Written evidence

Evidence submitted by the Department of Health (WP 01)

EXECUTIVE SUMMARY

This paper contains the Department of Health’s written evidence for the Health Select Committee for the inquiry into workforce planning in the NHS. The paper outlines the workforce achievements since the Committee’s last inquiry into workforce planning in 1999, the current process of workforce planning in the NHS and the challenges facing workforce planning in the near future.

Workforce planning has undergone many changes since the review of workforce planning in a Health Service of all the Talents in 2000. There are now processes in place that deliver a “bottom up—top down” approach to planning that ensures local employers and national planners are fully engaged and includes key stakeholder engagement. A vital component of workforce planning is each organisation’s Local Delivery Plan (LDP) that integrates service, finance and workforce plans. Each organisation now plans the workforce of the future that is right for them rather than a rigid “one size fits all” central plan. This concept is reinforced in the new Integrated Service Improvement Programme (ISIP) that ensures workforce reform is at the heart of local service delivery.

A lot has been achieved in the last five years in terms of filling the gaps, ensuring the service has sufficient staff and reforming the pay and reward systems to create a world class workforce. We have achieved the challenging targets laid down in the NHS Plan and met the European Working Time Directive (EWTD) target in 2004. New pay structures have been agreed for all staff groups and under Agenda for Change (AfC) the concept of a skills escalator is enabling services to be redesigned and supporting staff to develop new skills and new roles. The NHS is now a flexible employer better able to attract and retain good quality staff. The NHS Careers service and electronic recruitment via NHS Jobs are now part of an infrastructure to deploy staff more cost effectively and support their career development.

The NHS has seen a period of growth in both financial support to the NHS and the size of the workforce. There is now a much better balance between supply and demand with the NHS becoming more self reliant in training its own staff to meet the future needs. The past five years has been about staff growth and the next five years will be about transformation into a flexible affordable staff mix to deliver patient centred care. The NHS already has developments in place that will enable organisations to work in new ways and share best practice across organisations.

The future is not without several significant challenges; this paper explores the impact of external drivers such as the European Working Time Directive requirements for 2009 and the demographic shift in the population. In addition new providers, greater choice and new financial systems, together with the 2006 White Paper, will drive changes in how and where healthcare is delivered in the future.

Looking to the next five years, one thing is very clear. The investment and reform we have made in the NHS workforce puts us in good stead for dealing with A Patient Led NHS, where organisations will need to meet the challenges of patient choice, be able to compete in an environment of plurality and provision and drive productivity and efficiency in an era of lower financial growth. However this will not be achieved unless all organisations improve their capability and capacity to undertake workforce planning and development. Primary Care Trusts, Practices, Trusts and Strategic Health Authorities will need to base their service and financial plans on a clear strategy for the future direction of their workforce that creates the right skill mix in the workforce for the next five years. Only organisations with a skilled, flexible workforce, where people are their greatest investment, will succeed.

1. BACKGROUND

1.1 The need for workforce planning has long been recognised within the NHS. Any organisation with the size and staffing complexity of healthcare requires a system for forward planning. Prior to 1999, workforce planning relied on a central control of training numbers that were increased or decreased according to central returns of staffing numbers.

1.2 In March 1999 the Health Select Committee recommended a review of how workforce planning was undertaken in the health service. This led to the publication of A Health Service of all the Talents in April 2000 and recommendations around four key areas:

— Greater integration and more flexibility of workforce planning;
— Better management ownership, clearer roles and responsibilities within planning;
— Improved training, education and regulation; and
— Better planning for overall staff numbers and career pathways.

1.3 Since the publication of the paper the main recommendations have been implemented. There is a greater integration of workforce planning with service and financial planning within organisations and mechanisms to share and aggregate these plans to support local health economies. The funding of education and development is now within one budget and responds flexibly to the needs of staff training. There is a
clear national framework for planning with all the key stakeholders represented on the National Workforce Programme Board and clear lines of communication to ensure all the associated programme boards are linked into the plans.

1.4 One of the main structural changes as a result of the paper was the creation of 28 Workforce Development Confederations (WDC) to plan effectively for all staff groups on a locality basis and to work collaboratively with other organisations so that data and workforce plans could be aggregated nationally. In April 2004 WDCs were integrated with SHAs to bring together capacity for service and workforce planning within one body.

1.5 The move to more integrated workforce planning has improved the links across organisations responsible for education and training. There are improved links into the Postgraduate Medical Deaneries with a greater clarity of data to help plan the number of consultants entering service in future years. The processes for commissioning education and training are much improved. There is a clear structure for commissioning that is based upon strategic planning, is built upon good relationships across Higher Education Institutions (HEI) and involves links to service to ensure that qualified trainees are “fit for purpose”.

1.6 The structures put in place by Health Service of all the Talents were further supported by a clear strategic direction laid out in the NHS Plan published in 2000 and the HR in the NHS Plan which followed in 2002. The two broad aims of these papers were to publish the improved workforce planning structures to create more staff, working differently.

1.7 The NHS Improvement Plan, published in June 2004, set out the way in which the NHS needs to change in order to become truly patient led. These changes are fundamental, they affect the whole system and the way individuals and organisations behave.

1.8 In 2005 Creating a Patient Led NHS outlined how the improvements in capacity, with increased numbers of staff and reductions in waiting times and improvements in mortality rates, would be matched by changes in the structures of the NHS.

1.9 The paper Creating a Patient Led NHS set out “the ambition for the next few years is to deliver a change which is even more profound—to change the whole system so that there is more choice, more personalised care, real empowerment of people to improve their health—a fundamental change in our relationships with patients and the public. In other words, to move from a service that does things to and for its patients to one which is patient led, where the service works with patients to support them with their health needs.”

1.10 This shift will have a large impact on workforce planning in the future as organisations implement the practical steps in moving care closer to the patient and see the influence of the growth of the Independent Sector to meet this need. Integrated planning will no longer mean integration across service, finance and workforce but also integration across Health, Social Care, the Voluntary and Independent Sectors.

2. ACHIEVEMENTS IN THE PAST FIVE YEARS

2.1 Healthcare organisations have made significant progress in developing a workforce with the right skills and experience to deliver patient care since the NHS Plan was launched in 2000. Workforce Planning for an affordable workforce is an integral element of all organisations’ Local Delivery Plans (LDPs) and a required component of all new developments and Private Finance Initiatives (PFI) schemes.

2.2 The NHS Plan established the Improving Working Lives (IWL) initiative, which provided NHS trusts with a measured framework to create well-managed and flexible working environments through policy making, good communication and partnership between staff and managers. It has led trusts to fundamentally look at the ways to offer better working conditions such as access to childcare, carers support, safety and security at work and flexible working opportunities. It has also given staff the opportunity to discuss different ways of working that accommodate both their outside interests and service needs.

2.3 The IWL initiative recognises that improving the working lives of staff contributes directly to better patient care. IWL is becoming a feature of every day management in the NHS and all NHS trusts have achieved the IWL standard at Practice level and over 300 NHS organisations have attained the Practice Plus level, which requires them to provide demonstrable evidence through partnership working that the working lives of staff in all staff groups are continuing to improve.

2.4 Key elements of IWL include:

| Flexible Working—including self-rostering, annualised hours, flexi-time; |
| Flexible Retirement—providing options for experienced staff to continue to work, sharing their skills and knowledge towards the end of their career; and |
| NHS Childcare Strategy—providing good quality, accessible and affordable childcare through the development of on-site nurseries, school clubs, holiday play schemes and local childcare co-ordinators. The strategy was developed to support the provision of quality, accessible and affordable childcare, following the recognition that this led to improved recruitment and retention. |
2.5 In the NHS the Healthcare Commission carries out an annual survey into staff views. This is a useful tool for identifying where improvements are necessary and it is available for use by all NHS trusts. The results for 2003, 2004 and 2005 are positive and show a trend of improvement, but there is further work to do to demonstrate that the concept of a Model Employer is embedded across the service.

2.6 Skills gaps and shortages have been met as more staff have joined the NHS year on year. Since 1999 the NHS workforce has grown by a total of 234,000 staff. This includes 23,000 more doctors, 68,000 more nursing staff and 11,000 Allied Health Professionals. Vacancy rates have fallen steadily as these staff have entered service. The successful implementation of EWTD 2004 has seen a significant number of staff working fewer hours. For example, the majority of staff now work fewer than 48 hours and doctors in training work no more than 58 hours.

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RETURN TO PRACTICE

How return to practice midwives working within the Gloucestershire Hospital NHS Foundation Trust (Gloucester Royal site) were supported.

In the last year, Gloucestershire Royal has supported two midwives returning to midwifery practice each with varying requirements. One midwife had been out of practice for 10 years but had done a Return to Practice course. The other had not done the required amount of hours needed to maintain her registration within the given previous three years and was advised by the local University to do the Return to Practice course.

Before embarking on the clinical part of the programme, the midwives discussed their needs and requirement with either the research and practice development midwife or one of the midwifery managers.

A specific plan was then drawn up to suit the midwife (hours to suit family life/commitments and other places of work commitments), ensuring that all areas of midwifery practices were covered, for example high risk delivery suite, community and midwife-led birth unit.

Each midwife was given a named supervisor with whom they met regularly during the course, with the opportunity of meeting at any time to discuss practice or other issues. Advice and help was also given with their essays, particularly content, style and relevance.

OUTCOMES

Both midwives have since been successfully employed within the trust. The success of these midwives is due to their motivation, enthusiasm and flexibility along with a well planned, interesting and appropriate programme.

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2.7 Improved planning processes and increased staff numbers are not enough on their own to cope with the complex structures across health and social care. A range of initiatives has been required to develop the flexibility, new skills and new ways of working and productivity necessary to deliver world class healthcare. New programmes, such as Agenda for Change and Modernising Medical Careers (MMC) have put the building blocks in place for organisations to develop skilled multidisciplinary teams. In addition great strides have been taken to improve the working lives of NHS staff and make the NHS a much better employer.

2.8 Some initiatives have served their purpose and will not have a big impact in the next five years. International recruitment was not intended to be a long-term strategy and since 2005 there has been a steady decrease in the volume of international recruitment in all sectors. Increasingly as the year-on-year increases in training emerge, the health service will be more self-reliant on UK trained doctors, nurses and other healthcare professionals. International recruitment will be used sparingly to target specific strategic areas, for example, to bring GPs from Germany, Italy and Spain into under-staffed communities in England. Other initiatives are now in the mainstream of good HR practice after a period of central pump priming and support. For example, encouragement to employers to provide access to flexible working and return to practice.

2.9 In December 2005 the Department of Health launched A national framework to support local workforce strategy development. This document brought together all of the initiatives in a format to help HR Directors in the NHS and Social Care integrate their strategy for local staff development. The document covered six main areas:

- Capacity and Skills
- Working Flexibly
- Skills Escalator
- Model Employer
- 10 High Impact Changes in HR
- Integrated Planning
2.10 The aim of the document is to help organisations devise simple strategies to build upon the achievements of the last five years but take the initiatives further to create a workforce that is flexible, productive and affordable. There is no “one size fits all” answer to the current complex staffing issues, organisations need to devise local solutions based upon their own service and financial development. These plans are supported by national development programmes that share the results of pilot projects and highlight best practice.

2.11 It is only by continually developing the workforce strategy that the NHS will be in a position to solve the current issues in workforce planning and respond to future challenges in delivering high quality patient care.

2.12 The Department of Health and Workforce Review Team (WRT), who lead on workforce planning across the health care workforce, are developing a generic workforce-modelling tool, known as the “Christmas tree” model. This will allow national and local workforce planning by individual, local organisations to assess skills needs and future workforce requirements across levels rather than professions. In turn, this will support the development of competency-based workforce planning across the whole healthcare workforce: determining the skills and competencies needed to deliver services and defining these by care group and pathways, rather than specific healthcare professions.

2.13 This modelling approach enables the roles of the doctors of the future to be captured as part of the multi-disciplinary teams serving patients. Planning the medical workforce can then focus on those roles that only doctors can deliver. Below is a Christmas tree model which maps the medical workforce within the overall healthcare workforce of the NHS.

2.14 Total NHS workforce

3. **HOW WORKFORCE PLANNING IS UNDERTAKEN**

3.1 Workforce planning in the NHS aims to provide the future workforce needs of the service matching supply and demand. The NHS is very labour intensive with around 60% of budgets spent on staff costs. Training times vary across different professions. It takes up to 15 years to train a medical consultant and up to six years to train an experienced senior nurse, therapist or scientist. Thus any workforce planning has to take account of long term trends in healthcare if it is to meet the needs of patients in the next five to 10 years.

3.2 Robust workforce planning needs to bring together a “bottom up—top down” approach to the planning process. Each organisation needs to plan for its own workforce needs, based on their strategic service, financial and local workforce plans. Plans need to be shared widely to ensure that the local health economy’s requirements are met. These plans then need to be aggregated to ensure their wider coherence and that nationally there is sufficient provision for smaller specialties.

3.3 Each PCT, practice, Trust and SHA has a workforce plan that is shared via the Local Delivery Plan. These plans include the service, financial and workforce plans of the organisation for the next three years. SHAs are charged with monitoring these plans and ensuring equity of provision across the health economy. SHAs work across their patch to coordinate the planning activity via a network of workforce planners to ensure that emerging trends are incorporated in the LDP.
3.4 Service wide planning

3.5 Workforce Planning across local health economies operates within a streamlined framework of national analysis and support.

**WORKFORCE DELIVERY AND STAKEHOLDER ARRANGEMENTS**

The **Social Partnership Forum** comprises representation from the major health unions, management bodies and the Department of Health. It was set up in December 2002 and is the stakeholder group for the Workforce Programme Board.

The **Workforce Programme Board** was established in May 2003 to review and oversee the delivery of workforce strategy. The membership of the board includes workforce leaders in DH and SHAs, as well as key partners such as Skills for Health and NHS Employers, and reflects the strategic role played by the DH as a result of Shifting the Balance of Power and the responsibility of SHAs for implementation and delivery.

The **National Workforce Group (NWG)** meet regularly and influence policy and practice in planning the health and social care workforce of the future, with the view that objectives can be better achieved by acting collectively. The National Workforce Group has strong representation on the Workforce Programme Board and agrees the action required to deliver the workforce strategy. Membership is drawn from the Workforce Development Leads of SHAs and WDC Chief Executives (where applicable), as well as the Department of Health and other key partners.

The **Workforce Review Team (WRT)**, is hosted by Hampshire and IOW SHA on behalf of the NHS. Its role is to synthesise workforce supply and demand intelligence provided by a variety of national and local organisations including SHAs and professional bodies. Its analysis of the intelligence is gathered and used to develop a variety of options for SHAs to use in planning for an affordable workforce with the right skills, in the right numbers to meet local service plans.

**NHS National Workforce Projects’ (NWP)** works very closely with the Workforce Review Team (its “sister” organisation), informing and using their analysis. Its role is to help provide the NHS with the skills, transfer of knowledge, best practice and information to support effective local workforce planning. NWP aim to eliminate potential duplication to work across the service by providing a single credible source for knowledge management and to develop a more sophisticated approach to workforce planning with a greater integration of service and financial planning.

**Skills for Health** is a Sector Skills Council (SSC) with a UK wide remit. Their role covers all healthcare employers—including those in the NHS, independent and voluntary sectors. Skills for Health was established in April 2003. It is licensed by the Department for Education and Skills as the SSC for the health and healthcare sector. The aim of Skills for Health is to help the whole sector develop solutions that deliver a skilled and flexible UK workforce in order to improve health and healthcare. Skills for Health are members of the Workforce Programme Board and the National Workforce Group.

**NHS Employers** is the employers’ organisation for the NHS in England, giving employers throughout the NHS an independent voice on workforce and employment matters. Their goal is to make the NHS an employer of excellence. NHS Employers are members of the Workforce Programme Board and the National Workforce Group.
3.6 The Workforce Programme Board sets strategy and is responsible for the delivery of major workstreams such as Agenda for Change. It is informed by the Social Partnership Forum which is its stakeholder forum.

3.7 The board oversees delivery through individual workstream boards that concentrate on specific areas. These involve all interested parties in the NHS family. Local delivery is facilitated through the National Workforce Group where SHAs come together with the DH and partners. The work of NWG is supported by a broad range of organisations including WRT, NWP and Skills for Health.

3.8 Funding education, training and development. There is significant central investment in the funding for education and training of the future workforce via the Multi Professional Education & Training (MPET) Levy. This funding provides pre-registration training for the main healthcare professions and supports the investment made by employers to develop the skills and education of their staff.

3.9 MPET funding is allocated to Strategic Health Authorities (SHAs) at the start of the financial year although money for new training posts, particularly for postgraduate doctors, may be allocated in-year. Where new ways of working lead to the development of new roles MPET can also support training. An example of this would be the burgeoning numbers of assistant practitioner roles currently being developed. The costs of training for such new professionals may in differing circumstances come through DfES Foundation Degree funding routes, through investment from employers and through investment by SHAs using MPET development money. The challenge is to ensure cohesion in funding streams and to find new ways of allocating the MPET budget so that money for development is not squeezed out by existing contractual commitment for traditional three year diploma and degree courses.

3.10 The NHS as a Model Employer. There is a wealth of research evidence which demonstrates clear links between good employment practices and business outcomes. Creating an environment where staff are valued, rewarded, appropriately trained and developed, regularly appraised and properly managed has an impact on people who use services and their carers. Model employers are also more likely to attract and retain high-quality staff and are also more likely to have high-performing and motivated staff who are more flexible and take less time off work. Becoming a model employer is not the result of one initiative, it is made up of several linked projects. Within the NHS the Improving Working Lives initiative promotes equality and diversity policies and includes the NHS Childcare Strategy. As part of the initiative there is zero tolerance of violence and harassment for all staff within the NHS. Underpinning all of the employer initiatives is clear staff involvement and staff partnerships to create a culture of continuous improvement.

3.11 A range of workforce supply initiatives have supported local NHS organisations to ensure that the NHS workforce continues to be sufficient to meet local service needs. These recruitment and retention initiatives have been effective in the past five years as the NHS workforce has increased significantly. The current priority for workforce supply policies is balancing supply and demand, whilst ensuring that we maintain the profile of a career within the NHS.

3.12 National initiatives have included:
- promoting careers in the NHS through the NHS Careers service;
- national and local recruitment campaigns;
- attracting former staff back to the service;
- improving retention by continuing to make the NHS an employer of choice;
- offering flexible retirement schemes and flexible employment opportunities; and
- providing access to good quality, accessible and affordable childcare.

3.13 Two current initiatives are at the forefront of this policy.

3.14 NHS Careers is an interactive service, managed by NHS Employers on behalf of the Department of Health, which provides information on careers in the NHS through a national call centre and website at http://www.nhsicareers.nhs.uk/.

3.15 NHS Jobs was created in 2003 as a new electronic recruitment internet site that provides information on vacancies including an instant online application process, meaning that job-hunters can apply for jobs anywhere in England. NHS Jobs is currently funded by the Department of Health and is free to both the employer and the applicant. Over 510 NHS organisations are now participating in the service and, on average, over 3,500 jobs are live on the system at any one time. The website address is www.jobs.nhs.uk.

3.16 International recruitment has been an important part of the strategy to tackle key skills gaps and “hard-to-fill” jobs over the last five years. Local Delivery Plans will inform the approach to tackling the workforce supply gaps in the future. International recruitment, carried out in accordance with the Code of Practice for the international recruitment of healthcare professionals, is likely to have a smaller role in future but will be important in some of the most challenging recruitment areas such as social work and psychiatry.

3.17 Any development of international recruitment in the future would need to take account of international competition for healthcare professionals. In the past different country’s health economies have expanded at different times. For example, the USA are advertising widely for healthcare roles as the UK international recruitment slows. In the future the effect of the demographic shift in populations across
3.18 A large organisation such as the NHS needs to ensure that the NHS has the leadership and management skills it needs to deliver the depth and breadth of reform in health services, particularly with respect to sustainable improvements in quality and value. Put simply the NHS needs to:

- Develop leaders so that they have the skills and competencies to deliver—with a particular focus on increasing productivity and financial capability.
- Ensure greater learning and skills transfer between leaders from across the broader health and social care system—including the private and third sectors and local government.
- Ensure we are developing and retaining talent at all levels.

3.19 The vast majority of management training and leadership development takes place locally, organised around clinical networks, teams and individuals.

3.20 There are still issues to be addressed in workforce planning. The section above outlines the planning process and the steps that organisations can take to ensure integrated planning takes place. It should be emphasised that whilst we have good processes in place, the capability and capacity to undertake detailed planning varies across the NHS. Although the LDP process is in place there are still organisations where service, finance and workforce plans are linked only in the short term and do not contain an integrated long term strategy. The new ISIP process should help these plans develop further, but this integration will need to be driven by the new organisational structures outlined in *Creating a Patient Led NHS*.

3.21 The emphasis on performance targets in previous years has achieved measurable success but has not created a culture where long term solutions to issues in 2010 can be carried forward. There is a growing realisation across health and social care that action needs to take place today to solve the complex challenges that face organisations in the future. The initiatives outlined in section 4 will support the changes that need to take place but these changes need to be supported by a culture of integrated long term planning within organisations. The short term pressures will not disappear from the NHS and indeed are increasing but successful organisations will balance these pressures and still continue to develop longer term solutions.

3.22 Some NHS organisations are caught up in short term fire fighting due to structural, geographical or financial pressures that have existed for many years. These organisations may struggle to implement the large scale systems change required to meet the challenges in the medium term. These organisations will require support to implement the practical lessons from the many pilot sites and initiatives to develop the future flexibility of the workforce.

4. **Issues Impacting on the Health and Social Care Workforce**

4.1 The current processes for workforce planning have been outlined above and the need to develop a strategic framework for workforce planning has been highlighted. There are a range of issues facing the NHS at the current time that demand an integrated local response.

4.2 Issues such as the European Working Time Directive (EWTD) and demographic shift in the population are external drivers that affect all of the workforce in the UK but have a large impact on the NHS as the employer of 1.3 million staff. The demographic shift in the working population will have an increasing effect in the next five years. The combination of increased longevity, declining birth rate and the “baby boom” generation entering retirement age will all combine to shrink the available workforce of traditional working age. The effect of this change has been well documented and is already included in the national modelling of the workforce. The implications of this demographic shift need to be taken into account by organisation’s recruitment and retention policies. Initiatives to attract more mature entrants and flexible retirement options to retain the skills of the over 50s (and increasingly the over 60s) will become more important. It will also be crucial to ensure flexible working practices are fully utilised to maintain workforce capacity. Details of the demographic issues facing the UK are outlined in Annex 1.

4.3 The European Working Time Directive 2009 builds upon existing legislation but goes further and requires a rethink of how a service to patients is to be provided with a 17% drop in the hours doctors in training will work. The NHS health reform is supported by Payment by Results, Choice and the development of a plurality of providers. The workforce strategy builds upon this with programmes to develop flexibility in the workforce through Model Employer, Modernising Medical Careers, Agenda for Change, the new consultant contact and the new GMS contract for GPs. Elements of these linked developments are outlined in detail in section 4 but the effect of these initiatives will be to reward those organisations that are able to put in place streamlined clinical pathways that put the patient first.

4.4 This paper highlights six ways that organisations will work to develop an integrated strategy.
4.5 Planning for service priorities

4.5.1 The Department of Health has established four Workforce Boards to develop solutions and support the workforce needed to deliver the Public Sector Agreements (PSA). The boards cover services for:

- Health Improvement
- Long Term Conditions
- Urgent Care
- 18 Week Patient Pathway

4.5.2 Each of the boards is working with the National Workforce Group (NWG) around the identification of the new roles which will have the most impact in delivering the PSA targets and the development of support tools to help local commissioners, providers and workforce planners.

4.5.3 Health Improvement. This board covers all the workforce work programmes arising from the Choosing Health White Paper. Coverage includes all the contributing disciplines: health improvement, health protection, health information and academic public health.

4.5.4 Long Term Conditions. This board has representation from key stakeholders across health. The board has collated best workforce development practice across different organisations in support of the DH Long term conditions model. The aim is to improve the care of long term conditions in primary care and community settings, with the appointment of 3,000 community matrons and to reduce the overall emergency bed days by 5%.

4.5.5 Urgent Care. The main aim of the board are to reduce the overall emergency bed days by 5% by 2008 and to improve access to urgent care.

4.5.6 18 Week Patient Pathway. This board has representation from key stakeholders across health and social care. The target is to decrease the waiting time for a patient pathway from referral to treatment to under 18 weeks by 2008. There are currently a range of pilot sites and development projects underway to help organisations develop their services.

4.6 Planning for change and productivity

4.6.1 Productive Time aligns the modernisation strategies for people (pay and workforce reform), process (10 High Impact Changes) and technology (NHS Connecting for Health) in order to maximise service improvement recognising that these modernisation strategies will be most effective if implemented in an integrated way to meet both national and local service improvement expectations.

4.6.2 Within the NHS, productive time initiatives are designed to increase the time spent by health care professionals (clinicians, managers and administrators) on activities integral to delivery of improved services for patients. Improving productivity and efficiency underpins service improvement over the three years (April 2004 to March 2008). Productive time will contribute approximately £2.7 billion of the expected cumulative annual efficiency gains of £6.5 billion.

4.6.3 The 10 high impact changes in HR are outlined in Annex 2.

4.6.4 The Integrated Service Improvement Programme (ISIP) is the delivery vehicle for Productive Time to develop local integrated plans. ISIP supports integration across a number of dimensions and places workforce at the heart of reform. ISIP consist of:

- Integration of the major “enablers of change”: workforce reform, operational process improvement, technology solutions and infrastructure (estates and facilities). Typically, these have to be used in combination to maximize the benefits of investment in change. The ISIP process and guidance helps to integrate the deployment of all these enablers of change.

- Integration across local health communities: primary care, acute care, mental health, social services and ambulance services. Often a patient journey moves across NHS organisations which have to collaborate to provide fast, efficient, safe and effective care. For care services to be transformed to meet all priority objectives, there needs to be collaboration across organisations which serve a local population. Hence ISIP focuses on health economies not individual care organisations.

- Involvement of all professions in the transformation of the way services are provided. Change needs to involve clinicians of all disciplines, including nurses, allied health professionals and scientists. It needs to involve managers and those with specialist skills in, for example, workforce role reform, IT and finance.
Assistant and advanced practitioners in radiology, City Hospitals Sunderland

Implementing assistant and advanced practitioners in radiology at City Hospitals Sunderland (CHS) has advanced the role of the radiographer within the fluoroscopy on the barium enema service and as a result the fluoroscopy room is used much more effectively. It has also had a dramatic effect on waiting times for routine barium enemas, reducing them from 30 weeks to less than two weeks in the space of 11 months. Increased activity was achieved because these radiographers were given sessions to perform and report barium enema lists, some of which were dedicated radiographer lists, while others were lost sessions created due to radiologist leave.

Barnsley heart diagnostics

By reorganising their way of working, a team of cardiac physiologists have helped to cut the echocardiography waiting times from four months to just two weeks. This was achieved by training some of the junior grade physiologists to carry out exercise and lung function tests, freeing up more senior staff to carry out the echocardiography testing. A healthcare assistant was introduced to prepare patients for screening and return them to the ward afterwards. This has helped cut delays as the reports can be written up while patients are being prepared or taken back to the ward.

4.7 Planning for new technology

4.7.1 NHS Connecting for Health is delivering the National Programme for IT to bring modern computer systems into the NHS which will improve patient care and services. Over the next 10 years, the National Programme for IT will connect over 30,000 GPs in England to almost 300 hospitals and give patients access to their personal health and care information, transforming the way the NHS works.

4.7.2 The National Programme is central to the Government’s policy goals of changing the delivery of health care to one that is citizen-led and responsive to the needs and wishes of patients and their carers as set out in the NHS Plan.

4.7.3 Technological change needs to be taken into account in considering future demand for the workforce. Technological advances will enable organisations to be much more flexible in the provision of services in the future. The vision for future services outlined in the 2006 White Paper will take advantage of more compact and comprehensive patient testing equipment to provide an integrated near patient diagnostic service.

4.7.4 Currently future workforce plans take account of known research developments that may affect service delivery but we are on the threshold of another wave of innovation that will alter how services are delivered in the future. Developments in gene therapy and certain cancer treatments will mean that whole sections of service will have to change the way that they work. In recent times the same has happened within cardiac surgery with many conditions now being treated as day cases within radiology departments as the technology to perform procedures without major surgery improves.

4.7.5 The Electronic Staff Record (ESR) will offer a major step forward in workforce planning when the system is fully rolled out. This major IT project replaces the fragmented HR and finance systems in Trusts and SHAs with one single unified system. Workforce planning data will be available through the data warehouse and allow planners to work with and share accurate validated data from across the health economy.

4.8 Planning for a more flexible workforce

4.8.1 The NHS used innovative approaches to meet compliance with the European Working Time Directive from August 2004 for doctors in training. In 2002 the Department of Health funded 20 WTD pilot projects, and four Hospital at Night (H@N) pilots each testing innovative ways of delivering services while complying with the requirements of the WTD legislation. For most, this involved some combinations of new roles for non-medical staff, new rotas and working patterns for doctors (consultants as well as doctors in training) and new service delivery patterns.

4.8.2 The Hospital at Night model consists of a multidisciplinary night team, which has the competencies to cover a wide range of interventions but has the capacity to call in specialist expertise when necessary. This contrasts with the traditional model of doctors in training working in relative isolation, and in specialty-based silos. The project was a partnership between the Department of Health, the NHS Modernisation Agency, the British Medical Association and the Royal Colleges.

4.8.3 The NHS needs to build on successes to date in meeting the 2004 target and ensure that arrangements are sustainable, linking in with new ways of working, modernising medical careers and finding ways to improve productivity and efficiency whilst enabling doctors to enjoy a good work life balance.
4.8.4 Maintaining good quality medical education and patient services and delivering key priorities including waiting times is made more difficult by restrictions on working patterns from the SiMAP/Jaeger judgments, which has led to a rapid increase in shift working, replacing traditional resident on-call rotas, and inflexible rest breaks. Consequently, the EWTD 2009 target will have a major implication on workforce planning and will lead to new ways of working for the NHS. Work is well underway on planning and preparation for 2009. In the summer of 2005 NWP was appointed the lead organisation to support the NHS in finding and implementing solutions to WTD 2009. Its aim is to provide the NHS with models that can be adapted across the service, facilitate new solutions, address barriers to WTD compliance and ensure that solutions to WTD compliance are sustainable in the long-term.

4.8.5 Modernising Medical Careers (MMC) aims to improve patient care by delivering a modernised and focused career structure for doctors through a major reform of postgraduate medical education. It aims to develop demonstrably competent doctors who are skilled at communicating and working as effective members of a team able to meet the needs of patients. To this end, trainees’ progress will be through structured programmes of training following competency-based curricula.

4.8.6 This model provides the opportunity to ensure that the majority of service will be delivered by fully trained doctors. The aim is to provide patients and the NHS with a workforce that is safe and demonstrably competent and that has the flexibility to meet service needs.

4.8.7 The current system encompasses a centralised pay framework linked to skills, competencies and knowledge for a majority of staff. For doctors the new consultant contract uses the job planning structure to ensure the service provided fits with the needs of commissioners. The existing system is designed to be “equal pay proof”, although some risks remain in the different pay systems between doctors and other staff.

4.9 Planning for new staff roles

4.9.1 The National Practitioner Programme (NPP) co-ordinates a range of pilot projects which introduce new roles and which were started by the Modernisation Agency (MA). With the devolution of MA programmes to the NHS, the practitioner projects have moved to new host organisations. NPP is ensuring that the practitioner projects stay linked together, share information, identify common needs, address common policy issues, such as regulation, and develop a communication strategy. The NPP is hosted by North West London Strategic Health Authority.

4.9.2 The new roles include Medical Care Practitioner, Emergency Care Practitioner, Surgical Care Practitioner, Anaesthetic Practitioner and Endoscopy Practitioner. Some projects are well ahead and already making an impact on the way services are delivered. For example there are now over 700 Emergency Care Practitioners improving access to urgent care and bringing services closer to the patient.

4.9.3 These new ways of working reflect the aims of the NHS Improvement Plan to modernise the service by ensuring that staff talent and skills are recognised and for registered staff to practice in roles with increased breadth and depth.

4.9.4 The Large Scale Workforce Change Team is hosted by NHS Employers. Its purpose is to build and develop HR capacity within the NHS, focusing on the development and spread of an adaptable and flexible workforce that can deliver benefits that are measurably better for patients, better for staff and better for organisations, in respect of improved efficiency and productivity.

4.9.5 Current programmes include the development and implementation of:

— Maternity Support Worker roles and new ways of working across maternity services.
— A wide range of new and extended roles across children’s services to meet NSF targets.
— New ways of working in integrating health, social care and education.
— The maintenance and distribution of the national NHS modernisation tools to SHAs and to local service providers, providing training and guidance on the use of the tools.

4.9.6 The Care Service Improvement Partnership (CSIP) is hosted by the National Institute for Mental Health (NIHME) and is funded by the Department of Health. The purpose of CSIP is to support reform of the NHS and local government services and help to create and implement effective policy through a joined up approach across key stakeholders. CSIP maintains very close links with the Department for Education and Skills (DfES).

4.9.7 CSIP’s role provides an opportunity to help implementation across health and social care and to ensure that the necessary links are made to the work of other Government departments. CSIP’s regional development teams provide a local resource to facilitate whole system change at a grass roots level with workforce as part of the whole rather than an add on.
4.10 Improving planning and skills

4.10.1 National Workforce Projects (NWP) has created an accredited planners development programme designed to ensure skills are built up in this field—this will lead to the first postgraduate certificate in strategic workforce planning. This development work is seen as crucial if the NHS is to improve workforce planning in the future as the people in the service need to have the skills to deliver the improvements. A step-planning process has been created to facilitate good planning and resource packs produced to guide trusts through planning in key service areas that link into service priorities around provision of care such as long-term illness and the 18 week patient pathway.

4.10.2 The practical resources NWP provide are designed to be building blocks and guidance for the NHS that have been tested and proven in the field. Many of the tools facilitate the sharing of data across organisations. Benchmarking in this way is essential to long term workforce planning as it ensures that organisations can compare, contrast and cooperate on sustainable workforce plans rather than work in isolation. The need for this benchmarking has been a recurring theme in national NHS guidance issued on workforce planning in recent years.

4.10.3 Further details of the resources available to workforce planners in the service and each of the training programmes is available at www.healthcareworkforce.org.uk

Service redesign in Audiology

Reducing waiting times in audiology was a key challenge for the Royal Berkshire and Battle Hospitals NHS Trust. In March 2002, more than 2,000 patients were on their waiting list for hearing assessments and hearing aid fitting—some had been waiting more than two years—with a further 20 being added each month. Did Not Attend (DNA) rates for appointments were high, ranging from 15–35%, and staff morale was low.

In order to begin tackling the situation, and with the full cooperation of the audiology team, the trust undertook a range of initiatives as part of a whole system review of audiology. Their starting point was to examine the diagnostic and treatment processes in order to identify and remove unnecessary stages so as to create more efficient care pathways. They also looked to dismantle professional boundaries between staff, and redesign roles, with emphasis placed on education, training, and continuing professional development.

The working day was extended by starting patient contact time earlier and finishing later, supported by assistants who set up rooms, etc. During specific “waiting list initiatives”, they also extended to working week, with staff volunteers working evenings and weekends. The trust worked closely with patients to build confidence in the assessment system, negotiating appointment times and telephoning them the day before the check attendance, a collecting feedback on services through a patient satisfaction questionnaire. The trust also worked in partnership with local voluntary sector organisations including the National Deaf Children’s Society and the RNID to ensure that their knowledge and experience contributed to the modernisation process.

The result of all this activity has been extremely positive. Since January 2004, all patients have been seen within 18 weeks, DNA rates are now below 4% staff retention is high, and patients report satisfaction rates over 90%. In order to maintain the momentum, the service is continuously reviewed and changes made to ensure improvements are sustainable. The trust also carries out quarterly analysis of patients feedback and comments.

The head of audiology at the trust says that large gains in efficiency, reduced waiting times and high staff morale have been achieved by “working smarter and providing a high quality service that is informed by user participation and choice”.

5. Workforce Planning for Our Health, Our Care, Our Say and A Patient Led NHS

5.1 Developing a service built around patients

5.2 The NHS has responded to the needs of the patient and has started to introduce new ways of working and services that better meet the patient’s needs. This has been developed further in the new White Paper: Our Health, Our Care, Our Say: a new direction for community services which sets out a direction to deliver a greater proportion of services at a time and location that is more convenient to the patients.

5.3 System Reform, as elaborated in Health Reform in England aims to set in place local freedoms and incentives “to achieve an NHS that is self-improving”. The initiatives to achieve this end include: patient choice, wider range of providers, more freedom for hospitals, stronger commissioning, new patient mechanisms and independent inspection of quality. These initiatives should ensure that the NHS is led by the needs and wishes of patients and supported by staff with an in-built dynamic for continuous improvement. “The reforms will give doctors, nurses, managers and other NHS professionals incentives to help drive improvements in health and healthcare and to increase responsiveness to patients.”
5.4 The reforms are interrelated and mutually reinforcing. There are four connected streams of work:

- more choice and a much stronger voice for patients (demand side reforms);
- more diverse providers, with more freedom to innovate and improve services (supply side reforms);
- money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve (system management reforms); and
- system management and decision making to support quality, safety, fairness, equity and value for money (system management reforms).

5.5 Organisations workforce strategies must be adapted to match the vision embodied in System Reform. The next five years have significant implications for workforce planning. We are moving from a rapid expansion in staffing and investment in healthcare to a “steady state” of investment and a focus on productivity. We have put in place the building blocks of Agenda for Change, MMC and the Competency Skills Framework necessary to support a flexible workforce. We have many initiatives and projects aimed at sharing best practice across organisations to help them develop an affordable flexible workforce that delivers the needed productivity and service redesign.

5.6 The challenge is to create the skills and competences needed in the future workforce where there is greater focus on prevention and early intervention, where people have greater choice and services are provided closer to home by a bigger range of providers from across health and social care.

5.7 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 and the PSA targets.

5.8 Workforce planning in the next five years will develop in three ways.

5.8.1 Competency based workforce planning

5.8.2 The work on developing and listing the competencies for each role in the NHS by Skills for Health is vital to future workforce planning. The growth in new roles has blurred the previous professional boundaries and a new language to describe these roles and teams is required. The Career Framework for Health is a tool being developed by Skills for Health which enables local health organisations adopt a competence based approach to local workforce planning. The aim is to map the whole healthcare workforce. This will enable workforce and service planners to see what competences will be needed to deliver a professional role based model.

5.8.3 As the data from the roll out of ESR becomes available the ability to plan with robust data will be much improved. This together with improved workforce planning models currently being developed will mean that workforce plans will be able to reflect the strategic needs of the organisation much better.

5.8.4 The training programmes to develop the skills and competencies needed by workforce planners themselves will be in place to take advantage of all these new planning tools and techniques. The use of the electronic Knowledge and Skills Framework for all staff will enable education commissioning planning for the future workforce to be based upon real needs of individuals rather than a collated general training needs analysis.

5.8.5 In addition the language of planning will be much further developed with Skills for Health developing a full description of the skills and competencies for each role in each profession. The ability to implement competency based planning will offer a far greater range of scope to planners than the existing professional role based model.

5.8.6 Improved organisational strategic planning

5.8.7 The planning processes already in place at a local and national level will start to have their full impact with the implementation of the ISIP process that will allow truly integrated development of service. At the heart of ISIP is the need for effective long term strategic plans for the organisation that can be shared with the wider health community. Only when the future plans are integrated across Health, Social Care and the Independent Sector will organisations be able to solve the challenges set by the changes over the next five years.

5.8.8 One fundamental change will be better integration between those working in the NHS and those working in social care. A better-integrated workforce—designed around the needs of people who use services and supported by common education frameworks, information systems, career frameworks and rewards—can deliver more personalised care, more effectively.

5.8.9 The 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 Department of Health will consider and develop plans to achieve this in line with proposals to align service and budgetary
planning across health and social care and in consultation with stakeholders. Workforce issues will also be fully integrated in service improvement planning by the Care Services Improvement Partnership and the NHS Integrated Service Improvement Programme.

5.8.10 Increasingly, employers will plan around competence rather than staff group or profession. To encourage integration, we will bring skill development frameworks together and create career pathways across health and social care. Staff will increasingly be expected to have the skills to operate confidently in a multi-agency environment, using common tools and processes.

5.8.11 Skills for Care and Skills for Health, in partnership with other relevant organisations, will together lead this work so that staff can develop skills that are portable, based on shared values, recognised across the sectors and built around the needs of patients and service users.

5.8.12 Improved clinical pathways that focus on the patient

5.8.13 The need to redesign clinical pathways to meet the 18 week wait initiative and the shift to primary care are well known and examples of best practice are available. The challenge will be to implement these changes across all of the patient pathways and integrate them with the support structures in GP surgeries, Social Care provision and the growing Independent Sector. The implementation of best practice will require a much bigger shift towards multi skilled teams than at present, although a majority of staff in the future will remain in the traditional professions supported by new roles and integrating new ways of working across all staff.

5.8.14 Although these strands of work are already in place, workforce planning in the future will also be more complex. Drivers such as EWTD 2009 and the need to demonstrate productivity or quality improvements will change how teams are structured. The full implementation of PbR will alter what services an organisation offers and with what staff support. The 2006 White Paper will effect where service take place with the growth of IS and the need to deliver patient centered care.

5.8.15 For instance the White Paper has highlighted the need for scientists and scientific services to be provided closer to patients to provide improved access and turnaround times. We are working on a framework to support the introduction of scientists working in primary care. However, to ensure that quality services in many areas of diagnostics and some therapeutics are provided it is critical that the HCS workforce is recognised and included in any planning and commissioning arrangements—for example in equipment management.

5.9 These are only a few of the interrelated issues facing the NHS and all of them will combine to effect how care is delivered in the future. NHS organisations are still charged with getting workforce plans correct all of the time with no under/over supply. Organisations will need, not only to develop workforce plans that incorporate the firm “known” impact such as EWTD but also variable “unknown” outcomes such as the speed of the shift into primary care.

5.10 Looking to the next five years, one thing is very clear. The investment and reform we have made in the NHS workforce puts us in good stead for dealing with A patient led NHS, where organisations will need to meet the challenges of patient choice, be able to compete in an environment of plurality and provision and drive productivity and efficiency in an era of lower financial growth. However, this will not be achieved unless all organisations improve their capability and capacity to undertake workforce planning and development. PCTs, Practices, Trusts and SHAs will need to base their service and financial plans on a clear strategy for the future direction of their workforce that creates the right skill mix in the workforce for the next five years. Only organisations with a skilled, flexible workforce, where people are their greatest investment will succeed.

Department of Health

15 March 2006

Annex 1

DEMOGRAPHIC IMPLICATIONS FOR WORKFORCE PLANNING

The demographic shape of the western world is changing due to the combination of increased life expectancy, falling birth rates in developed countries and the effect of the “baby-boom” generation coming towards retirement age.

With each generation on average living longer than the last, and this trend continuing for the current generations, UK government actuary figures predict that a child born in 2000 has a life expectancy of 81 years\(^1\). These figures are by their nature averages and in future years a significant portion of the population will be living well into their 90’s and beyond.

\(^1\) Source: Government Actuary Department, UK.
These demographic issues will impact on the health and social care workforce in many ways. In addition to the impact of increased life expectancy on the provision of healthcare, the age of the workforce providing the service will also rise. The fall in birth rate will provide less young workers to the labour market than in previous generations whilst changes to the current pension arrangements include the expectation that people will work on past the current retirement age of 60.

In addition, currently, 60% of adults in England have a long term condition, and 80% of GP consultations relate to long term conditions. The demographics of the population show that by 2020 incidence of long term conditions in the 65+ age range will have doubled.\(^2\)

In addition a larger proportion of staff will be in their 50’s and 60’s which will have implications for staffing front line services and health and safety issues such as lifting and handling of patients. This is not saying that older staff are any less able but it is also unrealistic to expect staff to stay within a demanding role for 40 years without it taking its toll. However, it may also mean that those people providing front line services to those with long term conditions may indeed be living with a long term condition themselves. Therefore the staffing structure of health and social care organisations that delivers care to patients with long term conditions will need to take into account these demographic issues.

The demographic changes are one element of the wider changes within health and social care that will combine to fundamentally alter the delivery of healthcare services in the future. Together with the growth of the independent sector it will alter what care is delivered where in the future. The demographic changes combined with the Working Time Directive (WTD) 2009, which will limit staff working hours to a maximum of 48 per week, will affect the number of staff skills available to any organisation. Other developments such as the focus on productivity, payment by results and financial settlements after 2008 will also influence what care is delivered where and by whom in the future.

All of these initiatives will impact on the service in the next 3–5 years and will require a flexible workforce that can be described in terms of skills and competencies, rather than rigid professional boundaries.

Importantly other changes such as agenda for change, improving working lives (IWL) and competency frameworks will combine to help organisations to create and deliver this flexible workforce. Organisations will require long term plans that map out the effects of all these changes and work through the right skill mix for the delivery of services in the future. This long term plan then needs to inform and shape the workforce commissioning decisions, ISIP and local delivery plans within each organisation to bring about the workforce of the future.

Annex 2

THE 10 HIGH-IMPACT CHANGES:

_A National Framework To Support Local Workforce Strategy Development—A Guide for HR Directors in the NHS and Social Care_

Improving organisational efficiency

1. **Support and lead effective change management**—Organisations can expect to undertake major re-organisation every three years according to some experts. Many re-organisations fail to meet original objectives, which has a high cost in terms of both employee and customer satisfaction. The HR function has a major contribution to make.

2. **Effective recruitment, good induction and supportive management**—These are strategies that reduce turnover rates, save money and prevent service disruption. Some studies estimate that the cost of turnover can be 118% and up to 156% for specialist staff. As many as 85% of UK organisations in a Chartered Institute of Personnel and Development (CIPD) survey found filling vacancies difficult.

3. **Develop shared service models and effective use of IT**—Shared service arrangements for things such as payroll can achieve major efficiencies with savings of between 20 and 40% possible. Ashford and St Peter’s NHS Hospitals in Middlesex and Surrey reduced advertising spend by 60% through e-recruitment.

4. **Manage temporary staffing costs as a major source of efficiency**—East Kent Hospitals NHS Trust saved over £3.5 million in a year by implementing NHS Professionals.

5. **Promoting staff health and managing sickness absence**—This can significantly boost capacity and improve morale. The average cost of absence per employee in 2004 was £558 (CIPD 2004). Reports suggest that average sickness absence cost in an acute trust is £5.4 million per annum.

\(^2\) Source: Department of Health.
Improving quality and the patient experience

6. Job and service re-design—A redesign of therapy services in Milton Keynes PCT saved £200,000 and reduced length of hospital stay by seven days.

7. Appraisal policy development and implementation—One study has demonstrated that staff appraisal has a strong association with lower patient mortality. The 2004 NHS staff survey showed 63% of staff had received appraisals.

8. Staff involvement, partnership working and good employee relations—These are particularly important during times of change. Research evidence suggests that higher rates of staff involvement lead to lower absence rates, better organisational results, higher commitment and trust (West 2002).

9. Championing good people management practices—A recent Confederation of British Industry (CBI) survey shows that 40% of UK businesses see developing management skills as the most significant contributor to improved business performance.

10. Effective training and development—The use of the Careers Escalator in radiography to develop assistant and advanced practitioners has boosted capacity and has had a direct impact on waits for diagnostics services. Medway NHS Trust has increased capacity to take and read MRI scans by 50%, with waiting times falling from 48 to 12 weeks.

Evidence submitted by the Academy of Medical Royal Colleges (WP 17)

This is a submission from the Academy of Medical Royal Colleges It addresses generic issues which may not have been covered in individual College submissions

1. There has been a substantial increase in output from UK medical schools and further increases are planned. If we train all of these doctors then there must be a realistic expectation that there will be jobs for them work in. The expansion of the EU, the free mobility of labour, and the increasing attractiveness of the UK as a place to work make manpower planning challenging. EU and UK graduates all have equal access to training positions and higher specialist posts. The UK is more attractive to EU graduates because of the universal use of English even if it is not perfect. We cannot discriminate on language grounds. UK graduates do not have the same ease of access to other EU countries because most UK graduates are not fluent in another language. So, for fiscal and language reasons there is likely to be a continuing flow of EU graduates into the UK.

2. The increasing proportion of female doctors, many of whom will wish to work less than full time for parts of their career needs to be considered. Flexible careers must be part of thinking. It must also be remembered that most “flexible” trainees are very inflexible in terms of being able to move for posts.

3. Training is not seen by managers as a core business of the NHS. Nor is it really recognised by politicians. An increasing proportion of both time and resources needs to be ringfenced and devoted to training and retraining.

4. We recognise that there will be an increase in multiprofessional working. However we are clear that Health care teams should be led by medical doctors. At least from the medical point of view a medic needs to be overseeing all health care. A non medic may run the service but all health care practitioners should be linked to a medical team.

5. There are several “hyperacute” specialties eg acute medicine, acute paediatrics, intensive care and others where there will always be a lot of night work. We need to be able attract the right sort of person who is prepared to do this work. We also need to recognise that there needs to be a point in a career when a doctor can move into a less acute and stressful area.

6. All Colleges believe that the end point of training is the specialist or GP register. Most Colleges would like to see only 1 grade of specialist, ie the consultant. We are not generally in favour of the accredited specialist as a subconsultant.

7. We do not think that medical unemployment should be an accepted norm.

8. In general we think that manpower planning should be done centrally. Anything less that this will lead to major excesses and deficiencies. It would also be good to have UK wide planning but recognise the difficulties of this. We hope that these comments are of value to the Select Committee and are happy to elaborate on any of them.

Professor Sir Alan Craft
Chairman of the Academy of Medical Royal Colleges

14 March 2006
Evidence submitted by the Ambulance Service Association (WP 32)

The Ambulance Service Association (ASA) represents the 34 NHS ambulance services across England, Wales and Northern Ireland. As the representing body of ambulance services, the ASA provides an arena where members can share their experiences and collaborate on implementing new and better ways of working.

The ASA has consulted with members regarding the inquiry, “workforce needs and planning for the health service” and the following response encompasses some of the strategic issues discussed by the HR Directors of NHS Ambulance Trusts and members of the Ambulance Education and Training Advisory Group.

1. The interface and consequences of new higher education routes on workforce planning numbers and flow needs to include a recognition that these policy shifts require new funding for education (and for supporting bursaries).

2. Policy shifts can have a major impact on staffing and recruitment flows hence if there is a shift towards Patient Transport Services being moved to the private sector, this has to be planned for. Similarly, the current radical shifts in commissioning intentions as well as consequences of “Taking Healthcare to the Patient” can have a serious impact on workforce numbers and flows which cannot be managed within each year, therefore a more strategic approach should be taken or at least a three-year plan. A good example of this is the change to clockstart which might mean an extra 30 + ops staff and 25 + control staff.

3. Similarly big shifts in other care sectors can have major consequences elsewhere—a move to remix skills because it is anticipated that there may not be enough doctors or therapists can result in care transferring elsewhere. An example is that new roles such as ECPs working in Primary Care produce massive pulls on existing workforce numbers and it takes two to three years to replace these members of staff.

4. Planning should be done within SHA boundaries but then looked at nationally to evaluate what education funds are needed.

5. An additional area which should be explored is the number of policy initiatives that take staff away from operational duties and which set unrealistic timescales to achieve targets.

Ambulance Service Association
15 March 2006

Evidence submitted by Amicus (WP 05)

1.1 Amicus is the third largest trade union in the National Health Service with a membership working in primary care, mental health and acute NHS Trusts.

1.2 Amicus believes that workforce planning is one of the missing ingredients from a “joined up” approach to health service reform. In a people based service like the NHS we cannot allow effective workforce planning to be the sum total of decisions on this issue by NHS trusts. However at the same time we should avoid grand plans and instead provide strategic and indicative planning, assessing trusts on how well they improve the health and well being needs of the population that they serve in line with the government’s set health priorities.

2. How Effectively Workforce Planning, Including Clinical and Managerial Staff, Has Been Undertaken, and How It Should Be Done In The Future

2.1 This inquiry is timely and is welcome. For sometime there has been an apparent mismatch between the Department of Health’s (DoH) policy objectives and the need to properly undertake workforce planning in order that these are met. For example Amicus has previously observed in evidence submitted to the National Pay Review Body for Nurses Midwives and Health Visitors that despite many welcome new policy initiatives placing additional responsibilities on community practitioners, which our members are more than willing and competent to undertake, the Whole Time Equivalent (WTE) numbers involved in undertaking this work has remained virtually static. For example the latest figures for health visitor numbers reveals an increase from 10,046 to 10,137 WTE over the period 2000–04 or less than 1%. Survey evidence from Amicus reveal that this small advance has been reversed by recent cuts in numbers will not appear in DOH statistics until 2007.

2.2 Workforce Development Confederations are responsible for workforce planning at a Strategic Health Authority level. There appears to be little dynamic to this process in responding to changing health priorities as determined by the DoH. Where numbers are expanded in response to increasing government investment this takes place across broad occupational groupings and often at the expense of relatively small specialities. For example health visitors form approximately 4% of registered nursing workforce. One would expect in an era of expanded resources that numbers of staff employed will increase but in some occupations expand at a faster rate in response to the government’s health priorities. There is evidence that this has not happened which reflects a weakness in current workforce planning.
2.3 Likewise strategic planning has been broad brush in its approach. For example the Wanless report called for expanded numbers in very broad categories doctors, nurses, therapists and ignoring groups like healthcare scientists. We accept that this report was intended for another purpose, namely, making the case for expanding capacity in the NHS. So the report can be seen as an undoubted success, however its publication highlights the absence of any subsequent strategic planning.

3. In Considering Future Demand, How Should the Effects of the Following Be Taken Into Account

- recent policy announcements, including Commissioning a patient-led NHS;
- technological change;
- an ageing population; and
- the increasing use of private providers of services.

3.1 Demand for healthcare is relatively “elastic”. Many of these issues point to an increasing demand for clinical and other staff. Yet it may also point to different kinds of staff differently educated and trained. Whether this “demand” is identified and met depends on the health priorities of the day and the levels of investment involved. There are many drivers for demand in health services and not all demand is met.

3.2 The most tangible driver on demand is the recent White Paper: Our health, our care, our say: a new direction for community services as this represents a statement of government intent.

3.3 While welcoming the broad thrust of the White Paper, we are keen to ensure that the interpretation and implementation of this document recognises the work of our members who have a proven track record of success in many preventative interventions.

3.4 Amicus welcomes the comment that general practice was wider than general practitioners alone; however some of discussions related to surgeries rather than health centres, implying a medical focus. There is a need to highlight that primary care is delivered by a wide range of health workers.

3.5 Community healthcare professionals are vital in every aspect of health promotion and service delivery, helping and protecting some of the most vulnerable children and adults in our community, yet they are being treated as “soft targets” by Primary Care Trusts attempting to make cost savings. Cuts in frontline staff are short-sighted as they will inevitably impact on the nation’s health and will hamper government targets to deliver public health improvements.

3.6 There is a credibility gap for many of our members based on their own experience.

3.7 This is not the first White Paper produced by the DoH which has placed the emphasis on primary care, public health and health promotion but it does contain the clearest vision of this kind of approach. We simply ask that if we are going to effect change of this kind have the lessons about the delivery failures previous White Papers been learnt?

3.8 The NHS is subject to undue political pressure. This more often than not arises out of issues concerned with acute services as primary care services are seen as less measurable in terms of output or outcomes. This is despite clear clinical evidence and public acceptance that public health and health promotion in the medium to long term provides better health outcomes. But it is a fact that concern is expressed, rightly, if patients are on trolleys in corridors awaiting a hospital bed, but no such similar concern is expressed if school children do not receive health and well being advice from a school nurse because her caseload is over 5,000. Relative to acute services public concern about Community Mental Health Services does not feature on the political radar except for the most conspicuous failures that grab press attention.

3.9 This Inquiry is a once in a lifetime opportunity for the NHS to effect many of the changes contained within the White Paper. A transition of this kind would always be easier to achieve in an era of expanded investment. It means that on a like for like basis a greater emphasis can be placed on the goals of the White Paper by expanding resources in these areas at a faster rate. Combined with a stated intention to deliver more services closer to service users then real change can be achieved. Yet if the NHS waits to the next spending round, which may be less generous, then it would be doubtful if such change can be effected.

3.10 As for demand we expect to witness greater numbers of community healthcare professionals both in absolute numerical terms but also as a proportion of the overall workforce.

3.11 Likewise an ageing population is driver for demand. Whether this is recognised and met also depends on the health priorities of the day. The White Paper in a number of sections makes specific mention of this issue and how these health needs can be addressed. This is a statement of government intent so we would expect to see over time a greater number of community health and social care professionals involved in addressing the health and well being needs of this section of the population i.e demand will increase.

3.12 Technological change is demand neutral in our view. Health is not a production “process” where productivity can be greatly improved by more intense deployment of technology. In some areas (e.g. diagnostics) technological development may improve productivity but most developments in this area are focused on how these services may be delivered closer to service users. In other areas technological development may help better address particular health needs which in turn increases demand for this service.
Combined with the desire to deliver more clinical technical services closer to patient (e.g., Ear, Nose and Throat) we would hope that some workforce modelling would take place based on quality of service envisaged and numbers of staff and skill required to deliver it.

3.13 A key concern remains in relation to the government’s arguments in the White Paper in favour of the increasing use of private providers of services leading to fragmentation. The arguments in favour of contestability are not evidence-based. We welcome the admission by government that the requirement that PCTs divest themselves of provision by 2008 was wrong, however we believe this remains the direction of policy and would prefer new resources to encourage entrepreneurial enterprises to be invested in developing the spread of best practice between PCT providers where evidence-based evaluations show the highest standards of primary care outcomes.

3.14 More importantly for the focus of this inquiry we believe that it will make the strategic planning of the workforce more complex and private providers do not help meet any subsequent demand. On the contrary they are often “free-riders” on the backs of publicly funded initiatives to improve the number of skilled and professional staff required to meet the government’s health targets.

3.15 Whilst we accept that tackling health inequalities includes a need to shift resources it is essential that staff currently employed in the acute services are retained and that their skills and experience are deployed to meet the increased demands with delivery of primary care.

4. How Will the Ability To Meet Demands Be Affected By

— Financial constraints.
— The European Working Time Directive.
— Increasing international competition for staff.
— Early retirement.

4.1 Amicus recognises that not all health demands will be met. Health spending constitutes a social contract between the electorate and the government of the day. We have outlined what we believe the government needs to undertake to meet its health priorities. We hope these priorities have popular consent through informed consultation.

4.2 The European Working Time Directive (EWTD) is a “red herring”. Firstly strict compliance with no opt outs will improve public health as the EWTD is a health not an employment directive. Amicus revealed in research “lost” by the last government that the incidence of coronary heart disease and other conditions increased significantly amongst those who worked over 48 hours per week.

4.3 Long hours in the NHS is a function of two factors. Poor work organisation and an unwritten contract for some low paid workers that this could be “made up” through excessive overtime hours. This will be tackled for staff by Agenda for Change. The investment in the new pay system will make the NHS a more attractive organisation for skilled and professional staff to work for, thereby aiding recruitment and retention, and helping to reduce the need for excessive overtime. In addition, a degree of harmonisation will be achieved on overtime premia which may help “disincentivise” excessive overtime.

4.4 The long hours culture is an issue which all NHS employers in England have been required to address in reaching practice plus standard for Improving Working Lives (IWL) accreditation. The “model employer” next stage in this process to make the NHS a world class employer must continue to prioritise this issue.

4.5 There is a tendency for some professions to argue that long hours are required for appropriate training of clinical staff. We prefer to look at how many workforce questions can be addressed through appropriate skill mix through delegating roles, functions, and tasks to properly trained and competent health professions. The professions who argue the case for long hours are very often the same who are opposing developments in this direction.

4.6 Likewise early retirement is another “red herring”. Firstly, public sector workers draw their state pension the same age as everyone else. Under the terms of their occupational scheme some health service staff can draw their pension without reduction aged 60, whilst a declining number can draw this at 55 as this facility was closed in 1995. In reality the actual age of retirement from the health service is closer to 60 for those who draw this without reduction at 55 and 63 for those who can draw this without reduction at 60. Besides recruitment and retention will be not be addressed by forcing people to work for the NHS against their will but by making it an attractive employer. Current negotiations with the DoH on pensions are intended to give incentives for health service staff to work longer. These negotiations have not concluded, let alone determine whether any agreement meets this objective.

5. To What Extent Can and Should the Demand Be Met, for Both Clinical and Managerial Staff, By

— Changing the roles and improving skills of existing staff.
— Better retention.
— The recruitment of new staff in England.
— International recruitment.
5.1 Amicus not only has aspirations for our members on terms and conditions but also for their career development. Changing the roles and improving the skills of existing staff is very much line with the government’s ethos of creating opportunities and life chances. If the country’s largest employer was to pursue a path in this direction it would have a significant effect on life chance for the disadvantaged and those who have previously been failed by the formal education system. Social class is also a major determinant of health needs.

5.2 It is also economically desirable to pursue this path. If the government is to meet its workforce targets for health professions it is going to have to take a disproportionate number of university graduates year-on-year for at least the next five years and possibly decade. If it was successful in this objective it can only have the effect of denuding the wealth creating part of the economy of graduate employees. This is not sustainable.

5.3 Many health roles are highly regulated which is appropriate and protects patients. Clearly protection of the patient is paramount and regulation provides for protection of title so that patients can understand what kind of clinical services they are receiving. However, in some cases this is out dated or designed to protect work areas based on a “craft” mentality.

5.4 Some of this is based on practitioners’ experience that “skill mix” has been used by some employers to dilute the quality of services and cut employment costs. At the root of this problem is clinical services being driven by an “accountants” mentality rather than based on health needs. The White Paper typifies this confusion particularly in relation to “talking therapies” and at best identifies the nature of the problems without suggesting any clear solutions. This is a workforce issue because unless the nature of the appropriate skill mix for any service is informed by health needs, any moves in this direction are likely to be resisted by health professions.

5.5 At the same time we need to provide vocational routes into the professions. The “one size” approach may prevent some health staff from fulfilling their potential. Some professions (eg Biomedical Scientists) have opened up routes for support staff to attain qualifications but across the NHS there are few such examples and therefore the pace of change is slow and piecemeal.

5.6 This is unlikely to change if training budgets continue to be reduced in real terms. In this respect there is a strange parallel with British industry with training being hit first when expenditure restraint is required when exactly the reverse should take place.

5.7 Other changes are easier to introduce but held back by attitudes from Commissioners who do not fully appreciate the types of services that can be provided by these groups and effectively deny them to fulfil their potential. School Nurses are potentially able could to deliver many of the health needs of the school age population and their families provided they were given appropriate recognition through status and grading, and sufficient numbers were trained. Previous commitments to have a school nurse for every school have been watered down to access to a school nurse for every school resulting in many holding unmanageable caseloads.

5.8 Better retention is obviously also key. Amicus is very hopeful that the knowledge and skills competency framework which was negotiated as part of Agenda for Change will help in this process providing rewarding careers but also careers that reward.

5.9 New staff should obviously be recruited from England as long as this does detract from freedom of movement for labour amongst nations in the UK and our European Union partners. Amicus has a long tradition of international solidarity and are concerned at reports from our sister trade union in South Africa that their health services are being denuded of skilled and professional staff. The NHS has a good track record in this respect. However, such co-operative agreements are being undermined by independent providers who are envisaged as providing more health services in the “Our health, our care, our say” white paper. Contestability as well as leading to fragmentation of services may lead to the NHS no longer being able to enter into meaningful agreements on workforce issues with developing nations.

5.10 On international recruitment we would very much promote a co-operative approach between individual nations rather than a “beggar thy neighbour” approach. The NHS has a good track record in this respect. However, such co-operative agreements are being undermined by independent providers who are envisaged as providing more health services in the “Our health, our care, our say” white paper. Contestability as well as leading to fragmentation of services may lead to the NHS no longer being able to enter into meaningful agreements on workforce issues with developing nations.

6. How Should Planning Be Undertaken

— To what extent should it be centralised or decentralised?
— How is flexibility to be ensured?
— What examples of good practice can be found in England and elsewhere?

6.1 Amicus believes that the workforce needs and planning should be decentralised with strategic direction from the “centre”. We certainly would wish to avoid a NHS workforce version of Gosplan. We are not confident that such a plan could be reached and if so it would be undoubtedly over influenced by traditionally stronger voices at the expenses of those groups or services who may be in a better position to address the government’s health priorities.
6.2 So what are these health priorities? What quality of service is envisaged? What staff are in the best position to provide this service? Where should they be deployed? What support should they provide with so that they meet their objectives?

6.3 The White Paper sees the need for the stronger participation of the public in determining this. But this must be informed participation. Many community health professionals have analytical tools for assessing the health needs of their client groups. Health needs assessments could form the basic building block for informing this choice. It also provides for greater flexibility because health needs differ across the country.

6.4 In commissioning these services to meet agreed needs we have concerns on the emphasis of Practice Based Commissioning (PBC) as this may lead to exclusion of professions who are in a better position to determine how these health needs can be addressed or a bias to one kind of service over another which may be more clinically effective. There certainly should be greater “democracy” amongst health professions if PBC is introduced.

6.5 In turn workforce planning needs to take on board what are the health needs of the local population? What are the priorities in this respect? How can they be met? What are the obstacles to these being met? How can these obstacles be overcome?

6.6 The Select Committee Inquiry is welcome. We hope that its findings will contribute to a “joined up” approach to health service reform.

Gail Cartmail
Head of Health, Amicus
March 2006

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Evidence submitted by the Association of British Healthcare Industries (WP 56)

The Association of British Healthcare Industries welcomes this opportunity to contribute to the Health Committee inquiry into Workforce needs and planning for the health service. As the leading trade association in the UK for the medical technology industry, the ABHI seeks to enable the NHS to maintain a high quality and innovative service by realising the clinical and financial benefits of medical technology. The ABHI represents over 200 member organisations including leading corporations in the medical technology sector as well as many small independent companies that operate in the UK. These members produce everything from life support machines to latex gloves and are vital to the functioning of the NHS.

NHS capacity and efficiency problems have been attributed in large part to human resource problems; either staff costs are too high in some specialities and staff numbers are too low in others. Standard business models suggest the strategic use of productivity-enhancing technology can address both of these issues. Additionally, the medical device industry plays a key role in training NHS staff; a value-added service of many manufacturers easily overlooked in cost effectiveness analysis.

**Government White Paper Highlights Benefits of Medical Technology**

In providing more services “closer to home” (and moving away from a large hospital model) the Government strategy outlined in the recent White Paper emphasises safety and cost effectiveness. The products and services supplied to the NHS by the medical device and technology industry are key to delivering greater safety and cost effectiveness and helping the NHS meet its changing workforce needs and objectives.

The paper discusses experience in the US with the successful reduction in need for hospital based care for people with long term and complex needs. The Paper pledges to take advantage of advances in “assistive technologies” and proposes “intensive use of assistive and home monitoring technologies” such as in-home self monitoring link up systems for patients, emergency alert systems, remote monitoring of spirometric and cardiac readings and patients recovering at home.

The Paper urges that care closer to home requires effective and “appropriate diagnostic and other equipment in local settings” and acknowledges that diagnostic equipment procurement is a “critical component” in meeting the 18 week waiting time target. For example, with appropriate diagnostic equipment availability, the Paper reports that up to 40% of orthopaedic consultations from hospitals to primary care settings. Furthermore, advanced products minimise healthcare worker needs by allowing patients to remain active in the community. Active implantable devices such as pacemakers, ICDs and neurostimulation devices, sophisticated orthopaedic implants and advanced wound dressings allow patients to remain self sufficient or return home sooner after treatment.

By increasing care outside of hospitals with the help of appropriate assistive technologies NHS hospital workforce needs should be reduced and a shift to greater human resource needs in primary care settings may be expected.
THE IMPACT OF MEDICAL TECHNOLOGY INNOVATIONS ON WORKFORCE NEEDS

Rising staff costs have been identified as a key driver of budget deficits for some NHS trusts. Appropriate technology use has been shown to reduce workforce needs (and therefore staff costs). In fact, the Wanless review stated that increased spending on medical technology could help achieve a growth in NHS productivity of 3%.

Studies have revealed that under utilization of existing NHS imaging equipment is due to shortages of radiology staff and insufficient funds to pay radiographers over time. Although additional staff needs have been a barrier to technology uptake in the specific instance of diagnostic imaging, the vast majority of new medical technologies actually provide dramatic reductions in work force needs by improving productivity. In fact, appropriate technology use provides a potential solution for staff shortages in radiology.

Diagnostic scan images need to be read by a highly trained radiologist who need not be on-site. The use of digital and information technologies enable faster reporting and more efficient use of radiologists via tele-medicine. Infrastructural problems currently limit the use of tele-medicine to address work force challenges in diagnostic scanning and should be addressed, as these objectives are included in the recent White Paper as mentioned above. Additionally both the NHS Plan and the NHS Improvement Plan recommend increased application of telemedicine.

CONTRIBUTIONS OF THE MEDICAL DEVICE AND TECHNOLOGY INDUSTRY TO NHS STAFF TRAINING

The industry plays an important role in educating and training clinicians and healthcare workers. Manufacturers loan trainers to NHS trusts at no additional cost, and provide training opportunities for new surgeons, as well as experienced surgeons wanting to adopt new techniques such as minimal access surgery, a huge value added service to the NHS, which ultimately benefits patients. Most large implant suppliers operate hands-on training facilities for surgeons in the UK and others provide free access to a wide range of educational materials for medical professionals.

CONTRIBUTIONS OF THE MEDICAL DEVICE AND TECHNOLOGY INDUSTRY TO NHS STAFF SAFETY

Healthcare professionals work in a high risk environment and staff days lost to illness or injury represent a productivity loss to the NHS. Appropriate use of medical technology can limit such losses. One clear example of the importance of investing in medical technology is products and solutions for the safe use and disposal of sharps and needles. Healthcare professionals are at constant risk of needle stick injuries that are linked to the transmission of blood-borne diseases. Various new and innovative products are on the markets that help minimize these risks. Investing in such devices is not only in the best interest of staff but are a cost effective investment for hospitals. Sharps injuries can result in significant costs to the employer in lost work time, investigations and payment of damages.

The ABHI and its members remain committed to an active partnership with the NHS and Government to ensure the NHS remains a high quality innovative service.

Association of British Healthcare Industries

16 March 2006

Evidence submitted by the Association for Perioperative Practice (WP 61)

As a professional association, AIPP have been involved in the National Practitioner Programmes, in particular the Surgical Care Practitioner and Assistant Theatre Practitioner projects. We have also had significant input into the development of the Anaesthesia Practitioner project. In addition, we also have a publication entitled Staffing for Patients in the perioperative setting, which was published in 2003. This publication provides information on staffing establishments as well as a formula for safe staffing of both elective and emergency surgery. This publication was endorsed by the Modernisation Agency at the time of publication and has subsequently been recommended by the Healthcare Commission.

We trust that the information provided will be of assistance to those involved in the Health Select Committee in assessing workforce needs and planning for healthcare services.

This response is provided by the Association for Perioperative Practice (AIPP). AIPP is a professional association representing 8,000 perioperative nurses, Operating Department Practitioners (ODPs) and support staff in the United Kingdom working in the NHS and the independent sector. This response is the view of the AIPP Board.

INTRODUCTION

Since 1997 there has been a significant growth in the UK nursing workforce due to increased funding for pre registration nurse training and international recruitment. In March 2005 there were 672,897 qualified nurses, midwives and health visitors registered with the NMC. Of this number 30,000 registrants which is one in 20 are approximately resident overseas according to the RCN labour market report 2005. Therefore
the pool population in the UK is approximately 640,000. There were approximately 465,000 qualified nurses and midwives employed in the NHS. In September 2004 seven out of every 10 nurses on the register were working in the NHS. In addition there were 167,000 unqualified nursing staff.

The Royal College of Nursing (RCN) recently published the RCN annual labour market review 2005 which shows that information used for NHS workforce planning remains inadequate. The report highlights the lack of reliable information on the number of many newly qualified nurses working in the UK as well as the lack of information on vacancy rates and retirement. This lack of information is unacceptable and AfPP recommend the Health Committee are aware that NHS Employers are to put mechanisms in place to address the lack of data. Reliable information is required to inform workforce planners and DH as to the sustainability of NHS projects to improve clinical services and patient outcomes. This includes recent policy announcements such as Commissioning a patient led NHS.

The NHS is the main employer of nurses in the UK but nurses also work in other sectors such as nursing and residential homes, independent hospitals, clinics, treatment centres, hospices, medical device industry and public sector services such as the prison service. It would be useful to have reliable data on employment in other sectors where nurse currently work as this does not currently exist.

The RCN report highlights an ageing nurse population particularly in the community where the average age is 44. The latest NMC figures indicate that nurses over the age of 40 account for nearly two thirds of the workforce. The proportion over 55 has increased to 16% of those on the register. This change could reflect the social trend of people taking up new careers in their 30s or 40s but we do not have reliable data to support this. AfPP has recently analysed the age profile of its 8,000 members and the profile indicates 68% of members are aged 40 or over. Such a trend is worrying as a lack of competent registered theatre personnel will have a major impact on the healthcare establishment’s ability to reduce waiting times for elective surgery.

Presently there are 20,000 new UK registrants to the register annually, but the number of nurses due to retire raises concerns as to whether this is enough. There is a real risk that the UK may return to the chronic nursing shortages of the early 1990s. This is potentially a staffing “time bomb”. The NHS National Workforce Projects/Workforce Review Team claims that by 2014 we will need twice as many entrants as we do now just to keep the workforce constant. We need to recruit more, and more importantly make nursing an attractive career not only to school leavers but those that have had families and are looking for a new career. There is also an urgent need to review why up to 50% of nursing students drop out of training. One cause is the current bursary which is inadequate to support many student nurses in training.

An ageing workforce means the health service has to look at ways of encouraging older nurses to work longer. This includes human resource policies encouraging flexible pension schemes and more flexible working hours. AfPP welcomes NHS Employer’s commitment to fund a dedicated post within the NHS to work specifically on policies that will help retain experienced nurses and address the implications of age discrimination.

Staff shortages and inadequate funding are preventing many NHS Trusts from offering patient choice. A new report on NHS maternity services (www.reform.co.uk) states there is considerable strain on midwife led units. This is because there is a recruitment crisis for midwives consultant cover is inadequate and administrative burdens are rising.

The future of the workforce must be home grown as it is ethically questionable to rely on recruitment from overseas to sustain workforce demands in the UK. This is especially true where recruitment has adversely affected healthcare systems overseas by causing nursing shortages.

Healthcare Assistants (HCA) receive vocational training and are an increasingly important part of the healthcare workforce often working under the supervision of nurses. They are an important source of potential recruits into nursing. In 2005 the Department of Health in England allocated £185 million to support HCAs to train as nurses on paid secondment. Despite this investment funding available to support HCAs to do nurse training is limited. It is recommended that further investment is provided to enable more HCAs to convert to nursing. Some organisations also provide nurse cadet schemes which are successful in encouraging young people to become nurses. Cadet places are limited and availability of places is ad hoc. Investment is required so all NHS organisations have a cadet scheme in operation. It is difficult to assess the accurate size of the HCA workforce but this will be assisted with the introduction of regulation which is currently being reviewed.

The independent sector is being utilised to deliver in areas where the NHS does not have the capacity in terms of staff or physical resources. The independent sector is the largest employer of nurses outside the NHS but data does not exist as to how many work in this sector. There is a need to collate and monitor such data to assess future workforce trends.

The main challenge is to completely rethink professional boundaries including the introduction of new roles and responsibilities and flexible working patterns. AfPP is working collaboratively with Skills for Health and national workforce projects to develop non-medical perioperative roles which improve patient outcomes. Many new roles, such as the Surgical Care Practitioner (SCP) have developed in response to the impact of the European Working Time Directive (EWTD). The EWTD has resulted in a lack of medical personnel being available to assist in the operating theatre. In practice many nurses have taken on these roles
which have created backfill problems within operating departments. AfPP do not see the necessity of creating new roles and new titles which often confuse patients. AfPP supports the expansion of existing nursing roles to enable nurses to undertake tasks which improve patient outcomes.

The demographics of the workforce highlight an ageing population. Department of Health targets for increasing training places will secure future health professionals. However we also need to give attention to the best use of the staff we presently have, to ensure safe quality patient care. The debate regarding appropriate staffing levels and skill mix has also been prompted by the political focus on the “skills escalator” and the potential contribution that assistant grades may provide in supporting the delivery of care.

The attention being paid to staffing establishments sits against a backdrop of demands for increased theatre utilisation, as respective organisations respond to the service changes and improvements that are implicit in the NHS Plans of the home countries within the UK.

Challenges of enhanced efficiency are also encountered in the independent sector, and AfPP recognises that a competent and skilled workforce is central to achieving service improvements. AfPP believes that the delivery of the contemporary health care agenda is dependent upon recognising the core nursing contribution, as well as the skill sets arising from a flexible and diverse perioperative workforce, which comprises registered, non-registered and trained personnel.

AfPP believes that, to promote and achieve a quality patient experience for individuals requiring diagnostic and surgical intervention, the key core skills and competencies of all staff must be utilised. The staffing resource needs to be recognised as central to achieving clinical effectiveness and efficiency within health care. Most importantly, all staff need to be deployed across the diversity of perioperative activity within a clinical governance framework. Proactive shaping of the perioperative workforce is crucial if organisations are to achieve the vision outlined in the respective NHS Plans within the UK.

John Brunt
Chief Executive, Association of Perioperative Practice

March 2006

Evidence submitted by the Association of UK University Hospitals (WP 48)

INTRODUCTION

1. The Association of UK University Hospitals (AUKUH) is the key leadership body across the UK promoting the unique interests of University hospitals. Its role is to represent the unique tripartite, service, teaching and research, interests of UK University Hospital Trusts in partnership with other national bodies. The high quality teaching and research conducted within these institutions allows the quality of care provided to the patients they treat to be at the forefront of best practice throughout the UK.

2. The AUKUH also incorporates the Finance, Human Resources, Nursing and Medical Directors.

3. The AUKUH works closely with the Council of Heads of Medical Schools (CHMS).

EVIDENCE

In considering future demand, how should the effects of the following be taken into account:

Recent policy announcements

4. One of the greatest concerns at the present time for many NHS Trusts is the degree to which Modernising Medical Careers (MMC) may affect the supply of staff with the appropriate level of experience to meet service needs. Modernising Nursing Careers has at least the same potential impact as MMC, and arguably more in light of MMC relying to some extent on shifting responsibilities to other clinical staff, in particular nursing.

Individual Trusts should conduct a strategic marketing analysis to consider their external Social, Technological, Economic, and Political [PEST] factors, and measure their own Strengths, Weaknesses, Opportunities and Threats [SWOT] to their services. This approach should be conducted across local health systems (county wide) and results discussed with the local stakeholders. Actions need to be agreed based on the most likely outcomes over the next 10 years.

Technology

5. Technology is likely to have a significant effect, particularly on administrative and clerical staff, decreasing the numbers of staff required.
An Ageing Population

6. As the population ages there is likely to be an increasing need for care assistants and other staff with basic skills. Increases in demand will be focused in specific areas, such as stroke. The use of private care home and step-down facilities may see a particular increase as the population ages.

The Increasing Use of Private Providers of Services

7. The increasing use of private providers of services may be significant in that retention of employment models are relatively new and there may be issues about willingness of staff to work in these type of arrangements.

8. It will be a challenge to prepare staff to work flexibly across different sectors and a further challenge to ensure private sector health services contribute to training costs and resources. Nevertheless new partnerships with private providers could be forged.

9. Changes to the NHS pension scheme will affect these relationships. At present with the NHS pension acting as a significant retention and possible recruitment incentive, the prospect of staff leakage to the private sector could be limited. However, planned pension changes will impact on this.

How Will the Ability to Meet Demands be Affected by

Financial constraints

10. Financial constraints could lead to the rationing of services and staff within the health service. Trusts should consider utilising staff Scheduling, Rostering, Time and Attendance systems to ensure that the right mix of staff work to meet demand. Potential savings could be achieved though linking such systems to Electronic Staff Record (ESR).

The European Working Time Directive

11. The complexity of the healthcare system is increased as new policies are implemented. Chief among these is the European Working Time Directive (EWTD), which will reduce the availability of junior doctor time by up to 14%. EWTD targets in 2004 were met with the aid of considerable additional funding; however, the 2009 48-hour target must be achieved with no additional central funding. This is a problem of gargantuan proportions, which will only be resolved by substitution of one role for another, eg MCP for junior doctor, and by rationalisation of services within a service provider network. This will require sophisticated modelling, applied nationally, regionally within a health economy and locally within trusts.

Increasing international competition for staff

12. The market for health service staff is becoming increasingly globally competitive. In the US, for example, health service workers can secure higher salaries and enjoy better lifestyles than in the UK. Payment by results requires all patient activity is accurately coded in order that Trusts recover their true costs. The demand for Clinical Coding staff in the USA is such that they are amongst the highest paid staff in American hospitals, but in the UK Clinical Coders are some of the lowest paid staff.

Early retirement

13. The tendency for those currently employed with the health service to seek early retirement may affect the ability to meet demands. The complexities of this issue are dependent on current policy developments including forthcoming Age Discrimination Legislation in 2006 and also the outcome of current NHS pension negotiations.

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

14. AUKUH wishes to stress that existing roles are valued. Support for role redesign programmes can be adversely affected if staff believe that the role they have been carrying out has not been valued. Nevertheless changing roles and improving the flexibility of staff is pivotal to delivering the service. One approach would be for the professions to define their unique contribution to healthcare. In this way roles could be allocated and, if necessary, posts created. This is a challenge not just of ownership but also of regulation and patient and public protection.
**Better retention**

15. There is significant work still to be done on people leadership skills in the NHS, which is critical to aid retention. People leadership skills need to be highly targeted, to assist staff to learn how to retain good practices in less than ideal circumstances, such as financial constraints, reconfiguration etc. Better management, coaching and mentoring of staff is essential.

Trusts need to ensure staff morale and feelings of high engagement at work are high in order to keep staff. Employers that enable their staff to self-roster their time at work and allow staff to be fully engaged at work are likely to retain a happy and productive workforce.

**The recruitment of new staff in England**

16. There are clearly certain areas of the potential workforce for the NHS who can be targeted more closely in terms of recruitment, such as young males in certain ethnic minority groups etc. Evidence suggests that ideas about careers are formed early and so educating primary school children and later enticing the 14–19 year old age group into health service careers is particularly important. To this extent building up strong relationships between schools and local employers is key. Some Trust’s are developing “Ambassador” roles whereby staff volunteer to visit schools and show children why it is good to work for the NHS. Recruitment at this level should not be just about nursing but about the full scope of health service careers available. We must also put more emphasis on encouraging people to return to the NHS who have left temporarily and could be attracted back—sometimes once in their career, sometimes several times.

**International recruitment**

17. Whilst the international element of the health service workforce is important, options for significantly increasing international recruitment to support workforce supply requirements seem to be reasonably limited. Trusts should seek the opportunities that exist to recruit skilled staff from within the EU. In addition it is vital that comprehensive quality assurance measures are in place to prevent standards being compromised.

**How Should Planning be Undertaken**

18. High quality workforce research is still not in great evidence within the NHS, particularly in the way that research on supply and demand is being used within organisations to analyse workforce requirements for the future, to support LDPs and longer term planning. There also appears to be a shortfall in terms of really high quality workforce modelling tools to aid this type of in depth analysis, and limited examples of workforce re-modelling on a sufficiently large scale, to use as exemplars of productivity and efficiency gain. These are areas where further support through organisations like NHS Employers would be of significant assistance to Trusts and PCTs.

19. In addition better use must be made of existing data and models to avoid duplication. Current requests for data are often time-consuming to complete and rarely lead to effective tools and measures.

Trusts should base their workforce planning using the findings in local strategic marketing analysis (eg, using STEP and SWOT tools).

Each Trust should have a trained Workforce Planning Facilitator to challenge and support managers of services to develop workforce plans that reflect the findings of local strategic marketing analysis. Local health system workforce plans need to be assessed at a strategic health system level in order that an effective and economic workforce is available for the on-going needs of local populations.

**To what extent should it centralised or decentralised?**

20. There will always be a need for central strategic planning, particularly at the interface with education. However central planning that is divorced from local plans will inevitably generate fluctuations of feast and famine in the supply of staff. For example, there is currently a surfeit of physiotherapists, and central guidance is to reduce commissioning numbers. The oversupply may be a current disincentive to developing new ways of working but care must be taken that the impact of reduced commissions, in five years time, is not an undersupply, which could lead to a wage spiral. One should reflect on the wisdom of closing three Dental Schools 10 years ago only to have to create a new one this year.

21. Central medical workforce planning is even more a hostage to fortune in the absence of visionary but realistic scenarios. The future high output of graduate doctors from medical colleges, and the current changes in postgraduate medical education, will impact on the career expectations of newly-qualified doctors and may lead to feelings of disenchantment. This will happen in the context of a service which has met local clinical needs by expanding nursing roles into some medical functions, eg diabetes and asthma. More recently the NHS has seen the introduction of new types of clinicians—Medical, Surgical and
Anaesthesia Care Practitioners. The expansion in medical school intakes and the policy changes of *Modernising Medical Careers* are decisions made between 5 and 10 years ago but which apparently did not envisage these new ways of providing medical care.

22. What is needed now is robust modelling that will identify the staffing required to meet the increasing demand for healthcare services. *Modernising Medical Careers* will lead to a balance between the traditional doctor-in-training role and that of non-consultant career grade service doctors. This balance needs to match local circumstances and will vary between teaching and non-teaching hospitals. New roles such as the medical care practitioner need to integrate into this dynamic structure. Medical workforce planning is therefore not a simple stocks and flows system that will identify the number of medical students required to meet the demand for consultants fifteen years into the future. It requires an interplay between the likely demand for service, the affordability and the competences required to deliver safe, high-quality, healthcare. Such visionary scenarios will promote workforce plans to meet whole services rather than to assess, in isolation, numbers of staff.

Implementation of Electronic Staff Record (ESR) across the whole of the NHS by 2008 should present the first real opportunity for national workforce planning to be based on workforce data collected in a standard format for the first time. 

**What Examples of Good Practice Can be Found in England and Elsewhere?**

23. An example of a robust standardised model is the Manchester model, where a centralised model is cascaded down to line management.

Norfolk, Suffolk, Cambridgeshire SHA and local participating Trusts have good examples of local workforce planning based on the Manchester model.

**Further Comments**

24. AUKUH would welcome the opportunity to give verbal evidence to the Health Committee if required.

Dr Katie Petty-Saphon
Executive Director, Association of UK University Hospitals

March 2006

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**Evidence submitted by Boston Scientific (WP 21)**

1. **Introduction—Boston Scientific and Their Interest in the Inquiry**

Boston Scientific is a worldwide developer, manufacturer and marketer of medical devices whose products are used in a broad range of interventional medical specialties. Globally, Boston Scientific employs over 14,000 people and provides innovative medical devices that use the body’s natural orifices and arteries to treat conditions in the brain, heart, bowel, bladder, womb, digestive and vascular systems. The advanced level of technology used in minimally invasive procedures offers:

- **Patients**—minimally-invasive alternatives to traditional open surgery with less trauma and in most cases a reduced stay in hospital and faster recovery time.
- **Health Care Professionals**—fully-supported modern products allowing “gold-standard” treatments for their patients.
- **The NHS**—reduced total treatment costs and resource utilisation, freeing capacity and improving patient throughput.

However, there are significant issues regarding resources and planning in the NHS that impact on the availability of these technologies to all patients and on the ability of these new technologies to be used by the NHS to their full economic benefit.

2. **Technological Change—Numbers of Interventional Radiologists (IRs)**

2.1 The low number of trained IRs in the UK is a significant barrier to the uptake of technologically advanced, minimally invasive procedures in the NHS. The use of new, minimally invasive technology, relies on two specific resources: diagnostic scanning equipment, and trained IRs to operate them. Currently, there is evidence to suggest that scanning equipment is under-used and lying idle due to a lack of trained staff.

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3 For more information on Interventional Radiology please see, www.bsir.org
4 National Audit Office Report: Reducing Brain Damage; Faster access to better stroke care, 16 November 2006.
2.2 Investment in Interventional Radiology would allow more patients to be treated—and treated earlier—for conditions such as peripheral vascular disease and stroke; two of the biggest causes of death in the UK.\(^5\)

2.3 The UK currently has a shortage of IRs compared to other Western European countries.\(^6\)

2.4 With an increasingly ageing population and slowing birth rate, recruiting adequate numbers of staff to perform all tasks in the NHS (from cleaning and catering to nursing and specialist services) is proving difficult. The minimally invasive procedures undertaken by IRs result in shorter hospital stays and their adoption will go some way to relieving pressure on the labour intensive “hotel” services provided by hospitals and required of more traditional procedures.

3. Changing the Roles and Improving the Skills of Existing Staff—Career Pathways for IRs

3.1 Current arrangements for training in IR (post medical qualification) involves the completion of general radiological training (approximately four years) followed by one to two years of sub-specialist training. During the initial four year training period, trainees learn much about diagnostic radiology which is not of use to them in the daily practise of interventional radiology. The requirement for a substantial knowledge of diagnostic radiology is inefficient and unnecessary. Many doctors, on deciding their speciality, take into consideration the quality and duration of their training. The current training to become an IR makes many reluctant to choose this career path.

3.2 Currently, IRs do not have direct clinical responsibility for their patients and very few hospitals have nominated, ring-fenced beds for patients undergoing treatment with minimally invasive technologies. This lack of clinical and professional autonomy is likely to turn many doctors away from choosing IR as a speciality.

3.3 An increase in the numbers of IRs being recruited for training by promoting the structural changes would make this career choice more attractive to trainees. In addition, a new method of training for interventional radiology (consisting of two years in diagnostic radiology followed by three years instruction in interventional techniques and equipment) would help to address problems with under-capacity.

3.4 An example of best practice in IR is found at the Vascular Institute, University of Sheffield. This best practice allows the maximum number of patients possible access to minimally invasive technologies that often reduce trauma, bed stay and recuperation times. In this unit there are ring-fenced beds and the IRs manage their patients throughout their treatment.\(^7\)

4. Planning—Ensuring Flexibility

4.1 The Payments by Results (PbR) system is designed to facilitate choice and patient-centred care. However, the transition to Healthcare Resource Groups (HRGs) as the central method for achieving PbR risks the use of tariffs that do not reflect the true costs of patient care for a number of critical technologies. Therefore, hospitals are less likely to use new technologies if they will not be adequately reimbursed for them.

4.2 Additionally, HRG tariffs are calculated on the basis of prior two year data submitted by hospitals. Inaccuracy for certain tariffs may reflect routine errors on the part of hospitals in submitting costing data, as many hospitals are challenged in adapting to this complex system. For newer technologies, inadequate tariffs simply reflect the absence of an appropriate code available to collect data. Related costs then become lost in the hospital costing data. Again, inappropriate levels of reimbursement could lead to reluctance on the part of hospitals to engage with new technology.

4.3 The PbR system must be flexible and adaptable enough for new technologies to be accommodated. The system should encourage the up-take of new technologies to ensure that patients receive optimum health care and the NHS optimum use of the resources available to it.

4.4 The auditing mechanisms which support the National Institute for Health and Clinical Excellence’s (NICE) guidance should be efficient enough to allow adequate economic analysis of a technology to take place. Currently, there are no reliable national measures of technology utilisation. If uptake of technologies is adequately monitored the planning and commissioning of services can be more effective. Inadequate monitoring of technology uptake can lead to hospitals choosing between following NICE recommendations and overspending budget.

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\(^5\) www.dh.gov.uk
\(^6\) Interventional Radiologists in UK per million of population = 1:1,200,000. In Germany, France and Italy the ratio averages 1:400,000.
\(^7\) For further information please see: http://www.shef.ac.uk/dcsn/research/cardiovascular/vascular—surgery
5. CONCLUSION—INCREASED NUMBERS OF IR AND INCREASED USE OF TECHNOLOGY WILL LEAD TO MORE EFFECTIVE NHS PLANNING

Political parties are united in their desire to achieve optimum efficiency in the NHS. In order to achieve that efficiency, it is essential that available resources are utilised to their optimum. Therefore, the NHS should make full use of Interventional Radiology as a discipline and of the minimally invasive technologies and diagnostic equipment that enables them to treat their patients. Increasing the use of Interventional Radiology techniques and procedures in the NHS would help the service achieve targets on throughput, organisational efficiency, the patient choice agenda and procedural cost management via the Payments by Results system.

Therefore, Boston Scientific recommends that:

— Ensure that scanning equipment is used to its full potential by trained staff in the NHS.
— Steps are taken to address the NHS structure to provide IRs with direct clinical responsibility and IR with nominated hospital beds for minimally invasive treatments.
— A new training structure is considered that consist of two years in diagnostic radiology followed by three years instruction in interventional techniques and equipment.
— The PbR system is flexible and adaptable enough to accommodate new technologies.
— That auditing mechanisms which support NICE guidance are efficient enough to allow adequate economic analysis of a technology to take place.

Boston Scientific
March 2006

Evidence submitted by the Birth Trauma Association (WP 15)

1. THE BIRTH TRAUMA ASSOCIATION

BTA is a voluntary organisation working for the prevention of birth trauma and to support women suffering from it. We promote the welfare and interests of women with Post Natal Post Traumatic Stress Disorder and of all women traumatised by childbirth. We are mothers helping other mothers and working to establish respect for basic human dignity as a cornerstone of maternity care. This is most effectively achieved by providing quality information to women to enable them to be free to make their own informed choices about childbirth. The BTA believes that on receipt of the best information available, it is then the woman’s right to choose how she wishes to give birth and that this decision should be respected wherever clinically possible and should be criticised by none.

2. COMMENTS

The BTA welcomes this inquiry into Workforce needs and planning for the health service and we will be focusing our memorandum on maternity and mental health services. We feel this inquiry is particularly relevant to maternity services in the current climate where recruitment and retention of midwives is difficult and fewer young doctors are specializing in obstetrics. We know that when staff are put under unreasonable strain due to the numbers of open vacancies or unsatisfactory working conditions, the level of care experienced by labouring women and their partners is compromised. We are also concerned by the lengthy waiting times faced by women suffering from post natal mental health problems and the fact that many GPs and consultants seem reluctant to co-operate with patient led initiatives. We are also concerned about the lack of co-operation between different branches of maternity services. Initiatives like the National Service Framework for Maternity Services have provided many ideas for improving services but we would like to see these ideas filtering down to practice level.

3. AGING POPULATION

As a support organisation we frequently encounter women who have had such an appalling experience of childbirth that they have made the decision not to have any more children. If women are to be encouraged to have more children then it makes sense to prioritise the improvement of women’s experience of childbirth. It is also vital that maternity services staff are provided with adequate workplace support when going back to work after having children.

4. CHANGING THE ROLES AND IMPROVING THE SKILLS OF EXISTING STAFF

There is a huge hole in the education of all medical staff and that hole is mental health. Every single discipline in medicine, not just those specialising in mental health, has an impact on mental health. If you touch someone’s body, you touch their mind—this is especially true of such an intimate act as childbirth. Mental health education needs to be an important part of all basic medical training. It needs to be included
in basic midwifery training. It particularly needs to be included in obstetric and gynaecology training. Improving mental health training in maternity services could help reduce perinatal mental health problems and consequently the social and financial cost of such problems.

We have also found a resistance to patient led initiatives amongst consultants—whilst this is a generalization it is more often the case than not. So it is also vital that the training which is available becomes mandatory. The BTA have been leading a training scheme in East Sussex which has been very well received by the midwives (for whom it is compulsory). However despite fully informing obstetricians of this opportunity thus far, not one has attended. There is a huge need to create a more collegiate and supportive system of working practices between the different branches of maternity care. The ideal would be the establishment of “team culture” between consultant obstetricians, midwives, paediatricians, and the other disciplines often encountered in maternity wards such as anaesthetists.

5. Better Retention

There is currently a recruitment and retention problem amongst all disciplines of maternity practice. Good staff relations and co-operation reduce stress for staff and outcomes for service users. During the course of our work we have established three main issues that hinder staff retention:

(i) Flexibility in working patterns—particularly ensuring that part time work does not rule out promotion.

(ii) Lack of supportive working practices between the various disciplines as outlined in paragraph 4.

(iii) The need to eradicate blame culture and bullying in the workplace and encourage a more constructive workplace atmosphere and less paperwork.

One of the problems in maternity services is the vicious cycle of bad employment practice: a shortage of staff leads to poor working practices and stress for existing staff who are therefore more likely to leave leading to an even greater shortage. Staff are demoralised because they know how they should be carrying out their duties but lack of time and excessive paperwork mean that they are unable to focus fully on mothers during ante-natal appointments or labour and consequently miss crucial signs pertaining to their patient’s mental health. An example of this is emergency caesarean sections—It is obvious that being informed whilst in labour that an emergency caesarean section is necessary is a very frightening experience. One solution would be to have a designated person on the team whose sole job was to reassure the woman—to hold her hand, to say “please try not to worry, we know how frightening this must be for you, but we are going to help you and your baby, it’s going to be OK” and to give her some explanations about what will happen to her. It takes less than a minute to do this, but it can make the most enormous difference to the woman’s experience and how she processes it after the birth. However, all practitioners that we have spoken to agree that, most of the time there simply aren’t the resources to guarantee this happening.

5. Should Planning be Centralised or Decentralised

It is our experience that planning should not be overly centralised. What is suitable for one area is often not suitable for another—for example the needs of a rural area will differ from those of an urban area. Over-centralisation will lead to a “postcode lottery” where care is concerned.

6. Examples of Good Practice

In East Sussex the Trust has fully supported a pioneering training scheme for maternity practitioners, which is being piloted by the BTA. The sessions have been made mandatory for midwives and have been offered to other staff including consultant obstetricians. The training is a constructive way to ensure that staff working in maternity services are adequately provisioned in the skills necessary to look after the mental as well as the physical wellbeing of their patients. The BTA would like to collaborate with more health trusts to expand the scheme to give consultants as well as midwives the opportunity to attend.

7. Conclusions

What the BTA have found is that often money is being spent without achieving the best possible outcomes. The current under-investment in maternity services—ante-natal care and intra-partum care does lead to women being mentally and physically damaged. This then results in large sums of money being spent dealing with the consequent problems including physical damage and long-term mental health issues. The effects of long term mental health problems are wide ranging and affect not just the mother but also her whole family, with social and economic consequences beyond that for the whole of society. We have had contact with many women whose childbirth experiences and subsequent problems broken up their families. If the money were invested in better care before and during childbirth then long-term post-natal expenditure could be reduced.

Birth Trauma Association
March 2006
Evidence submitted by the British Association of Otorhinolaryngologists (WP 57)

INTRODUCTION

1. ENT UK is the specialty association for Ear Nose and Throat Surgeons in the United Kingdom. Well over 90% of ENT surgeons in the UK are members and the specialty is the third largest surgical specialty in the College of Surgeons of England. We have conducted detailed surveys of our workforce and working practices, the most recent in 2005, and we have details on working patterns, best practice, demand for the specialty, and facilities and support services needed to provide a high quality service for patients.

2. The scope of ENT is wide. It includes the following:
   (a) Ear conditions, in particular the assessment of hearing loss and ear disease and the diagnosis, treatment and rehabilitation of Hearing impairment. There are very close links with Audiology in this field.
   (b) Diagnosis and management of nasal and sinus disease.
   (c) Management of throat and voice disorders—again we work very closely with Speech and Language therapy in this field.
   (d) The diagnosis and management of diseases arising in the neck, salivary glands, thyroid gland, and cancers of the throat and neck.

ENT treats the entire population from newborn to old age. The specialty treats more children than any other surgical specialty. About 35% of an average ENT Surgeon’s surgical cases are under 16. The scope of ENT overlaps with Oral & Maxillofacial Surgery, Neurosurgery, Plastic Surgery and General Surgery and we collaborate with all these surgical specialities and many others.

3. Referrals to ENT services are very high and rising. The Department of Health figures indicate that in England alone, over two million patients were referred to ENT last year, which would be predicted to generate over five million consultations in ENT per annum, and 700,000 surgical procedures. Approximately 20% of referrals from General practice to hospital services are to ENT. Demand for ENT appointments has doubled since 1993.

4. The trained specialist workforce in ENT in England is lower per head of population than elsewhere in the UK, and in England there is less than one specialist (Consultant) per 100,000 population. There are currently the equivalent of 487 whole time ENT surgeons in England. Our target figure is for one per 50,000 (997 whole time equivalents) and existing demand indicates that we need at least 1,092. The existing number also compares very unfavourably with every European country except Ireland. The number of specialists in mainland Europe varies between one for 8,000 population in Greece to one for 43,000 in the Netherlands.

5. ENT UK has consistently worked with the Workforce Review Team and its predecessors, and with the Department of Health in such initiatives as Action on ENT to improve services. We supported expansion of the specialty, and there has been a 17% expansion between 1999 and 2005, but it remains seriously inadequate for the workload. We welcome the opportunity to submit this memorandum to the Health Committee, and would be very pleased to have the opportunity to present evidence to the committee on how to meet the demand for ENT services.

THE FUTURE

In answer to the specific points raised in the Terms of Reference, our responses are as follows:

1. Recent policy announcements—moving services into the community. This raises issues relating to quality of service. Many of the issues became apparent when GP fund holding was in place. ENT clinics require the following equipment and personnel in addition to medical staff.
   (a) Specialist nursing staff who assist, advise and facilitate the patient’s journey in clinics and sterilise and maintain the specialist diagnostic equipment. Specialist nurses often provide additional services such as skin prick testing for allergy and microscopic ear toilet for ear infections.
   (b) Audiologists trained to assess and rehabilitate the hearing impaired and Audiological testing with calibrated equipment in sound-proofed booths or rooms.
   (c) A range of specialist instrumentation, including the expensive flexible fiberoptic and rigid Hopkins rod endoscopes, requiring appropriate maintenance and sterilisation by staff trained to care for this expensive equipment.
   (d) The use of diagnostic microscopes, with the associated care and maintenance.
   (e) Access to imaging (mainly CT & MRI scanning).
   (f) Access to diagnostic cytology services for the prompt and accurate diagnosis of the causes of neck masses. This is essential to meet the current standards for Head and Neck Cancer care.

2. Technological advances. These are mentioned above. In particular the use of endoscopes has enhanced our diagnostic abilities and accuracy and has improved patient understanding and tolerance. This has allowed a dramatic reduction in the need to do diagnostic endoscopy under General Anaesthetic in
operating theatres. ENT UK has published a document on standards for outpatient provision. We regard the use of these instruments as essential to provide a modern, one stop assessment and diagnostic service for patients.

3. Ageing population. As with most medical services, demand is increased in the ageing population. A high proportion of the elderly need assessment and treatment for hearing impairment. Audiologists can do much of this directly, but access to ENT is essential for the diagnosis of atypical hearing loss and associated disorders such as vertigo. Head and Neck Cancers are more common in the elderly.

4. The use of Private Providers. Private providers are able to meet the standards achieved in the NHS, but few private ENT clinics provide the range of staff available in the best ENT clinics—medical, nursing, audiology, speech and language therapy—and few are equipped to the same level to allow a one stop assessment and diagnostic service. Minimising the number of visits to ENT clinics is one of the best ways of improving the efficiency of the existing resources.

Effects on the Ability to Meet Demand

1. Financial constraints. All accept that the NHS is always subject to financial constraints, but quality services require the level of equipment detailed above used in dedicated facilities by specialist staff. ENT UK considers that the best service for patients is provided by maximal use of well equipped facilities. Thus, if a clinic can be fully equipped and fully utilised at least five days a week, this is most cost effective without compromising quality. Good access for patients to specialist clinics is critical. Occasional use of expensive equipment in multipurpose facilities where it is maintained by staff who are unfamiliar with it may be appealing, but this is undoubtedly suboptimal.

2. European Working Time Directive. This has little bearing on meeting the referral demand for ENT services. 85% of ENT is non-emergency, and most patients are dealt with on an outpatient basis within office hours. Emergency cover is a concern, but can be dealt with best by providing beds and operating facilities in larger institutions. Day case surgery can be provided along with outpatient services in well used facilities on the “hub and spoke” pattern. ENT does a range of highly complex surgery including Neuro-otology, skull base surgery and major sinus and head and neck surgery for cancer and benign conditions. This work is best done in major centres where there are dedicated facilities and multidisciplinary support.

3. International Competition. There is no perceived threat from international competition. There are trained surgeons looking for posts in the UK and ENT is a popular specialty among trainees. We are able and willing to expand training, but NHS trusts appear reluctant to advertise consultant posts currently, possibly due to uncertainties over funding.

4. Early retirement. Again, this is not an issue. Given that there is a shortage of posts being advertised and there are increasing numbers of trained surgeons available because of our support for expansion under the NHS Plan, ENT could supply specialists to meet the needed expansion.

Meeting Demand

1. ENT UK feels that we can meet demand “in house” if expansion is allowed. We have rising numbers of trained UK specialists becoming available to permit this over the next five years.

2. Recruitment and retention are not currently issues for medical ENT staffing. There are shortages in some of the allied health professional groups.

3. International recruitment is not currently necessary or desirable for medical ENT staff.

Undertaking Planning

1. This should be done in collaboration with ENT UK, along with professional representatives from those professional groups closely associated with us, specialist nurses, audiologists and speech and language therapists. We already have been involved with planning under Action on ENT and we are currently establishing a forum with the Department of Health.

2. Ensuring flexibility. There is a risk that flexibility comes at the expense of high quality. By definition, specialism limits flexibility. ENT UK’s position is that we should look to provide the highest quality service possible within the resources provided. This necessitates high quality well trained staff from all the related disciplines working in a dedicated appropriately equipped environment which is readily accessible to patients.

3. Within this framework there are many examples of good practice around the UK.

Representatives of ENT UK would be happy to provide data to support the issues raised above and would welcome the opportunity to address the Health Committee or provide further documentation if requested.
Given the major difference between demand and supply for ENT services in England, we are very keen to be involved in any discussions and initiatives to improve access to the specialty for patients.

Alan Johnson
Workforce Lead and President Elect, Ear Nose and Throat UK
March 2006

Evidence submitted by the British Association of Urological Surgeons (WP 06)

INTRODUCTION
The British Association of Urological Surgeons is the Specialist Association representing Urology in the United Kingdom. Its membership includes almost all the current Consultants in Urology in the UK. The Association holds detailed data on the urological workforce which is agreed with the National Workforce Confederation. It also holds information on the number of urological procedures performed in the UK and uses this to project workforce requirements.

Ability to meet demand
(a) We have carefully calculated our workforce requirement based on the actual number of procedures needing to be performed annually and projected outpatient work. On this basis we believe we require 950–1,000 consultants (presently 650) in the UK. We have led the surgical specialties in adopting MMC and have redefined the roles and job descriptions of urologists in order to provide a workforce suited to service needs.

(b) We are concerned that with financial restraints Trust will lack the finance to make more appointments leading to a shortfall in service provision.

(c) In a recent survey the mean planned age for retirement for urologists was 61.3 years. All our current manpower planning is based on this retirement age. If NHS pension rules change in 2013 there are likely to be a significant number of urologist retiring early—this could affect delivery of service for a period of approximately two years.

Staffing
(a) A substantial amount of Urology is now performed by Nurses working in close association with medical staff. In Urology there is little scope for further expansion of these roles.

(b) We anticipate a small number of overseas recruits (2–5 pa).

Planning
(a) Surgical Urology is becoming very subspecialised. We therefore believe it is essential that planning for the subspecialties is performed centrally.

(b) We have already calculated the subspecialty requirements for urology. We are constantly monitoring service need and will adjust the number of trainees accordingly.

(c) We have created posts in urology which lend themselves to flexible or part-time working. We believe these will be attractive to many perhaps especially women. We hope to increase the number of women trainees over the next five years.

Krishna Sethia
British Association of Urological Surgeons
7 March 2006

Evidence submitted by the British Geriatrics Society (WP 35)

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,200 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, and scientists engaged in the research of age-related disease. The Society offers specialist medical expertise in the whole range of health care needs of older people, from acute hospital care to high quality long-term care in the community.
Geriatric Medicine

Geriatric Medicine (Geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home.

The Society welcomes the opportunity to contribute to this debate and would comment on particular questions as follows:

1. In considering future demand, how should the effects of the following be taken into account:
   — recent policy announcements, including Commissioning a patient-led NHS;
   — technological change; and
   — an ageing population.

1.3.1 While Commissioning a patient-led NHS may ensure that older people with intact cognition will be heard the same cannot be said for the frail older person being admitted to hospital who can often suffer from Dementia and or Delirium. They require specialist care.

1.3.2 The Society stresses the importance of a broad group of professionals required to provide care for older people. The key skill of the specialty is a multi-disciplinary team approach delivering a comprehensive assessment to frail older people. The Society recognises the importance of many models of care but believes a medical assessment and treatment model has its place in a multi-faceted continuum of care. This report focuses on the challenges of training, recruitment and retention of specialists in geriatric medicine in the UK as well as highlighting the issues responsible for a shortage of specialists required for an expanding population of older citizens.

1.3.3 The National Service Framework for Older People¹ came into force in England in March 2001. It espouses eight Standards to be applied to the Care of Older People and has been broadly welcomed by geriatricians, emphasising as it does the specialty nature of medical care of older people, particularly in the areas of:
   — Better acute hospital care for older people.
   — Falls and fractures (and their prevention as well as treatment).
   — Stroke (treatment and prevention—with good evidence that well coordinated stroke care saves lives and reduces disability). The inclusion of stroke mortality as a nationally required outcome measure by which hospital trusts are judged has had an impact in creating new consultant posts specialising in stroke.
   — Intermediate Care and rehabilitation.
   — Mental Health (not strictly the remit of this report but recognising the combined physical and mental health problems in frail older people).

1.3.4 Although still in its infancy as a formal part of health and social care, Intermediate Care (as part of the NSFOP for England) is now a reality with investment in both hospital and community based services evident. In 2002, a year after the launch of the NSFOP, the BGS surveyed 153 lead consultants (with excellent 75% response rate). It examined geriatricians’ involvement with NSF developments. In general, good early progress was reported in implementing the NSF. However there are substantial implications for demands on consultant time with consultant geriatricians providing leadership for “specialty led multidisciplinary teams” and involvement in:
   — Acute medical Care with a high proportion of medical emergencies occurring in frail older people.
   — Specialist clinical leadership in management of Stroke and Falls.
   — Comprehensive assessment of older peoples in various settings.
   — Specialist input into intermediate care whose main aim is reduce the need for acute hospital care.
   — Planning activities for NSF developments.

1.3.5 In the five years since its inception the NSFOP has had a significant impact on demands for the specialist expertise of geriatricians and a number of new posts have been created or adapted to fulfil the needs to service the NSFOP.

1.3.6 The recent changes to the General Practitioner contract have led to older people facing major obstacles when seeking help in a crisis.

1.3.7 The consequences are both immediate and far-reaching for vulnerable older people and those informal carers on whom they depend. The immediate crisis may result in an unwanted or unnecessary hospital admission in which the crisis is worsened by its late discovery the next day which may eventually lead to inappropriate premature institutional care.
1.3.8 Increasing demands are being made on geriatricians. As a result, the Society has for many years been putting the case for more geriatricians. In July 1998, the BGS published its recommendations for the provision of consultant geriatricians which were then recalculated. They calculated that an expansion from 764 consultants to 1,700 in England and Wales would be required by 2005 taking into account the needs of patients aged 75 and over, the requirements of academic staff within the speciality and the wider pressures being placed on the speciality. The latest Consultant Census carried out by the RCP in 2004 enumerated only 1,075 WTE in the UK and for England and Wales 913, well short of the original target of 1,332. For reasons described below a large shortfall is likely for many years.

1.3.9 Difficulties in filling consultant posts—Despite being the largest medical specialty in the UK, the RCP surveys (annually since 1993), have indicated a lower growth in posts in geriatric medicine (3.9% per annum) compared with the average for medical specialties of 6.5% per annum. In the last year, despite Geriatric Medicine being the largest medical specialty, expansion in Geriatric posts (12 between 2003 and 2004) is less than in other acute specialties (eg Cardiology up by 28 posts, respiratory Medicine 26, gastroenterology 25 and Endocrinology and Diabetes 20).

1.3.10 Increased demand has outstripped supply in all acute medical specialties, a situation which has deteriorated over the last few years. Taking all medical specialties, the RCP survey in 2004 noted that 36% of Advisory Appointments Committees failed to make an appointment, with especially high failure to appoint in acute/general medicine (56%), geriatrics (50%), rehabilitation medicine (47%) and Palliative care (44%).

1.3.11 The problem for geriatric medicine has been compounded by:
— The parallel (and faster) expansion in other specialties (notably cardiology, gastroenterology and respiratory medicine), attracting trainees away from geriatrics.
— A trend (unquantified) for consultants to move “sideways” into more attractive vacant posts.
— The danger of unfilled posts being withdrawn.
— An increasing number of consultants who wish to work part-time (41.5% of SpRs in the 2004 survey were women). Likewise the number of part-time trainees is increasing, which lengthens their training period.
— An eight to 10 year hiatus between the current recruitment rate of doctors and the expected increase in medical school output.
— Geriatric (Old Age) Medicine is the largest medical specialty in the UK and has a central place in the acute and rehabilitative care of older people with ever increasing demands on its consultant staff. The senior medical workforce of the specialty has increased by nearly 4% per year in the last 13 years to over 1,100 in the UK this year.
— In the 13 years since the Royal College of Physicians established an annual consultant census, the number of consultants in geriatric medicine has risen from around 650 to over 1,100 in the UK. As this paper will demonstrate, the work demands have increased even more and there is concern about a growing shortfall of consultants.
— This report attempts to quantify the medical workforce shortfall in the specialty of geriatric medicine and draws attention to the reasons for a widening gap between the work demanded of consultant geriatricians and the availability of consultants to do the work.
— Based on a requirement of one geriatrician for 35,000 population there is a current shortfall of over 600 whole time equivalent (WTE) consultants in geriatric medicine in the UK.

1.4 The increasing use of private providers of services.

2. How will the ability to meet demands be affected by:
— financial constraints; and
— the European Working Time Directive.

2.2.1 Hospital doctors provide a 24 hour, seven day a week service. As the largest contributors to emergency medicine, geriatricians and their trainees have been profoundly affected by the restrictions imposed by the implementation of the European Working Time Directive (EWTD). The RCP and BGS have examined this issue in great detail and have concluded that it will be impossible with the projected workforce supply to approach legal working hours for between six and eight years (if ever). The calculations upon which this conclusion is based are presented later.

2.2.2 The EWTD (with associated “hikes” in pay for working outside the normal working week), “family-friendly” Human Resource Policies and “flexible working” are pragmatic steps to encourage recruitment and retention of staff and provide the work-home balance which promotes quality of life for the workers in health and social care services.

2.2.3 Indirect effect of the EWTD—The indirect effect on consultants (of altered work patterns by junior medical staff) is having an even more dramatic effect:
— less day to day continuity of care and ward cover by junior staff who work full shifts and increasingly are engaged in working in Medical Admissions Units; and
— Frequent absences due to being off duty.

2.2.4 Many consultants in medical specialties declare that they are the only doctors able to provide continuity of medical care in a consistent manner. However if shift working became necessary, even that continuity would be lost.

2.2.5 Direct effect of EWTD—In the RCP surveys, consultants were asked to estimate the average excess hours worked over 48 hours (the legal limit for the EWTD). In the year 2000, geriatricians reported an excess of 6.4 hours. From this it was calculated that an additional 160 WTE geriatricians would be required comply with the EWTD. In the 2004 survey, despite an increase of 4% per annum in consultant numbers, the situation had deteriorated with geriatricians working 11.4 hours above 48h EWTD legal maximum.

— For geriatricians’ work to become “legal” (48 hours per week), an increase of 357 (33%) WTE consultant geriatricians would be required.
— To comply with the desired limit by most Trusts of 40 hours a week (10 Programmed Activities) an increase 54% in WTE would be necessary.
— In relation to all medical specialties, projections indicate that unless current work pattern changes, consultants will work.
— more than 48h (EWTD limit) till 2008.
— above contract till 2010.
— more than 40 hours till 2012.

2.2.6 The general conclusion is that most acute specialties will be forced to operate a full shift system at all levels.

— increasing international competition for staff; and
— early retirement.

3. 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; and
— the recruitment of new staff in England.

3.3.1 The disappearance of Senior Registrars with Calman reforms some years ago meant that many new Specialist Registrar (SpR) posts were created on the basis of “history or equity” rather than their capacity as good training slots. So some “dead-end” registrar posts, previously not considered suitable for training have been incorporated into SpR rotations, with several deficiencies possible:

— No research opportunities or the need to rotate to a research oriented department.
— Services inadequate to offer exposure to the specialty elements now required for accreditation, especially in relation to rehabilitation, subspecialty work, long term care, and the new service elements emphasised in the NSF such as falls, stroke care and geriatric specialisation within acute services.

3.3.2 The demands of acute medicine compounded by the dramatic effects of the European Working Time Directive (EWTD) are widely believed to be detrimental to the quality of specialty training and hence are likely to adversely affect recruitment to the specialty. Most obviously, the majority of SpRs in Geriatrics have been forced into partial or complete shift work in the service of acute emergency medicine, with a detrimental effect on specialty training (a situation also occurring in other specialties which contribute to emergency medical care).

3.3.3 The requirement to choose a specialty at an earlier career stage has reduced the market for geriatrics which (as an acquired taste) previously relied heavily on “late converts”. The additional effects of “Modernising Medical Careers” (MMC), a Government scheme to shorten post-graduate medical training (to be implemented between 2006 and 2008) will force doctors to choose their specialty even earlier in their career than hitherto and might further disadvantage the specialty.

3.3.4 Competition for trainees with other medical specialties which are expanding as fast or faster than geriatric medicine

3.3.5 A recent survey of recruitment of SpRs in geriatrics gives cause for concern. In 2005, certain areas of England (Yorkshire, Mersey and NW Thames) noted a sharp rise in the number of unfilled SpR posts while in Scotland, Northern Ireland and Wales there appeared little difficulty in recruitment.

3.3.6 Additional problems for academic geriatric medicine—In its recent submissions to the RCP Workforce Unit (RCP 2000 census), the BGS Workforce Committee has noted that only 91 out of 965 posts were academic appointments (9.4%) compared with 16.3% average for medical specialties. Academic Departments tend to be small but some are sub-departments or affiliated with other groups. The 12 who gave
detailed replies averaged four members of permanent academic staff (but varied from one to nine). 18 of 50 identified posts were non-clinical in nature. Two of 12 departments were headed by Senior Lecturers.

3.3.7 There are several factors which cause difficulties in recruitment to academic posts:

— Geriatrics is fairly recent specialty without a long track record of academic work.
— As an expanding specialty, there are plenty of NHS posts to choose from.
— The generality of the specialty makes research themes hard to identify, though sub-specialties emphasised by the NSFOP have helped.
— Departments tend to be small with varied research interests which make for a lesser impact.
— Small departments amalgamated with nearby departments of medicine lose their identity.
— Geriatric Medicine has never been an attractive target for mainstream research funding and in general does not attract strong support from the local medical schools. The specialty has depended very much on the valiant efforts of the Charity Sector: Groups such as Research Into Ageing, the Stroke Association and the Alzheimer’s Disease Society to fund research.
— The relatively low level of research activity and patchy research training at registrar level, recently highlighted in submissions to the BGS Training Committee.
— A low proportion of consultant posts in Teaching hospitals: in the 2000 census only 273 out of 965 (28%), compared with medical specialties such as cardiology (38%) and gastroenterology (37%).

3.4 International recruitment.

4. How should planning be undertaken:

— To what extent should it centralised or decentralised?
— How is flexibility to be ensured?
— What examples of good practice can be found in England and elsewhere?

5. How should planning be undertaken:

— To what extent should it centralised or decentralised?
— How is flexibility to be ensured?
— What examples of good practice can be found in England and elsewhere?

5.3.1 The above three issues will be answered together as follows:

5.3.2 The Government has recognised the need to increase rapidly the number of consultants not only to improve compliance with the EWTD but to address important health targets such as reducing deaths and morbidity from heart disease and stroke, and to improve detection, speed assessment and improve outcomes from treatment of an array of cancers.

5.3.3 A number of general measures are in various stages of development:

— The current expansion of UK Medical Schools and opening of new ones is welcome but will take 10 or more years to have an impact on consultant numbers.
— “Modernising Medical Careers” is an important initiative to shorten the time from basic qualification to attainment of specialist training. Initial implementation has just begun. One positive effect in terms of specialty recruitment may be the release of funds from a number of discontinued Senior House Officer posts which could be used to fund new Specialty training posts, an idea which the Joint Committee on Higher Medical training (JCHMT) has recently (January 2006) indicated a willingness to explore, provided the specialist training capacity can be found.
— Recruiting consultants from abroad—never a strong card, since few countries in the developing world have well-developed geriatric services (apart from the moral and ethical objections to such a strategy).
— The Workforce Numbers Advisory Board controls workforce numbers in the NHS. Doctors are the remit of a subsidiary Committee, the Medical Workforce Review Team. In previous years, strict controls or “ceilings” were imposed on specialties to curb the unbridled expansion of popular specialties at the expense of less popular ones. Encouragement by provision of some central funding was given to unpopular specialties which were either politically sensitive (eg psychiatry) or necessary for key health targets such as cancer (requiring an infrastructure in specialties such as histopathology and radiology). As the impact of the EWTD on doctors numbers became apparent the restrictions on SpR numbers has been eased especially in acute medical specialties.
— In Geriatric medicine, 80 new SpR posts were allowed in 2003 and a further 30 in 2004. Because of the subsequent emergence of difficulties in filling SpR posts, no further SpR numbers were allocated in 2005.
5.3.4 New workforce planning arrangements—The Strategic Training Authority (which issues certification of Specialist training) has recently been replaced by the Medical Education Standards Board. This is likely to diminish the power of the professional Colleges to decide where training posts should be placed. At the Department of Health, there has been a radical review of NHS workforce planning. The new NHS workforce arrangements are in their early days, but it is now clear that the traditional way of replacing “like with like” is considered a concept of the past. We now have to consider the total workforce needs for health and social care needs of a particular patient group. It is also clear that the traditional professional roles, boundaries and overlaps of roles are being challenged.

5.3.5 The Older Peoples Care Group Workforce Team was established in December 2001 to take a broad view of the workforce required to care for frail older people. Amongst its early priorities was to help with filling the “medical gap” in the care of older people, especially in relation to supporting new initiatives in Intermediate Care. It was proposed in 2002 (with mixed support from the Royal College of General Practitioners) to create a large number of General Practitioners with a Special Interest (GpwSI) in care of older people (and a number of other specialty areas).

5.3.6 Unfortunately this initiative has been largely unsuccessful because:
— There are few GPs not already involved in Elderly Care Services who are interested in this work.
— There was deep concern that this sort of work would distract GPs from providing basic services (in the context of a severe shortage of GPs especially in inner cities).
— Pre-occupation with establishing a new GP contract and a new range of General Medical Services (GMS 2).

Dr Jeremy R Playfer
President, British Geriatrics Society
15 March 2006

REFERENCES:
1 Department of Health 2001, National Service Framework for Older People.
3 British Geriatric Society 1998, General internal medicine/Geriatric medicine. Statements of principles and recommended practice, consultant manpower projections to provide an effective service.
5 British Geriatrics Survey (2005), Internal survey of national training numbers (Registrars in Geriatric Medicine).

Evidence submitted by the British Medical Association (WP 59)

EXECUTIVE SUMMARY

A major criticism of NHS workforce planning has been that it has failed to examine workforce requirements in an integrated fashion looking at service needs, preferring to look at each professional group, particularly doctors, in isolation in relation to assumed demand for its services. Although this memorandum deals for the most part with medical workforce planning, overall service needs should drive the planning process across all health service staff groups.

Medical workforce planning operates on two levels. At the macro level it deals in aggregate supply and demand whilst at a micro level it seeks to allocate numbers amongst competing sectors and specialities, paying particular attention to training requirements.

Successive reviews at the macro level have assessed the likely supply of doctors under certain assumptions and compared it with prospective NHS demand, the stepping off point being the existing position. As a result, no comprehensive needs-based evaluation of that position has been undertaken. This has cemented in a shortfall of doctors hidden by long hours of work and perverse incentives for substitution.

Substantial changes to working arrangements have taken or will shortly take place which will severely impact on the ability of the workforce to meet existing let alone prospective demand, including for example the European Working time Directive and system reform.

The Wanless Review’s workforce model looking at the government’s proposed increases in the NHS workforce concluded that looking 20 years ahead, the planned increase in the supply of nurses was almost sufficient to match demand, but the planned increase in doctors would fall well short of demand, totalling around 25,000 after 20 years. The Review concluded however that skill mix change and new reward mechanisms could ameliorate the position. Other research suggests that depending on skill mix change to meet the gap might be misplaced as labour cost savings could be offset by higher resource utilisation.
Ideally, workforce planning should be concerned not only with numbers of staff but also with recommending mechanisms for meeting demand via the effective deployment and rewarding of NHS staff to maximise their contribution to direct patient care. The role of incentive in encouraging additional labour supply from the existing workforce should not be underestimated.

For the workforce as a whole there has been a dramatic increase in non-clinical workload with management and administrative duties, teaching and training taking up an increasing share of available time.

SUMMARY OF RECOMMENDATIONS

— The demand for doctors is affected more radically by short term changes in NHS delivery systems than has hitherto been recognised by planners and governments should avoid making the sorts of change which exacerbate the position without first evaluating the impact.
— More account needs to be taken of medical advance and technological change in workforce planning than is currently the case.
— Skill mix change is not a universal panacea and should be carefully evaluated for both its cost and effectiveness before being introduced.
— Workforce planners should concern themselves with recommending change as much as with predicting it.
— More attention should be paid to designing incentives for encouraging recruitment, retention and changes in working practices.
— The need for a strong and effective regulatory environment should be tempered by recognition of its impact on the resources available for patient care.
— The way in which doctors make career choices is an important issue affecting recruitment into both the profession itself and individual sectors and specialties and should be taken into account in workforce planning.
— Whilst the service needs of NHS providers are a major variable in the process, overall resource constraints also impact on providers' capacity to employ or contract with NHS staff.
— The difficulty with which some doctors obtain posts at varying points in their careers is symptomatic both of the impact of funding pressures and poor medical workforce planning at the micro level.

INTRODUCTION

1. The BMA is pleased to contribute to the Health Committee's inquiry into Workforce needs and planning for the health service, which is examining how effectively workforce planning, including clinical and managerial staff, has been undertaken and how it should be done in the future.

2. A major criticism of NHS workforce planning has been that it has failed to examine workforce requirements, notably those for professional staff, in an integrated fashion looking at service needs, preferring to look at each professional group, particularly doctors, in isolation in relation to assumed demand for its services. Inevitably, this memorandum concentrates on workforce planning as it relates to the medical workforce but it also attempts to place the demand for and supply of doctors in a wider context, in discussing the role of skill mix change. The recommendations are also generally applicable.

HISTORY

3. Medical workforce planning operates on two levels. At the macro level it deals in aggregate supply and demand whilst at a micro level it seeks to allocate (insufficient) numbers amongst competing sectors and specialties largely, though not exclusively, on the basis of staffing norms.

4. The history of overall medical workforce planning in the UK—the macro approach—is a well known one and we do not intend to deal with it in any great detail. Suffice to say it has consisted of a number of major reviews at irregular intervals beginning with the Goodenough Committee in 1944 and culminating in the setting up of a standing body—the Medical Workforce Standing Advisory Committee (MWSAC)—in 1991. The format of such reviews has, with increasing levels of sophistication in modelling, been to assess the likely supply of doctors under certain assumptions and to compare it with (fairly crude) measures of prospective NHS demand. The third report of MWSAC in 1997 for example recommended:
— An increase of about 1,000 in the annual intake of medical students.
— The development of clinical courses with graduate entry.
— Holding constant the number of undergraduate medical students from overseas.
5. In addition it set out its longer term aims in relation to overseas recruitment:

We favour self-reliance as a long term goal, that is relying largely upon UK doctors although not aiming for a workforce comprised entirely of UK doctors.8

6. This distinction between self-reliance and self-sufficiency is an important one and has implications for future medical workforce planning, implying as it does a significant though stable role for international medical graduates (IMG). We should perhaps not overlook the potential contribution of refugee doctors already present in the UK in this respect.

7. Furthermore, the stepping off point for medical workforce planning has always been the existing position and no needs-based evaluation of that position has been undertaken. The starting position has always been a shortfall of doctors relative to demand and a very low stock relative to population by international standards—masked to some extent by long working hours and a remuneration system that did not encourage substitution of labour. Progressive changes to junior hospital doctor contracts and the threat of the European Working Time Directive have been major factors in altering this perverse incentive.

8. Notwithstanding this, the present approach to workforce planning means that the effect of any changes to the way in which the current workforce works will be felt long before the impact of future recruitment. Getting the numbers of doctors wrong has, furthermore, potentially serious consequences. The ratios of doctors to head of population served, both in hospital and in general practice, seem, for example, to be critical determinants of standardised hospital death rates; the higher these ratios, the lower the death rates in both cases.9

THE PRESENT SITUATION

9. The government having accepted MWSAC’s recommendation on medical school intake, the 2000 NHS Plan10 promised a further increase of 1,000 in medical school places to nearly 7,500. It also pledged to deliver by 2004:

— 7,500 more consultants.
— 2,000 more GPs.
— 20,000 extra nurses.
— 6,500 extra therapists.

10. In 2002, Delivering the NHS Plan made further commitments to deliver by 2008:

— 15,000 more GPs and consultants.
— 30,000 more therapists and scientists.
— 35,000 more nurses, midwives and health visitors.
— 10,000 more general and acute beds.

11. In 2005, 7,106 home students were accepted at UK medical schools together with 179 applicants from the European Union and a further 545 from elsewhere overseas.11

12. However, substantial changes to working arrangements have taken or will shortly take place which will severely impact on the ability of the workforce to meet existing let alone prospective demand. These include:

— The European Working time Directive.
— The full impact of consultant job planning under the 2003 contract.
— The impact of clinical governance on available clinical time (see below).
— The increasing feminisation of the workforce and its implications for flexible working.
— Increasing preferences for part-time working amongst the workforce as a whole.
— System reform—particularly patient choice and plurality of provision.
— Transferring activity from a hospital to a community setting.

13. We examine two of these issues—governance and system reform in more detail later in this memorandum.

THE WANLESS REVIEW

14. The Wanless12 workforce model assessed the implications of the increased activity projected in the Review for workforce demand, assuming for the most part current levels of workforce productivity. There were two exceptions:

8 Planning the Medical Workforce, Medical Workforce Standing Advisory Committee: Third Report, December 1997, p3.
— Doctors’ working hours were assumed to fall to 48 hours a week in line with the Working Time Directive.
— Average length of stay for inpatient admissions to hospital was forecast to fall in line with the estimates set out in the National Beds Inquiry.

15. Wanless forecast the need for substantial increases in the demand for health care workers over the 20 year time frame covered by the Review. His “solid progress” scenario implied a need for an additional:

— 62,000 doctors.
— 108,000 nurses.
— 45,000 professionally qualified therapists and scientists.
— 74,000 health care assistants (HCAs).

16. The Review’s workforce model compared these estimates with the increased supply expected if the Government achieves the plans for additional training, recruitment and retention set out above. This comparison revealed that the planned increase in the supply of nurses was almost sufficient to match demand, but the planned increase in doctors would fall well short of demand. Indeed this gap would start to emerge before the end of this decade and would be around 25,000 after 20 years.

17. The Wanless Review had, however, high hopes for the roles of skill mix change and new reward mechanisms in helping to ameliorate the position.

SKILL MIX AND SERVICE REDESIGN

18. The Wanless Review explored the potential contribution that skill mix changes could make to the potential mismatch between the demand for and supply of doctors. Its Interim Report highlighted evidence suggesting that Nurse Practitioners could undertake at least 20% of the work of doctors while maintaining the safety and quality of care. If, Wanless concluded, 20% of GP and junior doctors’ work were shifted to Nurse Practitioners, this would eliminate any potential capacity constraint in doctor numbers.

19. Research evidence shows that Nurse Practitioner consultations are longer, so more nurses would therefore be required to deliver a given level of activity. In a Cochrane review of skill mix in primary care, Laurent and others concluded that whilst patient health outcomes were similar for nurses and doctors, patient satisfaction was higher with nurse-led care. However, there were resource implications in that nurses had longer consultations and higher rates of patient recall than doctors. There were no significant differences in hospital referral rates or patient attendance at accident and emergency units. However, patients managed by nurses were more likely to be admitted to hospital. Savings on nurses’ salaries were generally offset by nurses’ higher resource utilisation and impact on physician workload was variable.

THE ROLE OF INCENTIVE

20. Although skill mix change could make a major contribution to eliminating any potential skills mismatch over the 20 years, there will clearly also need to be an increase in the number of doctors and nurses over that already planned. Wanless argued that this should be achievable if pay modernisation resulted in improved recruitment and retention. The role of incentive has been insufficiently explored by workforce planners in the past. Higher rewards for doctors have undeniably contributed to the increased popularity of medicine as a career. The rise in applicants in 2004 represented an increase in home applicants per place from 1.71–1.97, only just below the 1997 level (2.04), when the current expansion in places began. However spiralling student debt may be the next major disincentive and workforce planners should be aware of this. In this context, the BMA’s 2004 survey of medical student finances showed average 5th year debt of £19,248, an increase of 16% over its 2003 level. The role of incentive in retention should not be ignored. Research commissioned jointly by the BMA and the NHS Confederation during the new GP contract negotiations found, for example, that:

— Over one third of GPs (36%) reported that having insufficient financial incentive to stay in general practice was an important factor influencing their retirement decisions.
— Almost half of GPs (47%) felt that financial considerations were an important influence on their planned retirement age.
— The scenario most likely to postpone retirement was a retention bonus lump sum payment of £15,000 for each year retirement was deferred beyond the age of 60.

14 Laurent M; Reeves D; Brasperning J; Grol R; Sibbald B; Substitution of doctors by nurses in primary care (Cochrane Review) 2004.
THE OUTPUTS FROM WORKFORCE PLANNING

21. To date, the major output from overall medical workforce planning has been a recommendation to change (usually increase) the UK medical school intake. This has been because the methodology implicitly assumes increased derived demand for doctors arising from increased NHS activity. As we have seen, there might be scope for deflecting some of this demand to other staff groups although this does not affect the underlying premise that more activity equates with a need for more staff.

22. Ideally, workforce planning should be at least equally concerned with recommending mechanisms for meeting demand by implementing best practice not only in redesigning services but also in the effective deployment and rewarding of NHS staff to maximise their contribution to direct patient care. It will often, given lead times for adjusting the numbers of professional staff, be more effective to change working patterns at least in the interim. Such changes do occur so in isolation from workforce planning. For example, the new GP contract is practice-based and it provides resources to deliver primary care rather than linking payments to doctors. This leaves practices free to make better use of the available workforce—not only satisfying the requirements of a new generation of doctors wishing to work part-time or as salaried doctors but also making better use of other professionally trained staff. The workforce implications of this have yet to be evaluated.

23. On the hospitals side too, system reform has implications for workforce planning. If there is to be a competitive environment on the provider side, there needs to be spare capacity. It seems curious to talk of spare capacity in the context of an apparent overall shortfall in doctor numbers—to say nothing of the relative position in individual specialties. The mismatch between doctor numbers and demand will be exacerbated by system reform aimed at delivering choice of provider other than under three scenarios:

— A substantial influx of doctors from outside the UK on a temporary basis.
— A radically different contractual relationship between provider organisations and professional staff.
— Providers prepared to offer choice on the basis of substantially different models of care involving different staff mix.

24. Allied to system reform are the issues of changes to medical training (Modernising Medical Careers) and the service needs of NHS providers. The latter, particularly Foundation Trusts, will increasingly wish to plan their own workforces to meet service requirements and will seek to influence the future shape of training programmes. This has the potential to undermine effective workforce planning, unless taken into account by planners.

GOVERNANCE

25. For the medical workforce as a whole there has been a dramatic increase in non-clinical workload with management and administrative duties, teaching and training taking up an increasing share of available time. By way of example, time spent on management by whole time consultants increased by over four hours per week between 1989 and 1998, helping to increase average total hours of work (excluding emergency recalls) from 48.3–51.3 hours per week. In consequence the time available for clinical work has declined by around two hours (6%) per week. The Wanless review identified two competing trends in workforce growth—information and communication technology (ICT) investment which might significantly reduce the amount of time medical and nursing staff had to spend on administration, freeing up more time for patient care and the amount of time spent on clinical governance which would have the opposite effect. For its financial projections, the review assumed that 10% of professional staff time would be devoted to clinical governance.

HOW DOCTORS MAKE CAREER CHOICES

26. The way in which doctors make career choices is an important issue affecting recruitment into both the profession itself and individual sectors and specialties. The BMA has studied the career progression of a cohort of over 500 doctors who graduated in 1995. The results of the study have been hugely informative. The findings from the tenth and final year of the study are summarised below.

27. These suggest that a medical career no longer follows a traditional pattern for a significant proportion of doctors. Workforce planning will need to take greater account of this in future. This will be particularly true of planning at the micro level.

Findings from 10th (2005) report of BMA cohort study

— While three-quarters of cohort doctors are currently satisfied with practising medicine, a fifth report a lukewarm desire to practise medicine and the remainder have little or no desire to practise medicine. A key factor in the morale and motivation of cohort doctors is achieving an acceptable work-life balance.

— The proportion of cohort doctors working in general practice continues to increase, with a third of cohort doctors working as general practitioners (GPs) in the past year. Around a quarter of cohort GPs worked as full-time principals, with the remainder working in part-time principal or non-principal posts.

— One in five cohort GPs worked as a locum. Flexibility is one of the key reasons given for cohort doctors working as locums in both general practice and hospital medicine.

— The numbers of cohort doctors choosing to specialise in radiology, anaesthetics and pathology or pursue a career in academic medicine have increased over the nine-year period. In contrast, the proportions planning a career in general medicine or surgery have more than halved since graduation in 1995.

— In the past year, 15% of cohort doctors had changed their choice of career and one of the key factors influencing this change is “hours of work and working conditions”.

— A third of the cohort plan to practise medicine overseas in the future, either on a temporary or permanent basis. The main reasons centre on increased experience and improved standards of living.

— Many cohort doctors suggest that the real impact of the European Working Time Directive (EWTD) has not made the working lives of junior doctors any easier. Many doctors complain that although the number of hours worked may have been reduced, other important aspects of their job have suffered, including training and patient care.

— Three-quarters of the cohort are either currently working less than fulltime or would like to do so in the future. Since 2001, the proportion of cohort doctors working part-time has more than doubled, from 13% in 2001 to 30% in 2004. Despite the increase in the number of flexible trainees over the past four years, a third report difficulties in working less than fulltime.

— For two in every five cohort doctors, the reality of a career in medicine is very different from that envisaged at graduation in 1995. Many cohort doctors admit that they were unprepared for the reality of life as a doctor.

— The career choices of cohort doctors vary somewhat according to gender. Females are more likely to choose a career in general practice, while males are more likely to choose a career in hospital medicine or research/academic medicine. Female cohort doctors are more likely to be undecided about their future career options.

Conclusions and Recommendations

— Medical workforce planning needs to be an ongoing process and whilst this is theoretically the position, changes in demand are affected more radically by short term changes in NHS delivery systems than has hitherto been recognised by planners. One solution is clearly to avoid making the sorts of change which exacerbate the position without first evaluating the impact.

— This is not however, an option where such changes are prompted by technological or medical advance and more account needs to be taken of these forces in workforce planning than is currently the case.

— Skill mix change offers a potential solution to some of the problems likely to be faced by workforce planners in the future. It is not, however, a universal panacea and should be carefully evaluated for both its cost and effectiveness before being introduced.

— Workforce planners should concern themselves with recommending change as much as with predicting it and this is especially true of designing incentives for encouraging recruitment, retention and changes in working practices.

— The need for a strong and effective regulatory environment should be tempered by recognition of its impact on the resources available for patient care.

— The way in which doctors make career choices is an important issue affecting recruitment into both the profession itself and individual sectors and specialties and should be taken into account in workforce planning. It is particularly important in the context of training requirements, where any mismatch has costly unemployment consequences.

— Sitting across the whole planning process is the issue of resource constraints. We have identified the service needs of NHS providers as a major variable in the process but overall resource constraints also impact on providers’ capacity to employ or contract with NHS staff.
— The difficulty with which some doctors obtain posts at varying points in their careers is symptomatic both of the impact of funding pressures and poor workforce planning at the micro level. Recent problems in the medical workforce at SHO level testify to this.

British Medical Association
15 March 2006

Evidence submitted by the British Orthopaedic Association (WP 60)

1. INTRODUCTION

The British Orthopaedic Association (BOA) is the professional association of orthopaedic surgeons in the United Kingdom. It is a charity whose objects are: “the advancement for the public benefit of the Science, Art and Practice of Orthopaedic Surgery with the aim of bringing relief to patients of all ages suffering from the effects of injury or disorders of the musculoskeletal system.”

The BOA welcomes an inquiry into workforce needs and planning. The Association has been concerned about the under-provision of Trauma and Orthopaedics since the early 1990s and published a document on the need in 1995.1 An annual manpower census has been conducted since that time and demonstrated to the Department of Health on many occasions. We believe the long waiting lists in Orthopaedic Surgery are a result of a long-term under-provision of Trauma and Orthopaedic Surgeons. We believe our manpower figures are extremely accurate and reference is made to them in this submission. The tables and charts referred to are reproduced below.

2. THE ORTHOPAEDIC WORKFORCE IN UK

The total number of Trauma & Orthopaedic (T&O) surgeons in the United Kingdom was 1,769 on 31 December 2004 (figures from the 2005 census are imminent). The average population served by one consultant is 33,782 but this varies from region to region. The worst is Northern Ireland with 1:41,528 (Table 1). Another 621 T&O surgeons are required based on a ratio of 1:25,000, which has been our target. However, with MMC, EWTD and other changes, this figure may well have to be reduced to 1:20,000.

Table 1

<table>
<thead>
<tr>
<th>UK NATION</th>
<th>Population</th>
<th>Population Served Per Orthopaedic Consultant</th>
<th>Consultants Required for 1:25K Target</th>
<th>Deficit on Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>49,996,900</td>
<td>33,578</td>
<td>2000</td>
<td>511</td>
</tr>
<tr>
<td>Wales</td>
<td>2,946,200</td>
<td>34,258</td>
<td>118</td>
<td>32</td>
</tr>
<tr>
<td>Scotland</td>
<td>5,114,600</td>
<td>33,429</td>
<td>205</td>
<td>52</td>
</tr>
<tr>
<td>N. Ireland</td>
<td>1,702,628</td>
<td>41,528</td>
<td>68</td>
<td>27</td>
</tr>
<tr>
<td>UK</td>
<td>59,760,328</td>
<td>33,782</td>
<td>2,390</td>
<td>621</td>
</tr>
</tbody>
</table>

These figures compare unfavourably with workforce ratios in the rest of Europe. (Table 2—figures relate to 2002)

Table 2

<table>
<thead>
<tr>
<th>EUROPEAN NATION</th>
<th>Population</th>
<th>Number of Orthopaedic Specialists</th>
<th>Population Served Per Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria (1999)</td>
<td>8,000,000</td>
<td>560</td>
<td>14,286</td>
</tr>
<tr>
<td>Belgium</td>
<td>10,000,000</td>
<td>729</td>
<td>13,717</td>
</tr>
<tr>
<td>Croatia</td>
<td>4,500,000</td>
<td>170</td>
<td>26,471</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>10,200,000</td>
<td>370</td>
<td>27,568</td>
</tr>
<tr>
<td>Denmark</td>
<td>5,300,000</td>
<td>469</td>
<td>11,301</td>
</tr>
<tr>
<td>Finland</td>
<td>5,200,000</td>
<td>400</td>
<td>13,000</td>
</tr>
<tr>
<td>France</td>
<td>60,000,000</td>
<td>2,000</td>
<td>30,000</td>
</tr>
<tr>
<td>Germany</td>
<td>82,500,000</td>
<td>7,422</td>
<td>11,116</td>
</tr>
<tr>
<td>Greece (1999)</td>
<td>10,500,000</td>
<td>1100</td>
<td>9,545</td>
</tr>
</tbody>
</table>
There has been a steady increase in T&O numbers since 1990. (Chart 1)

Chart 1

HEADCOUNT OF SUBSTANTIVE ORTHOPAEDIC CONSULTANTS IN THE UK (AND ISLE OF MAN, CHANNEL ISLANDS) 1990–2004

The advertised vacancies for T&O consultants remain steady (Table 3). These should be increasing and there is a sense they are actually decreasing.

Table 3

ANNUAL NUMBERS OF ADVERTISEMENTS FOR SUBSTANTIVE ORTHOPAEDIC CONSULTANT VACANCIES IN THE UK & ISLANDS

<table>
<thead>
<tr>
<th>Year</th>
<th>No of Posts 1st Advertised in Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>128</td>
</tr>
<tr>
<td>1997</td>
<td>80</td>
</tr>
<tr>
<td>1998</td>
<td>122</td>
</tr>
<tr>
<td>1999</td>
<td>87</td>
</tr>
</tbody>
</table>
The age profile of the consultant orthopaedic workforce is in Table 4. A prediction of workforce changes over the next 10 years can be calculated from this. At the present time, there is an average of 150 Specialist Registrars a year completing training.

### Table 4

**AGE PROFILE OF CONSULTANTS**

<table>
<thead>
<tr>
<th>Consultant Age</th>
<th>Incidence</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 yrs or less</td>
<td>6</td>
<td>0.34%</td>
</tr>
<tr>
<td>36–40</td>
<td>318</td>
<td>18.14%</td>
</tr>
<tr>
<td>41–45</td>
<td>449</td>
<td>25.61%</td>
</tr>
<tr>
<td>46–50</td>
<td>391</td>
<td>22.30%</td>
</tr>
<tr>
<td>51–55</td>
<td>279</td>
<td>15.92%</td>
</tr>
<tr>
<td>56–60</td>
<td>219</td>
<td>12.49%</td>
</tr>
<tr>
<td>61–65</td>
<td>86</td>
<td>4.91%</td>
</tr>
<tr>
<td>&gt; 65 yrs</td>
<td>5</td>
<td>0.29%</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td><strong>1,753</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

**Median** 47

**Response to questions raised under the terms of reference**

Factors affecting future demands

8. **RECENT POLICY ANNOUNCEMENTS**

The BOA is concerned that the introduction of Payment by Results tariffs is in danger of creating a disadvantage for units that undertake complex trauma and orthopaedic cases. Trusts may be inadequately reimbursed and be unable to sustain the unit with its expertise.

The White Paper “Our Health Our Care, Our Say” will help acute hospitals to free up clinics, beds and theatre space but, if the consultants’ work pattern causes travel for long distances, valuable time will be lost, taking them away from the centre and, over a long period of time, the hours involved may become significant. On the other hand, if more facilities are freed then more work could be done, provided that the necessary support staff (i.e., anaesthetists, nurses and other theatre staff) are available.

Surgeons require significant support staff and therefore workforce planning must take all these other groups into account.

9. **TECHNOLOGICAL CHANGE**

Cartilage cell grafting and stem cell research will probably develop further and consume more operative time.

Drug therapy for Rheumatoid Arthritis may limit the joint destruction associated with this disease and reduce the need for surgery in this population. It is unlikely that drug therapy will change the increasing incidence of osteoarthritis.

Advances in the method of fixation of fractures will necessitate more theatre time. Surgeons will undertake more complex reconstruction following fractures. A reduction in Road Traffic Accidents may counteract this in terms of time.
10. **AGEING POPULATION**

This will cause a huge increase in the workload of the Trauma and Orthopaedic Surgeon over the next 10 years. The advent of drugs that reduce cardiac disease and the successful treatment of cancer will result in an older population. This means a rise in the number of people with osteoporosis and subsequent fractures (fragility fractures) which will require operative treatment by the orthopaedic surgeon; one in three women and one in 12 men are currently affected. It is estimated that this incidence may double over the next 50 years.

The White Paper may help the acute hospital to clear the beds which will be increasingly occupied by the elderly who, nowadays, often live alone.

The older population will also lead to an increased demand for the treatment of osteoarthritis (degenerative arthritis) which requires joint replacement. Over the last 20 years there has been a steadily increasing demand and there is still an unmet need amongst the population. Higher expectations in the younger age group means joint replacement at a younger age and therefore an increased need for revision surgery which is more time-consuming. It is unlikely that we shall catch up with the demand.

11. **THE INCREASING USE OF PRIVATE PROVIDERS**

This enterprise (ISTCs, G-Supp) increases the bed base and the operative facilities but they still require a workforce. It may be more efficient to keep the same workforce in an NHS hospital and use the operative facility more efficiently and for longer hours. Expensive facilities lie idle at both places. It would be preferable if the private facilities were staffed by British-trained surgeons rather than having to rely on recruiting agencies from abroad. We should not drain other countries of their medical graduates, especially if that country is in more need, eg cataract surgery in South Africa. The quality assurance issue has been addressed in the evidence given to the previous Inquiry into ISTCs.

There is an advantage in separating the trauma care from the elective care, as now occurs in the ISTC. However, 90% of orthopaedic surgeons are on call for the emergency treatment of accidents. The trauma and elective sites should be adjacent rather than having the latter being undertaken some distance away. It is less wasteful of the surgeons’ time and safer for the patient to be close to a major medical facility with all the appropriate back-up. The old stand-alone orthopaedic hospitals (which the ISTCs appear to replicate) were nearly all shut down for fear that lack of appropriate back-up facilities could pose a risk to patients undergoing major elective orthopaedic surgery and were more expensive to run.

12. **HOW WILL THE ABILITY TO MEET DEMANDS BE AFFECTED BY FINANCIAL CONSTRAINTS?**

The destabilisation of local health economies by ISTCs and the purchasing by PCTs (or lack thereof) has caused ward closures and lost operating time. Trusts are reluctant to replace surgeons retiring or increase the surgical workforce as they are unsure if they will have the work for the surgeons. There are a number of Specialist Registrars who cannot find a consultant job at present. It is very expensive for the state to spend this money on training only to produce a person who is unemployed. The manpower calculations have never been right; they swing from oversupply to undersupply, mainly because the expansion in jobs is unpredictable but the demand for services is more easily predictable.

13. **HOW WILL THE ABILITY TO MEET DEMANDS BE AFFECTED BY THE EUROPEAN WORKING TIME DIRECTIVE?**

The opinion on this will be expressed in evidence given by the BMA and the Royal Colleges. However it is very relevant to T&O because of the large emergency commitment of all grades in the specialty. Many accidents happen at night and weekends. The same surgeons are doing the elective work. Thus, more time on emergencies means less time on elective work, which is where the waiting list exists. In addressing waiting lists, scant attention has been given to Trauma, yet both services are provided by the same workforce. If a major element of the workforce is directed to elective waiting lists, then there will be nobody to undertake the care of trauma patients, the number of which will increase with the ageing population and the increased leisure time of the younger population.

14. **HOW WILL THE ABILITY TO MEET DEMANDS BE AFFECTED BY INCREASING INTERNATIONAL COMPETITION FOR STAFF?**

It would depend on the employer as to whether they wished to have overseas-trained personnel or locally-trained ones who are familiar with the culture and the system. British graduates have no problem finding jobs abroad. Other first world countries with good living standards are short of orthopaedic surgeons. We would not wish to lose those who we have spent so much time and money training.

About 30% of the consultant workforce in T&O is made up of the SAS (Staff and Associate Specialist grade, ie Non-Consultant Career Grades. About 60% of those graduated outside the European borders. This group contribute significantly to the provision of T&O in UK. Changes in immigration laws could reduce the numbers in this grade which would have a significant effect on workforce. They would need to be replaced.
15. **How will the Ability to Meet Demands be Affected by Early Retirement?**

The average age of retirement in T&O in 2004 was 57.5 years. The trend can be seen in Table 5. If the normal retirement age is 65, this could represent a loss of eight years of working life. Incentives to remain doing elective work would significantly increase the workforce. Pension rule changes may well see an increased number of retirements this year. Reason for retirement include burn-out, lack of encouragement by the employer to stay on, not physically able to carry on the emergency work, fed up with all the changes and pressure to clear waiting lists, loss of morale for multiple reasons. Herein lies a significant loss of workforce. The average age of retirement in Australia, for example, is much higher and many surgeons work into their late sixties.

**Table 5**

<table>
<thead>
<tr>
<th>Year</th>
<th>Retirements &amp; Other Losses</th>
<th>Average Age of Retirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>54</td>
<td>59.64</td>
</tr>
<tr>
<td>1996</td>
<td>55</td>
<td>59.81</td>
</tr>
<tr>
<td>1997</td>
<td>43</td>
<td>60.81</td>
</tr>
<tr>
<td>1998</td>
<td>31</td>
<td>59.35</td>
</tr>
<tr>
<td>1999</td>
<td>41</td>
<td>58.85</td>
</tr>
<tr>
<td>2000</td>
<td>34</td>
<td>59.49</td>
</tr>
<tr>
<td>2001</td>
<td>52</td>
<td>60.28</td>
</tr>
<tr>
<td>2002</td>
<td>55</td>
<td>57.25</td>
</tr>
<tr>
<td>2003</td>
<td>44</td>
<td>57.36</td>
</tr>
<tr>
<td>2004</td>
<td>51</td>
<td>57.55</td>
</tr>
</tbody>
</table>

**Meeting the demand**

16. **Changing Roles and Improving Skills**

It is estimated that when we reach an equilibrium of 1:25,000 of population T&O surgeons, only one in five surgeons will have a trainee with them to assist. The end result of MMC is unclear. The SHO grade will disappear. These staff undertake a lot of the emergency call with senior supervision. The consultants will need assistance and it is unclear who will provide this. The role of the health care practitioner is being defined. Such a person could be of great assistance to the surgeon, as they are in US as Physicians Assistants. However, if the junior staff are taken away from the consultant or if they are inexperienced, the consultant will spend more out-of-hours time in the hospital and will not be available to do the elective work. A suitable “Safety Net” is required.

The development of extended role practitioners has been successful in many areas. This frees up time for the surgeon to operate, if facilities are available.

17. **Better Retention**

As stated above (15), early retirement is depriving the T&O service of valuable, experienced personnel. Incentives to retain these surgeons would benefit the health service. Rationalising the trauma service would improve the quality of life for these surgeons. Making better use of their talents for teaching and administration would encourage their staying on until normal retirement age.

18. **Recruitment of New Staff in the UK**

In general, there is little problem with attracting high-quality candidates into T&O; lack of funding is the reason for the shortfall of numbers.

19. **International Recruitment**

As stated above (11), the BOA believes that care should be taken in recruiting from abroad, especially from developing countries who can ill afford loss of trained staff. If overseas staff must be recruited, we would ask that stringent quality assurance processes are in place to ensure that patient safety in the UK is not compromised.
20. Planning

A small number of national centres is required for some specialties such as musculoskeletal cancer and brachial plexus injuries. Such a limited number of centres means fewer job opportunities and a reluctance to enter such subspecialties as no job may be available. Other subspecialties such as children’s orthopaedics and spinal surgery could not be planned locally. Whilst local planning seems attractive, the pattern of disease around the country is fairly uniform and local planning may well be more complex and not achieve anything more than now.

The increasing number of females entering surgery is an important factor. In T&O the number is still small (Chart 2). If this expanded significantly, with many choosing to work part-time, the numbers of trainees would need to be adjusted. The part-timer may not take part in the trauma on-call rota, further depleting the workforce.

Chart 2

HISTORIC NUMBERS OF FEMALE ORTHOPAEDIC CONSULTANTS 1996–2004

Ian J Leslie
President, British Orthopaedic Association
15 March 2006

Reference

1 Consultant Staffing Requirements for an Orthopaedic Service in the National Health Service British Orthopaedic Association. London, 1995
1. Poor involvement in workforce planning structures at both national and local levels by the smaller professions due to an appropriate focus on care group planning but at the expense of representation of a psychological perspective on healthcare delivery and implicit dominance by the major professions of nursing and medicine.

2. An over-reliance on bottom up forecasting through Local Delivery Plans which preserve an over-reliance on forecasting existing workforce requirements at the expense of smaller professions and a failure to anticipate strategic developments in new or more flexible practitioners such as psychologists.

3. Despite national estimates of demand for psychologists being determined by both the Society and external bodies such as the NHS Workforce Review Team or the Sainsbury’s Centre for Mental Health ranging far in excess of 15%, commissioning at a local level is constrained.

4. We believe that these constraints have arisen for a variety of reasons:
   — Failure to set profession specific targets and reliance on general targets surrounding the Allied Health Professions resulting in commissioning of the cheapest common denominator.
   — A perception of psychology training being expensive despite it being best value in terms of student drop out and retained years to the NHS.
   — A failure to utilize or develop placement capacity due to inefficient local commissioning and the application of inappropriate initiatives to expand nursing placement provision.
   — Organizational failures including the continuous re-organisation of NHS workforce planning and education and commissioning structures, failure to utilize evidence and advice from professional bodies, an over-reliance on competency-based models and the current dominance of Skills for Health whose expertise is constrained to the micro-skills level, and inappropriate local commissioning for small professions.

THE RESPONSE OF THE BRITISH PSYCHOLOGICAL SOCIETY

The British Psychological Society welcomes the opportunity to submit information to the Committee’s inquiry into Workforce Planning. The British Psychological Society is the learned and professional body, incorporated by Royal Charter, for psychologists in the United Kingdom. The Society has a total membership of over 44,000 and is a registered charity.

The key Charter object of the Society is “to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge”.

GENERAL RESPONSES

1. The Society believes that it is very timely to be reporting to the Health Select Committee on NHS workforce planning processes. Applied psychologists, including clinical, counselling, forensic, health, neuropsychological and occupational psychologists (please see Annex 1 for definitions and role descriptions) contribute significantly to both health and social care. The public is also provided with the security of knowing that applied psychologists are Chartered and work to defined standards. Moreover, the government has promised better support for mental health and emotional well-being in response to the Citizen’s consultation which placed mental health as its second area of concern.

Some examples of the relevance and contribution of applied psychologists include the following:
   — the demand for psychological therapies (ie talking therapies) has never been greater from patients;
   — the NICE clinical guidelines endorse psychological treatments as clinically effective and in many cases safer, and with greater long-term efficacy than drug treatments for a variety of common mental health problems;
   — psychologists have been the major researchers responsible for conducting the randomised controlled trials from which the evidence base for NICE guidelines have been developed;
   — if access to psychological therapies can be achieved, this will result in better well-being and quality of life for patients and their families, and ma reduce economic burden through maintaining employment and reducing benefits;
   — the Choice Agenda and the requirement to manage treatment times below 18 weeks will place unachievable pressures on psychology services;
   — psychologists also assess and treat people with complex mental health needs including those with severe mental health problems and personality disorders;
   — psychological understanding of many physical health problems now provides the basis for public health interventions relating to life-style and behavioural risk factors;

18 Not printed here.
psychologists also work in services for children and families, and people with long-term intellectual and/or physical disabilities;

— psychologists are fulfilling new roles leading teams and services, and will take on even greater responsibilities under the proposed new Mental Health Act; and

— advising and supporting other health staff in how to deal more effectively with occupational stress and promoting healthy workplaces within organisations.

2. We firmly believe that evidence-based workforce planning has a major role in delivering psychological healthcare which is flexible and fit for purpose to patients. We have had a continuing dialogue with the Department of Health around estimating the demand for psychologists and how education and training commissions can meet such demands. We have surveyed the workforce profile of psychologists both in England and the devolved nations, published reports on the diversity of psychologists, and forecast the demand for psychologists in services for adults, families and children, people with disabilities, and older people.

3. In response to frequent requests from the Department of Health we have produced reports on how the supply of applied psychologists might be increased and have implemented changes within our education and training programmes to improve the quality, flexibility and training numbers of applied psychologists. Finally, psychology unlike many other health care professions has no problem recruiting graduate psychologists to train as applied psychologists. Psychology is the third most popular subject studied at degree level and produces around 13,000 graduates each year.

4. Our estimates for demand for applied psychologists within the NHS fall between an additional increase of between 15–30% of the current training commissions, and we believe these to be conservative. Indeed, the Workforce Review Team also estimate demand at 13% for clinical psychologists and refer to this as an under-estimate. We also believe that future policy initiatives, especially those already mentioned, will further increase demand. Future developments might see further growth in demand ranging from an additional 5,000 psychologists and upwards, over the next ten years. The public health and integrated care White Papers, both, highlight the growing demand for providers of psychological healthcare.

5. As with many other health care professions, the current supply does not meet neither the existing nor the forecasted demand for applied psychologists (see supply data in Annex 1). However, whereas for doctors, nurses and the other allied health professions, recent increases in financial investment in the NHS workforce has seen major increases in training commissions, we have actually seen for psychologists within England over the last three years a slowing down of expansion, and even a decline in estimated training commissions. In part, we believe that this has been a consequence of a failure to set profession specific recruitment targets for psychologists.

6. Furthermore, only clinical psychologists are commissioned by the DH; other forms of applied psychology training (ie counselling and health) which are directly relevant to the NHS are not NHS funded, despite re-assurances from the then Health Minister Rt Hon John Hutton that applied psychology funding would be equitably funded. Funding other applied psychologists has been consistently discussed with the DH for the last two years but no additional support has been identified.

7. We consider that the failure to meet the increasing demand for applied psychology identifies significant failings and short-comings in the workforce planning mechanisms both nationally and locally. Many of these issues, we believe arise from the dominance of workforce planning by the larger professions (ie medicine and nursing), which results in a lack of influence and representation by smaller but strategically important professions. The prevailing philosophy is to perform workforce planning around either care groups or service delivery frameworks, to the exclusion of uni-professional planning. Although we welcome this approach from a service development perspective; in practice, this still results in dominance by the major professions and the active exclusion of smaller professions. We consider a hybrid model that seeks input from all relevant professions, together with users' representations, around particular care groups or service models to be the most appropriate.

With respect to short-comings of the existing system, we would stress the following issues which we believe the Select Committee should consider:

— We have found it difficult to influence the previous national workforce planning structures (WNAB, care group workforce teams etc.) and hence ensure that proper consideration has been made to patients’ needs for psychological interventions within the workforce process. Effective involvement only occurred within the adult mental health care group, where we believed we made a significant and valued contribution as a profession contributing to a multidisciplinary strategic group.

— More recently we have enjoyed constructive dialogue with the Workforce Review Team, which has confirmed and validated our own workforce estimates. However, the nature of education and training funding, and the commissioning process, has meant that such estimates do not get translated into additional training places.

20 Layard, R., 2004, op cit; Layard, R., 2005, Therapy for all on the NHS, Sainsbury Centre Lecture; Sainsbury’s Centre for Mental Health, 2005, Defining a Good Mental Health Service, consultational document.

21 Not printed here.
— The DH Annual Workforce Census derived from the pay-roll is unreliable and fails to properly identify and assess the numbers of applied psychologists or psychological therapists employed within the NHS. This has been recognised by the DH and resulted in a one off survey of the psychology workforce (BPS/DH/HO, 2005). However, accurate annual data is required for effective workforce planning but is not currently available.

— Similar problems exist at a local planning level where psychology services and managers have only limited input into the development of Local Development Plans (LDPs). The difficulties of aggregating workforce estimates for the smaller professions from LDPs has been established through research by the Sainsbury Centre for Mental Health, but despite the widespread recognition of this problem, commissioning for the smaller professions is still heavily influenced by unreliable and inaccurate data collected at the local level.

— The continual and frequent re-organisation of education and training commissioners, together with their workforce planning procedures, leads to a lack of stability in policy development and implementation, periods of indecision, disruption of communications, networks and local knowledge due to staff turn over, and subsequent loss of expertise from the system. There is a continued organisational failure to recognise the importance of reliable workforce planning and to prioritise it or the staff responsible for its implementation.

— Along with other professions in the NHS, placement capacity is still a problem that can constrain expansion. However, despite the profession introducing greater flexibility for placement learning, commissioners have failed to provide the necessary additional resources (ie clinic space, office accommodation etc.) to capitalise on these changes. Initiatives designed to facilitate increases in placement capacity are invariably targeted at nurses and yield inappropriate inter-professional resources such as hospital-based clinical skills training suites that are of no relevance to the delivery of psychological therapies.

— The problems of recruiting clinical academics to staff training courses in Universities is a growing problem which has been recently exacerbated by the introduction of more favourable pay structures (Agenda for Change) within the NHS.

— Currently, we are concerned about the lack of structure and direction surrounding workforce planning within the DH and the NHS. There appears to be no overarching organisation coordinating the workforce process. We consider that the prominence given to workforce planning by *A health service of all the talents* (DH, 2000) has been seriously lost and dissipated. The current activities located around Skills for Health may be highly relevant for assistant and associate practitioners within the NHS, but we have some concerns about a purely skills-based competency model being applied to highly skilled and knowledgeable professional groups whose work requires a synthesis of skills knowledge and experience. Such approaches, we believe, may bring about major problems for commissioning services and the safety of the public, since they under-value the efficiencies of professional identity when recruiting to posts and the contribution that professions ought to make to regulation and public protection. We also have future concerns about the impact of foundation hospitals and trusts who appear outwith current planning and commissioning processes.

**Specific Responses:**

*How will the ability to meet demands be affected by financial constraints*

8. We believe this to be the most important factor affecting commissioning at times of financial cut backs, due to the perception of psychologists being seen as expensive. This comes about since our training costs are compared to those of undergraduate trained allied health professions. However, we are a post/graduate trained profession and given our low attrition from training (3%) and high retention within the NHS (95% at five years), we are seen by the WRT as one of the most cost-effective professions to train, with respect to retained years. Unfortunately, this is seldom acknowledged by local commissioners who will have only a very limited knowledge of psychologists. Without effective national guidance, we believe that our perceived expense will always result in commissioners investing in cheaper professions since they are attracted by short-term gains in meeting expansion targets for training places overall.

Nevertheless, putting expense to one side it may be important to the profession’s advantage to look at skills mix solutions to funding training across a number of different levels of practice and competency. The profession is currently engage in such a process: New Ways of Working for Applied Psychologists (see later).

Finally, the importance of establishing a viable National Benchmark Price for funding training will also be critical. Currently, although benchmarks exist for nursing and the major allied health professions, they have not been established for applied psychology.
the European Working Time Directive

9. This is unlikely to impact on psychologists currently since there are limited pressures to work out of hours or on call. However, it may become more important in the future when practitioners are required to work outside of normal hours either due the requirements of users from particular care groups or the implementation of new roles through the new Mental Health Act.

increasing international competition

10. Currently, due to the different systems of national regulation and licensing, the flexibility of movement of psychologists internationally can be problematic. This may change with the implementation of European Directive, but the UK is likely to benefit from an influx of psychologists rather than competition with health services overseas. The adverse impact of professionals trained in developing countries is limited, given the under-development of psychology training in the third world.

early retirement

11. The profession is relatively young given that training only really became established in the 1970–80s. Hence the impact of retirement and early retirement is just beginning to be recognised. Of equal importance, however, is the prevalence of part-time working within the profession. This is an important factor to consider in any future workforce projections.

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

12. The Society is actively looking at skills mix solutions and how the 13,000 p.a. psychology graduates can be better employed within the NHS in order to contribute to health and social care. A New Ways of Working for Applied Psychologists project which is sponsored jointly by the BPS and NIMHE/CSIP is currently examining training models, and developing new or supporting roles (ie assistant or associate, graduate primary care mental health worker) for psychologists. We also consider that it is important that psychologists are actively involved in (re)-training other staff in psychological therapies.

Greater thought is required as to how different training needs (applied psychology, graduate mental health workers, other professional staff and CBT, clinical supervision etc) might be co-ordinated across a single training provider. This would ensure efficiency and also promote inter-professional learning within psychological therapies. A possible solution might entail regional Centres of Excellence which are funded and bid for nationally to co-ordinate and provide these activities, together with other local psychological therapy providers. The scale of the enterprise would be like commissioning several new medical schools. They could also lead on evaluation and further developing the research and knowledge base behind psychological therapies.

better retention

13. Currently retention for psychologists within the NHS is extremely high. The majority of psychologists do return to work following maternity and career breaks, and continue to work on a part-time basis. The introduction of independent sector providers for psychological therapies might have a dramatic impact on the stability of the NHS psychology workforce. Competition from the independent sector currently is modest, but if expanded could lead to greater competition, further increases in vacancy rates, and inequalities of access for some care groups or geographical areas not well served by independent providers. The expansion of the independent sector for psychological therapies requires careful consideration and economic modelling.

international recruitment.

14. Currently little impact predicted.

How should planning be undertaken, to what extent should it centralised or decentralised?

15. The current system of planning and commissioning can be described as bottom up, relying on local determination of demand for staff, the setting of local priorities, and commissioning education and training to reflect these circumstances. Such an approach is consistent with a patient-lead NHS whereby patient needs for healthcare are assessed, translated into effective and evidence-based clinical protocols and care pathways, the skills and competencies to underpin the delivery of these care pathways identified, and the relevant education and training programmes commissioned. Although we believe that such an approach has its merits, we also have some major reservations that arise particularly for a small profession such as our own.
We have already emphasized the limitations of workforce plans based upon LDPs. The Department of Health whilst agreeing with the problems faced by professions such as our own, have failed to take steps to rectify the situation. The result is that national estimates of demand based upon strategic considerations will yield conservative increases in the workforce of 15%, whereas local estimates will not even register a demand for clinical psychologists, let alone other types of applied psychologists.

For small professions we would advocate a centralisation of workforce planning, together with either a regional or national system of determining education commissions as advocated by HEPI (2005). Devolvement of commissioning and training budgets for small professions such as our own to the primary care level would be both impractical and irresponsible given current research.

We also need to emphasize the challenge to workforce planning, especially as it relates to psychological therapies, to ensure that it encompasses the private and voluntary sectors, as well as the NHS. However, this raises the problem that many therapists in the independent sector are not subject to regulation or necessarily possess recognised qualifications relevant to the evidence-based practice of psychological therapies.

How is flexibility to be ensured?

16. Variations in the workforce are subject to slow changes due to the long gestation times for commissioning education and training over the period of a three year course. Hence, only limited flexibility can be afforded without de-stabilising the system. Having a range of skill mix options across the family of applied psychologists and levels of practitioners, might introduce greater flexibility in commissioning.

What examples of good practice can be found in England and elsewhere?

17. We would wish to commend the following three initiatives and programmes:

1. Workforce planning: The Mental Health Care Group Workforce Team prior to its disbandment.
3. Flexible working: NIMHE Workforce programme— New Ways of Working (Steve Shrub & Roslyn Hope).

Professor Graham Turpin and Pam Stirling
British Psychological Society
March 2006

Evidence submitted by the Cambridge Institute for Research Education and Management (WP 19)

I am pleased to submit this self contained memorandum of evidence (by Email) to the Health Select Committee. Cambridge Institute for Research Education and Management (CiREM) consider that the Inquiry is critical in the light of significant changes to service provision and the resultant impact on the skills of the workforce.

CiREM has undertaken research and evaluation programmes in the health sector over a number of years and provides evidence and analyses which supports improved workforce planning, skills development and workforce productivity in the short, medium and longer term.

We would be happy to provide further information and data should this be required by the committee.

1. INTRODUCTION

1.1 This memorandum primarily addresses one aspect of the Health Committee’s terms of reference namely:

How should planning be undertaken?

— To what extent should it centralised or decentralised?
— How is flexibility to be ensured?
— What examples of good practice can be found in England and elsewhere
Labour market intelligence (LMI) refers to the characteristics (data, information and analysis) of the workforce and their skills, potential workforce (labour pool) and to the future needs of the service (replacement and new demand). Cambridge Institute for Research, Education and Management’s spectrum of analysis spans LMI leadership, strategy, infrastructure, operational functioning and promotion with respect to the health care workforce and related skill demands.

In order to better understand the LMI needs of the future, a secondary objective is extract the LMI implications from likely changes in the workforce. Thus CiREM will review and comment on:

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; and
— international recruitment.

Thus whilst the former question looks at the how of workforce planning, inclusion of some aspects of the latter question encompasses the what of workforce data and information.

1.2 In doing so, it will make reference to what forms of data, information and intelligence (eg the shape and nature of the workforce) it should have in order to support a health service which continues to provide high quality provision as is able to continuously improve. Rather than reference sources in the text, a bibliography has been provided.22

1.3 In presenting a clear, concise and coherent case, this memorandum will also make reference to examples of LMI practice across the sector and beyond England.

1.4 Cambridge Institute for Research, Education and Management was founded in 2000–01 and is an independent organisation specialising in research and evaluation services to the health sector in general and to the NHS in particular.

1.5 The company’s strengths are in the following key areas:

Skills

CiREM undertakes primary and secondary research on skills shortages, skill gaps and latent skill shortages. We have experience in skills strategy development, particularly at sector skill council levels. Our clients are at regional and national levels.

Labour Market Intelligence

We undertake assessment and summary reports of UK wide labour market intelligence data in the health care fields. We have experience in future “scenario planning” in health care related workforce development.

Learning Needs Analysis

We have considerable expertise and experience in devising and analysing an organisation’s learning needs. Our work encompasses writing peer reviewed papers, scoping a field of study, analysis and synthesis of data to produce executive summary and full reports. Our client base is at national, regional and SME levels.

Evaluation

CiREM specialises in evaluations that are innovative in their methodology or subject matter.

— We design evaluation frameworks for organisations and particular programmes.
— We conduct meta-evaluations across employment sectors and professional disciplines.
— We advise on evaluation practice and policy.

Research based projects

CiREM specialises in short term research based project work. We participate and contribute to the project planning components of the research.

2. BACKGROUND

2.1 The health sector (ie NHS, independent and voluntary & community) employs nearly two million employees in the UK. It is important to view the health sector as a whole as:

(i) policy implications in England are resulting in an expansion of service provider; and

22 Not printed here.
(ii) the NHS draws from the same labour pool and thus the sector’s interdependence in workforce terms is reinforced. The sector is recognised as having a highly skilled workforce, a diversity of staffing professions and occupations, and high investment in education and training.

Prior to 1999 workforce planning had relied on a highly centralised structure which reviewed a series on year x year training numbers in the professions (medical and nursing). These numbers were increased or decreased according to central returns of staffing numbers.

In March 1999 the Health Select Committee recommended a review of how workforce planning was undertaken in the health service. Later, the publication of A health service of all the talents provided recommendations around four key areas:

— Greater integration and more flexibility of workforce planning.
— Better management ownership, clearer roles and responsibilities within planning.
— Improved training, education and regulation.
— Better planning for overall staff numbers and career pathways.

2.2 Workforce Development Confederations (WDCs) were created to plan effectively for all staff groups on a locality basis and to work collaboratively with other organisations so that data and workforce plans could be accrued nationally. In April 2004 WDCs were integrated with Strategic Health Authorities (SHAs) to bring together capacity for service and workforce planning within one body.

SHAs are undergoing review in relation to both scale (the numbers of SHAs in England) and scope (core strategic functions).

2.3 The NHS Improvement Plan, published in June 2004, set out the way in which the NHS needs to change in order to become truly patient led. These changes are fundamental, they affect the whole system and the way individuals and organisations behave.

In 2005 Creating a patient led NHS outlined how the improvements in capacity, with increased numbers of staff and reductions in waiting times and improvements in mortality rates, would be matched by changes in the structures of the NHS.

2.4 Skills gaps and shortages have been met as more staff have joined the NHS year on year. Since 1999 until September 2005 the NHS workforce has grown by approximately 23,000 more doctors, 68,000 more nursing staff and 11,000 Allied Health Professionals. Vacancy rates have fallen steadily as these staff have entered service. Staff are also working shorter hours as the successful implementation of the European Working Time Directive (EWTD) in 2004 limited a majority of staff hours to 48 and doctors’ hours to a maximum of 58.

International recruitment

2.5 International recruitment was viewed as a short to medium-term strategy. Since 2005 there has been a steady decrease in volume of international recruitment in all sectors. Increasingly as the year-on-year increases in training emerge, the health service will be more self-reliant on UK trained professionals.

International recruitment however will be used to target specific strategic areas for example dentists (from Poland) and GPs (from Germany and Spain) into priority locations.

2.6 The sector does not collect reliable data on inward migration. The Labour Force Survey can do this by proxy using “Organisational institution where qualified” but to date there is no coordinated method or plans for collating this data.

There is evidence to suggest that this facility would be needed at national at regional levels (especially in London which has seen the majority influx of workers).

2.7 Department of Health recently published A national framework to support local workforce strategy development. This document supported HR Directors in the NHS and Social Care to integrate their strategy for local staff development. The document covered six main areas:

— Capacity and skills.
— Working flexibly.
— Skills escalator.
— Model Employer.
— High Impact HR.
— Integrated Planning.

The objective of the document is to help organisations devise simple strategies to create a workforce that is flexible, productive and affordable.

There is recognition that local organisations need to devise local solutions based upon their service and financial development. However it is clear that the solutions fall short of the more medium and long term workforce planning issues—it assumes that “more of the same” will be required in workforce development.
2.8 The objective of workforce planning is straightforward: match supply to demand. Workforce planning (in the NHS) has had a somewhat chequered history. There is an oversupply of physiotherapists, a severe shortage of dentists and growing realisation from rapid changing technology in the service, an oversupply of cardiothoracic surgeons.

Workforce planning (NHS) has tended to overlook the financial implications of simply following a demand model.

2.9 A wide range of organisations in England share between them various roles and responsibilities. The main ones are listed below.

Department of Health (DH)—who have a key role in assimilating this information and advice; and taking key decisions. In particular, at a macro level DH seeks to ensure that in aggregate, NHS workforce plans are coherent alongside its financial and service plans. DH also has a central role to play in "steering" the investment of (approximately) £4 billion contained in the “MPET Levy” and issuing guidance and targets to individual SHA’s to inform their commissioning/investment plans. In practice this means that a large proportion of SHA resources are already pre-committed, firstly because there are many students who are on programmes which started two or more years ago. Secondly, DH comes to a view as to how many new pre-registration commissions are needed nationally each year for each of the healthcare professions; requiring each SHA to commission their “share” of the overall total.

Skills for Health—(SfH) was established in April 2002 and licensed as the Sector Skills Council (SSC) for health in May of 2004, a sector that employs some two million people with a mix of highly qualified and unqualified staff over a wide range of work roles and setting. The organisation is funded through the four UK health departments, DFES, the Education Act Regulatory Bodies and the sector, which as a whole spends over £3 billion pounds each year on direct training and development. Skills for Health is licensed as the SSC for health through the Sector Skills Development Agency (SSDA), under the Department for Education and Skills (DFES) Sector Skills Councils has four key goals:

— addressing skills gaps and shortages;
— improving productivity and performance;
— increasing opportunities to boost skills; and
— improving learning supply, including apprenticeships, higher education and National Occupational Standards (NOS).

Strategic Health Authorities—have a coordinating role for producing coherent workforce plans (linked to service and financial plans) for all the employers in their area—for commissioning the education and training in support of those plans; and submitting overall workforce and commissioning plans to the Department of Health for approval.

Individual NHS organisations—required to prepare their own workforce plans.

Other employers in the sector—(eg Nursing Homes, independent hospitals, voluntary sector organisations) who have the option of working closely with NHS organisations in a particular Strategic Health Authority (SHA) area.

The Workforce Review Team—who advise the Department of Health as to future workforce number requirements. National Workforce Projects (NWP) who are taking forward a number of innovations in workforce development to support service change.

Royal Colleges—who offer their own advice to the Department of Health, especially in respect of future requirements for doctors in training and Consultants/GP’s that come within the remit of each of the Colleges.

Other “Advisory Committees” and bodies such as NHS Employers and external organisations.

2.10 Skills for Health are responsible for the production and implementation of a sector skills agreement for the sector. Stages 1 and 2 of the research process noted that simply planning for “more of the same” will be insufficient to meet the challenges of the next 10 years and beyond.

There is a recognised need to produce a more flexible workforce rather than to continue to commission workforce education and training along traditional lines. A stage three report Case for Change highlighted the fact that strategic drivers converge in two specific areas namely: the need for a more flexible workforce (a more effective mix of people undertaking wider and different roles) and the role of competences as a currency and framework for addressing skills gaps and their workforce development implications through future planning and commissioning.

2.11 The need for a more systematic structure for workforce planning is now more widely recognised within the NHS.

Good (ie up to date, comprehensive, robust) LMI makes a vital contribution by providing the evidence base on numbers and skills, and informing future policy on what intelligence on the future workforce will be required to continue to provide high quality patient care.
We believe that in the current climate of financial instability, there has never been a greater time at which the tensions between “wants” (more doctors, more nurses) and “needs” (what is required in good clinical care by the patient at the right time) have had to be resolved.

2.12 The current systems of intelligence and planning has produced sufficient staff with appropriate skills to deliver the volume and service of healthcare, within budget. However, an analysis of the implications of the current policy implications suggests heavily that these systems will not be robust enough to be effective in changing healthcare contexts.

3. **Workforce: Key Characteristics**

3.1 *Employment composition by gender and status*

- Health care is one of the largest sectors, and covers more than two million workers, or around 7% of total employment the UK. Employment growth is expected to be positive over the next 10 years, and employment is anticipated to expand by another 10% over the period 2004 to 2014, representing more than 200,000 extra jobs.

- Women dominate the health care workforce: 80% are female, which is second only to care sector.

- The high proportion of women in health care is reflected in the high proportion of part-time employment, with almost 45% of workers employed part-time, almost all of which are women.

3.2 *Occupational composition of employment*

- As would be expected, Associate Professional & Technical Occupations, and Personal Service Occupations dominate the employment structure of health care.

- Together these two occupational groups comprise 56% of total employment in the sector in 2004.

- Almost 600,000 workers are classified in Associate Professional & Technical Occupations and almost 560,000 in Personal Service Occupations.

3.3 *Expansion demand, replacement demand and total requirement 2004–14*

- The health sector has a comparatively high replacement demand ratio, and coupled with the forecast expansion in employment, these give the sector a total recruitment requirement for the next 10 years of almost 50% of current employment.

- Total requirement is in excess of 60% of current employment levels for Managers & Senior Officials and in Professional Occupations, since these two occupational groups are forecast to grow strongly over the next decade in both levels and shares of total employment in the sector.

- In terms of the level of recruitment, total requirement for the sector is forecast to be in excess of one million new workers over the period to 2014.

3.4 Workforce planning data is currently based on numbers required in each of the already established healthcare professions and workforce groups. Very little data on the large proportion of the workforce not qualified as registered healthcare professionals.

3.5 Growth in knowledge and technology means that existing, new and changing job roles do not conveniently fit into the workforce group “profession typology” designed many years ago.

Workforce planning returns and other workforce information submissions to DH contain little reference to new roles particularly at Assistant and Advanced practice levels, therefore the scope and flexibility for investing in them is severely limited.

4. **Recommendations**

The key recommendations have been grouped into five categories: leadership, strategy, infrastructure, operational functions and promotion.

4.1 The practice of LMI workforce planning has suffered in part from:

- poor image;
- an inability to engage employers with the more strategic dimensions;
- poor coordination of resources and functions; and
- lack of strategic vision.

There needs to be clear leadership in this area. The health sector would be best served by UK/national LMI bodies which represent the whole sector or by sub sector organisations which have a firm grasp of the strategic direction of health care as a whole.

4.2 A UK strategy for the health care sector would necessarily span the sections here (leadership, infrastructure and operational functions).
A future workforce: undertake strategic analyses of the characteristics of the workforce required and thus the types of LMI data which will be required in the future.

Appraise the possibility of converging DH Census data with other UK national minimum data sets.

Progress plans for harmonisation of UK skill surveys (× 4) in relation to:

(i) sector footprint;
(ii) methodology; and
(iii) latent skill shortages for health care sector.

Need to explore potential with:
— Futureskills Scotland.
— Future skills Wales.
— NESS (England).
— Skills Monitoring Survey (NI).

Determine the critical mass of capacity and capability required at regional level for effective use and application of national and regional LMI.

Explore ways of linking short to medium and long term objectives in LMI planning: phasing of development programmes will be critical.

Assess demand for a UK web based portal for information and advice on health sector LMI.

4.3 Undertake an assessment and appraisal of a UK IT infrastructure which supports the integration of LMI national data sets (ie facilitate read across). There is significant work carried out in Scotland in this respect (SWISS).

4.4 There should be better utilisation of existing data and intelligence across the whole sector in terms of existing workforce and the labour pool.

Invest in the capture and collation of LMI data on staff relating to international recruitment and inward migration.

Undertake assessment of future LMI needs in relation to the future workforce (the development of a flexible, competent staff).

4.5 Promote greater understanding of:
— What LMI is.
— How it is generated.
— Better ways to disseminate findings.
— Improved approach to determining skills needs (current and future).

Production and dissemination of research bulletins of reports from LMI research.

Demonstrate link to productivity (via information to achieve greater effectiveness and efficiency) and indirectly to improved patient care.

Dr C Loughlan
Chief Executive, CIREM
14 March 2006

Evidence submitted by the Cancer Capacity Coalition (WP 22)

1. INTRODUCTION

1.1 The Cancer Capacity Coalition is an expert working party established to consider issues relating to “demand capacity” in cancer drug therapy delivery services and its importance to the provision of high quality cancer patient care. Demand capacity is defined as the resources required for the delivery of optimum care to all patients.

1.2 Members of the Cancer Capacity Coalition include:
— Professor Jim Cassidy (Professor of Oncology and Head of Department, Cancer Research UK Department of Medical Oncology, University of Glasgow) (Chair of Coalition)
— Kathy Corcoran (Nurse Consultant, Southend Hospital)
— Peter Gent (Cancer Network Manager, North East Scotland Cancer Co-ordinating and Advisory Group)
— Mark Gilmore (Cancer Network Nurse Director, North West Midlands)
— Dr Rob Glyne-Jones (Consultant Clinical Oncologist, Macmillan Lead Clinician in Gastrointestinal Cancer, Mount Vernon Cancer Centre)
The work of the Cancer Capacity Coalition is sponsored by Roche Products Ltd.

1.3 We have found that workforce shortages are a major explanation for problems in meeting demand capacity in cancer drug therapy delivery. Without effective workforce planning, the impact of these shortages can be expected to be acute given the context of increasing demand for cancer drug therapy delivery.

1.4 The Cancer Capacity Coalition therefore welcomes the Health Select Committee’s decision to launch an inquiry into workforce needs and planning for the health service. This response sets out the:

- Factors which will influence workforce planning in cancer.
- Challenges for NHS workforce planning.
- Impact these challenges will have on Government priorities.
- Potential solutions to the challenges.
- Effect of Payment by Results on the NHS’ ability to adopt solutions.
- Recommendations the Committee may wish to consider in relation to cancer workforce planning.

1.5 If the Committee would find it useful, the Cancer Capacity Coalition would be happy to provide further details of the issues outlined in this response, or to give oral evidence to the Inquiry.

2. Factors Which Will Influence Workforce Planning in Cancer

2.1 Demand for cancer services, and therefore the expertise and skills of the NHS Cancer workforce; this looks set to continue.

2.2 Impact of an ageing population

2.2.1 More than one in three people in England will develop cancer at some point in their life. One in four people in England will die from it. There are over 220,000 new cases per year in England, and 128,000 deaths. Overall cancer incidence increased by 31% between 1971 and 2000, yet cancer mortality has fallen by 12% in the same period.\(^{23}\) Five year survival rates for all cancers have improved and look set to continue to do so:\(^{24}\)

<table>
<thead>
<tr>
<th>Tumour Site</th>
<th>Five year survival, 1991–95 (%)</th>
<th>Five year survival, 1996–99 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>72.8</td>
<td>77.5</td>
</tr>
<tr>
<td>Prostate</td>
<td>53.6</td>
<td>64.8</td>
</tr>
<tr>
<td>Lung</td>
<td>Men: 5.2</td>
<td>Women: 5.4</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>Men: 43.3</td>
<td>Women: 49.2</td>
</tr>
<tr>
<td>Colon</td>
<td>Men: 42.1</td>
<td>Women: 42.8</td>
</tr>
<tr>
<td>Rectum</td>
<td>Men: 40.3</td>
<td>Women: 44.8</td>
</tr>
</tbody>
</table>

2.2.2 The NHS is continuing to improve on past performance in tackling most cancers. However, as the population ages, so the number of people diagnosed with cancer will increase, putting additional demand on services. For example, the Scottish Executive estimates that there will be a 28% increase in the number of people diagnosed with cancer over the next 20 years.\(^{25}\)

2.3 Impact of earlier diagnosis

2.3.1 In general, the earlier a person’s cancer is diagnosed, the better the chances of successful treatment. The variation in the stage at which cancer is presented and diagnosed is considered to be one of the reasons for the continuing inequalities in outcomes.\(^{26}\)

2.3.2 Screening programmes for breast and cervical cancer have improved survival rates and evidence suggests that the promised roll out of the National Bowel Cancer Screening Programme from April 2006


will have a major impact on survival, reducing the number of deaths from bowel cancer by 15% and saving approximately 1,000 lives a year in the UK.27

2.3.3 In addition, work by the Government and the voluntary sector to raise public awareness and understanding of the symptoms of cancer and how people can best seek help is likely to increase levels of early diagnosis. For example, in October 2005 the Department of Health announced a pilot awareness programme on the prostate and its function, which can be expected to increase early diagnoses of prostate cancer once it has been rolled out nationally.

2.3.4 The earlier diagnosis of cancer can be expected to have a positive effect on survival and quality of life but it will also place increased demand on cancer services. For example in 2003–04 the breast cancer screening programme screened 1.2 million women aged 50–64 and identified 8,400 cancers which may not otherwise have been diagnosed at such an early stage.28 Similarly, the bowel cancer screening programme is expected to increase the numbers of patients needing treatment. It is estimated that, for every 1,000 patients who complete the Faecal Occult Blood test (FOBt), 16 will report a positive FOBt result and will be offered colonoscopy and 12 will actually undergo a colonoscopy procedure. Of these five will be found to have polyps at colonoscopy (and require surveillance) and one will be found to have bowel cancer.

2.4 Impact of increasing “treatability” of cancer

2.4.1 As knowledge of cancer increases, so will the NHS’ ability to effectively treat the condition, either in terms of curative interventions, slowing progression or mitigating the effects of the disease. Patients with cancer are now being offered a series of often multiple interventions which were not possible only a few years ago. However new treatments are often in addition to, rather than a replacement of, existing options and are given over a prolonged period of time, resulting in increased pressure on cancer services.

2.4.2 Drug therapy is now being used to treat a rising number of cancers, increasingly at an early stage of the disease, as well as being employed as a second or third line treatment. Developments in this area are likely to substantially increase demand on chemotherapy services over the next few years. Early in 2005 NICE published its guidance on the management of lung cancer and this included a recommendation that adjuvant chemotherapy be offered to lung cancer patients after surgery.29 This will represent a change in practice and significant additional work in many centres.

2.4.3 For example, so-called targeted biological therapies are now increasingly being used in addition to chemotherapies, resulting in significant improvements to patient prognosis but also increased pressure on services. Current examples include the use of trastuzumab (Herceptin®) in breast cancer, imatinib (Glivec®) in gastrointestinal stromal tumours and bevacizumab/cetuximab (Avastin®/Erbitux®) in advanced bowel cancer.

2.4.4 Very few types of cancer are now considered to be chemotherapy resistant and the list is diminishing each year. For example, within the last year pemetrexed (Alimta®) has become the first drug to be marketed for the treatment of mesothelioma, a cancer associated with asbestos exposure that, until recently, was thought to be insensitive to chemotherapy.

2.4.5 Our increased ability to effectively treat cancer is leading to significant increases in survival. Dr Frank Lichtenberg has examined the impact of access to new cancer drug treatments on cancer survival rates in the US between 1975 and 1995. His conclusion is that new medicines account for 50–60% of the 25% increase in five-year survival rates seen in the USA over this period.30

2.4.6 There has been much debate about the cost of new cancer medicines. Although drug costs are increasing and can be expected to expand still further, perhaps more significant will be the impact of new treatments on NHS capacity. A report in 2005 by the Karolinska Institute estimated that drug costs form only a small part of the total cost of treating cancer, with inpatient hospital care accounting for approximately 70% of total budget.31

2.4.7 A survey of 42 hospitals published in 2003 found a huge increase in the use of intravenous chemotherapy over the past three years. The average increase was 200%, with some hospitals reporting a 500% increase.32 Unsurprisingly this increase has had significant impact on the demands placed on the workforce. The same survey concluded that the lack of staff trained in preparing and administering new cancer treatments was a significant rate-limiting factor in making available these treatments to all who could benefit.

27 Department of Health.
2.4.8 These findings are supported by the work undertaken on access to new cancer medicines by the National Cancer Director in 2003 and the Audit Commission in 2005. Professor Richards found a fourfold geographical variation in access to NICE-approved oncology drugs. The Report identified “constraints in service capacity” as having a major impact on the variation in usage. Specifically, the increased use of chemotherapy was found to have resulted in a lack of suitable space to prepare and administer cytotoxic drugs as well as shortages of specialist pharmacists, doctors and nurses.33

3. CHALLENGES FOR WORKFORCE PLANNING IN CANCER

3.1 Despite the potential of new technologies to make more efficient use of existing capacity, the factors outlined in Section 2 mean that increases in the cancer workforce will be necessary, mirroring the projected increases in demand for skilled healthcare staff across the NHS. Derek Wanless estimated that the healthcare workforce would need to be increased by almost 300,000 in the period up to 2022. He also noted that demand for healthcare professionals is likely to far exceed supply.34

3.2 Staff shortages will be compounded by at least three factors:

— Existing staff shortages—as well as dealing with projected increase in demand for staff, the NHS will have to cope with historical under-capacity. Much of the recent increase in staffing has simply compensated for existing deep-seated shortages in skilled staff.

— Ageing population—as the wider population ages and cancer diagnoses increase, so the healthcare workforce will also age, resulting in many skilled professionals reaching retirement age. The NHS will have to recruit replacements as well as the additional professionals needed to meet demand.

— Working Time Directive—the full implementation of the Working Time Directive in the NHS will mean that more full time equivalent staff will be needed to provide the same level of capacity as before. For example, one London hospital estimates that, whilst before 1991 three doctors sometimes each working over 100 hours a week were needed on a rota to cover a speciality, by 2009 eight to 10 doctors will be needed to cover a similar rota (on duty up to 48 hours a week).35 Clearly it is a benefit that staff should not have to work such long hours, but it also poses challenges to capacity planning.

3.3 These factors will make the swift adoption of capacity-saving measures even more essential.

4. IMPACT OF CHALLENGES ON GOVERNMENT PRIORITIES

4.1 Increased demand for cancer services is already impacting upon the ability of the NHS to meet Government priorities.

4.2 Implementation of NICE guidance

4.2.1 As set out in Section 2.4, the Government has already acknowledged that shortages in capacity have resulted in some cancer networks not fully implementing the recommendations of NICE technology appraisals. Although steps have been taken to address this, evidence suggests that capacity remains a challenge.

4.3 Patient choice

4.3.1 The Government has made clear its intention to expand patient choice around treatment. The Cancer Capacity Coalition’s understanding of choice includes four components: patients should have a choice of where they receive treatment, when they are treated, what they are treated with and how this treatment is delivered. If adequate capacity is not available in drug therapy delivery services, then patients will be denied options from which to make a realistic choice on one or more of these components.

4.3.2 Choice also impacts on clinicians, who are understandably reluctant to use a treatment that cannot be efficiently and effectively delivered, sometimes resulting in the full range of treatments available not being offered to all patients.

4.4 Waiting times

4.4.1 The Government has implemented targets of a maximum 62-day wait from urgent GP referral for suspected cancer to treatment for all cancers and a maximum 31-day wait from diagnosis and decision to treat, to treatment for all cancers. Shortages of staffing and equipment capacity remain a challenge for trusts in meeting these targets.

33 Department of Health (June 2004) Variations in usage of cancer drugs approved by NICE: report of the review undertaken by the National Cancer Director.
34 Derek Wanless, Securing our Future Health: Taking a Long-Term View, 2002.
4.4.2 A CancerBACUP survey of cancer networks published in 2004 found that staff shortages were one of the main barriers to achieving waiting time targets. Forty-five per cent of networks surveyed stated that a shortage of key staff is the biggest single barrier to achieving waiting time targets while only 15% considered lack of funding as the biggest problem.36

4.5 Health inequalities

4.5.1 Although good progress has been made in improving cancer outcomes, health inequalities in cancer remain a significant challenge. Research has found that the gap in survival between rich and poor is wider for those diagnosed during 1996–99 than for those diagnosed during 1986–90 for 12 of the 16 cancers looked at in men and nine out of the 17 cancers in women.37

4.5.2 Shortages in treatment capacity are likely to affect those suffering from health inequalities disproportionately as they are more likely to develop cancer and less likely to be equipped to effectively argue their case for access to the best treatments.

5. Potential Solutions

5.1 Although the challenges to effective workforce planning posed by trends in cancer incidence and treatment are significant, there are a number of opportunities to make more effective use of existing capacity.

5.2 Opportunities presented by technological changes

5.2.1 Section 2.4 sets out how technological advances have increased the treatability of cancer and therefore resulted in greater demands being placed on cancer services and the cancer workforce. However new technologies also have the potential to enable the NHS to make better use of its existing workforce capacity.

5.2.2 Some oral chemotherapies have been developed which enable patients to choose to take the majority of their treatments at home, therefore freeing up chemotherapy capacity in hospital and community settings, as well as saving on nursing and pharmacy time. Such therapies have no need for intravenous equipment and significantly reduce staff time spent on drug preparation and administration.

5.2.3 One such example is capecitabine (Xeloda®). During the NICE appraisal process for capecitabine in advanced bowel cancer (NICE Appraisal No 61), the independent technology assessment group model estimated substantial NHS budget-impact savings if all eligible patients were treated with oral chemotherapies (net savings of £17 million were identified if all metastatic bowel cancer patients were treated using oral alternatives to IV). Similarly the current appraisal process for capecitabine in early stage bowel cancer has indicated that substantial savings are possible (net £16.5 million if all early stage bowel cancer patients were treated using oral alternatives to IV). These savings were calculated using the cost of drug, plus an estimate of the resources required for preparation and administration, as compared to the cost of purchasing, preparing and delivering a standard IV drug alternative.

5.2.4 There are examples of how using oral therapies is leading to significant capacity savings in practice. For example, the Mount Vernon Hospital in Middlesex reports that the introduction of oral chemotherapy has been the factor which has had the most impact on maximising capacity to date.

5.2.5 Similarly, the Beatson Oncology Centre in Glasgow offers a nurse/pharmacy led chemotherapy (in this case capecitabine) service, avoiding patients being admitted to in-patient beds/day areas for infusional chemotherapy. Other centres in Scotland have followed the example of the Beatson Oncology Centre. Within Grampian, the development of out-patient based capecitabine services has saved around 2000 bed days each year. This has resulted in the abolition of oncology treatment waiting times for other tumour groups and the removal of the need for a larger cancer unit. The main pharmacy area in Aberdeen has significantly benefited from the increasing use of oral chemotherapy by avoiding the reconstitution of around 2,800 litres of IV chemotherapy annually. This is significant when we consider their workload over five years has more than tripled without a matching increase in their staffing establishment.

5.2.6 Some newer cancer drugs also have a longer shelf life, resulting in less demands being placed on pharmacy staff to be present to make it up. Such drugs can help support distant and remote administration services to patients.

5.2.7 Other areas where technological change can minimise demands on staffing include the development of less invasive surgical techniques, resulting in shorter hospital stays, and the greater use of telemedicine.

5.3 Opportunities presented by role and service redesign

5.3.1 Redesigning staff roles to make the best use of different skill sets can result in much greater use of existing capacity. Derek Wanless’ first report suggested that nurse practitioners could undertake at least 20% of the work of doctors while maintaining the safety and quality of care. However for such a move to be effective, responsibilities would then have to be devolved from nurses to healthcare assistants, resulting in additional demand for an estimated 70,000 additional healthcare assistants, on top of the extra 74,000 Wanless forecasted would be required.38

5.3.2 In relation to “demand capacity” in cancer drug therapy delivery, there are best practice examples of how role redesign is resulting in more effective use of existing capacity. The Cancer Services Collaborative “Improvement Partnership” with Maidstone and Tunbridge Wells NHS Trust has focussed on role redesign as a way of reducing patient waits and improving quality of care. The work incorporated developing new ways of working and the reallocation of tasks to suit the skill mix of the team. Over an eight-week period it was found that the chemotherapy nurse spent on average 14 hours a week on non-chemotherapy tasks. A non-chemotherapy nurse or a health care assistant could perform procedures such as applying dressings or removing the cannula, allowing the chemotherapy nurse to give treatments, attend pre-assessment clinics or perform technical tasks such as the chemotherapy line insertion.

5.3.3 The review suggested that developing the roles of nurses to perform nurse review clinics would improve the continuity in patient care, as well as making the nurses’ careers more rewarding. This would also release consultant time allowing them to see more new patients. It also concluded that additional capacity could be realised by re-structuring the scheduling system, reducing the variation in patient pathways and introducing a secure drug storage system.

5.3.4 Other ways of improving the use of existing capacity include:

- Up-skilling of primary care based staff so that they are able to safely evaluate toxicity problems using appropriate grading tools and refer patients appropriately to the cancer centre, avoiding unnecessary assessment and admission to beds and reducing the number of chemotherapy patients requiring hospitalisation.
- Increasing the availability of cancer drug therapy training courses to support the theoretical component of administration for nurses. This would broaden the number of nurses skilled not just to administer drug treatment but also to manage toxicities competently and encourage the development of nurse-led services.
- Maximising pharmacy delivery time by providing sufficient staff for departments to continue to operate through lunchtime and other breaks.
- Increasing unit operating times, for example earlier opening and manufacturing in aseptic suites permits patients to commence treatments earlier in the day, thus maximising capacity. At Southend Hospital, nursing and pharmacy staff shifts ensure all day working from 8 am through to 6.30 pm allowing treatment to commence at 8.30 am.
- Implementing flexible working practices. For example staff at the Royal Marsden Hospital, London have divided the day into morning and afternoon sessions so that unit beds can be used twice in one day.
- Demystifying the role that cancer treatments can play by encouraging greater education and understanding amongst non-“specialist” staff, therefore in time extending the structures and opportunities for oncological drug interventions to take place.

5.4 Opportunities presented by providing care closer to home

5.4.1 Devolving care to community settings when it is clinically appropriate can free up specialist centres for patients who require that level of attention. For example, the use of palliative care centres to administer bisphosphonate therapies to patients for whom all lines of chemotherapy have been exhausted can free up capacity. The Cancer Services Collaborative “Improvement Partnership” with Maidstone and Tunbridge Wells NHS Trust has focussed on role redesign as a way of reducing patient waits and improving quality of care. The work incorporated developing new ways of working and the reallocation of tasks to suit the skill mix of the team. Over an eight-week period it was found that the chemotherapy nurse spent on average 14 hours a week on non-chemotherapy tasks. A non-chemotherapy nurse or a health care assistant could perform procedures such as applying dressings or removing the cannula, allowing the chemotherapy nurse to give treatments, attend pre-assessment clinics or perform technical tasks such as the chemotherapy line insertion.

5.4.2 There is no clinical reason why the delivery of many different cancer treatments (oral or IV) cannot be devolved to community hospitals. Remote clinics can be linked to a main centre using new communications technology. For example a capecitabine clinic which is video linked allows staff in remote locations such as Orkney and Shetland to conduct remote reviews in parallel with the main clinic in Aberdeen. Using the link, patients can speak to the consultant on the mainland. More than 150 admissions are avoided annually as a result of this service. In addition NHS Boards save around £100,000 annually on flight and ferry travel costs for patients. The limiting factor in developing this work further in the Islands is the preparation of particular drugs, and then the subsequent shelf life of these treatments. Additional treatments could be offered if this was overcome. Similarly, satellite chemotherapy clinics have been set up to deliver chemotherapy in Merseyside and Cheshire.

38 Derek Wanless, Securing our Future Health: Taking a Long-Term View, 2002.
5.5 Opportunities presented by improved capacity modelling

5.5.1 The work undertaken by the National Cancer Director has demonstrated that effective capacity planning is essential if demand for cancer treatments is to be effectively catered for. In his report on uptake of NICE-approved drugs, Professor Richards called for the Department of Health to develop a capacity planning model for chemotherapy. This initiative has been led by the Cancer Services Collaborative “Improvement Partnership” as part of their work with the National Chemotherapy Advisory Group. The model has been incorporated into a broader toolkit entitled Modernising Chemotherapy Services—A Practical Guide to Redesign. It aims to form a basis for the multidisciplinary redesign of chemotherapy services within Oncology and Haematology and is set out as a series of challenges, each with a recommended approach, which if followed, will enable units to take a structured approach to service improvement.

5.5.2 The pharmaceutical industry can play a role in assisting with capacity planning. The Pharmaceutical Oncology Initiative (POI) is a cross industry collaboration that has been developed under the auspices of The Association of the British Pharmaceutical Industry (ABPI) with the objective of developing an integrated capacity management and planning toolkit to:

- Assist cancer networks in undertaking demand-led capacity planning allowing optimum exploitation of current capacity.
- Enable networks to identify the rationale for expanding capacity and assist them in developing business cases for expansion.
- Build on existing work already undertaken by the NHS.

5.5.3 Such collaborative approaches can help mitigate the effects of not having sufficient capacity planning expertise within NHS organisations.

6. Effect of Payment by Results on NHS’ Ability to Adopt Solutions

6.1 The Cancer Capacity Coalition welcomes the Government’s commitment to encourage, wherever clinically appropriate, the devolution of care to community settings as we believe that this has the potential to maximise the effectiveness of existing cancer workforce capacity.

6.2 However, anecdotal evidence suggests that perverse incentives are preventing Trusts from adopting capacity saving measures such as the use of oral chemotherapies as a result of the existing Payment by Results (PbR) tariff. Hospital trusts can face a substantial loss in short term revenue by using oral chemotherapies as they require a significant drop in the required number of patient out-patient visits (for which hospitals are renumerated under the tariff). One such example is a major northern cancer centre which has calculated that, for every 100 patients it switched from IV to oral chemotherapy, it would lose over £1.5 million in revenue. This calculation is based upon the hospital only being reimbursed for eight outpatient visits per patient when being treated with oral chemotherapy, as opposed to 30 visits to a chemotherapy unit when being treated by IV chemotherapy.

6.3 We therefore welcome the Department of Health’s White Paper commitment to review the Tariff so that it is based on best practice rather than standard national practice:

“Medical science, assistive technology and pharmaceutical advances will continue to rapidly change the way in which people’s lives can be improved by health and social care. It is important that the organisation of care fully reflects the speed of technological change . . . [the Tariff] was first introduced in the context of the reform of the hospital sector. For this reason, not everything about the current structure of the tariff aligns with the radical shift that this White Paper seeks to achieve. So we will improve it.”

6.4 It will be important that this opportunity is seized to incentivise capacity saving measures such as oral chemotherapies.

7. Recommendations the Committee May Wish to Consider

7.1 Through its work on demand capacity planning, the Cancer Capacity Coalition has developed a number of recommendations about how cancer capacity and workforce effectiveness could be maximised, which the Committee may wish to consider as part of its Inquiry:

- The NHS should base workforce capacity modelling on “demand capacity” (the resources needed to provide optimum care) rather than “current capacity” (the resources that are currently employed to deliver therapy) so that service planning reflects the realities of modern care and patient expectations.
- As recommended in the Audit Commission report on Managing the financial implications of NICE guidance, horizon scanning of future NICE guidance should be undertaken by all NHS bodies. Local consultation on the potential implications of implementation should include a robust assessment of the impact on local capacity.

39 Department of Health, Our Health, Our Care, Our Say, January 2006.
— Regular audits of available chemotherapy capacity (IV seats and trained personnel) should be undertaken at both a national and local level. These should be used to identify any capacity shortfalls which exist and to plan provision accordingly.

— Given the expected increase in demand for cancer treatments, NHS organisations should prioritise expanding cancer capacity. This should focus on building capacity to deliver the predicted treatments of tomorrow as well as those of today.

— A national strategy is needed for the education and training of chemotherapy nurses and primary care teams on all aspects of cancer drug therapy to ensure best use of capacity. Currently the role of cancer drug therapy staff varies nationally, making career progression difficult and compromising the ability of the NHS to establish clear care pathways which can be used across organisations.

— Initiatives such as using oral cancer drug treatments as an alternative to intravenous therapy should also be used wherever possible to free capacity.

— The adoption of capacity saving measures should be incentivised through mechanisms such as the PbR Tariff. Any perverse incentives inhibiting the uptake of capacity saving treatments should be identified and addressed through primary care trust monitoring of local contracts with providers.

— NICE’s role in assessing the potential capacity implications of new treatments should be strengthened so that NHS organisations can be made aware of, and advised on, capacity measures they will need to take to implement guidance.

— Initiatives such as using oral cancer drug treatments as an alternative to intravenous therapy should also be used wherever possible to free capacity.

Cancer Capacity Coalition

March 2006

Evidence Submitted by Capio Healthcare UK (WP 26)

OVERVIEW
— Capio Healthcare UK is the fourth largest provider of independent healthcare services. Capio has a contract with the NHS to establish nine independent sector treatment centres (ISTCs) across England, from Cornwall to Northumberland.

— The ISTC programme was introduced to create immediate capacity to reduce waiting times. Additionality rules were included in the first wave of ISTC contracts in order to bring additional doctors to work in the NHS. Capio has already recruited 150 clinical staff as part of the wave one ISTC programme.

— Additionality rules should now be relaxed to allow free movement of staff between providers, as is allowed in any other area of work.

— Capio is planning to make use of extended staff roles to introduce innovation to the ISTC programme. This involves adding additional responsibilities to existing staff roles and making them more adaptable.

— Capio is about to begin junior doctor training at its York ISTC. Capio would welcome the opportunity to train doctors and nurses in its other facilities.

— Capio second a number of clinicians from NHS trusts. Capio would recommend the increased use of secondment arrangements in order to aid training and increase skills in the workforce.

1. INTRODUCTION

1.1 Capio is a progressive company with a commitment to fair employment and has five board members who are trade union representatives. We provide healthcare in Sweden, Norway, Denmark, France, Finland, Spain and the UK. Across Europe, 90% of the patients Capio treats are publicly funded. Capio Healthcare UK is the fourth largest provider of independent healthcare services. Prior to the ISTC programme, Capio had 21 acute units throughout England, plus six mental health units (providing adult, child and adolescent services), two neurological units and a dedicated eye clinic. All Capio units continue to treat NHS patients under national and local arrangements.

1.2 Capio shares the values of the NHS, and wants a long term partnership. The company believes its contribution to treating NHS patients is helping to grow a publicly funded health service.

1.3 Capio has a contract with the NHS to establish nine ISTCs across England, from Cornwall to Northumberland. Six of the centres are newly constructed; two are on existing NHS estates and four are new builds in innovative locations, chosen to fit with the requirements of the local Healthcare Community and to improve patient access as pragmatically as possible. Of the remaining three Capio ISTCs: one is a
facility within an existing NHS hospital, and two are within existing Capio hospitals. Approximately 95,000 NHS patients will be cared for at our centres over the five year contract (until 31 March 2010). The value of the contract is £300 million. A previous Capio contract (G Supp) to treat 13,600 patients (worth £23.9 million) has been successfully completed.

1.4 Capio welcomes this inquiry by the Health Select Committee. Please note that our answers are focused on those areas where we feel we have the most to contribute.

2. Meeting Future Demand

Increasing Capacity

Additionality

2.1 The ISTC programme was introduced to create immediate capacity to reduce waiting times. In the longer term, the Government also constructed it to create sufficient capacity to enable choice and competition between providers.

2.2 Additionality rules were included in the first wave of ISTC contracts in order to bring additional clinical staff to work in the NHS. Capio has already recruited 150 clinical staff as part of the wave one ISTC programme. This will increase further as all Capio ISTCs across the country become live, adding capacity to the UK health economy.

2.3 We believe that the additionality rules should now be relaxed to allow free movement of staff between providers, as is the case in other areas of work. The NHS and private providers will continue to be attractive and competitive employers to foreign clinical staff and Capio will continue to search both at home and abroad for the best employees.

2.4 There are very few consultants who work purely in the independent sector, and additionality rules have forced Capio to deny employment to a number of UK clinicians who have wanted to treat NHS patients in ISTCs. Rigid separation of the NHS and ISTC workforces makes it more difficult to share and spread best practice and innovation. Patients would benefit from the movement of staff between the NHS and ISTCs.

2.5 One area in which we feel the NHS could learn a great deal from the independent sector treatment centres is the ability to deliver safe, high volume elective surgery. Delivering surgery in this manner demonstrates an effective patient and clinician management process, in addition to specific surgical skills, and could transform the clinical productivity currently achieved in the NHS.

Changing Roles And Improving Skills

Extended Roles

2.6 Capio is planning to make use of extended staff roles to introduce innovation to the ISTC programme. This involves adding additional responsibilities to existing staff roles and making them more adaptable. Not only will these new staffing roles benefit patients and add to the efficient running of Capio’s centres but they will also provide staff with the opportunity to develop new skills. Two examples of these new roles are being developed for nursing staff:

(a) Medical Care Practitioner, a role in which a suitably trained nurse will take on many of the clinical aspects of the doctor’s patient contact, including assessment and management of the patient’s condition, medication, care and after care. A Medical Care Practitioner will contribute particularly in Admissions/Out-patients and on the In-patient unit.

(b) Anaesthetic or Surgical Practitioner, a role in which a suitably trained nurse will be able to take on direct anaesthetic work under the overall guidance of an anaesthetist or will be able to undertake minor surgery and act as first assistant to the surgeon.

Training schemes are available for such roles and we are organising a scheme to provide us with places via the University of Hertfordshire. Nurses undertaking this training will spend half their time in the treatment centre and half on the study programme.

Training

2.7 Capio already facilitates the training of NHS nurses and physiotherapists in some of its hospitals. Capio would like to increase its role in the training of clinical staff to help meet the country’s workforce demand. Utilisation of the excellent clinical facilities in ISTCs to facilitate the training of junior doctors, in particular, would also improve the quality of the skills acquired, and expose young doctors and nurses to innovative clinical and patient management processes. Again the benefits to the NHS and patient care would be very significant.

2.8 Capio is about to begin junior doctor training at its York ISTC. We welcome this development and the Department of Health’s move to include training in the second wave of the ISTC programme.
Secondment

2.9 A small number of staff (mainly surgeons and anaesthetists) provide services in some of Capio’s ISTCs via a structured secondment arrangement with the local trust (for example in Capio’s York ISTC). Capio is happy to partner with PCTs wherever this is the preferred model for delivery. Movement of staff in this way allows for sharing, and therefore the spread, of knowledge and best practice. It also provides NHS staff with the opportunity to work in new or different ways and aids professional development. Capio is keen to ensure that those who are seconded to the ISTC team are rewarded with career enhancement and development. Capio would recommend the increased use of secondment arrangements in order to aid training and increase skills in the workforce.

3. SUMMARY

3.1 Capio would like to emphasise its desire to work with NHS colleagues locally and nationally as appropriate to develop the approaches listed above as well as the use of joint appointments and “reverse secondments” (from Capio to NHS Trusts) to develop the staff and the skills available in the health economy.

Capio Healthcare UK
15 March 2006

Evidence submitted by the Chartered Society of Physiotherapy (WP 36)

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. The CSP is pleased to give written evidence to the Health Committee on this important issue and would wish to provide oral evidence if called upon. The CSP’s recent experience of problems in NHS workforce planning (at both local and national levels), forecasting and the well-known issue of the lack of sufficient jobs for new physiotherapy graduates (while there exist over 1,500 unfilled vacancies for senior physiotherapists) would make our oral evidence very relevant to the Committee’s investigation.

2. Planning which aligns workforce with service needs is essential to the delivery of high quality patient centred care and value for money for tax payers. Fifty-nine per cent of all NHS costs in England are staff related and £4 billion is invested in NHS staff training each year (A National Framework to Support Local Workforce Strategy Development, DH, December 2005). The CSP believes that there is substantial scope for improving workforce planning in the NHS. Inadequate workforce planning has led to unprecedented numbers of newly qualified physiotherapy graduates being unable to find employment as junior physiotherapists in the NHS. The background to this situation is set out in some detail in this introduction because the CSP believes that this is a prime example of the effects of poor workforce planning in the NHS.

3. The CSP first became aware that newly qualified physiotherapy graduates were finding it increasingly difficult to obtain employment as junior physiotherapists in the NHS in 2004. Until then there had been no difficulties in finding sufficient posts to accommodate all graduates seeking jobs. Research undertaken by the CSP in the past has shown that over 95% of graduates take up employment in the NHS on qualifying in order to be able to undertake a range of rotational placements in various clinical areas to allow them to consolidate their undergraduate education.

4. Since 2004 the CSP has been tracking the employment status of all physiotherapy graduates in the UK. Our latest survey (undertaken in January 2006) has shown that of the 2,172 students who graduated in 2005 approximately one third have been unable to find work within the NHS. Each of these graduates has cost the taxpayer an average of £28,500 to train. The majority graduated during summer 2005 and have now been unable to find work within the profession for at least six months. Financial pressures mean that these graduates are increasingly likely to seek alternative careers. The NHS is in danger of losing them altogether from the profession which would result in an enormous waste of public money and talent which the NHS will need in the future.

5. A planned expansion of the physiotherapy workforce was generated by the NHS Plan 2000. Investment and Reform for NHS staff—taking forward the NHS Plan (DH, February 2001) stated that “physiotherapists are very much in demand for implementation of the NHS Plan…” (page 13). This document also projected an increase in the number of physiotherapists working in the NHS by 59% from 15,600 in 2000 to 24,800 in 2009. This projection was confirmed by John Hutton, then Health Minister, in a response to a Parliamentary Question on 28 January 2002.

6. Significant efforts have been made to expand the number of students to meet future workforce needs. However, very little effort has been made at local level to stimulate the creation of sufficient junior jobs to absorb the increased output of graduates. The number of physiotherapy jobs is continuing to expand rapidly but many of these new jobs have been senior and specialist posts which new graduates cannot fill on
longer term perspective. This is partly because of the time it takes to train and develop staff to be flexible to fit in with changing priorities, workforce planning in health care crucially requires taking a complement despite rising demand for physiotherapy services. At a macro policy level it is not clear how National Health Service: A Political History (2002) omission.

organisations. Given the need to begin now to plan the future community workforce this is a major fragmentation and expansion of service providers into private, voluntary and social enterprise to health care structures and delivery models—what NHS historian Charles Webster in his book V is it clear how e

Health care trends such as the ageing population, an increasing number of people with long term conditions along with government targets such as orthopaedic waiting times mean that demand for physiotherapy services will continue to grow over the medium and long term. Unemployed physiotherapy graduates are not then a symptom of over supply but of a failure in NHS workforce planning which has been unable to ensure sufficient posts for newly qualified staff, particularly in the primary care sector. Unless newly qualified physiotherapists can consolidate their education in a junior post, they cannot progress on to fill the more senior jobs. Junior physiotherapists make a major contribution to patient services and undertake work of real value to the NHS.

In our view, critical to more effective workforce planning is the need for planning and development to:

— Involve all stakeholders in a meaningful way, including trade unions and professional bodies.
— Be informed at all levels by expert information such as on disease trends and technological developments.
— Take a long term perspective so, for example, the NHS is able to respond to tightening labour markets, particularly for skilled staff, and to the future requirements of service modernisation.
— Embrace the whole NHS Career Framework (registered and unregistered staff, clinical and non clinical staff) ensuring appropriate access to training and learning resources.
— Be better joined up so, for example, NHS providers are able to respond to the workforce challenges of national policy developments.

In considering future demand, how should the effects of the following be taken into account: recent policy announcements, including Commissioning a patient-led NHS (CPLNHS), technological change, an ageing population and the increasing use of private providers of services?

10. Workforce planning means, therefore, ensuring that there are the right numbers of staff, with the right skills at the right time to meet service (patient) need. Workforce planning must comprise more than just a focus on staff numbers: “head content” as well as “head count” (Workforce Planning—The wider context, Employers Organisation for Local Government and Institute of Employment Studies, July 2003). In the NHS it should embrace access to learning, career development, diversity, continual professional development, recruitment, retention, pre registration commissioning, learning resources (such as libraries and e-learning), competency frameworks and more.

11. Through policy announcements such as CPLNHS (2005), Our health, our care, our say: a new direction for community services (2006) and The NHS in England: operating framework 2006/07 (2006), the Department of Health (DH) sets out the strategic framework and policy priorities against which workforce planning takes place. The CSP is not, however, convinced that workforce is always su

12. Effective workforce planning has been challenged nationally and locally by almost continual changes to health care structures and delivery models—what NHS historian Charles Webster in his book The National Health Service: A Political History (2002) has described as “constant revolution”. While needing to be flexible to fit in with changing priorities, workforce planning in health care crucially requires taking a longer term perspective. This is partly because of the time it takes to train and develop staff but also because
of the time frame of emerging health trends and policy developments such as the shift of resources from the acute to the community sector. The DH agrees with this—“Long-term workforce planning is important to provide a strategic view of supply and demand and to reflect the changes in the wider context of technology, resourcing patterns and demographics”. (A National Framework to Support Local Workforce Strategy Development, January 2006).

13. Far too often though decisions are based on short term factors. Proposals were made by the DH Workforce Review Team to cut physiotherapy pre registration commissions by 10% in 2006–07. This is despite evidence that demand for physiotherapy will continue to grow in the future (for example because of the rising incidence of musculoskeletal disorders). Indeed the recent White Paper Our health, our care, our say: a new direction for community services (January 2006) clearly sets out the factors that will increase demand for physiotherapy such as self referral, the importance of intermediate care, care provided nearer home and an ageing population. Cuts now will result in insufficient capacity in the future.

14. Workforce planning of professionals cannot be turned on and off like a tap. It is not a short term fix. Universities usually receive at least 12 months notice of changes to in-take numbers. The majority of training courses last for three years. The short term problems facing 2005 and 2006 graduates will not be solved by cuts in commissions which will not have an impact for a further three years.

15. The CSP in its evidence to the Healthcare out of Hospitals consultation said:

We are concerned that the impact of CPLNHS will result in a reduction in staff morale, retention and recruitment difficulties and limited opportunities for continuing professional development.

The CSP is concerned that the drive to increase the number of alternative providers of NHS services (and associated infrastructure changes such as practice based commissioning and payment by results) will increase financial instability within the NHS with some trusts “failing” in the new market (How should we deal with hospital failure? Kings Fund, December 2005). Financial instability will undermine sensible and integrated long term workforce planning.

16. Significant advances in medical technology such as genetics and remote monitoring of patients are likely in the near future. Technological advances increase the health service’s ability to treat people, especially the old. They do not result in a decline in demand for staff, in fact they imply a need for increased capacity and the development of new skills.

17. The number of people aged 85 years and over is projected to rise by 75% by 2025. Older people are major users of physiotherapy services with over half of new patient contacts made by physiotherapists in 2004–05 with people over 55. In 2003 the DH’s Care Group Workforce Team Recommendations (Older People) supported the need to increase the current (physiotherapy) workforce by up to 50% noting that “falls intervention and osteoporosis are significantly under funded”. Incidences of osteoarthritis are expected to increase as the age of population rises and because of rising rates of obesity (Burden of major musculoskeletal conditions, Wolf and Pfeiler, Bulletin of World Health Organisation: 2003).

18. Physiotherapists are playing a major role in reducing substantially the problems of delayed discharge from hospitals by increasing rehabilitation and enabling older people to return to independence in their own homes as well as decreasing the numbers of emergency admissions. This also provides a much cheaper alternative to nursing homes. In both ways physiotherapists have saved the NHS and Social Services substantial costs they would otherwise have incurred and have increased efficiency in service provision.

19. The CSP supports the government’s objective of promoting health and well-being in old age. To achieve this though will require greater staffing capacity (including more staff) and capability in the community sector. There will be a particular need to develop staff with specialist skills able to work in multi disciplinary teams and networks across health, local authority and other settings able to deal with patients with complex conditions. There is little evidence of planning being undertaken to develop this workforce or support available from the DH or SHAs to assist trusts.

20. The increasing number of private and voluntary providers of health care will in the CSP’s view create further significant challenges in planning a fit for purpose workforce. It is vital that the Knowledge and Skills Framework, NHS Career Framework and career and competency frameworks developed by Skills for Health and Skills for Care apply to all providers of health care so that there is a common structure for developing staff and developing competencies around patient pathways. Thought will also need to be given to how new providers can appropriately support the training of students through clinical placements. Plurality will increase the need to ensure a strong central overview of training and development and support for local employers to achieve this.

21. Smaller and medium sized professional groups such as AHPs have found it difficult to effectively influence decision making locally around workforce—ensuring an effective voice for all stakeholders is essential. The CSP believes that each SHA should have a senior post responsible for AHP workforce issues to help coordinate and support local activity as well as providing strategic leadership and engaging with education providers. This has worked more effectively recently and should not be lost in the SHA re-organisation.
How will the ability to meet demands be affected by: financial constraints, the European Working Time Directive (EWT), increasing international competition for staff and early retirement?

22. The NHS spends £4 billion on pre and post registration education for its employees. It is a major concern of the CSP that current NHS financial problems in England will result in short term decisions locally and nationally to cut workforce spends through further vacancy freezes, cuts in NVQ funding, reductions in post registration education expenditure and support for Foundation Degree courses for Assistant Practitioners and cuts in the MPET allocation and consequently pre registration commissioning numbers. Given the time it takes to train an undergraduate clinician or a support worker studying a NVQ cuts now will have a long term impact on capacity, the operation of the Knowledge and Skills Framework and the ability of the service to meet access targets and rising demand.

23. Financial constraints are also likely to stifle innovation such as new ways of working. There is emerging evidence of the impact that physiotherapists can have in emergency care reducing waiting times by rehabilitating injuries more quickly and facilitating early discharge. Developing the role of physiotherapists in A&E departments, as Derby Hospitals NHS Foundation Trust has, could have a major impact on waiting times and reduce unnecessary referrals. However it is less likely that trusts will undertake the necessary initial investment in role redesign (for example developing appropriate competencies and support) if they are required to cut back on education and training expenditure.

24. The need to ensure that medical staff comply with the European Working Time Directive, the age profile of the workforce and additionally a desire by staff to have a better work-life balance will all impact on capacity. The DH NHS Workforce Census for 2004 revealed that out of a total headcount of 19,139 qualified physiotherapists in England 8.8% (1,687) were aged over 55 years and a further 7.9% (1,511) were aged 50-54 years. Many physiotherapists still retain the right to retire from age 55 without any actuarial reduction to their NHS pension. Although not all these staff will chose to retire at this age, there will still be significant numbers of physiotherapists retiring in the next few years who must be replaced.

25. “Being a good employer is more than simply meeting legal requirements: supporting a good work-life balance, flexible working, childcare provision and healthy workplace policies are all important” (Our health, our care, our say, DH, January 2006:189). While the DH has signalled the importance of addressing demographic factors such as measure to retain over 50s and 60s there is little sign that such strategies are being pursued (A National Framework to Support Local Workforce Strategy Development, DH, 2006, page 12). An ageing workforce will mean a disproportionate rise in retirements in the future. These workers will need to be replaced.

26. An ageing population and declining birth rate means that competition for skilled labour such as physiotherapists will tighten in the future. National and international competition for labour will increase particularly from America (Workforce Crisis—How to Beat the Coming Shortage of Skills and Talent, Dychtwald, Erickson, Morison, Harvard Business School Press, 2006).

27. This view is shared by the DH who in A National Framework to Support Local Workforce Strategy Development rightly argues “demographic trends mean that for many health and social care employers maintaining ‘an edge’ in recruitment and retention of the best staff will be important” (DH, January 2006:14), while the Institute of Employment Studies notes “the future is expected to bring a shift to higher skilled ‘knowledge worker’ jobs, increased competition” (2003: 7). The CSP is concerned that the NHS is not planning sufficiently for the impact of demographic changes such as the retirement of the “baby boomer” generation on labour supply.

28. Attention must also be paid to the effects on the NHS workforce of changes in other countries. In London the vacancy rates for senior physiotherapists and high turnover among staff has led to a growing dependence on short-term physiotherapists from countries such as Australia and New Zealand. However, impending reductions in the numbers of physiotherapists being trained in Australia means that there is likely to be a dramatic decrease in the numbers of Australian physiotherapists able to bolster the London workforce in this way. This in turn will have a detrimental impact on waiting lists and the service provided.

29. The CSP believes that short term cuts in investment in training and development will have long term consequences and inhibit the NHS’s ability to recruit staff in the future and meet rising demand for health care.

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 and international recruitment?

30. While there is scope to redesign and enhance roles it is the CSP’s view that this will result in a changed workforce profile with, for example, more specialist and highly specialist physiotherapists (levels 7 and 8 of the NHS model Career Framework) and more Assistant Practitioners (levels 4). There is no evidence that changing roles will reduce demand for existing staff overall. The CSP believes that the Knowledge and Skills Framework offers the opportunity to improve the skills of existing staff but that it is vital that all staff whether registered or not have fair access to training. This is not the case at present with AHPs frequently struggling to access learning resources locally.
31. The CSP supports the government’s commitment to increase widening participation in learning and welcomes the establishment of the Widening Participation in Learning Strategy Unit headed by Professor Bob Fryer. For too long staff in bands 1–4, including physiotherapy assistants and administration staff working in physiotherapy departments, have struggled to gain access to NVQs and other means of learning. Fair access to education supported by appropriate learning environments for all staff is essential to ensure the effective delivery of services. It is particularly important that spending on NVQs and Learning Accounts is ring fenced. The CSP would be concerned about any move away from this.

32. At present the following stakeholders are involved to a greater or lesser extent in NHS workforce planning: Department of Health, Skills for Health, service providers, education providers, professional groups and networks, trade unions and professional bodies and SHAs. In the future local authorities and private and voluntary organisations will join this list. Given the size of the NHS workforce the CSP firmly believes it is vital that there is strong central leadership and strategic overview of NHS workforce planning which takes account of expert information and advice, as well as the long term perspective. Partnership working with professional bodies and trade unions must form part of this approach. The CSP regretted the demise of the National Workforce Development Board as this was the only body that allowed high level discussion with external stakeholders around workforce issues. Unemployed physiotherapy graduates illustrate the consequence of not joining up thinking around workforce planning. There is a real danger that plurality of provision will result in greater confusion.

33. The CSP is also concerned at the tendency to group all Allied Health Professions (and increasingly Health Care Scientists) into one group ignoring the different issues affecting each profession. Local Delivery Plans being developed by Strategic Health Authorities, which include their proposals to increase their local workforce numbers, only provide information for this group as a whole. This makes it extremely difficult for trade unions and professional bodies such as the CSP to comment on these plans in a constructive manner. For example, physiotherapy has one of the highest ratios of applications for each undergraduate training place and an extremely low attrition rate from the courses. In radiography the main problem is in finding sufficient applicants to fill the available training places. In physiotherapy there is a great deal of competition to attract staff into the private sector working in a range of settings such as sports clinics, occupational health, charities, private hospitals, private clinics etc. In radiography such opportunities do not exist outside the NHS to any great extent. If workforce planning does not take proper account of such differences, it becomes less and less meaningful.

34. The CSP’s view is that far more detailed workforce information is needed before effective national workforce planning can be instigated. A survey of our members undertaken in 1999 allowed us to obtain information about physiotherapists working in the NHS in greater depth than DH surveys have done. One example of the benefits of this level of information were shown when we examined the age profile of members working in the NHS by clinical specialty. Although it is well known that the NHS workforce is ageing, our research revealed that a disproportionately high number of physiotherapists working in care of the elderly (69%) fell within the 40+ age bracket compared to 50% of all those working in the NHS. Only 4% of those working in care of the elderly were aged 20–29 years compared with 17% of all those working in the NHS. This highlighted the need to ensure that student placements and junior posts are developed in this specialty to ensure that those retiring could be replaced in the future.

35. For some years the CSP has expressed its concern that the DH in England only collects vacancy statistics for posts which have been vacant for at least three months and which organisations are actively trying to fill. This presents a distorted picture of the true situation because posts which have been frozen or which are not currently being recruited to, often due to financial constraints, are not included. Although there is value in gathering information about posts which have been vacant for this length of time since this is the average time taken to fill a post, we also believe that it is essential that data is collected on all frozen posts and “on the day” vacant posts to obtain a clearer picture of the extent of the problem. This data used to be collected in the 1990s for the Pay Review Body. The CSP’s workforce survey revealed that the “on the day” vacancy rate was, on average, around twice as high as the three month vacancy rate. Vacant posts reflect the inability of the NHS to provide the level of service needed to meet patient need and without accurate information about the vacancy situation it becomes very difficult to plan action to address the full extent of the problem.

36. In conclusion, the CSP would wish to see:

- Involvement of all stakeholders in a meaningful way, including trade unions and professional bodies, and better sharing of information used to support long term planning and ensure partnership working in this complex area.

- Recognition that the short term impact of financial deficits in the NHS should not lead to “boom and bust” variations in university intakes which have serious long term impact on the future of healthcare.
— Action is taken to plan and create more junior physiotherapy posts to ensure that current graduates are fully employed recognising that there remain over 1,500 senior physiotherapy posts in the UK and that the juniors of today are the senior physiotherapists of tomorrow. Lack of effective NHS workforce planning could deprive the UK public and the NHS of the skilled professional workforce it has already paid to provide.

— More detailed workforce data collection including information by profession which examines age profile, clinical specialties, ethnicity, disability, and so on.

— Collection of “on the day” vacancy data for each profession in addition to three month vacancy data.

— Enhanced collaboration between national and local levels so that NHS providers are better able to respond to the workforce challenges of national policy developments.

— 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.

— Direct involvement of local service managers in collection of data to ensure that the information submitted for each profession is as accurate as possible.

— Strong central overview and monitoring of steps being taken at local and regional level to tackle problems which arise such as shortages in particular professions and clinical areas within those professions. This will become increasingly important with increasing plurality of providers.

— A longer term and wider perspective which takes account of demographic trends; developments in other countries which are likely to have a significant impact on the NHS; and the impact of the various strands of the NHS modernisation programme.

— Account being taken of the whole NHS Career Framework (registered and unregistered staff, clinical and non-clinical staff) ensuring appropriate access to training and learning resources.

Phil Gray
Chief Executive, Chartered Society of Physiotherapy

March 2006

Evidence submitted by Cheshire and Merseyside Strategic Health Authority (WP 39)

WORKFORCE PLANNING—IN PREVIOUS YEARS

1. Cheshire and Merseyside’s Workforce Development Confederation developed a local workforce planning submission—the “Workforce Supply Strategy” which continued to be collected annually by the Workforce Development Confederation until 2003 when it was discontinued.

2. This annual submission was provided locally by all NHS organisations within Cheshire and Merseyside—workforce projections for a five year planning period (seven years for medical staff).

3. The aim of the Workforce Supply Strategy was to inform the commissioning process, and provide a source of local intelligence on the NHS workforce. However, this process was discontinued in 2003 for a number of reasons:

   — It became evident that commissioning numbers could be calculated in a simpler top-down way by the WDC(SHA) commissioning team.

   — Staffing projections from Trusts/PCTs were often aspirational, and not consistently linked to financial plans/constraints.

   — A high degree of variance in the quality of data submitted.

   — Planning timescales revolved around the Medical Workforce Census

   — Difficulties in terms of “fit” with the new “Local Delivery Plan” process.

   — Expression of productivity and skill-mix improvements in terms of the equivalent gains in full-time staff.

   — Reconciling bottom-up planning submissions from Trusts/PCTs with top-down DH targets for staffing increases. [NHS Plan gave strategic direction although hindered by rigid targets that did not reflect needs of local communities].

4. Previous approaches to workforce planning, both locally and through the LDP have raised some common concerns:

   — Little evidence of communication between commissioner and provider organisations.

   — A rigid approach to planning according to traditional staff groups [Consultants, Qualified Nurses etc . . .].

   — Loss of local intelligence as soon as returns are aggregated at SHA-level.
— Lack of coordination with activity and finance plans.

5. Whilst Trusts/PCTs continued to develop their own workforce supply strategies, they did not have an understanding of how to implement.

Workforce Planning—the Current Process

6. Since the local annual workforce submissions were discontinued—SHA planning intelligence in Cheshire and Merseyside is collected solely through the LDP. Through this process, workforce submissions have improved in the following respects:

— NHS targets less of a priority for certain staff groups (related to access targets).
— More strategic direction (planning assumptions submitted in advance of staff growth projections).
— DH improved links between different policies (supported by ISIP).

7. A number of concerns remain however regarding the LDP workforce submission.

— Still focus on national policies rather than local workforce priorities.
— LDP (and ISIP) timetables enable a focus, but not enough to benefit the system locally.
— Links between workforce/finance/activity are still not firmly established at the local health community planning stages.
— Coordination in the process across local health communities does not appear to extend to workforce planning (where the PCTs could potentially benefit from acute Trusts’ expertise).
— A rigid approach based on traditional staff groups remains, with no scope to reflect the development of new roles.

8. In addition to the LDP, it is assumed that Trusts/PCTs across the SHA will undertake their own workforce planning in ways that meet their own organisations/health economies needs. In reality there is a risk that organisations vary in their capacity and capability to effectively workforce plan.

9. Commissioning and the development of new roles appear to have progressed without being directly linked to the rest of the workforce planning agenda. In some areas/organisations this has led to a lack of understanding of service models and of the workforce required to deliver the service.

This could potentially result in services trying to adapt to fit with newly developed roles—instead of roles supporting the service eg community matrons.

10. Nationally, the development of organisations such as “National Workforce Projects” has aided workforce planning/development. They have been able to support a national, coordinated message, being able to communicate/engage directly and effectively with Trusts/PCTs, and provide valuable resources and support for workforce planning capacity and capability.

New Developments to Meet Future Needs

11. New staff contracts have recently been put into place, but have not yet had time to become embedded—only when this happens will the benefits be fully realised and reflected in workforce plans. There is a lack of capability within the system to actively performance manage the consultant workforce in relation to job planning and review.

12. The new contracts, new roles, and new ways of working (the latter facilitated largely by NPfIT) represent some of the building blocks of change around which to base workforce plans. However before organisations are able to fully reflect these in their workforce plans they will have to better understand the forthcoming organisational changes ie Commissioning and Patient Lead NHS, the changes in the role of the PCT, and changing financial environment.

13. New technology in the form of the “Electronic Staff Record” (ESR) system should be able to provide organisations with better (real time) workforce information.

14. Regardless of the technological improvements promised by ESR, the information at the heart of the system also requires significant modernisation. The occupation codes system, which allows the DH to identify staff numbers by occupational area needs to be modernised so that it properly reflects newly developed roles and has the flexibility to identify staff in ways that are useful both to DH centrally, and the NHS at local level.

15. Current developments that are hampering workforce planning are:

— New ways of working remains orientated around a service within a particular organisation rather than across a local health community.
— National policy ie keeping a service local, remains in conflict with financial/service requirements/planning.
— Foundation Trusts not providing workforce information.
There is no clear message on if or how the independent sector will support the training and education of junior doctors.

Questions from the Select Committee

In considering future demand, how should the effects of the following be taken into account:

- Recent policy announcements, including Commissioning a patient-led NHS.
- Technological change.
- An ageing population.
- The increasing use of private providers of services.

16. Key to future planning is allowing changes brought about by policy to become embedded within organisations and their impact on commissioning and across the health economy understood.

17. There is a lack of clarity around the provider arm function of PCTs and this hampers future planning.

18. A clearer understanding of the impact of “choose and book” is required. Implementation as it currently stands removes the predictability of workforce planning.

How will the ability to meet demands be affected by:

- Financial constraints.
- The European Working Time Directive.
- Increasing international competition for staff.
- Early retirement.

19. Financial constraints reduce funding available for development of a workforce that is fit for purpose.

20. It is likely that some financial constraints will lead to a review of how services are delivered and the competencies/workforce required delivering it. It will help focus organisations thinking around productivity.

21. EWTD has already had a dramatic impact on the ability of service to meet demands within the financial constraints. This will be further hampered by EWTD 2009 that should be considered in parallel with the implementation of the specialist training programme of MMC, both of which will drastically reduce the availability of doctors in training to service. EWTD 2004 was achieved through changes to rotas/working practices, increased funding for additional medical and non-medical staff and on a more limited level through Hospital at night. Future planning will need to be across LHC rather than by organisation as more radical collaborative approaches will be required to ensure services are delivered; this may require reconfiguration of services in some cases.

22. Early retirement, particularly of the consultant medical workforce is becoming more difficult to predict. Information on consultant ages is limited at a strategic level making planning difficult. However, the introduction of MMC could be seen as an opportunity to change the model of service delivery ie service in the main led by “senior medical appointments” not necessarily consultants.

Workforce Planning in the Next 3–5 Years

23. Workforce planning must change over the next 3–5 years in order to meet the requirements of a modernised NHS and to meet patient and employee expectations.

24. The greatest single improvement in productive time may be obtained through developing a competency based approach to strategic workforce planning that will involve defining job roles in terms of the competences required and then evaluating them in accordance with AIC.

25. There will be a requirement for greater flexibility in the way staff are employed eg ROE (retention of employment model), self employment/Chambers and secondments, and flexible contracts to help address issues around early retirements, increasing percentage of female medical workforce and ageing workforce.

26. The implications of CPLNHS and provision of primary care services is still uncertain. This will become clearer in due course but at present is of great concern due to the planned shifts from secondary to primary care. Improving the patient experience must be central to changes to services; however without robust integrated service/workforce planning maintaining efficacy of provision will be problematic.

27. It is vital to make the connection between National policy and initiatives and what organisations want to achieve in terms of service delivery.

28. Workforce planning should be integrated into service planning in order to provide flexible, responsive, qualitative, cost-effective services. Without true integration service modernisation will be hampered. Should this be provided at an organisational level or at a local health economy level to ensure that the workforce plans/development follow the patient pathway across all sectors:

- Primary.
- Secondary.
— Tertiary.
— Las.
— Voluntary.

29. Workforce development must be linked to service modernisation, to fully reflect the changing nature of work, service provision and patient expectations.

30. Workforce planning must support service requirements, it should not be service developed around workforce (ie traditional professional workforce groups).

31. The changing population demographics, with its implications for workforce demographics, may work against national policy. The workforce will need to be more flexible to provide 24/7 when intelligence is showing that early retirement, and part-time working are becoming more popular.

32. Patients are becoming more knowledgeable—this will have implications of what treatment they want and where they may want it. Clinical need and patient choice are both paramount but this will impact on income and expenditure for organisations. Patient demands will put more pressure on service and the workforce and this will need to be effectively managed.

33. The impact of MMC needs to be understood to determine the impact on service—loss of junior/consultant doctors.

34. Increased female participation rate into medical/dental schools will lead to an increase in future flexibility by necessity. This needs to be resolved before its becomes a service issue—plan now, implement in the future. This should provide the impetus to change working practices across the NHS not just in medical specialties.

35. Lead in times for professional training cause a “time lag” for service modernisation/change. Therefore, the educational requirements need to become more flexible and responsive to service changes. Modular training determined by service need, not professional bodies, must be implemented—a business model.

36. The impact of international/European political and economic policy may impact on service or workforce provision—eg age discrimination, medical training programmes.

Cheshire and Merseyside Strategic Health Authority
March 2006

Evidence submitted by the College of Emergency Medicine and the British Association for Emergency Medicine (WP 27)

The specialty of Emergency Medicine (formerly Accident and Emergency Medicine) welcomes the opportunity to submit evidence to the Committee as part of the inquiry into NHS workforce needs and planning for the health service. Please see the “Way Ahead 2005” (www.emergencymed.org.uk) for a comprehensive summary of the challenges, including workforce planning, facing Emergency Medicine.

INTRODUCTION

Emergency Medicine (EM) has been at the forefront in introducing new ways of working and enhancing the roles of other staff. We have often led the introduction and training of nurses and ambulance staff in extended roles (eg nurse prescribing, pre-hospital treatment) and introduced new care pathways based on changes in processes of care (eg near patient testing, “see and treat”).

The job analysis provided by EM for the A&E Modernisation Group (Workforce Monograph, DH 1999) has been influential in government policy in HR. Yet challenges for staffing acute services have never been greater. Our specialty has a wealth of first-hand experience and a significant research base in matters of staffing, especially in role substitution.

How will the ability to meet demands be affected by financial constraints, the EWTD, international competition for staff and early retirement?

We would like to provide comment and evidence in three main areas:

— The challenges of providing 24/7 staffing for acute services.
— The benefits and limitations of role substitution.
— The financial constraints to workforce expansion.
1. **The Challenges of Providing 24/7 Staffing for Acute Services**

1.1 Emergency Departments (ED) are “open all hours”. There is increasing expectation of health care provision but there are fewer options available to patients at nights, weekends and during Bank Holidays. This leads to a funneling of demand into fewer providers at such times. This has recently been recognised and the DH wish to extend the availability of General Practice, pharmacies, and other community-based services.

1.2 Emergency Medicine welcomes this step but is concerned that the resource required may be very much greater than the resource released by GPs “opting out” of out-of-hours cover. Given the current state of NHS finances it is hard to see how this will be funded.

1.3 Other “new services” such as minor injury units, walk-in centres, emergency care practitioner (ECP) schemes all seem to close at night. Many computer triage tools such as those used by NHS Direct tend to over triage to the ED for less serious problems (P Gaffney et al. An analysis of calls referred to the emergency 999 service by NHS Direct, Emerg Med J. July 2001; 18: 302–304).

1.4 Along with Obstetrics and Paediatrics we are concerned about the negative motivation of shift work on recruitment. Emergency Medicine has seen an increasing drift of Staff Grade doctors to retrain in General Practice. Given the dual attractions of no out-of-hours responsibility and better financial rewards, this is an understandable trend. Worryingly we have had reports of Specialist Registrars also leaving the specialty for Primary Care. Emergency Medicine, like Obstetrics, is both highly stressful and exposed to a relatively high number of medico-legal challenges.

1.5 There has been an inexorable rise in the numbers of patients attending Emergency Departments over the past 25 years despite efforts to redirect patients to primary care. The evidence to date is that increased alternative provision attracts previously unmet demand.

1.6 We would urge policy makers to consider these problems. The solutions are not straightforward but CEM and BAEM are willing to advise on steps that should be taken to reverse this worrying trend.

1.7 We have worked closely with DH workforce planning and derived very clear workforce plans that predict the numbers of EM Consultants required to provide a defined level of ED service. These models are agreed by the DH. However these plans will involve significant investment in new Consultant posts over the next five to 10 years. We are concerned regarding the current financial problems of the NHS and the ability to meet such expansion. Please see the attached chart on the outcome of Consultant recruitment in Emergency Medicine in 2005.

1.8 In the past the NHS has enjoyed a relatively inexpensive medical workforce. Junior doctors tolerated short spells of difficult work such as night shifts in the ED as they received excellent training and experience. Various policy decisions have led to a change in junior doctors working anti-social shifts. Furthermore, the expectations of patients have increased requiring more senior support. This is obviously going to be more expensive.

1.9 EM is hard, stressful 24/7 work. Many older doctors indicate that they find it increasingly difficult working through the night, often on an “on-call” basis with duties the next day. There is a realisation that job plans will have to accommodate and reflect different Consultant strengths at different stages of their careers.

1.10 Gender changes in the medical student population, the EWTD and trends towards more flexible working amongst doctors also introduce new challenges to conventional ways of working. The same policies that reduce staff hours also impose additional constraints on developing a comprehensive specialist workforce.

1.11 Another challenge is the implementation of Modernising Medical Careers (MMC). The abbreviated training linked to more structured competency assessments in the workplace will require greater supervision. Therefore, both trainees and trainers will need more time away from service delivery.

2. **The Benefits and Limitations of Role Substitution**

2.1 Emergency Medicine has been very proactive in recognising the skills in other professional groups and in providing leadership and training to expand roles to fit service needs.

2.2 Emergency nurse practitioners are a very good example. Many minor injury units are now staffed with nurse practitioners with support and advice from local EDs. Many EDs have developed a minor injury stream staffed by nurse practitioners. Proportions of patients seen only by nurses vary from 0–20% of attendances. Nurses requesting x-rays and nurse prescribing have contributed to safe and efficient care.

2.3 Randomised trials have shown the services to be safe and popular with patients. The costs are similar to traditionally delivered medical care of patients with minor injuries. Patient satisfaction is high.

2.4 Specialist nurse practitioners who care for patients with chest pain or patients suspected of having a deep vein thrombosis (DVT) have also been shown to be effective.

2.5 Paramedics acting in the practitioner role have been shown to be effective in the management of older people after a fall. Again the costs of the service are similar to traditionally provided care.
2.6 One of the main limitations is the nurses/paramedics are most successful working within fairly narrow roles. This is to be expected given the very much shorter training compared to an EM specialist. This is not a problem in services with high volume such as minor injuries or in larger departments with enough volume of patients with chest pain or suspected DVT to justify the service. However such systems tend to be provided mainly during the day. Few minor injury units are open at night. Few specialist nurse services operate at night.

2.7 We also have seen real problems in implementing the roles due to lack of investment, especially in training. These advanced clinical roles require both theoretical education and practical skill training. Primary Care Trusts (PCTs) seem unwilling to invest.

2.8 We are concerned about the continuing lack of any national standard of quality assurance of the clinical skills of these practitioners. We acknowledge that Mr Andrew Forster is producing a report of the registration of these roles but we feel that at present there is no standard of competency or test of competency. At a time when increasing tests of competencies are being expected in medical education, it seems odd that there is little or no such national work regarding practitioner roles. Work may be underway but these roles have been in existence for 10 or more years.

2.9 We are aware that Skills for Health has compiled an extensive list of baseline competencies. However these are mostly at the level of individual skills with little evidence of how these are synthesised into the clinical processes needed for patient care. We are also concerned that the level of competency described is often basic and gives no regard to the complexity of some tasks.

2.10 One unexpected effect is that the practitioners will deal with all the straightforward work leaving more complex problems to be seen by doctors. This is a reasonable model but it means the intensity of work for doctors has increased. The complex case is often one with much higher degrees of diagnostic and therapeutic uncertainty. Without the dilution of work with “easy cases” doctors sometimes find stress levels to be increased. In addition, the training of junior doctors may suffer as they are not exposed to the same spectrum of cases.

2.11 GPs contribute to services in numerous EDs by providing a more appropriate response to the persistent pattern of patients attending with problems that could be dealt with in a primary care setting. In departments where GPs practise as primary care specialists they see between 10–15% of patients. Evidence has shown that GPs investigate, prescribe, and refer less than if the same types of primary care patients are seen by hospital-orientated doctors.

2.12 Emergency Medical Technicians (EMTs), introduced in the last five years, perform procedures and selected investigations that complement the role of the doctor. This has allowed medical staff to focus on those aspects of assessment and management that reflect medical training. However, these staff also need supervision and professional development.

2.13 EM has led the field in promoting role enhancement and role substitution. While some roles have been very successful, others have significant limitations. The issues of 24/7 working remain an issue. The definition of national standards is long overdue.

3. THE FINANCIAL RESTRICTIONS TO WORKFORCE EXPANSION

3.1 This has already been referred to above, but we are concerned that despite the acknowledged need for trained specialists to provide emergency care, there are difficulties in funding the training posts in sufficient numbers to provide the Consultant target agreed with the DH. It remains to be seen whether the abbreviated training programmes as part of MMC will partially offset this cost.

The College of Emergency Medicine and the British Association for Emergency Medicine would be happy to provide further information on request.

Edward Glucksman
Vice President, College of Emergency Medicine

15 March 2006

Evidence submitted by the College of Pharmacy Practice (WP 55)

I am writing on behalf of the College of Pharmacy Practice to submit evidence to the above enquiry.

The College of Pharmacy Practice is an educational charity and membership body established 25 years ago in order to promote excellence in pharmacy practice. Membership is open to all pharmacists registered in UK. Its main work consists of:

- assessing its members for progress to the different grades of membership;
- accrediting courses, events and published material as suitable to support pharmacists in their Continuing Professional Development;
- accrediting basic training for pharmacy support staff; and
We wish to comment on only two aspects of the terms of reference:

1. **Recent Policy Announcements**

   Recent and proposed policy changes such as the new contract for community pharmacy, the development of the Advanced and Consultant Level Framework in hospital pharmacy, non-medical prescribing and the Pharmacists with a Special Interest Project all present both opportunities and challenges for the pharmacy workforce.

2. **Changing the Roles and Improving the Skills of Existing Staff**

   We believe that pharmacists and their staff already have much of the knowledge and skills necessary for these new roles. However, there is a need for further training and the assessment of knowledge and skills. At present this is done in a variety of ways and personnel who move from one PCT to another may find themselves having to repeat training or assessment in their new location. This is wasteful of time and resources. We have the experience to provide accreditation of training against pre-determined competency frameworks to ensure recognition of training throughout the UK. We also have a faculty structure which can provide advice on development of competencies and a peer review process for Continuing Professional Development.

   We would be very happy to expand on this brief statement in further oral or written evidence to the Committee.

Ian G Simpson
Chief Executive, College of Pharmacy Practice
16 March 2006

Evidence submitted by the Council of Deans and Heads of UK University Faculties for Nursing and Health Professions (WP 73)

**Introduction**

1. The Council of Deans and Heads of UK University Faculties for Nursing and Health Professions is pleased to respond to the request to submit evidence to the Health Committee for its inquiry into the workforce needs and planning for the health service.

2. The Council (often referred to as the “Council of Deans”) represents the health and nursing faculties in its 86 member universities throughout the United Kingdom. It seeks to maintain and enhance the quality of nursing and health profession education, and acts as a forum for the exchange of information and good practice.

3. The Council has developed position papers on the future nursing and allied health profession clinical workforce and on the future academic “faculty” workforce (which can be made available to the Committee if required) and has recently established a database on the academic staff involved in education and research in nursing and the allied health professions. It is closely involved in the current work being undertaken under the auspices of the UK Clinical Research Collaborative (UKCRC) on nursing research careers and also in the “Modernising Nursing Careers” project led by the Chief Nursing Officer for England.

4. The Council has been concerned for some time that the current healthcare workforce planning approach is neither effective, robust, nor fit for purpose. This is of particular concern given the size of the nursing and allied health profession workforce and the certainty that these professionals will take on increasingly key roles as first point of contact in care delivery, as well as care management and coordination. A radical review of workforce planning is long overdue.

**Background and Immediate Issues**

5. Universities provide, in partnership with healthcare organisations, all pre-registration education for nursing, midwifery and the allied health professions. The education programmes in England are commissioned by Strategic Health Authorities (SHAs) on behalf of the Department of Health (DH). There are currently about 87,000 students studying full time degree and diploma programmes in nursing and 24,000 students following full time degree programmes in the allied health professions.

6. Since the publication of the National Audit Office report “Educating and training the future healthcare workforce in England” in 2001, Universities UK and the Council of Deans have been in protracted discussions with DH to agree a national model contract between SHAs and universities for this provision,
together with agreed benchmark prices. This has finally been agreed and published by the DH this month.

(www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/Publications
PolicyAndGuidanceArticle/s/en%CONTENT_ID=4133085&chk=okq8x%5-April)

7. Over the last five years the numbers of student places commissioned by SHAs in nursing, midwifery?
and allied health profession pre-registration programmes have increased by 60%, in line with the NHS Plan.
Universities have worked hard in collaboration with their service partners to recruit, provide placements
and educate these increased numbers of students. However, there is now evidence of shortage of initial posts
available to qualifying nursing and allied health profession students. This has been well documented in the
case of physiotherapy where there has been a severe problem of new graduate unemployment for the last
two years. The situation will almost certainly deteriorate very significantly this summer for all professional
groups, especially nursing, as NHS Trusts freeze vacancies as a result of pressures to balance budgets. This
in turn is likely to have a negative impact on future student recruitment.

8. There is a current planning hiatus as Universities await firm information from SHAs on nursing and
allied health profession student numbers commissioned for 2006–07, once the MPET budget and
subsequent allocations have been agreed. Information from member universities show a considerable
variation in changes in commissioned student numbers being suggested by individual SHAs. Nearly all have
indicated some reductions in the 10–15% range, but in some cases large reductions of up to 30% are being
proposed for some programmes. Such reductions in student numbers notified at this late stage may simply
not be achievable as the recruitment of students (via the University Central Admissions System (UCAS) for
all degree students) is an extended process and universities are legally committed to honour offers of places
made to applicants. Thus reductions in commissioned numbers may not be possible for September 2006 in
programmes where offers appropriate to current student numbers have already been made. In addition, the
reductions will have immediate financial implications for universities, which will lead to instability in the
nursing and allied health profession education workforce. Such swings in commissioned student numbers
are a clear indication of the lack of any workforce planning and the fragility of the funding stream for
planning the future workforce.

9. Universities also provide a very wide portfolio of continuing professional development (CPD) and post
registration programmes in nursing, midwifery and the allied health professions. They range from short
courses, tailored specifically to a particular CPD requirement in a local health economy, to post-graduate
and masters programmes, which are normally developed in partnership with local healthcare organisations.
There are 127,000 students studying part-time programmes in these subject areas. This figure does not
include large numbers of students undertaking continuing professional development opportunities which
do not contribute towards an academic award. However, historically there are no clear national career
trajectories or pathways for nursing and allied health profession staff to which post-registration
programmes can be related. It is essential that this lack of career pathway is addressed. Unlike medicine,
there is no connection between course commissioning and planned workforce numbers at different career
grades.

10. A significant proportion of post-registration programmes are commissioned by SHAs and funded
from the Multi-Professional Education and Training (MPET) levy. However, post-registration
commissioning is still based on short-term contracts, which do not provide the stability and long-term
planning required for high quality education and training provision and career development. In addition,
the current uncertainty in the MPET allocation for 2006–07 has led many SHAs to signal to their
Universities a further large reduction in the provision to be funded. This is compounding previous erosion
of the resource being invested by SHAs in post-registration education and CPD.

ISSUES EMERGING FROM THE QUESTIONS POSED BY THE INQUIRY

A. Effects of recent policy announcements, technological change, ageing population and increased use of
private providers of services

11. There will be an increasing need for well educated, highly skilled advanced nurse and allied health
profession practitioners, educated to degree level, to deliver front line services, especially in the community,
to support the management of long-term conditions and to facilitate choice and access for patients.

12. The ageing population, the proliferation of long-term conditions, together with the increasing use of
private providers means more “hands-on” care and support will be provided by lay carers and assistant or
second level practitioners, or support staff, working under the supervision of professionally registered
graduate nurses and allied health professionals. The Council of Deans believes that the proportion of well
prepared and regulated second level practitioners should grow and that the numbers of professionally
registered nurses and allied health professionals should plateau. This will require a robust career pathway
framework, linked to a cohesive workforce plan similar to that operated in medicine, which in turn will
increase retention. Such a framework needs to be supported by a clearly identified funding stream to support
career development and progression.

13. One of the potential threats posed by the increased use of private providers is to reduce education and
training capacity due to reductions in the availability of clinical placements that are essential elements in all
healthcare education programmes. This threat will be particularly severe in primary care, where there is an
increasing demand for placements which is currently very difficult to satisfy. This issue applies to all healthcare education programmes, but there are historical differences in funding streams for practice experience between medicine and the other health professions. Whereas practice experience in medicine is financially supported by a funding stream “Service Increment for Teaching” (SIFT), there is no such funding stream available in nursing and the allied health professions. This anomaly needs to be addressed to ensure placements continue to be available within private providers of healthcare.

B. Effects on ability to meet demand by financial constraints, European Working Time Directive, increasing international competition for staff, early retirement

14. All these issues will have an impact, but this can be minimised by taking a radical, long-term and whole-systems review of workforce requirements. Historically, workforce issues have been tackled in a uniprofessional way. This has led to a conservative approach and an adherence to the status quo. The factors identified, including the EWTD, mean that a uni-professional approach must be avoided. Rather than commissioning more of the same, ie more doctors, nurses, allied health professionals, future workforce plans should acknowledge reductions in some professional groups as new and extended roles emerge (for example physicians’ assistants or community matrons). The Council of Deans believes that more of the same is neither sustainable, nor affordable.

15. Increasing international competition means that career pathways for all professional groups must be robust and attractive in order to retain experienced staff. It is therefore vitally important that the funding streams for post-registration education and training and continuing professional development are protected. The dangers of short-term “savings” in such budgets, as currently proposed, will be highly damaging and will prevent the necessary re-profiling of the healthcare workforce (see paragraph 10 above).

C. The extent to which demand can be met by changing roles and improving the skills of existing staff, better retention, the recruitment of new staff in England and international recruitment

16. The Council of Deans believes that, as described above, demand will only be met by changing roles and improving skills. Changing roles and role boundaries will have a significant impact on education programmes, which will also need radical updating. For example, new pathways for surgical assistants/practitioners need to be based on clear skills sets and new technology rather than the traditional medical courses. Similarly, advanced skills in care management for long-term conditions are needed rather than adherence to traditional nursing education programmes. Such changes need to be supported by the existing regulatory bodies and facilitated by changes to professional regulation emerging from the current review of both “medical” and “non-medical” regulation.

17. A consistent and cohesive approach to preparing and supporting second level (assistant/support) roles is urgently required. Successful local initiatives based on foundation degrees provide an ideal solution, particularly as they facilitate progression on a skills escalator for those who wish to do so. However, there is no national coherence in such developments and, importantly, no identified funding stream. Thus students choosing to undertake a foundation degree must support themselves with no access to a NHS bursary. Even more pertinent to this review, the student numbers are not included in the commissioning process for the future healthcare workforce.

18. There needs to be an agreed view about the wider shape of the future healthcare workforce, in order to determine future educational requirements. This can then inform universities and their NHS partners in the planning and development of new programmes and their curricula. All universities attempt to engage in these discussions with the local NHS, but many developments are occurring in an unplanned and haphazard way without a national overview. This has resulted in duplication of effort. In addition there have been a number of examples where local initiatives for new programmes aligned with new roles have not been matched with employment opportunities for the qualifying students.

19. Changes in commissioning and educational approaches in nursing and allied health profession education will have implications for the future healthcare education academic workforce. Recent work undertaken in a project commissioned by the Strategic Liaison Group for Education and Research in Health and Social Care (StLaR) identified the lack of clinical academic pathways in nursing and allied health professions. The difficulties in moving between (or combining) service and education roles are an obstacle to the development of the current workforce and to attracting young educators and researchers in this area. These issues are also highlighted by the emerging findings of the recent survey undertaken by the Council of Deans.

D. How should planning be undertaken—to what extent centralised or decentralised, ensuring flexibility, examples of good practice in England and elsewhere

20. The Council of Deans believes there is a need for a stronger national overview for both workforce planning and education commissioning. The previous assumptions that SHAs commissioned student numbers from universities to provide for the projected local workforce numbers in each profession are no longer valid nor appropriate. The workforce in most geographical areas is increasingly mobile, particularly at the point of qualification.
21. There is a wide current variation across SHAs in the maturity of planning partnerships with universities. In a few cases of good practice SHAs have entered into longer-term planning agreements with universities to identify trends in commissioning numbers and changes in the patterns of requirements, including the need for more assistant practitioners. However, in most other areas, particularly in this current cycle, SHAs appear to be responding to short-term funding issues and demanding some draconian reductions in student intakes at very short notice (as described in paragraph 8 above). The Council is very concerned that the national impact of these local decisions could return us to a “stop-go” cycle of student (and thus newly qualified staff) numbers last experienced in the 1990s.

22. As argued in paragraphs 12 and 17 above, the Council believes there is a need to plan positively for commissioning a greater proportion of assistant practitioners to nursing, medical and allied health profession professionals. This needs to be addressed on a national basis with some local input from SHAs.

23. Although the introduction of a national model contract and benchmark prices should produce some rationalisation of the previous plethora of different contracts and prices for nursing and allied health profession education, the funding and contracting arrangements remain complex and resource intensive to implement for both SHAs and universities. The Council of Deans would wish to explore a revised funding model whereby funding for healthcare programmes is provided via the Higher Education Funding Council for England (HEFCE). This would also provide a clearer mechanism than exists at present to ensure that budgets for education and training are ring-fenced and protected from short-term variations in healthcare funding. In Scotland, funding for nursing and midwifery programmes contracted by the Scottish Executive Health Department is moving in this direction. From August 2006, funding is to be channelled to the universities via the Scottish Funding Council.

24. At the same time the opportunity must be taken to eliminate some of the current funding and student support anomalies which inhibit flexibility of programmes and planning. For example, foundation degrees, which are the preferred study route for assistant practitioners, are funded via HEFCE and students are not eligible for NHS bursaries. In nursing, students following diploma programmes are eligible for non-means tested NHS bursaries, whereas degree students are only eligible for means-tested bursaries. This means that decisions about the academic level of study are determined by financial implications rather than ability.

Summary

25. To summarise the key issues raised in this submission:
   — There are no defined clinical career pathways (or clinical academic career pathways) in nursing and the allied health professions and no dedicated funding stream(s) to support education and training for such pathways.
   — The provision of post-registration education and continuing professional development, which supports extended and changing roles, is particularly threatened by the lack of workforce plans and any secure funding.
   — The link between workforce planning and education commissioning is non existent at least and tenuous at best. The processes are susceptible to short-term funding changes. This is exemplified by the current financial issues in the NHS in England, which are having immediate short-term effects on education commissioning. This threatens the long-term provision of newly qualified staff in nursing and allied health professions.
   — There is no whole-system view of the future workforce and skill mix requirements.
   — A systematic analysis is required of the requirements for second level practitioners and the education programmes and funding arrangements to support them.
   — The issues around the future development of the nursing and allied health profession academic workforce, as identified in the StLaR HR project, need to be addressed. These include the lack of clinical academic pathways, pay and human resource differences between universities and the NHS, and the age profile of staff.
   — Although the introduction of the national model contract and benchmark prices should produce some rationalisation, the funding and contracting arrangements for nursing and allied health profession education remain complex and resource intensive to implement for both SHAs and universities. Simplified funding via HEFCE should be considered.

26. The Council of Deans would welcome the opportunity to give verbal evidence to the Health Committee.

Professor Dame Jill Macleod Clark
Council of Deans for Nursing and Health Professions

April 2006
Evidence submitted by the Council of Heads and Deans of Dental Schools (WP 47)

INTRODUCTION

1. The Council of Heads and Deans of Dental Schools (CHDDS) is the principal source of informed opinion and advice on all matters concerning dental education and research in dental schools in the United Kingdom. As such it is well placed to respond to this inquiry.

2. The Council works closely with the Council of Head of Medical Schools, and with the General Dental Council and other related organisations.

3. Our responses will for the most part be restricted to how workforce planning affects dentistry.

FACTUAL INFORMATION AVAILABLE TO THE HEALTH COMMITTEE

4. Decisions should be taken on the basis of hard data and CHDDS strongly recommends that the Health Committee refers to the Clinical Academic Staffing Levels Survey, collated and published annually by CHMS and CHDDS. An in-depth report is published approximately every three years and the last of these was in May 2004. This report and additional data including the 2004–05 Annual Report can be downloaded from the CHMS website at www.chms.ac.uk.

5. Planners will also need to take into account the age and gender profiles of clinical academics—which are again provided in the CHDDS/CHMS report. More than 50% of all clinical academics are over 45 and fewer than 10% are under 35—young doctors and dentists do not perceive clinical academia as an attractive career path—partly because of the increased time required to complete training. Dental School intake is now 56% female—yet only 20% of clinical academics are women—and at the professorial level this drops to 12% for medicine and 11% for dentistry. CHMS and CHDDS have set up a group to look into Women in Clinical Academia in the hope of identifying barriers to participation and encouraging more women to consider such careers.

6. CHDDS also recommends that the Health Committee refer to the General Dental Council (GDC) for data on anticipated workforce numbers and life long learning requirements, a large element of which continues to be provided by university dental hospitals and, in particular, clinical academics.

7. In addition further surveys are carried out as required and these provide invaluable data, for example in relation to the number of dental students, the availability of placements etc. The Health Committee is advised to contact Dr Katie Petty-Saphon, at the CHDDS Secretariat, for further information.

EVIDENCE

How effectively has workforce planning been done, and how should it be undertaken in future?

8. Oral health has a key role in “Quality of Life” and must be considered in an holistic examination of the health service.

9. In terms of workforce planning a picture needs to be developed of how care will be delivered in 20–40 years’ time—the problem is, the pace of technological development and of organisational change tends to outstrip the planning horizon. The NHS is not alone in finding over and over again that its planning assumptions have proved wrong. However the almost continuous turbulence in the NHS—the changes in structure, finance, performance management—and increased patient expectations—has heightened the problems. A lengthy period of stability is a prime requirement. Indeed extended planning cycles rather than a multitude of short-term initiatives should become the norm. It is unhelpful for the NHS to work to a single financial year.

10. CHDDS welcomed the Dental Workforce Reviews there have been in England, Scotland and Wales but history demonstrates that such initiatives tend to be sporadic and in response to a particular problem. The proposals for change are rarely implemented in full, nor are they appropriately funded. It would be better to embed the proper use of the data which are already routinely collected. There should, for example, be better links with the Public Health Observatories. These Observatories develop clear pictures of current health issues—and planning should be based on the need to meet the likely requirements. Much better, joined-up use should be made of existing systems.

11. A recurring problem since the merger of Workforce Development Confederations (WDCs) into Strategic Health Authorities (SHAs) has been the difficulty in maintaining expertise and retaining the focus on workforce. Service imperatives subsume all others and drive the agenda. A more long-term view would recognise the vital importance of educating and training the next generation. The current structures are unhelpful with multiple groups fulfilling similar functions. It would be helpful if education and training were fixed firmly in the universities where the expertise lies—it makes no sense for Post Graduate Deaneries to commission training for post-graduates from a different pool from those working with undergraduates. This separation is inefficient and a poor use of resources. Workforce planning should be inclusive of skills escalations up to and including specialist training.
In considering future demand, how should the effects of the following be taken into account

Recent policy announcements

The New Dental Contract

12. The transfer of funding streams to Primary Care Trusts (PCTs) puts the provision of Dental services in direct competition with other Heath care services for funding. Funding for NHS Dentistry will be limited.

Technological change

13. Information Technology needs to be used effectively. Barriers in communication between the NHS and other networks need to be resolved. Information Technology could help to provide resource-efficient distance learning opportunities.

14. Technological advancements in service delivery usually lead to an increase in the demand for services, eg dental implants and this needs to be taken into account.

An ageing population

15. An ageing population will also increase demand for services. As dental health has improved, more people are keeping their own teeth into old age. The Nursing Home population has, in consequence, many more people with their own teeth. The high staff turnover in such homes means that knowledge of oral health is not high and that problems develop as old people fail to look after their teeth.

16. In addition an ageing population means that people are likely to work longer as pensions are looking less favourable. Many staff may choose to work part-time in their 60s. Demand for flexible working may increase.

Increased use of private providers

17. Given the proportion of UK dental work that is carried out by private sector companies it would be extremely helpful in educating future dentists if it could be made attractive for GDPs to help train students. DenPlan should be made aware of the need to educate the next generation and its responsibilities in this regard.

How will the ability to meet demands be affected by

Financial constraints

18. Financial constraint limits output, increases complaints and causes staff to leave the NHS.

19. One way of using resources more efficiently might be concentrating all education and training in the universities, as mentioned above.

The European Working Time Directive

20. The European working time directive should increase the need for more staff by limiting the hours staff are allowed to work. Trusts do not appear to have enough money to pay for existing contracts (Consultants and Agenda for Change) so they would be unlikely to employ more staff and this lead to further shortages of dental staff.

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

21. Improving skills of staff is helpful, however these skills must be focused on the core competencies of clinical dentistry. Clinicians are best at clinical work. A few may have the flair for management but it is wasteful to put too many clinicians into management roles.

Better retention

22. Improving retention of staff means improving pay and conditions. Flexible and part-time working would also aid the retention of existing experienced staff. Flexible working opportunities are particularly important due to the feminisation of dentistry and the ageing workforce.
The recruitment of new staff in England

23. Meeting targets would need an increase in the number of staff required. New patient activity is attainable but meeting the treatment need from 2008 is unthinkable at present. To this extent the new dental school recently announced by HEFCE is good news. Dentistry is still suffering from the effects of closing three good schools 10–15 years ago and the number of clinical academic staff in dentistry is the lowest it has been for over a decade.

International recruitment

24. Future workforce planning must take account trends in Europe, let alone the rest of the world, if it is to be effective. A review process limited to UK consideration is unlikely to be accurate.

25. In terms of employing staff from abroad there is a moral issue; we do not know if they will return with newly developed skills to their country of origin. In addition, training standards vary between different countries and it is vital that systems for effective quality assurance are in place to ensure patient safety.

Further considerations

26. In considering future demand for oral healthcare, a number of additional issues need to be taken into account over and above those listed. These additional issues include:

— dentists’ and public response to the new dental contract;
— growing patient expectations of a preventatively driven system for oral healthcare provision;
— a growing proportion of the population seeking/expecting to receive routine dental care;
— increasing awareness of the benefits of good oral health/an attractive dental appearance;
— the changing pattern of oral and dental disease;
— future attitudes to public health measures, notably the fluoridation of water supplies;
— the introduction of new groups of dental care professionals (DCPs) and the expansion of the roles and responsibilities of existing DCPs;
— the attitude of future oral healthcare providers, in particular dental students, to their work/life balance once members of the profession;
— the “feminisation” of the profession; and
— international mobility of oral healthcare providers.

How should planning be undertaken

To what extent should it centralised or decentralised?

27. Concerning the approach to planning, CHDDS believes that first and foremost, it must be a continuous process. As stated above stability is essential. Workforce planning is not easy and needs to be flexible and responsive. This requires funding of a skilled unit to keep on top of the changes that might impact on workforce numbers. These data should be collected and used centrally to avoid imbalances within the UK as a whole.

28. In addition to this more centralised planning there must be regional input, involving all key stakeholders. Commitment to new planning arrangements would be dependent on the commitment of stakeholders to act on the findings/recommendations and so it is essential that they are integrated into the planning process at every stage.

29. To be effective dental workforce planning must take a long-term view, following through from the earliest stages of dental education to how to retain older, experienced staff. The cost consequences of effective planning will be considerable, both in terms of number of people in training and the provision of modern teaching/training environments. A commitment to funding the implementation of planning is vital if the potential benefits are to be realised.

Further comments

30. CHDDS would welcome the opportunity to give verbal evidence to the Health Committee if required.

Council of Heads and Deans of Dental Schools

March 2006
Evidence submitted by the Council of Heads of Medical Schools (WP 45)

INTRODUCTION

1. The Council of Heads of Medical Schools is the authoritative voice of all the UK’s Medical Schools. Its main purposes are to:
   — be a principal source for informed opinion and advice on all matters concerning basic medical education and medical school research in the UK and on the relationship between medical schools and the NHS;
   — improve and maintain quality in basic medical education and general clinical training and to facilitate sharing of experience;
   — promote medical education and research through collaboration with the NHS, Government Departments, the General Medical Council, the Royal Colleges, the Research Councils and the Medical Research Charities;
   — promote and develop relationships with medical schools and universities in other countries concerning medical education and research; and
   — serve as a point of reference for the media.

2. The Council works closely with the Council of Head and Deans of Dentals Schools, and the Association of UK University Hospitals, which represents all the major university teaching hospitals. CHMS is the principal source of informed opinion and advice on all matters concerning medical education and research in medical schools in the United Kingdom, on relations between medical schools, the National Health Service and other treatment providers, and on relations with university medical schools and faculties in other countries. As such it is well placed to respond to this inquiry.

FACTUAL INFORMATION AVAILABLE TO THE HEALTH COMMITTEE

3. CHMS strongly recommends that the Health Committee refers to its Clinical Academic Staffing Levels Survey, collated and published annually. This gives the precise number of doctors and dentists employed by the UK’s Universities with details of their medical and dental specialties. An in-depth report is published approximately every three years and the last of these was in May 2004. This report and further data including the 2004-05 update and Annual Report can be downloaded from the CHMS website at www.chms.ac.uk. It is intended that data for the year to 31 July 2005 will be published in May 2006.

4. In addition further surveys are carried out as required and these provide invaluable data, for example in relation to the availability of placements for clinical experience, the number of graduate entry students, the number of women in senior positions etc The Health Committee is advised to contact Dr Katie Petty-Saphon, Executive Director of CHMS should it require further statistics.

EVIDENCE

In considering future demand, how should the effects of the following be taken into account?

General Comments

5. The education and training of the future health service workforce is both central and essential. Workforce planning needs to consider not only NHS staff but also those doctors, dentists and nurses employed by universities who teach the next generation and whose research leads to innovations in the delivery of care. It needs to protect the investment in education and training. Before deciding on numbers required, a careful evaluation of the roles which make up the clinical workforce should be undertaken.

6. Successive Governments have recognised the importance of education and research in delivering ever improved patient care. Given universities are the country’s key foci of innovation, leadership and acute analytical skills the Government should consider making more use of this resource to scrutinize policies before implementation to guard against unforeseen consequences. CHMS would welcome greater collaboration between Higher Education and health services in this way.

7. In the 2000 CHMS and CHDDS (Council of Heads of Dental Schools) survey there were 28,275 NHS consultants and 2,243 clinical academics (7.9%). By 2004 NHS consultants had grown to 35,152 whereas total clinical academics numbered 2,351—down to 6.7% of the total. More worryingly hidden behind the small increase in overall clinical academic numbers is a dramatic 17% decrease in the number of junior staff in the 12 months from the 2003 survey to 2004. This is more pronounced in some disciplines than others: the number of clinical lecturers in pathology now stands at a mere 19% of the numbers in 2000. The situation for dentistry is even more serious as there are now only 444 dental academics in the whole country.

8. It is encouraging that the Government recognised the gravity of this position and responded by setting up the Academic Careers Sub-Committee of Modernising Medical Careers chaired by Mark Walport to suggest ways of ameliorating the situation. It will be imperative to ensure that the funding for the new
positions being put in place on the recommendation of that group is protected despite current NHS budget difficulties. Indeed it is vital that a long-term view be taken and that the Education and Training budget is protected—and not eaten into to provide a simple cure for Trust deficits.

9. In terms of workforce planning outside the universities, a picture needs to be developed of how care will be delivered in 20–40 years’ time—the problem is, the pace of technological development and of organisational change tends to outstrip the planning horizon. The NHS is not alone in finding over and over again that its planning assumptions have proved wrong. However the almost continuous turbulence in the NHS—the changes in structure, finance, performance management—and increased patient expectations—has heightened the problems. A lengthy period of stability is a prime requirement.

Gender and an ageing population

10. Planners will also need to take into account the age and gender profiles of clinical academics—which are again provided in the CHMS report. More than 50% of all clinical academics are over 45 and fewer than 10% are under 35—young doctors do not perceive clinical academia as an attractive career path—partly because of the increased time required to complete training. Medical School intake is now 58% female—yet only 20% of clinical academics are women—and at the professorial level this drops to 12% for medicine and 11% for dentistry. CHMS and CHDDS have set up a group to look into Women in Clinical Academia in the hope of identifying barriers to participation and encouraging more women to consider such careers.

The increasing use of private providers of services

11. The Committee has asked specifically about the impact of the increased use of private sector providers. One of the many strengths of UK Medical Education is the early experience of clinical situations given to students (as well as emphasis on Fitness to Practise—instilling the correct behaviours and attitudes as well as acquiring knowledge and competencies). Allowing students to see patients slows down treatment and it is already very difficult to find sufficient "placements" for students in hospitals and GP practices. There is at present no requirement for private hospitals or Independent Sector Treatment Centres (nor indeed Foundation Trusts) to accept students—this should be made obligatory.

To what extent can and should the demand be met, for both clinical and managerial staff, by?

The recruitment of new staff in England

12. The UK has one of the lowest ratios of doctors per head of population in the EU. This needs to be remedied. If it is intended that the UK becomes self-sufficient so that the number of doctors trained matches those required by Trusts and Universities then, as mentioned above, a mechanism will have to be found to ensure Trusts have sufficient training posts available to match the output from the Medical Schools. There has been an issue this year because there were more UK and rest of EU applicants for Foundation Year 1 posts (the year immediately after Medical School when doctors are only provisionally registered with the GMC) than there were posts. Six years ago, when the decision was taken to increase medical student numbers by 40%, it was agreed that the number of F1 posts would also be increased—this now needs to happen as a matter of urgency.

13. A Joint Implementation Group (JIG) with members from DH, DfES and HEFCE is currently trying to determine whether the number of medical and dental students should be increased again—its deliberations should be considered carefully. If young doctors are not to become disillusioned it will be important to ensure that sufficient specialist training posts are available for those with the capacity to develop their skills to the highest levels. It would be surprising if the JIG did not stress the importance of future flexibility, of continuous professional developments and the need to re-skill and update. It is however essential to recognise and respect profession-specific competencies—patients will confirm that their overriding desire is that the correct diagnosis is made first time and that they are then managed effectively and with dignity and respect. The doctor has a key role here, as part of the health care team, in making critical and analytical medical decisions.

Changing the roles and improving the skills of existing staff

14. Consequently CHMS would argue that any long-term commitment to a health service workforce must have a core of medically educated professionals. CHMS does accept the role of a wide range of health professionals and recognises that delegating some jobs currently carried out by doctors to allied health professionals may free doctors to perform essential tasks. However, it is vital that all allied health professionals receive adequate training with a medical perspective.

15. It is essential that the roles that currently make up the clinical workforce be evaluated before considering how they might be changed or augmented. Any change must be evidence based.
International recruitment

16. International recruitment has long been necessary to deliver the required volume of service within the health service—and the variety of background and experience has enriched the care delivered and often enhanced the quality of research undertaken. However it is vital that systems for effective quality assurance are in place that recognise the differences in the training received by medical professionals.

17. Further Comments

CHMS would also highlight that the professional life of healthcare workers involves lengthy training to consultant level and a commitment to continuous professional development. The infrastructure and funds to provide this must be made available—it would be foolish to expand medical student numbers without an equivalent commitment to increase training posts in the NHS.

How should planning be undertaken?

To what extent should it be centralised or decentralised?

How is flexibility to be ensured?

18. Central planning has not worked well in the past—and given the freedoms allowed to Foundation Trusts, CHMS would argue that local solutions are likely to be more successful, flexible and innovative and would encourage moves in this direction. Nevertheless it is vital to ensure the central collection and use of workforce planning data to avoid imbalances within the UK as a whole.

19. CHMS would welcome the opportunity to give verbal evidence to the Health Committee if required.

Council of Heads of Medical Schools

March 2006

Evidence submitted by the Dental Practitioners’ Association (WP 20)

INTRODUCTION

1. The Dental Practitioners Association (DPA) has produced this response to the House of Commons Health Committee’s inquiry into Workforce needs and planning for the health service.

2. The DPA was formed in 1954 to advise, represent and support high-street dentists. Currently, the DPA is the largest dental organisation that specialises in general practice, representing over 1,200 practices (3,000+ dentists) in the UK and produces the Industry-standard Private Fees and Wages Guide.

3. To maintain contact with the profession, the 15 members of the principal executive committee, and the Chief Executive, must all be dentists.

4. The Dental Practitioners Association would welcome the opportunity to contribute to the work of the Health Committee by giving oral evidence. This is particularly important as the DPA is not consulted by the Department of Health.

EXECUTIVE SUMMARY

5. The Health Committee has chosen a difficult time to review dental workforce needs.

6. Substantial changes to registration groups and revalidation requirements are imminent.

7. Dentists are self-employed subcontractors which sets them apart from the NHS workforce as far as planning is concerned.

8. After 1 April 2006 Primary Care Trusts, who have very little experience of dental contracting, will determine NHS employment patterns.

RESPONSE

9. The Committee has set a very difficult task for itself in reviewing the dental workforce at this time.

10. Unlike doctors, dentists are independent practitioners who provide and pay for all facilities, equipment, materials and staff in their surgeries out of fees received. With the exception of rates rebates, dentists receive no other support for costs.

11. This is a very different situation to General Medical Practitioners and is frequently misrepresented to the public. Recently the DPA brought a successful complaint to the Press Complaints Commission, against the Sunday Times for misrepresentation of dentists’ earnings.
12. It is a time of considerable change in dentistry at present. Perhaps all we can best do is to suggest some of the difficult questions that will need to be answered before proper workforce planning can be undertaken.

13. There is no real shortage of dentists. Even in an emergency, one will find a dentist with reasonable ease, perhaps not everywhere on the NHS but if patients wish to pay privately there is access. Access to an NHS dentist is not easy.

14. Registration, which caused much of the bad press for dentistry, is a recent concern in dentistry. It was imposed along with the previous contract in 1990. Prior to that, the concept of being on a dentist’s list did not exist. Recent workforce concerns have been prompted by it. The new contract greatly changes the emphasis on registration.

15. The other factor that highlights access difficulties within the NHS is emergency care. This is an area which, although an essential service, is very poorly rewarded and it still will be under the new arrangements.

16. It is a laudable desire for the NHS to provide a comprehensive service for all. It never has done. Less than 50% of the population are regular attendees. There was never sufficient funding for this 50%. The year October 2004 to September 2005 used to measure funding for the new contract, reflects this level of existing funding and therefore does not accurately represent the cost of providing the desired service. Even with the introduction of NICE recall guidance, the funding will go little further. Workforce requirements will be guided by this. But it is not only dentists who will be providing the service.

17. The timing of this investigation is difficult because:
   17.1 A new dental contract is to be imposed in two weeks time.
   17.2 The Review Body on Doctors’ and Dentists’ Remuneration has a remit to look at workforce retention and motivation as well as pay. Their report for this year has not been released before dentists must sign the new contract.
   17.3 Well over 1,000 new dentists have entered the country. In the last 18 months.
   17.4 Primary Care Trusts are just coming to grips with dentistry. Their resources are limited. Provision of dentistry in PCTs will evolve to match resources and local need, dictating the workforce.
   17.5 There are many changes at the General Dental Council broadening the workforce.
   17.6 New training places and methods are coming on-stream.
   17.7 The Department of Health’s strategy is unclear.

18. The NHS, by poor manpower management in every respect and constant cynical manipulation of payments to attempt to create the most productive dental service, has cast a shadow over dentistry and dentists.

19. The workforce has bled away and the pace of that haemorrhage is quickening. The new contract will do nothing to staunch it. It will never be possible to deliver the present level of service again.

20. The new contract is a fiasco. It sets all its stakeholders against each other. Many dentists, perhaps the majority, will sign the new contract, but this will be only to give them control over their exit.

21. The contracts are valued in Units of Dental Activity (UDAs). The monetary value of a UDA for each dentist is different. A dentist may have a UDA value twice that of his colleague who works in the same street or even the same practice.

22. Conscientious dentists with a list of healthy patients will receive the lowest payments. Of, before the new contract, they have worked on annual recalls as per NICE guidance, instead of six-monthly they will find that they have to see many additional patients for the same money.

23. New patients cost considerably higher amounts to make healthy than do healthy patients. There is no additional payment to compensate.

24. For example, a dentist working in the NHS may have 700 child patients. When calculating his UDA target, each child has been deemed to have visited twice, so 700 additional UDAs have been added to his list. Although the DoH says that he has had a 5% reduction in workload, his figures including the extra 700 UDAs show an increase of 2%. His UDA value is £16.50 against a national average of £19–£20. He will sign the contract but only to leave at time of his choosing.

25. He will move to private practice or join one of the third-party modified capitation schemes such as Denplan. Over 600 dentists joined Denptan in 2005. This is an indication of the rapid move to private practice. There are other companies like Denplan and many dentists do not privatise through such companies. The extent of the drift away from the NHS can not be accurately stated yet.

26. Although over 1,000 extra dentists joined the NHS in the year to September 2005 there was no increase in productivity.

27. It must be asked what beneficial effect the NHS involvement in dentistry has brought.

28. A properly designed NHS dentistry service could succeed.
29. A well-designed dental public health programme could automatically reduce dental disease and therefore the need for additional dentists. The workforce of the future will be very different if the strategy is right. Dentists will not be necessary to deliver such a programme.

30. Currently the political strategy is unclear.

31. The GDC is about to register Dental Care Professionals (DCPs). There are training programmes in place and plants to increase the numbers in these groups. The pace of training hygienists for example has been too slow to match the need. This has served to increase their value in the market place. They are more likely to be found working in the private sector.

32. The current buzzword is Teamwork. But the new members of that team are seeking to establish independence. There is already a growing desire amongst DCPs to be able to work in their own businesses and therefore to have the right to examine, diagnose and prescribe for patients.

33. The position of the dentist is becoming unclear and appears under attack from DCP interest groups.

34. On the one hand, Dental Schools are considering fast-track training for graduates while on the other, groups are pressuring for dental nurses to be permitted to diagnose. Can the training for dentistry be made shorter than the time it takes to fast-track train a graduate?

35. The roles of the new members of the Dental Team need to be defined. These new groups will have important roles to play in a dental public health strategy.

36. Measuring workforce requirements for the NHS must await a clear strategy from Government, it must await also the evolution of PCTs and their requirements in dentistry.

37. Currently PCTs are learning about dentistry. They have yet to understand their budgets. The number of fee-paying patients is a great concern to PCTs because if the income from these patients drops, funding is lost. The budget is therefore unpredictable and will be for some time.

38. PCTs wait have to decide what treatment they need to deliver in their area. Having decided this they will decide who will best deliver that treatment; will they need dentists or DCPs? At this point, a suitable workforce will be in urgent demand.

39. Until now a dentist could move into a district of his/her choosing, find a premises, equip it, open a dental practice and send forms to the Dental Practice Board for payment. Under the new arrangements this is no longer possible. PCT funding is all that is available.

### 2004 Workforce Review

40. The first workforce review since 1987 was published in July 2004 by the Department of Health. It covers dentists and DCPs in primary care (not hospital or community dental services) in England. Biennial update reviews will be undertaken.

41. The Dental Practitioners’ Association (which represents the views of 72% of dentists in the target group) was not consulted by the DoH.

42. The Variable used in the study was “clinical time”, that is direct contact between patient and dental professional. Dentists are expected to have less clinical time in future due to an increase in bureaucracy, which multiplies the number of dentists required.

43. Demand modelling suggested a slight increase for adults between 2004–11 followed by a levelling-off between 2011–21. Child demand showed no significant change over the next 20 years.

44. Demand is estimated at 30 million clinical hours, rising to 31–33 million in 2011 and 30–33 million in 2021.

45. The number of whole-time equivalent (WTE) dentists in England is expected to fall by 2,400 between 2001 and 2021, however there will be 870 more therapists and 330 more hygienists.

### The Projected Undersupply

<table>
<thead>
<tr>
<th>Year</th>
<th>Undersupply in hours</th>
<th>Undersupply (dentists)</th>
<th>Undersupply as % of demand</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>1.5</td>
<td>1,050</td>
<td>5%</td>
</tr>
<tr>
<td>2003</td>
<td>2.7</td>
<td>1,850</td>
<td>9%</td>
</tr>
<tr>
<td>2011 lower projection</td>
<td>5.0</td>
<td>3,640</td>
<td>16%</td>
</tr>
<tr>
<td>2011 (upper projection)</td>
<td>7.1</td>
<td>5,100</td>
<td>21%</td>
</tr>
</tbody>
</table>

47. How much work dentists will do on the NHS will have a greater impact on the supply side, than the actual number of dentists. This is why it is not relevant to quote the number of dentists with NHS contracts or the number qualifying each year.

48. Even if more dentists qualify, due to student debt in view of the length of the dental course, it is unlikely that many of them will stay in the NHS.
49. These figures do not include any meaningful structural changes such as a large-scale preventive approach.

50. Workforce considerations preclude a serious attempt to attract the 50% of the public who do not have regular dental care.

Derek Watson
Chief Executive, The Dental Practitioners’ Association
14 March 2006

Evidence submitted by the Equal Opportunities Commission (WP 46)

1. The Equal Opportunities Commission was set up by the Sex Discrimination Act 1975. Its duties are to work towards the elimination of discrimination between men and women, to promote equality of opportunity between men and women generally and to keep under review the workings of the Sex Discrimination and Equal Pay Acts. The Equal Opportunities Commission (EOC) welcomes this opportunity to provide evidence to the Health Committee.

2. The EOC does not intend to address all the issues set out within the terms of reference for the Committee but does have some specific comments to make on how addressing gender equality issues within the NHS will be critical to effective workforce planning.

THE CENTRALITY OF GENDER EQUALITY TO EFFECTIVE WORKFORCE PLANNING TO DATE

3. The EOC very much supports the work that has already been done within the health service through Agenda for Change. The biggest overhaul of NHS pay, terms and conditions since its inception, Agenda for Change was introduced in response to equal pay claims brought by women working for the NHS and is designed to provide equal pay for work of equal value and has begun to address the undervaluing of women’s work within the NHS. Agenda for Change also provides a better framework for training and career development of health service staff.

4. Agenda for Change is an illustration of how well a partnership between the medical colleges, the unions and NHS employers can work and we would hope that any future workforce changes would follow this model. It is also important to note that Agenda for Change benefited from both political leadership and funding which facilitated its implementation. Most importantly, Agenda for Change was based upon a vision for the future—an effective and efficient structure for pay and progression, which sought to maximise the contribution each individual employee, can make to the NHS. Future developments in workforce planning need to be based upon a similar vision.

WHY GENDER EQUALITY WILL BE CRITICAL TO EFFECTIVE WORKPLACE PLANNING IN THE FUTURE

5. Workforce planning in the NHS is affected by a number of factors. These include:
   — Demographics.
   — The Gender Equality Duty.
   — Policies and practice in relation to procurement.
   — Becoming and remaining an employer of choice.

THE DEMOGRAPHICS

6. The population of the country as a whole is both changing and ageing with consequences for the working age population. By 2020 two-fifths of the population will be aged over 50. However, some ethnic minority populations have relatively young populations and it has been projected that ethnic minorities will account for half of the growth in the working age population from 1999–2009.

7. Women’s share of the labour market is approaching half and we have one of the highest workforce participation rates for women in Europe. Around three-quarters of women who have children now return to work within less than a year. It is projected that by 2010 only 20% of workforce will be white, male and non-disabled. This demographic change means that the NHS will need to recruit and retain an increasing proportion of female staff, many of whom will be from black and minority ethnic communities.

40 Government’s Actuary Department 2004.
41 Cabinet Office 2003.
8. The existing NHS workforce is also ageing. One in four nurses, midwives and health visitors on the Nursing and Midwifery Council (NMC) Register is aged 50 or over. In total there are almost 100,000 nurses aged 55 or older on the Register. The number of nurses likely to retire is set to double between 2005 and 2015—equivalent to a quarter of all nurses.42

AN AGEING POPULATION

9. The ageing of our population will have a significant impact on the provision of health care it is also important to take account of the gendered aspect of this ageing profile. An increasing number of health service staff, both male and female, will be faced with the need to provide care for elderly relatives which will increase the need for working practices within the NHS to be fit for purpose in enabling staff to balance their home and work lives.

10. An ageing population will also mean increased need for both health and social care services. Currently there is a dearth of social care provision which too often leads to “bed blocking” where people who no longer need health care within hospital are unable to leave, as they are unable to source the care facilities they require. In considering future demand on services it is essential, therefore, to consider both the demand for both health and care services and develop wherever possible an integrated approach to workforce planning.

11. The social care sector is also highly gender segregated with women forming 92% of care assistants. Recruitment and retention are already a problem within the sector due to the low pay and low status of the work and these problems look set to continue since a quarter of the current workforce is over 50.

12. The Health service also needs to develop a range of strategies to retain/draw in older workers (50+) who may well want flexible work (including part-time options) to help increase the pool from which staff can be drawn. EOC research last year suggested over a million older workers would re-enter the workforce if conditions were flexible enough.43 This also has implications for the NHS’s training formats and would fit with the Government’s broader agenda of extending working lives.

THE GENDER EQUALITY DUTY

13. From April 2005 the health service will also have an obligation under the gender equality duty to eliminate discrimination and harassment and to actively promote equality of opportunity between women and men. Public bodies will also have to consider their duty to promote equality in the procurement of goods and services. The duty will also mean that the health service will need to carry out gender impact assessments, in consultation with key stakeholders, on any major developments in workforce planning. The EOC’s view is that this would include widespread and ongoing use of agency staff.

PROCUREMENT

14. The duty to pay due regard to the need to eliminate unlawful discrimination and harassment and to promote equality between men and women means that the NHS will have to build in relevant gender equality considerations into their procurement processes. This encompasses the full range of public authority contracts—including private finance initiative (PFI) projects and public private partnerships (PPP).

15. It will be important to establish at the earliest opportunity the relevance of gender equality considerations to specific contracts so that they can be built into technical specifications.

16. The weight given to gender equality should be proportionate to its relevance to a particular procurement. The EOC anticipates that a large number of areas of health service procurement are likely to be affected including the contracting out of ancillary services such as cleaning so that procuring authorities promote good practice in diversity and equal pay matters.

BECOMING AND REMAINING AN EMPLOYER OF CHOICE

Recruitment and Better retention

17. Research evidence suggests that nurses have been leaving the NHS not just because of a lack of flexible working arrangements but “because of a more complex dissatisfaction with pay, the erosion of their skills and occupational downgrading, heavy workloads and the inability to influence health care practice.”44 Doctors are also leaving the NHS and the feminisation of medicine—women now make up 60% of medical school places and 75% of GPs under 3045—means that these issues must be addressed across the workforce as a whole and not just amongst nursing staff.

43 Britain’s hidden brain drain EOC September 2005.
44 Women and flexible working in the NHS Angela Coyle EOC 2003.
45 ibid.
18. Much has been done within the health service to increase the amount of flexible working to enable staff to balance their home and work responsibilities and the EOC welcomes these developments but remains concerned that other key issues need to be addressed.

19. The EOC’s recent investigation into flexible and part time working has found that four in five women working part time do so below their potential—due to the lack of available, high-quality part time opportunities. These findings resonant with an earlier study within the health service found that 30% of nurses who returned to work part-time after maternity leave suffered occupational downgrading and that the prevalent view amongst NHS managers is that part-time working is not compatible with nurse management. Increasing the access to high quality part time working within the health service will, therefore, deliver efficiency gains through maximising the potential of workers who want to work on a part time basis.

BME WOMEN

20. As already demographic change will mean that the NHS will need to be an employer of choice for women from black and minority ethnic communities. The EOC has recently launched a major investigation into the labour market experiences of BME women—the full interim findings from this project will be available in June.

21. However, we have already identified that young Pakistani, Bangladeshi and Black-Caribbean women are almost three to four times more likely than white women to take a job at a lower level than the one they are qualified for and one in five Pakistani and Bangladeshi women, over 90% of whom are Muslim, said they had experienced negative attitudes towards religious dress at work.

22. A long hours culture and lack of flexible working arrangements has a more severe impact on ethnic minority women since Pakistani and Bangladeshi women have four or more children on average and a high proportion of Black Caribbean women are single parents.

23. It will be important, therefore, for workforce planning to take into account the experiences of BME women within the NHS workforce. Monitoring BME women and by faith, in terms of applications, interview, appointment, retention, promotion and pay will be essential to that the NHS can identify any groups of women who are missing out on opportunities or leaving and investigate why.

24. Agenda for Change has made inroads into some of these issues but it is important that any future workforce planning gives due regard to these issues not only will this enable the health service to comply with its obligation under the gender equality and other equality duties but should help to recruit staff, attract back staff who have left to return and retain them.

Equal Opportunities Commission

16 March 2006

Evidence submitted by the General Medical Council (WP 68)

1. The GMC welcomes the opportunity to assist the Health Select Committee in its Inquiry into workforce needs and planning for the health service.

2. The GMC’s remit does not extend to workforce planning or employment issues. However, the GMC is an important component of the medical workforce supply chain and we believe it would be helpful to clarify our roles in registration and in the education and training of UK doctors.

Statutory Purpose

3. Under the Medical Act 1983, the GMC’s purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

4. In support of this purpose, the GMC has four main functions:
   a. Registering doctors, who meet the required standards, for medical practice in the UK.
   b. Defining the outcomes to be achieved through, and assuring the standards of, basic medical education; and promoting high standards in, and coordinating all stages of, medical education.
   c. Setting the standards of practice, standards of performance, and ethics that society and the profession expect of doctors throughout their working lives.
   d. Dealing firmly and fairly with doctors whose fitness to practise may be impaired.

46 Britain’s hidden brain drain EOC Sept 2005.
47 Women and flexible working in the NHS Angela Coyle EOC 2003.
48 16–34 year olds. 2001 Census Commissioned Tables, Crown Copyright 2003. Crown copyright material is reproduced with the permission of HMSO.
5. Doctors who wish to practise in the UK must be registered with the GMC.

6. There are three main routes to registration:
   a. For doctors who qualified at a UK medical school.
   b. For doctors who qualified within the European Economic Area and are EEA citizens or have European Community rights.
   c. For international medical graduates who qualified outside the EEA or who qualified within the EEA and do not benefit from European Community rights.

7. Table 1 shows the total number of new registrations each year from 2002–05, subdivided across the three main routes. Please note that this information is not necessarily indicative of the number of doctors entering the workforce in the UK. For historical reasons many doctors have held GMC registration, though they remain resident in another jurisdiction. In 2003 for example the closure of a former direct route to registration (without an assessment of medical knowledge and skills) for doctors qualifying from seven countries ceased. Several thousand International Medical Graduates (IMGs) secured registration prior to the closure of the route though there is no evidence that they planned to come to the UK in the foreseeable future.

<table>
<thead>
<tr>
<th>Year</th>
<th>UK doctors</th>
<th>EEA doctors</th>
<th>IMGs</th>
<th>Total new registrations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>32%</td>
<td>16%</td>
<td>52%</td>
<td>14,835</td>
</tr>
<tr>
<td>2004</td>
<td>32%</td>
<td>24%</td>
<td>44%</td>
<td>14,737</td>
</tr>
<tr>
<td>2003</td>
<td>25%</td>
<td>10%</td>
<td>65%</td>
<td>18,684</td>
</tr>
<tr>
<td>2002</td>
<td>39%</td>
<td>14%</td>
<td>47%</td>
<td>11,235</td>
</tr>
</tbody>
</table>

8. The surge in EEA registrations in 2004 was the result of the expansion of the EEA through the addition of the EU accession countries.

9. The numbers of newly registered EEA doctors may not provide a reliable indicator of the doctors who joined the UK workforce for the first time. Although all EEA doctors must now complete the registration process in the UK, we are aware that a proportion of EEA doctors secure registration in advance of deciding to practise here.

International medical graduates

10. Table 1 shows that IMGs represent the largest proportion of new registrations, ranging from 44% in 2004 to 65% in 2003.

11. The surge in IMG registrations in 2003 was stimulated by the impending withdrawal of the special recognition, for historical reasons, of qualifications from seven countries—Australia, Hong Kong, New Zealand, Singapore, South Africa, the West Indies, Singapore and Malaysia. Qualifications from those countries are now treated on the same basis as other countries outside the EEA.

12. From 2004 onward, the numbers of newly registered IMGs provide a reasonably reliable indicator of the doctors who joined the UK workforce for the first time. IMGs must complete the registration process in the UK and registration is granted only when they have secured an offer of employment. This was less true prior to 2004, for example because of special recognition explained above.

13. Most IMGs secure registration having demonstrated their knowledge and skills by passing the Professional and Linguistic Assessments Board (PLAB) test. The PLAB test is in two parts, with Part 2 being available only in the UK. Doctors must pass Part 1 before taking Part 2. The great majority of IMGs who secure registration are seeking employment in training grades, not as specialists.

14. The number of PLAB test applicants rose steadily from 2000, when about 3,400 doctors took Part 1, to a peak in 2004, when about 12,600 doctors took Part 1. The numbers taking Part 2 rose correspondingly, from about 1,349 in 2000 to about 8,200 in 2004.

15. There has been widespread concern that the numbers of IMGs who have passed Part 2, and are in the UK seeking work, greatly exceed the number of posts available. Among other things, this led to calls that the GMC should ration test places, particularly for Part 2, on the basis that this would help to secure a better match between demand for, and supply of, jobs. This, however, would be unlawful.

16. We have, however, sought to work with the Department of Health and others to improve the information available to IMGs who are considering coming to the UK and to ensure that they understood that passing the PLAB test did not guarantee employment. For example:
that workforce planning takes into account this relationship between training and throughput. It is essential that medical students, without detriment to NHS services. Training inevitably reduces the number of procedures available on the GMC website www.gmc-uk.org. We would be pleased to supply a copy if that would be helpful. It can also be viewed on our website at www.gmc-uk.org/doctors/employment—surveys/index.asp.

The steps we and others have taken to improve the availability of information, combined with feedback through IMG networks, have led to a sharp drop in applications for Part 1 of the PLAB test, from about 12,600 in 2004 to about 9,100 in 2005. This downward trend has continued in the first two months of 2006.

While further analysis would be required, the experience of recent years appears to demonstrate that the supply of IMGs who wish to work and train in the UK can be stimulated and depressed through the availability of good quality information about the market.

On 7 March 2006, the Home Office announced that all IMGs wishing to work in the UK would be required to have a work permit from July 2006. We are communicating this to potential candidates via our website. We foresee that this will lead to a further drop in the numbers of applicants.

**Medical Education and Training**

Under the 1983 Act, our Education Committee has the general function of promoting high standards of medical education and coordinating all stages of medical education. The 1983 Act lays down specific roles for the Education Committee in relation to undergraduate education and training for doctors with provisional registration. Doctors are granted provisional registration, usually for one year, on completion of their medical degree to enable them to continue their training in a managed environment.

The Postgraduate Medical Education and Training Board (PMETB) has functions relating to postgraduate medical education and training, set out in the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. Effective medical education and training requires doctors with the time and the skills to deliver it in the workplace.

Neither the GMC nor PMETB has a remit to set the number of medical students and trainees. In England, medical schools are funded through the Higher Education Funding Council for England (HEFCE) and the Joint Implementation Group of HEFCE and the Department of Health makes decisions on student numbers. The funding of medical school numbers in the devolved nations is similarly a matter for the health departments and analogues to HEFCE.

In relation to undergraduate medical education, the GMC Education Committee determines the “knowledge and skills” and the “standard of proficiency” required on graduation from a UK medical school and we also set standards for medical schools. The guidance is set out in Tomorrow’s Doctors which is available on the GMC website www.gmc-uk.org. We would be pleased to supply a copy if that would be helpful.

The GMC Education Committee ensures that undergraduate medical education is appropriate but does not attempt to define the workforce or other resources needed. In Tomorrow’s Doctors we state that medical schools must make sure that their staff follow our guidance and are provided with the necessary training (paragraph 97). The UK health departments must make facilities available for students to receive training and decide how students may have access to patients (paragraphs 99 to 100). “Doctors with particular responsibility for teaching students must develop the skills, attitudes and practices of a competent teacher. They must also make sure that students are properly supervised,” (paragraph 103).

To develop appropriate knowledge, skills, attitudes and behaviour, medical students should have contact with patients throughout their undergraduate courses. Tomorrow’s Doctors states, “From the start, students must have opportunities to interact with people from a range of social, cultural and ethnic backgrounds . . . Such contact with patients encourages students to gain confidence in communicating with a wide range of people, and can help develop their ability to take patients’ histories and examine patients,” (paragraph 50).

Medical schools therefore place students in a variety of NHS settings. It is important that workforce planning takes into account the need for doctors to find the time appropriately to train and assess medical students, without detriment to NHS services. Training inevitably reduces the number of procedures that can be carried out in the NHS, as doctors must take the time to show students what to do. It is essential that workforce planning takes into account this relationship between training and throughput.
28. In addition, doctors and other health service staff are involved in teaching medical students on university premises and in associated research. Workforce planning therefore needs to reflect the requirements of medical schools with their expanding student rolls.

29. Following medical school, graduates now enter the two-year Foundation Programme, which takes place within the NHS. The GMC Education Committee has responsibility for the first year. To enter the second year, graduates need to secure full registration with the GMC. Thereafter, PMETB is responsible for postgraduate medical education and training, incorporating the second year of the Foundation Programme and subsequent GP and other specialist training. We are working closely with PMETB to ensure that the outcomes required of doctors in the Foundation Programme, and the standards required of those providing that training, are clear and coherent.

30. The New Doctor sets out our guidance for the first year of the Foundation Programme. The current edition, published in 2005, is transitional, in preparation for expected changes in the Medical Act to modernise the legal structure for training. The current edition states that the health departments should make sure that NHS organisations work with universities and must make facilities available (paragraphs 135–136). Health service organisations must “put in place appropriate structures for making sure that high quality training is provided,” (paragraph 137). “Doctors with particular responsibility for supervising PRHOs [Pre-Registration House Officers, that is, doctors in the first year of the Foundation Programme] must develop the skills, attitudes and practices of a competent teacher. They must also make sure that PRHOs are properly supervised,” (paragraph 140). It is important therefore that workforce planning reflects the need for doctors to have the skills and finds the time to train and assess Foundation Programme trainees.

31. Alongside the Education Committee’s interest in workforce planning that takes full account of the requirements of medical education and training, the GMC is keen to ensure that the knowledge, skills, attitudes and behaviour required of doctors remain appropriate. During 2005, we held an international conference and conducted a full-scale formal consultation on strategic options for undergraduate medical education. This covered themes that should be reflected in the next edition of Tomorrow’s Doctors (scheduled for publication in 2008) alongside consideration of changes to the present arrangements for assessment and for consideration of students’ fitness to practise. The Education Committee has a stream of work to consider how medical practice could develop in the decades ahead. Separately, the GMC Standards Committee is reviewing Good Medical Practice, our key guidance for doctors.

General Medical Council
March 2006

Evidence submitted by the Healthcare Commission (WP 67)

INTRODUCTION

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we are responsible for assessing and reporting on the performance of both the NHS and independent healthcare organisations, to ensure they are providing a high standard of care. We also encourage providers, in both the public and independent sectors, to continually improve their services and the way they work. In Wales, our role is more limited and relates mainly to working on national reviews that cover England and Wales, as well as to our annual report on the state of healthcare.

While much of the inquiry’s terms of reference is outside our remit, the Healthcare Commission collects some evidence from NHS staff which is directly pertinent to the inquiry. The annual survey of NHS staff is conducted to provide information about the attitudes and experiences of directly employed NHS staff. Our submission summarises key results from the 2005 survey that may be of some use to the inquiry into workforce needs and planning in the NHS.

BRIEF OVERVIEW OF THE NATIONAL SURVEYS OF PATIENTS AND STAFF PROGRAMME

The third national survey of NHS staff was conducted in October 2005 and this followed similar surveys in October 2003 and October 2004. The purpose of the surveys is to provide a variety of information about NHS staff in England which can be used by the NHS, the Department of Health and the Healthcare Commission to improve the quality of care for patients. All 570 NHS trusts in England took part in the survey. A total of 209,124 NHS employees responded, 58% of those who were invited to take part.
BACKGROUND TO THE NHS STAFF SURVEY

The NHS Staff Survey contributes to the Healthcare Commission’s annual ratings process. Some of the questions and key scores in the NHS Staff Survey 2005 are directly relevant to some of the Department of Health’s Core Standards and will be used by the Healthcare Commission in the 2006 annual health check. The survey results also enable the Department of Health to assess the effectiveness of national NHS staff policies (such as training and flexible working) and in particular the Improving Working Lives initiative.

Summary of Key Findings

WORKING HOURS

Work life balance is an important consideration for any workforce. Good work life balance is associated with the wellbeing of staff, low absenteeism and high levels of staff retention. In the 2003 and 2004 surveys, work life balance was found to have strong links to outcomes such as job satisfaction, stress, errors and incidents, and the intention of staff to leave their job.

This survey asked staff how many hours, paid and unpaid, they worked in addition to their contracted hours during an average week. In total, 71% said they routinely worked more than their contracted hours. This is the same proportion as in 2004. Thirty six per cent said they work extra hours for which they are paid, and 56% extra hours for which they are not paid. Sixteen per cent said they worked extra hours, both paid and unpaid. There has been no significant change in the extent of additional hours being worked.

One of the key indicators of staff feeling overloaded is the proportion of staff who work extra hours for reasons that are due to the pressure and demands of their job. That is, where they gave at least one of the following reasons: because it is necessary to meet deadlines; because it is expected by my immediate manager; because it is expected by colleagues; because it is impossible to do the job without doing so; or because I don’t want to let down the people I work with. In 2005, 64% of staff said they did this, compared with 63% in 2004.

QUALITY OF WORK LIFE BALANCE

Staff were asked a series of questions to assess the extent to which they believe that the trust they work for and their immediate manager are committed to helping them find a good balance between their work and home life. Possible scores range from one to five, with one representing almost no commitment from the trust, and five representing excellent commitment from the trust.

The average score in the 2005 survey was 3.39, indicating a generally positive employer attitude towards work life balance. This compared with 3.42 in 2004 and 3.39 in 2003 and suggests that the attitude of NHS employers is stable.

IMPROVED RECRUITMENT AND RETENTION

The provision of flexible working arrangements is important for employers, as it can lead to improved recruitment and retention of staff. The most common options were working flexi-time (33%), working reduced hours, for example part time (32%) and team rostering (27%).

When asked about the care options offered by their employers, over half of staff with dependant children were not sure what options were on offer; 38% said they had access to a childcare coordinator, 30% said that their employer provided subsidised childcare, and 29% said their employer offered childcare vouchers. Comparing these figures with those for 2004 and 2003 suggests that either the level of care options is increasing, or an awareness of them is increasing (or possibly both awareness and supply are increasing).

Staff were asked a series of questions about how satisfied they were with different facets of their jobs, including: recognition for good work; support from their immediate manager and colleagues; freedom to choose methods of working; amount of responsibility; opportunities to use their abilities; and the extent to which the trust values their work. Possible scores range from one to five, with one representing staff who were very dissatisfied and five representing staff who were very satisfied. The average score for job satisfaction was 3.44, indicating that staff in the NHS are generally fairly satisfied. However, this compares with scores of 3.55 and 3.50 in 2004 and 2003 respectively, suggesting a drop in the overall level of satisfaction since 2004.

About a third of NHS staff (34%) either agreed or strongly agreed that they often think about leaving their current employer. A quarter (24%) said they would probably look for a new job at a new organisation within the next year. In the 2004 survey, these figures were 33% and 25% respectively, and in the 2003 survey 34% and 26% respectively, indicating relatively little change over time.
Flexible Retirement

The 2005 survey asked whether or not staff had been provided with information about flexible retirement. Twenty three per cent of staff aged 51 or over said that their trust had provided them with this information.

Changing Roles and Improving Skills

A good appraisal enables staff to have greater clarity about their role and to have their training needs identified, and leads to them feeling valued by their employer. Results from the 2003 and 2004 surveys have shown that staff who had received an appraisal in the previous 12 months were more satisfied with their jobs and less likely to be considering leaving.

In the 2005 survey, 60% of staff had had an appraisal or performance development review in the previous 12 months. This compares with 63% in the 2004 survey, and 60% in the 2003 survey, suggesting that the apparent increase in 2004 was not a lasting improvement.

Personal development plans (PDPs) are an important feature of systems for appraising staff. Nearly half (47%) of all respondents had agreed a PDP with their line manager as part of their appraisal in the previous 12 months. Of those who had agreed a PDP in the previous 12 months, 56% had since received the training, learning and development that was identified in the plan while 25% said their PDP had taken place too recently to say.

Training, learning and development have been shown in many studies to be linked with good organisational, and individual, performance. Ninety five per cent of staff said they had taken part in at least one type of training, learning or development that was supported by their employer in the previous 12 months. This compares with 93% in 2004 and 89% in the 2003 survey. It is possible that this increase is because a larger number of types of training were mentioned specifically on the questionnaire in 2005 compared with previous years. Staff were also asked whether they had experienced difficulties obtaining training, learning or development from their trust in the previous 12 months. Overall, 79% said they had experienced some difficulty. The most commonly experienced difficulties were getting time off work and getting cover for work to attend training, training at inconvenient times and a lack of funding for training.

Copies of the report, National Survey of NHS staff 2005, Summary of key findings, will be available on the Healthcare Commission’s website www.healthcarecommission.org.uk, from Wednesday 22 March 2006.

Healthcare Commission

17 March 2006

Evidence submitted by the Health Professions Council (WP 76)

The Health Professions Council welcomes the opportunity to give evidence to the Health Select Committee’s workforce planning enquiry. The following is designed to give a brief overview to the role of HPC, and more detail about some particular areas of HPC’s responsibility which could be of interest to workforce planning.

About the HPC

1. The Health Professions Council is a UK wide healthcare regulator, established by the Health Professions Order 2001 ("the Order"). It registers around 170,000 members of the following thirteen professions:
   — Arts therapists;
   — Biomedical scientists;
   — Chiropodists and podiatrists;
   — Clinical scientists;
   — Dietitians;
   — Occupational therapists;
   — Operating department practitioners;
   — Orthoptists;
   — Paramedics;
   — Prosthetists and orthotists;
   — Radiographers; and
   — Speech and language therapists.
2. The HPC was established to protect the public, in the words of the Order, “to safeguard the health and well-being of persons using or needing the services of registrants”. In order to do this, it runs four key functions:

- setting standards for health professionals, including standards for professional skills and knowledge, education and training, continuing professional development, conduct, character and health;
- keeping a register of health professionals that meet those standards;
- approving programmes which lead to entry to the Register; and
- taking action when health professionals do not meet those standards.

Protecting Professional Titles

3. The Health Professions Order protects common professional titles, meaning that only HPC registered health professionals can use protected titles such as “physiotherapist” or “chiropodist”. Anyone who uses a protected title who is not on the HPC Register can be prosecuted and fined up to £5,000. HPC undertook research with the public in 2002 to establish the most commonly recognised and commonly used titles for each profession, and can protect further titles if necessary.

4. Regulation of title not function establishes a flexible system of regulation, which does not stifle innovation and development, and allows employers and providers to devise flexible ways of delivering healthcare. Registered health professionals can develop their scope of practice as they progress in their career: they can specialise, or move into an advanced role, provided that they are able to do so safely. All health professionals are required to meet the HPC’s standards of conduct, performance and ethics, which require them to work within their scope of practice, and any health professional who does not may have action taken against them which could result in them being struck off the Register.

New Professions

5. Under the Health Professions Order, the HPC can also make recommendations to the Secretary of State regarding other professions which it believes should be regulated. In October 2004, operating department practitioners became the first new group to join the HPC Register.

6. New professions (aspirant groups) can make an application to the Council to be considered for regulation. The Council has established ten criteria against which it assesses applications, which include the requirements that the group must cover a discrete area of activity displaying some homogeneity and operate a voluntary register.

7. Thus far, the Council has considered applications by nine groups, including applied psychologists, clinical technologists, and clinical physiologists. In addition, the Council has been approached by over 40 groups who have expressed an interest in being HPC regulated.

Approving Programmes

8. The HPC approves programmes (courses) which lead to registration. This is done by assessing programmes against the HPC’s Standards of Education and Training, and the Standards of Proficiency. The assessment is carried out by “Visitors” who are registered health professionals. They visit education providers to meet programme staff, placement providers, students and others, in order to write their report on how far the programme meets the standards. If approved, the programme is added to the HPC approved course list, which is published online. Students who successfully complete the course can then apply for registration with HPC.

9. In planning workforce development which requires the establishment of new programmes, it may be useful to know that a six month lead time is necessary to schedule a visit with our Education department.

The Registration Process

10. Having completed an approved programme, students then need to register with HPC before they can practise using the protected title for their profession. Most UK graduates, numbering around 8,000, submit their applications during the peak summer period. The HPC therefore recommends to students that they allow at least two weeks between submitting their application, and the time when they need to be registered in order to practise.

11. When applying for registration, applicants need to send information to HPC which includes:

- A health reference signed by their GP;
- A character reference signed by someone “of professional standing in the community”; and
- A copy of their passport and birth certificate.

12. HPC runs a series of student talks, delivered to final year students, to explain the registration process, how regulation works, and the standards expected of registrants.
HEALTH PROFESSIONALS FROM OUTSIDE THE UK

13. Health professionals who trained outside the UK must apply to HPC to be registered. HPC uses registration assessors, who are trained health professionals, to look at each application individually to see whether it meets the Standards of Proficiency. Each applicant provides information about their education, training and experience to be assessed. If the registration assessors consider that the applicant meets the standards, they will recommend that they should be registered. The time to process an application via the international registration process is fifteen weeks at the time of writing.

STATISTICS

14. The HPC registration database holds information about all 170,000 health professionals currently and previously registered, including their sex, date of birth, work address, and other information. HPC can provide this information (anonymised to protect registrants’ identity) which may be of use to workforce planning in, for example ascertaining the numbers of health professionals who are likely to retire over a given period, or the pattern of distribution across different age brackets, broken down by gender. As an example of the kinds of information HPC can provide, attached to this response is a breakdown of the numbers of registered physiotherapists, by year of birth and gender.

THE FOSTER REVIEW

15. At the time of writing this response to the committee, the Foster review of non-medical regulation has not yet been published. This review, which was run concurrently with the Donaldson review of medical regulation, is expected to make recommendations about the future of regulation which will have an impact on HPC and how it is run. In particular, the remit of the review included topics such as revalidation, the regulation of assistant practitioners and advanced practitioners, and the fitness to practise process. The HPC is looking forward to the publication of the results of the Foster review, and will work with the government to implement the proposals.

WORKFORCE PLANNING AND THE HPC

16. Our role as a regulator means that HPC does not have direct input into workforce planning issues, other than to provide information for other organisations who are looking into health needs. However, moving forward it could be useful for HPC to be involved at an earlier stage in this process. HPC could provide information (as above) to inform planning, and could if alerted make its own preparations for any proposed changes in the numbers of health professionals to be registered. Depending on the outcome of the Foster review, planned developments in health professions’ roles could also inform the standards that we set, or could be considered in the light of our new professions process.

Health Professions Council
April 2006

Evidence submitted by the International Longevity Centre-UK (WP 30)

1. THE ILC-UK

The International Longevity Centre-UK (ILC-UK) is a think-tank which aims to help decision makers in the public, private and voluntary sectors understand the implications of an ageing population. It provides evidence to facilitate new policy solutions and promotes awareness of these issues in the public domain. Further information can be found at www.ilcuk.org.uk

2. SCOPE OF SUBMISSION

This submission considers the following issues raised by the Select Committee call for evidence:

“In considering future demand, how should the effects of the following be taken into account:
— Recent policy announcements, including Commissioning a patient-led NHS.
— An ageing population.

How will the ability to meet demands be affected by:
— early retirement.

To what extent can and should the demand be met, for both clinical and managerial staff, by:
— changing the roles and improving the skills of existing staff;
— better retention; and
— the recruitment of new staff in England.”
3. **The Implications of Population Ageing for Healthcare Services**

3.1 The Committee will be well aware of demographic trends in the UK: low birth rates and increasing life-expectancy are reshaping our population. There were 19.8 million people aged 50 and over in the United Kingdom in 2002, a 24% increase from 16.0 million in 1961. The number is projected to increase by a further 37% by 2031, when there will be close to 27 million people aged 50 and over. More importantly the “oldest old” over 85 are projected to rise from over 1.7% of the population in 1994 to over 5% in 2055 (ONS 2005).

![Figure 1: Population change by age bracket 2006 to 2036 England and Wales](image)

**Data source:** Government Actuaries Department 2005.

2. **The Importance of New Working Practices**

2.1 Greater longevity poses new challenges to human resources in health at two levels. Firstly, as people age, they are more likely to suffer from multiple chronic conditions, often occurring at the same time. Secondly, the health and social care workforce itself will experience population ageing.

2.2 The management of chronic illness is at odds with the traditional acute, medically dominated, hospital-based model of care (McKee et al 2005). The focus of service delivery must therefore change to encompass settings outside the hospital and recognise the value of care solutions based in the community, for example:

- Geriatric assessment, conducted by a multidisciplinary team, including risk assessment for malnutrition.
- Prevention (eg housing adaptations, information).
- Rehabilitation, manifested particularly in the creation of intermediary care facilities that allow older persons a transition between (expensive) hospital beds and the community setting.
- Integrated care, which spans across all components of the health care system (primary, secondary and tertiary care) as well as social care.

2.3 The integration of health and social care services is recognised as a key lever to providing efficient, patient-centred care to ageing populations. Integrated care may also confer significant economic benefits to health care systems, as it relieves the burden of care from acute hospitals and moves it into the community. Multi-disciplinary approaches (eg stroke unit teams) to managing chronic conditions have been shown to result in better patient outcomes (Wait S, and Harding E, 2005.)
Figure 2: future numbers of people in care: projected numbers of older and physically disabled people living in residential settings, UK*

* based on applying 2003 risk of living in a residential setting (L&B) to GAD principal projections. (Source: Laing & Buisson, 2003).

2.4 Figure 2 above represents a somewhat simplistic projection of the 2003 age-specific risk of living in residential settings and applies it to future demographics. However, other studies have also concluded that population ageing is expected to lead to considerable future increases in the numbers of people requiring residential and nursing care, particularly due to the likely rise in chronic diseases such as dementia (Warburton, 1994; Wittenburg et al, 2004). Such figures are, at least, a strong signal for the need for greater investment in preventative initiatives.

2.5 Demand is expected to increase for those who work on the interface between health and social care, such as home-care workers, nurses, community health nurses and physiotherapists (Dubois, McKee and Nolte 2006). There is evidence from several care settings that nurse-led clinics achieve better results than traditional physician-led care (vrijhoet et al, 2000). Nurse-led diabetes management clinics, for example, represent a shift towards enhancing the role of nurses as the primary provider and coordinator of care as well as moving the nexus of care into the primary care setting (Renders et al 2001).

2.6 These new models of integrated, holistic and community orientated care render the traditional boundaries between professions obsolete and call for a change to the current hierarchy of professions within health and social care (Wait, Harding 2006). Thus attitudinal changes will be necessary alongside new strategies in human resource management.

2.7 Despite ambitious new policy guidance, significant gaps between policy and implementation exist (Lewichsenring 2003.) Increased decentralisation of services and local resource constraints often create cumulative hurdles to achieving integrated care. As a result, many people with chronic illnesses end up “falling through the net” as available services fail to meet their needs (Wait, Harding 2005). Indeed, a significant risk is that people may delay access to physicians and thus have delayed diagnosis if access to care is limited. These issues need to be urgently addresses by health service planners.

3. The Implications of an Ageing Workforce

3.1 The ways in which the health care workforce is recruited, trained, rewarded, regulated and managed have often failed to keep pace with the changing demands facing health care systems, and workforce ageing represents a new challenge for the UK (Dubois, McKee and Nolte 2006).

3.2 Whilst population ageing increases the demands on healthcare systems, it also restricts the population of working age available to provide care. The UK—as with many European countries—is seeing the greying of their nursing workforce. In the UK, one nurse in five is over 50, and nearly half are over 40. Some 40% of consultants over 50 are expected to retire in the next 10–15 years. Recruitment of younger nurses is a major concern, between 1988 and 1998 the proportion of nurses aged under 30 fell from 30% to 15%. Only 19% of the UK consultant workforce was under the age of 40 in 2002. Furthermore about 40% of those over 50 are likely to retire during the next 10–15 years (Dubois, McKee and Nolte 2006).

3.3 Although aggressive policies for boosting supply have been implemented in the UK, such as training new doctors, nurses and recruiting and training foreign clinicians, the time lag needed to fully train health professionals is at least 10 years. Severe imbalances between supply and demand of health care labour are
both inevitable and imminent (Dubois et al., 2005). Previous policies such as restrictions on training and intake for medical positions are partly responsible for the likely future shortages in human resource (Dubois, McKee and Nolte, 2006).

3.4 Attempts to reverse the trend towards early retirement the workforce have yet to make any real impact in boosting participation rates. The proportion of physicians working beyond the age of 60 years has fallen in most European countries since the mid 1990s (Dubois, McKee and Nolte, 2006), and nursing professions show similar trends. Effective policies are likely to be those that recognise issues of low remuneration, the physical demands of many healthcare professions, and the growing burden of family demands such as informal care.

We urge the committee to:

— Strongly advocate sustainable policies to recruit and train new medical staff over the long term.
— Consider how the existing healthcare workforce can be better retained, and in the case of those near retirement age, promote flexible and advantageous arrangements to encourage the extension of working life.

4. **Ensuring the Correct Balance of Skills: Geriatric Medicine**

4.1 Population ageing, and the corresponding shift in patterns of disability and disease, demand that healthcare systems aspire to a balance of skills relevant to user needs. About 40% of the NHS budget—£10 billion—and around 50% of the social service budget—£5 billion—was spent on people over the age of 65 in 2001 (Department of Health, 2001). Two thirds of acute hospital beds in the same year were occupied by people over the age of 65. We can expect these trends to increase over the next decades.

4.2 Comprehensive geriatric assessment and rehabilitation are of proven benefit in the management of frail older people in hospital and the community, resulting in improved mortality, functional status and reduced discharges to nursing homes (Stuck et al., 2003). “Standard practice” may sometimes need to be adapted for older persons, for example the course of presentation of many diseases may be delayed in older persons, due to weaker pain sensitivity and cognitive impairment (Derejcek, 2004). Many symptoms may be masked by the presence of other morbidities.

4.3 The United Kingdom was one of the pioneer countries to recognise and develop the clinical discipline of geriatric medicine, which is now one of the largest specialties in medicine (British Geriatric Society, 2005). However, a recent survey of medical school teaching by the British Geriatric Society (BGS) revealed that it was still possible for medical undergraduates to bypass geriatric medicine training entirely. There was not sufficient evidence from the survey to show whether there was any teaching about impairments, disability and functional status.

4.4 The role of geriatricians has also changed. Over the last 10 years, geriatricians have become increasingly responsible for the acute intake in hospitals at the expense of their role in the management of chronic, frail older patients. Closure of academic departments of geriatric medicine is a further concern (BGS, 2005).

4.5 Given that the over 65s represent the majority of health service users and that this trend is likely to increase in future, we must:

— Ensure that undergraduate and postgraduate clinical training includes factors such as co-morbidity and chronicity of conditions.
— Where training is being undertaken, ensure that geriatric medicine modules include adequate exposure to community-based settings and principles of integrated care, and are not overly dominated by clinical, hospital-based practice.
— Ensure that all clinicians, not just geriatricians, are trained in how to manage older persons’ conditions in a holistic and multidisciplinary approach.
— Ensure that social care workers are trained to meet the complex needs of older persons, particularly dependent adults disabled by co-morbidities.

5. **Confronting Age Discrimination in Healthcare**

Age discrimination is an “action which adversely affects the older person because of their chronological age alone.” (National Service Framework for Older People, 2001).

“Age discrimination happens when someone makes or sees a distinction because of another person’s age and uses this as a basis for prejudice against, or unfair treatment of that person” (Department of Health, 2001).

5.1 Population ageing, coupled a growing recognition that discrimination against older people is unacceptable, demands that healthcare services revise ageist practices and ensure the most equitable, efficient provision of care possible.
5.2 Older people are recognised as the largest consumers of health care services, and as such are often viewed as a “burden” on crippling publicly-funded health care systems (Wait, 2005 b). The media encourages a “catastrophic” view of health care system sustainability by constantly reminding us of the financial drain that older people pose on our scarce health care resources. There is a tremendous need to dispel the myth of the “expensive older patient”, a problem possibly exacerbated by resource constraints, and to recognise the limited role that ageing plays in explaining exploding health care expenditure (ibid). There is now a rich wealth of literature indicating that high levels of resource use are predominantly a function of dying and not of old age—high use of services occurs principally in the 12 or 18 months prior to an individual’s death (ibid).

5.3 The depiction of older people as frail and dependent (Henwood, 1990), condescending terms such as “little old lady” (Bytheway, 1995), are echoed in health services’ own jargon, most notably in the concept of old people as “bed blockers” (Roberts, 2002). The fact that older patients may be “blocking” precious hospital beds because of a lack of available community-based facilities may be overlooked. As is stated by Roberts, “the label ‘bed blocker’ tempts [medical] staff to asportion blame to individual patients although the problem is caused by a system failure.” (Roberts, 2002). Most importantly, age discrimination may occur because we are all going to become old—reflecting our own fears of old age and what it implies for our health and well-being (Wait, 2005).

5.4 Nonetheless, such discrimination results in multiple barriers in access, financing, planning and delivery of care for older people (Roberts 2002; Wait 2005). For example:

- Symptoms in older people may be dismissed as a natural manifestation of ageing, resulting in compromised health outcomes. For example, a survey in one PCT in Haringey found that there was a tendency amongst clinical staff to re-label mental health problems as dementia as soon as they hit the age of 65 (Office of Public Management 2004).
- Reduced choice being offered to older patients, denial of surgical procedures or expensive but effective treatment, and delayed admission to intensive care units.
- Explicit age barriers to treatment, for example, in various aspects of cardiovascular care.
- Inadequate information and little referral to self-help or patient groups designed to improve availability of information and promote patient rights.
- Older people may be excluded from clinical trials (Wait, 2005).

5.5 Most restrictions in access to services are dictated, not by explicit protocols but by historically-inherited practices and staff behaviour. Commissioners of health services may have lower expectations of what older people need compared to younger people. Medical staff may alter their communication, transmission of information and expectations of outcomes with older patients if they feel a social distance from them (Robinson, 2002). Quality of care offered to older people may be lower, be it in terms of longer waiting times, less attentiveness to detail, less choice being offered in treatment options (Ellis 2002).

5.6 Surveys of medical staff reveal little awareness of systematic ageist policies but point instead to ad hoc ageist behaviors and practices. For example, clinical staff may assess the needs of older and younger people differently, for example by only asking younger persons whether they have a social life.

We urge the select committee to advise in favour of:

- Continued and enhanced training for the healthcare workforce to challenge and raise awareness of ageist and arbitrary barriers to care for older people. Dedicated training of all clinical and managerial staff may help dispel false assumptions and slowly change behaviours.
- Continued support, promotion and policy development and of the National Service Framework for Older People at the highest level.

6. The Importance of Recognising the Informal Care Workforce

6.1 Discussions on the healthcare workforce have tended to omit reference to the 6 million informal carers in the UK, some 10% of the total population, or approximately 12% of the adult population (Carers UK 2005). This is a burden likely increase in future. The 2001 Census and the General Household Survey revealed that the number of carers providing support for 20 hours or more every week increased from 1.5 million in 1990 to 1.9 million in 2001. Those with very heavy care burdens (defined as over 50 hours of care per week) increased to 1.25 million (Carers UK 2005).

6.2 Their contribution to services is immense and remains largely unrecognised. Yet policy-makers cannot take the presence of informal carers for granted. Family structures in the UK are changing, as are expectations of the role of children 6.3 towards their parents. Women form the majority of carers (Carers UK 2005) yet this role is under pressure from changing lifestyle ambitions such as career demands—boosting workforce participation is, incidentally, a stated government objective.

6.3 The growing age gaps between generations caused by women waiting longer to have children also has many implications for care. There is a fear of the “women in the middle” scenario: whilst 20 year generations create 45 year old women helped by 65 year old mothers to support 20–25 year old children today, 30 year
generations will create 50 year old women caring for both 80 year old mothers and adolescent children (Harper S, 2003), with a likelihood of increased workforce participation caused by various factors, not least less advantageous pension arrangements.

We urge the committee to:

— Recognise that informal care is the bedrock of our formal healthcare services and public support will achieve significantly positive outcomes for health and wellbeing.
— Recommend that training, community care support, better information and empowerment for carers in healthcare provision forms part of a wider strategy to prepare our healthcare system for future need.

7. SUMMARY RECOMMENDATIONS

In summary, we urge the Select Committee to:

— Advocate long-term sustainable policies to recruit and retain staff in both medical and social care services.
— Recommend continued and enhanced workforce training to cope with the changes in service demands associated with population ageing, such as a greater emphasis on community-based, integrated care and co-morbidities.
— Recommend continued and enhanced training for the healthcare workforce to challenge and raise awareness of ageist and arbitrary barriers to care for older people.
— Recognise that informal care is the bedrock of our formal healthcare services and public support for carers will achieve significantly positive outcomes for health and wellbeing and our formal healthcare services.

Ed Harding
International Longevity Centre—UK
March 2006

Evidence submitted by the Joint Epilepsy Council of the UK and Ireland (WP 10)

1. INTRODUCTION

1.1 The Joint Epilepsy Council of the UK and Ireland represents 22 epilepsy organisations operating in England, Wales, Scotland, Northern Ireland and the Republic of Ireland. Our mission is to promote improved standards of and access to integrated services in health, education and social care for people with epilepsy and their carers and to increase epilepsy awareness amongst politicians, civil servants, service providers and the general public. The JEC includes representation from patient organisations and the International League against Epilepsy (ILAE) representing clinical specialists with an interest in epilepsy.

1.2 Over 456,000 people have epilepsy in the UK. It is the most common serious neurological condition and is a major long-term disability with similar numbers of people affected as insulin dependent diabetes. JEC is a member of the Neurological Alliance and our recommendations for workforce planning in the area of neurological services has relevance to all people with a neurological condition.

1.3 The JEC welcomes this opportunity to submit evidence to the Health Committee relevant to the inquiry into Workforce needs and planning for the health service including:
— How effectively workforce planning, including clinical and managerial staff, has been undertaken, and how it should be done in the future.
— Recent policy announcements, including Commissioning a patient-led NHS.
— Technological change.
— An ageing population.
— How ability to meet demands will be affected by financial constraints.
— The European Working Time Directive; increasing international competition for staff; early retirement.
— To what extent can and should the demand be met, for both clinical and managerial staff by changing the roles and improving the skills of existing staff; better retention; the recruitment of new staff in England; international recruitment.
— How should planning be undertaken: To what extent should it centralised or decentralised?

— How is flexibility to be ensured?
— What examples of good practice can be found in England and elsewhere?

2. SUMMARY

2.1 The key issue in this area as far as the JEC is concerned is the apparent absence of any plan (national, regional or local) to address the critical shortfall in the number of neurologists in England.

2.2 There is evidence that this shortfall is critically affecting the level of care provided to people with epilepsy, including increased levels of epilepsy related deaths.

2.3 A number of major recent initiatives have been launched that could positively impact on patient care if effectively implemented, that implementation is seriously compromised by shortages of neurologists. These include, but are not limited to:
— The National Service Framework for Long Term Conditions, focussing on Neurological Conditions.
— The NICE Clinical Guidelines on the Epilepsies.

2.4 “The Department of Health does not have a target for growth in the number of neurologists”—quote from correspondence from the Department, 2005.

2.5 This is in the face of the (conservative) view of the Royal College of General Physicians that England requires a minimum of 781 WTE neurologists by 2012, compared to the current 403 and the Department’s estimate of 510 by 2012.

2.6 networks

3. RECOMMENDATIONS

3.1 Central planning is key if there is to be any progress on increasing the number of neurologists to that required to provide a comprehensive and effective service.

3.2 The JEC recommends that the government adopts as a target for the number of neurologists the recommendation of the Royal College of General Physicians that England will require 781 WTE by 2012.

3.3 The JEC further recommends that the government adopts as a target the recommendations of the Consensus Group:
— Epilepsy specialist nurses from 140 to 600 across all epilepsy disciplines (adult, paediatric, learning difficulties) within two years.
— Paediatric neurologists from 75 to 150 within five to 10 years.
— Learning disability specialists from 340 to 500 within five to 10 years.
— Neuroradiologists from 110 to 160 within five to 10 years.
— The JEC recommends that the government puts in place such measures as are needed by way of training and recruitment to achieve these targets.

4. HOW EFFECTIVELY WORKFORCE PLANNING, INCLUDING CLINICAL AND MANAGERIAL STAFF, HAS BEEN UNDERTAKEN, AND HOW IT SHOULD BE DONE IN THE FUTURE

4.1 The initiatives noted in the following section have the potential to address many of the key shortfalls in epilepsy services also highlighted in that section.

4.2 It is clear to the JEC that there has been no effective planning to address the workforce needs of the majority of those initiatives. Indeed in the Department of Health’s own words, “it does not have a target for growth in the number of neurologists”50 Two initiatives in particular have key workforce implications in Neurology, particularly on the numbers of clinicians working in this field.

4.3 The NICE Clinical Guidelines on the Epilepsies published in 200451

4.3.1 A consensus group of expert clinical epileptologists and representatives of the epilepsy voluntary sector met in November 200452 to review various survey findings characterising the current state of epilepsy care and to compare against standards outlined in the (then) recently published NICE epilepsy guideline.

4.3.2 The expert consensus was that:
— Little progress has been made in the status of epilepsy care since 2001 when, in his Annual Report,53 the Chief Medical Officer described epilepsy as a “disease in the shadows”, and since 2002, when the National Sentinel Clinical Audit of Epilepsy-Related Deaths54 was published.

50 Reply to enquiry from Epilepsy Action by Mary King, Customer Service Centre, Department of Health.
51 The epilepsies; diagnosis and management of the epilepsies in adults (and children) in primary and secondary care, NICE, October 2004.
52 http://www.epilepsy.org.uk/campaigns/lobbying/consensus/index.html
— Current services fell well short of the standards set out by NICE in terms of waiting times for specialists and diagnostic tests, and research findings indicated that little was likely to change in the next four years.

4.3.3 The expert group was aware that the shortage of neurologists and other epilepsy specialists was not going to improve overnight and called for a number of short-term solutions. In the medium term the group believed that addressing this shortage is the principal change needed to ensure epilepsy services improve sufficiently to achieve the standards set by NICE.

4.3.4 The group called for a national plan to increase the number of epilepsy specialist nurses from 140 to 600 across all epilepsy disciplines (adult, paediatric, learning difficulties) within two years. Nurses play a critical role in treatment monitoring, offering advice and support to patients and families, and education for patients and GPs, therefore providing much needed support to people with epilepsy, the primary care team and to neurologists.

4.3.5 In the medium term (next five to 10 years) the group called for the Government to immediately put in place 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 neuroradiologists from 110 to 160, all within five to 10 years.

4.3.6 This statement was supported by over 100 epilepsy clinicians, seven voluntary sector groups and 115 MPs (EDM 685, 2005).

4.3.7 No formal government response to this call was ever received.

4.4 The National Service Framework for Long TermConditions, focusing on Neurological Conditions

4.4.1 In a speech by Stephen Ladyman MP, Parliamentary Under Secretary of State for Community, 11 May 2004: Long Term Medical Conditions Alliance he stated that he would, in relation to the Long-Term NSF:
— evaluate and cost the recommendations;
— assess the implementation issues; and
— assess workforce and resource implications.

4.4.2 Based on an answer from Baroness Andrews, House of Lords, 10 Jun 2004, that the Long Term Conditions Care Group is working to increase the number of neurologists and that the Speciality Workforce Advisory Group has been reviewing the number of consultants on an annual basis, along with the professional groups; The Department of Health has come to the conclusion that there are sufficient higher specialist trainees for there to be enough qualifying for consultant posts to meet estimated future demands.

4.4.3 In response to an enquiry to the Department of Health to enquire as to the outcome of the then minister’s statement and that of Baroness Andrew we were informed that: “The Department of Health does not have a target for growth in the number of neurologists. The answer given in the House of Lords refers to projected growth based on a number of factors including number of trainees, expected retirements and potential for international recruitment. The assessment of demand was taken from information provided in the Royal College of Physicians publication “consultant physicians working with patients” which estimated a requirement of 2.5 whole time equivalent consultants per 250,000 head of population. That information and projected growth available in 2004 suggested that supply of and demand for neurologists would be equal, 510 whole time equivalent trained specialists, in 2012.

4.4.4 Unfortunately the information the department based their answer on is incorrect—which leaves a major question mark against the departments workforce planning. Whilst the supply might equal 510, the demand is much greater than that.

4.4.5 The Royal College of Physicians publication “consultant physicians working with patients” actually estimates that the workforce requirements for Neurology in England are as follows:

4.4.6 “To provide comprehensive neurological care, including the care of the acutely ill neurological patient, one whole time equivalent consultant neurologist is required for 40,000 population. . . . In summary, this model demands 1,250 NHS neurologists, 175 centre-based neurologists and 78 academic neurologists, which gives a total of approximately 1,400 nationally”.

4.4.7 The Royal College concedes this target is perhaps unrealistic in the short term and goes on to call for a target of 909 Whole Time equivalent across the UK by 2012 (3.9 WTE for 250,000 population). Based on the population of England (mid 2004) of 50.1 million this equates to a (conservative) demand for 781 WTE neurologists.

55 EDM 685, 2005.
59 Reply to enquiry from Epilepsy Action by Mary King, Customer Service Centre, Department of Health.
4.4.8 There were, at September 2004, 403 fte equivalent neurologists in England60, the Department of Health, by its own words, does not have a target for the number of neurologists, yet estimates by 2012 it will have 510.

4.4.9 Even if this “target” is met the shortfall against the conservative Royal College estimate is that England will only have 65% of the neurologists required to provide comprehensive care. Against the full calculated requirement of 1,400 neurologists in the UK (1,165 in England), England will have only 43% of the neurologists required.

4.4.10 It should also be noted that the Royal College of Physicians estimates were prepared before any of the various initiatives mentioned above had been published.

4.4.11 It should be further noted that there is evidence (although not as comprehensive evidence) of similar shortfalls in the numbers of Paediatric Neurologists, Epilepsy Specialist Nurses, Learning Disability Specialist and Neuroradiologists.61

4.5 The Long Term Conditions Care Group Workforce Team

4.5.1 We are aware of The Long Term Conditions Care Group Workforce Team; however we have seen no evidence that it is undertaking any work to address the shortfall in capacity as identified above.

4.5.2 According to the DoH website “The CGWT supports the development of the Long Term Conditions NSF. It explores how the development of new roles can support the existing workforce, and thereby increase overall workforce capacity.”62

4.5.3 However we have seen no evidence that it is undertaking any work to address the shortfall in capacity as identified above.

5. Recent Policy Announcements

5.1 This section firstly sets out the nature of the epilepsies and the standard of existing epilepsy services and secondly sets out JEC concerns about the impact of recent policy announcements on workforce issues relating to epilepsy services. Epilepsy illustrates well the challenges of workforce planning for a condition that has unpredictable severity. Many of the world’s leading epilepsy specialists work in the UK, but very few GPs understand epilepsy sufficiently at a community level and there are too few consultant neurologists specialising in epilepsy in both adult and paediatric care.

5.2 The nature of epilepsy and epilepsy services

5.2.1 Epilepsy is a neurological condition which presents in as many as 50 different types. It is diagnosed when someone has recurrent seizures (also known to many people as fits, grand mal, petit mal, absences). It is caused by excess electrical activity in the brain.

5.2.2 The Chief Medical Officer has confirmed that epilepsy has suffered historical neglect and lack of investment compared with other long-term conditions.63 As a result there is a serious treatment gap identified since 1950 in six national reports. There is a serious treatment gap at present for people with epilepsy.

5.2.3 Seven out of 10 people with epilepsy should be seizure-free on appropriate first-line medication but currently only 5 out of 10 people are estimated as achieving this. This means two out of every five people experiencing seizures could be seizure free, but are not. In total over 80,000 people with epilepsy are having seizures that could be prevented if they received the same level of care as people attending the best epilepsy treatment centres. As well as improving quality of life and saving lives, investment in epilepsy would begin to deliver major savings in public expenditure.

5.2.4 The National Institute of Clinical Excellence states that epilepsy misdiagnosis rates in the UK are between 20 to 31%.64 The annual cost of misdiagnosis is estimated at £160 million65 plus the medico-legal costs associated with complaints and claims and investigations such as the Holton Inquiry in Leicester.

5.2.5 50% of children with epilepsy under perform at school. 58,900 people with epilepsy are claiming disability living allowance. This currently costs £184 million per year66 (Source: Information and Analysis Directorate), but it is estimated with investment in workforce £66 million could be saved per annum.

5.2.6 A UK-wide NICE Clinical Audit on Epilepsy Deaths 200267 found that up to 400 of 1,000 epilepsy deaths each year are potentially avoidable through improved management of seizures. The Findlay Fatal Accident Inquiry 2002 also highlighted the need for implementation of national guidelines on epilepsy as a key preventative strategy in respect of SUDEP (Sudden Unexpected Death in Epilepsy). SUDEP mainly affects young people and can affect anyone with epilepsy who is not seizure-free.

60 Hospital, Public Health Medicine (PHM) and Community Health Service (CHS) medical and dental workforce census, England, at 30 September 2004, Department of Health, 2005.
62 www.dh.gov.uk
5.3 Government Policy in this area is set out in:
5.3.1 the Government Action Plan for Epilepsy 2003;68
5.3.2 the NICE Clinical Guidelines on the Epilepsies published in 2004;
5.3.3 the new GP Contract;
5.3.4 the National Service Framework for Long Term Conditions, focussing on Neurological Conditions;
5.3.5 Our health, our care, our say: a new direction for community services White Paper;
5.4 Amongst other things these initiatives provided evidence of the need, and guidance on how to deliver improved epilepsy services, providing:
5.4.1 the need for local epilepsy plans;
5.4.2 urgent referral to epilepsy specialist consultants;
5.4.3 prompt investigations;
5.4.4 a structured annual review, with a specialist if the patient is a child or has on going problems with their condition;
5.4.5 that patients should be well informed on important issues such as drug interaction and side-effects, issues for women of child bearing age, the risk of seizures and fatality.
5.5 Whilst these national initiatives are to be welcomed as raising the profile of epilepsy, they have not been followed (as noted in the preceding section) by investment in workforce requirements to implement necessary change.
5.6 Most critically, the Department of Health’s Epilepsy Action Plan, produced in response to the NICE Clinical Audit on Epilepsy Deaths 2002 included no plans to address the critical workforce shortage at the heart of many of the shortfalls in epilepsy care identified in the Audit.

6. IMPACT OF RECENT POLICY CHANGES

6.1 The JEC wishes to register concerns that to the extent that there have been any recent advances in epilepsy care in recent years these are particularly precarious at a time of restructuring and potential fragmentation in service providers. These changes are also proposed at the same time as increasing financial and other constraints on residential care providers further increasing demand and risk in the management of epilepsy in the community.

6.2 Commissioning a patient-led NHS. Proposals for restructuring of services may increase costs in the short term, but will not generate any increase in relevant workforce. JEC is concerned about the impact on services by a diversion of funds to restructuring of services at this time.

6.3 Recent proposals for reform are set in a context of a significant number of localities facing financial crisis and leading to service cuts in some areas. One example that impacts on people with epilepsy is the proposed closure of the Park Hospital in Oxfordshire.

6.4 Of equal concern is the impact of reorganisation on vital planning of services. There will inevitably be significant delays due to lack of certainty; staff morale and the necessary time and resources needed in establishing new organisations. Existing services are unlikely to be further developed and initiatives within PCT provided services stifled. The JEC would like to see an epilepsy champion in each current sized PCT.

6.5 Further, it is difficult to see under the current proposals how people with epilepsy would be involved in the planning of epilepsy services. Epilepsy patient and carers organisations can most effectively provide evidence-based information on the needs of people with epilepsy, but it is not transparent that this would be required of all commissioning or provider organisations under the proposed new reforms.

6.6 Payment by results JEC has serious concerns about the tariff level for epilepsy because the cost appears not to reflect the real cost and the differing complexity of care between conditions. This could make it difficult for complex epilepsy cases to access appropriate care, especially where a multi-disciplinary team is required. The extra cost for the more complex cases means that providing these services will not be cost efficient. The Government has stated that if providers fail to provide services at or below the current tariff, funding will be withdrawn and the service will close. Concerns have been expressed to us by clinicians about the impact of payment by results. Unless some services are protected and mandated, you will see providers withdrawing from those services for economic reasons, which would disadvantage people with epilepsy.

6.7 Practice-based commissioning JEC would also like raise concerns about the capacity of practice-based commissioning to commission epilepsy services and also the capacity of practice-based commissioning to adequately involve patient expertise and experience. There is also a serious question of the ability of the new system to effectively monitor access and the quality to services. JEC has concerns that

68 Improving services for people with epilepsy: Department of Health action plan in response to the National Clinical Audit of epilepsy-related death, Department of Health 2003.
practices may be too small to establish and deliver practice based commissioning effectively. Epilepsy is a good example of a condition where the level of knowledge and expertise of GPs is poor and where significant safeguards would need to be in place before (Chief Medical Officer Annual Report, 2001).

6.8 Changes of Service Providers—Choice Agenda. The organisation of integrated care should be such that no unnecessary barriers are created between sites of health service delivery. Epilepsy services management requires coordination across primary; secondary care and tertiary care. Each person with epilepsy will have different healthcare needs. This relies on the individual being able to make informed choices about their own, complex and changing care needs, with the support of competent practitioners who are willing and able to work collaboratively. Integration of services is key.

6.9 JEC is concerned that new systems introduced may lead to increased fragmentation of services. Changes to service providers must be done in consultation with existing providers; with specialist patient organisations and people with epilepsy. These changes should be structured, agreed and take into account individual needs and preferences.

6.10 Another critical issue is the capacity for effective monitoring of access to and quality of services.

7. Technological Changes

7.1 The diagnosis of epilepsy is very difficult and requires specialists with training and expertise in the condition.69

7.2 The diagnostic tool of choice is MRI.

7.3 The growing sophistication of MRI and the shortage of suitably skilled technicians to interpret effectively the results is a further area where the JEC believes Workforce planning is not meeting the needs of people with epilepsy and keeping up with increasing technological development.

8. An Ageing Population

8.1 The incidence of Epilepsy increases in the elderly, due to a number of factors, including epilepsy developing as a result of brain injury following a stroke.

8.2 Indeed old age is the most common time of life to develop epilepsy.70

8.3 Clearly an ageing population is going to result in an increasing number of older people with epilepsy placing yet more demands on an already under resourced area.

8.4 No plans are evident to accommodate the impact of the ageing population on epilepsy services.

9. Ability to Meet Demand

9.1 Estimates of workforce needs for epilepsy in 2005 indicate a serious short-fall, see section 3.

9.2 Epilepsy is a condition of historic under-funding.

9.3 Table 1 below compares the population per neurologists in the England with the rest of Europe.71

<table>
<thead>
<tr>
<th>Population per neurologist</th>
<th>Ratio compared to England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>23,202</td>
</tr>
<tr>
<td>Denmark</td>
<td>21,186</td>
</tr>
<tr>
<td>France</td>
<td>38,462</td>
</tr>
<tr>
<td>Greece</td>
<td>21,322</td>
</tr>
<tr>
<td>Italy</td>
<td>8,117</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>23,866</td>
</tr>
<tr>
<td>Norway</td>
<td>18,416</td>
</tr>
<tr>
<td>Netherlands</td>
<td>25,733</td>
</tr>
<tr>
<td>Portugal</td>
<td>33,113</td>
</tr>
<tr>
<td>Sweden</td>
<td>35,587</td>
</tr>
<tr>
<td>Switzerland</td>
<td>29,070</td>
</tr>
<tr>
<td>England*</td>
<td>124,000</td>
</tr>
</tbody>
</table>

*English figure adjusted for 2004 Neurologist numbers and Population

69 The epilepsies; diagnosis and management of the epilepsies in adults (and children) in primary and secondary care, NICE, October 2004.


Other figures from 2002 report

9.4 Table 2 below sets out JEC estimates of the existing resource and demand and the estimated cost per annum of meeting demand.\(^\text{72}\)

<table>
<thead>
<tr>
<th>Access to a GP with basic knowledge of epilepsy</th>
<th>Existing Resource</th>
<th>Demand</th>
<th>Cost Per Annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to a specialist nurse</td>
<td>Poor knowledge base</td>
<td>Epilepsy Training—One course per year in each PCT</td>
<td>£700,000</td>
</tr>
<tr>
<td>Access to a paediatric neurologist with an interest in epilepsy</td>
<td>Some informal clinical networks</td>
<td>An epilepsy “Tzar” or lead in each region</td>
<td>£750,000</td>
</tr>
<tr>
<td>Access to a consultant neurologist</td>
<td>150</td>
<td>600</td>
<td>£12,600,000</td>
</tr>
<tr>
<td>Access to a clinical neurophysiologist</td>
<td>70</td>
<td>150</td>
<td>£8,000,000</td>
</tr>
<tr>
<td>Access to a paediatric neurologist with an interest in epilepsy</td>
<td>352</td>
<td>1,400</td>
<td>£104,800,000</td>
</tr>
<tr>
<td>Access to a clinical neurophysiologist</td>
<td>75</td>
<td>24</td>
<td>£4,325,000</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>£131,175,000</td>
</tr>
</tbody>
</table>

Footnote: recommended numbers of neurologists, paediatric neurologists and neurophysiologists are taken from the Association of British Neurologists, British Paediatric Neurologists Association and Association of British Clinical Neurophysiologists.

9.5 Additional pressures such as the European working time directive and international competition increase the urgency for action in this area.

9.6 Workforce planning to implement existing national policies on epilepsy does not exist or is not in the public domain. Despite increased funding in the health service, there is growing evidence that, locally, health officials do not feel that they have sufficient money to implement clinical guidelines and national policy. A JEC survey of PCTs and SHAs identified financial constraints as the main barrier to implementing government policy outlined in the Government Action Plan on Epilepsy 2003.

10. Changing Roles, Improving Skills, Better Retention, Recruitment

10.1 Changing roles

JEC supports the development of managed clinical networks as a model for delivery of epilepsy services which can best manage the risks resulting from a serious workforce shortfall in the area of delivery of epilepsy services. Managed Clinical Networks have been adopted as the model of service delivery in Scotland. Whilst clinical networks significantly reduce the numbers of specialists needed through use of an integrated team of GPs, nurses and a range of specialists, networks cannot be developed without an investment in workforce.

10.2 Improving Skills

A training strategy for existing staff is clearly important. In particular JEC recommends the investment of one epilepsy course for GPs in each PCT area.

10.3 Training for managers

One particular concern reported by clinicians to the JEC is the constant demand from management that the number of patients remaining under hospital follow-up should be as low as possible, and this demand increases whenever there are increased concerns about the financial situation in the NHS, as now. Although on the face of it this is a reasonable demand, pressure of this kind represents a particular threat to patients with chronic diseases, whose long-term care devolves to the GP (who may well not be familiar with epilepsy and particularly with new drugs etc). JEC would recommend that training for NHS managers should include clinical risks associated with demand management of patients with long-term conditions.

10.4 GP Contract

Epilepsy is part of the GP contract, but there has been no national requirement for training GPs to deliver quality epilepsy care in spite of a series of national reports identifying that the knowledge base for epilepsy is particularly weak at a primary care level in comparison with other chronic conditions.

\(^{72}\) Epilepsy, the case for, the Joint Epilepsy Council, 2004.
10.5 **Better Retention**

JEC increasing receives reports from existing clinicians about difficult working conditions and low morale. There are also reports about concerns about the impact of new policy measures such as payment by results on their work. JEC would support an independent report based on a confidential survey of existing NHS clinicians allowing their views and concerns to be raised in the public domain.

10.6 **New Staff**

Table 2 sets out the estimated investment needed in the workforce for epilepsy services to enable the development of clinical networks across England. The greatest source of investment identified is to fund a far greater number of neurologists and specialist nurses. The benefit would not be restricted to people with epilepsy, but also to people with Parkinson’s disease, multiple sclerosis, cerebral palsy and every other neurological condition.

11. **How Should Planning be Undertaken?**

11.1 **Practice-based commissioning**

Concerns have already been stated regarding the competence and capacity for practice-based commissioning relating to epilepsy. There is also the concern that if commissioning is too localised it will not be possible to involve the relevant expertise and views of stakeholders.

11.2 There needs to be a critical mass of funding in order to support specialised services and the proposed reforms will make funding uncertain and difficult to plan ahead of time.

11.3 Planning for consultant neurologists and paediatric neurologists needs to be centralised. There is such an acute shortage of specialists in this area that it requires national planning. As it takes 10 years to train a neurologist planning needs to take account of short-term, medium and long-term needs.

12. The Joint Epilepsy Council would welcome the opportunity to expand on this evidence and present oral evidence to the committee.

David Josephs  
Chair, Joint Epilepsy Council of the UK and Ireland  
13 March 2005
— Address external changes
— Encompass the skills and competencies of the whole workforce in all health care sectors.
— Be used to inform:
  Human resource strategies
  Modernisation of the workforce with improved productivity
  Educational investment
— Be coherent at a local and national level.

5. HOW FAR HAS “EFFECTIVE WORKFORCE PLANNING” BEEN ACHIEVED?

5.1 Alignment with service planning

The NHS Plan, National Service Frameworks (NSF’s) and specific policies such as “Choosing Health” and the “Cancer Plan” have given clear direction to service delivery. Where workforce planning has been able to underpin these policy drivers it has been effective. At a national level this has been achieved where policy boards have engaged workforce experts and by the use of care group workforce teams. Locally in Leicestershire, Northamptonshire and Rutland (LNR) there are workforce development managers working closely with specific care teams for example, Mental Health and Cancer. This has been particularly successful where the care teams encompass both health, social and independent providers of care. The workforce development managers link the workforce plans of employers with the plans needed to deliver effective care pathways for individual patients. It is difficult to aggregate all the care group workforce plans into a coherent whole especially numerically.

Both nationally and locally, Local Delivery Plans (LDPs) have been used to help to align the workforce requirement clearly with the achievement of the national and local targets as outlined in the Planning and Priorities guidance. This has resulted in a numerical assessment of need.

It is important to achieve coherence between the workforce planning undertaken in care groups and the quantitative planning in LDPs, but this is difficult.

In considering future demand, how should the effects of the following be taken into account:
— recent policy announcements, including “Commissioning a patient-led NHS”

As with all policy documents there needs to be a clear articulation of what a new policy will mean in terms of workforce, both at a local and a national level, and what action needs to be taken. Although “Commissioning a patient-led NHS” has a greater emphasis on structural change rather than service delivery change, the need to assess the workforce implications is no less important. One important point is that while service planning can in the future be done through the commissioning process, this is not the case in workforce planning where there will continue to be a need to link to all providers and to plan across health communities.

5.2 Alignment with financial planning

Alignment with financial planning both nationally and locally has been woeful considering the pay bill is the largest part of the health service expenditure. Some attempts are being made to improve this, for example, the introduction of the Financial and Workforce Return. However there is still no commitment from all strategic Financial and Human Resource leads to plan jointly.

It continues to be very difficult to demonstrate a clear correlation between increased investment in new staff, and achievement of targets eg waiting lists and improved quality.

How will the ability to meet demands be affected by:
— financial constraints

It is clear that all aspects of workforce utilisation will come under scrutiny and rightly so. It will focus attention on the NHS reliance on agency staff and the need to retain staff. We need to plan for an affordable workforce but one in which we optimise capacity and capability. There will be a clear tension between the need to achieve the tight targets of the 18 week journey time, and moving care closer to home (as articulated in “Our health, our care, our say”) with financial constraint.

It is easy for the education budget to be raided for short-term operational need. This is unsustainable and will lead to insufficient workforce supply longer term or a boom and bust effect.
5.3 Ability to address external changes

There are demographic, social, technological, legal and employment changes that need to be taken in account in workforce development planning. Locally over the last four years our expertise in this area has improved.

In considering future demand, how should the effects of the following be taken into account:

--- technological change

Every attempt should be made in workforce planning to anticipate the effect of technological change and any help proffered by those instigating the change should be used. This will never be easy as a small, unanticipated development could fundamentally change service delivery relatively rapidly especially in the area of drug treatments eg the advent of artificial blood, use of statins and interventional radiology severely reducing the need for cardiothoracic surgery.

--- an ageing population

This needs to be considered in terms of the service input this client group will need. The assessment needs to be done both nationally and locally as the demographics can be very different. Undoubtedly effort should be put into developing the preventative workforce thus reducing the burden on the acute sector.

--- the European Working Time Directive

Like all other changes to employment law, we need to plan for the introduction of EWTD. It will particularly affect junior medical staff. It is clear that the more radical solutions are required in 2009 than were utilised previously, and will need advanced planning in order overcome the time required to train staff. This change will undoubtedly result in workforce growth, though not necessarily an increase in the pay bill. This change needs to be planned in tandem with the affects of changes as a result of Modernising Medical Careers that is the new education pathway for doctors.

The health service also needs to revise it workforce plans in the light of the Employment Equality (Age) Regulations 2006.

5.4 Ability to encompass the skills and competencies of the whole workforce in all sectors

5.4.1 At national and local level workforce development planning has been criticised for:

--- Concentrating on numbers rather than skills and competencies.
--- Being focussed on clinical professionals.
--- Not being integrated across professional boundaries especially between medical and non-medical.
--- Examining only the acute sector.
--- Not being inclusive of social care, independent, private and voluntary sectors.

This section examines whether this criticisms are still valid.

5.4.2 Concentrating on numbers rather than skills and competencies.

There is tendency to think of workforce planning as purely a technically numerical exercise that enables us to balance demand and supply. However the far more complex issue of ensuring the workforce is available with the required skills and competencies is becoming increasingly important. There are many signs that at a local level attempts are being made to tackle this in a coherent way. The Sector Skills Councils are assisting this. The advent of the Knowledge and Skills Framework in Agenda for Change and the supporting National Occupational Standards begin to provide a framework. Ensuring everyone has a personal development plan and the Electronic Staff Record will give increased impetus to achieving this.

5.4.3 Being focussed on clinical professionals.

The major educational investment in the NHS is on clinical professionals hence there is a tendency to concentrate on planning for these groups. In LNR there has been a strong move to start by planning the whole workforce and then extract the professional requirements from this. Locally we have focussed on:

--- Ensuring that there are clear routes into the workforce for those that might not traditionally have considered it.
--- Embedding the Skills Escalator into all our development planning so that in each care area there are clear routes by which individuals can develop.
--- Making sure that all the support areas eg HR, finance, facilities, IT are planned for as well as the key service areas.

5.4.4 Not being integrated across professional boundaries particularly between medical and non-medical clinicians.

It is clear that this is still a problem area. The Workforce Review Team is playing a leading role nationally in bringing this planning together. Locally the Postgraduate Medical Deaneries and Workforce Directorates in SHAs need to become fully integrated so this can become a reality. In LNR the advent of the Healthcare Workforce Deanery is beginning to ensure true integration.
5.4.5 Examining only the acute sector.

It is not surprising that this has been the case given the difficulty with getting robust workforce information from primary care contractors, such as GP’s and dentists. However “the emergency bed day target” and now the “18 week imperative” have made it essential to give equal attention to community and primary care. The skill will be to maintain cross-organisational boundary planning despite the advent of Foundation Trusts and the increasing number and diversity of providers. This will undoubtedly be helped by the Integrated Service Improvement Programme (ISIP) and the White Paper “Our health, our care, our say”.

5.4.6 Not being inclusive of social care, independent, private and voluntary sectors.

It appears that improvement in this area has been patchy. Locally in LNR we have a workforce development manager specifically to work on this agenda. The emergence of the three increasingly strong Sector Skills Councils is helping. It is important both nationally and locally that this planning becomes seamless. The second wave ISTC and diagnostic procurements will make this even more essential.

In considering future demand, how should the effects of the following be taken into account:
— the increasing use of private providers of services

We are planning for the whole healthcare workforce and as such need to be aware of the workforce in all providers. This is not easy at a national level but can be achieved at a local level by establishing sustainable, supportive networks.

The NHS funds the pre-registration training of all non-medical professionals—wherever they end up working, so it is important that the needs of all healthcare providers are taken in account.

5.5 Workforce development plans must be dynamic and useful

5.5.1 Human resource strategies

The workforce plan needs to inform human resource strategies within organisations and across health communities. Producing and using well informed recruitment and retention and other employment strategies will enable workforce capacity and capability to be maximised. The experience in LNR is that there is still room for improvement.

How will the ability to meet demands be affected by:
— increasing international competition for staff

This should be viewed as an opportunity within healthcare in the UK being able to attract some expertise from elsewhere, while sharing our expertise with other countries. However it does need to be controlled so the flows either way do not destabilise the system either here or abroad. Despite this, it is essential that “first” jobs be protected for those who have trained in this country. The investment in that training is considerable especially for medical staff.

How will the ability to meet demand be affected by:
— Early Retirement

As was mentioned earlier, effort needs to be put into retaining those over 45. This may well be able to balance any losses coming through early retirement due to changes in pension arrangements.

To what extent can and should the demand be met for both clinical and managerial staff by:
— better retention

This is the key tool to securing adequate workforce capacity and capability. Modelling locally suggests that it is important to retain those over 45 by careful career planning. A further 15 years service from this group could significantly increase our capacity. Every effort should be made to ensure that the environment in which people work is the best possible through such initiatives such as “Improving Working Lives”, that the systems and processes function as efficiently as possible, and all the workforce have access to the training and development they need to do their job. With managerial staff it is clear they are often seen as an expendable group as each new change hits the NHS. This loss of expertise is devastating and should be halted.

To what extent can and should the demand be met for both clinical and managerial staff by:
— the recruitment of new staff in England

Mechanisms should be put in place to ensure UK graduates are given the first option at opportunities as the NHS/HEFCE has invested heavily in their training. There should be flexibility in the system to retain newly qualified staff where a short-term oversupply occurs eg Physiotherapy. This would prevent the boom and bust that has happened in the past.

To what extent can and should the demand be met for both clinical and managerial staff by:
— international recruitment
Where possible the UK should “grow its own” creating a workforce with the ethnic diversity of the people it serves. International recruitment is not a long-term sustainable solution.

5.5.2 Modernisation of the workforce with improved productivity.

It is clear that the traditional composition of the workforce will not meet the needs of patients. There are excellent examples where new roles have been developed and utilised with great effect. There is no point in promoting a new role or devising a new way of a team working if it is not going to improve patient care. The evidence for change must be clearly visible in workforce plans. The development of new roles needs to be within a national framework so that there is some consistency and to enable transferability. To capitalise on these changes and optimise workforce capacity and capability the systems and processes surrounding the delivery of care need to function as effectively as possible. A Whole Systems Modelling Project in LNR has been tackling this successfully.

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

This is one of the major tools to be used in order to deliver a future workforce fit for purpose. However it is clear we have to create sustainable roles within a clear framework. To improve the skills of existing staff there will need to be increased investment in Continuing Professional Development, Learning beyond registration and the development of non-professional staff. The composition of the workforce needs to change with a drive to develop more staff at the assistant practitioner level whether this is support to clinicians or to managers and also at advanced practitioner level to spread the work that was traditionally done by doctors.

5.5.3 Education Investment.

To be effective, workforce plans must drive educational investment. There is a much better alignment than prior to the existence of Workforce Development Confederations but there is still work to be done. This should reflect the needs of all groups not just those of the larger professions.

Balancing the needs of the future within the present day financial constraints is not easy. In the past ineffective workforce planning has resulted in inconsistent education commissioning. This has improved where intelligence has been shared effectively between national and local players. However there is still a clear tendency to create a boom or bust situation in workforce supply by making one off large-scale changes in commissioning decisions rather than making gradual evidence based alterations.

5.6 Be coherent at a local and national level

Workforce planning is not a rigorous scientific discipline and as such has been subject to criticism. There still remain considerable tension between the national and the local views. In terms of the medical workforce the numerical assessment of demand and supply at a national level has always occurred but this has not been echoed at a local level. However, non-medical workforce planning has been done relatively effectively at a local level but not echoed at a national level. The advent of the Workforce Review Team and the extension of their role to encompass non-medical staff have strengthened this. Now we need to strive for consistency of modelling at a local and national level with a clear feed and understanding between the two. It is also important to ensure that all impending changes are combined to give an overall workforce plan for the whole workforce.

6. Action Required to Improve the Effectiveness of Workforce Planning

6.1 Alignment with service planning

Continue to improve the alignment of service and workforce development planning. This can be achieved by ensuring workforce development planning and underpins the Integrated Service Improvement Programme (ISIP). This will also bring an alignment with the changes coming in healthcare through “Connecting for Health” and will enable health communities to demonstrate how they can achieve their objectives by maximising workforce capacity and capability. It will be important to demonstrate a change using consistent metrics such as costs of a unit of labour and labour productivity measures.

6.2 Alignment to Financial planning

The lack of alignment to financial planning must be addressed. The financial constraints must be seen as a lever to optimise workforce capacity and capability rather than a way to force workforce reductions. For example, it should focus attention on our proper use of internal flexible temporary workforce rather than our over reliance on agency staff.
6.3 External changes

There needs to be a regular review of those external changes that will affect the healthcare workforce. The impact of each change must be assessed and incorporated into revised workforce plans. Particular attention needs to be paid to technological changes in healthcare, areas of specific population growth and legal changes.

6.4 Competency based planning

Competency based workforce planning should be used wherever possible. This will become easier as new tools such as the electronic staff record (ESR) become available. The concept of the Skills Escalator should be demonstrable in all plans.

6.5 Integrated planning

Integrated workforce development planning across health and social care communities, and inclusive of the independent and private sectors, must improve despite the plurality of providers. The driver for this must be the white paper ‘Our care, our health, our say’. This will involve recognising the considerable shift of care from secondary to primary and community care.

6.6 Human resource strategies

Workforce development planning needs to be reflected in all national and local human resource strategies. The main strategies to achieve optimum workforce capacity should be to ‘grow our own’, improve retention of staff especially older staff, and ensure an excellent working environment.

6.7 New ways of working

The workforce needs to change to meet the needs of the patient with the development of new and innovative roles. The nature of this change needs to be in direct response to workforce plans. This needs to happen within a clear framework to ensure sustainability and transferability. These changes will need to be underpinned by an increased investment in training for all staff.

6.8 Education development

As the modernisation of the workforce takes place, so too will education need to evolve. The service, in collaboration with the professional bodies, needs to be brave enough to challenge traditional education pathways. For example, Health Visitors are required to train as a qualified nurse first and then complete a second education pathway. Is this necessary and can it be afforded?

6.9 National and local planning coherence

It is important to see an improvement in understanding and influence between national and local planning. It is also important for everyone to recognise the long-term nature of workforce planning and to prevent having large peaks and troughs in workforce supply.

How should planning be undertaken:

— To what extent should it centralised or decentralised?

Both are needed with very clear inter-connections allowing neither one to be dominant. There needs to be a consistency of modelling at a local and national level with a clear feed between the two. The local element of planning across organisations in health communities is essential if there is to be a coherent picture that supports ISIP and incorporates all providers. The output of that planning must influence national planning.

— How is flexibility to be ensured?

There needs to be meaningful dialogue between all the players. Where actions need to be taken—they are followed through. There needs to be the ability for scenario planning. The use of such tools as Whole Systems Modelling with clear links to service delivery are essential.

— What examples of good practice can be found in England and elsewhere

Good Practice examples from LNR:

— Workforce Development Plan for Leicestershire, Northamptonshire and Rutland 2005–10
— Leicestershire, Northamptonshire and Rutland Skills Escalator Resource
  http://www.lnrskillsescalator.nhs.uk/
— Report into Whole Systems Modelling Project in Leicestershire, Northamptonshire and Rutland

7. CONCLUSION

Workforce development planning has improved considerably. Further improvement can be made by:
— Creating clear partnerships between planners at national level, at health community level and within healthcare providers.
— Integrating workforce planning with all other planning.
— Taking positive action to optimise workforce capacity and capability.
— Increasing workforce development planning expertise at a national, health community and organisational level.

Trish Knight
Director of Workforce Development and Commissioning
14 March 2006

Evidence submitted by Professor Tony Butterworth, University of Lincoln (WP 16)

I welcome the opportunity of responding to this important enquiry. I wish to make some general observations on workforce needs and planning and some particular observations about emerging concerns relating to the educator workforce. I have confined my observations to these two areas but preface this with more general observations.

1. General observations

The previous “Boom and Bust” approached to workforce needs and planning has largely been resolved over the past five years. The establishment of a National Workforce Review Team www.healthcareworkforce.org.uk now provides a strategic oversight for workforce planning in England. This national oversight is important in relation to small workforce groups (eg in prosthetics) In parallel to this national oversight, the establishment of Workforce Development Confederations in 2002 raised the profile of more local workforce planning, which has continued into the present day (and eventual) Strategic Health Authorities. The dynamic of a national expert view combined with more local expertise has emerged as a sound and more sensitive model. The NHS is experiencing far reaching organisational change. It is vital that national strategic planning and more local workforce planning at SHA level is sustained and strengthened. It is likely that some of the professions have now reached a “steady state” in recruitment terms and the temptation therefore is to either reduce numbers or take one eye off the ball. It is imperative this does not happen or we will return to the boom or bust workforce planning of the 1980s and 90s which was disastrous.

2. Emerging policies and their effect on workforce planning

The present strong emphasis on a primary care based patient lead health system will require more innovative educational commissioned and workforce planning. It is the case that most professions gain their qualifications through educational experiences largely gathered in an acute hospital environment. Skills are acquired that may not be needed in the community setting. Ironically, most then are expensively re-trained to work in community and primary care settings. It would be logical and probably more cost effective to establish initial training programmes located within primary care/community settings and then train to specialise in more particular acute environments. This re-emphasis will be necessary if health care is to be effectively delivered within the primary healthcare setting and if the bulk of the workforce will work there. It would also help to acculturate the workforce and professions towards community based care.

3. Retention of staff

The greater part of the MPET Levy is spent on initial qualification programmes (with the exception of medicine and dentistry). If commissions are at a steady state then any residual funds should be used to develop staff through continuous professional development (CPD), thus encouraging them to stay in the health system. When funding is tight (as now) the first casualty is CPD. It may be that in nursing for example, the numbers of commissions should fall somewhat so that investment can be made by additionally developing the qualified workforce through a funding stream that is held centrally. Central funding is necessary so that it does not become a first casualty of employer savings at times of financial difficulty.
4. **Ageing workforce**

Evidence shows demographic change within the healthcare workforce. The ageing workforce in most professions is a matter of some concern. My own particular expertise rests with qualified staff who move into careers as educators and researchers. In relation to this, between 2002 and 2004 I led work for the Committee on Strategic Learning and Research (a high level committee of the Departments of Health and the Department for Education and Skills) www.stlarhr.org.uk which articulated these concerns and offered a series of recommendations. The committee should note that without a well found educator workforce the next generation of professionals cannot succeed. Two pieces of data make the point eloquently. The undergraduate medical student intake has increased by 40% since 2004. However the number of medical clinical lecturers in the same period has fallen by 17% www.chms.ac.uk. Nurses report that their university programmes hold a 28% educator workforce vacancy lasting for six months or more www.councilofdeans.org.uk. Although significant remedial action is being undertaken by UKCRC to address issues for researcher careers, educator careers are much less well articulated. Education is a significant activity for the NHS and it is estimated that as many as 300,000 staff are involved in education on a day to day basis. I would urge the Committee to investigate this element of the present workforce.

I would be more than happy to offer evidence in person to the Committee should they wish to explore these matters further. I have attached a copy of the StLar HR Strategic Report for reference.73

*Professor Tony Butterworth*
Directer, The Centre for Clinical and Academic Workforce Innovation
University of Lincoln
14 March 2006

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**Evidence submitted by Lincolnshire Health Community (WP 37)**

1. **Introduction**

The Health Select Committee is undertaking in inquiry into workforce planning, the terms of reference are *How effectively workforce planning, including clinical and managerial staff, has been undertaken and how it should be done in the future.* The Health Select Committee has asked specific questions and this response is structured around those areas.

2. **Background**

In April 2005 Trent SHA devolved responsibility of workforce development planning to its local health communities and integrated the existing Workforce Development Confederation into its Directorate of Strategic HR and formed a Multi-professional Deanery. The Lincolnshire Health Community developed the Lincolnshire Workforce Modernisation Service (LWMS) in order to carry out the devolved functions. LWMS is accountable to the Lincolnshire Workforce Modernisation Group (LWMG), which is made up of representatives of health and social care organisations and chaired by the Chief Executive lead for workforce across the Community. In 2004 LWMG produced a Workforce Strategy for 2005–10, a Business Plan for 2005–06, a Commissioning Plan and an Investment Plan. These documents are attached in order to provide additional background to our response.74 This response has been prepared and agreed by the LWMG.

3. **Response to Health Select Committee Questions**

3.1 In considering future demand, how should the effects of the following be taken into account:

— recent policy arrangements, including commissioning a patient-led NHS

In Lincolnshire workforce development planning and identifying demand is undertaken on a health and social care community basis, working with individual organisations but identifying need across organisational boundaries recognising that in a rural health community recruitment is from a limited pool and therefore the employment practices of individual organisations impact on one another. Over the past two years the approach to workforce development has been on a health community basis with demand being identified by strategic care group themes, ie long term conditions, integrated unscheduled care, etc Commissioning a patient-led NHS seems to reinforce organisational boundaries and for workforce development planning there is a need to work across health and social care communities.

— technology change

The Implications for the workforce of changes to service delivery as a result of technology change must be considered. The Integrated Service Improvement Programme focuses change programmes around people, process and technology. This should be embedded into planning processes.

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73 Not printed here.
74 Not printed here.
an aging population
Health and Social Care Communities must have detailed information on the health needs of its population and workforce planning should be integrated into the service and financial planning decisions being made to meet the population’s needs.

the increasing use of private providers of services
Local Health and Social Care Communities can work across organisational boundaries and should ensure they are identifying the workforce development needs of all employers. There will be significant benefits to employers if their employment practices complement each other and the ability to train professional staff and provide them with different practice learning experiences will benefit the workforce in the future.

3.2 How will the ability to meet demands be affected by:

financial constraints
The recent financial constraints within the Lincolnshire Health Community as a result of needing to achieve financial balance has meant workforce planning to reduce the workforce rather than increasing the workforce to meet nationally set workforce targets over the past couple of years. This change of approach can be demotivating for staff and does not reflect good planning at national and local level. There is much work that can and should be done about ensuring a more efficient and effective workforce and realising the benefits of pay reform and modernisation.

The current funding processes for education and training are not helpful and hinder the ability to plan for the workforce. There is a need for a longer-term planning framework and increased flexibility to train the workforce differently.

the European Working Time Directive
Although there are examples of good practice and innovative ways of working established to date in order to meet EWTD targets, more work is required commencing now to support the workforce for 2009. This has to link to training plans for the whole workforce and the need to use the Multi-Professional Education and Training levy in a more flexible way to support advanced and assistant practitioner roles.

increasing international competition for staff
This is a source of recruiting staff that needs to be controlled carefully at a national level in order to support the workforce in this country and other countries. However, it has value for individuals and employers and should continue.

early retirement
Local Health Communities will have detailed information on their staff and should workforce plan accordingly.

3.3 To what extent can and should the demand be met, for both clinical and managerial staff, by:

changing roles and improving the skills of existing staff
The Lincolnshire Health and Social Care Community’s current workforce planning is based entirely on the need to do this rather than recruiting new staff and the ability to move staff from secondary to primary care. However, this is only achievable if the MPET funding levy is available to support advanced practice, assistant practice and ensuring the workforce is able to access the skills and competency it needs from accessible quality education providers.

better retention
Workforce development for Lincolnshire will be planned and co-ordinated on a health community-wide basis and will support the vision outlined in the Lincolnshire Workforce Strategy document 2005–10. The workforce development plans will ensure:

(i) Collaborative working and workforce planning with employers across health and social care including the independent and voluntary sector.

(ii) The workforce capacity needed to deliver services.

(iii) Productivity and skill mix will increase to boost capacity.

(iv) Development of new roles and working differently.

(v) Innovative commissioning of training based on planned future need that supports new ways of working.

(vi) A competent, flexible workforce within a clear career framework.

(vii) Development of model employment practices that improve staff well-being and deliver better patient outcomes.

This recognises the need for model employment practice is a key element of planning the workforce.
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3.4 How should planning be undertaken:

— to what extent should it be centralised or decentralised

In order to ensure workforce planning integrates with service and financial planning it has to be decentralised to LHC level. However, it has to inform and complement the national planning processes and recognise workforce supply is a national and international tool.

— How is flexibility to be ensured

By ensuring flexible use of funding streams with clear monitoring and performance management systems.

4. Conclusion

The Lincolnshire Health and Social Care Community has responded positively to a devolved approach to workforce development planning and is working towards an integrated approach with service and financial planning across all organisations. It is recognised that there will need to be clear responsibilities for workforce at a national and SHA level and that there should be a partnership with LHCs. Workforce capacity and capability should be increased across all levels of the service. The key issues the Lincolnshire Health Community would wish the Health Select Committee to consider as part of this inquiry are:

— Increased flexibility in MPET funding in order to develop the whole workforce.
— Longer-term financial planning frameworks for workforce development.
— Increased knowledge of national processes and ability to influence decisions.

Lincolnshire Health Community
15 March 2006

Evidence submitted by the 5 London Strategic Health Authorities (WP 34)

How effectively workforce planning, including clinical and managerial staff, has been undertaken and how it should be done in the future?

1. Workforce planning is changing and developing. In 1999 the main emphasis was to derive robust numbers for pre-registration training in a financial growth environment. Now workforce planning has become a key component of capacity planning, local development planning (LDPs), financial balance planning and Integrated Service Improvement Planning (ISIPs) and is more integrated with the service and financial processes.

2. Workforce plans should encompass the short, medium and long term:

— a short term plan for an organisation would cover the next financial year assuring that the costs of substantive and temporary staff do not exceed the available budget and would identify the training and development needs of staff and a recruitment and retention policy for the year. Uncertainties on the available budget due to patient choice, practice-based commissioning, payment by results etc will mean that the workforce should be trained to be flexible.

— a medium term workforce plan for an organisation would cover the next two to three years and would cover the new roles, new ways of working required to meet the changing requirements of the service provision and affordability. This would also cover the traditional secondment training opportunities (eg health care assistants to nursing, health visitors, district nurses etc). Each organisation’s training plan would be derived from the short and medium term plans. Currently the secondment planning is quite effective (but threatened by the proposed cut in MPET allocations) whilst the planning for new roles is acknowledged as a requirement but some organisations are struggling. Benefits realisation of the pay modernisation initiatives could fall into this category.

— a longer term workforce plan for an organisation would cover four plus years ahead and would include the recruitment of newly qualified staff (to inform the commissioning of pre-registration students for nursing, allied health professionals, healthcare scientists etc), the identification of new
roles where training is not yet developed, planned major service reconfiguration and European working time directive (EWTD) implications. The effectiveness of these long term plans is not properly evaluated and may have been developed by a mix of local and national imperatives not always working in the same direction.

3. It has become clear that with the emphasis on new roles, new ways of working, skilling the unregistered workforce and changes in skill mix there will be a need to have a change in focus towards competency-based workforce planning. This will create the demand for a national data set of skills and competencies to be developed for all posts and used by all organisations providing health and social care.

4. Above all we need to be clear on what we are talking about when using the wide umbrella term of “workforce planning” and acknowledging that it is a wider role that estimating future pre-registration student numbers.

5. Several smaller healthcare scientist staff groups (eg cardiac physiologists) have been identified as key to meeting the access targets and also as having a high number of vacancies, particularly in London. MPET funding does not cover the commissioning and training of many of the more vulnerable of these staff groups so it has proved difficult to effectively manage the long term planning of future numbers.

In considering future demand, how should the effects of the following be taken into account:

recent policy announcements, including Commissioning a patient-led NHS

6. The government’s recent White Paper on Health (Our Health, Our Care, Our Say) placed heavy emphasis on the need for an integrated approach to the delivery of health and social care services. Currently, these two services are delivered in silos and focussed work on how to integrate the service/workforce planning of these two care sectors will need to be undertaken to ensure an efficient and streamlined workforce to deliver appropriate care. However the implications of the charging arrangements to patients needs to be resolved before further integration of service and workforce can be considered (Panorama 05.03.06)

7. In addition, over the past few years, the DH has been actively encouraging the participation of the Independent and the Voluntary Sector to deliver healthcare services. Careful consideration needs to be given on how to guarantee that the independent and voluntary sector participate in local planning processes, particularly in relation to the commissioning of pre-registration training places for healthcare professionals. Without the participation of these parties, any workforce plans developed will not be robust or comprehensive. Moreover, the contribution to training that these sectors will provide needs to be discussed and the impact on recruitment and retention for the NHS also needs to be considered.

8. Although the boundaries of the Primary Care Trusts will not change in London, there is still the imperative to save a large amount of management costs (approx £1 million per PCT) plus the future uncertainty surrounding the PCTs’ provider arms. These changes are making more complicated the planning of the community and primary care workforce in the London area.

Technological change

9. The pace of technological change presents two major challenges to the robust workforce planning and to the Education Commissioning process:

   (a) The impact on training for the current and potential workforce: technological advances may make the way healthcare services are delivered more efficient, but that relies upon the appropriate training of current staff and potential workforce to use the new technology.

   (b) In addition, technology has an impact on workforce demand: As a result of technology, the demand for certain areas of workforce will fall and requirements for other areas of expertise will rise. The workforce planning process must incorporate assumptions for these scenarios, which presents a substantial risk to robust planning due to the rate of technological change that the healthcare service is currently facing.

10. The need to re-shape organisations means a comprehensive data system and the ability to re-cut and drill down into the information is essential. This could be provided by the Electronic Staff Record (ESR) but is entirely dependent on the timeliness and quality of the data entered which will, in any case, only cover those staff employed by the NHS. The move towards competency-based workforce planning strengthens the case for a full integration between eKSF and ESR which is currently still being discussed. More human resources skilled in planning and better attention to quality control on areas such as coding would improve accuracy and overall be more cost-effective.
An ageing population

11. Workforce planning should be service driven and service plans would take into account the ageing population in terms of increasing lengths of stay (hospital) and increasing demands on eg services for long term conditions (primary care). Demand management becomes increasingly challenging with an older population and the emphasis on preventative resourcing as in “Our Health, Our Care, Our Say” would need to be increased.

12. In London an ageing population is not such as significant factor as in the country as a whole with the 65+ population increasing by 8% over the next 10 years compared with a predicted national increase of 20%. The impact of the Thames Gateway project, the opening of Heathrow Terminal 5 and the 2012 Olympics are likely to have a much greater effect. An ageing workforce may also have less of an impact than previously predicted if the NHS pension age rises and thus employees delay retirement.

13. Another demographic challenge particularly for London is its transient and diverse population. This has been explored in depth in the King’s Fund publications of “In Capital Health” December 2002 and “Trends in London’s NHS Workforce” March 2005. This is likely to have the following impact:

(a) workforce planning needs to incorporate what the impact of a more diverse customer-base will have on the workforce skills: language, access and healthcare needs of certain ethnicities and develop training appropriately

(b) The effect on recruitment and retention with the increase of the global job market.

(c) The workforce is also more transient in London than the rest of the country with high turnover, particularly among newly qualified healthcare professionals. This is unlikely to change and so needs to be built into workforce plans from the beginning.

(d) Organisations should plan for their workforce to reflect the diversity of their local population (which can be very varied in London) but some organisations now employ a workforce that is significantly more diverse than in the local area.

— the increasing use of private providers of services

14. Workforce planning for future professional training numbers without the baseline knowledge of current staff numbers outside of the NHS will be a significant challenge. The need to provide robust accurate data on needs to be explored through SLAs and confidentiality agreements.

How will the ability to meet demands be affected by:

Financial constraints

15. Over the past few years, the focus of workforce planning has been growth. Currently, the emphasis has switched to streamlining making efficiency or productivity gains within the workforce where possible to produce an affordable workforce capable of delivering the service targets.

16. This is will create a challenge to effective short, medium and long term workforce planning for the following reasons:

(a) The credibility of the long term workforce planning process: if workforce planning is seen as only short term and reactive rather than strategic, there will be no organisational imperative to develop medium or long term plans especially in times of financial constraint, when it is more important that proper workforce planning is undertaken to ensure the most efficient and effective workforce.

(b) Workforce planning is most effective as a long-term strategy that is re-evaluated on annual basis to ensure that the plan agreed still meets the current service needs. Reactive changes to the workforce plan will create more serious workforce issues in the future. An example of this would be reducing the training numbers in times of financial constraint without consideration of the impact on available staff at the appropriate grade this action will have in three years time.

(c) It is only by understanding the workforce and planning for future needs can an appropriate and effective workforce be developed: in times of financial constraint, workforce planning should become a priority as it can contribute to increases in productivity and the development of more effective skill-mixes to deliver the required services

17. a key objective must be much more effective alignment of workforce and financial planning, which has been very poor. We need to achieve a clearer correlation between delivering financial performance targets and investment in human resources.

the European Working Time Directive

18. EWTD 2004 has resulted in around 98% of junior doctors being able to work 56 hours a week or below as at September 2005. This was achieved predominantly by employing more doctors, most of whom were entirely Trust funded, an expensive option and this will not be possible for the 2009 EWTD requirements both in terms of availability and affordability. Trusts need to plan now how their service can be changed, whether other staff could do work currently done by juniors and most importantly what juniors
have to do to fulfil their training requirements, taking MMC into account. New roles such as care practitioners are one option, but they require a workforce to be trained before 2009, the education developed and commissioned and the new roles to be embedded in the culture of the organisations.

**increasing international competition for staff**

19. Recruiting from abroad is not a cheap or long-term option, and Trusts and PCTs need to be sure they are prepared to offer the support and mentorship needed for international recruits. The market within Europe remains fluid and a lot will be short term and based on language competence, as well as clinical ability. There is some evidence that the US is now wanting to attract staff from Europe. However, many of these will not want to relocate permanently, but rather to gain experience abroad and then return to their own country. Redesigning roles and services slanted towards the UK labour market is a more sustainable option.

**early retirement**

20. This was thought to be a particular problem for the consultant workforce in 1999 when the previous Health Select Committee report was published. The number of doctors taking early retirement has not significantly affected the provision of service but the introduction of job plans and annual appraisals give the trusts and opportunity to discuss retirement plans with the consultants and plan ahead, considering step down and other pre-retirement opportunities. As the pension age in the UK rises and the NHS arrangements are re-negotiated accordingly the extent of this problem is likely to diminish.

**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**

21. This is crucial. Pay modernisation has allowed Trusts the opportunities to do this and key to the benefits realisation of such is that roles are flexed to reflect developing need and staff trained accordingly. The need for this to happen strengthens the argument for competency-based planning and the need to develop skills in this area in every organisation. This will, of course, not meet the total demand as retirements and other leavers will leave a gap that can only be filled by new entrants to the workforce.

**better retention**

22. London has always had a younger more mobile workforce which reflects the capital’s major training role for the country, and turnover is at least 30% higher than the national average. Although turnover has reduced over the past five years and may further reduce with initiatives like Improving Working Lives, it is important to continue to plan for a realistic level of turnover.

23. However, better retention will support a reduction in staff costs, as it has been estimated that it costs organisations around £10,000 to replace each staff member. This accounts for recruitment costs (which will fall with the increased use of e-recruitment) and loss of productivity (which varies with the reason for replacement). Trusts will reap the benefits of AfC only if they properly utilise the KSF framework to develop the skills of their staff and move them up the career escalator. Within a robust workforce planning process, this will support organisations to retain their staff and provide a workforce that is more competent to deliver the required service.

**the recruitment of new staff in England**

24. It is vital that a review of the way MPET monies are spent is made to ensure that the NHS is not wasting money training staff in inappropriate areas. Robust workforce planning will ensure that Commissioners will know exactly which areas to focus training monies on. If workforce plans show that new staff are required, however, where demand cannot be met by retention or changing roles then recruitment of new staff from the UK is the next best option as their employment has more longevity and is an investment in the health labour market of the future.

**international recruitment**

25. Whilst NHS organisations struggle to achieve financial balance and are planning in some cases to make staff redundant it seems ill-considered to be recruiting from abroad other than in exceptional circumstances.
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**How should planning be undertaken**

To what extent should it centralised or decentralised?

26. It depends on which branch of workforce planning we are talking about (see paragraph 2). It would clearly be inappropriate for any short term workforce planning to take place outside the employing organisation (or perhaps the local health economy). Medium term plans (for example local delivery plans) would be done at a local level as would some longer term plans (eg major service changes).

27. If we are only talking about pre-registration training numbers then a centralisation of workforce planning could mean a return to the way workforce planning was undertaken in the 1990’s, when the numbers that were produced did not reflect the local reality of what was actually needed. For workforce planning to be an effective part of the planning process, considerable local engagement will need to be retained to ensure ownership of the process at a local level in order to keep the numbers real. For London, for instance, central planning indicated a sufficiency of midwives throughout the country when local knowledge could demonstrate a severe shortage of midwives in the capital. Similarly the acknowledged shortage of radiographers was less severe in some areas of the country. London can demonstrate that the problems, challenges and opportunities in the capital are different from the rest of the country and need to be considered at every level.

28. However, a central overview of the process is still required to ensure that all areas of the workforce are incorporated into the workforce planning process and to continue to assess the need for medical students. Small specialities are in danger of being ignored in a purely de-centralised process. Moreover, it does not make economic sense for every sector to be planning for groups of staff that may only number up to 10 people in any one region of the country. Planning is most effective if done for a local health economy ie a group of organisations or a region/sector. This means there is a balance between central/de-centalisation and facilitates workforce intelligence being shared across organisations with a common local interest.

29. Medical and non-medical workforce planning have not yet been successfully integrated as medical workforce planning continues to be done on a national basis and is still very much based on a growth model and on replacing existing consultant posts when they become vacant. This will need to change as other roles replace posts that are currently occupied by doctors and so more local input to an integrated long term workforce plan is required. The skills to achieve these long term plans also need to be developed at a local level.

30. At regional level we welcome the decision to make strategic workforce development a key role for the new SHAs. That will allow workforce planning to be fully integrated with other aspects of strategic planning, performance monitoring and system management.

**How is flexibility to be ensured?**

31. Flexibility in the plans will only be ensured via a framework for stakeholder engagement: scenarios should be developed and discussed with employers’ through stakeholder boards. Any assumptions made on behalf of stakeholders should be explicit in order to ensure a transparent process and provide greater opportunity for proper discussion the merits of the scenario put forward. Agreement should be reached with these boards, with the possibility of amendments to the figures following discussions, to guarantee a robust set of workforce demand and supply figures.

30. Competency workforce planning can also be used as a tool to help ensure a flexible workforce—a robust, consistent, up-to-date database for all health and social care workers would be required (plus a change in NHS culture) to enable flexibility to work effectively.

**What examples of good practice can be found in England and elsewhere?**

32. The following are a selection:

(a) Commissioning of workforce planning courses focussed at service and other general managers to increase the understanding of the impact of workforce planning on service delivery and financial balance.

(b) The development of education courses to develop a cohort of workforce planning specialists

(c) The inclusion of employers to sign-off all workforce planning numbers to ensure their engagement in the workforce planning process.

(d) The development of a stakeholder framework to ensure local engagement in workforce planning which will produce a more robust plan.

(e) The introduction of Workforce Information Networks locally, regionally and nationally for workforce leads to facilitate discussion and share best-practice on the workforce planning

(f) The production of annual workforce reports to enable local employers to understand the impact workforce planning has had on the sector and recognise the achievements of the workforce planning process.
(g) The establishment of focused project teams to look at certain shortage staff groups (e.g. radiography workforce, mental health workforce, midwifery) where the design of new roles, new ways of working together with a concerted effort on recruitment and retention has considerably improved the workforce available for these services.

(h) National Workforce Projects providing a centre of workforce planning expertise with funds to enable projects to go forward.

The 5 London Strategic Health Authorities

March 2006

Evidence submitted by Merlin (WP 31)

BACKGROUND

Merlin is the only UK specialist agency, which responds worldwide with vital healthcare and medical relief for vulnerable people caught up in natural disasters, conflict, disease and health system collapse. Merlin’s aim is to ensure that vulnerable people who are excluded from exercising their right to health have equitable access to appropriate and effective healthcare.

This aim is inspired and underpinned by the World Health Organisation (WHO) declaration75 that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination of race, religion, political belief, economic or social condition”. In support of this aim, Merlin works in partnership with global, national and local health agencies and communities to strengthen health systems and build community resilience to better prevent, mitigate and respond to health outcomes.

Many countries are unable to provide even the most basic package of primary health services and information essential to an individual’s well being. The rise in the burden of communicable disease combined with chronic under investment in health systems means that many countries face acute health systems collapse. This situation is exacerbated in countries where governments lack the capacity or political will to deliver basic health services. These fragile states account for 15% of the world population.

Building and strengthening health systems is critical to achieving the Millennium Development Goals (MDGs).76 The lack of human resources for health is one of the most serious constraints to achieving the health MDGs. In Sub Sahara Africa, six out of 10 women still deliver a baby with no skilled birth attendant.77 The current crisis in human resources is characterised by growing inequities in health service delivery; poor staff morale and quality of care, inadequate investment in staff training and development and decreasing staffing levels due to the high burden of communicable disease (notably HIV/AIDS), displacement through conflict and migration.

The NHS can make an important contribution to strengthening human resources in health and there are already a number of mechanisms in place that encourage links78 between Primary Care Trusts and programmes in developing countries. This submission to the Health Select Committee covers International recruitment and improving the skills of existing staff.

INTERNATIONAL RECRUITMENT

Migration of health workers from developing countries is a key aspect of the current crisis. It is important to recognise that while each individual has a right to seek employment and secure better wages and opportunities overseas, there are additional “push” factors at play that lead to higher than normal levels of migration in developing countries. The NHS has faced criticism for its use of recruitment agencies that have targeted staff in already resource poor countries, contributing to “brain drain”. Merlin welcomes the NHS Code of Practice for International Recruitment aimed at stopping these recruitment activities. It is essential that this Code is properly implemented and adhered to and that the NHS is mindful that not all commercial recruitment agencies comply with that Code.

There is a fine balance to be struck: using training and work opportunities abroad can help transfer skills and build capacity without draining poor countries of essential human resources. The NHS has clearly benefited from the skills of overseas health workers and should be encouraged to seek innovative solutions in this area: schemes to enable overseas nurses and medical students to train in the UK at lower fees and return home, could be piloted with government support, benefitting both NHS and national health systems.

75 As reflected in the WHO constitution (1946), Alma Ata Declaration (1976) and World Health Assembly (1998).
76 A set of eight international development goals for 2015, adopted by the international community in the UN Millennium Declaration in September 2000. They are: Eradicate extreme poverty and hunger; Achieve universal primary education; Promote gender equality and empower women; Reduce child mortality; Improve maternal health; Combat HIV and AIDS, malaria and other diseases; Ensure environmental sustainability; Develop a global partnership for development.
77 Health in the Millennium Development Goals, WHO 2005.
78 www.thet.org.uk
IMPROVING THE SKILLS OF STAFF

The publication of the International Humanitarian and Health Work toolkit79 by the Department of Health February 2005 reflects a clear change in policy toward strengthening the capacity and capability of the NHS to assist with international development and humanitarian emergencies. It also represents a further sea change in its recognition of overseas work as adding value to the skills and professional development of clinical and managerial staff and to the NHS as a whole.

However, despite policy guidance to this effect to Trust Managers, information does not seem to be filtering down and there is limited understanding amongst staff about the benefits of working overseas and the opportunities available to them. The guidance although informative, clearly places the onus on the individual to initiate and pursue opportunities overseas with NGOs and professional bodies. Staff may be required to use annual leave entitlement which will preclude many from applying. Secondment opportunities and career breaks are not formalised across the NHS and there are no assurances about continuity of employment. While Merlin fully recognises the obstacles to releasing staff from the NHS, the policies are already in place; it is roadmap of how to get there that is lacking. Merlin’s recent experiences following the Earthquake in Pakistan and the Tsunami demonstrate that there is a clear willingness to provide assistance but no advice on how to act (particularly given the immediacy of the need). A formal sabbatical system could be introduced, enabling professional and personal development.

Critically, information is also lacking for staff about the personal and professional benefits derived from working overseas. Increased confidence gained from working in a challenging environment, greater awareness and understanding of cross cultural issues, management issues in a resource constrained environment and disease associated with poverty are aspects that are not necessarily available to all in the UK.

Merlin
March 2006

Evidence submitted by NHS Employers (WP 29)

INTRODUCTION

1. NHS Employers welcomes the Committee’s inquiry into the workforce needs and planning for the health service and the opportunity to present evidence on this topic. If the NHS is to achieve the targets it has been set, it will need to ensure that it can recruit, retain and utilise its staff effectively. Improved workforce planning has a key role to play in helping to achieve this.

2. NHS Employers represents employers in the NHS and gives them an independent voice on workforce matters. NHS Employers welcomes the opportunity to comment on NHS workforce planning issues and highlight the work we have undertaken in this area. NHS Employers is part of the NHS Confederation.

3. The NHS Confederation is a membership body that represents over 93% of all statutory NHS organisations across the UK. Its role is to provide a voice for the management of the NHS and represent the interests of NHS organisations. It is independent of the UK government but works closely with the Department of Health and the devolved administrations.

IN CONSIDERING FUTURE DEMAND, HOW SHOULD THE EFFECTS OF THE FOLLOWING BE TAKEN INTO ACCOUNT?

Recent policy announcements, including Commissioning a patient-led NHS

4. Commissioning a Patient Led NHS will lead to a reduction in management roles at SHA and PCT level. It will also however require an expansion of the commissioning role as the result of Practice Based Commissioning. This is currently an underdeveloped area. Delivering the new NHS will also require managerial staff with the right mix of skills for a more pluralistic environment with an increased need for effective commissioning and strategic management of the system. NHS Employers has helped develop an Executive Redeployment Pool to ensure the NHS can retain skilled and experienced staff in a time of organisational change.

5. The most important recent policy announcement with significant implications for workforce planning in the NHS is the White Paper “Our Health, Our Care, Our Say”. This sets out a new direction for NHS services which will require a shift of the NHS workforce into community settings as well as a range of other workforce changes such as an expansion of numbers of staff working in public health and new roles such as personal health trainers and care navigators.

6. Most importantly it will require an increased focus on planning of the primary care workforce. In particular there are plans to increase the number of general practitioners in deprived areas, create more GPs with a special interest and nurse practitioners working in primary care.

7. In the medium term the White Paper also calls for the shift of a range of specialities from hospital outpatients to delivery in community based facilities. This will require workforce changes to support this shift with a mix of new roles and relocation of existing staff. For instance, it is suggested that consultants may increasingly work outside hospitals in order to deliver a more accessible service.

8. The White Paper also suggests that there needs to be greater integration of the health and social care workforce to create integrated teams and in some areas new job roles such as community based support workers in mental health and elderly care. This will require greater integration of planning of the health and social care workforce. NHS Employers will be involved in taking work forward in this area.

9. In the area of learning disability local authorities are now taking the lead role but there continue to be shortages of key staff and demand is likely to increase.

10. In some areas of mental health there are plans for expansion such as Support Time and Recovery staff and graduate mental health support workers. In addition, the Mental Health Act when passed will require an expansion of the workforce to support the new Mental Health Tribunal system. The “New Ways of Working” initiative in mental health will increase demands for a range of staff in this sector.

11. The Government envisages an increasing role for non-NHS providers including new social enterprises, existing Independent Sector Treatment Centres and nursing care home providers as well as the voluntary sector. Workforce planning will need to include the growing workforce of these employers. It should also incorporate the workforce of private contractors.

12. The White Paper suggests that patients will increasingly take on roles in self care with assistance from the Expert Patients Programme. The NHS will also draw on the contribution of volunteers.

Priority areas

13. There is a case for increasing staff numbers in a number of areas in order to ensure that the NHS can achieve the targets it has been set. In the short term these areas, based on information from workforce planners and our members, include:

- Specialist nursing areas such as school nursing, community matrons, mental health and also for advanced practitioners and health care support workers.
- Healthcare scientists across most of the diagnostic disciplines. Work by the diagnostic Care Workforce Group indicates shortages of up to 30% in this area with key bottlenecks in imaging/radiography and biomedical scientists in pathology. Solving these shortages will be key to achieving the 18 week target.
- Allied health professionals especially in radiography, occupational therapy and mental health (eg applied psychologists) and for the new talking therapists.
- Emergency care practitioners in accident and emergency and ambulance services. National standards could usefully be developed for these roles.
- GPs, especially in underprovided areas. Current plans are for a 3.5% increase GP numbers.

14. In order to deliver training, the NHS needs educators. NHS Employers is concerned that there appears to be a growing shortage of educators in a number of the health related professions. The Council of Heads of Medical schools cited in its 2005 survey of the academic workforce related to medicine that despite a 40% increase in the number of medical students the number of clinical teachers has declined by 17%. In addition, the present educator workforce is ageing. A UKRC report on this issue is expected in April. This group of staff are employed in part of the university as well as the health system.

Technological change

15. Technological change in healthcare is interwoven with the issue of workforce change. Technological advances enable:

- services to be redesigned. For example, the Picture Archiving System (PACS) in radiography allows for clinical staff to have speedier access to X-rays in a more useable form. This has enabled those areas which have adopted this technology to dramatically improve their processing speeds;
- substitution of technology for human intervention and new drugs which can reduce the need for surgical intervention;
- the use of handheld devices to assess care needs;
- reduction in errors and increasing safety; and
- greater use of telemedicine to provide care remotely and telecaring to provide more effective home based care.

16. There will need to be increased investment in staff training to make the most of IT investment in the “Connecting for Health Programme” including Choose and Book.
17. The traditional NHS approach has tended to “add on” technology to existing work organisation and system design. To fully realise benefits the NHS must integrate new technology into service redesign. Investment in technology can assist in improving productivity as has been shown by the use the PACs.

An ageing population

18. The Wanless Review indicated that the ageing of the population will lead to an increased demand for health and social care services. Particular groups of the isolated elderly will continue to be a major focus for NHS and social. Pharmaceutical advances are likely to allow for supported home living rather than reducing overall demand on the NHS.

19. Assessments by the Clinical Workforce Advisory Groups indicate that there will increased demands for specialist staff in geriatrics, mental health for older people and in particular for physiotherapy as the incidence of arthritis grows. It is widely anticipated that this demand will increasingly be for rehabilitation, community and home based support services rather than in hospitals.

The increasing use of private providers of services

20. The growing use of private providers in the NHS means that workforce planning needs to be properly integrated to include all providers.

21. There have been concerns over the impact of first wave ISTCs on training. NHS Employers and the Department of Health have developed new arrangements for ISTCs in Wave 2. ISTCs will be required to provide training across the full range of clinical services they provide for the NHS. This includes not only medical training, but other clinical training such as nurse or AHP training. ISTCs may also be required to provide training in non-clinical skills such as the management of patient flows, outcome measurement and audit.

22. The NHS provides support for education and training through the Multi Professional Education and Training Levy (MPET). This includes defined support for the salaries and bursaries of trainees, including a contribution to the salaries and study leave of junior doctors in training. MPET also includes a contribution towards the costs of the training infrastructure for undergraduate medical education called the Service Increment for Training (SIFT). ISTCs will be entitled to a share of these funds which are allocated by SHAs annually to take account of planned training loads.

How will the ability to meet demands be affected by:

Financial constraints

23. There are indications that the current financial challenges facing the NHS are having a significant impact on decisions around training. It appears that some SHAs have reduced commissions and that the Deaneries have also been asked to prepare for a funding reduction. In addition, many NHS employers are operating vacancy freezes which are affecting the ability of recently qualified staff to find jobs. In some areas employers are cutting entry level posts as part of local cost improvement programmes.

24. NHS Employers believes that there is a need for stability in funding for training. We would not support hasty reductions in training commissions or cutbacks in post entry training budgets. Investment and expansion should be focussed on service priority areas. Overall spending levels on education should be protected where possible.

The European Working Time Directive

25. The NHS has successfully implemented the first step of ensuring that doctors in training comply with the European Working Time Directive.

26. By 2009 the NHS will need to comply fully with the provisions of the Directive. It could reduce the availability of junior doctor time by up to 14%. EWTD targets in 2004 were met with the aid of considerable additional funding; however, the 2009 48-hour target must be achieved with no additional central funding. The “Hospital at Night” model will need to be extended. This could also be tackled by role redesign eg substituting other practitioner for junior doctors and by rationalisation of services across local networks.

Increasing international competition for staff

27. There is some evidence that the UK may face increasing international competition for staff. For example, the USA and Australia are both seeking to import labour into their health systems and offer more competitive salaries. Due to the projected increases in supply of UK and nursing and medical staff this should not be a serious problem. However it may have an impact if experienced staff are aggressively “poached” from the United Kingdom.
Early retirement

28. The NHS workforce is older than the workforce in the economy as a whole. In some sectors, notably GPs and community nurses, substantial numbers of staff are within five years of their retirement age. As a result retirements could increase substantially in the next 10 years. The average retirement age is currently 63 and the NHS Pension scheme review is aimed at ensuring that the NHS can retain its older workforce and attract new recruits.

29. NHS Employers’ age diversity team assists the NHS in preparing for age legislation and take steps to address workforce capacity in the light of demographic change. The emphasis is on ensuring that the NHS remains attractive to younger people and to those for whom we can offer a second career, as well as putting energy into retaining our current workforce. Later this year we will have tools to support employers and staff “Returning to Work, Working Longer, and Working Healthier” and another resource pack on “Extended Working”.

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

30. NHS employers need to develop a consensus on what roles they envisage they will need in future and have a dialogue with all relevant stakeholders about the nature of job roles that will be needed. NHS Employers has recently initiated discussions with key stakeholders around the issues arising for the medical workforce from Modernising Medical Careers. We are also examining a number of workforce planning issues for the physiotherapy workforce.

31. Role redesign and expansion of roles of junior staff has a key role in helping the service to expand staffing capacity. The new Agenda for Change job evaluation system should facilitate this. The “Skills Escalator” will allow staff to progress through the “Knowledge and Skills Framework” to fill their potential.

32. One key focus at present is redesign of job roles eg to help achieve the 18-week target. The “Productive Time Project” and “High Impact Changes” will have a continuing impact here as will roll out of job redesign under Agenda for Change.

33. NHS Employers is involved in a number of projects on role redesign through our Large Scale Workforce Change Team. For example, a project to develop a midwifery support worker role has developed trained support workers in maternity teams. The aim was to release highly skilled midwifery time from duties such as administration. This enabled the freeing up of up to 64% of midwifery time.

34. Through its Agenda for Change benefits realisation team NHS Employers promotes innovative approaches to role redesign and use of staff in new job roles. Since the demise of the Modernisation Agency there is currently a wide range of bodies involved in this area and there is a case for systematic evaluation of different approaches to ensure there is a focus on those providing the most benefit.

35. The pressure on the service to deliver against targets and ready availability of recruits has led to a focus on filling current posts rather than redesigning roles. To deliver the productivity improvements that are now required it will be necessary to take a more comprehensive approach to role redesign.

Better retention

36. The NHS has improved its retention of existing staff across a range of disciplines since 1997. As a result vacancy rates for almost all staff groups have fallen. Existing data is limited but continue to show that wastage rates have fallen. When NHS staff change jobs they tend to do so within the NHS and the loss of staff to non-NHS employers is around 9–10%.

37. The Agenda for Change pay structure provides better opportunities for pay progression and this should help to improve retention. NHS Employers sponsors work in a range of areas which are designed to improve retention eg the Improving Working Lives initiative.

38. The Improving Working Lives programme, which was first rolled out to the service in November 2000, has successfully raised the profile of issues such as childcare, flexible working and work life balance with all trusts achieving Practice status by late 2003 and on target to achieve Practice Plus by May 2006. Both the annual Staff Survey and evidence from the Royal College of Nursing indicate that staff have chosen to stay in the service because of the introduction of these policies. This work is due to be mainstreamed across the service through the HR Balanced Scorecard during 2006–07.

39. NHS Employers is addressing the key issues of stress and bullying identified in the 2005 Staff Survey and is working with NHS trusts and the Health and Safety Executive to develop tools and interventions for use by the service in reducing the causes of stress and the incidence of bullying. Alongside this we are also working with the HSE and DWP on improving rehabilitation for long term sick staff and improving manual handling across the service in order to reduce the current high rate of accidents and improve upon the current ill health retirement rate.
The recruitment of new staff in England

From undersupply to oversupply?

40. The Government targets for increasing the number of consultants and GPs in the NHS have generally been achieved or will be by 2008. There is however a requirement to expand the medical workforce in some areas of care according to the work of the Clinical Workforce Group.

41. Historically the UK medical training system has tended to undersupply doctors. From 2005 onwards this picture could start to change as the expanded training commissions from 1997 start to produce new graduates. National Training Numbers have not increased to keep pace with this growth. In some areas of the country however there continue to be staff shortages and some specialties continue to face recruitment problems.

42. The expansion in medical school places since 1997 means that we are now moving to a scenario of potential oversupply of doctors compared to the number of planned posts. NHS Employers estimates that annual “oversupply” could rise from 7 to 12% by 2009 based on existing models of care and rates of retirement.

43. NHS Employers believes there now needs to be an assessment of where the increased number of medical staff can best be deployed. New patterns of care and organisation of services mean that the traditional models may no longer serve the needs of the NHS. NHS Employers is in discussion with the Royal Colleges and other stakeholders on deployment of doctors in a way which is more suited to the needs of the NHS.

44. The new Modernising Medical Careers training framework represents a shift in the nature of medical training which provides new opportunities to change the role of hospital doctors. The expansion of primary care also requires new thinking about the development of the GP role and the range of work carried out outside hospitals.

45. NHS Employers believe there is a case for planning for a modest oversupply of doctors and other staff as this will enable some greater choice for recruitment and greater flexibility in deploying staff. Training also needs to be kept under review to enhance flexibility. The NHS should seek to respond to the changing expectations of employees.

46. The system for National Training Numbers provides a useful system of matching supply to demand but may need to be reviewed. Employers need to work more closely with deaneries to match supply and demand.

47. For other staff, the current recruitment and retention position is an equally complex one. For example, in areas such as physiotherapy, oversupply at entry level may be a product of lack of headroom at higher levels. In addition, if the NHS reduces training commissions for physiotherapy now this may lead to problems in three to five years when demand will increase for their services due to an ageing population. There continue to be shortages of nurses in areas such as London, and of specialist nurses, despite an overall increase in students. There continue to be shortages for some non clinical groups and training paths need to be developed for support worker roles using the skills escalator to fill gaps at higher levels.

48. The Agenda for Change pay system offers more competitive salaries and better opportunities for pay progression. Currently the NHS is successful in attracting applicants for most areas of work but there are problems in some key specialist areas. The increased expenditure on NHS pay has enabled the NHS to tackle long standing problems of recruitment.

49. In addition, there are particular problems in London. The high cost of living in the capital has a direct impact on the ability of employers to recruit and retain staff. The new arrangements for London weighting under Agenda for Change should have a positive impact but need to be kept under review. Employers are also seeking to draw more effectively on local communities into their workforce.

50. NHS Employers is responsible for a number of services which directly assist the NHS in recruitment including the NHS Jobs website for online recruitment. This enables the NHS to offer a single cost effective and easy to use online resource to applicants. It has also produced cost savings for the NHS. NHS Employers operates the NHS Careers service and a range of others including the NHS Housing Service.

51. One of the themes of NHS Employers Positively Diverse programme is to seek to ensure that the NHS draws on the widest possible pool of applicants including black and ethnic minority young people who are a growing part of the labour market.

International recruitment

52. The NHS has had a historical reliance on overseas medical staff due to undersupply in the UK. Overseas doctors have played a key role in the NHS. More recently the increase in overseas nursing numbers has allowed the NHS to expand its services in the short term. The UK is now moving to a position where it may have sufficient UK graduates to meet its needs though there will continue to be some areas where overseas recruitment remains necessary.
53. The recently introduced Code of Practice on international recruitment promotes ethical recruitment and prohibits active recruitment in developing countries. It also applies to nurse agencies used by the NHS.

54. NHS Employers currently offers advice and support to employers where they recruit overseas. In some areas overseas staff will continue to play a major role and it is likely that there will continue to be a flow of EU nationals into the UK. There has been a change in policy in this area as part of new Home Office migration policy.

55. On 7 March 2006 the Department of Health announced changes to the immigration rules for postgraduate doctors and dentists. The changes, which will come into effect shortly, mean that all doctors and dentists who wish to work in the UK from outside the European Union will need to meet the requirements of an employment category, such as the work permit provisions.

56. In future, any NHS trust wishing to employ a doctor or dentist from outside the EU will have to prove that a “home-grown” doctor cannot fill the vacant post. Entry from EU countries is not affected and some entry of overseas staff will still be permitted.

**How Should Planning be Undertaken?**

13. To what extent should it centralised or decentralised?

57. Workforce planning in a service as complex as the NHS needs to have both a central focus in order to ensure the service has the right numbers of staff and be decentralised in operation so that workforce planning responds to the needs of individual employers. There has been a tendency to alternate between advocating localised and more centralised systems when the system needs to combine both elements.

58. The current structure of workforce planning emerged following the implementation of the “Workforce of all the Talents”. The NHS Confederation believes that the new framework is based on the right principles and that Workforce Development Confederations were a step forward compared to previous arrangements, though operational success varied. NHS Employers supports the integration of WDC with SHA and in most cases that is the model utilised.

59. A growing number of foundation trusts are questioning whether Workforce Development Confederations/Directorates are adding value to their workforce planning activities. The Foundation Trust Network (hosted by the NHS Confederation) is currently exploring with its members alternative models which give greater scope for Foundation Trusts to develop appropriate contracting arrangements within an agreed national framework.

60. There will continue to be a need for national, area and individual employer roles in workforce planning. At national level the NHS needs to take a view on overall levels of training commissions in order to ensure the NHS has sufficient staff to meet its targets. This will have to give a “global overview” and can only be indicative.

61. In addition, for some smaller professional groups there is a strong case for planning and commissioning at national level as numbers of staff in some groups are very small. SHAs and PCTs should coordinate approaches across the health economy and link planning by the NHS with educational bodies, Deaneries and non NHS employers.

62. Individual employers have a responsibility to draw up workforce plans for their own needs taking into account wider needs and linking with other partners. This should take account of the health economy and of national targets. It should be linked to Integrated Service Improvement Plans. Commissioning arrangements with higher education will best be developed at local level or via existing mechanisms for medical and nursing staff.

63. NHS Employers welcomes the work of the Workforce Review Team in providing expert data analysis to inform workforce planning at national and SHA level. This also needs to inform workforce planning by NHS trusts. The Electronic Staff Record should provide a useful information resource.

64. There needs to be better coordination between overall priorities and local commissioning. NHS Employers is involved in the National Workforce Board but closer links need to be developed at appropriate levels with employers.

**How is flexibility to be ensured?**

65. There is a fundamental challenge in NHS workforce planning. It is extremely difficult to ensure that the type of staff required in future will be commissioned effectively. The time lag between commissioning of training places and output of trained staff is fairly lengthy (up to seven years for a nurse and fifteen for a doctor). It is very hard to match this to future demand for the types of healthcare that will be needed. Government policy also changes frequently and this can influence demands for staff. Predicting future demand is a complex but necessary task to ensure that tomorrow’s healthcare professionals fit tomorrow’s service demands.

66. As has recently been pointed out by a HR Director in response to our consultation on this topic:
“The Holy Grail of workforce planning is seamless integration with service and financial planning. Sadly that has often proved elusive, mainly because of the different time frames within which each element functions. For example, the current output from our nursing schools relates to decisions made at least five years ago and in medicine the lead time is closer to 10 years; service and financial planning operate on a maximum three-year time span. Therefore central and local planning is in a dynamic relationship.”

What examples of good practice can be found in England and elsewhere?

67. NHS Employers is not directly responsible for workforce planning and so does not collect data on good practice in this area. We would refer the committee to evidence submitted by the workforce planners group and the Department of Health.

OTHER COMMENTS

68. NHS Employers would suggest that the committee may like to consider some of the following additional issues:

— Curricula for most types of NHS course are largely determined by professional bodies or higher education institutions. There needs to be more dialogue between the service and these bodies to ensure that curricula reflect the needs of the service. NHS Employers is currently working with the Professional Medical Education and Training Board on a concordat on these issues.

— Training and succession planning for managers have historically been neglected though there are now some innovative schemes in place, for example, management education initiatives such as the General and Human Resource schemes. NHS managers do a complex and difficult task in a highly challenging environment. The NHS needs to support and promote the set of skills that will be needed in the new NHS.

NHS Employers
March 2006

Evidence submitted by NHS Partners Network (WP 43)

KEY POINTS

— The NHS Partners Network is an alliance of independent healthcare organisations—commercial and not-for-profit—which provide diagnosis, treatment and care for NHS patients through the Department of Health’s procurement programmes.

— Our centres have performed almost 200,000 elective and diagnostic procedures for the NHS since the Government launched its programme in 2003.

— The main function of ISTCs is to provide high quality diagnostic and elective surgery procedures for NHS patients and, by increasing available capacity, provide greater choice for NHS patients.

— Workforce planning would be better done if the total need of NHS patients was considered not just traditional NHS providers.

— Workforce planning should be based on the business expectations of commissioners and not on the views of the Royal Colleges and providers.

— We would also like to see a level playing field for ISTCs regarding the use of foreign registered specialists who are able to work in the NHS but not in ISTCs.

— For the NHS reforms to work, there is a need to remove additionality requirements and introduce a free labour market.

— The recruitment and training of local NHS staff for ISTCs workforce needs will have a positive impact on staffing knowledge and skills and benefit traditional NHS providers when they return to work.

— ISTCs can help meet the demand for workforce through the training they can offer their staff thereby improving skill levels.

INTRODUCTION

1. The NHS Partners Network is an alliance of independent healthcare organisations—commercial and not-for-profit—which provide diagnosis, treatment and care for NHS patients through the Department of Health’s procurement programmes.

2. Our members are: Alliance Medical, BMI Healthcare, BUPA, Capio, Clinicenta, Mercury Health, Nations Healthcare, Netcare UK, Nuffield Hospitals, Partnership Health Group and UK Specialist Hospitals (UKSH). We are leading national and international independent sector healthcare companies, with extensive experience of managing elective surgical centres and diagnostic facilities.
3. Our centres have performed almost 200,000 elective and diagnostic procedures for the NHS since the Government launched its procurement programme in 2003.

4. Our aim is to ensure that patients, doctors and the public have a better understanding of how new and traditional healthcare providers are working together in partnership for the benefit of NHS patients.

5. We support the NHS, in principle and in practice, and believe that the principles behind the government’s reform programme—extending patient choice, encouraging innovation and stimulating competition—are integral to the development of higher quality NHS provision into the future.

How effectively has workforce planning, including clinical and managerial staff, been undertaken, and how it should be done in the future?

6. We do not think that workforce planning has been done very effectively to date. We would like to see it done in the context of the total need of NHS patients not just traditional NHS providers.

7. It should be based on the business expectations of commissioners and not on the views of the Royal Colleges.

8. We would also like to see a level playing field for ISTCs regarding the use of foreign registered specialists who are able to work in the NHS but not in ISTCs. This is particularly important in the case of Commonwealth Registered doctors whose training and experience follows the UK clinical tradition, model and culture and whom in many cases have worked in the NHS at some point and either speak English as a first language or as an excellent second language.

9. The use of specialists registered and qualified in Europe is working well, but efficiencies can be improved if the Commonwealth Doctors are used in the independent sector too.

10. In the case of nursing, we are concerned at the over-regulation of their activities. A large number of nurses will reach retirement age in the next five years and the impact will be exacerbated if early retirement happens (paragraph 21).

In considering future demand, how should the effects of the following be taken into account?

The increasing use of private providers of services

11. Future workforce demand should be based on commissioners’ plans for purchasing care rather than on providers’ plans for delivering it.

12. If demand exceeds the capacity of the independent sector workforce market and outstrips the pace at which provision can be brought on stream, both price inflation and pressures on quality control can occur. To offset this, there should be careful planning and modelling for the existing supply capacity and the speed at which it can be flexed without reducing standards such as training and certification requirements.

13. However, if the pace of supply and demand can be aligned then it may be possible to improve value for money relative to workforce costs by creating a more robust and sustainable competitive environment.

14. Wave 1 ISTC contracts imposed strict additionality requirements on ISTC providers prohibiting providers from employing staff currently working in the NHS or who had worked in it within the last six months.

15. For wave 2 contracts, additionality will only be justified where specific shortages of certain NHS clinical and professional staff exist. NHS staff will also be able to offer their non-contracted hours to ISTCs. For the NHS reforms to work, a free labour market is needed.

16. We are very keen to be able to recruit and train local staff currently employed with traditional NHS providers and believe this will have a beneficial impact on staffing knowledge levels when they return to traditional NHS providers. Our staff develop and are trained in more innovative and efficient working practices than in the traditional NHS and use more efficient and productive techniques, all of which they will take back to traditional NHS providers.

17. All staff employed by ISTCs are qualified to work in the NHS—robust measures with regards staff competency apply, including registration on the GMC specialists register.

How will the ability to meet demand be affected by:

Financial constraints

18. There will always be a tendency to train fewer staff than are actually needed because of concerns about training too many staff. However, rarely have there been situations where the NHS has had too many medical staff. Having too many is more cost-effective, exerting a downward pressure on labour costs and ensuring sufficient supplies.
Increasing international competition for staff

19. This will put additional pressures on the workforce supply chain leading to increased inflationary pressures and will exacerbate any problems with a misalignment of supply and demand. It may result in other Governments such as South Africa reversing its present support for the UK proposals to rotate the use of clinicians from overseas.

20. There will also be less hostility to training too many if they can get jobs abroad.

Early retirement

21. This is likely to have quite a big impact on staffing levels and needs, particularly on nursing levels, given the number due to retire in the next five years.

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

22. This is likely to have a huge potential as it will mean that staff knowledge and skills are transferable within the NHS and should reduce some demand for staff.

23. Additionally, it will free up resources in specialties where shortages exist—for example, the use of Radiography Assistants to help Radiographers in the processing of patients. Also Advance Practitioners are now undertaking roles previously undertaken by Radiologists including reporting, ultrasound scanning and barium enemas.

Better retention

24. This has historically been an issue but initiatives such as Agenda for Change have begun to address this through enhanced payscales and progression opportunities.

25. In some cases, a higher turnover of staff would be beneficial.

The recruitment of new staff in England

26. This is vital and can be more effective than the use of overseas staff in terms of avoiding concerns around quality control and long term sustainability of the service. But this can lead to higher costs and take longer to implement than utilising pre-trained overseas staff.

International recruitment

27. This is of limited value in the short term. It may be suitable where the services can be performed remotely and can help sustain competitive tension within the UK to ensure value for money.

How should planning be undertaken? To what extent should it be centralised or decentralised?

28. There are arguments for both—centrally works where there is a national programme of change that needs to be imposed, sometimes in the face of objection arising from local interest that is secondary to national interest. The upside is that overall benefits can be prioritised, initiatives can be implemented more rapidly and greater economies of scale can be achieved. The downside is well understood and is primarily a problem of lack of ownership and concerted resistance that can damage the initiative during implementation.

29. This could also be a role for the Strategic Health Authorities.

How is flexibility to be ensured?

30. By engaging with the market during the planning of procurement and, based on their input, ensuring that competition is structured in a manner that enables the bidders to offer flexible solutions.

31. Additionally, by training slightly more than estimates suggest are needed and moving towards a flexible and open labour market.

Mark Smith
NHS Partners Network
10 March 2006
Evidence submitted by Norfolk, Suffolk and Cambridgeshire SHA (WP 74)

In response to questions from the Health Committee, in particular in relation to how planning should be undertaken in the future.

What examples of good practice can be found in England and elsewhere?

Norfolk, Suffolk and Cambridgeshire Strategic Health Authorities project evaluation results prove that the “patient centred approach to workforce planning”\(^\text{80}\) is an effective tool to planning changes in the workforce along care pathways, if supported by appropriately trained and motivated champions in workforce planning.

The 14 pilot projects have indicated to the NHS a need for the patient centred approach to workforce planning to complement service redesign and tackle the challenges of the modernisation agenda.

Table 1

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<th>PATIENT CENTRED APPROACH—ADVANTAGES AND DISADVANTAGES</th>
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<td>Supports NHS modernisation agenda and its approach to service redesign, including development of national standard care pathways(^\text{81}).</td>
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<tr>
<td>Enables people to look at services and workforce from a different angle and identify more efficient whole system solutions.</td>
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<tr>
<td>Facilitates collaborative working and creates ownership across all sectors along the care pathway through stakeholder engagement.</td>
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<tr>
<td>Is supported by a simple and versatile toolkit, which can be tailored to specific needs and builds up information over time.</td>
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What needs to happen to make it work?

1. Attitude and approach to workforce planning needs to be changed at all levels, starting from the top.
2. Develop a role or mechanism that facilitates service planning and development, of which workforce planning is an element of, ensuring involvement of all key stakeholders from an early stage.
3. Workforce planning and workforce development needs to be embedded as a core skill for all managers.

A full copy of the project evaluation report can be obtained from Gabi Trojan at Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (gabi.trojan@nscsha.nhs.uk).

To what extend should it be centralised or decentralised?

Project evaluation results from patient centred approach to workforce planning (see above) have demonstrated that workforce planning can only be fully effective, if it is embedded with service development. As service development is undertaken

— nationally (by DH in the form of NSFs, policies, etc.),
— regionally (by SHAs, LITs, clinical networks, etc.) and
— locally (by PCTs and service providers in the form of LDPs, Business Plans, etc),

workforce planning needs to be undertaken at those levels too.

However, for such an approach to be fully effective, it needs to be supported by synchronisation of service, finance, workforce and education planning cycles at all levels.

Gabi Trojan
Workforce Planning Manager, Norfolk, Suffolk and Cambridgeshire SHA

24 April 2006

\(^{80}\) Bosma, Brooks and Bradshaw (2005): “Population Centred Approach to Workforce Planning”, described as “patient centred” approach in previous versions from University of Manchester.

\(^{81}\) “Do once and Share” NPfIT project at www.connectingforhealth.nhs.uk
Evidence submitted by North East London Strategic Health Authority (WP 02)

Please find attached notes in response to your Inquiry—please note my response is for maternity services.

A summary of my responses are:

National recognition and acceptance of a maternity specific workforce tool. Nationally agreed and accepted midwife to births ratio.

Payment by Results and Practised Based Commissioning offers an opportunity for maternity services to be commissioned independently and for funding to follow the woman rather than become part of the general funding within the acute Trust as happens currently.

Investment in maternity IT system and the development of competencies for data input clerks is essential if Payment by Results is to be successful.

The possibility of Independent Midwifery Practices providing a home birth service for London should be explored and considered.

At the current funding levels the opportunity for maternity services to achieve Standard 11 in the Children’s National Service Framework 2005 is seriously compromised.

Career pathways for “branches” of midwifery practice should be established to ensure that not all senior midwives are encouraged to practice as “mini doctors” rather than “maxi midwives” due to greater status and financial reward. The European Working Time Directive may adversely effect junior doctors training.

Clinical leadership within midwifery and obstetrics should be strengthen along with the availability of flexible retirement options.

Midwifery leadership and the position of the Director of Midwifery within an organisation must be strengthened along with the development of the maternity support workers role.

A clear career structure and recognition of mandatory training days along with good affordable housing for rent/purchase to address the problem of retention.

The funding of midwifery training programmes require review and a 10 year plan developed to ensure adequate training to match increased birth projections and the planned retirement of existing midwives.

The Nursing and Midwifery Council are currently reviewing their recommendations for overseas qualified midwives.

Centralised planning for physical capacity would ensure greater flexibility within the maternity services.

I hope that these comments are useful and I am very happy to provide further information should you require it.

1. HOW EFFECTIVELY WORKFORCE PLANNING, INCLUDING CLINICAL AND MANAGERIAL STAFF, HAS BEEN UNDERTAKEN AND HOW IT SHOULD BE DONE IN THE FUTURE

Currently the only maternity specific workforce tool recognised by the Department of Health, The Royal College of Midwives and the Royal College of Obstetrics and Gynaecology is the Birth Rate Plus audit tool, which has been in use since 1988 (formerly Birth Rate audit tool). The tool assists the maternity unit to plan their service and commissioning based on their current service model and provides a baseline for midwifery staffing. Many maternity units have commissioned this audit at some considerable cost to the organisation; however the recommendations from these audits have never been fully accepted by the commissioning PCT’s and midwifery establishments remain largely historical in their agreed level. This results in the ratio of midwife to births varying from 1:26 in some parts of the country to 1:45 in others, irrespective of the dependency level of the women accessing the maternity service. Future planning must be based on an agreed national ratio of midwife to births, which are mandatory for providers to comply with. This could be enforced through the Clinical Negligence Scheme for Trusts (CNST) which already includes medical staffing levels within its criteria. Service models across London should be reviewed, with the view to identifying non-midwifery tasks currently being provided by midwives that could be provided by appropriately trained and supervised support workers eg London postnatal services could be provided by maternity support workers with midwives providing targeted services for eg vulnerable women.

2. IN CONSIDERING FUTURE DEMAND, HOW SHOULD THE EFFECTS OF THE FOLLOWING BE TAKEN INTO ACCOUNT

2.1 Recent policy announcements

Practised based commissioning (PBC—maternity services have historically suffered from the practice of being funded from block contracts. PBC offers a unique opportunity for maternity services to stand alone, independent of the acute Trust with the possibility of an alternative provider (eg maternity network) commissioning maternity services. Organisations such as maternity networks commissioning maternity
services and Payment by Results (PBR) could ensure that funding flowed directly back into maternity services, leading to far greater flexibility within the service and ability for organisational accountability, quality and standards to be obtained.

2.2 *Technological change*

The Department of Health is currently working on a national maternity data set. However the level of IT support/infrastructure within some maternity units is below acceptable standards and investment is required if PBR is to be effectively managed. Crucial to the success of PBR will be the standard and accuracy of the information entered therefore it is imperative that data input clerks are well trained and competent. A competency framework should be identified and training commissioned which is nationally recognised to allow transferability of skills from one Trust to another.

2.3 *The increasing use of private providers of services*

Many maternity units report a reluctance of midwives to provide homebirth’s within their sector due to the unsocial hours required for midwives to be on-call from home. It can also prove difficult for some Trusts to comply with family friendly initiatives and provide a 24 hour homebirth service. However, many midwives who enjoy this model of working prefer not to work within the NHS, therefore the possibility of Independent Midwifery Practices providing a home birth service for London should be explored and considered.

3. **How will the ability to meet demands be affected by:**

3.1 *Financial constraints*

Without significant investment in to maternity services the opportunity for services to develop to meet the requirements of Standard 11 of the Children’s National Service Framework 2005 will be seriously compromised for the majority of London providers of maternity services.

3.2 *The European Working Time Directive*

There is a downward trend in the number of junior doctors undertaking obstetric specialist training. To cover the gaps in the obstetric service senior midwives may be encouraged to take on the role of junior doctors. This role may bring with it a greater incentive in the form of status and financial reward and may lead to devaluation in the role of the senior midwife who remains within midwifery, with the most innovative and creative midwives being encouraged to become “mini doctors” by taking on the junior doctor role. This would lead to a greater drain on maternity provision. It is therefore imperative that a clear and defined career pathway is established for midwives to encompass both “branches” ie those who remain within the midwifery sphere and those who branch into formerly obstetric practice. The ability of the Trust to provide 24 hour consultant Obstetrician cover and comply with EWTD may prove difficult for some Trusts, and impact negatively on the training of junior doctors within obstetrics.

3.3 *Early retirement*

Mavis Kirkham’s work Why Midwives Leave (2003) identified a culture of bullying and harassment leading to high stress levels in many maternity units. Clinical leadership both in midwifery and obstetrics, team working and transparency in clinical practice must be actively promoted to reduce the rate of leavers along with the availability of flexible retirement options.

4. **To what extent can and should the demand be met, for both clinical and managerial staff, by:**

4.1 *Changing the roles and improving the skills of existing staff*

Maximum deployment of existing midwifery staff to ensure that productive time is maximised should be assured. This will necessitate protection of the professional role of the midwife, greater administrative and clerical support for maternity services and reallocation of some parts of service to assistant/support workers eg postnatal care could be provided by maternity assistants with midwives providing care to targeted groups such as vulnerable women. Midwifery leadership and the position of the Director of Midwifery within an organisation must be strengthened.
4.2 Better retention

Agenda for Change payment banding should be the same across London including that offered by Foundation Trusts. At present newly qualified midwives are offered band 5 in some areas and band 6 in other areas of London. Good standard affordable housing within London should be available both for rent and purchase. A clear career structure and recognition of mandatory training (provided within the working day) would provide greater job satisfaction too.

4.3 The recruitment of new staff in England

An uplift in midwifery WTE establishments is required across London. In response to this an increase in midwifery training commissions is required for both 18 month and 3 year midwifery training programmes.

Three year midwifery students currently receive either a bursary or a loan depending on whether they are completing a diploma or a degree programme. The issue of student poverty should be addressed in relation to the attrition rates of students within Higher Education Institutes.

18 month midwifery students are currently paid at AfC band 5 with shared funding of 80% by the local Strategic Health Authority and 20% by the employing Trust. This arrangement means that the employing Trust is responsible for paying all “on costs” such as weekend working, night duty etc which are an essential part of the students experience during training. Trusts are reporting that, due to financial restraints, they can no longer afford to support 18 month midwifery students. However these students are gaining a second registration as they are already registered nurses, and therefore bring with them skills in acute nursing that are essential to ensure that the midwifery workforce reflects the case mix of women accessing maternity services. This problem needs to be addressed nationally to ensure that the option of midwifery training is not closed to trained nurses.

4.4 International recruitment

This is currently under review by the Nursing and Midwifery Council, and new recommendations are expected later in 2006.

5. How should planning be undertaken?

5.1 To what extend should it be centralised or decentralised?

Planning physical capacity within maternity services should be centralised for London and the practise of ‘capping’ within each Trust stopped due to the repercussions for the surrounding maternity units when one maternity unit closes to bookings. A more shared approach would lead to greater flexibility and removal of bottle necks which can occur due to reactionary measures being adopted by one Trust.

Debbie Graham,
Lead Midwife, NE London SHA
21 February 2006

Evidence submitted by North Western Deanery (WP 08)

Summary: Example of Good Practice in Integration of Training GPs and Workforce Planning

I am responsible through the Deanery for the education and training of general practitioners. The North West faces one of the most severe crises in the general practice workforce. General practice is still denigrated within teaching hospitals to undergraduates. The new form of training with Modernising Medical Careers should give all young doctors an experience of general practice in their foundation training which will be beneficial to counteract stereotype prejudice acquired in early years as medical Students.

1. Strategy to manage workforce problems should be at three levels:
   — To keep the staff we have by cherishing and supporting them.
   — To develop training capacity to train more doctors.
   — In the longer term, interest young people in an exciting career by giving work experience in general practice at sixth form level in school and effective careers advice, especially in schools not usually involved in medical school applications.

2. The best method of dealing with workforce is to grow one’s own and expand training capacity. There is recent evidence that training practices produce quality of service provision and that doctors settle near where trained. Where there was a capital investment scheme involving the deaneries, there was a major increase in training capacity for a relatively small outlay. Where capital investment was given to PCT’s without reference to Deaneries, there was no training enhancement.
3. Investment in learning environments in primary care (which provide training opportunity at undergraduate and postgraduate medical as well as nursing and allied professions) provides the best return and creates an environment of excellence and maximises educational efficiency.

4. A further capital investment programme is urgently needed if we are to deliver training experience at all levels, as envisaged in MMC. I have been the GP Director in the North Western Deanery for nine years and have had a particular interest in our recruitment crisis. I jointly undertook a study in 1999 into the retirement prospects of all doctors over 50 in North West England. Many of these doctors came from overseas to support the NHS in the 1960s and are very close to retirement. Many have been single-handed GPs or husband and wife teams and will leave major gaps. Similar research in North East England supported our findings. There has been a temporary reduction in retirements due to the anticipated enhanced pension provision under the new GMS contact for GPs. There will be a big retirement explosion when the pension increases feed through.

5. We have worked closely with PCT’s to develop a strategy contained in the second edition of our publication “A Gardener’s Guide for PCT’s—How to grow and keep your own GPs” available on our website. This guide also contains reference to current literature on the topic.

http://www.nwpgmd.nhs.uk/genprac/publications.htm

6. I have recently provided a paper for the GP Tsar, Dr David Colin-Thome making the case for further capital investment in training capacity which is attached.

7. A recent piece of published research in the British Medical Journal entitled “Determinants of primary medical care quality measured under the new UK contract: cross sectional study” showed that quality in primary care service was linked to training practices.

8. Although my experience is mainly around general practitioners, with close co-operation between the Deanery and the Strategic Health Authorities we have also managed a major expansion of opportunities for specialist registrars to train in under doctored areas in Cumbria and Lancashire.

**THE CASE FOR FURTHER CAPITAL INVESTMENT IN MULTIDISCIPLINARY LEARNING ENVIRONMENTS**

**Summary Points**

— A learning environment in primary care is a GP training practice, approved and developed to undertake training in multiple modalities, including undergraduate medicine, postgraduate medicine (GPR, Foundation 2, Remedial, specialist doctors requiring GP experience) undergraduate and postgraduate nursing and undergraduate and postgraduate allied health professionals.

— The 2002–04 Capital Investment Scheme, processed through Deaneries working closely with NHS Estates, was highly successful. Nationally it delivered approximately 650 additional GP training places for an outlay of approximately £30 million.

— The £108 million capital investment in general practice premises allocated directly to PCTs without reference to Deaneries did not significantly enhance training capacity.

— The Primary Care Development Fund monies require consultation with Deaneries in order to develop primary care in deprived areas and offer a small opportunity for PCT’s to improve training capacity.

— The North Western Deanery has worked with the two SHA’s to identify a small sum of funding and has established a group of stakeholders. It has evolved a model to prioritise funding in areas of most need, where learning environments can be encouraged to offer multi disciplinary training.

— Joint investment of undergraduate and postgraduate resources in primary care training capacity maximises effectiveness.

— A further capital investment programme in training capacity in primary care is urgently needed to deliver training capacity in primary care in all modalities to train professional staff for the future of the NHS. This is particularly important in areas of deprivation where locality training is a vital strategy in addressing recruitment and retention issues.

**Background**

In 2002–03, £30 million nationally (£5 million in the North Western Deanery) was released through NHS Estates working closely with the Deaneries, to invest in premises to enhance GPR training capacity. This generated 650 nationally (North West 54) new training places. Training practices in the North West committed to at least five years enhanced training capacity. Many were in deprived areas. Research in the London Deanery has shown that GPR’s wish to remain in practices near their place of training.

Training practices are quality assured by Deaneries to a high level and have high standards of care and high QOF achievements. Doctors in training in the practice also contribute to the maintaining of the CPD standards of other partners and training practices are likely to be leading edge. There are therefore
Health Committee: Evidence

I particularly wish to refer to

To what extent can and should the demand be met, for both clinical and managerial staff, by:

— the recruitment of new staff in England.

I wish to draw to the attention of the Health Committee the potential resource of Refugee Doctors and suggest that, with some structured support, in terms analysis of their potential, followed by training we can get doctors with a much smaller outlay than training them post school and, if not able to return to medicine by obtaining a UK post, have people prepared to re-train into other branches of the NHS—probably where there are shortfalls.

Currently most refugee docs do not make it back into medicine. The competition is too fierce and because they have to do IELTS, PLAB 1 and 2 exams and get a clinical attachment to appraise themselves of the NHS by the time all this is completed have been out of medicine so cannot compete equally with UK applicants.
The ideal scenario would be for them to have an assessment of their potential and then for a properly funded and educationally structured returners course provided which would be similar to and SHO/F2 job. There would be additional content on language and cultural adaption, team working, the nature of the NHS. During this time they would have the same status as an employee or students thus having access to libraries, Post Grad Centres and the other support facilities and events. At the end they would be in the same situation as post F2 doctors and be able to compete for specialist training.

Following an assessment of their potential some will not be up to the standard required to follow a SHO/F2 programme. For these there could be a discussion on alternative careers with some source with an over view of all careers in the NHS (and particularly the shortage ones) but some body who could look through their skills, interests and abilities and suggest alternatives. To be able to say your they could consider X, Y or Z and be able to say for each how long the training is, cost and financial support, career structure and pay and conditions. This support would be part of their returners course as some will fail such a course and be repeated during the course.

Such a programme would be centrally funded and be available for all refugee doctors to apply to. It would use as far as possible the current support structures but would have the authority of being a Government initiative. OK in absolute terms it would be expensive but in terms of the outcomes compared to the usual costs of recruiting and training for these posts it would be value for money.

Max Webb
Trent Multi Professional Deanery, University of Nottingham
17 March 2006

Evidence submitted by the Nursing and Midwifery Council (WP 69)

1. The Nursing and Midwifery Council (NMC) is the statutory regulatory body for the nursing and midwifery professions. Every nurse and midwife in the UK has to be on the NMC’s register in order to be able to practise. The NMC’s register is probably the largest of its kind in the world, with over 670,000 health professionals on it.

2. The register is the primary public protection tool at our disposal. We set standards for entry to the register and the proficiencies for training and education that enable nurses and midwives to maintain and improve their knowledge and skills throughout their careers. The NMC’s other key public protection role is to investigate allegations of lack of competence and impaired fitness to practise against nurses and midwives. We have a range of sanctions available to deal with serious cases of misconduct and incompetence.

3. The NMC’s code of professional conduct supports nurses and midwives in their professional practice by making clear what is expected of them. This is a vital tool in delivering effective public protection.

THE ROLE OF THE REGULATOR IN WORKFORCE PLANNING

4. As one of the NMC’s key roles is to set standards for entry to the register and, therefore, for entry into employment in the health service, it is essential that we are closely involved in workforce planning issues. For example, changes in the nature of nurses’ and midwives’ role are likely to necessitate changes to the broad proficiencies set by the NMC for entry to the register. Even a modest change may take at least four years to be put in place, i.e. that is the time it may take for a change to work through pre-registration and the first cohort of student nurses or midwives to have passed through the system and onto the register. Early NMC involvement is therefore vital—but frequently overlooked by workforce planners—and is almost certainly the case for the other health regulators.

5. Similarly, changes in demand for overseas recruitment—particularly where greater numbers are required in the UK by employers—are dependent for delivery on the NMC. We handle all inquiries for registration from overseas-trained nurses and midwives to have passed through the system and onto the register. Early NMC involvement is therefore vital—but frequently overlooked by workforce planners—and is almost certainly the case for the other health regulators.

6. The NMC should be consulted about the elements of workforce planning that impact on our ability to regulate the professions and the ability of practitioners to deliver safe care to their patients. We firmly believe, therefore, that strategic aspects of workforce planning have to be undertaken centrally. It cannot be wholly decentralised to the regions or beyond.

7. Equally, flexibility can best be ensured by encouraging those who set standards, such as the NMC, to set broad rather than specific ones. That is certainly the NMC’s approach to our standards for entry into nursing and midwifery education and entry onto the register. We don’t currently specify the precise

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82 The NMC code of professional conduct: standards for conduct, performance and ethics (2004).
qualifications required for entry to training, nor do we set a national curriculum for universities. However, we are reviewing this approach as part of a wider review of the fitness to practise of nurses and midwives at the point of registration.

**Changing Roles**

8. The NMC would draw a distinction between the extension of an existing role and the establishment of a totally new role. For example, while the role of the nurse has developed considerably over the last 30 years, the core values of nursing remain unchanged. Nurses now run clinics, make diagnoses, undertake minor operations, routinely take blood pressure and so on, yet these were considered the job of a doctor not long ago. Where the role has been developed from an existing one, and assuming student nurse education has kept pace with such change, there is no need to move away from the initial education and training or the current regulatory framework. However, where the role is brand new, such as in the case of surgical care practitioners or anaesthesia practitioners, there may be an argument for separate pre-registration training and separate regulation by a new body. There is a distinction between direct entry into a profession—new or old—and existing roles that develop new functions within their scope of practice.

9. A brand new role necessitating separate regulation can be defined as one that has sufficient impact on patient safety and quality of care as to require new standards of practice and training in law, and where the role is so different from the original regulated qualification that patients and health professionals have to be able to identify the new practitioner.

10. However, it is difficult to define what the scope of practice should be for these new groups of practitioners because roles evolve on a continual basis. Seeking ever more narrow definitions of practice may even be counter-productive as it could make nursing less able to respond to society’s changing health care needs.

11. The coming shift from acute to primary care will, for example, see a major change in the role of many nurses. A growing number will become the primary “gatekeeper” to the NHS, necessitating a wide range of diagnostic and treatment knowledge and skills. While the NMC will continue to set core standards for nurses and midwives, too tight a definition of their scope of practice could prevent future development.

12. The NMC broadly defines a nurse’s scope of practice within its code of professional conduct. In effect, the NMC enables nurses to undertake any task or activity within the health care legal framework that they are trained and competent to do. They are obliged to keep their knowledge and practice up to date, undertaking a minimum period of learning activity within the three-year registration period. They must acknowledge the limits of their professional competence. That broad approach seems to the NMC to be sensible, practical and flexible.

**The NMC and Employers**

13. The NMC works closely with employers to ensure that regulation is relevant and effective, and to ensure that the roles of the regulator and the employer are not duplicated. To those ends, we produce guidance for employers on issues such as continuing professional development and appropriate fitness to practise referrals; we hold regular workshops with employers throughout the UK to discuss commons areas of activity and interest; and we regularly send NMC Circulars to employers about practitioners removed from the register, new standards and guidance, etc. NMC involvement with workforce planning would be a natural extension of our healthy relationship with the employers of nurses and midwives.

Nursing and Midwifery Council

*March 2006*

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**Evidence submitted by the Office for National Statistics (WP 75)**

1. **Introduction**

ONS publishes statistics which can provide contextual information for the Health Select Committee’s inquiry into “Workforce needs and planning for the health service”. These are:

- Public Service Productivity: Health
- Labour productivity; and
- Public Sector Employment.

This note provides a brief description of these statistics, and links to more details online. ONS welcomes the opportunity to provide further information and discuss.
2. Health Productivity

In July 2005, the National Statistician accepted the broad recommendations set out in the January 2005 final report from Sir Tony Atkinson’s review into the Measurement of Government Output and Productivity for the National Account. At the same time, ONS set up the “UK Centre for the Measurement of Government Activity” to take forward the work involved. ONS has published two articles on health productivity, entitled Public Service Productivity: Health. These articles provide information on total factor productivity of the NHS—that is productivity associated with all of the goods, services, labour and capital used by the NHS. These articles do not provide information on labour productivity, although the calculations do include measures of NHS labour. These articles differ in scope compared with other ONS publications on productivity, as suggested in their title. These articles cover “public service” rather than “public sector”. The articles report estimates of productivity relating to public expenditure on health, irrespective of whether it is the public or private sector that provides the health service.

The first article, published in October 2004, presented estimates of NHS inputs (the goods, services, capital and labour used in providing health services), NHS outputs (the activities operations, GP appointments—Provided by the NHS) and NHS productivity (defined to be the ratio of the volume of output to volume of inputs), as well as what Sir Tony Atkinson termed “triangulation material”—evidence that might corroborate the implied productivity estimates. This first article did not take explicit account of quality change in the NHS: the output and productivity estimates did acknowledge changes in the number, say, of operations carried out, but they did not pick up changes in the quality of those operations.

Atkinson regarded measurement of quality change in health care as difficult. He also pointed out that quality of health care has a number of dimensions, including saving lives and extending life span, preventing illness, speed of access to treatment and quality of patient experience.

The second article, published in February 2006, drew on proposals for measuring aspects of quality change published in two research publications in December 2005: one by a consortium involving the National Institute for Economic and Social Research (NIESR) and the Centre of Health Economics at the University of York; the second by the Department of Health. The York/NIESR publication includes experimental labour productivity estimates for the NHS.

Publication of a third ONS article is planned for the end of the 2006–07 financial year.

http://www.statistics.gov.uk/articles/nojournal/PublicServiceProductivityHealth(27_2_06).pdf


http://www.york.ac.uk/inst/che/

3. Labour Productivity

ONS produces estimates of labour productivity for the whole economy by hour worked—the internationally preferred measure—and also by worker and by job, along with unit wage costs. However, no estimates are currently produced for the public sector or any part of it. More detail is provided for the manufacturing industries and experimentally—for the service industries but these are for those industries across the public and the market sectors combined.

Labour productivity is published quarterly. The most recent “Productivity First Release” gave estimates for 4th quarter 2005; this was published on 30 March 2006.


4. Public Sector Employment

Statistics of employment in the NHS are obtained by ONS, as part of the process of producing statistics on public sector employment. They are compiled using estimates provided by the NHS Health and Social Care Information Centre (for England), the Scottish Executive, the National Assembly for Wales and the Department of Enterprise, Trade and Investment for Northern Ireland. The statistics presently depend on projections, based on annual data, in order to provide quarterly estimates in line with other public sector employment statistics, and are thus subject to revision. The figures go back to 1991. The GP workforce is classified as part of the private sector in accordance with economic accounting principles, and is excluded from the public sector returns, although some data are available separately if required.

The figures are produced on numbers of people employed and also in terms of full-time equivalents. There is some information available on NHS employees by occupation although the classifications used vary for different parts of the United Kingdom. Some possibility exists of using analysis from the Labour Force Survey (LFS) for more detailed and systematic breakdowns such as occupation, although there are limitations to the quality of such LFS data which could be obtained on the NHS as they depend on information collected from individuals about the organisation they (or, by proxy, other members of the
household) work for. While the LFS is a good source of information about employment generally, comparisons between the LFS and employer-based sources indicate that the LFS variables for type of organisation and industry both suffer from reporting error. ONS is investigating the feasibility of linking LFS records to the register of businesses maintained by ONS, to improve the quality generally of the LFS results for type of employer and industry.

A major issue in using any of these available estimates of NHS employment as a basis for measurement of productivity is how to align them with corresponding outputs or functions. Many outputs which result from NHS funding will depend at least partly on NHS employees not readily identified as contributing to those outputs and also on some input from people not directly employed by the NHS.


Karen Dunnell
Office for National Statistics

April 2006

Evidence submitted by the Parkinson's Disease Society (WP 53)

How Effectively Workforce Planning, Including Clinical and Managerial Staff, has been undertaken, and how it should be done in the Future?

1. Introduction

The Parkinson's Disease Society has been concerned by the issue of workplace planning particularly because of the need for the diagnosis to be made by a specialist in Parkinson's and the effective support of a person with Parkinson's throughout their condition by a multi disciplinary team centred around the Parkinson's Disease Nurse Specialist. It is vital that we ensure there are a sufficient number of specialists in Parkinson's disease and Nurse Specialists trained and in post.

2. Parkinson's Disease Specialist Nurse

2.1 The Parkinson's Disease Society has championed the post of nurse specialists in Parkinson's for the last 15 years and has developed a network of over 200 posts across the UK. In 2005 the PDS secured 19 additional Parkinson's Disease Nurse Specialist (PDNS) posts in collaboration with Primary Care Trusts (PCTs) across the UK, keeping us on track to hit our target of 240 posts by the end of 2006.

2.2 Access to a specialist nursing service is recommended by NICE in its draft Parkinson's disease Guideline due for publication in June 2006. However in the Society's AGM Survey of members 50% stated that they had insufficient nurse support for their needs and a further 20% stated they had no access to a nursing service at all. The Society itself recognises that meeting the target of 240 posts will still be insufficient to guarantee full access to the nursing service across all the UK.

2.3 It has been demonstrated that the PDNS can reduce the need for hospital admissions, outpatient appointments and GP consultations, as well as improve clinical outcomes and well-being for people with Parkinson's and their carers. Parkinson's disease is a complex and individual condition, and improving the quality of life of people with Parkinson's is hugely important. Parkinson's Disease Nurse Specialists play a vital role by identifying and linking individuals to appropriate care services and therapies, liaising with doctors and other health professionals such as Community Matrons, and increase awareness of Parkinson's through the education and training of fellow professionals.

3. Destabilisation of the workforce due to, Commissioning a Patient led NHS

3.1 The current uncertainty over the proposed changes in community provider models and how the provision of community services such as specialist nurses will be developed, is of concern to the Society. The proposals set out in Commissioning a Patient-Led NHS that PCTs should divest themselves of their provider function for community health services to non-NHS providers by the end of 2008 raise fundamental questions about who will provide services such as specialist nurses. Although government policy no longer make this disinvestment compulsory it still remains unclear and is causing destabilisation in the workforce.

3.2 Financial pressures within the NHS are also contributing to destabilisation of the workforce. Deficits are already beginning to impact on the provision of specialist nurses for example in Chester the local Trust have been forced to withdraw provision of a nursing service to help reduce their budget deficit.
4. Community matrons

4.1 Changes in the NHS are particularly of concern in relation to the introduction of the Community Matron post. Community matrons will be tasked with improving the care of those who are most vulnerable and at risk of health deterioration, that often results in avoidable hospital admissions. PCTs are required to appoint Community Matrons by 2008 to take the total number up to 3,000 across the NHS.

4.2 The Society is concerned that with the pressure on Primary Care Trusts and Strategic Health Authorities managing their re-organisation and reducing local budgetary deficits, the Community Matron role may be seen as one which can cover similar populations as nurse specialists thus reducing the need for both roles to exist in the same area. The role of the specialist nurse and the community matron are not interchangeable, they both have a vital role in the care of people with PD.

4.3 It is essential that Community Matrons work with PDNS and other specialist nurses to ensure that individuals are properly supported throughout the changing needs of their conditions as set out in the “Supporting People with Long Term Conditions” strategy published in 2005—with Community Matrons focussing on individuals with the most complex needs. The Society believes it is vital that the specialist nurse role continues to exist to support people with Parkinson’s and that the Government must provide greater clarity as to how services will be provided to secure appropriate care and treatment for those with long term conditions.

5. Multi Disciplinary Teams

5.1 The Society is also concerned about the workforce planning of other health professionals in the Multi Disciplinary team which are vital to the effective management of long term conditions such as Parkinson’s. A recent international survey of Parkinson’s disease identified several factors other than medication and severity of the condition that influenced the quality of life of people with Parkinson’s disease. These included depression, attitude, outlook on life and the level of satisfaction with explanations of Parkinson’s disease given at the time of diagnosis.

5.2 These findings highlight the importance of a multi-disciplinary approach to management and care. Many professionals can play an important role in helping people manage their Parkinson’s, including physiotherapists, speech and language therapists, occupational therapists, social workers, psychologists and voluntary organisations such as the Parkinson’s Disease Society. It has long been recognised that chronic illness can have a major impact on emotional wellbeing.

5.3 The physical impairments often associated with chronic illness are also likely to affect many other areas of a person’s life, for example social support, mental health and quality of life.

The Society is concerned that for the proper implementation of the NSF and NICE guideline when it is published in June multi-disciplinary team working must be encouraged. However access to many of these services is limited with respondents to the Society’s AGM Survey in 2005 stating that 45% of respondents felt they had insufficient access to physiotherapy services and just under 50% felt that access to speech and language therapy services was insufficient.

6. Practice Based Commissioning

6.1 With the introduction of Practice Based Commissioning it is also vital that GPs, responsible for commissioning services, such as those of the multi disciplinary team, for people with Parkinson’s in the community have a proper understanding of Parkinson’s, its co-morbidities and the care and treatment people require. However it was another concern raised at the Society’s AGM Survey in 2005 that approximately two thirds of respondents felt their GPs had insufficient knowledge of PD—a finding that was consistent across the regions.

6.2 In the Society’s Employment Survey some people with Parkinson’s reported that even their consultants lacked insight and experience in dealing with the complex symptoms experienced by individuals with Parkinson’s disease. The PDS strongly recommends that appropriate training in Parkinson’s disease must support the role to be undertaken by GPs and health professionals as in supporting people to self manage their conditions and in commissioning services for people with long term conditions.

7. Ageing population

The UK has an ageing population and an increasing number of people with long term conditions, which present new challenges including higher demands across health and care services. It is necessary to invest now in health and social care development and reform the system to ensure equality of access focusing on the rights and the needs of the people with Parkinson’s disease. The focus on keeping people with Parkinson’s active and out of hospital means that community care and assistive technologies will play a significant role in improving outcomes for this group of people.

greater role in the management of the condition. Promptly provided community equipment can make a significant difference to the mobility, comfort and daily living activities for many thousands of people with the complex needs.

8. Assistive technology

8.1 The use of assistive technologies can free up clinicians time for other care, which results in greater efficiencies. New assistive technology—such as telecare—enables people with Parkinson’s and their carers to lead more independent lives in their own homes. For instance, a side effect of some Parkinson’s medication can be a lowering of blood pressure, contributing considerably to the risk of falling. For this reason people with Parkinson’s may find a community alarm system vital for peace of mind and assurance of help, in the occurrence of a fall. The technology may also aid compliance by reminding them of medication times and other activities. They may also assist in the monitoring of health and care conditions.

8.2 Extra Care Housing exemplifies one way in which older people can maintain their independence. Investing in technologies is not just a welfare issue. Considerable savings can be made within health and social care economies thus reducing the financial burden on the NHS and the focus on the development of preventative services through better-targeted and timely interventions will defer the need for more costly intensive care support for many people living with Parkinson’s.

8.3 To ensure current services are further developed to become increasingly preventative and personalised to the individual, greater resources will be required, greater use of technology such as telecare, telemonitoring and assistive aids will be key to reducing the burden on health and social services and will increase the numbers of people managing their conditions effectively in the community with the support of the multi disciplinary team. People with Parkinson’s are regular users of assistive technologies and community equipment. A recent study found that almost one third of people with Parkinson’s lived in the community and required assistance with daily living.84

8.4 The focus on keeping people with chronic conditions active and out of hospital means that community care and assistive technology must play a greater role. This will require greater collaborative and coordinated working across health and social care professionals—an issue which remains a significant frustration for people with Parkinson’s.

9. Conclusion

9.1 The Society believes it is most important that health professionals across the multi disciplinary team are recognised as essential in managing long term conditions if people are to remain healthy, active and out of hospital. The Parkinson’s Disease Nurse Specialist is central to the effective coordination of the care and treatment of people with Parkinson’s throughout their condition and the Society is therefore concerned that this role is not endangered by the changes to PCTs, the introduction of Practice Based Commissioning and financial constraints in the NHS which may encourage PCTs to view Community Matrons, which they are required to provide, as a role which can manage all long term conditions effectively.

9.2 Additionally it is important that all health professionals involved in the care and treatment of people with Parkinson’s are sufficiently trained to support them in achieving the optimum health outcomes. This is particularly of concern in relation to the commissioning of appropriate services by GPs, including speech and language therapy, dietician services and mental health support and for the effective use of technologies for managing long term conditions.

10. The Parkinson’s Disease Society

10.1 The Parkinson’s Disease Society (PDS) was established in 1969 and now has 30,000 members, 23,000 supporters and over 300 branches and support groups throughout the UK. The Society provides support, advice and information to people with Parkinson’s disease, their carers, families and friends and information and professional development opportunities to health and social services professionals involved in their management and care.

10.2 The Society commits more than £3 million each year on funding new research into the cause, cure and prevention of Parkinson’s, and improvements in available treatments. The Society also develops models of good practice in service provision, such as Parkinson’s Disease Nurse Specialists and campaigns for changes that will improve the lives of people affected by Parkinson’s.

84 Jacqui Handley, Parkinson’s Disease Nurse Specialist, *What is Parkinson’s Disease?* Parkinson’s Disease Society, January 2005.
11. About Parkinson’s disease

11.1 Parkinson’s disease is a progressive neurological disorder. It affects all activities of daily living including talking, walking, communication, swallowing and writing. It is estimated that 120,000 people in the UK have Parkinson’s and approximately 10,000 people are newly diagnosed with Parkinson’s each year in the UK.

11.2 Parkinson’s disease occurs as a result of a loss of cells that produce the neurotransmitter dopamine. Dopamine is one of the chemical messengers that exist in the brain, which enables people to perform coordinated movements. As yet it is not known why these cells die.

11.3 The three main symptoms are tremor, muscle rigidity and slowness of movement. However not everyone will experience all three. Other symptoms include a lack of facial expression, difficulties with balance, problems with an altered posture, tiredness, speech difficulties, pain and depression. Parkinson’s affects people from all ethnic backgrounds and all ages. The majority of people are diagnosed over the age of 60, however it is estimated that one in 20 people are diagnosed with Parkinson’s under the age of 40.

11.4 The symptoms of Parkinson’s disease usually begin slowly and develop gradually, in no particular order. Symptoms experienced by people with Parkinson’s disease vary widely, similarly there are differing responses to treatment between individuals. The fluctuating nature of the condition and the side effects caused by the medication can cause unpredictability during the day and throughout the night.

11.5 As the condition progresses, it becomes more difficult to manage the complex range of symptoms and decreasing mobility and this can result in an increased dependency for support from care providers. Assistance may be required in all activities of daily living, to allow the person to maintain as much mobility and independence.

Robert Meadowcroft
Parkinson’s Disease Society of the United Kingdom

March 2006

Evidence submitted by Patient and Public Involvement Forum, Hull and East Yorks Hospital Trust (WP 07)

1. The finite number of radiology staff, and the national shortage, is exacerbated by plurality of service between NHS and independent sector. They pull in different directions. The ethos is different. NHS is a not-for-profit organisation driven by human need, whereas IS is commercial. Its aim is profit. It has no embedded and continuing relationship of trust, clinician-to-patient, in the locality. Its “better working conditions” with which it attracts staff, often away from the NHS, are at the expense of the NHS which carries the onus of teaching and training costs, of provision for complex procedures, and of acute care, twenty four hours a day, every day of the year.

2. Extending the roles, responsibilities, and skills of current staff, both radiographers and radiologists, and thus retaining them within the NHS by enriching their job satisfaction and enhancing their professional skills, pays dividends. There is no lack of take-up of this provision; the issue is backfilling the more “basic” roles to free them to practice these new skills.

3. Crucial to this are the support staff. The traditional “porter”, “nurse”, “chaperone” roles benefit from redefined as new posts such as CISWs (clinical imaging support workers). This is a more flexible role, has clear vocational opportunities for those who want to take advantage of this, greater responsibility, and more accurately reflects and serves the needs and the potential of medical imaging in the 21st century.

4. At one time, every additional consultant post was accompanied by “0.3% of a consultant radiologist”, so that the expansion of the clinician-complement was realistically enabled by proportionate expansion of radiology provision. This system has ceased to operate, yet every speciality depends heavily upon radiology. It is a gateway service. In my Trust, over 90% of patients coming to the Trust access the service.

Recommendations:
1. Recognise the pivotal importance of diagnostic and therapeutic radiology in workforce planning.
2. Recognise that government policy and NICE guidelines are increasing the demands on the service.
3. Retain the whole spread of clinical imaging within in NHS (plain film, ultra-sound, dexta scanning, mammography, CT and MRI) as role rotation enables and enhances in-house training.

Ruth Marsden, Chair,
Clinical Radiology Patient Liaison Group for HEYHT (Hull and East Yorks. Hospitals Trust) and, Chair, Patient and Public Involvement Forum for HEYHT.

7 March 2006
Evidence submitted by the Postgraduate Medical Education and Training Board (WP 52)

INTRODUCTION

1. PMETB welcomes the opportunity to provide evidence to the Select Committee’s inquiry into Workforce Needs and Planning for the Health Service.

BACKGROUND TO PMETB’S ROLE

2. To set this in context
   — PMETB took up its statutory responsibilities on 30 September 2005.
   — PMETB subsumed the functions of two Competent Authorities: The Specialist Training Authority of the medical Royal Colleges (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP).
   — PMETB responsibilities are UK-wide.
   — PMETB has responsibilities only for postgraduate medical education and training.

PMETB’S LEGAL RESPONSIBILITIES

The principal functions of PMETB, as set out in the Statutory Instrument made on 8 May 2003—The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 are to:
   — Establish standards of postgraduate medical education and training.
   — Secure those standards and requirements.
   — Develop and promote postgraduate medical education and training in the UK.
   — Accredit training in hospital and general practice to meet PMETB standards.
   — Issue (or refuse) Certificates of Completion of Training or eligibility for specialist registration.

PMETB’S STATUTORY OBJECTIVES ARE TO

   — Safeguard service users.
   — Ensure the needs of those undertaking training are met.
   — Ensure the needs of employers are met.

PMETB ALSO HAS A STATUTORY DUTY TO COOPERATE WITH

   — The General Medical Council.
   — Any other body that appears to it to be representative of the medical Royal Colleges in the UK.
   — Any other body that may be specified by the Secretary of State.

WORKFORCE—IMPLICATIONS FOR PMETB

3. A skilled medical workforce tomorrow depends on high quality education and training being delivered today. PMETB therefore regards itself as being central to plans for the medical workforce of the future.

4. It is important that a culture of education and training is embedded throughout the NHS. By their very nature, education and training are long-term objectives and do not always sit easily alongside the short-term imperatives by which Chief Executives in the NHS are often judged.

5. PMETB is committed to achieving excellence in postgraduate medical education and training throughout the UK. In the context of workforce planning this means that we must ensure that doctors are exposed to comprehensive specialist training programmes which equip them with the appropriate breadth and depth of knowledge, skills and attributes against standards and curricula set by PMETB. In doing so, PMETB is committed to ensuring that specialist training curricula are relevant to and reflect the needs of modern medical practice, service delivery and—crucially—patient need.

CURRICULA DEVELOPMENT

6. Historically, the medical Royal Colleges and Faculties have produced curricula for specialty training. In view of PMETB’s recent inception, Colleges and Faculties have been asked to review and submit revised specialty and general practice curricula to ensure they meet PMETB’s published standards. There are nearly 60 specialties which will need to be scrutinised by the PMETB Curricula Approvals Panel (a sub-committee of PMETB’s Statutory Training Committee) during the course of this year.
7. We are considering how representatives of the service—particularly NHS Trust Chief Executives—might be enlisted to ensure that we meet our statutory responsibility to consider the needs of the service. We do not underestimate the challenge in doing so, because of the diversity of the service and increasing plurality of providers. To this end, PMETB’s Training Committee is considering how mechanisms can be established.

8. The NHS Confederation, through its constituent body NHS Employers, has been asked to advise as we believe they can play an important role in enlisting the necessary support from the service.

DELIVERABILITY OF CURRICULA

9. As a further safeguard to the curriculum development process, discussions are taking place between members of the Training Committee and the Conference of Postgraduate Medical Deans (COPMeD) to explore how the Workforce Committee of the latter might assist PMETB in ensuring that training, envisaged in curricula, is deliverable i.e. that trainees have access to the necessary infrastructure, resources and opportunities to fulfil their training programme. For example, it may be that the highest quality of education and training, together with financial economies of scale, may be achieved by concentrating education and training in certain centres, while others focus mainly on service delivery.

OTHER PMETB ACTIVITY WHICH HAS A BEARING ON WORKFORCE ISSUES

10. i. Content and outcomes of training

We plan to carry out a major consultation on the content and outcomes of training to be achieved in all specialties, which will include:

— review of the current content and outcomes in the context of anticipated developments in medical practice;
— a move towards a core and options approach; and
— a generic curriculum, common to all specialties, and covering various aspects of “professionalism” including communication skills, dealing with uncertainty, clinical governance etc, building on the platform provided by the undergraduate curriculum.

Work will commence in 2006–07 and be completed during 2007–08.

ii. Academic Medicine, medical education and medical management

During 2006–08 it is also proposed that, as part of our curriculum development work, we will ensure that specialist curricula develop options for the attainment of more advanced training in academic medicine, medical education and medical management in order to provide a structured training for careers oriented to these subjects.

Postgraduate Medical Education and Training Board

March 2006

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Evidence submitted by Prostate Cancer Charter for Action (WP 24)

1. INTRODUCTION

1.1 The Prostate Cancer Charter for Action consists of 24 signatories from the voluntary and professional sector who have an interest in tackling prostate cancer. A full list of signatories is included in Appendix 1.85

1.2 Initially formed in January 2003, the Charter launched a new series of calls on 31 October 2005. These are included in Appendix 2.82 These calls represent the signatories’ shared agenda for change and are highly relevant to the issues which have been raised by the Committee’s inquiry on workforce needs and planning. We therefore welcome the opportunity to submit a memorandum to this inquiry.

1.3 The Prostate Cancer Charter for Action works closely with the Department of Health through the Prostate Cancer Advisory Group (PCAG), chaired by Professor Mike Richards, and through other channels. While we are able to feed in our views on workforce and planning to the Department through this mechanism, as a campaigning organisation we welcome Parliamentary scrutiny of this vital area of healthcare planning. We would welcome the opportunity to contribute in more detail to the inquiry, for example by submitting oral evidence if requested.

85 Not printed here.
2. **Poor Planning in the Past Has Given Prostate Cancer Patients a Poor Deal**

2.1 Over 30,000 men are diagnosed with prostate cancer in the UK every year and it has recently overtaken lung cancer as the most commonly diagnosed form of cancer in men. It is also a major killer, with around 10,000 men dying from it every year—or one every hour.

2.2 Although there have been improvements in prostate cancer services over the past few years, there is still much more to do. The National Audit Office has found that men with prostate cancer report a significantly worse experience of their care than patients with other cancers. Although there have been improvements in the prostate cancer patient experience since 1999, these have been slower than for other cancers. For example, only 50% of prostate cancer patients have a named nurse in charge of their care, compared with 61% for the other major cancers.

3. **Addressing Capacity Issues and Planning for the Future**

3.1 **Specialist Prostate Cancer Nurses**

3.1.1 The NICE Improving Outcomes Guidance (IOG) on urological cancers indicates that all prostate cancer patients should have access to care and support provided by a specialist nurse working as part of a multi-disciplinary team. The Department of Health has recognised that effective implementation of the IOG is crucial to improving patient outcomes. However anecdotal evidence suggests that there is a shortage of specialist prostate cancer nurses and that this is having an impact on levels of care (see paragraph 2.2).

3.1.2 The Prostate Cancer Charter for Action calls for specialist nurses to be appointed to all prostate cancer treatment units by 2008, with standardised funding for specialist nurse posts, focused training and national recognition for prostate cancer nurses. However, for this call to be made a reality, a comprehensive workforce planning programme will be necessary, with targeted investment in specialist nursing posts. This will be especially important as the demand for specialist prostate cancer nursing looks set to increase due to the ageing population. This trend will be exacerbated if a reliable screening test is developed.

3.1.3 There is currently no agreed definition of what constitutes a “specialist prostate cancer nurse” and evidence collected by Charter signatories suggests that nurses operate under a wide variety of different job titles and descriptions which may be considered “specialist”. Nurses also work in a wide variety of settings, encompassing inpatient, outpatient, hospital and community locations.

3.1.4 This confusion in definition can hinder career development (as witnessed by the different grades being given to specialist nurses under Agenda for Change), as well as making it extremely difficult to accurately monitor the number of specialist nurses in the NHS, plan career progression and ensure sufficient training capacity to meet future needs. Simply enshrining a proper definition of the role and title of specialist prostate cancer nurses will reduce duplication and waste in the NHS, and make it easier to measure outcomes.

3.1.5 However, current budgetary pressures are resulting in pressure on specialist nurses to undertake more general tasks, meaning that they may have less time available to devote to their specialism in prostate cancer. Some specialist nursing posts do not have core funding, meaning that there is no long term guarantee of their existence.

We would welcome a recommendation from the Committee that the Government commit itself to appointing specialist nurses—with defined job roles—to all prostate cancer treatment units by 2008, in order to improve patient care and reduce duplication and waste.

3.2 **Multi-Disciplinary Team Working**

3.2.1 The Department of Health believes that much of the reason for the inequality reported by prostate cancer patients, compared with patients with comparable cancers, is that the Improving Outcomes Guidance for Urological Cancers (IOG) was published later than similar guidance for other cancers and as a result multi-disciplinary teams (MDTs) are less developed.

3.2.2 The IOG recommends that all men with prostate cancer have their care managed by an MDT, mainly in order to improve the decision-making process. MDT’s also play a vital role in promoting specialisation and therefore saving capacity. For example, hospitals can no longer perform a radical prostatectomy unless they are doing more than 50 such major operations a year. Similarly, no surgeon is able to carry out this operation if he or she is doing fewer than five such operations a year. This is of benefit not only to the patient but also to the hospital and the NHS itself, as work is streamlined and extra capacity freed up along an economies of scale model.

3.2.3 However, the Prostate Cancer Charter for Action understands that there have been significant delays in some cancer networks agreeing IOG implementation plans with the Department of Health, resulting in delays to important workforce planning which will be vital if the IOG is to be implemented effectively. The Charter is currently undertaking an audit of the implementation of the IOG by cancer networks.
We would welcome a recommendation from the Committee that the Department of Health should conduct regular follow up audits of progress and that the implications for workforce planning should be taken into account as part of a national strategy for prostate cancer specialist nurses.

3.3 Tackling delays

3.3.1 The Government’s one and two month waiting times targets have brought a new focus on rapid treatment for all those who want it. However these targets only focus on first treatment and the Prostate Cancer Charter for Action believes that the experience gained from implementing them should now be built on to investigate all delays in the patient journey. We therefore welcome the decision of the Prostate Cancer Advisory Group to stage an investigation into delays after the point of first treatment, looking at all aspects of the care pathway including pathology, and radiology, and suggesting alternative solutions, which may involve concentrating these functions into centres of excellence.

3.3.2 Many delays occur because of shortfalls in workforce capacity and, where this is the case, it will be important that national strategies are put in place to address the problem. Without wishing to prejudge the outcomes of the investigation, we believe that delays caused by shortages in pathology and diagnostic capacity could be addressed by concentrating functions in centres of excellence for pathology and diagnostics.

We would ask the Committee to consider recommending that a pilot be established to assess the workforce implications of establishing a centre of excellence for pathology and diagnostics.

3.4 Preparing for new treatments

3.4.1 The Prostate Cancer Charter for Action welcomes any new treatment which can improve the lives of men with prostate cancer. Where the safety, efficacy and cost-effectiveness of these treatments is proven, they should be rapidly made available to all patients who can benefit from them.

3.4.2 As with all cancers, it is likely that new, effective treatments will come on-stream in the next few years. It is vital that the NHS is prepared, both financially and organisationally, to ensure that these treatments (once approved) are available to all who can benefit from them regardless of where they live.

3.4.3 Increasingly new cancer treatments are in addition to, rather than in replacement of, existing regimens. This can result in significant additional demands being placed on the NHS workforce. As new oncological interventions are developed, it is also likely that the skill sets required will change (increasingly specialist oncologists, oncology nurses and chemotherapy nurses will be in demand).

3.4.4 We would ask that the Committee recommends that NHS organisations prioritise expanding cancer capacity, in order to deliver the predicted prostate cancer treatments of tomorrow. Similarly measures which save or optimize capacity should be prioritized.

4. SUMMARY OF RECOMMENDATIONS

— The Government commit itself to appointing specialist nurses—with defined job roles—to all prostate cancer treatment units by 2008, in order to improve patient care and reduce duplication and waste.

— The Department of Health should conduct regular follow up audits of progress and that the implications for workforce planning should be taken into account as part of a national strategy for prostate cancer specialist nurses.

— The Department of Health should establish a pilot to assess the workforce implications of establishing a centre of excellence for pathology and diagnostics.

— NHS organisations prioritise expanding cancer capacity, in order to deliver the predicted prostate cancer treatments of tomorrow. Similarly measures which save or optimize capacity should be prioritized. The Prostate Cancer Charter for Action would be happy to provide further details of the issues outlined in this response, or to give oral evidence to the Inquiry.

The Prostate Cancer Charter for Action would be happy to provide further details of the issues outlined in this response, or to give oral evidence to the inquiry.

Prostate Cancer Charter for Action

March 2006
Evidence submitted by the Public and Commercial Services Union (WP 14)

INTRODUCTION

1. The Public and Commercial Services union (PCS) is the largest civil service trade union with a membership of over 325,000 working in the civil service and related areas. PCS is the largest union in the Department of Health with around 2,000 members involved in preventative, strategic or support delivery functions.

2. PCS welcomes the select committee’s inquiry, and is happy to supplement this written submission with oral evidence or further written evidence.

3. This memorandum addresses in particular the workforce needs involved in planning for the Health Service and those administrative, policy, education and strategic functions that are provided by the Department of Health.

WORKFORCE NEEDS AND PLANNING FOR THE HEALTH SERVICE

4. As a result of the diversion of resources to the delivery arm of the health sector changes have been introduced which undermine any policy or planning to effect better services.

5. The importance given to front line services at the expense of the Health Service administration has upset this essential relationship and will ultimately affect service delivery.

6. The Departmental Change Programme (DCP) and the Arms Length Body (ALB) Review have lead to job cuts and relocations which have created havoc in the service. There has been little management of the changes and the continual restructuring without any prioritisation of work or management of workloads has led to morale problems amongst the staff.

MANAGEMENT OF CHANGE

7. The Department Change Programme cut a third of posts in the department without a decrease in workload. As a result of this staff currently face unmanageable workloads and are often in positions without job descriptions or clear aims and objectives. Many long term experienced staff have taken redundancy and skills gaps are evident, however there is no money for skills training and development.

8. The diversity of the department has suffered as a result of the drastic cuts which required a level of mobility and flexibility on the part of staff within a very short time frame that was inconsistent with caring responsibilities or secondary breadwinner status. No proper equality proofing has been done of the changes.

UTILISATION OF RESOURCES

9. The change programme has resulted in significant redundancy costs to the department in order to meet an arbitrary job cuts figure.

10. The change programme has resulted in significant redundancy costs in order to achieve a figure that was totally arbitrary. The failure to plan for maintaining the same workload with a third less staff has resulted in significant expenditure on consultants and agency workers. They are being paid more than permanent staff in the department which, added to agency fees and the extra training and support resource required to get them up to speed, means the department is paying out money to maintain its services. It would appear that delivering the required reduction in permanent staff numbers is all that mattered.

11. This additional expenditure is easily disguised by the department’s inadequate records of who works for them. When Minister Jane Kennedy was asked in Parliament on 20 December 2005 how many agency staff, contractors and consultants were currently employed within the department she replied that this information was not collected centrally and could only be obtained at disproportionate cost. However, PCS are aware that one division, the Health Improvement Directorate, is spending almost £7 million a year on contractors. Another section has 180 civil servants and 170 consultants. The internal staff directory lists 1,200 contractors out of the staff in post figure of 2,245.

12. The ALB Review saw organisational changes which essentially transferred many of the department’s functions to agencies, NDPBs and the private sector. These changes have involved service disruption, additional costs in the creation of new agencies and in many cases has resulted in the department underwriting ongoing staffing and change cost to the new organisation. Again, it seems that as staff do not appear in the department’s accounts the real costs of change do not have to be quantified.

13. In many cases the formation of new agencies has become a financial black hole. The Business Services Authority (BSA) is an authority set up purely to procure and manage outsourcing. It has, because of undue haste and poor advice become a very expensive parking bay for five agencies that are earmarked for privatisation. Whilst all five agencies will go through a double transfer, different arrangements apply for each. Some go through market evaluation, some though an OJEC process and others no process at all, they are just handed to a current contractor. The Authority will have a CEO and six Executive Directors plus six Non-Executive Directors, all to manage five contracts. The only clear savings that can be seen in any of the
agencies are those to be delivered through technological change in the Prescriptions Pricing Authority. It is likely that significant costs will be incurred in changes to the other agencies in the privatisation process and will be hidden in BSA overall costs. It is unclear how this diverts resources to the frontline.

14. The proposal to outsource is not accompanied by any analysis of costs and benefits, service standards or impact on efficiency. In its current form it is hard to see how the decision was taken given there is no evidence to indicate that it will achieve efficiencies, maintain service standards, or result in the closer working between health and social care and greater stakeholder involvement. The PCS have been asking for a business case since the announcement of the decision to outsource these areas. It is apparently still being worked on.

**Privatisation**

15. In the case of the NHS Pensions Agency, part of the BSA process, a current contractor will be awarded the contract for services on the basis of an option in an existing contract. There will be no competitive tendering but rather a monopoly situation for services that were not previously scoped or considered under the current contract. The existing contractor, Paymaster, will become the biggest pensions provider in Europe. This will create a situation which is not conducive to good service provision or price control. The contract is a no risk contract because BSA have now underwritten all the costs of change including redundancies. This is a paper exercise giving the illusion of achieving efficiencies and savings but in fact hiding the real costs in a separate entity.

16. Even if the contract was opened up to competition any alternative competitors would be at a distinct disadvantage as discussions have been progressing with Paymaster and information provided to them since October last year. The implication is that there is no process for awarding lucrative contracts to, or spending taxpayers money on, the private sector.

17. The Price Waterhouse Cooper report of 15 September 2005 identifies the proposal to contract out the administration of the pensions scheme as “challenging and poses a degree of business continuity risk”. The report states that achieving efficiencies are dependent on the restructuring of the current contract, an acknowledgement that the current contract presents a barrier and also that it has not delivered the efficiencies envisaged. It also states that there is still considerable planning and structuring to be carried out before the private sector can be engaged in the process. It envisaged an OJEU open tender process in April 2006 and commercial close by 2007. The unions have been denied access to the Taylor Report of May 2005 which preceded this.

18. The union has had no involvement, and until recently, had no knowledge of either report. The process, or lack of, clearly leaves the path wide open for legal challenges, creating significant further cost risks.

**How Should Planning be Undertaken?**

19. Planning should be undertaken in consultation with the stakeholders, including the unions in accordance with statutory obligations. Planning should be long term and informed and proposals analysed in terms of progress towards specified goals. Those delivering health care services have enough to do without having to do their own administration, support and planning. They should be free to focus on delivering the services for which they have the skills whilst others get on with creating the environment in which they can deliver services most efficiently and effectively.

Public and Commercial Services Union

*March 2006*

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**Evidence submitted by Reache North West (WP 09)**

**Reache North West**

Reache North West is a purpose built centre in Hope Hospital in Salford. It has been set up to assist refugee and asylum seeking Healthcare Professionals in the North West to register their qualifications in the UK. We also assist them in seeking professional employment in the UK National Health Service (NHS). Reache works with organisations in the NHS, higher education and refugee support. The unit is funded by the Lancashire and Cumbria and Greater Manchester Strategic Health Authorities.

The professional staff at Reache are active clinicians and are involved in the training of health care students and NHS staff as well as their refugee work. All keep as up to date as possible with developments in the health service, in order to give the best service to the health professionals we help.
OUR COMMENTS

Reache would like to comment on the following item of the terms of reference:

To what extent can and should the demand be met, for both clinical and managerial staff, by:

— The recruitment of new staff in England.
— International recruitment.

1. We would ask that workforce planners be aware of the refugee health care professional resource already living in the UK. It is estimated that there are 2000 refugee/asylum seeking doctors resident in the UK, more than 1000 of whom are on the BMA database. Many of them have several years of experience in a specialty in their own country and with the appropriate support could be job ready in the UK in less time and cost than it takes to train a medical student. Utilisation of this potential workforce is hindered by recent changes to the training system of junior doctors.

2. In the past the most appropriate level for many of these doctors to enter the system was at PRHO level. As a result of the modernising medical careers programme, PRHO posts, now called F1 posts, are no longer available to refugee doctors who have undertaken a similar post in their own country. These overseas internships may not have provided appropriate experience to allow the refugee doctor to apply for a higher grade post in the NHS. This means that the refugee doctors are unable to access the new training pathways in the UK.

3. It was anticipated that there would be some F2 posts (second year post qualification) available for overseas and refugee doctors but there is lack of clarity regarding this. It would be helpful to have a clearly outlined statement of what provision is expected and how it will be implemented.

4. There are 230+ nurses on the Royal College of Nurses database and 131 dentists on the British Dental Association database, and numbers of pharmacists, radiographers and other professional groups registered with projects around the country. They all represent a potential source of experienced, highly motivated staff for the NHS.

5. We recommend that workforce planners consider value and develop the refugee health care professional resource already resident in the UK before looking to international recruitment. They will contribute to a stable, long term workforce in the NHS as well as bringing cultural diversity reflecting the local population of the areas where they work. Individual success and participation in the Health service also delivers a firm message about the valuable contribution of refugees to the UK and will aid efforts to improve social cohesion and furthering the aspirations of people from disadvantaged communities.

I hope this is of use to you, and I would be very happy to present oral evidence to the inquiry.

Dr Maeve Keaney
Director, Reache North West, and Consultant Microbiologist, Salford Royal Hospitals NHS Trust
13 March 2006

Evidence submitted by Brennan Wilson, Consultant Paediatric Radiologist, Reache North West (WP 58)

INTERNATIONAL AND REFUGEE HEALTH CARE PROFESSIONALS

1. It is thought that there are over 1,200 refugee doctors in Britain, and an unknown number of refugees who are qualified nurses, pharmacists, and so on. These people have to clear a large number of difficult hurdles before they can start practice in the United Kingdom: they must learn to speak fluent English and then they must satisfy the requirements of the professional bodies in the UK to accredit their previous qualifications and experience in this country. There are no centralised facilities for these healthcare professionals, and no recognition by official support services that they require considerable re-training before they can work here. Thus, they may be allocated accommodation by the National Asylum Seekers’ Service far distant from any suitable training centre, and their jobseekers’ allowance may be discontinued because of the length of their training. Local organisations such as REACHE North West in Manchester provide integrated training for refugee doctors and other health care workers. Here, doctors ready for work in the NHS can be trained for approximately 10% of the cost and in two thirds of the time of training a medical student in a mainstream medical school. Yet there is no central recognition of such training schemes. Accredited refugees in such schemes cannot, for example, claim a student loan, although this should be an extremely cost-effective way of producing healthcare workers. In some cases, for example the case of qualified radiographers, there appears to be no system at all for accrediting non-EU qualified professionals in Britain. All these anomalies should be corrected.

2. These refugee health professionals have been actively welcomed into the United Kingdom. In this respect they are different from the estimated 3,000 to 5,000 other unemployed qualified doctors in Britain, the great majority of whom are international medical graduates who have voluntarily come to Britain in the hope of working in the NHS. Official guidance for these overseas doctors now includes advice not to come to the UK without an offer of a job. This guidance is given, for example, to those planning to take the PLAB
examinations at foreign centres. It therefore seems unfair to expect refugee health professionals to have to compete with involuntary international medical and other graduates in the job market. The Government’s new scheme for reclassifying immigrants as at present proposed will not prevent a continued influx of unemployable foreign medical graduates. Priority should be given to refugees who have gone through the personal distress and inconvenience to come to Britain and re-train, and voluntary international doctors should not be allowed to enter Britain unless they have a firm job offer.

Brennan Wilson
Consultant Paediatric Radiologist, Tutor, REACHE North West
16 March 2006

Evidence submitted by the Refugee Healthcare Professional Project (WP 13)

SUMMARY

1. The Migrant & Refugee Communities Forum (MRCF) believes that to solve the demand for professionals working in the NHS the UK Government should focus on supporting and employing settled migrants and refugees who are overseas-qualified healthcare professionals already living in the UK and not recruit from overseas. MRCF welcomes the government initiative to consult on this issue. All information submitted here is submitted on behalf of MRCF.

2. The Migrant & Refugee Communities Forum (MRCF) is a community development agency working with migrant & refugee led community organisations. We were established in 1993 to promote the interests and rights of migrants and refugees and to strengthen their community organisations. MRCF has run a support project for overseas-qualified dentists and doctors since 2001 and has acquired experience and expertise in relation to the issues and barriers facing overseas-qualified healthcare professionals living in the UK. MRCF provides lectures, clinical training, funding, advice and guidance, study clubs, library facilities and job search support.

RECRUITMENT

3. MRCF recognises the demand for qualified dentists to work in the NHS and the drive by the Department of Health to recruit overseas-qualified dentists.86

4. MRCF believes that the demand for dentists in the NHS can be met by settled migrants and refugees already resident in the UK and should not be met by international recruitment. Resources should be given to assisting overseas-qualified dentists already settled in the UK. The costs of the IQE exams facing dentists are very high (IQE A—£600; IQE B—£650; IQE C—£1,550). There are no concessions for refugee dentists. The Department of Health subsided the IQE for all candidates in 2005 but this subsidy no longer exists and candidates have to bear the entire cost. MRCF has a database of 1,220 overseas-qualified dentists already living in the UK. Of these 136 have already passed all stages of the IQE and 29 of these are working. We therefore have 107 job-ready dentists looking for employment and 1,084 dentists working towards their IQE exams.

5. There are many experienced overseas-qualified doctors settled in the UK and recruiting from overseas would lead to wasting the skills of these doctors. The British Medical Association/Refugee Council Refugee Doctor Database currently have 1,073 asylum seekers/refugee doctors registered with them. Of those 77 doctors are currently working in the NHS and a further 219 doctors are job-ready88.

6. The majority of overseas-qualified healthcare professionals we see are keen to work in their profession and want to work in the NHS. Many have years of experience and would be a huge asset to the UK. Refugee and overseas-qualified healthcare professionals who have settled in the UK are more likely to remain in the UK than those who are brought from abroad as a temporary measure. They are therefore a more suitable solution to the problem of recruitment.

7. Recruiting refugees and settled migrants already living in the UK also supports the Department of Health policy on ethical recruitment. Issues surrounding the “brain drain” from developing countries and “poaching” overseas-qualified healthcare professionals would be tackled. Refugees did not have a choice to leave their country of origin and settled migrants are often living in the UK through marriage and other settled migration routes.


87 IQE: International Qualifying Exam. Dentists have to pass three International Qualifying Exams. The first is theoretical, the second practical on manikins, and the third is clinical on patients. Most dentists take an average of two years to pass these dental exams, and require extensive support and training to be able to achieve good results.

88 In order to work in the UK, all overseas healthcare professionals have to pass an International English Language Testing System (IELTS) exam. Following this, doctors have to pass 2 Professional and Linguistic Assessment Board (PLAB) exams, one theoretical and one practical. A lack of opportunities for clinical training hinders doctors’ chances of passing the practical exam.
8. All these principals concerning recruiting overseas-qualified healthcare professionals from refugees and settled migrants already living in the UK are equally applicable to all other healthcare professionals—nurses, allied health professionals etc. Supporting and recruiting from this pool of labour brings diversity into the NHS and ensures BME communities are represented in the health sector.

Natasha David
Refugee Healthcare Professional Project, The Migrant and Refugee Communities Forum
14 March 2006

Evidence Submitted by Roche (WP 49)

1. INTRODUCTION

1.1 Roche Products Ltd is a leading manufacturer of innovative treatments across a wide range of disease areas, including oncology, virology and long term conditions such as rheumatoid arthritis and osteoporosis. We are committed to working in partnership with the Department of Health and NHS to add value to the quality of care that patients receive.

1.2 As well as developing new treatments which can increase survival and improve quality of life, we seek to improve the efficacy and convenience of our products by offering additional support and services to patients and healthcare professionals. We have therefore gained an insight into some of the wider issues relating to the therapeutic areas in which we work, not least the impact that new methods of treatment can have on workforce needs and capacity planning. We welcome the opportunity to contribute to this inquiry.

1.3 Our response:

— Sets out the factors that will influence demand for workforce capacity, including an ageing population, changes in lifestyle, earlier diagnosis of medical conditions, increasing “treatability” of disease and existing staffing issues.
— Examines the opportunities to manage demand for capacity, including improving capacity planning, decentralising the administration of intravenous treatments, using oral therapies to free up capacity, less frequent medication dosing, maximising the effectiveness of NHS staff and utilising the expertise and capacity of other organisations.
— Assesses the steps that will need to be taken to effectively plan future workforce capacity requirements.
— Makes recommendations which the Committee may wish to consider as part of its inquiry.

1.4 We would be happy to provide more written information, or oral evidence, if the Committee would find this to be helpful.

2. FACTORS INFLUENCING DEMAND FOR WORKFORCE CAPACITY

2.1 Derek Wanless estimated that the healthcare workforce would need to be increased by almost 300,000 in the period up to 2022. He also noted that demand for healthcare professionals is likely to far exceed supply. There are many factors that will influence the demand for additional workforce capacity, including:

2.2 Ageing population

2.2.1 There are nearly 20 million people aged 50 years and over in the UK, which is one third of the total population. By 2020 this will have increased to 25 million. An increasing burden of care can be expected to result from an older population leading greater demand for skilled healthcare professionals.

2.2.2 Long-term conditions are particularly prevalent amongst older people. For example, two thirds of UK residents aged 75 and over have a long-term medical condition and one third have more than one long-term medical condition. Over 17 million people in the UK now live with a long-term condition such as asthma, arthritis, diabetes or some cancers and nearly half of this group experience more than one condition.

2.2.3 An example of the likely impact that an ageing population can be expected to have on health services is in relation to hip fractures. On the basis of current trends, hip fracture rates in the UK may increase from approximately 46,000 in 1985 to 117,000 in 2016. This alone would result in significant extra demands being placed on the NHS and social care workforce, with many fracture patients having to spend significant amounts of time as hospital inpatients or in supportive care settings.

89 Derek Wanless, Securing our Future Health: Taking a Long-Term View, 2002.
2.2.4 Similarly overall cancer incidence has increased by 31% between 1971 and 2000, partly due to the ageing population. Increases in incidence look set to continue with, for example, the Scottish Executive estimating that there will be a 28% increase in the number of people diagnosed with cancer over the next 20 years\(^94\).

2.3 Changes in lifestyle

2.3.1 The extent to which society is able to successfully encourage the uptake of healthy lifestyles will also affect the likely demand which will be placed on the NHS workforce in future. Sir Derek Wanless’ first review of healthcare identified three possible scenarios which would impact upon the demand for, and cost of, healthcare, demonstrating the extent to which demand for workforce capacity will be influenced by healthy lifestyles\(^95\).

- **Slow uptake**—life expectancy increases but people do not live longer in good health. People aged over 65 are more likely to experience long-term chronic ill health than today. There is a 10% increase in health problems requiring GP visits and hospital admissions.

- **Solid progress**—life expectancy increases but older people experience around 5% fewer health problems than today. However the probability of experiencing long-term health problems at a given age is the same as today. Roughly speaking, half the additional years gained through higher life expectancy will be healthy.

- **Fully engaged**—people live longer and in better health: as life expectancy rises, the proportion of a lifetime spent in long-term ill health declines. Acute ill-health among the elderly declines by 10%.

2.4 Earlier diagnosis of medical conditions

2.4.1 Improvements in diagnostic technology have meant that medical conditions can increasingly be diagnosed at an early stage, increasing the chances of successful treatment. However increasing diagnosis is also likely to be a factor in influencing workforce demand.

2.4.2 For example, screening programmes for breast and cervical cancer have improved survival rates and evidence suggests that the promised roll out of the National Bowel Cancer Screening Programme from April 2006 will have a major impact on survival, reducing the number of deaths from bowel cancer by 15% and saving approximately 1,000 lives a year in the UK\(^96\).

2.4.3 However screening has also increased demands on cancer services capacity. For example in 2003–04 the breast cancer screening programme screened 1.2 million women aged 50–64 and identified 8,400 cancers which may not otherwise have been diagnosed at such an early stage\(^97\). Similarly, the bowel cancer screening programme is expected to increase the numbers of patients needing treatment. It is estimated that, for every 1,000 patients who complete the Faecal Occult Blood test (FOBt), 16 will report a positive FOBt result and will be offered colonoscopy and 12 will actually undergo a colonoscopy procedure. Of these five will be found to have polyps at colonoscopy (and require surveillance) and one will actually have bowel cancer.

2.4.4 Similarly, if it is to be successful, the inclusion of condition monitoring in the Quality and Outcomes Framework as part of the new GMS Contract is likely to lead to increasing early identification of medical conditions which require treatment. In the most recent revisions to the Quality and Outcomes Framework (QOF), testing for chronic kidney disease (estimated glomerular filtration rate—eGFR) was introduced. Chronic kidney disease (CKD) is a long-term condition which may be progressive, and can be serious. 2.5 million people are thought to have CKD in the UK, however most are unaware of their condition. The introduction of eGFR testing can be expected to make a improvement in the management of CKD, ensuring that at risk people are identified early and their condition managed appropriately. However, anecdotal evidence from kidney consultants suggests that the scheduled introduction of eGFR to the QOF in April 2006 is leading to extra pressure being placed on specialist services, as GPs begin to come to terms with an area of clinical practice in which many have little prior experience.

2.4 Impact of increasing “treatability” of conditions

2.4.1 Advances in medical technology are making conditions increasingly treatable. One such example is oncology, where patients are increasingly being offered a series of interventions which were not possible only a few years ago. However new treatments are often in addition to, rather than a replacement of, existing options and are given over a prolonged period of time, resulting in increased pressure on cancer services. Very few types of cancer are now considered to be chemotherapy resistant and the list is diminishing each year.

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\(^96\) Department of Health.

2.4.2 Drug therapy is now being used to treat a rising number of cancers, increasingly at an early stage of the disease, as well as being employed as a second or third line treatment. Developments in this area are likely to substantially increase demand on chemotherapy services over the next few years. For example early in 2005 NICE published its guidance on the management of lung cancer and this included a recommendation that adjuvant chemotherapy be offered to lung cancer patients after surgery. This will represent a change in practice and significant additional work in many centres.

2.4.3 A survey of 42 hospitals published in 2003 found a huge increase in the use of intravenous chemotherapy over the past three years. The average increase was 200% with some hospitals reporting a 500% increase. Unsurprisingly this increase has had significant impact on the demands placed on the workforce. The same survey concluded that the lack of staff trained in preparing and administering new cancer treatments was a significant rate-limiting factor in making available these treatments to all who could benefit.

2.4.4 These findings are supported by the work undertaken on access to new cancer medicines by the National Cancer Director in 2003 and the Audit Commission in 2005. Professor Richards found a fourfold geographical variation in access to NICE-approved oncology drugs. The Report identified "constraints in service capacity" as having a major impact on the variation in usage. Specifically, the increased use of chemotherapy was found to have resulted in a lack of suitable space to prepare and administer cytotoxic drugs as well as shortages of specialist pharmacists, doctors and nurses.

2.4.5 So-called targeted biological therapies are also increasingly being used in addition to chemotherapies, resulting in significant improvements to patient prognosis but also increased pressure on services. Current examples include the use of Herceptin (trastuzumab) in breast cancer and Avastin (bevacizumab) in advanced bowel cancer.

2.5 Existing staffing issues

2.5.1 In addition to the healthcare trends outlined above, there are pre-existing structural issues with the NHS workforce which will impact upon future planning.

2.5.2 As well as leading to increased demand for health services, the ageing population will also affect the NHS workforce, resulting in many skilled professionals reaching retirement age. The NHS will have to recruit replacements as well as the additional professionals needed to meet demand.

2.5.3 The scale of the task of replacing experienced staff will be compounded by the historical staff shortages which have affected the NHS. Although there have been commendable increases in staffing in recent years, much of this has simply compensated for existing deep-seated shortages in skilled staff.

2.5.4 The full introduction of the Working Time Directive in the NHS will mean that more full time equivalent staff will be needed to provide the same level of capacity as before. For example, one London hospital estimates that, whilst before 1991 three doctors sometimes each working over 100 hours a week were needed on a rota to cover a speciality, by 2009 eight to 10 doctors will be needed to cover a similar rota (on duty up to 48 hours a week). Clearly it is a benefit that staff should not have to work such long hours, but it also poses challenges to capacity planning.

3. Opportunities to manage demand for capacity

3.1 Although the factors outlined in Section 2 indicate that demand for workforce capacity will inevitably rise, there are opportunities to manage this demand through effective planning and making more effective use of existing resources.

3.2 Improving capacity planning

3.2.1 As the record increases in NHS funding slow down and the demands being placed on capacity grow still further, accurate demand forecasting and effective capacity planning will become ever more important.

3.2.2 Although capacity planning in the NHS has improved, further advances are necessary. For example, both the 2005 Audit Commission Report on the implementation of NICE guidance and the National Cancer Director’s own work on the subject found that inadequate capacity planning is a major reason for delays in implementing new guidance.

100 Department of Health (June 2004) Variations in usage of cancer drugs approved by NICE: report of the review undertaken by the National Cancer Director Audit Commission (September 2005) Managing the financial implications of NICE guidance.
3.2.3 Roche recognises the crucial role of health service commissioners and managers in improving services and modernising the NHS, through effective capacity planning. Our aim is to assist with this planning process by designing and delivering innovative tools such as health economic models, business case proposals, budget impact models and service development materials.

3.2.4 For example, a service impact model has been developed that demonstrates the capacity impact of using Herceptin in early stage breast cancer to assist with both the financial and capacity planning that the NHS will have to undertake to make the treatment available to all women who can benefit. Currently, adjuvant breast cancer patients receive chemotherapy alone. Therefore Herceptin will be additive and will not be replacing any therapy for which resources are already provided. To allow effective implementation of Herceptin as a treatment for early stage breast cancer a number of factors will need to be considered by NHS trusts:

- HER2 testing pathology availability (Roche has undertaken a project in conjunction with the National Cancer Director to ensure all Cancer Networks have the necessary infrastructure in place to enable HER2 testing to occur, including making available a £1.5 million fund to assist the NHS in establishing appropriate systems).
- Treatment capacity, including pharmacy preparation time, nurse availability and chemotherapy chair space.
- Cardiac monitoring resource.

3.2.4 Similarly a Xeloda (capecitabine) implementation toolkit has been developed highlighting the key elements that are required in setting up and delivering an oral chemotherapy service (see Section 3.4).

3.2.5 These tools are being used extensively to modernise the service in the disease areas in which we have expertise. They are intended to support the stated aims of each of the National Service Frameworks (NSFs) and the national reimbursement organisations in the UK such as the National Institute for Health and Clinical Excellence (NICE), the Scottish Medicines Consortium (SMC) and the all Wales Medicines Strategy Group (AWMSG).

3.3 Decentralising the administration of intravenous (IV) treatments

3.3.1 The administration of intravenous chemotherapy is a secondary care therapy area which has the potential for devolution into community settings (within new community hospitals and larger general medical practices) to reduce demands on specialist staff, lower unit costs and increase patient convenience.

3.3.2 Devolving this form of care would be particularly beneficial for patients with long term medical conditions who are currently forced to regularly receive their therapy in secondary centres with associated travelling times, waiting times, expense and impact on the time of specialist staff.

3.3.3 However, for this opportunity to be realised, a number of steps would have to be taken which would impact upon workforce planning, including altering workforce development around the administration of intravenous therapies and relocating auxiliary skill sets including resuscitation/crash services. Recent small-scale proliferation of resuscitation services technology into primary care demonstrates the viability of relocating intravenous capacity.

3.4 Using oral therapies to free up capacity

3.4.1 Increasing the usage of oral therapies can free up chemotherapy capacity in hospital and community settings, as well as saving on nursing and pharmacy time. Such therapies have no need for IV equipment and significantly reduce staff time spent on drug preparation and administration.

3.4.2 On the other hand, IV chemotherapy preparation is a complex and time intensive procedure, involving a range of staff skills, as well as the reconstitution, mixing and diluting of raw materials. IV Chemotherapy is made up under aseptic conditions in isolator (machines used to create the correct environment for drug preparation). Only one person can work at an isolator at one time.

3.4.3 One example of an oral chemotherapy is Xeloda (capecitabine). During the NICE appraisal process for the use of Xeloda in advanced bowel cancer (NICE Appraisal No 61), the independent technology assessment group model estimated substantial NHS budget-impact savings if all eligible patients were treated with oral chemotherapies (net savings of £17 million were identified if all metastatic bowel cancer patients were treated using oral alternatives to IV). These savings were calculated using the cost of drug, plus an estimate of the resources required for preparation and administration, as compared to the cost of purchasing, preparing and delivering a standard IV drug alternative. Similarly the current appraisal process for Xeloda in early stage bowel cancer has indicated that substantial savings are possible (net £16.5 million if all early stage bowel cancer patients were treated using oral alternatives to IV).

3.4.4 There are examples of how using oral therapies is leading to significant capacity savings in practice. For example, the Mount Vernon Hospital in Middlesex reports that the introduction of oral chemotherapy has been the factor which has had the most impact on maximising capacity to date. Similarly, the Beatson Oncology Centre in Glasgow offers a nurse/pharmacy led oral chemotherapy (in this case Xeloda) service, avoiding patients being admitted to in-patient beds/day areas for infusional chemotherapy.
3.4.5 Other centres in Scotland have followed the example of the Beatson Oncology Centre. Within Grampian, the development of out-patient based Xeloda services has saved around 2,000 bed days each year. This has resulted in the abolition of oncology treatment waiting times for other tumour groups and the removal of the need for a larger cancer unit. The main pharmacy area in Aberdeen has significantly benefited from the increasing use of oral chemotherapy by avoiding the reconstitution of around 2,800 litres of IV chemotherapy annually. This is significant when we consider their workload over five years has more than tripled without a matching increase in their staffing establishment.

3.4.6 Despite the potential for oral chemotherapies to reduce the pressure on staff time and capacity in a therapeutic area which is likely to experience significant increases in demand, anecdotal evidence suggests that the current Payment by Results Tariff has resulted in some hospital trusts being disincentivised from switching from IV.

3.4.7 Hospital trusts can face a substantial loss in short term revenue by using oral chemotherapies as they require a significant drop in the required number of patient out-patient visits (for which hospitals are remunerated under the tariff). One such example is a major northern cancer centre which has calculated that, for every 100 patients it switched from IV to oral chemotherapy, it would lose over £1.5 million in revenue. This calculation is based upon the hospital only being reimbursed for eight outpatient visits per patient when being treated with oral chemotherapy, as opposed to 30 visits to a chemotherapy unit when being treated by IV chemotherapy.

3.4.8 Roche is therefore encouraged by the Department of Health’s Our Health, Our Care, Our Say White Paper commitment to review the Tariff so that it is based on best practice rather than standard national practice:

“Medical science, assistive technology and pharmaceutical advances will continue to rapidly change the way in which people’s lives can be improved by health and social care. It is important that the organisation of care fully reflects the speed of technological change . . . [the Tariff] was first introduced in the context of the reform of the hospital sector. For this reason, not everything about the current structure of the tariff aligns with the radical shift that this White Paper seeks to achieve. So we will improve it.”102

3.4.9 We would welcome a recommendation from the Committee that, under the revised Tariff, workforce capacity-saving techniques should be incentivised.

3.5 Less frequent medication dosing

3.5.1 New medical technologies also enable less frequent dosing for patients. This can have the double benefit of freeing up NHS staff time (in the event of them having to be involved in the administration of medication) and improving health outcomes by increasing patient concordance, therefore reducing future burden on workforce capacity.

3.5.2 For example, bisphosphonates are the most commonly prescribed treatment for post-menopausal osteoporosis sufferers, but require patients to follow a strict routine when taking their tablets. Patients must fast before and after taking their medication, and must then remain standing or sitting upright for between 30–60 minutes. This inconvenience is a major reason why people stop taking their treatment, and recent studies have shown that up to two-thirds of patients stop taking their osteoporosis bisphosphonate treatment within a year.103 Poor adherence has a negative effect on treatment outcomes including lower gains in bone mineral density (BMD),104 smaller decreases in the rate of bone turnover105 and a significantly greater risk of fractures.106

3.6 Maximising the effectiveness of NHS staff

3.6.1 There are also ways in which skilled NHS staff can be freed up to concentrate on areas where they have a specialist skill. Derek Wanless’ first report suggested that that nurse practitioners could undertake at least 20% of the work of doctors while maintaining the safety and quality of care. However for such a move to be effective, responsibilities would then have to be devolved from nurses to healthcare assistants, resulting in additional demand for an estimated 70,000 additional healthcare assistants, on top of the extra 74,000 Wanless forecasted would be required.107

102 Department of Health, Our Health, Our Care, Our Say, January 2006.
103 DIN-LINK data, Compufile Ltd, January 2004. NB. Patients are excluded from the analysis at the point where they stop taking therapy altogether or have failed to comply fully.
107 Derek Wanless, Securing our Future Health: Taking a Long-Term View, 2002.
3.6.2 A number of examples of service redesign, resulting in the more effective use of capacity exist:

- **Maidstone and Tunbridge Wells NHS Trust**, in partnership with the Cancer Services Collaborative “Improvement Partnership” has focussed on developing new ways of working to suit the skill mix of the team. Over an eight-week period it was found that the chemotherapy nurse spent on average 14 hours a week on non-chemotherapy tasks. A non-chemotherapy nurse or a health care assistant could perform procedures such as applying dressings or removing the cannula, allowing the chemotherapy nurse to give treatments, attend pre-assessment clinics or perform technical tasks such as the chemotherapy line insertion. The review suggested that developing the roles of nurses to perform nurse review clinics would improve the continuity in patient care, as well as making the nurses’ careers more rewarding. This would also release consultant time allowing them to see more new patients. It also concluded that additional capacity could be realised by re-structuring the scheduling system, reducing the variation in patient pathways and introducing a secure drug storage system.

- **Southend Hospital** has increased its chemotherapy unit operating times. Nursing and pharmacy staff shifts ensure all day working from 8 am through to 6.30 pm, allowing patient treatment to commence at 8.30 am.

- **The Royal Marsden Hospital** has divided the staff day into morning and afternoon sessions so that unit beds can be used twice in one day.

- **Patient Group Directives (PGDs)** free up GP capacity by enabling other healthcare professionals to prescribe. Roche has extensive experience working in partnership with pharmacists in order to create PGDs and has done so with particular success in the therapy areas of obesity and influenza. In order to help deliver an effective strategy for influenza patients, Roche worked with a multi-disciplinary team of pharmacists and general medical practitioners to develop the first National Pharmaceutical Association-accredited PGD. A PGD is a written protocol whereby a named prescriber (in this case a pharmacist) is able to supply a medication in certain situations. At-risk individuals over the age of 13 years who have symptoms of influenza will no longer have to wait for a GP appointment and can instead visit their community pharmacist who, if they consider it appropriate, will be able to supply them with anti-viral medication such as Tamiflu (oseltamivir). Similarly Roche worked in close partnership with clinicians and other healthcare professionals to allow appropriately trained pharmacists to prescribe the anti-obesity drug Xenical (orlistat). This was as part of a much broader and holistic pharmacy located weight management programme. There are now well over 100 such PGDs operational in the UK, giving patients access to professional advice and support from community pharmacists who have a wealth of experience and expertise and are often more accessible in terms of location, opening hours, rapid access and immediacy than are general medical practitioners. Only appropriately trained pharmacists have the authority to supply Tamiflu or Xenical under a PGD and each PGD is specific to the locality of a Primary Care Trust alone. For example, Wandsworth PCT has trained 10 pharmacies to run the authority to supply Tamiflu or Xenical under a PGD.

- **Medicines utilisation reviews** are incentivised under the new pharmacy contract, encouraging pharmacists to utilise their skills to rationalise a person’s medication, reducing the burden on GPs and helping avoid adverse medical incidents. However, for these reviews to be effective, pharmacists need to be equipped with the necessary skills to focus on appropriate medical conditions.

- **Shared care arrangements** enable GPs to work closely with consultants on advising a patient on medication and therefore become involved in specialist areas of medicine, freeing up consultant time in the long run. This allows the development of specialist services in a community setting for long-term medical conditions such as rheumatoid arthritis, HIV and hepatitis C, optimising the effectiveness the existing healthcare workforce.

3.7 Utilising the expertise and capacity of other organisations

3.7.1 The NHS can also maximise its own capacity by utilising the expertise and resources of others. In Section 2 we set out the capacity planning expertise which pharmaceutical companies such as Roche can provide to the NHS.

3.7.2 The pharmaceutical industry also provides significant support and advice on the appropriate use of medicines. An example of this is the Bonviva® active! Support Programme. As discussed in Section 3.5, osteoporosis patients can have difficult in concording with bisphosphonate treatment regimens. The active! Support Programme, is designed to support long term compliance with through a freephone helpline staffed by nurses who provide information on osteoporosis, as well as regular contact and support through treatment.

3.7.3 The Xenical MAP programme (to support patients through their orlistat weight loss by helping them make informed choices about their food intake, physical activity levels and weight loss goals) is another example of private sector-provided clinical support, reducing unnecessary demands upon existing NHS workforce. MAP is provided through a two-way call centre open seven days a week, 365 days a year,
managed on behalf of Roche by an independent company, International SOS. Patients are told about MAP by either their GP or pharmacy and are given a free-phone telephone number (0800 731 7138) to ring to register for the programme. Patients can opt for follow up calls at days 15, 30, 90 and 180 of their programme and can call in to MAP at anytime. All calls are with a dietician or a nurse trained in nutrition.

3.7.4 However the pharmaceutical industry could do more to support NHS workforce capacity by providing additional low cost (or free) solutions to capacity issues, particularly relating to the more holistic needs of those with long term conditions where the expertise may not always be available within the NHS. Current restrictive requirements on packaging can make it difficult to effectively draw attention to relevant healthcare services which may be available.

3.7.5 The voluntary sector can also play an important role in supporting NHS capacity. For example, many charities support nurse specialists through funding and training, increasing the resources available to NHS organisations. For example the Lymphoma Association is in the process of establishing lymphoma specialist nurses. Similarly, many patient groups operate patient support helplines staffed either by trained nurses or patients themselves, therefore reducing the demands placed on NHS staff.

3.7.6 Bowel Cancer UK's Bowel Cancer Advisory Service was set up in 1987 in response to an increasing amount of requests for specialist information on the disease, treatment options, prevention and symptoms. The Advisory Service is open Monday to Friday between 10 am to 4 pm and is run by specialist colorectal, stoma care and oncology nurses and is underpinned by Bowel Cancer UK’s team of expert advisors whose specialities range from surgery through to oncology. The Bowel Cancer Advisory Service has taken over 35,000 calls since it was established. The Advisory Service’s number will feature on all literature associated with the forthcoming bowel screening programme and Bowel Cancer UK estimates that this will further increase demand for support which otherwise would have to be provided by the NHS directly.

4. Effectively Planning Future Workforce Capacity Requirements

4.1 Roche believes that, if future workforce capacity requirements are to be effectively planned, then central guidance will be necessary alongside local innovation. We are concerned that many commissioners are unlikely to have sufficient expertise to be able to accurately predict future demand, especially in an era when patient choice and Payment by Results makes future service usage unpredictable.

4.2 If widespread staff vacancies occur then local workforce capacity planning will be made very difficult, with NHS organisations competing for too small a pool of suitably qualified staff. Therefore national strategies to address staff shortages will be required.

4.3 We commend initiatives such as the National Cancer Director’s capacity planning work as an example of how the centre can assist the devolved NHS in planning future requirements. In his report on uptake of NICE-approved drugs, Professor Richards called for the Department of Health to develop a capacity planning model for chemotherapy as part of the national review of chemotherapy services. This initiative has been led by the Cancer Services Collaborative “Improvement Partnership” as part of their work with the National Chemotherapy Advisory Group. The model has been incorporated into a broader toolkit, entitled Modernising Chemotherapy Services—A Practical Guide to Redesign, which aims to form a basis for the multidisciplinary redesign of chemotherapy services within oncology and haematology.

4.4 The pharmaceutical industry can also play an important role in developing capacity planning models and this should be recognised by the NHS in planning its future requirements.

5. Recommendations

5.1 There are a number of recommendations which the Committee may wish to consider as part of its inquiry:

— Given the expected increases in the demands placed on the workforce, capacity planning should be based on future demand rather than existing demand.

— Regular audits of available IV capacity (seats and trained personnel) should be undertaken at both a national and local level. These should be used to identify any capacity shortfalls which exist and to plan provision accordingly.

— Pilots of community-based chemotherapy should be undertaken.

— The expertise of the pharmaceutical industry and others in preparing capacity impact models should be harnessed in assisting the NHS plan.

— National planning tools should be developed to assist local NHS organisations plan workforce requirements in therapeutic areas of high demand.

— Initiatives such as using oral cancer drug treatments as an alternative to intravenous therapy should also be used wherever possible to free capacity.
— The adoption of capacity saving measures should be incentivised through mechanisms such as the Payment by Results Tariff. Any perverse incentives inhibiting the uptake of capacity saving treatments should be identified and addressed through primary care trust monitoring of local contracts with providers.

— Measures should be taken to free up skilled staff from doing generalised jobs which could be undertaken by less specialist personnel.

— The Department of Health should oversee national programmes to introduce specialist nurses for major conditions where there are currently significant shortages, such as lung, bowel and prostate cancer, as well as rheumatoid arthritis and cystic fibrosis.

— A best practice guide of examples of service redesign should be prepared by the Department of Health, providing practical examples of how staff time can be freed up.

— PGDs should be encouraged throughout the NHS.

— The NHS should be encouraged to utilise the ability of pharmaceutical companies and others to offer services which can alleviate pressures on the workforce.

Roche Products Ltd

_March 2006_

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**Evidence submitted by the Royal College of Anaesthetists (WP 11)**

The Royal College of Anaesthetists welcomes the opportunity to contribute to this inquiry. As a service speciality, the anaesthetic workforce is critical to the delivery of anaesthesia, critical and pain management in today’s NHS.

Anaesthetists undertake a much wider role than simply providing anaesthesia; they also form the majority of doctors working in critical care and pain management. Because of this variety of practice, medical staff trained as, or training to be anaesthetists, contribute to the care of 65–70% of hospitalised patients.

**Current Workforce Situation (February 2006 data)**

— Anaesthesia is the largest single hospital speciality with approximately 2,800 SHO’s, 2,062 SpR’s, 1,200 SAS Grades and 5,300 Consultants (including approximately 250 locums).

— About 400 anaesthetists enter SpR training each year and so a significant number of SHO’s never progress to SpR training.

— About 160 retirement vacancies occur each year, and there is likely to be a bulge of retirements in March 2006 and March 2007.

— Net increase of about 240 CCT holders to become consultants per annum.

— Every four to five years we increase the consultant anaesthetic workforce by 1,000.

**Future Projections**

Our currently used projection estimates that:

— 8,500 whole time equivalent consultants would be required to support a consultant delivered service.

— This means that with current expansion we will have attained 8,500 consultants in about 2,019.

— At that stage we will only need sufficient trainees to fill retirement vacancies, which would be increased to approximately 200 per year or 50% of our current SpR numbers.

— But estimates from DOH and our College show that the average consultant only works for 0.7–0.8 of a whole time equivalent during their whole career.

— This means that we will need approximately 11,000 anaesthetists to deliver a specialist based service, which at current expansion rates and using UK trained anaesthetists, would be attained in 2030.

The way in which anaesthetists contribute to clinical care can be summarised as providing elective and emergency anaesthetic services for:

— General Anaesthesia
— Critical Care
— Outreach teams
— Pre-admission clinics
— Acute medical admissions units
Anaesthesia workforce problem.

Obstetric cover altogether would free up a considerable number of consultants and alleviate the in-theatre requirement. In Critical Care a similar problem emerges in that approximately 2,500 Consultants are required to provide 24-hour cover throughout the country. Conversely, removing medically provided consultant workforce. In Critical Care a similar problem emerges in that approximately 2,500 Consultants are required to provide 24-hour cover throughout the country. Conversely, removing medically provided consultant workforce. In Critical Care a similar problem emerges in that approximately 2,500 Consultants are required to provide 24-hour cover throughout the country.

The range of activities is sufficiently wide and specialised that in many instances, there are sub-speciality on-call rotas and limitations in the possibilities of daytime cross-cover.

Elective services—current situation

Anaesthesia in the UK is currently very safe, with a very low morbidity and mortality. The quality delivered is excellent and we would not be prepared to see this diminished in any way. As trainees complete their training, although competition in some parts of the UK is increasing, it is rare to find one who does not get appointed to a consultant post within a reasonable time. This would tend to suggest that there is still an unfulfilled need for consultant anaesthetists. It is difficult to get an exact estimate of vacant posts because many Trusts do not advertise until they think there are suitable applicants or indeed prefer, because of financial constraints, to leave them unfilled. Hospital Training Visits do however, continue to reveal significant areas of service which are regularly covered by trainees. Although this is possibly good for their experience, it can seriously limit their advancement of new skills. The use of trainees for service purposes to the detriment of their training continues to worry the College. On the other hand, what level of service commitment is appropriate for trainees at various stages of their Specialist Registrar training is something that needs further discussion. In addition there has been a very strong growth in SAS grade doctors, (sometimes to cover out-of-hours rotas) as a result of the reduction in junior doctors from EWTD implementation. If they continue to play a major part in out-of-hours work, the opportunity for in-hours training of junior anaesthetists will decrease as their working hours are further reduced and will reach critical levels if the European working time directive continues to be strictly implemented. In contrast, the consultant workload is increasing at an alarming rate, partly because of sheer volume and also because of covering relatively inexperienced trainees both within and out-of-hours. This unpredictable rise in clinical commitment is currently causing considerable stress in the older consultants, resulting in early retirement.

The specialty also uses non-consultant career grade doctors as to provide service (often by plugging unpopular gaps) and as a result, they can feel misused and recruitment is poor. Training is often minimal, supervision is nominal and few people are interested in their career progression. It is crucial that we increase the status of doctors in this role and be inclusive and use all those involved with anaesthesia, critical care and pain management to their best ability. It is however our stated policy that all trainee and NCCG staff must be responsible to a named consultant.

Non-Medically Qualified Anaesthesia Practitioners

As a Speciality, we are also faced with considerable challenges to traditional work patterns and have been asked to look at non-medical roles within anaesthesia. Many of the more senior anaesthetists in the UK have had considerable experience of working in such systems, both in Europe, Scandinavia and North America but it is by no means a straightforward solution.

The Royal College of Anaesthetists and the Association of Anaesthetists have been actively involved in developing and piloting the training of Anaesthesia Practitioners to work as part of the anaesthetic team, providing an alternative workforce opportunity in some hospitals. The Royal College of Anaesthetists has produced the following statement on Skill-Mix within Anaesthesia:

“Council of the Royal College of Anaesthetists supports the concept of the anaesthetic team and the development of non-medical roles within it. Council further supports the concept of medically-led delivery of anaesthesia, critical care and pain management, in order that the current low levels of morbidity and mortality in our specialty can be maintained.”

Emergency Services—Current Situation

Anaesthesia offers a wide range of out-of-hours emergency services, both in general anaesthesia, obstetrics, intensive care and a wide range of specialist rotas covering neurosurgery, cardiac surgery and paediatric anaesthesia and intensive care. As a result of the combination of greater demand, reduced junior doctors hours and no rationalisation of the out-of-hours service, many trainees and trained specialists spend a significant proportion of their work covering these rotas, increasingly on a full shift basis.

If all the out of hours work was to be done by consultants, every emergency anaesthetic service would require far more consultant staff than are currently available. For example, obstetric anaesthetic cover on a 24-hour basis by Consultants would require approximately 2,200 consultants, or almost one third of the consultant workforce. In Critical Care a similar problem emerges in that approximately 2,500 Consultants are required to provide 24-hour cover throughout the country. Conversely, removing medically provided obstetric cover altogether would free up a considerable number of consultants and alleviate the in-theatre anaesthetic workforce problem.
With the current numbers of anaesthetists, we are so dependent on trainees that the Royal College of Anaesthetists has calculated that we would have to rationalise the use of approximately 100–150 acute hospitals in order to maintain a safe service. ie one-third of all those hospitals in the United Kingdom who currently have trainees covering out-of-hours rotas would have to have no night time operating or anaesthetic cover.

Staffing emergency rotas will always be a problem because of the quality, risk management and safety aspects which apply. The emergency workload inevitably diminishes daytime availability of both trainees and Consultants. We have found from experience, and this is supported by our trainees, that the ideal training rota is a one-in-eight with prospective cover, which provides one period of on call and four days work together with a day off after the night on-call, per week. Rotas, which are any more frequent than this, are detrimental to both service and training. Shifts are unpopular, produce difficulties with training and adversely affect continuity and “seeing a patient through” the whole treatment episode.

The number of on-call rotas, which are provided in any single hospital, is a major source of difficulty since they have to be divided into the total staff available. Those, which reflect sub-specialist practice, have a high dependency on consultant attendance. In many people’s opinion, it is only a matter of time before Consultants being resident on call is the norm rather than the exception (unless of course Consultants start to work in shifts, with the European working time directive applying to everyone). Certainly this is already happening in intensive care medicine, where, with the introduction of Modernising Medical Careers, increasing numbers of inexperienced doctors will be rotated through intensive care units to obtain basic experience and “tick competency boxes”. Many are not anaesthetists and therefore do not possess the necessary skills to allow distant consultant supervision out of hours. As a result we will need to have large numbers of consultants on-call and living in. On the plus side, if senior staff are involved in on-call rotas, it is usually possible to remove one or two tiers of junior staff as a result, thereby increasing training opportunities.

**Terms of Reference**

*How effectively workforce planning, including clinical and managerial staff, has been undertaken, and how it should be done in the future?*

Anaesthesia, including intensive care medicine and pain management, regularly contributes data to and takes part in the Department of Health’s Workforce review team’s analysis. Our data is drawn from census information, initially gathered on an annual basis and now every three years with a 100% return rate from our census questionnaires across all hospitals in the UK. The problem with workforce predictions relates to the inevitable assumptions which are necessary and which constantly change. Some of these are outlined above. Other examples include:

— It still takes seven years to train an anaesthetist and given that we have to start planning to reduce numbers about five years ahead, how far in advance should this process commence in order achieve the correct balance by 2019 or 2030? This will depend on how fast consultant anaesthetists take on out of hours work and also, in turn, when consultant surgeons do the same as increasing numbers do now, the demand may well fall.

— But as outlined above, in order to provide 24 hour consultant cover in obstetrics would itself require 2,200 WTE consultants and so it only needs a decision to provide, for example, an anaesthetist on every acute care team, to further distort the figures.

— Almost every new initiative, however, will require more, rather than less anaesthetists.

— How many consultants, either male or female, will want to work full time for the whole of their anaesthetic careers?

— Will the changes in gender balance of medical graduates produce significant changes in anaesthetic recruitment and retention?

— How many will follow other interests, management, teaching, training, Deanery work, etc?

— Will future trainees put location in advance of their career preferences and therefore sustain competition in some parts of the UK and on-going shortages in others?

— Will a consultant job be for life in the future?

There will also always be significant uncertainties such as:

— How many posts are agreed but not advertised for financial reasons.

— How will alterations in service delivery and the introduction of ISTC’s etc alter the workload.

— How will alterations in surgical, radiological and pharmacological techniques affect the demand for anaesthesia.

— How will increasing demand for acute and critical care affect the demand for intensivists?

— Demographic changes.

— Possible political decisions to provide less care because of affordability; this is most likely to affect Critical Care.
How much further will our speciality expand? Some believe that by 2020 the only 24 hour acute “physicians” in hospitals will be anaesthetists or Emergency and Acute Medicine physicians.

In considering future demand, how should the effects of the following be taken into account

Recent policy announcements, including Commissioning a patient-led NHS

Anaesthesia is increasingly involved in areas of healthcare outside our traditional role. If patients are to be offered more choice and more locally delivered care, this will increase demand not only on workforce, but also to ensure the continuing competence and clinical governance of specialists, if their practice is increasingly remote from major hospital departments.

Technological change

This constantly affects anaesthesia, but the benefits are in patient safety and quality of care, rather than on workforce needs.

An ageing population

The expectation of patients to receive treatment despite significant co-morbidity makes enormous demands on anaesthetists, both in terms of increasing numbers of cases but also in pre-and post anaesthetic assessment and recovery and also on high dependency and critical care facilities.

The increasing use of private providers of services

If this is transferred activity, then the actual demand on anaesthetic services should not be great, but if it is additionally, then this has obvious workforce implications. Efficiency gains occur from undertaking operating lists rather than isolated cases, distributed in different locations.

How will the ability to meet demands be affected by:

Financial constraints

As we have outlined, many Trusts have unappointed anaesthetic posts and rely heavily on trainees to deliver service work from an early stage. On current estimates, in Consultant “PA terms”, the weekly service contribution of anaesthetic SHOs is 2 PAs, and of SpRs, 3-4 PAs.

The European Working Time Directive

This has had a major impact which is largely being addressed by full shift working. Of major concern is that this Directive applies to all doctors, not just trainees, and career grade staff are increasingly working unmonitored hours well in excess of EWTD.

Increasing international competition for staff

This certainly occurs in anaesthesia and 50% of current anaesthetic SHOs have not received their primary medical training in the UK. However anaesthesia is an easily internationally transferable skill and many UK anaesthetists have worked in Europe and further afield and continue to do so.

Early retirement

Anaesthesia is an acute and high risk speciality, which many find very stressful. Very few anaesthetists, particularly with the high demand for out of hours work, are anticipating working beyond 60, and the average retirement age at present is around 58.

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

The question of introducing non-medical roles has already been covered. One could ask whether the aspiration of a Consultant delivered service is crucial to future workforce predictions in terms of trainee numbers? In fact the current situation is unsustainable. There are two choices:

— If we continue to use the same number of trainees to deliver service work, but don’t create consultant posts for them to take up, we will overproduce by 240 CCT holders each year.

— If on the other hand, service work which trainees undertake is transferred to career grade posts, then expansion in the number of such posts is essential.
**Better Retention**

Many anaesthetists leave the service for very simple reasons. Job planning is very insensitive to the changing demands of age, gender and external responsibilities. Key reasons for leaving are frustration with the system, boredom (being asked to do the same work day after day), on-call commitment (a major problem), managerial interference and not being allowed to do what they are good at and take a pride in. Anaesthetists like any other employee deserve to feel satisfied, feeling valued and competent with a reasonable work/life balance, which if necessary allows flexible and part-time working.

**The Recruitment Of New Staff In England**

We have already considered non-medical roles

Other possibilities include:

- Offering SAS grade staff additional training. This would have to be done with temporary, additional training numbers as many of them have entered the SAS grade having failed to obtain a national training number and thus fulfil the prescribed, pro rata time commitment. Although this may be solved with the advent of competency based training, there is still a need to be able to offer trainees a more expeditious route to a consultant post or alternative style of employment which does not carry the connotations of ‘failed doctor’. Like all specialities anaesthesia needs to recruit pragmatically for the following reasons:
  - The 2006 Medical school intake is more than 70% female.
  - Anaesthesia is and should be a family friendly speciality.
  - Work/Life balance issues are increasingly important to today’s doctors.
  - However, training programmes cannot be infinitely flexible if they are to be fair to everyone and new ways of training need to be explored.

**International recruitment.**

Overseas trainees. For many years the Health Service has relied upon overseas trainees coming to fill vacancies in the UK. This has occurred because of a shortage of our own trainees and also because of the natural desires of doctors from other countries to come and work in the UK. Everyone has the right to be part of an international mobile medical workforce. However, although it is comparatively easy for an overseas trainee to come to the UK for training, either by obtaining PLAB and then applying for a job, and subsequently limited registration, or on a sponsored programme through ODTS, the difficulty of getting on a recognised training programme is another matter altogether. As a result many overseas trainees end up disillusioned and feeling used and abused which is not what we should be trying to achieve.

Trained overseas doctors. At the present time there are significant initiatives to attract trained doctors to come to work in the UK from European or other countries. It is recognised that the training will not necessarily be compatible with immediately appointment to a consultant post in the UK and so it is intended that they should come and spend one or two years “acclimatising” to the British system. The assumption is that they will then perhaps work here for a few years before returning to their home country but we do not have evidence that this will be so. It is quite likely that those who come will apply for consultant posts and obtain them in the UK; particularly those who have a right of entry to the specialist register as EU nationals anyway.

European Regulations on Interchangeable Speciality Recognition. EU enlargement has and will continue to introduce large numbers of trained anaesthetists into the European labour market and this has the potential to distort workforce planning, in both the immediate and the long term.

**How should planning be undertaken?**

To what extent should it centralised or decentralised?

National planning is essential, and we have found that combining our data collection with the Department of Health has been very valuable in keeping a regular and current view of workforce requirements. New initiatives or commitments made centrally can have profound consequences on workforce requirements and proper consultation is essential before politically sensitive commitments are made to the public. Public expectation is a major workforce driver, which can significantly distort longer term planning, for example, the provision of 24 hour consultant cover in obstetrics or critical care.
How Is Flexibility To Be Ensured?

By continuous monitoring of issues, which affect either workforce demand, duration of training or patterns of working. These must include the effect of lifting the absolute ceiling on training time with the introduction of competency based training, and continually assessing the whole time equivalent correction factor; that currently used is 0.82. Is this applicable to all specialities or should it be individually adjusted? In anaesthesia, we estimate this should more accurately be 0.7 over a whole career.

We need to know what the intentions of Trusts, Hospitals and PCTs are about the future development of services and then work out the workforce implications in an informed way.

What Examples Of Good Practice Can Be Found In England And Elsewhere?

We have outlined the process undertaken within anaesthesia and critical care by the Royal College of Anaesthetists and the Department of Heath’s Workforce Review Team.

Dr Peter Simpson
President, Royal College of Anaesthetists
13 February 2006

Evidence submitted by the Royal College of General Practitioners (WP 66)

INTRODUCTION

1. The Royal College of General Practitioners submits this Memorandum of Evidence to the Health Committee’s Inquiry into Workforce needs and planning for the health service, and expresses its willingness to give evidence at a later date.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the “voice” of GPs on issues concerned with education; training; research; and clinical standards. Founded in 1952, the RCGP has over 24,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

3. Workforce planning for such a large and diverse organisation as the NHS is a complex task which requires considerable expertise. It has not worked well to the extent that whilst there has been a major expansion of the consultant workforce, the number of GPs has only risen slightly so that, for the first time, we have roughly the same number of GPs and consultants in the NHS. International studies looking at the ratio of generalists to specialists suggest that health outcomes, including mortality rates, correlate to this ratio with better outcomes where the number of generalists exceeds the number of specialists. Of course, the NHS needs good specialists but it needs many more good generalists and the two can work together in balanced partnerships.

4. In recent years such planning has been blighted by constant changes in the mechanisms used without giving any single mechanism time to establish itself.

5. At a national level the mechanism for planning the medical workforce, lead by the Specialist Workforce Advisory Group, was disbanded as a result of the recommendations of A Workforce for all the Talents. The subsequent Workforce Numbers Advisory Board tried to grapple with all the clinical staff in the NHS, and was doing innovative work around clinical scientists for example, when it was disbanded. The parallel mechanisms for planning based on National Service Frameworks simply replaced the criticised vertical silos representing professional groupings with horizontal ones representing artificial and incomplete patient groupings. Additionally, planning of this sort tends to be related to single disease conditions, whereas the majority of elderly people live with more than one chronic condition.

6. At a local level Local Medical Workforce Advisory Groups, Non-Medical Education & Training Consortia and, later, Workforce Development Confederations, were introduced, under-resourced, poorly supported at a senior level and abandoned.

7. Shifting the Balance of Power made any attempt at centralised planning difficult and centralised control impossible. From the General Practice point of view, the disbanding of the Medical Practices Committee has blocked any progress that might have been possible in redressing the imbalances between the most well
doctored and the least well doctored Primary Care Trusts and this imbalance remains at a ratio of almost two to one, with the least well-doctored areas correlating highly with areas of deprivation. It is for this reason that the College believes GP workforce distribution to be an health inequalities issue.

8. All policy announcements, including Commissioning a Patient-led NHS, should have, as an integral part of the document, a careful and considered analysis of the workforce consequences of the policy.

9. Technological change cannot be accurately predicted in the timescale of medical workforce planning but an effective process of horizon scanning should inform such planning.

10. The requirements for health care of an ageing, but increasingly healthy, population need to continue to be addressed.

11. There is a need for new schemes and incentives to encourage GPs to work in deprived areas.

12. Private providers must be planned into the total provision of service and either must directly contribute to training and career development of health service staff or must pay a premium to use staff they have had no part in training.

How will the ability to meet demands be affected by financial constraints; the European Working Time Directive; increasing international competition for staff; early retirement

13. Financial constraints are already causing problems. A number of Strategic Health Authorities have cut back on training of General Practitioners by as much as 10% to reduce costs. Given the transfer of work into the community this cannot be anything but short-sighted. It also contradicts the advice the WRT were disseminating two years ago to deliver adequate numbers of GPs for England.

14. The future effects of the European Working Time Directive from 2009 are being considered by a national Stakeholder group. However one of the key solutions for hospitals—transferring work to the community—has not been complemented by appropriate planning of the primary care workforce to accommodate such increases in workload.

15. At present there is little evidence of wholesale emigration of doctors or other key staff. However, neither is there any evidence of coherent planning to retain staff in circumstances of changing demography. While the NHS medical education and training systems stand comparison with the rest of the world, there will always be people keen to come here to work and train. Increased numbers of UK medical graduates and the recent changes in immigration regulations have signalled that the NHS sees itself as soon becoming self sufficient. Whether this turns out to be accurate or not remains to be seen. There are widely differing views.

16. Early retirement is multifactorial. It is noted that the large number of GPs anticipated to retire in 2003–04 and in 2004–05 did not do so and the question is asked whether they delayed retirement to secure the pension enhancements of the nGMS contract to be introduced. There is no coherent strategy within the NHS to accommodate changing aspirations of the workforce at differing stages of their careers.

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

17. Skill mix in all its facets will continue to be important in seeking solutions to health care resources. However, planning this requires inter-disciplinary co-operation and not just one professional group “dumping” on another. The long term effects of changing the job expectations of groups of staff need to be evaluated.

18. Retention is an issue and all surveys show that constant change and a feeling that they are not valued are the major determinants for people leaving the service.

19. Recruitment, like retention, needs to demonstrate to people that they are valued. Part of this is having coherent personal and professional development strategies. The recent sudden change in the funding and management of the Flexible Careers Scheme (retrospectively applied in year) is a major disappointment and an example of appalling practice which can only de-motivate staff and inhibit recruitment. A real sense that there is no connection or continuity between training and employment or between various stages of employment is a barrier.

20. International recruitment is a complex issue with, on the one hand, recruitment from within the EEA and the reciprocal acceptance of qualifications and, on the other hand, the sudden and unheralded announcement changing the immigration rules to greatly disadvantage applicants from outside the EEA will change the balance of applications. Ethical considerations also play a part in recruitment from under-doctored countries and the local domino effect in places such as Southern Africa is of concern.


How should planning be undertaken?

21. Planning must be centralised to even out imbalances and inequalities and to manage scarce resources but there must also be scope for local innovation.

22. Flexibility can be managed by appropriate systems of control. It need not imply anarchy.

23. There are many examples of good practice but usually developed to deal with local circumstances. Transplanting these without careful thought has not always been successful.

Dr Maureen Baker  
Honorary Secretary of Council, Royal College of General Practitioners  
17 March 2006

Evidence submitted by the Royal College of Midwives (WP 54)

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 families.

The RCM welcomes the opportunity to contribute to the Health Committee’s inquiry into workforce needs and planning for the health service, particularly given the continuing shortage of midwives in the NHS and the high dropout rate for student midwives.

SUMMARY OF RECOMMENDATIONS

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 RCM recommends that the DH publish without delay the plan of how it will implement not only the maternity standard of the National Service Framework for Children, Young People and Maternity Services but all other relevant commitments made on maternity services, including its manifesto commitments.

The RCM recommends that the DH act to reduce unnecessary intervention, particularly caesarean sections, increasing home births and births that take place in midwife-led units and birth centres. This will cut unnecessary demands on the midwifery workforce and aid retention.

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 recommends that providers of NHS maternity services should be prevented from establishing schemes aimed at income generation that detract from their ability to provide high-quality and equitable maternity care for all women and families.

The RCM further recommends that commissioners should explore the potential for contracting with midwifery group practices to provide antenatal and postnatal care services in deprived areas or in the event of GP practices opting-out of providing such services.

The RCM recommends that current NHS deficits should not be addressed by cutting maternity services budgets or by cutting the number of places for student midwives. Given the continuing chronic national shortage of NHS midwives, the number of places for student midwives must actually be increased.

The RCM recommends that the impact of the European Working Time Directive is taken into clearly into account when planning future workforce requirements.

The RCM recommends that to readjust the age profile imbalance of the midwifery workforce more student midwives are trained and brought into the profession.

The RCM recommends that trusts are required to provide sufficient support to NHS staff to allow them to undertake continuing professional development.

The RCM recommends that Agenda for Change be implemented in full if the retention benefits flowing from it are to be realised. The current NHS deficits are no justification whatsoever for any further delay in implementation or for attempts to water down the agreement. Moreover, three Secretaries of State for Health are on the record as stating that Agenda for Change is fully funded.

The RCM recommends the urgent introduction for all student midwives of an annual non-means-tested £10,000 bursary to replace all existing financial grants and bursaries.
The RCM recommends an induction and support programme for all midwives in their first year of NHS practice.

The RCM recommends that—given the lack of places offering adaptation programmes to midwives coming from other countries because of our midwife shortage—funding is in place to ensure that places offering such adaptation programmes are available to midwives able and willing to work in the NHS in England.

**The NHS midwifery workforce**

Current midwife numbers are insufficient to deliver a universally first-class service to women and these numbers have only crept up very gradually since 1997.

Using the Department of Health’s own non-medical workforce census, which provides a snapshot of staffing in England as at 30 September each year, the number of whole-time equivalent (WTE) midwives in England’s NHS has risen by a little over 4% from 18,053 in 1997 to stand at 18,854 in 2004 (the latest year for which figures are currently available). The headcount figure is better—rising by 11% from 22,385 in 1997 to stand at 24,844 in 2004. However with increased part-time working, it is the WTE figure that more accurately reflects staff availability.

This is in the context of a greater workload, more screening tests to be carried out, more first-time mothers, a higher caesarean section rate and other factors that place greater demands on midwives.

Moreover, the equivalent increases in the overall nursing, midwifery and health visitor workforce were much higher: the combined WTE figure for all the professions combined was up 23% and the headcount up 25% over the same period.

In addition to the NHS figures, the Royal College of Midwives itself produces an annual staffing survey. The latest—a snapshot as at 1 July 2005—revealed that:
- 74% of maternity units in the UK (78% in England) were experiencing vacancies;
- 59% of all these vacancies had been unfilled for more than three months; and
- in England, vacancies represented 5% of actual establishment (in London this was 12% and for the South East it was 9%—the two most problematic areas).

It is in this context that the RCM makes its submission.

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.

**Recent policy announcements**

Recent policy announcements such as those contained in the National Service Framework for Children, Young People and Maternity Services and indeed in the Labour Party manifesto 2005 compel every trust to meet certain commitments regards minimum level and standards of care in maternity services.

The Labour manifesto promises that: “by 2009 all women will have choice over where and how they have their baby and what pain relief to use. We want every woman to be supported by the same midwife throughout her pregnancy.”

Currently, although England’s maternity services are safe, the chronic national shortage of midwives means that we do not yet have the kind of first-class service that women, the NHS and the Government clearly want and deserve. More midwives are needed before this high-quality service can be delivered.

This is a position supported by the Department of Health Minister the Rt Hon Jane Kennedy MP, who in her recent oral evidence to the Committee on NHS Charges confirmed the impact the shortage of midwives is having on delivery of first-class care:

“one-to-one midwifery support is part of the National Service Framework, it is a commitment we made in our manifesto. The brake on us delivering that is the lack of midwives and we are working hard, as in other areas, to increase the numbers of people in that area. I think it has increased by 2,200. Progress is being made on that score but it is slow . . . The only reason they are not getting it is because we do not have enough midwives to be able to provide it and that is why we are increasing the numbers and trying to raise the profile of midwifery as a career and promoting it as a career.”

The RCM recommends that the DH publish without delay the plan of how it will implement not only the maternity standard of the National Service Framework for Children, Young People and Maternity Services but all other relevant commitments made on maternity services, including its manifesto commitments.
**Technological change**

Birth is an increasingly interventionist and medicalised practice; as a result, postnatal hospital stays are longer, which places additional demands on the midwifery workforce.

The percentage of spontaneous births, for example—as opposed to instrumental or caesarean—fell from 76.5% in 1980 to 66.5% in 2003–04. At the other end of the intervention spectrum, the percentage of caesarean deliveries has more than doubled from 9% in 1980 to 22.7% in 2003–04.

This increased level of intervention leads directly to longer postnatal hospital stays for the mother. Figures for 2003–04 show that where the onset of labour was spontaneous, 94% of women whose babies were born spontaneously—ie without any intervention—and mothers were out of hospital within three days; this fell to 86% of those whose babies were delivered with the use of an instrument, such as forceps; and of women whose babies were delivered by caesarean, only 57% were out of hospital within three days. These numbers were roughly the same for those women whose labour was induced.

With intervention in birth increasing, that places more and more demands on the midwifery workforce.

The shift towards greater intervention and medicalisation is not however inevitable, provided that there are sufficient numbers of midwives to support women during pregnancy. In our written evidence to the House of Commons Health Committee Maternity Services Sub-Committee’s inquiry into Provision of Maternity Services in 2003 we were able to cite evidence that at some trusts intervention can be kept to a minimum by intensive midwifery support of women during pregnancy and birth.

Moreover, the additional burden resulting from elevated levels of intervention comes at a time when the overall number of births is also increasing: there was a 5% growth in the number of births in England in 2003–04 compared to the previous year. This places yet more demands on midwives.

The RCM recommends that the DH act to reduce unnecessary intervention, particularly caesarean sections, increasing home births and births that take place in midwife-led units and birth centres. This will cut unnecessary demands on the midwifery workforce and aid retention.

**An ageing population**

Increasing numbers of older women are becoming pregnant and they are making up a growing proportion of all pregnant women. Midwifery care for such women is more demanding and this has a direct impact on what is required from the midwifery workforce.

Between 1991 and 2003 the number of women in England aged 40 or over conceiving almost doubled from 11,497–20,128. That is a 75% increase in 12 years. This happened at the same time as the overall number of conceptions to all women in England actually fell.

It is also noteworthy that over this period the abortion rate for women aged 40 or over fell (from 41.8%–34.9%), so not only were more women in this age bracket conceiving but a greater proportion were also having babies.

The 2003 figures also show that 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. These are the women whose pregnancies will require the most from midwives.

It is also relevant to midwifery not only to look at older mothers but also at pregnant teenagers, who need additional help from midwives. Again, a comparison between 1991 and 2003 shows a rise in England in conceptions in this group. Conceptions to those aged under 16—the youngest teenagers requiring the most assistance—actually rose by 529 over that period despite the overall number of conceptions to all women falling by 41,183.

The ageing of the profile of pregnant women and the increased numbers of the youngest teenage mothers have a direct effect on care that midwives must provide.

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.

**Increasing use of private providers of services**

The provision of private maternity services in England is very limited.

Around 593,600 births took place in England in 2003–04, of which about 0.5% occurred in private hospitals.

Additionally, a total of only 407 births (out of a total of around 593,600) were attended by an independent midwife. That amounted to less than 0.07% of the total.

As suggested by the number of births attended by an independent midwife, their numbers are limited. In May 2004, for example, the stated total membership of the Independent Midwives Association was 47. As a comparison, in September 2004 there were, according to the Department of Health, 24,844 midwives working in the NHS in England alone.
So, the current non-NHS provision of maternity services is largely irrelevant to the question of workforce needs and planning, and indeed many of the very small number of deliveries attended by an independent midwife end up using NHS—and not private—facilities.

There is of course the possibility that an international company could “enter the market” and set up maternity units in England. This could happen as part of a contracting out of GP provision to a private company, which might very well include traditional GP functions in antenatal and postnatal care. This could then lead to the trusts commissioning private companies to operate maternity units. Such a process would not be easy however. Even European companies would not find it easy to set up here: in February 2006 the European Parliament voted to exclude healthcare from the scope of a European Directive that aims to make it far easier for EU companies to set up in other countries. The European single market in services, especially in healthcare, is far from complete. Nevertheless, this remains a possibility, however this process would not create any new midwives and it is the ongoing chronic national shortage of midwives that is the central problem.

Should this happen, the RCM would want such companies to be bound tightly by the very same rules and regulations that apply to NHS providers. Of paramount importance would be the quality of care provided to women.

Very recently we have witnessed the emergence—in the Jentle Scheme at Queen Charlotte’s Hospital—of what might be described as a kind of NHS/private hybrid. As the Committee knows from the evidence it took in its recent inquiry into NHS Charges, the Jentle Scheme offers one-to-one midwifery care throughout pregnancy to women able and willing to pay £4,000 to the trust. The College does not support this scheme because by linking one-to-one care with wealth it will undermine totally attempts to reverse health inequalities. The RCM believes that care should be free at the point of need. This is not a model we would advocate other NHS trusts follow nor is it a blueprint for the future of the NHS.

The RCM recommends that providers of NHS maternity services should be prevented from establishing schemes aimed at income generation that detract from their ability to provide high-quality and equitable maternity care for all women and families.

The RCM further recommends that commissioners should explore the potential for contracting with midwifery group practices to provide antenatal and postnatal care services in deprived areas or in the event of GP practices opting-out of providing such services.

Financial constraints

Most maternity units are facing static or falling budgets and over a quarter are being asked to reduce midwife numbers or use cheaper, less qualified staff to care for women as a result of budget pressures. This will inevitably limit the ability of maternity units to meet demands placed upon them.

As part of our latest annual survey of Heads of Midwifery (HOMs), the RCM asked all HOMs whether their budget had increased over and above inflation: 28% said it had increased; 19% said it had decreased; and 54% said that it had stayed the same.

It is surprising that in a time when the demands on midwives are increasing, almost three-quarters of units have a static or falling budget.

For the first time this year we also asked HOMs whether they had been asked to reduce their staffing numbers or alter the skill mix as a result of trust-wide budgetary constraints. 26% reported that they had; 29% that they had not; and 44% gave no answer.

Further evidence from HOMs revealed that maternity care assistants/maternity support workers were being used to combat budget pressures rather than as a way to improve care. This was not the reason these new roles were created and we fear that budget pressures are leading to reductions in the quality of care in this way. The RCM supports the use of such staff as a part of the team supervised by midwives to enhance continuity of care and subject to ensuring that statutory requirements are met.

The RCM recommends that current NHS deficits should not be addressed by cutting maternity services budgets or by cutting the number of places for student midwives. Given the continuing chronic national shortage of NHS midwives, the number of places for student midwives must actually be increased.

The European Working Time Directive

As a part of the same survey, we asked HOMs who felt that they had an inadequate number of midwives what factors contributed to that. One third identified a reduction in junior doctors’ hours as contributing to that situation. It is therefore identifiable as a factor for many maternity units in trying to meet the demands placed upon their midwives.

The RCM recommends that the impact of the European Working Time Directive is taken into clearly into account when planning future workforce requirements.
Early retirement

A clear desire amongst midwives to retire over the coming years and an ageing profession point clearly to a workforce problem on the horizon that must be addressed sooner rather than later.

In December 2005, the RCM surveyed 6,000 of its members. The survey revealed that when asked in which year they plan to retire, more than half stated a year that fell between now and 2017, which is a little over a decade away.

One factor behind this may well be the ageing of the midwifery workforce. By comparing the age profile of midwives given in the last four statistical analyses of the Nursing and Midwifery Council (NMC) register (from the 2001–02 analysis through to 2004–05), a picture of the situation emerges. In the age profile given for 2001–02, 44.1% of midwives were aged under 40 but by 2004–05 this had dropped substantially to 31.6% (down 12.5%). The age profile of NHS midwives is now significantly older than even four years ago.

The RCM recommends that to readjust the age profile imbalance of the midwifery workforce more student midwives are trained and brought into the profession.

Changing the roles and improving the skills of existing staff

The position of the midwife as the primary carer for women experiencing normal pregnancy and birth has remained essentially unchanged for many years. Over the years however midwives have proved themselves very adaptable to the changing NHS environment.

Moreover every midwife is responsible not only for maintaining their existing skills but also ensuring that they become competent in any new skills required for practice.

Both the adaptability that midwives possess and the requirement to keep their levels of competency up-to-date are demands on midwives’ time and the RCM is concerned that insufficient support is being given to midwives to enable them to do this.

For example, research commissioned by both the RCM and the Chartered Society of Physiotherapy into the attitude and experiences of both midwives and physiotherapists in relation to NHS reforms and their working lives revealed that: 69% of midwives received none or less than two days’ formal on-the-job training; and 36% of midwives had received time off for education and training that they had organised and paid for themselves [Wilkinson F (2006) NHS Reforms and the Working Lives of Midwives and Physiotherapists: an interim report].

The RCM recommends that trusts are required to provide sufficient support to NHS staff to allow them to undertake continuing professional development.

Better retention

An important aim of the Agenda for Change pay system was better retention of NHS staff, including midwives. This was achieved by, for example, lengthening pay bands so that an individual’s pay did not plateau so soon after being placed on a pay band. The effectiveness of Agenda for Change as a tool for improving retention is evidenced by NHS Employers who consider a 25% improvement in retention rates over the next 25 years to be reasonable.

In addition it is know from work commissioned by the RCM that where midwives are able fully to utilise all their skills—for example in midwife-led units—retention is greatly improved.

The RCM recommends that Agenda for Change be implemented in full if the retention benefits flowing from it are to be realised. The current NHS deficits are no justification whatsoever for any further delay in implementation or for attempts to water down the agreement. Moreover, three Secretaries of State for Health are on the record as stating that Agenda for Change is fully funded.

The recruitment of new staff in England

As the age profile in particular shows, 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 more of them make it into NHS practice and have a post to go to on qualification.

The present dropout rate amongst student midwives is around 20%. This is making it very difficult to deliver the extra midwives the NHS needs as too many training places are taken up by individuals who will not finish the course and will not therefore go on to practise as midwives within the NHS.

To reduce the proportion of student midwives who drop out of their studies we must see greater financial support for student midwives to keep them in their studies and lead them through to qualification and into NHS practice. Indeed, financial hardship was the main reason cited by student midwives who have dropped out of their studies.
Financial support for student midwives is currently a hotchpotch of bursaries and grants with some means-tested and some not. With student midwives more likely to be older and therefore more likely both to have pre-existing financial commitments and with three-quarters having dependent children, and with their spare time taken up with clinical placements, these financial pressures can become acute.

To address this the RCM has consistently called for an annual non-means-tested bursary of £10,000 for all student midwives. An EDM (number 197) calling for just such a bursary has—as of 15 March 2005—secured the support of 170 MPs, including over 100 Labour MPs; more than half of all LibDem MPs; over half the members of the Health Committee; the entire Plaid Cymru and Democratic Unionist parliamentary parties; and overall more than a quarter of all MPs.

In addition, all new midwives should have an induction and support programme for their first year of practice to assist them in consolidating the skills and competences they have on qualification. This will assist them to be able to cope with the stresses and strains of employment in today’s overworked maternity units—for example, simultaneously caring for two or more women in labour.

The RCM recommends an induction and support programme for all midwives in their first year of NHS practice.

International recruitment

International recruitment of staff is not as great for midwives as it is for other NHS professions, such as nursing, and so provides limited scope for meeting future workforce requirements. Genuine solutions must be homegrown.

Our HOMs survey, for example, showed a slight increase in the number of units reporting that they recruited from overseas “very frequently” compared to last year (up from 6.5% to 11%). The number of units who have recruited “occasionally” from overseas however has remained at 9% whilst the number of units who have recruited on a “seldom” basis is just 1.4%. Those who have “never” recruited from abroad is now 75%, compared to 73% last year. Three-quarters of units therefore are unaffected.

Whilst it may be relatively straightforward to recruit nurses from overseas, midwives from outside the European Economic Area wishing to practise in the UK as a midwife must complete an adaptation programme which varies depending on the preparation programme they have already gone through in their home country. This can require strong resource commitments from HOMs and senior staff but it can be shown that where these resources are committed rewards can be achieved as the overseas midwife stays in practice.

The RCM recommends that—given the lack of places offering adaptation programmes to midwives coming from other countries because of our midwife shortage—funding is in place to ensure that places offering such adaptation programmes are available to midwives able and willing to work in the NHS in England.

Royal College of Midwives
March 2006

Evidence submitted by the Royal College of Nursing (WP 42)

1. INTRODUCTION

1.1 The Royal College of Nursing (RCN) represents over 380,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets in the UK. This makes the RCN the largest professional union of nursing staff in the world. The RCN promotes patient and nursing interests on a wide range of issues by working closely with government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

2.0 SUMMARY AND RECOMMENDATIONS

2.1 The RCN recommends a comprehensive centralised function for workforce planning across the UK health sector. This approach will ensure that the gaps in knowledge about the workforce are filled, trends can be monitored, including movement between countries and different health sectors (private and independent) and also the profile and aspirations of the workforce.

2.2 This approach is fundamental to ensuring NHS care is fair and equitable rather than dependant on local circumstances or markets which could lead to variation in healthcare staffing and care quality.

2.3 Worryingly it is unclear where workforce planning lies under the reconfigured NHS. This is especially important with the increase in choice and plurality of providers.
2.4 There is a growing body of evidence that links the numbers of registered nurses in the acute hospital sector to patient outcomes. Effectively, patients are more likely to die in the surgical settings studied when there were fewer registered nurses on the ward. The RCN recommends that further research is urgently needed to ascertain impacts of the workforce on patient outcomes in order to base changing roles within the health care workforce rather than merely cost.

2.5 The patient: nurse ratio findings are particularly worrying given the context of financial pressures on the NHS in which the RCN has noticed a growing trend to limit workforce numbers. All Trust should have the option to stage deficits for an agreed period of one to three years as agreed within the health economy where achieving in year balance may restrict choice and adversely impact service provision.

2.6 Advanced and extended nurse roles have made a considerable contribution in a number of areas for instance reducing junior doctors hours, and caring for patients at home avoiding hospital admissions. The RCN recommends more attention is paid to advanced nursing roles within workforce planning including investment in nurse education.

2.7 Technology must be properly integrated into working systems, alongside increased access for nurses and healthcare staff supported by training and education.

2.8 The RCN welcomed the Governments drive to increase the number of nurses. However, sustainability in the level of growth of registered nurses is unlikely in the future. Continued focus on recruitment and retention is vital including sustained use of good employment practices.

2.9 Agenda for Change (AfC) incorporated into service contracts in the same way that soft facilities AfC rights have been safeguarded in the private sector, likewise NHS pension regulations.

2.10 Code of Practice on international recruitment is extended to the independent and private sectors and made mandatory.

3. HOW EFFECTIVELY WORKFORCE PLANNING, INCLUDING CLINICAL AND MANAGERIAL STAFF, HAS BEEN UNDERTAKEN?

3.1 Until recently, healthcare workforce planning in England was more centralised. National data has been collected and trends monitored by the national Workforce Review Team with implementation by Workforce Development Confederations aligned to each Strategic Health Authority (SHA). However, responsibility for workforce planning does not appear to be included as part of the newly configured SHA and we do not know where this function will lie in the future or even if it will still exist.

3.2 Information on the health care workforce has been and remains limited and imperfect which works against effective planning. The RCN commissions an annual Labour Market Review (LMR) of the nursing workforce and an annual employment survey of RCN members to monitor workforce developments. The RCN identified shortcomings in workforce information in 2002 and compared progress made on these gaps in 2005 (Appendix 1).

3.3 The RCN welcomes the Governments drive to increase the number of nurses which has seen an increase in registered nurses in the NHS by 23% full time equivalents in England since 1997. However, the recruitment drive has not ended staffing shortages, prevented nurses working unpaid overtime or reduced reported heavy workloads. Furthermore, increased student nurse commissioned places is being undermined by vacancy freezes due to deficits. These graduates will be lost to the system.

3.4 The growing demands of the health service combined with a growth in evidence linking the numbers of registered nurses in the acute hospital sector to patient outcomes including quality of care and patient satisfaction, and clinical outcomes including adjusted mortality rates and morbidity rates, contribute to the imperative that nursing numbers should be maintained at an appropriate level.

3.5 For example, recent independent research in the UK setting by Professor Anne Marie Rafferty, University of London, reveals that for surgical patients in 30 NHS acute hospitals their chance of associated mortality was increased by 12 to 49% in hospitals with the lowest registered nurse to patient ratios. Put another way patients are more likely to die in the surgical settings studied when there were fewer registered nurses on the ward. This is supported by a review of research by West, Rafferty and Lankshe are research that demonstrated links between higher numbers of registered nurses in the nursing workforce with improved patient outcomes in the US.

3.6 Determining the threshold or ideal equation of registered nurse to patient ratios is complex and not amenable to national prescription, for a number of reasons including seriousness of patient illness and case mix, treatment and support function facilities and even ward lay out. However there are some key principles which ward managers can apply to determine appropriate (rather than minimum) nurse: patient ratios. The RCN is currently developing work in this area.

108 Buchan, J. and Seecombe, I. Op Cit
109 Forthcoming publication: personal correspondence.
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 (CPLNHS)

4.1.1 There is uncertainty and low morale amongst the nursing workforce about the impact of CPLNHS. A major concern relates to issues of employment, specifically who will employ them. This may impact on their decision to take early retirement or leave the service.

4.1.2 The drift of the Government’s White Paper “Our health, our care, our say” proposes moving care away from the acute and into community settings. However, the increased role for nurses in the primary and community sector indicated by the White Paper could be undermined by the age profile of this group of nurses. When compared with the average age of all NHS nurses, this particular workforce has the oldest age profile with about 23% of District nurses, Health visitors and Community nurses aged between 40 and 50 years. Moreover, some nurse specialisms for example Health visitors have seen no growth in numbers and others, such as District nurses have experienced a decline in numbers.

4.1.3 Under the CPLNHS proposals Primary Care Trusts would remain employers as long as they wanted to, the reality is that PCTs service provision in many cases may be outsourced. The TUPE protection for staff moving from the public to the private sector is a very weak provision and easily eroded.

4.1.4 The RCN want to see Agenda for Change (AfC) secured. This means that AfC terms and conditions are incorporated into service contracts in the same way that soft facilities AfC rights have been safeguarded in the private sector.

4.1.5 Similarly, there is no provision for the independent sector or private businesses to adhere to NHS pension regulations. The RCN does not want to see the reforms delivered through a two-tier workforce and recommends that if a provider supplies an NHS service is should be under NHS conditions.

4.2 Technological change

4.2.1 The RCN welcomes the introduction of new technology and the impact that this could have on the nursing and healthcare workforce. Currently, the amount of time nurses spend on administrative work is estimated to be around 25%. The evidence of the impact of technology use in Telehealth on the clinical workforce suggests that a decrease in workload would be achieved only where integrated technological solutions are used and where workflows are changed to reflect new ways of working.

4.2.2 In 2005, an RCN survey of members highlighted access and training as key issues. Access to IT is mixed although 88% of members used a computer daily about a third shared a computer with around 20 people. Also, community nurses have very limited access if at all. The survey also found a major lack of IT training opportunities within the NHS. The user needs to have the knowledge to use the technology effectively.

4.2.3 In addition the data—patient records—need to be complete and current in order to provide appropriate care. Of those who responded to the survey 63% felt that without timely access to accurate and complete records, the care they deliver could be ineffective or even unsafe.

4.2.4 The RCN recommends that technology must be properly integrated into working systems, alongside increased access for nurses and healthcare staff supported by training and education.

4.3 The increasing use of private providers of services

4.3.1 The Government’s drive toward increasing patient choice and the diversification of providers will undoubtedly make workforce planning more complex, with increased competition for nursing staff in local labour markets.

4.3.2 With the increase in providers it is likely that there will be more variation in terms and conditions of nurses’ employment contracts. The RCN recommends using Agenda for Change pay scales in all sectors incorporated into service contracts. If organisations are providing an NHS service it should be under NHS conditions.

4.3.3 The contract for Wave 1 of the Independent Sector Treatment Centres (ISTC) contained an additionality clause which prevented providers from employing staff who either worked in or had worked in the NHS in the previous six months. This clause is being relaxed in the current procurement for phase 2 ISTCs. The clause will only apply to staff in specialist areas where there is a known shortage. The work undertaken to identify shortage has raised concerns regarding the lack of workforce information in relation to nursing.
5. **How Will the Ability to Meet Demands Be Affected By:**

5.1 **Financial constraints**

5.1.1 The RCN has been monitoring the impact of financial constraints on patient care services. The RCN believe that deficits in trusts in England could hit £1.2 billion. Last year’s National Audit Office report indicated that deficits totalled £140 million, however, for this year there have been reports that the total level of deficits could be between £750 million (Health Service Journal) and £1.6 billion (Health Emergency).

5.1.2 We have noticed a general trend in how NHS organisations progressively respond:

- Bans on the use of temporary staff;
- Vacancy freezes—this impacts on the intake of students;
- Limitations on service provision, for example, health visiting;
- “Disinvestment” in some clinical services;
- Staff redundancies, voluntary or compulsory.

5.1.3 In order to prevent instability in service provision Trusts should be allowed to operate within a more flexible financial regime. Short term cost cutting can seriously impact medium and long term improvements in service provision. In an RCN survey of 1,000 nurses in February 2006 over a quarter of those surveyed cited that patient treatments were being delayed in order to save money.

5.1.4 All Trust should have the option to defer deficits for an agreed period of one to three years as agreed within the health economy where achieving in year balance will restrict choice and adversely impact service provision.

5.1.5 Furthermore, sustainability in the level of growth of registered nurses is unlikely in the future, partly as a result of increased government funding in the NHS ending in 2007–08.

5.2 **The European Working Time Directive (EWTD)**

5.2.1 Implementation of the EWTD, without compromising patient care, demands new approaches to staffing and service deliver with Nurse practitioners and other advanced nursing roles making a positive impact on patient outcomes.

5.2.2 Advances and extended nurse roles have made a considerable contribution to current compliance with EWTD/reduced junior doctors working hours and this is recognised within the Department of Health evaluation of the “Hospital at Night” scheme. Nurses are now often the first point of contact and deal with a substantial proportion of patients who are acutely ill and need intervention. As of June 2005, over two dozen hospitals across England have implemented the Hospital at Night concept for out-of-hours cover.

5.2.3 More generally, a joint Department of Health/RCN recent survey Maxi Nurses: Advanced and Specialist Nursing Roles reveals that advanced nursing practice (by nurse practitioners, clinical nurse specialists, specialist nurses and nurse consultants) has significantly contributed to improved patient care and service capacity, including caring for patients at home thus avoiding hospital additions. In addition these roles aide meeting targets in a variety of settings including accident and emergency departments and clinical diagnostic services:

- 60% of these nurses’ time is spent in clinical activity;
- one third say patients can access their expertise directly; and
- one quarter provide on-going and continuous care and treatment of the same patients.

5.2.4 There is also hard evidence to demonstrate the effectiveness of nurse practitioners in patient care. For example a recent Cochrane review—which is a “gold standard” structured review of research—found that nurse practitioners in primary care had at least equivalent patient outcomes to doctors, and in fact scored higher in terms of patient satisfaction.

5.2.5 However there are difficulties for nurses in obtaining funding for national courses in advanced practice such as the nurses practitioner programme, and also problems with “backfilling” their posts whilst they study. Yet appropriate education and support is an essential prerequisite for advanced nursing roles.

5.2.6 The RCN recommends more attention is paid to advanced nursing roles within workforce planning including investment in nurse education for advanced nursing roles across a range of sectors including mental health and learning disabilities.

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5.3 Increasing international competition for staff

5.3.1 International recruitment grew rapidly in the late 90s and last year accounted for about 40% of new entrants Nursing and Midwifery Council (NMC). Apart from data from the NMC register on nurses entering the UK, there is no monitoring of the movement of international nurses either in the NHS or the Independent sector. There is no available data on the flow of UK-trained nurses going to work abroad or the movement of nursing staff between the four UK countries.

5.3.2 Buchan’s report for the Kings Fund reports on the country and demographic profile, motivations, experiences and career plans of recently recruited international nurses working in London, and gives a detailed insight into why they have come to the UK, and what their future intentions are. In order to put these findings in context, the paper also outlines the overall trends in the number of nurses coming to the UK, and examines the policy context in which international recruitment activity has been conducted.

5.3.3 The NHS in London has more staff vacancies and shortages than the rest of the country and employers have become increasingly reliant on overseas health workers to make good the staffing shortfall. The annual survey of RCN members in 2003 found that 14% of nurses based in London had qualified outside the UK compared with just 4% in the UK as a whole.

5.3.4 London is also more vulnerable to outflows of these workers. Buchan argues that alongside the challenge to develop effective human resources strategies to support and integrate these staff in the NHS will be the challenge to retain these staff as other countries seek qualified staff to boost their own workforces. Sustained use of good employment practice that encourages staff to stay in, and return to, the NHS and the local recruitment of new workers as part of a “grow your own” strategy, will, according to Buchan reduce the need for international recruitment.

5.4 Early Retirement

5.4.1 The RCN annual employment survey 2005 shows that one in six of all nurses intend to continue to work in nursing beyond retirement age which is 60 for current employees. There is some variation between sectors; the planned retirement age of respondents in the independent sector is 60 (NHS, 59) and respondents’ ideal retirement age is 57 (NHS 56).

5.4.2 In 1991 one in four (26%) nurses on the register was aged under 30 but by 2005 this had dropped to only about one in 10. At the same time, the proportion of nurses on the register who were 55 or older had risen from 9% to 16%. More than 100,000 nurses are now aged 55 or older and a further 80,000 are 50 to 55 years-old.

5.4.3 Buchan argues that the level of nurses leaving the register is bound to grow as the large numbers aged 50-plus increases over the decade. It is also likely that fewer of the older nurses who remain on the register are likely to continue working and older nurses who do continue to work are less likely to work full-time.

5.4.4 This is partly because of the reductions in student nurse intakes in the early to mid-1990s. It is also partly the result of a trend towards an older age profile of students with more mature entrants, and the emphasis on attracting those returning to the profession.

5.4.5 The main challenge for workforce planning will be to replace the 180,000 nurses who are 50 plus and who are considering retirement or to encourage them to delay retirement.

5.4.6 The impact of phasing in a higher pensionable age for new entrants will also need to be monitored in terms of retirement behaviour and its effect on the attractiveness of nursing as a career.

6. To what extent can, and should demand be met, for both clinical and managerial staff by:

6.1 Changing the roles and improving the skills of existing staff

As stated above, nurses have expanded and advanced their roles in order to accommodate reform, and improve patient care. However, further investment in educational preparation for advanced practice roles is needed in order to continue to progress this trend.

6.1.2 There are difficulties for nurses in obtaining funding for national courses in advanced practice such as the nurse practitioner programme, and also problems with “backfilling” their posts whilst they study. Changing the roles of healthcare staff is much more complex than simply passing work from one group, for

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example doctors, down to another, for example nurses, and so on. Changing roles is also a dynamic process and depends upon the numbers of staff, their skills and expertise, patient acuity and case mix, but especially how health care staff function and work together as a team.

6.1.3 The evidence base in this area is limited, but growing. There are three main areas of research, which can inform current policy and practice: improving multi-disciplinary team work; skill mix within nursing; and, skill mix between nurses and doctors.\textsuperscript{119, 120}

6.2 \textbf{Better retention and the recruitment of new staff in England}

6.2.1 The 2004 report on improving recruitment and retention in primary care commissioned by the Department of Health\textsuperscript{121} aimed to find out what will assist Primary Care Trusts and Workforce Development Confederations to establish flexible and supportive entry routes and programmes that will enable nurses to work in primary care at registered nurse level.

6.2.2 The RCN Labour Market Review 2004-05\textsuperscript{122} also gives some figures on the number of nurses completing return to practice courses and other data on retention and recruitment of nurses.

6.2.3 Research suggests that nurse choice in shift decisions may alleviate some of the ill effects of shift work, and may promote nurse recruitment, retention and return to practice. Work schedules impact on many aspects of nurses’ working and domestic lives, and on their retention in the workplace. A number of studies suggest that nurse retention is related to control or choice over working lives and conditions, and that rigidity of rostering results in increased nurse turnover.\textsuperscript{123}

6.2.4 Student attrition is another area of concern. A survey carried out by Nursing Standard magazine revealed that around one in four student nurses are failing to complete their training courses. The RCN recommends monitoring students’ reasons for leaving their training in order to provide evidence that could help to reduce attrition rates in the future.

6.3 \textbf{International recruitment}

6.3.1 A report, by the Health Systems Resource Centre,\textsuperscript{124} provides an overview of the implications of international recruitment of health workers to the United Kingdom. The authors recommend that data on the numbers of international nurses recruited by and working in the NHS be routinely collected. They also suggest that Department of International Development examine the potential of working with representative bodies from the independent sector to develop a parallel Code of Practice on international recruitment.

6.3.2 Our member survey indicates the heavy reliance that nursing has on overseas recruitment. Although all registered nurses are included on the UK Work Permits shortage list, this is currently being reviewed with a steer from the Department of Health to remove nursing from the list. If this is actioned it will create difficulties for ensuring an adequate nursing workforce.

6.3.3 The RCN recommends that data is collected on the numbers of international nurses recruited from overseas and working in the NHS and private sector and monitored.

6.3.4 The RCN also recommends that the Code of Practice on international recruitment is extended to the independent and private sectors and made mandatory.


\textsuperscript{121} Flexible entry to primary care nursing project 2004, Improving recruitment and retention in primary care, Vari Drennan, Sarah Andrews, Rajinder Sidhu, Project leader: Professor Sarah Andrews. Commissioned and funded by the Department of Health


7. How Should Planning be Undertaken?

7.1 To what extent should it be centralised or decentralised

7.1.1 In the early 1990s workforce planning was left to local planning decision and direction. This led directly to shortages of registered nurses because insufficient numbers of pre-registration nurse education places were commissioned, insufficient attention was paid to independent health sector recruitment, and local and national problems with recruitment and retention of qualified nurses were not detected or remedied.125

7.1.2 The RCN believes there should be a centralised function for workforce planning across the UK health sector in order that trends can be monitored, including movement between countries and different health sectors but also the profile and aspirations of the workforce. This is fundamental to ensure NHS care is fair and equitable rather than dependant on local circumstances or markets which could lead to further variation in healthcare staffing and care quality. The approach will also avoid “see-sawing” with drives to recruit then redundancies.

7.1.3 The international literature seems to support workforce planning for the entire health service “integrated workforce planning” taking into account changing roles and the reconfiguration of services.126

7.2 How is flexibility to be ensured?

7.2.1 Knowledge about local and regional workforce and labour market issues will be vital, however as the number of employers increase and job mobility and flexibility increases, monitoring movement between employers will need to be centralised in some way.

7.2.2 Without this approach, there will be more scope for ever increasing gaps in knowledge about the healthcare workforce as nurses move in and out of the NHS or increasingly work through banks and agencies, making strategic planning increasingly more difficult to manage.

7.3 What examples of good practice can be found in England and elsewhere?

7.3.1 The growing recognition of the linkages between effective staffing levels and outcomes (including patient safety) have led to attempts to identify the “best” methods of determining staffing levels.127, 128 However there is evidence that different systems applied in the same care environment will give different staffing “answers”.129

7.3.2 Examples of computer-based projections and simulation models used to forecast human resource needs are discussed along with their limitations.130 Best practice examples are given from Scotland where planning involves projections, combined with involvement from stakeholders (see below).

Multi Stakeholder Workforce Planning in Scotland

The nurse workforce planning system in Scotland is one working example that involves employers and the private sector in national level nurse workforce planning.131 This annual system uses “bottom up” planning involving all health service employers, as well as representatives from nursing associations and the education sector. The approach attempts a whole system perspective by factoring in estimates of future demand for nurses from the private sector. There is now a statutory duty on the NHS in Scotland to carry out workforce planning.

7.3.3 Some countries have used national recommended staffing rates but these vary in terms of definition, source, and the extent to which they could be regarded as mandatory or minimum, and they often apply to narrow, precise specialties.

Alison Cairns
Royal College of Nursing

15 March 2006

126 Tackling Nurse Shortages in OECD Countries 2005; Steven Simoens, Mike Villeneuve and Jeremy Hurst for the Directorate for Employment, Labour and Social Affairs.
## APPENDIX 1

### MIND THE INFORMATION GAP: GROWING THE WORKFORCE

**Things we need to know** | **The reality**
---|---
(1) We do not have accurate UK wide attrition rates during pre-registration of nursing and midwifery education. | A common definition has been agreed in England for common measurement but there is currently no complete and comparable data across the UK.
(2) We do not know with any accuracy how many newly qualified nurses and midwives take up employment in the NHS or elsewhere. | No improvement: has been made more problematic because of changes in student indexing.
(3) We have little published evidence of the actual retirement behaviour of nurses; a vital issue given that so many are in the 50+ age group. | Little improvement: and the issue is now even more significant because of ageing workforce and proposed changes in NHS retirement scheme for future entrants.
(4) We have no accurate knowledge of how many of the growing number of overseas registrants are actually working in the UK, or where they are based. | No improvement. NHS in England does not record how many international nurses it employs, despite this being recommended by House of Commons Committee. No accurate information on outflow of nurses.
(5) We have only scant information on the “cross border” flows of nurses between the four UK countries—this is likely to become a growing issue with devolved government and diverging health policies in the four countries. | No improvement in published information.
(6) We have no recent detailed information on the actual number of “re-entrants” who stay working in the NHS after refresher training, where they are working, and the hours they work. | Worsened. Return to practice data no longer collated in national level in England.
(7) We do not have consistent or complete information on vacancy rates across the four countries to assess the impact of shortages. | No improvement; and more questions being asked about relevance of “point in time” three month vacancy rate.
(8) We do not have complete data on flows of “joiners and leavers” in the NHS to assess with any accuracy the current sources of recruits and destinations of nurses leaving the NHS. | No improvement in England; major source is OME sample survey, with worsening response rates.
(9) We have only scant information about the dimensions of the growing non-NHS nursing labour market and the “flows” of nurses between the NHS and other nursing employment. | Worsened. Data no longer collated nationally in England.
(10) We do not have UK wide information about the ethnic composition of the UK nursing population or workforce, to enable any assessment for potential to recruit, or to monitor equal opportunities in employment. | Attempts at improvement, but changes in definitions, and large “unknown” response rate limit utility of data.

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**Evidence submitted by the Royal College of Ophthalmologists (WP 33)**

**Executive Summary**

1. The Royal College of Ophthalmologists (the College) thanks the Health Committee for this opportunity to contribute to the Inquiry into workforce needs and planning for the health service. The College has been very active in anticipating the workforce required to deliver quality eyecare for patients equitably throughout the UK. We have published a chapter on “Medical Workforce in the Hospital Eye Service” as part of our Ophthalmic Service Guidance and this is available in the public section of our website http://www.rcophth.ac.uk/docs/profstands/ophthalmic-services/WorkforcePlanningOct2005.pdf

   The College also has a tradition of collaborating with other professional groups (orthoptists, optometrists etc) to ensure ready patient access and the best use of NHS resources.

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2. In summary, the College’s concerns centre on:
   (i) The challenges presented by an ageing population as so many eye conditions are age-related.
   (ii) The disruption of the balance between the number of specialists completing training and the
        number of opportunities for their employment.
   (iii) The local recruitment of doctors specifically to deliver targets to the detriment of services for
        patients with complex or chronic debilitating conditions.
   (iv) The trend towards short, fixed term and locum contracts for career doctors.
   (v) The employment of less well qualified doctors to take inappropriate levels of responsibility.
   (vi) The knock-on effect on the provision and quality of training for the next generation of specialists.
   (vii) The need to improve the status and training of Staff and Associate Specialist (SAS) grade doctors
        who deliver much of the hospital eye service.
   (viii) The trend away from salaried contracts to fee-for-service for professionals.
   (ix) The impact of the European Working Time Directive (EWTD) which from 2009 is likely to
        significantly reduce the availability of a 24 hour on-call service.
   (x) The number of uncertainties that make workforce planning difficult and these include:
       (a) Whether the changes in the gender balance of medical graduates will result in changes in the
           recruitment and retention of ophthalmologists.
       (b) Whether the introduction of Independent Sector Treatment Centres (IS-TCs) will affect
           hospital eye units that offer a total service to all local patients.
       (c) The extent to which retirement of medical staff before the age of 65 can be predicted

3. The College’s response now follows based on the issues raised by the committee:

**Effective Workforce Planning**

4. The College collaborates with the Central workforce team and for many years planning was very
   effective, achieving a balance between specialist vacancies and the provision of qualified specialists.
   However, since recruitment was devolved to a local level, and particularly in the last two years, consultant
   opportunities have fallen by 50% as preference has been given to (cheaper) less well qualified doctors. The
   emphasis on delivering volume to meet targets has benefited certain patients but has been to the detriment
   of those patients with more complex or chronic blinding conditions (e.g. diabetic retinopathy, glaucoma) who
   require more comprehensive holistic care. Newly qualified specialists, expensively trained through years of
   postgraduate education are unemployed, taking locum positions or being lost overseas.

**Workforce Needs**

5. The Modernising Medical Careers (MMC) initiative has developed a robust training scheme for
   specialists and the Postgraduate Medical Education and Training Board (PMETB) has recently approved
   the College’s curriculum. This is intended to produce a specialist who can provide comprehensive quality
   care for patients and manage ophthalmic provision for local communities in collaboration with other
   professional groups (orthoptists, optometrists, nurses, medical photographers). The Association of Health
   Professions in Ophthalmology (AHPO), worked with the College to develop training programmes to extend
   the expertise and versatility of staff across professional boundaries. This has led to a Foundation Degree for
   Ophthalmic Science and Technology offered at New College, Nottingham and is an example of good
   practice that will result in more comprehensive services for patients.

6. Connecting for Health and the electronic patient record will facilitate ophthalmic assessments on
   different sites by a variety of professionals as the results are recorded in digital format. However diverse the
   delegation, the process needs to be medically led to ensure high standards of diagnosis and clinical decision
   making and ensure quality through robust audit. The College discourages isolated practice, preferring
   professionals to work in group premises for the protection of the patients and the mutual support of the
   professionals.

**Future Planning**

7. The ophthalmic workforce should be planned centrally, taking demographic and epidemiological data
   into consideration, to ensure the most accurate projections. Implementation should be undertaken more
   locally but in areas of sufficient size to facilitate cooperation (rather than competition) between the primary
   community services—e.g. health centres, optometric practices, community hospitals—working in harmony
   with the treatment centres and more comprehensive hospital services. Quality care for the management of
   patients with ophthalmic disorders, including accidents and emergencies, should be available for all patients
   within their locality, with experienced senior specialists managing teams of ophthalmologists and other
   professionals to ensure the best outcome. Travel to centres of excellence should be reserved for those with
rare conditions which require super-specialist treatment modalities. Fragmentation of services into separate groups with separate contractual arrangements leads to dysfunctional delivery of care. Planning of initiatives in separate areas of the Department of Health requires close communication and cooperation to ensure no duplication of effort or conflicting solutions. Planning at a more devolved level inevitably leads to duplication of effort in each locality. Flexibility can be ensured by training the workforce in extended roles such as through the AHPO scheme. A pyramidal structure led by senior clinicians, with planning in partnership with managers both for the community services, treatment centres and hospitals, leads to a seamless service for patients. Local or short term contracts for services lead to disrupted care for patients and an uncommitted and disillusioned workforce. They make multidisciplinary team working much more difficult to establish and weaken continuity of care for patients.

**TRAINING THE WORKFORCE**

8. Training should be part of the way of life for all healthcare professionals. It should be undertaken in an environment providing holistic care where the patient’s needs are central and there is an ethos of cooperation and integration. Professionals in fixed term or locum posts are unsuitable for training the professionals of the future. Similarly overseas professionals on short term working holidays are not subject to the rigorous UK appointment systems, on-going appraisal or other clinical governance procedures.

9. The numbers training for each profession should be regulated centrally and be in balance with the anticipated need assessed on a countrywide scale. For example, orthoptists belong to a specific paramedical profession and are crucial to the management of children with ophthalmic problems and to the screening in schools for children with visual impairment. Orthoptists are a versatile profession and with appropriate training, readily take on other tasks when necessary. However there is a severe shortage nationally as training opportunities have been reduced and children’s screening services have been curtailed in some areas.

10. Optometrists also represent a valuable resource in the delivery of eye services and are trained in considerable numbers. With appropriate additional training and working in medically led teams, they may deliver ophthalmic screening and primary care in the community. However, the Department of Health will need to consider the economic rationale of such a system.

11. Mechanisms for continuing education and professional development should be in place for all professional groups delivering healthcare and robust appraisal and revalidation procedures should be rolled out to safeguard the patients.

Royal College of Ophthalmologists

15 March 2006

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**Evidence submitted by the Royal College of Physicians (WP 51)**

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 20,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

We have been actively involved for many years in defining workforce needs for patients who require the services of consultant physicians working within a team of other health professionals. Most recently this has culminated in the College working with its specialty committees to produce Consultant physicians working with patients: The duties, responsibilities and practice of physicians in general medicine and the specialties.1 This publication analyses the service needs for patients and proposes the likely workforce requirements within the UK for consultant physicians within each specialty. This document, and over the years its earlier versions, have proved invaluable in providing the NHS Workforce Review Team with a logical target for planning, especially with regard to the required number of National Training Numbers (NTNs) for each specialty. Specialties frequently review the roles of consultants and junior doctors in relation to other clinical and support staff and this work has resulted in more detailed analysis in some specialties eg cardiology2 and gastroenterology.3

The Federation of the Royal Colleges of Physicians in the United Kingdom also undertake an annual Census of Consultant Physicians in the UK.4 This has monitored changes in physician numbers over the last 13 years and provided information on changing demography and gender of the workforce, new appointments, retirements and working patterns. Again the NHS Workforce Review Team uses this document for planning the future workforce.

The current and future workforce needs to be fit for purpose and able to deliver high standards of medical care to patients. The RCP is committed to encourage training and supervision of juniors and continuing professional development for seniors to promote the delivery of professionalism and clinical excellence in care. This requires an adequate workforce both in number and skill level to deliver care at the expected standard.

We have outlined below our thoughts on future workforce needs and planning for the health service.
1. How effectively workforce planning, including clinical and managerial staff, has been undertaken and how it should be done in the future?

1.1 The current contribution of the College to the business of the NHS Workforce Review Team is set out in the previous section.

1.2 Has workforce planning been effective in the past?

Under arrangements that existed 10 years ago, the Specialist Workforce Advisory Group made decisions on training numbers. They asked for data from Health Authorities and Trusts to get an idea of local views but rarely obtained a good response to this. Subsequently, a document entitled *A Health Service for all the Talents* was produced that, amongst other things, made the valid point that medical workforce needs should take account of all health professionals providing care. However, it also said that there had been too much central planning and proposed the development of local Workforce Development Confederations—now subsumed into Strategic Health Authorities. These now feedback to the central planning committees via a variety of pathways.

Some years ago, there was a difficulty in obstetrics and gynaecology where there was an excess of fully trained doctors who could not find consultant posts; this caused great anxiety, although the problem was unique to that specialty. This had an adverse effect on workforce planning across the board including specialties where a much better grasp of the long-term workforce issues prevailed. As a result, the numbers allowed to enter higher specialist training were less than required. This has resulted in the current situation where about a third of consultant posts advertised across all the medical specialties are unfilled due to a lack of suitable applicants; this has little to do with the geographical areas involved. It must be acknowledged that since then, much more money has been put into the NHS by the government so that the ability to develop services for patients now exists whereas before it did not. However, this was not anticipated 10 years ago when these decisions were being made.

1.3. In the future, a system that addresses the local needs of patients, new ways of working, national priorities and developments in medicine is required.

2. In considering future demand, how should the effects of the following be taken into account?

2.1 Recent policy announcements, including commissioning a patient led NHS

2.1.1 The way in which specialists will work in the future is not clear because of the many new policies coming from the government, including the recent White Paper, *Our Health, Our Care, Our Say,* and *Commissioning a Patient Led NHS.*

2.1.2 It is clearly logical to provide specialist care as close to the patient’s home as possible and thus many of the ideas of the White Paper are to be applauded. However, there is concern that these will be more expensive than the current models that deliver high quality care, in a period when the Health Service is already in financial difficulties. Moreover, until medical services in the Community are delivering the proposed changes, hospitals in their present form will still be required. Certainly there will always be a need for acute hospitals although their function and they way they work will change. The recent trend to consolidate acute hospitals has been partly financially driven and partly to concentrate expertise. It is not yet clear what the effects will be of Payment by Results on hospitals built under the private finance initiative.

2.2 Technological change

2.2.1 Technological changes (eg better IT, diagnostic and therapeutic advances) will improve efficiency but may require more sophisticated and complex facilities, which cannot easily or cheaply be placed in many sites in the community.

2.3 An ageing population

2.3.1. An ageing population is likely to increase the health needs of this group of people and hence the need for an expansion in the caring workforce. Moreover, an increasingly ageing population will result in many more people with chronic diseases but also perhaps continue the trend for an increasing number of acute admissions to hospital.

2.4 The increasing use of private providers

2.4.1. There will be increasing use of private providers of services. If patients can be treated more quickly and effectively by these providers and safely without adverse consequences on other parts of the Health Service then this would be in the patient’s best interest. However, there is a risk that private providers will attempt to provide care just to elective (9am to 7pm) cases or select less complicated cases. Care has to be taken that the NHS workforce is not depleted by such private provision by loss of economies of scale. This
may lead to more out of hours work with less staff available, which may destabilise emergency provision of some services. We would suggest that core medical services and the workforce required to provide these are defined for given populations.

2.4.2 In order to prevent adverse consequences, the College feels that financial arrangements, both to the NHS and for private facilities should be equal and take account of the need for emergency provision and case mix. We feel that overall clinical supervision of all patients should be from the local NHS Trust, as has been the model for renal dialysis units for many years. All medical staff at Independent Sector Treatment Centres (ISTCs) should either be from the NHS or be appointed by an advisory appointments committee with Royal College advisers. All ISTCs should have provision for training according to nationally agreed standards and be assessed by the Postgraduate Medical Education and Training Board against these. The Healthcare Commission also has a role to play with regard to inspection of ISTCs. Clinical governance in all areas should be at the same level as for the NHS.

3. How will the ability to meet demands be affected by:

3.1 Financial Constraints

3.1.1 Payment by Results is a potential threat to many secondary care services. A tariff that inadequately compensates providers for complex services may lead to reduction or loss of local services with a major impact on the workforce, training (of medical and non-medical staff) and quality of care. We believe that tariffs need to be much more sophisticated and applied equally to all providers. Also, there is still a great deal of work to be done in improving coding quality and adapting tariff to take account of appropriate funding for long term conditions and rehabilitation.

3.2 The European Working Time Directive

3.2.1 When the European Working Time Directive (EWTD) came into action in 2004 the RCP highlighted previously unforeseen consequences. Several of the solutions to these were developed and enacted at relatively short notice. We would advocate careful planning of the 2009 implementation with pilot sites developing and testing solutions. Successful programmes should be introduced to the wider NHS before the 2009 deadline to allow adjustments during the transition phase.

3.2.2 Three areas of the introduction of EWTD deserve special mention:

— Firstly to resolve emergency cover, extra Senior House Officer (SHO) and Specialist Registrar (SpR) grade posts were introduced, some of which were purely service posts. Most of those in training are likely to gain a certificate of completion of training (CCT) at similar times and it is possible that these doctors will have difficulty in finding senior posts when they reach the end of their training. Fortuitously this cohort is likely to gain CCT around the time of the 2009 EWTD changes. We would advocate planning to expand the number of posts at appropriate levels to ease some of the 2009 tensions and utilise the skills of this cohort of trainees.

— Secondly, the shift patterns introduced as a result of the EWTD have made significant changes to working practice. The RCP has provided some advice in this area by producing standards of good practice to support continuity of care and advice to junior doctors on working the night shift. Finally, the RCP has been working with the Royal College of General Practitioners and the Department of Health to develop a new role of medical care practitioners who have the potential to relieve doctors’ workload to make it EWTD compliant. They can also improve the service to patients. It will be some years before these have an effect but evidence from the USA suggest that they will be a valuable addition to the workforce.

3.2.3 Our data indicates that the 2004 EWTD changes to hours have met the targeted time constraints for junior doctors in virtually every Trust for medical departments but suggest the 2009 EWTD changes are going to be a real challenge to achieve. The workforce changes that come out of the 2009 EWTD should be co-ordinated with long-term workforce plans rather than be an ad hoc arrangement.

3.2.4 RCP data show consultant physicians work an average of 59 hours per week for the NHS yet they are only allocated 44 hours (equivalent to 44 hours) in their job plans. If these changes are followed rigidly, there is a danger that consultants’ productivity will fall. One of the problems is that consultants are providing both elective and emergency care. We need to explore new paradigms of the role of a consultant in the context of the whole healthcare team.

3.3 Increasing international competition for staff

3.3.1 The UK is now training, appropriately, more doctors and hopefully will reduce its reliance on international medical graduates. However, it is vitally important that these new doctors should feel that they have a satisfactory career structure in the United Kingdom otherwise we will become an exporter of medical talent. It would be regrettable if investment in training doctors were not of direct benefit to people in the UK. One current model predicts that the United States will have 200,000 too few Physicians by 2020. In
the 1970s and early 1980s, the UK lost some very talented people to North America. We believe the NHS should strive to retain those in whom it has invested large sums in training especially potentially highly successful clinicians, researchers and senior physicians. The most important factor is job satisfaction.

3.3.2 As the Government has recognised in *Best Research for Best Health* and as was recommended in *Clinical Academic Medicine*, academic medicine and research should be supported and encouraged. There should be active support for the development of clinical academic training and career pathways.

3.4. Early Retirement

3.4.1 Data from the RCP indicates that over the last few years the average age of retirement for Consultant Physicians has been between 60 and 62 years of age. Over the next decade 2,063 Physicians across the UK will reach 65, suggesting that an average of 200 per annum might be expected to retire at 65. Of those surveyed 78% have indicated that they intend to retire between 60 and 62, resulting in potentially three years lost per Consultant to NHS work. This totals some 6,189-person years of experience that may be lost at a conservative retirement age of 62; this is equivalent to losing one and a half to two Consultant Physicians from every large hospital in the UK. 67% of respondents to the survey indicated that they would be keen to continue with NHS work if their acute medical commitments were reduced, and most are keen to continue with specialty work, management, and training and education. The College believes that a doctor’s career should be considered in stages. Early on, consultants would do more acute work whereas later in their career, they might do more elective work and teaching. Thus with careful planning, more care could be delivered by consultants for longer. The Department of Health’s flexible working schemes have provided a mechanism whereby Trusts could alter the working patterns of senior physicians to encourage staff retention but pressures on the service mean that such measures are seldom used. We would support more enthusiastic and innovative ways of reducing pressure and out of hours work on senior consultants to enhance retention.

3.4.2 The RCP is developing the specialty of Acute Medicine. This concerns the immediate and early specialist management (first 72 hours) of adult patients with a wide range of medical conditions who present to hospital as emergencies. The main reason for this is to provide improved care for the acutely ill, and allow specialist medical practice to continue in spite of increased numbers of acute medical admissions. The advantages it should bring are likely to ease some of the pressures on senior consultants undertaking acute specialist medical roles and would aid senior staff retention by reducing the requests for early retirement. In the RCP Census for 2004 there were only 51 physicians who recorded their main specialty as acute and general medicine alone. The RCP believes that to provide an optimal acute medical service under the new model a minimum of 3 acute physicians would be required in every acute hospital suggesting some 600 are needed across England. We would support a large and rapid expansion in this workforce. In addition it should be possible to include sessional work to encourage flexible working practices which may encourage participation of women, and by established consultants who may be able to fit such sessional work into job plans more readily than many of the current systems.

4. To what extent can and should the demand be met, for both clinical and managerial staff by:

4.1. Changing the roles and improving the skills of existing staff

4.1.1 The RCP is supportive of plans to change the roles of non-medical staff who work with doctors and improve the skills of existing staff to assist in delivery of medical care for patients. Technicians and physiologists have extended their roles in numerous fields, for example in cardiology with echocardiography and exercise testing and in neurophysiology with technician scientists undertaking electrophysiological tests. Where such roles can be developed to improve efficiency they should be encouraged although usually they require appropriate consultant supervision. The RCP has been supportive of extending the role of nurses to assist in clinical situations. In gastroenterology, nurses have taken on roles of coordinating care for cancer patients, running out-patient clinics for patients with inflammatory bowel disease, become operators assistants in endoscopic gastrostomy placement, and have very successfully taken on roles as gastroscopists and colonoscopists.4.1.2. Many of the tasks undertaken by junior doctors have proved difficult to deliver with the changes in hours that have affected this group of workers. In addition many of the tasks are repetitive and once learnt have little educational value for the juniors undertaking them. The RCP is supportive of the development of a nationally accredited grade of medical care practitioners (MCPs) whom it is considered would support the delivery of medical services at the equivalent of a junior doctor level in well-defined areas of practice. Nurses can potentially undertake these roles but as they are a scarce resource the development of this new workforce would seem appropriate.

4.2. Better retention

4.2.1 More women are moving through the training grades to take up senior medical posts. Our data indicate that 23% of consultant physicians in the UK are women whilst 42% of SpRs are women. This ultimately means that greater than 40% of the senior medical workforce will be female in the future. Working patterns for trainees and seniors need to be appropriate for men and women as well as for those who wish to work flexibly. The College has already contributed to the debate with the NHS Workforce Review Team
on how numbers of trainees relate to the number of whole time consultant posts; the impression being that each SpR is likely to contribute on average 0.7 whole time equivalents of senior work given likely choices for flexible work, the gender mix of the SpR grade and the new consultant contract.

4.3. The Recruitment of new staff in England

4.3.1 As the number of medical students is rising in the UK there will inevitably be more doctors available for NHS work. With reorganisation of training under “Modernising Medical Careers” these young doctors are likely to reach accredited specialist status holding a certificate of completion of training (CCT) more quickly than in the past 20 years. We would encourage the development of a long-term plan that will define the likely employment opportunities for this group. Consultant physician expansion in England has run at an average of 6.5% per annum, equivalent to a compound increase of 6% per annum. However in the future financial climate it seems unlikely that such a trend will continue, even though the clinical need is still there. It seems wasteful to train large numbers of highly skilled people under MMC if posts for such people are likely to be limited. It seems only fair that medical students and junior doctors have some concept of the likely employment opportunities at the end of training before they embark on such training. The potential aspirations of young doctors have not altered and most who come into a career in medicine would presume they were likely to end up as a consultant (or principal in general practice), which in the future may not be always be true. We would encourage the development of a long-term plan as to the structure of the NHS for CCT holders that tries to predict their likely employment opportunities.

4.3.2. The talents, skills and experience of refugee doctors in the UK are currently under-utilised. Supporting refugees through the professional registration pathway and into posts in the NHS would aid the government to deliver its agenda on patient choice in areas with significant refugee and migrant populations, meet public health improvements and address health inequalities as detailed in Choosing Health. The NHS workforce must include the skills and experience of local communities in order to better understand the health needs of their patient population.

4.4. International Recruitment

4.4.1 Historically the UK has been seen as an excellent training ground for international medical graduates (IMGs). IMGs come to the UK for a variety of reasons, including higher salaries, career progression, training and research opportunities, and educational partnerships between the UK and overseas institutions. The large number of IMGs who have passed the General Medical Council’s Professional and Linguistic Assessment Board (PLAB) has led to extremely high competition for posts in the NHS, particularly in the junior grades. Advertised junior grade posts in medicine receive an average of 154 applicants, and there is evidence that some advertisements have received in excess of 1,000 applications. Large numbers of IMGs now take a substantial time to find employment, or fail to find work, and may limit the opportunities for UK graduates. We would recommend that a mechanism be developed so that IMGs could be accepted into appropriate training grades prior to entry and provision of a work permit, thus guaranteeing successful candidates appropriate employment and training. This would also limit those coming in search of work and training who subsequently suffer. The new immigration rules may aid in delivering this aim but this needs to be monitored carefully.

4.4.2 Increasingly EU/EEA graduates are competing for junior posts at Foundation 1 (F1) and Foundation 2 (F2). Current assessment methods are sub-optimal and interview free and this has caused great concern. The number of applications for F2 posts has in some cases become unmanageable. We recommend that F1 posts (and ideally F2 posts) are included in the educational requirements for training and medical practice in the UK. Our understanding is that this would mean allocating all such posts to UK graduates first, the residual post being open to competition from the EU/EEA and elsewhere. The latter process could be run in a similar manner to the current system but with more careful assessment of spoken and colloquial English and assessment of attainment of medical skills and knowledge. There need to be improved selection methods available after the second Foundation year at entry to specialist training.

4.4.3 At senior level consultant appointments from overseas are increasingly delivering a service parallel to classical NHS care. Appointment in a standard manner via a classical Advisory Appointment Committee should provide no cause for concern. Appointments without such checks potentially expose patients to poor quality services or communication that may harm care. Communication can be a crucial issue eg with radiology reports—an Irish radiologist outlined his difficulties in writing such reports as a long, painful process of interpreting the images and mentally translating his thoughts into French, leading to curt, declarative sentences, leaving no gray areas or doubts. We believe that senior medical services should be provided by highly skilled appropriately trained and certified (in future revalidated) doctors who have appropriate communication skills and have been appointed by an appropriate AAC.
5. How should planning be undertaken:

5.1 To what extent should it be centralised or Decentralised?

5.1.1. It is clear that a model that is purely centrally driven or one in which local planning is supreme is unsatisfactory. A combination of the two is required. It is suggested that models of care are agreed nationally. Local networks, groups consisting of specialists, generalists in primary care (GPs) and other health care professionals should work together as in the pattern for diabetes. They could then decide on the best care pathway to provide services for patients locally and choose which of the models was most appropriate for their community. This information could be fed back centrally and appropriate calculations made by the NHS Workforce Review Team to provide medical and other health care professionals to deliver services to patients in the future. We feel this would provide flexibility in the system and allow clinicians in the front line to feel that they had engagement and ownership in the process and some ownership of it. The RCP will continue to provide both workforce information and information on ways in which high quality care can be provided for patients.

5.1.2 We believe minimum levels of workforce, to provide a given level of service, as indicated in Consultant physicians working with patients,1 should be defined centrally to ensure equity of service and quality. More than one model may lead to differing methods of delivery. For example, Dr Roland Valori, the National Clinical Lead for Endoscopy Services, has provided examples of this for colonoscopy in the colorectal cancer-screening programme, where unit standards define the required support staff and other quality indicators within the endoscopy service. (Ref) However, any endoscopy service must take account of the demand for specialist endoscopy required out of hours eg for the emergency treatment of upper gastrointestinal haemorrhage.

5.1.3 We believe that certain consultant activities should have minimum defined time commitments allocated to them centrally eg for training and supervision of trainees as well as work for the wider NHS in Deaneries and Colleges.

5.2. How is flexibility to be ensured?

5.2.1 The role of a consultant physician in the UK has an international reputation. Consultants have demanding clinical roles. The work can vary, week to week, from mildly unwell outpatient care to seriously ill inpatient care to managing critically ill patients with specialist or general medical needs as well as providing a wide range of procedure related care. Consultants usually develop other areas of interest, eg teaching, research or management that contribute to the quality and development of the service. Over the last two decades with the rise in specialisation and the recent increase in acute medical admissions, which has led to the development of a new specialty of acute medicine, it is only the broad training of consultants that has provided the flexibility to maintain acute medical services at the current level. We believe that highly trained consultants optimise the long-term flexibility of the workforce.

5.2.2 We believe services should be analysed to develop methods of delivering high quality care on a sessional basis whilst maintaining team continuity. This should encourage part-time workers back into the service, may lead to more flexibility for seniors approaching retirement, and potentially leads to more flexibility in job planning to optimise delivery of the service.

6. Other Issues

6.1 Research

6.1.1 Medical research is under great pressure at present. We believe medical research is vital to improvements in patient care and efficient management strategies as well as being important as a scientific endeavour in its own right. Academic medicine needs to be supported in the present and future. Sufficient quality workforce needs to be maintained to advance medical practice and teach undergraduates and supervise postgraduate medical studies. Sufficient junior doctor research posts should be funded to promote the area whilst maintaining competition to ensure the most able are selected. Rewards particularly in terms of sufficient career grade posts are required to provide a sensible chance of success and encourage applicants.

6.2. Management

6.2.1. Doctors provide many key roles in management within the NHS. Clinicians should have sufficient time and resource to engage in the design of local and national services. Workforce planning should ensure and encourage sufficient doctors to take up these positions in part-time (standing alone or with continuing clinical commitments) and full-time roles. The College has encouraged a good relationship between doctors and managers at all levels, as we believe this is vital to future success.
6.3 Training non-medical workforce

6.3.1 Doctors play a key role in teaching and training nurses and other staff allied to the medical profession. This should be included in defining the future workforce requirements for the NHS.

6.4 Specialist care

6.4.1 We believe patients usually choose to see a specialist in the disease or system affected and sufficient accredited specialists should be available locally to provide such choice.

6.5 Junior doctor selection

6.5.1 We believe selection for junior doctor posts should be based on appropriate tried and tested qualities and changes should be introduced carefully. Some current systems, which appoint from large numbers of applicants with short application forms and no interview with the Trust, supervising consultant (or a nominated deputy) do not seem to be working in the interests of employers or candidates.

6.6 Acute Medicine

6.6.1 The specialty of acute medicine is a new initiative and is likely to deliver improvements in delivery of this critical and expanding area of care in the NHS. To drive development we believe the number of SpRs and consultants in the field need rapid expansion to gain critical mass to deliver acute medicine efficiently. It is thought that three or more consultant posts are needed to begin to develop and efficient and practical service in each acute medical unit. As Modernising Medical Careers commences, the opportunity would seem ideal to expand the number of SpR trainees in this field to provide sufficient applicants for the current (some 40% advertised posts unfilled) and future consultant posts.

6.7 Collection of data

6.7.1 We would encourage collection and use of appropriate data on consultant and team workloads to aid workforce planning in the future. Hospital Episode Statistics are not fit for this purpose for a variety of reasons, including the fact that specialty codes do not reflect the actual work of the individual, the outpatient workload, inpatient cross referrals, team working or management roles. Activity is often incorrectly allocated.

Royal College of Physicians

15 March 2006

REFERENCES

6 Department of Health. Our health, our care, our say: a new direction for community services. London, TSO 2006;
9 Royal College of Physicians, The case for a “cell of 10” to provide 24/7 cover by junior doctors, London: RCP, 2003.
Evidence submitted by the Royal College of Psychiatrists (WP 71)

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and the Republic of Ireland and is the professional and educational organisation for doctors specialising in psychiatry.

1. General Overview of Workforce Planning for Medicine

1.1 Long-term planning for the medical workforce has never been an easy task. Doctors take a long time to transform from aspiring medical school entrants into fully trained hospital specialists or general practitioners. Many become highly specialised early on in their careers so the possibilities of changing track to meet varying service demands are very limited. There are numerous points in the career pathway where even small changes can affect the final overall pool of appropriately qualified applicants for consultant posts. Matching supply to demand is a tricky business.

1.2 Allowing too many to train for too few eventual consultant vacancies leads to disappointment, discontent, and possibly a loss of doctors to the workforce whose training costs have been huge. A recent example of that occurred in obstetrics and gynaecology when too many doctors completed their higher training ahead of the anticipated consultant expansion.

1.3 There is strong central control at some points in the pathway. Medical school places are carefully regulated and the recent increase in student numbers has been planned to meet projected future requirements, and to reduce to a large extent the dependence on international medical graduates (IMGs) to fill both training scheme places and service posts.

1.4 At SHO level for many years there has been a virtual freeze on the creation of new posts, though during 2003–04 there was some relaxation in order to try and relieve the bottleneck in some specialities between the SHO and SpR grades by altering the ratio of SHO to SpR posts.

1.5 It is at the specialist registrar level though that central control has existed in the most comprehensive way with the aim of ensuring that any new training opportunities (via additional National Training Numbers—NTNs) are given to the specialties with the greatest need to grow their particular consultant workforce.

1.6 The aim of all this control from the point of view of Health Departments is to ensure the correct balance between supply and demand is maintained, with the emphasis mainly on not training too many. However, on the demand side of the equation, more service work exists than can be covered by those in these regulated training grades. So the last decade has seen a huge growth in the numbers of non-consultant career grade doctors, recently renamed SAS doctors (Staff and Associate Specialist grades). This is a response to market forces and individual employers perceptions of service needs, developments and available funding. How many of these doctors will eventually find their way by one route or another into consultant posts is hard to predict.

2. Overview for Psychiatry

2.1 The problem for psychiatry with this model of control, aiming for supply and demand to stay in balance, is that as a specialty we have never managed to get anywhere near the training targets set, either by central government or as a profession, to generate sufficient fully trained psychiatrists to fill even existing established posts. Census data from both the Health Departments and independently from the Royal College of Psychiatrists over many years have shown a high level of consultant vacancies, currently overall in excess of 11%. These are much higher in some subspecialties and some geographical areas.

2.2 The reasons behind this failure to match supply to demand are complex. Psychiatry has never attracted enough UK graduates to fill existing training posts at SHO level. Medical schools vary in their ability to generate the next generation of psychiatric SHOs, but consistently the overall figure is stuck at around 4% to 5% of graduate doctors choosing psychiatry (2005 Goldacre). The slack, therefore, has to be taken up by overseas graduates whose career pathways may be more difficult to predict, and whose initial aptitude for the subject may be harder to gauge if their exposure to psychiatry before coming to the UK has been limited. We have also struggled to retain in the specialty those who have been recruited. Too many fail to make the expected transition along the career pathway, so all the factors that play a part in retaining staff
need examining as part of the overall equation. In addition, many doctors aiming for a career in General Practice spend at least six months training in psychiatry, so psychiatric training posts can be used by doctors whose eventual career destination is not that of becoming consultants in the specialty and we have to recognise that in both our training and workforce planning.

2.3 Workforce planning not only for doctors but for all staff within the NHS has continued to receive a higher profile in recent years. This is partly because of the need to translate the aspirations of government initiatives such as in England the NHS Plan and the various National Service Frameworks for Mental Health, Children and Older People’s Services, to drive up standards and modernise services for the 21st century, into care being delivered by the right staff with the right training, in the right place at the right time. In short, a workforce “fit for purpose”.

2.4 Many questions remain to be answered about how to do this:
   — What is the “right” number of doctors for a specialty?
   — Where will they come from?
   — How will changes to training and working practices affect this in the future?
   — How can we achieve the right balance between central control and the autonomy of local services to recruit as many (or as few) doctors as they feel necessary?

3. **Historical Background to Manpower Planning**

3.1 The history of what used to be called manpower planning, now workforce planning, has been marked by a number of landmark initiatives as successive governments have grappled with the problem of the imbalance in medical staffing. Four of the key ones deserve particular mention as they have shaped the way that central control has increasingly been taken over the medical workforce.

3.2 *Achieving A Balance 1986*: This set out the basic principle that far more care for hospital patients should come from consultants, and hence senior registrar numbers should be tailored to the expected consultant expansion needed to achieve this end. This meant in the medium-term planning for consultant growth at around 2% per year whilst progressively reducing career register numbers. A new staff grade was introduced in 1988 to plug the gap in service needs for employers and originally a ceiling was set so that numbers could not exceed 10% of the total number of consultants in that specialty.

3.3 *Joint Planning Advisory Committee (JPAC)*: This was given the task of advising on the total number of training posts needed in each specialty and psychiatry was a beneficiary of this annual process which allowed for increasing numbers of what were then called senior registrar posts. Subspecialties were aided in their development by these JPAC allocations.

3.4 *The Calman Report*: The next significant impact on training and manpower came with the need to embrace the changes brought about by the freedom of movement within the European community. Because the length of specialist training was longer in the UK than the rest of Europe, there was a need to achieve a degree of harmonisation. The reforms came to be known as the Calman proposals because the committee’s chair was Sir Roy Calman. They aimed to bring the UK in line with EU legislation on specialist medical training.

3.5 This report came out with five key principles which are still in force today.
   (i) Through structuring programmes, overall training times would be reduced.
   (ii) At the end of training, doctors would obtain a UK Certificate of Completion of Specialist Training (CCST) on the advice of the relevant faculty or college.
   (iii) CCST holders would then be eligible for consultant appointment.
   (iv) A unified training grade combining registrar and senior registrar would be introduced so that training would comprise basic specialist training—SHO level and higher specialist training, at SpR level.
   (v) A new system of National Training Numbers was to be introduced, with each specialty having a fixed, but annually negotiable quota of numbers which had to be completed for. Progress in higher training became subject to the RITA process (Record of In-Training Assessment) to ensure there were not significant delays in people progressing to CCST and thus blocking the release of a NTN for another doctor.

3.6 *Medical Workforce Review Team*: In England, this team took over responsibility for the annual review of NTNs for each specialty. It used computer modelling to predict the likely growth in consultant numbers if variables on the input side changed. Colleges, postgraduate deans and Health Departments all had the opportunity to influence this modelling process with any evidence they were able to muster as to the particular needs and circumstances of their specialty.

3.7 During 2004 the remit of this team was broadened to cover other grades and other professional groups as well and this has been reflected in a change of title to the Workforce Review Team.

4.1 Medical School Numbers: The number of places at UK medical schools has increased dramatically over the last five years from 3,749 in 1998 to a projected 5,894 in 2005. The increase has come about by introducing new four year graduate entry programmes, establishing four new medical schools, and adding places to existing schools. It will take several years for these numbers to translate into extra doctors, but the aim is to reduce some of the excessive dependency on overseas doctors in the future to fill training grade posts.

4.2 The Feminisation Of Medicine: Over the past 40 years the number of women entering medicine has increased dramatically too. Over 50% of medical school places are occupied by women and in some schools the number exceeds 60%. Of the RCPsych's membership, 40% of UK and Irish graduates are now women. This raises interesting questions about the likely future career paths, demand for flexible training, and ultimately a higher degree of uncertainty about how many doctors will be needed to staff services if or when traditional full time working through most of a career ceases to be the norm. Funding of flexible training has always been subject to short-term decisions and the lack of adequately protected budgets for this growing group of doctors (which clearly includes men as well, but in far lower numbers) means delays to training programmes completion and so further unpredictability in CCST times and eligibility for consultant posts.

4.3 The Postgraduate Medical Education And Training Board—PME: In September 2005, PMETB took over responsibility for standards and quality assurance of all postgraduate education, training and assessment in medicine and dentistry. One of its responsibilities is to assess the eligibility for specialist registration under new EU legislation (articles 11 and 14). In brief, this means many doctors both outside and within the UK, previously unable to get onto the specialist register and hence be available for consultant appointments, may be able to do so by an alternative route. This is based on their experience and demonstrated competences, rather than having obtained MRCPsych and a CCST, the “current standard” route onto the register. This is likely to have a very significant short to medium term impact on the numbers of doctors able to be considered for consultant appointment. Psychiatry will be one of the main beneficiaries of this change, but the numbers involved are unknown as yet.

4.4 Modernising Medical Careers—MMC: MMC is an initiative developed from Professor Liam Donaldson’s proposals to reform the SHO grade Department of Health 2002). In February 2004 the four UK Health Departments endorsed the importance of care being based on effective interdisciplinary team work and flexible training pathways, tailored to meet service and personal development needs.

4.5 The first change came on-stream in August 2005 and that was the replacement of one year of pre-registration house officer training with a two year integrated foundation programme, focusing on generic competences and the management of acute illness. This will act as a bridge between undergraduate and specialist medical education, and full GMC registration will come after successful completion of the first year, F1. Psychiatry will figure in the second year, F2 programme, with likely four month slots and a very different training emphasis to current initial SHO posts. All the assessments in F2 will be workplace based.

4.6 Beyond foundation training, the plan is for selection for run-through training in one of eight broad specialties, which include psychiatry. The College has already developed a competency based curriculum for SpR training and work is underway on a curriculum to precede it, the equivalent of what is now of basic specialist training. Work based assessments of performance and competences will be key. How selection for the programmes will take place, and the part formal examinations like the MRCPsych will have in this new world are questions still to be answered. In five years’ time though, training will look very different with a curriculum running through from F2, basic and higher training and embracing lifetime CPD.

4.7 The unknowns for all this in workforce planning terms are how many F2 slots will be achieved for psychiatry and whether they will come from the existing SHO stock. An alternative may be to use some of the nearly 500 extra unfunded SHO posts released in England during 2003–04 which had been intended as a means of improving the ratio of SHO to Specialist Registrar posts in psychiatry. There is agreement generally that getting psychiatry firmly established in F2 is crucial. Given the relative reduction of the time allocated to psychiatry in many undergraduate curricula, giving large numbers of young doctors a positive education and professional experience of the subject in F2 is vital if we are to improve the recruitment figures for UK graduates into the specialist run-through programmes. Overseas doctors will have the opportunity for competing for the schemes as well and may have access to some of the F2 posts.

4.8 European Working Time Directive—EWTD: This is a piece of health and safety legislation originally formulated in 1993 by the European Union. It came into force in 1998 for all doctors with the exception of trainees. From August 2004, trainees have been included with an initial reduction in weekly hours to 56, then down to 48 by 2009. Further restrictions around the definition of “working time” and “on call” and “compensatory rest” have been added. This means junior doctors are increasingly working shifts rather than on call rotas. They are less available for work during 9 am – 5 pm and when working at night their supervision and opportunity for educational activities is reduced. This in turn may lead to longer training times to achieve defined competences. Another uncertainty has been thrown into the equation by this.

4.9 New Consultant Contracts: A variety of new consultant contracts were introduced over the four UK jurisdictions. Doctors who have moved over have individually tailored contracts with agreed numbers of programmed activities, the whole exercise being underpinned by the job planning process, an annual event
linked to, but separate from, appraisal arrangements. The distinction between full and part-time posts is now much more blurred and talking of WTE consultant numbers very difficult to do. This means for census purposes it will become harder to establish the total available consultant workforce and hence more difficulty predicting future demand.

5. **Current Key Issues for Workforce Planning—The Psychiatric Specialty Context**

5.1 *Influencing The Workforce Modelling Process:* As mentioned earlier, the Department of Health in England has developed through its statistical section a sophisticated computer simulation model of workforce requirements. Psychiatrists have their turn as one of the 65 specialities considered annually by the Workforce Review Team at its meeting to look at the variances in the inputs and expected or required outputs of the model in terms of eventual consultant numbers.

5.2 Within psychiatry each of the six recognised subspecialties has the chance to present its individual case, General Adult, Old Age, Child and Adolescent, Learning Disability, Psychotherapy and Forensic, and until recently, Substance Misuse, Rehabilitation and Liaison Psychiatry have also been considered, but within the overall framework of General Adult psychiatry. The task is to make the case for increasing the share of the national cake of any additional NTNs made available centrally in order to grow more consultants.

5.3 All the issues listed above for the national context need to be addressed for each specialty as part of the review and psychiatrists like others, have to provide credible evidence for each area to show how the balance is likely to be affected by any changes, particularly on the supply side of the equation. Factors relevant for Psychiatry which feed into the model are as follows:

- percentage of SHO posts filled by GP Registrars;
- attrition rate of SHOs;
- percentage of flexible trainees;
- length of SpR training time to CCST;
- NTNs unfilled,
- retirement age of consultants
- international recruiting;
- post-retirement flexible returners; and
- consultant vacancy rates.

5.4 Much of the evidence used to bolster psychiatry’s case for additional NTNs has been derived from research studies carried out by the College Research Unit under the overall title of CIPTAC (Career Intentions of Psychiatric Trainees And Consultants) (Mears 2000). The annual College census of psychiatric staffing gives a detailed picture of geographical and speciality variations in consultant vacancies (2002 Royal College of Psychiatrists). Work on the use of locums in psychiatry by the Sainsbury Centre for Mental Health has helped to clarify both the cost and quality issues of having so many vacancies for established consultant posts (Sainsbury Centre for Mental Health 2005). Information gathered from College assessors on Advisory Appointments Committees for Consultants demonstrates how many or few applicants there are for each advertised vacancy. How many F2 posts are established in psychiatry and the plans for the transition to run-through training are likely in future to be added to the input side of the model.

5.5 What has become apparent in recent years is that action needs to be taking place at every point of the career pathway in order to improve recruitment and retention in psychiatry. Running the computer model makes it clear that improving consultant numbers in the short-term can only be achieved by either retaining existing consultants longer or importing fully trained doctors from elsewhere to fill vacancies and new posts.

5.6 All this work has led to three specific initiatives which although not only applicable to psychiatry, have been of particular relevance in looking at improving the overall workforce position:

- International recruitment.
- Post-retirement options.
- New Ways of Working for Psychiatrists.

5.7 *International Recruitment:* The Department of Health in England has been running an International Fellowship Programme since 2003, designed to recruit overseas doctors to fill vacant NHS consultant posts. The stated intention is to enable overseas doctors to take up appointments for two years to broaden their own experience. This programme has recruited more psychiatrists than all other specialties put together (124 out of 202 by the end of 2004) and in some areas it has been seen as a great success with both Fellows and local services deriving mutual benefit. There have been considerable anxieties expressed though at the ethics of taking fully trained staff from countries who can ill afford to lose them. Despite attempts to encourage applicants from countries with an oversupply of doctors, most still come from the Indian subcontinent and...
widespread concerns exist about taking so many doctors away from the developing countries which have trained them. It is also impossible to predict how many will stay beyond two years and for how long. So another uncertainty in the supply of consultants for the permanent workforce has arisen (Goldberg 2004).

5.8 Post-Retirement Flexible Options: Research from the CIPTAC studies showed the mean planned retirement age for consultant psychiatrists was 60. As many psychiatrists now in their 50s have Mental Health Officer status, which can be an encouragement to retire early from 55 onwards, there is a potential pool of experienced consultants who could return or continue in the workforce post-retirement. The flexible careers scheme initiative of the Department of Health has made it much easier and more attractive for doctors to be retained, perhaps in less full time and also different roles. It is too early to say how attractive this is going to be, but persuading more to do so will have the quickest and most positive effect on the overall consultant numbers, as the computer model clearly demonstrates. Such doctors may take on new roles, for example, meeting the projected workforce demands of the introduction of the new Mental Health Act. Whether that happens or not is difficult to predict at this stage.

5.9 Because Psychiatry is a specialty which both attracts women doctors and has been in the forefront of promoting flexible working patterns, it is of particular concern that there have been significant difficulties in providing a steady stream of funding for doctors, both men and women wishing to work in this way, especially those returning to medicine, or choosing to switch specialty.

5.10 New Ways of Working for Psychiatrists: Consultant dissatisfaction with their jobs, workload pressures and changing expectations of mental health services for staffing new teams has led to a great deal of work on what have come to be known as “New Ways of Working for Psychiatrists”. The final report was published in November 2005 by the Department of Health. Moving to a more consultative style of working, for example, and challenging some of the traditional boundaries around what has been felt only consultants can do, may well free up existing psychiatrists to deploy their skills more appropriately. It is too early to say whether these moves will result in a more contented workforce. An optimistic view though is happier consultants will make better clinicians, better role models and mentors for their trainees and perhaps longer serving team members. That has to be the better way forward to producing a fully staffed consultant led service for the future working in conjunction with all other disciplines within the mental health workforce, who also are looking at new and different ways of working.

6. Conclusions

6.1 The basic workforce question, how many psychiatrists do we need in the UK to deliver appropriate services for the 21st century probably cannot be answered.

6.2 The current more pragmatic questions seem always to take precedence:

— How many can we afford?
— How many posts can we fill?
— What is the quality of the post holders?
— How do we tackle the burdening cost and quality issue around locums?

6.3 The next few years will see huge changes in the way medical training from undergraduate through to CCST is delivered and assessed as a result of MMC. In the medium-term, planning for the medical workforce may become even more problematic than in the past. Keeping pace with the changes and trying to take advantage of them to recruit and retain more psychiatrists will remain a major challenge for the profession. We continue though to work actively to tackle the many issues outlined in this submission.

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Deputy Registrar, The Royal College of Psychiatrists

March 2006

References

6 Sainsbury Centre for Mental Health (2005) Scoping the current problems and solutions relating to
Evidence submitted by the Royal College of Radiologists (WP 70)

The Royal College of Radiologists (RCR) has approximately 7,000 members and Fellows worldwide representing the disciplines of Clinical Oncology and Clinical Radiology. Of these, 4,900 are resident in the UK. All members and Fellows of the College are registered medical or dental practitioners. The role of the College is to advance the science and practice of radiology and oncology, further public education and promote study and research through setting professional standards of practice.

Clinical Radiologists are trained to interpret images from a wide range of different radiological techniques and, more importantly, they provide a clinical opinion based on such interpretation to assist in patient management. Clinical Radiologists also undertake interventional techniques to diagnose and treat disease under image guidance. In the light of technological advance interventional radiology is becoming increasingly important in patient management in a range of conditions including vascular disease, heart disease and cancer.

Clinical Oncologists are clinical doctors who specialise in the treatment of cancer. They are trained to prescribe radiotherapy, chemotherapy and other systemic treatments. Most Clinical Oncologists today subspecialise in specific tumour types.

The College’s two specialties are in the spotlight with respect to the demands made on the medical workforce. Government priorities to develop and deliver effective cancer services in the UK focused on multi-disciplinary teams has significantly impacted on the workforce demands made on Clinical Oncologists. More recently, the focus on diagnostics as being the “bottleneck” in the patient pathway and the need to invest in diagnostics and particularly in clinical imaging has brought Clinical Radiology to the forefront.

The College aims to assist the Departments of Health in the UK in workforce planning by offering statistical evidence and analysis whenever possible. It is necessary to gather this data regularly given the changing demographics around the medical workforce with up to 70% of medical students now being female. That gender balance within the workforce clearly has a major effect on the total working lifetime commitment of the workforce but furthermore, the new and appropriate emphasis on work/life balance leads to all medical graduates of both sexes potentially seeking to work less intensively or for shorter overall periods than has been the case hitherto.

Plurality of provision of healthcare services in the UK will also bring new complexities to the already complex process of assessing future workforce needs. The College would hope that artificial boundaries placed in the way of freedom of movement between sectors—such as additionality—will soon be entirely relaxed enabling doctors and other healthcare staff to deliver services seamlessly between providers to the benefit of the patient.

In this evidence, the College has addressed issues raised in the Terms of Reference which are relevant to both our specialties. However, there are particular dynamics that apply only to Clinical Oncology or Clinical Radiology which should be taken account of by the Committee in assessing the workforce needs and planning for the future. Therefore specific aspects relating either to Clinical Oncology or Clinical Radiology are considered under each specialty separately.

Clinical Radiology

There are chronic workforce shortages of radiologists worldwide. Furthermore, the UK radiology workforce per head of population is traditionally one of the lowest in Europe. In response to this, the Royal College of Radiologists in collaboration with the Department of Health (England) has delivered the Integrated Training Initiative with the primary aim of significantly increasing the number of radiologists in training. The Radiology Integrated Training Initiative (R-ITI) is a novel approach to training using an electronic based programme which is being evaluated in special designed Radiology Academies. Three Radiology Academies opened in 2005 to deliver this innovative approach to training and the initiative will increase the number of radiologists significantly over the next five years. In 2005, an extra 40 trainees entered radiology and in 2006 a similar number of additional trainees are to be appointed. Even before the opening of the Academies in 2005, there has been recognition of the need to train more radiologists and this year nearly 200 trainees will be completing their training and will gain a CCT, thereby gaining access to the Specialist Register. However, even this welcome investment has to date not eliminated the overall shortage of radiologists in post.

Shortages of radiologists vary considerably throughout the UK. There are particular shortages in Scotland and the North of England whereas in the South of England the shortages are much less apparent. The need to attract trainees to posts in shortage area needs to be addressed. These factors must be taken into account together with further workforce pressures, namely:
— Increase in multi-disciplinary team meetings in which the radiologist is key.
— Increase in use of more advanced technology in emergency evaluation and treatment of patients (ie providing 24 hour cover).
— Decrease in clinical experience of clinicians with resultant increased reliance on imaging and imaging reports from radiologists.
— Increase in feasibility and complexity of interventional procedures.
— The need to provide rapid turn around of imaging reports to determine management decisions in acute medicine.
— Recent focus on waiting times imaging services to meet Department of Health (England) targets, including 18 weeks.

Despite these pressures, expansion involving new consultant posts is hindered by financial constraints in acute Trusts and although there are still consultant post vacancies in the UK, some have been filled by graduates from the newly extended EU. UK CCST/CCT holders are finding there has been a significant decrease in the number of available posts over the past 12 months. A survey of vacant funded posts in the UK carried out by the RCR in January 2006 identified that the number of CCST holders would almost balance the number of advertised posts this year, but the number of posts required clearly exceeds this.

**In considering future demand and the effects of recent policies, how should the effects of the following be taken into account?**

*Recent policy announcements* will have an important impact on the delivery of radiology services. An increase in out of hospital care and plurality of provision has major implications for imaging. The Royal College of Radiologists is working with the Royal College of General Practitioners to provide guidelines for access to imaging in primary care to inform and to facilitate attainment of the 18 week target and has also worked tirelessly with the Department of Health to improve imaging services provided by the Independent sector. However the lack of integration of services provided in the NHS and by independent providers is a barrier to the delivery of best practice. A uniform, high quality service can only be provided for individual patients if the pathway of care is seamless and conducted to the highest standards laid down by the College and other professional bodies.

*Technological advances* in imaging continue to revolutionise the way in which medicine is practised. The number of images obtained today in a single examination far exceeds those obtained even a decade ago. Three-dimensional images are available in seconds after acquisition and clinicians now rely more heavily on imaging for treatment decisions than ever before.

*The ageing population* will impact on imaging as more elderly patients are treated for cancer, stroke and other conditions which require imaging for management (see Clinical Oncology evidence). By 2010 there will be an increase in over 65 year olds of over 20% and an increase in over 85 year olds of over 50% compared with 2004.

*The increasing use of private providers of services* has had a major impact on imaging as this initiative has clearly reduced waiting times dramatically. However, problems persist because the services are not sufficiently integrated into NHS Departments of Radiology and the additionality clause precludes appropriate links between Independent sector radiologists reporting overseas and NHS radiologists in the associated NHS department.

*How will the ability to meet demands be affected by the following?*

Financial constraints will clearly lead to Trusts being unable to advertise posts which are required to deliver the service.

The European Working Time Directive will have an adverse effect both on service delivery of radiology and on training.

Increasing International competition for staff at present is not a concern as the major flow is to the UK rather than away from the UK. However, if opportunities for a well-balanced career diminish, we may well witness reversal of this trend. Early retirement is not perceived as a major issue in radiology but occurs in some areas due to undeliverable increasing demands for services.

*To what extent can and should the demand be met, for both clinical and managerial staff: by changing roles and improving skills of other staff?*

Over the past few years radiography staff have increasingly taken on traditional radiologist roles but this is under strict protocol arrangements working within the team in radiology departments. Skill mix can be a valuable asset to disease management and is welcomed, however these personnel take a significant amount of consultant time to train and the work they are best suited to perform is focused on a particular task and
is therefore necessarily limited. Questions have been raised about the cost-benefit of extending skill mix and the College is looking into the feasibility of a detailed study to evaluate this important aspect of modernising healthcare further.

Better retention of staff in radiography is likely to be a benefit of properly implemented skill mix but it must be noted that only a minority of radiographers are likely to want such high levels of clinical responsibility. Initiatives to attract new radiography staff in England should be explored.

International recruitment of UK radiologists is less likely than recruitment of overseas graduates to the UK. In the latter scenario problems may be encountered when English is not the radiologist’s first language. Radiological reports are in written form and nuances of language can be vital in defining patient management with implications for patient safety. The international recruitment potential is also limited by worldwide radiologist shortages. Diagnostics (including imaging services) are moving more towards primary care but this could exacerbate workforce shortages despite having advantages for the patient. The efficient model would be that Independent Sector Treatment Centres/primary care imaging facilities are under the umbrella of Trust imaging departments and serviced by staff rotating through all parts of the service. This would ensure flexibility of staffing, could make best use of teleradiology with images acquired peripherally being transmitted to an available radiologist while maintaining skills, good clinical governance and quality assurance of machines and staff.

It would also improve the efficiency and quality of primary care referral by improving communications between radiologists and primary care doctors and other healthcare workers.

How should planning be undertaken?

As indicated in the Clinical Oncology section, overall planning of the workforce should be centralised but should take into account regional and local differences and there should be local flexibility to meet the needs of local patients.

CLINICAL ONCOLOGY

In considering future demand and the effects of recent policies, how should the effects of the following be taken into account?

Recent policies will have an important impact on clinical oncology workforce planning if chemotherapy and radiotherapy services are devolved to local independent sector providers who are completely new to the market. Strong management as well as clinical links between the cancer centre and the devolved service will be required to ensure patient safety and a seamless service. If such services are provided by the independent sector it will be vital to have input into multidisciplinary teams, irrespective of the provider. This will require co-ordination of services by clinicians/managers and an additionality clause in a contract would be unsuitable for both clinicians and radiographers.

Technological advances in radiotherapy are leading to more complex treatments which are more accurate due to the ability to define treatment target volumes more precisely, thus avoiding irradiation of unnecessary normal tissue. The impact is likely to result in reduced morbidity and even mortality but will require a highly skilled workforce to deliver such sophisticated treatments.

An ageing population is already placing increasing demands on clinical oncology because cancer is predominately a disease of the elderly. Currently cancer incidence is increasing in Europe by 2% per annum.

Over 50% of patients should undergo radiotherapy during the initial management of their disease but a lower percentage do because of inadequate provision. Thus there is a need to examine health trends such as population growth, the age spectrum and consequent cancer incidents. This work has been done in Scotland to the period to 2015 in its Cancer Scenario document and recommended for development in England by the National Audit Office. The College is pleased to see that this work is now in hand as it will be important in predicting workload and thus future staffing needs.

The Scottish document correctly identifies that a very substantial increase in radiotherapy provision will be required to cope with demand; however only 20% of this is accounted for by predicted increases in cancer incidence. There is a current shortfall of 60% in current provision. A similar gap was identified in a pan-European review of radiotherapy services which indicated that in 2003, the UK only had 50% of the required radiotherapy capacity. The Department of Health’s National Radiotherapy Advisory Group (England) the College has two places which has commissioned planning work to address these issues. It is clear that a major expansion of the radiotherapy workforce is urgently needed, together with capital investment.

How will the ability to meet demands be affected by the following?

Financial constraints will clearly have a major detrimental effect on meeting demands for radiotherapy. Major capital investment is needed even to meet current demands and the analysis above indicates how large the gap is. A recent re-audit of waiting times by the Royal College of Radiologists has shown that, although there has been reduction in waiting times since 2003, they still remain longer that they were in 1997 with 53% of patients waiting longer than the recommended one month for potentially curative treatment.
The continual developments of new systemic cancer therapies which are more complex and time consuming to administer are placing pressure on treatment capacity. Waiting lists for curative chemotherapy and systemic treatments are now starting to develop: the major obstacle is the availability of trained staff and the funds to employ them. Clinic, day case and inpatient capacity are also starting to become overstretched.

While the European Working Time Directive, international competition and early retirement will all need to be addressed in prediction of workforce needs in clinical oncology, we do not think there are special circumstances in clinical oncology which need to be considered separately.

To what extent can and should the demand be met, for both clinical and managerial staff by changing roles etc?

The College believes that the key to effective workforce planning is in the best use of skilled staff. There is a need in radiotherapy to increase radiographer training places and this points to the need to develop, perhaps, three skills laboratories to train therapy radiographers out of the spotlight of clinical pressures. An innovative solution is required to address the substantial shortfall and might assist in addressing the current 30% dropout rate of trainee radiographers. Such approaches have been successful in histopathology and radiology. There is scope for consultant radiographers to facilitate the service by taking an active role in the treatment planning process that is emerging as a potential bottleneck in the patient pathway. There is also a need to retain staff once trained through developing appropriate career pathways.

The College is hoping that the Integrated Training Initiative (see Clinical Radiology Section) which is a groundbreaking way of delivering significant elements of training through e-learning for radiology training will be made available for training in Clinical Oncology and for therapy radiographers in the not-too-distant future. Such an initiative will require major investment but in the longer term would provide a highly skilled workforce of uniform high standard.

How should planning be undertaken?

In clinical oncology, workforce planning should be carried out with the engagement of clinicians, radiographers and managers to provide a comprehensive plan. An overall framework should be developed centrally which can be adapted for local use to meet local service and patient needs. There is a need to continue to examine cancer trends due to changing population demography, and indications for treatment and to profile the consequent cancer treatment consequences.

No one has successfully completed an equivalent analysis for chemotherapy and biological therapies where all indicators show that enormous growth is expected in this area of oncologists’ work over the next decade.

Professor Janet Husband
President, the Royal College of Radiologists
22 March 2006

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Evidence submitted by the Royal College of Surgeons of England (WP 28)

INTRODUCTION
1. The Royal College of Surgeons of England (RCSEng) welcomed the announcement of the above inquiry on 27 January 2006. It wishes to thank the Health Committee for the opportunity of submitting this memorandum of evidence. The College would value the opportunity to present additional oral evidence should the Committee feel that this would be of assistance. The Committee should also note the College’s 2005 report, Developing a Modern Surgical Workforce, from which we draw many of our conclusions.
RESPONSES TO QUESTIONS RAISED UNDER THE TERMS OF REFERENCE

2. Recent Policy Announcements

2.1 Commissioning a patient-led NHS

The College supports the aims of Practice Based Commissioning, to drive up the quality of services, improve patient experience, reduce inequality and provide value for money. However, the College is concerned that unless Payment by Results tariff rates reflect the true costs of medical procedures in both elective and emergency there is a danger that the reforms will have the opposite effect and disadvantage NHS units required to take on patients of a complex nature. Tariffs need accurately to reflect case-mix, taking into account the complexity of the procedure, co-morbidity and length of stay.

The College welcomes plans to reduce wastage across the health service and to better allocate resources towards patient care. However, it is important that plans to reduce management and administrative costs are carefully managed. The high number of surgical procedures being performed requires sophisticated process management and clinical directors of surgery and middle management have an essential role to play in allocating scarce financial and workforce resources. Administrative staff play a similarly important role in the day to day administration of surgical lists.

2.2 White Paper—Our Health, Our Care, Our Say

The College supports any affordable initiative to increase and improve access to and quality of patient care in the NHS, including the intention to examine ways to free up beds in acute hospitals through better use of intermediate step-down beds. This has the potential to remove pressure on acute care beds, currently an obstacle to the efficient utilisation of the surgical workforce.

However, the College is concerned to ensure that any transfer of care into a community setting must not be allowed adversely to affect the delivery and management of emergency services. This is particularly important in general surgery and trauma and orthopaedics, which bear a heavy emergency load. In a survey conducted by the Royal College of Surgeons, 64% of consultant surgeons said that they are often “on call” for emergencies while they are undertaking elective work. Moving consultants into the community may therefore adversely affect the provision of emergency cover.

The College is concerned about the impact of resources moving away from acute care, and how this will affect the financial stability of existing acute facilities and the training of surgical staff. The simple operations planned to be carried out in community hospitals are important for training. If these procedures are to be carried out in the community appropriate training of new staff will be required and access for consultants and surgical trainees provided.

The College is also concerned that transferring up to 40% of outpatient and diagnostic work out of the hospital setting could affect the initial treatment of the patient. Outpatient consultations and diagnostic tests are currently often undertaken within multiprofessional, multidisciplinary teams. This lessens patient anxiety, obtains quicker results and more expert opinions; it also reduces the number of hospital visits for patients.

The College is pleased to be invited to assist with Care Closer to Home Demonstration Group. It is important that any problems identified in the six pilot areas are fully taken into account in order to ensure that the move to community based services does not occur at the expense of acute hospital care.

2.3 Modernising Medical Careers (MMC)

The College recognises the potential for the improvement of services by improving the appropriateness of training, a principle which led to the MMC initiative. However, while the College supports the fundamental aims of MMC to streamline training, we are concerned by the impact on training opportunities of the European Working Time Directive (EWTD) with the planned reduction of working hours to 48 hours in 2009 and the current restrictions of the junior doctor hours agreement (New Deal).

The College is concerned at references to new grades of staff, such as “accredited specialist” on receipt of CCT and “credentialed service doctor”. These terms are currently being used without any definition, details of training, experience and conditions of service, or any indication of where they fit in the existing structure of surgical staff. The College believes that surgical care should be delivered by fully trained consultant surgeons, who have an unique responsibility for the patients’ care pathway and patients have justifiable confidence in a service led by consultants.

The College believes that surgical trainees should continue to be trained to at least the same standards as today’s consultants, a process rigorously assured by the Royal Colleges and PMETB. NHS employers need consultant level surgeons who are sufficiently skilled to deal with high risk areas such as emergency care and high volume elective surgery. It is now acknowledged that specialist training under MMC will be competence-based and that an individual’s training will take as long as necessary to reach the desired standard.
The incorporation of large numbers of existing SHO posts into the new training pathway will also pose a challenge, particularly during transition. The College has formally requested the Secretary of State for a one-off increase in specialist training grade numbers to cope with the excess of qualified surgical trainees competing for SpR posts following the implementation of MMC.

3. **Technological change**

Changes in technology and innovations in medical techniques can lead to rapid changes in the number of surgical procedures undertaken in specific specialties and sub-specialties. Given the long training period required to produce a consultant surgeon this can lead to an oversupply of qualified surgeons in some specialties, a recent example being in cardiothoracic surgery. Changes in the delivery of cancer treatment could create a similar problem in breast surgery. It is important that the skills of trainees and consultants should be developed with a strong generic base, allowing flexibility in career choice so that service development can occur in parallel to the personal development of the consultant’s practice. These issues are explored further in section 15.

4. **An ageing population**

Over the next few years the ageing population is likely to increase the demand for surgical services. Firstly, a numerical increase in the demand for surgical services as the proportion of older people in the population increases. This is particularly the case in illnesses such as cancer, prostate diseases, arthritis and fractures associated with the elderly population. Secondly there could be a disproportionate increase in certain demand-led surgical procedures commonly associated with older people (for example hip replacements). This is likely to mean that a higher proportion of operations are of a complex nature, eg revision hip procedures, which will require specifically skilled and trained surgical staff. The surgical workforce will need sufficient numbers of consultants and other staff to be able to meet this increased need.

5. **The increasing use of private providers of services**

The College has a number of concerns relating to the use of private providers of services, causing an imbalance and destabilisation of existing NHS facilities. There is already evidence of ISTCs “cherry picking” more straightforward cases with low co-morbidity, loss of surgical training opportunities and, in some cases, reports of poor standards of care.

The College recently presented evidence to the Health Committee regarding these concerns, which are set out in the College's recent short memorandum of evidence to the Health Committee on the use of ISTCs.

**HOW WILL THE ABILITY TO MEET NEED BE AFFECTED BY:**

6. **Financial constraints**

In a recent survey of Clinical Directors of Surgery in England 30 of the 40 respondents reported that financial issues were affecting the surgical workforce in its ability to deliver an appropriate surgical service. Fourteen respondents also reported that financial considerations were affecting the efficient utilisation of surgical services in their hospital, due to shortages of key staff, bed space and similar bottlenecks. In most cases a small additional investment was identifiable that would improve utilisation of resources, but clinical directors reported that they were often not empowered to implement the improvements which they could see were needed.

The College has also received reports from some of the surgical specialist associations that uncertainty about the long-term security of funding is deterring many Trusts from creating new consultant posts. As described in Section 13 below, the College has identified the need for an increase in the number of consultants to meet future clinical need in certain surgical specialties. It is of great concern that despite recent increases in trainee numbers, financial concerns could mean that this potential is not realised by the required increase in consultant numbers.

Uncertainty about future employment prospects, combined with the length of training, could also discourage medical graduates from taking up surgical training, particularly in smaller specialties and sub-specialties, threatening long term recruitment. This is increasingly relevant with the feminisation of the medical workforce.
7. The European Working Time Directive

The European Working Time Directive was identified as the major issue of concern in a recent survey of Clinical Directors of Surgery in England. Thirty-five of the 40 respondents to the survey identified EWTD as one of the key issues currently compromising the surgical workforce. Plans to implement the 48 hour maximum working week in 2009 will have an enormous impact on standards of patient care, opportunities for training and the efficient utilisation of the surgical workforce.

In a survey of consultants undertaken by the College in 2004–05 84% of the 873 respondents suggested that continuity of care for patients had worsened due to revised working patterns and 67% believed that there had been a decline in quality of patient care. In a similar survey of 1,323 surgical trainees, half of specialist registrars considered that quality of care had declined.

The EWTD also has a significant impact on opportunities for training. Eighty per cent of consultant respondents reported that direct contact time with trainees had decreased by an average of 33%, and in the survey of trainees almost three-quarters of SHOs considered that contact time with their trainer had decreased. The Department of Health’s own estimate is that implementation of the 48 hour week is likely to lead to a further 14% reduction in training time, which will place additional constraint on opportunities for training and on the quality of patient care.12

Given the concerns expressed by such a large proportion of consultants and surgeons in training about the impact of the EWTD legislation, the College is pressing for an opt-out arrangement for surgeons-in-training, similar to the opt-out for the police, ambulance services and other 24/7 services. The European Federation of Surgical Specialties has recently made a similar request for an opt-out to the European Parliament.13

8. Increasing international competition for staff

Historically surgery has not suffered dramatically from international competition for staff. A significant proportion of trainees have come from overseas, and some of these do return to their country of origin after completion of training.

However, if uncertainties about funding cause Trusts to delay recruiting consultant level posts for financial reasons, this may lead to newly qualified CCT holders leaving the NHS in the near future.

9. Early Retirement

The trend to early retirement is difficult to quantify and even minor changes to retirement age profiles have a profound effect on workforce numbers, particularly in the case of smaller surgical specialties. The length of time it takes to train a consultant surgeon means that there is little flexibility when a higher than expected proportion of surgeons take early retirement. A general trend towards retirement at 60 instead of 65 would shorten the average working life of a consultant by 15–20%. Such a change could be offset only by a commensurate increase in consultant numbers.

A study of 1,043 general surgeons by the ASGBI found a mean projected retirement age of 61.14 However, it is possible that the lifetime pension capping arrangements that come into effect in April 2006 may produce a one-off increase in early retirements. There is anecdotal evidence in some specialties that a higher than average number of surgeons have made plans to retire early. A similar one off problem could occur in 2013 if proposed changes to the NHS Pension Plan are introduced. Though these changes are unlikely to cause a major problem for the larger surgical specialties, smaller numbers of surgeons taking early retirement in smaller specialties and sub-specialties could create unexpected shortfalls in these workforces.

A BMA study found that up to 4,000 consultants would reach their maximum achievable pension entitlement by 2007 under the new consultant contract. The effects of such a large potential retirement cohort have not been quantified or modelled against workforce needs. Research for the ASGBI found that most clinicians seeking early retirement would be prepared to continue serving longer in the NHS if a part time contract and without emergency on-call commitments could be arranged.15 However, Trusts are unlikely to fund posts of this nature without specific resources due to need to cover other aspects of work and the relatively high cost of continuing to employ senior staff.

TO WHAT EXTENT CAN AND SHOULD THE DEMAND BE MET, FOR BOTH CLINICAL AND MANAGERIAL STAFF, BY:

10. Changing the roles and improving the skills of existing staff

The College is strongly supportive of initiatives to make more effective use of the existing surgical workforce and more efficient utilisation of the surgical team. This is evidenced by the College’s role in the development of a curriculum for the health care practitioners in surgery. The health care practitioner has a role to play in the surgical team and in the delivery of Hospital at Night initiative, particularly in the light of changes to the SHO role under MMC. However, a balance needs to be obtained to ensure that health care practitioners do not dilute surgical training opportunities for doctors and are not used as a substitute for surgical staff.
However, the College is very concerned at references to new, undefined roles, such as “accredited specialist” and “credentialed service doctor”, discussed in section 2. The College would welcome an opportunity to work with the Department of Health in developing the criteria and function for any new posts within the surgical team, but will insist on a clear definition of roles, responsibilities and quality assurance, and will seek confirmation that consultant surgeons retain ultimate responsibility for care of surgical patients.

11. Better retention

Given the long training period and relatively short working life of current surgeons, improving retention is a highly effective means of maintaining surgical workforce numbers. As discussed in section 10 above, persuading consultants to retire at 65 rather than 60 would prevent a loss equivalent to 15% of the consultant workforce.

In an era where the majority of medical graduates are women, retaining women in the surgical workforce will also become increasingly important. Flexible training can be an important part of both recruiting and retaining women in the surgical workforce. Inquiries about flexible training come into the College at the rate of one or two per week, yet a recent survey of surgical trainees found that very small numbers (less than 2%) of all trainees in higher surgical training were training flexibly, a long way short of the Department of Health target of between 10% and 20% by 2012.16 This suggests that there is a strong case for reviewing the way flexible training options are funded in order to attract and retain a modern surgical workforce. Currently trainees are often denied a flexible training post due to limited or delayed funding.

12. Recruitment of new staff in England

The NHS Plan,17 launched in July 2000, promised 7,500 additional consultants in England by 2004, and there has been a welcome increase in surgical consultant numbers over recent years. The College’s 2005 report, Developing a Modern Surgical Workforce,18 identified a shortfall of consultant surgeons on the targets set for 2010, based on assessed need across the nine surgical specialties, particularly in light of ambitious 18 week waiting list targets and the adjustment to the 48 hour working week under EWTD.

However, most surgical specialties are now closer to meeting the required level of surgical need within the next decade. An additional one-off increase in national training numbers to address the problem of the SHO bulge and MMC could provide a much needed increase the consultant workforce and help to achieve targets sooner.

In the longer term, when recruitment and retirement are in balance, training numbers will need to be substantially reduced. As consultant practice exceeds 20 years and higher training lasts only five or six years, a ratio of four consultants to one trainee is required for stability. In spite of this reduced demand for trainees, there are reasons to be concerned that recruitment of trainees may become increasingly problematic in the future.

Medical school intake is set to become 70% female in the near future and Sheffield University has already admitted 80% female medical students. This is likely to result in a reduction in the number of graduates applying for surgical training, which is seen as a particularly demanding career. A survey of medical graduates in 2000 identified just 10% of females who were considering a career in a surgical specialty, compared to 30% of males. More needs to be done to attract women into the surgical workforce, and to ensure that surgery is compatible with family life, including increasing flexible training opportunities and providing full funding for flexible training. However, in spite of the increasing need for flexible training, recent media reports indicate that the end of central funding for flexible training will result in the scheme being stopped in many areas due to financial pressures.

Concern about the future availability of surgical posts may also deter students from taking up surgical training, particularly in some of the smaller specialties. The long period of training combined with concerns about long-term employment prospects in light of rapid technological change mean that trainees may be unwilling to commit to certain surgical specialties and sub-specialties.

13. International recruitment

International recruitment has always played an important role in the surgical workforce in the NHS, in particular through recruitment into junior training posts and subsequently non-training grades, has led to a disproportionate number of foreign graduates in the staff and associate specialist grades. However, the use of imported specialists to bridge the current consultant shortage is more problematic, both for quality assurance reasons and because of a moral reluctance to deprive other countries of scarce resource. International recruitment should not be seen as a permanent solution to the problem of shortages in high level surgical staff. There are undoubted benefits in the recruitment of overseas graduates but the NHS should avoid dependence on international recruitment for meeting UK service needs.
HOW SHOULD PLANNING BE UNDERTAKEN:

14. To what extent should it be centralised or decentralised?

The best way to undertake planning depends upon the size of the specialty and its workforce. Larger specialties such as general surgery and trauma and orthopaedics are best planned on a regional basis. Every site has its own unique mix of requirements and facilities and inventive local management programmes are often required. At present the structure, skills and support given to clinical directors and middle managers does not provide a good basis for effective change and the College would like to see the development of structures that would give clinical directors more freedom efficiently to allocate and redirect scarce financial and workforce resources.

For highly specialised surgical skills, planning needs to be undertaken on a national, ideally UK-wide, basis. Smaller specialties, such as cardiac surgery and neurosurgery, are only viable serving a large population. There is some scope to make better use of scarce personnel in these specialties, by the development of a centralised service for inpatient and complex care and a networked service to smaller hospitals for less serious interventions and out patient services.

A good illustration of the need for national planning in smaller specialties is provided by recent problems recruiting trainees to interface groups such as cleft lip surgery, hand surgery and head and neck surgery. A separate funding stream is necessary for this type of specialist post, as these highly specialist skills are not sufficiently required by any one Trust, but are essential to the overall needs of the UK health service.

15. How is flexibility to be ensured?

Predicting the number of surgeons required remains inexact, due to the array of factors influencing demand and supply, including demographic and technological change and the long training period.

There is a danger that curriculum changes following MMC and the focus on competence based delivery of services could encourage over-specialisation. While beneficial for the development of special skills there is a risk that a narrow practice may reduce the capacity to adapt to changes in need. The broad range of skills and experience offered by the consultant surgeon is still the best way to meet the diverse and changing needs of a modern health service. However, there is some scope to increase flexibility in the surgical workforce by examining opportunities for increased interface working across the specialties.

An improved process for planning in-patient care is also urgently required, to reduce the serious costs of the mismatch between available theatres, beds and staff. In many cases the causes of problems are easily recognised and the process problems are well understood. However, the skill and will of local managers and clinicians to alter embedded patterns of practice to improve efficiency is not always manifest and change can be difficult to achieve.

16. What examples of good practice can be found in England and elsewhere?

1. Lessons learnt from the separation of elective and emergency care, for example NHS DTCs and ISTCs show that an improved process for planning in-patient care can be achieved.

2. Other good practice has included the development of multi-disciplinary team working and an increasing reliance on team working as a consequence of EWTD.

3. The inclusion of patient groups within the College and specialist associations to inform developments.

4. In a recent (as yet unpublished) survey of Clinical Directors of Surgery in England three-quarters of respondents (30 out of 40) had taken some kind of initiative in order to improve the use of surgical resources. The most common solutions reported were expanding facilities, either through use/development of an extra ward, theatre or unit, or in carrying out more day surgery, and increasing numbers of staff, trainees and nursing support. Other solutions adopted were the ring fencing of surgical beds, improved pre-operative assessments, redesign of the patient pathway and the introduction of Hospital at Night.

5. The Emergency Care Project Team at the Department of Health have produced useful toolkits and guidance that can contribute to a more efficient utilisation of workforce resources and better patient care. These include a simple discharge from hospital toolkit, a best practice guide to medical and surgical admissions and a four-hour checklist for streamlining emergency care.

17. The Royal College of Surgeons of England: Recommendations for way forward

1. Separation of emergency and elective will lead to a greater emphasis on consultants managing acutely ill patients and will improve training opportunities in emergency care.

2. National Training Numbers (NTNs)—there are grounds for a temporary expansion of specialist training grades to cope with excess of qualified surgical trainees arising from impact of MMC. The College has identified a number of potential SHO conversions. This expansion would be for one training cycle only, but would provide a much needed increase of the consultant workforce.
3. The further development of surgical teams and the culture of team working is vital for the continuity of safe patient care.

4. Reviewing the way flexible training options are funded in order to attract and retain a modern surgical workforce, and to actively recruit women into surgery.

5. A separate funding stream is necessary for the training of highly specialised surgeons embarking on complex and rare surgical skills, eg cleft lip and neck.

6. The College support an opt-out for surgical trainees from the 48 hour week under the European Working Time Directive.

Bernard Ribeiro
President, The Royal College of Surgeons of England

March 2006

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Evidence submitted by the Royal National Institute for the Deaf (WP 18)

Introduction

RNID is the largest charity representing the nine million deaf and hard of hearing people in the UK. Around six million people in UK have a hearing loss that could benefit from some degree of amplification of whom only two million currently have a hearing aid.

Audiology services in England have changed considerably over the last five years from being services that had developed little from the 1970’s and lacked modern technology to becoming fully modernised as a result of the Modernising Hearing Aid Services (MHAS) programme. The RNID managed the MHAS project,
funded by the Department of Health, which has enabled audiology services to offer high quality digital hearing aids, programmed to meet each person’s needs according to nationally agreed protocols. Similar modernisation programmes have taken place in the other countries of the UK. The Newborn Hearing Screening Programme (NHSP) was another recent initiative that also impacted on audiology services.

The MHAS programme was extremely successful with all 164 Trusts now enjoying modernised hearing aid services. Medical Research Council (MRC) evaluation of the Programme has demonstrated that people have reported a significant improvement in their quality of life as a direct result of receiving digital hearing aids free of charge from the NHS.

However the success of this and other initiatives has meant that demand and expectations on services have also increased. There is a historic shortage of audiologists and this coupled with a higher demand has led to increased waiting times in many areas, particularly in adults’ services. The NHS has struggled to provide the capacity necessary to meet the demand from those who require hearing care.

These issues make it imperative that audiology departments have the appropriate skill mix and staffing levels to deal with the increased demand and expectations on services.

The work towards 18 week targets from referral to treatment has highlighted the need for the Department of Health to plan the Healthcare Scientists Workforce as a matter of urgency.

What workforce planning has currently been undertaken?

The British Academy of Audiology (BAA), is the largest UK Audiology organisation representing the views of Audiologists. The BAA have looked at the “future of the audiology workforce” and written a comprehensive paper documenting their proposals (Sutton, 2005). According to the BAA’s report much of the work that is currently carried out in Audiology departments is fairly routine such as simple clinical tasks and administration. High-level audiology staff carry out much of this work, when it could be done by assistants, which would also be more cost effective.

The BAA worked with the Department of Health to develop National Occupational Standards and the healthcare scientists’ career pathway framework, and is currently looking at developing a foundation degree for an associate position.

There are estimated to be around 2,000 WTE qualified audiologists working in the NHS throughout the UK currently.

A recent NHS workforce project has suggested an additional 1,700 qualified audiologists are required to cope with current pressure. This could take between 10 and 15 years to realise under the current training programmes.

There are currently around 350 assistant audiologists and BAA suggests that the NHS needs a similar number of the new associate grade staff. There is an urgent need for more training for these positions.

A BSc (Hons) Audiology was introduced in 2002, which aims to partially address the need for more highly trained audiologists. The degree is now available in nine Universities in the UK. As the degree is a four-year full time course, with the first cohort of students graduating June 2006, it will be a number of years before these graduates really do impact on the numbers of audiologists.

Without the right workforce, audiology will not be able to deliver effective and efficient services to patients and waiting times—currently around a year in many areas—will continue to increase. There is a consensus that the audiology workforce needs to have highly trained staff, with appropriate skills and be flexible.

In considering future demand, how should the effects of the following be taken into account?

— Recent policy announcements, including commissioning a patient-led NHS.

Provision of audiology services may change in the future—most of the service can be provided in a community setting. There may be an increase in non NHS provision. The current system requires different training and accreditation for the individual depending on whether they are working in the NHS or private sector. There is a need for unified training and qualifications.

The future state registration should include both the public and private sectors. ie one body regulating professionals employed in the public and private sectors. This will help to assure quality for service users while also giving a more flexible workforce.

— An ageing population

Age related hearing loss is the most common cause of deafness. As the population ages this will have a massive impact on audiology services as a higher number of people will start to lose their hearing in later life. Currently, more than half of people over the age of 60 have lost some hearing. The Medical Research Council estimates that the number of deaf and hard of hearing people in the UK—already exceeding nine million—is set to increase by 14% every 10 years. This means that in 30 years time (by the year 2036) there will be more than 13 million deaf and hard of hearing people in the UK.
The government’s agenda is to encourage older people to lead more healthy, independent, active lives—participating more fully in their families and communities and even working longer. However, for this to happen, older people losing their hearing must have ready access to the technology and services that can reconnect them to society. It is therefore essential that there are high quality, easily accessible hearing aid services.

— *The increasing use of private providers of services*

The private sector is already helping with delivering hearing aids to NHS patients through the Public Private Partnership (PPP). However, there are not enough new people training/qualifying, as Hearing Aid Dispensers currently to enable the private sector to meet NHS demands. Equally whatever the potential for diversification of provider organisations and better use of skill mix, there are certain tasks within audiology & hearing aid services that can only be undertaken by staff who are fully qualified in audiology and trained to follow nationally agreed protocols. This is essential to ensure quality and equity in outcomes for service users. Diversification of provider organisations will not overcome the fact that there exists at present a limited pool of qualified audiology staff in all sectors, giving inadequate capacity to meet demand. There has already been substantial international recruitment but this has not solved the problem—and in order to ensure quality and equity for service users such recruits need specific training in standard procedures and protocols in the UK.

*How will the ability to meet demands be affected by:*

— *Financial Constraints*

It is important that all the substantial investments in audiology over recent years are maintained and this must include investing in staffing and the workforce. The momentum must not be lost as there is a risk that access to the modernised services become restricted due to ever increasing waiting times and/or narrower eligibility criteria. The Department of Health released funding for 2005–06 to support modernisation of audiology, but there is a danger that this funding (approx £38 million) may be cut in 2006–07 for both staffing and hearing aids. It is important that this does not happen and that commissioners are encouraged to fund audiology services.

*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*

As outlined above, it is necessary to have a workforce with the right skill mix in audiology departments. The BAA is working towards developing more formal requirements for assistant and associate posts with the Department for Health—eg the foundation degree for Associate Audiologists.

— *The recruitment of new staff in England*

The BSc will help with the recruitment of new staff in England. However, the profession of audiology is not currently promoted effectively, there is little information available to potential employees, and what information is available is difficult to find.

— *International recruitment*

There are currently many locums from other countries working in the NHS. While this is helpful in the short term, it is expensive and doesn’t address underlying capacity issues. It can also create quality assurance problems because international recruits need additional training in UK procedures and protocols.

*How should planning be undertaken?*

— *To what extent should it be centralised or decentralised?*

Decentralised workforce planning is essential to ensure services can meet local needs. However, it is vital also that centralised planning occurs to ensure there is an adequate pool of appropriately qualified staff across the UK, and that the necessary training is in place. There also needs to be effective information flows between central and Strategic Health Authority planners.

**Recommendations**

Core funding of audiology services must be continued by ensuring that £38 million goes through to local audiology services as in 2005–06 to support modernisation.

Priority must be given to introducing formal training routes for associate audiologists to ensure that there is the correct skill mix in departments.
The BSc in Audiology should be extended to additional HEIs to ensure that the audiology workforce can meet capacity.

*Angela King*
Senior Audiologist Specialist, RNID

*March 2006*

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**Evidence submitted by the Royal Pharmaceutical Society of Great Britain (WP 50)**

**SUMMARY**

Key features of the pharmacy workforce:

— The majority of pharmacists, whilst delivering services on behalf of the NHS or to NHS patients, are employed in the private sector, working for either large publicly quoted companies or for small and medium sized enterprises.

— More than a third of pharmacists working in community pharmacy are locums, some work regularly for the same pharmacy combining community practice with teaching and sessional work in general practices.

— More than half of pharmacists working in community pharmacy are working part time (which is defined as less than 32 hours per week).

— Around 10% of pharmacists are multiple job holders undertaking part time work in up to three different sectors.

The RPSGB working with the Department of Health and Welsh Assembly Government has developed and tested the first workforce planning model for the profession that covers the NHS and major private sector pharmacy providers. This has demonstrated an emerging gap between demand and supply: highlighted areas of risk of over and under supply of pharmacists in a number of policy, demographic and technological scenarios over a 10 year period and allowed recommendations to be made to manage the emerging risks.

The RPSGB has opened a voluntary register for pharmacy technicians and is awaiting legislation to make this statutory. This, together with proposals in the Health Bill which will define the extent to which pharmacists may delegate certain activities to technicians under supervision and where pharmacy technicians might supervise certain activities in place of the pharmacist, will allow proposals around skill mix to be developed where appropriate.

An area of particular concern, arising from the expansion in pharmacy student numbers (44% since 1998) and the demographic profile of the current workforce, is the lack of planning and capacity development amongst the academic workforce—this is being investigated further but a capacity development programme will be needed. The RPSGB has recently re-launched its PhD Studentship programme in response to the growing problems.

**BACKGROUND**

The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional and regulatory body for pharmacists in England, Scotland and Wales. It also regulates pharmacy technicians on a voluntary basis, which is expected to become statutory under anticipated legislation. The primary objectives of the Society are to lead, regulate, develop and represent the profession of pharmacy.

1. The RPSGB is concerned to ensure that the profession has the capacity (in terms of numbers and skills, knowledge and attitudes/values) to deliver high quality services that, above all else, are safe for patients and in which the public can have confidence. It is from this perspective that the RPSGB takes forward its portfolio of work relating to workforce and education policy.

2. The primary practice responsibility of the pharmacy team is to ensure that patients, their carers and the public achieve their desired health outcomes, primarily through the safe and effective use of medicines. These responsibilities are delivered through the provision of up to date, safe and cost effective pharmaceutical services, information and products. The teams work in partnership with patients (and their carers) and other members of the wider healthcare team in order to discharge their professional responsibilities. An increasing number also undertake teaching and training responsibilities for students and trainees in pharmacy and more widely within the healthcare team.

3. However, it must be recognised that for a number of pharmacists and technicians, who work primarily in industry and academia, whose practice responsibility relates more widely to the discovery and development of medicines themselves and covers research, development, regulatory affairs and production amongst other functions—whilst their practice is not focussed on direct patient care their activities contribute to the wider purpose of the profession of pharmacy.

4. Based on results from the 2003 Workforce Census, carried out by the RPSGB, the pharmacist workforce is distributed as follows:
5. Key features to note are as follows:
   — The majority of pharmacists, whilst delivering services on behalf of the NHS or to NHS patients, are employed in the private sector, working for either large publicly quoted companies or for small and medium sized enterprises.
   — More than a third of pharmacists working in community pharmacy are locums, some work regularly for the same pharmacy combining community practice with teaching and sessional work in general practices.
   — More than half of pharmacists working in community pharmacy are working part time (which is defined as less than 32 hours per week).
   — Around 10% of pharmacists are multiple job holders undertaking part time work in up to three different sectors.

6. The pharmacy team also includes pharmacy technicians and other support staff; technicians are currently able to join a voluntary register at the RPSGB which it is anticipated will become a statutory register in due course. There are currently 2,770 technicians voluntarily registered with the RPSGB. Detailed workforce data is not yet available for technicians, once a statutory register has been established it will be possible to undertake a census and to establish a similarly detailed picture of the technician workforce.

7. The RPSGB, working with the health departments in England, Scotland and Wales, has recently completed the development of a computer based workforce planning model for pharmacists which is designed to assess the impact of different policy options on the risk of either over or under supply of pharmacists. The information provided below is based on the background work underpinning development of the model and outputs from it.

8. How effective has workforce planning been and how should it be done in the future? Until the work described above was commissioned in 2002–03 no attempt had been made to undertake a profession wide workforce planning exercise for pharmacy. The size of the workforce in pharmacy has been essentially market driven with no centralised planning as seen in for example medicine and dentistry. Overall supply has kept pace with the demand with existing schools of pharmacy increasing student numbers and new schools of pharmacy opening—there has been an overall increase in student numbers of 44% since 1998. The recent modelling work indicates that there is now a gap between supply and demand, especially in some sectors of the workforce and, most worryingly for the long term, in the academic workforce.

9. Many of the large private sector employers in pharmacy have traditionally undertaken quite detailed planning for their own workforce needs. The NHS has monitored its workforce with regular surveys for many years identifying shortage areas and vacancy rates as indicators of undersupply—no central view of workforce demand has been available.

133 The model was developed and the underpinning research undertaken by The Human Resource Management Research Group, Department of Management, King’s College, London, under the leadership of Professor David Guest.
10. In relation, specifically, to the longstanding involvement of major private pharmacy providers it should be noted that for private sector employer’s workforce planning data are intrinsically linked to the business plans of the organisations and, as a result, are commercially sensitive. In conducting its work the RPSGB utilised an independent research team to collect information and to maintain confidentiality. The need to protect commercially sensitive information and to respect commercial confidences was quite unique in pharmacy at the time the RPSGB project was undertaken. However similar concerns will increasingly impact on how and indeed whether workforce planning can be undertaken for other professional groups if the use of private sector providers in the NHS increases.

11. The workforce planning model now available for pharmacy will support all the stakeholders interested in analysing the pharmacy workforce. However, for the data to be useful in terms of ensuring that supply and demand are broadly aligned, joint working will be needed at a strategic level—the StLaR initiative between DH & DfES offers a useful model which has progressed discussions about academic workforce and career development.

12. How should the effects of technology, policy, changing demographics and private provision be taken into account? Impact of these factors on both demand and supply should be considered separately and then combined to assess overall impact on workforce—this requires identification and verification of measures that reflect current workload and determination of attitudes to work amongst the workforce in order to predict impact on supply.

The workload measures used for pharmacy are as follows:

- **Community Pharmacy**: prescription items per pharmacist hour.
- **NHS Hospital Pharmacy**: Whole time equivalent pharmacists per 1,000 FCEs (Finished Consultant Episodes).
- **NHS Primary Care Pharmacy**: Whole time equivalent pharmacists per GP Partnership.
- **Industrial Pharmacy**: weighted demand based on a function of the average number of new medicines introduced per year plus a proportion of the number of new medicines in Phase 3 clinical trials + a proportion of the number of GP Partnerships.
- **Academic Pharmacy**: Undergraduates in Schools of Pharmacy per pharmacist.

Three sets of career anchors have been identified and used to predict the likely impact of policy, technology etc on the supply of the pharmacy workforce. The following three attitudinal profiles (career anchors) predict the propensity of the workforce to leave jobs, sectors or indeed the profession or to reduce working hours:

- Improving people’s well-being and making a contribution to society.
- Ensuring long term employment and financial security.
- Balancing and/or integrating work and life outside work.

As the nature of the workforce changes in terms of socio demographic, gender and ethnicity these profiles are likely to vary across different cohorts within the workforce and need to be monitored and updated regularly to maintain the model.

13. To what extent can and should demand be met? A range of approaches can be used to bring supply and demand back into balance—a combination has been proposed to address the emerging gap between demand and supply in pharmacy. Care has to be taken in deploying demand side solutions as many will have impacts (often negative) on supply factors—a balance has to be struck and trade offs made regarding timescales to implementation in order to manage expectations and avoid negative impacts on supply side features. This suggests that a significant amount of work is needed to develop a long term view of workforce needs, especially where the training pipeline is relatively long (for pharmacists this is five years to initial registration and up to 10 years for some specialist and advanced areas of practice). Initiatives in retention with recruitment should be carefully balanced to avoid alternating and damaging periods of over and under supply.

14. There is a gap between demand and supply in the pharmacy workforce and anecdotal evidence suggests that this is covered in a number of ways:

- Working longer hours (the attitude survey indicates that pharmacists work an average of four hours a week longer than their contracted hours).
- Dealing more swiftly with scripts at a rate above the official safety levels.
- Cutting back on non-core activities and back-up activities.
- Some reduction in service provision (e.g. out of hours work; vacancies left unfilled).
- Extending the role of pharmacy technicians and assistants, and others, to substitute for pharmacists.

15. Thus whilst there are no outward signs that the service is failing to meet demand and expectations of patients going forward, there must be concerns over the safety and sustainability of the emerging picture. Recognising this a series of policy recommendations have been made by the Pharmacy Workforce Planning and Policy Advisory Group—a number of which have already been set in train.

16. How should workforce planning be undertaken? For small professional groups, especially those with long training pipelines and whose practice depends on a high level of technical/clinical skill and/or specialist knowledge, a case can be made for an element of centralised planning. As acknowledged previously supply and demand have stayed largely in balance in pharmacy with expansion in student numbers keeping pace with increased demand—this has occurred through the responsive market in higher education and without any centralised planning. However, the emerging problems with academic workforce are a consequence which can realistically only be addressed at a national level. A planned expansion, similar in process to the recent expansion in medical education, would have allowed a more strategic approach to funding and capacity development.

17. Of itself workforce planning for any professional or managerial group will not prevent under or indeed over supply of clinical and professional groups, realistically workforce planning enables those with power to increase recruitment and retention or to manage demand to assess risks and make choices. Unless there are clear lines of accountability to allow appropriate and timely action to be taken the risks identified cannot be managed or minimised effectively.

Dr Sue Ambler
Royal Pharmaceutical Society of Great Britain
March 2006

Evidence submitted by Shared Solutions Consulting (WP 03)

A. INTRODUCTION

1. This response is from George Blair who had lead responsibility for the Education Training workforce planning at the Department of Health, 1992 to 1995 and has spent 20 years in this field in the NHS.

2. This paper is divided into three main sections:
   B. Issues to take into account—this explains some of the assumptions and underlying principles that are behind our answers.
   C. Answers—this responds to the Committee's questions.
   D. Recommendations.

B. ISSUES TO TAKE INTO ACCOUNT

What is workforce planning?

3. Workforce planning is often defined in a way that ignores crucial issues such as productivity. This is because a definition such as the following is used: the "right number of staff, with the right skills, in the right place, at the right time.” This then focuses on supply issues, such as training needs analyses, commissioning education at training and improving recruitment and retention.

4. However, recently there have been serious concerns about the declining productivity in the NHS. There are a many of examples of this, such as buying expensive equipment to treat more patients, when existing equipment is only used on a nine to five basis, Mondays to Fridays or using expensive on-call arrangements instead of extending the shift system.

5. One of the interesting aspects of this issue is the lack of useful data on changes in productivity. This is because there has been historically a lack of management focus on the topic. There has been a complete lack of clarity regarding who is responsible for trying to improve productivity, due to a silo culture where the data on staff, costs and patient activity sit in three different departments, without much consideration being given how best to integrate it.

6. In the few areas with excellent productivity data, this tends to be only in the possession of service managers who have many other concerns and little or no incentive to do anything about it. However, this will change with the implementation of payment by results.

7. It is proposed that organisations should be encouraged to have productivity leads. They could be workforce planners working with clinical leads and finance staff or management accounts staff who have some training in workforce planning, working with their other colleagues.
The long-term nature of workforce planning

8. The timescale of workforce planning for most professions is at least five years. This is because negotiations need to take place with education providers about the future size of their intakes, which can take a couple of years to implement in addition to the usual three years duration of degree or diploma courses. This process is even longer in the case of medicine, due to the seven year duration of their education programmes. Thus at least five years need to elapse before the adequacy or otherwise of a workforce plan can be established. Therefore, in 2006 we can only evaluate with any certainty workforce decisions made before 2002!

What is successful workforce planning?

9. How accurate can such plans be, given the need to plan so far ahead? Many events or policy changes could take place after the plans have been made that will have a substantial impact on them. This could take the form of a large increase in staff, as in the case of the NHS Plan, or changes in the location of care with the shift to primary care, or between the NHS and the independent sector, with 15% of certain types of services to be provided by the latter. Therefore, the best that can be hoped for is that workforce plans are a close approximation of demand. Given the impossibility of accuracy, a decision needs to be made whether it is better to under or over train? Under-training saves training costs, but leads to staff shortages, increased waiting times and the use of more, high cost agency staff. In the case of over-training, the advantages and disadvantages are reversed. The established wisdom is that slight overtraining is the preferred option.

Geographical differences

10. There are very pronounced regional differences in terms of levels of education, rates of employment and pay that need to be taken into account.

Clinical placements

11. Before newly qualified staff can become effective members of the workforce, they need a considerable investment in terms of on-the-job training and close supervision. Providing clinical placements has proved difficult in the past and is likely to be more so in the future, unless healthcare providers are financially compensated for their loss of throughput. Therefore, mechanisms that support the provision of clinical placements should be a success criterion for any proposed workforce planning system.

C. Answers to the Committee’s Questions

How should the effects of recent policy announcements, including Commissioning a patient-led NHS be taken into account?

12. This would entail unravelling their many facets that have workforce implications. For instance Commissioning A Patient Led NHS would mean: fewer management staff with the mergers of SHAs and PCTs; training GPs in commissioning skills; anticipating the workforce impact of changes in commissioning.

13. There would be value in a central group of people from different levels of the NHS with workforce planning skills reviewing such documents and producing a workforce implications grid that would spell out: possible changes in workforce numbers; roles; locations; patterns of working; education and training; and finally, where responsibilities for meeting these changes falls.

How should the effects of technology be taken into account?

14. The impact of technology and new drugs can be huge. For instance, if a vaccine against cervical cancer were developed, a great deal of time would be released, as practice nurses and laboratories would cease screening. There are a growing number of tests that patients can carry out themselves, meaning patients will be able to monitor and manage their conditions with less intervention from healthcare staff. However, there would need to be substantial up-front investment in patient training.

15. Given the wide ranging nature of the above, drug and equipment manufacturers should be invited to write papers on this topic. They could be allowed to have their name on the documents, so that they would gain kudos from the exercise. The papers could then be put on a workforce planning website, eg that of the National Workforce Projects.
How should the effects of an ageing population be taken into account?

16. This has several facets, such as the impact on the demand for healthcare on the one hand and on the other NHS’s own workforce, namely what types of jobs are most suited to the older worker?

17. One approach is to study how societies with a higher percentage of old people manage, eg Japan and China135 and then apply the lessons to England.

18. When it comes to planning to replace retirements, this is best done centrally, with reference to national age profiles from professional registers or the NHS electronic staff record. The reason is that it is easy for employers to lose sight of this problem. For instance, many acute trusts would not plan to replace nurses coming up to retirement because they only have a few of them. However, community and practice nurses tend to not to plan to replace their many nurses coming up for retirement either, as they can readily recruit experienced nurses from the local acute trust, rather than directly from university.

How should the effects of private providers of services be taken into account?

19. The number of staff employed in the private sector could be obtained from registration bodies, if they were to extend the mandatory information required of their members.

20. However, this would not provide information on future demand and therefore an important piece of information would be missing. Unfortunately, private sector providers are likely to be unwilling to provide this information, as this would reveal too much of their confidential marketing strategy.

How will the ability to meet demand be affected by financial constraints?

21. Financial constraints are likely to result in a reduction in the use of agency staff and possibly, redundancies. This might mean that some newly qualified staff will not get jobs, as these might be taken by more experienced, unemployed staff.

How will the ability to meet demands be affected by the European Working Time Directive (EWTD)?

22. This will affect parts of the NHS where staff work substantially more hours in excess of EWTD regulations, such as medical staff, radiography and pathology staff. This can be addressed by new ways of working, such as teams of staff working across specialties in the Hospital at Night programme or by changing skill mix to make better use of more expensive professional staff, eg introducing assistant practitioners who would release professional staff from undertaking many chest x-rays.

How will the ability to meet demands be affected by increasing international competition for staff

23. This is likely to have a serious impact on England’s capacity to recruit and retain nurses. Many Filipino nurses only work in Britain because they were barred from applying for jobs in the USA, their first preference, until recently. In addition, some expensively trained UK trained nurses in hard to recruit specialties, eg intensive care, are likely to be attracted by better America rates of pay.

How will the ability to meet demands be affected by early retirement

24. This is presumed to refer to medical staff being encouraged to retire early due to the unintended consequences of pension changes. This will clearly have an adverse impact on the whole of the service.

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

25. This would be attractive option in terms of developing existing staff and improving efficiency. However, it should be noted that past achievements have been limited and excellent examples of innovation have not been copied widely. It is hoped that Payment by Results and the Knowledge and Skills Framework will encourage more innovation of this type.

26. In addition, benefits can be gained from improving working processes, eg simplifying workflow in pathology.

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135 Shanghai has become the Chinese city with the highest proportion of residents over the age of 60 one in five, or 2.6 million. The situation facing the whole country is equally worrying. By 2035, a quarter of Chinese will be above the age of 60 more than the total projected populations of Britain, France, Germany, Italy and Japan combined.

To what extent can and should the demand be met, for both clinical and managerial staff, by better retention?

27. All things being equal retention rates may well decline, due to the greater choice of employers with the growth in the number of independent providers. In addition, there would be losses due to more retirements, even with the development of post-retirement careers. A further consideration is that there are marked regional variations in retention due to the very distinct labour markets, such as London and the South East attracting younger and more mobile workers. Indeed, Capital Health? Creative solutions to London’s NHS workforce challenges\(^{136}\) suggests rather than try to stem this tide, London organisations should design career opportunities to make the most of recruits wanting a brief career in London, before moving on.

To what extent can and should the demand be met, for both clinical and managerial staff by the recruitment of new staff in England or by international recruitment?

28. The objective should be that England is self-sufficient in the supply of health staff. This is because there are benefits to patients in having staff who understand their culture and can more effectively communicate with them. Therefore, reliance on foreign trained staff for anything other than a sudden and unforeseeable increase in demand should be regarded as a failure in workforce planning.

29. This goes beyond planning around nationality to include ethnic origin. It means that ethnic populations are better served if more staff with whom they have face-to-face contact are recruited from amongst them. Urban regeneration can be fostered by investing in the education and training of disadvantaged populations.

30. There are ethical issues to consider when overseas recruitment is at the expense of poor, sub-Saharan Africa countries where such staff are in short supply. For instance, of the 600 Zambian doctors trained since independence, only 50 are said to have remained in the country.\(^{137}\) It is said that there are now more Zambian doctors in Birmingham than in their country of birth.

To what extent should planning be centralised or decentralised?

31. Planning for whom? There are some small, but important staff groups with just 50 staff and clearly they can only be planned for centrally. Usually, the best way to do that is in conjunction with their professional body that would have membership lists, age profiles, etc.

32. The NHS has a tendency to alternate been centralised and decentralised approaches every three to four years, as each approach has its own set of advantages and disadvantages.

33. More important issues are, what are the checks and balances in the system? For instance, when education monies can be diverted to funding health care provision deficits, this has been too great a temptation for trusts to resist.

34. The advantage of central planning is that it is likely to take into account the need to replace a large number of staff coming up for retirement. However, it is difficult for a central system to respond to the needs for very different local labour markets. The advantages and disadvantages are summarised below in tables 1 and 2.

Table 1

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<tr>
<th>CENTRALISED PLANNING—ADVANTAGES AND DISADVANTAGES</th>
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<tbody>
<tr>
<td><strong>Advantages</strong></td>
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<tr>
<td>Can readily address the needs to maintain the workforce, eg retirements, by commissioning more education</td>
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Table 2

LOCAL PLANNING—ADVANTAGES AND DISADVANTAGES

<table>
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<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td>Local changes in demand are more likely to be met</td>
<td>Can lead to short-term policies. The serious shortage of nurses was driven by the massive and unsustainable reductions in education in the early 1990s.</td>
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<tr>
<td>Local organisations are more likely to take planning seriously, as they are making the decisions themselves</td>
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35. As there are quite marked advantages and disadvantages to both approaches, can elements of centralisation and decentralisation be combined, as part of the same model? For instance, national work could set floors and ceilings for education supply and then local organisations decide how they are going to contribute to meeting the targets. This would also need a mechanism to force local organisations to increase training, when it is below the level of the centrally set floor.

How is flexibility to be ensured?

36. This is difficult to achieve. One approach is to use scenario planning so that if the preferred scenario were to prove unattractive because of unforeseen events, another scenario can be adopted.

D. Recommendations

37. This section includes recommendations on:
   — criteria for evaluating a workforce planning system;
   — a structure for workforce planning;
   — a means of distilling the workforce impacts of healthcare policy;
   — a means of contribution to long-term thinking on the impact of technology and drugs; and
   — the need to focus on productivity improvement.

(i) Criteria for evaluating a workforce planning system

38. These should be:
   (1) To respond effectively to the needs of small groups, i.e. with 50 members as well as large ones.
   (2) To prevent education and training monies from being diverted to fund financial deficits in the provision of healthcare, where this is to the detriment of the future workforce.
   (3) To enable enough clinical placements to be provided to support the required volume of education and training.
   (4) To involve all relevant stakeholders, i.e. including education providers and professional bodies.
   (5) To avoid serious staff shortages as indicated by: the number of unfilled vacancies; the number of agency staff and the number of overseas recruits.

(ii) Recommended system of workforce planning

39. The following are recommended:
   (1) Membership: to be employer driven, while engaging legitimate stakeholders, e.g. education, professional bodies and patient groups.
   (2) Roles of different bodies:
      (a) The Department of Health or The Employers Organisation should set national ceilings and floors, based on commissioned research that would have some professional body input. Department of Health clinical strategies should spell out the likely workforce implications. In addition, the national lead organisation is to commission papers on long-term issues. All this information should be available to all on the web.
      (b) Regions or whatever amalgamated Strategic Health Authorities will be called, would conduct workforce planning exercises with Trusts and other healthcare providers to negotiate with the national body regarding what its target should be for each staff group. Any disputes on the
level of commissions should err on the side of slightly over-training than under-training. SHA/ Regions would also engage education providers about the design of courses and commission education, in the way currently undertaken by SHAs.

(c) Healthcare providers should provide plans to their SHA/Region.

(iii) Government policy documents and their workforce implications

40. It is recommended that a workforce group with representation from different levels of healthcare produce a workforce implications paper for each policy document for which this might be useful. This would include the likely impact on staff numbers, roles, ways of working and education and training.

(iv) Assessing the impact of technological change

41. Given the wide ranging nature of the above, drug and equipment manufacturers should be invited to write papers on this topic. They could be allowed to have their name on the documents, so that they would gain kudos from the exercise. The papers could then be put on a workforce planning website, e.g. that of the National Workforce Projects.

(v) Recommendation on productivity

42. It is recommended that consideration is given to how information on productivity is produced and reported to the different layers of management. This should include how action is taken to improve productivity that goes beyond reducing budgets to high cost services and covers benchmarking top performers and sharing information on process improvements. NHS organisations tend to suffer from too much data and too little information. Information should be presented in an integrated manner, with clear options regarding areas where action should be taken.

43. One option would be to give an award of £50,000 to the organisation that handles the efficiency agenda across the whole organisation most effectively. This could be written up and shared on the web. Therefore, the approach would be of demonstration and not prescription.

George Blair
Managing Consultant, Shared Solutions Consulting
20 February 2006

Evidence submitted by Skills for Health (WP 12)

I am pleased to submit this self contained memorandum of evidence to the Health Select Committee. Skills for Health consider that the inquiry is well timed in the light of significant changes in the service and the resultant impact on the workforce.

As the Sector Skills Council for Health, we have been charged with developing a Sector Skills Agreement (SSA) which we and our partners consider will have a major role to play in supporting improved workforce planning, skills development and workforce productivity in the short, medium and longer term.

WHAT IS “SKILLS FOR HEALTH?”

1. “Skills for Health” is a Sector Skills Council (SSC) with a UK wide remit. Our role covers all healthcare employers—including those in the NHS, independent and voluntary sectors. Established in April 2002, Skills for Health is licensed by the Department for Education and Skills as the SSC for the health and healthcare sector. We are part of a UK network of Sector Skills Councils covering 85% of the UK economy, and are integral to the government’s Skills Strategy.

2. The aim of “Skills for Health” is to help the whole sector develop solutions that deliver a skilled and flexible UK workforce in order to improve health and healthcare.

3. To achieve this aim, we have expertise in the following areas:

(a) Developing and managing national workforce competences

Leading and facilitating the development, maintenance and use of national workforce competence frameworks, embracing National Occupation Standards and evaluating their impact and use.\(^{138}\)

\[^{138}\] National Workforce Competences and National Occupational Standards reflect a set of statements identifying what people or teams need to know and be able to do to deliver that service. They:

— Describe the work activities which need to be carried out to achieve a particular purpose.
— Outline the quality standards to which these activities need to be performed.
— Indicate the knowledge and skills people need to carry out these activities.
— Begin with the question—“What do patients and their carers need?”
— Disregard existing boundaries such as location and professional demarcations.
— Are patient-centred, recognised UK-wide, transferable competences.
(b) **Profiling the UK workforce**  
Bringing together Labour Market Intelligence for the whole UK health and healthcare sector.

(c) **Identifying and articulating sector workforce needs**  
Working with and on behalf of a network of employers in the nations and regions of the UK.

(d) **Improving workforce skills**  
Developing and implementing a strategy for skills escalation embracing the use of qualifications and career frameworks.

(e) **Influencing education and training supply**  
Ensuring the sector gets the skills it needs through influencing learning supply. We are currently developing a UK wide “Sector Skills Agreement” (SSA)—See Annex 1 and 3. We are also developing employer-led partnership approaches to the quality assurance of education and training.

(f) **Working with partners**  
Working in a focussed and strategic way with key partners, stakeholders and customers across the sector.

**INTRODUCTION**

4. In the light of our forthcoming Sector Skills Agreement (SSA), Skills for Health welcomes the Health Committee’s timely decision to initiate an inquiry into “Workforce Needs and Planning for the Health Service”. Our assumption is that the Health Committee’s remit for this inquiry encompasses all health service organisations—including those in the independent and voluntary sectors. They draw from the same labour pool and their interdependence in workforce terms is important to our evidence. Although the focus of the Health Committee is on England, the remit of SfH is UK-wide. This is a critical factor in our response. Whilst we appreciate that health policy is devolved to the 4 UK countries, there are significant linkages across the UK Workforce (for example, radiographers who train in Edinburgh may often work in London).

5. Our overall view is that whilst “traditional” approaches to workforce needs and planning have worked fairly well to date, we consider the sector is facing key new challenges. These arise from a number of strategic drivers which, when combined, have a significant impact on workforce needs and planning. We put forward a case that traditional approaches to workforce planning and decision making have to change if the sector is to secure and maintain competent staff needed to deliver high quality healthcare services.

**EFFECTIVENESS OF CURRENT WORKFORCE PLANNING ARRANGEMENTS**

6. Current arrangements in England are complex. A wide range of organisations (and types of organisations) share between them various roles and responsibilities. We assume Department of Health will have covered these roles in detail but we summarise them here for contextual purposes. Roles cover:

- Individual NHS organisations—required to prepare their own workforce plans.
- Other employers in the sector (eg Nursing Homes, independent hospitals, voluntary sector organisations) who have the option of working closely with NHS organisations in a particular Strategic Health Authority (SHA) area.
- Strategic Health Authorities who have a co-ordinating role for producing coherent workforce plans (linked to service and financial plans) for all the employers in their area—for commissioning the education and training in support of those plans; and submitting overall workforce and commissioning plans to the Department of Health for approval.
- Skills for Health—per paragraph 3 above.
- The Workforce Review Team who advise the Department of Health as to future workforce number requirements.
- National Workforce Projects (NWP) who are taking forward a number of innovations in workforce development to support service change.
- Royal Colleges who offer their own advice to the Department of Health, especially in respect of future requirements for doctors in training and Consultants/GP’s that come within the remit of each of the Colleges.

139 In the Government’s national Skills Strategy the SSA is identified as the critical mechanism through which Sector Skills Councils will deliver four strategic objectives across the workforce (Increase productivity; Address skills gaps and shortages; Provide greater skills opportunities; Achieve more responsive education and training, aligned with sector employment needs). The practical outcome is a compact or “deal” between employers; partner organisations (including education and training providers) the sector and government. The agreement will be designed to ensure that “the skills the sector wants are the skills the sector gets”. The expectation is that the SSA will result in employers shaping and endorsing learning provision; skills demand more directly shaping supply; employees benefiting from increased high quality learning linked explicitly to better job prospects.
— Other “Advisory Committees” and bodies such as NHS Employers and external organisations.
— Department of Health (DH), who have a key role in assimilating this information and advice; and taking key decisions. In particular, at a macro level DH seeks to ensure that in aggregate, NHS workforce plans are coherent alongside its financial and service plans.
— DH also has a central role to play in ‘steering’ the investment of (approximately) £4 billion contained in the “MPET Levy” and issuing guidance and targets to individual SHA’s to inform their commissioning/investment plans. In practice this means that a large proportion of SHA resources are already pre-committed, firstly because there are many students who are on programmes which started 2 or more years ago. Secondly, DH comes to a view as to how many new pre-registration commissions are needed nationally each year for each of the healthcare professions; requiring each SHA to commission their ‘share’ of the overall total.

7. Despite the complexity, in general terms, this approach has produced sufficient staff with appropriate skills to deliver the volume and “style” of healthcare, within affordable limits. However there is no guarantee that systems of the past will continue to be effective in changing healthcare contexts.

DEFICIENCIES IN THE CURRENT WORKFORCE PLANNING ARRANGEMENTS IN ENGLAND

8. Criticisms of the current arrangements fall into the following main areas:
— Current workforce planning arrangements pay too little regard to the large proportion of the workforce not qualified as registered healthcare professionals. Similarly, education and training resources to support future workforce planning and development are almost exclusively devoted to professional and other qualified staff.
— Workforce planning (and the focus of investment) is currently based on numbers required in each of the already established healthcare professions and workforce groups. As a consequence, innovation needed to ensure that individuals working in the sector have the right competences to deliver modern healthcare is not prioritised. Growth in knowledge and technology means that existing, new and changing job roles do not conveniently fit into the workforce group ‘silos’ designed many years ago. Workforce planning returns and other workforce information submissions to DH contain little reference to new roles particularly at Assistant and Advanced practice levels, therefore the scope and flexibility for investing in them is limited. This has the effect of fossilising the structure of the workforce and assumes that ‘more of the same’ jobs and roles will meet service and financial requirements, at a time when policy and market conditions across the sector are changing radically.
— The strategic element of workforce planning is insufficiently considered within current arrangements.

KEY STRATEGIC DRIVERS FOR FUTURE WORKFORCE PLANNING

9. In analysing evidence gathered from the early stages of developing the Sector Skills Agreement, we suggest there are a number of key drivers impacting significantly on the future healthcare workforce—some directly, others indirectly. Some are sector wide, others more relevant to the NHS. A number of them were specifically identified by the Health Committee in the terms of reference for this inquiry.

10. The known key drivers include:
— European Working Time Directive 2009(1)
— Modernising Medical Careers(2)
— “Payment by Results”(3)
— Reduced financial growth for the NHS after the next Spending Review—ie from 2008 onwards
— “Agenda for Change”(4)—the new NHS pay system(5)
— The ‘Knowledge and Skills Framework’(6) which underpins ‘Agenda for Change’
— ‘Improving Working Lives’(7)
— The requirement for improvements in ‘Productive Time’
— The implications of the Gershon report(7)
— Changing market conditions including growth of the independent and voluntary sectors as a provider of NHS services

140 The Agenda for Change pay reform strategy is designed to replace out-moded policies and ensure staff are developed in their existing and future roles through an associated UK-wide ‘Knowledge and Skills Framework’ (KSF). KSF focuses on how knowledge and skills needs to be applied to meet the demands of work. KSF is designed to be consistent with occupational standards and workforce competences. It will be a major lever in achieving ‘skills escalation, a modern career framework and pay progression in the NHS. There will be ongoing implications for staff working in the independent and voluntary sector services over time and for medical staff.”
— The introduction of the “Electronic Staff Record” system(7) in the NHS
— Demographic changes—both in the population at large (e.g. more very elderly people) and in the workforce (e.g. changes in retirement trends)
— Age diversity legislation in 2006(8)
— Current financial pressures within healthcare in 2005–06
— Retirement “hot spots” in certain professions i.e. GPs
— Workforce shortages in diagnostic services
— Government policies—e.g. ‘Commissioning a Patient Led NHS’(9) and ‘Practice Based Commissioning’(15)

11. These drivers combined pose a challenge to the existing paradigm that job roles can continue to be defined purely in terms of the established workforce groups, inclusive of healthcare professions. This does not mean that these groups and professions do not continue to have a critical role, but healthcare workforce planners need to contemplate the significance of the drivers in developing ‘non-traditional’ approaches to competences and job roles to meet the challenges arising from them.

**Convergence of Strategic Drivers**

12. The strategic drivers we highlight converge in two specific areas namely the need for a **more flexible workforce** (a more effective mix of people undertaking wider and different roles) and the role of competences as a currency and framework for addressing skills gaps and their workforce development implications through future planning and commissioning.

**Developing the Resultant Vision for Future Workforce Planning**

13. It is evident from our work in progress on the Sector Skills Agreement that current models of workforce planning are unlikely to meet the needs of the future health sector. Simply planning for “more of the same” will be insufficient to meet the challenges of the next 10 years and beyond. There is a recognised need to produce a more flexible workforce rather than to continue to commission workforce education and training along traditional lines. Annex 2 sets out proposals for a systematic process of “Skills Escalation”.141 This process is founded on a structure of National Workforce Competences (designed around what individuals and teams need to be able to do to meet patients’ needs). The vision for skills escalation in the health sector represents the development of a holistic system for workforce planning /development that supports individually focussed healthcare, by optimising performance, practice and learning opportunities for employers and employees. Key characteristics include:

— Emancipating and equipping individuals to reach their full potential in accordance with their abilities and preferences

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141 Not printed here.
— Achieving maximum flexibility in workforce development and planning/skill-mix choices for employers
— Enabling transferability of competence and recognising achievement across the UK sector
— Ensuring that learning opportunities are fit for practice, purpose and award

14. A full system of competence-based workforce planning/investment would be underpinned by the development of new/existing roles linked to a new career framework and a national qualification framework—enabling transferability and progression for individuals and workforce/team flexibilities for employers.

15. Much work has already been undertaken towards developing a competence-based system of workforce development and planning. Skills for Health have developed a framework of National Workforce Competences that covers 70% of generic transferable skills. Work is also underway on the development of a new national Qualifications Strategy and related Career Framework. The emergent Sector Skills Agreement outlines the strategic actions that will need to be taken by a range of key stakeholder bodies if a competence-based approach to workforce planning and development is to become a reality on a “whole systems” basis.

SUMMARY AND CONCLUSIONS

16. This memorandum of evidence demonstrates that whilst the existing workforce planning arrangements have served the health and healthcare sector in England reasonably well; they are 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 not long term enough to take account of strategic drivers and the lead times needed to develop changes in the ‘shape’ of the workforce.

17. 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 and locally—and elements 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 and the development of Strategic Workforce Plans that demonstrate that they deliver the more flexible, competency-based workforce that is needed.

18. This more sophisticated approach to workforce planning and development needs to be matched with an effective implementation process. We propose that the Sector Skills Agreement should be an appropriate vehicle for future coherence and action across stakeholders, partners and delivery bodies.

John Rogers
Chief Executive, Skills for Health

14 March 2006

REFERENCES:


(3) Payment by Results aims to provide a transparent, rules-based system for paying trusts. It is intended to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment is linked to activity and adjusted for casemix. Importantly, this system is intended to ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers. For more details see http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/fs/en

(4) 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. A collective agreement was reached with the NHS unions at the NHS Staff Council on 23 November 2004, following the completion of a second ballot process by some unions. Agenda for Change is being rolled out nationally beginning on 1 December 2004, with pay and most terms and conditions backdated to 1 October. The aim is for 100% assimilation (less those who wish to remain on local contracts) by 30 September 2005.

(6) ‘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, www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModelEmployer/ImprovingWorkingLives/fs/en

(7) The Electronic Staff Record (ESR) solution will replace 29 payroll systems and 38 HR systems with a single, national, integrated solution and will be used by all NHS organisations—some 615 throughout England and Wales. For more details see http://www.esrsolution.co.uk/

(8) 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. The Age Regulations will apply to all workers and to people who apply for work, and in addition, they will cover access to vocational training. The Age Regulations will prohibit direct and indirect age discrimination, harassment and victimisation. See www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/DearColleagueLetters/DearColleagueLettersArticle/fs/en?CONTENT—ID = 4126389&chk = otMfio

(9) Commissioning a Patient Led NHS is the name given to the letter and document sent to NHS Chief Executives and others on the 28th July 2005 from Sir Nigel Crisp, the NHS Chief Executive. The document sets out the Government’s plans to restructure PCT’s and SHA’s which it feels are imperative to support front line staff in the commissioning decisions they make to reflect patient choices. www.dh.gov.uk/assetRoot/04/11/67/17/04116717.pdf

(10) Hospital at Night is a model of shift patterns and staffing mix for the NHS to use in response to the European Working Time Directive has delivered improvements to patient care. For more details, see http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT—ID = 4118010&chk = 7P/nGP


(15) Practice Based Commissioning enables GPs and other front line clinicians to redesign services that better meet the needs of their patients.
Memorandum submitted by The Skin Care Campaign (WP 04)

WORKFORCE NEEDS AND PLANNING FOR THE HEALTH SERVICE

Background

1. Skin disorders are amongst the commonest diseases encountered by health professionals. Between 15% and 20% of GP consultations have a dermatological component. Whilst there are some four thousand recognised skin diseases, eight of them make up some 80% of consultations for skin disease in general practice. In 2001–02, skin disease generated more than 600,000 referrals from GPs to secondary care, more than all other medical specialities combined.

2. Dermatology has long been neglected by the NHS but it is an important specialty, not least because improved models of dermatology service delivery can greatly improve clinical outcomes and patient satisfaction while, at the same time, reducing significantly the burden skin diseases impose on the NHS. The commonest inflammatory skin diseases can usually be self-managed by patients with appropriate support from properly trained health professionals (chiefly nurses) in primary care.

3. Recognition of this is alluded to in the White Paper, Our Health, Our Care, Our Say, in which dermatology is included amongst the six specialties in which the DH will be looking at models for providing care closer to home. While we applaud this initiative, the chief difficulty the study will encounter will be the very severe shortage of suitably trained health professionals in primary care.

Responses to (some of) the Inquiry’s questions

In considering future demand, how should the effects of the following be taken into account:

4. An ageing population: as is the case in many other disease areas, the ageing population may be expected further to increase the prevalence of skin disease, including especially skin malignancies, autoimmune blistering disorders and leg ulcers.

5. The increasing use of private providers of services: may offer opportunities to address the chief difficulty identified at 3. above. (See 8c below.)

How will the ability to meet demands be affected by:

6. Early retirement: may be expected to exacerbate the forecast shortage of primary care clinicians, especially nurses. (See 8a below.)

To what extent can and should the demand be met, for both clinical and managerial staff, by:

7. Changing the roles and improving the skills of existing staff: real improvements in dermatology services can best be achieved by enabling the self-management of most of the commonest inflammatory skin diseases. Such self-management must be properly supported. The Dermatology Workforce Group (DWG) sees this being achieved by the establishment of nurse-led inflammatory skin disease clinics in primary care. Precedents are to be found in the existing and very successful asthma and diabetes clinics. The prerequisite for such clinics is that the staff running them should be properly trained. At present, practice nurses receive no education in dermatology at any stage in their training.

8. Better retention, and the recruitment of (new) staff in England:
   (a) In 2004, the Dermatology Workforce Group conducted a survey of the British Dermatological Nursing Group’s members. It showed an alarming age profile, with the majority being in their 40s and 50s, and with very few young nurses being attracted to the specialty. The profile was compared with figures provided by the Royal College of Nursing which showed a very similar age profile for nursing as a whole. The clear implication is that numbers of nurses will reduce dramatically over the next 10 to 15 years if the situation is not addressed aggressively.
   (b) There is in the community a sizeable cohort of women who were nurses in the past, left the profession to raise families and could be expected to be available to return to nursing when their children go to school; but too few of them do so. The reasons appear to be fourfold:
      (i) most of the recruitment effort has been aimed at attracting such people back into secondary care, rather than primary care;
      (ii) understandably, while their children are at school, they wish only to work limited and predictable hours;
      (iii) there is a reluctance among such people to become involved with the bureaucracy and administration of the NHS; and
      (iv) there is a reluctance amongst many such people to re-embark on a career that has become increasingly academically based.
(c) All this suggests that there may be a case for establishing an agency (either privately or NHS-owned) to re-recruit ex-nurses, facilitate their Return to Nursing courses, provide training in appropriate specialties such as asthma, dermatology and/or diabetes, and to enable GP practices to contract them in to run specialist clinics in primary care.

HOW SHOULD PLANNING BE UNDERTAKEN:

9. To what extent should it be centralised or decentralised? Planning for initiatives of the sort described at 8e above should ideally be centralised with local branches, perhaps at SHA level.

10. What examples of good practice can be found in England and elsewhere? The existing asthma and diabetes clinics provide examples of good practice, as did the pilot studies of nurse-led inflammatory skin disease clinics run by the NHS Modernisation Agency’s Action on Dermatology programme—see http://www.modern.nhs.uk/scripts/default.asp?site_id=30&id=9630

Peter Lapsley
Chief Executive, Skin Care Campaign
February 2006

Evidence submitted by the Society of British Neurological Surgeons (WP 25)

SUMMARY

— Neurosurgery is one of the smaller specialist surgical disciplines in the Health Service.

— Nevertheless, it makes a major contribution to the nation’s emergency services and provides a wide range of technologically advanced treatments.

— The health gain of many of these treatments is considerable. They are often directed towards the most disadvantaged and disabled members of the community.

— Neurosurgical services are provided by a network of 34 regional centres in the United Kingdom serving populations of 1-3 million.

— The neurosurgical patient case-mix is complex and heterogeneous. It demands high levels of consultant expertise and sub-specialisation with support from a wide range of related hospital departments and disciplines.

— Neurosurgery has a strong tradition of consultant-led and consultant-provided services.

— The SBNS and SAC are concerned to note that approximately one third (12/35) of recently qualified neurosurgeons are yet to secure definitive consultant appointments in the Health Service.

— Effective national manpower planning for a small speciality is difficult when consultant appointments are based on local business plans.

RECOMMENDATIONS

— The overall planning of neurosurgical services should take place at a national level with the commissioning of services secured at a regional level, in order to ensure equitable and effective service delivery.

— Manpower planning for the four nations should be coordinated by a single body which includes representation from the profession (SBNS), training body (SAC), national commissioners and regional specialist service providers.

Neurosurgical Workforce Planning

The Society of British Neurological Surgeons represents 215 consultant neurosurgeons in the United Kingdom and Eire, of which 180 are based in England and Wales. Neurosurgery is undertaken in 36 units in the United Kingdom and Eire of which 29 are in England and Wales. Neurosurgical services require expensive radiological and specialist operating equipment and multi-disciplinary support from critical care, oncology, neurovascular and neurological services and other specialties such as orthopaedics, otolaryngology and ophthalmology. Neurosurgery plays a key role in a variety of service frameworks with concentration of the key resources at the hub, but responsible for patients drawn from a wide population and partly managed outwith the centre. Paediatric Neurosurgery became a sub-speciality in the middle 1980s and has been strengthened following the Bristol enquiry.

Neurosurgery has a strong tradition of workforce planning. In 1993, Safe Neurosurgery was published setting out the standards and resources required for a safe neurosurgical service. This was followed in 1999 by the SBNS Workforce Plan 2000–15 which examined the requirements of the Working Time Directive for
junior doctors and predicted that 250 consultant neurosurgeons would be needed for the United Kingdom and Eire by 2015. In 2004 a further manpower review took account of the new consultant contract and a more detailed understanding of the implications of the working time directive. This predicted an increased requirement of between 325 and 375 consultants across the United Kingdom and Eire.

This year the SBNS and SAC will undertake a national census of the neurosurgical manpower and activity in the light of the new consultant contract, the consultant job plan, the extended surgical team, and the implications of modernising medical careers. The census is to be distributed to the neurosurgical units by the end of March 2006 and the information will be collated by the end of June 2006.

**Neurosurgical Services**

The planning of neurosurgical services must take into account clinical and technological advances, demographic changes and the development of new roles and working practices. Examples of significant advances in the last 10 years include:

2. The development of spinal instrumentation for degenerative and malignant spinal disease.
3. The widespread adoption of computer-guided approaches enabling more accurate and less invasive surgery with shorter hospitalisation.
4. The development deep brain stimulation for Parkinson’s disease, vagal nerve stimulators for epilepsy and baclofen pumps for the management of spasticity in children.
5. Neuroendoscopy for the treatment of hydrocephalus and as an adjunct to open or microscopic surgery.

Many neurosurgical units have embraced the concept of the extended surgical team and are using nurse practitioners, extended scope practitioners and surgical care practitioners. These teams are essential if a balance is to be achieved between service delivery and the training of neurosurgeons following the introduction of the Department of Health’s initiative on Modernising Medical Careers. Training in neurosurgery, which will take nine years from qualification to the award of a CCT, will comprise two foundation years, two years of core neuroscience training and five years higher training in neurosurgery. All trained neurosurgeons at CCT level will be emergency competent and will be able to contribute to specialist services. Major concerns remain regarding the capacity of units to maintain 24 hour emergency services following the changes in working hours and practices.

The size and distribution of neurosurgical units must take into account patient access for the commoner neurosurgical conditions as well as journey times for emergency admissions. Some neurosurgical conditions are rare and must be managed at a supra-regional level. Units will require a minimum of six consultant neurosurgeons working with an extended team. They will have a population base sufficient to provide a workload that balances the neurosurgical needs of the population and the ability of the consultant staff to maintain competency and to train. Except where geographical considerations dictate otherwise, the optimal population for a neurosurgical unit will be greater than two million. For paediatric neurosurgery and some other subspecialty conditions this figure is nearer five million.

Mr A Steers, President, and Mr R Netron,
Society of British Neurological Surgeons & Specialist Advisory Committee in Neurosurgery
5 March 2006

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**Evidence submitted by the Society of Radiographers (WP 40)**

**Workforce Needs and Planning in the Health Service**

Thank you for the opportunity to submit views on the workforce planning process.

Historically for radiography, both diagnostic and therapeutic, workforce planning has been based on what has gone before rather than what are future needs. It has always too been cash limited with reducing commissions for entry level education and training being a soft target. Throughout the 1990s this trend was very apparent and is a direct contributor to the current shortfall in these professional groups. In addition, education and training has predominantly been aimed at the entry qualifications level with almost no commissioning at post graduate level or at the assistant/support workforce.

For radiography the Department of Health realised the seriousness of the workforce shortfall and invested a small sum of money (approximately £100,000) in 2002–03 to improve recruitment and retention, followed by a much larger project to grow and develop the radiography workforce in 2003–05, led by the South West London Strategic Health Authority, with some success.

Year on year, the Society of Radiographers has met with the Workforce Review Team and provided contributions to assist in developing a workforce fit for future purpose. We have asked consistently for:
— Commissioned numbers to be related to the projected growth in the need for cancer treatments, and clinical imaging examinations, rather than on previous year’s commissioned numbers.

— Commissions to be flexible so that a spectrum of education and training traditional, fast track, in service type programmes are available across the country.

— Commissioning of post graduate programmes so that clinical departments can support staff to develop into advanced and consultant practice fields and ease bottlenecks due to shortfalls in our collegiate professions, clinical radiology, clinical oncology and medical physics.

— Investment in assistant practitioner programmes to free radiographers to take on more demanding roles.

— Some more robust processes for considering future trends in demography, service demands and technological change.

While the Department of Health guidance to Strategic Health Authorities on commissioning has reflected some of the above, it has resulted in almost no change in commissioning practice at SHA level (with one or two notable exceptions).

We have also argued that there needs to be some coherence to commissioning nationally such that the overall needs of the country are served. This is particularly important for therapeutic radiography where English commissions are small overall (334 in 2005) and yet students are spread across 10 Higher Education Centres in England. It is also important given the extremely expensive equipment required to support clinical skills development. For example, a long standing proposal for a national centre for therapeutic radiography skills development has met with general approval but no funding and the costs of funding are beyond any single SHA at present.

Due to the work on attracting recruits into radiography education and the radiography workforce over the past three to four years, and an increase in the number of entry level education and training commissions in 2004 and 2005, diagnostic radiography is just about holding its head above water. However, the effects of “Commissioning a Patient Led NHS”, the 18 week wait initiative, the gross under-utilisation of imaging examinations in the UK compared to European standards, and “Our Health, Our Care, Our Say” all point to more demand for radiographers. They also point towards much increased use of advanced and consultant practitioners in radiography as imaging services move closer to patients and patients expect reports of their examinations to be available immediately after their examinations. It should also be borne in mind that diagnostic radiographers are the back-bone of “out of hours” imaging services. These now extend well beyond traditional “accident and emergency” procedures where one or two individuals could provide the cover required. Clearly, the working time directive is relevant here.

In relation to Therapeutic Radiographers, there is what can only be described as a chronic crisis. Vacancy rates remain very high and the push for a world class cancer service will not be achieved if there is not a radical change in commissioning education and training. The overall message here is “more, different and now”! Indeed, in relation to the workforce planning needs of the entire radiography workforce, this is probably our overall message.

Radiographers are the largest group of staff employed in clinical imaging and radiotherapy services (with the exception of administrative and clerical staff); they provide services throughout the 24/7 period. Planning for this group of staff is rested at local level and based on what has happened in the past rather than what will happen in the future. In our view a co-ordinated approach is required to secure “more, different, now and future oriented” education and training commissioning to meet the workforce needs inherent in current government health initiatives. Given, too, that there is a worldwide shortage of radiographers, whether NHS or private providers are providing clinical imaging and radiotherapy services, there is a need to plan for the size and nature of the entire radiography workforce needed in the future. It is not appropriate to expect the independent sector to be able to source registerable staff from overseas and in any event, proper responsible staffing for an integrated patient centred service is the fundamental requirement of workforce planning. Segmenting this requirement to only part of the provision is irresponsible. The essential requirement is effective education and training commissioning, supported by excellent recruitment and retention practices in Higher Education Institutions and by clinical service providers.

I trust these comments are helpful. I should be happy to provide more detail on any points should this be required.

Richard Evans
Chief Executive Officer, The Society and College of Radiographers

March 2006
1. **EXECUTIVE SUMMARY**

1.1 TANDBERG is a leading global provider of visual communication products to public services in 90 countries across the world. TANDBERG designs, develops and markets systems and software for video, voice and data technologies. The company possesses a particular expertise working with Government agencies to promote the use of visual communications to provide major benefits in the delivery of public services. TANDBERG has been at the forefront of developing visual communications systems for healthcare organisations across the UK, both in primary and secondary care settings.

1.2 TANDBERG is committed to supporting the Government’s Transformational Government: enabled by technology strategy, a Cabinet Office initiative led by the e-Government Unit which aims to deliver public service improvements through the innovative use of information technology. Visual communications can play a valuable role in supporting the Government’s e-Government priorities: delivering better public services, reducing burdens of front line staff and improving the efficiency of service provision.

1.3 In particular, video conferencing technology offers significant potential benefits for the delivery of greater efficiencies and performance improvements in the NHS. Fundamentally, visual communications bring the capacity to share scarce resources—in this instance, the NHS workforce—and ensure their services reach the maximum number of people in as effective a way as possible.

1.4 Video conferencing has been transformed over recent years. Modern systems provide the highest real time video and sound quality in “face-to-face” communication over existing broadband infrastructure. Additionally, video conferencing systems now possess the capability to share presentations and other computer applications alongside live video, record meetings for later streaming to desktop PCs, and integrate with existing collaboration software packages from providers such as Microsoft and IBM Lotus.

1.5 Our response sets out the role of visual communications in supporting NHS workforce and service needs and provides two case studies of services that are already in operation, in Haringey PCT and Yorkhill Hospital in Glasgow.

2. **THE ROLE OF VISUAL COMMUNICATIONS IN SUPPORTING NHS WORKFORCE AND SERVICE NEEDS**

2.1 The applications of visual communications solutions are relatively well understood. Video brings people together for meetings without them having to be physically present in the same location. This improves productivity, saves travel time and costs, helps meet sustainability targets and allows more frequent face-to-face contact with colleagues, partners, suppliers and users. There is much untapped potential for visual communications as an effective delivery partner across the NHS to help achieve greater efficiencies in workforce needs and planning.

2.2 On a cross-departmental level, central government has set out a bold vision for the better use of technology to deliver public services and policy outcomes that have an impact on citizens’ daily lives. Its vision document, Transformational Government, sets out the Government’s desired policy outcomes for the use of information technology across all the public services, including the NHS. Visual communications can be applied to each of these policy objectives. The policy goals include:

- Delivering better public services by providing a more personalised approach to end users.
- Encouraging more access to expertise.
- Facilitating faster decision-making processes.
- Reducing burdens on frontline staff by giving individuals the tools to be more effective.
- Supporting backoffice functions to be more efficient and cost-effective.
- Fully utilising technologies which government has yet to exploit properly.
- Driving the delivery of information through greater use of telephone, internet, mobile and digital channels.
- Enabling a step change in the use of technology to exchange information and transact directly with citizens and front line staff.

2.3 The Department of Health has also recognised the potential for visual communications in the recently published Department of Health White Paper Our health, our care, our say. Our health, our care, our say. The policy paper places an emphasis on the importance of shifting the delivery of care and treatment away from centralised hospitals and into the local community. This is an objective that video communications is well positioned to deliver on. In particular, the White Paper notes that,

> “In future, far more care will be provided in more local and convenient settings. People want this, and changes in technology and clinical practice are making it safer and more feasible.”
2.4 The White Paper cites examples of international best practice where this approach has been supported by the use of visual communications solutions, such as the TELeHEART programme for veterans with a high risk of cardiovascular disease in the USA where video systems have been used to support improved healthcare outcomes:

“Through a comprehensive approach, with a strong focus both on helping people to help themselves and use of remote health technologies, there were significant improvements in health outcomes and far higher patient satisfaction, as well as substantial reductions in hospital use—admissions down 66%, bed days of care down 71% and emergency visits down 40%”.

2.5 The potential cost-efficiencies and healthcare improvements which could be gained from this approach are significant, but the White Paper stresses the need for greater credible evidence to demonstrate the benefits to individuals, carers and healthcare professionals. Visual communications can play a major role in showing that the complementary objectives set out in Transformational Government and Our health, our care, our say can be achieved.

2.6 Although the uses of video conferencing can vary widely, the most common applications and benefits for health organisations would include:

— Reductions in travel and commensurate cost savings for both patients and healthcare professionals by linking primary and secondary care services over a video network.
— The ability for patients and clinicians to communicate immediately and in real time with specialists from multiple sites without the need for travel.
— The opportunity to expand the range of services to a wider patient base across both the primary and secondary sectors.
— Increases in service capacity as a result of reduced burdens on frontline staff and services.
— Facilitating.
— Promoting equitable access to services for geographically isolated or minority communities, where distance or language barriers are problematic constraints.
— Higher satisfaction for both healthcare professionals and patients by increasing ease of access to services and intra-service communication.
— Improved backoffice communications between primary and secondary care and strategic health organisations.

3. CASE STUDIES OF VISUAL COMMUNICATIONS IN A HEALTHCARE ENVIRONMENT

3.1 We have a track record in delivering in the NHS, and have set out examples of our experience in the two attached case studies. In each case, success is due to both the technology used and the research, training and planning that accompanies its roll-out. To briefly outline:

3.1.1 Yorkhill Hospital, Glasgow, Scotland

TANDBERG technology has been used at Yorkhill Hospital in Glasgow to link heart specialists with a paediatric ward in Wishaw General hospital, Lanarkshire. The link is the first of its kind in the UK, and allows paediatricians to obtain immediate expert advice from specialist consultants immediately without the need for travel. Details are included in Appendix 1.142

3.1.2 Haringey Primary Care Trust, London

TANDBERG video conference technology is being used at the Broadwater Farm Health Centre in Haringey to help ethnic minority communities to access primary care services. Desktop video conferencing units have been installed in GPs’ surgeries and connected to professional interpreters so that non-English speaking patients can be effectively treated by their doctors. Details are included in Appendix 2.142

3.2 We would welcome the opportunity to demonstrate, or perhaps organise a visit for the Committee to see firsthand, the role of video conferencing in these instances.

Tandberg

March 2006

Evidence submitted by UNISON (WP 62)

1. IN CONSIDERING FUTURE DEMAND, HOW SHOULD THE FOLLOWING BE TAKEN INTO ACCOUNT

— recent policy announcements, including commissioning a patient led NHS;
— technological change;

142 Not printed here.
— an ageing population; and
— the increasing use of private providers of services.

1.1 UNISON is the major union in the health service. Its health care service group represents more than 400,000 employees in the NHS and staff employed by private contractors, the voluntary sector and general practitioners. We recognise fully the importance of workforce planning to the effective delivery of health services and welcome the opportunity to contribute to the Select Committee’s inquiry.

1.2 An ageing population and technological advance pose significant but not insurmountable challenges to the health service workforce. In this submission we set out how recruitment and retention, changing roles, improving skills and effective planning all have a part to play in meeting the challenge of delivering a patient led NHS.

1.3 Recent policy announcements and increasing use of private providers of services clearly do need to be taken into account in considering future demand. As we explain below, reforms set out in Commissioning a Patient Led NHS and Our Health, Our Care, Our Say threaten to fragment the health service, forcing providers to compete rather than co-operate, causing financial pressures and damaging workforce morale. This in turn will undermine the ethos of universality and make workforce planning ever more difficult. These policy announcements should be contrasted with the NHS Ten Year Plan and Agenda for Change, which facilitated a partnership approach to workforce planning for the longer term.

2. How will the ability to meet demands be affected by
— financial constraints;
— the European Working Time Directive;
— increasing international competition for staff; and
— early retirement.

2.1 Financial constraints

It is axiomatic that financial constraints will impact on workforce planning. UNISON take the view that such constraints are an inevitable consequence of the introduction of a competitive commercial market within the NHS.

2.1.2 Despite record levels of investment, the NHS is facing a major financial crisis. It is not for us, in this submission, to examine the reasons for this financial crisis. However, we do feel that it is important to highlight our concerns that, by encouraging a multiplicity of providers and introducing a payment system where money follows patients, financial constraints can only become more pressing. Providers will inevitably choose to provide the most financially attractive services and patients will avoid those where they risk making losses, compromising the principle of equal access for those in equal need. Competition between providers undermines collaborative working and the sharing of good practice. Evidence from other countries shows that the transaction costs of administering such a system will be high. Healthcare provision requires substantial capital investment and long-term workforce planning, both of which are undermined by the constraints of a competitive market.

2.2 Working Time Directive

The Working Time Directive has had a positive impact on work life balance for many health service workers. We note, however, that it is not yet fully operational and that its implementation masks the continuation of long hours culture. As the 2004 Healthcare Commission NHS national staff survey revealed, 71% of staff routinely worked more than their contracted hours. What’s more, 55% of all staff worked unpaid additional hours. Forty three per cent of all staff worked between one and five additional unpaid hours per week, 9% worked between six and 10 additional unpaid hours, and 3% said they worked more than 10 hours unpaid overtime in an average week.

2.2.1 UNISON continue to monitor the operationalisation of the working time directive, but most definitely does not see meeting the requirements of the directive as a problematic issue.

2.3 Increasing international competition for staff

UNISON note that competition for health service staff is a global phenomenon and that recruiting staff from developing countries raises profound moral and economic issues. However, we also recognise that as a consequence of the demographic issues facing the health service, the UK needs to recruit staff from abroad.

To address this problem we should permit the immigration of unqualified health service workers from overseas and train them in the UK. We note that this planned approach was pursued successfully by UK governments during the 1960s and 1970s. We believe that this would benefit both our health service and,
potentially, the countries of origin of migrant workers. It is important, however, that a planned expansion of the workforce in this way will need to be linked to protections, high standards of training and clear career paths.

2.4 Early retirement

UNISON is acutely aware of the demographic challenge facing the health service. This is demonstrated by the increase of 74,907 registered nurses since 1997, against the 100,000 who are due to retire by 2010.

2.4.1 The implications of the aging workforce are significant for the future of nursing. Only 7.5% of midwives are under 30 years old, 60% of nurses are over 40 and 1/4 of nurses are over 50 (this figure is even higher in midwifery and community nursing). This has to be addressed by a combination of effective recruitment and retention, valuing staff, changing roles and improving skills of the existing workforce.

2.4.2 UNISON welcomes the NHS commitment to flexible retirement set out in “Improving Working Lives”. The opportunity to change working patterns, or move to a less demanding role is particularly important to staff, such as paramedics and ambulance staff, who have been working in very demanding and stressful frontline services. Similarly the opportunity to undertake forms of further work after retirement is an opportunity that some staff value. However, we do remain concerned that early retirement can mask wider issues. Why, for example, do people retire early from the health service? Is this linked to the stress of work in the health service? Are all workers equally placed to retire early? Do low paid women, for example, have the same opportunities to retire early as other groups of staff?

3. 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; and
— international recruitment.

3.1 Changing the roles and improving the skills of existing staff

As a union representing clinical occupations and grades across the health service UNISON welcomes opportunities to work in partnership with the health service to meet future demands through changing roles and improving skills of existing staff.

3.1.2 UNISON prides itself in being at the forefront of developing new educational pathways and increasing access to continuing education for all NHS staff. We are a board member of Skills for Life and of the KSF Development Group. UNISON is a partner in both the NHS Institute for Innovation and Improvement, which is responsible for training and education policy across the NHS, and the Widening Participation Unit. UNISON participates in this work, not simply because this can improve the lives of our members, or because we are invited to do so by employers. We do so because we believe that working in partnership on workforce planning issues is the most effective way of delivering an optimum service.

3.1.3 We have worked with partners, including employers and the Open University, to put in place a skills escalator. This ranges from Skills for Life and Health (including English as an Additional Language), through “second chance” learning and onto work-based professional qualifications. We also serve as a “broker” for learning opportunities provided by further and higher education providers through our Open College and train and develop a network of workplace learning representatives, who provide advice and guidance on learning opportunities to their colleagues at work.

3.1.4 We welcome the funding that the government has provided for training and learning opportunities including NHS Learning Accounts, NVQs and Skills for Life Frameworks. We note that between April 2001 and March 2005 this funding has supported around 240,000 learners.

3.1.5 However, we are increasingly concerned that this driver of workforce development is under threat. We note that the separately designated Department of Health funding stream which supports NHS Learning Accounts, NVQs and Skills for Life Frameworks has not yet been finalised. Posts supported by this funding are already falling vacant or coming under threat and planning for provision beyond March is proving difficult. Failure to finalise the funding stream also threatens proposals to attract match funding from the Learning and Skills Council.

3.1.6 UNISON take the view that learning and skills budgets need to be ring fenced nationally so that improving workforce skills can play an appropriate part in meeting the workforce demands of the future. As explained in more detail below, training unregistered staff, such as Healthcare Assistants, is vital to meeting future workforce demand. This will only be achieved if education and training is appropriately funded.
3.2 Better retention

Making staff feel valued is a pre-requisite to ensuring that they remain in the health service. Unfortunately, the sense of being valued at work is seriously at risk from the uncertainty caused by financial difficulties and policy change across the health service. As a consequence of Commissioning a Patient Led NHS and the Our Health, Our Care, Our Say White Paper many staff in primary care face uncertainty about their future terms of employment and, indeed, who their future employer will be. We note evidence that continual organisational change in the public sector has a negative effect on morale (CIPD survey 2004).

3.2.1 UNISON accepts that there have been some improvements in recruitment and retention. Overall vacancy levels have improved and turnover has declined. The transition to Agenda for Change pay scales may have temporarily stabilised staffing, as staff may be reluctant to leave their current position until after assimilation.

3.2.2 UNISON would however draw attention to the fact that most employers have significant recruitment and retention problems according to the Office of Manpower Economics survey of NHS employers (OME 2004).

3.2.3 Wastage has also worsened slightly and remains at an unacceptable level of 9.2% for registered staff and 12% for Non Registered staff.

3.2.4 We are also concerned about high attrition rates for student nurses. These continue to be an average of 20% and as high as 24% in London. We are concerned at this level of wasted public spending and the negative impact on students.

3.2.5 For Professions Allied to Medicine the highest vacancy rates are found amongst Therapeutic Radiographers (6%) and Occupational Therapists (3.9%). Occupational Therapy employers also face significant recruitment and retention problems with 76% of employers reporting problems. UNISON recently made the case to the Pay Review Body that there should be a national recruitment and retention supplement for Occupational Therapy to tackle the national problems.

3.2.6 UNISON fears that the financial problems being experienced in a substantial minority of Trusts are leading to cutbacks in staff numbers which will exacerbate current problems and this will have an adverse effect on the ability of the NHS to attract staff in future.

3.2.7 UNISON supports the improvements in non pay terms and conditions of service that have been introduced through the Improving Working Lives programme but believes improving pay remains a central issue for staff who leave. Employers cite pay as an important reason why staff leave. The NHS does not systematically collect information on leavers and their destinations. UNISON believes that there should collection of such data as part of proper planning.

3.3 Recruitment of new staff in England

The NHS needs to develop a comprehensive strategy to release the untapped potential of its non-registered workforce as the future pool of registered recruits. We represent over 90,000 Healthcare Assistants and see this group of staff as key to meeting future workforce demand.

3.3.1 Healthcare Assistants currently make up 17% of the NHS workforce and are the staff group displaying the greatest growth. This is also a highly aspirational group of staff. A recent UNISON survey revealed that 75% of Healthcare Assistants were interested in accessing professional training. The survey also found that 82% would consider undertaking a secondment. Where Healthcare Assistants have undertaken secondments the attrition rates have been negligible in comparison with bursary students.

3.3.2 UNISON have recommend to the Department of Health that the secondment rate of Healthcare Assistants into nurse training be increased on a systematic nationwide basis, that a national induction programme be introduced for all Healthcare Assistants, and that NHS Learning Accounts be continued. We have also recommended that Healthcare Assistants be regulated by the Healthcare Professions Council, as discussed in more detail below.

3.3.3 UNISON welcomes Agenda for Change, which has led to increases in NHS pay in recent years, particularly for low paid staff, and addressed equal pay for work of equal value issues within the service. Through working together in partnership with employers, 97% of staff have been assimilated into the national framework, guaranteeing equal pay (England only). This contrasts with the situation in local government where there is no national framework and where only 16% of staff have been assimilated into equal pay frameworks. The TUC say that all employers should aspire to being an employer of choice. In many respects the NHS has achieved this, and we think that the government and the NHS should do more to trumpet their achievements.

3.3.4 We note, however, that there remains an historical legacy of low pay, and poor pay relative to other public service occupations. This must be addressed if the NHS is to recruit and retain sufficient staff in the future.
3.4 International recruitment

Analysis of the recruitment of overseas nurses has shown that without the doubling of the rate of overseas recruitment the NHS would have barely maintained the numbers of nurses it employs despite the expansion of nurse training places and better recruitment and retention (Kings Fund 2003). The substantial recruitment and retention of overseas nurses has allowed the NHS to fill the vacancies created by the expansion of services. UNISON believes that overseas nurses have played a pivotal role in allowing the NHS to deliver the Governments targets. However, as a result of international recruitment some developing countries are now struggling to maintain their own health infrastructure and it is incumbent upon us to help those countries.

3.4.1 We strongly support the protocol “A Guide to Ethical Recruitment”. We note, however, that its effects are too often undone through blanket recruitment by the private sector and so called “back-door” recruitment to the NHS. This occurs when health sector professionals are recruited outside of the protocol, and, following an initial period working in the private sector, switch to the NHS.

3.4.2 As explained above we also support the immigration of unqualified health service workers from overseas, where this can be carefully planned, and where such workers can be suitably protected and supported. This can be beneficial to both the UK health service and to the country of origin of such workers. Along with our sister unions we are also supporting a Public Services International project to develop a trade union passport, so that overseas health service workers receive the same protections and representation as UK health workers, as well as access to English courses when they arrive in the UK.

3.4.3 We note that there are potential recruitment issues within the UK, as a consequence of devolution of health services to Scotland and Wales and that there is currently scope competition for staff within the UK. We would be interested to learn whether the Committee has considered this issue and whether any arrangements could be put in place to ensure that health service workforce planning could be appropriately co-ordinated in England.

4. 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?

4.1 To what extent should it be centralised or decentralised?

If the health service is to remain a universal service and achieve its historic mission of providing equality of care, overall workforce planning must take place within a centralised framework. Without such an overarching strategic approach shortfalls, gaps and unevenness in provision are inevitable.

4.1.1 We note that countries in which there is no national health system, such as the USA, are more dependent on attracting healthcare professionals from overseas.

4.1.2 We would be interested in learning whether the Committee has undertaken any research into historic trends, and the extent to which centralised workforce planning has been used to meet demand during previous periods of expansion.

4.2 How is flexibility to be ensured?

UNISON recognise that flexibility is needed to meet the future demand. However, if flexibility is to be ensured it has to take place within a framework of universality and consistency of standards.

4.2.1 The post code lottery of duties provided by Health Care Assistants demonstrates how flexibility outside of a national framework has led to an inconsistency that if not addressed will make it extremely difficult to deliver on future workforce demand.

4.2.2 The title Healthcare Assistant was created in the 1993 Health Act, which enabled NHS trusts to offer local terms and conditions to this group of staff. This has resulted in inconsistency, with Healthcare Assistants performing different tasks across the country. At a recent UNISON Healthcare Assistants conference, we heard from a delegate who had been trained in female catheterisation by her ward manager. However, when the manager left, her new manager was not happy for her to continue to undertake this task despite being trained and deemed competent to perform it. UNISON continues to lobby for regulation of Healthcare Assistants by the Health Professions Council, so that we can guarantee consistency, transparency and standards of care on a nationwide basis.

4.2.4 We also note the example of teaching assistants. As with Healthcare Assistants, this group of staff remain outside of a national structure. However, as the Government have recently pointed out in their Education White Paper, this situation is leading to untenable inconsistencies, which it is proposing to address in the first instance through a national dialogue with the trade unions.
4.3 What examples of good practice can be found in England and elsewhere?

Agenda for Change, the NHS framework for pay and conditions, has had a major impact on the workforce across the health service. It has fostered a partnership between health service managers and employees which in turn facilitated steps being taken towards guaranteeing equal pay for work of equal value. As such Agenda for Change is an example of a framework that supports effective workforce planning.

4.3.1 We would welcome the opportunity to give oral evidence to the Health Select Committee on how Agenda for Change is working, and on how policy changes will impact upon its future operation.

Karen Jennings
UNISON
17 March 2006

Evidence submitted by Universities UK (WP 65)

Introduction

1. Universities UK, the body which represents the Vice-Chancellors and Principals of UK universities and some higher education colleges, is pleased to submit evidence to the Health Committee to aid its inquiry into workforce needs and planning for the health service.

Background

2. The partnership between universities and the health service encompasses teaching, research and service delivery:

   — Universities provide virtually all the pre-registration education for the nation’s doctors, dentists, nurses, midwives and allied health professionals. There were approximately 489,000 health professions and medical students studying in UK universities in 2003–04. This represents 22% of higher education students.

   — Universities also provide most of the clinical and basic medical research on which the future of UK healthcare depends.

   — Universities’ 6,000-plus clinical academic staff make a substantial contribution to patient care, often in positions of leadership.

3. Student numbers have expanded to meet health service demands as set out in the NHS plan:

   (a) Medical student intakes have risen by around 50% since 1999 and four new medical schools have been established. One hundred additional places will be available in 2006–07.

   (b) In 1999–2000 there were 60,000 undergraduate nurse students in higher education; in 2003–04 that number had risen to 83,000.

   (c) Student dentist intakes have increased by approximately 200 students per annum in 2005–06, and a new dental school is being established in the South West.

4. Other European health systems face similar workforce problems to those in England—in particular, inadequate infrastructure to support workforce development and fragmentation which leads policymakers to focus on individual health workers or a specific aspect of the system, instead of the wider picture. The result tends to be short term, ad hoc interventions to redress specific shortages, rather than a wider approach that takes account of the long lead times for professional education, and the social and economic environments that concern service users and health workers.

Issues

5. The issues of relevance to higher education, and on which we will focus in this submission are:

   (a) the increasing use of private providers (and the impact this has on practice placements etc);

   (b) increasing international competition for staff (and the extent to which UK can move to a situation of self-sufficiency in preparing the health care workforce);

   (c) changing the roles and improving the skills of existing staff (and how education can support this);

   (d) the desirability of centralised/decentralised planning (and how HE engages with this); and

   (e) examples of good practice in all/any of the above.

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The increasing use of private providers of services

6. The increasing use of private providers in the health service may be a threat to training capacity at pre-registration and post-registration level. With routine cases being diverted from the NHS, clinical placements there will become less suitable for basic level student training, where practicing elementary skills is essential. While some universities have negotiated private sector placements, usually free of charge, the private sector is not obliged to provide these. Since placement shortages are one of the main limits to education capacity, the future contribution of the private sector and foundation trusts in health service education and training, needs to be clarified and formalised. At present, it is assumed that the Department of Health (DH) will fund pre-registration education for virtually all health professionals in England, and also support the necessary clinical practice for qualification for professional registration.

7. There are historical differences in funding for practice experience between health professions and medicine; in the case of the latter, Service Increment for Teaching (SIFT) funding is available. Greater flexibility about how that funding is used may assist with the number and range of clinical placements available to all professions in future.

Increasing international competition for staff

8. UK reliance on overseas healthcare workers has increased markedly over the last 10 years. In 2003, 11,000 overseas doctors registered with the GMC, and over 15,000 overseas nurses registered with the NMC. This activity has to be set against the backdrop of an increasingly mobile world population—in 1965, 75 million people migrated; by 2000 the figure was estimated to have doubled to 150 million.

9. Many see the current situation, where a considerable proportion of the healthcare workforce come from developing countries, as unacceptable and unsustainable in the long run. Universities UK’s Health Committee is seeking to work with relevant agencies to mitigate the adverse effects of migration by health professionals from developing countries.

10. Meanwhile, there is increasing international competition for staff, particularly from the US and Australia, which could make UK’s traditional reliance on overseas healthcare staff unsustainable. The rate of applications to sit PLAB (the initial pre-requisite for doctors wishing to come to this country to work) has fallen dramatically in the past year. Anecdotal evidence suggests that medical graduates are choosing alternative destinations because of difficulties in finding employment in the UK. While self-sufficiency in the health care workforce is desirable, it may not be realistic—James Buchan145 has calculated that to end reliance on international entrants to nursing would require a 17% increase in successful home entrants. Currently the DH is reducing education and training commissions for these students.

Changing the roles and improving the skills of existing staff

11. Service needs are changing in line with public expectations, new technology, and an ageing population. Services are shifting to the community sector and there is increasing integration with social services. DH and DfES are currently working together on “Options for Excellence”, a review of social work and social care. The knowledge base and skill mix health professionals require is also changing. Professional preparation is more than training—it is the basis for lifelong learning, helping to ensure that practitioners remain safe and competent throughout their careers.

12. HEIs work closely with the health service on an ongoing basis to support changing staff roles and improve staff skills; however, some of these developments are occurring in an unplanned and haphazard way—a strategy that identifies the roles and training needs of future health professionals, and is agreed among all stakeholders (health care providers, commissioners, the Department of Health and education providers) would provide coherence and reduce uncoordinated duplication of effort. It would also entail close collaboration with professional regulatory bodies whose caution in dealing with such changes can slow down recognition of innovative and flexible training mechanisms eg skills labs.

13. If the wider shape of the workforce can be agreed, its educational requirements can then be determined, and curriculum planners and NHS managers can work together to ensure appropriate programmes are delivered and systematic evaluation of the outcomes of the education process, particularly for some of the emerging new practitioners, are undertaken. Educational providers are aware of service changes, and can help employers anticipate and train staff for the new delivery mechanisms that are emerging; the integrated team working that will be necessary across primary care settings; the more holistic approach to health promotion and disease prevention; and new arrangements for social care and mental health services.

14. Universities also need to consider their own healthcare educator workforce. Submissions from CHMS and CDDS detail the declining clinical academic staff population, and the difficulties in recruitment at a time of student expansion. For the nursing and health professions workforce, the limitations on moving

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between the two sectors have been an obstacle to developing this workforce, and attracting new cadres of younger educators and researchers. This is a particular concern, bearing in mind the age profile of this workforce, and the likelihood of high numbers of retirements over the next 10 years.

THE DESIRABILITY OF CENTRALISED/DECENTRALISED PLANNING

15. Planning the overall structure and approach to health care delivery has to have a national focus, which takes account of overall population health, and includes primary care, acute care, health protection and promotion. This also ensures that smaller, specialist health services and their educational preparation are not neglected. The need to take a wider cross-professions approach was recognised in the DH workforce planning structures introduced in 2001, but changes to those structures have not allowed the approach to embed itself and develop the capacity to look critically at how planning for separate professions is fully integrated.

16. The ongoing discussions between the higher education sector and the DH about health professions education for the coming two to three years give an indication of the difficulties. HEIs are currently being asked to make cuts of up to 30% in their health care student intakes for 2006–07. It appears that these figures are based on financial projections, and not workforce needs. It is not clear when commissioned numbers will be finalized—on occasions, StHAs have requested changes in August, for September intakes. In Scotland, funding for healthcare students flows via the funding council, which works with the health department to make announcements in December for student intakes in the following September.

EXAMPLES OF GOOD PRACTICE IN ENGLAND/ELSEWHERE

17. One innovative way of approaching planning has been suggested by a new medical schools: it is managed by a Joint Venture Board which comprises the CEOs of the local Health Care Organisations along with senior members of the University. This provides a forum where the impact of changes in health care on the educational programme can be openly debated and plans to take these changes into account developed.

18. Some StHAs have worked with their partner universities to develop a longer term (eg five year) perspective on workforce needs in their region. However, this seems to be the exception at present, but a model that may have wider application across England, with scope to feed into a more coherent overall plan.

19. Universities UK would welcome the opportunity to give verbal evidence to the Health Committee if required.

Professor Janet V Finch
Chair, Universities UK Health Committee
17 March 2006

Evidence submitted by Wyn Jones, West Yorkshire Workforce Development Confederation (WP41)

INTRODUCTION

I believe this review of workforce planning within the NHS is to be welcomed following the considerable progress that has been made over the past five years since the publication of “A Health Service of All the Talents” (2000). The development of new organisational structures being formed from “Ensuring a Patient Led NHS” will need to be cognisant of the output from the Health Select Committee’s findings.

I have worked within the NHS for 18 years in a number of posts. My current role is Acting Director of Workforce Development with the West Yorkshire Workforce Development Confederation that includes managing the workforce planning and management information functions of the organisation.

Why Plan the Workforce?

There is a need to be clear why the healthcare sector needs to plan the workforce. The objective is to provide the best possible healthcare to the public, patients and users. Traditionally the focus for workforce planning has been on inputs to commissioning education of the qualified workforce and this has led to the support staff and non-clinical workforce being neglected and the actual needs of students sometimes being missed off the agenda.

The purpose of workforce planning should be to support managers make decisions on designing and employing the best possible workforce to deliver patient care, in the most cost effective way, and therefore needs to go beyond the numbers of education commissions.
In the past the output from workforce planning has been a series of numbers of staff required at some point in the future. This often leads to one vision of the future and fails to considered alternative models for the workforce, or developing alternative Human Resource strategies, such as retention of staff or developing new ways of working.

Personally I feel the current workforce planning models lack the opportunity to consider a number of scenarios for the future workforce.

New ways of working are often developed in an ad hoc and local way and opportunities for sharing learning are lost.

There is a need for workforce planners to demonstrate real benefits of introducing new ways of working and of workforce planning to meet clinical expectations of evidence based practice and decision-making. The national bodies can support this, by conducting, or commissioning research.

**KEY IMPROVEMENTS SINCE 2000**

I believe a key improvement in workforce planning has been the move away from a numbers and education commissioning focus to a more holistic approach that incorporates the wider HR agenda, including the focus on Improving Working Lives (IWL).

There is now a greater mix of bottom-up and top-down planning and this mix appears to be working. Previous solutions that relied on one or the other had too many weaknesses to allow for the implementation of effective plans.

There also appears to be a greater recognition of workforce needs and planning in policy development, with the National Service Frameworks (NSFs) and other policy documents including key workforce considerations, this allows for improved decision making and local implementation.

A key improvement in recent years has been the greater alignment of workforce planning with other planning processes, such as service, finance and estates planning following the publication of “A Health Service of All the Talents” and introduction of Local Delivery Plans (LDP). There are further opportunities for greater integration using the Integrated Service Improvement Programme (ISIP), which is currently being introduced across the service.

In West Yorkshire feedback from local organisations has shown that a key improvement is that the Workforce Development Confederation demonstrates that it uses the information it requests in the form of regular quarterly and annual reports. This has the benefit of

- Showing that something happens to the data when it is submitted.
- The information is shared with a wider audience and is then used for different purposes.
- The quality of the data is improved because people know it is used and a wider range of managers review the data and work to improve it, if errors are found.

All reports and a summary of Key Performance Indicators are published on the WDC’s website (www.westyorkswdc.nhs.uk) on a quarterly basis.

The introduction of the Electronic Staff Record (ESR) should make planning in the future easier, due to the standardisation of systems and because the intermediate and national bodies will be able to access data, thereby reducing the workload on planners producing reports for various different organisations, therefore increasing local capacity to plan the workforce.

**LOCAL DELIVERY PLANNING**

The LDP process took over from local workforce planning cycles in many areas in England, replacing local systems and introducing a standard approach. The LDP process required plans to be integrated and made the assessment across workforce, activity and finance plans much easier, and moreover, the need for integrated planning was brought to the attention of a wider audience than previously had been the case. However, there are a number of weaknesses with the LDP model.

- The first round of LDP submissions had to be completed relatively quickly and some organisations did not complete the returns well.
- The first round of LDP submissions were subsequently used for performance management purposes when this was not part of the original purpose.
- The LDP submissions only provide one view of the future workforce.
- The LDPs do not incorporate the whole workforce, but focus mainly on professionally qualified clinical staff, missing the complete picture of the workforce, or allow for flexibility in future planning.
- Lack of long-term horizon for planning, in that LDPs currently finish in 2008, but planning for education commissioning needs to look to 2010 at least.
CURRENT POSITION

In the development of workforce planning there is still work to do, however, there is a risk that with the implementation of “Ensuring a Patient Led NHS” the progress to date and best practice may be lost, or at least hindered as the responsibilities for planning change and momentum may be lost in key areas.

The current mix of top-down and bottom-up planning models appears to be the best solution, however, there needs to be consistent across functional/professional groups. Currently planning for medical and dental staff is a top-down planning model, whereas non-clinical staff planning is bottom-up. The feedback to the West Yorkshire WDC from local organisations indicates that the separation of medical and dental workforce planning from the rest of the workforce remains a problem area that has not been overcome.

There is a concern that the impact of Payment by Results, plurality of provision and the choice agenda will make workforce planning more difficult to do. This increases the need for collaborative planning across organisations. Also Payment by Results will focus organisations on the cost of employment, both in terms of recruitment, training and separation. To date there is not a workforce planning model that can effectively incorporate these issues.

An ongoing concern is the annual allocation for the Multi-Professional Education and Training (MPET) levy. This makes decision making on commissioning difficult, as big changes in annual allocations cannot be easily managed within a single year. The majority of funds are committed in the costs of existing students and often the solutions to manage the constraints may not be the best for the long-term outcome of the healthcare workforce, eg reducing seconded places on programmes, or reducing funding on post-registration programmes.

The financial constraints placed on the service will force organisations to review their labour costs and productivity and to seek improvements. It is in the interest of the whole service to share practice and increase productivity, without impacting on quality of patient care. There is a role for the intermediate tier to support and monitor productivity of organisations as part of the workforce performance management system, in conjunction with finance and activity monitoring.

The key to increased productivity is sustained improvements that will be achieved through a mixture of skill mix reviews and modernising working processes.

NATIONAL BODIES

The national work of National Workforce Projects (NWP) and the Workforce Review Team (WRT) has greatly helped the development of workforce planning in terms of process, capacity and capability. For example following a WRT led review of processes there is greater alignment of data collection and reporting on workforce issues that now allow Strategic Health Authorities to consider national assessments of the workforce, where previously many national reports were published too late.

NWP has run a series of events and published guides on key workforce planning issues, including guides on workforce planning and has commissioned a workforce planning course for over 50 people.

Skills for Health will support the move away from planning numbers, by increasing awareness of competencies and this linked to the Knowledge and Skills Framework will require organisations to plan in a different way.

LOCAL PLANNING

The strength of local planning is the understanding of the local population in terms of health needs and employment opportunities. The local ownership of the plans is key to successful implementation. Providers of healthcare will be the future employers of the majority of people trained and therefore have a major stake in workforce planning. However, there is a risk that local providers do not consider the wider health needs of the population, or are not aware of the wider implications of their plans.

Also the local input is required to ensure education and employers work closely together in partnership to ensure people undergoing education and learning gain the maximum benefit and are able to deliver good quality patient care upon completion of their training.

There is a need to ensure workforce planning uses the flexibilities from the various pay modernisations and this will require local planners to develop local solutions, based on best practice gathered centrally and disseminated effectively. This will also need local planners to work with line managers to develop and implement local solutions.

Local planning should be designed around patient need and clinical pathways, rather than be based on organisational boundaries. This approach will encourage clinical engagement in the planning process and should make public and patient involvement easier in the planning processes. To date there is little evidence that I am aware of to show how the public, patients and users are able to influence workforce planning decisions.
Local planning must incorporate social services and other non-NHS providers in the process to ensure consistency in the plans and the potential supply of the workforce can be properly considered. This needs to include the independent contractors, such as General Practitioners, Dentists and Pharmacists.

**Intermediate Tier**

The intermediate tier needs to monitor local organisations to ensure local planning is taking place and to support organisations to implement their plans. The intermediate tier should also monitor the data for key trends and feedback where there are perceived problems, such as:

- An ageing population, either in the general population or in the workforce.
- Increases in turnover or early retirements.
- A mismatch between potential vacancies and newly qualifying students.

There is a risk within “Ensuring a Patient Led NHS” that no one will be accountable for workforce planning and that the intelligence and processes will be lost. The new SHAs need to ensure ISIP plans fully engage all organisations and incorporate a full assessment of the future workforce needs.

As organisations develop and the ISIP process is embedded in healthcare the role of the SHA should diminish and should evolve into an overview role to ensure consistency and identify potential conflicts or problems with the local plans.

There may also need to be some plans that are based on wider geographical boundaries where patient flows make it more sensible to on the SHA basis.

At the intermediate tier there will be better opportunities for integrated planning with other agencies, such as the Regional Government Offices, Regional Development Agencies and Learning and Skills Councils. The demands for the future workforce can be fed into these agencies to improve the shared intelligence and influence the agendas or the different organisations to improve the cost effective investment in the local working population.

Within healthcare there needs to be an organisation with an overview of the wider health and social care workforce that can make decisions on investment in education and commissioning and support the provision of practice placements for learners.

**National Planning**

The need for top-down planning allows the longer-term position and policy directions to be considered and mapped against the local plans in order for local organisations to “fine-tune” their plans. Policy development and introduction of new policies is a fact of life and the plans need to be able to build in the impact of new policies, this requires flexibility of the planning cycle and a need not to performance manage organisations on the actual plans.

I would anticipate top down planning taking an advisor role in assessing the impact of new policies, such as the European Working Time Directive and technologies on healthcare. The actual role of developing and implementing plans would have to take place at a more local level to ensure the solution was appropriate to local needs.

There would need to be an ongoing role in assessing the actual impact on the workforce and sharing best practice. However, some of this work may be more appropriately managed at the intermediate tier.

The work of WRT and NWP have shown the strength of top-down interventions. However, the recommendations from national bodies need to be assessed by the SHAs to ensure the national trends were relevant to the local health economy.

**Future Model**

The future model of workforce planning needs to link with PCT Health Impact Assessment for localities, where a service need or development is identified. This can lead to service models being designed and relevant workforce plans can be developed in partnership between commissioners and providers. The best model will be the one that provides the service to the required quality standards, whilst offering value for money, with an available workforce.

All plans should be based on an iterative process and organisations need to be able to review and amend plans as new information becomes available within an appropriate network. This approach does not lend itself to using plans for performance management purposes. The plans should be assessed against trajectory, but recognise deviation is almost inevitable.
The current ISIP model appears to be the best vehicle for progress as it is based on local geographical areas, rather than organisations that are subject to change during policy developments. Within ISIP all the developments within healthcare need to be incorporated, including Connecting for Health.

Wyn Jones
Acting Director of Workforce Development, West Yorkshire Workforce Development Confederation

March 2006

Evidence submitted by the British Association of Physicians of Indian Origin (WP 79)

We are grateful to the Committee for giving us an opportunity to offer evidence to the Enquiry—Workforce needs and planning for the health service.

Since the announcement of New Work Permit Regulations by the Department of Health on 7 March 2006, we have been inundated with messages from International Medical Graduates whose careers have suddenly become uncertain. We therefore have focused our evidence within that specific parameter with some key recommendations.

Our initial feedback suggests that there is an overwhelming support for the principals of the new point system for controlling worker migration proposed by the Home Office as a means of meeting the needs of the UK’s job market in general.

Please let me assure your members that it has been always our intention to co-operate with Government Departments and other professional bodies to find practical resolution to difficulties through consultations and negotiations.

On behalf of BAPIO I am submitting our evidence in the attached document for the Health Select Committee.

1. Background

The British Association of Physicians of Indian Origin [BAPIO] is a voluntary organisation established in 1998 and launched by a Minister of State for Health. It aims are: to realise the potential of its members in achieving clinical excellence, assist members in improving their career prospects, to monitor and highlight the difficulties faced by doctors coming from the Indian sub-continent and to support them and to promote professional links with the Indian subcontinent.

(a) With seven regional divisions BAPIO provides a regional perspective on national issues affecting over 25,000 doctors from the Indian subcontinent who work in the United Kingdom. Its members include doctors trained overseas and in the UK. It has established close working relationships with institutions such as the Royal Colleges, the General Medical Council and British Medical Association, including the Department of Health to highlight issues affecting doctors from the Indian subcontinent.

(b) BAPIO organises conferences, seminars and training events to improve clinical skills and understanding of the NHS and life in the United Kingdom for migrant doctors. It is also involved in the consultation processes more generally related to the health sector.

2. Aims of this Submission

(a) To inform on the input of international medical graduates (IMGs) into the service needs of the NHS.

(b) To inform on the contribution of the NHS to the training of IMGs and their subsequent.

(c) Contribution to the health services of their home countries.

(d) To inform on the advantages of employing IMGs in the health sector.

(e) To inform on the implications of Modernising Medical Careers (MMC) to IMGs.

(f) To inform on implications of European Work Time Directive (EWTD) on IMGs.

(g) To inform on implications of new immigration ruling (effective 3 April 2006) on IMGs.

3. International Medical Graduates and the Health Sector

(a) There is a long history over many decades of doctors completing their primary training in the Indian subcontinent and then coming to the UK for higher specialist training. These doctors have filled a lacuna in the service needs of the health care sector for a long period of time when the UK was simply not training enough doctors to meet the service needs in the primary care sector and in hospitals.
(b) It is estimated that there are about 81,000 doctors currently working in the hospital sector in the UK. Of these around 50,000 are UK trained and 31,000 have obtained their primary training overseas, mostly from the Indian Subcontinent. Around half of these international doctors are working as junior doctors. There may be an additional 5,000 doctors who have passed the PLAB entrance examination and are currently unemployed. (ref DH)

(c) Workforce needs assessment has been lacking in the health sector; however the ready availability of IMGs has reduced the impact of poor workforce planning. This has been especially important as there is the expected pyramid in the system with not all junior trainees assured of consultant positions at the end of their training. However this has not caused significant difficulties as many IMG doctors have been happy to move back to their home countries on completion of training and others have accepted non-consultant career grade positions in the UK.

(d) All this is set to change because of three separate issues:
1. The introduction of the Modernising Medical Careers programme.
2. The implementation of EWTD especially from 2009 when junior doctors will be allowed to work only 48 hours per week.
3. A new immigration ruling, which was introduced in April 2006 with no prior consultation with any of the stakeholders.

4. MMC and the IMGs
(a) The Modernising Medical Careers programme went live from August 2005. The first stage of this programme was the introduction of a Foundation programme after completion of medical school.
(b) F1 is open only to UK graduates and titrated to the output of medical schools in the UK. It is expected that the number of F2 posts would be about 15% greater than the F1 posts and these would then be available for European graduates and IMG doctors. At the end of the F2 year these doctors can apply for a seamless five year programme leading to certification of specialist training. (Ref: http://www.mmc.nhs.uk/pages/home)

(c) The IMGs will be at a disadvantage for application for these posts as foundation year competencies will be expected for selection. The intake of the medical schools is expected to rise to up to 8,000 per year over the next two years. This will mean there would be 8,000 new doctors coming out of medical schools every year from 2012 or so;—this figure currently stands at over 6,000. (Ref DH)
(d) The MMC will put the IMGs at a competitive disadvantage and it is likely that fewer IMGs are likely to obtain and complete training and this is therefore likely to discourage influx of IMGs into the UK.
(e) The large number of UK graduates will expect to be accommodated in consultant or GP positions at the end of the training and it is concerning that a recent report raised worries that there will be inadequate positions for all these UK graduates (Ref: Prof Nick Bosanquet’s report on Reforms).

5. EWTD 2009 and IMGs
(a) The EWTD in 2009 will mean that there will be a need for a larger number of junior doctors to run a compliant rota. Figures have varied from eight to 11 doctors on each tier. It is unlikely that the increased medical output from UK medical schools would be adequate by 2009 to meet up to this need and therefore there is likely to be dependence on European graduates or IMGs to fill the service needs in the NHS. However the impact of the MMC and the new immigration ruling (see below) may be that there is less interest amongst IMGs to come to the UK as there is a high risk that the training they obtain will be patchy in the climate of discriminatory short listing for jobs.

(a) Background

1. Permit free training was the mechanism that over the last three decades allowed doctors from outside the United Kingdom to work and train in the UK. This ensured there was equal opportunity for doctors who were not UK citizens to obtain appointments based on merit. Thousands of international medical graduates have come to the UK and have served the NHS well and also obtained excellent quality training which many have taken back to their home countries. Others have completed their training and chosen to continue in career grade appointments here and have given their skills and expertise to the British health service.
(b) **The New ruling**

1. The Department of Health declared on 7 March 2006 that a decision has been made to end permit-free training. This effectively ended equal opportunity for international medical graduates as they would only be able to obtain an appointment if the NHS Hospital Trust could prove that they could not fill the post by a suitable candidate who was a UK or EU citizen.

2. The New Rules have been announced without appropriate consultations with the organisations such as BAPIO as well as BMA and the Royal Colleges.

3. There is no evidence available in public that the Department of Health had undertaken comprehensive Race Equality Impact Assessments in line with the requirements of the Race Equality Scheme.

(c) **Effects of the new ruling**

1. The new ruling would have devastating consequences for IMGs already in the UK. To worsen matters, the ruling has been interpreted in a variety of ways by various medical personnel departments.

2. Many IMGs who had been short listed and called for an interview suddenly received a phone call informing them that they had been removed from the shortlist. Some IMGs who had arrived at the examination hall for the GPVTS test were offered an opportunity to not sit the exam but simply leave as they were told that they would no longer be considered for the posts.

3. Advertisements for jobs often carry a warning that those who are no UK or EU citizens will not be considered and therefore need not apply. Those IMGs who do not obtain a job at a particular point in time would have to leave the UK immediately and have to apply for jobs from their home countries.

4. The rules also appear to suggest that IMGs can no longer move from a visitor’s visa to a work permit visa or vice versa without returning to their home countries.

5. IMGs who have already been in the UK for many years and in training will not be treated differently from those who are not yet in the UK. Some of these very experienced doctors may have to leave the UK because they have not been able to obtain a job because of this ruling. This will lead to abrupt end to their training and also a serious loss to the NHS health care system. Additionally trainees from countries like Sri Lanka and Pakistan often have to complete some period of training outside their home countries before they can take up consultant position in their own country.

6. Under the new regulations the NHS Trusts as employers will have to support a new culture of recruitment practices based on “nationality” rather than “merit”.

7. This ruling will prevent this and damage the close relationships that exist between UK and the Commonwealth doctor communities.

7. **BAPIO POSITION**

   (a) BAPIO unequivocally believes the retrospective application of this ruling is wrong. It also believes that this ruling was brought about without any consultation and in an abrupt fashion with no concern for the welfare of the IMG community who for many decades have been the backbone of the NHS.

   (b) BAPIO believes that there is a need to manage workforce requirements better and to protect the interests of the UK trained graduates. However this must not happen with complete disregard to the effect on IMGs. IMGs already in the UK have committed huge amounts of time, money and effort to come to UK, sit necessary exams and apply for jobs, work hard and make career progress. They did this on the premise of equal opportunity and it is wrong to change the rules of the game midway.

   (c) BAPIO believes that this ruling will have significant detrimental effect on the morale of the IMGs working in the UK and this may affect the health care they deliver. It may also lead to loss of trust with many IMGs leaving the UK at a time when home grown graduate numbers are still not adequate to meet all service needs.

   (d) BAPIO believes the way forward is by having clearly declared annual quotas for IMGs which are applied in a prospective manner. This will discourage excess influx of IMGs and prevent recurrence of the current problem of estimated 5,000 unemployed IMGs in the United Kingdom. Those IMGs who have entered the UK must be treated equally to UK and EU citizens and merit must continue to be the sole criteria for career progress.

   (e) This is in the best interests of the IMGs, the NHS and the British people.

8. **BAPIO ISSUED FOLLOWING JOINT STATEMENT ALONG WITH THE JUNIOR DOCTORS COMMITTEE OF THE BMA**

   (a) BAPIO and JDC call for the following transitional arrangements to be made for non-EEA residents already in the UK training or seeking training posts.
(b) Those who have not completed the PLAB II examination should be given up to 18 months in which to do so and in which to seek employment in a training post which will then be subject to permit-free status for its duration.

(c) Those who have passed PLAB II but are as yet unemployed should be granted up to two years from the date they passed the exam to find a training post that will attract permit-free status for its duration.

(d) Those doctors currently on SHO training programmes should be given leave to enable them to compete equally alongside EEA-residents for new MMC specialist training programmes in August 2007.

(e) Those doctors currently on SpR training programmes should be allowed to complete their postgraduate training to CCT with permit-free status.

(f) Clarification of how the changes will affect those currently undertaking research in the UK.

(g) Those doctors who are currently in non-training posts as a transient measure whilst waiting for training posts, should be allowed leave to enable them to apply for training posts.

(h) The status of HSMP visa holders is unclear especially from the Deaneries’ point of view. These doctors should be treated on par with UK/EEA doctors when they apply for training posts irrespective of the duration of the HSMP (Home Office has stated that this should be so).

(i) Overseas doctors graduating from UK medical schools.

1. We call for overseas doctors graduating from UK medical schools to be allowed to complete their postgraduate training in the UK under permit-free status. In most cases, doctors having to return to their home countries after completing the foundation programme will not be in a good position to continue their training or careers and will have to start at the beginning of their home systems. This does not create any advantage or incentive for overseas students to study at UK universities, who would have taken this very expensive option with the hope of completing their postgraduate training in the UK.

2. Overseas students currently studying in or about to graduate from UK universities will also have an expectation of completing their training in the UK as these regulations were not inplace when they commenced their medical education in the UK. The new ruling comes too late for them to do anything about it.

9. GENERAL

Finally, BAPIO regrets that despite having excellent working relationship with the Department of Health, letters on this issue were not replied to so far. Since the announcement of the new regulations BAPIO was inundated with inquiries from doctors who were anxious about their career and uncertainty about their future. Over 600 doctors a petition signed by over 6,500 doctors expressing their concerns was presented at the reception Department of Health on 21 April 2006.

Dr Ramesh Mehta
President, BAPIO

May 2006