Staffing and human resources in the NHS – facing up to the reform agenda

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CONTENTS

Executive Summary

- In this report we examine the effects of centralised manpower planning which are found to be negative. We then set out a feasible programme for change.
- There are three general defects of the central planning system:
  - Human resources are planned on a silo basis without regard to team building, contrary to the fact that it is impossible to make sensible decisions about medical manpower without regard to other team members and supporting staff that play vital roles in patient care. In primary care, where there is more scope for local initiative in staffing, the chosen mix is now very different from the hospital service with fewer doctors and more practice nurses and support staff. The number of consultants has increased by 70 per cent in the past 10 years while the number of GP's has risen by 10-15 per cent.
  - A total lack of focus on cost and economics. Doctors and other staff represent a major cost yet decisions on staffing levels appear to have been taken without reference to levels of funding. The Department of Health has yet to bring forward long term cost estimates for staffing (and other programmes).
  - An emphasis on quantity rather than quality. Healthcare Commission analysis has shown that inexperienced nurses achieve lower levels of patient satisfaction than a smaller number of experienced nurses.
- These defects are now about to impact on services and on staff ability to deliver care:
  - The combination of a doubling in the number of medical trainees, a low level of retirements and a very tight financial environment means that there is likely to be severe medical unemployment in coming years. There are far more young doctors graduating than the number of funded posts likely to be available. Even before the recent financial problems of the NHS there was clear evidence of a gap between numbers graduating and numbers retiring. Recent financial problems mean that the problem is likely to be brought forward as acute trusts which carry out most of the training are most affected.
  - There are serious shortages in some key areas of staffing. The expansion in staffing has been very patchy with some areas of care likely to have situations of rising workload and declining staff hours. This can be illustrated particularly in areas as diverse as midwifery and in radiotherapy for cancer patients where there will be little change in radiographer hours available.
  - The NHS has much higher rates of sickness absence and lower morale than many smaller independent organisations. The recent Royal College of Nursing report, *At breaking point? A survey of the well being*

and working lives of nurses in 2005, is a striking indictment of the system as it has worked. There is good recent survey evidence that stress levels among nurses have already risen and are now nearly twice as high as in the population generally.

- There is a tendency to exaggerate the increase in human resources in nursing, especially in relation to on-the-ward hospital nursing. Increased entry into training is likely to be accompanied by a higher drop out rate in the early career years and many experienced nurses have moved to new posts as specialist nurses and nurse consultants. The realistic outlook for nursing is one in which there will be little or no increase in experienced staff hours in a situation where nursing care has become much more complex and clinically demanding.

- Centralised silo manpower planning has produced a staffing investment which is unbalanced and unaffordable. We welcome moves towards family-friendly policies and better human resource management as set out in Agenda for Change but such improvements are likely to be undermined by the overall crisis of affordability which is likely to lead both to reduced options for staff in post as well as to further redundancies.

- There is an urgent need for a new approach to human resources which will support reform. The new approach will be driven by elements of the current reform programme:

  - Foundation Trusts, a greater variety of providers and practice based commissioning of new services will drive the system towards much more local and flexible systems of staff roles and pay structures. National agreements will play a declining role, based on defining minima.

  - Payment by results will come increasingly to mean that pay levels will be related to the competitive performance of the local healthcare enterprise.

  - Commissioning which sets quality standards will drive forward innovations in quality of care and will reward higher productivity. Equally, competition can empower staff by rewarding teams which achieve outstanding performance. The centralised NHS still suffers from the old problem of perverse incentives where additional effort or change leads to serious problems with budgets and workload.

  - Foundation Trusts could give a strong lead in developing roles as care boundaries change. Independent treatment centres will also show what can be done through team–working to raise productivity and to provide patients with a one stop shop experience.

- The new NHS human resource approach has to ensure that patients can fully benefit from these changes. There will be a tendency to freeze innovation and to restrain changes which may threaten the hallowed tradition of a job for life.

- The transition will certainly be difficult. It is likely that productivity gains will mean that staff numbers are reduced by at least 10 per cent. This reduction should occur across all generic staff, skilled and unskilled.
- This change will make it possible to improve quality, with more investment in fewer people. One strong gain from reducing the number of hospital beds will be that of concentrating time and available skill on fewer services and giving staff better support.
- In the longer term staff will have gains from more choice, higher morale and greater job satisfaction from working in smaller, more independent organizations. Reform can produce gains for patients but it can also produce gains in control, rewards and job satisfaction for many staff as well.
- This is the first of a series of reports from *Reform* on the opportunities presented by the reform programme in the NHS. We would hope that they will counteract some of the overwhelming gloom and negativity of current comment. For staffing reform could mean a system with flexible, local, initiative and scope for team building which will create much greater job satisfaction and professional pride. Reform can help to ensure that we make full use of the great commitment and ability of so many staff in the NHS, replacing the frustrations caused by the failed system of centralized manpower planning.
- A smaller workforce with more effective support can be empowered to deliver quality in care. A quality approach could also reduce cost pressures and free up funding for new services. We would see a 10 per cent reduction in numbers as a realistic medium term outcome from the new incentives. Such productivity gains reflect the experience of ITCs and of primary care and payment by results will create powerful new incentives to lower costs.

1. Key defects of central manpower planning

There are clear defects to the system of centralised planning which has governed staffing resources in the National Health Service. These include:

- An emphasis on increasing numbers of single categories of staff rather than building teams;
- A lack of emphasis on costs;
- An emphasis on quantity rather than quality.

Human resource planning by silo rather than by team

A sensible and successful manpower strategy will seek to create teams based on both senior doctors and supporting staff. This has been achieved more successfully in primary care, where there is more scope for local initiative in staffing, than in secondary care.

The chosen mix in primary care is now very different from the hospital service with fewer doctors and more practice nurses and support staff. In the past ten years, the number of GPs has risen by 12 per cent. In contrast, the number of consultants has risen by 70 per cent and the number of hospital doctors in training has increased by 50 per cent.

Table 1: Number of doctors, 1994-2004, full time equivalent

	1994	1996	1998	2000	2002	2004	1994-2004 percentage increase
Consultants	16,500	18,600	20,400	22,200	24,800	28,100	70
Hospital registrars	10,600	10,700	11,600	12,200	13,000	16,100	52
Other doctors in training[1]	15,500	17,300	18,500	19,000	20,900	24,500	58
Other medical and dental staff[2]	4,900	5,600	6,400	7,100	8,200	8,600	76
GMPs including registrars	27,500	27,500	27,800	28,200	28,700	30,800	12
All doctors	**76,800**	**81,800**	**86,600**	**90,200**	**97,000**	**109,200**	**42**

Source: Department of Health. NB Figures are rounded and do not include retainers. [1] Includes PRHOs, SHOs, F1 and F2 pilots and equivalents. [2] Includes associate specialists, staff grades and community and public health medicine and dental staff

Some trusts have reduced numbers of support and administrative staff. While this might be politically acceptable in the short term, it reduces the overall capability of the trust in the long term.

The aim should be to enhance professional confidence in a high standard of care. This will require adequate systems of support.

Lack of emphasis on cost

Because UK healthcare is so labour intensive, with total staff numbers now beyond 1.3 million, staffing costs are amongst the most important costs in the system. Total headcount has increased by around 45,000 per year since 1999, indicating that it may reach 1.6 million by 2010.

Table 2: Total NHS staff, 1994-2004, full time equivalent and headcount

	1994	1999	2004
Headcount	1,033,900	1,097,400	1,331,100
Full-time equivalents	835,000	873,200	1,071,200

Source: Department of Health. NB Figures are rounded and do not include retainers

This is particularly the case because the maximum annual salary of a consultant is now approximately £96,000 plus any extra payments for "clinical excellence" which a consultant may be awarded. All consultants are on the same salary structure for pay and conditions of service whatever their specialisation. Simply put, an extra ten consultants on the payroll will cost over £1 million per annum.

Similarly, many GPs now earn in excess of £100,000 per annum. If there were an additional 28,000 doctors by 2015 there would be an additional salary cost of approaching £2 billion.

Despite these costs, there has been a total lack of focus on cost and economics. Previous *Reform* reports have shown that the long term cost pressures on the system have not been adequately measured by the Department of Health. The Department has yet to publish its own estimates of the long term cost pressures.

Reform's latest analysis of NHS finances found that the gap between cost pressures and available funding could reach a total of £7 billion by 2010 without a "productivity miracle".[1] This implies that the current trend to freeze recruitment and cut jobs is likely to get even worse as the deficit mounts up in the forthcoming years. With the very large spending increases

[1] Bosanquet, N., de Zoete, H., Beuhler, E., *The NHS in 2010: reform or bust*, Reform, 2005

enjoyed by the service due to slow considerably after 2008, the NHS will face even more financial pressure in the years ahead.

The Department of Health's latest operating framework stated that the "overall weighted increase across the full tariff in 2006-07" is "1.5 per cent".[2] This increase is much smaller than the 5.3 per cent uplift in the tariff baseline between 2004-05 and 2005-06. It is also considerably smaller than the level of NHS inflation which is running at 4-5 per cent per annum.

Different staff levels and combinations have very different implications for longer term costs in the NHS. Decisions on staff numbers ought to be assessed for their affordability.

Quantity rather than quality

A review of ward staffing by the Healthcare Commission has shown that the quality of nursing staff is the key variable for quality of care rather than simply numbers of nursing:

> "The data also shows that satisfaction of patients and clinical outcomes are linked to trusts spending more money per member of staff, rather than merely employing more staff. This means that it is employing more experienced and skilled staff, as opposed to simply more staff, that has the more positive influence on the experience of the patient. In general, though, it is the trusts that employ more staff that spend more in total on staffing the wards, rather than those that spent more per staff member. Spending more per staff member therefore represents better value for money."[3]

The truth that experience and quality counts for more than quantity applies across medical manpower. Simply put, a manager will benefit more from ten experienced staff than twenty inexperienced staff. This confirms that improving the quality of staff should be the more important policy objective.

Despite this, the emphasis of policy has been to increase quantity rather than quality.

Table 3: Number of nurses, headcount and full-time equivalent, England, 1994-2004

	1994	1999	2004
Headcount	313,200	329,600	397,500
Full-time equivalent	255,000	261,300	315,400

Source: Department of Health Workforce Statistics

[2] *The NHS in England: the operating framework for 2006-07*, Department of Health, 2006
[3] *Ward Staffing*, Healthcare Commission, June 2005

The NHS Plan, in July 2000, made little or no mention of quality of staff. Instead it singled out staff numbers alone:

> "The biggest constraint the NHS faces today is no longer shortage of financial resources. It is shortage of human resources – the doctors, nurses, therapists and other health professionals who keep the NHS going day-in and day-out. Between now and 2004 there will be: 7,500 more consultants; 2,000 more general practitioners; 20,000 more nurses; and over 6,500 more therapists and other health professionals ... We will achieve them by: increasing throughput from training; modernising pay structures and increasing earnings; improving the working lives of staff; and recruiting more staff from abroad."[4]

More recently the Department of Health has placed more emphasis on quality. *The NHS Improvement Plan* stated that new contracts for GPs and consultants, and Agenda for Change, would improve quality and performance:

> "The new primary care contracts ... are based on quality indicators with providers rewarded for outcomes not inputs. This will drive skill-mix as GP practices tailor services with the investment they have to meet local need .... The new contract for consultants ... provides sustained incentives for high quality performance over the course of a career .... The Agenda for Change programme includes rewards for increased knowledge and skills rather than time served."[5]

The aspects of the Agenda for Change programme and the new contracts that place an emphasis on quality are to be welcomed. However, the reforms to UK education and training may fall short in some cases. For example, the shortening of medical training in the Modernising Medical Careers programme could leave some surgeons and medical staff with less experience and training than previously. Modernising Medical Careers relies on the goodwill of large numbers of existing consultants delivering training to students in a six month time frame in different hospitals when there may not be sufficient opportunities for the training to take place.

Training has also been affected by the European Working Time Directive so that contact with the consultant responsible for their training may be reduced. Work patterns have changed and shift systems have been introduced for consultants and junior staff. A recent survey from the Royal College of

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[4] *The NHS Plan*, Department of Health, 2000
[5] *The NHS Improvement Plan, Putting people at the heart of services,* Department of Health, 2004

Physicians of specialist registrars found that 84 per cent considered that the introduction of shifts had worsened continuity of care.[6]

Temporary staff

The Healthcare Commission also showed that a key determinant of patient satisfaction is lower expenditure on bank and agency nursing staff, in particular by scores for a question about the ability of nurses to answer the questions put to them by patients.[7]

This suggests that the dramatic increase in spending on temporary nurses – spending more than doubled in real terms between 1997-98 and 2003-04 – has reduced levels of patient satisfaction.

Table 4: Increased expenditure on temporary NHS nurses and doctors

Year	Temporary nurses, £	Temporary doctors, £	Total, £
1997-98	216,338,567	87,273,079	303,611,646
1998-99	272,225,162	93,524,750	365,749,912
1999-00	361,656,683	106,125,019	467,781,702
2000-01	435,431,882	138,342,148	573,774,030
2001-02	554,323,821	196,057,591	750,381,412
2002-03	589,738,042	278,530,346	868,268,388
2003-04	524,675,129	345,390,918	870,066,047
1997-98 at 2005-06 prices	260,164,846	104,953,025	365,117,871
2003-04 at 2005-06 prices	548,601,455	361,141,495	909,742,950
Real change in expenditure 1997-98 – 2003-04, per cent	**111**	**244**	**149**

Source: *Hansard*, 12 December 2005, Col. 1819WA

[6] *Royal College of Physicians Workforce Survey*, Royal College of Physicians, 2005
[7] *ibid*

2. Medical unemployment

The defects outlined in Chapter One are now about to impact on services and on staff ability to deliver care. A key consequence is approaching increases in medical unemployment.

Rise in training places for doctors

Annual medical school intake grew slowly over the 1990s. After 1999 it rose dramatically to nearly 6,300 in 2005-06. The table below shows the increase in intake, actual output and projected output.

Table 5: Medical school intake, actual output and projected output, England, 1991/92 – 2008/09

Academic Year	Intake	Graduate Output
1991/92	3,191	2,788
1992/93	3,263	2,759
1993/94	3,374	2,866
1994/95	3,514	2,911
1995/96	3,486	2,983
1996/97	3,594	3,025
1997/98	3,749	3,261
1998/99	3,735	3,097
1999/00	3,972	3,373
2000/01	4,300	3,286
2001/02	4,713	3,280
2002/03	5,277	3,522
2003/04	6,030	3,734
2004/05	6,294	3,935
2005/06	6,298[1]	4,394
2006/07		5,083
2007/08		5,676
2008/09		5,798

Source: HEFCE

[1] This figure is provisional until November 2006 when a finalised figure will be declared

As a result there will a dramatic rise in the number of medical graduates per year in the next five years. In academic year 2008-09 there will be 32 per cent more graduating doctors than in academic year 2005-06. Given the 8 per cent attrition rate that is used to predict the future output, future output is likely to plateau at roughly 6,000 from 2007-08 onwards. The medical student intake will stabilise at around 6,300.

Retirement projections for doctors

According to government estimates the number of GPs retiring from the health service in 2010 will only be fractionally lower than the number currently retiring while the number of retiring Hospital and Community Health Service (HCHS) doctors will actually decrease. As a consequence, by 2009 there will be 5,800 doctors graduating but only 2,250 doctors retiring.

Table 6: GP and HCHS doctor retirement projections, 2005-2010

	2005-06	2006-07	2007-08	2008-09	2009-10
GPs[1]	832	833	837	840	846
HCHS doctors[2]	1,602	1,524	1,468	1,435	1,401

[1] GP projections are based on the numbers of GPs forecast to leave the workforce aged 55 and over. They assume that the proportion of leavers in each age group will remain the same as the average number of leavers over the period 1994-2004

[2] The figures show estimates of the current workforce who will leave in each year who in that year will be aged 55 or above. The current workforce is defined as those recorded on the 2004 census. The figures will not include those doctors who join the workforce subsequently to September 2004 who then leave aged 55 or above. That the figures reduce over time may be indicative of the HCHS workforce being more transient than other groups, with an additional number of doctors retiring who are not recorded on the 2004 census

Source: Department of Health

Other medical staff

Other areas of the medical profession will not see such an influx of new medical graduates. For example projected new graduates for nurses and midwives grow only marginally while remaining static for specialist areas such as diagnostic radiographers and therapeutic radiographers.

Table 7: Total projected new graduates, England, by financial year, 2005-10

	2005-06	2006-07	2007-08	2008-09	2009-10
Nurses[1]	17,824	18,708	19,737	19,394	19,394
Midwives[1]	1,185	1,505	1,296	1,205	1,205
Diagnostic radiographers[2]	670	670	670	670	670
Therapeutic radiographers[2]	178	178	178	178	178

[1] Numbers entering training each year will remain at current levels and attrition rate during training is 18 per cent

[2] Numbers entering training each year will remain at current levels and attrition rate during training is 15 per cent

Source: Department of Health

Retirement projections for these staff areas increase slightly over the next five years with the largest increase in the number of nurses retiring. After 2008 there is a significant increase in the number of retiring radiographers.

Table 8: Nursing, midwifery and radiographer retirement projections, England by financial year, 2005-2010

	2005-06	2006-07	2007-08	2008-09	2009-10
Nurses[1]	4,181	4,651	5,163	5,683	6,224
Midwives[1]	457	462	485	512	538
Radiographers[2]	200	200	200	340	340

[1] Nursing and midwifery retirement projections are based on the probability by age group nurses are most likely to retire
[2] Radiographer projections assume a retirement age of 60

Source: Department of Health

Medical unemployment

In a very tight financial environment, medical unemployment is all but inevitable. Alongside a large rise in graduate output there must be a large rise in the number of funded posts available.

The Workforce Review Team recommends that the number of funded posts available should be 12 per cent higher than the English graduate output of each corresponding year. This is to ensure competition for places as doctors from outside England apply for places but also so that all graduates are ensured a job. Given the rise in graduate output, the Workforce Review Team estimates that the number of funded posts needs to rise by 1,768 posts by 2007-08.

Table 9: Funded F1 posts necessary for forthcoming years

Academic Year	Graduate Output	Funded F1 posts necessary for following year
2004-05	3,935	4,589
2005-06	4,394	4,922
2006-07	5,083	5,694
2007-08	5,676	6,357

Source: Allocations of Foundation Year 1 Posts, letter from Professor Graham Winyard, COPMeD Chair, 27 January 2005

Realistically this scenario is unlikely to be met as the funding situation worsens. New medical graduates are already facing serious obstacles to

getting jobs. In its latest recommendation for 2006-07, the Workforce Review Team has noted that there will not only be a slowing in workforce growth but also a reduction in some areas due to financial problems:

> "A small number of SHAs will almost certainly be unable to achieve financial balance in 2005-06 and a further, larger group, will find this very challenging. It is anticipated that the entire first group and many of the second will need to either control or reduce their total workforces. It is likely that such health authorities will also be using MPET allocations to broker recovery plans.
>
> "Many SHAs plan to maintain or reduce staffing levels overall. It is entirely possible that the rate of workforce growth will drop back (rather than slow) in 2006-07 to levels at or below the previous trends. We already have evidence that newly trained staff are having difficulty in finding jobs in a number of specialities and staff groups."[8]

For just qualified doctors the pressure to find jobs is likely to increase dramatically in the next few years as graduate numbers outweigh retirees massively and the financial situation in the NHS causes a dramatic slowing in recruitment and even a reduction in staffing numbers.

Pressures already apparent

Numerous examples of trusts cutting jobs due to financial pressures have been present in the last few months. The Workforce Review Team noted that training budgets are generally the first to be cut in times of financial hardship: "We know that budgets for post-registration training and continuing professional development are particularly vulnerable when funding is tight."[9]

The low increase in the tariff mentioned earlier means a squeeze on the finances of acute trusts and in particular foundation trusts which are most affected by the payment by results mechanism and tariff. Considering that the vast majority of medical graduates are employed in the secondary care sector this restriction on their finances will add to their burden and will decrease their willingness to hire new members of staff.

A survey by the BMA in July 2005 found that 38 per cent of graduates had not been offered a post to start in August 2005 while 87 per cent expressed concern about the availability of training posts within medicine. The Government did raise queries about this survey in particular the number of participants. A January survey of medical graduates from the graduating years 2003, 2004 and 2005 by GfK NOP for the General Medical Council found that 2 per cent of those surveyed did not have a job though they wanted one.

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[8] *Workforce review team recommendations 2006-07: healthcare scientists, allied health professionals, nurses, midwives, doctors, dental teams and pharmacists*, NHS, 2005

[9] *ibid*

This is not a great amount and would indicate that there is only a small amount of pressure on medical graduates at the current moment to find jobs.

A more interesting indicator of the direction and possible future pressure is that the survey looked at the time for graduates to find a job once they had started looking. For the 2005 graduates 57 per cent said it took over a year. This compares to 31 per cent in 2003 and 19 per cent in 2004.[10]

Three month vacancy rates for jobs in the NHS have been on a downward trend indicating that once jobs become available they tend to be taken up more quickly in recent years.

Table 10: Three month vacancy rate excluding doctors in training and equivalents in England, per cent

	2002	2003	2004	2005
All consultants	3.8	4.7	4.4	3.3
Clinical radiology	7.7	7.6	7.5	5.2
GPs	2.7	3.4	3.1	2.4
Nurses	3.1	2.9	2.6	1.9

Source: Department of Health Vacancy Surveys, 2002-2005

There must be a review of medical training plans in the light of the likely shortage of funded posts and the greater than expected recruitment of doctors from outside the UK on a career basis. There is little point in pulling more able young people into training with heavy costs when their employment chances are poor.

[10] *Survey of UK Graduate Doctors January 2006, A research report for the General Medical Council*, GfK NOP Social Research, 2006

3. Shortages of staff

Despite the large increase in the number of nurses over recent years, the Royal Colleges argue that there are still not enough particularly in midwifery. The Royal College of Midwives recently argued that at least 10,000 more midwives were needed to avert a crisis in maternity services.[11]

Table 11: Midwives working full and part time, 1994 and 2004, UK

	Number working full time	Working full time, per cent	Number working part time	Working part time, per cent	Total number of working midwives
1994	20,889	59.5	14,238	40.5	35,127
2004	12,999	38.6	20,688	61.4	33,687

Source: Statistical Analysis of the Register, Nursing and Midwifery Council, August 2005

Reform's recent publication – *Maternity services in the NHS* – found that while the number of midwives has changed little over the last 30 years the number of midwife hours worked had fallen by 14 per cent. This is due to a shift from full-time to part-time working by midwives. At the same time the responsibilities and workload of midwives has increased.[12]

Table 12: Number of working midwife hours per week, UK

	1994	2004	Change	Percentage change
Full time hours per week	783,338	487,463	-295,875	-37.8
Part time hours per week	320,355	465,480	+145,125	+45.3
Total hours per week	**1,103,693**	**952,943**	**-150,750**	**-13.7**

Source: Statistical Analysis of the register, Nursing and Midwifery Council, August 2005
Assumptions: full time hours per week = 37.5; part-time median hours per week = 22.5

Another area of severe staff shortage is radiography. One analysis by leading oncologists found that long waiting times for radiotherapy were due to staff shortages.[13] The Royal College of Radiologists latest audit showed over half of patients waited longer than the recommended waiting time of a month. Waits had shown an improvement since 2003 but they are still worse than in 1997. It recommended "a planned programme of national investment in staff, recruitment and training" so as to meet this problem.[14]

[11] *The Independent*, 20 February 2006
[12] Bosanquet, N., Ferry, J., Lees, C., Thornton, J., *Maternity Services in the NHS*, Reform, 2005
[13] Dodwell, D., Crellin, A., *Waiting for radiotherapy,* British Medical Journal, Jan 2006
[14] *Re-audit of Radiotherapy Waiting Times 2005,* Royal College of Radiologists, 2005

Deprived areas

There have been vacancies for GPs in deprived areas for many years. In 2003-2004 some 424 GP vacancies were reported in London alone, and areas such as mental health also have difficulties recruiting sufficient staff.[15] These shortages are long standing and threaten the improvements the Government says it wants.

Where there are long-running recruitment problems there would appear to be a failure of the planning system. These vacancies are for a whole range of staff when one includes professions allied to medicine such as radiographers and physiotherapists. The worst cases of staff shortages do not appear to have been energetically addressed. The quality of patient care, especially with cancer patients and the mentally ill has been found wanting and it is reasonable to state that the idea of successfully planning numbers in this way is doomed to failure.

Part of the reasoning behind the Government 's latest White Paper, *Our health, our care, our say*, was to use other providers, such as the independent and voluntary sector to get GP and health care provision into areas which have historically lacked such services. The White Paper said:

> "There are persistent and particular problems in deprived areas which have long been under-served. We intend to increase provision in areas that are not well served – which are typically the most needy areas – to increase the equity of provision and to ensure that everyone has a real choice ….
>
> "The distribution of general practice has been uneven since the beginning of the NHS. Research also shows that those areas with poorest health outcomes are also those with the fewest GPs. The variation is quite large. The PCTs that had the most GPs per 100,000 weighted population had more than double that of the least."[16]

[15] Hutt, R., Buchan, J., *Trends in London's NHS workforce*, King's Fund, 2005
[16] *Our health, our care, our say*, Department of Health, January 2006

4. Morale

The centralised structure of the NHS has meant that some staff have little freedom in the workplace. Sickness and absence rates have been higher in the health service than in smaller independent organisations.

A recent Royal College of Nursing survey found that "psychological wellbeing" for nurses – as measured by the CORE Outcome Measure – has decreased since 2000 and stress is now nearly twice as high as for the general population. The survey also found that nurses find NHS hospitals more stressful than independent ones in terms of workload demands, employee control, workplace support, working relationships, understanding of role in work and communication of organisational changes at work. "Psychological wellbeing" of nurses working in the independent sector is a quarter higher than those working in the NHS according to the CORE Outcome Measure.[17]

The Healthcare Commission's review of ward staffing, published in 2005, found very high levels of sickness absence for nurses. The average time lost to sickness equated to 16.8 days per staff member.[18] This amounts to an annual cost of £275 million.

This is very high compared to other public sector workforces. In 2004, the Cabinet Office found that the average across seven sectors (civil service, local government, police, teachers, social services, health and the prison service) is only 11.3 days per employee, which is substantially lower than that found for the ward workforce.[19]

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[17] *At breaking point? A survey of the wellbeing and working lives of nurses in 2005,* Royal College of Nursing, 2006

[18] *Ward Staffing*, Healthcare Commission, June 2005

[19] *Managing sickness absence in the public sector*, A Joint Review by the Ministerial Task Force for Health, Safety and Productivity and the Cabinet Office, November 2004

5. Recommendations

There is an urgent need for a new approach to human resources which will support reform. The new approach will be driven by elements of the current reform programme:

- Foundation Trusts, a greater variety of providers and practice based commissioning of new services will drive the system towards much more local and flexible systems of staff roles and pay structures. National agreements will play a declining role, based on defining minima.
- Payment by results will come increasingly to mean that pay levels will be related to the competitive performance of the local healthcare enterprise.
- Commissioning which sets quality standards will drive forward innovations in quality of care and will reward higher productivity. Equally, competition can empower staff by rewarding teams which achieve outstanding performance. The centralised NHS still suffers from the old problem of perverse incentives where additional effort or change leads to serious problems with budgets and workload.
- Foundation Trusts could give a strong lead in developing roles as care boundaries change. Independent treatment centres will also show what can be done through team–working to raise productivity and to provide patients with a one stop shop experience.
- The current path of the NHS is towards a patient-led integrated system of care with much greater levels of care being provided outside of the acute secondary sector in more efficient local units. Staff will move between NHS providers, voluntary sector providers as well as the independent sector. Specialist doctors will no longer be placed in one location for the entirety of their contracts.

An important option is whether or not to allow Trusts to vary the contractual arrangements for consultants so that there is both greater flexibility and some incentives. The new contract pays all consultant staff on a fairly rigid salary structure whatever the speciality or demands of the workload. As a consequence there are shortages in crucial areas such as radiology but no means of encouraging more consultants to enter the speciality. If Trusts are to meet the demands which will be placed upon them in terms of treatment times then they need to be able to adjust the consultant contract and be able to incentivise their medical staff.

The new NHS human resource approach has to ensure that patients can have the full benefit from these changes. There will be a tendency to freeze innovation and to restrain changes which may threaten the hallowed tradition of a job for life.

The transition will certainly be difficult. It is likely that productivity gains will mean that staff numbers are reduced by at least 10 per cent, representing a sharp change in policy direction. This reduction should occur across all

generic staff, skilled and unskilled. This is not a centrally directed manpower prescription but instead a recommendation based on possible productivity gains.

This approach is consistent with the new emphasis on productivity and value for money. Crucially, it will also make it possible to improve quality. One strong gain from reducing the number of hospital beds will be that of concentrating time and available skill on fewer services and giving staff better support.

In the longer term staff will gain from more choice, higher morale and greater job satisfaction from working in smaller, more independent organizations. Reform can produce gains for patients but it can also produce gains in control, rewards and job satisfaction for many staff as well.

This is the first of a series of reports from *Reform* on the opportunities presented by the reform programme in the NHS. We would hope that they will counteract some of the overwhelming gloom and negativity of current comment. For staffing reform could mean a system with flexible, local, initiative and scope for team building which will create much greater job satisfaction and professional pride. Reform can help to ensure that we make full use of the great commitment and ability of so many staff in the NHS, replacing the frustrations caused by the failed system of centralized manpower planning.

A smaller workforce with more effective support can be empowered to deliver quality in care. A quality approach could also reduce cost pressures and free up funding for new services. We would see a 10 per cent reduction in numbers as a realistic medium term outcome from the new incentives. Such productivity gains reflect the experience of ITCs and of primary care and payment by results will create powerful new incentives to lower costs.

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