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**Health Select Committee
Submission from Amicus Health on Workforce Needs and Planning
for the Health Service**

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

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

2. How effectively workforce planning, including clinical and managerial staff, has been undertaken, and how it should be done in the future.

2.1 This inquiry is timely and is welcome. For sometime there has been an apparent mismatch between the Department of Health’s (DoH) policy objectives and the need to properly undertake workforce planning in order that these are met. For example Amicus has previously observed in evidence submitted to the National Pay Review Body for Nurses Midwives and Health Visitors that despite many welcome new policy initiatives placing additional responsibilities on community practitioners, which our members are more than willing and competent to undertake, the Whole Time Equivalent (WTE) numbers involved in undertaking this work has remained virtually static. For example the latest figures for health visitor numbers reveals an increase from 10,046 to 10,137 WTE over the period 2000-2004 or less than 1 per cent. Survey evidence from Amicus reveal that this small advance has been reversed by recent cuts in numbers will not appear in DOH statistics until 2007.

2.2 Workforce Development Confederations are responsible for workforce planning at a Strategic Health Authority level. There appears to be little dynamic to this process in responding to changing health priorities as determined by the DoH. Where numbers are expanded in response to increasing government investment this takes place across broad occupational groupings and often at the expense of relatively small specialities. For example health visitors form approximately 4 per cent of registered nursing workforce. One would expect in an era of expanded resources that numbers of staff employed will increase but in some occupations expand at a faster rate in response to the government’s health priorities. There is evidence that this has not happened which reflects a weakness in current workforce planning.

2.3 Likewise strategic planning has been broad brush in its approach. For example the Wanless report called for expanded numbers in very broad categories doctors, nurses, therapists and ignoring groups like healthcare scientists. We accept that this report was intended for another purpose, namely, making the case for expanding capacity in the NHS. So

the report can be seen as an undoubted success, however its publication highlights the absence of any subsequent strategic planning.

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

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

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

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

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

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

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

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

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

3.8 The NHS is subject to undue political pressure. This more often than not arises out of issues concerned with acute services as primary care services are seen as less measurable in terms of output or outcomes. This is despite clear clinical evidence and public acceptance that public health and health promotion in the medium to long term provides better health outcomes. But it is a fact that concern is expressed, rightly, if patients are on trolleys in corridors awaiting a hospital bed, but no such similar concern is expressed if school children do not receive health and well being advice from a school nurse because her caseload is over 5000. Relative to acute services public concern about Community Mental Health Services does not feature on the political radar except for the most conspicuous failures that grab press attention..

3.9 This Inquiry is a once in a lifetime opportunity for the NHS to effect many of the changes contained within the White Paper. A transition of this kind would always be easier to

achieve in an era of expanded investment. It means that on a like for like basis a greater emphasis can be placed on the goals of the White Paper by expanding resources in these areas at a faster rate. Combined with a stated intention to deliver more services closer to service users then real change can be achieved. Yet if the NHS waits to the next spending round, which may be less generous, then it would be doubtful if such change can be effected.

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

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

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

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

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

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

4. How will the ability to meet demands be affected by:

- **financial constraints**
- **the European Working Time Directive**
- **increasing international competition for staff**
- **early retirement**

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

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

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

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

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

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

5. To what extent can and should the demand be met, for both clinical and managerial staff, by:

- **changing the roles and improving skills of existing staff**
- **better retention**
- **the recruitment of new staff in England**
- **international recruitment**

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

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

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

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

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

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

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

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

5.9 New staff should obviously be recruited from England as long as this does detract from freedom of movement for labour amongst nations in the UK and our European Union partners. Amicus has a long tradition of international solidarity and are concerned at reports from our sister trade union in South Africa that their health services are being denuded of skilled and professional staff by the NHS. Besides, as we have stated, we believe that the public sector can help maintain socially acceptable levels of employment and provide opportunities for social mobility.

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

6. How should planning be undertaken:

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

6.1 Amicus believes that the workforce needs and planning should be decentralised with strategic direction from the “centre”. We certainly would wish to avoid a NHS workforce version of Gosplan. We are not confident that such a plan could be reached and if so it would be undoubtedly over influenced by traditionally stronger voices at the expenses of those groups or services who may be in a better position to address the government’s health priorities.

6.2 So what are these health priorities? What quality of service is envisaged? What staff are in the best position to provide this service? Where should they be deployed? What support should they provided with so that they meet their objectives?

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

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

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

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

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