

Getting into shape: Delivering a workforce for integrated care

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Executive summary

A new NHS workforce policy to support integrated care and reform

The Government is rightly committed to a radical reshaping of NHS delivery, based on a shift to new care models and treatment in the community. Its management of the NHS workforce, however, has not delivered with nearly three times more doctors, and four times more nurses in the acute sector than in the community.¹ Since 2009, the number of consultants has risen by nearly a third, whilst the number of GPs has fallen.² Freedom of Information requests made for this report found that, across 61 acute trusts, only 6 per cent of consultants work in the community for at least one session per week.

As the Government and the NHS leadership have repeatedly said, the priority for the NHS is to increase its speed of innovation.³ To do this, the NHS is rightly seeking to devolve decision-making and to deregulate. For the workforce, however, policy remains highly centralised and tightly regulated. This paper shows how to bring the same reform ideas to the workforce as the NHS is applying to other areas.

A number of practical and cultural barriers need to be overcome if this imbalance is to be redressed. The funding model of the NHS continues to drive activity, and resources, towards the acute sector.⁴ Medical training is based on specialisation and gives little recognition to inter-specialty transferable skills.⁵ Interviewees for this paper concluded that this approach creates a workforce of “super-specialists” based predominately in the acute sector rather than an integrated team built around patient needs. The vast majority of clinical training placements are weighted towards the acute sector.⁶ Interviewees also reported a “snobbish” attitude that places primary care at a lower status than secondary care.⁷

This paper follows a previous *Reform* report, *Work in Progress*, which showed how better use of technology and a better culture of employment can increase efficiency in the whole public-sector workforce.⁸ The paper focuses on the structural barriers to delivering integrated care.

Invigorating the medical labour market

Removing the cap on training places for doctors

The deregulation of the NHS workforce begins with the removal of the national cap on doctors’ training places, set by the Department of Health. The aim of the cap has been to control costs by limiting the number of doctors in training. The result, however, has been an inadequate pool of labour, difficult working conditions and a powerful staff body, many of whom choose to work for expensive agencies.⁹

There is a worldwide shortage of healthcare professionals and yet the NHS imports 26 per cent of its doctors, many from poorer countries struggling to afford the drain on their workforce.¹⁰ OECD statistics show the UK as the sixth biggest importer of foreign trained

1 NHS Digital, *NHS Workforce Statistics - February 2017, Provisional Statistics*, 2017.

2 Ibid.

3 Jeremy Hunt, ‘Innovation and Efficiency’, Speech, (13 November 2014). NHS England, *Health service embracing innovation as NHS England announces major trials to improve patient care* (2016).

4 Kate Laycock and Elaine Fischer, *Saving STPs. Achieving Meaningful Health and Social Care* (Reform, 2017).

5 General Medical Council, *Adapting for the Future: A Plan for Improving the Flexibility of UK Postgraduate Medical Training*, 2017.

6 Professor Val Wass, Professor Simon Gregory, and Katie Petty-Saphon, *By Choice – Not by Chance* (Health Education England, 2016).

7 Ibid.

8 Alexander Hitchcock, Kate Laycock, and Emilie Sundorph, *Work in Progress: Towards a Leaner, Smarter Public-Sector Workforce* (Reform, 2017).

9 National Audit Office, *Managing the Supply of NHS Clinical Staff in England*, 2016.

10 Jeremy Hunt, ‘Speech to Conservative Party Conference 2016’, October 2016; Carl Baker, *NHS Staff from Overseas: Statistics*, HC 7783 (London: House of Commons Library, 2017). World Health Organization, “New global alliance seeks to address worldwide shortage of doctors, nurses and other health workers”, Press Release, (25 May 2006).

doctors.¹¹ Talented individuals are being turned away from medicine. In 2017, 19,210 applicants applied for just under 6,000 places.¹² The NHS should uncap training places for doctors following successful removal of caps for pharmacists whilst learning lessons from the removal of bursaries for nurses and allied health professionals.

By removing the cap on training places, the NHS could produce a sufficient or excess number of trained individuals that it could employ. Greater number of trainees should give managers more flexibility in shaping the workforce in accordance with population demand rather than workforce supply. It should aim to create a more conventional labour market, as seen in other sectors.

Reduced bill for agency staff

High vacancy rates have resulted in excessive agency spend. In 2015/16, the NHS spent £1.3 billion on agency doctors.¹³ This is the same amount it spent on training student doctors.¹⁴

Accurate costing of medical education

This report proposes a review of the true cost of medical training. At present, there is a wide variation between institutions, with some hospitals paid tens of thousands of pounds more per student by HEE than others.¹⁵ Buckingham University provides training for doctors at a total cost of £162,000,¹⁶ compared with the Department's own target of £230,000.¹⁷ This suggests that there are great efficiencies to be made. The report estimates that a doubling in the annual output of trained doctors, to 12,000, could cost an additional £140 million per year.

New funding arrangements for student doctors

Ministers should require trained doctors to pay back the taxpayer-funded costs of medical training should they decide not to work in the NHS. This report suggests that students should pay back £11,700 per year, for a maximum of ten years, for each year spent working for a non-NHS employer or locum agency. In other professions, such as accountancy, it is normal for employers to pay for the cost for training, but for trainees to take on that cost should they leave the firm during training.

Devolved workforce planning and pay

The NHS is right to seek to devolve decisions on the future pattern of services to the local level, in the form of Sustainability and Transformation Partnerships (STPs). Local health economies are best placed to decide how to reform health and social care in their areas. Decision-making over the workforce, however, remains highly centralised, with the key actor being the Department of Health, working through the arms-length body Health Education England.¹⁸

New powers for STPs to innovate

STPs should take control of the training budget in the same way as they should take responsibility for the whole health and social care budget in their areas. Different STPs have different priorities and require different workforces. An STP in an area with a large elderly population, for example, could invest in community nurses and geriatricians capable of

11 OECD, "Health at a glance", Web Page, (4 November 2015).

12 UCAS, *Deadline Applicant Statistics: October*, 2016.

13 NHS Improvement, 'Reducing Reliance on Medical Locums: A Practical Guide for Medical Directors', Web Page, (2016).

14 Department of Health, *Expansion of Undergraduate Medical Education*, 2017.

15 NHS England, 'NHS National Tariff Payment System 2016/17' (GOV.UK, 23 March 2016).

16 The University of Buckingham Medical School, 'Selection Process', Webpage, (2017).

17 Department of Health, *Expansion of Undergraduate Medical Education*.

18 House of Lords Select Committee on the Long-term Sustainability of the NHS, *The Long-Term Sustainability of the NHS and Adult Social Care, Report of Session 2016/17*, HL Paper 151, 2017.

managing multi-morbidity. STPs with high numbers of children will invest in paediatricians and health visitors. Kaiser Permanente is an international accountable care organisation highly engaged with training doctors. They are “moving beyond traditional health care settings, acknowledging the importance of team-based care, and promoting a focus on diversity and inclusion to deliver health equity.”¹⁹ As well as training, a one-system-one-budget approach across STPs between approach and should incentivise staff to work across the local area rather than being confined to a hospital or general practice.

STPs should use their freedom to develop innovative ways to attract, train and retain staff. Interviewees pointed to cheaper training courses, shorter courses, guaranteed jobs on completion of medical school and flexible training opportunities. STPs should embrace new routes into health and social care employment, in particular apprenticeships.

Health Education England

Under this proposed model, Ministers would abolish Health Education England. The General Medical Council would take over its work on training and development. STPs would take over their role in the commissioning of training.

Devolution of decision-making on pay

Devolution should apply to pay as well as training. National pay bargaining has, in part, been held responsible for significant variations in regional vacancy rates across the country.²⁰

Individual providers should not be restricted by rigid pay scales or the 1-per-cent pay cap. Instead, providers should be able to use all the tools available to design contracts that promote working across boundaries whilst suiting staff needs. These include pay, excellent performance management, progression opportunities, holidays, study leave and pensions.

Overcoming professional boundaries

A new model of regulation

The present system of workforce regulation in the NHS has a number of significant flaws. In some areas, the decision to regulate medical activity seems unrelated to patient risk. Perfusionists, for example, operate heart and lung bypass machines during cardiac surgery but are not regulated.²¹ Music therapists are regulated but art therapists are not.²² In others, the regulation of staff members in specific job roles contributes to a siloed and disjointed system.²³ It leads to an old-fashioned model of care in which patients are referred around the system to different regulated professionals, when care could be delivered by a smaller number of clinical staff working in one place.

The aim should be to lift more low-risk tasks out of professional regulation. This would empower those staff that have the skills necessary to deliver more care but are frustrated by current regulation. It would also ease the ‘bureaucratic jungle’ that characterises the current system, allowing staff to shift time from compliance to delivering care.

A Skills Pass

Developing a universal Skills Pass for all NHS staff would enable staff to work across professional boundaries. The Skills Pass would be based on a competency-based training framework of unregulated tasks.

¹⁹ Kaiser Permanente, “A different kind of medical school”, Web Page, (6 September 2017).

²⁰ Ed Holmes and Matthew Oakley, Local Pay, Local Growth (Policy Exchange, 2012).

²¹ The Health Foundation, *Fit for Purpose? Workforce Policy in the English NHS*, 2016.

²² Ibid.

²³ House of Lords Select Committee on the Long-term Sustainability of the NHS, *The Long-Term Sustainability of the NHS and Adult Social Care, Report of Session 2016/17*.

In the short term, it would provide much-needed progression opportunities, especially for the unregulated workforce. The number of voluntary resignations due to lack of opportunities in the NHS has increased by 68 per cent in the last five years.²⁴ In the longer term, it would be a key enabler to the vision set out in the *Five Year Forward View*.²⁵ It would create a workforce whose skills and experience were not aligned to one particular professional group or sector, but rather a workforce of generalists which could flex its skills to the needs of the patient workers are caring for.

The unregulated tasks covered by the Skills Pass would include clinical skills such as simple wound dressing and cannulation, caring for someone in their own home and digital skills. It would use an online portal as a support tool for training that is largely delivered on-the-job. Senior staff members will assess whether an individual has the appropriate level of knowledge and skill to gain a competency.

Improved performance management

A deregulatory approach will be supported by improved performance management. At present NHS provision of performance management is highly variable, with evidence suggesting that it can be absent for lower paid, unregulated workers and those in social care. According to the recent NHS Staff Survey, only 20 per cent of Allied Health Professionals said their appraisals had helped them improve how they did their job.²⁶ Meaningful appraisal should be universal amongst NHS and social care employees.

Recommendations

Recommendation 1: Undergraduate training should be uncapped across the health and social care system.

Recommendation 2: Doctors who choose not to work for the NHS should reimburse the cost of their training. For doctors working within the NHS, the cost should be automatically paid back by the NHS. For those choosing not to work in the NHS, they (or their employer) must pay back the cost on an annual basis. There must be a fair approach taken to arrangements such as part-time working, unemployment, sickness, maternity and paternity leave and time doing research.

Recommendation 3: All health and social care professionals should be fully registered at the point of graduation.

Recommendation 4: As STPs develop into accountable care systems, they should become responsible for workforce planning across the whole health and social care system. Training budgets should be included within their funding envelope and they must seek to deliver training that cuts across all sectors and for all staff.

Recommendation 5: STPs must take a 'one-system, one-budget approach' to ensure that all organisations are working towards the same outcomes. This would enable STPs to create a workforce that works across boundaries with more generalists.

Recommendation 6: Staff contracts should be designed to promote working across the acute and community sector.

Recommendation 7: STPs should develop and trial the full range of alternative and flexible routes into health and social care.

Recommendation 8: Organisations within the STP must work together to ensure high quality training is being delivered at capacity.

²⁴ NHS Hospital and Community Health Service, *NHS Hospital & Community Health Service Monthly Workforce Statistics: Timeseries of Reasons for Leaving/Staff Movements and Redundancies*, 2017.

²⁵ *Reform* calculations. NHS England, *Five Year Forward View*, 2014.

²⁶ NHS England, *National NHS Staff Survey 2016*, 2016.

Recommendation 9: Pay should be negotiated locally. It should be used in conjunction with other performance management strategies to attract and retain staff. Both AfC and the 1 per cent pay cap should be removed.

Recommendation 10: The Government should amend the legislation detailing the remit of the 9 regulatory bodies to include a requirement to work with health and education stakeholders to produce a database akin to the UKMED. This should include details of trainee and professional performance and should identify tasks and procedures within professions that carry risk to patients.

Recommendation 11: The Government should introduce legislation requiring each regulatory body to carry out at fixed intervals a risk audit of all the professions and roles they regulate. This should be informed by their database indicating the level of risk associated with different roles and procedures. Where evidence suggests it would not be detrimental to patient safety, bodies should deregulate tasks.

Recommendation 12: A universal Skills Pass, with non-regulated competencies, should be introduced by NHS England. All employees working in the health and social care sector will have an opportunity to gain any competency. STPs must introduce the Skills Pass in their health economy, though they will have flexibility on dictating the training structure and competencies offered.

Recommendation 13: An annual appraisal should be mandatory for all staff members. The appraisal must be useful to staff members by being outcomes focused and recognise where staff have challenged and developed themselves using the Skills Pass.

Introduction

Policymakers have attempted to deliver more integrated care in the NHS for decades. This has taken various guises. In the 1960s, multidisciplinary approaches were developed.²⁷ In response to growing concerns about the division between hospital, primary care and local authority services, ‘partnership working’ initiatives, including closer financial alignment, were introduced throughout the 1970s.²⁸ In the 1980s and 1990s, wider sharing of patient information between health professionals became a priority.²⁹ These policies aimed to deliver better patient outcomes alongside cost savings.

Following the financial crisis, the efficiencies associated with a more integrated care model brought the topic back up the political agenda. A 2010 White Paper set out a vision for an NHS that is “less insular and fragmented, and [that] works much better across boundaries”,³⁰ whilst also noting the need to achieve “unprecedented efficiency gains”.³¹ The *Five Year Forward View* recognises that “services need to be integrated around the patient”,³² and pledges to “unleash system efficiencies” by creating “major new care models”.³³

Despite strong rhetoric, examples of integrated care remain the exception in the NHS. Patients continue to “fall through the gaps or suffer at transitions from poor communication and coordination and a system not designed around their needs.”³⁴ This is especially concerning given patterns in demand. Population ageing means the service will need to deliver more care, increasingly to patients with multiple, complex and long-term conditions.³⁵ Treating such conditions efficiently and effectively requires a “partnership with patients over the long term rather than providing single, unconnected ‘episodes’ of care”.³⁶

Integrated care is not possible without an integrated workforce. Yet the current workforce operates in isolated components and is imbalanced towards the acute sector – a trend which is on track to worsen. This paper makes bold recommendations designed to build a workforce for integrated care. It highlights pervasive cultural factors that divert trainees away from high-need specialities and describes bureaucratic barriers preventing some staff from utilising all their skills. It details radical reform to the funding and training systems that currently prevent staff spanning physical and professional boundaries. Without this fundamental reform, steps towards integrated care will remain slow, piecemeal and small in scale.

27 Shaw, Sara, Rebecca Rosen, and Benedict Rumbold. *What Is Integrated Care? An Overview of Integrated Care in the NHS*. (Nuffield Trust, 2011).

28 Jenny Priest, *The Integration of Health and Social Care* (British Medical Association, 2012).

29 JP Hampson, RI Roberts, and DA Morgan, *Shared Care: A Review of the Literature* (Oxford University Press, 1996).

30 Department of Health, *Equity and Excellence: Liberating the NHS*, 2010, 9.

31 *Ibid.*, 5.

32 NHS England, *Five Year Forward View*, 2014, 16.

33 *Ibid.*, 17.

34 NHS England, *Safe, Compassionate Care for Frail Older People Using an Integrated Care Pathway: Practical Guidance for Commissioners, Providers and Nursing, Medical and Allied Health Professional Leaders*, 2014, 2.

35 Centre for Workforce Intelligence, *Future Demand for Skills: Initial Results*, 2015.

36 NHS England, *Five Year Forward View*, 2014.

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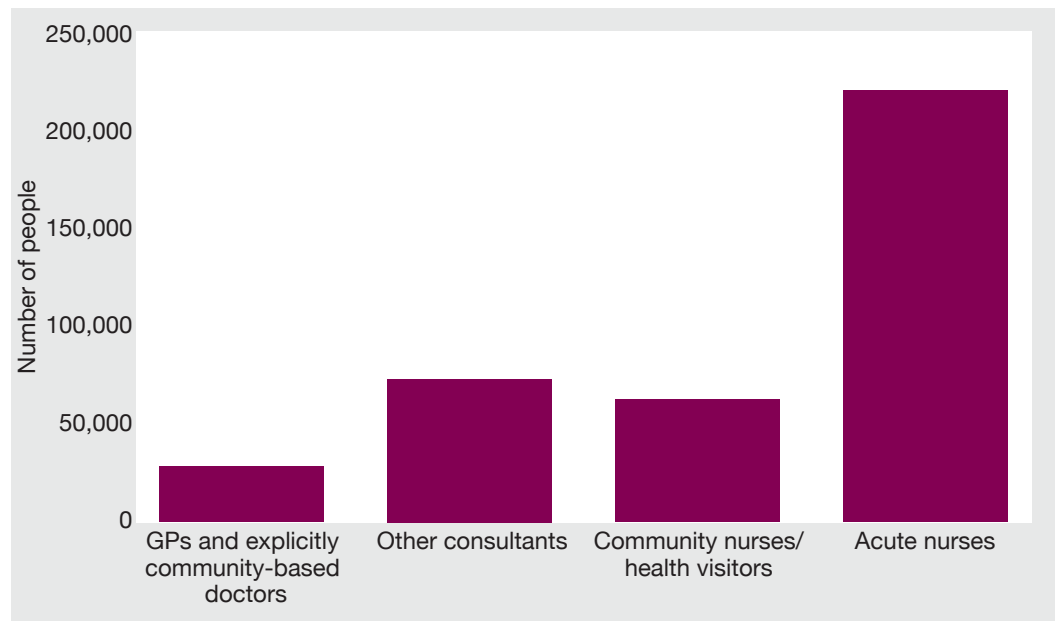
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1.1 The shape of the workforce

Workforce planning in the National Health Service (NHS) has been poor over the last decade. Decisions on the number of staff employed, their specialty and the location in which they work have given little attention to long-term patterns in demand or the sustainability of the service. In 2007, the Health Select Committee described NHS staff forecasts as a “disastrous failure”, noting an “appalling lack of coordination between workforce and financial planning”.³⁷ *The Five Year Forward View* acknowledges that growth in the NHS workforce since 2000 has “not fully reflected changing patterns of demand”.³⁸

The result has been a continued focus on expanding numbers, rather than reforming delivery models, and an unbalanced workforce based predominately in the acute sector. On the latest available data, there were nearly three times more doctors and nearly four times more nurses based substantively in the acute than the community sector (see Figure 1).

Figure 1: Number of full-time equivalent NHS staff, March 2017



Source: NHS Digital, *NHS Workforce Statistics - March 2017, Provisional Statistics, 2017*.

In 2016, Jeremy Hunt, Secretary of State for Health hailed recent workforce expansion and pledged to make a further 11,000 doctors and 40,000 nurses available over the next parliament.³⁹ However, recent workforce growth has also fallen predominately in the acute sector (see Figure 2), despite the *Five Year Forward View* noting the need to move more care into the community⁴⁰ and Health Education England (HEE) reporting shortages in general practice and primary care.⁴¹

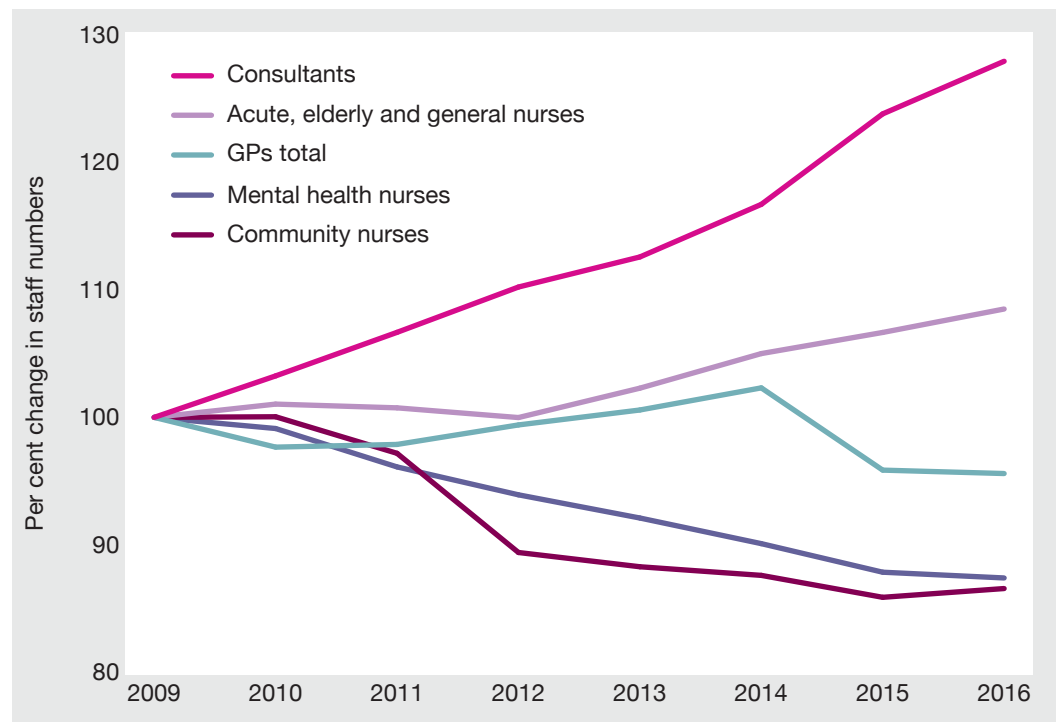
³⁷ House of Commons Health Committee, *Workforce Planning: Fourth Report of Session 2006-07*, HC 171-I, 2007.

³⁸ NHS England, *Five Year Forward View*, 30.

³⁹ The Rt Hon Jeremy Hunt MP, “NHS Providers Annual Conference Keynote Speech,” Web Page (30 November 2016).

⁴⁰ NHS England, *Five Year Forward View*.

⁴¹ Health Education England, *Annual Reports and Accounts 2015/16*, 2016.

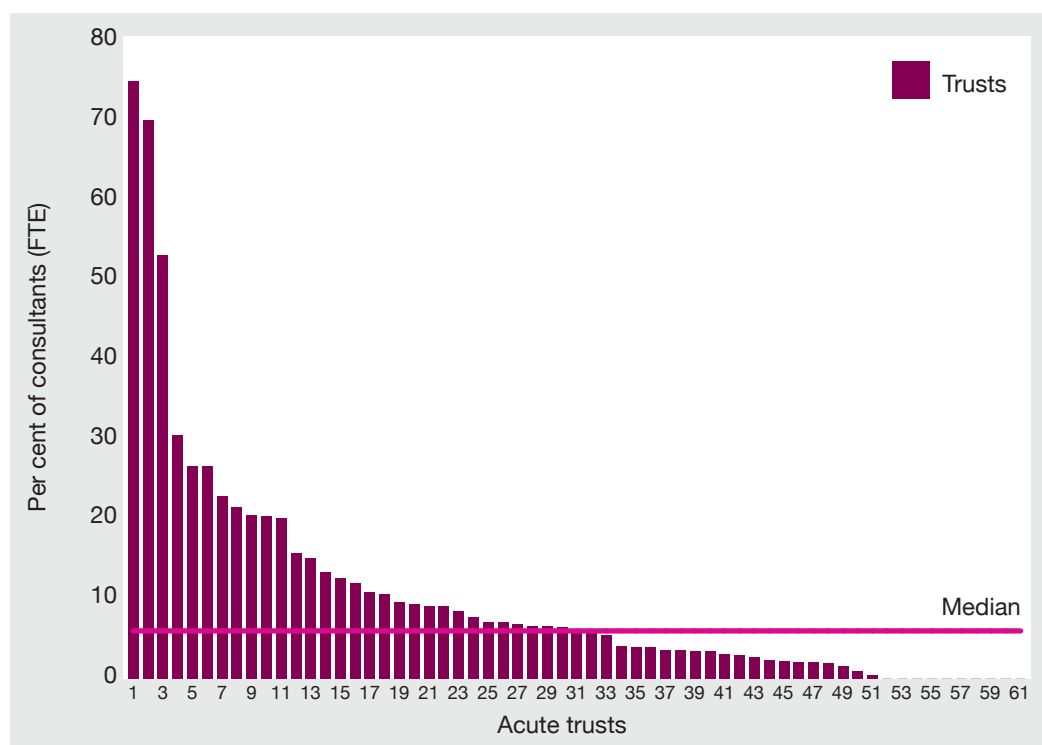
Figure 2: Percentage change in full-time equivalent staff 2009 – 2016 (base = 2009)

Source: NHS Digital, *NHS HCHS monthly workforce statistics – Provisional Statistics: Nurses & health visitors and Midwives and support to doctors, nurses & midwives by Staff Groups, Area and Level – Full Time Equivalent NHS Digital, 2017*. NHS Digital, *Healthcare Workforce Statistics: England September 2016, 2017*. NHS Digital, *General and Personal Medical Services in England 2004-2014, 2014*.

However, moving care into the community goes beyond increasing the number of general practitioners and community nurses; it requires staff from different aspects of the health and social care system to span professional boundaries and work together. In practice, this means doctors and nurses who are predominately based in the acute sector delivering community care.

Data availability makes it difficult to accurately assess the extent to which this currently happens, but obtainable evidence suggests it is not commonplace. Freedom of information requests to 61 acute trusts reveals a median of only 6 per cent of consultants are currently working in the community for at least one session per week (see Figure 3).

Figure 3: The proportion of consultants who work at least one session per week in the community



Source: Freedom of information requests, 2017.

1.2 The case for integrated care

A workforce designed to deliver integrated care based in the community where possible would improve user experience and deliver better value for money. A primary factor driving future demand for healthcare is the increase in the average age of the population.⁴² The changing composition of the population has implications for the amount and type of healthcare that is required. Older people are more likely to have multiple, complex and long-term health conditions. The Centre for Workforce Intelligence (CfWI) estimate that by 2035, the number of care hours required from the NHS will increase by 36 per cent to 12.2 billion.⁴³ Over 80 per cent of this additional demand is expected to be driven by an increase in patients with long-term conditions, largely due to population ageing.⁴⁴

Individuals with such conditions are best served by integrated care. The *Five Year Forward View* recognises that “caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected ‘episodes’ of care”.⁴⁵ However, the current lack of integration between different aspects of the health service prevents the highest quality service being delivered. This is echoed by NHS England, which suggests that professional “siloes” mean patients “fall through the gaps or suffer at transitions from poor communication and coordination and a system not designed around their needs.”⁴⁶

A more integrated model of care would also be more efficient. The *Next steps on the NHS Five Year Forward View* highlights how new care models that have integrated strands of community care and, crucially, moved specialist care out of hospitals, have reduced

⁴² Centre for Workforce Intelligence, *Future Demand for Skills: Initial Results*.

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ NHS England, *Five Year Forward View*, 2014.

⁴⁶ NHS England, *Safe, Compassionate Care for Frail Older People Using an Integrated Care Pathway: Practical Guidance for Commissioners, Providers and Nursing, Medical and Allied Health Professional Leaders*, 2.

emergency admissions, particularly amongst the elderly.⁴⁷ With the average accident and emergency (A&E) visit costing six times more than a visit to the GP, more patient-centred care models could offer significant cost savings.⁴⁸ International models of integrated care have also shown promising results. Blue Cross Blue Shield's Alternative Quality Contract in Massachusetts, United States, for example, has delivered improvements in quality of care alongside cost savings of 6.8 per cent.⁴⁹

Integrated care within a hospital setting could also deliver efficiencies by encouraging staff to work more effectively across professional boundaries. In practice, this means greater recognition of transferable skills between different roles, allowing less senior clinicians to deliver more care than is commonplace currently. The Aravind Eye Care system in India, for example, delivers the equivalent of 60 per cent of annual eye surgeries performed by England's National Health Service, but at less than 1 per cent of the total cost.⁵⁰ Seventy per cent of activities in surgery are done by a team of four nurses, who prepare a second patient on one table while the surgeon operates on the first patient.⁵¹ The process is standardised with the use of key skills and discretionary elements are reduced to a minimum.⁵² In other developing countries faced with shortages of senior medical professionals and constrained budgets, there are many similar examples of role substitution leading to more efficient and better-quality care.⁵³

There are some examples of similar practice in the NHS in England. Nurses are increasingly managing people with chronic diseases such as diabetes or hypertension, where previously this would have been done by a doctor.⁵⁴ Pharmacists are also extending their work into settings such as community, mental health and acute patient care. For example, the Haxby Group Practice – 10 GP surgeries in York and Hull – now employs three pharmacists.⁵⁵ The pharmacists specialise in remotely managing patient medicine. The group reports that, on average, each pharmacist completes in 35 hours the amount of work it took GPs 60 hours.⁵⁶ The quality of medicines management has also improved, delivering better patient experience and net savings for the practice.⁵⁷ Similarly, Taunton and Somerset NHS Foundation Trust employ three assistant practitioners in its radiology team, complemented by two radiographers – a model which has made the service more efficient and reduced bottlenecks for ultrasounds and biopsies.⁵⁸ However, such examples are rare and small in scale. Given the financial pressures facing parts of the NHS, adopting an integrated care model system wide is imperative for the future sustainability of the service.⁵⁹

1.3 Barriers to integration

The reasons for the imbalance between community and acute workforces and the lack of integration between them are complex and multifaceted. However, the way in which care is funded and clinical staff are trained are clear contributory factors that must be addressed.

47 NHS England, *Next Steps on the NHS Five Year Forward View*, 2017.

48 National Audit Office, *Stocktake of Access to General Practice in England*, 2015.

49 Zirui Song et al., "Changes in Health Care Spending and Quality 4 Years into Global Payment", *New England Journal of Medicine* 371, no. 18 (2014).

50 Tom Cawston, *Aravind Eye Care Case Study: High Volume, Specialist Eye Care in India* (Reform, 2013)

51 Ibid.

52 Ibid.

53 Michael Macdonnell and Ara Darzi, "A Key to Slower Health Spending Growth Worldwide Will Be Unlocking Innovation to Reduce the Labour-Intensity of Care," *Health Affairs* 32, no. 4 (April 2013).

54 Candace Imison, Sophie Castle-Clarke, and Dr Robert Watson, *Reshaping the Workforce to Deliver the Care Patients Need* (Nuffield Trust, 2016).

55 Ibid.

56 Ibid.

57 Ibid.

58 Ibid.

59 For example, see: Mirko Licchetta and Michal Stelmach, *Fiscal Sustainability Analytical Paper: Fiscal Sustainability and Public Spending on Health* (Office for Budget Responsibility, 2016); The King's Fund, "Trusts in Deficit," Web Page, (12 May 2017); David Maguire, Pheobe Dunn, and Helen McKenna, *How Hospital Activity in the NHS in England Has Changed over Time* (The King's Fund, 2016); NHS Improvement, *Quarterly Performance of the Provider Sector as at 31 December 2016*, 2017.

Around 96 per cent of primary-care providers hold a capitated contract.⁶⁰ This means that GPs are paid per registered patient in advance of any care being delivered, with the amount received varying depending on patient characteristics such as age or gender. As GP partners keep the difference between the capitated budget and the amount the practice spends on care, they are incentivised to spend as little as possible.⁶¹ By contrast, around two-thirds of hospital activity is covered by activity-based funding.⁶² In *Who cares? The future of General Practice, Reform* described how capitated funding in primary care incentivises GPs to restrict the amount of care they deliver, whilst secondary providers are rewarded for delivering more.⁶³ This creates a system in which patients, and consequently staff, are directed towards the acute sector.⁶⁴

The way in which clinical staff are trained also contributes to workforce imbalance. Doctors are typically required to select a speciality after just two years of postgraduate training.⁶⁵ Once selected, training routes are rigid, and movement between specialities requires re-entry at the same stage as third-year postgraduate trainees, with little recognition of inter-speciality transferable skills.⁶⁶ Interviewees for this paper were clear that this approach creates a workforce of “super-specialists” based predominately in the acute sector, rather than an integrated team built around patient needs. The General Medical Council (GMC) also recognise that this approach is “out of date and urgently in need of reform”.⁶⁷

The amount of clinical exposure during medical training also affects the shape of the workforce. Interviewees explained that the majority of clinical training for student nurses, doctors, midwives and allied health professionals (AHPs) is based in the acute sector. Yet, evidence shows that medical students and junior doctors who have greater exposure to general practice are more likely to work in primary care later in their career.⁶⁸ Cambridge University, for example, more than tripled its output of GP trainees in 2016 after implementing measures to give students and foundation doctors more time in general practice.⁶⁹ This illustrates the important link between the location of medical training and the shape of the resultant workforce.

There are also cultural factors within medical training that push trainees towards the acute sector. Interviewees commonly described a “snobbish” attitude that exists across the medical and nursing profession, by which primary care is considered inferior by the acute sector. This is corroborated by Health Education England (HEE), which notes that “students experience an uncomfortable divide between primary and secondary care across which they meet unfortunate professional tribalism leading them to perceive primary care of ‘lower status’”.⁷⁰ An interviewee recounted how a medical school dean would point to general practice as the likely consequence of not working hard enough in motivational talks with their students.

This paper makes recommendations to overcome the barriers to integrated care that funding and training systems present. On a national level, Chapter 2 illustrates that the current cap on medical training places introduces rigidity into workforce planning and undermines staff commitment to the service.

60 Monitor, *Improving GP Services: Commissioners and Patient Choice*, 2015.

61 Monitor, *Capitation: A Potential New Payment Model to Enable Integrated Care*, 2014.

62 Louise Marshall, Anita Charlesworth, and Jeremy Hurst, *The NHS Payment System: Evolving Policy and Emerging Evidence* (Nuffield Trust, 2014).

63 Leo Ewbank, Alexander Hitchcock, and Thomas Sasse, *Who Cares? The Future of General Practice* (Reform, 2016).

64 Ibid.

65 British Medical Association, “Career Pathways,” 13 April 2012.

66 General Medical Council, *Adapting for the Future: A Plan for Improving the Flexibility of UK Postgraduate Medical Training*, 2017.

67 Ibid., 4.

68 Paula McDonald, Ben Jackson, Hugh Alberti and Joe Rosenthal, “How Can Medical Schools Encourage Students to Choose General Practice as a Career?,” *British Journal of General Practice* 66, no. 647 (May 2016).

69 David Millett, “Medical School Tripled GP Trainee Output after Raising Exposure to General Practice,” *GP Online*, 9 February 2017.

70 Professor Val Wass, Professor Simon Gregory, and Katie Petty-Saphon, *By Choice – Not by Chance* (Health Education England, 2016).

Chapter 3 demonstrates that central direction over NHS budgets and workforce planning has failed to deliver the staff local areas need, and has inhibited collaboration between local stakeholders. It therefore argues that budgets for training and care delivery be combined and devolved to Sustainability and Transformation Plan (STP) areas on a capitated basis.

Delivering integrated care also requires staff to work differently and overcome pervasive cultural barriers. Chapter 4 therefore details how NHS staff can be encouraged to work more effectively across professional boundaries.

2

Invigorating the medical labour market

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The health service does not currently have an adequate supply of people to call upon resulting in high vacancy rates in some areas. This has led to difficult working conditions and a powerful staff body, many of whom choose to work for expensive agencies.⁷¹ Staff, the NHS and the Government each feel aggrieved that the others do not understand the issues they face and this has led to fractious relationships.⁷²

Long-standing limits on university places for health care workers has prevented expansion of the labour market. Until recently, the number of places on most courses was capped by the Department of Health, in part, because degree courses involving clinical placements are more expensive and the NHS pays the additional costs.⁷³

The NHS should seek to produce sufficient, if not excess, trained individuals that it can employ. By doing so it could create a more conventional labour market, as seen in other sectors, driven by the balance between supply and demand. This chapter outlines the case for uncapping training for all healthcare professionals.

Increasing the number of trained individuals should not necessarily result in widespread workforce expansion. Instead, the NHS would have much more flexibility to shape the workforce in accordance with population demand rather than workforce supply. This means diverting employees towards shortage specialities and under-staffed regions. The NHS needs more generalists and this model will allow it to fill such posts. It could also address over-reliance on overseas and agency staff.⁷⁴

The system would also be fairer for staff. Standards should rise as the most capable staff secure work and progress. This would improve working conditions for staff and care for patients. Filling vacancies means that staff would be able to spend more time with patients to focus on improving outcomes and the NHS would design more flexible contracts for staff.

2.1 Pharmacy

The number of places to study pharmacy is uncapped. This provides insight for nursing, midwifery and AHPs, uncapped this year, and medicine, where places are still restricted. In pharmacy, allowing universities to recruit according to student demand has, in part, removed the need for accurate modelling and intake controls.⁷⁵

The labour market is more responsive than much of the NHS. In 2009, pharmacy was recognised as a shortage occupation by the Migration Advisory Committee.⁷⁶ Shortages were a result of both an expansion in the labour market and the ‘fallow year’ in 2000, when pharmacy degree courses moved from three to four years and thus no students graduated.⁷⁷ The labour market and universities responded accordingly and pharmacy training expanded. Most employers now “report no problems in recruitment” and pharmacists have been removed from the shortage occupation list.⁷⁸ The expansion in the number of pharmacists means that locums are reporting significant reductions in hourly rates, and graduate jobs are more competitive.⁷⁹

One outcome the CfWI has pointed to is an oversupply of pharmacists. They predict that by 2040 the oversupply could be between 11,000 and 19,000 pharmacists.⁸⁰ This modelling

71 National Audit Office, *Managing the Supply of NHS Clinical Staff in England*, 2016.

72 Department of Health, *Junior Doctors Contract Agreement*, 2016.

73 Department of Health, *Expansion of Undergraduate Medical Education*, 2017.

74 Johnny Runge, Nathan Hudson-Sharpe, and Heather Rolfe, *Use of Agency Workers in the Public Sector: Report to OME* (National Institute of Economic and Social Research, 2017).

75 Russell International Excellence Group, “Russell Group Response to the HEFCE-HEE Consultation on: Ensuring a Sustainable Supply of Pharmacy Graduates,” 2013.

76 Migration Advisory Committee, *Skilled, Shortage, Sensible: Third Review of the Recommended Shortage Lists for the UK and Scotland*, 2010.

77 Higher Education Funding Council for England, *Ensuring a Sustainable Supply of Pharmacy Graduates*, 2013.

78 Ibid.

79 Ibid.

80 Centre for Workforce Intelligence, *A Strategic Review of the Future Pharmacist Workforce, Informing Pharmacist Student Intakes*, 2013.

however, only considers the value of pharmacy graduates within traditional pharmacy roles. These graduates have scientific knowledge and expertise valuable to other fields, including life sciences and science teaching. The Russell Group of universities has explained that “over-supply against likely recruitment needs in the NHS is therefore not necessarily a ‘bad’ outcome, but clearly prospective students will wish to understand more about their potential employment opportunities so that they can make informed decisions on what and where to study.”⁸¹ In a functioning market, oversupply will adjust in the medium term as saturating job opportunities translate into fewer university applicants. With greater data available to prospective higher education students about employment outcomes, they will be able to make informed decisions.

2.2 Nurses/Allied Health Professionals

From August 2017, the numbers of nursing, midwifery and most allied health students was uncapped.⁸² This means that education institutions can now train as many of these students as they wish.⁸³ This is the most significant change to undergraduate training of the health workforce in recent years.

To increase numbers of graduates, whilst trying to contain costs, new students will no longer receive NHS bursaries. As with other degree courses, students will pay tuition fees and living costs and have access to loans. University courses with clinical components are more expensive to run and the additional funding will come from both the Higher Education Funding Council for England (HEFCE) and HEE. HEE have retained responsibility for commissioning the placements for 2017/18.⁸⁴ That is, HEE will increase the number clinical of placements it funds by up to 1,500 this year but universities are free to create additional places on top of these in partnership with their local trusts.⁸⁵ The Department of Health is currently considering future funding and commissioning arrangements.⁸⁶

The removal of bursaries could increase the number of UK trained health care professionals in a cost effective way. Jeremy Hunt has said that, if done right, the intervention could see 20,000 more nurses by 2020.⁸⁷ Interviewees for this paper said this is unlikely because central and local bodies are not yet working effectively to increase available training places across the whole country within budget. Some local areas however, are finding innovative ways to increase the number of students. This idea is explored further in Chapter 3.

Organisations representing nurses and AHPs have raised counterarguments that introducing tuition fees will reduce participation from poorer students.⁸⁸ It is too early to assess in the case of nurses, but this has not been the case for other degree courses where, despite rises in tuition fees, numbers of disadvantaged students have increased.⁸⁹ Evidence from the Office for Fair Access also finds no observable relationship between institutional bursaries in place between 2006 and 2011 and the continuation in study of degree students.⁹⁰ Furthermore, bursary removal is part of a much wider programme of changing the way the health service trains its staff. A programme for 1,000 new degree-

81 Russell International Excellence Group, “Russell Group Response to the HEFCE-HEE Consultation on: Ensuring a Sustainable Supply of Pharmacy Graduates.”

82 Department of Health, *Reforming Healthcare Education Funding: Creating a Sustainable Future Workforce, Government Response to Public Consultation*, 2016.

83 Ibid.

84 Philip Dunne, “Nurses: Training: Written Question” (HC45500, n.d.), 45500, 7 September 2016.

85 Sean Lintern, “Government Releases Cash in Last Minute Push to Expand NHS Training,” *HSJ*, 17 August 2017; Department of Health, *Reforming Healthcare Education Funding: Creating a Sustainable Future Workforce, Government Response to Public Consultation*.

86 Department of Health, *Reforming Healthcare Education Funding: Creating a Sustainable Future Workforce, Government Response to Public Consultation*.

87 News Shopper, “Jeremy Hunt Defends Scrapping of Nurse Bursaries as ‘System Is Not Working,’” Web Page, (2 December 2015).

88 UNISON, National Union of Students, Royal et al., “Finance for Student Nurses, Midwives and Allied Health Professions,” Web Page, (11 January 2016).

89 Higher Education Statistics Agency, “Widening Participation Introduction,” Web Page, (2017).

90 Office for Fair Access, *An Interim Report: Do Bursaries Have an Effect on Retention Rates?*, 2014.

level nursing apprenticeships has been launched and 35 pilot sites are in the process of training 2,000 nursing associates, a role that “aims to bridge the gap between health and care support workers”.⁹¹ Apprenticeship and part-time training routes must allow students to enter professions from all backgrounds.

Applications to nursing and AHP degree courses fell 20 per cent between 2016-17.⁹² 16,100 students were accepted onto nursing degree courses on the first day of clearing, down from 17,460 in 2017.⁹³ Whilst some have linked falling numbers to bursary removal,⁹⁴ enrolment figures have not yet been announced and it is too soon to assess the longer-term impact. One stakeholder explained that this reduction in applications was not unexpected and that in the past, because the NHS has paid for these courses, they were an obvious choice for some who wanted to go to university but were not necessarily dedicated or suited to the profession.

Stakeholders said that they expect improvements in drop-out rates as students invest more in their own training. Following his *Shape of Caring* review, Lord Willis described attrition rates on undergraduate nursing courses as the “Achilles heel” of the nursing world.⁹⁵ Attrition rates are on average greater than 20 per cent over the three years.⁹⁶ Some universities and trusts are already working together to deliver courses not commissioned by HEE. The first entirely fee-paying nursing degree course saw Lancashire Teaching Hospitals partner with the University of Bolton. There were over 650 applications for 25 places in 2015 and the programme has now been extended.⁹⁷ At 9 per cent, attrition rates are lower for these nursing students than the national average.⁹⁸ Furthermore, the trust is seeking to retain graduates in the area by developing “a sense of pride and belonging”.⁹⁹

2.3 Doctors

Medical training has not been uncapped and student numbers are decided centrally by the Department of Health with input from HEE.¹⁰⁰ According to interviewees, this is because there are higher stakes involved in training doctors. It is expensive in terms of both time and cost, and the level of expertise required is higher to manage greater risk and responsibility. Increasing the number of medical students could align doctors to local NHS workforce need (addressing regional variation); support expansion of shortage specialties and encourage “innovation and market liberalisation”.¹⁰¹

2.3.1 The cost of training

If the NHS is to reconsider training arrangements for doctors, it must first understand the cost of training. Medical education is heavily subsidised by the taxpayer. Each year approximately 6,000 new students start medical school.¹⁰² The Government invest around £1.3 billion per year in training medical students.¹⁰³ Figure 4 breaks down the approximate current funding for educating one doctor.

91 Department of Health, “New Nursing Degree Apprenticeship,” Press release, (30 November 2016); NHS Employers, “Nursing Associate,” Web Page, (15 June, 2017).

92 Greg Hurst, “Nursing Degree Applications Fall by a Fifth,” *The Times*, 17 December 2016.

93 Sean Lintern, “NHS Bursary Reform Fails to Increase Student Nurses,” *HSJ*, 17 August 2017.

94 Rachel Adams, “Nursing Degree Applications Slump after NHS Bursaries Abolished,” *The Guardian*, 2 February 2017.

95 Erin Dean, “War on Attrition: Government Tackles Drop-out Rates on Nursing Courses,” *Nursing Standard*, 16 November 2016.

96 Lord Willis, *Raising the Bar. Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants*.

97 fab, “Update on the First Fee Paying Nursing Course in the Country at University of Bolton,” Web Page, (11 October 2015).

98 Whatuni?, “Nursing (Adult) Lancashire Teaching Hospitals NHS Foundation Trust BSc (Hons),” Web Page, (1 September 2017).

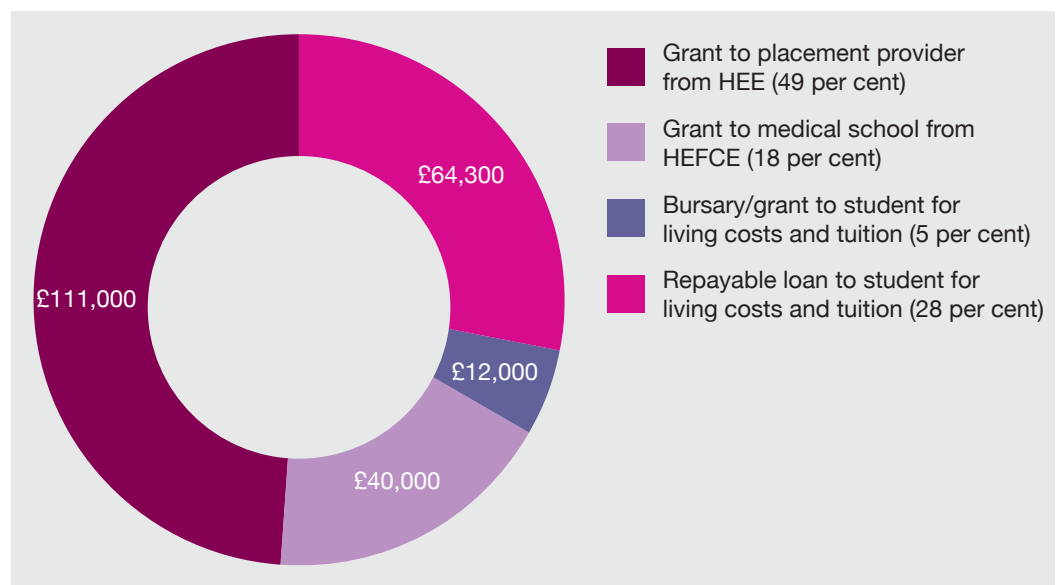
99 Which?, “University of Central Lancashire, Nursing Adult,” Web Page, (1 September 2017); Nursing Times, “First Self-Funded Nursing Course Launched to Tackle Shortage in NW,” Web Page, (7 January 2015).

100 Department of Health, *Expansion of Undergraduate Medical Education*.

101 Department of Health, *Expansion of Undergraduate Medical Education, Government Response to Consultation*, 2017.

102 Department of Health, *Expansion of Undergraduate Medical Education*.

103 Ibid.

Figure 4: Approximate breakdown of medical education funding

Source: Department of Health, *Expansion of Undergraduate Medical Education, 2017*.

However, the cost of training is not known with accuracy, with one interviewee describing it as “the elephant in the room.” The training tariff, the payment made by HEE to providers such as hospitals, was designed to make providers more accountable for training.¹⁰⁴ The distribution of resources is not fully transparent however, with funds moving directly from HEE to providers and then, at times, diverted into service provision. Students spend much of their time learning in clinical environments and it is difficult to quantify the effect this has on the productivity of the system. For instance, it is difficult to assess the impact a student attending clinic has on the time it takes to see patients.

Perhaps most concerning, the cost of training is highly variable between institutions. For example, some hospitals are paid almost 30 per cent more per student by HEE than others.¹⁰⁵ These hospitals tend to be London based and whilst higher costs are designed “to compensate for the cost differences of providing training placements in different parts of the country”,¹⁰⁶ there is limited transparency in funding distribution. Interviewees described arrangements as “historical”. At Buckingham Medical School, students pay £36,000 per year for the full costs of their tuition and placement fees (totalling £162,000 for a four and a half year course that meets GMC requirements).¹⁰⁷ The Higher Education Act 2017 encourages such new entrants to the market as a means of driving standards up and costs down.¹⁰⁸ For foreign students, HEE pays their placement fees (due to stop in 2018/19),¹⁰⁹ but tuition fees vary between universities, with some charging more than £40,000 for each clinical year and others £20,140.¹¹⁰

There is limited information on where variations in the cost of training arise from. For the NHS to increase doctor numbers, doctors must take on the cost of their training. This is discussed in the next section. However, before this can happen, the Department of Health must accurately establish the cost of training.

¹⁰⁴ NACTUK, *A Guide to the Funding & Accountability of Medical Education*, 2016.

¹⁰⁵ NHS England, “NHS National Tariff Payment System 2016/17” (GOV.UK, 23 March 2017), 17.

¹⁰⁶ Department of Health, *Education & Training Tariffs, Tariff Guidance for 2016-17*, 2016.

¹⁰⁷ The University of Buckingham Medical School, “Selection Process,” Web Page, (2017).

¹⁰⁸ HM Government, *Higher Education and Research Act 2017*, Chapter 29, 201.

¹⁰⁹ Department of Health, *Expansion of Undergraduate Medical Education*.

¹¹⁰ University of Nottingham, “Undergraduate Courses 2016-17,” Web Page, (1 September 2017); University of Southampton, “Undergraduate Course Fees,” Web Page, (1 September 2017).

2.3.2 Training excess doctors within the current framework

The Department of Health recognises the case for increasing undergraduate medical training numbers and has pledged to increase training places by 1,500 per year by 2020/21.¹¹¹ This is a 25 per cent increase. When Jeremy Hunt announced the policy, he explained that the intention is to create an NHS that is “self-sufficient in doctors” as increasing supply by 25 per cent will mean the NHS can, over time, stop importing doctors when there is a worldwide shortage (currently 26 per cent of the workforce).¹¹²

Given rising demand, a desire for flexible working arrangements and high vacancy rates, this policy does not go far enough. Many talented individuals are being turned away from medicine. In 2017, 19,210 applicants applied for just under 6,000 places.¹¹³ Numbers have reduced slightly but medicine remains highly competitive and there is no evidence this will change. The NHS must allow more of these applicants to study medicine and increase the number of graduates beyond reducing reliance on foreign doctors. One interviewee explained that their organisation had estimated that high attrition rates and ‘less-than-full-time’ working mean that, following postgraduate training, this expansion will translate to approximately 750 full-time equivalent consultant or GP posts. The Government spends £1.3 billion on agency doctors each year, the same amount it spends on training medical students.¹¹⁴ A business case can clearly be made for substantially increasing the numbers of trainees beyond 1,500 to fill vacancies and reduce excessive agency spend.

When the Department of Health announced plans to expand student numbers by 1,500, it came with the proviso that students work a minimum of four years in the NHS following graduation.¹¹⁵ In a subsequent government consultation, respondents did not endorse the principle of service periods.¹¹⁶ That being said, it is not fair on taxpayers that medical students are heavily subsidised throughout university, far more than any other undergraduate degree, and can then choose to either not work for the NHS or to take advantage of current under-staffing by working for agencies.

Junior doctors should be accountable for their training and expected to work in the NHS on permanent contracts for longer than four years if an expanded training system is to deliver value for money to taxpayers and better working conditions for staff. Interviews from medical schools said that their internal research had shown that service periods need to be around 10 years to be effective. Additional flexibilities for doctors within this system are discussed in section 3.2.2.

As highlighted, the true cost of training is unclear. However, there are indications to suggest the Department’s estimation of £230,000 is too high. Buckingham Medical School, for example, are delivering GMC-approved medical training for £162,000.¹¹⁷ Though it is not possible to extrapolate from Buckingham to accurately model the cost of training across the whole system, it nevertheless provides an instructive example of how the funding model could work.

Students currently have loans of £9,000 per year, totalling £45,000 over 5 years. Using Buckingham’s £162,000, this leaves a shortfall of £117,000. Across 10 years, for each year a doctor chooses to spend out of permanent work in the NHS, they would repay £11,700: an ‘employer loan’ that totals £117,000. For doctors working on NHS contracts, the cost would be paid by the NHS. As students become accountable for their training costs, the NHS must ensure medical training is costed accurately. Furthermore, current

111 Department of Health, *Expansion of Undergraduate Medical Education, Government Response to Consultation*.

112 Jeremy Hunt, “Speech to Conservative Party Conference 2016,” October 2016; Carl Baker, *NHS Staff from Overseas: Statistics*, HC 7783 (London: House of Commons Library, 2017).

113 UCAS, *Deadline Applicant Statistics: October*, 2016.

114 NHS Improvement, “Reducing Reliance on Medical Locums: A Practical Guide for Medical Directors,” Web Page, (12 September 2016); Department of Health, *Expansion of Undergraduate Medical Education*.

115 Jeremy Hunt, “Speech to Conservative Party Conference 2016.”

116 Department of Health, *Expansion of Undergraduate Medical Education, Government Response to Consultation*.

117 The University of Buckingham Medical School, “Selection Process.”

tariffs are diverted into service delivery and so reducing them would impact funding for care. This will need more work.

Doctors working in agencies can expect to earn at least £11,700 above those working on permanent contracts. For instance, the average hourly pay rate for a foundation year two agency doctor in quarter two of 2016-17 was £45.58 (with some earning up to £80 per hour), two and a half times NHS Improvements' wage rate for those on permanent contracts (£18.26 per hour).¹¹⁸

Should the output from medical schools double to 12,000, with all graduates staying in NHS employment, the policy would cost £140.4 million per year (£11,700 X 12,000 doctors). Had the £230,000 figure been used, the cost would be much higher. For every year a doctor spends out of the NHS, for instance working for pharmaceutical companies or locum agencies, they (or their employer) should reimburse the NHS the training repayment cost for that year. Such arrangements should consider part-time working, unemployment, sickness, maternity and paternity leave, as well as time doing public research.

It may be that some doctors, at some points in their careers, cannot get jobs, particularly training jobs. It is not right that in the current system poorly performing doctors continue to practice. Interviewees described how shortages mean that substandard doctors continue to work in the NHS. Whilst this is difficult to quantify, areas with shortages require more temporary staff and this is linked to poorer quality care, including higher death rates and lower patient satisfaction.¹¹⁹ A more competitive system would aim to deliver a system whereby the most able find work – meaning standards improve. Those that do not get a job in their chosen speciality would either need to look for less competitive jobs within the NHS or apply to other related sectors, or other countries. This is the way most employment markets work.

At present, doctors are not registered to practice independently until the end of their first year.¹²⁰ To deliver this model, registration should be moved to the point of graduation. This would mean that the NHS does not need to guarantee a job for every new graduate. Furthermore, for doctors who do not get jobs, they would be fully qualified to work as doctors elsewhere (industry, private health care, locum work or abroad). Training needs to adapt to this new structure. In New Zealand for example, the final year is spent as a Trainee Intern.¹²¹ The main purpose of the year is to “allow the transitioning student to function as a valued member of a health care team” and according to The New England Journal of Medicine acts as a “good bridge between student and practitioner” as students are immersed in clinical teams.¹²²

The next chapter proposes a devolved model of training. Until that transition, however, the NHS must work within the existing system more effectively. The Department of Health should be commissioning more places to medical schools that:

- > Will deliver more doctors wanting to go into shortage specialties, such as general practice, psychiatry and accident and emergency.¹²³
- > Are based in, or near, under-staffed geographic regions. Forty-eight per cent of graduates remain where they trained and so diverting students to such areas could address regional variation in vacancy rates.¹²⁴

118 Liason, *Taking the Temperature*, 2017.

119 Johnny Runge, Nathan Hudson-Sharpe, and Heather Rolfe, *Use of Agency Workers in the Public Sector: Report to OME*.

120 General Medical Council, “Important Information about Provisional Registration,” Web Page, (24 August 2017).

121 Warwick Bagg et al., “How the Trainee Intern Year Can Ease the Transition from Undergraduate Education to Postgraduate Practice” 123, no. 1318 (July 2010).

122 Ibid.

123 Health Education England, *HEE Commissioning and Investment Plan - 2016/17*, 2016.

124 M Goldacre, J Davidson, J Maisonneuve, T Lambert, “Geographical Movement of Doctors from Education to Training and Eventual Career Post: UK Cohort Studies.” *Journal of the Royal Society of Medicine* 106, no. 3 (March 2013).

Recommendation 1: Undergraduate training should be uncapped across the health and social care system.

Recommendation 2: Doctors who choose not to work for the NHS should reimburse the cost of their training. For doctors working within the NHS, the cost should be automatically paid back by the NHS. For those choosing not to work in the NHS, they (or their employer) must pay back the cost on an annual basis. There must be a fair approach taken to arrangements such as part-time working, unemployment, sickness, maternity and paternity leave and time doing research.

Recommendation 3: All health and social care professionals should be fully registered at the point of graduation.

3

Devolved workforce planning and pay

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Current ambitions for NHS and social care reform rest on the success of Sustainability and Transformation Plans (STPs). The idea of STPs is that local health economies, rather than individual NHS organisations, are best placed to decide together how to reform health and social care in their areas. STPs will encompass all health bodies – primary, secondary, tertiary, mental health providers and commissioners – as well as local authorities, who are responsible for social care and public health provision.¹²⁵

Developing the labour market and opening training is the first step towards creating a sustainable workforce. The next is to devolve workforce planning to STPs. This means local areas having control over the staff they train and employ. Workforce is one of the greatest challenges facing STPs and if they are to succeed they must be in a position to build the workforce they need.

The current balance between central and local workforce planning has not produced a sustainable workforce. STP areas have been carefully mapped out to form health economies across England.¹²⁶ This chapter proposes that it should be for these areas to decide how training is commissioned and to be accountable for it. Different STPs have different priorities and thus require different workforces. Including training in their remit means they could work directly with local providers and universities to negotiate training arrangements and design a workforce that delivers for local people. STPs should also use their power as a health economy to co-ordinate employment arrangements beyond training. This means ensuring that contracts allow staff to work across the health system, both in the acute and community sector and that pay is fair for staff and the NHS as the employer.

3.1 The current system

HEE is the body responsible for workforce planning. HEE was established in 2012 to commission undergraduate training places for doctors, nurses, midwives and AHPs.¹²⁷ The organisation works with the Department of Health to advise and commission the number of postgraduate training posts for clinical staff (mainly doctors) each year.¹²⁸ For 2017-18, HEE will fund undergraduate nursing and AHP placement tariffs. Recent policy suggests that HEE may stop commissioning placements but future arrangements are unclear.¹²⁹ At present, medical training looks set to continue under central controlled.

The capacity of HEE to shape the workforce is limited.¹³⁰ Ultimately, the Department of Health and NHS Improvement make training commissioning decisions and plans change little year on year, with local areas struggling to tailor their workforce.¹³¹ The Lords' NHS Sustainability Committee found that although HEE has produced some encouraging work, there is no evidence that they are able to influence a shift in the allocation of financial resources to shape workforce planning.¹³² Interviewees described workforce plans being approved by their local HEE branch but rejected by NHS Improvement.

Many STPs have barely touched on workforce issues in their proposals.¹³³ This may be in part because HEE is responsible for a ring-fenced training budget of £4.8 billion, and the centre dictates how and where this is spent.¹³⁴ This siloed model reinforces inflexibility in the way that training is delivered.

125 Kate Laycock and Elaine Fischer, *Saving STPs. Achieving Meaningful Health and Social Care* (Reform, 2017).

126 Monitor, *Considerations for Determining Local Health and Care Economies*, 2015.

127 Health Education England, "About Us," Web Page, (1 September 2017).

128 Department of Health, *Education & Training Tariffs, Tariff Guidance for 2016-17*.

129 Department of Health, *Reforming Healthcare Education Funding: Creating a Sustainable Future Workforce, Government Response to Public Consultation*.

130 National Audit Office, *Managing the Supply of NHS Clinical Staff in England*.

131 Ibid.

132 House of Lords Select Committee on the Long-term Sustainability of the NHS, *The Long-Term Sustainability of the NHS and Adult Social Care, Report of Session 2016/17*, HL Paper 151, 2017.

133 Laycock and Fischer, *Saving STPs. Achieving Meaningful Health and Social Care*.

134 Department of Health, *A Mandate from the Government to Health Education England: April 2016 to March 2017*, 2016.

3.1.1 Going against integrated care

The current system is not training students and staff to deliver care in the community. In medicine, community placements in hospices and general practice are not covered by the tariff system for undergraduate placements. Interviewees described inequitable funding between training placements in primary and secondary care with the majority of funding for training diverted into hospitals.¹³⁵ The House of Commons Health Committee said that funding arrangements “make it more difficult for medical students to gain experience of primary care.”¹³⁶ Curricula are designed so that students see patients in distinct settings, such as in the emergency department, on the ward or in general practice, rather than seeing the wider context. There is currently a move internationally to design curricula so that students can follow patient journeys in both the community and hospitals and also, for students to learn with the multidisciplinary team.¹³⁷ Interviewees said that new apprenticeship models are finding funding arrangements challenging: because funding is provided by a single employer, it is difficult to give apprentices exposure to different types of care.

Whilst training is managed centrally, employment arrangements and remaining workforce planning are the responsibility of individual providers. Indeed, 70 per cent of recurring provider costs are workforce related.¹³⁸ Within regions, there is little co-ordination between providers and fortress mentalities have developed where organisations protect their own self-interest.¹³⁹ For instance, overseas recruitment was previously organised regionally but responsibility now rests with providers meaning that trusts within the same STP are competing for staff and duplicating work.¹⁴⁰

3.2 Implementation

To create a sustainable workforce, it should be incumbent on STPs to attract, train and retain staff to deliver the workforce they need. This means creating training programmes and working conditions that suit staff whilst diverting them into the areas of the health and care system where they are required most in order to deliver integrated care.

3.2.1 One-system one-budget

Separate budgets throughout health and social care have been a key driver of the fortress mentality between organisations. Each STP should receive a capitated budget that covers health and social care. This approach is designed to ensure that all organisations are working towards the same outcomes and has been discussed in previous *Reform* research, *Saving STPs. Achieving meaningful health and social care reform*.¹⁴¹

To ensure that training staff is an integral part of STPs, training budgets should be part of their funding envelope as they mature into accountable care systems.¹⁴² Local areas could then invest in training the workforce they need which, for most, will be generalists. An STP, for example, may invest in community nurses and geriatricians capable of managing multi-morbidity in areas with a large elderly population, or paediatricians and health visitors in those with lots of children.

As well as addressing training, a one-system one-budget approach should look to incentivise staff to work across the local area rather than being confined to a hospital or general practice. Both generalist and specialist staff should work across different parts of the system to deliver high quality, cost-effective care without having to navigate

¹³⁵ Wass, Gregory, and Petty-Saphon, *By Choice – Not by Chance*.

¹³⁶ House of Commons Health Committee, *Primary Care*, HC 408, 2016.

¹³⁷ Wass, Gregory, and Petty-Saphon, *By Choice – Not by Chance*.

¹³⁸ Rachael Addicott et al., *Workforce Planning in the NHS* (The King's Fund, 2015).

¹³⁹ Laycock and Fischer, *Saving STPs. Achieving Meaningful Health and Social Care*.

¹⁴⁰ National Audit Office, *Managing the Supply of NHS Clinical Staff in England*.

¹⁴¹ Laycock and Fischer, *Saving STPs. Achieving Meaningful Health and Social Care*.

¹⁴² An accountable care system is an arrangement in which all the bodies that commission and provide health and social care in an area come together into one organisation that is accountable for all care.

complicated funding systems. Oxford University NHS Foundation Trust, for example, has recruited 60 care workers to provide care in patients' homes following their discharge from hospital.¹⁴³ 75 beds have been freed up as a result.¹⁴⁴ Other organisations currently implementing cross-boundary working have created new contracts, for instance the Portsmouth and South East Hampshire diabetes service. To increase support from consultants in primary care, the community diabetes service designed a contract to reimburse the acute trust for the consultant time.¹⁴⁵

Oxford University NHS Foundation Trust and the South East Hampshire diabetes service provide examples of what can be done within the current system. As interviewees and published literature have outlined, however, such programmes are commonly driven by a highly motivated individual, or group, willing the system to deliver care differently.¹⁴⁶ These initiatives provide a sticking plaster. Looking forward, the NHS must consider how it commissions services to ensure that staff are delivering integrated care in community settings where possible. Previously, *Reform* has argued that, in time, STPs should act as the commissioner.¹⁴⁷ They could then design contracts with providers that promote working across boundaries.

Recommendation 4: As STPs develop into accountable care systems, they should become responsible for workforce planning across the whole health and social care system. Training budgets should be included within their funding envelope and they must seek to deliver training that cuts across all sectors and for all staff.

Recommendation 5: STPs must take a 'one-system, one-budget approach' to ensure that all organisations are working towards the same outcomes. This would enable STPs to create a workforce that works across boundaries with more generalists.

Recommendation 6: Staff contracts should be designed to promote working across the acute and community sector.

3.2.2 Devolve training

If STPs are to make effective workforce decisions in the interest of their population, the Government must uncap training numbers and fully devolve funding and responsibility for training. Under this proposed model, HEE should be dissolved. The work of HEE on training and development should be integrated with the GMC or relevant regulatory body, and their work on commissioning training integrated into STPs.

Uncapping nursing training and devolving control to local areas is already resulting in some STPs designing innovative ways to attract, train and retain staff within current budgets, as outlined in Figure 5.

¹⁴³ House of Commons Health Select Committee, *Winter Pressure in Accident and Emergency Departments, Third Report of Session 2016–17*, HC 277, 2016.

¹⁴⁴ *Ibid.*

¹⁴⁵ Ruth Robertson et al., *Specialists in out-of-Hospital Settings* (The King's Fund, 2014).

¹⁴⁶ *Ibid.*

¹⁴⁷ Laycock and Fischer, *Saving STPs. Achieving Meaningful Health and Social Care*.

Figure 5: Local interventions to increase nurse training in local areas

Area	Intervention
Greater Manchester	During his mayoral campaign, Andy Burnham pledged to introduce a system of education funding in which bursaries are provided if nurses agree to work in the NHS for at least five years following qualification.
Birmingham Children's Hospital NHS Foundation Trust and Birmingham City University	The Trust and the University have partnered to provide fee-paying students nursing degrees in exchange for a guaranteed job following graduation at the trust.
Oxford Brookes University	The University has expanded its adult nursing course since student numbers were uncapped. In a bid to attract additional trainees and staff to the region, a new collaboration between the university and NHS trusts in Oxford has been set up to improve research and learning opportunities.

Source: Nicola Merrifield, "Burnham Pledges to Keep Bursaries if Elected Manchester Mayor," *Nursing Times*, 29 July 2016. Steve Ford, "Students Offered Job Guarantee but Must Pay for Course," *Nursing Times*, 13 May 2016. Nicola Merrifield, "Oxford Trust and University Launch Research Partnership to Attract More Recruits," *Nursing Times*, 15 March 2017.

For all staff, STPs should consider the training options described in Figure 5, as well as non-degree routes into the sector and flexible training options that appeal to staff. STPs may have to work together to deliver this. For the training of medical students, STPs should use the framework described in section 2.3.2, but go further in offering greater flexibility. Interviewees pointed to cheaper courses, shorter courses, guaranteed jobs on completion of medical school or flexible training opportunities. They could also offer doctors flexibility in the way the proposed 'employer loan' is paid back, for instance, offering time off on the proviso doctors return to post within a specified period of time. The GMC must continue to regulate training and monitor quality.

Devolved funding for training would incentivise STPs to design training models that attract and retain staff capable of working across boundaries. Flexible training routes are key. They were an important theme in HEE's *Enhancing junior doctors' working lives* report.¹⁴⁸ Increasing flexibility is believed to "improve training, promote recruitment, maintain resilience and interest and encourage retention."¹⁴⁹

STPs should continue to remove the cultural and practical barriers that exist to flexible training. In medical specialties that increased the numbers of 'less-than-full-time trainees', such as general practice, psychiatry, palliative medicine and public health, recruitment and retention was boosted.¹⁵⁰ The Royal College of Emergency Medicine is currently piloting a scheme in emergency medicine to improve access to 'less-than-full-time training' in a bid to improve recruitment and retention.¹⁵¹

Flexibility is about more than working part-time or on a flexible rota. Post-graduate medical training is rigid. It is difficult to move across specialties or sectors. If a doctor decides to change specialty they must go back to the beginning of training. The GMC describes this process like "snakes and ladders".¹⁵² STPs should move away from training programmes with limited manoeuvrability and encourage staff to pursue other interests (e.g. research or management) or to train across different or multiple specialties.¹⁵³ Major

148 Health Education England, *Enhancing Junior Doctors' Working Lives: A Progress Report*, 2017.

149 Ibid.

150 Ibid.

151 Ibid.

152 General Medical Council, *Adapting for the Future: A Plan for Improving the Flexibility of UK Postgraduate Medical Training*.

153 BMJ Careers, "Nearly Half of Trainees Chose Not to Progress Straight to Specialty Training in 2015," Web Page, (2 December 2015).

reviews of postgraduate education, such as *Aspiring to Excellence*¹⁵⁴ by Sir John Tooke and *Securing the future of excellent patient care*¹⁵⁵ by Professor David Greenaway, concluded that the current system is not producing generalists and thus has not yet adapted to patient needs. Both propose that training is structured within broader specialty groupings. In Greenaway's model, doctors can work more flexibly across the system, between specialties and across the community and acute sectors. As demand changes, doctors can adapt. Instead of specialising too early, they have been trained across a breadth of areas. HEE trailed a short two-year broad-based training programme, but did not commission places this year as it was not considered a priority investment area.¹⁵⁶ Instead the expansion of general practice and emergency medicine took precedence. At present HEE are learning the lessons from the programme "as part of the intelligence to inform the design of future programmes."¹⁵⁷ Much more needs to be done to ensure stakeholder and junior doctor buy-in for such training.

STPs must also diversify training by embracing new routes in to health and social care. As of April 2017, employers with more than 250 staff pay an apprenticeship levy of 0.5 per cent of their wage bill and those in the public sector have a legal duty to employ 2.3 per cent of their staff as apprentices.¹⁵⁸ Apprenticeships provide an alternative route into the clinical and administrative NHS workforce by offering paid on and off the job experience.¹⁵⁹

STPs should be designing apprenticeship programmes that not only span hospital and community settings, but the whole hierarchy of the NHS. For instance, care assistants could move into nursing and AHP roles. A physiotherapist or pharmacist already has relevant knowledge and skills, and so those wishing to do medicine should be able to via tailored, flexible (and potentially part-time) training routes. These could be through both apprenticeships and more traditional graduate routes. With that in mind, health care professionals should not feel they must aspire to change jobs. Instead, there should be dissolution of boundaries between professionals so that, for instance, pharmacists can take on tasks currently done by GPs. This is discussed in Chapter 4.

Alternative routes into the care sector go beyond apprenticeships. NHS England has introduced Nurse First, a postgraduate programme that fast-tracks high achievers into registered graduate nursing positions, inspired by the Teach First programme.¹⁶⁰ The first cohort starts in September and the programme aims to support the development of future nurse leaders in key areas, starting with mental health and learning disabilities.¹⁶¹

The Open University offers part-time adult and mental health nursing courses, designed specifically for care assistants who remain employed part-time for the duration of the programme.¹⁶² This means that organisations can grow their own qualified nursing workforce. Distance learning is provided over four years and the close partnership with employers is crucial to the programme's success. Attrition rates are low, at 11.3 per cent across the UK.¹⁶³ Crucially, accreditation of prior experiential learning can account for up to 50 per cent of the programme, allowing people to build on existing skills and experience.¹⁶⁴

154 Professor Sir John Tooke, *Aspiring to Excellence*, 2008.

155 Professor David Greenaway, *Shape of Training, Securing the Future of Excellent Patient Care*, 2013.

156 Health Education England, *HEE Commissioning and Investment Plan - 2016/17*, 17.

157 Health Education England, *HEE Commissioning and Investment Plan - 2016/17*.

158 NHS Employers, "Apprenticeship Levy," Web Page, (6 April 2017); New NHS Alliance, *Supporting the Development of Community Pharmacy Practice within Primary Care*, 2016.

159 South Warwickshire GP, "Guide to Taking on an Apprentice," Web Page, (8 June 2017).

160 NHS England, "Next Steps on the NHS Five Year Forward View: England's Chief Nurse Announces 'Nurse First' to Attract the Best and Brightest Graduates to Nursing," Web Page, (31 March 2017).

161 Ibid.

162 Lord Willis, *Raising the Bar. Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants*.

163 Ibid.

164 Ibid.

3.2.2.1 System capacity

Interviewees for this paper from royal colleges, universities and regulatory authorities raised concerns about the capacity of providers to deliver more quality clinical training placements in medicine and nursing. Some projected a situation where, for instance, a single hospital providing education for nurses to multiple education institutions, could limit the number of students they train and inflate the cost of training above market value.

The role of the STP will be vital in preventing market failure and ensuring neither trusts nor universities become too powerful in such negotiations. Organisations within the STP must work together to provide sufficient, high-quality training places. The relevant regulatory body would continue to ensure training providers are adhering to standards.

If areas wish to increase training numbers they must ensure training is being delivered at capacity. One acute trust (rated overall outstanding by the Care Quality Commission) interviewed for this paper said that, in a recent review of nurse training capacity, they had space to increase numbers by 50 per cent. Dynamic training models should also be trialled, for instance with students spending more time in hospitals out of hours or in underutilised out of hospital settings such as general practice.

Recommendation 7: STPs should develop and trial the full range of alternative and flexible routes into health and social care.

Recommendation 8: Organisations within the STP must work together to ensure high quality training is being delivered at capacity.

3.2.3 Devolve pay

All staff in the NHS, other than doctors, dentists and senior managers, are paid according to the Agenda for Change (AfC) pay scale.¹⁶⁵ The scale was designed to deliver equal pay for equal work. In theory, staff who develop successfully progress annually to the maximum pay within their band. In practice however, this is not the case and pay progression is usually automatic.¹⁶⁶ In 2016-17, 54 per cent of NHS staff on the AfC pay scale were due to receive pay increments of around three to four per cent in addition to the one per cent pay award.¹⁶⁷ Of those not progressing, most were already at the top of their pay band.¹⁶⁸

AfC is failing to deliver for local providers. The framework is optional but, in practice, many providers have seen it as an enforced change and very few agree pay locally.¹⁶⁹ Indeed, the South West Pay Consortium tried to negotiate local pay but lacked political and union support and were unable to implement change.¹⁷⁰ In a review of employers, HayGroup said that “the gains which organisations generally look for from reward improvements, such as better cost control, talent management, productivity or performance, were missing.”¹⁷¹ Furthermore, national pay bargaining has, in part, been held responsible for significant variations in regional vacancy rates across the country.¹⁷²

If workforce planning is to be effectively devolved, local employers must be able to control pay so that it is fair for staff and the NHS. The appetite to control pay is variable amongst providers but they should not be restricted by rigid pay scales or the one per cent pay cap. Instead, they should be able to use all the tools available to design contracts that

¹⁶⁵ NHS Employers, “Agenda for Change,” Web Page, (4 July 2017).

¹⁶⁶ Richard Baum, “NHS Pay Is Complicated, Unfair and Frankly Absurd,” *The Guardian*, 22 September 2014; Ed Holmes and Matthew Oakley, *Local Pay, Local Growth* (Policy Exchange, 2012).

¹⁶⁷ NHS Pay Review Body, *NHS Pay Review Body: Thirtieth Report 2017*, 2017.

¹⁶⁸ *Ibid.*

¹⁶⁹ HayGroup, *Setting the Scene for Public Sector Reward - Why and How*, 2012.

¹⁷⁰ “NHS Hospitals Trust Leaves South West Pay Consortium”, *BBC News*, 13 November 2015.

¹⁷¹ HayGroup, *Setting the Scene for Public Sector Reward - Why and How*.

¹⁷² Holmes and Oakley, *Local Pay, Local Growth*.

promote working across boundaries whilst suiting staff needs. These include pay, excellent performance management, progression opportunities, holidays, study leave and pensions. This should be extended to all staff.

Recommendation 9: Pay should be negotiated locally. It should be used in conjunction with other performance management strategies to attract and retain staff. Both AfC and the 1 per cent pay cap should be removed.

4

Overcoming professional boundaries

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The paper has so far described policies that would help overcome the imbalance in the size of the acute and community workforces, as well as the geographic boundaries dividing them. Chapter 2 demonstrates how introducing a functional labour market for doctors would allow national workforce planners to create incentives for trainees to move into high-demand specialities, including general practice. One of the benefits of devolution detailed in Chapter 3 is that it would empower and encourage STPs to deploy staff where care can be delivered most efficiently, which is likely to mean shifting care from the acute sector into the community.

By moving more care into the community and encouraging staff to work across the acute and primary sector, these recommendations bridge the physical boundaries that currently prevent integrated care being delivered. However, as the King's Fund note, "co-location alone is often not sufficient to generate co-working or integration of care".¹⁷³ This chapter therefore makes recommendations to help overcome professional boundaries and ensure staff work together in a more integrated way.

4.1 Deregulation

Many clinical staff within the NHS, such as doctors, nurses and pharmacists, are regulated.¹⁷⁴ This means they are certified by an independent regulatory body to have met certain standards of training and care delivery.¹⁷⁵ In effect, these bodies provide professional standards and a checklist of tasks for which a professional is qualified and registered. However, the regulatory system in the NHS unnecessarily stifles workforce innovation and prevents staff working across professional boundaries. Regulation is stopping some professions from working at the top of their potential. In the case of care assistants, they are unable to develop their skills by completing currently regulated tasks, which they could actually do, and are not delegated tasks from nurses because of their lack of registered status.¹⁷⁶ A new model of regulation would ensure that staff are competent to do tasks that carry risk but would not act as a performance management tool.

The decision on whether to regulate a profession is supposed to be based on patient risk.¹⁷⁷ However, interviewees for this paper were clear that the present regulatory system in the NHS arbitrarily restricts certain tasks to the remit of regulated professionals, when they could safely and more efficiently be carried out by others. This is corroborated by the Health Foundation, who argue that "statutory professional regulation is as much an accident of history as a rigorous risk-based assessment".¹⁷⁸ In support of this, they point to examples of regulated and unregulated professionals where the decision to regulate or not seems disproportionate to patient risk. Perfusionists, for example, operate heart and lung bypass machines during cardiac surgery and are not regulated.¹⁷⁹ Music therapists, who use music to help people with emotional or behavioural issues, are regulated, whilst art therapists, who use art for the same purpose, are not.¹⁸⁰

Interviewees described how this underutilisation of staff skills is not only inefficient, but also contributes to a siloed and disjointed system. This is because patients are often referred around the system to different regulated professionals, when care could safely be delivered by a smaller number of clinical staff working in one place. This view is supported by the Lords Committee on the Long-term Sustainability of the NHS, which emphasised the strongly conservative culture in healthcare where "different professional groups form

173 Candace Imison, Chris Naylor, and Jo Maybin, *Under One Roof: Will Polyclinics Deliver Integrated Care?* (King's Fund, 2008), 2.

174 The Health Foundation, *Fit for Purpose? Workforce Policy in the English NHS*, 2016.

175 General Medical Council, *The State of Medical Education and Practice in the UK*, 2016.

176 Candace Imison, Sophie Castle-Clarke, and Dr Robert Watson, *Reshaping the Workforce to Deliver the Care Patients Need*.

177 General Medical Council, *The State of Medical Education and Practice in the UK*.

178 The Health Foundation, *Fit for Purpose? Workforce Policy in the English NHS*, 22.

179 The Health Foundation, *Fit for Purpose? Workforce Policy in the English NHS*.

180 Ibid.

groups and tribes... and do not want to change.”¹⁸¹ Overregulation plays a major role in preventing some staff from using their skills effectively. Staff feel that if they are not regulated they cannot compete certain tasks. One interviewee described a reluctance on the part of nurses to refer to suitable AHPs because they do not know what care they are regulated to deliver, meaning patients are referred away from more efficient methods of treatment. With respect to extended roles such as advanced nurse practitioners, the Nuffield Trust note that lack of regulation can cause a reluctance to perform all aspects of the role they are skilled to, as they are concerned they may be in breach of regulation.¹⁸² Similarly, they highlight that lack of regulation can “limit the ability of physician associates to work autonomously without the presence of a senior doctor.”¹⁸³

One option is to regulate more widely so that staff are empowered to deliver all aspects of healthcare they are safely able to. However, expanding the number and remit of regulatory bodies (of which there are already 9) is likely to be costly.¹⁸⁴ Moreover, regulatory bodies already enforce standards and practices that are unlikely to have a direct or severe impact on patient safety. For example, the regulatory body for paramedics issues standards of proficiency that include the ability to communicate effectively with service users and colleagues.¹⁸⁵ Interviewees suggested that this may be because regulation is currently used in part to convey status, and is therefore not restricted only to high-risk activities. Extending regulation in this way is therefore likely to add unnecessary further restrictions on who can deliver care. Indeed, several others submitting evidence to the Lords Committee on the Long-term Sustainability of the NHS argued that rationalisation of regulators and their remit would encourage workforce innovation.¹⁸⁶

Deregulation is therefore a preferable option. Lifting more low-risk tasks out of professional regulation would reduce the administrative burden on staff and regulatory bodies. In practice, this would work as follows. Regulation for nurses would be reduced. A nurse would be regulated for the task of dispensing drugs as this is a high-risk task, but a nurse would not be regulated for low-risk tasks such as working cooperatively with colleagues. Making sure that a nurse completes low-risk tasks to a required standard would instead be the responsibility of the employer, and should be evaluated in a yearly appraisal meeting as set out in section 4.2.3 of this chapter. This would help address the “bureaucratic jungle” that characterises the present system, allowing staff to spend less time demonstrating compliance and more time delivering care.¹⁸⁷ Crucially, by regulating only those tasks that present a clear risk to patients, deregulation would also empower staff who possess the necessary skills to deliver more care, where currently they are frustrated by legislation.

The benefits of scaling back “intrusive” over-regulation and moving to a more risk-based approach are recognised by the GMC.¹⁸⁸ They also note the importance of accurate data in providing an evidenced-based understanding of risk.¹⁸⁹ To help in this regard, they have worked with stakeholders across the health and education sectors to create the UK Medical Education Database (UKMED).¹⁹⁰ This combines data mapping the performance of medical trainees and professionals and highlighting key risk areas of the role.¹⁹¹ They also note the benefit of data sharing between regulators, highlighting that data from their

181 House of Lords Select Committee on the Long-term Sustainability of the NHS, *The Long-Term Sustainability of the NHS and Adult Social Care, Report of Session 2016/17*.

182 Candace Imison, Sophie Castle-Clarke, and Dr Robert Watson, *Reshaping the Workforce to Deliver the Care Patients Need*.

183 *Ibid.*, 51.

184 The Health Foundation, *Fit for Purpose? Workforce Policy in the English NHS*.

185 Health and Care Professions Council, *Paramedics: Standards of Proficiency*, 2014.

186 House of Lords Select Committee on the Long-term Sustainability of the NHS, *The Long-Term Sustainability of the NHS and Adult Social Care, Report of Session 2016/17*.

187 *Ibid.*, 40.

188 General Medical Council, *The State of Medical Education and Practice in the UK*.

189 *Ibid.*

190 *Ibid.*

191 *Ibid.*

annual national training survey now informs the work of other regulatory bodies, including the CQC.¹⁹²

Whilst the GMC recognise that this evidence-based approach to regulation is in relative infancy and faces challenges in ensuring collaboration between different parts of the system, it nevertheless presents a promising roadmap for delivering risk-based regulation.¹⁹³ Other regulators must therefore follow suit. This starts with building a database akin to the UKMED, so that the risk associated with different roles can be accurately determined. Once in place, regulators should be required to complete a risk audit of all the professions they currently regulate. This should entail mapping the tasks and procedures each role has the skills to safely complete, and deregulating those where the evidence suggests patients would not suffer.

Recommendation 10: The Government should amend the legislation detailing the remit of the 9 regulatory bodies to include a requirement to work with health and education stakeholders to produce a database akin to the UKMED. This should include details of trainee and professional performance and should identify tasks and procedures within professions that carry risk to patients.

Recommendation 11: The Government should introduce legislation requiring each regulatory body to carry out at fixed intervals a risk audit of all the professions and roles they regulate. This should be informed by their database indicating the level of risk associated with different roles and procedures. Where evidence suggests it would not be detrimental to patient safety, bodies should deregulate tasks.

4.2 Continuing professional development

A less-regulated NHS and social care workforce would soften professional boundaries that emerge when low-risk tasks can only be carried out by specified roles. It would enable care to be delivered by a wider range of staff, reducing the need for patients to be referred to different isolated sections of the system. However, whilst deregulation would allow staff to utilise more of their skills, it would not by itself help them to advance and gain new skills. An effective system of continuing professional development (CPD) is also required.

4.2.1 State of play

Although care workers provide over 60 per cent of hands-on care in the NHS, personal development and training opportunities for them are limited and no formal qualifications are expected.¹⁹⁴ In the 2016 NHS staff survey, social care workers were among the least likely to have had training and development opportunities in the last 12 months, at 68 per cent.¹⁹⁵ In comparison, 86 per cent of registered nurses and midwives had.¹⁹⁶ A Skills for Care report shows variable training opportunities for those working in social care; 74 per cent of social care workers have been trained in moving and handling whilst only 39 per cent have been trained in dementia care.¹⁹⁷ Furthermore, qualifications gained through one employer in social care were not necessarily recognised by another, with concerns about the quality of courses delivered by some training providers.¹⁹⁸

A non-mandatory care certificate has been introduced for all un-regulated care workers.¹⁹⁹ This followed *The Cavendish review* in 2013 which recommended a Certificate of

¹⁹² Ibid.

¹⁹³ Ibid.

¹⁹⁴ Department of Health, *The Cavendish Report*, 2013.

¹⁹⁵ NHS England, *National NHS Staff Survey 2016*, 2016.

¹⁹⁶ Ibid.

¹⁹⁷ Skills for Care, *The State of the Adult Social Care Sector and Workforce in England*, 2016.

¹⁹⁸ Department of Health, *The Cavendish Report*.

¹⁹⁹ NHS England, *Next Steps on the NHS Five Year Forward View*.

Fundamental Care based on the National Minimum Training Standards, itself developed and published following the Francis Inquiry.²⁰⁰ However, the care certificate does not address ongoing learning and skills development. It is also targeted at new staff, meaning currently only 62 per cent of care workers have gained it.²⁰¹

For regulated NHS staff, CPD opportunities vary across professional groups and sectors. A survey of nurses indicates that 87 per cent of those working in the acute sector feel they have training and development opportunities.²⁰² There are additional training opportunities for pharmacists working in hospitals, such as a prescribing qualification and other accreditations to move them into extended roles.²⁰³ However, training for nurses, AHPs and pharmacists in the community sector is less frequent and variable. Pharmacists working in the community, for example, generally have a flat career structure and limited career progression.²⁰⁴ According to several interviewees, it is very challenging to move into the acute sector after working for a prolonged time in the community, illustrating the importance of CPD for professional progression.

Doctors have the most structured and specialised training and CPD opportunities. Following graduation, doctors have a prolonged period of postgraduate training (minimum three years for a GP following two years of foundation training, five years for a hospital consultant following two years of foundation training). Those in training are expected to complete clinical competencies, work-based assessment, 360-degree feedback and have satisfactory supervisor reports.²⁰⁵

Access to CPD opportunities for all staff would help make the most of the skills the workforce possesses. The Nuffield Trust argue that developing essential competencies for delivering high-quality care rather than focusing on existing professional labels can help the NHS maximise the use of staff skills and encourage professionals to work at the “top of their licence”.²⁰⁶

Ensuring all staff have access to development opportunities is also likely to improve staff retention. Between 2011-2012 and 2016-2017, the proportion of staff leaving the NHS each year increased by 9.5 per cent.²⁰⁷ Staff redundancies where the NHS is harnessing technology, automating tasks and streamlining work are to be expected. But worryingly, the number of voluntarily resignations due to lack of opportunities in the NHS is also an issue and has increased by 68 per cent over the last five years, as shown in Figure 6.²⁰⁸

200 Department of Health, *The Cavendish Report*.

201 Skills for Care, *The State of the Adult Social Care Sector and Workforce in England*.

202 NHS England, *National NHS Staff Survey 2016*, 2016.

203 Anthony Smith and Robert Darracott, *Modernising Pharmacy Careers Programme - Review of Pharmacist Undergraduate Education and Pre-Registration Training and Proposals for Reform*, 2011.

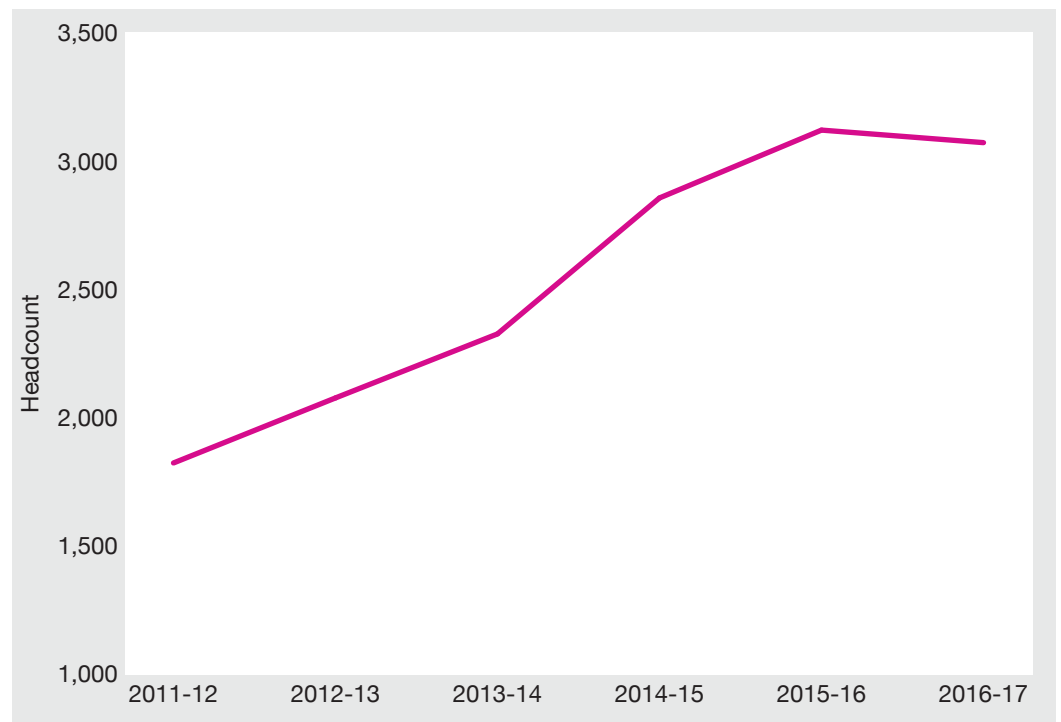
204 Ibid.

205 General Medical Council, “Medical Career Structure.”

206 Candace Imison, Sophie Castle-Clarke, and Dr Robert Watson, *Reshaping the Workforce to Deliver the Care Patients Need*, 26.

207 NHS Hospital and Community Health Service, *NHS Hospital & Community Health Service Monthly Workforce Statistics: Timeseries of Reasons for Leaving/Staff Movements and Redundancies*, 2017.

208 Ibid.

Figure 6: Voluntary resignations in the NHS from lack of opportunities

Source: *Reform* calculations. Timeseries of Reasons for Leaving and Staff Movements, *NHS Hospital & Community Health Service monthly statistics*, 2017.

4.2.2 A Skills Pass

Developing a universal Skills Pass for all NHS staff would offer an effective mechanism for achieving this aim. This would be a competency-based training framework of unregulated tasks and should introduce greater flexibility into the training system, meaning staff are able to work effectively across professional boundaries. In the short term, the Skills Pass would address the issue of standardisation of training for the unregulated workforce and ambiguity of skill level. The Skills Pass would also provide much needed progression opportunities, especially for the unregulated workforce. In the longer term, the Skills Pass would be a key enabler to the vision set out in the *Five Year Forward View*: it would create a workforce whose skills and experiences were not aligned to one particular professional group or sector, but rather a workforce of generalists who could flex their skills to the needs of the patient they were caring for.

In 2009-2010, a skills passport proof-of-concept was undertaken among nursing staff at seven English NHS Trusts, led by Skills for Care.²⁰⁹ Workers created a verified online record of their skills, qualifications and experience, which could then be viewed by existing or prospective employers. Feedback was positive; employers believed it had the potential to reduce unnecessary duplication of statutory and mandatory training, whilst nurses said it helped them plan and manage their careers more effectively.²¹⁰ This skills passport has not been rolled out nationally but has remained on the agenda as a future reform for Skills for Care. Interviewees explained it would be a good mechanism to allow movement around different providers, verify skills and qualifications and act as a toolkit for performance management.

To introduce a Skills Pass, a task-force of providers and employers should be recruited from across health and social care. The task force should work closely with Skills for Care and draw from lessons-learned on the previous attempt to introduce a Skills Pass.

²⁰⁹ Cath Everett, "NHS to Roll out 'Skill Passport' Scheme," *Trainingzone*, 2010.
²¹⁰ Ibid.

The high-level practical steps for how a Skills Pass could be introduced are as follows:

Step 1: The Skills Pass would encompass a set of unregulated competencies. Competencies could include:

- > clinical skills such as simple wound dressing and cannulation;
- > caring for someone in their own home;
- > communication and teamwork;
- > leadership;
- > safeguarding vulnerable groups; and
- > digital skills.

Staff will be able to choose which competencies they want to pursue, how far up the competency levels they want to progress and whether they want to move between the different competencies, i.e. becoming a novice in six different competencies or highly proficient in a couple. This will provide staff with the flexibility and opportunity to plan and manage their own development and careers

Step 2: The Skills Pass will use an online portal as a support tool for training. This will feature detailed information describing each competency and what is needed from the staff member to pass (i.e. amount of time working in the competency, feedback, and training material). The portal will also provide access to online training material, supplementary to 'on-the-job-experience'. Drawing on best practice from the NHS Leadership Academy²¹¹ and feedback from the Competency Framework for Pharmacy Technicians,²¹² the Skills Pass should involve more 'on-the-job' training than training courses, to ensure that all professionals have the time and opportunity to gain competencies, and that managers do not need to stop staff from training because of staff shortages.

The online portal can also act as a record of the skills staff have gained. Feedback from the proof-of-concept trialled in 2009 highlighted that collecting employee data on an integrated platform meant that "employers could adopt an approach to talent management where they proactively deploy people into the most impactful roles."²¹³ An online portal, similar to that developed by Allocate Software, can help to provide real-time information and valuable insights to employers, predicting skill shortages and identifying low staff engagement.²¹⁴

Step 3: Assessment of whether a staff member has the appropriate level of knowledge and skill to gain a competency will be made by senior staff members. For example, a senior doctor can decide whether a Foundation year one doctor shows the appropriate level of skill to pass the teamwork competency. It is expected that senior staff members should already be competent in most areas and able to make informed judgements, using the online material for support. Competencies that could be perceived as higher risk in terms of impact to the patient, such as safeguarding vulnerable groups, would require the senior staff member to take part in an additional training course before becoming accredited to assess others.

211 NHS Leadership Academy. "The Mary Seacole programme for first time leaders", Web Page, (1 September 2017).

212 NHS Pharmacy Education and Development Committee, *Nationally Recognised Competency Framework for Pharmacy Technicians: Final Accuracy Checking of Dispensed Items*, (2013).

213 Ibid.

214 Allocate Software, "Our Workforce Solutions," Web Page, (24 August 2017).

Recommendation 12: A universal Skills Pass, with non-regulated competencies, should be introduced by NHS England. All employees working in the health and social care sector will have an opportunity to gain any competency. STPs must introduce the Skills Pass in their health economy, though they will have flexibility on dictating the training structure and competencies offered.

4.2.3 Performance management

For the Skills Pass to be adopted and used most effectively, well-developed and well-used performance management frameworks must be in place. This would encourage the workforce to build their competencies and utilise the freedoms afforded by deregulation and the Skills Pass. If a risk-based approach to regulation leads to reduced bureaucracy, employers will need to ensure staff are completing deregulated tasks to an appropriate standard and have received the correct amount of training to carry out tasks properly. Introducing an effective performance management framework for all health and social care staff will do this.

The NHS Constitution requires organisations to provide all staff with personal development and line management, recommending that an organisation-wide appraisal process is a good way to do this.²¹⁵ However, performance management is highly variable, with evidence suggesting limited performance management is available for lower paid, unregulated workers and those in social care.

The recent NHS Staff Survey, for example, indicates that not all staff have an annual appraisal and the outcomes of these appraisals are not always useful. Only 20 per cent of AHPs said their appraisals had helped them to improve how they did their job.²¹⁶ Some describe the appraisal as a stressful rite of passage with a binary pass or fail being the only perceived outcomes, rather than a chance to identify progression opportunities.²¹⁷ Interviewees for this paper similarly argued that the current method of appraisals created a ‘tick-box’ attitude and instead of installing a culture of improvement, confirmed to staff that they ‘couldn’t get fired’. In *The Cavendish Review*, an hospital care worker focus group said, “appraisals are not worth the paper they are written on.”²¹⁸

Moreover, many workers with limited performance management have expressed a desire to progress professionally. In a recent Health Education England Survey, for example, 35 per cent of care assistants said they wanted to become a registered nurse.²¹⁹ *The Cavendish Review* highlighted how many support workers cannot see a clear career path and felt that more access to training was needed.²²⁰ This highlights the significant untapped human capital that could be utilised through more effective performance management.

Staff appraisal systems should be designed to give employees the opportunity to establish what they want to achieve from work and how to attain this. For some, employment is about having a steady work-life balance and income, whilst others wish to seek rapid progression up the system, and some need support and encouragement to step up. The appraisal needs to promote the use of the Skills Pass; it should recognise when an employee has progressed or developed a new skill using the Skills Pass and when they have challenged themselves to work across different sectors. Figure 7 outlines the principles and rationale for a more effective model of appraisal.

215 NHS Employers, “Appraisals,” Web Page, (1 March 2017).

216 NHS England, *National NHS Staff Survey 2016*, 2016.

217 The British Medical Journal, “Postgraduate Medical Training in the NHS: Complex and Transforming,” Blog, (August 31 2016).

218 Department of Health, *The Cavendish Report*, 73.

219 Health Education England, *Building Capacity to Care and Capability to Treat*, 2016.

220 Department of Health, *The Cavendish Report*, 29.

Figure 7: A new model of staff appraisal

Principle	Reason
Shared goals	The shared values of the employer and employee should be discussed and common goals established.
High standards	Achievement should be recognised and reinforced. The appraiser should offer constructive criticism in order to challenge and support the staff member to provide world class care.
Outcomes based	Staff should be encouraged to focus on key outcomes for their role. For example, outcomes for a ward manager could include the number of falls on their ward or the number of sick days their staff have taken. An outcome for a care worker could be feedback from a patient.
Personalised	The conversation should be tailored specifically to the individual to help them learn and develop.
Meaningful	Appraisals should be linked to new opportunities and allow an employee to monitor their progress towards a goal.
360-degree	Appraisals should feature 360-degree feedback and evidence from a range of sources, including staff feedback, patient satisfaction and clinical outcomes. This will act as a basis for performance improvement and individual development.
Developmental	The appraisal should recognise where a staff member has been proactive in pursuing development opportunities, especially competencies offered on the Skills Pass. This will encourage sustained performance in the future.
Performance management	Inaccurate appraisals are a barrier to improving performance, dishonest and unfair. Performance should be analysed appropriately and it should be recognised and flagged when an individual is not performing within the requirements of a role. Some staff have used previously 'passed' appraisals as a defence when managers have tried to discipline them.

Source: CIPD, *Performance appraisal*, 2017. Department of Health, *The Cavendish Review*, 2013.

Recommendation 13: An annual appraisal should be mandatory for all staff members. The appraisal must be useful to staff members by being outcomes focused and recognise where staff have challenged and developed themselves using the Skills Pass.

Conclusion

To continue the same trajectory of workforce planning will only deepen the divides between acute and community care and between different members of the workforce. To bridge the gap, the NHS must uncap training places completely and enable STPs to attract, train and retain the staff they need. Regulation needs to be rationalised and universal effective performance management put in place. These measures aim to deliver an adaptable workforce that can flex in accordance with demand. Underpinning this paper is a change of approach aimed to deliver integrated care. Similar principles will help the NHS continue to adapt and meet the wider productivity challenge it faces.

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