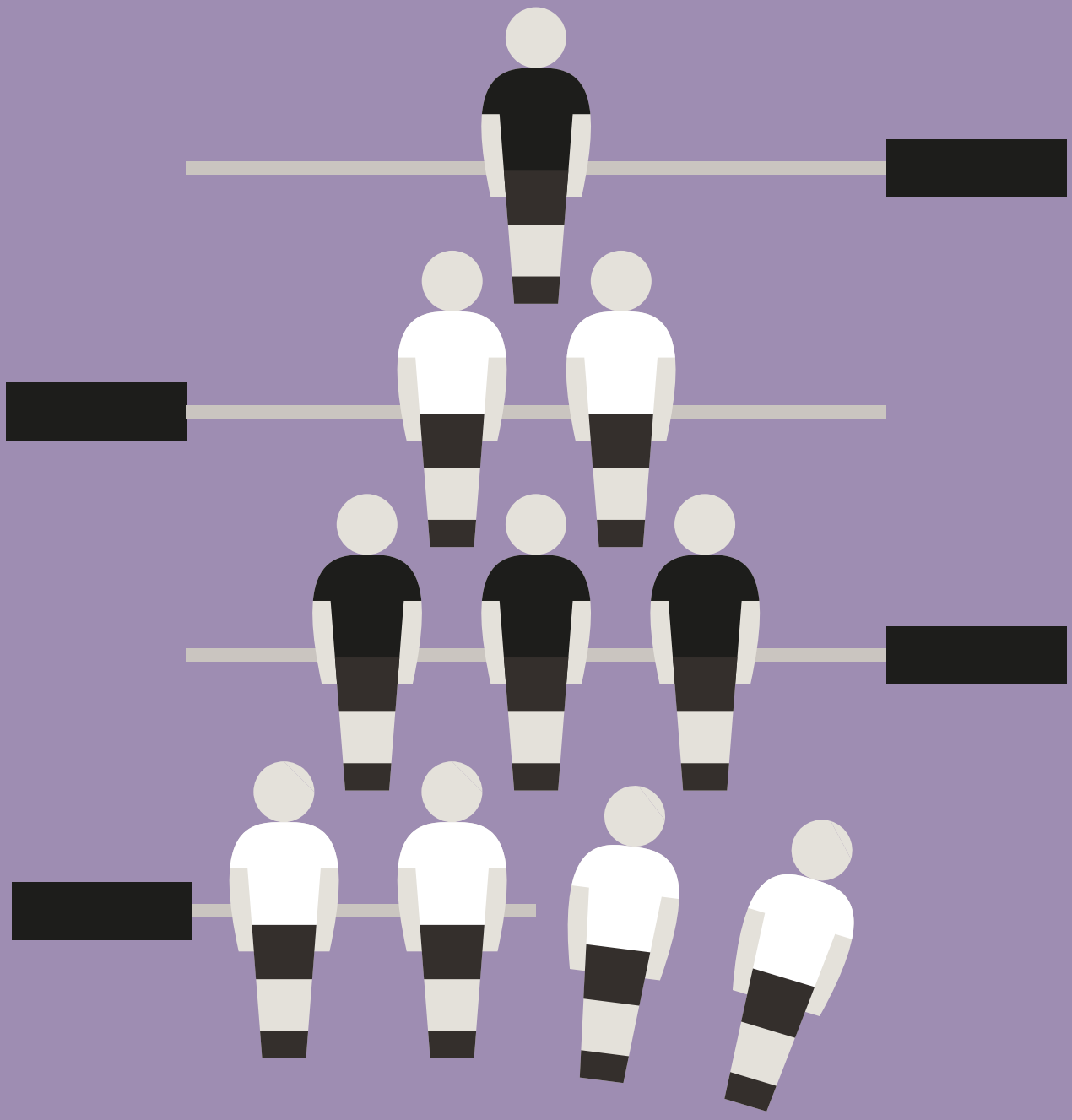
Analysis

March 2016

Fit for purpose?

Workforce policy in the English NHS



The Health Foundation

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The size, scale and diversity of the NHS workforce — at a glance

1.4m

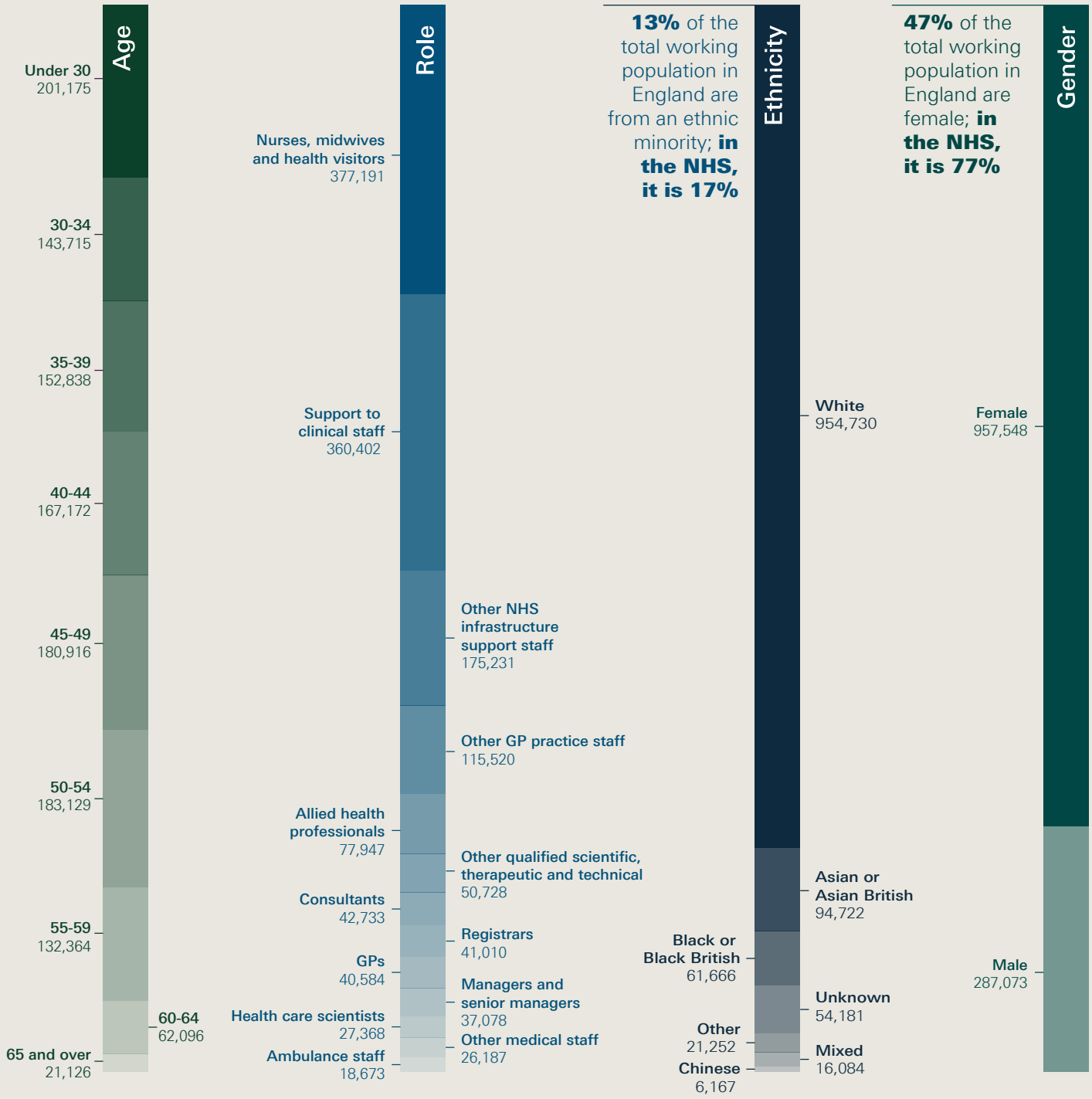
The NHS in England employs 1.4 million people

£48bn

In 2014/15, NHS providers spent £48bn on staff costs; 63% of their total expenditure

5%

About 5% of everyone working in England is working for the NHS



Source: HSCIC. *NHS Workforce: Summary of staff in the NHS.* HSCIC, 2014. www.hscic.gov.uk/catalogue/PUB16933/nhs-staf-2004-2014-over-rep.pdf

Please note: *Age, gender and ethnicity figures exclude 144,126 GP registrars and other GP staff for whom we do not have age and gender information. We also do not have ethnicity data for GP practices at all, therefore the totals will not add up. Role totals do not sum to NHS staff total due to HSCIC figures.*

Contents

Overview and key points

Overview

Health care is a people business. The 1.4 million people who work in the English NHS are its greatest asset. As modern health care becomes ever more complex, designing effective 'workforce policy' – how the health service plans, trains, regulates, pays and supports its people to ensure affordable, good quality care – is one of the central challenges facing our system today.

This challenge has to be met nationally through strategic leadership, policy formation and planning, but equally depends on good leadership, engagement, and management locally.

This report gives an overview of the components of workforce policy in the English NHS and the bodies which shape it. The report proposes ways in which workforce policy could be strengthened to improve the quality and productivity of care.

Key points

- Workforce is a relatively neglected area of policy which is often pursued as an afterthought, with important clinical, operational and financial impacts on the front line.
- Workforce policy has tended to focus on contractual and financial incentives to encourage NHS staff to improve performance or productivity. Insufficient attention is being paid to equally important factors – staff engagement, work-life balance, stress, morale and supportive management – which are critical to the recruitment and retention of staff, as well as the quality of care that patients experience. Working with the grain of the intrinsic personal and professional motivation of staff is likely to deliver faster and more sustainable change.
- The key elements of workforce policy – workforce planning, education and training, professional regulation, pay and conditions – are developed and negotiated nationally under close political supervision and to a surprising level of detail. The resulting national contours of the workforce can reduce the flexibility needed for services to adapt to change and to tailor care to local circumstances and populations. Central attempts to encourage local institutional diversity and innovation in models of care can be frustrated by the uniformity of the culture and behaviour of staff in different parts of the country.

- These nationally conducted elements of workforce policy are part of a complex system encompassing more than 40 national and European Union organisations. Central strategic coordination of these organisations on workforce policy is weak. There is no sense of a compelling plan or clear direction around which this diversity of bodies can coalesce to support the objective of workforce policy to deliver high quality and affordable care.
- The solution to the workforce system's structural problems is not to seek wholesale reorganisation, but to improve opportunistically, and to introduce better strategic coordination.
- We recommend the formation of a National Workforce Strategy Board to take forward this new approach. Responsibility for workforce policy is widely distributed, yet the Department of Health remains the most influential single workforce organisation and should convene and lead this group.
- Many professions play their own vital roles in delivering front-line NHS care, supported and enabled by hundreds of thousands of non-clinical and support staff. But winning the trust and enthusiasm of the medical profession in particular is likely to be the key to unlocking rapid, radical and enduring change in the NHS.
- To support high quality, sustainable care a radically different style of policymaking is needed, which has the needs of patients and the public as its central purpose. For managers and leaders this will require better ways of demonstrating understanding of the daily dilemmas of clinical practice. In return, clinicians – and doctors in particular – need to lead change and take their professional colleagues with them.
- Early priorities for a more strategic policy approach would be to review medical education, focusing on the development of new roles, and understanding why the United Kingdom – in contrast to many other health systems – is beset by staff shortages. For the longer term, the national system needs to start laying the foundations for passing central control to more regional and local leaders.

1. Introduction

Effective workforce policy – how the health service plans, trains, regulates, pays and supports its people – is critical to the delivery of affordable, quality care.

To care about quality of care and the future shape of the NHS, prefigured in the *Five year forward view* (Forward View),[1] is to care about the workforce. High quality and sustainable health care depends on having the right mix of people, with the right skills and personal qualities, in the right place at the right time. Evidence shows that staff who are happy in their work and feel well treated will themselves feel better motivated to treat patients well.[2]

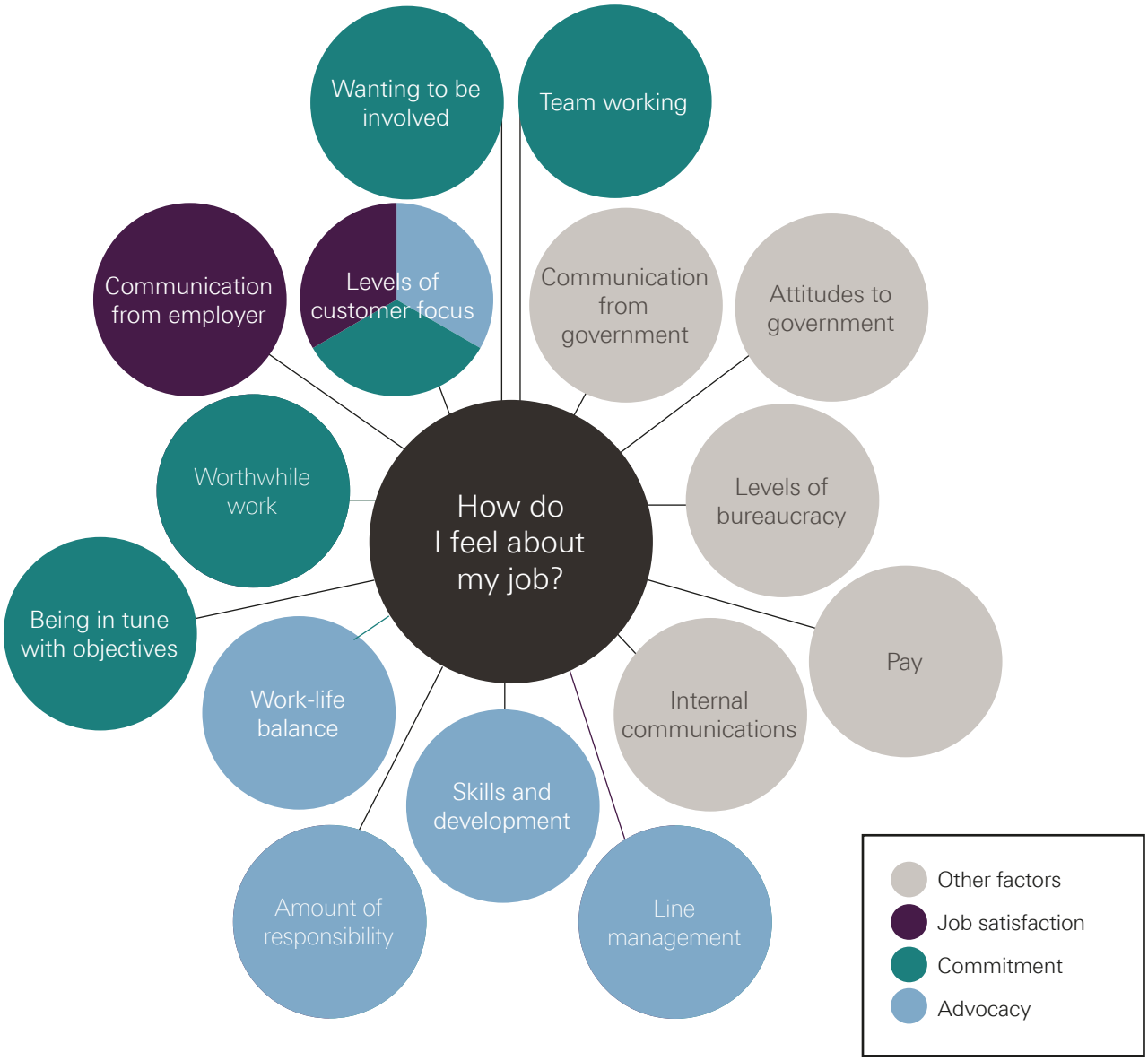
In addition, to be concerned about NHS finances is to be concerned about NHS staff: pay makes up more than two-thirds of the budget for hospitals.[3] If NHS care is to be affordable, this will require significant change to the overall cost, efficiency and productivity of the people who work in the NHS.

Furthermore, what 1.4 million staff say to their patients, families and friends about their work is important to the reputation of both the NHS and those who lead it.[4] This shapes public opinion and media sentiment about a health care system that is rarely far away from the top of the list of public, and therefore political, priorities.

However, workforce policy is rarely found in the mainstream of health policymaking or research, and can be poorly understood. Radical reform of care that impacts on the workforce can feel particularly hazardous for policymakers. Ministers and advisers prefer to avoid measures which might directly challenge powerful interest groups who can cause significant reputational damage.

National policy on workforce tends to depend largely on the renegotiation of national pay and terms and conditions as the principal means of securing change in the way staff work. The reality is that the motivations of staff are multiple and varied (see Figure 1 overleaf). Recognising the importance of behaviours, values, feelings and relationships when dealing with people has been a marginal consideration in policy.

Figure 1: The key drivers of job satisfaction, commitment and advocacy[4]



Workforce policy in England involves a complexity of institutions, including more than 40 statutory bodies working at a national level, a further 16 Royal Colleges, 18 trade unions, as well as over 100 professional and specialist institutions (see Box 1 overleaf). This level of complexity (and sometimes obscurity) makes it a difficult policy web to untangle.

Workforce policy can be categorised in many ways. This report is structured around the following five main functions:

- The national mechanisms for workforce planning, which seek to ensure that the NHS trains the number and mix of staff needed for health care in the future (chapter 2).
- The design, commissioning, quality assurance and administration of the education and training system, which seeks to produce health professionals and other NHS staff with the ethos, knowledge, skills and attitudes needed by the NHS (chapter 3).
- Professional regulation, which sets the standards, skills and knowledge needed to practise in the health professions, assures the quality of clinical education, controls admission to professional practice and takes action against unprofessional behaviour (chapter 4).
- Pay, pensions and terms and conditions, agreed through a system of national collective bargaining between the government, employers and trades unions (chapter 5).
- The motivation, engagement and leadership of the workforce, mainly in the hands of local NHS employers, but often influenced, directly or indirectly, by the actions and leadership narrative of national policymakers (chapter 6).

While this in itself is a very broad territory, it is only a partial picture. This report largely restricts itself to the medical model and the groups of professional and other staff with which it is associated. The report focuses predominantly on NHS employees and NHS contracted professionals in England. This report does not seek to cover the following:

- **Social care workforce**: The social care workforce, formal and informal, dwarfs that of the NHS. Integration of care for an ageing population and for effective support for people with mental health problems is an increasingly urgent problem that will require the blurring of traditional boundaries and the reinvention of conventional roles.
- **Public health workforc**e: Public health is critical to the future sustainability of health and care services. It also extends far beyond the confines of the clinical and bio-medical frontiers defined by the clinical professions.
- **Carers and volunteers**: Without thousands of volunteers and hundreds and thousands of carers, the health service would be unsustainable.

Box 1: A complex architecture: national and EU bodies that shape the NHS workforce

Centre for Workforce Intelligence	Her Majesty's Treasury
Committee of General Practice Education Directors	Higher Education Funding Council for England
Council of Deans of Health	Home Office
Council of Ministers	Independent Medical Tribunal Service
Council of Postgraduate Medical Deans	Medical Schools Council
Department for Business Innovation and Skills	National Clinical Assessment Service
Department for Education	NHS Business Services Authority
Department of Health	NHS Employers
Department of Health and Social Services, Wales	NHS England
Department of Health, Social Services and Personal Safety, Northern Ireland	NHS Leadership Academy
Disclosure and Barring Service	NHS Pay Review Body
Doctors and Dentists Pay Review Body	NHS Professionals
European Commission	NHS Protect
European Parliament	Nursing and Midwifery Council
Foreign and Commonwealth Office	Parliament
General Chiropractic Council	Privy Council
General Dental Council	Professional Standards Authority (and 17 assured voluntary registers)
General Medical Council	Scottish Government Health and Social Care Directorate
General Optical Council	Senior Salaries Review Body
General Osteopathic Council	Skills for Care
General Pharmaceutical Council	Skills for Health
Health and Care Professions Council	Social Partnership Forum
Health Education England (and 13 local education and training boards)	Universities UK
Health Select Committee	
16 medical royal colleges	18 trades unions
100+ professional and specialist associations	

2. Workforce planning

The NHS workforce planning system* aims to secure a reliable and affordable supply of sufficient numbers of staff across the diversity of professions that make up the modern health care team.

The process can often be more of an art than a science and there is a multiplicity of elements interacting in a political context.[5] Long lead times for the training of staff (a new consultant in 2016 is likely to have started training in 2002), combined with rapidly changing social and technological practices, makes health workforce planning particularly difficult.

As such, the outputs of the system are often out of kilter with what is needed. For example:

- The recent growth in agency spend for nurses in the acute sector partly stems from central policy responses to the Mid Staffordshire Public Inquiry, driving demand for less risky staffing levels on the wards. The failure to plan for the increased demand for acute sector nurses has been a significant driver of costs and a key contributor to the burgeoning trust deficits.†
- Unanticipated problems in recruiting and retaining sufficient numbers of GPs[6] remain a significant risk for the expansion of services in primary care set out in the Forward View.
- There are longstanding significant geographical variations: some areas that are remote or sparsely populated can find recruitment particularly difficult while others, such as London, also have a high turnover of staff.

The results of getting workforce policy 'wrong' are significant, impacting on quality of care, finances (staff shortages are likely to increase costs) and progress towards new models of care delivery. Instability in the membership of clinical teams can put safe and effective care at greater risk, as individuals will be unfamiliar with working processes and may have no personal long-term stake in the team or the organisation. Longstanding shortages may make it difficult for employers to introduce change, as staff can move elsewhere relatively easily if they resist the changes.

The difficulty involved in workforce planning is likely to increase: demographic trends mean shortages of key staff are likely to be one of the principal challenges facing health care systems across developed economies. While other developed economies do experience staff shortages periodically, health care in England already has a history of staff shortages and appears to be particularly vulnerable to these forces.

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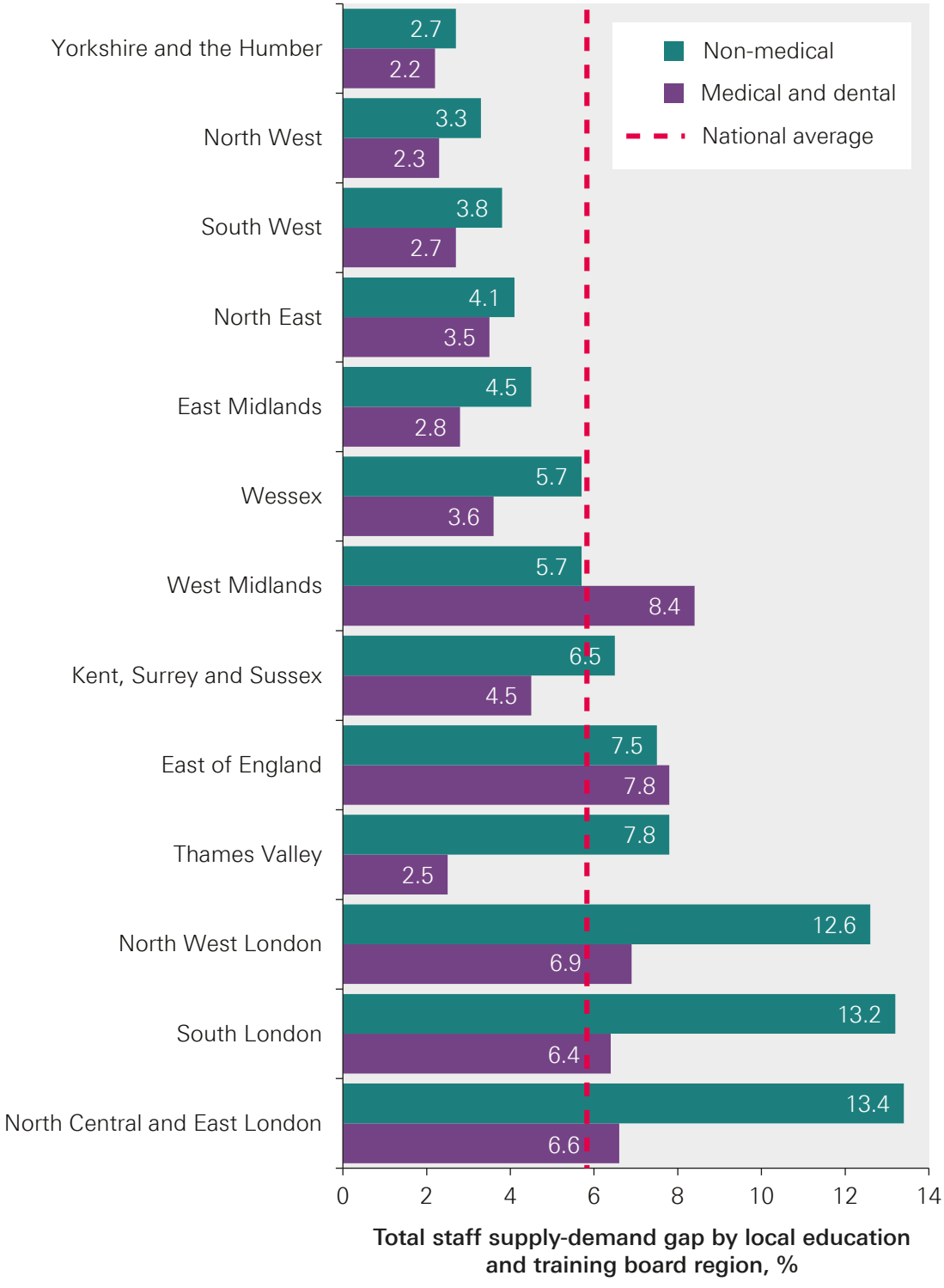
* CIPD (The Chartered Institute of Personnel and Development) defines 'workforce planning' as a process to ensure the right number of people with the right skills are employed in the right place at the right time to deliver an organisation's short- and long-term objectives.

† For example, see Figure 4.1 in the Health Foundation report *A perfect storm: an impossible climate for NHS providers' finances?*. www.health.org.uk/perfectstorm

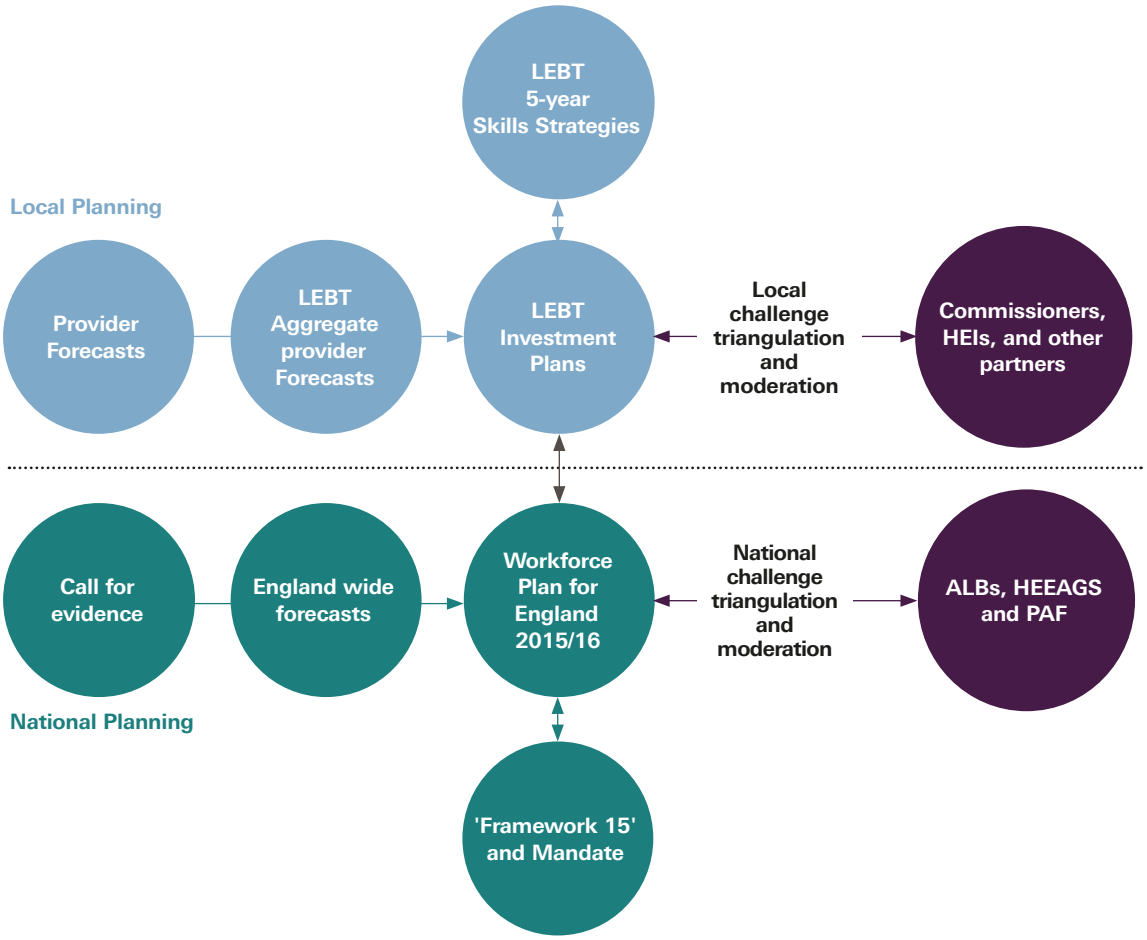
Figure 2: Shortfalls for medical and other clinical staff groups by region, April 2014[7]



There have been a series of attempts to improve workforce planning. The creation of the Centre for Workforce Intelligence by the Department of Health in 2008 was intended to put forecasting of supply and demand on a more robust basis, underpinned by greater academic and statistical rigour.

In 2012, Health Education England (HEE) was created as the dedicated national workforce planning body. Its planning processes are set out in Figure 3. It has 13 local education and training boards (LETBs) to corral local intelligence and gather together local employers' judgements about future need across the health professions. Each year, it publishes its planning assumptions and commissioning intentions, informed by these local judgements; guided by its 15-year strategy; and encouraged by government, professional bodies and trade unions to pursue particular paths.

Figure 3: HEE workforce planning process 2014[8]



HEE's most recent forecast, in December 2015, shows the high level of uncertainty about how many people will be available to the NHS in four years' time. For example, the most likely forecast of the supply of adult nurses is that it will grow by over 21,000 full-time equivalent staff by 2020, but HEE's worst case scenario is a fall of almost 3,000.

This uncertainty stems from a range of factors. Local employers may plan for what they think they will be able to afford rather than what they think may be clinically optimal. HEE reserves the right to second-guess on these grounds in commissioning additional training places.

Changes in clinical practice can also have a rapid impact on planning assumptions. For example, in the early 2000s, the Department of Health significantly increased the number of training places for cardiac surgeons as it invested heavily in new surgical centres as part of a drive to reduce waiting times for heart operations. This coincided with the unanticipated growth in the use of angioplasty instead of bypass surgery for the treatment of coronary artery disease, as well as the rapid impact of the growth in prescribing of statins and hypertension drugs in primary care. Demand for cardiac surgeons fell significantly, leaving some surgical trainees struggling to find domestic consultant posts.

The planning system is open to being swayed as much by 'today's noise' as long-term clinical evidence because particularly strong lobbies, for institutions or clinical conditions, make their voices heard.* LETBs, dominated by acute sector trusts, tend to plan for consultant growth rather than expansion of community services.

Workforce planners also consider the degree to which the NHS shares its staff, particularly consultants, with the private sector. It has been estimated that just over half of NHS consultants do private work.[9] This is a cause of tension that was partially resolved in the 2003 consultant contract,† but it can remain a source of distrust when employers agree or monitor how individual hospital doctors divide their time. Opportunities to practise privately in London and other big cities make consultant recruitment easier, but conversely cause difficulties in attracting staff to poorer and more isolated areas.

A thorough review of workforce planning issues by The King's Fund in 2009[5] found that problems often stemmed from national policymakers in the Department of Health and its arm's length bodies (ALBs) treating workforce planning as an afterthought and altering the landscape the workforce planners had prepared for – for example, by creating central pressure for safer staffing levels in the aftermath of the 2013 Mid Staffordshire public inquiry,[10] while depending on the financially determined outputs of nurse workforce

* See, for example, Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005 Sep; 83(3): 457–502. www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145. The researchers found, in the same year as well as in time-lagged analyses (between 1985 and 1995), that a greater supply of primary care physicians was significantly associated with lower all-cause mortality, whereas a greater supply of specialty physicians was associated with higher mortality. When the supply of primary care physicians was disaggregated into family physicians, general internists, and paediatricians, only the supply of family physicians showed a significant relationship to lower mortality.

† In the negotiations that led to the 2003 consultant contract, Alan Milburn attempted to ban newly qualified consultants from private practice for the first seven years to maximise the time they spent on NHS patients. In the end, the 2003 contract set out a compromise in which consultants were free to practise privately once they had met their obligations to the NHS.

planning in 2009 and 2010. It remains to be seen whether the creation of HEE as a separate entity from the Department of Health and NHS England will prove to be helpful in mitigating this kind of risk.

In conventional labour markets the solution might be to aim for sufficient oversupply of staff to mitigate these risks. In the NHS the trade-offs are less straightforward; where education is subsidised, there are significant additional costs in training a surplus of clinical staff. In addition, the politics can be more powerful than the economics: if there are long waits for care, doubts about the quality of services, or if patients see valued staff as overworked, then the public will be sympathetic to health professionals who struggle to secure jobs, and unions will lobby hard to ensure that politicians find the money to employ them.

This means that a strategy of oversupply does not necessarily work, since the system would be then under pressure to create posts for unemployed staff. With the continuing globalisation of the health care employment market, the attractions of the United States, Australia and New Zealand may provide a safety valve for such pressures. It is uncertain how the recent decision to open up nurse and allied health profession (AHP)* training to the market through a loan-funded system (rather than restricting numbers through state subsidies) from 2017 will play out.

In the meantime, as an anglophone system with chronic training shortages, the UK health service continues to depend more heavily on overseas recruitment than most other countries in the Organization for Economic Cooperation and Development (OECD) (see Figure 4).

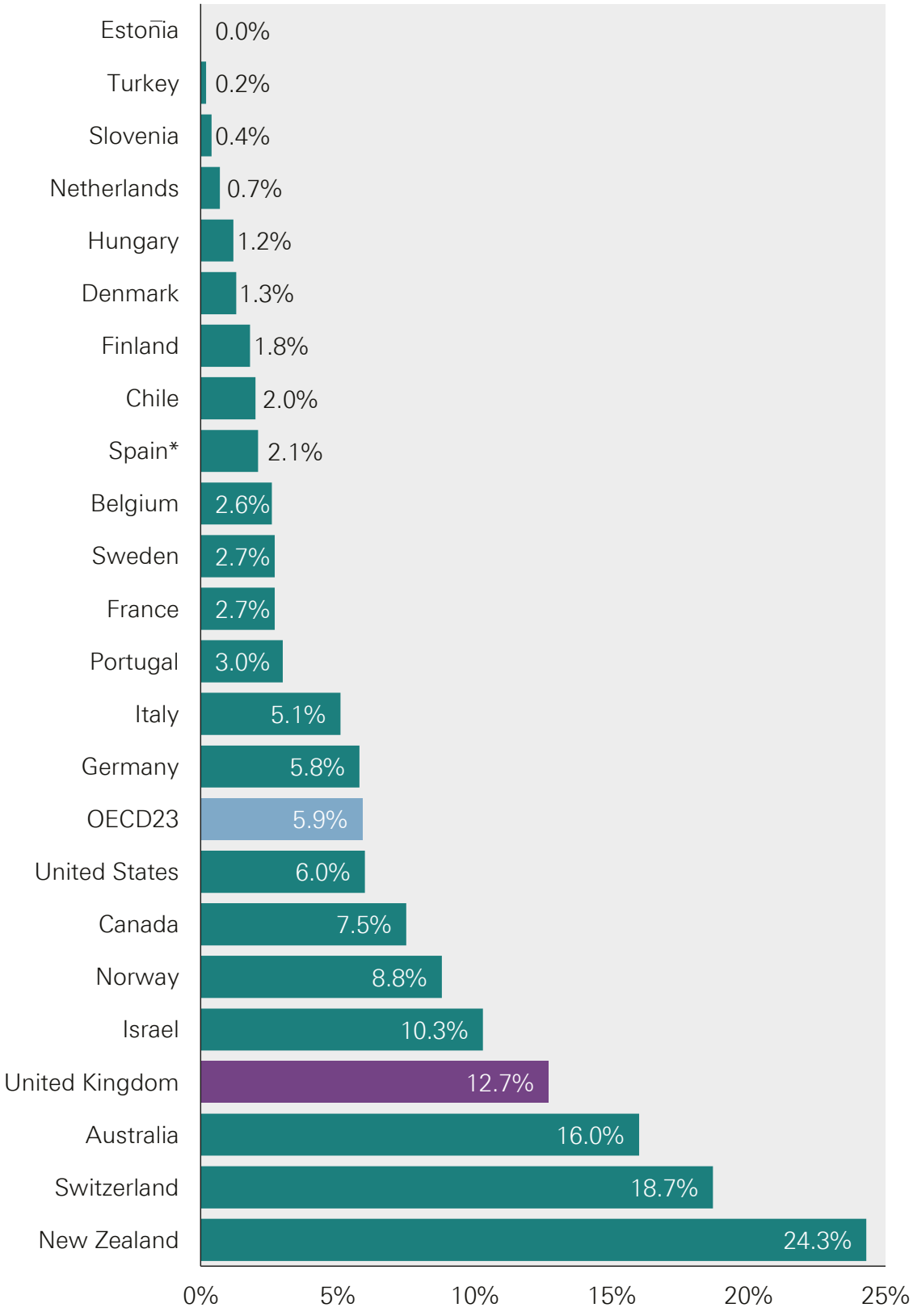
Development of new roles

One alternative to this dependence on international recruitment is to plan for different mixes of different kinds of health care workers. Where conventional roles are too difficult to recruit, resistant to change or too expensive to maintain, policymakers have been arguing for decades that new roles can offer an affordable solution. For example:

- administrative support roles to enable clinicians to maximise their clinical time
- care coordination roles to join up care and reduce length of stay
- extended roles which widen or specialise the scope of practice (for example, specialist heart failure nurses), sometimes as a less costly substitute for medical care
- assistant or associate roles, such as nurse practitioners and associate practitioners in primary care.

* The allied health professions consist of speech and language therapists, radiographers, prosthetists, orthotists, podiatrists, paramedics, physiotherapists, orthoptists, occupational therapists, dietitians and arts therapists.

Figure 4: Share of foreign-trained nurses in OECD countries, 2013 (or nearest year)*



* Data for some regions in Spain relate to foreign nationality or country of birth, not the place of training. Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

While small-scale experimentation with new roles is becoming more common across the NHS (and are of particular interest in 'Vanguard' areas), this does not represent the norm and innovation is not sufficiently widespread to really drive change. There is also limited evidence on their cost effectiveness and impact on quality. The culture, habits and traditions relating to the professional divisions of labour in health care are strongly rooted. It takes persistence to secure the multi-professional support, trust and alignment required for successful change in any particular care pathway. It is only with this in place that staff performing new and unconventional roles will be accepted and supported as people who will help improve patient care, without undermining the position of their colleagues in the conventional clinical team.

Given the difficulties in developing new roles and the long lead times for training new generations of existing professions, current workforce strategy (see Box 2) is increasingly placing greater emphasis on training health professionals with the agility to adapt to new technologies and changing working patterns.

Box 2: Health Education England: Our strategic framework[11]

- We need a workforce fit for the future, able to meet the needs of patients today and tomorrow.
- The future is necessarily uncertain, and we should therefore plan for uncertainty.
- The workforce is both a key enabler and a driver of change in health, and must be integral to all future planning and investment decisions if the opportunities to improve care are to be realised.
- If we maintain current approaches to investment and training, we will perpetuate current models of care.
- Our best chance of success is to base our long-term workforce strategy primarily on the anticipated needs of future patients, rather than just stated service visions, which may or may not come to fruition.
- The distinction between the present and the future is a false one in health: today's workforce will be working 10, 20, 30 years from now, and have a duty to serve both the patients of today and tomorrow.

3. Education and training

Education and training enables people to gain the knowledge, skills and behaviours needed for their work. For the regulated professions, it is also the route to securing the formal registration which gives them a legal right to practise.

Box 3: Skills for Health and Skills for Care

Skills for Health and Skills for Care are the skill sector councils for health and care professionals respectively. They support employers in the training and recruitment of staff, primarily in relation to unregulated support workers, developing and promoting standards, codes of conduct and articulating the skills and knowledge required for particular roles. Formerly arms-length bodies, they are now independent not-for-profit bodies, licensed by government.

Most professions require an intensive period of learning before workers begin their careers, but people also have a professional duty to continue to learn and develop throughout their professional lives to keep themselves up to date, often known as 'continuous professional development'. Education and training also plays a critical role in shaping the culture of the professions and the world view of individual professionals.

Training times vary considerably depending on the complexity and responsibilities of each professional role. For example:

- For hospital consultants, after five years as an undergraduate and at least eight years as a postgraduate, following a Royal College examination in one of the 61 medical specialties training programmes, successful trainees are awarded the prized Certificate of Completion of Specialist Training (CCST) and become eligible to apply for consultant posts.
- For GPs, five years' undergraduate education, two years in the Foundation Programme and three years* in GP speciality training, and success in the Royal College of General Practitioners examination secures GP status.
- Nurse training takes three years of full-time training to secure a degree that qualifies the graduate for Nursing and Midwifery Council (NMC) registration and a first nursing job.

There are currently no formal requirements when applying to be a health care assistant, although there is now an expectation that staff will acquire a care certificate (see Box 4) while on the job.

* There is system wide agreement that GP training should be extended to four years, but implementation has been delayed while the costs and practicalities are worked through.

Health Education England (HEE) leads the education system, with local leadership and oversight carried out by thirteen Local Education and Training Boards (LETBs). With a budget of £4.8bn, it recruits doctors and dentists into training and funds the training of a wide range of other health professionals, having taken responsibility for workforce planning, education commissioning and education provision from strategic health authorities when they were formally abolished in 2013.

Box 4: The care certificate

Following the Francis Inquiry, Camilla Cavendish was asked by the Secretary of State to review and make recommendations on the recruitment, learning and development, management and support of health care assistants and social care support workers. The resulting report,[12] published in July 2013, found that the preparation of health care assistants and social care support workers for their roles within care settings was inconsistent, and recommended the development of a fundamental certificate of care. The review recommended that the certificate should:

- be applicable across health and social care
- be portable between roles, and transferable between employers
- encourage quality and consistency of delivery by being prescriptive about observation and assessment in the workplace
- equip people with the skills and knowledge to be able to provide quality care, and test their capacity to be caring.

Health Education England, Skills for Care, and Skills for Health, have worked together to develop the Care Certificate. The minimum level for quality assurance of the Care Certificate, and the certification itself, will be the responsibility of employers.

From April 2016, HEE will take responsibility for the NHS Leadership Academy, which seeks to build clinical and managerial leadership capacity at all levels of the service. It also operates the longstanding NHS Graduate Trainee Scheme, many of whose alumni now populate senior management positions across the NHS.

For all the professions the formal curricula give a fairly clear sense of the overt knowledge and skills required, but the concept of the 'hidden curriculum' is an important one in health care. This is made up of the lessons which are learned but not openly intended, the unconscious transmission of norms, values, and beliefs conveyed in the classroom, the social environment and the behaviour and attitudes of professional role models in their dealings with patients, managers and other health professionals in their daily work.

What consultants say about managers in front of junior doctors over many years of training, or what the ward sister says repeatedly about the consultant to newly qualified nurses, is an important cultural message to trainees about what is really expected, tolerated or forbidden when they step out of the classroom into the real world of clinical practice. For those who see the reshaping of professionals and professional cultures as central to more effective health policy, rewriting curricula is the easy bit: the real policy challenge is to reshape the informal teaching transmitted continuously by deed and by word of mouth.[13]

Education and training of doctors

The system is at its most complex in its oversight of postgraduate medical education, which trains junior doctors as they seek to progress to the consultant grade. HEE and its LETBs commission the training places and pay junior doctors in training. The General Medical Council assures the quality of medical training in the teaching hospitals.

LETBs are responsible for coordinating postgraduate medical and dental education within a given region, to standards that are set by the General Medical Council. The medical deans within each LETB administer local relationships with medical schools and teaching hospitals.

The deaneries are advised by a Specialty Training Committee (STCs) for each specialty school, consisting of representatives of the medical school, training units, trainees and academics. The STCs support the deaneries in establishing education programmes and in overseeing and appraising trainees.

Under a mandate from the Department of Health, HEE spends about £3.5bn each year on medical education, the bulk of it on pay for junior doctors. This substantial spend on the dominant profession in the NHS generates powerful interests, impacting on junior doctors themselves (who make up about half of all hospital doctors), teaching hospitals and universities.

The contribution to day-to-day health care provision that junior doctors make means that the clinical and financial viability of the 21 English teaching hospitals is bound up in the funding and trainee flows which HEE and LETBs oversee. Universities also have a strong interest in the substantial income that comes from training doctors and other health professions.

The medical profession itself, in its various national incarnations, takes a close interest in the affairs of medical schools as intellectual and cultural transmitters of what it means to be a doctor to each new generation of students. For postgraduate medical education there is a standing forum in which the various national manifestations of the profession talk together – the Conference of Postgraduate Medical Deans (COPMeD). This forum allows NHS postgraduate deans to discuss current issues, share best practice and agree a consistent and equitable approach to medical training in all deaneries. It acts as a focal point for contact between the postgraduate medical deans and the General Medical Council (GMC), the British Medical Association (BMA), the Academy of Medical Royal Colleges, the Council of Heads of Medical Schools and the four health departments of the United Kingdom.

Given the importance of the medical profession, both in itself and in terms of its leadership role within health care, how it is shaped for the future is of significant public interest. While HEE is conscientious in seeking to gather wider views on this, at each level of both the undergraduate and postgraduate training systems, the conversations can feel dominated by the professions themselves. The opportunities for employers, the public and patients to engage with an opaque and complex system are limited and exacerbated by chronic information asymmetry, where medical professionals will always have the upper hand in assessing the clinical risks and benefits of new policies.

As such, society often relies on the benevolence and far-sightedness of the professions themselves to ensure the flow of the right kind of doctors needed to meet health care needs in the future. Despite some effort from medical schools, most of the curricula and their delivery are dominated by acute care and have a strong hospital bias.

There are significant altruistic as well as self-regarding forces at play here; this is not, as described by George Bernard Shaw, a 'conspiracy against the laity.'[14] However, relying primarily on internally generated change may mean slower and more cautious adaptation to changing patient and employer needs and expectations. This conservative and evolutionary approach can be a source of deep frustration to policymakers and ministers in a hurry. The medical profession has deep roots, with culture, assumptions and habits developed over centuries, frequently transcending the short-term needs of the NHS. When the NHS celebrates its seventieth birthday in 2018, the Royal College of Physicians will be celebrating its 500th.

Education and training in nursing, midwifery and the allied health professions

For nursing, midwifery and the allied health professions, a parallel network of Deans of Health within LETBs carries out similar responsibilities to the medical deans across a multiplicity of professions, NHS institutions and educational providers.

Just as concerns about variability in the quality of graduates from medical schools have led to calls for a national graduation examination for doctors, the nursing profession continues to find itself the focus of anxieties about whether Nursing and Midwifery Council and LETB oversight is sufficient to ensure consistent standards among nursing graduates from over 80 institutions currently offering nursing degrees in the UK.*

The nursing profession finds itself now at a somewhat uneasy place in its evolution. For the most part it continues to enjoy high levels of public trust and respect. Specialist nursing continues to innovate, experiment and find new ways of getting the best for patients in a range of new settings. But there is still at times the sense of a profession seeking a more self-confident identity and a clearer sense of its own direction.

Nursing has been put on the back foot in recent years by a number of factors - ongoing unease about the impact of the move to a wholly graduate profession; a nostalgia from some for the return of the state enrolled nurse (SEN)†; the announcement in December 2015 of a new Nurse Associate role to 'bridge the gap' between health care assistants and qualified nurses; sporadic media reporting of a 'too posh to wash' culture; and a generalised concern about a weakening of professional values in the wake of the Mid Staffordshire inquiries.

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* For example, Central and North West London Foundation Trust has reported that between 40 and 60 per cent of band five nursing interviewees were rejected because they were innumerate, illiterate or lacked compassion. It is unclear how representative this is but it does merit further thought from HEE, the NMC, the deans and the nursing schools about how best to assure themselves that nursing graduates are consistently meeting the high standards of care expected.

† Before the implementation of Project 2000, which reformed the nursing profession in mid 1990s, state enrolled nurses (SEN) were trained within two years in a simplified version of the longer training offered to state registered nurses (SRNs, later to be renamed RGNs — registered general nurses — and now known as level one nurses). People training to be SRNs who failed their exams at the third attempt were also able to enter the nursing register as a SEN. No new SENs are trained in the UK today.

In 2012 the Chief Nursing Officer for England led the development of a new vision for nursing, set out in *Compassion in Practice,*[15] which was in part an attempt to address these concerns. Its 'six Cs' – care, compassion, competence, communication, courage and commitment – were an explicit articulation of the values that modern nursing should espouse, a sort of professional 'back to basics'. These issues remain deeply sensitive for the nursing profession and it has been difficult for the profession to find a safe and non-political context in which to pause and reflect on its future. The CNO for England is currently developing a new vision to support the Five Year Forward View and it will be interesting to see the extent to which it engages with these issues, and sustains the 'six Cs' in a period of staffing constraints and austerity.

4. Professional regulation

Most of England's key staff groups are overseen by a UK-wide* system in which nine professional bodies regulate 31 different types of health professional (Figure 5).

The system of professional regulation centres around ensuring certain health professions are only practiced by individuals with particular qualifications. However, the regulators also have a diverse set of functions, including:

- setting standards of education and training for the professions that they regulate
- maintaining a register of those who demonstrate they meet these standards by securing appropriate qualifications
- inspecting and assuring the quality of education and training providers and qualifications (with statutory powers to shut down courses and withdraw trainees from training hospitals)
- setting standards of conduct, ethics and competence required to remain on the relevant professional register
- investigating concerns about registered professionals who are taking appropriate action where individuals might present a risk to the public
- taking action against those falsely claiming to be a registered professional (a relatively rare occurrence).

The regulators sit at the centre of a statutory system that works with other key professional groups and institutions to shape, adapt – and occasionally enforce – what are accepted as the norms of reasonable professional attitudes, proper professional behaviour and professional competence. As such, they leave a mark on their registrants and have an important reach into the quality of individual interactions between hundreds of thousands of patients and professionals every day.

The system is statutory, yet with independence from government. This is both financial (professional regulators are wholly funded by fees and receive no state subsidy – unlike the regulators of organisations), and in terms of accountability.

* Under the current devolution settlements, matters relating to the professions that were regulated prior to devolution continue to be 'reserved' for Westminster, but any group subsequently regulated is a devolved matter for Edinburgh or Cardiff. Since the 1974 power sharing agreement Northern Ireland has had full autonomy for all regulated groups, but has chosen in practice to work on a United Kingdom basis, with the exception of the regulation of pharmacists, where the Pharmaceutical Service of Northern Ireland (PSNI) regulates practitioners (not to be confused with its acronym namesake, the Police Service of Northern Ireland!)

There has been a longstanding consensus, enshrined in the Medical Act of 1858 and maintained in professional regulation ever since,* that without independence from government, the clarity of focus on professional issues would be put at risk by short-term or political pressures.

While reforms in 2008 removed professional majorities on the governing councils of the regulators, by and large, ministers in successive governments have respected the convention of independence. In addition, perhaps preferring to keep distance from the reputational risks of managing high profile cases, ministers also retain the right to defer to, or criticise, an independent regulator on controversial matters.

In the absence of ministerial governance, there is a regulator of the regulators: the Professional Standards Authority, which assesses the regulators' performance, and itself reports to parliament. The authority reviews decisions about individual cases made by the professional regulators. It can, and does, refer cases to the courts for review if they appear to be too lenient to protect the public effectively.

Despite genuine efforts by the regulators to promote better patient, public and professional understanding of their role, they rarely impinge on public consciousness,[16] except for the occasional high profile investigation into alleged misconduct of doctors by the General Medical Council or nurses by the Nursing and Midwifery Council.

Low visibility does not mean low impact or low importance. Regulators have a very significant formative influence on the people they admit to their registers: shaping curricula and courses; assuring the quality of education provision; and espousing, promoting and developing the ethos and standards of the professions they regulate.

With the introduction of revalidation for doctors and nurses (see Box 5), and the development of similar schemes for the other professions, the professional regulators are increasingly asserting a more present, proactive and career-long influence on their registrants. It is early days, and the systems are still clunky,† but revalidation may become a valuable mechanism for improving the quality of practice of the existing 'stock' of health professionals, primarily by strengthening local clinical governance and ensuring more systematic and meaningful appraisal.

* See, for example, Patricia Hewitt's forward to *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (2007) – 'Professional regulation needs to sustain the confidence of both the public and the professions through demonstrable impartiality. Regulators need to be independent of government, the professionals themselves, employers, educators and all the other interest groups involved in healthcare.'

† The Health Foundation has funded Plymouth University's in-depth evaluation of the introduction of medical revalidation, which can be found at www.plymouth.ac.uk/your-university/about-us/university-structure/faculties/medicine-dentistry/pupsmd-research/camera/camera-revalidation-research. See also V Nath, B Seale and M Kaur, *Medical Revalidation: From Compliance to Commitment*, King's Fund, March 2014.

Figure 5: Main health regulators in England

Regulator	Staff Regulated	Number of Registrants	Annual Fee	Annual Expenditure (2014)
General Chiropractic Council (GCC)	Chiropractors	2,900	£800	£2.8m (2013)
General Dental Council (GDC)	Dentists, orthodontic therapists, dental hygienists, dental technicians, dental nurses	41,000 dentists 65,000 other dental professionals	£890 £116	£39.9m
General Medical Council (GMC)	Doctors	267,179	£420	£101m
General Optical Council (GOC)	Optometrists, dispensing opticians	28,000	£290	£6.02m
General Osteopathic Council (GOsC)	Osteopaths	4,800	£610	£2.8m
General Pharmaceutical Council (GPC)	Pharmacists, pharmacy technicians	50,292 22,693	£250 £118	£22.4m
Health and Care Professions Council (HCPC)	Arts therapists, biological scientists, chiropodists and podiatrists, clinical scientists, dieticians, hearing aid technicians, nutritionists, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists and orthotists, radiography, social work, speech and language therapists	330,887 (including 87,000 social workers)	£90	£26.1m
Nursing and Midwifery Council (NMC)	Nurses, Midwives, Health visitors	680,858	£120	£62m
Pharmaceutical Society of Northern Ireland (PSNI)	Pharmacists in Northern Ireland	2,355	£372	£1.05m
		Total: 1,495,993		Total: £264.07m

Box 5: Medical revalidation

First proposed in the mid-1970s as the profession came to terms with the burgeoning technological and pharmacological body of knowledge, after many years of argument about its form, medical revalidation finally began in December 2012. Over a five-year cycle, doctors are required to undergo annual appraisal in a framework which covers the four dimensions of *Good Medical Practice,* the doctors' professional code: knowledge, skills and performance; safety and quality; communication, partnership and teamwork; and maintaining trust.

As part of this appraisers review a doctor's continuing professional development; their quality improvement work; complaints and significant events; and at least one round of 360° feedback from patients and colleagues.

Every five years the evidence from appraisal is considered by a doctor's Responsible Officer (in trusts, the Medical Director), who then makes a recommendation to the GMC on the suitability of the doctor for revalidation.

A strikingly rapid growth in complaints to regulators under their 'fitness to practice' function (see Figure 6) presents an ongoing challenge to the professional regulators, both financially and operationally, and they remain hamstrung by outdated legislation which constrains their freedom of manoeuvre to adopt more streamlined processes.

There is no single driver behind this trend. It is not the result of a sudden collapse in professional standards or clinical competence. Rather, researchers point to:

- wider societal trends in which employers, professionals and the public have become less accepting of poor care and more likely to report it
- greater confidence that reformed regulators will take action
- both the media and social media encouraging more reporting of problems.*

This increase in referrals, combined with political and trade union pressure not to increase professional fees, has contributed to growing pressure for further reforms to the regulators to improve the speed and efficiency of their work.

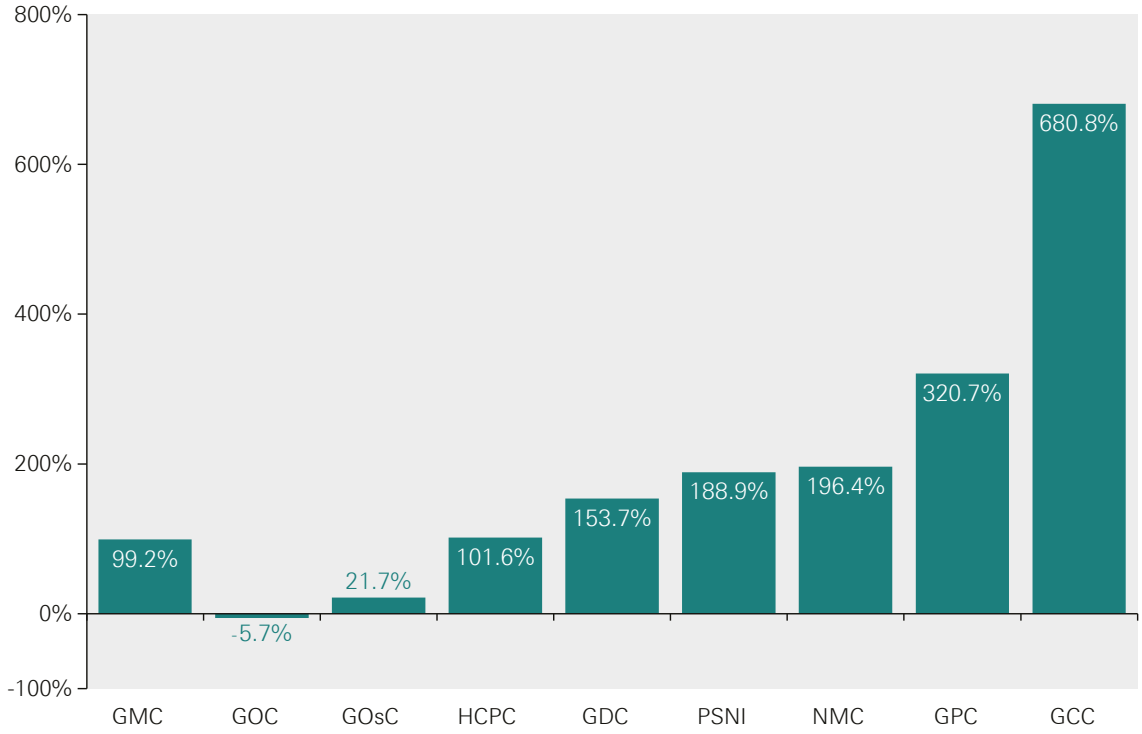
Regulating the unregulated

Who is 'in' and who is 'out' of statutory professional regulation is as much an accident of history as a rigorous risk-based assessment. Perfusionists, who operate heart and lung bypass machines during cardiac surgery, are not regulated in statute. Arts therapists, who use art to help people with emotional and behavioural issues, were brought into statutory regulation in 2003.

Around a quarter of NHS staff are unregulated support workers, the majority of them nursing assistants. There is significant debate about whether such unregulated staff should be brought within a statutory regime.

* Collaboration for the Advancement of Medical Education, Research and Assessment (CAMERA) at Plymouth University Peninsula Schools of Medicine and Dentistry: 'Understanding the Rise in Fitness to Practise Complaints from Members of the General Public' – July 2014

Figure 6: Percentage increase in complaints to regulators, 2008-2012 (median increase: 153.7%)[17,*]



Employers and Whitehall policymakers remain sceptical that professional regulation is a proportionate approach for many of the remaining unregulated groups, arguing that it is the responsibility of employers and regulated professionals who delegate to support workers to ensure that unregulated staff are properly trained and conduct themselves appropriately.

Government has also argued that the Disclosure and Barring Service (DBS – see Box 6), which vets all NHS staff who have direct contact with patients, provides a sufficiently robust mechanism to exclude unsuitable people from health and social care and that the introduction of the Care Certificate for health care assistants is an effective measure to ensure that they have the values, skills and knowledge needed to provide safe, effective and compassionate care.

Some doubts remain about the adequacy of the Care Certificate and the consistency of its application. While some employers are compliant with the DBS requirements, professional regulators have expressed doubts about how conscientiously other NHS employers carry out their legal obligation to report concerns to the DBS,[†] and the service itself covers behaviour only, not competence.

The issue will remain one of real concern, particularly in unsupervised domiciliary care services. However with well over a million people carrying out support roles in health and social care, and the number set to double over the next two decades, the prospect of drawing over two million low-paid workers into state regulation is an unattractive one for national policymakers and the Treasury.

* Note: GCC was the subject of a campaign at the time in which nearly all of its registrants were subject to a complaint about false claims of efficacy.

† As a result, in March 2013, as part of its initial response to Mid Staffordshire Public Inquiry, the Department of Health gave the Care Quality Commission the responsibility of ensuring that organisations complied with this obligation.

Box 6: Disclosure and Barring Service

The Disclosure and Barring Service (DBS), sponsored by the Home Office, helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

It is responsible for processing requests for criminal records checks (DBS checks); deciding whether it is appropriate for a person to be placed on or removed from a barred list; and placing or removing people from the DBS children's barred list and adults' barred list for England, Wales and Northern Ireland.

DBS searches police records and, in relevant cases, barred list information, and then issue a DBS certificate to the applicant.

Referrals should be made to the DBS when an employer or organisation, such as a regulatory body, has concerns that a person has caused harm, or poses a future risk of harm to vulnerable groups, including children.

Meeting European Union requirements

At the level of the European Union and European Economic Area, the Mutual Recognition of Qualifications Directive provides a mechanism for international registration for the main health professions, enabling free movement from state to state. It is overseen by the European Commission directorate concerned with competition and economic affairs, rather than health, so in Whitehall it is led by the Department for Business, Industry and Skills in close liaison with the Foreign Office.

So the Directive is as much concerned with the free movement of architects, lawyers and teachers as it is with health professionals. This general employment focus means that some organisations with a particular health focus remain concerned that on issues of clinical equivalence with other training systems and language and communication skills, the directive has insufficient focus on patient safety issues and prevents UK regulators from checking overseas health professionals robustly.

The most controversial element of European regulation of the health care workforce is the European Working Time Directive which limits the maximum amount of time that employees in any sector can work to 48 hours each week. This has had a particular impact on doctors who habitually worked far more hours than this in the past. There has been a concern* that limiting the clinical and practical exposure of doctors in training diminishes their capabilities. Others point to the gruelling ordeal of extended working that trainees were subjected to in the past, with its consequent risks to the safety of patients as well as the health of trainees, and few now argue seriously for a return to those times.

* See for example Henry Marsh on the impact of the European Working Time Directive: 'Shifts have been tried elsewhere and are universally unpopular, one of them said. "It destroys any continuity of care. The doctors will be changing over two or three times every day. The juniors on at night will rarely know any of the patients nor will the patients know them. Everybody says it's dangerous. The shorter hours will also mean that they will have much less clinical experience and that's dangerous also. Even the president of the Royal College of Surgeons has come out against shifts."' (p169) Marsh H. *Do No Harm. Stories of Life, Death and Brain Surgery.* Phoenix: 2014.

5. Pay, terms and conditions

The NHS in England centrally agrees the pay, terms and conditions for over 1.4 million staff in a form of national collective bargaining unseen in many other industries for decades.

While the policy narrative for the NHS since the 1990s has been one of markets, commissioning and competition, its workforce arrangements are still rooted in the planning, partnership and negotiation of the Whitley system* of public sector industrial relations adopted by the NHS in 1948.

National collective bargaining for both employees and independent contractors (see Box 7) has survived largely intact considering the wider labour market reforms of successive governments. Where freedoms have been granted (for example to foundation trusts) they have not been widely used.

Strangers to this world might be surprised at the level of detail and small print specified nationally in the NHS contracts. The Staff Handbook, which codifies the main *Agenda for Change* contract for non-medical staff, currently runs to 307 pages in 47 sections and 30 annexes. The product of detailed national negotiations, it covers everything from pay and progression to flexible working and career breaks in a level of prescription which in most other employment contexts would be left to much greater local discretion.

Box 7: National collective bargaining – the contracts

- Agenda for Change, which covers the majority of directly employed staff, including nurses, midwives, health care assistants and the allied health professions.
- The General Medical Service (GMS) contract, which articulates the expectations on GPs as independent contractors. The Personal Medical Services (PMS) contract enables GPs to work as salaried doctors. (The Alternative Medical Services Provider (APMS) contract is used for independent sector provision of primary care.)
- The consultant contract for NHS hospital doctors who have completed their specialist training.
- The junior doctors contact for doctors in training.
- The staff and associate specialist contracts for hospital doctors who are no longer in training but have not completed specialist consultant training (known as SAS doctors).
- The general dental services contract/the personal dental service contract for community and high street dental services.
- The NHS community pharmacy contract.
- The general ophthalmic services contract.

* The Whitley system was established towards the end of the First World War to sustain industrial effort to supply the front. Using local and national 'Whitley Councils' that encompassed both workers and employers, it sought to secure agreement through negotiation and arbitration and was widely adopted in the UK public sector in the twentieth century.

Contract negotiations

Government generally prefers to avoid direct negotiations with trade unions and instead concentrates national negotiating expertise in NHS Employers, a part of NHS Confederation. Under a contract with the Department of Health, NHS Employers represents both government and local NHS employer interests and negotiates with relevant trades unions on their behalf.

The Department of Health is, however, present in most of these discussions, reporting back to Ministers, Treasury and No 10 on progress, red lines and risks to industrial relations. In times of crisis, politics and politicians tend to move to the foreground.

For Agenda for Change, discussions with the relevant trades unions are carried out through the NHS Staff Council (see Box 8). NHS Employers, funded by the Department to represent NHS organisations, also leads negotiations with the British Medical Association (BMA) on the consultant, junior and SAS* doctor contracts, and negotiates the GP contract on behalf of NHS England (which is also responsible for the other primary care contracts governing pharmacy, dentistry and optical services).

Although it has no formal role, Health Education England, which funds the salaries of doctors in training, also takes an interest in the junior doctors' contract negotiations.

Box 8: The NHS Staff Council

The NHS Staff Council replaced the old NHS Whitley Council in 2004 when the new Agenda for Change pay system was implemented. Its remit is to maintain the Agenda for Change system; agree changes and provide national support on interpreting its terms. Chaired by a senior HR Director from the service on behalf of NHS Employers, it has senior representatives from the key trades unions such as RCN, Unison, UNITE and GMB as well as HR directors from NHS providers and representatives of the health departments in England, Wales and Northern Ireland.

Agenda for Change

Agenda for Change (AfC) was designed to allocate posts to set pay bands, using a job evaluation scheme. It was intended to deliver fairer pay for non-medical staff based on the principle of 'equal pay for work of equal value'; to provide better links between pay and career progression using a new 'Knowledge and Skills Framework' (the 'KSF'); and to harmonise terms and conditions of service such as annual leave, hours and sick pay, and work done in unsocial hours.

Staff are placed in one of nine pay bands (see Box 9) on the basis of their knowledge, responsibility, skills and effort needed for the job. Within each pay band, there are a number of pay points. In theory, as staff successfully develop their skills and knowledge and meet local performance requirements, they progress in annual increments up to the maximum of their pay band, although in practice progression is usually automatic.

* Specialty and Associate Specialist (SAS) doctors are non-training roles where the doctor has at least four years of postgraduate training, two of those being in a relevant specialty. SAS doctors are usually much more focused on meeting NHS service requirements, compared to trainee or consultant roles, and are considered by many to be a neglected asset in the medical workforce.

Box 9: Agenda for Change Pay Bands

NHS workers talk about AfC bands a lot. While there are additional allowances, such as London weighting, which often increase basic pay, in April 2015 rates were:

- Band 1 (Points 1-2): £15,100 to £15,363
- Band 2 (Points 2-8): £15,100 to £17,800
- Band 3 (Points 6-12): £16,633 to £19,461
- Band 4 (Points 11 to 17): £19,027 to £22,236
- Band 5 (Points 16 to 23): £21,692 to £28,180
- Band 6 (Points 21 to 29): £26,041 to £34,876
- Band 7 (Points 26 to 34): £31,072 to £40,964
- Band 8 (Points 35 – 50): £46,174 to £81,618
- Band 9 (Points 49 to 54): £77,850 to £98,453

This contractual entitlement to an annual pay rise as they move up the scale is sometimes known as 'automatic pay progression'. This means that staff who were not at the top of their pay spine continued to receive pay increases of up to 3% during the 'pay freeze'. This is a significant factor when a 1% increase in pay for the whole workforce equates to about £400m additional expenditure. Ending automatic progression is likely to remain an important negotiating aim for both government and employers, and something that trade unions will be keen to avoid.

While the government did negotiate changes which allowed employers to make increments conditional on achievement of objectives, in practice only a few institutions exercise this freedom;* and in general terms, local HR and appraisal systems which have the will, capacity or capability to do so are the exception rather than the rule.

GP contracts

The main contract for GPs, the 2004 general medical services contract, applies to practices rather than individuals and gives every practice a share of the funding allocated each year for primary care services (known as the 'global sum'). The share is weighted for the stability, size, morbidity and demographics of the practice list; the higher expense of working in rural areas; and for regional differences in the cost of employing staff (known as the 'Market Forces Factor').

To protect practices that would have lost income in 2004, the BMA negotiated a 'Minimum Practice Income Guarantee', which will be phased out some 17 years later in 2021. In addition, most practices opt in to the Quality and Outcomes Framework (QOF) through which they earn points, and more money, for meeting nationally set requirements for clinical practice.

* For example, Salford Royal NHS Foundation Trust.

The contract also ended GP responsibilities for directly providing out-of-hours services.* This, combined with substantial increases in GP income that resulted from the new arrangements, means that GPs were perceived to have done very well out of the early years of the new contracts, although many of the financial gains have been eroded in subsequent negotiating rounds. This factor that may be feeding the continuing difficulty in attracting young doctors into family medicine. Ensuring good provision in deprived areas remains a challenge. The contract is amended each year, and was most recently changed to seek to secure named accountable doctors for patients and to reduce the size and complexity of the QOF.

The consultant contract

The current consultant contract, implemented in 2003, allows for a typical working week of ten programmed activities (PAs) of four hours, with any additional work by mutual agreement. PAs are agreed through job planning discussions between the consultant and their clinical manager, and are divided into: direct clinical care; supporting professional activities; additional NHS responsibilities; and external duties. Pay progression depends, in theory,† on achievement of individual objectives in the job plan and the expectation is that about three quarters of any job plan will be direct clinical work.

After 7pm or before 7am during the week, or any time during the weekend, PAs are reduced to three hours, rather than four, or the rate of pay increases to 'time and a third.' Consultants can all receive additional pay from premiums for recruitment and retention; clinical excellence awards (see Box 10) and on-call availability supplements.

Box 10: Clinical Excellence Awards

The Clinical Excellence Awards (CEA) scheme is intended to reward consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services, and as a way of recognising the contribution of academic medicine to the NHS.

Awards are made to consultants who: demonstrate sustained commitment to patient care; sustain high standards of clinical practice; demonstrate a sustained commitment to the values and goals of the NHS; are responsible in the conduct of private practice; show commitment to service objectives; participate in clinical governance and service improvement; contribute to research and research governance; are excellent teachers or trainers; contribute to policymaking and planning in health and health care; or make an outstanding contribution to professional leadership.

Awards can be made for both local and national contributions to the NHS. Employer-Based Awards Committees (EBAC) assess applications for the employer based awards (levels 1-9). Higher value national awards (9-12) are decided by the Advisory Committee on Clinical Excellence Awards (ACCEA) and its subcommittees. The higher awards are substantial, giving as much as an extra £75,000 on top of salary each year.

* The perception that much of out-of-hours could be done by those with less expensive training than GPs may well have led to some of the increased referrals through to A&E. Perceptions of saving money may have cost money.

† In 2013 the National Audit Office found that less than a third of trusts make consultant pay progression conditional on meeting their objectives.

While significantly increasing consultant income, the contract did resolve longstanding disagreements about private practice, while job planning introduced, in theory if not always in practice, stronger management input into what consultants do at work. Some believe that dividing a professional commitment into paid pockets of clinical time has weakened the professional ethos of consultants,[18] made their employment relationship transactional, diminished the spirit of service in clinical practice and therefore tampered unwittingly with a precious part of the psychological contract.

At time of writing, negotiations on a new contract have resumed after a period of public disagreement between the government and the profession. The government is seeking to secure the changes proposed in the independent Doctors and Dentists Remuneration Body report of 2015.[19] These changes include:

- removing the opt-out from anti-social hours
- linking pay progression to achievement of excellence (as assessed at annual appraisal)
- basing pay on pay spot rates reflecting recognised stages of a consultant career
- enabling recruitment and retention premiums for some specialties and regions
- reforming local clinical excellence awards (see Box 9).

While the government cannot force existing consultants to adopt any new contract, they can allow it to wither on the vine, and publish a new model contract for local employers to use when consultants move jobs, or when junior doctors seek their first consultant appointments.

The junior doctors contract

The current dispute between the government and the BMA over the contract for doctors in training (these so-called 'junior' doctors are often in quite senior roles), centres on the terms and conditions of a group of doctors who make up about a half of the NHS's medical workforce. While both sides are clearly framing the logic of their position in terms of patient safety, both sides also have important financial interests at stake. The key components under negotiation have been:

- an increase in basic pay
- the extension of 'plain time' hours, where normal rates are paid, into evenings and weekends
- limits on excessive hours and safeguards, and fines where limits are exceeded
- the introduction of flexible payments to make unpopular specialties more attractive, notably general practice, emergency medicine and psychiatry
- linking pay progression to progress on training and taking on greater responsibilities.

In the course of extremely difficult negotiations, all sides have acknowledged that there are deep-seated morale issues among junior doctors which go beyond the specific terms of the contract; Sir David Dalton's proposal of a review that can step back and examine some of the deeper-seated issues surrounding the working lives of modern doctors in training is welcome. At time of publication of this report the contractual outcome of the ongoing dispute remains unclear, but the widespread disaffection of such an important group of professionals within the NHS is of deep concern.

Pay review bodies

The pay review bodies are an established part of the annual national negotiating infrastructure, providing an independent view on pay increases as well as the content of the national contracts. In recent years, with the persistence of pay restraint, despite the detailed consideration of the evidence by the review bodies, the government answer – 'between one and zero per cent' – has inevitably had the feel of having been decided in advance.

However, the review bodies have been influential in relation to wider contractual issues, notably weekend working and the shape of the junior doctors contract. Whether pay restraint can be sustained as private sector rewards start to outpace public sector pay remains to be seen but for this year the review bodies and the government have again agreed a simple 1% uplift across the board as their offer to NHS staff

Professional representation

The centralised negotiating framework means that NHS employee relations tend to be national and are conducted in a national political context. Where negotiation spills into conflict, command of public opinion on the issues in question is critical. For organisations that act as trade unions for health care workers (see Box 11), many of their members have professional and ethical reluctance for action that might affect patient care. This is combined with low media and public tolerance of any such action, meaning that strikes are rare or that when they do occur they tend to be brief.

So for both sides, the public negotiating case is expressed in terms of benefit or risk to patients, or occasionally, in terms of existential threats to the NHS itself. The Social Partnership Forum, set up in 2008, provides a space in which all sides can build and sustain relationships by working together on areas of common interest, as a counterbalance to some of the tensions that arise from the higher stakes discussions of national contract negotiations.

For all the professions, in addition to trade union interests, there is a comprehensive collection of professional bodies and societies (see Box 12) seeking to influence policy and practice by stating the particular case for their own area of professional expertise.

Often setting the gold standard of care to which individual services should aspire for particular areas, they can be less attentive to opportunity costs elsewhere. So a call for investment to meet international best practice on consultant numbers in one specialty will not have regard to any consequent reductions in others. A number of these organisations play a dual role of trade union and professional association, and at times outsiders can struggle to determine which hat they are wearing at any given time.

Box 11: Main organisations that act as trade unions for health care workers

Organisation	Staff represented	(Health related) membership
British Dental Association (BDA)	Dentists	18,900
British Medical Association (BMA)	Doctors	152,000
British Association of Occupational Therapists (BAOT)	Occupational therapists	25,300
Chartered Society of Physiotherapy (CSP)	Physiotherapists	54,500
Federation of Clinical Scientists	Scientists working in audiology, clinical biochemistry, clinical genetics, clinical immunology, clinical microbiology, clinical physiology, embryology, haematology, histocompatibility and immunogenetics, medical physics and clinical engineering	Not available
GMB	Includes: ambulance, administrative staff, porters, domestic staff, some nurses and health care assistants	c80,000
Hospital Consultants & Specialists Association (HCSA)	Consultants and staff and specialty hospital doctors	3,200
Managers in Partnership (MiP)	Managers	6,070
Royal College of Midwives (RCM)	Midwives and maternity support workers	45,000
Royal College of Nursing (RCN)	Nurses and health care assistants	415,800
The Society of Chirpodists and Podiatrists	Chiropodists and podiatrists	8,200
The Society and College of Radiographers	Radiographers	18,600
Unison	Includes: nurses and health care assistants; midwives; health visitors; administrative, finance and HR staff; ambulance staff, including paramedics, technicians, control room and maintenance staff; therapy and health care science staff; estates and housekeeping staff; technicians and maintenance staff; commissioning staff; allied health professionals; scientific staff; health care managers.	c500,000
Unite	Includes: community practitioners and health visitors, ambulance staff, applied psychologists, art therapist, counsellors and psychotherapists, estates and maintenance, health care chaplains, health scientists, hospital physicists, mental health nurses, school nurses, speech and language therapists.	c100,000

Box 12: Professional bodies and societies

Association for Palliative Medicine	British Association of Spine Surgeons	Clinical Genetics Society
Association of Anaesthetists of GB and Ireland	British Association of Urological Surgeons	College of Occupational Therapists
Association of Breast Surgery	British Cardiovascular Society	College of Operating Department Practitioners
Association of British Clinical Diabetologists	British Dietetic Association	College of Optometrists
Association of British Neurologists	British Geriatrics Society	College of Paramedics
Association of Clinical Pathologists	British Hip Society	Craniofacial Society of GB and Ireland
Association of Coloproctology of GB and Ireland	British HIV Association	Faculty of Sport and Exercise Medicine UK
Association of Optometrists	British Infection Association	Intensive Care Society
Association of Respiratory Nurse Specialists	British Orthodontic Society	National Association of Assistants in Surgical Practice
Association of Upper Gastrointestinal Surgeons	British Orthopaedic Association (plus sub-speciality societies)	Royal Pharmaceutical Society
British Association for Head and Neck Oncology	British Pain Society	Society for Acute Medicine
British Association for Sexual Health and HIV	British Society for Allergy and Clinical Immunology	Society for Cardiothoracic Surgery in GB and Ireland
British Association of Aesthetic Plastic Surgeons	British Society for Clinical Neurophysiology	Society for Endocrinology
British Association of Arts Therapists	British Society for Haematology	Society for Vascular Nursing
British Association of Audiovestibular Physicians	British Society for Immunology	Society of British Neurological Surgeons
British Association of Cosmetic Surgeons	British Society for Interventional Radiology	Society of Vascular Technology of GB and Ireland
British Association of Day Surgery	British Society for Oral Medicine	The Association of Cancer Physicians
British Association of Dermatologists	British Society for Paediatric and Adolescent Rheumatology	The Association of Clinical Biochemists
British Association of Drama Therapists	British Society for Rheumatology	The Association of Professional Music Therapists
British Association of Endocrine and Thyroid Surgeons	British Society for Surgery of the Hand	The British and Irish Orthotic Society
British Association of Occupational Therapists	British Society of Audiology	The Primary Care Respiratory Society UK
British Association of Oral and Maxillofacial Surgeons/British Association of Oral Surgeons	British Society of Neuroradiologists	UK Clinical Pharmacy Association
British Association of Otorhinolaryngologists	British Society of Rehabilitation Medicine	Vascular Anaesthesia Society of GB and Ireland
British Association of Paediatric Surgeons	British Thoracic Society	Vascular Society of GB and Ireland
British Association of Plastic, Reconstructive, and Aesthetic Surgeons	British Transplantation Society	

The NHS pension scheme

The persistence of a national system and unified terms and conditions has allowed the NHS to realise significant benefits through centralised administration of its pensions, pay and HR functions. Administered by the NHS Business Services Authority,* the NHS pension is the largest centrally run public sector scheme in Europe, with 1.4 million actively contributing members from across the UK. It also has 550,000 members who have moved elsewhere but will benefit when they retire. The scheme pays pension benefits to over 750,000 pensioners every month.

Scheme liabilities in 2014 were valued at more than £337bn – about the same size as the GDP of Norway in the same year. The contributions paid into the scheme from both employers and employees have increased significantly in recent years and staff will have to work longer before they retire, but it still remains one of the most generous in Europe.† As such, it is an important part of the NHS employment package.‡

In an era of sustained pay restraint, the Department of Health has been keen to make the benefits of the pension scheme more apparent to staff, introducing electronic 'Total Reward Statements' which set out the value of people's pay and pension as well as other entitlements such as child care vouchers, cycle schemes, learning and development opportunities or entitlement to flexible working.

Local employers

Opponents of institutional NHS policy reform over the past decade have raised concerns that markets, devolution and variation in local commissioning of services will undermine the 'national' component in 'NHS'. But the uniformity of terms and conditions for NHS staff, combined with the standardisation that is inherent in professional regulation and professional education, still sustain a remarkable homogeneity of culture and practice in health care provision across the NHS. Institutionally preoccupied policymakers may try to decentralise and encourage local diversity of services and new models of care, but the national forces of standardisation that shape the local workforce are potent.

With wages making up the majority of spending on the NHS, and tight workforce supply giving employees a continued bargaining advantage, successive administrations have chosen to manage these financial risks centrally. This has also suited trade unions, their seat at a national table and their bargaining power giving members a good reason to pay their

* The NHS Business Services Authority is a Special Health Authority and an Arm's Length Body of the Department of Health which provides a range of central services to NHS organisations, NHS contractors, patients and the public.

† The relatively generous terms and conditions in the national contracts may also act as a brake on efforts to diversify NHS provision, as private sector and independent sector employees look cautiously at competing for staff on these terms or taking on NHS staff who transfer. The expense to employers of the NHS pension has also been a concern, and government itself has been cautious about extending an already generous scheme to an even wider membership, fears which have reduced as increased contributions, a later retirement age and a move from final salary to career average terms have put the scheme on a more affordable footing for the taxpayer.

‡ When comparing the costs of NHS staff to either agency staff or private sector comparators it is important to recognise that basic pay is only one part of the equation.

regular dues. When a consortium of hospitals in South West England attempted to use existing local freedoms to opt out of national conditions, ministers eventually withdrew their backing in the face of trade union opposition and the experiment stalled early in 2013.

With so much of the policy and operational framework decided nationally, local employers in the NHS are left to work with the outcomes of necessarily pragmatic national deals, the ups and downs of national and global labour markets and the imperfections of workforce planning some years earlier.

While only retaining an advisory capacity for consultant appointments in foundation trusts, in NHS trusts the medical Royal Colleges have a statutory seat at the table of the Advisory Appointments Committee for every consultant post. They also approve job descriptions in advance. The system for dismissing consultants is the product of two years of national negotiations. So for the two most blunt employer instruments for a key professional group – hiring and firing consultants – local employers can find their hands are tied at a national level, as they are on pay, hours and nearly all the other key components of management.

6. Motivation, engagement and leadership

There is a growing body of evidence from customer-facing industries that engaged and well-motivated staff are central to consumer satisfaction.

Evidence from the NHS has shown staff engagement is closely linked to the safety, effectiveness and patient experience of care. Indicators of good management of staff correlate with higher quality of care, more satisfied patients and lower patient mortality. Good staff management can also offer significant financial savings for the NHS.[2]

Advocates of a policy approach that is more focussed on staff engagement frequently frame their arguments – implicitly or explicitly – as a rebuke to a centralised and target-driven management style that became common in the 1990s and 2000s, culminating in the exposure of care failings which had been allowed to persist at Mid Staffordshire NHS Foundation Trust. Heated and often politicised discussions about the continued prevalence of authoritarian leadership behaviour and the incidence of poor care remain the subject of ongoing controversy in the NHS, a cultural wound within the system that is still to heal.

The specific issue of the treatment of whistleblowers* has become a totemic part of this debate, seen by some as indicative of flawed managerialism and a closed and defensive culture that is widespread in the NHS. The Public Interest Disclosure Act of 1988 gives legal protection to all employees in the UK if they raise concerns in the public interest. The government has been active in seeking to promote and make real these protections for some time – funding a whistleblower's helpline, enshrining whistleblowing rights within NHS contracts; and amending the NHS constitution.

Following a national review led by Sir Robert Francis,[20] the Care Quality Commission (CCQ) established the post of the National Guardian on whistleblowing and every NHS organisation is required to employ a 'freedom to speak up guardian' as a means of resolving whistle-blowing concerns more constructively.†

As underlined by Don Berwick's report on patient safety[21] in the wake of the public inquiry into events at Mid Staffordshire, an open, inquisitive and undefensive response to staff concerns is a key feature of the culture of safer organisations. However, there are also concerns that where it is necessary to take legitimate disciplinary action against members of staff who may pose a risk to patients, whistleblowing protections may be deployed vexatiously to delay and frustrate proceedings or to vilify the employer and manager concerned.

* More properly 'people who raise concerns', which avoids some of the pejorative connotations of 'whistleblower'.

† The *Freedom to speak up* review's terms of reference did not engage with the difficult area of adjudication on the rights and wrongs of individual cases. Even so, the very damaging impact of many of these cases on people's lives makes this a policy area in which studied neutrality can still elicit intense hostility from all sides.

Figure 6: NHS staff survey results: raising concerns and perceptions of actions[22]

	% saying they would know how to report concerns about unsafe clinical practice	% saying they would feel secure raising concerns	% saying they would feel confident their organisation would address concerns
Overall	86%	68%	66%
Acute	84%	68%	56%
Ambulance	80%	58%	45%
Community	90%	73%	61%
Mental health	89%	69%	57%

The 2015 NHS staff survey found mixed results (see Figure 6) and interpretation of the figures, both nationally and locally, depends to an extent on whether the observer is 'comfort seeking' or 'problem-sensing'. Sir Robert Francis's review, *Freedom to speak up*,[20] was clear that NHS culture and its response to whistleblowing remained an area of real and significant concern.

In the search for NHS sustainability and efficiency, a desire to see the application of more systematic scientific management principles, backed by information technology, is likely to be a common response. Most recently, Lord Carter's review of hospital efficiency focused on workforce as the first port of call for efficiency, noting that of the £72bn total provider spend in 2013-14, £45.3bn went on pay – 63% of the cost.

Lord Carter's prescription, as part of 'a culture of relentless cost containment', is to focus on maximising clinically productive time; better rostering (particularly making use of new software tools); and tight management of annual leave and sickness leave. However, given the mixed track record NHS management has of deploying such techniques, and with a sceptical trade union and professional outlook on management motivations, it is important that such approaches are not simply seen as ways of getting fewer people to work harder at lower cost.

If professionals feel disempowered, with diminished control over their working lives, then such measures may prove counterproductive, with key staff groups preferring the control of more expensive agency and locum arrangements to employed and salaried commitments on increasingly busy wards that are oppressively managed.

With continued pay restraint seeing private sector earnings begin to match the public sector, recruitment and retention of staff through financial incentives alone will be more challenging. For the foreseeable future the NHS will need to compete for staff on non-financial aspects as well. So to recruit, retain and engage people, it needs to make them feel much more valued and supported than they do at present, while at the same time engaging them with an unprecedented period of change.

Doing this will require leaders, managers and health professionals themselves to develop much better insight both into the intrinsic motivators of clinical staff and the unique emotional and psychological challenges inherent in clinical practice. While it has many rewards, being a health professional is demanding and entails a working life confronting things that human nature programmes people to avoid – such as infection, suffering and death.

The inherent psychological burdens of care can combine with poor organisational culture and stressful working conditions to create compassion fatigue and emotional burnout.[23] Growing awareness of the risks in recent years has resulted in a range of responses. For example, the Department of Health has funded more than a 100 NHS bodies to experiment with Schwartz Center Rounds® under the auspices of the Point of Care Foundation.[24] Schwartz Rounds are semi-structured meetings of clinical staff that allows them to discuss the emotional aspects of their work.

Conversely, in the United States, the Institute for Healthcare Improvement has been pressing the case for rediscovering 'the joy in work'[25] as inherently the right thing to do, as well as an important factor in ensuring that care is safe, effective and kind. Early indications from apparently successful experiments in new models of care – such as Buurtzorg's radically different organisation of community nursing in the Netherlands[26] – are suggestive of a possible ideal mix of better staff morale, better care and significantly reduced costs.

Overcoming scepticism and reticence about concepts like 'joy in work' and shifting away from hierarchical 'pace-setting' leadership styles* may be critical in future to the affordable recruitment and retention of well-motivated staff in the NHS. The mechanism for generalising remarkable examples of positive deviance across a system as large and complex as the NHS is far from clear.

A first step might be to foster a better understanding of the multitude of interacting factors which influence the motivations, attitudes and behaviour of people who work in health care.† While national public policy has tended to focus on financial incentives to influence staff, there are a large range of other factors in play. At a time when money is tight, there is a need to move beyond contractual and financial incentives to develop a more sophisticated policy toolkit.

A more multifaceted policy strategy might also seek to integrate factors such as vocation, values, professional culture, employment context, workload, disciplinary and regulatory systems, accountabilities, peer comparison and measures to address some of the inherent emotional burdens of working in health care.

* The pace-setting style of leadership might be characterised as a somewhat driven and insistent approach, using hierarchical authority to insist on high performance and delivery of targets.

† Interestingly a recent, though small, NHS Confederation survey of 203 doctors, nurses and AHPs found that 39% thought that payment and financial mechanisms did not influence their behaviour, while 36% thought that they did. www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/WEB-DoV%20A4%20Infographic.pdf

7. Discussion

This report can only give a rough guide to a large and complex policy landscape, but some key themes have become apparent.

- Power is held nationally. Workforce policy in England is heavily centralised. Detailed pay, terms and conditions of 1.4 million staff are agreed in national negotiations under political supervision. National workforce planners draw on local estimates, but can and do override them where they are judged to be wrong. The nationalisation of workforce policy means that central political concerns and negotiated deals between government and trade union interests can crowd out local employers' interests and ability to innovate.
- The national architecture that shapes the workforce policy world is large, complicated and opaque – a loose association of organisations more than a system. There is no single guiding strategy, nor an effective mechanism to develop a shared vision among the multiple players. Some aspects, such as pay and pensions, are tightly managed from the political centre, while others, such as professional regulation, are relatively independent from both government and employers. There are bilateral and multi-lateral arrangements for parts of workforce policy nationally on particular issues, but there is no point of coordination that ensures overall coherence in pursuit of wider NHS strategic policy.
- Conventional policy is not effective enough. The past three decades of workforce policy have seen painful contract renegotiations, a major legislative overhaul of professional regulation, new workforce planning mechanisms, the complete redesign of the national and local education and training architecture and continued efforts to invent new types of health professional. But, with the exception of adoption of new clinical techniques and use of information technology, what health professionals do today, how they work together and how they relate to their employers, does not seem to have changed very much at all during that time.

We need a radically different approach.

A new style of policymaking

The complexity and sensitivity of workforce issues means that policymakers often prefer to focus on more tractable, less risky and shorter-term policies that emphasise the importance of institutions rather than people. Too often workforce policy is peripheral to mainstream policymaking and considered as an afterthought when it should be the starting point.

This is compounded by change often being done to staff rather than with them – with predictable results. A different style of policymaking is needed that can gain the trust of the professions, and particularly doctors. Too many members of the medical profession

are frustrated by policy which they perceive as being made on the hoof, without their involvement in its construction, with limited understanding of the realities of their working lives, and with insufficient regard for evidence. Whatever the truth, that perception among doctors, given their importance in mobilising support for change in the NHS, means that centrally orchestrated changes will be partial and slower than is needed.

Resetting the relationships between medicine, management, mandarins and ministers demands a shift in mindset and behaviour from all concerned, to one which has the needs of patients and the public as its central guiding and uniting purpose. This requires cooperation rather than confrontation; a policy programme anchored firmly in evidence; and a patient, thoughtful, persistent and determined shared effort, difficult though it might be, to find fruitful common ground. Real change will not be secured in a context of distrust.

Managers and leaders need to learn better ways of engaging senior clinicians, demonstrating understanding of the daily dilemmas of clinical practice, and convincing them that there is a shared mutual interest. A sustained and sincere effort to provide better support to staff could be an important component of that engagement, helping to start to build trust between distinct management and clinical worlds that have long been estranged. At a time when financial incentives will be increasingly feeble, recruiting and retaining staff affordably will depend on them feeling valued, understood and looked after. There is good evidence that this emotional investment in the working lives of staff will pay off in terms of the quality of care that their patients experience.

In turn this shift demands that doctors take the risk of leading change and taking their other professional colleagues with them. In a National Audit Office survey conducted in 2013 only 41% of consultants thought their organisation motivated them to meet organisational objectives.[27]

While change in this area requires a shift in mindset more than discrete interventions, it could be supported by incorporating an appetite and capacity for staff engagement and inclusive decision making as a key criterion for the recruitment and development of all leaders in the health and care system.

A further option would be to reconstitute the Social Partnership Forum as a meaningful forum for shaping policy from the initiation stage, so that ministers, employers, officials and trade unions are in a continual conversation about policy as it develops and as it is implemented.

Recognise the complexity: modify opportunistically

Given the centralisation of workforce policy, and its centrality to the future of the NHS, it is concerning that the institutional architecture that shapes it is so complicated, with more than 40 national bodies playing a part.

The English NHS policy world is one in which devolved administrations, five Whitehall departments, the European Commission, independent professional regulators, pay review bodies, NHS Employers, skill sector councils, Health Education England and a range of other national bodies interact to try to secure affordably the right number of motivated staff with the skills, attitudes and behaviours needed to meet public and patient expectations of the NHS.

Further national institutional reorganisations would be counterproductive when the urgent need is to focus on the major workforce challenges the NHS is facing. Accordingly, we recommend that the Department of Health adopts an evolutionary and opportunistic approach towards a simplification and consolidation of the national system. Addressing the complexity of the professional regulation system in the legislation already planned for this area would be an obvious starting point and the further review of legislation announced by ministers in December 2015 represents an important opportunity.[28]

Treat it like a system: introduce strategic coordination

System complexity makes a strong strategic coordination function particularly important.* It may be the case that the system is simply too big and too complicated to be overseen from a single point. Even so, while parts of workforce policy show evidence of design there is a lack of strategic coherence.

There is no mechanism to agree a single vision for the workforce or secure coherent action in its pursuit across the national bodies. There is also additional complexity arising from institutional tensions about roles and territory that continue to play out in the wake of the 2012 Health and Social Care Act and the Mid Staffordshire Public Inquiry.

In March 2016 the independent NHS Pay Review Body concluded that all four UK countries should develop a strategic health workforce framework at national level.[29] We share that view. The Department of Health, Health Education England (HEE) and NHS England do not appear to have a shared view of who does what on strategic workforce policy. This is perhaps a symptom of wider lack of clarity about who does what in the new NHS as a whole and of system confusion about what the overall NHS strategy is, beyond the Forward View. The Forward View is an initiative which could help provide focus and coherence, in part, to workforce policy.

December 2014 saw the announcement of a Workforce Advisory Board chaired by Health Education England. However, its terms of reference, membership, agenda and minutes have not been published, it is unclear if it has met, and HEE does not have the reach across the national architecture to convene the system or to steward organisations over which it has no formal authority. There is also a Strategic Workforce Forum co-chaired by senior Department of Health and HEE officials, but again it is unclear what it talks about and with whom.

Outside the Forward View, there is little evidence of a coherent and compelling system vision that will guide the multiple and disparate players towards a common goal.

We recommend that the existing national committees are reconstituted as a National Workforce Strategy Board to provide strategic leadership on workforce policy in England and assure consistency of purpose and coherence of action across the national bodies, consistent with the Forward View.

* The 2020 workforce vision and plan published by the Scottish Government in 2013 is one example of how different strands of workforce policy can be brought together with an explicit and more coherent framework. See: *Everyone Matters: 2020 Workforce Vision. Implementation Framework and Plan 2014-2015*, Scottish Government 2013.

From the outset the Board should adopt a habit of transparency in conducting its business so that staff and employers can help to shape change and maximise the success of new policy. The scale of change needed may mean longer and more difficult conversations at the start, but these will result in better policy that is more effectively and meaningfully delivered onthe ground.

The Board could be established by the arms-length bodies leading implementation of the Forward View: NHS England, NHS Improvement (from April 2016), Health Education England and NICE. However, the single most influential body within workforce policy remains the Department of Health. While the 2012 Health and Social Care Act and 2014 Care Act directly conferred a range of powers onto independent arms-length bodies, the Department retains significant operational workforce functions (such as pay and pensions), as well as stewardship of the overall system.

As such, we recommend that the Department of Health should take leadership of establishing a collective Board, and ensuring it works constructively and is consistent with coordination activity on non-workforce topics undertaken under the auspices of the Forward View.

Better understand people: think broadly about motivations

Conventional workforce policy instruments focussed on regulation, financial incentives and contracts are not currently securing the rapid changes in the shape, motivation and behaviour of the workforce needed to support affordable new models of care in the NHS. If the current pace of change continues, it seems likely that the workforce the NHS depends on in 2020 and 2030 will be broadly similar in character and composition to the one it has today, just as today's staffing picture is similar to that of five and 15 years ago.

Policies based on a more sophisticated understanding of the intrinsic motivation of health professionals, and focused on professional culture and values, staff morale, staff well-being and staff engagement will be needed if the NHS is to retain and motivate people to provide good care in a busier NHS and in the context of continued pay restraint.

We recommend that the National Workforce Strategy Board use HEE's 15-year forward view[11,*] as starting point for the development of a comprehensive, integrated and long-term workforce strategy encompassing these less transactional drivers of staff behaviour as well as the traditional elements of pay, contracts, regulation, education and planning. It is critical that this is done with, not to, both staff and employers and time should be taken to build support, ownership and consensus.

The strategy will need to address the short-term priorities, to enable and drive the delivery of the vision set out in the Forward View to 2020, and also take a longer-term view about more profound policy changes now needed to begin bringing about more fundamental changes to the professions that will sustain and improve the service in the 2020s and beyond.

* It may also be helpful to draw on any early outputs from the valuable work the Department of Health has commissioned from the Centre for Workforce Intelligence on the workforce needed in 2035, 'Horizon 2035'. See: www.horizonscanning.org.uk/HS-research/horizon-2035/

The new Board will also need to consider urgently how to retain and motivate staff as the system gets busier and as pay constraints continue. A strategy based solely on contractual changes to secure more work from fewer staff at reduced cost will be counterproductive as staff move to more family-friendly agency or locum arrangements over which they have control, and as recruitment problems drive inflationary pressures on the pay bill.

Developing an approach to staff engagement that looks beyond financial reward must be an essential element of that strategy. As a starting point, this could include:

- considering the national messages that system leaders send about the value of NHS staff
- better understanding of how local leaders can create organisational cultures that celebrate their staff
- building models of care that give staff time to care
- structuring working patterns that recognise the family and caring responsibilities of a predominantly female workforce
- addressing the continuing barriers to progression for women and black and minority ethnic staff
- ensuring a sustained and effective focus on the health and wellbeing of staff
- fostering genuine social partnership arrangements between employers and trade unions locally
- creating working cultures where health care staff have the time and the space to decompress from the particular stresses and psychological burdens inherent in clinical practice.

Three priorities: medical education, new roles, staff shortages

Workforce policy is too large to attempt to reform all at once. We suggest three areas to focus on first: medical education, new roles and staff shortages.

Medical education

The central importance of medicine to health care is increasingly being rediscovered across the globe. In a world where multi-professional working is central to safe and effective care, we do still need to talk about doctors. Their formal and informal power, both nationally and at the front line, continues to dominate health care. System relationships with the profession can be difficult or prickly. The asymmetry of information between the profession and the public makes it sometimes difficult to judge whether resistance, doubt and concerns are legitimate or otherwise.

As such, a holy grail of health care policy remains finding and growing a new generation of doctors who will lead change across organisations. Kaiser Permanente, the biggest non-profit health plan organisation in the United States, has recently announced it will be establishing its own medical school, so that it can select and grow new generations of doctors with the attitudes and expectations they need for the future.[30]

A strategic priority for the NHS should be to ensure that the education and training of doctors:

- shapes a professional culture that engages constructively with properly evidenced change in the interest of patients
- grows doctors who lead change themselves in the name of improved patient care
- shapes a profession in which colleagues who step up to the leadership mark are valued and willingly followed.

Opening the box of medical education and reviewing – with doctors, their professional colleagues, patients and employers – what kind of doctor society needs in the future will be difficult and controversial. It will require sensitivity, maturity and patience to reach a consensus. However, it is important that conversations start soon, as they will shape the skills and attitudes of doctors taking up their first consultant posts in 2030. In parallel to that review, working in partnership with colleagues in local government and Skills for Care, the Board should commission HEE to review the workforce implications of more radical integration of health and social care for all health and care professionals beyond the timeframe of the Forward View.

New roles

The second key early priority should be a rapid assessment of the national and international evidence on the value and impact of new roles and extended roles. This should consider safety, effectiveness, patient experience and efficiency, together with what is known about the best methods for introducing new roles productively and sustainably into new and conventional working contexts.

This should include an assessment not just of the cultural barriers to innovation, but also whether professional regulation needs to adapt its oversight framework to enable new types of worker to carry out higher risk clinical work, such as prescribing of a limited formulary under appropriate supervision or minor procedures that are traditionally the preserve of regulated professionals. This might consider whether local processes for accrediting staff as skilled to perform a particular intervention or procedure might be used to create qualifications or 'credentials' which are transferrable to other employers, perhaps using the electronic staff record to do so. This approach of 'credentialing' might offer a less burdensome and costly regulatory framework than full blown statutory regulation.

Staff shortages

Thirdly, policymakers should consider undertaking an in-depth review of why England, unlike health care systems in other developed countries, is beset by chronic staff shortages and an unusually high dependence on overseas recruitment.

With the globalisation of health care labour markets offering a safety valve for the risk of induced demand, a strategy erring on the side of surpluses, with students taking a greater share of the financial risk, may be a preferable strategic aim to the current situation. At present, shortages of staff drive up labour costs, which in turn centralises decision making and pulls it closer to politics and further from the needs of local organisations and the patients they serve.

Let go: empower local employers

Looking to the longer term, the national system needs to begin to lay the foundations for letting go of central control where it makes sense to do so, and to begin to consider where and when it might best do this.

In the meantime, we recommend that the National Workforce Strategy Board commissions NHS Employers to conduct a strategic review of local NHS HR functions with the aim of increasing capacity and capability. The purpose of this would be to not just enable effective use of the few local freedoms available, but more importantly to re-energise the HR profession in the NHS with a new stronger focus on staff engagement, health and well-being, morale, culture, professionalism and organisational development. The abolition of strategic health authorities – both as a sensible planning footprint and a vessel of expertise – has denuded the system of strategic workforce capability and urgent thought is needed on mechanisms to support local cooperation and innovation.

Conclusion

Securing people with the values, skills, experience and expertise which the NHS needs is central to the future of the England's health care system. It holds the key to both affordable and high quality care. Achieving at speed the changes needed to unlock this – both nationally and locally – requires a substantial rethink of how we go about workforce policy and a reformation of the relationships between professional and managerial cultures.

The Health Foundation will be pursuing a number of projects to inform the development of a new strategic workforce programme for the organisation. These projects will look at a number of issues, including:

- effective interventions to build engagement and sustain staff motivation
- how successful leaders engage members of the clinical workforce and harness their positive professional instincts
- the factors that shape professional behaviour and attitudes and how changes to medical education might shape a different medical workforce in the future.

We will also be conducting a series of expert seminars to discuss further the issues raised in this report.

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The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

The Health Foundation
90 Long Acre, London WC2E 9RA
T +44 (0)20 7257 8000
E info@health.org.uk
@HealthFdn
www.health.org.uk

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