The Government Response to the Health Select Committee Report on Workforce Planning

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
May 2007

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Introduction

The House of Commons Health Select Committee (the Committee) published its report into workforce planning on 22 March 2007. This Command Paper sets out the Government's response to the conclusions and recommendations in that report.

The Government agrees with the Committee's conclusion that workforce planning is a major issue and welcomes the report and the contribution it makes to the ongoing debate on improving workforce planning across the health service.

Many of the issues raised in the report were covered in extensive evidence provided by the Government to the Committee. This response provides further information on the expansion of the workforce since 1997 and further actions either currently under way or planned to improve workforce planning in the future.

The Government has a clear vision for the NHS. It is to promote health, reduce health inequalities and deliver the best possible care for the population with the resources available. Workforce planning is integral to that vision as it is about ensuring that the NHS has the people, skills and flexibility required to deliver high-quality healthcare to patients. It remains the Government's position that detailed planning such as this is best delivered locally by those who are in a position to respond to patient needs. The role of government is to take a national overview and work with the NHS to ensure that policy direction and national trends are both understood and built into local workforce plans.

Since 1997, the Government has invested unprecedented levels of funding in the NHS. By the end of 2007/08, the total NHS budget will have effectively trebled from £34 billion in 1997 to £90 billion. This increased level of funding provided the opportunity for reform and investment in NHS services and the workforce that delivers those services.

When the *NHS Plan* was launched in 2000, the public made it clear that they wanted more staff working in the NHS and lower waiting times. That desire was translated into action, and we now have 280,000 more staff in the NHS in England than in 1997.

This significant increase in workforce has meant that the staff shortages and gaps inherited from the 1990s have been filled. With almost 80,000 more nurses and 35,000 more doctors since 1997, the NHS is delivering more care to more patients with less waiting.

There has been an increase in the number of students entering medical school. Between 1997 and 2006, this has increased by 72% from just over 3,700 to just under 6,500. In the same period, the number of doctors in training and equivalents employed by the NHS has increased by 53%, which is almost 16,000 more than in 1997.

We have also seen a 65% increase in the number of pre-registration students training to be a nurse or a midwife since 1997 with almost 25,000 more in 2006.

All parts of the NHS are consistently delivering for patients against national priorities. Objective evidence (e.g. NHS performance data on accident and emergency (A&E), cancer, waiting times, meticillin-resistant *Staphylococcus aureus* (MRSA), access to primary care services) confirms that services are being maintained and improved, for example:

- waiting lists continue to be at an all-time low. At the end of February 2007:
  - the number of patients waiting more than six months was 378, a decrease of over 282,000 since 1997;
  - 99.9% fewer people (338,838) were waiting more than 13 weeks for a first outpatient appointment than in 1997;
- patients can now expect to wait no more than 13 weeks for their first outpatient appointment and a maximum of six months for an operation from a decision to admit;
- for the year 2006/07 as a whole, over 98% of patients were seen, diagnosed and treated within four hours of their arrival at A&E; and
- cancer mortality in people under 75 fell by nearly 16% between 1996 and 2004. This equates to over 50,000 lives saved over this period. Over 99% of patients with suspected cancer are now seen by a specialist within two weeks of being referred by their general practitioner (GP) compared with 63% in 1997.

The Government's response to the Health Select Committee's Conclusions and recommendations

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

Government response

We accept and agree with the Committee's conclusion that there was a rapid growth in the workforce. In our view, this was an appropriate growth to address the issues arising from low workforce numbers in 1997. The targets in the *NHS Plan* were not the only targets for workforce growth. For example, the *NHS Plan* target was for 20,000 more nurses and midwives by 2004 over the 1999 baseline. This was followed by the Manifesto commitment in 2001 for 20,000 more nurses and midwives over the 2000 baseline by 2005. Finally, *Delivering the NHS Plan* gave a commitment for at least 35,000 more nurses and midwives by 2008 over the 2001 baseline. In all cases, these were minimum increases not maximums.

During the period covered by the report, it is true that the NHS recruited staff from overseas. This was necessary until sufficient new UK trainees became available. Internationally trained healthcare professionals have brought fresh ideas and experience to the NHS and in times of shortage have provided much needed human resource. International recruitment was never intended as a substitute for sound long-term policies and those policies – increased training places, return to practice and *Improving Working Lives* – have contributed to the move to UK self-sufficiency. Consequently, we are now in a position of a much closer match between affordable demand and workforce supply, with less reliance on recruitment from other countries.

Independent auditors and a recent Public Accounts Committee (PAC) report on NHS financial management agree with the Department that NHS deficits have arisen for a variety of reasons and over a number of years. It is not possible to attribute deficits to any one factor taken in isolation. There is no single, simple cause of deficits, just as there are no single, simple solutions for eradicating them.

We accept that, in past years, the accountancy rules operating in the NHS may have masked underlying financial problems. Therefore, we have increasingly tightened the NHS financial regime to prevent this – and our actions have exposed the real financial position in many organisations. For example, from 2006/07 we have stopped the movement of money round the system by abolishing both brokerage and planned support.

While in the short term, our tightening of the financial regime will have exposed deficits in the NHS that might otherwise have remained hidden, individual organisations must deal with their financial problems, make difficult decisions and address the issues causing them.

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

Government response

The latest data from the 2006 NHS Workforce Census (published on 26 April 2007) shows an increase in clinical capacity of almost 7,000 full-time equivalent (FTE) staff from last year. We have more doctors, scientific and therapeutic staff and, despite a small decrease in the headcount number of qualified nurses, there has been an increase in the FTE number. There has been a reduction of almost 2,500 managers in the NHS between September 2005 and September 2006, which is in line with our Manifesto commitment to cut administration costs in the NHS to release up to £250 million for front-line services. We expect the number of managers in the system to reduce further over the coming months as a result of the recent reduction in the number of strategic health authorities (SHAs) and primary care trusts (PCTs).

This does not indicate large numbers of job reductions. Rather, it shows that the NHS is now in a position where the demand for workforce is balanced with the supply of new staff. It shows that the NHS is making effective decisions about the use of the increased workforce capacity and, as people move around (and out of) the system, organisations are planning appropriately for how to replace them. In many cases, this will be to replace like for like. In other cases, it is about looking at new ways of working and new roles replacing more traditional ones.

Our latest data is that there have been 1,446 compulsory redundancies between April and December 2006. This should be seen in the context of a workforce in excess of 1.3 million people and against a backdrop of continued delivery of improved services and lower waiting times.

Graduates are not facing large-scale unemployment and the NHS as a responsible employer seeks to maximise the employment opportunities for new qualifiers. The latest data we have from SHAs shows that over 67% of new qualifiers who left training between May and September 2006 have now found NHS posts. However, we are not complacent, and action is already under way following an NHS Employers summit (involving representatives from SHAs, trade unions, the independent sector, social care, higher education and Jobcentre Plus) where a joint action plan was agreed. This includes the creation of talent pools, through the NHS Jobs website www.jobs.nhs.uk, for newly qualified staff.

Nationally, the number of nurses in training has increased significantly in recent years by 12% from 2003/04 to 2005/06. Numbers of nurses in training depend on the commissioning decisions of individual SHAs, based on their assessment of their future workforce need and the financial capacity to invest in commissions. For nursing, this year some of the reductions have been driven by financial issues and some by SHA assessment of future workforce need. The position has varied according to local circumstances and the final position will not be known until later this year when SHAs receive final numbers from their education providers.

A new service level agreement and accountability framework is being developed to underpin 2007/08 SHA allocations. This will ensure that SHAs are held to account for the training they arrange for students and the NHS workforce, and for developing the workforce needed to deliver services required by patients. We believe 2007/08 allocations should provide sufficient resources to enable SHAs to do this.

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

Government response

It is true that pay rates have increased since 1997. This was one of the aims of the modernisation agenda the Government set out in the *NHS Plan* in 2000. This was a key priority for everyone after years of under-investment in the NHS prior to 1997. Doctors and nurses deserve to be paid well for what they do.

Improvements in NHS pay have played a key role in the expansion of the NHS workforce which in turn has led to unprecedented falls in waiting times, a reduction in staff vacancy rates and delivering equal pay for work of equal value.

Agenda for Change was not just about more pay. It was a new pay system underpinned by a national job evaluation process to ensure fairness for all non-medical staff.

Modernisation and investment has resulted in consultant pay increasing by up to 25% as a result of the new contract and *Agenda for Change* has given 10% pay rises to many over its first three years.

It is true that pay reforms have absorbed a large proportion of the extra money allocated to the health service in recent years. The reforms are addressing fundamental weaknesses in previous contracts, including recruitment and retention problems, little control over the work delivered by doctors and other staff, poor control over earnings growth, low productivity growth and significant exposure to equal pay risks. The fact that the new contracts address these inherent weaknesses means they will deliver long-term benefits.

Independent auditors and a recent PAC report on NHS financial management agree with the Department that NHS deficits have arisen for a variety of reasons and over a number of years. It is not possible to attribute deficits to any one factor such as new pay arrangements. Although the NHS ended 2005/06 in deficit, the situation has improved significantly over the last year and the NHS is on course to deliver a surplus at the end of the 2006/07 financial year.

It remains the Government's position that affordable pay uplifts are essential if the NHS is to meet the financial targets needed to reach and maintain financial balance. This year's settlement is expected to deliver an overall increase in average NHS earnings of around 4%, which is in line with achieving the Government's long-term inflation target rate of 2%.

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

Government response

The Committee is right to point out that there have been a range of initiatives designed to introduce new ways of working in the health service. The new ways of working (NWoW) approach has included redesigning services, extending and enhancing the skills of existing staff, sometimes in different settings, the development of some new roles and changes in skills mix management. New roles include emergency care practitioners (ECPs), anaesthesia practitioners (APs) and maternity support workers (MSWs).

Increasingly, the emphasis of the NWoW approach is shifting to enhance the competencies of existing staff so as to increase flexibility within and across organisations, and develop a more team-based approach to delivering services. It is also increasingly focusing on ways to support delivery of the 18-week waiting target, reduce A&E attendances and emergency admissions, reconfigure acute hospitals, provide *Better Care, Closer to Home* and maintain financial balance. NWoW can improve productivity and cost-effectiveness. However, we recognise there is still scope to do more.

Skills for Health and Skills for Care are working to identify gaps in the current workforce and the priorities for NWoW. This work is overseen by the National Governance Group set up in October 2006. The group includes representatives from the NHS and social care, the independent sector and workforce planning organisations. Its role includes ensuring that the development and co-ordination of health-related roles are service driven, strategically aligned and based on achieving tangible benefits for service users. It also supports the development of nationally transferable roles at the interface of health and social care, as well as developing processes to gather information about trends in and benefits of innovative workforce development.

The multi-professional educational training (MPET) budget was not cut in the 2006/07 SHA allocations. In fact, allowing for inflation, it was broadly similar to the level of funding in 2005/06. In 2006/07, the Department of Health (DH) allocated £3,694 million to the NHS, and £460 million to the Student Grants Unit (SGU). In cash terms, this represents a 3% increase in MPET budgets.

However, we do acknowledge that some SHAs, in meeting their responsibilities to balance their budgets, have made savings from their overall MPET allocation. This has had an effect on the amount available for investment in training. The effects of these savings are emerging at around 9% of the MPET budgets.

We expect SHAs and higher education institutions (HEIs) to be able to deal with short-term problems by working closely together.

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

Government response

When we launched the *NHS Plan* in 2000, the public made it clear that their top priority was to have more staff working in the NHS. Despite a small fall identified in the 2006 Census, we still have around 280,000 more staff working in the NHS in England than in 1997. This has helped improve the delivery of treatment and care across the NHS and has driven down waiting times. For example in March 1997, over 283,000 patients were waiting over six months for an operation from the date of the decision to admit. At the end of February 2007, the number of patients waiting more than six months had fallen to 378, a decrease of over 282,000 since 1997.

As the latest Census data shows, we are now moving away from annual growth in the NHS workforce to a steady state where there is a closer match between affordable demand and supply. The focus now is on strengthening front-line capacity through increases in productivity and improvements in the skill mix.

Numbers in training have steadily risen over recent years, for example, from 2003/04 to 2005/06, the number of trainee nurses supported by MPET increased by 12% (64,995 to 72,930). Although numbers of training places have reduced in 2006/07 due to a combination of financial pressure and estimated future demand, numbers in training remain high by historical standards.

SHAs have been encouraged to find a sensible balance between achieving financial stability and not compromising the ability of HEIs to deliver the training commissioned for the NHS. This needs to be done in ways that do not adversely affect students and do not damage the medium and long-term ability of HEIs to provide the level of education to which both they and SHAs are committed. We are confident that they can work together to achieve this.

The Government also accepts that pay levels increased between 1999 and 2005. This was a planned modernisation of the pay systems within the NHS. It has resulted in consultant pay increasing by up to 25% and nurses pay by around 10% from 2003 to 2006. We do not accept that this has been followed by severe pay restrictions. Recommendations for annual pay uplifts are made to the Government by independent pay review bodies. Their recommendations for 2007/08 have been accepted by the Government but staged to align with the Bank of England's inflation target. The pay awards are fair, will help protect jobs and services and will deliver an average increase in earnings of around 4%, which is above the current rate of inflation.

We also contest the Committee's assertion that there are widespread job losses. Despite the scare stories of thousands of job losses, the latest data we have clearly shows that there were 1,446 compulsory redundancies between April and December 2006, of whom 79% were non-clinical staff.

This is not a boom and bust approach but a managed delivery of investment and reform.

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

Government response

The Government has a clear vision for the NHS. It is to promote health, reduce health inequalities and deliver the best possible care for the population with the resources available. Achievement of that vision is only possible with the right workforce.

Workforce planning is about ensuring that we have the right people, skills and flexibility available to deliver the service to meet the public's needs. We understand the Committee's comments on re-organisation, but we maintain that the current structure is now the right one to take the NHS forward. Workforce Development Confederations were not removed. They became an integral part of SHAs.

This was a positive move and one that ensured workforce planning became an integral part of wider local health planning arrangements. The fact that workforce planners are now an integral part of the 10 new SHAs demonstrates that we see workforce planning as one of their primary roles. It remains one of DH's intentions to work with SHAs to use this report to identify opportunities to improve local and national approaches to planning the workforce for the future.

We believe that there are many experienced, skilled and enthusiastic workforce planners in the NHS. The establishment of the Workforce Review Team demonstrates a commitment to provide a national focus for SHAs to receive advice and expert analysis on workforce supply.

National Workforce Projects have also provided a range of resources to support coherent planning across the service and recently commissioned the one-year postgraduate certificate in strategic workforce planning at Thames Valley University. This will equip local SHA workforce planners with the set of skills and abilities needed to facilitate better local workforce planning.

The Workforce Review Team, which provides information to SHAs on workforce supply, is developing a generic workforce-modelling tool. This will allow national and local workforce planning by local NHS organisations to be undertaken by assessing skills needs and future workforce requirements across levels rather than professions. 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.

We agree with the Committee that robust workforce planning needs accurate data. With the continued introduction to the NHS of the new Electronic Staff Record system (implementation due to be completed by April 2008), there will be a new accurate repository of local data that will be very useful in future workforce planning decisions.

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

Government response

Workforce planning in the NHS aims to fulfil 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 in order to inform the education requirements to deliver the workforce needed in the future.

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 example for smaller specialties.

Within the NHS, planning is from the bottom up:

- PCTs are responsible for creating local plans which describe health and service improvement in their area. They address the needs of the community as a whole and incorporate the national priorities.
- Each NHS trust is responsible for creating its own business plan which shows how it will deploy its resources to deliver on both national and local priorities and fit within the plans of its PCT commissioners.
- All organisations work locally to contribute to these plans and support SHAs to create the workforce plan as part of the Local Delivery Plan (LDP).
- SHAs will bring together those PCT plans into a comprehensive LDP for their area.

Taken together, these plans will make up a coherent national picture. SHAs are charged with monitoring these plans and ensuring equity of provision across the health economy. SHAs work across their patch to co-ordinate the planning activity via a network of workforce planners to ensure that emerging trends are incorporated in the LDP.

The independent sector currently accounts for a relatively small but significant proportion of total provision of services to NHS patients. For example, it is estimated that around 8% of total NHS elective activity will be undertaken in the independent sector by 2009/10. The proportion of such provision in future will be determined by the choices made by patients and those who commission services locally on their behalf.

The Department has established a formal, cross-cutting third sector programme overseen by a Third Sector and Social Enterprise Delivery Board, chaired by Ivan Lewis. The board includes representatives from the third sector and social enterprise, the NHS and local government. The board will act as the executive decision-making authority within DH to ensure that the necessary action is taken across all relevant DH programmes – including workforce programmes – to deliver corporate DH ownership of the cross-cutting third sector and social enterprise agenda.

The board's objectives include:

- achieving demonstrable improvements in effective partnership working between DH and the third sector and social enterprise at national level and between NHS and local government with the third sector and social enterprise at regional and local level; and
- influencing capacity building within both the public and third sector and social enterprise, and through this achieving improved outcomes for patients, service users and carers.

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

Government response

The Government agrees with the Committee that there is an essential link to be made between financial and workforce planning. We would go further and include the need to ensure integrated financial, workforce and service planning at a local level to lead to the development of affordable services. This is an area we want to see improve. That is why local workforce data has been an integral part of the Finance Information Management System (FIMS) since early 2006. This means SHAs and trusts are able to provide integrated data. We are currently exploring further opportunities for improving this co-ordination, including using the new Electronic Staff Record system currently being introduced across the NHS.

DH has made a number of significant changes during 2006/07 in terms of making improvements to financial management. The publication of quarterly financial information supports DH's commitment to transparency and has led to an improvement in data quality.

The appointment of the NHS Financial Controller in 2006/07 has significantly strengthened DH's strategy to improve the financial management and performance function of the NHS, not least through regular face-to-face challenge and encouragement of greater accountability for senior NHS managers. There has been a considerable level of new performance management activity with the NHS. For example, both the NHS Financial Controller and the Director General of Commissioning have been meeting with each SHA Chief Executive and Director of Finance monthly to review activity and forecast financial results. The Financial Controller's team has assisted the SHAs in terms of data quality by developing computer-based error checks on information submissions at source, and providing monthly detailed analysis of SHA data and the frequent follow up of queries raised. The team has also visited all SHAs on a rolling programme to identify issues of concern across the system and address these at monthly SHA Director of Finance meetings. Improved feedback mechanisms are now in place to ensure that issues of data quality and the results of analysis are played back to the NHS, so that corrective action can be taken as appropriate.

In terms of both annual plans and monthly monitoring of the NHS, we collect and analyse both workforce and financial data for decision-making and performance management purposes.

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

Government response

We agree that effective workforce planning must have a long-term focus. That is why we identified our long-term goals in the *NHS Plan* and *Delivering the NHS Plan*. We have now achieved the increased capacity seen by all in 1997 as necessary and the NHS has reached a position where the demand for and supply of workforce is in balance. The focus is now on improving workforce productivity to improve services for patients. This can be achieved through improved planning, for example, through using the job planning approach in the new consultant contract and new ways of working facilitated by job evaluation and the Knowledge and Skills Framework in *Agenda for Change*.

We recognise that there is more to do. We will therefore continue to work with stakeholders to develop a robust approach to workforce planning that can deliver a workforce required for the coming years.

DH will review the range of workforce metrics available to provide local and national benchmarking data to underpin the *Better Care, Better Value* indicators. In addition, we will consider the range of workforce improvement tools and develop a framework for workforce productivity to assist local commissioners and providers.

Workforce planning is very much a matter for local NHS organisations. They are best placed to assess the health needs of their local health community and will commission the required number of education and training places to meet those needs. DH closely monitors SHA plans to ensure that they will deliver the activity required within the finance envelope. As part of that approach, DH also expects SHAs to satisfy themselves that local workforce plans are sufficiently robust to deliver local planned service activity within local financial plans.

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

Government response

We take the issue of productivity very seriously. As part of the cross-government Gershon efficiency programme, DH is on target to deliver the required savings of £2.7 billion through our Productive Time programme (for reinvestment in front-line services) by March 2008. We have worked with the NHS Institute for Innovation and Improvement, the NHS and others to provide a range of products and tools to enable front-line services to improve for the benefit of staff, the organisation and patients.

We know that the combination of new pay contracts and Payment by Results is helping to accelerate the rise in day case procedures. However, the new pay contracts have only recently been introduced so it is still too early to assess comprehensively the impact on productivity and the extent to which benefits have been realised. This has been acknowledged by the National Audit Office in its report on the consultant contract, published on 19 April 2007. However, there are positive signs that productivity is improving:

- In 2005/06, activity increased by the same rate as the number of consultants.
- We are seeing improvements in quality across the NHS, including waiting times, mortality rates and Public Service Agreement targets.

- We are on course to achieve the Gershon efficiency target, of which £2.7 billion a year is from front-line service improvements such as reduced length of stay, switching activity to day cases and outpatients and reducing inappropriate treatments.

The new consultant contract provides for flexible working that was not possible previously. For example, in one NHS trust a consultant was able to use the flexibilities to work a three-session day. This allowed previously unused theatre space to be used for an evening elective operating list. This was found to be extremely popular with patients because they could go in after work and be back at work the next day. It also made it possible to use beds that had been freed up by day cases going home in the afternoon and vacating most of them again by the next morning ready for the next day's day cases.

As part of the General Medical Services (GMS) contract negotiations for 2006/07, the British Medical Association and NHS Employers (on behalf of DH) agreed that primary medical care contractors should be subject to the same level of efficiency improvement as that placed on other parts of the NHS. Amendments to the 2006/07 contract, including changes to the Quality and Outcomes Framework and a zero inflationary uplift, are estimated to generate efficiencies of over £400 million or 6% over 2005/06 levels.

Details of the 2007/08 GMS contract have still to be finalised. However, against a backdrop of a zero increase in GP pay recommended by the Review Body on Doctors and Dentists' Remuneration, no new investment in the contract and the ending of a number of enhanced service arrangements, significant further efficiencies and improved value for money are expected. We estimate this to be in excess of £250 million or 3.5%.

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

Government response

The Government supports the need for a flexible and multi-professional workforce. Through local workforce planning and commissioning, SHAs have the ability to develop flexible approaches to education and training. Innovative use of the MPET funding in the NHS will support the commissioning of fit-for-purpose education and training. Ultimately, commissions will be driven by the skills and competences employers require to deliver patient- and public-focused services.

Skills for Health are leading work to ensure that qualifications and educational credit are more accessible and transferable.

The introduction of significant IT-based approaches to education and training is recognised as essential for delivering business continuity and major financial savings in health and social care, whilst simultaneously driving improvements in patient safety and quality of care.

We have already delivered this solution in radiology, through the Radiology Integrated Training Initiative (R-ITI), to international acclaim and with clear financial and quality gains for the NHS. We plan to expand the R-ITI approach across the healthcare sector within a comprehensive e-learning strategy.

In November 2005, the SHAs published a framework document *Supporting best practice in e-learning across the NHS*, to support a sector-wide dialogue around an e-learning strategy and direction of travel. DH subsequently co-sponsored the development of a delivery road map *Modernising healthcare training: e-learning in healthcare services* (April 2006) and the creation of an informal stakeholder group, the UK Alliance for e-Learning in Healthcare, to support and champion the e-learning agenda.

DH, in conjunction with the SHAs and devolved administrations, is taking forward the development of e-learning content. This will provide an extensive database of multi-professional, generic and specialist nationally quality-assured e-learning material, complemented by an e-portfolio. The associated Learner Management System will provide tracking and recording of individuals' career progression and support quality assurance, revalidation, personal development plans and bespoke learning paths for retraining and, where necessary, for remedial support. Initially, content will be provided for the UK healthcare sector, with later extension to social care.

The Modernising Health Care Careers programmes for medicine, nursing and midwifery, allied healthcare professionals and healthcare scientists will deliver a modernised and focused career structure for health professionals.

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

Government response

DH is committed to ensuring that workforce planning is seen as a mainstream activity by all in the NHS, led locally by SHAs. By consolidating the workforce planning across the SHAs rather than the previous 28 Workforce Development Confederations, we have been able to pool expertise more effectively and ensure greater consistency of approach across the country. This will continue in the 10 new SHAs, with workforce planning a mainstream NHS activity.

The new GP contract has realised a number of significant benefits. It is one of the first in the world that puts GPs on performance-related pay. The quality and outcomes framework has led to GPs doing far more preventive work (for example, identifying people with cardiovascular disease and reducing their blood pressure and cholesterol). Care for patients with chronic diseases has improved as a result of the GP contract incentives. NHS patients are now experiencing shorter waits to see a family doctor – almost all patients are now seen within 48 hours, compared with just half in 1997. An independent patient survey, covering 800,000 patients and 2,000 practices, showed improvements in access, quality of consultation and practice services, including health promotion.

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

Government response

The Government agrees with the Committee's conclusion that increasing workforce flexibility is an important priority and that workforce productivity must be improved. The Department is on course to achieve the Gershon target of £6.5 billion by March 2006, including the £2.7 billion from the DH Productive Time programme.

It is important that an integrated approach is taken to developing greater workforce flexibility. Details are still being finalised, but we would expect, for example, the work of the NHS Institute in promoting and providing tools and techniques to support service improvement to continue. The *Better Care, Better Value* indicators are currently being expanded and may include additional measures of skill mix and unit labour costs. DH will also be working with a range of stakeholders (NHS Institute, NHS Employers, NHS Confederation, Workforce Review Team, National Workforce Projects, etc) to provide tools and advice on good practice.

Improved productivity and workforce flexibility, as the report highlights, needs to be underpinned by effective workforce planning and HR interventions, which support well-managed change. For example, the 18 Week programme of work provides an early opportunity to develop, test and promote improved flexibility. DH is working in partnership with SHAs, with national workforce organisations, such as those listed above, and is drawing on the experience of 18 Week early implementer sites in the NHS to support delivery. Workforce development interventions, which have been planned to support this work, include:

- a catalogue of evidence-based case best practice from early implementer and pilot sites;
- an easy-to-use directory of available support and resources;
- a practical step through guide on workforce strategies for commissioners;
- a toolkit for workforce reprofiling and change;
- a mentoring for change leadership initiative, focused on what good 18-week delivery looks like.

We agree with the Health Select Committee's recommendation on the need for an increased primary care workforce. Such an increase is needed to address the growing population and changing age profile; the aim of government policy to deliver more services in a primary care environment; and the changing working patterns of the healthcare workforce.

This increasing demand will be met by a combination of GPs, practice nurses and other healthcare professionals working in a primary care setting. DH is working with the Workforce Review Team to identify the likely service delivery models and to forecast the size of training capacity in the above categories needed in future years.

We also agree with the Committee on the need for high standards of management and leadership. We are already working on improvements in this area. All SHAs during 2007 are required to put in place a development programme to strengthen and broaden NHS senior leadership, combining improved support for people already in senior roles and the achievement of a more diverse leadership community with more clinicians as future chief executives, a better equality mix (race and gender) and more people from outside the NHS.

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

Government response

DH acknowledges that a lot of data is collected and used for a variety of purposes at national and local level. We are committed to keeping information requirements under review. The Review of Central Returns Steering Committee (part of the Information Centre) is charged with the regular and rigorous review of all information requirements. Its approval is required for all business cases for new requests for information collection, including one-off surveys. The criteria for approval are the strength of the business need and the extent of the NHS effort involved in supplying the data.

The *Better Care, Better Value* indicators are a response to the request from the NHS for one set of benchmarking data that can be used for performance management as well as a tool to identify where to focus service improvement. The development of national-level productivity measures and benchmarking tools was outlined in the *NHS in England Operating Framework for 2007/08*. The initial release of the *Better Care, Better Value* indicators contained 13 existing data sources, including four workforce indicators: staff turnover, sickness absence, agency spend and finished consultant episodes (FCEs) per consultant.

DH and the NHS Institute are currently considering the responses to the consultation on the expansion and future development of the *Better Care, Better Value* indicators. This includes consideration of whether activity data will be adjusted for case mix to give a measure of workforce efficiency. We will bear the Committee's view in mind.

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

Government response

DH agrees that the tools within *Agenda for Change* provide an opportunity to increase workforce productivity. *Agenda for Change* makes it easier to develop and pay for skill mix changes either through an enhancement of a role or the development of a new role, for example.

The job evaluation scheme aims to provide a structured method of comparing job demands in order to allocate jobs within the new pay structure. It covers the diverse demands present in NHS posts and is supported by equal pay principles to ensure that all jobs and job holders are treated fairly. In addition, through the Knowledge and Skills Framework (KSF), staff will be rewarded for developing their roles and taking on greater responsibility, providing opportunities for career progression and moving through the new pay band. *Agenda for Change* also introduced appraisal in the form of an annual KSF development review for all non-medical staff and, as part of this process, staff and managers will identify what competencies need to be developed to enable the role to be efficiently carried out. All Skills for Health competencies are linked to the KSF and can also be identified through the development review process.

All *Agenda for Change* posts have a KSF outline which identifies the knowledge and skills required by the postholder in order to deliver a high-quality service. Individual development needs are identified in relation to the outline. This ensures that training is focused on the specific requirements of the service. Training should only be provided where there are clear links to the KSF and the requirements of current or future posts.

DH has also enabled a bi-directional interface between the Electronic Staff Record and e-KSF, which means that it should therefore be possible to measure levels of skills in the workforce against cost on a yearly basis. The Department will look to use this to develop a measure of year-on-year productivity gained.

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

Government response

The recommendations are accepted and the Government has already taken and continues to take action to implement them.

The Quality and Outcomes Framework (QOF) is a pioneering approach to improving quality of patient care through a voluntary incentive scheme. Research by the National Primary Care Research and Development Centre at the University of Manchester (published in the *British Medical Journal* in 2004) showed that significant health gains could result from achieving the quality targets in the QOF. Practices have responded positively towards the QOF, with almost universal participation. The data collected has given us the most comprehensive database anywhere in the world about the prevalence of chronic conditions.

There is already emerging evidence of progress. A survey of 6,000 GPs in the UK, Australia, Canada, Germany, the Netherlands, New Zealand and the US carried out by the Commonwealth Fund and published in November 2006 found that GPs in the UK are leading the world in the use of information technology, management of chronic disease and uptake of financial incentives to improve the quality of services. An independent evaluation by the University of Exeter of the results of patient experience surveys carried out as part of the QOF, covering 800,000 patients and 2,000 practices, showed improvements in access, quality of consultation and practice services, including health promotion. DH has commissioned the University of York to carry out an economic evaluation of the QOF, reporting later this year.

The QOF was reviewed and amended for April 2006 by removing some indicators, moving payment thresholds upwards and recycling 138 points (worth approximately £140 million nationally) from redundant or duplicate indicators. These points have been invested into new clinical areas which will benefit more patients, more directly: palliative care, dementia, depression, chronic kidney disease, atrial fibrillation, obesity and learning disabilities. In addition, 28 points (worth approximately £30 million nationally) were redistributed to change the reward for some existing indicators which were previously not thought to be adequately rewarded. The QOF remains under review to ensure that it follows best practice and reflects new evidence. In future, GPs will be expected to achieve similar levels of efficiency and productivity as other parts of the NHS and public sector.

The QOF is a voluntary part of the GMS contract. It has always been open to PCTs to agree local quality incentive schemes with non-GMS contractors in place of the QOF or to offer local quality incentives in addition to the QOF for GMS contractors. In practice, the vast majority of all general practices take part in the national QOF. As part of the ongoing process of review and development of the QOF, the Government wishes to explore the scope for further flexibility for local commissioners to address local quality issues.

The Government agrees that it is very important for PCTs to manage the QOF assessment process efficiently and effectively. All contractors are required to submit their latest achievement data (including clinical data) and supporting documentary evidence to PCTs as detailed in the contract. This evidence is subject to pre-payment verification checks by the PCT. In addition, QOF assessment visits are carried out by teams of QOF assessors – including clinicians and lay assessors. Finally, there is a systematic counter-fraud check on a random 5% of contractors.

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

Government response

The estimated cost overrun on the consultant contract in 2005/06 represented around 2.3% of the total consultant pay bill that year. In addition, pay settlements have fallen compared with inflation, unplanned earnings drift has fallen and vacancies have fallen to record lows. All of this helps to show that the contract has helped the NHS secure increased consultant activity at a lower cost than under the old arrangements.

It is fair to say that the initial cost of pay reform exceeded DH's initial estimates and, together with stronger than expected recruitment and retention, there has been higher growth in the pay bill than expected. This has contributed to a short-term financial pressure on the NHS but this is not the main reason for deficits, nor does it point to any financial failure of the system.

The new consultant contract was necessary. It addressed fundamental weaknesses in the previous contract including recruitment/retention problems, poor control over outputs, poor control over earnings growth and low (or falling) productivity. We have seen a fall in the vacancy rate for consultant posts, falling from 4.4% in March 2004 to 1.9% in March 2006, demonstrating improved recruitment and retention. This has already provided benefits with the new (and retained) consultant staff making a significant contribution to the reduction of waiting times.

Although it is too early to assess the benefits from the new consultant contract, it is clear that it provides greater clarity for all parties. Since the introduction of the contract in 2003, we have seen an increase in the proportion of time spent on direct clinical care from 68% to 72% and compliance with the European Working Time Directive (51 hours per week down to 44). All of this indicates a better fit between the activity commissioned by PCTs and the trusts' ability to deliver.

We do agree with the Committee that, through agreeing rigorous and detailed objectives, benefits from the contract can be achieved locally. This will be possible through the annual job planning arrangements which are fundamental to the new contract. It will take time to see the effects and it is still too early to judge, as agreed by the National Audit Office in their report on the consultant contract published on 19 April 2007.

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

Government response

DH agrees that having consistent data to compare the activity rates of consultants is important.

In December 2002, DH wrote to trusts with surgical specialties to share the initial results of a pilot exercise that looked at the potential for using Hospital Episode Statistics (HES) data to determine the variation in activity rates of NHS consultants. Following this, we commissioned the University of York to develop a second pilot analysis using HES data that clinicians and managers can use to examine activity rates in their trust. *Delivering Quality and Value: Consultant Clinical Activity* was published in July 2006 using 2004/05 HES data for five medical (general medicine, gastroenterology, cardiology, paediatric medicine and geriatric medicine) and five surgical (general surgery, urology, trauma and orthopaedics, ear, nose and throat, and ophthalmology) specialties. The anonymised report is available in the DH Library and at www.hesonline.nhs.uk. We have commissioned the Health and Social Care Information Centre to repeat this exercise using 2005/06, 2006/07 and 2007/08 HES data.

In addition, we are currently considering the responses to the consultation on the expansion and future development of the *Better Care, Better Value* indicators. We are looking (in conjunction with the NHS Institute) at potentially developing a unit labour cost indicator. This would enable the NHS to move towards an overall measure of NHS trust productivity (that compares the value of activity produced, based on tariff income, against the relative cost of delivering the activity), rather than presenting a collection of indicators.

A true measure of productivity would take account of the quality of care provided, a point raised by the Committee. While undeniably important, it is extremely difficult to account for quality, and the development of a measure based on output of a trust (rather than outcomes) is an important step in the process of improving measurement of productivity, which is essential to improving productivity itself.

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

Government response

The Government welcomes the Committee's views on increasing workforce flexibility and DH will take these views on board as the review is progressed.

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

Government response

A new service level agreement and accountability framework is being developed to underpin 2007/08 SHA allocations. This will ensure that SHAs are held to account for the training they arrange for students and the NHS workforce, and for developing the workforce needed to deliver services required by patients. We believe 2007/08 allocations should provide sufficient resources to enable SHAs to do this.

The Key Performance Indicators enable year-on-year variations in commissions so long as they are justified against long-term national and local workforce needs, training commission decisions are made in accordance with contractual requirements and there is evidence of advance dialogue with partner universities.

As part of the service level agreement, SHAs are required to provide opportunities for Healthcare Assistant staff at all levels to progress through the skills escalator and into professional training and beyond (including NHS Learning Accounts, NVQs and secondments of healthcare assistants and Allied Health Professions helpers onto training programmes). In addition, they should provide investment and opportunities for staff to receive appropriate training to enable implementation of new ways of working to support new roles, especially where they are designed to improve cost effectiveness, productivity and skill mix and support the delivery of key Public Service Agreement targets and White Paper commitments.

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

Government response

We agree with the Committee's view that primary care is important in the delivery of reform. We are developing new roles, including the underpinning education and training, with a primary care focus to deliver services closer to home.

A range of actions are already taking place at different levels to support the NHS and ensure that education is in place as services are redesigned. For example, the DH Shifting Care Board will publish a series of reports in June this year setting out the implications for the nursing workforce. This will be analysed with stakeholders, including trade unions, to identify potential action.

An evaluation project has been funded to identify ways of enabling newly qualified nurses to obtain employment in primary and community care. Several examples of good practice across the country have been highlighted. These include rotation programmes across acute and community care, which enable new nurses to be supported into posts. This project is now being updated, secondary data is being sought to establish its success and good practice is being shared.

Within Modernising Nursing Careers (MNC) the focus is on primary and community settings as the prime setting for practice. This will impact on pre-registration training, as well as post-registration and specialist and advanced practitioner programmes. We are currently working with the Nursing and Midwifery Council and others to take this forward. Detailed plans for consultation are likely to be ready by December 2007. The Royal College of Nursing is heavily engaged in all aspects of MNC and they will be crucial to affecting a shift in thinking and communicating changes to the profession and wider public.

The Government's Chief Nursing Officer hosted a national education summit for key stakeholders on 13 February 2006 to review nurse education. A series of regional workshops took place in March and April to consider how new career paths with clear educational and regulatory requirements can be built around care pathways.

Nurses involved in the DH Care Closer to Home demonstrator sites participated in a workshop which explored the factors that eased their move from hospital to community settings. The nurses represented a variety of services and their experience of relocating into the community offers an important insight into how we can prepare nurses in the future. The outcomes of the demonstrator sites will provide examples of good practice to share across the NHS to help the development of movement from hospital to community settings.

We are developing a framework, due for publication in 2007, for healthcare scientists delivering and supporting services closer to home, which includes workforce development needs.

In the Modernising Scientific Careers project, we are embedding in both pre- and post-registration education and training the requirements to deliver scientific services, including interpretation, to support primary care.

For medicine, over 50% of trainees in England on the Foundation Programme (the first stage of postgraduate medical training following graduation from medical school – introduced in 2005) now undertake a four-month placement in a primary care setting. This is designed to both ensure more doctors gain exposure to primary care and to help boost recruitment to general practice training. Opportunities for more specialty training in primary care settings would need to be facilitated locally through SHA/postgraduate deanery networks.

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

Government response

The Government agrees with the Committee on the importance of high quality management and leadership. Indeed, improving and developing NHS leadership is one of the NHS Chief Executive's three early priorities for 2007.

All SHAs during 2007 are required to put in place a development programme to strengthen and broaden NHS senior leadership, improved support for people already in senior roles with combining and achieving a more diverse leadership community with more clinicians as future Chief Executives, a better equality mix (race and gender) and more people from outside the NHS.

Significant work is also currently being carried out by the NHS Institute for Innovation and Improvement that contributes to the improvement of management and leadership capability and includes:

- Building leadership capacity
  Graduate schemes – annual recruitment of around 220 graduates into the NHS, with the opportunity to specialise in general management, HR or finance.

  Gateway to Leadership – annual recruitment and development of around 40 leaders from other sectors into management positions within the NHS. This is an important source of talent in the NHS.

  Breaking Through – development programmes for around 200 black and minority ethnic staff each year who aspire to more senior leadership positions within the NHS.

- Building leadership capability
  Board-level development – providing development opportunities for around 3,000 senior leaders across the NHS, targeted both at individuals and whole boards.

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

Government response

NHS leadership is one of the NHS Chief Executive's three early priorities for 2007. He is keen to achieve a more diverse leadership community with more clinicians as future senior general managers.

The Department is sponsoring a project called Enhancing Engagement in Medical Leadership, being run by the Academy of Medical Royal Colleges in association with the NHS Institute for Innovation and Improvement. The project goals are to:

- create a culture of greater medical engagement in management and leadership with all doctors at every level;
- identify and disseminate examples of best practice of medical engagement in management and leadership;
- develop an integrated medical management and leadership competency, education and assessment framework shared and endorsed by all appropriate medical professional and regulatory bodies; and
- create clearer links with management and leadership in other health professions and social care through inter-professional activity and work done on competency frameworks by the two sector skills councils.

The NHS Clinical Leaders Network was set up just over a year ago and has recruited a number of senior clinical leaders (representing clinicians and allied healthcare professionals). Clinical engagement in leadership and management activities will help to ensure that a clinical perspective is integral to all aspects of NHS reform initiatives.

Work is also being undertaken by other organisations such as the King's Fund, British Association of Medical Managers and the Royal College of Nursing to provide training programmes for clinicians specifically designed to develop managerial skills and transformational leadership behaviours. DH welcomes these initiatives and believes that proactive work such as this will have a long-term benefit for the development of leadership in the NHS.

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

Government response

We agree with the Committee that long-term workforce planning is an essential component of strategic change. That is why there were specific targets in the *NHS Plan* aimed at improving workforce capacity and why DH supported the NHS to deliver an increased workforce.

We have a devolved approach to planning the workforce that ensures local employers and national planners work together alongside local stakeholders. Each local employer should make plans for their workforce based upon the needs of patients. Those plans need to be informed by the health needs assessments and service commissioning approach of local PCTs. SHAs play a vital role in co-ordinating workforce, activity and finance plans. That is why DH will continue to work with SHAs to ensure that local and national workforce needs are fully integrated.

For example, DH is currently developing a Framework for Transformation and Improvement to assist managers in responding to current and future Estates and Facilities Management (E&FM) workforce issues. In the E&FM profession, the opportunity to influence and impact on the delivery of patient services has never been greater and the need to ensure that the right staff with the right skills in the right place at the right time has never been more important.

The Framework is a robust mechanism for ensuring both practical and transformational change, which can be underpinned by applied learning in the form of modules from the Managing Health and Social Care programme. It will support and inform strategic planning, including training, succession planning, and recruitment and retention of the E&FM workforce, helping planners to identify:

- current skills within their organisations;
- the percentage of staff that will retire over the next ten years;
- the potential risk of skills shortages to meet demands, caused by the loss of an experienced workforce; and
- how future gaps might be filled.

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

Government response

We agree with the Committee about the importance of long-term workforce planning and the need for good quality information. However, it should be remembered that Local Delivery Plans are not primarily workforce plans. They are plans to deliver the service targets in the Public Service Agreements and the workforce plans are to support delivery of those service targets. It is important when planning local service changes that all local NHS organisations work together to ensure an appropriate workforce is in place to deliver the services being planned.

DH believes that robust workforce planning needs to bring together both top-down and bottom-up information and analysis to provide clear information to ensure that short-term and long-term implications are clear on the development and supply of people and skills. We will take the views of the Committee in this area into consideration when working with local NHS providers/commissioners and SHAs to bring local and national needs together into robust workforce plans.

We accept that going forward there are still issues to be addressed to improve workforce planning. That is why we will be concentrating on supporting the development of capability and capacity within the NHS, ensuring workforce planning can react to changing demands/technology and integrating planning across the plurality of providers. The last few years have focused on building up the workforce; the immediate future will be about improving productivity, services and staff engagement.

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

Government response

The Committee are right to point to the importance of an integrated approach to workforce planning. Some processes are in place with the aim of achieving this and we will take on board the views of the Committee to find ways of making improvements to the system. An example of the approach we are developing is the cross-cutting third sector programme overseen by a Delivery Board chaired by a DH Minister.

Since 1997, NHS workforce capacity has increased to levels where we are now able to see the demand for staff equalling domestic supply. Now that the capacity issue has been addressed, we agree with the Committee's view that there is a need to include incentives within the workforce planning system to improve productivity. Improved productivity and workforce flexibility, as the report highlights, need to be underpinned by effective workforce planning and HR interventions which support well managed change. For example, the 18 Week programme of work provides an early opportunity to develop, test and promote improved flexibility, and the workforce development interventions planned to support this work will include:

- a catalogue of evidence-based case best practice from early implementer and pilot sites;
- an easy-to-use directory of available support and resources;
- a practical step-through guide on workforce strategies for commissioners;
- a toolkit for workforce re-profiling and change; and
- a Mentoring for Change leadership initiative, focused on what good 18 week delivery looks like.

DH will continue to take a national overview of aggregated local workforce plans and work with SHAs to ensure that policy developments and national trends are understood and built into local and SHA workforce planning. It is also DH's role to set the national framework for working with the key stakeholders, including higher education.

Monitor will continue to work with NHS Foundation Trusts to ensure that organisations operate in an economic, efficient and effective manner and meet the requirements for governance, financial stability and delivery of essential NHS services. Monitor authorises trusts on the basis of a five-year business plan. NHS Foundation Trusts are also subject to close financial scrutiny by Monitor. The fact that the workforce forms a major part of the cost base of NHS organisations should mean that workforce and financial planning are closely integrated in NHS Foundation Trusts.

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

Government response

The Committee are right to conclude that workforce planning should take account of the whole workforce. We would go further. It is equally important to have a clear and complementary picture of individual staff groups. Data and analysis need to cover both. That is why the Workforce Review Team are planning to produce a more focused workforce risk assessment this summer rather than the more detailed recommendations they have produced in recent years.

We do not accept that DH has not made it clear to SHAs that money can be transferred between medical and non-medical training pots, nor that there is currently confusion over whether this is the case. We published *Investment and Reform for NHS Staff – Taking Forward the NHS Plan* in February 2001 and said in paragraph 2.6:

"The NHS Plan commits the NHS to breaking down such outdated demarcations between staff. From April 2001, we are bringing together the three NHS funding streams into a single Multi Professional Education and Training Levy (MPET). This will enable resources to be used more flexibly to support multi-disciplinary learning and workforce development, for example, through the provision of common library and IT facilities."

Furthermore, when we issue the annual MPET allocations to SHAs, the covering letter explicitly states that "allocations for the individual MPET funding streams are purely indicative and SHAs must use the money as they feel best supports the local needs and priorities".

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

Government response

We agree with the Committee's statements on the value of integrated workforce planning across all sectors delivering services to NHS patients. Contracts for independent sector treatment centres (ISTCs) – which are negotiated centrally by DH – require ISTC providers to work with the NHS if requested on workforce planning.

The independent sector currently accounts for a relatively small but significant proportion of total provision of services to NHS patients. For example, it is estimated that around 8% of total NHS elective activity will be undertaken in the independent sector by 2009/10. The proportion of such provision in future will be determined by the choices made by patients and those who commission services locally on their behalf.

DH has established a formal, cross-cutting third sector programme overseen by a Third Sector and Social Enterprise Delivery Board, chaired by a DH Minister. The Board includes representatives from the third sector and social enterprise areas, the NHS and local government. The Board will act as the executive decision-making authority within DH to ensure that the necessary action is taken across all relevant DH programmes (including workforce programmes) to deliver a consistent approach on how private and voluntary sector issues are included in wider development decisions.

The Board's objectives include achieving demonstrable improvements in effective partnership working between DH and the third sector at national level and between NHS and local government with the third sector at regional and local level; and to influence capacity-building issues within both the public and third sector and through them achieve improved outcomes for patients, service users and their carers.

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

Government response

DH supports this recommendation. There are no plans at present to alter the arrangements for the commissioning of education and training. Of course, the Higher Education Funding Council for England (HEFCE) retains responsibility for the commissioning of medical, dental and some healthcare science courses and it is important that DH and SHAs work in partnership with them to ensure that the courses they commission are fit for purpose in a reformed health service and support workforce planning objectives.

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

Government response

The Government agrees that it is important to ensure support for newly qualified healthcare professionals in finding suitable employment. That is why, working through the Social Partnership Forum, DH is seeking to put in place national and local action plans to support newly trained staff.

Following ongoing collaborative working through the Social Partnership Forum and events involving stakeholders including DH, NHS Employers and trade unions, an action plan *Maximising employment opportunities for newly qualified healthcare professionals in a changing NHS* was published on 13 April. As a result of that plan, NHS East of England are to assess the feasibility of an employment guarantee scheme for newly qualified healthcare professionals. The study will last for one year and is being officially launched on 15 May. If the study concludes that employment guarantees are a viable option, the nature, length and need for such schemes can be determined across the country.

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

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

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

Government response

The role of DH should be to focus on outcomes and accountability rather than on ensuring a fixed amount of money is spent for a particular purpose regardless of local priorities. A new service level agreement and accountability framework is being developed to underpin 2007/08 SHA allocations. This will ensure that SHAs are held to account for the training they arrange for students and the NHS workforce, and for developing the workforce needed to deliver services required by patients. We believe 2007/08 allocations should provide sufficient resources to enable SHAs to do this.

SHAs have the lead role in developing the local workforce and are expected to work in partnership with local stakeholders in determining numbers of training places to be commissioned. This year, SHAs received notification of budget levels with the publication of the *Operating Framework* at the end of November 2006 to provide time for planning in advance of the new financial year. SHA Chief Executives need to ensure that their organisation has sufficient capacity and capability to discharge their workforce responsibilities effectively.

Work is already under way with stakeholders including trade unions, professional bodies, SHAs and education providers to review and modernise the NHS Bursary. We are working to ensure that the Bursary is as fair as possible for all students and meets the needs of NHS employers.

DH is aware of the need for clinical academics and the evidence that there are declining numbers of professionals choosing this particular career pathway. We welcome the Committee's views on this and can confirm that we are supporting work already under way to address shortages in the medical and dental field. Work is also under way with the United Kingdom Clinical Research Collaboration (UKCRC) on tackling shortages of nurse academics.

Since 2000, the Council of Heads of Medical Schools (CHMS) and the Council of Heads and Deans of Dental Schools (CHDDS) have undertaken a regular (annual since 2003) survey of clinical academic staffing levels in UK medical and dental schools. The most recent data update (for 2005) published in June 2006 shows that, for the first time since data collection began, the number of clinical academic doctors has dropped below 3,000. The number of clinical academic dentists remains critically low.

This issue was addressed in respect of doctors and dentists in a joint Academic Careers Sub-Committee of Modernising Medical Careers and the UKCRC (chaired by Dr Mark Walport). Implementation of the recommendations of that sub-committee is already under way with training schemes launched for the provision of 250 **clinical fellowships** and 100 **clinical lectureships** over five years. HEFCE and DH have also pledged to invest up to £100 million in the creation of 'new blood' senior lectureships. Up to 200 of these posts will be jointly funded by the two organisations over the next 10 years.

Building on the model established for clinical academic careers, the UKCRC, in conjunction with Modernising Nursing Careers, is undertaking a similar process aimed at developing clinical academic and research career structures for nurses. The UKCRC Sub-Committee for Nurses in Clinical Research (Workforce) is investigating the barriers that stand in the way of nurses undertaking research careers, and making recommendations for a training and support structure for nurses to work as researchers and educators at different stages in their career. Final recommendations are not yet available.

Pathology has seen an increase in clinical academic numbers, approximately 19% since 2004, due to the success of the Royal College of Pathologists and DH initiative to establish Senior House Officer histopathology training schools around the UK.

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

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

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

Government response

We agree with the Committee that SHAs are central to workforce planning. As part of the normal performance management role, DH will monitor SHAs in not only their workforce planning role but also their management of the local NHS system. DH will work with all SHA Workforce Directors to consider the appropriate action required to follow through on the Committee's recommendations. This may take the form of local action plans. In addition, we will continue to take a national overview of aggregated local workforce plans and work with SHAs to ensure that policy developments and national trends are understood and built into local and SHA workforce planning.

The Workforce Review Team will work with SHAs individually and collectively to improve the quality of analysis of workforce trends and support the integration of financial, service and workforce planning. In addition, the Workforce Review Team have expressed a desire to help SHAs develop local action plans to address issues raised by the Committee.

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

Government response

The Government endorses the views of the Committee on the role of SHAs in the workforce planning arrangements. They will have access to reliable information on the workforce as implementation of the new Electronic Staff Record (ESR) system is completed across the NHS by April 2008. ESR as an integrated workforce management system will deliver accurate and timely information about workforce numbers, skills and costs across England. This will result in leaner, more informed decision making with regard to the NHS workforce. Information from NHS organisations will be contained within a national data warehouse, enabling national (and therefore local) data to be extracted to inform planning decisions.

DH's Director General of Workforce recognises the need to ensure that the NHS has a high-performing cadre of leaders who have the right skills to capitalise on the benefits offered by NHS reforms and to empower and motivate all staff to deliver excellent services. This needs to be informed by a clear understanding of the issues that matter to both staff and patients, and a process is under way to identify those issues.

One way in which NHS leadership will be strengthened and made more diverse will be through each SHA establishing, during 2007, a leadership development programme. This will help to improve support for people already in senior roles including Workforce Directors within SHAs. It will also help to develop a more diverse leadership community within the NHS, including more clinicians as future Chief Executives, a better equality mix (race and gender), and more people from outside the NHS.

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

Government response

The Government agrees with the Committee that PCTs will have a major role to play in defining the workforce in the future. As providers of care, they need to be fully aware of their own workforce needs, but as commissioners of services they have a responsibility to ensure that the appropriate workforce is in place to deliver the services to meet the needs of their population.

PCTs will have access to ESR data on workforce and will need to work closely with SHAs to ensure robust local planning decisions can be made.

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

Government response

The Government agrees that all providers of NHS services have a vital role to play in workforce planning and development. As with all NHS providers, NHS Foundation Trusts are key stakeholders in workforce planning and development and have a direct interest in building and developing the future NHS workforce to deliver improved services according to national standards.

PCTs as commissioners of NHS services also have a major role to play in workforce planning. PCTs hold the purse strings and make decisions on service investment on behalf of patients. They need to be satisfied that as services are commissioned there is an appropriate workforce in place to deliver that service. That is why we will be ensuring consistent messages are provided at every opportunity with regard to the role of PCTs.

Reliable workforce data will be available from the ESR system to provide complete, accurate, up-to-date and consistent information. Such a wealth of data enables strategic planning to be underpinned by facts rather than opinions and half-truths.

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

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

Government response

The Government agrees with the Committee on the role of these organisations in workforce planning. The 18 Week programme of workforce development is a good example of how DH is working in partnership with other national workforce organisations to ensure that the support which these organisations provide to the NHS is well co-ordinated, complementary and tailored to address workforce development needs which the NHS has identified.

In this case, the programme of work has been designed by creating opportunities for joint planning and dialogue between the national workforce organisations, SHAs, PCTs and trusts, drawing in particular on the experience of early implementer sites in the NHS to ensure that the workforce development support offered by the national organisations is fit for purpose.

Close liaison has also taken place with the 18 Week Taskforce to integrate the workforce development support with service improvement initiatives and the overall programme of support which DH is providing to the NHS.

DH will continue to work closely with all stakeholders to ensure local and national workforce planning is delivered in a consistent manner.

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

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

Government response

We agree with the Committee that DH has a lead role in strategic workforce planning and development. SHAs will continue to lead at a local level to ensure service modernisation and improvement is supported by an appropriate workforce. DH has a clear view that, at a national level, our role is to provide a national framework, facilitate the development of tools and support sharing of good practice to make a difference locally.

This is already the position with the delivery of accurate and timely data on the workforce at a national and local level. We have developed and are now supporting the implementation of the Electronic Staff Record (ESR) system across the country to provide timely access to national and consistent workforce data. For example, the ESR Data Warehouse (a database populated from the ESR) will provide full access nationally to specific workforce data in relation to workforce composition, movement, skills, absence management, vacancies, payroll/earnings, career management and training attendance. By using a single system, there will be a greater consistency and coherence of information across NHS organisations, and it will be accessible to SHAs.

The Government believes that, like all NHS organisations, NHS Foundation Trusts should define and plan their long-term supply of a skilled workforce carefully. However, as autonomous corporations, NHS Foundation Trusts are free from central government direction or SHA performance management. They are responsible for managing their own budgets, setting their own strategies, making their own decisions and assessing and managing risk. Directors are responsible for the performance and success of the organisation and should have latitude to develop their own systems to ensure effective, integrated workforce planning. The Government supports NHS Foundation Trusts in engendering good local relationships and adopting a collaborative approach to effective workforce planning with SHAs.

The Government has had an ethical recruitment policy since 2000 and published a strengthened version in 2004 to which much of the private sector signed up in a groundbreaking agreement. The UK has led the way in developing an ethical approach to overseas healthcare professional recruitment and the EU and the Global Healthcare Forum are now following suit with their own ethical codes of practice. Reaching a situation where domestic supply meets demand, which leads to a lower need to recruit from overseas (including developing countries) is in line with the recommendation contained in the World Health Organisation report of April 2006 entitled 'Working together for Health'.

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

Government response

It is true that between 1997 and 2005 there were significant increases in the number of staff working in the NHS and the number of students training to become health professionals. When we launched the *NHS Plan* in 2000, the public made clear that their top priority was to have more staff working in the NHS. We now have over 280,000 more staff working in the NHS in England than in 1997. This has helped improve the delivery of treatment and care across the NHS and has driven down waiting times. For example, in March 1997, over 283,000 patients were waiting over six months for an operation from the decision to admit date. At the end of February 2007 the number of patients waiting more than six months had fallen to 378, a reduction of over 280,000 since 1997.

However, we do not agree with the Committee's interpretation of this as boom turning to bust. It must be remembered that the increases identified in the *NHS Plan* were not the only workforce improvements we were aiming for. In addition to the *NHS Plan* (20,000 more nurses and midwives by 2004 over the 1999 baseline), there was the Manifesto commitment in 2001 (for 20,000 more nurses and midwives over the 2000 baseline by 2005) and a commitment in *Delivering the NHS Plan* (for at least 35,000 more nurses and midwives by 2008 over the 2001 baseline). All of these commitments were for a minimum increase and were never meant to be maximum ceilings for recruitment. We are now moving away from annual growth in the NHS workforce to a steady state where there is a closer match between affordable demand and supply. The focus now is on strengthening front-line capacity through increases in productivity and skill mix.

There are still jobs for newly qualified staff in the NHS but, as a consequence of the measures to reduce vacancy rates, there is much more competition. This situation varies across the country and in different clinical specialties. We still need more newly qualified staff to replace those who retire or take career breaks, but graduates will not always be able to find the job they want in the location they want and may need to be more flexible.

The Social Partnership Forum Action Plan *Maximising employment opportunities for newly qualified healthcare professionals in a changing NHS* was launched as a joint publication between NHS Employers, DH and NHS trade unions on 13 April 2007. The plan sets out a series of recommendations and actions for SHAs to support newly qualified professionals in finding suitable employment. The latest data we have from SHAs shows that 67% of new qualifiers who left training between May and September 2006 have now secured a post in the NHS.

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

Government response

We do not agree that little happened in the area of productivity. The improvements in pay, particularly as a result of *Agenda for Change* and the new consultant contract, were designed to support recruitment and retention as well as support improvements to patient care. New pay arrangements have helped to reduce vacancy rates, which continue to fall, and provide the NHS with clear mechanisms for supporting staff to develop the new skills needed for new services.

The new consultant contract was designed to deliver over time an increase in career earnings of 15% and a reduction in the number of hours worked every week. Reduction in the working week is not only a good thing for patients but it is also necessary to meet European Working Time requirements. The contract has delivered this and the amount of time a consultant spends on direct clinical care has increased as a proportion of time worked since the implementation of the contract – from 68% in 1998 to 72.4% in 2005.

Annual job planning means NHS organisations are able to agree with their consultant workforce a contract that is aligned to the needs of patients as expressed by the PCT commissioners. We accept that the full effects of those changes are not yet clear, but as the recent National Audit Office report into the consultant contract published on 19 April 2007 acknowledges, it is still too early to assess productivity in relation to the consultant contract.

The overall aim of workforce productivity should be to improve services for patients. This can be achieved through improved planning (for example, through using the job planning approach in the new consultant contract) and new ways of working facilitated by job evaluation and the Knowledge and Skills Framework in *Agenda for Change*. However, DH recognises there is more to do and will therefore be (1) reviewing the range of workforce metrics available to provide local and national benchmarking data to underpin the *Better Care, Better Value* indicators, (2) reviewing the range of workforce improvement tools, and (3) developing a framework for workforce productivity to assist local commissioners and providers.

We are on target to deliver the required savings of £2.7 billion from the DH Productive Time programme (part of the Gershon efficiency programme) for reinvestment in front-line services by March 2008. DH has worked with the NHS Institute, the NHS and others to provide a range of products and tools to enable front-line services to improve for the benefit of staff, the organisation and the patients.

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

Government response

We agree with the Committee that workforce planning is a major part of healthcare planning as a whole. We do not accept that there has been a failure. The increased NHS capacity has, for example, helped to deliver lower waiting times and the development of new and improved services. There are lessons to learn but we do not accept that there has been a disastrous failure.

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.

Creating a Patient-led NHS stated: "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."

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.

Integration has also 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 and involves links to the NHS to ensure that qualified trainees are 'fit for purpose'.

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

Government response

We agree with the Committee that it is not always possible to know precisely what workforce will be needed in the future for a wide range of reasons. We also agree that this means there will be a need for a flexible workforce which can readily respond to the opportunities and challenges as they arise.

There will be opportunities to improve productivity in the future. DH is on course to achieve the Gershon target of £6.5 billion by March 2006, including the £2.7 billion on Productive Time. This will help the NHS maximise the time spent by clinical, managerial and administrative staff on activities aimed at improving services for patients. In addition, local decision making on workforce planning is itself an incentive to help all local stakeholders achieve the workforce they believe best meets local patient need, which will lead to improved productivity.

One area where DH will be looking for improved efficiency is in reducing variation in performance on, for example, length of stay, building on existing work such as that of the NHS Institute in promoting and providing tools and techniques to support service improvement. The *Better Care, Better Value* indicators will continue to be developed. DH will also be working with a range of stakeholders (NHS Institute, NHS Employers, NHS Confederation, Workforce Review Team, National Workforce Projects, etc) to provide tools and good practice guidance to support NHS organisations in meeting and sustaining activity at national performance levels.

In addition, we believe that service reform, the Foundation Trust programme and Payment by Results will encourage organisations to look at continuous service improvement, leading to improved productivity.

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

Government response

The Government does not agree that there has been boom and bust in recent years. We have seen an increase of almost 280,000 in the workforce since 1997, with around 80,000 more qualified nurses and 35,000 more doctors. This is what the public said they wanted back in 1997, and it has been delivered. The targets in the *NHS Plan*, the 2001 Manifesto and *Delivering the NHS Plan* were minimum increases, not maximums. We are not seeing a bust period, the clinical capacity of the NHS continues to grow and the large numbers of job losses predicted by some have not materialised.

We do support the Committee's recommendation that SHAs should continue to have a lead role in workforce planning. By consolidating the workforce planning across the 10 new SHAs rather than the previous 28 Workforce Development Confederations (WDCs), we are able to pool expertise more effectively and ensure greater consistency of approach across the country.

We also believe that there continues to be a role for DH to provide a national focus for workforce matters and continue to support SHAs and others in developing capability in the important discipline of workforce planning.

43. We propose one key change: workforce planning must become a priority for the health service. In practice, this means a number of straightforward but important improvements. SHAs must recruit as workforce planners people of the highest calibre and ensure that they are supported by staff with the appropriate skills. Most human resources staff do not have these skills. Others organisations, including trusts and the Department of Health, must improve the quality and accuracy of the information they produce on a range of matters, including workforce forecasts, productivity and the cost of new policies. Finally, the Department of Health must stop micromanaging. In addition to ensuring SHAs have information of a high quality, the Department should act in an oversight capacity ensuring that SHAs are giving workforce planning the priority its importance requires. (Paragraph 292)

Government response

We welcome and share the Committee's view that workforce planning should be a priority. Our approach over the last ten years has been to increase workforce capacity to meet the shortages that had built up over time. This has been addressed and the NHS is in a better position now than it was in 1997. The additional capacity has helped to transform the NHS with lower waiting times and more patients treated than ever before.

The overall focus now is improvements in workforce productivity to support further development of services for patients. This can be achieved through improved planning, for example through using the job planning approach in the new consultant contract and new ways of working facilitated by job evaluation and the KSF in *Agenda for Change*.

We recognise that there is more to do. That is why we will continue to work with stakeholders to develop a robust approach to workforce planning that can deliver a workforce required for the coming years.

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