DEPARTMENT OF HEALTH

FUTURE STAFFING REQUIREMENTS

THE GOVERNMENT'S RESPONSE TO THE HEALTH COMMITTEE'S REPORT ON FUTURE STAFFING REQUIREMENTS

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INTRODUCTION

This Command Paper sets out the Govemment's response to the Health Committee's Report on Future NHS Staffing Requirements. This response to the Health Committee relates generally to England, although certain issues do apply to other parts of the UK also. Where appropriate, such matters are discussed between the Government departments concerned.

The Government welcomes the Committee's conclusion that "the Government is on the right track for re-vitalising the NHS" and the endorsement of many of the developments we have set in hand.

Our strategic aims for the NHS workforce remain those set out in "Working Together", the new national framework for managing staff in the NHS:

- to ensure that we have a quality workforce, in the right numbers, with the right skills and diversity, organised in the right way, to deliver the Government's service objectives for health and social care;

- to be able to demonstrate we are improving the quality of working life for staff; and

- to address the management capacity and capability required to deliver this agenda and the associated programme of change.

We have set priorities for action at local level in pursuit of this agenda, with national and local targets; and we are continuing to develop a range of policies and programmes at national level aimed at improving and modernising employment practice in the NHS. We have taken careful note of the Committee's analysis and suggestions for improvement, many of which are clearly in line with the course we have already set. Our response to the Committee's detailed recommendations is set out below.

The Committee's report highlighted a number of the problems that have to be tackled as we pursue these aims. It recognises, fairly, that many of these are long-standing and stem from the failure of previous Governments to tackle them. The Committee drew attention in particular to two areas where long-term, systematic change is needed: the pay system and the current systems for workforce planning.

The Committee concluded that "a new pay system is now necessary". The Government agrees. We have now published our proposals for modernising the NHS pay system. Our aim is a pay system which:

- enables staff to give their best for patients, working in new ways and breaking down traditional barriers;

- pays fairly and equitably for work done, with career progression based on responsibility, competence and satisfactory performance;

and

- simplifies and modernises conditions of service, with national core conditions and considerable local flexibility.

"Agenda for Change" sets out our detailed proposals for achieving these aims; and we are now in discussions with NHS professional and staff organisations and representatives of NHS employers about them. Our aim is to seek a conclusion on the way forward by September 1999.

In our evidence to the Committee we acknowledged that current systems of workforce planning in the NHS need to be improved. The Committee is right to acknowledge the "notoriously problematic" nature of workforce planning in an organisation of the size and complexity of the NHS and where the lead times for professional education and training are so long. But the Government is determined to make progress in this area. We have already set in hand some developments which should provide a stronger basis for future planning: a new requirement for local organisations to produce an annual workforce plan, for example; and a commitment to ensure that the workforce implications of Health Improvement Programmes and National Service Frameworks are assessed and reflected in planning assumptions. We have just created a single workforce planning branch within NHS Executive Headquarters, which will be responsible for planning right across the NHS workforce. Planning for doctors and for other staff was previously done in separate branches.

As the Secretary of State made clear in his evidence we agree with the Committee that more fundamental improvements to workforce planning are required; and intend to launch a major review in the near future. We will announce the arrangements for the review shortly, including how the interested parties will be consulted.

We need a combination of determined local action to modernise employment practice and sustained long-term development of better systems both for rewarding and incentivising staff and for workforce planning and development. This is also the key to tackling staff shortages. The response to the national nurse recruitment campaign has been hugely encouraging: by the end of April 1999 the campaign hotline had received around 53,000 calls of which around 5,000 were from qualified nurses asking about returning to the NHS. 650 had already done so.

That demonstrates both the continuing good will towards the NHS and, we believe, an increasing confidence in the Government's determination to make the NHS a better place to work. We will, as the Committee recommended, monitor progress on recruitment and retention carefully and keep our assumptions about future staffing requirements under continuing review. There is a long way to go. But there is also a great deal on which to build. We are determined to give the NHS the staff it needs and to provide the leadership and strategic framework to ensure that those staff are treated with respect and rewarded fairly for the work that they do. That is essential if we are to succeed in our overall commitment to build a modern, dependable health service, and to provide a fast, responsive, high quality service consistently in all parts of the country.

We recommend that the Government takes steps to introduce links between the National Advisory Group for Scientists and Technicians and national professional bodies. (paragraph 31).

The Government accepts this recommendation.

The National Advisory Group for Scientists and Technicians (NAGST) met with representatives of a wide range of professional bodies in February 1999 and NAGST have agreed a joint work programme with the professional bodies. Some of the scientific and technical disciplines are so highly specialised that they are only found in a very small number of national centres, making a national overview of workforce requirements essential. Existing workforce planning arrangements do not provide an accurate picture of the work actually undertaken by the various scientific and technical disciplines, how this is distributed nationally and where the service gaps are. The first stage of the work programme is to gather robust national data about which scientist and technician groups are currently employed where and what they actually do, as a basis for identifying possible gaps and future workforce demand. A sub group of NAGST, which includes representatives from the professional bodies, has been set up to undertake this work. NAGST and the professional bodies are committed to holding regular meetings.

We consider that with immediate effect there should be improved interaction between the medical and non-medical planning bodies. (paragraph 34).

We believe that there should be regular meetings between MWSAC and REDGs, who should exchange information, discuss new ideas and develop plans. (paragraph 35).

We recommend a major review of current planning procedures which should pay particular regard to their rationalisation and eventual replacement by an integrated planning system. We think it necessary that any new system should not only incorporate the national overview currently provided by the sub-group of the NHSE, but also actively promote a national strategy for workforce planning which, allowing for local conditions, brings a sense of consistency and cohesion at present notable for its absence. (paragraph 36).

The Government accepts the thrust of these recommendations. We recognise that workforce planning arrangements for the NHS need to be improved. This will require action at national, regional, sub-regional and local levels. As indicated above, we have already set improvements in hand, including steps to bring together planning for the medical workforce and other staff in a single branch in NHS Executive Headquarters.

And we agree with the Committee that more fundamental improvements to workforce planning are required; and intend to launch a major review in the near future. We will announce the arrangements for the review shortly, including how the interested parties will be consulted.

Although the Government does not wish to pre-empt the outcome of this work, some of the requirements for improved workforce planning arrangements are apparent.

a. The NHS and NHS Executive need to be clear about service needs and the skills and staff needed to deliver those services efficiently and effectively. Thinking about services, the workforce and

resourcing should be done together, so that plans and developments are consistent and co-ordinated.

b. There should be an appropriate mix between central (top-down) and local (bottom-up) planning, to ensure coherence in this area.

c. Planning should cover the whole healthcare workforce, in terms of sectors (primary, community, secondary and tertiary care, including private and voluntary providers) and workforce groups (nurses, doctors, other professionals, other staff), taking account of evolving future roles.

d. Workforce planning arrangements should reflect clear and agreed responsibilities and accountabilities, with effective performance management arrangements (including objectives, milestones, monitoring and reporting).

At present, a number of individuals and bodies (apart from Trusts, HAs, PCGs, professional organisations, trade unions and the NHS Executive) are involved in workforce planning and related matters. These include education consortia (which provide a forum for workforce and education matters), local medical workforce advisory groups (LMWAGs), regional education and development groups (REDGs) and postgraduate deans. In addition, the Government is advised by various bodies, eg the Medical Workforce Standing Advisory Committee. Although all of these bodies have relevant responsibilities in relation to workforce issues, it is now appropriate to reappraise their roles (as part of the work to improve workforce planning arrangements) and, where appropriate, rationalise the position, so as to ensure that new arrangements are clear, efficient and effective in terms of supporting national and local responsibilities and accountabilities in relation to workforce and other matters.

For the time being, we continue to expect the bodies mentioned above to work together co-operatively, which should be facilitated by the fact that there is cross-representation in many instances. In particular we agree that there should be good links between MWSAC and REDGs; and we will seek to strengthen these.

The issue of the provision of appropriate joint training throughout the UK should feature largely in the major review of current planning procedures that we have recommended. (paragraph 38).

We accept this recommendation. The Government recognises the importance of multi-disciplinary education and training as a means of developing and promoting effective team working and integrated care. The research has shown that;

- there is a perception that multidisciplinary education fosters and enhances collaborative working practices;
- integrated workforce planning is a significant driver for the development of multidisciplinary education;
- multidisciplinary education supports changes in patterns of service delivery; and
- it is perceived to be more effective at post registration level than at pre-registration level.

The Government will work closely with higher education institutions, statutory and professional bodies and education consortia to explore the positive benefits that multi-disciplinary education can give to the NHS especially as part of a planned Continuing Professional Development (CPD) programme . Education and training planning guidance has encouraged NHS education commissioners to explore opportunities for shared learning at both pre and post-registration levels.

The Consultation on 'A First Class Service' showed strong support in the NHS and the professions for multi-disciplinary approaches to lifelong learning. The government is developing further guidance on locally managed systems of CPD. This will support lifelong learning and help develop the learning environment within every health organisation. Learning in multi-disciplinary teams, across traditional service and professional boundaries, will be an increasingly important element of CPD.

Employers will need to review skill mix in service teams and address any skills gaps as a basis for developing improved models of service delivery, for example, in response to the requirements of national service frameworks.

We recommend that DoH should ask MWSAC to look in more detail at the balance between specialist and generalist training for doctors in achieving a flexible medical workforce. (paragraph 39)

The Government accepts that there should be an appropriate balance between specialist and generalist training. We will keep this, and the wider implications for education and training, under review as we assess future workforce needs and in the light of the proposed review of workforce planning arrangements. Following introduction of the Calman reforms, specialist training programmes ordinarily involve training which, initially at least, is common to a number of specialties. Identical periods of training which are common to two specialties may count more than once towards the award of different Certificates of Completion of Specialist Training (CSTs). This arrangement is known as dual certification, and occurs frequently in the psychiatric and medical groups of specialties where, for example, the majority of "ology" specialties (eg, gastro-enterology) are combined with general (internal) medicine. These arrangements allow trainees to receive specialised training while at the same time ensuring that sufficient doctors with generalist skills are available to the NHS.

We recommend that efforts are made to co-ordinate local initiatives and assess their strategic impact on the future workforce numbers. We further recommend that co-ordinated pilot studies are undertaken to assess the impact of altering the skill mix. (paragraph 47).

We accept the thrust of this recommendation. Developing better, more responsive services means developing new approaches in healthcare and in the professional teams delivering healthcare and in the way staff are trained and deployed. We need to strike a balance between encouraging innovation and new approaches on the ground and their wider evaluation and implementation.

The NHS Executive is responsible for developing a more co-ordinated, strategic approach which does not stifle local management initiatives. The aim of Health Improvement Programmes (HImPs) is to develop more coherent local planning to improve health and health services. The HImP will provide a stronger strategic

context for local workforce planning and each HImP will be supported by a comprehensive Human Resources and Organisational Development action plan which will address workforce implications and the skill mix needed deliver effective local services.

At a national level, in addition to the general review of skill mix undertaken as part of the national workforce planning mechanisms, for example in the work of MWSAC, National Service Frameworks are one of a range of measures to raise quality and reduce variations in service. They will set national standards and define service models for a defined service or care group, and will put in place strategies to support implementation and establish performance indicators against which progress within an agreed timescale can be measured.

A good deal of research and development work has been done in the past in relation to skill-mix, labour efficiency and other aspects of workforce utilisation. Currently, we are digesting the lessons of these exercises; and considering, as part of the NHS human resources research and development strategy, how best to take this forward in the future.

We recommend that the proposed number of medical students be increased by a minimum of 1,000 per year. This increase should be accompanied by a commensurate expansion in the number of senior doctors and consultants in order to provide for the necessary career opportunities and supervisory roles. (paragraph 59)

The evidence we have received leads us to conclude that on current trends the projected increases in the number of nurses and other clinical staff fall well short of what is required to deal with current shortages and future developments in the NHS. We hope that recent Government initiatives will reverse these trends, but we suggest that the Government urgently reassesses its staffing figures to ensure an NHS workforce that is sufficient for requirements. (paragraph 64).

We urge the Government to collate information from trusts in order to allow them to formulate a specific recruitment and retention strategy for pharmacists, scientists and all of the Professions Allied to Medicine as soon as possible. (paragraph 93).

As the Committee is aware, the Government has accepted the recommendations of the Medical Workforce Standing Advisory Committee, including an increase of 1,000 in the annual intake to undergraduate medical courses in the United Kingdom over the next few years. Increases in intakes have already been announced for autumn 1999; and announcements about the levels of intake in autumn 2000 and beyond should be made during the next few months. MWSAC's recommendations were based on the steadily rising trend in the number of doctors over the past 20 years; and an expectation that doctor numbers would continue to grow well into the next century.

In the shorter term, the Government is assuming that doctor numbers in England will continue to rise steadily during the next three years; and previous investment in undergraduate and postgraduate training should allow further increases beyond that. In other words, our workforce strategy is intended to provide sufficient doctors both to meet service objectives and to train and supervise undergraduate and postgraduate doctors in training. We also indicated, when announcing our acceptance of the MWSAC recommendations that the increase in medical school

intake would be reviewed over time, in the light of other work on medical productivity, the recruitment and retention of doctors, and, more generally, the future roles of doctors and other professionals.

The Government accepts that its assumptions about future staffing requirements need to be reassessed on a regular basis. We announced last summer that, with the extra money that was being made available following the Comprehensive Spending Review, the NHS would be able to take on up to 7,000 more doctors and 15,000 more nurses over the next three years. These figures take account of both service objectives and the resources available; and are based on existing staffing levels and assumptions about such factors as productivity and skill-mix. They also take account of workforce participation, recruitment, retention and return to practice rates.

Achieving these increases will be challenging. But the Government believes that a new human resources framework for the NHS, as described in "Working Together", provides a strategy and environment which should mean that these increases in staffing levels are achievable. In particular, the February 1999 pay announcements and the current nursing recruitment campaign should help to improve workforce supply. By the end of April 1999 the campaign hotline had received around 53,000 calls of which around 5,000 were from qualified nurses asking about returning to the NHS. In addition, there has been a good local response with many former nurses contacting their local trust or education consortium to find out more about the new NHS. However, the Government is not complacent in this area and recognises that a good deal of further work is required.

We will review our assumptions about staff requirements in the light of the autumn 1998 censuses of NHS staff, the current survey of recruitment, retention and vacancy levels, and any other recent and relevant material. The census and the survey will also provide better, up-to-date information about all the health professions, including pharmacists, scientists and all the Professions Allied to Medicine, which can then be reflected in specific recruitment and retention strategies as necessary, on the lines recommended by the Committee.

We recommend that the Government consults with NHS employers and staff representative groups in order to establish a rigorous but fair system of appraisal of efficiency measurement. (paragraph 68)

The Government is committed to achieving annual efficiency and value for money gains in the NHS totalling 3% per year for each of the three years 1999/2000 to 2001/2002.

As stated in the White Paper, "the new NHS", we are committed to a new approach to measuring efficiency. We have abolished the Purchaser Efficiency Index (PEI) and are developing more appropriate, broader based, performance measures which take account of the things that count most for patients, including the costs and outcomes of treatment and care.

The service has been closely involved during this developmental phase. In setting efficiency targets for 1999/2000, Regional Offices of the NHS Executive have had discussions with Health Authorities and Trusts as an integral part of agreeing Service and Financial Frameworks, informed by a national schedule of reference costs for NHS procedures to support benchmarking of costs between NHS Trusts.

Action is also being taken to encourage the NHS to improve not only the

efficiency of local services, but also the quality, effectiveness and outcomes of care provided. The document "The new NHS Modern and Dependable: A National Framework for Assessing Performance" was published for consultation in January 1998. It set out a new, broader-based approach to assessing NHS performance which received widespread support from those who responded to the consultation exercise.

The new Performance Assessment Framework, published on 9 April 1999, provides comparative performance information across six dimensions (health improvement, fair access, effective delivery of appropriate care, efficiency, patient/carer experience and outcomes of health care). The associated set of high level performance indicators is designed to encourage benchmarking of performance locally and to boost overall NHS performance nationally. Health Authorities and Primary Care Groups will be encouraged to compare the performance of local services with those elsewhere across the NHS. Working with local NHS Trusts, they will be expected to agree the actions needed to reduce unacceptable variations, where they exist, in both the quality and efficiency of local services.

It seems to us that the introduction of formal exit interviews would help workforce planning by providing a better sense of why staff leave the NHS. We also recommend that DoH initiate a formal consultation on standardisation of information as soon as possible. (paragraph 79)

Effective workforce planning arrangements are dependent on relevant, timely and high-quality information and intelligence being available to inform decision-making. This is an issue the review of workforce planning procedures will have to address, with the overall aim of ensuring that those responsible for workforce planning have the information they need, while avoiding unnecessary burdens on data suppliers.

More specifically, we recognise the case for standard information as far as possible and where this will not place an unacceptable burden on NHS trusts. There is no reason why standardised information should not be available from new surveys. For example, following the Secretary of State for Health's statement at the Health Committee in January 1999, a survey has been conducted to collect information about vacancies and recruitment and retention difficulties faced by NHS trusts. When the survey is complete, the results will be discussed with representatives from other stakeholder organisations to reconcile the various sources and figures available. The object is to ensure that in future the efforts of Ministers, management, staff and staff representatives are directed to dealing with problems rather than diverted into arguments about their scale. This is only a first step, and the same approach will be used in other areas of workforce information.

The Government accepts that an important part of improving the staffing situation in the NHS is to understand why people leave it. There are a number of different reasons why staff leave the NHS, some of which are specific to the circumstances within individual NHS trusts. Some employers already carry out exit interviews. We will encourage their greater use; and we will develop our capacity for obtaining a better overall, national picture of why staff leave the NHS from this and other information sources

Since the NHS will rely on overseas staff for many years to come, it is important that the Service ensures their career opportunities are not being restricted by their immigration status. We recommend that DoH consults with the Home Office and the Department for Education and Employment

on these issues. (paragraph 83).

The Government acknowledges the importance to the NHS of overseas staff and will, as the Committee recommends, continue to have close contacts with the Home Office and the Department for Education and Employment on issues relating to their immigration status. However the Government does not wish actively to "poach" staff from developing countries.

The vast majority of overseas qualified doctors who come to the UK do so in order to undertake postgraduate or specialist training. Important changes were made to the Immigration Rules in 1997 to assist overseas qualified doctors wishing to pursue specialist training in the UK. Doctors appointed to higher specialist training programmes are now admitted to the UK for an indefinite period, commensurate with the length of the training programme agreed with their postgraduate dean. Overseas qualified doctors are now able to enter training on the same footing as EEA nationals and will not find that the Immigration Rules act as a barrier to their pursuing training to its conclusion.

Nurses from overseas can have their career opportunities limited by the length of their work permits. The Department of Health has been liaising with the Home Office and the Department for Education and Employment and to help continuity of employment the Overseas Labour Service has extended the initial work permit period for a nurse beyond the two year limit to a maximum of four years.

We would encourage education consortia, universities and the NHS to collaborate to ensure that the opportunity exists for student nurses to experience clinical practice in a safe and supervised environment as early in the training programme as possible. (paragraph 111)

The Government accepts this recommendation. Research commissioned by the NHS Executive into the pre-registration nursing Diploma of Higher Education has confirmed that students prefer early contact with patients and clients and longer practice placements.

The Government has published guidance requiring a gradual increase in the length of practice placements to enable students to gain maximum benefits from their placements and to increase their important contribution to the health service.

The Government will work with education consortia, the statutory bodies, and higher education institutions to provide a secure and supportive learning environment and one that will ensure students experience early exposure to practice and undertake long placements nursing sick people early in their training.

We recommend that healthcare assistants working with nurses should be called "Assistant Nurses" and be registered with the UKCC. Healthcare assistants working with other professional groups should also be registered appropriately. Registration is such circumstances would provide professional motivation for the individual and would act as a necessary safeguard for the public who could then be assured that at all times care was being delivered by people whose competence was known and recognised. (paragraph 116).

The Government is already committed to reviewing the case for the regulation of health support workers following the report of an independent review of the Nurses, Midwives and Health Visitors Act 1997, published on 9 February 1999. We have noted the Committee's conclusion on this issue and will take it into account

in the course of the review, details of which will be published shortly.

We recommend that every member of the NHS staff alone on duty in the community or otherwise at risk should have access to a mobile telephone or other means of establishing emergency contact with colleagues. (paragraph 128)

The Government accepts this recommendation. The crucial factor is to have emergency contact arrangements that actually work in an emergency. Having to try to dial for assistance on a mobile phone could in some circumstances be a hindrance rather than a help. As part of the drive to improve the security of all NHS staff it is already established policy, published in recent guidance on safer working in the community, that NHS employers should:

- carry out proper assessment and evaluation of different means of communication for staff working off site; and

- provide adequate means for staff to be contacted and for staff to contact base. Suitable methods of communication include two-way radios, mobile phones and alarm systems.

We will monitor implementation of this policy.

We recommend that overtime payments should replace undue reliance on agencies as soon as possible. Moreover, the bank system should not be used as a method of cheap labour but should instead be used as a useful flexible working practice to cover unexpected shortages. (paragraph 135).

The Government is concerned about the increasing costs of agency staff and would like to see a reduction in the use of agency staff. We accept that there is a need to explore alternative approaches to covering temporary vacancies. The use of agency staff will still be needed at least in the short term until nursing levels have increased There will always be a need for some temporary staff to cover periods of high activity, holiday periods and sick absences etc. It should be the responsibility of individual NHS employers to decide how to spend their income to achieve the most cost-effective delivery of the services they are expected to provide. This could include the use of agency or bank staff, paying existing staff overtime, allowing time off in lieu or introducing new shift arrangements.

We agree that bank systems should not be regarded as a source of cheap labour. Bank nurses should be paid according to the number of hours worked on the appropriate salary scale for the post in which they are working. We accept that banks can provide employers with flexibility to cover short-term vacancies and absences, whilst providing bank staff with flexibility over the hours they work.

The Government proposes to establish a working group, including representatives from employers and staff and under the auspices of the NHS Social Partnership Forum, to look at the wider issues around the use of bank and agency staff and alternative approaches to employment flexibility, with a view to recommending good practice guidance to NHS employers.

We recommend that the NHS finances in full the relevant professional educational needs of its staff. We also believe that current study arrangements are inadequate and need to be extended. (paragraph 138).

The Government recognises the importance of lifelong learning to the delivery of more consistent and higher quality care in the NHS. There is strong support within the NHS and the professions for all staff having personal development plans (PDPs) which reflect local service objectives as well as meeting professional and personal development needs. The Government has set a target for the majority of health professional staff to have a PDP by April 2000.

Funding for CPD currently comes from a variety of sources including employers' training budgets, education consortia development funds, the commercial sector and funding in part by individuals. NHS organisations need to refocus their investment in CPD to make sure it is aligned with local clinical governance plans. The government's recent guidance on clinical governance reinforces this. Each health authority, NHS trust and primary care group (PCG) is required to submit annual reports on clinical governance and these should include details of targeted investment in CPD.

An important principle of CPD is that it includes much more than going on courses. All health organisations need to develop a learning culture with work based learning at the heart of this. Work based learning involves a wide range of activities. For example, it includes learning from the results of clinical audit and putting in place service improvements based on audit. It includes learning on the job how to make better use of information systems and how to apply the results of research. Work based learning should also include the process of reflection within a team about untoward incidents which may have occurred and how to learn the lessons from these.

Guidance on continuing professional development (CPD) will be issued shortly. This will stress the importance of aligning existing training funds with local service objectives and clinical governance plans and it will emphasise the importance of work based learning.

We regret the transfer of ancillary staff to the private sector that is currently a consequence of PFI. The often spurious division of staff into clinical or non-clinical groups can create an institutional apartheid which might be detrimental to staff morale and to patients. We believe the Government should limit PFI to a number of pilot schemes until a proper evaluation of the impact on staff and patient care is produced. (paragraph 152).

The Government recognises the Committee's concerns in this area but cannot accept this recommendation. PFI is only used where it offers value for money. It is used alongside public capital to meet health service needs. It is our success with the PFI and the increase in public capital expenditure - it will have risen by almost 50% in real terms, to £2.4 billion, by 2001/2 - that has enabled this Government to start the largest hospital building programme in the history of the NHS.

The Government inherited a bill of £2.5 billion for backlog maintenance *alone* in the NHS when we took office in May 1997. We therefore need to use resources carefully and efficiently. Nevertheless, we have given the go-ahead to 25 major PFI hospital projects at the same time as 6 publicly funded schemes worth almost £220 million. This must represent good news for patients. At the same time, we remain determined at all times to ensure that schemes are affordable and that they represent value for money. Above all, we are determined to ensure that any staff affected by a PFI deal will have a say in the PFI process, and that their interests will be properly protected at all times.

Adoption of the Committee's recommendation would raise significant practical difficulties.

The division of staff into clinical and non-clinical groups, to which the Committee refers, is not new in practice and predates the introduction of PFI into the NHS. The existence of different employers for different staff groups need not create all the practical difficulties suggested - the experience of many years has shown that the staff groups concerned can still work together as a team.

The private sector takes on non-clinical staff because it is responsible for running the hospital support services and managing the risks associated with the provision of those services. It is not suggested by the Government that the private sector is automatically better at running services than the NHS- obviously there are varying standards in both the private sector and the public sector. However, we would not approve a scheme unless the private sector partner had a record of good service delivery.

Naturally some staff who are transferred to the private sector feel concern about such a change. However, their pay and conditions are protected by the Transfer of Undertakings (Protection of Employment) Regulations (TUPE). Furthermore the NHS Executive insists that, in any PFI deal, the private sector offers transferring staff pension rights that are broadly comparable to NHS pension rights.

The Government is committed to ensuring fairness at work. As part of this the Department of Trade and Industry is leading work on the revision of the TUPE Regulations in liaison with several other Departments, including the NHS Executive. A draft of the revised regulations will be made available for public consultation in the next few months. Among the issues being considered is the application of TUPE to second and subsequent transfers and the practicality of extending the protection afforded by TUPE to cover occupational pensions.

The Government is also committed to giving unions the right to meet bidders, to discuss their staffing records with them and to report their views to the Trust Board charged with selecting a preferred bidder. Formal guidance on this is included in the NHS Executive's detailed guidance on PFI, shortly to be published.

We note the points made by the Committee about reductions in staff numbers. New facilities - whether funded through PFI or not - may lead to some reductions in staff because efficient modern premises are likely to need fewer support staff to run them than old ones. However, value for money would certainly not be achieved if hospitals were under-staffed, and we will not approve any scheme unless it offers value for money.

PFI schemes can offer value for money because of the use of innovative design by the private sector and the transfer to the private sector of many building and operational risks (such as cost and time overruns during construction, the cost of on-going maintenance and failure to meet agreed service performance standards).

It is also suggested in the report that PFI is not an affordable long-term strategy for investment in the NHS . The Government's view is that it can provide best value for money in many cases and that, when it does, it is only sensible to use it. This does not mean that the provision of public capital will dry up- on the contrary, public capital spending is increasing.

The Committee's report asks how the NHS can afford the cost of servicing private sector capital investment, given that this is likely to be more than the standard capital charges levied for public sector capital investment. It is true that the private sector cannot borrow as cheaply as the Government can, but the difference is accounted for - as mentioned above - by the use of innovative design by the private sector and the transfer to the private sector of many risks.

The first wave PFI schemes have, in effect, served as pilot sites. Many lessons were learned from them and these have been fed into negotiations on subsequent schemes, and have been reflected in ad-hoc guidance and on the codified guidance on PFI in the NHS that is to be published.

We recommend that the time has come for the NHS to move towards a single pay spine for all personnel. Terms and conditions should be negotiated nationally. (paragraph 160).

We think it is time now to reorganise the pay review body system in order to inculcate a greater sense of team spirit within the NHS. We therefore recommend its replacement with the establishment of a single body charged with the task of reviewing the pay of all NHS professionals. This body should have within its remit all NHS staff, for example, clinical scientists and ancillary workers, who are not included in the current pay review bodies. The independence of the body should be secure and unassailable. (paragraph 165).

As indicated above, the Government has now published its proposals for modernising the pay system and is discussing them with representatives of the unions, professional organisations and employers.

There are currently hundreds of different pay-scales and grades in the NHS. The Government agrees that this is an overcomplicated and confusing system. In "Agenda for Change" we recommend a move to three pay spines (one for doctors, one for health professionals and one for remaining staff).

We need three spines because there are different labour markets for different broad groups. Separate consideration is needed for doctors and dentists, for other health professionals whose pay has to respond to the national market, and for staff whose skills are used by other employers locally.

The Government agrees that pay Review Bodies should continue to be independent. Under our proposals the Doctors and Dentists Review Body will continue under the new remit agreed with the professions in 1998, and the Nursing Pay Review Body will continue, with a review of whether some smaller groups of health professionals might move under the remit of the NPRB. We also propose a single pay negotiating forum for all NHS staff not covered by the Review Bodies, replacing 11 separate negotiating bodies.

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