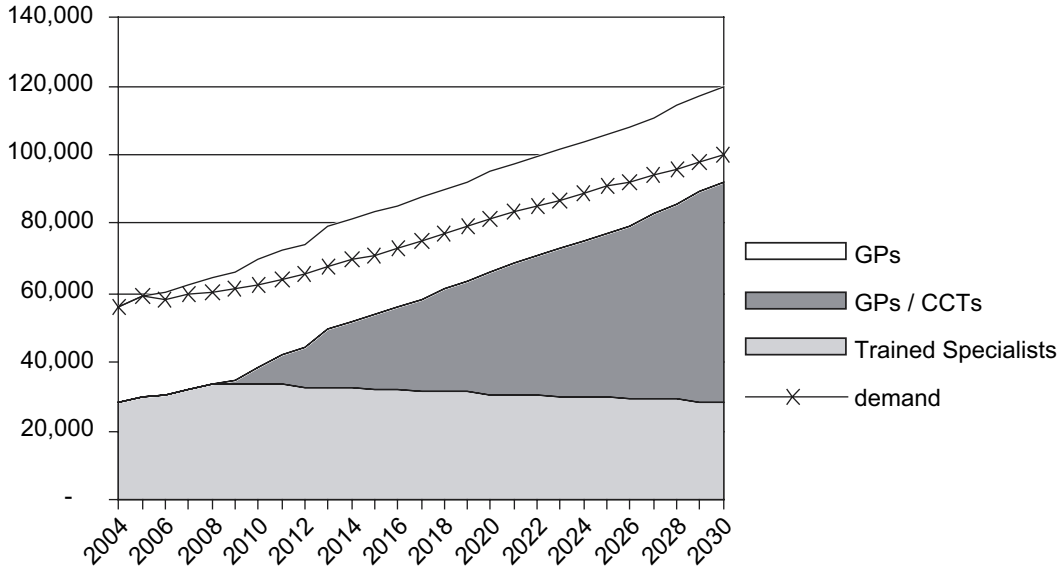
25. The modelling projects an over supply of trained specialist and GP doctors of about 20,000 wtes by 2030 as the supply of trained doctors increases faster than demand.

26. This is offset by a forecast under supply of trainee doctors equivalent to about 26,000 CCT trained wtes by 2030. It is debatable how far (fewer more experienced and productive) CCT doctors can substitute for the service currently provided by trainee doctors as this implies much fewer doctors per patient covering rotas than at present. If the gap cannot be filled by fewer CCT doctors, the total gap could by much larger[2].

Specialist doctors and GPs

Note: demand and supply in charts 5 and 6 is assessed as Full Time Equivalent (fte) figures unlike chart 1.

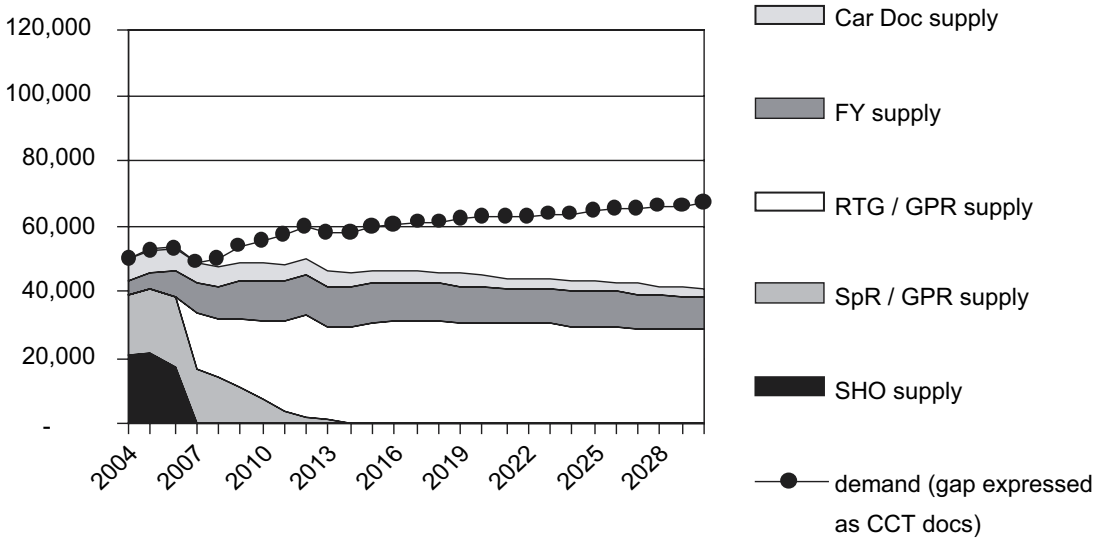
Chart 5: trained specialist demand and supply (wte)



Note: the gap between demand and supply is expressed as numbers of wte CCT doctors.

Trainee and NCCGs

Chart 6: suppply and demand of trainee and NCCG doctors (wte)



Note: the gap between demand and supply is expressed as numbers of wte CCT doctors. If the gap were expressed as numbers of trainee doctors it would be much larger.

[2] For example, if the gap were filled by (less productive) career doctors it would be about 35,000. If it were filled by (much less productive) Run Through grades, it would be over 100,000 ftes.

Affordability

27. The changing medical supply will have implications on the paybill. One way of estimating whether the projected supply of doctors is affordable is to compare the projected pay bill with growth in NHS expenditure. If pay bill growth is higher than NHS expenditure, this implies medical pay will take up an increasing proportion of NHS expenditure and is unaffordable. If pay bill growth is lower than NHS expenditure, this implies growth in the workforce is affordable.

28. The table below sets out the projected paybill costs given the base medical supply scenario and non-medical workforce growth based on Wanless[3]. It also sets out an estimate of the long run (1971–2007) growth in annual real NHS expenditure. A trend in expenditure covering the period since 1999 would show higher average growth. Further analysis of the trends in NHS expenditure is contained in the appendix.

Table 2

PROJECTED GROWTH IN PAY BILL

		With accredited specialist grade paid 75% of a consultant		*All CCT holders become consultants*	
Workforce category	*2004–05*	*2030–31 projected paybill (2004 prices)*	*Average real p/a growth*	*2030–31 projected paybill (2004 prices)*	*Average real p/a growth*
Medical pay bill	9,525m	21,688m	3.2%	24,684m	3.7%
Non medical pay bill	24,006m	68,416m	4.1%	68,416m	4.1%
Trend in NHS expenditure (1971–1999)—Low					3.2%
Trend in NHS expenditure (1971–2007)—High					4.1%

Non medical paybill growth assumes staff growth is 2.2% per year (equal to Wanless demand minus ½%)

Hospital staff pay drift assumed to be 1% per year

GP pay drift assumed to be 0%

Annual pay settlement assumed to be inflation + ½%

Accredited doctor grade assumes newly qualified CCT doctors earn 75% of current consultants

29. Growth in the medical pay bill of 3.2% and the non-medical paybill of 4.1% shows that Wanless demand could be affordable in the long run, only if the long run trend (1971–2007) in real growth in NHS expenditure continues.

30. The growth in the medical pay bill will depend on the future pay and grade structure of specialist doctors. Two scenarios are modelled, one where all new CCT holders are appointed to doctor grade whose pay is on average 75% of a consultant and another where all CCT holders are appointed to consultant positions.

Conclusion

31. Many variables could affect the supply and demand of staff over the coming decades, which make projections difficult to make. However, we can draw the following conclusions from the analysis.

- Recent medical school expansion means that the trained medical workforce will continue to expand past 2030 until reaching a steady state 2040–50.
- The trainee workforce is not projected to grow. MMC trainees are likely to have lower productivity than current trainees.
- The service therefore needs to be prepared to deliver growing activity with a medical workforce with proportionately fewer junior grades of doctors.
- The expansion in the medical workforce is sufficient to meet Wanless demand *only* if fewer, more productive, CCT doctors can substitute for work currently performed by doctors in training. Otherwise, there is likely to be excess supply of CCT doctors and continued imports of junior IMGs.
- Increases in medical workforce would not offset the impact of WTD by 2009 based on current design of services. Higher medical supply could offset reductions in supply from the WTD and falling participation only with service redesign. The impact of changing participation rates is not certain and should be monitored and managed closely.

[3] Wanless growth minus ½% per year.

— There are some uncertainties in MMC which might affect the supply and cost of the medical workforce. These include: pay, length of training, the popularity of FTSTAs and career grades.

— The evidence that using different skill mix solutions to substitute non-medical staff for doctors in the secondary care sector is equivocal. The impact of skill mix particularly from new roles should be monitored.

— Future growth in NHS Expenditure is unknown; however, if growth reverts to its 1971–2007 trend then Wanless growth could be affordable, but lower rates of growth could limit affordability.

Department of Health

11 December 2006

Annex 1

WORKFORCE PLANNING MODELLING STRATEGIES

How to model:

Estimating the need for training capacity can be done in a number of ways:

1. **Project medical workforce supply and demand.** This approach attempts to identify the drivers of healthcare demand and assess how these factors will change over time. The long time frames involved in medical workforce modelling can inevitably mean the output of the analysis becomes very sensitive to a few key assumptions. This is the approach we have used in our analysis.

2. **Comparative bench marks**. This approach compares projected supply with other areas that are assumed to have the "right" number of doctors. There are always value judgements to be made when choosing the comparator system, and often are difficult as like is not being compared with like.

3. **Equalising up**. This approach assumes that the average number of doctors in a system (per population, area etc) represents the "right" number and "demand" equals the number of doctors required to bring all areas up to the current average level. This method ignores the fact that inequality of provision will not be remedied by simply increasing supply.

What to model:

(i) *Specialist demand only*

Previous modelling of medical workforce demand in the NHS has focused on modelling demand for trained consultants and GPs. Demand for junior doctors was considered only as an input in the supply of consultants or GPs. This method is simple and focuses on the key out put of medical training. However, it ignores the service provided by non-consultant career grades and training grades.

(ii) *All medical staff*

Alternatively, model demand for "all trained NHS doctors" as a single homogenous group. This approach assumes that projected growth in activity would lead to growth in demand for all types of doctors.

(iii) *Grade specific demand modelling*

A third approach is to model demand separately for fully trained and junior level doctors.

Annex 2

Relative Medical productivity

The following table sets out the relative productivity assumptions used in the modelling. The assumptions aim to quantify the relative service contribution of different current grades and MMC grades of medical staff.

PRODUCTIVITY ASSUMPTIONS

	Grade	*Current*	*MMC*
Trainee grades			
	PRHO	0.00	XX
	F1, F2	XX	0.00
	SHO	0.09	XX
	SpR	0.37	XX
	FS (Time Limited Training Posts)	XX	0.07
	RT12	XX	0.07
	RT3456	XX	0.23

	Grade	*Current*	*MMC*
Career grades			
	GP	0.78	0.78
	Staff grade	0.54	0.54
	CCT-holding specialist (non-consultants)	XX	0.72
	Consultant	0.78	0.78

Annex 3

Trends in NHS expenditure

The projected growth in NHS expenditure could be estimate in two ways:

— By looking at long term trends in real (ie inflation adjusted) growth in expenditure; or

— By looking at growth in the whole UK economy. We would expect health expenditure to grow at about the same rate or slightly faster than the rate of growth of the economy (implying health expenditure takes a constant or slightly increasing share of GDP).

Trends in NHS expenditure have been higher than the long term trend economic growth implying that health takes up an increasing proportion of GDP spend.

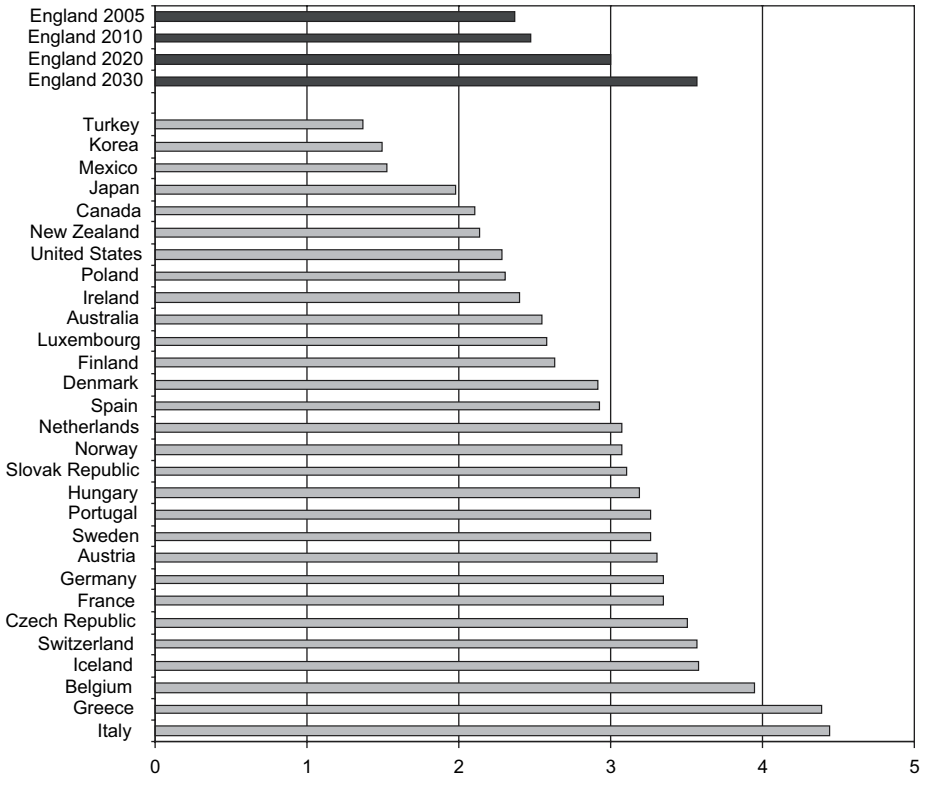
Table

Period	*Real p/a % growth rate*	*Comment*
1971–72 to 2007–08	4.1%	Longest period available
1971–72 to 1999–2000	3.2%	Long term trend before recent "catch-up" increases
1999–2000 to 2007–08	7.6%	Average growth during recent period
1975–76 to 1999–2000	2.6%	Lowest long term period of growth
Long term trend in GDP growth	2.75%	

Annex 4

The following chart shows that based on current projections, increases in medical supply should take the ratio of doctors per population above the 2002 OECD average by 2030. However, it is likely that numbers of doctors in OECD countries will also increase over the period.

Chart 1: Doctors per '000 population - various OECD countries 2002



32. Caution should be exercised when comparing across countries because differences between systems mean often like is not being compared with like. Comparing ourselves to countries that have traditionally oversupplied (eg Spain or Italy) might lead us in turn to over supply.

Further supplementary evidence submitted by the Department of Health (WP 01E)

PURPOSE

1. The purpose of this note is to bring to the attention of the Committee, the work of the National Workforce Programme (NWP) of the National Institute for Mental Health in England (NIMHE) in respect of mental health, as part of the Care Services Improvement Partnership (CSIP). In particular, the Committee may not be aware of our recent publication around our Workforce Planning Pilot Programme; our work on New Ways of Working; New Roles; Recruitment and Retention; and Education and Training.

BACKGROUND

2. CSIP is commissioned by the Department of Health (DH) to help services implement national policies across health and social care in respect of mental health; learning disabilities; physical disabilities; older people; children and families; and people with health and social care needs in the criminal justice system.

3. NIMHE is part of CSIP and one of the key national programmes in NIMHE is workforce.

NIMHE NWP

4. Working primarily at the national level, the purpose of the NIMHE NWP is to support local workforce change through the publication of guidance and practical support that can enable greater flexibility for making change. Guidance is developed through collaborative work with professional bodies and other national workforce players and implementation is supported through various local pilots and Accelerated Development Programmes (ADP). Such development is for the whole of the mental health workforce. This includes all staff, professionally qualified or not, across the full age range of mental health services (children, people of working age, and older people) and across all NHS and social care commissioners and providers of mental health.

5. The NWP is supported by having a workforce lead in each of the eight CSIP/NIMHE Development Centres (DCs) across England. It also works very closely with other key stakeholders. These include Skills for Health; Skills for Care; the Centre for Clinical Academic Workforce Innovation (CCAWI); the DH; the Workforce Review Team; Strategic Health Authorities (SHAs); the Mental Health in Higher Education network; the NHS National Workforce Projects; the various Royal Colleges; members of the voluntary and independent sector; and service users and carers.

6. The role of the NIMHE NWP is to work at the strategic, developmental level. The NWP does not have a performance management function ie measurement against DH targets under the National Service Framework (NSF) for Mental Health[4] and the NHS Plan.[5] That is for the DH Mental Health Policy and Performance Branch.

NATIONAL MENTAL HEALTH WORKFORCE STRATEGY

7. In August 2004, the NWP published a National Mental Health Workforce Strategy that sets out six key aims:

- to improve **workforce design and planning** so as to root it in local service planning and delivery;
- to identify and use creative means of to **recruit and retain people** in the workforce;
- to facilitate **new ways of working** across professional boundaries;
- to create **new roles** to tap into a new recruitment pool and so complement existing staff types;
- to develop the workforce through revised **education and training** at both pre- and post-qualification levels; and
- to develop **leadership** and change management skills.

8. The most recent publications produced or commissioned by the NWP are set out in Annex A. A list of our planned publications is at Annex B.

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[4] Modern Standards and Service Models: Mental Health National Service Frameworks—September 1999 [NHS Our Healthier Nation].

[5] The NHS Plan: A plan for investment: A plan for reform—July 2000 [NHS].

WORKFORCE PLANNING PILOT PROGRAMME (WPPP)

9.1 Workforce Planning has been an expectation in mental health since the publication of the NSF where mention was made about the production of a local workforce strategy to include a review of local workforce issues. Initial and subsequent self assessments by localities across health and social care showed poor progress was being made. As a result, DH assembled a Group to look at developing some Best Practice Guidance and this was published in March 2003.[6]

9.2 What subsequently became clear was that whilst the guidance was warmly welcomed, the Local Delivery Plans showed that workforce planning is not sufficiently robust at Trust level (nor is it in other organisations) and that localities required help over and above the guidance.

9.3 The NIMHE NWP then decided to develop a WPPP to explore in practice, what the issues were. A central Team was set up to drive the project forward and it commissioned each NIMHE DC to put forward no more than two sites each to help test and support the development of the planning process set out in Best Practice Guidance.

9.4 The aim was not just to help those particular sites but to disseminate the lessons learnt by way of a published Report available to all localities. This includes SHAs and their Workforce Development Directorates; Primary Care Trusts (PCTs); Mental Health and Foundation Trusts and Local Authorities (LAs) and to provide advice and support by way of the NIMHE DCs.

9.5 The intention was to support one pilot site in each of the eight DC areas but London was not able to submit a nomination. The final sites were:

— Birkenhead and Wallasey and Bebington and West Wirral PCTs

— Cambridgeshire and Peterborough Mental Health Partnership NHS Trust

— Dartford, Gravesham and Swanley PCT—Kent countywide project

— Dorset Healthcare NHS Trust and North Dorset PCT as one county wide project

— Northamptonshire Healthcare NHS Trust

— Sandwell Mental Health and Social Care Trust

— Tees and North East Yorkshire NHS Trust

9.6 Following an extensive two year programme of events, local workshops, site visits, preparation of supporting materials, teleconferences, consideration of local draft reports and plans etc, a Report on the WPPP was published in May 2006.[7]

9.7 In essence, the Report set out a number of lessons learnt to include 10 key points (see below), as well as a number of resources to support the workforce planning function. As part of the preparation of a local Integrated, Joint Workforce Plan, the Report also made a link to mainstream health and social care policy by making a cross reference to the White Paper, "Our health, our care, our say" where it says on pages 185–186: "Key to closer integration will be joint service and workforce planning. The NHS and local authorities need to integrate workforce planning into corporate and service planning". The Report on the WPPP clearly helps meet that commitment by showing how it can be done.

9.8 The 10 key points set out in the Report were:

— Recognise Workforce Planning is important.

— Get senior (Trust) Board commitment and support to the Workforce Planning process.

— Secure Workforce Planning champions at all levels in the organisation.

— Keep it simple—link to existing established processes such as business and service planning.

— Provide sufficient resources to carry out the Workforce Planning function.

— Ensure there is both the capacity **and** capability to undertake Workforce Planning.

— Use the Department of Health Best Practice Guidance as a model.

— Develop an Action Plan identifying what is to be done, by whom and by when.

— Consider piloting in some parts in small areas first and do it in stages.

— Use it to meet local needs.

9.9 The NWP is now engaged in a programme of dissemination of the Report by way of the web sites; presentations; working with the CSIP DCs; the Foundation Trust unit; the NHS National Workforce Projects group; the Mental Health Partnership Group of Chief Executives etc.

[6] Mental Health Services—Workforce Design and Development: Best Practice Guidance [DH publications Ref: 31146].

[7] Mental Health Services—Workforce Design and Development: Report on the NIMHE National Workforce Planning Pilot Programme (WPPP)—Best Practice [DH publications Ref 274929].

New Ways of Working (NWW) of the Current Workforce

10.1 A programme of looking at NWW in mental health has been under development since 2003 under the auspices of a National Steering Group. This has been jointly chaired by NIMHE and the Royal College of Psychiatrists and representing all professional and other staff working in close collaboration with the CSIP/NIMHE DCs. The early work focussed on psychiatrists and the need for change. Two reports published in 2004[8] and 2005.[9] The Interim Report provided guidance on a number of issues such as medical responsibility and new models of service and the Final Report provided a framework for the development of NWW across the whole of the mental health workforce along with new, Joint Guidance between employers and the College on the employment of consultant psychiatrists.[10]

10.2 All professions eg psychology; nursing; social workers; pharmacy; allied health professions; the non-professionally affiliated workforce; and primary care are exploring what NWW and workforce reform means to them. Current work streams are addressing:

— medical and clinical responsibility across primary and secondary care including accountability of non-medical prescribers in extending their practice;

— work with Coroners, the HealthCare Commission and others to address the implications of NWW; and

— competences, Career Frameworks, Education and Training (E&T), and the implications of new practitioner roles for the existing professions.

10.3 The intention is to produce a progress report in March 2007.

10.4 As part of the NWW initiative, the NWP is also developing as Creating Capable Teams Approach (CCTA) that will provide a methodology for mental health teams to review their practice and so develop their capabilities and competences to meet the needs of service users utilizing the opportunities and flexibilities of NWW and New Roles leading to improved workforce planning. The CCTA is scheduled for publication in March 2007.

Mental Health Legislation

11.1 The Mental Health Bill introduces roles that replace the existing approved social worker (ASW) and responsible medical officer (RMO):

— The functions of the ASW, which include submitting the application for a patient's detention under the Mental Health Act, will be taken on by professionals approved in the new role of Approved Mental Health Professional (AMHP). The Bill allows this role to be taken on by a broader range of professionals in addition to social workers. In England, this may include mental health and learning disability nurses, occupational therapists and chartered psychologists. Welsh Ministers will decide which professional groups AMHPs can be drawn from in Wales. AMHPs will be approved in the role by Local Social Services Authorities (LSSAs), who must ensure that minimum training and competency requirements are met before approval can be given. These requirements will be laid out in separate regulations for England and Wales.

— The functions of the RMO, which include being in charge of a patient's treatment, deciding if a patient should go on leave of absence, have their detention renewed or if they should be discharged, are being taken on by professionals approved in the new role of Approved Clinician (AC). The AC with overall responsibility for a patient's case will be the patient's Responsible Clinician (RC). The Bill allows this role to be taken on by a broader range of professionals, in addition to doctors. In England, this may include chartered psychologists, mental health and learning disability nurses, occupational therapists and social workers. ACs will be approved in the role by Strategic Health Authorities (SHAs), who must ensure that minimum training and competency requirements are met. Welsh Ministers will decide who will approve ACs in Wales and the minimum requirements for approval in Wales, including the professional groups from which ACs can be drawn. Minimum approval requirements will be set out in separate directions from the Secretary of State and Welsh Ministers.

11.2 CSIP is working with professionals and providers on the implementation of the AMHP and AC roles. Employer Guidance, which will be drafted with the full input of stakeholders, will set out recommendations and best practice on implementation issues.

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[8] *National Steering Group:* Guidance on New Ways of Working for Psychiatrists in a Multi-disciplinary and Multi-agency Context: Interim Report—August 2004 [DH publications Ref: 40379].

[9] New Ways of Working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency contexts [DH publication Ref: 270394A/B/C].

[10] Joint guidance on the employment of consultant psychiatrists—October 2005 [DH publication Ref: 271394].

New Roles (NR)

12.1 A number of NR have been introduced into mental health to help expand the workforce across health and social care. These have been supported by the publication of Guidance that includes:

— Primary Care Graduate and Gateway workers who, trained in brief therapy techniques of proven effectiveness, will help GPs to manage and treat common mental health problems in all age groups (published in January 2003[11]);

— Support, Time and Recovery workers who will support service users by giving them time and so help their recovery (published in March 2003[12]). The introduction of STR workers was supported by an ADP that will conclude in March 2007 with the publication of a Handbook; and

— Community Development Workers for Black and Minority Ethnic (BME) communities who will act at a strategic level as a Change Agent; a Service Developer; a Capacity Builder; and an Access Facilitator for the whole of the BME community (Interim Report[13] published in December 2004; Education and Training[14] published in October 2005; and a Handbook[15] published in November 2006)

Recruitment and Retention (R&R)

13.1 In recognising the NWP cannot of itself recruit and retain staff employed by NHS Trusts and LAs, it has undertaken a number of strands of work to help local health and social care systems with these functions. This includes:

— working with CCAWI and the University of Lincoln to produce a report in December 2004 on the recruitment of health and social care professionals in mental health;[16]

— commissioning a mental health R&R research project[17] that provides both a useful reference source as well as a Checklist and Self Assessment Guide (published in January 2005);

— production of a Good Practice Guide for mental health nursing[18] as part of the Chief Nursing Officer's Review of mental health nursing that sets out the potential actions that can be taken to strengthen R&R of mental health nurses supported by examples of good practice and a resource library of contemporary documents about R&R (published April 2006);

— collaborative work with the Royal College of Psychiatrists; the NHS Confederation; and the National Mental Health Partnership Group of NHS Trusts to produce guidance in October 2005 on the employment of consultant psychiatrists.[19] This set out new advice about how consultant psychiatrists may be recruited to new or changing posts by using a more contemporary and flexible approach that takes account of new and emerging models of mental health care; and

— further collaborative work with the Royal College of Psychiatrists; NHS Employers; DH; NHS Professionals; and the National Mental Health Partnership Group of NHS Trusts to produce a practical guide for handling consultant vacancies as part of a national initiative to reduce the costs and use of locums. The intention is to publish this in early 2007.

Education and Training (E&T)

14.1 Despite the development and publication of National Occupational Standards for Mental Health and the NHS Knowledge and Skills Framework, it was clear that what staff working in mental health services wanted was a clear, succinct statement about what essential capabilities they needed to undertake their work effectively. As a result, the 10 Essential Shared Capabilities (ESC) were published[20] in 2004. This provides, in one overarching statement, the essential capabilities required to achieve best practice for E&T of all staff who work in mental health across all ages in both health and social care. Learning materials to

[11] *Fast-Forwarding Primary Care Mental Health:* Graduate primary care mental health workers: Best Practice Guidance [DH publications Ref: 30366].

[12] *Mental Health Policy Implementation Guide:* Support, Time and Recovery (STR) Workers [DH publication Ref: 30742].

[13] *Mental Health Policy Implementation Guide:* Community Development Workers for Black and Minority Ethnic Communities: Interim Guidance [DH publications Ref: 265796].

[14] *Mental Health Policy Implementation Guide:* Community Development Workers for Black and Minority Ethnic Communities: Education and Training—Supplementary Guidance [DH publications Ref: 271259].

[15] *Mental Health Policy Implementation Guide:* Community Development Workers for Black and Minority Ethnic Communities: Final Handbook [DH publications Ref: 278271].

[16] time to act—Choosing to Work in Mental Health: The Recruitment of Health and Social Care Professionals [The Centre for Clinical Academic Workforce Innovation and the University of Lincoln].

[17] Mental Health Workforce Recruitment and Retention Research Project [University of Central Lancashire].

[18] Recruitment and retention of mental health nurses: Good Practice Guide [DH publication Ref: 274284].

[19] Joint guidance on the employment of consultant psychiatrists [DH publication Ref: 271394].

[20] The 10 Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce [DH publication Ref: 40339].

support their introduction have been produced and field testing evaluation, they are currently being revised. The 10 ESC have been widely welcomed and the various professional bodies in mental health are looking to see how they can be incorporated into their E&T programmes.

14.2 In addition, the NWP, in collaboration with a number of partners. has produced some learning materials on Recovery and Race Equality and Cultural Capability scheduled for publication in early 2007.

14.3 To help support the E&T agenda, an E&T Toolkit is also in development with a planned publication date of March 2007.

SUMMARY

15.1 This note provides a brief overview on five key areas of activity for the NWP that relate directly to the *workforce needs and planning for the health and social care service* that the Committee might find useful in formulating their Report.

15.2 We have demonstrated that integrated, joint workforce planning can be undertaken successfully given the right circumstances and support and there are valuable lessons to be learnt that can be shared more widely. We are also collecting evidence on the other aspects of our Programme that directly supports the statement in the written evidence from DH dated 15 March 2006 where, under **System Reform** (on page 21), it said ". . . *In essence, the last five years has been 80% about growth and 20% about transformation and new ways of working. The next five years will be almost exclusively about transformation of the workforce. Future plans will need to incorporate new and extended roles and new ways of working in order to deliver the gains in productivity that will be necessary to achieve patient led care*".

15.3 We stand by ready to discuss with the Committee.

CSIP/NIMHE National Workforce Programme
Department of Health

December 2006

Annex A

THE MOST RECENT PUBLICATIONS PRODUCED OR COMMISSIONED BY THE NWP

- Mental Health Workforce Strategy (August 2004)
- New Ways of Working for Psychiatrists—Interim Report (August 2004)
- The 10 Essential Shared Capabilities (August 2004)
- Community Development Workers—Interim Report (December 2004)
- Mental Health Workforce Recruitment and Retention Research Project (January 2005)
- Community Development Workers—Education and Training Supplement (October 2005)
- New Ways of Working for Psychiatrists—Final Report (October 2005)
- Joint Guidance on the Employment of Consultant Psychiatrists (October 2005)
- Discussion paper about "The social work contribution to mental health services—The future direction" (November 2005)
- Recruitment and retention of mental health nurses: Good Practice Guide (April 2006)
- Report on the NIMHE National Workforce Planning Pilot Programme (June 2006)
- DVD on New Ways of Working for Psychiatrists (Summer 2006)
- Recovery Approach Learning materials (September 2006)
- Community Development Workers—Final Handbook (November 2006)

Annex B

PLANNED PUBLICATIONS
MARCH 2007

- New Ways of Working—Progress Report
- Race Equality and Cultural Capability
- Learning and Development Toolkit
- STR Handbook
- Creating Capable Teams Approach
- Ten ESC Revised Learning Materials
- Mental Health Workforce Strategy—three years on: Summary of Progress
- A practical guide for handling Consultant Vacancies

Further supplementary evidence submitted by the Department of Health (WP 01F)

Thank you for the opportunity to provide evidence at the hearing on 25 January. I welcomed the discussion and am writing to enclose the additional information I agreed to provide about the following issues:

Annex 1: An assessment of productivity and international comparison.

Annex 2: Specialist nurses at risk of redundancy and their roles.

Annex 3: Funding for nursing career pathways in primary care.

Annex 4: Community matrons and the impact on emergency admissions.

In addition, I agreed to keep you informed on progress around the measures being taken to address the employment situation for newly qualified healthcare graduates, such as nurses and physiotherapists. As I explained to the Committee, I want to encourage the NHS to develop local flexibilities so that as many healthcare graduates as possible are employed, rather than impose any cast-iron directives from the centre. The consistent message that I have received from employers is that they need solutions which are flexible, locally driven and founded on partnerships between employers, staff side and the higher education sector. Imposing central targets would not help this process.

Having reflected further on this, I have explored options for establishing local voluntary employment guarantees within the NHS for new graduates leaving training. Following further discussions, East of England SHA have volunteered to pilot a short-term voluntary scheme to graduates qualifying from the Eastern region over the next six to 12 months. In the interim, we will also continue to work with all SHAs across England to implement sensible arrangements with local employers that will maximise the opportunities for new graduates. I will keep the Committee informed of progress on this issue.

I look forward to receiving your recommendations in due course.

Lord Hunt of Kings Heath
Department of Health

5 February 2007

Annex 1

AN ASSESSMENT OF PRODUCTIVITY AND INTERNATIONAL COMPARISONS

How is productivity measured?

1.1 Productivity is difficult to measure in a consistent way that can be tracked internationally given the different measuring systems. Healthcare expenditure in the UK has traditionally been lower than other leading countries and there is some evidence that when Canada applied a productivity model used in the NHS that their productivity was shown to be reducing whilst the NHS was fairly level despite rising input costs.

1.2 Productivity is measured as the change in the outputs produced by the NHS divided by the change in the inputs used to produce these outputs.

1.3 The change in NHS inputs is based on the resources used by the NHS, eg labour (number of staff employed) and land (amount of land used). These different inputs are weighted by their costs to give overall change in inputs used, but as with the output calculation, changes in the costs of different inputs do not affect the changes in inputs, eg wages of doctors and nurses are held constant.

1.4 NHS output is calculated using a cost-weighted activity index. This output index contains over two thousand items of NHS activity, and applies the average cost of each type of activity to obtain a financial value for NHS output. Data on Primary Care Consultations, Primary Care Prescriptions and new types of activity such as NHS Direct and NHS Walk-in Centres are also included in the index.

1.5 The change in output over time is expressed as a percentage and is not affected by changes in costs of the units of activity (by holding prices constant the true change in output is calculated).

1.6 Using this process, however, would take no account of improvements in quality or patient experience. In 2004 DH jointly commissioned the University of York/the National Institute of Economic and Social Research (NIESR) to determine if quality could be included in the NHS output index. York/NIESR built on the DH output index and recommended the inclusion of three quality variables:

— hospital mortality;

— an adjustment to take account of the improved health patients have following hospital treatment; and

— waiting times.

1.7 These quality adjustments added on average 0.17% a year to NHS output over the five years to 2003–04. In their report, York/NIESR stressed that a better approach would be based on systematic collection by the NHS of information on outcomes from treatment.

1.8 DH published a summary of the York/NIESR research, together with other measures of quality change (eg lives saved from statins, improved blood pressure control, and longer survival following heart attacks), in "*Accounting for Quality Change*" in December 2005, with the aim of encouraging further discussion about quality measures. The methods on quality adjustment in "*Accounting for Quality Change"* added an average of 2.7% a year to output growth and productivity. .

1.9 In their most recent article on NHS productivity, published 27 February 2006, ONS take account of the different methods of calculating productivity by presenting their independent analysis of NHS productivity with and without quality. Without any quality adjustments ONS estimate that NHS productivity fell on average by between 0.6% and 1.3% a year between 1995 and 2004.

1.10 ONS therefore present further quality adjusted productivity estimates, using the York/NIESR and DH figures in two stages:

— Including York/NIESR and DH adjustments for quality change (hospital mortality, estimated benefits from hospital treatment, waiting times, improved blood pressure control, lives saved from statins), NHS productivity changed on average by between −0.5% and +0.2% a year from 1999 to 2004, the period over which quality data are available;

— Using the argument that health and NHS output become increasingly valuable over time, in an increasingly prosperous economy, by an estimated 1.5% a year, NHS productivity increased on average by between 0.9% and 1.6% over the same period (1999–2004).[21]

1.11 Regardless of which methodology is used it is clear that there is potential for improvements to be made in productivity in the NHS. We have published the quality and value indicators which provide hospital trust by hospital trust bench marking for the first time ever so that people can see much more clearly the real scope of productivity improvements that they have.

How can we improve productivity?

1.12 NHS organisations will be able to make improvements to productivity in a number of different ways.

1.13 DH can improve productivity through policy making (eg White Paper, Agenda for Change) and through providing the information and guidance to help local organisations improve productivity. DH, working with NHS bodies such as the Modernisation Agency and NHS Institute, have made steps to provide information on areas that provide the greatest opportunities for productivity improvements and by identifying and sharing best practice.

1.14 The High Impact Changes and Delivering Quality and Value publications have identified a number of ways to deliver service improvements, for example:

— To reduce Length of Stay (LOS) by improving discharge and admission processes, queuing systems and patient flows by improving access to diagnostic tests.

— To treat patients as day cases rather than inpatients where appropriate.

— To reduce the number of emergency bed days through improved management of patients with long term conditions. Improved community care can reduce admissions, and therefore, overall costs to the NHS.

— To reduce inappropriate outpatient attendances and inpatient admissions.

— To improve staff sickness absence and turnover rates . . . thereby increasing the capacity of NHS staff.

1.15 The Productive Time Programme was designed as a collection of indicators based on these high impact changes to ensure that the Gershon efficiency savings were translated to something meaningful and useful to the NHS. The Productive Time Programme has worked closely with the NHS Integrated Service Improvement Programme and the NHS Institute to raise the profile of these service improvement possibilities within the NHS, to ensure that the efficiency savings are achieved and services provided to patients are improved.

To date,

— approximately 1.5 million bed days have been saved by reducing LOS for Elective Inpatients, providing an efficiency saving in the region of £500 million;

— the day case rate has increased to 72%, providing an efficiency saving of over £40 million;

[21] The ONS make clear that this principle was recommended by the Atkinson Review into the measurement of government output and productivity for the National Accounts, published in January 2005, and as such should be used cautiously pending further debate.

— over 2 million emergency bed days have been saved, providing an efficiency saving of £650 million; and

— approximately 100 million outpatient appointments have been saved, providing an efficiency saving of £90 million.

1.16 DH has now launched the Better Care Better Value benchmarking tool, in association with NHS Institute. This tool allows Trusts and PCTs to compare their performance in these key areas with other organisations to identify the areas which provide the greatest opportunity for delivering efficiency and productivity gains through service improvements.

Annex 2

Do we have evidence that specialist nurses are being targeted for redundancies? and/or that they are doing generalised work rather than specialist work?

2.1 In the first half of the financial year, there were 135 nurse redundancies (15%) of the total compulsory redundancies in the NHS. We do not collect a more detailed breakdown since the title specialist nurse covers a number of roles, titles and bands. There are the NMC registered specialist practitioner roles such as Health Visitors, School Nurses, and Learning Disability Nurses, and there are specialist roles, such as cancer or MS nurses, where significant post registration training is required and not all are readily identifiable in standard workforce collections.

2.2 It is for local trusts in partnership with local stakeholders to determine how best to use their funds to meet national and local priorities for improving health and to commission services accordingly, this includes provision of such posts and the deployment of specialist nurses. There is anecdotal evidence that some trusts are looking critically at specialist posts to ensure they are targeted in the right areas, are productive and are meeting service needs. There is also some evidence of specialist neurological nurse posts being cut or transferred to generalist roles as part of organisations' cost savings plans.

2.3 I would like to reiterate the comments I made to the committee. Specialist nurses are crucial to the reform programme and organisations will not make the type of change we want to see without using specialist nurses

Annex 3

Funding for nursing career pathways in primary care

3.1 Modernising Nursing Careers is part of a UK wide programme aimed at modernising health careers. Chris Beasley, CNO, is leading programmes of work on behalf of the four countries. The Secretary of State launched the document entitled "Modernising Nursing Careers: setting the direction" in September 2006.

3.2 Whilst restating the constants of nursing and its core values, this document sets the context of healthcare, what this means for nursing and the achievements of nursing today. The future direction of nursing careers is set out, identifying the four priorities and actions needed

3.3 Attached to each priority is a set of actions that will be progressed through projects and workstreams led by the UK health departments or other stakeholders. Some actions like the work on supporting nurses to work in the community have already begun

3.4 One MNC workstream is reviewing the career paths and educational preparation needed for nurses working in the community. This will make recommendations on the training programmes needed to equip nurses to work in hospital and the community and to ensure nurses have the right level of skill in public health, first contact care and long-term care.

3.5 The coalition established to lead the process of modernising nursing careers are developing proposals to:

— strengthen the opportunities for nurses to move between hospital and community as patient pathways and services change; and

— reviewing options for the future career pathways for nurses once they qualify that will support care near home and deliver a flexible highly skilled nursing workforce.

3.6 Nursing in the community is changing and ensuring that nurses are equipped to deliver that change is crucial for our reform programme. We will need to embed training in pre-registration education as well as ensuring that there is appropriate training for specialist and advanced level nurses in the community.

3.7 Meanwhile Primary Care Trusts and education commissioners need to ensure that they have sufficient numbers of qualified specialist community nurses to support the shift from hospital to home.

Annex 4

Community matrons and impact on emergency admissions

4.1 Case management services, led by a community matron or other case managers are a key element of the Government's strategy for improving care for people with long term conditions and reducing emergency bed days. The service aims to provide more proactive, coordinated care in community settings through community matrons and other case managers working as part of joint health and social care teams, reducing emergency admissions and enabling patients who are admitted to return home more quickly.

4.2 The Department is encouraging Primary Care Trusts to develop their own systems for identifying the impact of community matrons on improved patient care and emergency bed days. We are developing a balanced scorecard to help PCTs measure the impact of the service.

4.3 The case management service provided by community matrons is still in early implementation stages across the NHS. Its benefits, nationally, in reducing emergency bed days are not yet being fully realised. We do expect community matrons and case management to have an impact on reducing admissions across the NHS once the service has fully embedded locally.

4.4 A number of PCTs are nevertheless already showing the impact the service can have. Information from the NHS Employers' large scale workforce change programme which focused on long term conditions, showed that:

4.5 Kingston PCT and The Royal Borough of Kingston saved 565 bed days in six months by five community matrons implementing integrated working and case management. They have calculated that this approach saved £127,000 over the six month period.

4.6 North Lincolnshire PCT saved 136 bed days for five patients in six months by community matrons adopting the case management approach. They have calculated that this approach saved them £26,517 over this period.

Supplementary evidence from the British Medical Association (WP 59A)

Following my oral evidence with the Health Select Committee on 8 June, I am writing to provide the Committee with further information on two points raised with me at the evidence session.

Basic Pay Increases

I was asked by the Committee to comment on the assertion in the King's Fund report that consultants had received increases in basic salary of 49.4% over four years on transfer to the new contract. The King's Fund Report (Assessing the New Consultant Contract May 2006) presents a scenario that follows the career of a consultant appointed on 1 April 2001. S/he moves up to point 2 of the old scale in April 2002. At April 2003, s/he would have completed two complete years as a consultant so would move onto the new scale with 2 + 1 years seniority, which paid £66,065 in 2003–04 then £70,328 in 2004–05. In 2005–06 s/he moves to point 4 on the new scale, ie £75,899.

As I mentioned at the session, this progression is an atypical case. A more typical progression would be that of an established consultant with between seven and 16 years seniority at April 2003. This large group of doctors transferred at point 5 and will stay there for at least three years before going to point 6. The table below shows progression, annual increase and cumulative increase under this more common scenario.

Date	*Basic salary*	*Percentage increase*	*Cumulative increase*
April 2001	£66,120		
April 2002	£68,505	+ 3.6%	+ 3.6%
April 2003	£73,290	+ 7.0%	+ 10.8%
April 2004	£75,654	+ 3.225%	+ 14.4%
April 2005	£78,094	+ 3.225%	+ 18.1%

Piloting

There were mixed recollections from the parties of the discussions on piloting. To our recollection, the issue was initially raised in April 2002 in the context of a perceived need to undertake joint work on modelling service and cost implications of the proposed contract and also longer term testing of behavioural change. We understood this to mean modelling prior to implementation and post-implementation monitoring of behavioural change. The latter was the only possible means of proceeding given (a) that it would be difficult to simulate aggregate behavioural change using pilots and (b) that the prolonged time period necessary to test behavioural change would have prejudiced the implementation of the contract in 2003–04.

As to modelling, we shared with the health departments our pre-negotiation diary survey of consultant hours and working patterns. This indicated not only that whole and maximum part-time consultants were working around 51 hours per week but also showed the proportion of this work undertaken at various times of day, at night and at weekends.

I hope that you find the information useful.

Dr Jonathan Fielden
Deputy Chairman, Central Consultants and Specialists Committee
British Medical Association

28 June 2006

Further supplementary evidence submitted by British Medical Association (WP 59B)

The BMA's Junior Doctors Committee (JDC) looks after all matters affecting doctors engaged in hospital practice in the training grades. It does this by promoting the interests of junior doctors, improving the quality of their working lives and seeking to influence the direction of the medical profession as a whole. It represents all junior doctors, whether or not they are members of the BMA. The BMA is pleased to contribute this further evidence following our earlier submission to the Committee on 16 March 2006. This evidence specifically focuses on the transitional problems of Modernising Medical Careers (MMC) and junior doctor unemployment.

The BMA is extremely concerned that at least 11,500 junior doctors could be unemployed next summer under the MMC plans for specialty training. The MMC initiative seeks to reform postgraduate medical training and as part of MMC, the Department of Health announced on 5 June 2006 that there would be a minimum of 9,500 specialist training posts in England. Next year, existing Senior House Officer (SHO) posts will all be phased out and replaced by these 9500 specialist training posts.

However, the group of doctors applying for the specialist posts in England is likely to number around 21,000, which include SHOs, doctors emerging from new foundation programmes, and international medical graduates. With only 9,500 specialist training places that would leave a possible 11,500 doctors out of post in England next summer.

Transition to Modernising Medical Careers and the Shortage of Training Posts

It is likely that SHOs who have not been able to secure a specialist training post under the previous system by August 2007 will find themselves in competition with those emerging from the foundation training programme for entry into the new specialist training programmes, and there may then be no training posts available for those who are unsuccessful. How many of these displaced doctors will be affected? What measures has the Department of Health taken to take account of these displaced doctors? The government has not confirmed what will happen to the remaining 11,500 doctors.

In short, the current number of SHO posts does not match the number of specialist registrar posts. Therefore, what is needed are more of the new style specialist training posts to mop up the excess. The reason for this shortage of training posts is poor workforce planning and transition management as the Department of Health has known that the SHO workforce would need to be reconfigured to fit into the new training system for some time. We are told that the Department of Health team charged with implementing the training reforms does not have the power to create more posts. It is up to trust chief executives locally who and how many they decide to employ. Recruitment will begin at the end of the year but it is still not clear where everyone is going to go.

Some may have the option to move into "non-training" posts, where their development is essentially put on hold. However, a BMA survey last year indicated that most junior doctors would prefer to continue their training overseas than to take up a non-training post. Australian authorities have already come to the UK to recruit doctors.

Given that it costs about £250,000 to train a doctor, the prospect of thousands of doctors becoming unemployed seems a waste and a great loss to the NHS. The BMA has been calling for a temporary increase in the number of national training numbers (NTNs) so that as many existing SHOs as possible can progress to higher specialist training before having to compete for a limited number of new run-through training with those emerging from F2 posts in 2007. Unfortunately, even educationally sound trust grade posts are not recognised for training purposes and this is causing a further delay to SHOs' eligibility to apply for Specialist Registrar posts. The BMA is therefore calling for the Postgraduate Medical Education and Training Board (PMETB) to arrange retrospective training recognition of appropriate posts.

Before the Home Office/Department of Health made their sudden announcement that postgraduate doctors would no longer be eligible for work permit-free training, the BMA in conjunction with the British International Doctors' Association (BIDA) proposed a single-point of entry applications process to

foundation year 2 posts for international medical graduates (IMGs) which, if based on good workforce planning, would enable IMGs to be matched to available headroom, rather than contributing to the over-supply of junior doctors in the UK.

In the long term, the number of UK graduates expected over the next few years has increased beyond the planned expansion due to over-recruitment by medical schools. Although the Department seems to have put funding in place for a headroom of 12% for foundation programmes to accommodate the as yet unknown demand for places from the newly expanded EEA, it is thought that this may reduce to as little as 7% or lower from as soon as 2006 onwards. The BMA has not been informed of any expansion of post-foundation training posts.

Modernising Medical Careers could bring major benefits to both doctors and patients, but its implementation needs to be properly planned and funded. However, the BMA is extremely concerned about the lack of planning and the speed with which the service is being re-organised and its effect on the existing workforce. Inadequate financial management and cuts to funding also threaten to undermine the training of doctors. The BMA is therefore calling for a delay in the implementation of MMC until enough posts are confirmed. It is vital that carefully thought-out solutions are put in place over the coming years or workforce problems will worsen.

Jo Hilborne
Chairman, Junior Doctors Committee
British Medical Association

17 July 2006

Further supplementary evidence from the British Medical Association (WP 59C)

On 13 December, the Department of Health announced the number of places for doctors entering specialist training in England in 2007. Following this announcement, the BMA would like to take the opportunity to contribute supplemental written evidence to the Health Committee's current inquiry on NHS workforce planning.

The BMA has taken an active interest in the implementation of Modernising Medical Careers (MMC). In particular, the BMA's Junior Doctors Committee and the Central Consultants and Specialists Committee (CCSC) have been concerned about the progress of implementation of the Run Through Grade of Specialty Registrar (StR).

The BMA welcomed the announcement from the Department of Health that there will be at least 18,000 places for doctors entering specialist training in England in 2007. This is a major improvement on the figure of 9,500 posts previously announced by the Department of Health.

However, whilst the BMA welcomes this announcement, there are still a number of crucial issues remaining unaddressed and causing anxiety among doctors. In particular, the JDC is concerned that:

- It is not yet known how many of these posts will be entry points to long term training, and how many will be short-term appointments—nor do we know at what level they are.
- Junior doctors have not had enough careers guidance, even though many will be forced to change speciality as a result of the reform. Although money has been made available for doctors currently in Foundation programme year two to receive careers advice, there have been no extra resources for the approximately 16,000 doctors working at SHO level, many of whom are facing difficult decisions about their future career.
- Competition is still likely to be intense and, as the government acknowledges, no-one knows how many applications there will be from overseas, or from UK doctors in non-training posts.
- NHS Trusts have had insufficient time to prepare, and there could still be a significant service impact, particularly during the interview period.

The BMA's CCSC is fully supportive of junior doctors' own concerns about their training and the potential effects of MMC on their career progression. Moreover, the CCSC has a particular focus on how the recruitment to Specialty Registrar in the Spring might impact on consultant workload and, potentially, patient care through absence of doctors on the wards. A letter dated 10 November to trusts by Steve Barnet, Director of NHS Employers, states:

> The absence of 21,500 junior doctors attending up to four interviews [between 28 February and 13 April] could have a major impact . . . on service delivery and/or the cost of locum cover.[22]

This is a major worry for consultants whose responsibility it is to deliver the service. The need to publicise the precise timetable, stating the daily level of absence across all deaneries for each speciality in each day during the whole recruitment process is becoming increasingly urgent. It is, therefore, an issue which is growing in its prominence for the CCSC. It is essential that the timetable is published as early as possible.

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[22] http://www.nhsemployers.org/workforce/workforce-1944.cfm

Together with junior doctors, the CCSC also fears that because the curricula will not be published until the New Year, junior doctors will be forced to apply for posts without a full understanding of the training which is to be provided. Furthermore, there are concerns about the potentially detrimental effect of cuts to MPET,[23] especially on the availability of posts.

MMC should bring major benefits to both doctors and patients; however, the BMA is extremely concerned about the lack of planning of implementation and the speed with which the service and training is being re-organised. We particularly worry about its effect on the existing workforce making a transition to the new system.

Dr Jo Hilborne
Chairman, Junior Doctors Committee, and
Dr Jonathan Fielden
Chairman, Central Consultants and Specialists Committee
British Medical Association

18 December 2006

Further supplementary evidence from the British Medical Association (WP 59D)

Modernising Medical Careers

The BMA's Junior Doctors Committee and Consultants Committee submitted supplementary evidence to the Health Select Committee on 18 December 2006 outlining concerns with the process of implementation of MMC.

Following your request for further information at the BMA dinner with the Health Select Committee on 10 January, this current letter provides you with an update of the BMA's view of the increase in specialty registrar posts. As you are aware, on 13 December, the Department of Health announced that the number of places for doctors entering specialty training in England in 2007 had increased to 23,000. This is a major improvement on the figure of 9,500 posts previously announced by the Department of Health. However, please note that these are indicative numbers and therefore the number of posts is not guaranteed. There already appears to be disparity between the number quoted and the number of posts being advertised on the Medical Training Application System (MTAS), even when accounting for the fact that some fixed term posts are being reserved for the second round of recruitment. As you may be aware, there are a minimum of 21,000 applicants in England alone.

The breakdown of indicative post numbers is now available, for both specialty and run through training. Full details can be accessed at from the MMC website:

http://www.mmc.nhs.uk/download/MMC%20SHO%20Transition%20Figs.xls

The percentage of fixed-term specialty training appointments (FTSTAs) is on average 20% but for surgeons this increases to 50%. This is the fault of poor workforce planning, along with the Royal College of Surgeons encouraging people into surgery knowing there are not enough SpR posts at the end. Many get stuck in the SHO bulge, providing a service and then have little opportunity to progress further with their training. This has obviously come to the fore now run through training is being offered in limited numbers.

Improvements in workforce planning would give more junior doctors access to structured training grades, while providing consultants for the future. It is agreed that a consultant led workforce is what patients need and deserve.It is still important to note that competition is still likely to be intense and, as the government acknowledges, no-one knows how many applications there will be from overseas, or from UK doctors in non-training posts, or the rest of the EEA.

Dr Andrew Rowland
Vice Chairman, Junior Doctors Committee
British Medical Association

25 January 2007

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[23] MPET stands for Multi Professional Education and Training levy (MPET). It is a funding stream from the Department of Health that funds the additional costs to the NHS of supporting the practice experience of medical and dental students.

Evidence submitted by Breakthrough Breast Cancer (WP 99)

1. Introduction

1.1 Breakthrough Breast Cancer is the UK's leading breast cancer charity and is committed to fighting breast cancer through research, campaigning and education. Breakthrough has established the UK's first dedicated breast cancer research centre, in order to realise our vision: *a future free from the fear of breast cancer*. Breakthrough campaigns for policies that support breast cancer research and improved services, as well as promoting breast cancer education and awareness amongst the general public, policy makers, health professionals and the media.

1.2 Breakthrough works closely with healthcare professionals, specifically with specialist breast care nurses, to ensure breast cancer patients receive the highest level of care.

1.3 Breakthrough welcomes this inquiry into workforce needs and planning for health services. Our memorandum focuses on the need for effective workforce planning and the impact poor planning has on breast cancer care.

2. Identifying Future Demand—Trends in Breast Cancer Diagnosis

2.1 Breast cancer is currently the most common female cancer in England. Data published by the Office of National Statistics confirms increasing incidences in breast cancer diagnosis, rising from 34,319 in 2002 to 36,509 in 2003 and a further increase to 36,939 in 2004. Increasing incidences are accompanied by increased referral rates to breast units. Between 2002–03 and 2005–06 urgent referrals for breast diagnosis increased by 29% (from 104,823 to 135,919 referrals).[24]

2.2 With an aging population it is unlikely these figures will decrease. In fact, despite greater (though still limited) knowledge about risk factors and progress in terms of earlier detection, they are likely to increase over the next 10–20 years. It is therefore essential that breast clinics are staffed with adequate levels and appropriately qualified clinicians in order to continue to build capacity to deal with the increasing demands on breast care services.

3. Workforce Planning

3.1 *The impact of poor planning on breast care*

3.1.1 As the Department of Health does not record the number of breast care nurses working in the NHS, it is difficult to quantify the extent and impact of poor workforce planning and job losses.

3.1.2 Breakthrough is currently working with the Royal College of Nursing (RCN) and Breast Cancer Care to carry out a survey of UK breast care nurses to gain a snapshot of the impact NHS deficits may be having on specialist posts and any consequent impact on patient care. It is feared that specialist nurses are sometimes seen as a "soft target" and, in a submission by Breakthrough to the Health Committee's Inquiry into NHS Deficits, there is some evidence that specialist breast care nursing posts are being frozen or left vacant across England due to financial constraints. This places extra pressure on existing staff. Fewer staff in the breast unit, more nurses working unpaid overtime in order to deliver the service, less time to spend with individual patients and low staff morale will inevitably have an impact on patient care and the patient experience.

3.1.3 Financial and workload constraints also mean that staff are not being given the opportunities to develop their professional skills. In addition to study days being cut, many breast care nurses have had their training budgets cut or have had to take annual leave in order to attend training events, sometimes even financing the training themselves.

3.1.4 Breakthrough is concerned that the introduction of Payment by Results may mean that activities promoting patient care may suffer as income-generating activities are prioritised. Specialist breast care nurses have voiced concerns about a lack of understanding within NHS Trusts about the nature of their role in supporting and caring for patients and there being no tariff placed on this type of activity. Breakthrough believes this reflects an overall lack of emphasis on the importance of patient care.

3.1.5 Breakthrough believes poor workforce planning threatens specialist nursing posts, damages patient care continuity, and potentially limits the quality of breast cancer care.

[24] Cancer Waiting Times Statistics, 2003–06, Department of Health. *This figure does not include non-urgent breast diagnostic referrals, which are not collected centrally.

3.2 *Changing roles*

3.2.1 Increased referrals to breast units has led to discussions of how to make more effective use of consultant and specialist breast care nursing time. The current financial situation is also requiring breast units to think more creatively about existing resources and meeting Government targets, as well as plans for "Going Further on Cancer Waits" as part of the Cancer Reform Strategy.

3.2.2 In October 2003, Breakthrough launched the "Left in the Dark" campaign calling for all people with breast problems to be seen by a specialist within two weeks following a referral by a GP. The campaign highlighted the fact that every year, 10,000 women subsequently diagnosed with breast cancer in England are given a routine referral and were waiting up to 17 weeks for an appointment with a specialist.

3.2.3 With the support of a clinical advisory group, Breakthrough developed an Advanced Nurse Practitioner role, where nurses and other healthcare professionals such as radiographers could be trained to perform advanced tasks in breast clinics to assess, diagnosis and follow-up patients with breast disease.[25] In 2005 the Prime Minister and the then Secretary of State for Health committed the Government to implementing a two-week wait for all by 2008.This post could be used to help breast units in meeting existing targets and in implementing this two-week commitment.

3.2.4 Support for the Advanced Nurse Practitioner role has been received from clinicians and the Department of Health. A Breast Working Group, established by the Department of Health, is working with Skills for Health to confirm the competencies for a Breast Assessment Practitioner, similar to Breakthrough's Advanced Nurse Practitioner role. While the role and competencies required have received support, the Department of Health has confirmed there is no additional funding to support the development of training courses or additional funding for Primary Care Trusts to support clinicians to undertake the training.

3.2.5 It is vital that the necessary infrastructure is in place to support the development of competencies for the Breast Assessment Practitioner role. Training courses must be developed, and time and resources made available for this training, for staff who may take on this role. Furthermore, it is difficult to see new targets, such as the two-week wait, being met and reforms made to the working practices of staff in breast units if no priority is given to workforce planning for the future.

3.2.6 Breast cancer treatment has the potential to change greatly over the next 10 years with better technologies, such as less invasive and more targeted treatments, delivered in different ways by different clinicians. In addition, patients will continue to need someone to support them through their experiences. It is therefore essential that specialist nursing posts are both funded to meet current needs and allowed to develop to meet future challenges, free from short term pressures to balance budgets.

4. Recommendations for Action

4.1 The Department of Health should support workplace innovation and changing workplace practices, ensuring resources are available to trusts and frontline staff to implement the Department of Health's Breast Working Group's Breast Assessment Practitioner role.

4.2 All those involved in the National Health Service including the Department of Health, Primary Care Trusts, and NHS managers recognise the role specialist breast care nurses play in patient care and how that care is being affected by deficits and poor workforce planning.

4.3 The Department of Health should ensure that Primary Care Trusts make available annual budgets for staff professional development, ensuring there are no further obstacles, such as cuts to study days and a lack of "bank staff nurses" restrict ability to attend training.

4.4 The Department of Health should ensure that short term financial situations do not impact upon the NHS's ability to retain and recruit skilled and motivated specialist breast care nurses.

Vicki Nash
Breakthrough Breast Cancer

24 January 2007

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[25] *Towards a Two-Week Wait for All: Reducing Waiting Times for Breast Cancer Diagnosis, A Role for Advanced Nurse Practitioner*, Breakthrough, 2003.

Supplementary evidence submitted by the Council of Deans and Heads of UK University Faculties for Nursing and Health Professions (WP 73A)

Use of MPET budgets (including NMET element of MPET) to reduce deficits in the overall health economy of the SHA

Introduction

In response to the request from the Health Committee, this note highlights evidence from recent board papers from pre-July SHAs demonstrating that funding from MPET budgets has been used to reduce deficits in the overall SHA health economy. Extracts are provided from five SHAs.

In each case they demonstrate that "underspends" from MPET funding have been used to contribute to reductions in overall SHA health economy deficits. They also indicate that these SHAs had also required the WDDs to underspend and in some cases had imposed specific financial targets for this.

Thus in example 1 (Avon, Gloucestershire and Wiltshire SHA):

> "The WDC has taken significant measures to achieve £7.8 million, which has contributed to the overall AGW wide financial position."

and

> ". . . the SHA set the WDC a savings total of £10 million to contribute to achieving a balanced LDP and to avoid cost-shifting to the service. This meant further reductions in education commissions had to be made."

In example 4 (Thames Valley SHA):

> "At the end on Month 11 there is a £5.6 million underspend and this is expected to remain the same for Month 12 . . .
>
> The SHA has still not received confirmation of allocations for 2006–07 but continues to work within the proposed budget. There are still huge financial pressures across the health economy and the committee has been asked to find a further £500k in support from the Workforce budget."

The Council of Deans also believes that savings have been targeted towards the NMET element of the MPET budget (savings in which impact less directly on NHS organisations than for savings in MADEL and SIFT). This is more difficult to evidence directly.

However, in example 1 (AGW) the forecast variance in the PG medical and dental budget is stated as 2.04%, whereas the variance in the "other healthcare professions budget" is 6.28%.

In example 4 "The bulk of the underspend is from the NMET budget."

and

> "EMS asked for the money to be delivered from genuine savings and not by shifting costs to Trusts".

Extracts from SHA board papers published on the web

1. Avon, Gloucestershire and Wiltshire

Board meeting 4 May 2006, financial performance 2005 to 2006—as at 28 February 2006

> "The WDC is continuing to stop all activity that has either not been firmly committed or has not been earmarked for allocation to NHS organisations in AGW. The forecast underspending on the budget amounts to £7.3 million (5.3%). The WDC has taken significant measures to achieve £7.8 million, which has contributed to the overall AGW wide financial position."

Forecast variance for PG medical and dental budget	2.04%
Forecast variance for Other Healthcare Professions	6.28%

Board meeting 27 June 2006

Pre-registration education and training contracts

Education commissions

> "During the period of negotiations in April, the SHA set the WDC a savings total of £10 million to contribute to achieving a balanced LDP (Local Delivery Plan) and to avoid cost-shifting to the service. This meant further reductions in education commissions had to be made".

2. Hampshire and the Isle of Wight SHA

Board meeting 9 May 2006

Financial monitoring report 2005–06

Strategic Health Authority Position

> "Workforce Development Directorate—has by far the largest annual budget of £136 million. Breakeven has been forecast, which is a net position after making an increased contribution of £20 million to the Central Risk Reserve."

Board meeting 13 June 2006

Workforce Development Directorate Operating Plan 2006–07

> "The Draft Operating Plan is based on the assumption that further new brokerage of £10 million to the SHA is required."

The draft Operating plan is based upon anticipated allocations as previously notified. The SHA request for £10 million brokerage has been covered by the £8 million already identified by the WDD.

The remaining £2 million will be found by not releasing any developments (£1.5 million) and increasing the expected slippage on programmes.

3. North West London SHA

Board meeting 25 April 2006

Finance report

SHA Administration and Education and Training Position

> "As the main education and training allocation budget was not notified until mid October 2005, commitments were kept to a minimum. As a consequence an element of natural slippage has materialised.
>
> All budgets have been further scrutinised to assess the contribution that can be made to assist the sector position. An estimated underspend on the education and training budget is now forecast. Budgets are under constant review to identify the potential for an increased surplus to assist the sector position."

4. Thames Valley SHA

Paper for Board Meeting on 10 May 2006

Draft minutes of the workforce Committee held on 13 April 2006

> "At the end on Month 11 there is a £5.6 million underspend and this is expected to remain the same for Month 12.
>
> This is spread across all workstreams with pressures on the MADEL budget re flexible careers. The bulk of the underspend is from the NMET budget.
>
> The SHA has still not received confirmation of allocations for 2006–07 but continues to work within the proposed budget. There are still huge financial pressures across the health economy and the committee has been asked to find a further £500k in support form the Workforce budget."
>
> "EMS asked for the money to be delivered from genuine savings and not by shifting costs to Trusts."

5. North and East Yorkshire and Northern Lincolnshire SHA

Board meeting 28 June 2006

Workforce Report

The WDC has reported an underspend of £1,824 against current budgets. These budgets had already been reduced by brokerage transferred to the SHA of £2,098k. Furthermore £3,630k of brokerage relating to 2004–05 has not been repaid in 2005–06, by agreement with the SHA. In totality therefore the overall surplus generated by the WDC in contribution to the overall SHA financial position is as follows:

Brokerage not repaid from 2004–05:	£3,630k
Brokerage generated in 2005–06	£2,098k
Further budget underspends	£1,824k
Total	£7,552k

Council of Deans and Heads of UK University Faculties for Nursing and Health Professions

21 July 2006

Evidence submitted by the English Community Care Association (WP 91)

1. The English Community Care Association (ECCA) is the leading representative body for independent care homes in England.

Members provide a wide range of services in residential and nursing settings for adults. Member care homes are small individual concerns and large corporate organisations both charitable and commercial.

ECCA campaigns to ensure the optimum environment exists for care homes to provide high quality care for those who wish and need it.

2. Workforce planning needs to involve the independent sector, because (a) the independent sector is the main (provider of social care (b) the opportunities and direction set out in the Health White Paper (Our Health, Our Care, Our Say) with integration of health and social care and use of the independent sector.

3. Key areas of concern in workforce planning include:

3.1 Recruitment and retention:

The Department of Health social care adverts (small things make a difference) are useful, however in 2006 the slogan "at home not in a home" was not helpful for attracting staff into working in care homes. Care roles need to be perceived in a more positive light in order to recruit dedicated staff. It is important to have career structures in place that acknowledge, reward and encourage staff to join and remain in the sector.

There needs to be the provision of more flexible working processes in line with other jobs in the marketplace. In addition the workforce will be older and their commitments and abilities, need to be taken into account, especially for shift work.

3.2 Increased fees for regulatory bodies and vetting fees may discourage recruitment because potential employees will not want to invest the money to cover their checks or wait for them to be returned. For many, the alternative to working in social care is to work in a supermarket where the wages are similar and no checks (nor additional expenditure) are needed.

For example Criminal Record Bureau checks are compulsory for care staff at a cost of £31 for a standard disclosure and £36 for an enhanced disclosure, there is an additional charge of £6 per PoVA First check.

It is anticipated that charges will rise when the Bichard proposals are in place, in addition employees will be required to register with the General Social Care Council (approximately £30). There are also proposals in the Protecting Vulnerable Groups Bill that would make ID cards a compulsory pre-requisite for those wishing to obtain) CRB checks. This is another cost for the employee to consider before applying for a job that pays little more than the national minimum wage.

Many employers bear the costs of the above checks, but this is not sustainable especially with the substantial under-funding of the independent care sector.

3.3 Immigration Control. The sector could not manage without recruiting from the overseas workforce. The new points based system will need to address the fact that social care is classified as low paid and relatively low points awarded. The current position assumes that European countries can fill all the care vacancies, however owing to the shortage of workforce this is unrealistic. It also means that European nationals take precedence over staff who may be better qualified, potentially more culturally sensitive and have a better knowledge of the English language. This is not a helpful approach for the development of workforce planning.

It is essential that the Home Office consults the health and social care sectors about the new points system. Joined up Government together with the necessary political will is needed.

3.4 Extension of Annual Leave. The Government has recently published consultation on extending holiday entitlement to 28 days. This will have a knock on effect on workforce planning owing to the additional costs involved. ECCA will be responding to this in due course, but clearly for those homes that are currently not able to offer the 28 days currently will be adversely affected in terms of costs.

It will be important to know if it is the intention to amend the Working Time Directive. At present, if an employee has an annual leave entitlement that exceeds the minimum 20 days, it is not unlawful for them to work on the additional days (effectively for double pay). ECCA believes that many staff in the sector may also choose to work on some or all of these days if it is not unlawful to do so.

4. Technological change may facilitate workforce development, however in the care home setting, technology will not decrease the need for care staff or nurses. In the caring sector, there is no substitute for one on one care, 24 hours a day, 365 days a year.

Even with the advent of technology, one of the dangers of Government policy of everyone living in their own homes is that individuals will not be able to receive one on one care and attention and therefore may become isolated. It can also demean choice andldignity.

5. With the increased use of the independent sector in the provision of health and social care it is essential that the ideology that voluntary equals good and private equals bad is dispelled. Whoever can deliver the best outcomes should be utilised.

6. Training. The independent sector has long been delivering social care on behalf of local authorities. It may be useful to learn lessons from this relationship in order that new partnerships in the health sector do not face the same barriers. The independent sector has major problems accessing funding and resources; particularly training resources. It is essential that training contracts are negotiated directly with the provider rather than funding being passed to the local government department as often they do not pass on the relevant funding.

6.1 Adequate attention needs to be given to the continuous professional development of the workforce. They need to be up to date with the plethora of rules and regulations, for example trained in the Mental Capacity Act, Bichard Vetting & Barring Scheme and the revised National Minimum Standards.

6.2 Often the independent sector will invest resources in new staff and train them to the appropriate levels only for them to be "poached" by the NHS, because the pay and conditions are better. A level playing field is necessary for workforce planning to become a reality.

6.3 Much of the current training for the social care workforce is no longer fit for purpose. It is focused on processes rather than enabling people to live with maximum independence. It is necessary to radically re-think staff training agendas across health and Social care. The NHS in particular needs a better understanding of social care and some significant cultural shifts.

6.4 ECCA maintains that Skills for Care and Skills for Health should be joined together and review the appropriateness of the current training including the relevance of NVQs and whether they are fit for purpose.

7. There needs to be a joined up approach to workforce planning and recognition that public sector pensions are not viable. By and large, the independent sector finds arrangement under TUPE too expensive and cumbersome.

In order to meet the needs of the future workforce across health and social care it is essential that barriers including public sector pensions and TUPE are, analysed as they currently prevent the transfer of workforce across sectors. In order to stimulate cross Sector workforce development the barriers such as commissioning costs and joint recruitment plans need to be put into place.

7.1 Measures need to be explored that attract staff with the relevant skills. For example ECCA has worked with the Practice Learning Taskforce on developing strategies in practice learning (*Developing Strategies in Practice Learning, A Guide for Organisations New to Practice Learning*). Members of ECCA participated in a scheme to host social work students in care homes and identified the benefits, challenges and practicalities of practice learning. The students brought an enthusiasm and new perspective which in turn can aid the delivery of high quality care. The publication offers practical guidance, based on the experience of working with organisations, including members of ECCA, about the various aspects of developing, and delivering a practice learning strategy. Social workers of the future need to have a good understanding of the range of services that care homes offer and how they deliver the services.

7.2 The National Minimum Standards should be amended to allow 16 year old care workers to have a direct caring role. It makes no sense to exclude this age group.

8. Financial Constraints. There need to be incentives in the system for the delivery of outcomes. Currently there are perverse incentives to make people more dependent rather than rewarding for increasing their independence and well being. Staff also need to understand that independence is a state of being not a geographical location.

The independent sector is under-resourced and it is essential to have an independent cost of care in every local authority in order to establish (and pay) the real costs of care.

Please contact me if you would like expansion on any of the above points.

Martin Green
Chief Executive, English Community Care Association

20 June 2006

Supplementary evidence submitted by the Joint Epilepsy Council (WP 10A)

INTRODUCTION

The Joint Epilepsy Council (JEC) initially submitted written evidence to this inquiry in March 2006. Since the submission and during the course of the inquiry, a number of further serious issues have emerged, largely related to the current NHS financial crisis. Recent figures suggest that around 10% of all Epilepsy Specialist Nurses (ESNs) across the UK are currently threatened with redundancy, reduced hours or assignment to non-specialist duties. The JEC is also concerned that the current financial climate within the NHS is not conducive to addressing additional workforce issues, including the critical shortfall of neurologists in the UK. The JEC would therefore like to take this opportunity to raise these serious issues with members of the Committee and with the Health Minister, Lord Hunt of Kings Heath.

Epilepsy Specialist Nurses

Epilepsy Specialist Nurses (ESNs) are a crucial source of support and advice to patients with epilepsy, and enable many patients to manage their epilepsy effectively and to remain independent in the community. Their vital role has been recognised by the Government on numerous occasions, including the recent NICE clinical guidance on the diagnosis and management of epilepsy which stated that "epilepsy specialist nurses should be an integral part of the network of care of individuals with epilepsy". There are approximately 170 Epilepsy Specialist Nurses in the UK and the JEC has been campaigning for this number to increase to 600, following a consensus statement produced by expert clinical epileptologists and representatives of the epilepsy voluntary sector. However, despite the already chronic shortage of ESNs across Britain, 10% of the current workforce is under threat and the JEC is now forced to defend the status quo, rather than focusing on expanding the excellent service provided by ESNs.

There is no dispute regarding the efficacy of ESNs. Epilepsy specialist nurses save the NHS money by releasing consultants' and neurologists' time, reducing accident and emergency admissions, enhancing patients' adherence to anti-epileptic treatment and reducing the use of hospital beds. Clear evidence displays high levels of patient satisfaction, reduced psychosocial trauma, less time off work, less medical input and fewer readmissions.

In addition, the threat to Specialist Nurses posts is not limited to those who have specialised in Epilepsy. Specialist Nurses providing services for people with a wide range of other long-term neurological conditions, such as Parkinsons and Multiple Sclerosis are facing similar threats. It would appear that service providers find Specialist Nurses an easy target when trying to balance the books.

Shortfall of Neurologists

As the JEC highlighted in its Written Evidence, there is serious concern over the lack of planning in addressing the critical shortfall in the number of neurologists in England, particularly those who are specialised in epilepsy. This shortfall has serious implications for the treatment and care offered to people with epilepsy, further compounded by the threats to ESNs as highlighted above.

It is vital that the Government adopts a national target with regards to neurologists in order to effectively implement key programmes such as the recommendations of the National Service Framework for Long-Term Conditions and the policies clearly set out in the recent White Paper, Our Health, Our Care, Our Say.

In terms of longer-term workforce planning for those with long-term conditions including epilepsy, the JEC would like to see a programme to increase the number of adult neurologists from 352 to 1,400; paediatric neurologists from 75 to 150; learning disability specialists from 340 to 500; and neuro-radiologists from 110 to 160.

Further Information

The Joint Epilepsy Council of the U.K. and Ireland (JEC) is an umbrella organisation of 22 epilepsy organisations, operating in England, Wales, Scotland, Northern Ireland and the Republic of Ireland, to work collaboratively in a focussed, professional and effective manner, facilitating the sharing of information, expertise and skills, promoting good practice, maximising resources and identifying unmet needs.

Joint Epilepsy Council

24 January 2007

Evidence submitted by the Faculty of Public Health of the Royal College of Physicians of the UK (WP 81)

The Faculty of Public Health is an authoritative public health body which aims to advance the health of the population through three key areas of work: health improvement; service improvement and health protection. In addition to maintaining professional and educational standards, the Faculty advocates on key public health issues and provides practical information and guidance for public health professionals.

We are pleased to be asked to submit evidence to the Health Select Committee's Inquiry into Workforce Planning. We will focus our response on the public health workforce, as this is the area that is currently of grave concern. The Faculty has undertaken workforce surveys for a number of years and a copy of the most recent survey is attached to this submission. Key findings from the recent survey are highlighted below:

— The 2005 survey of the specialist public health workforce identified 1,107 individuals working at consultant level in public health in their primary post, 224 (17%) less than in 2003. About 20% of this fall is in service pubic health posts.

— The problem is particularly acute in England, with only 36% of Primary Care Trusts England believing that they have sufficient capacity and capability to deliver public health effectively. This is compared to Northern Ireland , Scotland and Wales where 70%, 60%, 56% respectively of those surveyed agreed their team was adequate to deliver the public health agenda.

— Academic public health has shown a decline of 53.3% reduction in numbers. This fall is consistent with data from the Council of Heads of Medicals Schools (CHMS).

— The restructuring of Primary Care Trusts and Strategic Health Authorities following Commissioning a Patient-Led NHS (CPLNHS) could result in 100–150 more senior positions being lost.

— There is a 40% reduction in planned recruitment for public health training for 2006, compared with 2005. Sources within the Deaneries reveal that four of the 13 regions plan to cancel their public health training completely for this year.

Figures collected by the NHS Health and Social Care Information Centre on public health consultants and dentists show variable numbers for earlier years with a decline in 2004–05. Information from the Council of Heads of Medical Schools also demonstrates in the number of clinical public health academics in medical schools over the same period.

This picture is of particular concern given the NHS restructuring subsequent to CPLNHS in UK, which threatens to lead to loss of senior public health consultants in the NHS given the reduction in the number of strategic health authorities and primary care trusts. Despite the assurances given to the Select Committee that there would be no loss of public health posts, there is serious concern that the human resources approach is not set up in such a way to deliver this. In addition, recruitment is currently under threat to specialist public health training programmes as postgraduate deaneries also deal with anticipated cuts to their budgets next year.

Given the strong support for public health demonstrated by the Government in the Wanless Report and Choosing Health, it is extremely worrying that the current re-organisation actually threatens the public health workforce still further.

How should effects of the following be taken into account?
Recent policy announcements including CPLNHS
Technological change
An aging population
The increasing use of private providers

The potential adverse effect on the public health workforce, both consultants and their teams, of CPLNHS has already been highlighted. Explicit assurances are needed that current levels of the public health workforce will be protected. The 2005 FPH survey found that only 36% of PCTs would describe their public health team as of adequate capacity- the creation of larger PCTs with the pooling of resources has the potential to improve this position but only if the total levels of staffing are protected.

As highlighted in the Wanless Report, the impact of technological change, and an aging population, together with a number of behavioural and life style factors mean that investment in public health services must be made if the health services are not to be overwhelmed.

The increasing use of private providers threatens to fragment care, and the multiplicity of providers may affect both access and quality. More vulnerable populations may find it difficult to negotiate more complex systems. Thus the public health role of considering at a population level, access, equity and quality of care across care pathways will become ever more important.

How will the ability to meet demands be affected by?
Financial constraints
EWTD
Increasing international competition for staff
Early retirement

As already alluded to, the financial constraints on SHAs and PCTS in the restructuring are likely to jeopardise an already thinly stretched public health function unless specific action is taken to protect these resources. Loss of senior experienced individuals to early retirement or redundancy is a real likelihood.

Early retirement generally for public health professionals is a real issue, and very much higher than in the clinical specialities. This must be taken into account when workforce planning is undertaken to avoid the overestimation of future workforce numbers. A further issue is that many public health professionals are highly experienced and many have also completed GP training prior to public health. We are already seeing a number leaving public health to return to general practice. The establishment of the Health Protection Agency has also created a further large and important employer of public health professionals that provides a significant alternative to the NHS.

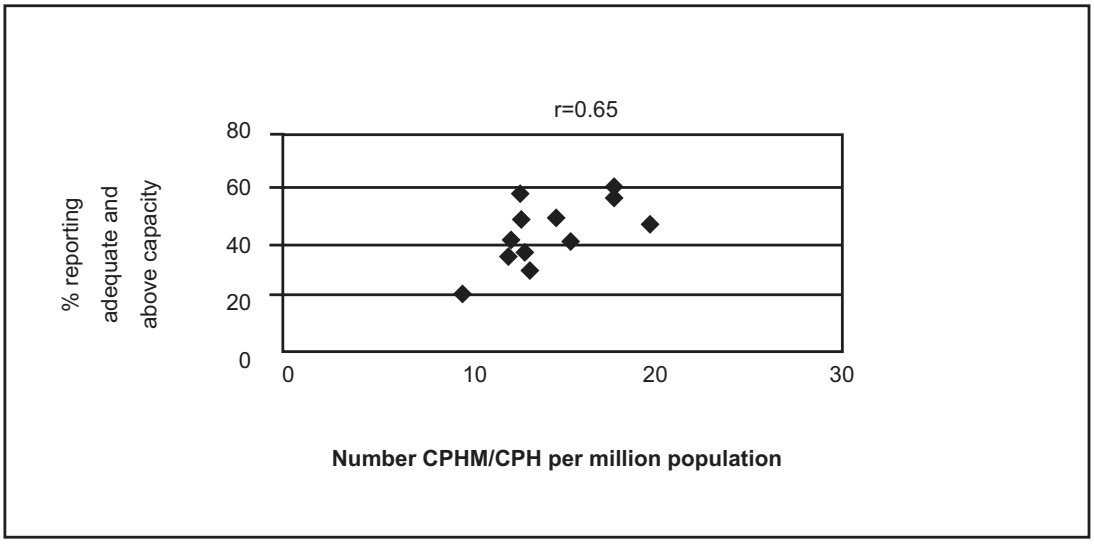
At the same time, pressure on training budgets within postgraduate deaneries may lead to public health training budgets and recruitment being cut for 2006–07. As public health training budgets are not embedded in acute service delivery in trusts in the same way that junior hospital doctors are they can prove more vulnerable to cuts.

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

The Faculty of Public health has pioneered the development of multidisciplinary public health. Senior public health posts are open to those from a variety of backgrounds, not just medicine, and the UK Voluntary Register has established a specialist register for those working in public health from backgrounds other than medicine. However, it is clear that there remains a need for individuals in public health from both clinical (including specifically medicine) and other backgrounds if a comprehensive service is to be delivered across the three domains of public health: health protection, health improvement and service improvement.

It is essential that Directors of Public Health are well supported by appropriately resourced teams, which include other consultants, health promotion specialists, information and intelligence analysts and adequate administrative support. The Faculty workforce survey found a strong correlation between the number of consultants per million population and the self reported capacity of the team. This suggests that there has not been a compensatory shift from senior to more junior posts, and that quite simply where there are not enough consultants there are not enough junior posts either. Whilst it is essential to ensure a wide skill mix within teams this does not negate the need for senior posts to provide leadership and direction.

Figure 1. Self reported capacity and numbers of those working in UK at consultant level in service public health and related areas in their primary posts per million population



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?

The planning of the public health workforce is essential, and it needs to take into account a number of factors:

- The diversity of key employers for a comprehensive public health service; the NHS, the Health Protection Agency, central and local government—the FPH target of 2.5 service consultants per 100,000 population takes the variety of service locations into account.
- The additional need for public health academics in universities.
- Actual data on attrition and early retirement.
- The numbers of senior public health consultants and dentists and Directors of Public Health AND.
- The size of the wider public health workforce.

The work undertaken by the National Workforce Review Team has in general been of high quality, timely and useful for planning, and we would support its continuation. It is particularly important for areas such as public health where there is a need for long-term vision and planning to ensure that there is a robust workforce in place. Given the flexibility and adaptability of the public health workforce (in contrast to some of the clinical specialities) we are concerned that "under-production" is a very much more serious issue than "overproduction" of public health specialists.

FPH has worked with the WRT to try to ensure that an appropriate target is set, and importantly that realistic assumptions about retention and early retirement are included in the model. In contrast to other clinical specialities it must be recognised that public health professionals work in areas other than the NHS in order to deliver a comprehensive public health system, and this must be recognised in the planning.

There is also a need to ensure that the NHS staff census captures not only the senior public health staff working at consultant and director of public health level, but also the wider public health workforce of health promotion, public health intelligence analysts and so forth who form an integral part of the delivery system.

It is essential that robust links are made between the WRT and the newly established Health and Social Care Information Centre. The HSCIC may need to consider what approach it should take to identifying the consultant public health workforce within the Health Protection Agency.

Overall we support the national approach to planning but would wish to see it refined further.

Faculty of Public Health

8 May 2006

Evidence submitted by the Federation of Clinical Scientists (WP 82)

1. The Federation of Clinical Scientists (FCS) within the Alliance for Health Professionals represents clinical scientists working in some 50 or more different disciplines across the NHS. Whilst the largest numbers are in clinical biochemistry and medical physics, which will provide services in most routine hospital settings the group includes many other specialities providing local, regional, national or even international services. Within teaching hospital, medical school and research institution settings clinical scientists deliver the highest level of clinical and clinical applied research in diagnostics and therapeutics including point-of-care (bedside) diagnostic testing, the application of new analytical techniques into clinical settings, stem cell research, molecular genetics capitalising on the international investment in the Human Genome Project and health protection issues (eg within the Health Protection Agency) such as "bird flu" and radiation protection. Within the service setting consultant clinical scientists are, together where relevant with medical consultant colleagues, the clinical leaders in the application of these developments into routine healthcare and leaders of the "working differently" initiatives that underpin the reform of the NHS. Those in the positions of being national and international experts within their fields are in this small group of NHS staff. Their achievements have been applauded at the regular Chief Scientific Officer's conference and importance of their contributions recognised in the delivery of "High Impact Change number 2" (NHS Modernisation Agency, September 2004).

2. In order to deliver at this level clinical science seeks to recruit the very best from the nation's educational system, ie graduates or doctorates with good pure science degrees and/or academic research expertise, thereby capitalising on the high level of investment. The lead time to being ready to take a clinical leadership consultant post is of the order of 10–12 years and typically includes further vocational academic training (four years to professional registration under the Health Professional Council) and higher professional training and practice experience to Medical Royal College membership (typically Royal College of Pathologists) or qualifications of equivalent standing. Inevitably this entails a great deal of commitment from both post holders in their initial post-graduate training and further professional training and the NHS clinical leaders training them. The output of training programmes are national assets to the professions and are expected to move around the NHS during their subsequent career progression.

3. The clinical science professional bodies work closely with the Royal Colleges and Department of Health to:

1. Plan and deliver professional training to the necessary standards
2. Achieve workforce planning.

It will be appreciated that the workforce planning for small professional groups is very delicate. The funding of professional entrance level training (formerly referred to as Grade A under the now obsolete Whitley system) is devolved to SHA level Workforce Development Confederations (WDCs). FCS maintains that, given the small numbers involved in any one speciality, the necessity that trainees will subsequently move away from their initial training department and the need to avoid wastage and attrition from the NHS of these high investment staff workforce planning, training planning, subsequent career progression to higher professional posts can only effectively be achieved on a national (ideally UK-wide) rather than local, even if SHA-wide, perspective.

4. The issue is currently pressing as WDCs (in England) or equivalent funding bodies for the other home nations have not been allocated funding increases commensurate with the implications of NHS pay reform, Agenda for Change. This is now in very real-terms putting training posts in jeopardy. Several SHAs across England have withdrawn entrance level training posts in the current appointment round (for posts starting October 2006). Whilst numbers may be small in absolute terms the impact for the professions (and thence healthcare delivery) will be very high as, in common with the demographics of many areas of healthcare, the years 2005–20 will see retirement of a large number of current consultant level staff. It is essential for the future and continued quality, progression and reform of services that:

1. Training post numbers are determined nationally (ideally UK-wide) taking into account the training lead time, retirements and service developments implications.
2. Funding for supernumerary entrance training posts is assured to cover the number of posts at previous levels as an absolute minimum.
3. Attrition is minimised by national (ideally UK-wide) planning for second and subsequent level posts.

G H Lester
Secretary, Federation of Clinical Scientists

18 April 2006

Evidence submitted by Guidant Limited (WP 90)

Guidant is a world leader in the design and development of cardiovascular medical products. Making devices which help patients with heart disease return to active and productive lives. And providing physicians with leading-edge technologies for improved patient management and clinical outcomes.

Radiofrequency (RF) technology for ICD's (implantable cardioverter defibrillator), CRT (Cardiac Resynchronisation Therapy) and Pacemakers are now available for patients and physicians in the UK, however, the technology and its benefits for patients, and the National Health Service have yet to be fully understood and appreciated. This is relevant to the workforce planning inquiry in relation to technological change and how this can help both clinical and managerial staff in reducing the demands upon NHS staff.

RF and the Future Impact on the Workforce Issue

The true impact of RF technology is yet to be seen in the UK, this technology gives clinicians the ability to manage ICD and Pacemaker patients remotely in the home Later this year several manufacturers will introduce Remote Patient Management to the UK. This will allow clinicians to manage patients in their own homes with out the need for a hospital visit, greatly benefiting these often elderly, sick patients from having to make a lengthy journey to hospital. The impact on the workforce issue of cardiac technicians will be highly beneficial, as the introduction of RF will mean a reduction in the number of outpatient clinics required.

Reduction in TIME

The use of RF technology has the potential to reduce theatre procedure times, which benefits the patient and allows greater productivity for the Cardiologist and theatre staff.

Patients with ICD's/Pacemakers need to have their devices checked and interrogated on a regular basis at an outpatient clinic. Pacemaker clinics are heavily oversubscribed and there is a shortage of cardiac technicians in the UK (25% below recommendations ref: http://www.dh.gov.uk/assetRoot/04/09/76/48/04097648.pdf). RF technology facilitates in clinic follow-up and has the potential to improve productivity.

Industry Helping the Workforce Issue

In industry, we use an innovative approach to training in the form of an Escalator Skills Model to train company personnel to assist in the implant of ICD's. This model has been highly successful and individuals can gain accreditation in six months. At Guidant we have shared our programme and methods with the Greater Manchester Cardiac Network and are acknowledged by the Strategic Health Authority in the Catheter laboratory Edition of the Critical Care Skills Programme. This system is now used in Greater Manchester as well as other areas of the country. We hope that this demonstrates industries commitment to assist with the Workforce Issue.

Julie Lyon
Guidant Limited

July 2006

Evidence submitted by the Independent Healthcare Advisory Services (WP 87)

Independent Healthcare Advisory Services (IHAS)

The IHAS represents independent health care providers including independent sector treatment centres and other specialist groups.

The IHAS:

- facilitates effective communication between all its members, the government and external organisations;
- drives policy advancement through shared member input and consultation; and
- delivers focused, practical information and guidance in all areas of regulation and policy, sharing and distributing knowledge.

The IHAS facilitates an Education and Training Working Group with the following terms of reference:

1. Progress and monitor the "pledge of assistance" offered to the Department of Health for the provision of Clinical (Practice) placements.

2. Share examples of best practice in education and training within, and for, the independent sector.

3. Take the lead in visioning the future independent sector workforce and the educational needs which partner this.

4. Influence members of the healthcare sectors by using strategies that promote wider involvement in the development and delivery of healthcare education.

5. Take every opportunity to raise the profile of the independent sector within the public sector and other professional organisations.

6. Establish robust working relationships with learning and professional organisations to facilitate best practice and equal opportunities.

A separate group was meeting when the Workforce Development Confederations were first formed with the following objectives:

1. Share examples of best practice with regard workforce issues within, and for, the independent sector.

2. Seek to promote wider involvement and influence by the independent sector within the Workforce Development Directorates and Strategic Health Authorities.

3. Establish robust communication strategies within and between the independent sector and the Workforce Development Directorates.

The independent healthcare sector makes a vital contribution to the provision and delivery of healthcare in the UK and to the economy. The independent sector is made up of healthcare providers and private medical insurers working together. In addition many patients opt to be treated in the independent sector on a self-pay basis.

The independent sector works with a wide range of stakeholders including the NHS and Primary Care Trusts, GPs and community health, consultants and their professional associations, regulatory bodies, intermediaries, patients and customers.

Independent Health Care Providers

In England alone, independent sector health care providers:

- Treat nearly one million patients a year, saving the NHS around £700 million a year. As a result the Government is now looking to independent hospitals to undertake up to 15% of elective surgery for the NHS.
- Help reduce waiting lists to roughly half what they would otherwise be—when the Government announced a reduction in waiting lists for heart operations recently, 80% of that was achieved by the independent sector.
- Contribute around £1,550 million in tax—the equivalent of paying for 82,331 newly qualified nurses (without London weighting).

Private Medical Insurance

In addition to the essential contribution of independent health care providers, private medical insurance, valued at £2.2 billion per annum, helps to reduce costs and pressure on the NHS.

- In 2004 private medical insurance saved businesses 2.5 million working days that would otherwise have been lost to illness, saving businesses at least £325 million.

— In 2003 medical insurers paid for over £6.2 million worth of healthcare every day, substantially reducing pressure on NHS budgets.

The following contains information about some of the services and facilities provided by providers in the independent sector. It is based on an audit that was carried out by the Independent Healthcare Forum (IHF) the predecessor organization to IHAS last year using data from 2004.

The purpose of this audit was to:

— promote the wide range of procedures undertaken within the independent sector; and

— make the data collected more accessible to stakeholders and the general public.

Patient Numbers

In 2004 members of the IHF looked after nearly 700,000 patients on an in-patient/day case basis of which nearly 500,000 underwent an anaesthetic episode. Additionally, nearly two and a half million patients attended members' facilities on an out patient basis.

Patient Satisfaction

Over 97% of patients treated by IHF members in 2004 said they would recommend the hospital or treatment centre to others, 92% of patients rated the service they received very highly and more than 90% rated the cleanliness of the facility as excellent or very good.

Members of the IHF received very few complaints from patients, in fact the number of complaints made to members of the IHF in 2004 represented only 0.9% of all inpatient and day case discharges.

Clinical quality

In his June 2003 report, Making Amends, England's Chief Medical Officer reported that 10% of hospital in-patient admissions may result in some kind of adverse event. Members of the IHF and now IHAS work hard to control against the risk of adverse clinical events. In 2004 only 0.3% of all patient discharges from IHF member facilities over the course of the year resulted in unplanned returns to the operating theatre, and only 0.2% were transferred to NHS facilities in the area.

Workforce

There is great potential within the UK independent sector to contribute to the development of effective, skilled health care workers. The NHS Plan (Department of Health 2000) acknowledges this by stating that:

> "NHS organisations should work closely with higher education, the independent sector and voluntary healthcare sectors to plan for expansion in practice placements and relevant infrastructure to begin to build sufficient placements to deliver new training commissions set out in the NHS plan".

Delivery of Quality Practice Placements

There is pressure to increase the number of practice placements in order to support current and future training needs. However, the independent healthcare sector recognises that successful placement delivery requires:

— High quality experience available to students—the standards set by professional and statutory bodies, together with the requirements of the Quality Assurance Agency for Higher Education must underpin the experience offered regardless of location.

— Teachers with close links to both the academic and practice based elements of education.

— High levels of support from expert educators, practitioners, managers and front line staff.

— Commitment and expertise from service providers at all levels.

The willingness of the independent sector to participate in the delivery of practice placement experience is not in doubt. The effective utilisation of all potential practice placements is within the remit of the Workforce Development Directorates (WDD's) within the Strategic Health Authorities. It is important that this is not lost within the reorganization of the Strategic Health Authorities from 28 to 10.

The independent sector provides more health and social care beds than the NHS and local authorities combined, so the potential contribution is immense. However, there are constraints to the effective mobilising of this resource, most of which are logistical and organisational in nature. Unlike their public sector counterparts, independent sector providers are seldom locally grouped. They are often part of corporate bodies spanning areas covered by two or more directorates. Furthermore, WDD's, not all of which foster a close relationship with their local independent sector, may not always be aware of the nature and number of potential providers.

Because of the lack of a traditional educational infrastructure within the independent sector clinical credibility has in the past been adversely affected however, independent hospitals already undertake significant post-graduate training for nursing and professions supplementary to medicine. Numerous links

with university nursing departments exist and examples of shared initiatives can be found throughout the sector. The independent sector is not only making a contribution to training costs through the provision of post-graduate courses but is also funding basic training eg occupational therapists, operating department practitioners. Staff benefiting from this may well move from the independent sector to the NHS at some point with transferable skills.

The sector also contributes towards training eg through no cost placements for students and health care assistants, through sponsored student bursaries and EN/RGN conversion courses. In addition it contributes significantly to training NVQ staff and return to nursing courses.

The sector is retaining registered nurses in the profession who may otherwise leave the profession totally and its education and training provision contributes to their continuing professional development. For example BUPA Hospitals, through their Clinical Education Manager, have offered a Return to Practice programmed for nurse returnees since 1988. They have returned nearly 400 nurses to NHS Trusts, primarily in the West Yorkshire region. This trend continues with a substantial partnership through the University of Huddersfield. At least 15 students per university cohort are returning to the profession. This is currently to continue through to February 2007.

Role of the Healthcare Commission (HC) with workforce planning—The HC currently registers and inspects the following:

- 272 Acute Hospitals.
- 188 Mental Health Hospitals.
- 260 registered private doctors (mostly GPs), 300 single speciality services (eg IVF, Dialysis) 1,000 non-clinical services (non-surgical lasers, intensed pulsed light, type 3 hyperbaric chambers).
- In the future it will regulate approximately 2,500–3,000 new establishments performing non-surgical procedures.

All these organizations will submit their workforce figures on a yearly basis.

The IHAS strongly recommends that the Health Committee consider that the Healthcare Commission could through a service level agreement agreed by providers provide an accurate picture of the acute healthcare independent sector to the Workforce Review Team.

Workforce Review Team (WRT)

The WRT has a recommendation in its current business plan as follows:

> Locally and nationally, there is a need to assess the impact of sharing service delivery with the independent sector and social care on demand for staff and skills, and to find ways of sharing plans and workforce information across sectors. The role of the independent sector in providing training and clinical placements must be explored further.

This could be fulfilled by taking into consideration the recommendation under the HC section.

Skills for Health

The IHAS and its predecessor organizations have worked closely with Skills for Health and have ensured that the development of competency frameworks have independent sector representation to ensure that their products are appropriate across all healthcare organizations wherever healthcare is delivered. A best practice example is the new National minimum standards developed for Long-term Condition organizations regulated by the HC have utilized the competences that were piloted successfully in two independent sector long-term condition organisations. In addition, a representative of BUPA Hospitals represents the IHAS on the Skills for Health— Health Awards Strategic Advisory Group. BUPA Hospitals is approved to offer 11 of the new NVQ Health awards and is only the second venue to offer the NVQ health award in decontamination. They currently have 124 registered health award candidates and assessor candidates across all the disciplines they provide. Candidate registration is growing at 8–10% per month. The new awards are extremely popular.

New Roles Within the Independent Sector

The sector through its working groups has taken forward new roles such as the Advanced Scrub Practitioner, Surgical Care Practitioner and innovative roles for support workers utilising the Skills for Health awards.

Higher Surgical Training—IHAS members are currently working under the chairmanship of Professor John Lowry CBE to look at innovative models as to how training for medical staff can be taken forward in the independent sector. A model that is being considered is that developed for Cosmetic Surgery Mandatory Training. The paper can be shared by members of the Health Committee is requested. It is considered that this model can be translated for other surgical specialities.

Conclusion

The recommendation to have a service level agreement with the Healthcare Commission would give a baseline of the sector's workforce should be taken forward. The IHAS is about to embark on a number of workstreams in conjunction with the Chief Nurse/Independent sector partnership meeting which includes the movement of the workforce between the sectors which will include "myth busting" to ensure that it recognized that the independent sector can make a valuable contribution and should be included in workforce needs and the planning for the service.

Sally Taber
Independent Healthcare Advisory Services

14 June 2006

Evidence submitted by Institute of Healthcare Management (WP 77A)

1. General Comments

The Institute's comments are broadly divided into three areas. Firstly, a general response to the points raised by the Committee. Secondly, and in view of the emerging issues in the need for high quality Primary Care and Commissioning arrangements, a Primary Care perspective. And thirdly some brief comments on how the Institute of Healthcare Management may be able to assist in developing more robust workforce planning through its professional management development programmes.

— Workforce planning in the NHS is a skill that is evolving and dependant on a comprehensive understanding of the complexities and changes at both a national and local level There are a plethora of tools available which need to be used in a more collaborative and focussed way.

— Over the last decade current workforce planning at individual organisation level has relied heavily on local judgements. Some consistency was achieved through Workforce Development Confederations, but subsequent re-organisations has diluted the expertise and talent in this area. The submissions to SHAs have very much been reliant on the local resource and expertise which has differed widely across the country.

— The NHS has been supported by the centralised planning of workforce who have attempted to keep abreast of the ever changing NHS landscape, but as a consequence of a combination of planning rules, College rules and individual Trust's ability to poach or procure internationally for shortage specialities the process has not been transparent or seamless.

— There is a confusion between DH general policy to achieve an increase in employment in health disciplines and the economic reality at individual organisation level. There is a case for workforce modelling to be scrutinised be health economists for a "reality check". It is likely that health economists could have predicted the current mismatch between DH planned level of manpower and the economic development of the NHS.

— The NHS can take advantage of the flexibilities that the consultant contract and agenda for change offer. However, there will be constraints with the demands of individual professional bodies (including nurses, doctors and therapists) with continued protection of areas and ways of working.

— Little has been achieved on retention rates. The highest turnover occurs in the lowest paid groups, (eg auxiliaries, domestics, porters) where absence from work is also greater. There is little evidence that retention can be improved to a significant degree. Turnover amongst professionals is seen as desirable as career ladders are climbed and/or professional development is sought.

— Achievements in diversity are being made. The Birmingham and the Black Country Black and Ethnic Minority programme is an example of good practice.

— Modelling of workforce needs requires a combination of centralised and devolved working; neither, (in isolation) have proven to be consistently successful.

2. Comments from a Primary Care Perspective

2.1 *Workforce planning and development*

Workforce planning and development is a dynamic process. Service redesign, new models of care and new ways of working require a flexible and creative response and the strategy will have to respond to new initiatives developed by the NHS nationally and locally, and with its partners.

The NHS and each local health economy and NHS organisation needs a vision for the future delivery of services. This requires the PCT to look at its current and future staffing requirements and to assess what new roles and skills are needed for the future. An integrated approach to service planning will facilitate the creative interaction between new care pathways across the healthcare system and known and projected staff resources.

For primary care this requires a strategy which increases capacity in primary and community services, enabling a wider variety of services to be delivered in these settings in order to improve access and increase flexibility for patients. The aim is also to reduce the demand on acute and secondary services. This is reinforced by the recently published White Paper "Our Health, our care, our say: a new direction for community services".

PCTs need to work in partnership with Acute Trusts and Local Authority Social Care to deliver on this strategy and develop an integrated approach to service delivery.

New models of work are being developed which will mean that staff will require skills to enable them to work across primary, community and secondary interfaces as well as social care.

More patients will be cared for in community and primary care settings so requiring new and additional skills to manage care effectively. The clinical staff will also need an infrastructure to support them in their new roles, thus requiring non clinical staff to learn new skills such as commissioning services at local level in primary care and also across the health and social care sector.

The development of National Occupational Standards should help organisations to develop hybrid roles that need a newly defined set of competencies to meet patient needs.

2.2 *Drivers for Change*

— **Integrated Teams**

In order to be able to deliver services which reflect local need the NHS needs to develop models of multi-disciplinary integrated teams through a singly managed structure. These teams deliver a range of primary care services at local level within a specific geographical area while working closely with local GP's.

Health needs assessments should be undertaken in each local area and a local service plans developed in order to ensure service delivery reflects local need. This needs the involvement of local people and other stakeholders as part of a community engagement strategy as well as GP's and other independent contractors.

Staff within these teams need new skills to enable them to work in this multi-disciplinary environment and over time will be required to inform the Commissioning Agenda at local level once practice based commissioning is implemented (see below).

— **Practice Based Commissioning**

PCTs are developing strategies to implement Practice Based Commissioning with full coverage by December 2006. The aim is enable local GP's and community health staff to commission services for their own population.

This will result in a wider range of services being delivered at local level and commissioned differently for the local populations so requiring staff to develop new skills and expertise in both clinical and organisational development arenas.

— **Integrated Multi Agency Children's Teams**

As a result of the recommendations in the Laming Report on Victoria Climbie, PCTs are working in partnership with Local Authorities to develop integrated multi agency teams across health, social care and education to deliver on children's services at local level. It is envisaged that these teams will be linked closely into the Primary Care teams as above in order to be able to be responsive to local need. There will also be models of locally based commissioning on a multi agency basis which will inform a commissioning strategy for the delivery of children's services.

— **Reforming Emergency Care**

The Reforming Emergency Care Agenda has three main planks; Unscheduled Care, Active case management and Scheduled care. These models will require staff to have the ability to work in differing care settings as key elements of the move to services delivered in more appropriate settings.

— **Mental Health**

Major cities have highest incidence of people suffering with mental health problems. PCTs in inner city areas should be developing models to provide services which can help prevent mental health problems but also support people in Primary Care and Community settings for those with common mental health problems and less complex needs. Primary Care Mental Health (PCMHT) teams are required to support people with a range of common mental health problems but all staff require a grounding in care of people with mental health problems and mental health should be a core element to training for all staff in order for them to be able to undertake more prevention work.

— **Joint Appointments**

PCTs, Acute Trusts and Social care should work together to develop joint appointments in certain areas of work in order to support the models of care outlined above. Public Health is an area where the Local Authority and PCTs have worked closely. Manchester's Joint Health Unit is a good example.

Joint appointment require staff to have continuing professional development and ad hoc training in the different skills that will enable them to work across these different care settings.

2.3 *Equality and Diversity*

Embedding equality and diversity is essential if NHS organisations are to deliver services that meet the needs of local people. This requires successful recruitment from all local communities. Patient and Public Involvement initiatives can contribute to improving recruitment from local people, (eg the new health trainers need to be part of and therefore drawn from local communities to be successful). The NHS needs to meet its obligations under legislation.

2.4 *Current Workforce*

A good picture of the existing workforce in any organisation is a prerequisite for understanding the development needs of the workforce. Significant issues include:

— % of staff are aged 50 or over and as 90% are female are likely to retire in next 10 years or less;

— gender differences in job roles reflecting NHS patterns of employment;

— high turnover rates in certain occupational groups which will affect continuity of care and service to patients and support for staff;

— under-provision of GPs in inner cities; and

— recruitment and retention problems with particular staff groups; health visitors, practice nurses and administrative and clerical staff.

2.5 *Key Barriers*

Key Barriers to successful Implementation of the organisational vision should be identified: an example is attached which identifies issues which then need to be reflected in the Workforce Action Plan. The complexities of the issue are clear from this analysis which drew on a survey of general and clinical managers.

2.6 *Categories of Training Required*

A clear strategy for education and training is required. This has various elements:

A—ad hoc training, for example study days and other learning opportunities that deliver organisation focused updating, such as might be required for health and safety purposes associated with, for example, moving and manual handling and with risk reduction such as infection control or techniques for control and restraint;

B—continuing professional development, which we take to mean learning and development intended to update and refresh professional knowledge and skills and to maintain professional competence which is focussed mainly on the current sphere of practice (a minimum of which is mandatory for all registrants and exists independently of employment status or organisational context);

C—more formalised education and training associated with the acquisition of additional knowledge, skills and professional competencies of a specialist and or advanced nature, intended to enable the practitioner to move from their current sphere and scope of practice to more specialist and or advanced professional activity;

D—education, training and development of a more generic nature that is nevertheless of relevance to the practitioner's professional practice such as, for example, a leadership development programme or a Masters degree in healthcare ethics.

3. How the IHM can Help

As the leading professional body for individual healthcare managers, the IHM already provides a range of development programmes, requires its members to undertake CPD, and requires its members to abide by a code of professional practice, (on which the dh's own management code is based).

The IHM recognises that from its experience in working with managers across the NHS that:

— There are good training schemes in place.

— There is a shortage of appropriately trained and experienced general managers at the middle/ senior level.

— There is a key skill and knowledge deficit in moving from public service model to a market led model. (Developing commercial skills now forms a key part of the IHM's new programmes).

— There remains a shortage of quality development programmes aimed at producing first class CEOs.

The IHM is willing to assist in the development of programmes to support a more robust Workforce Planning regime for the NHS.

Should the Committee require further information, or clarification of any part of this response please contact us.

Sue Hodgetts
Chief Executive, Institute of Healthcare Management

21 December 2006

Evidence submitted by the London Ambulance Service NHS Trust (WP 85)

Taking Health Care the Patient: Transforming NHS Ambulance Services, published by the Department of Health in June 2005, outlined a vision of where NHS ambulance services should be within the next five years:

— Providing significantly more clinical advice to callers and work in a more integrated way with partner organisations;

— Providing and coordinating an increasing range of mobile healthcare services for patients who need urgent care;

— Continuing to improve the quality of services to patients with emergency care needs;

— Providing an increasing range of other services in primary care, diagnostics and healthcare promotion.

This has huge implications for the ambulance service workforce and in order to achieve this vision, a new approach is needed to how we assess, treat, transport and refer patients. Education and development needs to be designed more closely around the needs of the 800,000 patients attended each year by the London Ambulance Service. We have already started this by redesigning all our training courses.

Safe assessment and where possible diagnosis is vital given the need not only to decide what is wrong with the patient but also to decide where the patient should receive their definitive health care. Ambulance staff work unsupervised and do not have medical advice routinely available, so the provision of underpinning medical knowledge is vital to enhance clinical decision making in the pre hospital environment. If this is done, it will over time, improve patients care, job satisfaction for staff and reduce costs to the NHS. This is particularly the case if we are to achieve our aim of transporting up to 200,000 fewer patients each year to A&E departments in London in five years time.

A great start has been made, the London Ambulance Service has a number of highly trained Emergency Care Practitioners (ECPs). These staff, working in the community are providing primary care alongside (and in some cases instead of) GPs and other health professionals. A high percentage of the patients they attend do not require transport to hospital and can be successfully treated in the home.

The ambulance workforce, in contrast to medicine, nursing and other Allied Health Professionals has not been designed within a formal external education framework. However over the past few years, we have, working with Higher Education Institutions, developed new qualifications for ambulance clinicians that are fit for purpose and regulation in the 21st Century.

We are working towards developing a much more sophisticated, integrated and forward thinking approach to workforce planning. As the range of responses to patients widens, skill mix and workforce diversity needs planning for. Traditionally we have had difficulties in attracting staff from ethnic minorities to work in the ambulance service. We have to make the jobs more attractive in local communities and show that the ambulance service offers excellent career opportunities.

Although much of the work undertaken by ambulance staff is urgent care (not requiring an immediate response), a critical part of the work is the 24/7, emergency 999 service which deals with life threatening and serious conditions. Although this represents only a small percentage of calls in terms of volume, these are also potentially catastrophic for patients, their families and their community. As the vision states, we must continue to improve the quality of services to patients with emergency care needs.

Over the next few years we have a unique opportunity to really create an ambulance service workforce that has the right skills and knowledge to have major impact on patient care, job satisfaction and the wider NHS in London. We look forward to working with the new London Strategic Health Authority in making this vision a reality.

Peter Bradley CBE
Chief Executive Officer, London Ambulance Service NHS Trust

May 2006

Evidence submitted by London Deanery (WP 93)

I have been asked to clarify a number of points in my evidence given to the Select Committee on 29 June 2006.

1. Medical School Numbers

The review I mentioned in my evidence was the, Medical Workforce. Numbers Stakeholder Event, organised by the DH to "road-test" the workforce analysis on medical student numbers. I have enclosed the notes of that meeting with the permission of the Chair. The notes do not represent DH policy, although they may contribute to informing policy.

2. MMC Impact

I carried out an analysis of the cost and likely impact of implementing MMC on consultant workload in London. I have enclosed this also.

3. Specialist Training Numbers

1. In September 2005 the census showed there were 21,000 doctors in SHO level posts.

2. By September 2006, 5,000 of these posts will have been reconfigured into F2 posts (the equivalent of the current first SHO year), leaving 16,000 SHO level posts. (The individuals will of course have moved on by a year, a junior cohort of around 5,000 moving into the F2 posts as a similar sized senior cohort move out to SpR or GPR posts.)

3. By September 2007, most of the 16,000 SHO posts will have been reconfigured into run-through training posts, in each of years ST1, ST2 and ST3. The rest will be reconfigured as Fixed Term Specialist Training Appointments (FTSTAs.) If, for example, 5,000 posts went into ST1, 5,000 into ST2, 3,000 into ST3, and 3,000 into FTSTAs that would accommodate all the posts—and all the doctors (who will all by now have moved up a year, as before).

4. How realistic is it to expect all 21,000 SHO-level posts to be retained? The NHS is in financial difficulties, and cutting staff is one solution. However, most Trusts have an eye to the challenges presented by WTD 2009, and seem not to be minded to reduce a relatively inexpensive source of medical service. The specialty balance of these posts will certainly have to change, but it is less likely that the stock of posts will fall dramatically, unless the educational funding that supports the majority is cut.

5. The problem will be in the specialty balance, where the aspirations of trainees do not match the needs of the service, and where there will be disappointed, if not necessarily unemployed, trainees at every level. But that is not a new phenomenon.

Elisabeth Paice
Dean Director, London Deanery

28 July 2006

Evidence submitted by the Medical Women's Federation (WP 92)

Summary

1. For over 30 years the NHS medical workforce has benefited from the Flexible Training Scheme, which made provision for postgraduate training for doctors who for personal reasons required to work less than full time. This has developed and grown in parallel with the increasing number of women in the medical workforce. It has enabled many hundreds of doctors gain specialist qualifications and to continue to develop their professional careers and by allowing them time for their personal responsibilities, it has prevented them from taking career breaks and premature retirement from the NHS. The flexible training scheme has been shown to produce trainees who were able to gain appointment to hospital consultant posts, the majority of whom would then return to full time work within the NHS.

2. More recently the Flexible Careers Scheme funded retainer and returner programmes, which allowed doctors to remain in the medical workforce during periods when they might otherwise have taken career breaks and been lost to the NHS. In the three years that the flexible careers scheme was centrally funded, over three thousand doctors were appointed to it and so remained in professional practise, making an active contribution to the NHS.

3. In the past two years central funding for both these schemes has been withdrawn and those doctors already in these schemes must now rely on funding being made available locally by NHS Trusts. At a time when many NHS Trusts are in financial crisis, the result is the reduction in the numbers of doctors in flexible training and a reluctance to appoint any further applicants to either scheme.

4. At a time when almost 70% of the graduates from British medical schools are women, this represents a significant immediate loss to the NHS workforce of doctors trained in Britain at public expense, and unless action in taken to reverse this situation by ensuring funding for these or similar schemes, a potential cumulative loss of trained doctors in future years.

Costs

5. Approximately £250,000 to train a doctor Total cost of a returner scheme General Practitioner(GP) is £60,000, a one off cost. Once a returner scheme GP has returned to general practice, they continue to practice. Retainer Scheme GP working four sessions per week costs approximately £12,000 per year.

Background

6. In its report on Future NHS Staffing Requirements (March 1999) the Health Select Committee reported on Doctor Numbers and acknowledged the Government's acceptance that the intake into medical schools needed to be increase by 1,000 (20%). The report added that, during this process, a major factor in medical workforce planning is the extent to which the UK has become dependent on overseas qualified doctors as the majority of new registrants with the General Medical Council were from overseas. This report endorsed the Government's decisions to increase intake at medical schools by 1,000 places a year with the aim to become self-sufficient in doctors.

7. The report considered if the increased intake could create an over-supply of doctors. It stated:

> "An increase of 1,000 in the annual medical school intake, in the view of MWSAC [Medical Workforce Standing Advisory Committee], would not produce a domestic over-supply by the year 2020 under any realistic scenario. It should be noted that past predictions and actual increases in medical student intakes have consistently fallen below demand for doctors in the UK. The consequence is the current need for a substantial increase in medical student numbers. Because small percentage point shifts in wastage and growth rates over time have large effects on the number of medical graduates required these indices need to be kept under constant review."

8. Following from this it was considered necessary to retain all trained and registered doctors within the medical workforce and to allow them facilities for their full professional and career development and it is relevant to note that among its recommendations this report suggested that the Department of Health should ask the Medical Workforce Standing Advisory Committee to look in more detail at the training with the aim of achieving a flexible medical workforce.

9. Since then there has continued to be considerable recruitment of doctors who have trained overseas and there has recently been much publicity about the difficulties that some of them have had in gaining employment, to the extent that the needs of doctors who trained in Great Britain have received little public attention.

10. The majority of doctors graduating from medical schools in Great Britain are women, in recent years over 65%. These young women have achieved their places at medical school in open competition and continue to distinguish themselves academically and professionally through their training and the early stages of their careers. Like other women in contemporary society the majority of them marry and have families, two-thirds of women doctors have children by their mid-30s, a stage when most will still be in training posts. However several studies over the years have shown a high level of continued commitment to

a career in Medicine and the majority continue to make significant contributions to the NHS, provided they can maintain their links to the NHS as trainees and career post doctors who are employed with a less than full time commitment during the comparatively few years when they have responsibilities for the care of young children. The majority of them then return to full time employment and remain professionally active years later than many of their male colleagues.

11. Given the current trends in medical school intake, adequate provision of flexible training opportunities after qualification is essential to ensure that the needs of both the NHS' current and future workforce and of these women doctors, are met.

Flexible Postgraduate Medical Training

12. Part time postgraduate medical training and working in the NHS was pioneered under the leadership of Dr (later Dame) Rosemary Rue in the 1960s. As a single parent herself, and with responsibilities regionally for the medical workforce, she recognised the need to retain trained women doctors within the NHS and so she pioneered "Returner schemes" for those who had retired from medical practice when they started a family. She rapidly realised the difficulties that these women encountered when they attempted to re-enter professional life, so she started a part time training scheme to allow those with young children to remain professionally active during their child bearing and rearing years.

13. This scheme grew in size and spread throughout the branches of medicine. It also became more widespread and flourished in several parts of the country and was adopted nationally by the NHS in 1969 as the part time postgraduate medical training scheme. The general administration of the scheme locally and nationally, including the acceptance of trainees for the scheme and the approval for training posts, was over seen by associate postgraduate deans attached to the postgraduate deaneries throughout the NHS. Many of the key features of this scheme were retained when it became the Flexible Training Scheme, which was introduced in 1993.

14. Data from cohort studies of doctors suggests that the period of five to seven years after qualification is a critical time for retention of female doctors. However the evidence suggests that retention rates of women doctors in the NHS can be improved by the provision of appropriate opportunities that accommodate their family responsibilities:

> "of a cohort qualifying in 1988, 10% were not currently working at five years, compared to 6.5% of male doctors, but of the 1993 cohort only 6.2% of female doctors were not currently working compared to 4.2% of male doctors."

15. This scheme has allowed many hundreds of women doctors to remain professionally active contributing to the NHS while continuing with their professional postgraduate training and career development alongside their male colleagues. The quality of this training is high and has allowed a comparable number to achieve career consultant posts within the NHS when compared with colleagues who have trained full time:

> "A survey of all flexible Specialist Registrars (SpRs) and matched full time controls who left the training schemes in three Postgraduate Deaneries between April 1996 and March 2004 showed that the outcomes of training were broadly similar with 92% (104/113) of flexible SpRs obtaining a Certificate of Completion of Training compared to 90% (172/191) of full time SpRs. 81% (91/113) of flexible SpRs worked as consultants compared to 77% (147/191) of full time SpRs."

16. In 1999, the Medical Women's Federation reported to the House of Commons Employment Sub-Committee of the Education and Employment Select Committee that: Part time doctors accounted for 15% of principals in general practice, and 12.2% of career grade doctors among the hospital medical staff, including 2,190 consultants. Only 3.5% of junior doctors were working part time.

17. Since that time the numbers of part time trainees have continued to increase year on year.

> "In 2005, 6% of all trainees were training less than full time, with up to 14% of all Specialist Registrars in some regions. They were generally working 60% of the time of their equivalent full time colleagues."

18. However the national funding stream for flexible training was withdrawn in the middle of 2005 and in the report to COPMeD in May 2006, this figure had fallen to 5%. The fall from 2,413 to 2,143 is the first drop of this size since the scheme began. It was also highlighted that:

> "There were 141 trainees with an agreed post hoping to commence flexible training within the next six months across the UK, this is a reduction compared to the last years figure of 284, indicating that the downward trend will continue. This has also to be seen against a rise in full time trainees of 17.7%."

19. The removal of the national funding stream for flexible training, and the pressures on NHS budgets are already having an effect. The change means that flexible trainees should work in standard posts. Commonly two trainees share one full-time slot and both work 60% of full-time. The disadvantage is that it may be difficult to find a slot-share partner even in London. Doctors cannot start training flexibly until

they have a partner. This could restrict access to training in some areas and especially in specialty and subspecialty posts. Flexibility is lost: most trainees in a slot share are restricted to 60% because of financial implications.

20. Flexible training keeps female doctors in the workforce at a critical time in their lives. Part-time training is not synonymous with part-time commitment, and those who have been through the scheme go on to make a long term, often full-time time contribution to medicine and the NHS.

Flexible Careers Scheme

21. The success of the flexible training scheme lead in time to a realisation that some women on completing their postgraduate training would still need flexible working patterns and would initially require less than full time employment as hospital consultants and in career posts in general practice. There was also an acknowledgement that the majority of women doctors are not geographically mobile and may be required to relocate in response to their partner's careers. To meet these needs and to allow the NHS to continue to benefit from their contribution, the *flexible careers scheme* was developed with an entirely separate funding stream and launched nationally in November 2002. The Scheme was administered and funded nationally by NHS Professionals but postgraduate deaneries were responsible for arranging placements and signing off work programmes for those who were on the returner and retainer part of the scheme.

> "The Hospital Scheme included funding for part time career grade posts and funding for six months whole time equivalent salary for those who had been out of medicine (a 'returner') package. For the first time there was a retainer package for those in training grades who were unable to work half time with appropriate incentives to encourage study leave and further training. There was also a General Practice Scheme for returners and funding for new part time posts. A General Practice retainer scheme had existed for some years."

22. The Flexible Careers Scheme has been invaluable for two main groups: those returning to medicine after a break, and those who are unable for a short period to work half time or more, usually because of caring responsibilities, often combined with location moves due to their partner's career moves.

> "Review of the experience in three deaneries showed over a two year period that the majority (40 out of 63) rapidly made a successful transition back into clinical medicine and within a six month placement were able to secure training posts (24) or career grade posts (16)."

23. These studies have demonstrated that the returner element of the Flexible Careers Scheme has been an effective way of helping those who have been out of medicine to return to practice and also for some an opportunity to remain in professional practise after a move and before more long term employment can be negotiated in a recognised training or career post.

24. The Department of Health instructed NHS Professionals to stop their involvement with this scheme at the end of 2005. From 2006 the Flexible Careers Scheme was devolved to Postgraduate deaneries and Strategic Health Authorities(SHA). Funding was devolved to SHA for the Scheme for 2005–06, but this was insufficient even to cover existing commitments, and there is no central funding identified for 2006–07. The lack of continued funding means that in many regions new applicants have not been accepted, and with the local pressures on funding the Scheme is currently regarded by many as dead.

25. There will always be doctors who leave clinical medicine but who will wish to return to practice and who are capable of making a valuable contribution. In particular, as the number of women in the medical workforce increases, those taking short career breaks to have children or to follow their partner's career will rise. It has been shown that many of these have continued to work in the NHS. Given the substantial national investment required for medical training, a scheme which allows individuals a quick route back to clinical practice after a short career break is a highly cost-effective.

26. The total number of enquiries was over 8,000 from the launch of the scheme by the Department of Health in 2002 till NHS Professionals creased to have any role in it at the end of 2005; an indication of the scale of interest in it. The scheme did not offer an appropriate solution for all but over 4,000 applications were received and by the time NHS Professionals responsibility for the scheme ended on 31 December 2005 over 3,000 doctors had been approved to join the scheme. The schemes were mainly used by female doctors during the years when they are caring for young children or by male doctors reducing their commitment towards retirement or delaying retirement. Doctors were overwhelmingly positive about the scheme and about NHS Professionals' contribution with many offering personal thanks for their help. In hospitals over 450 part time consultants were appointed, mainly young women, for many of whom this scheme prevented their loss to the NHS workforce.

27. Retaining doctors in this way could reduce the numbers needing to return in future. Although the scheme came out of the Improving Working Lives initiative a major concern was always that the cost of training new doctors is significantly higher than the cost of retraining or retaining qualified doctors. The

average cost of a Hospital doctor on the scheme was around £15,000 per year so overall around £30,000 in total per doctor; compared with the figures of somewhere between £200,000 and £300,000 which have been quoted to train a new doctor.

28. When viewed against the strategic planning of the medical workforce, and the previous investment in highly trained and competent individuals, it is surely short sighted that there does not appear to be further funding available at national level to continue this valuable scheme.

29. Instead it appears that present policies and the funding of training, have:

> "effectively ended the hugely successful flexible career scheme".
>
> Report by Health Editor *The Times* 16 June 2006

The Present Situation

30. The website advertising NHS Professionals, included at Annex C,[26] would appear to suggest that it has a responsibility for fostering flexible working within the NHS. However the organisation no longer has responsibility or funding for the Flexible Careers scheme and feed back from those doctors who make contact suggests that the organisation now has the needs of the NHS trusts as its priority. The needs of the individuals in the workforce who register are considered as a poor second.

31. While NHS Professionals claim to assist in appraisal and training, they are not perceived by the doctors registering to support individuals who are seeking to obtain further training and career development. The mentoring from the Postgraduate Deanery which has characterised the flexible training scheme from it inception and which was also a part of the flexible careers scheme, is missing, and many as a result are opting out from this service and attempting, especially in General Practice once they have their accreditation, to arrange their own locum work without any professional supervision. In the long term this will lead to professional isolation cannot be for the greater good of either the NHS or of the individuals concerned.

32. In the hospital specialties, trainees may gain their Certificates of Specialist Training (CSTs) through flexible training and some of these are not able, by reason of their family responsibilities, to apply either for full time consultant posts or work distant from their homes. Several of these are known at this stage to be leaving medicine because they cannot obtain less than full time work in their geographical area.

33. While a career break with young children is easy to justify both personally and publicly, these are women who have continued to contribute to the NHS while training in their specialty, and who are now lost to the NHS workforce at what could be the peak of their professional contribution. They are women with intelligence and drive and we cannot assume that they will not make successful careers for themselves elsewhere if they are not given some encouragement to return to medicine before they loose the skills that they have worked hard to acquire.

34. With the changing working patterns resulting from the European Working Time Directive, attitudes towards flexible working in Medicine are beginning to change, but with the current financial difficulties in many Trusts, flexible working is unlikely to be given high priority for funding by them in the near future. Numbers of female medical students have exceeded male for several years and there is evidence that a significant number of doctors will wish to work flexibly at some point in their career. Provision needs to be made for flexible working to avoid staffing difficulties in future.

35. Regrettably much evidence about the present position is anecdotal as this section of the medical workforce is no longer the responsibility of Postgraduate deans or of NHS Professionals and neither is able to collect the statistics that would paint a more complete picture. The Department of Health may in the long term be able to define how many trainees and trained hospital specialists and GPs are not working in the NHS, but short term reviews and accurate figures of this drain from the trained workforce are not currently available.

36. Such evidence as I have found is gathered from personal experience and is in Annex A and Annex B.[27] It tells the story of reducing levels of funding and declining numbers of part time trainees all over the country, with a serious impact on individual lives and careers. In the long term the demand for flexible working in the NHS will increase and if the NHS does not tackle the problem a new staffing crisis is likely in spite of the increasing numbers of doctors who are being trained and graduating from British medical schools.

Medical Women's Federation

23 September 2006

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[26] Not printed here.
[27] Not printed here.

Evidence submitted by the NHS Alliance (WP 97)

1. The terms manager and management in primary care have been historically ill defined but are not interchangeable. Much of management and leadership in primary care is not undertaken by exclusively by mangers but also by clinicians and others at both practice and PCT levels.

2. The managerial task in primary care in the "new NHS" is particularly demanding and different from the institutional management focus of, for example a hospital, because:

(a) At the highest level it is about health improvement and not simply health care. This requires notions of working with communities and across agencies. These are not necessarily conventional management skills within the NHS.

(b) It involves managing with groups and individuals who are independent contractors not employees.

(c) These groups and individuals are scattered across large geographic areas, may rarely meet PCT senior managers and largely direct their own day to day activities. This presents particular communication and other issues that are quite different from those faced by managers and management elsewhere.

(d) Critically, it involves the commissioning and not simply the provision of services, including decisions as to planning, priority setting service configuration at all levels and across different statutory and, increasingly, commercial bodies.

3. Against this background, the NHS Alliance would argue that both the quality and quantity of management in primary care has been insufficient to meet past needs and is insufficient to meet future needs.

4. Key tasks for the future which have been given insufficient attention in the past include:

(a) The identification of need and demand, which will require PCTs and PBC consortia to take a more sophisticated approach to research and data analysis in the future.

(b) Market shaping, which will require PCTs to balance the need to provide choice with market management to ensure that services are provided in a sustainable way.

(c) Holding the market to account, which requires PCTs to act as local stewards of NHS funding and ensure they achieve quality and value for money from providers.

(d) Holding PBC commissioners to account, which is crucial to ensuring that all stakeholders—not least the general public—can be satisfied that the NHS is delivering value for money, and acting in the interests of patients and citizens as NHS Shareholders.

5. The Alliance view is, therefore, that expressions of opinion as to the sufficiency of numbers of managers alone are unhelpful and potentially misleading. The focus should be on the overall task, the competencies needed to undertake that task, and the allocation of those competencies to individuals, based on ability to achieve end results rather than professional background. The Alliance would contend however that the objectives of the NHS will only be met by clinicians, managers and local people working together.

6. It follows that workforce planning should be based on an audit of existing skills and competencies; the identification of future needs based on objectives, and action to fill the gaps between the two. Given the distributed managerial responsibility and the more subtle accountability arrangements in primacy care, this needs to be based on a multi disciplinary approach reflective of mutual dependency and not a line management approach. Such a focus is not present within the current workforce planning as far as primary care management is concerned.

Michael Sobanja
Chief Executive, NHS Alliance

18 January 2007

Supplementary evidence submitted by NHS Employers (WP 29A)

Since the submission of evidence to the Health Select Committee by NHS Employers and our oral evidence session there have been a number of major policy developments in areas of concern to the committee. Below is an update on each of these developments and on the work of NHS Employers to support them.

Policy on Education and Training Expenditure

NHS Employers believes that expenditure on training and education is an investment by the NHS in its "human capacity" and is concerned to ensure that the NHS continues to make adequate resource available in this area. We believe that the central allocation of money for education and training via the Multi-Professional Education and Training (MPET) budget has helped ensure long-term investment is being made in education and training. The system of funding may need to be reformed and we are currently working with the Department of Health on ideas for improvement.

NHS Employers understands that there is now greater flexibility in the allocation of central budgets to Strategic Health Authorities including over the use of MPET funding. We are aware of concerns that this may result in lower levels of spending on education and training. We believe that, just as money allocated for capital investment is safeguarded from diversion into day-to-day expenditure, investment in education should also be protected.

NHS Employers supports a strong role for SHA in workforce development and clearly this should include balancing investment in education and training with local service priorities. We believe, however, that there needs to be adequate investment in education and training to avoid the re-emergence of "stop-go cycle" that contributed to the workforce planning problems in the 1980s. Expenditure on post graduate training and training for non-professionally qualified staff is essential if the NHS is to meet its staffing objectives.

NHS Employers believes that there may be value in assessing the impact of the first year of greater flexibility in expenditure on education and training and suggests that the Health Select Committee might be interested in exploring this further. We welcome the assurance that the Department of Health will be asking SHAs to report on spending allocations in this area.

Overall Job Reductions in the NHS

According to the Department of Health, the number of reductions in NHS posts has stabilised around 14,000. In the majority of cases this is being achieved by a combination of vacancy controls, reductions in temporary staffing, natural wastage and voluntary redundancy measures. However, in a small number of trusts compulsory redundancies are likely to be necessary for a variety of reasons and some redundancies have been declared. NHS Employers will be asking trusts for an update on their situations in the autumn.

NHS Employers is supporting employers in seeking to manage job reductions and avoid redundancies, working with national staff side organisations. We have recently issued a range of information to advise and support NHS organisations facing workforce changes.

Opportunities for Newly Qualified Staff

There has been more publicity recently about the difficulties that graduate nurses and physiotherapists are having in finding posts. New graduates in these professions are likely to find more competition in finding their first job that in the recent past and may have to be prepared to be mobile to secure a post. NHS Employers is identifying and sharing good practice examples of what trusts are doing to address this issue.

Recruitment and Retention in the NHS

In our original evidence to the Health Select Committee NHS Employers drew attention to the potential challenges created by the large expansion of medical school places.[28] We welcome the fact that the Department of Health has provided funding to ensure that all medical students graduating this year will be able to find places in the Foundation Programme. With support from deaneries and employers it appears this will be achieved, although newly qualified doctors will need to be flexible about where they are willing to practice. We continue to believe that a modest measure of "oversupply" does have some benefits, eg for recruitment.

NHS Employers is also working with Modernising Medical Careers and the Department of Health to address concerns over the transition of existing doctors into the new Foundation Programme or Fixed Term Speciality Training Appointments. The aspirations of doctors need to be balanced with the needs of the service in both the short and the longer terms.

All existing Senior House Officers (SHOs) cannot expect to get straight into run-through training in 2007 anymore than all SHOs were able to get Specialist Registrar jobs in the past; nor can SHOs expect to be able to train in the specialty of their choice if this does not give the NHS the right mix of consultants in the right specialties to deliver clinical services.

In the medium-term there will remain an issue of how the growing numbers of medical students can best be employed in future.

NHS Employers has recently set up a Medical Workforce Forum to engage employers in shaping policy on how best to use these increased numbers of medical graduates eg by changing job roles.

[28] Fifth Report of the Health Committee, Session 2005–06, Workforce Planning, HC 1077–11, Ev 126–Ev 132.

ISTC Changes to Additionality Policy

To address current staffing challenges, there has been a change in the "additionality" rules to allow newly qualified nurses or those at risk of redundancy to be employed by ISTC providers. NHS Employers has worked in partnership with the trade unions and the Department of Health to develop these new rules.

Work Permit Changes: Medical

As the committee will be aware, the increasing supply of graduates from UK medical schools has led the Government to alter the work permit regulations for entry to seek a post as a doctor in the UK. NHS Employers supports this change, which brought doctors in line with other occupations so that work permits are now required before medical students can enter the UK to study. Transitional arrangements have been implemented for students already in the UK. NHS Employers is offering advice to trusts on the implementation of these changes.

NHS Employers is concerned however about the operation of the Highly Skilled Migrants Programme. This means that that large numbers of overseas students will continue to be able to compete for places against a rising number of UK and EU graduates.

Work Permit Changes: Nursing

The Home Office has taken nurses at Band 5 (entry level newly qualified nurse) off the "shortage list". This means that employers will not be able to recruit to a vacant post without first placing an advert within the UK. They will have to demonstrate that they cannot fill a post with a UK or EEA applicant first. After they have advertised, if employers are still unable to fill a particular nursing post, they may then apply to the Home Office for a work permit. Work permits may be granted for a period of up to five years. We broadly welcome this change as it will assist the service to employ the increasing numbers of UK nurse graduates in the NHS.

Due to a growing number of newly qualified UK nurses, trusts are likely to be able to recruit UK nurses at Band 5. However, there are still shortages in certain specialties among the most advanced and senior nurse grades in bands 7 and 8 and they are unaffected by this change. Most international nurses permanently employed by the NHS will have time-limited contracts of employment. There are arrangements within the work permit rules to allow an employer to seek an extension of a work permit without needing to test the resident labour market. The position for other health professionals should be kept under review. NHS Employers is advising trusts on implementation of the new arrangements.

Productivity

On behalf of the Department of Health, the NHS Institute for Innovation and Improvement has published a set of workforce productivity metrics including sickness absence, use of temporary staff and Finished Consultant Episodes.

NHS Employers will be working with the service to use this data effectively. We believe this type of data is useful as long as it is used in a balanced way and takes account of the different pressures on trusts. Such data can be taken into account in job planning for consultants.

NHS Employers has been asked by the Department of Health to develop best practice advice on the devolution of budgets to clinical teams.

NHS Employers

4 September 2006

Supplementary evidence submitted by NHS London (WP 34A)

1. Executive Summary

1.1 This memorandum provides a re-submission of evidence from NHS London to the Health Committee—workforce needs and planning for the health service.

1.2 The memorandum describes how NHS London is developing a health strategy for London that will inform health care commissioning and inform workforce planning for London. The workforce plan in turn will be implemented through commissioning of service through PCTs.

1.3 The memorandum presents evidence in response to each of the Health Committees terms of reference.

1.4 Since the publication of "A Health Service of All the Talents" there has been some progress with workforce planning. However the evidence points out that the planning of medical training numbers is still carried out separately from workforce planning for all other NHS staff.

1.5 The impact of "Commissioning a Patient led NHS" on workforce planning is considered alongside the impact of an ageing population, advances in technology and other policy changes. In particular it considers how CPlNHS puts the focus on community health care delivery being managed through commissioning. The evidence highlights how this will require consideration of workforce planning, development and education commissioning to be carried across different providers from health, social care, independent and voluntary sectors.

1.6 How the workforce and workforce planning is affected by financial constraints is also considered. The evidence makes the case that as long as future funding broadly aligns with future demand financial challenges should not in themselves represent a threat to the workforce. However to plan a workforce able to respond to the demands of future health care provision the NHS must be able to use funding flexibly rather than have it tied to particular targets or specific project.

1.7 The evidence looks at demand for clinical and non-clinical staff, and the need to ensure that workforce plans are sustainable over the longer term. As growth in funding slows we need to manage the NHS workforce closely, ensuring that it is appropriately directed at service need and that workforce productivity is maximised.

1.8 The memorandum makes three recommendations for future workforce planning:

— To facilitate integrated workforce planning for all staff groups (medical and non-medical) in order to ensure that workforce planning appropriately underpins service commissioning.

— Ensure that the NHS can direct funding flexibly to underpin workforce plans.

— At a national level, integrate workforce policy with health policy to support the alignment of workforce planning with service commissioning.

2. Introduction

2.1 The original submission of evidence to the Health Select Committee was submitted on behalf of the 5 SHAs for London in March 2006. NHS London, the Strategic Health Authority for London, came into being on 1 July 2006.

2.2 The DH in May 2006, described one of the key function for SHAs as:

> "Workforce development, including (a) ensuring all aspects of workforce supply—including education, training, and workforce planning—best support service demand; and (b) leadership development, including talent management; all in partnership with PCTs and providers".

(PCT and SHA roles and functions, May 2006).

2.3 NHS London will be discharging this responsibility through the Director of People and Organisational Development and senior workforce strategy and planning posts. The organisation structure enables NHS London to manage the development of PCT Commissioning separately to the development of providers into Foundation Trusts which is undertaken by the Provider Development Agency an arms length body of the SHA. A Health Strategy for London will inform the commissioning of services for the capital and direct workforce planning to support it.

2.4 The key priorities for NHS London currently are:

— Managing the financial position of the NHS in London. This will have an impact for workforce planning in NHS London as service and workforce is reconfigured to address the both the immediate and long term financial position.

— Developing a health strategy for London. A complimentary workforce plan for London will be key to ensuring that the appropriate workforce is available to deliver the required healthcare outcomes for London.

— Managing the transition from the five previous health authorities due to be completed by 31 March 2007. This process will see the reduction in the number of staff employed at health authority. Workforce planning is a key component of the structure for NHS London at a senior level.

2.5 This re-submission of evidence re-frames evidence previously submitted reflecting the role that one SHA for London has and reflecting the strategic priorities. The evidence is presented under each of the Committee's terms of reference.

3. How Effectively Workforce Planning, Including Clinical and Managerial Staff, has Been Undertaken and How Should it be Done in the Future?

3.1 Historically workforce planning for most NHS staff including nursing, allied health professionals and managerial staff has been carried out in a bottom up method with trusts and PCTs informing the intermediate tier (SHA or WDC) of their workforce plans and linking this into their local delivery plans. This has relied on each employer having the workforce planning knowledge and expertise to do this effectively which is often not the case.

3.2 Workforce planning that informs education for undergraduate medical staff is carried out away from NHS Providers by the DH through the national quota system delivered through HEFCE based on information from the NHS Workforce Review Team's replacement model. PMETB is a national body responsible for the assuring the quality of training of junior doctors, SHAs sign off the MADEL allocations and the Deaneries approve the trusts' training posts every three years. The implementation of Modernising Medical Careers is underway and London is assessing the impact of full implementation next year.

3.3 These two separate approaches to workforce planning has often resulted in disjointed workforce planning for the NHS.

3.4 The WDCs and SHAs have done much to ensure that workforce planning is integrated with financial and activity planning at an intermediate and local level. The work of the WDCs has improved workforce planning to the education commissioning process particularly as the LDPs have become the main focus for integrated planning.

3.5 In response to "A health service of all the Talents" the commissioning and provision of education and training has developed longer contracts and forged strong relationships with education providers of both pre-and post-registration training. WDCs in London have developed strong stakeholder engagement through stakeholder boards with both education providers an NHS employers represented. Clinical placement facilitators have ensured that there are sufficient clinical placements for the increased numbers of students coming through training. However the introduction of the national contract and national contract price has been slower than envisaged owing to the length of term of existing contracts and further negotiations with all parties.

3.6 The Modernisation Agency and subsequently WDCs promoted the development of new roles and new ways of working. The NHS in London adopted the methodologies and was an early implementer for many new ways of working. However this work is in it infancy and there needs to be more sharing of the learning and embedding new roles.

3.7 "A Health Service of all the Talents" also gave rise to Agenda for Change and the new GP and consultant contracts which have all been implemented across London. The focus has been on implementation to national timetables and now the benefits arising form the pay modernisation need to be realised in terms of productivity gain.

3.8 Workforce planning for primary care staff still remains a challenge as many staff employed in primary care are not directly employed by the NHS but by independent GP practices. Workforce and service data is currently largely unavailable for this key area.

The Future

3.9 NHS London will develop a health strategy for London that will set out the strategic direction for health and social care across the capital to achieve the government health policy objectives. The Health Strategy will inform PCT commissioning intent and therefore the workforce plan will necessarily closely aligned.

3.10 The Commissioning regime for London has three key elements to its five year strategic plan:

The Strategic Plan establishes direction and sets priorities in light of the changing environment. It will be submitted annually, have a major refresh every three years, and provide a five- to 10-year outlook.

The Operating Plan describes in-year working priorities with detailed targets, financial plans and action plans to accomplish the Strategic Plan's goals. It will be produced annually.

The Capability Development Plan sets out the capabilities required to deliver the strategy, current capability gaps, and how these will be filled. It will be produced in parallel with the Strategic Plan: annually, with a major refresh every three years.

3.11 The plan will be future focused and will be developed in conjunction with stakeholders, education providers, national bodies and other health care providers to ensure that it reflects future health care provision in London. It will necessarily be a working document that reflects different scenarios and expectations of health care providers. It will act as a template for employers providing some expertise but will also provide a model from which to monitor workforce performance.

4. In Considering Future Demand, How Should the Effects of the Following be Taken into Account?

4.1 *Recent policy announcements, including Commissioning a Patient Led NHS*

The NHS Plan heralded significant investment in the NHS and growth of the healthcare workforce. Since 2000 NHS employers have had workforce targets that focus on growth of the health care workforce. However the investment to implement the NHS plan is to end in 2008. The continuation of improvement in health care will rely on greater workforce productivity and alternative approaches to workforce development.

4.2 The Health Strategy for London will reflect "Our health Our care Our Say" and the shift form acute care provision to health care closer to home. The workforce plan will reflect this by considering the impact on the workforce of changing models of care and associated care pathways. We will need to become effective at planning across employer organisational boundary (independent, voluntary and social services sectors) to ensure that the appropriate workforce is recruited and trained to effectively deliver the changes required.

4.3 *Technological change*

4.3.1 Electronic Staff Record will provide a much needed consistent baseline of information for NHS employers about current workforce—how many staff with details on WTE, occupation code, leavers, joiners etc available through the data warehouse to SHAs and the central DH team without the need to specifically collect any data. Therefore ESR will make analysis of the current position much easier but, on its own, will not be able to project future staffing or training requirements as this requires an advanced level of informed estimation.

4.3.2 Connecting for Health—there has been no specific exercise by CFH London to assess the implications for workforce planning in London of the implementation of NPfIT. The expectation is that as Trusts and PCTs update their workforce plans, they would anticipate changes in workforce that will be enabled by the new IT available to them through Connecting for Health.

4.3.3 To assist Trusts and PCTs in doing this, CFH is:

- Making clear to the NHS what functionality will be available.
- Supporting the NHS on the identification of benefits to be gained from implementation of new products.
- Ensuring there is a process for the sharing of lessons learned.
- Working with BT and the NHS on process redesign to implement the system and to support wider service change.

4.3.4 Overall there is a planned approach to ensuring appropriate training of NHS staff to use the new technology. This involves developing both the capability and capacity within the NHS for IT Training. The underlying expectation of the new IT is that in the future health and care professionals involved with direct patient and service user care will have safe, fast, modern IT to support them routinely in their work.

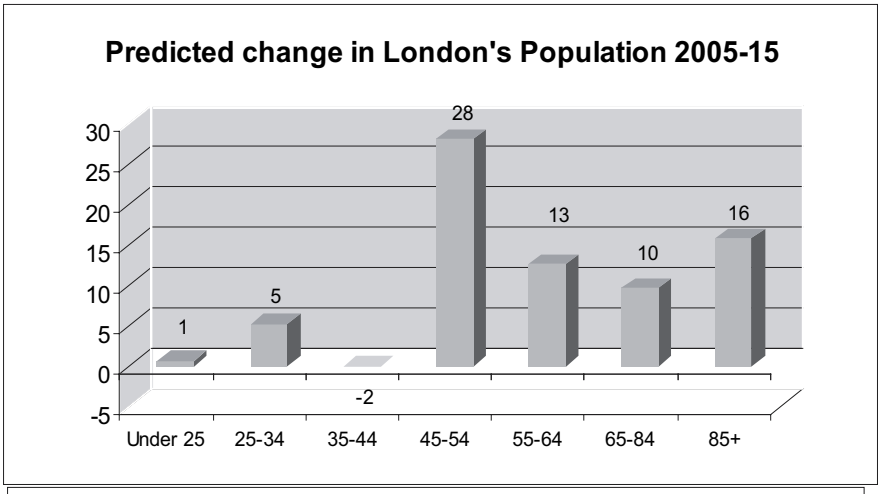
4.4 *An ageing population*

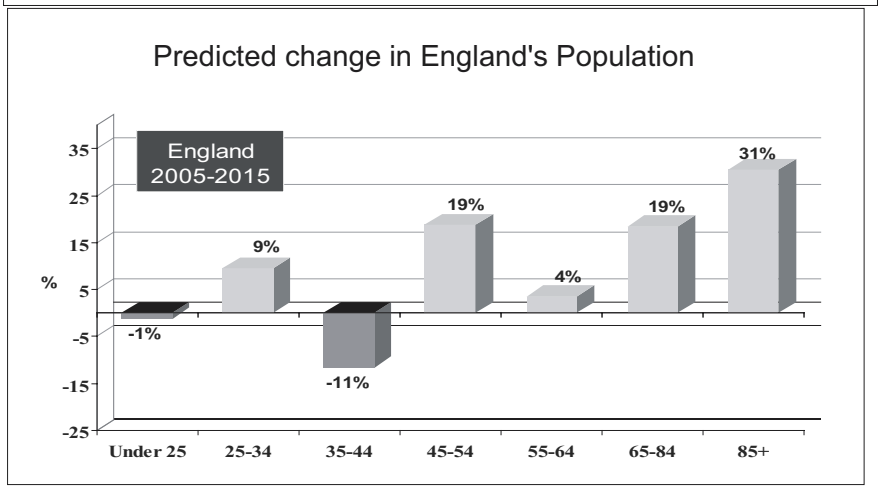
4.4.1 The highest population projection for London for 2015–16 predicts an increase of 850,000 on top of the current population of approx 7.5 million (+11.3%) and the lowest predicts an increase of 500,000 (+6.6%).

4.4.2 The chart shows the planned change in age structure for London (using the ONS projections) and compares this with the projected age structure for England. This demonstrates that nationally the over 65s will increase by 50% compared with London where the increase will be much lower at 26% (but still a substantial increase). The change in the over 85s is a particular concern for healthcare planning as this age group uses significantly more health resources than younger people.

4.4.3 The Older persons NSF states that as well as chronic illness, older people are also more likely to have a disability. Nearly half of disabled people are aged 65 or older. The most common problems relate to movement and to vision and hearing. Sensory impairments become increasingly common as people age: around 80% of people over 60 have a visual impairment, 75% of people over 60 have a hearing impairment, and 22% have both a visual and hearing impairment. These disabilities can reduce the ability of older people to look after themselves, resulting in a need for personal care. This in turn will have an impact on the nature and provision of health and social care.

4.4.4 London is anticipating a significant rise in the 45–54s which indicates that the local labour market will still be available but older; the reduction in 35–44s (less marked in London) however indicates that there will be a shortfall in the succession market.





5. The Increasing use of Private Providers

5.1 Through commissioning of health care for London NHS London will engage with both health care providers and providers from the independent sector. The workforce will be affected as providers change as a result of commissioning decisions. Therefore we need to plan flexibly to ensure that the appropriate skills, competence and education support is available in the workforce to deliver the health care desired.

5.2 NHS London, through the development of the workforce strategy for London will make links with health care providers across London (social care, independent and voluntary sectors) to ensure that we take a whole systems approach to workforce planning and development in London.

6. How will the Ability to Meet Demands be Affected by

6.1 *Financial constraints*

6.1.1 In response to the NHS Plan workforce numbers have grown considerably over the past six years with the number of non-medical staff in London increasing by 26% (compared with England at 20%). The majority growth has been in clinical support posts (+280%) rather than in qualified nursing numbers (+4%). Medical staff has grown by 45% during the same period. London employs more than one fifth of the total NHS labour force.

6.2 *MPET funding*

6.2.1 Up to 2006–07 central training funding has enjoyed significant levels of growth commensurate with the overall levels of increased investment in the NHS as a whole. This additional funding made a significant contribution to addressing historic workforce shortfalls (ie vacancies) even through a period of rapidly increasing workforce demand.

6.2.2 It is clearly important to ensure that the NHS both locally and nationally has a financial strategy for workforce which supports and underpins the broader workforce strategy itself. This is both in respect of the overall amount of investment but perhaps as importantly in the flexibility of how resources are used.

6.2.3 It would be difficult to argue that the level of funding alone, unless significantly out of line with the broader workforce strategy should be a material constraint to meeting workforce demands.

6.2.4 The specific financial challenges faced in 2006–07 should not in themselves represent a material threat to meeting future demand, as long as future funding broadly aligns with future demand. The fact that this funding is now a component of a wider "bundle" of central funds delegated to SHAs will only become an issue if this resulted in funding and demand becoming misaligned. We would anticipate that future funding for workforce development will mirror the context for NHS funding in general ie lower levels of growth in funding compared to recent increases.

6.2.5 There is still significant additional value for money which can be extracted from current investment. Such additional value can be delivered through improved delivery of existing activities, both in respect of innovation in delivery and through a more thorough approach to education procurement and performance management.

6.2.6 However the greater value for money is likely to be delivered by ensuring investment is targeted at:

(i) delivering a workforce which is closely aligned with emerging service strategy and service developments; and

(ii) delivering a workforce which it supports productivity in service delivery (including assuring appropriate quality and patient safety).

6.2.7 It is in meeting services demand for a more productive workforce that the inflexibility in the existing funding regime can represent a constraint. For example the shift to out of hospital care will require a significantly different skill mix eg primary care paramedics. however the funding regime, with its focus on funding defined activities can act as a barrier to developing new staff with such skills, by preventing the rapid redeployment of resources.

6.2.8 Activities which are clearly "self funding" in terms of productivity should not require central resources to be delivered, but it is imperative that we improve our ability to demonstrate the "bottom line" value of workforce development so health & social care organisations make improved use of there own resources.

6.2.9 These two areas highlight the importance of being able to use resources flexibly, rather than being constrained by either funding methodology or the ring fencing of resources for specific activities.

6.2.10 Alternative models for funding and commissioning workforce activity continue to be discussed, but it is important that any proposal that addresses perceived weaknesses in existing arrangements do not have unintended consequences of limiting the ability to generate maximum value from this important use of public funds.

6.3 *Gershon Efficiencies*

6.3.1 The Gershon productivity targets focussed on the following workforce issues:

— Temporary staffing.

— Turnover.

— Sickness absence.

6.3.2 Spending on agency has decreased over the past two years—work done by the National Agency Project has shown that the 33 participating trusts have reduced their agency spend by £50 million in the year and that £45 million of this saving was achieved by the participating 17 trusts in London. Across London, Trusts and PCTs in London will spend approximately £200 million on medical and non ımedical agency fees in 2006–07 and this represents 3.5% of the total paybill compared with the national rate of 2.5%. Although acute trusts employ two thirds of the staff in London they only account for just over half the total agency spend.

6.3.3 Bank staff represented approximately 7% of the total workforce at the beginning of the year and this had fallen to 6% by the end October 2006. This means that the WTE of bank staff has fallen by 13% in seven months to 8,000wte.

6.3.4 London is currently below plan for agency spend (–9%) compared to the national picture (+ 5.3%) and slightly above plan for medical locum spend (+ 1.3%) compared to the national (+ 30.8%).

6.3.5 Turnover has fallen by an average 1% year on year for all staff to an average of 14%.

6.3.6 Sickness has also fallen and is slightly lower in London than in England.

Sickness Rate	*National*	*London*
2003–04	4.70%	4.30%
2004–05	4.60%	4.20%
2005–06	4.50%	4.10%
% Decrease over Period	**−4.26%**	**−4.65%**

6.3.7 The task for NHS London is to work closely with the DH to develop workforce productivity measure that measures change efficiency in working practice.

7. The European Working Time Directive and Modernising Medical Careers

7.1 Modernising Medical Careers aims "to improve patient care by delivering a modernised and focused career structure for doctors through a major reform of postgraduate medical education. To develop demonstrably competent doctors who are skilled at communicating and working as effective members of a team. MMC will also bring about significant changes to career structures, providing qualified staff who are able to meet the needs of patients."

7.2 Running alongside MMC implementation is the need to reduce junior doctors' hours to 48 by August 2009 in line with EWTD. Most London Trusts have made some progress, but still have a long way to go in the next two years to reduce the hours of all their trainees.

7.3 MMC has not led to an increases overall in the number of doctors employed though some specialties will be training more doctors and some less. Therefore the additional reduction in hours by 2009 at the latest means that Trusts will have to review all service provision to ensure that it is appropriately covered and undertaken by doctors or by other appropriately trained health professionals. Many of these professionals are already employed in Trusts, some such as the recently approved medical and surgical care practitioners are currently being recruited to training programmes. Alternatively MMC and EWTD will promote the need to look at different models of provision such as clinical networks.

7.4 Expansion in UK medical schools will increase the number of graduates. These graduates will have an expectation of being recruited onto a training programme and there is a risk with anticipated reconfiguration of the acute sector that there may well be an oversupply of doctors in future years. The workforce planning implications of this will need to be reflected in the workforce plan.

7.5 The increase in medical school places should mean that most MMC places will be filled by UK trained graduates. This should reduce the London NHS' historical reliance on doctors from overseas, and this is already becoming apparent.

8. To What Extent Can and Should the Demand be Met for Both Clinical and Managerial Staff?

8.1 The nature of the demand for health workforce has changed. The demand in terms of workforce growth has been achieved. The requirement now is for new roles to support the changing health care provision and increased productivity. NHS London will manage this workforce agenda through delivering the health Strategy for London through service commissioning.

8.2 New models of care arising from the health strategy may have an impact on the configuration of services and this will need to be reflected in the workforce plan and managed appropriately to minimise impact on the workforce.

8.3 In response to the changing financial context plans are in place to reduce the workforce establishment in London from 135,000 to 130,000 posts (−4%) by April 2007; These changes will be managed in a number of ways—closely managed recruitment, reducing temporary staff usage (bank and agency), capitalising on turnover and redundancy as a last resort.

8.4 Finance Information Monitoring System (FIMS) already show that the WTE staff in post in London have fallen by 2000 (−1.5%) in the last seven months. Comparing this with the redundancy data shows that over 80% of this reduction was achieved through staff turnover rather than redundancies. During this period the PCTs have lost 2.7% of their staff whilst the acute trusts and mental health trusts have lost approx 1.5% of their substantive staff at the end March 2006.

London NHS WTE Staff in post	*end March 2006 in 000s*	*end October 2006 in 000s*	*Forecast outturn end March 2007 in 000s*
Acute trusts	84.5	83.1	82.0
PCTs	25.3	24.6	25.5
Mental Health trusts	17.0	16.8	17.1
Total	**126.8**	**124.5**	**124.6**

8.5 London is currently below plan for staff in post (−3%) and for paybill (−2%)—these percentage variances are similar to the national figures.

9. How Should Planning be Undertaken?

9.1 The Workforce Plan for the NHS in London will reflect the health strategy and will be relevant to health care outcomes required for London. This will provide a long term view of the workforce in London to inform health care commissioning expectations and to inform health and education commissioning. In addition NHS London will provide workforce planning expertise and over view for employers to use as a template for local planning.

9.2 The SHA will need to build alliances with a number of stakeholders—education providers, social care, independent and voluntary sectors to ensure that workforce planning at the intermediate tier informs health care commissioning and appropriately reflects health care provision now and in the future.

9.3 The NHS London workforce plan, to support the Health Strategy for London, will rely on a robust national picture of the workforce, local employer baseline data and education forecasting. Therefore workforce planning should be the concern of the employer, the SHA and Department of Health as each level contributes to the overall plan.

9.4 However In order for workforce planning to be sustainable, the whole workforce should be planned as one. Medical and non-medical workforce must be a planned together to ensure that the interdependencies are recognised, and to ensure that workforce planning truly reflects health care provision.

9.5 At a national level health policy and targets should not constrain the flexible use of funding to support commissioning by tying resource to particular projects or to specific targets. The use of funding will be informed by the health strategy and supporting workforce plan.

9.6 In addition, at a national level, the close integration of workforce policy with finance and health policy will assist with the alignment of workforce planning with service commissioning.

9.7 In conclusion although much has been done to improve workforce planning in the NHS over recent years, there remain a number of steps to take to ensure that activity, finance and workforce planning are further integrated for the whole health care workforce. Current policy provides further challenges with the encouragement of a plurality of providers, but also provides an opportunity to ensure that workforce is at the centre of health care planning with the focus on commissioning of health services for the future.

NHS London

11 December 2006

Evidence submitted by the National Union of Students (WP 88)

About NUS

1. NUS (National Union of Students) is a voluntary membership organisation comprising a confederation of affiliated local student representative organisations in colleges and universities throughout the United Kingdom. The organisation has nearly 750 constituent members—virtually every college and university in the UK—and represents the interests of around five million students. It provides research, representation, campaign work, training and expert advice for individual students and students' unions.

Summary

2. Healthcare students are reporting significant problems with the administration of NHS bursaries. Most worrying is that the delays in paying out bursaries are causing considerable financial hardship to students. This could help explain the high drop out rate amongst healthcare students.

3. NUS proposes that this has clear implications for workforce planning in terms of recruitment from within the UK.

Administration of Bursaries

Background

4. NUS has been working with NASMA (National Association of Student Money Advisors) to research problems with NHS bursaries reported to us by healthcare students.

5. NASMA conducted a survey amongst these students, and the results reveal that the administration of the NHS Student Grants Unit is "woefully inadequate" and that students are experiencing unprecedented problems in receiving their NHS bursaries. Particular problems have included delays in payment; problems with dependants allowance; and lack of communication from the Students Grants Unit.

Delays

6. Students have faced significant delays in receiving their bursary payments, with some students having to wait as late as December before getting their money. This is despite getting their paperwork in on time and starting their course in September. The NASMA survey revealed particular problems that have contributed to these delays.

- Administration—It can take up to a week to get a student's file from the records room —which is in the same building—to begin resolving a problem. Universities and students have consistently reported that they have had to send in the same forms over and over again, clearly indicating a problem with paperwork routinely going missing.
- Application forms—In 2005–06, the publication of application forms for bursaries was delayed. The result was inevitable delays in students receiving payments. This year, NUS has heard reports that an instruction to send a vital piece of information was omitted from the form. This resulted in many initial applications being returned to the applicant.
- Leave of absence—Students taking a leave of absence have reported particular delays as their details are wiped from the system, therefore requiring them to reapply once they return to university.

Dependants Allowance

7. The extra paperwork involved in claiming this additional payment means that the delay in students getting dependents allowance is often even worse than in getting an ordinary bursary. It has been reported to NUS that there are often cases where Dependants Allowance does not get paid or is suddenly stopped without explanation, despite students fitting the eligibility criteria.

Communication and Misinformation

8. These problems are being exacerbated because students have not been able to get in touch with the Students Grants Unit. Students are left on hold, phones remain unanswered, and letters and emails receive no response. Routinely notification letters advising students of their entitlement are not being received until several weeks after the course has started.

9. When students have finally managed to get through, misinformation is also a problem. Several students have reported that the Students Grants Unit has misadvised them about their entitlement to bursaries.

Impact on Recruitment to NHS

10. The delays in bursary payments have meant that many students face severe financial difficulty. This is causing students to consider discontinuing with their chosen career within the medical sector.

11. Lack of money obviously has a detrimental impact on all students, but it has a disproportionately large impact on the high number of older women, many with children, undertaking healthcare degrees.

12. It is notable that whilst the drop out rate for full-time students throughout higher education is 14.4%,[29] the rate is a considerably higher for nursing students at 24.8%.[30] Whist NUS understands that this is not solely due to problems in receiving funding, this must be a factor.

13. The high drop out rate clearly has a significant implication for workforce planning in the NHS in terms of recruitment from within the UK.

Tuition Fees

Background

14. The increase in tuition fees from September 2006 mean the NHS will now pay more than twice what it currently pays to subsidise the private tuition fee contribution on behalf of students—in most cases, it will be a rise from £1,200 to £3,000 per annum. As approximately 90,000 students receive funding from the NHS,[31] this represents an increase of £162 million per annum by 2009, when all students will be on this new funding system.

The need for subsidies

15. NUS would emphasize that the NHS's subsidisation of students' tuition fees has already led to an increase in application rates to nursing and Allied Healthcare Professionals courses. The organisations warns against ending this practice as it would risk reducing the numbers applying and causing a long-term problem with recruitment from within the UK.

Impact on Recruitment to NHS

16. This extra cost of tuition fees will no doubt be difficult for the NHS to absorb. However, a higher drop-out rate, caused and exacerbated by the problems with the Student Grants Unit, will only succeed in wasting the many millions of pounds that the NHS has already invested in these students.

Recommendations

17. The Department of Health needs to urgently review the working of the Student Grants Unit, and ensure that problems are ironed out before the next application round for students going to university in September 2006. This is particularly urgent as the budget is set to increase dramatically over the coming years.

18. The NHS needs to budget for an increased budget of approximately £162 million per annum in 2009 to continue subsidizing the private tuition fee contribution on behalf of healthcare students.

Karen Williams
National Union of Students

26 June 2006

Evidence submitted by Reform (WP 80)

STAFFING AND HUMAN RESOURCES IN THE NHS—FACING UP TO THE REFORM AGENDA

Defects of Current System

1. The effects of centralised manpower planning are negative. There are three general defects of the central planning system:

1.1 Human resources are planned on a silo basis without regard to team building, contrary to the fact that it is impossible to make sensible decisions about medical manpower without regard to other team members and supporting staff that play vital roles in patient care. In primary care, where there is more scope for local initiative in staffing, the chosen mix is now very different from the hospital service with fewer doctors and more practice nurses and support staff. The number of consultants has increased by 70% in the past 10 years while the number of GP's has risen by 10–15%.

[29] BBC News, "University drop out rate rising", 22 September 2005.
[30] Telegraph Online, "Millions lost as one student nurse in four quits before the end of training", 15 February 2006.
[31] House of Commons *Hansard,* 7 June 2006, Col 726W.

Table 1

NUMBER OF DOCTORS, 1994–2004, FULL TIME EQUIVALENT

	1994	*1996*	*1998*	*2000*	*2002*	*2004*	*1994–2004 % increase*
Consultants	16,500	18,600	20,400	22,200	24,800	28,100	70
Hospital registrars	10,600	10,700	11,600	12,200	13,000	16,100	52
Other doctors in training	115,500	17,300	18,500	19,000	20,900	24,500	58
Other medical and dental staff	24,900	5,600	6,400	7,100	8,200	8,600	76
GMPs including registrars	27,500	27,500	27,800	28,200	28,700	30,800	12
All doctors	76,800	81,800	86,600	90,200	97,000	109,200	42

Source: Department of Health. NB Figures are rounded and do not include retainers.

1. Includes PRHOs, SHOs, F1 and F2 pilots and equivalents.

2. Includes associate specialists, staff grades and community and public health medicine and dental staff*

1.2 A total lack of focus on cost and economics. Doctors and other staff represent a major cost yet decisions on staffing levels appear to have been taken without reference to levels of funding. The Department of Health has yet to bring forward long term cost estimates for staffing (and other programmes).

1.3 An emphasis on quantity rather than quality. Healthcare Commission analysis has shown that inexperienced nurses achieve lower levels of patient satisfaction than a smaller number of experienced nurses.

2. These defects are now about to impact on services and on staff ability to deliver care:

2.1 The combination of a doubling in the number of medical trainees, a low level of retirements and a very tight financial environment means that there is likely to be severe medical unemployment in coming years. There are far more young doctors graduating than the number of funded posts likely to be available. Even before the recent financial problems of the NHS there was clear evidence of a gap between numbers graduating and numbers retiring. Recent financial problems mean that the problem is likely to be brought forward as acute trusts which carry out most of the training are most affected.

Table 2

MEDICAL SCHOOL INTAKE, ACTUAL OUTPUT AND PROJECTED OUTPUT, ENGLAND: 1991–92 to 2008–09

Academic Year	*Intake*	*Graduate Output*
1991–92	3,191	2,788
1992–93	3,263	2,759
1993–94	3,374	2,866
1994–95	3,514	2,911
1995–96	3,486	2,983
1996–97	3,594	3,025
1997–98	3,749	3,261
1998–99	3,735	3,097
1999–2000	3,972	3,373
2000–01	4,300	3,286
2001–02	4,713	3,280
2002–03	5,277	3,522
2003–04	6,030	3,734
2004–05	6,294	3,935
2005–06	6,298[1]	14,394
2006–07		5,083
2007–08		5,676
2008–09		5,798

Source: HEFCE

[1] This figure is provisional until November 2006 when a finalised figure will be declared.

2.2 There are serious shortages in some key areas of staffing. The expansion in staffing has been very patchy with some areas of care likely to have situations of rising workload and declining staff hours. This can be illustrated particularly in areas as diverse as midwifery and in radiotherapy for cancer patients where there will be little change in hours available.

Table 3

NUMBER OF WORKING MIDWIFE HOURS PER WEEK, UK

	1994	*2004*	*Change*	*% change*
Full time hours per week	783,338	487,463	−295,875	−37.8
Part time hours per week	320,355	465,480	+145,125	+45.3
Total hours per week	1,103,693	952,943	−150,750	−13.7

Source: Statistical Analysis of the register, Nursing and Midwifery Council, August 2005
Assumptions: full time hours per week = 37.5; part-time median hours per week = 22.5

2.3 The NHS has much higher rates of sickness absence and lower morale than many smaller independent organisations. The recent Royal College of Nursing report, At breaking point? A survey of the well being and working lives of nurses in 2005, is a striking indictment of the system as it has worked. There is good recent survey evidence that stress levels among nurses have already risen and are now nearly twice as high as in the population generally.

2.4 There is a tendency to exaggerate the increase in human resources in nursing, especially in relation to on-the-ward hospital nursing. Increased entry into training is likely to be accompanied by a higher drop out rate in the early career years and many experienced nurses have moved to new posts as specialist nurses and nurse consultants. The realistic outlook for nursing is one in which there will be little or no increase in experienced staff hours in a situation where nursing care has become much more complex and clinically demanding.

Reform

3. Centralised silo manpower planning has produced a staffing investment which is unbalanced and unaffordable. We welcome moves towards family-friendly policies and better human resource management as set out in Agenda for Change but such improvements are likely to be undermined by the overall crisis of affordability which is likely to lead both to reduced options for staff in post as well as to further redundancies.

4. There is an urgent need for a new approach to human resources which will support reform. The new approach will be driven by elements of the current reform programme:

4.1 Foundation Trusts, a greater variety of providers and practice based commissioning of new services will drive the system towards much more local and flexible systems of staff roles and pay structures. National agreements will play a declining role, based on defining minima.

4.2 Payment by results and patient choice will come increasingly to mean that pay levels will be related to the competitive performance of the local healthcare enterprise.

4.3 Commissioning which sets quality standards will drive forward innovations in quality of care and will reward higher productivity. Equally, competition can empower staff by rewarding teams which achieve outstanding performance. The centralised NHS still suffers from the old problem of perverse incentives where additional effort or change leads to serious problems with budgets and workload.

4.4 Foundation Trusts could give a strong lead in developing roles as care boundaries change. Independent treatment centres will also show what can be done through teamıworking to raise productivity and to provide patients with a one stop shop experience.

5. The new NHS human resource approach has to ensure that patients can fully benefit from these changes. There will be a tendency to freeze innovation and to restrain changes which may threaten the hallowed tradition of a job for life.

6. The transition will certainly be difficult. It is likely that productivity gains will mean that staff numbers are reduced by at least 10%. This reduction should occur across all generic staff, skilled and unskilled.

7. This change will make it possible to improve quality, with more investment in fewer people. One strong gain from reducing the number of hospital beds will be that of concentrating time and available skill on fewer services and giving staff better support.

8. In the longer term staff will have gains from more choice, higher morale and greater job satisfaction from working in smaller, more independent organizations. Reform can produce gains for patients but it can also produce gains in control, rewards and job satisfaction for many staff as well.

9. Staffing reform could mean a system with flexible, local, initiative and scope for team building which will create much greater job satisfaction and professional pride. Reform can help to ensure that we make full use of the great commitment and ability of so many staff in the NHS, replacing the frustrations caused by the failed system of centralized manpower planning.

10. A smaller workforce with more effective support can be empowered to deliver quality in care. A quality approach could also reduce cost pressures and free up funding for new services. We would see a 10% reduction in numbers as a realistic medium term outcome from the new incentives. Such productivity gains reflect the experience of ITCs and of primary care and payment by results will create powerful new incentives to lower costs.

11. This submission is based on the *Reform* report *Staffing and human resources—facing up to the reform agenda* by Professor Nick Bosanquet, Andrew Haldenby, Henry de Zoete and Roger Fox. The full report can be found at www.reform.co.uk.

Reform

5 May 2006

Evidence submitted by the Royal College of Pathologists (WP 78)

1. Introduction

The Royal College of Pathologists (RCPath) welcomes the request of the new Inquiry, made on 27 January 2006, to present evidence on the current status of the Pathology Workforce in the United Kingdom and the projected requirements of that specialty within the terms of the Inquiry. The College thanks the Health Committee for accepting this written submission.

The RCPath works closely and regularly with the NHS Workforce Review Team and with members of the Department of Health to share data and to formulate policy with respect to Workforce planning. The complexity and extent of "Pathology" in the United Kingdom precludes a detailed appraisal of the various different specialties contained within the subject. Therefore, this memorandum comprises a generic assessment of the common factors principally constraining planning and development of the pathology Workforce in the National Health Service. For reference purposes, the Appendices contain greater detail with respect to each of the individual specialties within the totality of "Pathology".

2. Background

"Pathology" represents a combination of clinical and laboratory-based (scientific) disciplines [Appendix I] and activities that underpin a large amount of patient investigation and management within the Health Service of the United Kingdom and is required for up to 70% of diagnosis. The Workforce is extensive and varied in its composition, including medically-trained pathologists (3,468 of which 323 posts are vacant), clinical scientists (3,983) and biomedical scientists (21,256) together with a wide range of ancillary but essential support from a range of laboratory assistants, phlebotomists, anatomical technicians, clerical, secretarial/administrative and other personnel[1]. These latter figures are in general agreement with the 28,242 non-medical scientists identified in the 2004 survey [Appendix II] of non-medical personnel within the NHS[2].

These figures underestimate the total Workforce necessary to deliver the Pathology service required by the UK NHS. However, existing systems of data collection preclude a more accurate assessment of the size, composition and complexity of the Workforce currently delivering the Pathology service. Although many activities are based in laboratories, Pathology is a "clinical service that supports other clinical disciplines", and not merely a "support service" and in many areas is also responsible for providing the clinical service. Pathology is an integral part of the multi-disciplinary team and discussions between a Consultant Surgeon and a Consultant Pathologist are of a similar status and nature to those between a surgeon and physician when discussing how best to advise a patient and what treatment options should be considered.

Pathology, defined by the Government as the "Essential Service"[3], comprises the four major specialties of Histopathology (including Cytopathology), Haematology (including Blood Transfusion), Clinical Chemistry (including Metabolic Medicine) and Medical Microbiology (including Virology and Parasitology) together with a number of smaller of specialties including Immunology, Embryology and Medical Genetics. The group of laboratory-based specialties termed "Pathology" analyses the entire spectrum of bodily materials including fluids (blood, urine, cerebrospinal fluid, ascites etc) and secretions (respiratory, cervical etc) as well as intact tissues and their derivatives (proteins, lipids, carbohydrates, hormones, minerals, nucleic acids etc) using a variety of specific laboratory techniques.

The materials studied originate from individual patients and the data generated through laboratory analyses are assessed objectively against a spectrum of values or appearances judged to represent "normality" within the caveats of age, gender, disease, medication and other factors. Following interpretation, decisions based upon the pathological data directly affect the clinical management of individual patients. The role of pathology is to identify, develop and provide the scientific infrastructure that

enables accurate diagnoses to be made and, thereafter, to monitor patients and assess disease progression, including response to therapy. Thus, pathologists (ie all those involved in the practice of pathology) are patients' advocates with respect to their clinical management. Following initial diagnosis, interpretation of pathological processes potentially influence disease progression and hence determine the outcome of each individual patient.

Within the UK NHS, pathology currently provides a highly efficient and effective service, despite the constraints it has continued to endure over a number of years. While there is no doubt that some improvements in structuring and delivery of the pathology service could be made, these changes should be considered only on the basis of informed understanding of present structures and functions. There are few clinical situations in which provision of pathological information is not acquired early and used as an integral part of the clinical diagnostic-management pathway. Increasing sophistication of the technologies and methodologies routinely employed by pathologists is providing the constantly-evolving scientific basis by which ostensibly identical diseases are being sub-divided into biologically distinct entities (eg malignancies, cardio-respiratory disease, hypertension, metabolic bone diseases, autoimmune inflammatory disease etc etc), often requiring significantly different therapeutic approaches.

Thus, the practice of Pathology (and hence the role of Pathologists) is core to the clinical diagnosis and monitoring of patients. In the very near future, Pathologists will also determine the biologically appropriate therapeutic regimens employed to manage individual patients and to change treatments as the diseases affecting those individual patients become modified.

3. Pathology Workforce Overview

The NHS Pathology service in each of the subject specialties previously identified (see Section 2) is provided by an integrated workforce that can be considered in four broad groups of: (1) Medically trained doctors; (2) Clinical Scientists; (3) Biomedical Scientists and (4) Clerical/Secretarial/Administrative. Smaller groups may be considered within these broad categories, according to skills, training, competencies and responsibilities (eg Anatomic Pathology Technicians may be included within the group of Biomedical Scientists). Recruitment, development and retention of an appropriately skilled Workforce "fit for purpose" is crucial to an effective and reliable Pathology service that is the cornerstone of modern healthcare delivery.

Within all pathology specialties, there is overlap with respect to roles, technical competencies and responsibilities between the principle groups [Appendix III]. Pathology Modernisation[4, 5] as a concept initially set-out to explore the similarities and differences between the activities of these groups and to make recommendations with the objective of improving performance in Pathology by adoption of new strategies and working practices. Simultaneously, additional approaches embodied within the *Knowledge and Skills Framework*[6] and *Agenda for Change*[7] prompted and strengthened the drive towards rationalising practices within pathology laboratories. Thus, diverse efforts are being made from different agencies to remodel the structure and delivery of pathology. Often, these pressures are uncoordinated, poorly-informed and frequently conflicting in their purposes.

Within the "Pathology Workforce" the concept of strict demarcation between individual specialties is becoming outmoded with respect to innovations that include robotic handling of specimens, modern molecular biological technology and automated image analysis (from DNA arrays to histopathological specimens). However, before the objective of a fully integrated "cross-specialty approach to Diagnostic Pathology can be attained, the fundamental and common factors of recruitment, retention and competencies require to be addressed and current deficiencies resolved.

4. Effectiveness of Workforce Planning

4A. *Effects of Policy Announcements and Changes*

(i) Workforce Planning in the Pathology Specialties is unique within the National Health Service since it involves a large number and diverse range of highly trained personnel, both Medical and Scientific. Provision of appropriate skills to a level of competence within the workforce involves a delay of at least five years for those medically-trained to reach MRCPath and at least four years for Clinical Scientists to reach PhD.

(ii) There is increasing reliance on non-medically trained personnel to take responsibility for ordering pathology tests, often using protocols drawn up by pathologists (Demand management) or for pathological investigations performed by a variety of "One-Stop" agencies or "Walk-In" centres to be repeated. There is also a significant trend for personnel not trained or experienced in a broad understanding of medicine to rely upon laboratory investigations for diagnostic and monitoring purposes.

(iii) Emphasis on a "patient-led" NHS and employment of Medical Care Practitioners[8] without a broad medical background is likely to increase demand on all sectors of the Pathology service.

4B. *Technological Change*

(i) Technological change is occurring in three major sectors of pathology activity:

(a) Near Patient, or Point of Care testing is increasingly being deployed to allow regular monitoring without the expense or inconvenience of transporting those patients to a laboratory to perform tests. Increasingly, these modern instruments convey data by telecommunication links[9] to a central laboratory, to clinicians and to the patients' electronic records. Such investigations may be performed by the patients following training (eg blood glucose measurements), by Medical Care Practitioners or by nurses, thus obviating the need for doctors or laboratory personnel to administer each test.

(b) Truly novel technologies allow acquisition of patient-specific pathology data not hitherto available. These modern technologies are often robotic and automated up to the point of delivering the validated data. Obvious examples include all molecular genotyping and phenotyping of human cancers. For example, sentinel node assessment of a primary cancer not only permits detection of otherwise occult micrometastases but simultaneously provides unique information on tumour differentiation and biological competence with respect to drug sensitivities, and hence therapeutic options. Similar principles may be applied to haematological malignancies as well as to the microbiological investigation of tissue infections and infestations.

(c) Digitisation of a disparate array of image-based information together with web-based telecommunications provides ready access to mathematical analyses (application of algorithms) and the integration of remote data to provide levels of novel information not previously attainable.

(ii) Utilisation of these new technologies is often hampered by shortages of personnel (workforce), expertise, time and funding.

(iii) The lack of numbers of laboratory personnel, particularly those with appropriate expertise, often means that those available are fully committed to the traditional delivery of service and have no flexibility or opportunity to learn new skills. Time spent developing new methods of working, including acquisition of new skills, is considered as detrimental to efficiency, of delivering a service and attaining targets, and hence is not encouraged or funded within the existing system.

(iv) To acquire and develop the new technologies to a level of common usage within the NHS service requires increased flexibility within the workforce.

(v) Introduction of automated instrumentation will change the profile of the workforce. Fewer middle-grade scientists will be required in preference to more technicians to supervise the instruments together with more medically-trained pathologists or clinical scientists to interpret the data, to advise clinicians and to take-on increasing Clinical roles.

(vi) Technological change has been assumed (erroneously by many) to be the panacea for correcting any perceived inefficiencies within the existing pathology service. "Technological change" can potentially achieve an increase in the availability of pathological investigations through point-of-care testing using a range of novel instruments outside main laboratories. This is not necessarily cheaper or workforce saving but has a place and a value in a number of clinical situations, particularly allowing patients remote from hospitals to be closely monitored with the tests being administered by non-medical and non-scientific staff.

(vii) Many such instruments are now readily available, especially within the community. Effective deployment of this technology requires the training of a support workforce knowledgeable in technical aspects of administering the tests but without responsibility for their interpretation.

(viii) The other major technological advance involves the introduction of new technologies where there is no previous expertise within laboratory medicine. Such new technologies include the full range of evolving molecular biological methods with which to detect and classify an expanding range of human diseases (benign as well as malignant).

(ix) There are a number of newer innovative technologies now seeking application in Pathology. These include exhaled breath analysis to detect and monitor a range of non-respiratory systemic illnesses including hepatic dysfunction and degenerative CNS disease. These will ultimately provide rapid-access and non-invasive technology with which to identify and manage patients with those conditions.

4C. *Influence of an Ageing Population*

(i) With respect to workforce, the term "Ageing Population" might be applied equally to laboratory personnel as to the patients served by the pathology service.

(ii) The major specialties within pathology contain a medical and a scientific component in which a high proportion of each membership is within 10 years of retirement [Appendix IV] and of which a significant proportion is within five years of retirement.

(iii) This group of personnel within pathology contains significant knowledge and expertise to ensure continuity of training but is undergoing attrition before that knowledge can be passed to the trainees entering the various professions [Appendix V]. Loss of training capacity, probably affecting the scientists more than the medically-qualified pathology workforce, is resulting in numbers of laboratories no longer

accepting trainees in favour of maintaining target-oriented services in a manner analogous to that already described for technological change (see Section 4B(iv)). Without centrally-directed support, the Pathology Workforce will continue to contract relative to workload and demand because the capacity to train new recruits will continue to diminish.

(iv) Within the community, ageing populations generally require more pathological investigations than younger populations and are more likely to have chronic disease that needs long term monitoring. However, many of the types of investigation required are predictable and hence programmed monitoring of ageing populations could be planned so that appropriate resources are available. For example, occult thyroid dysfunction (both hyper- and hypo-thyroidism) is more common with advancing age but can be readily detected by appropriate laboratory investigations. It is economically justifiable, through planned surveillance of ageing populations, to prevent many diseases while they are yet minimal from becoming clinically overt and requiring additional NHS resources.

(v) Other diseases that benefit from early pathology laboratory detection include diabetes, metabolic bone disease, cardiac failure, hypertension, colorectal (and other) neoplasia, renal failure and many more. However, while such programmes are economically justifiable and hence desirable, the current pathology Workforce is too small relative to the present or predicted workload to implement such surveillance.

4D. *Increasing use of Private Providers*

(i) There is a general misconception that, within the United Kingdom, a large private pathology sector is available with capacity ready to accommodate excess work from the public sector. While it may be true that highly selected parts of the country's pathology workload could be performed within private laboratories, this is demonstrably untrue for the totality of pathological investigations.

(ii) The majority of work that would be suitable for transfer falls into the low technology automated category (typically routine biochemical and haematological). These require little staff input.

(iii) These "high-volume, low-cost" tests underpin much of the expense of more complex investigations ("low-volume, high-cost") that make NHS pathology laboratories viable. Diversion of these automated and remunerative tests ("cherry-picking") would seriously undermine current efficiency of NHS pathology laboratories as well as fragmenting provision of an integrated assessment of individual patients' pathological data.

(iv) A consequence of unrestrained use of private suppliers would be a less efficient and less cost-effective NHS pathology service in which unit workforce costs for specialist complex investigations would be driven-up.

5. Predicting Future Demand

5A. *Financial Constraints*

(i) Pathology has often been viewed by Hospitals, Trusts and Health Authorities as an expensive service removed from the actual provision of healthcare. This view was reinforced during the period of competitive tendering between laboratories in which pathology budgets were reduced and services curtailed. This led to significant inter-laboratory rivalry that has persisted and remains a significant obstacle to development of "pathology networks" in which cooperation rather then competition has been the primary objective.

(ii) Current financial constraints originating in this earlier era continue to inhibit development of pathology services in two principal respects:

(a) A lack of financial flexibility to invest in additional workforce, in developing new technology or in reconfiguring services in favour of maintaining current working practices to achieve targets (see Section 4B. vi). Such a rigid approach ensures maintenance of the *status quo* by the majority of laboratories within the NHS while ensuring lack of essential support for the overall pathology service to evolve.

(b) The majority of laboratory budgets are insufficient to continue supporting the final (fourth) year of clinical scientist training. Provision of funding for this pre-registration year has always been *ad hoc* in many laboratories. However, different Pathology specialties are affected differently. For example, Haematology and Immunology have been successful in developing Grade A clinical scientist training schemes, although a number of these trainees have left the specialties following completion of training through lack of funding to support career progression. Histopathology currently trains and employs few clinical scientists, but is likely to require more as the nature of the tests performed within those laboratories change. Conversely, Clinical Chemistry is highly dependent on its scientist workforce but the combined impact of factors including continued decline in funding relative to demand, a large pre-retirement workforce and diversion of funding to achieve service targets have reduced the capacity to maintain this science-based workforce.

(iii) Responsibility for funding Pathology within the NHS is about to be transferred to StHAs and to PCTs—two layers of administration likely to be disbanded in the near future. Unfortunately, the majority of persons working within these administrative bodies are physically and experientially remote from

investigative aspects of patient care such that their appreciation of the value of Pathology is frequently inadequate. History has repeatedly shown Pathology to be a prime target whenever economies are to be made and budgets cut.

5B. *European Working Time Directive*

(i) Throughout the Pathology Workforce, but affecting medically-trained pathologists more than the scientist workforce, it is common practice for individual personnel to work more than 40 hours per week in order to complete outstanding work.

(ii) However, many Trusts consider it unnecessary for pathologists to work more than 40 hours per week with the consequence that only 10 PAs are offered to pathology consultants under the terms of the new contract. Pathology trainees in many laboratories do not receive banded payments for additional work. If Consultants accept this reduction we may soon see a significant reduction in the hours they work.

(iii) Current attitudes engendered in Trainees to work only within fixed time schedules, and not to work outside those planned times for which they are remunerated, will increase the necessity for a larger Pathology Workforce, if workload demands are to be successfully addressed.

(iv) The Working Time Directive (WTD) is beginning to have an impact on pathology. Compliance with the WTD without detriment to clinical services through lack of pathology services will not be possible without consultant expansion to enable reductions in working hours.

(v) There is some possibility for cross-cover by developing links between neighbouring hospitals, which will occur in parallel with changes in the acute services strategy. However, the impact is likely to be slight in view of the need to have local advice on site in all acute hospitals. Histopathology, in particular, is a "hands-on" specialty at Consultant level in most DGHs with little or no dedicated junior doctor cover, thus precluding effective operational availability on more than one site simultaneously. Many of the other specialties provide a clinically based service and important pan-hospital services, such as infection control and blood transfusion services.

5C. *Feminisation and Part-Time Working of Pathology Workforce*

(i) An increasing proportion of medical students are female. A similar trend is developing in the Pathology Workforce whereby more medically trained pathologists are female [Appendix VI].

(ii) Currently, women seek more time away from work than men in order to look after children and young families, thus increasing the total required headcount to match the full time equivalents (FTEs) of the Workforce necessary to meet pathology workload demands.

(iii) Increasing part-time working (whether by women with family commitments or by men seeking less time at work for whatever reasons) imposes an uncertainty on workforce planning that cannot be fully compensated. In the workforce planning algorithm used by the NHS Workforce Review Team and the RCPath to estimate the numbers of medically-trained pathologists required in future years, the factor used to relate "headcount" to FTEs has fallen from 0.8 in previous years to 0.75 in this current year—indicating a necessary increase in the numbers to maintain the same effective Workforce.

(iv) To compensate for a declining Medical Pathology Workforce through additional recruitment and training requires approximately eight years to generate independent, competent and effective Pathologists following their initial Medical training (see Section 4A(i)).

5D. *International Competition for Pathology Laboratory Staff*

(i) The UK Pathology Workforce (Medical and Scientific) is currently trained to a very high international standard. Organisation of an integrated Health Service (including Pathology) is more extensive in the UK than anywhere else in the world. These two factors provide a unique opportunity for UK pathology to become a net exporter of Pathology services and hence to attract revenue into the country.

(ii) The converse of this projected scenario is that, without appropriate reorganisation, the UK NHS could purchase some of its pathology services from other countries.

(iii) The UK could benefit (financially and structurally) from reconfiguring its pathology services and thus fully realize this currently undervalued resource.

(iv) There are significant potential opportunities in working with UK-based manufacturers of pathology equipment and instrumentation to develop "integrated packages" that might be supplied as functional units to pathology laboratories in less sophisticated countries. Development of equipment that complies with common internationally-standard operating systems would allow the direct interfacing of different pieces of equipment from different suppliers ("plug-and-play") without supporting monopolies. Manufacturers of such equipment would find ready markets in Eastern Europe, the Middle East, the Indian subcontinent and other parts of the world before those countries developed their own systems.

(v) Development of large automated laboratories that are environmentally competitive would make financial sense for non-urgent pathology tests (eg clinical trials) or specialist tests that would be expensive to establish on a small scale elsewhere (including a wide range of Histopathology together with all of the other Pathology sub-specialties). Installation of routine digital image scanning together with web-conferencing have already demonstrated this option to be viable.

(vi) The UK pathology workforce is highly competent but requires additional funding to expand and to develop further. This expertise is in international demand and should be nurtured, developed and protected. Rather than allowing this national resource to migrate from the UK, reconfiguration of pathology services in which the trained expertise is fully exploited would provide a strong business-case to purchasers of this expertise from other countries.

(vii) The UK has always had a tradition of attracting both trainees and pathologists from other countries. This has not only supplemented workforce deficiencies but has provided important international links and has helped enhance the standard of medical practice world-wide. An increasing number of doctors are now being seen from Eastern Europe. While the RCPath does not support or condone recruitment of pathologists from "Third World" countries or from any places where such expertise is in short supply or its removal would be detrimental to its location of origin, personnel trained in laboratory Medicine may benefit from short periods of additional training in the UK, but with the proviso that they return, with their added expertise, to their country of origin following training.

(vii) Trained pathologists, trainee pathologists and medical scientists may be recruited from countries within the EEA, USA, Canada, Australasia and other countries where pathology is already practiced at a high standard and where there is a surfeit of this expertise. Such recruitment may prove beneficial to UK pathology, to those persons choosing to work within the UK and/or to international cooperation and understanding between foreign nationals.

5E. *Early Retirements, Resignations and Other Losses*

(i) The RCPath is unique within the NHS in commissioning a bespoke Electronic Workforce Database (EWD) able to encompass numbers and membership of all groups working within pathology in the delivery of healthcare. Funding for this database has been suspended, temporarily. However, both the DoH and NHS Workforce realize that, without the proposed electronic database, there will be incomplete understanding of current Workforce—in terms of both numbers and competencies.

(ii) Until the EWD is established, the RCPath will continue to maintain a database, updated annually, of all Consultant pathologists currently in post as well as a listing of those posts that, for any reason, have recently become vacant.

(iii) While the RCPath data are as accurate as possible, several factors mitigate against this information being a true representation of all posts available at any time [Appendix VII].

(iv) Trusts and PCTs do not protect the funding of Consultant Pathologist posts but rather consider vacancies in Pathology posts to be opportunities to direct funding towards so-called "front-line" posts directly identified with patient-related activities.

(v) In recent years, Universities and other academic institutions have transferred many pathology staff from their academic (particularly HEFCE-funded) employment to the NHS in order to be more competitive in previous and current RAE exercises.

(vi) Some senior academic Pathologists, at the proposal of transfer to the NHS, have taken early retirement, particularly when Trusts have refused to fund those individuals.

(vii) Inter-personal stresses caused by increasing loss of Consultant Pathologist Workforce has directly contributed to resignations and early retirements, particularly in Histopathology[10].

(viii) Loss of academic Pathologists from medical schools has compounded the already diminished profile of Pathology disciplines as an integral part of the new medical curriculum and as viable career options, thus worsening problems of recruiting 'home-trained' medical staff into Pathology-related professions[11, 12].

6. Constraints on Ability to Meet Projected Demands

6A. *Changing the Roles and Improving the Skills of Existing Staff*

(i) Pathology services are heterogeneous with respect to the composition of the workforce within the different pathology disciplines. However, all comprise various mixtures of medically-trained staff (Consultants and Trainees) together with clinical scientists, biomedical scientists and clerical/administrative personnel. Some of the disciplines contain specialist staff such as Anatomical Technicians (Histopathology) and Phlebotomists (Haematology and Clinical Chemistry).

(ii) The career pathways for the individual types of staff are becoming aligned through processes such as the *Agenda for Change* and the *Knowledge and Skills Framework*. Rationalisation of clinical scientist careers is currently being undertaken. The long-term objective is to identify the roles of all personnel to fulfil the activities identified within the Pathology services and to align staff with appropriate skills and expertise to those roles.

(iii) Lack of flexibility within the Pathology Workforce caused by insufficient funding to generate an adequately large human resource, poor retention of scientific staff following initial training (see Section 5A(ii)) and concentration of available resources on achieving short-term targets rather than investing in reconfiguration to develop imaginative and modern methods of integrated working are contributing to the retention of a rigid and stylised approach to Pathology within the NHS.

(iv) Recruitment is a matter of profile[13]—whether medical, scientific, technical or clerical. Individuals will not be recruited into any profession that has no profile or appears to have no relevance. Once recruited, individuals will not be retained without personal job-satisfaction, prospects of career progression and levels of remuneration that are competitive with external options.

(v) The concept of "competency" is defined as the product of skills (including knowledge) already acquired (through school, university and/or medical school) together with aptitude and ambition to progress to professional training in the discipline.

(vi) Currently, there is a strong subjective sense that, on entry, the skills and experience offered by science-trained graduates is currently higher than at any time previously with the consequence that there is a valuable opportunity for pathology in the UK to recruit talented and well-trained young scientists capable of developing the profession.

7. Strategies for Meeting Projected Demands

7A. *Nature of the Projected Demands*

(i) There are two components to this question: First, the size and nature of the projected demands and, second, the size and competencies of the workforce to match the demands.

(ii) As UK healthcare becomes more proactive with minimal diseases (new and residual) being detected earlier, so the number and complexity of tests required will continue to increase at a rate of approximately 13% *per annum* for the foreseeable future, if the trends over the past decade continue unabated.

(iii) Pathologists are also being asked to provide many new types of information with respect to disease phenotype, prognosis and likely response to therapeutic manipulations.

(iv) The fact that increasing amounts and complexity of tests will be requested does not *per se* predicate increasing numbers of pathology staff. As many new tests become automated, and laboratories function as a 24/7 routine, the workforce is likely to become redistributed from predominantly those with "hands-on" expertise at the laboratory bench to a lesser number with skills to supervise and maintain instruments together with a larger number competent to interpret the data to be transferred to clinicians and to be stored in patients' records. These evolving profiles will be specialty-dependent according to the individual levels of laboratory automation achieved.

(v) The numbers and profiles of clinically-trained pathologists are likely to rise significantly as demand increases to interpret more sophisticated tests related to individual patients. Already, this change is most significant in Haematology and Clinical Chemistry where pathologists are skilled in performing laboratory investigations as well as clinically to manage patients. Similar trends are already occurring in Medical Microbiology, Allergy and Immunology and in Genetics and are about to occur in Histopathology.

(vi) Histopathologists now perform complex investigations to determine the phenotype, prognosis and likely response to treatment of a variety of diseases, not just cancer. The potential clinical significance of these data frequently cannot be encompassed in simple reports but require detailed interpretation and simultaneous communication to clinicians and to patients in order that appropriate management strategies might be formulated and agreed and reviewed as response to treatment becomes apparent. Therefore, it is most appropriate that Histopathologists adopt a role more central to the clinical management of patients than occurs at the present time.

(vii) The consequence of a more central clinical role will be to support the profile and apparent relevance of pathologists as clinicians in the core management of patients. There will be more and better teaching of pathology in the undergraduate medical curriculum. Recruitment of high-calibre "home" trainees into pathology will increase and funding of Consultant Pathology posts by Trusts and PCTs will be perceived as essential rather than as being of questionable value in the front-line management of patients.

8. Recommendations

— Effective Workforce planning in Pathology urgently requires the commissioning of a dedicated Electronic Workforce Database (EWD) of the type originally conceived and initially funded through the DoH. This Database is now available for use. The proposed Electronic Workforce Record is no substitute for the EWD since it is insufficiently detailed to capture all of the information necessary for effective Pathology Workforce planning. A detailed analysis of the costs

of deploying the EWD are appended [Appendix VIII]. An essential requirement to the use of an EWD is that it should be a requirement of employment (individuals and/or Trusts should be mandated) to maintain their entries at least once, annually.

— Pathology Workforce should be monitored and planned on a national basis using the proposed Electronic Workforce Database as a matter of urgency. There needs to be a greater awareness of the dangers in the predicted loss of expertise as senior members of the workforce (all specialties) reach retirement.

— Pathology specialties could recruit nationally to training programmes based around teaching centres and utilising rotations to other Trusts or trainees to gain specific expertise in a manner analogous to that currently used by Histopathology Training Schools. To assist this process, NTNs should be transferred from locations where no training occurs and relocated to the training centres.

— Wherever possible, specialist training could be integrated between medically-trained Pathologists, Clinical Scientists and Biomedical Scientists for specific areas of the curriculum. Joint training across specialties and between the three groups would provide a foundation for role rationalisation and cross-specialty working, particularly in common fields such as molecular genetics but would still maintain the unique nature of each specialty.

— As a generalisation, medically-trained pathologists should make greater use of their clinical skills and become more proactive in the management of patients.

— Since establishment of pathology services involves complex planning over a long term, StHAs, Trusts and PCTs should ring-fence and protect monies currently designated for workforce personnel.

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Professor Christopher S Foster
Director of Workforce Planning, The Royal College of Pathologists

9. Referenced Material

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[5] Department of Health, *Modernising pathology: Building a service responsive to patients*—2005.

[6] Department of Health, *The NHS Knowledge and Skills Framework (NHS KSF) and the Developement Review Process (October 2004)*—2004.

[7] Department of Health, *Agenda for Change Proposed Agreement (September 2004): Final draft*—2004.

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[10] Liebmann R and Foster CS. *Workforce—Greener grass? Consultant histopathologists moving between Trusts—survey results*. The Bulletin of the Royal College of Pathologists **133**, 11–13 (2006).

[11] http://www.gmc-uk.org/education/undergraduate/tomorrows_doctors.asp

[12] John Hutton: *£73 million for junior doctor training programme.* MMC Programme, 23 March, 2005.

[13] Domizio P and Du Boulay C. *Working smarter—Career Choices And Career Progression In The Pathology Specialties: National Surveys Of UK Medical Graduates.* The Bulletin of the Royal College of Pathologists **134**, 31–35 (2006).

10. Specialty-Specific Information

The foregoing document has provided generic information with respect to overall trends in Pathology Workforce. However, Pathology is a complex and heterogeneous subject in which each of the specialties currently experiences unique and specific problems and constraints. These are addressed in Supplementary Documents I containing Appendices I-VIII. The Proformas developed annually with the NHS Workforce Review Team are contained within Appendices IX-XV in Supplementary Documents II.[32]

[32] Not printed here.

Supplementary evidence submitted by the Royal College of Midwives (WP 54A)

Since submitting our original evidence to the inquiry into Workforce Planning, further and more up-to-date information has been published that reinforces many of the points we made in that original evidence. For that reason, we wanted to submit supplementary evidence to inform the Committee's work further.

The Royal College of Midwives (RCM) represents over 95% of the UK's practising midwives, and is the world's oldest and largest midwifery organisation. It works to advance the interests of midwives and the midwifery profession and, by doing so, enhances the wellbeing of women, babies and their families.

NHS Midwifery Workforce in England

The number of midwives is down, according to the latest NHS workforce figures released on 24 April (subsequent to the submission of our earlier evidence).

In the 12 months to 31 September 2005, the headcount number of midwives working in the NHS in England fell 36 to stand at 24,808. The headcount system is the Government's preferred system for counting workforce numbers.

There was better news on whole-time-equivalent (WTE) midwives, but they were up in number by only 95 to stand at 18,949; this means that the number of WTE midwives working in the NHS in England is up by just 5% in the eight years from 1997–2005 despite significant extra demands on midwifery time through changes in practice.

At best the workforce situation is standing still; at worst the earlier slight improvements in the NHS midwifery workforce in England are being reversed. Moreover these latest workforce statistics relate to a period prior to the financial deficits in some trusts.

The RCM recommends that to reduce the excessive amounts of stress and the workload of midwives, the Department of Health (DH) must urgently seek to recruit significantly more midwives whilst retaining those currently in post. To achieve this, the DH must use the Birthrate Plus workforce planning tool to assess workforce needs, set new and ambitious targets for increasing the size of the midwifery workforce and ensure sufficient funding to achieve that is in place, increase the number of places for student midwives and give those student midwives better financial assistance.

The Recruitment of New Staff in England

As stated in the RCM's earlier evidence, to reverse the worsening age profile of the midwifery workforce there is a clear need to recruit into midwifery more and younger midwives to ensure the ongoing sustainability of the profession. The chief route to delivering that inflow of new and younger midwives is through training more student midwives and ensuring that more of them make it through their studies and into NHS practice—and that they have a post to go to after qualification.

With a fifth of student midwives dropping out of their studies and most citing financial difficulties as the reason they finally dropped out, the RCM is calling for a step-change in the level of support given to student midwives—we call for an annual £10,000 non-means-tested bursary for all student midwives.

Early Day Motion 197, which calls for just such a bursary, has—as at the Summer Recess—attracted the support of 224 MPs. It has now been signed by members of every political party with MPs in the House of Commons, including over half of the Health Committee.

In addition to extra support for student midwives however there needs to be suitable employment available for the student midwife upon qualification and increasingly we are finding that this is not the case. We are receiving reports from soon-to-qualify student midwives and recently-qualified midwives from right across England who are unable to find employment as a midwife. This is despite the fact that midwife numbers are dropping and—as cited in the RCM's earlier evidence—Ministers readily admit that it is this very lack of midwives that is the barrier to improvement.

The RCM recommends therefore that trusts do not whittle away maternity services in an attempt to scrimp and save money to make up their deficits. Midwifery was at the end of the queue when extra investment was being poured into the NHS; midwives must not now head the queue as the axe falls. New positions must be created for newly-qualified and more experienced midwives—put simply, to achieve the world-class maternity service in England that the Government has repeatedly promised we need more midwives, not fewer.

An Ageing Population

Figures released by the Office of National Statistics on 18 May show that in 2005 there were in England 22,246 women aged 40 or above who gave birth 1 this was an increase of 1,453 women or 7% on the previous year. The number of older mothers has doubled in the last decade.

As the figures submitted in our original evidence showed, in England—and indeed throughout the UK—the highest rate of babies born with congenital anomalies were those born to women aged 40 or over. Midwifery care for older mothers is therefore more demanding and this has a direct impact on what is required of the midwifery workforce.

Also cited in our earlier evidence was the rise in teenage pregnancies and these girls and young women also require particular support from midwives. Both these developments do not show up in the fluctuations of the birth rate, which new statistics show has in any event increased in England in the past year, but are very important in planning for future workforce requirements.

The RCM recommends that the national tariffs relating to maternity services be developed that reflect all additional costs associated with providing maternity care to women and babies with diverse clinical and social needs. The RCM is working with North East London SHA on developing an informed tariff along these lines and would be happy to work with the DH on this.

Increasing use of Private Providers of Services

601,000 deliveries took place in England in 2004–05, of which 0.5% took place in a private hospital, according to official statistics released in 26 May. This very low private-sector contribution is unchanged on the previous year.

Additionally, only 390 deliveries in England were attended by an independent midwife in 2004–05, which was down by over 4% on the previous year, and again amounted to less than 0.07% of all deliveries.

This is additional evidence therefore that the ability of the private sector to assist in the provision of maternity services to the NHS is very limited.

Financial Constraints

The current financial deficits in some trusts are clearly impacting on the provision of maternity services, according to the findings of a survey of heads of midwifery released on 8 May.

The survey, carried out by the RCM, found that:

- more than one in three managers reported that their maternity services budget had been cut;
- more than one in four reported that their training budget had been cut;
- more than one in four reported that their midwifery staffing establishment had been reduced;
- half reported trusts operating a recruitment freeze;
- one in four reported that vacant senior midwife positions had been replaced with more junior posts and a similar number reported that support staff had been substituting for midwives; and
- one in four reported that trusts had reduced the number of home visits by midwives.

These financial constraints clearly will not help to improve midwife numbers, referred to above, a decline in which was identified in the latest NHS workforce figures.

Royal College of Midwives

8 August 2006

Supplementary evidence submitted by the Royal College of Surgeons of England (WP 28A)

The Royal College of Surgeons of England submitted a memorandum of evidence for the Health Committee's Inquiry into Workforce Planning on 15 March 2006 and the President, Bernard Ribeiro, subsequently gave oral evidence to the Committee on 29 June 2006.

The College has since been invited to submit supplementary evidence relating to cuts in the Multi-Professional Education and Training (MPET) levy and the effect on medical training opportunities. One element of this financial allocation, the Medical and Dental Education Levy (MADEL), relates specifically to postgraduate medical and dental education and training.

The College is aware of reports from various parts of the country indicating average cuts to these budgets in the order of 10% that are being imposed by Strategic Health Authorities and Trusts in addressing their operating deficits for the current financial year. Contrary to general belief, this funding has not been ringfenced and the College and other professional bodies are concerned that there may be recurring raids on it. The impact of such reduced funding, that affects everything from recruitment into training posts to

clinical supervision, education programmes and study leave allowances, may be incalculable. Many highly motivated doctors, trained at considerable public expense to embark on specialist surgical training, will be deprived of this opportunity and see their career plans ended, while others who may progress will find it difficult to attend courses to learn new skills and develop their technique. Training and standards of patient care and safety will inevitably be compromised.

It is essential that patients, health service managers and politicians are aware, as are health professionals, of the damage that reckless erosion of medical education budgets will do to training today and standards of care and safety tomorrow. The previous funding levels should be reinstated and these budgets should be ringfenced without delay.

Bernard Ribeiro CBE
President, The Royal College of Surgeons of England

10 January 2007

Evidence submitted by Specialised Healthcare Alliance (WP 95)

The Specialised Healthcare Alliance (SHCA) is a coalition of forty patient-related groups supported by seven corporate members. It has been set up to campaign on behalf of people with conditions which require specialised medical care.

Effective commissioning is essential to ensure the NHS can plan services for patients with rare and often expensive conditions. This was recognised last year when Lord Warner invited Sir David Carter to undertake a review of specialised commissioning arrangements in England. The subsequent report recommended the establishment of Specialised Commissioning Groups (SCGs) aligned with the new Strategic Health Authority (SHA) boundaries with responsibility for jointly determining commissioning arrangements on behalf of all PCTs in the area.

The recommendations of this comprehensive review have largely been accepted, with key elements incorporated in the recently published Commissioning Framework.

Recent structural changes within the NHS, coupled with the Agenda for Change programme, have given the SHCA cause for concern in relation to whether the NHS has the necessary workforce capacity and expertise to implement the new arrangements.

Agenda for Change has been subject to different interpretation in various areas of the country and in some cases this is understood to have resulted in pay reductions for a number of experienced commissioners. This seems unfortunate at a time when commissioning expertise is recognised to be in short supply.

The SHCA recognises that the Department of Health aims to improve commissioning skills within the service as a requirement of successful reform. The Fitness for Purpose reviews currently underway within PCTs are intended to lend support. The Alliance notes with some concern, however, the emphasis on procurement of extensive commissioning services from the private sector as apparently attractive solution to current skill shortages.

The SHCA has no philosophical objection to the use of private sector skills but considers it important to ask whether there is an adequate pool of commissioning expertise available within the private sector. Commissioning, and in particular specialised commissioning, is complex and requires an understanding of the condition in addition to the ability to work with providers.

The SHCA is concerned that the current emphasis on purchasing commissioning skills from the private sector, rather than developing them within the NHS, may precipitate recruitment from the public sector into the private sector at higher rates of pay exacerbating shortages within the NHS and causing it to buy back expertise at an inflated price.

In the SHCA's view, the primary emphasis needs to be on development of commissioning skills within the NHS if trusts individually and collectively, through SCGs, are to fulfil their responsibilities.

Specialised Healthcare Alliance

7 November 2006

Evidence submitted by Shared Solutions Consulting (WP 03A)

NHS WORKFORCE PLANNING AND PRODUCTIVITY

Introduction

1. This workforce planning and productivity paper has been written for the House of Commons Health Select Committee meeting on 8 June. It is based on over 20 years workforce planning experience, gained at Trust, SHA and Department of Health levels. This paper has been circulated to SHA workforce planners for comment and their contribution is gratefully acknowledged.

2. Concern about low UK productivity levels goes back about 150 years, when our pre-eminent industrial position was gradually lost to a range of competitors. A particular weakness has been where regular improvements in working processes are required. This has only been overcome in motor manufacture by foreign management and imported working practices. On the other hand, where innovation and advanced research skills are required, such as in pharmaceuticals we have been successful. Therefore, it would be unsurprising if the NHS were better at creating islands of excellence, rather than rapidly imbedding advances in knowledge into working processes that would accelerate the diffusion of best practice.

3. The workforce planning process has improved in many ways, as indicated by other submissions. However, there is scope for further improvement, particularly with regard to productivity. This paper takes a pragmatic approach and places the emphasis on recommending how information, planning and organisational structures can best support productivity improvements. Those who are interested in a more theoretical framework for productivity are recommended to read The Productivity Agenda: Future Options[1].

4. This particular report makes a range of recommendation that include:

- Gaining greater clinician involvement, through the development of extensive productivity and quality key performance indicators. In order for clinicians to have a sense of ownership, they need to have played an important role in developing them.
- Integrating the service, financial and workforce planning processes more closely.
- Increasing flexibility between capital and workforce investment.
- Accelerating the introduction of new roles.
- Deciding on the optimum organisational size for a particular activity—the criteria to used to decide whether to centralise or decentralise an activity or function.

Gaining Greater Clinician Involvement in Productivity

5. In order to improve productivity, it is essential to engage clinicians. They decide how work is done (working processes) and which staff group and which grade of staff undertakes it (skill mix). However, engaging clinicians in productivity improvements can be difficult, as they may feel that patient care might suffer as a result, particularly when initiatives are driven by financial pressures.

6. In order to address this concern, it would be necessary to show that quality and productivity are often mutually re-enforcing, rather than mutually contradictory. For instance, factors that are important to clinicians, such as clinical outcomes, hospital acquired infections, eg MRSA rates, or drug errors also have an impact on productivity, as they can result in longer lengths of stay. In instances where productivity improvements are of less immediate interest to clinicians, these initiatives need to be evaluated in terms not just of productivity, but also from the perspective of the patient experience and clinical outcomes.

7. Furthermore, clinicians need to be involved in managing productivity and quality, as a support to their clinical work.

8. Currently, all these various measures are difficult for clinicians to evaluate together, as they receive them in disparate reports at different timescales. This is because they are produced by many different departments and sections.

Recommendation 1: Greater clinician involvement is needed in improving quality and productivity, by demonstrating the close link between the two.

Improving Information for Clinicians

9. Timely, extensive and easy to absorb information is essential for management. Therefore it is proposed that a clinicians' dashboard be developed of quality and productivity information. This might consist of key performance indicators such as:

- patient outcomes and experience;
- throughput: length of stay; percentage of day cases; finished consultant episode;

— staff indicators: sickness and absence: turnover; staff satisfaction survey results;
— cost information;
— productivity indicators; and
— process information: time based targets.

10. The dashboard would be easy to read, as the factors that required attention would be indicated by traffic lights. The indicators would need to reflect differences in the work between various specialties and professions, to ensure that the indicators were relevant. It should use readily available information. There may be value in implementing a simpler version first and them following it up with a more comprehensive version. This would apply the very successful "balanced score card"[2] approach to healthcare. So far, the Department of Health as only promoted this within one function, Human Resources. It would be necessary to extend this approach to indicators covering all the other key functions. One approach would be to learn from one or perhaps more trusts that have implemented the balanced score card approach and spread the approach much more widely.

11. For the clinicians' dashboard to be successful, it would need to be developed with the active participation of the clinicians themselves and their Royal Colleges and professional bodies, SHAs and trusts. Clinicians would need to see the value of the exercise for themselves, rather than for others. The attraction to clinicians is that the quality indicators in the dashboard would go a long way to allay some of their fears regarding the impact of financially driven competition on patient care.

Recommendation 2: Clinicians need more comprehensive information on quality and productivity that is easy to absorb, by developing a clinicians' dashboard.

12. In order to ensure that future generations of clinicians adopt an integrated approach to managing productivity and quality, the use of these indicators should become an integral part of student education. Students could be involved in producing these indicators as part of their clinical placement, as this would relieve busy experienced clinicians from this work.

Recommendation 3: students should assist in the production of the clinicians' dashboard during their clinical placements.

13. The sign of the success would be when up-to-date dashboards are on display in most clinical areas.

Improvements to the Planning Process

Integrating the service, financial and workforce planning processes

14. There is a tendency for service, financial and workforce planners not to work sufficiently closely together. The Department of Health planning documentation tends reflect the very different needs of their main functions, which makes it harder to integrate at trust or SHA level. This is often mirrored at trust level, where the three functions tend to work separately, each with their own spreadsheets that do not link to each other dynamically. Thus, it is difficult for last minute financial changes to be accurately reflected in workforce figures. However, foundation trusts are required to produce information in a more integrated way, the issue is to spread this requirement to all trusts.

15. The NHS is not alone in silo working. This is why British and American motor manufacturers took longer to design and introduce new models than the Japanese. The latter place their functional heads in multi-disciplinary teams.

16. The NHS planning exercise works well in trusts when service, finance and workforce planners have known each other for many years. However, what is needed is an organisational structure that would make such interdisciplinary working a matter of course, even when new staff are involved.

Multi-disciplinary planning teams

17. It is proposed that much greater use is made of multi-disciplinary teams of functional experts who would work together on a project basis.

Recommendation 4: multi-disciplinary teams should be a feature of planning to ensure closer integration between service, finance and workforce plans.

Integrated service, financial and workforce software

18. It is proposed that integrated service, financial and workforce planning software is developed. Thus, a new service development would have all the information needed together, relating to activity, capital investment, non-staff revenue costs and staff groups by grade and their associated costs in the same database. So if for financial reasons, it became necessary to slim down a scheme at the last moment, any reductions in staff numbers would feed across into lower staff costs and reduced activity levels.

19. For this software to be really useful, it would need to be developed with trust staff, closely involving SHA and Department of Health colleagues. This would mean that trusts would find it easier to use and also much more valuable to them locally, as well as in centrally driven planning exercises.

Recommendation 5: software integrating service, finance and workforce plans should be developed to meet the needs of trust, SHA and Department of Health staff.

Greater flexibility between capital and workforce investment

20. There is an underlying assumption in capital planning that the workforce will magically appear once the decision to invest has been made. In some cases, bids are made for capital equipment, even when it is known that it would be incredibly difficult to recruit staff. This is because central capital funding cannot be held over to the next financial year, or whenever staff finally become available.

21. An example of where greater flexibility is needed was with the introduction of new scanners. Their purpose was to reduce patient waiting times substantially, as there is a serious bottleneck in diagnostics. However, many existing scanners could be used more intensively, as they are switched off at 5 pm Mondays to Fridays and at weekends, only to be switched on again for emergencies during those hours. In a few cases, PCTs did not have the money needed to fund additional posts, as this had not been ring-fenced.

22. The argument is not that superb new technology is not needed, rather that its introduction should be more closely linked to the utilisation of existing equipment and availability of staff. This would vary according to the local circumstances.

Changes to the planning process

23. It is therefore recommended that trust workforce planners or other human resources staff, along with their service managers, evaluate the availability of staffing, before capital investments are made. This could take the form of "traffic lights". Where staff are readily available, the scheme could be given a green light to go ahead. On the other hand, if there were a significant number of vacancies before taking into account the additional staff required for the new development, this would necessitate a yellow light. This would mean that the workforce plan would need to be very robust for the project to proceed. Finally, where there were very serious staff shortages, this should receive a red light and the investment would be postponed for a fundamental rethink. This could include, could this service be supplied completely differently, by radically altering how patients access healthcare?

Recommendation 6: greater flexibility is needed so that the investment in capital matches the availability of staff more closely. This could be achieved through traffic lights that would indicate the extent to which additional staff would be available.

The Diffusion of Innovation

Accelerating the introduction of new roles

24. Innovation is often a slow process. This is because there are only a few innovators who like the excitement of the new[3]. It takes a while before the innovation spreads more widely. Therefore, it is entirely to be expected that the introduction new roles, such assistant practitioners in radiography follow the same pattern, with marked differences in the number in each SHA[4]. This was in spite of an extensive and very well managed skills escalator exercise to support the initiative. A competitive labour market was insufficient in itself to encourage innovation, as take up was particularly disappointing in London. Therefore, more incentives are required to swell the number of innovators, which is often the approach adopted by commercial organisations.

Providing incentives to implement new roles

25. Firstly, there would need to be evidence that a particular new role would be cost effective. For instance, it could reduce vacancies by attracting new sources of staff or it could increase productivity. It would be necessary to estimate the number of staff who could be employed in a new role when it became fully established. This could then be turned into annual targets. Incentives could be given to each trust meeting the target. This could vary from a contribution to the cost of staffing for a limited period, to additional monies for post registration education or staff facilities. This size of the incentive could relate to the potential benefit of the new role. It would be necessary not to penalise trusts that have good reasons to employ fewer staff in new roles, by being sensitive in setting targets.

Recommendation 7: the introduction of new roles should be accelerated by giving incentives to service managers, such as contributions to staff costs for a limited period, funding for more post registration training or staff facilities.

Identifying good practice

26. This can be done through offering prizes to competition entrants. While this already takes places, many more ideas would be identified if more and larger prizes were offered. Thus each specialty or discrete area of work should have their own prize for the organisation making the greatest improvement in quality or productivity.

Recommendation 8: the diffusion of good practice should be accelerated through making more use of competitions with more valuable prizes.

Organisational Design and the Economies of Scale

27. The optimal size of an activity varies from activity to activity. For instance, small PCTs were originally created to mirror the local clinical networks that were represented in professional executive committees. However, this led to the optimal size of the committee dictating the size for management functions such as finance, human resources and IT. This has now been recognised as very costly in management terms and many PCTs have been amalgamated.

28. Some economies of purchasing were lost when regions were abolished. The purchasing of medical equipment was devolved from regions to trusts that have much less bargaining power. This is not to argue against the creation of trusts and their numerous achievements, but rather that more thought should have been given to how purchasing power could have been preserved under the new arrangements. This has been recently acknowledged by the emergence of pathology networks, acting on behalf of a group of trusts.

Key issues in deciding on the correct level of activity

29. The first issue is not come up with a "one size fits all" solution, which would create problems for the functions that need to operate at a different level. In the case of PCTs, the optimal size of professional executive committee should have been treated separately from those of the management functions. This would have enabled several small local committees to have come under one chief executive. The size of the commissioning and financial functions would need to be large enough to attract the calibre of candidates who could look their acute counterparts in the eye, on level terms.

30. In the case of pathology laboratories, the cost of processing tests could be reduced by using highly automated equipment covering hospitals within a reasonable travelling time. In addition, hospital laboratories would lose some other work to clinicians who take tests at point of care themselves. Thus, some developments in technology can increase the economies of centralisation, while others increase the economies of decentralisation.

31. Any reorganisation should answer the following questions:

- What functions need to be undertaken?
- What is the optimal scale of operation for each function?
- What type of organisational structure would best suit this operation?
- What were the benefits of the previous organisational structure?
- How could these benefits continue to be realised, to some extent or other, under the new arrangements?

Recommendation 9: much more consideration needs to be given to the economies of scale that vary hugely between activities. This is particularly the case for reorganisations.

Conclusion

32. Greater clinician involvement is fundamental to improving productivity. This would need to be supported by information systems that cover all the key indicators for clinicians, in a way that best meets their needs. In addition, service, finance and workforce plans need to more closely integrated. There is scope to improve the diffusion of innovation through providing more incentives to services managers. Finally, more consideration needs to given to the economies of scale in organisational design.

Table 1

IMPACT ON PRODUCTIVITY OF ISSUES RAISED IN THIS PAPER

Theme in paper	*Impact on productivity*
1. Increasing clinician engagement	Emotional capital
2. Improving information for clinicians: clinicians' dashboard	Monitoring trends to assist in more effective management
3. Multi-disciplinary working	Better capital utilisation and staff productivity through more robust plans
4. Integrated planning software	Better capital utilisation and staff productivity through more robust plans
5. Greater flexibility between capital and workforce investment	Better capital utilisation and staff productivity through more robust plans
6. Accelerating the introduction of new roles	Improving productivity by faster spread of innovation
7. Identifying good practice	Improving productivity by faster spread of innovation
8. Deciding on the correct level of an activity	Economies of scale

References

1 Blair, George (2005) *The Productivity Agenda: Future Options* www.sharedsolutions.net

2 Kaplan, R S and Norton, D P (1996) *The Balanced Scorecard: Translating Strategy into Action* "Imagine entering the cockpit of a modern jet airplane and seeing only a single instrument there". Boston, MA: Harvard Business School Press.

3 Everett M Rogers (1995) *Diffusion of Innovations*. New York: The Free Press.

4 While only one SHA had 25 or more assistant practitioner radiographers, 16 SHAs had five or fewer, by March 2004. The number of SHAs with over 25 increased to three and the number with five or fewer declined to four by December 2005. However there were 13 SHAs with 10 or fewer. Source: South West London SHA.

George Blair
Managing Consultant, Shared Solutions Consulting

May 2006

Supplementary evidence submitted by Wyn Jones (WP 41A)

I am unsure of the protocol of the Health Select Committee (HSC) so I thought I would contact you in the first instance. I did attend the session last week, in the public gallery and note a number of points I would have liked to raise had I been in front of the committee. I would hope these points could be considered by the members of the committee.

- The role of the PCT should be key in the future as they provide the service strategy for providers to deliver against. In addition I believe there is a need to monitor the NHS on a health economy basis, in particular I am concerned that as service provision becomes more fluid because of Independent sector provision and shifts to primary care a number of organisations will be left with staff who they have to make redundant if the process is not managed effectively. The redundancy costs would inhibit a productive health economy, even if individual organisations can demonstrate their own efficiency. I have further information on this issue if the committee require it.
- I am concerned over the capacity of the Department of Health and the new Strategic Health Authorities to deliver their agenda given the pressure on management costs. Although I accept that improvements can and must be made.
- I believe that integration of workforce planning across staff groups, in particular medical and non-medical and professional and non-professional, is essential for the future of the service. Also there is a need to integrate across finance and activity. The ISIP process is the right philosophy but in reality to date has not delivered an integrated approach for workforce development and planning.
- This review of workforce development and planning has proved useful in uncovering the range of processes, tasks and strategies required for workforce planning, I believe a useful outcome from the Committee's review would be a map of who is responsible and who is involved in workforce planning within the current NHS structure. In the future this map could be used to ensure the responsibilities are not lost in other re-organisations of the service.
- Within the LDP process the limit of three years does provide a problem for education commissioning, in West Yorkshire I developed an additional proforma which expanded the LDP one to include all key staff groups and to extend the timeframe to five years. Some organisations had problems completing the form as there was little evidence of the long term strategy for the organisation, however, it did provide us with more evidence for education commissioning.
- There was a discussion around financially changed organisations recruiting staff, I believe that organisations must control their recruitment and clinical managers must not be allowed to recruit as they see fit, but there are a number of scenarios where it will make sense for an organisation to recruit, even if they have financial difficulties; these include, ensuring a service is safe for patients/users, reducing the reliance of agency staff, delivering increased activity which will provide increased income under Payment By Results.
- There was a discussion on the impact on staff on Agenda for Change Bands one to four. In West Yorkshire I led a partnership with the local Learning and Skills Council. As a result of the partnership we have secured £1.4 million over three years to support training, development and employment opportunities of these Agenda for Change bands through LSC, Regional Development Agency and European Social Funding commissioning process. In addition the partnership has just agreed 500 train to gain places for NHS Yorkshire and the Humber organisations, these are level 2 qualifications and equate to approximately £600,000.

I would be happy to provide further information on any of the points I have raised. If you have any queries please let me know.

Wyn Jones
Workforce Planning Manager, NHS Yorkshire and the Humber

8 January 2007

Evidence submitted by Dr Deirdre Kelley-Patterson, Thames Valley University (WP 96)

One year ago National Workforce Projects commissioned from us a Postgraduate Certificate in Strategic Workforce Planning. The first cohort is nearing the end of the taught part of the course. Those on the course are drawn from across the NHS in England, working in SHAs, PCTs, NHS Trusts and Foundation Trusts. There are also a few attendees from Wales and Scotland and one from Skills for Health.

The purpose of the certificate is four-fold. First to equip the students with some workforce planning tools, but more importantly to provide them with an understanding of both the current and future strategic policy context in which they work, to provide them with a network of contacts working in the same area and finally to demonstrate the importance of linking workforce planning (WFP) with service and financial planning and service modernisation, so that they can appreciate the need to plan tomorrow's workforce for tomorrow's world.

At the end of the course we asked them to complete a short questionnaire on how they saw the current state of workforce planning from their perspective and how well linked it was with general service development. They have given us their permission to use the results of the survey for this submission. It offers a snapshot of how some of those actually involved in the daily front line business of NHS workforce planning see its current state.

Those on the course were asked to rate on a scale of 1 to 5, one being the lowest and five the highest rating, how they perceived the NHS valued workforce planning, to what extent WFP was done on a multidisciplinary basis, how well it was integrated with service, business, financial and PFI/capital planning, and the level of integration with service modernisation and with social care and the independent and voluntary sectors.

These last two received the lowest scores with ones and twos predominating. Not surprisingly the lowest scores were from those working in Trusts. However those in PCTs and SHAs averaged between 1.5 and 2.5. The perceived value of WFP in practice was also low with a mean score of 2. There was some comment that the value of the concept of WFP was more highly rated than that of its practical application. Integration with the other elements of planning listed was scored by most at between 2 and 3, with only the occasional 4, but rather more ones. Within the low overall scores there were examples of good innovative practice, but they tended to stay local and not spread. This failure to capitalise on successful innovation is a recurrent theme.

Respondents were unanimous that there was no recognised career structure for workforce planners and that the NHS, in the main, associated such planning with data collection and number crunching. Many managers felt that it had little relevance to their work, particularly at Trust level. There has clearly been considerable local variation in the amount of training and support given. Some localities and institutions eg Manchester and its business school were mentioned by several respondents as providing good support and training courses. In other parts of the country there was little or nothing. The workforce support material being produced by National Workforce Projects was quoted by many as being very useful.

The response to questions about the strategic leadership of WFP locally and about the role of the SHAs and PCTs in this process was also mixed. These new structures are bedding down and a number of respondents felt that, while things were currently unclear, it was too soon to make any judgement about how they would develop. In a number of SHAs the prominence given to this area does seem to be reduced, while in others a strong team is being put in place. While there is general agreement about the importance of commissioning being properly integrated with WFP at PCT level, no one seems very clear about how this will be done in practice and from where PCTs will get the necessary expertise. At Trust and PCT level workforce planners did have links with service managers. A few had links with clinicians too, but clinicians, about whom most workforce planning is concerned, seemed quite remote from these processes. The exceptions were a few postgraduate deaneries, which are getting more closely involved with their SHAs.

Those on the course are a self-selected group and we cannot tell whether their comments would be typical of their colleagues across the country. They are keen and thoughtful. It is striking that they have come to the course with very different levels of expertise and those whose thinking is most highly developed and integrated with other service strands, have come from areas where there is high level interest and commitment to WFP as a useful service function. They want to see a more integrated and critical approach that goes beyond data collecting and number crunching. They see the reorganisation as an opportunity for this, but many are fearful that there will, in fact, be a loss of key skills and influence. Effective work with social care seems patchy and that with the independent and voluntary sectors almost non-existent. Clinicians, with the exception of some postgraduate deans, seem remote from WFP. A few respondents mentioned Modernising Medical Careers, but there was no mention of other clinical professional groups.

Dr Deirdre Kelley-Patterson,
Centre for the Study of Policy & Practice in Health & Social Care,
Thames Valley University

6 December 2006

Evidence submitted by John Sargent (WP 94)

INTRODUCTORY REMARKS

1. This memorandum of evidence is being submitted by myself, John Sargent, in a personal capacity. I am the only person in the country who has been Chief Executive of a Health Authority, an NHS Trust and a Workforce Development Confederation (WDC). The specially relevant experience that I have relates to the period from 2001–04 when I was Chief Executive of Greater Manchester Workforce Development Confederation. During this period I also chaired the "Standing Conference of Workforce Development Confederation Chief Executives" nationally; which meant that I also needed to become reasonably conversant with healthcare workforce planning issues at a national level as well as at a local level.

2. Greater Manchester WDC was assessed by the Audit Commission as the best performing WDC in the country. In large part this was attributable to the very clear strategic vision that had been agreed (to eliminate vacancies in healthcare employing organisations in Greater Manchester); and the systematic strategies that were formulated and implemented in order to deliver that strategic vision. (It needs to be borne in mind that the big issue in 2001 was staff shortages.)

3. Of particular interest to the Committee may well be my experiences in formulating and then implementing the "Delivering the Workforce" programme—which is still the only large scale and systematic example in the country (and probably the world) of designing healthcare job roles around the competences required to deliver safe, effective and high quality patient care.

4. Since being required to take early retirement as a result of yet another NHS reorganisation in 2004; I have since tried to promote many of the same ideas with various NHS organisations through my current role as a "Workforce Development Consultant".

Strategic Context

5. In order to fully appreciate the relevance of the "Delivering the Workforce" initiative in Greater Manchester; and to assess its potential for transferability; it is first necessary to give some strategic context by reference to a number of strategic drivers. Some of these strategic drivers were around in 2001 and remain just as relevant today. Others have emerged since; and doubtless new as yet unknown drivers will materialise in the future.

6. These strategic drivers include:

- European Working Time Directive 2009.[33]
- Modernising Medical Careers.[34]
- "Payment by Results".[35]
- Reduced financial growth for the NHS after the next Spending Review—ie from 2008 onwards.
- "Agenda for Change"—the new NHS pay system.[36]
- The "Knowledge and Skills Framework".[37] which underpins "Agenda for Change".
- "Improving Working Lives".[38]
- The requirement for improvements in "Productive Time".
- The implications of the Gershon report.[39]
- Growth of the independent sector as a provider of NHS services.
- The introduction of the "Electronic Staff Record" system in the NHS.[40]
- Demographic changes—both in the population at large (eg more very elderly people) and in the workforce (eg changes in retirement trends).
- Age diversity legislation in 2006.[41]
- Current financial pressures within healthcare in 2005–06.
- Retirement "hot spots" in certain professions (eg GP's).
- Workforce shortages in diagnostic services.
- Government policies—eg "Commissioning a Patient Led NHS".[42] and "Practice Based Commissioning".[43]

[33] See www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/WorkingDifferently/EuropeanWorkingTimeDirective/fs/en

[34] www.dh.gov.uk/assetRoot/04/07/95/32/04079532.pdf

[35] Payment by Results aims to provide a transparent, rules-based system for paying trusts. For more details see http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/fs/en

[36] Agenda for Change is the new pay system that applies to all directly employed NHS staff, except very senior managers and those covered by the Doctors' and Dentists' Pay Review Body. See http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingPay/AgendaForChange/fs/en for more details.

[37] The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process, Department of Health, October 2004.

[38] Improving Working Lives is a blueprint by which NHS employers and staff can measure the management of human resources. Organisations are kite-marked against their ability to demonstrate a commitment to improving the working lives of their employees.

[39] The Gershon Review: Releasing Resources for the Frontline: Independent Review of Public Sector Efficiency. See http://www.hm-treasury.gov.uk./spending_review/spend_sr04/associated_documents/spending_r04_efficiency.cfm

[40] For more details see http://www.esrsolution.co.uk/

[41] The Employment Equality (Age) Regulations 2006 come into force in October 2006 and will implement the age strand of the EU Employment Directive 2000/78/EC. They will outlaw age discrimination in employment and vocational training.

[42] Commissioning a Patient Led NHS is the name given to the letter and document sent to NHS Chief Executives and others on the 28 July 2005 from Sir Nigel Crisp, the NHS Chief Executive.

[43] For more details see http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/fs/en

7. More information and analysis can be found in the document entitled "The Case for Change" published by Skills for Health.[44]

8. The critical issue that arises from this; and the inescapable conclusion is that the healthcare employer of the future will need to evolve a more flexible workforce if it is to survive and thrive. Further, probably in collaboration with other employers, at least part of the planning for that workforce will need to be based on competences, rather than relying entirely on a workforce built solely round the traditional healthcare professions.

Effectiveness of Current Workforce Planning Arrangements

9. The first point to make is that despite the bewildering complexity of the arrangements; and the many different organisations that have a role in them; in truth the current arrangements have hitherto been relatively effective in overall terms. This is evidenced by the fact that workforce shortages have been relatively small scale and short lived on the one hand; whilst surpluses causing significant unemployment levels amongst healthcare workers have similarly been relatively small scale and short lived. However, that is a historic perspective. If healthcare employers are to respond positively to the already known strategic drivers on which their futures depend, there simply has to be a paradigm shift towards reform of the workforce planning system that reflects the impact of these strategic drivers.

Deficiencies in the Current Workforce Planning Arrangements in England

10. This analysis quickly exposes some of the deficiencies in the current workforce planning arrangements in responding to the strategic drivers. These deficiencies fall into the following main categories:

- The workforce planning arrangements pay scant regard to the very large numbers of healthcare workers that are not registered healthcare professionals. Furthermore, the education and training resources to support future workforce planning and development are almost exclusively devoted to the professionally qualified section of the workforce.
- The workforce planning approach is based on the numbers assessed as being required in each of the already established healthcare professions. The investment in education and training follows the same course. Increasingly this fails to respond to the innovation that is needed to ensure that staff have the competences they need to deliver modern healthcare. Unsurprisingly, given the explosion in knowledge and technology, not all the job roles currently required conveniently fit into the professional "silos" that were designed many years ago. None of the workforce planning returns and other workforce information submissions required by the Department of Health contain any reference to such new roles. Consequently, the scope for investing in the development of such roles at local level is extremely limited.
- Whilst the Department of Health's approach may well be sensible and coherent at a national level; this does not always translate easily at local level. For instance, an SHA may be required to invest in more student nurse commissions; even though there is no demand locally for such an increase; and is thereby denied the opportunity of investing in local priorities—including innovative priorities such as Assistant Practitioner programmes.
- The strategic element of workforce planning is insufficiently developed within the current arrangements. For example 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. This gap has now been filled in the NHS from a variety of sources including international recruitment and a spectacular rise in the number of pre-registration students. For example, the annual student nurse/midwife intake has increased from its low point of 12,500 in 1994–95 to about 25,600 in 2005–06—an increase of over 100%. Many of these students have already qualified, or will shortly do so; and this has been a principal source of overall workforce growth in the NHS which averaged 4.5% per annum in the years from 2001–02 to 2004–05. However, the strategic dimension is still missing. In fact the number of new student nurses/midwives increased between 2004–05 and 2005–06 from 25,000 to 25,600. At the same time, the Comprehensive Spending Review (CSR) is imminent and it is inconceivable that the NHS will continue to receive year on year real term funding increases of 7.3%. Given all the other financial pressures facing the NHS, even a fairly generous CSR settlement of 3–4% average real terms funding growth would only be sufficient to fund overall workforce growth of the order of between zero and 1%. The point is that the increasing number of students who have commenced their training in 2005–06 will not qualify until 2008–09—ie after the start of the next CSR period. Therefore, far from increasing student numbers in 2005–06; there is a substantial argument that the number of new starters should have been significantly reduced from 25,600 to perhaps

[44] For more details see http://www.skillsforhealth.org.uk/ssa/reports_and_presentations. php?cat=Skills+for+Health+SSA+Research+and+Publications

18,000–20,000 or thereabouts. This would still leave provision for the anticipated increase in nurse/midwife retirements from staff born in the "baby boom" years. Future further changes would of course be required, informed by more up to date information as it emerges—including the actual outcome of the CSR process. However, reductions to student nurse/midwife intakes of less than 18,000 should not be ruled out at this stage. Unless this strategic issue is addressed urgently in 2006–07; the risk of having significant numbers of unemployed, qualified healthcare staff becomes very tangible. Furthermore, this is only the "tip of the iceberg" in the sense that it is but one example of the impact of one strategic driver. As the Health Committee has indicated, there are others too. Taken together, they cannot be ignored; and the case for a changed approach to workforce planning in the health and healthcare sector becomes undeniable.

— Workforce planning is still not truly integrated with service and financial planning. Some improvements have been made in recent years; but there is still much to do. For example, the Local Delivery Plans (LDP's) which NHS organisations are required to compile and then submit to SHA's; and then on to the Department of Health only 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. This is because the supply for the next three years or more for all the registered professions is already known and can't be changed—they started on their courses up to three years ago! If the LDP is to be meaningful in planning for future workforce changes at all; it simply has to look to year 4 and beyond—probably to year 10 or thereabouts. It is only in this timescale that material changes in the workforce can be planned for and implemented, bearing in mind that in practical terms it takes several years of student cohorts to deliver enough competent healthcare workers to make a material difference at a whole workforce level.

11. Despite these difficulties, there are some very good examples around the country where NHS organisations have tried to overcome some of these difficulties at local level; and have developed a strategic workforce vision which they have proceeded to implement. The example I am most familiar with is the "Delivering the Workforce" initiative in Greater Manchester. The rest of this memorandum of evidence gives an overview of my own experiences and draws heavily on the excellent work done by the "Delivering the Workforce" Project Director, Chris Mullen and the rest of her team.

The "Delivering the Workforce" Vision for Greater Manchester

12. "Delivering the Workforce" was conceived in 2000; and approved by the Greater Manchester WDC at its first Board meeting in March 2001. It was a response to the analysis that had been done at the time which showed that the NHS in Greater Manchester was under-supplying compared with the demand during the expansionary phase of large real terms funding growth. The extent of the "under-supply" was assessed at about 2,000 staff over a five year period unless a large scale and systematic initiative was taken to fill the gap.

13. It was also recognised that, even if the money was available (which it wasn't) or if the University and clinical placement capacity was available (which it wasn't); the lead time to produce additional "traditional" registered professionals in the numbers needed was way beyond the five year period.

14. Nonetheless, despite the vacancies, the fact remained that applications for some job categories were still heavily oversubscribed. Healthcare Assistant vacancies rarely attracted less than 30 applications, many of them excellent. However, all except one were turned away as there was only one Healthcare Assistant vacancy—despite the large numbers of vacancies for newly qualified registered staff. Further, it was already known that many Healthcare Assistants were sufficiently talented to acquire NVQ levels 2 and 3; and then progress to pre-registration programmes. Thus in analytical terms, the answer was very obvious—the NHS in Greater Manchester needed to recruit many more of the talented applicants for Healthcare Assistant and similar job roles; and develop them more quickly than traditional pre-registration programmes such that they could safely deliver patient care based on the specific "bundles" of that was required in specific patient care settings. The term "Assistant Practitioner" was coined to describe the staff who would be appointed to such roles after completing their development programmes.

15. By the same token, it was also recognised that the combined effect of the European Working Time Directive in 2009 and the implementation of "Modernising Medical Careers" meant that it was no longer tenable for hospitals to rely on junior doctors to provide medical services, especially during "out of hours", in the traditional way. Some of the impact might be overcome through massive service reconfiguration and hospital closures. However, much of the problem could not be solved this way because merely reorganising would not reduce the workload per se in the "busy" specialties. Furthermore, hospital closures would be deeply unpopular and contested—and even if the opposition was overcome, it would still be impractical and unaffordable to deliver the change required by 2009; and still only have a partial solution.

16. The alternative which was promoted by the WDC was to recognise that 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. However, the world is changing very rapidly and the probability of the same bundles of competences being maintained within professional boundaries whilst still optimising patient care appears to be remote. The competences themselves are "non-denominational"; and indeed, despite the widespread mythology to the contrary, there is virtually nothing in the statutory regulatory system that I am aware of that requires particular competences to be "owned"

by particular professions. Thus, the conclusion reached was that experienced registered professionals needed to be developed such that, as part of the development programme, they acquired a range of competences which had hitherto been solely in the domain of junior doctors. The term "Advanced Practitioner" was coined to describe the staff who would be appointed to such roles after completing their development programmes.

17. However, it was also recognised that given all the operational pressures and vacancies, it would be very difficult to persuade healthcare employers to release large numbers of their most experienced clinicians onto Advanced Practitioner development programmes. It was principally for this reason that the decision was taken to start the process with the planned commissioning of 500 Trainee Assistant Practitioners for each of the four years to 2005–06. The logic was that the first step needed to be a demonstration to employers that vacancies were being eliminated. Once this was recognised, it then ought to be much easier to persuade employers to release registered practitioners onto Advanced Practitioner development programmes. Firstly, it could be argued that the "backfill" would already have been provided through the development of Assistant Practitioners, albeit with consequences for the overall "shape" of clinical teams. Secondly, the European Working Time Directive implications for 2009 would no longer seem to be quite so far over the horizon to NHS senior managers. Thirdly, it was recognised that the development of Advanced Practitioner programmes was far from straight forward and that even more time than for the Assistant Practitioner programme was required if an appropriate initiative was to be successfully planned for and implemented in collaboration with several of the established professions. This collaboration was deemed essential because if roles are planned that cross professional boundaries, even though there may not be any regulatory restrictions, the fact remains that the only people who are currently competent to assess the competences of potential Advanced Practitioners are members of the different professions!

18. Taken together, the initiative to develop significant numbers of Assistant Practitioners and Advanced Practitioners over a strategic period was given the title "Delivering the Workforce".

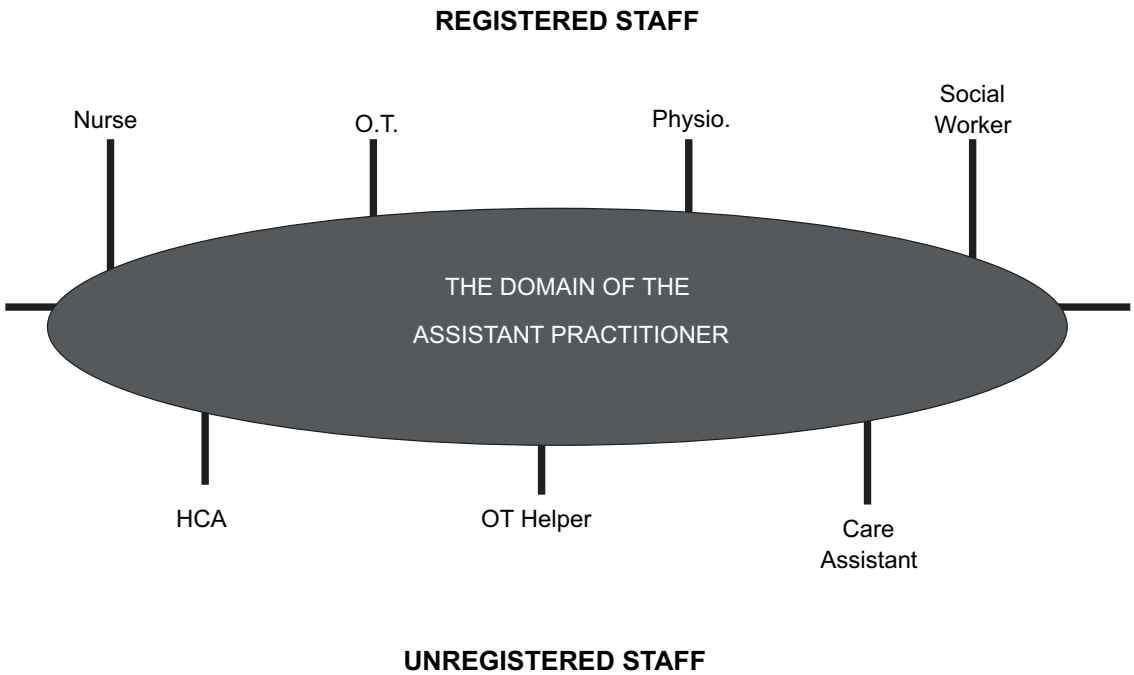
Assistant Practitioners

Definition

19. The definition that was coined in Greater Manchester to describe Assistant Practitioners is as follows:

> "An Assistant Practitioner is a health and social care worker who delivers health and social care to patients with a level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. He or she would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals. In many cases this healthcare delivery role would also transcend many of the boundaries that have hitherto been strictly demarcated between different professions. He or she would also have the underpinning knowledge and assessed level of competence to undertake such a role".

20. This can be represented visually as follows:



Core Characteristics of the Assistant Practitioner Role

21. The Assistant Practitioner role, (per the paper "Assistant Practitioners—Delivering the Workforce 2002–07—The Core Characteristics" produced by the Delivering the Worksforce Project Director[45]), varies depending upon the service in which he or she is based. However there are some core characteristics that relate to the role of the Assistant Practitioner regardless of the service area:

- Provide direct health and social care; and treatment.
- Where relevant, provide day to day management of a group of patients.
- Assist in the assessment of patient needs.
- Undertake a variety of clinical skills—eg catheterisation, insertion of a peg tube, swallowing assessment, mobility exercises, assist in ADL assessment, venepuncture, immunisation, ECG's etc.
- Undertake Health Promotion work.
- Undertake clinical work and the application of the essence of care.
- Possess communication skills.
- Act on the authority of a Registered Healthcare Practitioner.
- Work in a way that ensures the scope of practice is constrained to protocol or a prescribed plan of care determined by a Registered Healthcare Practitioner.
- Is subject to clinical supervision.
- Engages in Continuous Professional Development.
- Takes responsibility for own actions.
- Supervise other support workers.
- Undertake A1 award to support colleagues working towards NVQ Levels 2 and 3.

Education, Training and Development

22. At the start of the initiative, it was agreed that formal educational training was required that would be transferable, credible and work based. Thus, in partnership with service and education providers, it was decided that a Foundation Degree in Health and Social Care would be the appropriate vehicle. This is a two year course and is at diploma level educationally on completion. It is a flexible course that has blended learning with an emphasis on combining knowledge with competences in practice. The national occupational competences have been used to inform the assessment process. From the external evaluation that has been undertaken, it is clear that the Assistant Practitioners at the end of the course have acquired new knowledge. The key areas of knowledge are shown below:

- Awareness of confidentiality issues for service users.
- Increased confidence and abilities to challenge.
- Familiarity with legislation relevant to caring for service users.
- Accountability of the caring professional.
- Legislation issues related to record keeping, data protection and freedom of information.
- Knowledge and application of principles of equality and diversity.
- Information technology skills.
- Reading and digesting evidence of clinical and care practice.
- Reflection on practice with theory.
- Written and oral presentation skills.
- Time management (through working with competing demands of study, work and home).
- Psychology and mental health (to differing levels depending upon the service).
- Care planning and a focus on processes related to admission and discharge.
- Team working.
- Health, safety and risk management.
- Health, safety and risk management.

[45] "Assistant Practitioners—Delivering the Workforce 2002–07—The Core Characteristics", Chris Mullen (project Director for "Delivering the Workforce"), Greater Manchester SHA, February 2006.

Key Features Designed to Assist the Implementation of Assistant Practitioner Roles

23. From the outset it was recognised that the Assistant Practitioner programme represented a major challenge; especially as there were no similar programmes elsewhere in the world; and therefore no body of evidence, experience and learning on which to draw. In consequence, it was also recognised that if implementation was to be successful, the WDC needed to ensure that a number of key features were in place which were calculated to facilitate the implementation process. These key features included:

— The appointment of a Project Director who would be viewed as clinically credible by most registered practitioners. (The person appointed was a Director of Nursing at a large Teaching Hospital Trust prior to taking up the post.)

— The WDC took the decision that the initiative should be "fully funded" such that employers did not have to bear any costs whatsoever as part of the initiative. This was in recognition of the fact that whenever NHS organisations are under pressure to balance their books, all too frequently the decision is taken to pull out of support for such initiatives on the grounds there is no money in the short term—regardless of the long term consequences for having the right staff to deliver patient care in the future.

— The concept of "fully funded" included funding for project management and dedicated Practice Based Educators for the trainees—one Educator for each cohort of 15–20 trainees.

— The WDC recognised that by introducing one new role into a clinical team, almost by definition this changed the roles of the other team members. It also provided an opportunity to review the way services were delivered and a chance to plan for "service modernisation"; This involved considering the competences needed to deliver care; and how those competences should be distributed amongst team members.

— Wherever possible, trainees were allocated to organisations on the basis of "deep rather than wide"—ie several trainees in one service area rather than one trainee for each of several organisations. This was in recognition of the fact that all too often individual members of teams are developed, but use is not made of their skills because of the prevailing culture in the teams. It was felt that by developing a critical mass of trainees in a few service areas it would be much more difficult for the teams to avoid addressing the cultural changes needed to make best use of the skills and competences of Assistant Practitioners.

— The intention was that Assistant Practitioners should be capable of being deployed in almost any service area, including Social Care—and including roles that delivered care across the Health/ Social Care "divide" when this was in the best interests of the patient, for example in an Intermediate Care Centre. To achieve this, the Trainees' programmes are designed such that they all participate in the same core modules in the first year and then access modules in their second year which are particularly relevant to the service areas in which they are deployed.

— In return for this investment in their future workforces, employers who accepted Trainee Assistant Practitioners had to commit to creating posts for Assistant Practitioners on a one for one basis on the successful completion of their programmes. (Such posts were not to be automatically filled by any particular ex-trainee to ensure compliance with equal opportunities legislation.)

— In addition, employers had to commit to disestablishing posts for registered practitioners in the clinical teams concerned at the same time. Firstly this was to ensure affordability. Secondly it was an explicit statement of the need to make cultural change. Thirdly it was the opportunity to avoid reliance on bank and Agency staff. Fourthly it was the opportunity to develop a registered practitioner for new challenges such as those inherent in the Advanced Practitioner role. (Thus, whilst it may be that a "junior" practitioner post was to be disestablished, the postholder should not be made redundant. Instead the expectation was that the "junior" practitioner should be developed into a more senior practitioner in the team and so on, with perhaps the most experienced practitioner in the team released and put on an Advanced Practitioner programme.)

— The Foundation Degrees which trainees received on completion of their programmes should be designed such that they would be fully recognised by healthcare and education providers alike when contemplating Assistant Practitioners' subsequent development. (Thus, for example, Assistant Practitioners could step onto year 2 of a pre-registration programme in recognition of the knowledge and skills they already possess.)

— Because of the innovative nature of the initiative, it was deemed essential to commission an independent evaluation to ensure that a full and honest account of the lessons to be learned was openly available. This was with a view to planning future improvements in the programme in Greater Manchester; and also to assist other parts of the country who may wish to set off down the same path.

The Story So Far

24. As of February 2006, 32 separate organisations were participating in the Assistant Practitioner programme. 480 people had completed their training and were deployed as Assistant Practitioners. A further 500 trainees were part way through their courses. Whilst this is still a massive achievement, it still falls some way short of the original aspiration. This reflects a number of factors, including:

- The WDC, like all WDC's, was reorganised away in 2004. Thus some of the focus and drive was lost and inevitably some of the key people were lost as always seems to happen in NHS reorganisations. (The same group of people have been subjected to yet another reorganisation in 2006.)
- Other sources of workforce supply (eg international recruitment) were accessed by some organisations, thereby reducing the amount of under-supply and hence the demand for Assistant Practitioners.
- The change management effort required to successfully take on trainees, deploy them appropriately when trained and make the other workforce and service changes is not universally welcomed. This can be a particular problem when there is rapid turnover of management staff—eg when a committed manager is replaced by one who is less committed.
- The financial pressures in the last two years have driven many managers to address short term financial savings as a very high priority agenda item. This means that they have had little time or enthusiasm for workforce development initiatives—even when such initiatives would deliver large and sustainable financial savings in the medium and long term.

Advanced Practitioners

Overview

25. The information given below is per the paper "Two New Roles: Assistant and Advanced Practitioners" produced by the Delivering the Workforce Project Director.[46]

26. "Delivering the Workforce" moved to the second phase of its development with the express objective of developing registered professional non-medical staff into Advanced Practitioners. There were six main reasons for developing the role:

- To modernise the workforce through developing roles that are based on the needs of patients/clients; and not restricted by professional boundaries.
- To support the development of new services such as case management, "tier two" services, surgical and diagnostic centres/services, out of hours services, and joint services with social care.
- To improve existing services through the modernisation of roles.
- To prepare for the impact of changes to the medical profession so that wider teams of professionals can undertake some of the duties currently undertaken by medical staff. The main issues are:
  - The introduction of foundation training for House Officers and Senior House Officers which impacts on service delivery (Modernising Medical Careers).
  - The Consultant Contract and the associated modernisation of the working arrangements for Consultants.
  - Pressures facing organisations due to the reduction in working hours for doctors, to be achieved by 2009.
  - The high numbers of medical staff expected to retire in the next few years.
- To support the NHS Plan and HR workforce targets.
- To develop teams based on an appropriate skill mix.
- To support the development opportunities for staff within the context of learning at work and developing wider career opportunities.

What is New About the Role of Advanced Practitioner?

27. The Advanced Practitioner is "new" in some ways but not in others. Many would say that some staff already work as Advanced Practitioners; sometimes with the same title and sometimes with a different one. That is to be expected with such a large workforce. The main difference however with this role is:

- The "driver" for the role is service need and the role is designed around the needs of the patient/client.
- These roles form part of the organisations strategic service and workforce plan. (LDP)

[46] "Delivering the Workforce—Workforce Modernisation: Two New Roles; Assistant & Advanced Practitioners", Chris Mullen (project Director for "Delivering the Workforce"), Greater Manchester SHA, February 2006.

- The design of the job is not pre-determined or fixed by either a profession or a previous post. It is contextualised to the service in which it is based, with clearly identified "measurable" outcomes.
- The roles are open to practitioners from any professional background.
- The role builds on the professional skills, knowledge and competences of the recruited person. At the same time, it will support the development of new skills and competences often outside the domain of the individual's own profession.
- The additional skills and competences for the role will vary but will mostly likely come from the following fields:
  - Medical skills
  - Medicine management
  - Social care skills
  - Radiological skills
  - Diagnostic skills

A Summary of the Education and Development Aspects for the Posts

28. There are two education providers who have been working in partnership with service to develop a masters level, work based course. The key information about the course is:

- It is a two year Masters programme.
- It is work based.
- It is called a Masters in Advanced Practice (Health and Social Care).
- The providers are the Universities of Salford and Bolton.
- There are two intakes a year—there had been three intakes as of early 2006; February 2005, September 2005 and February 2006.
- The programme is tailored to meet the needs of the role and the individual—ie it is learner centred.
- The support in practice involves:
  - One Learning Facilitator for 20 trainees who will be based in practice and employed by the universities.
  - A mentor.
  - A number of assessors throughout the course depending upon the learning support required for particular modules.
  - Link tutors from the universities.
  - The champion and line managers in service.

29. Many organisations have "signed up" and are participating in the development. This includes primary care, mental health and acute services organisations. The trainees can be recruited from all professional backgrounds (non-medical); and the first three cohorts were from nursing (mental health, midwifery, community nursing and adult nursing), physiotherapy, podiatry, occupational therapy and radiography. The participating sites have typically recruited three to six practitioners per site. As of February 2006, there were about 150 people in training.

30. The roles are in development; and each role will vary depending upon the needs of that service. However there will be some characteristics of the "Advanced Practitioner" role that will be common to the majority of these new posts. It is anticipated that the new role will:

- Work across organisations and different agencies.
- Provide advanced levels of clinical practice, knowledge and skills.
- Be self-directed, manage risk, have high levels of communication skills and be a member of a wider clinical/ service team.
- Include in many cases managing medications including assessment, review and prescribing.
- Include managing a patient/client caseload with decision-making responsibilities.
- In most cases, undertake a physical, psychological and social examination.
- Complete a patient's history, diagnosis and treatment plan.
- Refer to others, signpost patients to services, and coordinate care and treatment.
- Promote health and the prevention of ill health.

How Will This Affect the Patient?

31. The impact for patients is intended to be positive. The aim of the role is to ensure patients are seen in a timely way by competent staff. This may mean that a patient's first contact will be an assessment done by an Advanced Practitioner, rather than a doctor. Assessments occur in a variety of places including GP centres, primary care facilities, patients' own homes and hospitals. However, as well as completing an assessment, the Advanced Practitioner will also at the same time undertake other aspects of patient care and/or treatment needs. This will potentially reduce the number of people the patient sees and may reduce the waiting time for patients. It will certainly ensure that the patient does not wait any longer for his/her assessment and treatment.

32. A key role of the Advanced Practitioner will be to manage the coordination of care and or treatment through effective signposting; so that people get the right care/treatment in the right place at the right time and by the right people. This will hopefully improve the patient's journey and experience.

How Will This Affect the NHS Organisations that Provide Services?

33. It is intended that NHS organisations will benefit from these roles by ensuring they can continue to meet the waiting times required; and by meeting the new challenges of providing more services in the community described in the White Paper "Our Health, Our Care, Our Community".[47]

34. The Advanced Practitioner development also has the potential to provide services with increased flexibility whilst promoting a competent, clinically safe service. It supports the retention of staff and provides career opportunities for those staff; and thus also supports the notion of being an attractive employer.

SUMMARY

35. This memorandum of evidence demonstrates that whilst the workforce planning arrangements have served the health and healthcare sector in England reasonably well hitherto; they are extremely unlikely to be "fit for purpose" in the future. This is partly because they undervalue the contribution of a large section of the workforce, partly because they are focussed on the individual "traditional" professions and partly because they are not sensitive enough to local requirements—but mainly because they are simply not strategic enough to take account of strategic drivers and the lead times needed to develop changes in the "shape" of the workforce.

36. This all suggests that healthcare employers are going to require a more flexible workforce in the future; and that they need to plan accordingly. Whilst it is impossible at this stage to define precisely what "a more flexible workforce" would look like; I do believe it is possible to suggest a strategic direction such that perhaps 30% of the future clinical workforce might be in "new roles", of which about half would be in Assistant Practitioner or similar roles. This assessment is based on of the proportion of clinical work which could, on average, be undertaken by Assistant Practitioners is based on the evidence that is emerging from Greater Manchester (ie 15%), the number of Advanced Practitioners required to solve the European Working Time Directive plus sufficient other posts to facilitate the career development of those registered practitioners who chose to develop some competences outside of the narrow confines of the particular professions they originally registered with.

37. However, the exact figure is not the essential issue at this stage, although it would probably helpful if some well informed modelling work was commissioned to try and derive a more authoritative figure. The practicalities are such that it would take about 15 years under the most practical scenario to achieve a 30% figure. The sheer scale of the numbers of people involved means that the transformation could only take place within manageable numbers on a year by year basis—partly because of financial constraints, partly because of capacity constraints in the NHS and Education sectors—but mainly because the consequences of a rapid transformation would be too destabilising to contemplate. There is also a very positive aspect to such a considered approach, as it allows new learning to emerge on a year by year basis; and new strategic drivers to be taken into account as they emerge. Thus, even if the 30% figure needed to be amended by even a quite substantial amount in later years; it does not affect the strategic direction and it does not affect the need for the transformation to take place through reasonably sized increments on a year by year basis. Those increments can be flexed up or down in due course to reflect any future changes needed based on the learning that takes place and on any new strategic drivers that emerge.

38. In order to deliver the modernised approach to workforce planning suggested in this memorandum of evidence, there will continue to be aspects which should be undertaken centrally, aspects which should be undertaken locally—and aspects which can best be addressed by "the intermediate tier" (currently Strategic Health Authorities). The key difference as compared with the current arrangements is the need for a more strategic approach—beginning with clear leadership from the Department of Health; and the development of Strategic Workforce Plans that demonstrate that they deliver the more flexible, competency-based workforce that is needed.

[47] "Our Health, Our Care, Our Community", Department of Health, 2006. For more details see http://www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf

39. It does though need to be borne in mind that this more sophisticated approach to workforce planning and development needs to be matched a determined and effective implementation process. However, it also needs to be borne in mind that the prize is very great. Quite apart from the service and patient related benefits of a more flexible workforce; the financial contribution is enormous. A move to 15% of the workforce in Assistant Practitioner roles would alone release recurrent financial savings which exceed the whole of the NHS deficit in 2005–06!

John Sargent,
Workforce Development Consultant

3 November 2006

Letter from Professor Steven West, University of the West of England to Dr Doug Naysmith MP (WP 89)

As you will see from the letter head I am DVC at UWE and prior to that I was Dean of the Faculty of Health and Social Care. My other roles in the region include being a Non-Executive on the Strategic Health Authorityand I chaired the Integration Board for the merger of the Ambulance Trusts.

The purpose of writing is to provide you with some background information concerning the health workforce education commissioning situation in our local health community and the impact it will have on the university, its students and staff. I am also aware that I shall be presenting evidence to you in a few weeks in your capacity as a member of the health committee considering "workforce needs and planning for the health service" towards the end of this month.

As you will be aware our health community is in significant financial difficulty. Historically we have been trying to manage a recurring debt of approximately £200 million pa. This year AGW presented local delivery plans to the Department of Health that were not financially balanced. The Department rejected them and the SHA was tasked to close the £40 million deficit. In order to do this the service has been required to reduce services and freeze posts. In addition, in May of this year the university was informed that the commissioned activity for September 2006 and January 2007 needed to be reduced to make a saving of £1.6 million over the NHS financial year. Unfortunately the reductions, if implemented, will reduce our activities over a three years period, will see some programmes close completely and this will lead to no outputs of some students in 12 months and three years time. The overall financial cost to the University will be in the order of £5 million and will necessitate some redundancies. There are several worrying features to the action being taken:

1. The very late notice of intention to reduce and stop commissions.
2. The lack of any relationship to workforce planning needs to the action taken by the SHA given that we had previously received assurances in December 2005 and March 2006 that the minimum commissioned numbers were assured. These numbers had already seen some reduction in activity on 2005–06 commissions.
3. The total lack of any modelling on the implications of the proposed actions on service delivery next year and then in 2009–10.
4. The reduction in pre and post registration commission which impact offers already made by the university to prospective students and the reduction of the continuing professional development for existing NHS staff, thus reducing the potential for modernisation of the workforce.

Whilst the University understands the difficulties the NHS are currently experiencing we are surprised that they are taking such extreme actions to resolve what we have been told is a 2006–07 problem. It is surprising that the solutions offered by the University to make the cash savings without the need to significantly reduce commission numbers have not been accepted. It is also surprising that the NHS accepts no liabilities associated with these reductions. Most worrying of all is the clear message that the funding initially allocated to SHAs by the DoH to support education and training against workforce plans is no longer "ring fenced" for that purpose.

I hope that this information will provide you with the local context and might aid in exploring workforce planning, funding and modernisation agendas further. Our major concern is that the rapid expansion in commissioned numbers over the last five years to deliver the government agenda now seems to be in reverse and we are likely to return to the rapid swings observed in workforce during the 1990s. It is very interesting to note that medicine and dentistry do not show these swings and seem to be more stable in respect of their education funding streams and workforce numbers.

I have attached to this letter a table showing the reductions against 2005–06 intakes. I look forward to presenting oral evidence in due course and in the meantime would be happy to discuss our local issues with you if it would be of value.

Professor Steven West
University of the West of England

16 June 2006

Table 1: NHS Contract Activity – Pre-registration and Post registration

Programme	**2005/06 Activity**	Dec 05 cut	%	**May 06 additional cut**	%	**Total proposed Cut (actual)**	% total cut against 05/06	% cut against December Numbers
Adult Nursing	**585**	-52	8	**-48**	17	**-100**	17%	9%
Learning Disability	**20**	0	0	**-20**	100 10	**-20**	100%	100%
Mental Health	**155**	0	0	**-15**	12.5	**-15**	10%	10%
Child	**80**	0	0	**-10**	10	**-10**	12.5%	12.5%
Midwifery	**50**	-1	2	**-4**	0	**-5**	10%	8%
Ass.Pract-Adult	**12**	0	0	**0**	0	**0**	0%	0%
Ass.Pract-MH	**20**	0	0	**0**	31	**0**	0%	0%
Physiotherapy	**130**	-30	23	**-10**	37	**-40**	31%	10%
OT (part-time)	**27**	-3	11	**-7**		**-10**	37%	29%
Overall totals	**1079**	-86		**-114**	100	**-200**	18.5%	11.5%
Community Nursing	**50**	0	0	**-50**	100	**-50**	100%	100%
Midwifery conversion	**17**	0	0	**-17**	100	**-17**	100%	100%
RGN to MH	**21**	0	0	**-21**	100	**-21**	100%	100%
EN Conversion	**20**	0	0	**-20**	100	**-20**	100%	100%
RGN to Child	**19**	-19	100	**0**	100	**-19**	100%	100%
Overall totals	**127**	-19		**-108**		**-127**	100%	100%

Table 2: UWE Post reg - interim contract activity 2006/07

						Propsal B (12th May 2006)			Proposal A Original (26th April 2006)	
Programme	Intake Date	Duration	Student Commissions	Price	Months to pay	Total Contract Price	WDC revised intake	revised cohort price	Student Commissions	Revised cohort Price
Midwifery 2nd Reg	Sep-06	18months	17	8036	7	£79,690	0	£0	0	£0
Community Nursing	Sep-06	1 year	50	5478	7	£159,775	0	£0	50	£159,775
Conversions-MH and Child	Jul-06	1 year	40	5478	9	£164,340	0	£0	20	£82,170
EN Conversions	Jan-07	1 year	20	5478	3	£27,390	0	£0	0	£0
General Credits			36352 credits			£1,230,672	-10%	£1,107,604	-£500,000	£730,671.51
T&A						£350,000		£300,000	-£50,000	£300,000
Total						**£2,011,867**		**£1,407,604**		**£1,272,617**

	Proposal A	Proposal B
Post Reg Programme Savings	£739,250	£604,262
Pre-Reg Savings carried from previous sheet	£883,510	£314,031
Total Savings	£1,622,760	£916,293

Figures at 23/05/06

Table 3: UWE Pre-Registration - New Contract Activity 2006/2007

UWE							Propsal B Following WDC Board Meeting (22nd May)		cohort savings per programme	Proposal A Original (26th April 2006)	
Programme	Intake Date	Duration	Student Nos	Unit BMP	Months to pay	Total Contract Price	WDC revised intake	revised cohort price		Student Commissions	Revised Cohort Price
N&M Degree/Diuploma											
Adult Nursing	Sep-06	3 years	317	6637	7	1,227,292	317	1,227,292	0	267	1,033,713
Adult Nursing	Jan-07	3 years	168	6637	3	278,754	120	199,110	79,644	0	8
LD	Sep-06	3 years	20	6637	7	77,432	0	0	77,432	20	77,432
Mental Health	Sep-06	3 years	105	6637	7	406,516	90	348,443	58,074	80	309,727
Mental Health	Jan-07	3 years	35	6637	3	56,074	35	58,074	0	0	0
Child	Sep-06	3 years	40	6637	7	154,863	40	154,863	0	40	154863
Child	Jan-07	3 years	40	6637	3	66,370	30	49,778	16,593	0	0
Midwifery	Sep-06	3 years	49	7632	7	218,148	45	200,340	17,808	30	133,560
Associate Practioner students											
Adult Nursing	Jan-07	1 year	12	6637	3	19,911	12	19,911	0	12	19,911
Mental Health	Nov-06	18 months	20	6637	5	55,308	20	55,308	0	20	55,308
Sub toatl -N&M pre-reg						2,562,688		2,313,118			1,784,514
AHP Degree students											
Therapeutic Radiography	Sep-06	3 years	27	8396	7	132,237	27	132,237	0	27	132,237
Diagnostic Radiography	Sep-06	3 years	58	8396	7	284,055	56	264,065	0	58	284,065
Physiotherapy	Sep-06	3 years	100	7007	7	408,742	90	387,866	40,874	80	326,993
Part-time OT	Sep-06	4 years	27	6781	7	91,055	20	57,448	23,607	20	67,448
Full-time OT	Sep-06	3 years	27	7007	7	110,380	27	110,360	0	27	110,360
Sub-total-AHP students						1,026,458		981,977	314,031		921,103
UWE Pre-Reg Annual contract total						3,589,127		3,275,096	314,031		2,785,617

	Proposal A	Proposal B
UWE Pre Reg Saving	£883,510	£314,031

Figures as at 235/05/06

Evidence submitted by Pascal Zurn (WP 86)

Pascal Zurn is a health economist with a master's degree in health economics from the University of York and a PhD in economics from the University of Lausanne. He joined the World Health Organization in August 2001. His area of work covers analysis regarding the issues of imbalance and migration of health workforce, as well as data collection and monitoring activities. From August 2005 to July 2007, he will be on a secondment at the OECD in Paris, where his work will focus on health workforce migration in OECD countries. His evidence is submitted on an individual basis.

Ageing population, technological change and ageing health workforce

1. It can be anticipated that shortages of health professionals in OECD countries will grow in the next 20 years, unless countermeasures are taken, because population ageing and changing technologies are likely to contribute to an increase in the demand for health workers, while workforce ageing will decrease the supply as the "baby-boom" generation of workers reaches retirement age. Unless domestic training programmes, or other domestic policy changes, take the strain, there is likely to be an even greater "pull" on health workers from developing countries into OECD countries and between some OECD countries with both gains and losses for receiving and sending countries.

2. In many countries, a trend towards earlier retirement dovetails with a rise in the average age of health workers, and these dual shifts could lead to mass exits from the health workforce. Middle-aged nurses, who are part of the "baby boom" generation born after the Second World War, dominate the workforce in many countries and will reach retirement age within the next 10 to 15 years (From the World Health Report (2006), page 110).

To what extent can and should the demand be met, for both clinical and managerial staff, by:

- Changing the role and improving the skills of existing staff.
- Better retention.
- The recruitment of new staff in England.
- International recruitment.

3. Addressing the demand for both clinical and managerial is a challenging task. It appears that a mix of policies is likely to produce better result than by just focusing on one. However, the issue of better retention is a central one. Indeed, in addition to the potential loss of group efficiency and organizational performance due to high turnover rates, evidence suggests that the costs associated with high turnover, recruitment and retentions problems are substantial.

4. The literature shows that the costs associated with recruitment and retention problems can be substantial. In the USA, the National Association for Health Care Recruitment estimated direct costs of recruiting and hiring a nurse at US $2,396. In the UK, administrative costs associated with the recruitment of a nurse were estimated to be between £401 and £637 (Gray et al 1996). An early study estimated the initial productivity losses occurring as recruits learn on the job at between £1,422 and £6,166 per staff nurse (Buchan et al 1991). In an attempt to account for those indirect costs, Johnston evaluated total turnover costs at around US $25,000 per nurse (Johnston 1991). In terms of policy option, policies developed by so called "magnet hospital" seem to offer examples of policies improving nursing recruitment and retention in hospital. The main characteristics of such hospitals are:

- high-quality nursing leadership;
- flat organisational structure;
- open management style;
- supportive, individual personnel policies and processes;
- high-quality care;
- professional models of care;
- high level of autonomy of nurses;
- quality assurance initiatives;
- consultation and other resources available;
- positive relationships between community and hospital;
- support role of nurse as teacher;
- positive image of nursing;
- positive nurse-physician relationship;
- professional career development.

(This paragraph is derived from Zurn P, Dolea C, Stilwell B. Nurse retention and recruitment: developing a motivatedworkforce. Geneva, International Council of Nurses, 2005 (Issue Paper 4; http://www.icn.ch/global/Issue4Retention.pdf, accessed 2 February 2006).

5. The issue of migration has raised a lot of concern recently. In comparison with other countries, England is among the countries with one the most important share of foreign trained workers.

	Doctors trained abroad		*Nurses trained abroad*	
OECD country	*Number*	*Percentage of total*	*Number*	*Percentage of total*
Australia	11,122	21	NA	NA
Canada	13,620	23	19,061	6
Finland	1,003	9	140	0
France	11,269	6	NA	NA
Germany	17,318	6	26,284	3
Ireland	NA	NA	8,758	14
New Zealand	2,832	34	10,616	21
Portugal	1,258	4	NA	NA
United Kingdom	69,813	33	65,000	10
United States	213,331	27	99,456	5

NA, not applicable.

Source: World Health Report, 2006.

6. In this context, one of the key challenge for England would be to manage migration in order to contribute to generate benefits for both England and the sending countries. In this context, ethical guidelines for recruitment, memorandum of understanding between England and other countries, such as the one with South Africa, twinning health institutions between receiving and sending countries, developing knowledge transfer through health worker immigrants are all example of policies aiming at a better management of migration.

Pascal Zurn

31 May 2006

Supplementary evidence submitted by the Chartered Society of Physiotherapy (WP36A)

Introduction

1. The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the 47,000 chartered physiotherapists, physiotherapy assistants and students in the UK

Summary

2. NHS workforce planning has put few resources into future demand forecasting for the smaller professions such as the Allied Health Professions (AHPs) or healthcare scientists. The considerable effort at forecasting made during the development of the *NHS Plan* in 2000 has not been sustained. Any work has concentrated on nurses and multiple medical specialties. AHPs have been subject recently to poor guess work not workforce planning.

3. This is against a background of an increase in demand for physiotherapy as a consequence of the many Department of Health (DH) policy initiatives since the publication of the *NHS Plan*. These include: delivery of the 18 week wait; primary care developments; faster access to treatment via patient self referral; increased rehabilitation and independence provision; meeting the needs of older people; the Musculoskeletal Services Framework; and recognition of the value of prompt intervention in order to reduce the number of people requiring incapacity benefit.

4. Graduate employment problems are serious in physiotherapy, speech and language therapy, dietetics; occupational therapy; nursing and midwifery. The problems in physiotherapy:

— are not caused by too many physiotherapists. The present output is in approximately in accordance with the *NHS Plan*.

5. The problems are caused by:

— the NHS deficit reduction programme; resulting in many frozen posts (and some eliminated) which would have been suitable for new graduates;

— the creation of senior posts by Primary Care Trusts (PCTs) instead of planning new junior posts;

— the senior post vacancies have been filled by a flow of overseas (including Europe) physiotherapists of around 1,200 pa. in 2004 and 2005; and

— serious failure by Strategic Health Authorities (SHAs) and trusts to take responsibility for the new graduates they have commissioned.

Solutions

6. The CSP is seeking the following solutions:

— increased resources into future demand forecasting for AHPs and scientists in particular around national co-ordination and at SHA level;

— "unfreezing" physiotherapy posts;

— removal of physiotherapy from the Home Office shortage occupation list; and

— a 1 year guarantee of jobs for new graduates with a view to ensuring that new graduates are not lost from the NHS.

Recruitment, Retention and Workforce Planning

7. There has been a serious lack of resources put into future demand forecasting for physiotherapy, other AHPs or healthcare scientists. The exception to this was the work undertaken in forecasting for the *NHS Plan* in 2000. However, in recent times this focus on the future of the smaller professions has not been maintained. Since 2000 the number of physiotherapy posts expanded substantially; and traditionally there were many vacant posts. The impact of measures to address NHS deficits has resulted in many frozen posts and some post reductions in physiotherapy and most other professions.

8. A workforce survey of physiotherapy managers was undertaken by the CSP in July 2006. Responses covered nearly half the physiotherapy workforce in England. Managers were asked about the numbers of vacant and frozen posts within their physiotherapy service and this revealed that in total 4.7% of funded establishment posts were vacant on 30 June 2006. Taking account of numbers of part time roles, and allowing for non-respondents, it is calculated that across the UK 1,215 physiotherapists would be needed to fill all vacant posts.

9. This is far in excess of the 1.1% vacancy rate reported by the DH in its latest vacancy survey (31st March 2006) and, being closer to the "coal face" represents a much more accurate picture of the true extent of vacant posts in physiotherapy. The DH survey only records posts which have been vacant for three months or more and which employers are actively trying to fill. This therefore completely disregards any frozen posts or posts which employers have stopped advertising due to lack of applicants. The numbers of job freezes imposed as a result of the financial problems affecting the NHS has reduced turnover and impacted on the numbers of Band 5 posts available for new graduates.

10. In Spring 2006, using the Freedom of Information Act, the CSP obtained copies of the information submitted by SHAs at the request of the WRT on future demand for physiotherapy. The CSP was concerned to learn that the SHAs were only asked to supply predicted figures and were not asked to justify or explain how they had reached those totals. Furthermore, when questioned by the CSP, few senior physiotherapy managers had known that this information had been requested or had been asked to input their views to the process. Eleven out of 28 SHAs had not submitted information on future demand, including all (of the then) five London SHAs. Few SHAs had separate data for physiotherapists. This exercise resulted in predicted expansion in 2006–10 of just 1,648 wte. physiotherapists in England—the fact that the same figure has been given for both headcount and wte. also has caused the CSP concern about the accuracy of these predictions and how much background work had gone into their calculation. Yet it was this less than robust information that led the WRT to conclude that there may be an oversupply of physiotherapists if current commissioning levels are not reduced.

11. The CSP was extremely concerned by the reports of the draft DH workforce planning document that was leaked to the Health Service Journal (4 January 2007). Although reported comments by Andy Burnham MP, Minister of State, that this was an early draft might have been intended to reassure, the reported predicted levels of oversupply of 16,200 AHPs and scientific technical and therapeutic staff (ST&Ts) by 2010/11 have not been dismissed. Of equal concern is that there has been no explanation of how such a conclusion was arrived at, especially as it represents an "about turn" in DH policy as set out in the *NHS Plan*. To produce a "headline" figure for such an amalgamation of professions indicates how little resource has been invested in workforce planning for these professions since the extensive work done in producing *Investment and Reform for NHS Staff—Taking forward the NHS Plan*.

12. The CSP has been unable to obtain any details of the proportion of the predicted oversupply that physiotherapists would constitute. According to the DH Workforce Census figures for September 2005 physiotherapists form around 14.5% of this group. On this basis the DH prediction would imply that around 2,350 wte. physiotherapists (equating to a headcount of 2,800) would be affected.

13. Demand for physiotherapy has been increasing for many years. The DH workforce census shows that between 2003 and 2005 alone the workforce in England expanded by 11% or nearly 2,000 physiotherapists. The CSP has supplied detailed evidence to the DH and WRT on the many ways in which expansion of physiotherapy services can contribute to a range of government targets for the NHS across a number of clinical specialties; reduce the workload of GPs and consultants; contribute to achieving the 18 week wait and the 4 hour waiting target for A&E; promote healthy living; reduce the length of hospital stays, etc.

14. Out-patient waiting data is not routinely collected by the DH (although Welsh and Scottish Executive bodies do). A "snapshot" telephone survey of over 30 CSP stewards in England (May 2006) confirmed anecdotal concerns raised by members that significant increases in waiting times for physiotherapy treatment are being experienced, with musculoskeletal outpatients the worst affected, but also access to paediatric services, learning disabilities, older patients and those with long-term conditions. Examples include:

- in North Staffordshire, waiting times for musculoskeletal outpatients were reported to have increased from 36 weeks to 47 weeks, and waiting times in respiratory from zero to four months;
- one trust in the West Midlands reported community physiotherapy waiting times to have increased from one week to six weeks;
- in Kent and Yorkshire, waiting times increased to six-seven weeks from two weeks previously, with musculoskeletal, rheumatology and neurology patients most affected;
- a doubling of waiting times from four to eight weeks in Thames Valley, Kent and the North West;
- in the North East, outpatient waiting times increased up to three months;
- in the East Midlands, routine waiting lists reported to have increased to 43 weeks and rising.

15. In terms of services being cut or withdrawn, outreach community work in GP surgeries and patients' homes were mentioned the most frequently, but also hydrotherapy services, women's health, mental health, respiratory rehabilitation, amputees, falls and exercise clinics were also being affected

16. The issues outlined above highlight the inadequacies of current workforce planning mechanisms and the CSP is keen to work in partnership with the DH and NHS Employers to provide constructive solutions to establish effective and meaningful workforce planning. A strong co-ordinating role in workforce planning should be established at national level. This must be supported by the establishment of a senior post responsible for AHP workforce issues within each SHA to help coordinate and support local activity as well as providing strategic leadership and engaging with education providers

Graduate Employment

17. The CSP has undertaken regular surveys of employment of physiotherapy graduate since 2004. The DH did not collect such data until quite recently.

18. The survey of the employment status of physiotherapists graduating in 2005 (undertaken in January 2006) showed that approximately one third had been unable to find work within the NHS. Whilst it has not been possible to track them all, anecdotal information suggests that many of these have now sought alternative careers and are lost to the profession and to the health service.

19. A survey of those graduating in 2006 revealed that in July around 93% had not secured a physiotherapy position. In December a sample survey of the employment status of 706 of the 1,954 physiotherapists who graduated in England in 2006 revealed:

- 13% had found permanent employment as physiotherapists.
- 17% had only been able to obtain short-term contracts as physiotherapists.
- 68% were still seeking their first physiotherapy post.
- The remainder were no longer seeking employment as physiotherapists.

20. In general, physiotherapy graduates are very flexible in terms of how far they are prepared to move geographically across the UK to take up a post—this has inevitably caused a problem in other parts of the UK. There is also recognition that service provision is moving from the acute to the community sector. Although in the past physiotherapy graduates have traditionally taken up their first post in the acute sector they are both competent and willing to begin their career in the community. The CSP is therefore concerned that both the DH and NHS Employers continue to state that physiotherapy graduates need to be more flexible in where they are prepared to work. The problem is a serious lack of any suitable physiotherapy posts to apply for as evidenced by managers reporting receiving up to 100 or more applications for each "newly qualified" post.

21. The CSP remains extremely concerned that:

- At a cost of around £30,000 to train a physiotherapist, £40 million pounds of taxpayers' money will have been wasted if 68% of English graduates are unable to find physiotherapy posts.

— Due to the current financial situation within the NHS in England, many of those who have obtained short term contracts may find that their contracts are not renewed in order to help meet the vigorous financial savings targets that are being imposed in many trusts. Junior physiotherapy posts traditionally have a high turnover, with junior physiotherapists seeking to expand their experience in a variety of settings. As these posts fall vacant they become vulnerable to being frozen and cut.

— It is now six months since the majority of these physiotherapists graduated and they will soon face increased competition for posts from the 2,250 (over 2,600 across the UK) physiotherapists due to graduate in England in 2007.

— A very clear commitment to expand the physiotherapy workforce by 59% between 2000 and 2010 was made by the Government as part of the *The NHS Plan—a plan for investment, a plan for reform*. This was deliberately planned in recognition of the increasing role physiotherapists have in meeting rising patient demand and helping to realise a variety of key Government manifesto commitments since 1997, such as the 18-week wait. The Plan required a total headcount of 24,800 qualified physiotherapists by 2010. The latest available DH workforce census for England (September 2005) shows that there were 19,997 physiotherapists in post. This means that in order to achieve the target of 24,800 an increase of 24% or 4,803 physiotherapists will be needed. In answer to a written question (*Hansard,* 29 July 2002, col WA155) Lord Hunt of Kings Heath replied that as at 30 September 2001, there were 16,210 physiotherapists employed in the NHS in England and that projections were that there would be around 8,000 more in 2009. The latest WRT projections exceed this.

22. The CSP remains committed to working in partnership with the Department of Health and NHS Employers to resolve this problem. Although dissemination of good practice and encouragement to SHAs and trusts to take action will provide some help, this will only tamper at the edges and will not have a major impact on reducing unemployment. The CSP, along with other health service trade unions and professional bodies is continuing to press for a guarantee of one year's employment for graduates. Only by such direct action can this problem be prevented from escalating. All SHAs and employers must take their share of responsibility for providing employment opportunities, as must third and independent sector providers. If left to good will alone this will not happen.

International Recruitment

23. During the past few years the high vacancy rates among physiotherapists has resulted in a significant increase in the recruitment of overseas-qualified physiotherapists. Non-EEA citizens requiring work permits to work in the UK are only able to apply for posts which appear on the Home Office shortage occupation list. Since the summer of 2005 junior physiotherapists have been removed from this list in recognition of the large numbers of newly qualified UK physiotherapists who were unable to find jobs.

24. The CSP has analysed the figures collected by the Health Professions Council (HPC) of the numbers of non-EEA physiotherapists successfully applying for registration in the UK.

25. In 1999 the CSP commissioned a report into the recruitment of international physiotherapists.[48] It has been useful to compare the information on international registrants collected at that time with the current data as highlighted below:

— There has been a huge rise in the number of non-UK nationals who have successfully applied for HPC registration since 1999. In that year there were 579 non-UK nationals registered with the then Council for Professions Supplementary to Medicine—the forerunner of the HPC. In 2005 there were a total of 1,219 registrants—a rise of 210%.

— The country with the biggest increase in registrants is India. In 1999 registrants from India featured only in a category labelled "Other" which totalled 22. In 2004 there were 432 registrants from India rising to 472 in 2005.

— There are also a significant number of registrants from the Africa with 376 applicants in 2004 and a further 245 in 2005.

— There has been a fall in the numbers being registered from Australia, from 256 in 1999 to 151 in 2004 and 178 in 2005. Numbers from New Zealand have dropped slightly from 90 in 1999 to 70 in 2005. Many of these physiotherapists use working holiday visas rather than work permits to obtain physiotherapy posts in the UK and so will not be affected by the restrictions of the shortage occupation list.

26. It is understood that a proposal to remove all physiotherapy posts from the work permit shortage list is now with Ministers—this was first mooted by the DH in June last year. The CSP has supported this move on the basis that this will help to create more vacancies at Band 6 and above and will allow more movement of physiotherapists from Band 5 posts, thus freeing up more posts for new graduates. More physiotherapists will be needed to fill the vacancies that will be created in future once non-EEA physiotherapists are no longer able to apply for jobs in the UK.

[48] International Recruitment of Physiotherapists, Buchan & O'May, 2000.

CONCLUSIONS

27. Whilst workforce planning across the health service will never be easy, it is disappointing that so little effort appears to be made in the case of physiotherapy or indeed other AHPs, as the FoI request revealed. Given that the Government has done much to rightly to take advantage of the skills that physiotherapists employ in an increasing range of treatments and settings to complement the ongoing reform programme, not to try to adequately quantify this growing demand is difficult to understand.

28. The supply of physiotherapists, had until this month, been a much more straightforward matter. The Government had shown real courage with the *NHS Plan* in 2000 in seeking to implement a strategy that looked beyond the next General Election, indeed beyond the next two. This enabled the profession, the NHS and the academic institutions to produce the necessary number of physiotherapy graduates to support the investment in and reforms to the health service. With a three-year training period, longer for other health professionals such as doctors, the certainty of working to such a plan was a significant improvement for all concerned—not least patients. The draft workforce strategy report leaked earlier this month challenges the *NHS Plan* and does so without appearing to have any basis for suggesting hugely differing workforce demand. Against a background of the impact that trying to return the NHS to financial equilibrium over too short a period has had, it is questionable whether there is any workforce strategy other than a return to a "boom and bust" approach.

Phil Gray
Chief Executive, Chartered Society of Physiotherapy

January 2007

Evidence submitted by the Faculty of Family Planning and Reproductive Health Care (WP 98)

During 2005 the Faculty brought to the attention of the Department of Health and the Minister for Public Health, serious workforce deficits in community Sexual & Reproductive Healthcare services. If these issues are not addressed as a matter of priority, there is a serious risk of losing these specialist services which currently provide a significant area of preventive health care particularly to vulnerable and marginalised groups. In addition, capacity within the NHS for training in contraception and holistic sexual health care will be lost. The issues raised were:

— There is a serious shortage of trained medical specialists currently available to replace retiring service leads in Community SRH services. This is due to a shortage of national training numbers (NTNs) for sexual and reproductive healthcare which has not been increased in line with workforce requirements in the specialty. There is also considerable anxiety amongst trainees intending to enter training programmes in SRH due to the possible disappearance of SRH consultant posts in the community, as PCTs are reducing services and not looking to replace retiring service leads.

  These trained specialists are essential if there is an intention within national policy to provide specialist services outside hospital as well as improve access to high quality sexual and reproductive health services. The recommended national standard is for one consultant per 125,000 population which is far from the current position of around 100 consultants across the whole of UK (Faculty workforce census 2003–04). An additional 343 WTE consultants/specialists would be required to achieve the recommended staffing level (HPA Report on Sexual Health 2006).

— Recruitment and retention of nurses and speciality trained non-consultant doctors is a serious problem in community services, due to the lack of a career structure and training opportunities for both groups.

— The problems in medical recruitment are a result of the rapidly increasing pay disparity between general practice and community SRH services. The latter operate mainly during unsocial hours which further compounds the recruitment problem.

— Nurse members of the Faculty report that training and development of the enhanced role of nurses in SRH care in the community is ignored by many PCTs who focus only on general practitioner development.

Dr Meera Kishen
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