REFORM

Doctors and nurses

Thomas Cawston
Andrew Haldenby
Nick Seddon

November 2012

The authors

Thomas Cawston is Research Director at *Reform*

Andrew Haldenby is Director at *Reform*

Nick Seddon is Deputy Director at *Reform*

Reform

Reform is an independent, non-party think tank whose mission is to set out a better way to deliver public services and economic prosperity. *Reform* is a registered charity, the Reform Research Trust, charity no. 1103739. This publication is the property of the Reform Research Trust.

We believe that by reforming the public sector, increasing investment and extending choice, high quality services can be made available for everyone.

Our vision is of a Britain with 21st Century healthcare, high standards in schools, a modern and efficient transport system, safe streets, and a free, dynamic and competitive economy.

Doctors and nurses

Thomas Cawston
Andrew Haldenby
Nick Seddon

November 2012

#doctorsnurses

Contents

Executive summary

The quality of care depends on more than the sheer quantity of staff. Quality healthcare requires a quality workforce. Reforming the workforce will be essential to improve the quality of healthcare. Pioneers of healthcare excellence are already demonstrating how to effectively manage and motivate clinicians to deliver better quality services. Government now needs to ensure that all providers can adopt the lessons of high performing organisations.

The best healthcare organisations in the world are the best employers because they understand the importance of human capital. In getting the best out of their doctors and nurses they exhibit shared behaviours or habits. Principally, they adopt modern management practices, such as rigorously selective recruitment processes; staff engagement; devolving clinical and often financial power and accountability to the frontline; encouraging flexible working and team-based care; investing in staff development, measuring performance and outcomes; celebrating and rewarding excellence, and identifying and dealing with mediocrity and failure. This report highlights the good practice of:

- Salford Royal NHS Foundation Trust. Salford Royal is one of England's highest performing Trusts. Standardised mortality is in the top 10 per cent of hospitals in the country and 92 per cent of patients receive harm-free care. Salford's leadership has improved its workforce by innovative links between pay and performance and by new methods to measure nursing quality. Staff satisfaction has been the highest in the NHS for two years running.
- The Mayo Clinic. The Clinic has improved care by enabling doctors to work together in cooperative and multidisciplinary teams. One reviewer found: "Mayo employs highly capable doctors and other caregivers, but so do other healthcare organisations. What distinguishes Mayo is effective medical staff team work. The Clinic excels in pooling talent for the benefit of patients."
- Care management teams in Massachusetts and Illinois. These providers have used clinical staff in non-traditional roles. For example, nurses have been retrained in order to become care managers for caseloads of 50 patients, coordinating care by different clinicians and providers and encouraging self-management.
- Healthcare providers in India. The greater scarcity of healthcare workers in the developing world is stimulating innovation in professional roles. At Narayana heart hospital, junior surgeons open and close surgical procedures while consultants complete only the most complex part of the operation. This allows them to spend one hour on a six hour operation. At Aravind Eye Care System, ophthalmic assistants receive a two-year training programme enabling them to assist surgeons. At LifeSpring maternity hospital, all clinical and non-clinical tasks are standardised and able to be undertaken safely by less expensive nurses.

The report also refers to good practice at University Hospitals Birmingham, UK, the Cleveland Clinic, the Geisinger Health System, Kaiser Permanente, all in the United States, the Coxa Hospital in Finland, and the Hospital de Manises in Valencia, Spain.

Empowering the leaders

Although NHS organisations have the flexibility to develop their own terms and conditions, they have often sought national action and reform to national contracts to manage workforce costs. Yet national policies to control costs, such as freezing pay, undermine the drive for a more productive workforce by preventing employers from using their discretion to change working practices or incentivise performance. To improve the quality of healthcare and get better value for money from the NHS workforce, employers need the motivation and freedom to be better leaders and employers.

Dealing with financial and clinical failure is essential in order to protect patients and make NHS chief executives accountable for their organisations' performance. In 2011-12, 34 Trusts ran up combined debts of £356 million and another 42 relied on handouts from local health authorities or the Department of Health to keep them going – almost 19 per cent of the 411 NHS organisations in total. Administrators appointed to oversee the crisis-hit South London NHS Healthcare Trust, which overspent by £65 million last year, have recommended that it be broken up and run by other NHS Trusts or private companies. However, according to the Public Accounts Committee, the Department of Health still does not have a proper failure regime.

Protected from failure, most employers do not deal with workforce challenges within their own organisations, and instead call for action by central government to manage workforce change. NHS Employers, the organisation that represents the interests of employers during pay negotiations, has recently called for discretionary pay increments to be frozen and for the NHS pay freeze to be extended into a third year. Nearly all NHS providers are planning workforce reductions. Although acute Foundation Trusts had planned to reduce their workforce by 6 per cent between 2012 and 2014, in 2012 the workforce actually increased by 1 per cent. National efforts that seek to improve quality, such as greater regulation, often shift responsibility away from providers and crowd out local initiative.

Before 2010, only one NHS Foundation Trust had used its freedoms to break from national contracts. Now, as in other public services, financial pressure is proving a positive catalyst for new thinking. In the South West, a consortium of 20 employers has announced plans to reform pay and conditions and reduce costs. The proposals, which will affect 60,000 staff, include ending overtime for nights, weekends and bank holidays, reducing paid leave and sick pay, making staff work longer shifts and cutting pay as much as 5 per cent.

Despite evidence of the variations in quality and productivity, national contracts have preserved a virtual GP monopoly over primary care. Primary care largely remains a cottage industry with many small and often inefficient practices delivering highly variable care quality. To improve the quality and productivity of primary care, and also ensure that out of hospital care is more coordinated, it is essential to radically change primary care. This will mean moving from national GP contract negotiations to local contracting arrangements. Clinical Commissioning Groups should commission local primary care services through locally determined contracts. Local commissioning and local contracts will allow CCGs to change the shape of service provision and bring in alternative and more cost effective providers.

Recommendations

- The Government should establish a clear mandate for all NHS providers to innovate with terms and conditions and the skill mix of their workforce. It should support initiatives such as the South West Consortium which replace national terms and conditions with local arrangements. Such initiatives are consistent with the best practice examples outlined in this report which have all been driven by local clinicians and managers.
- Ministers should take the same position on the NHS workforce as Ministers responsible for other public services. Health Ministers, and indeed the Prime Minister, still defend the Government's NHS policies by pointing to an increase in the number of doctors since 2010. Instead they should follow the approach set out by the Home Secretary who has rightly argued in relation to the police: "what matters is not the total number of officers employed, but the total number deployed, and how effectively they are deployed".
- As in other public services, the financial pressure on the NHS should act as a catalyst for innovation. For this to happen, Ministers will have to hold NHS leaders properly accountable for performance, including financial performance. The placing of the South London Healthcare NHS Trust into administration sends exactly the right signal to the rest of the Service.
- The UK is heading towards a surplus of doctors. If existing pay structures were maintained it is estimated that the rise in consultants will cost the NHS an additional £2.2 billion. Yet the surplus creates an opportunity to drive down pay and review medical ranks. A number of organisations are exploring variations on the traditional medical career, ending the notion that when doctors become consultants their "Certificate of Completion of Training" is a grant of freedom and job for life. Ministers should welcome these developments.

- The Government should also relax immigration rules for doctors. In the past, workforce planning and medical training were concerned with avoiding medical unemployment. In the future all healthcare providers should have the freedom to decide how they will recruit and reward employees. Doctors and nurses are highly skilled professionals and they would be able to find work in other countries or elsewhere in the labour market.
- The primary care workforce needs urgent reform. Clinical Commissioning Groups should commission local primary care services through locally determined contracts. CCGs need the ability to manage the performance of GPs and bring in new providers, including the private sector.
- The Royal Colleges have focused on protecting the standing of the profession, such as maintaining boundaries between clinicians and traditional curricula, but they should lead reform of the profession to raise standards and back employers who seek to innovate with different working practices – especially team-based care.
- Health regulators should move away from regulating professional silos and protecting highly stratified professional hierarchies. They should create over-arching regulations to encourage greater role shift and team-based care.

1
High quality healthcare

Workforce matters

All health systems recognise the importance of the clinical workforce to deliver high quality care to patients. The focus of policymakers in the NHS and many other health systems has been the number of clinical professionals and improving the quality of pre-registration training. The recent House of Commons Health Select Committee report on workforce argued that "the quality, safety, effectiveness and efficiency of healthcare services depend on the availability of sufficient numbers of well-trained and well-motivated staff".[1] However quality of care depends on more than the sheer quantity of staff. Quality healthcare requires a quality workforce. It is the working environment that determines the performance of doctors and nurses. The most successful providers of care for patients are the best employers of staff.

Good organisations make better care

The best hospitals in the world are pioneering better healthcare. These providers are able to maximise productivity and deliver the highest quality. At the heart of better healthcare is the ability to obtain the full potential of doctors and nurses by reforming the front line through adopting modern management practices commonly used in the private sector. "High performance working practices", such as staff engagement, empowering the front line, highly selective recruitment, and staff development and performance-related reward, are now increasingly used in high performing providers.[2] These organisations deliver better outcomes through their focus on managing clinical staff, and not simply the number of staff.

Recent studies have highlighted the correlation between the workplace, patient safety and quality of care. A major survey of hospital care in 12 countries found a strong association between good working environments (management support for front line staff, good doctor-nurse relations, clinical participation in decision making, and organisational focus on care quality) and care quality and patient satisfaction.[3] A further survey based on nine countries found that nurses working in better environments were positive about the quality of care for patients.[4] Studies focused on single countries find similar patterns. In intensive care wards in North America organisations that had a strong team work ethos and flatter hierarchies had better record for patient safety.[5] In Germany better working conditions among doctors led to higher patient satisfaction.[6] In Belgium hospitals with better working environments had better workforce stability and staff perceptions of the quality of care.[7]

NHS hospitals with high rates of staff satisfaction in the NHS Staff Survey tend to be the highest performers in delivering quality outcomes. The annual survey ranks employers against the average staff satisfaction in the NHS across key indicators such as whether staff feel their employer provides effective appraisals, opportunities for continuing professional development and whether they would recommend the trust as a place to work. As tables 1 and 2 show, the 20 hospitals with lower than expected mortality rates in two or more measures in the Dr Foster Hospital Guide have on average higher scores in the NHS staff survey than the 19 hospitals that have lower than expected mortality rates in two or more measures. Hospitals in severe financial difficulties such as South London Healthcare NHS Trust also typically have among the lowest levels of staff satisfaction in the NHS.

1 Health Select Committee (2012), *Education, training and workforce planning.*
2 McAlearney, A. (2011), "Opportunities for High Performance Work Practices (HPWPs) to Improve Quality of Care", Health Innovation Program Seminar, University of Wisconsin, 24 October.
3 Aiken, L. et al. (2012), "Patient safety, satisfaction and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States", *British Medical Journal*, Vol. 344:e1717.
4 Aiken, L. et al. (2011), "Importance of work environments on hospital outcomes in nine countries", *International Journal for Quality in Health Care*, Vol. 23:4.
5 Speroff, T., Nwosu, S., Greevy, R. et al. (2010), "Organisational culture: variation across hospitals and connection to patient safety climate", *BMJ Quality and Safety*, Vol. 19:6.
6 Mache, S., Vitzthum, K., Klapp, B., and Groneberg, D. (2012), "How to improve the quality of medical hospital treatment and person-centered care: working conditions and job satisfaction as preconditions for satisfying medical care in German hospitals", *International Journal of Person Centered Medicine*, Vol. 2:2.
7 Van Bogaert, P., Meulemans, H., Clarke, S., Vermeyen, K. and Van de Heyning, P. (2009), "Hospital nurse practice environment, burnout, job outcomes and quality of care: test of a structural equation model", *Journal of Advanced Nursing*, Vol. 65:10; Milisen, K., Abraham, I., Siebens, K., Darras, E. and Dierckx de Casterlé, B. (2006), "Work environment and workforce problems: a cross-sectional questionnaire survey of hospital nurses in Belgium", *International Journal of Nursing Studies*, Vol. 43:6.

Table 1: Hospitals with lower than expected mortality rates and staff satisfaction
Source: Dr Foster Intelligence (2011), *Inside your hospital;* Picker Institute (2012), *NHS Staff Survey 2011.*

Hospital	Top 20 per cent	Above average	Total high scores	Bottom 20 per cent	Below average	Total low scores
Cambridge University Hospitals NHS Foundation Trust	25	4	29	1	4	5
Frimley Park Hospital NHS Foundation Trust	21	8	29	1	6	7
West Suffolk Hospitals NHS Trust	23	6	29	3	0	3
Guy's and St Thomas' NHS Foundation Trust	22	4	26	7	2	9
Chelsea and Westminster Hospitals NHS Foundation Trust	17	7	24	5	4	9
University College London Hospitals NHS Foundation Trust	15	8	23	5	6	11
University Hospitals Bristol NHS Foundation Trust	9	14	23	2	7	9
The Whittington Hospital NHS Trust	13	8	21	6	6	12
Imperial College Healthcare NHS Trust	5	15	20	7	1	8
King's College Hospital NHS Foundation Trust	7	10	17	7	7	14
Royal Free Hampstead NHS Trust	12	5	17	11	4	15
North West London Hospitals NHS Trust	6	10	16	7	8	15
Barnet and Chase Farm Hospitals NHS Trust	6	9	15	9	10	19
Barts and the London NHS Trust	4	9	13	10	6	16
Sheffield Teaching Hospitals NHS Foundation Trust	4	8	12	11	8	19
St George's Healthcare NHS Trust	3	8	11	14	6	20
Newham University Hospital NHS Trust	5	4	9	15	6	21
Epsom and St Helier University Hospitals NHS Trust	4	4	8	9	11	20
Kingston Hospital NHS Trust	3	1	4	20	8	28
South London Healthcare NHS Trust	0	3	3	27	4	31

Table 2: Hospitals with higher than expected mortality rates and staff satisfaction
Source: Dr Foster Intelligence (2011), *Inside your hospital*; Picker Institute (2012), *NHS Staff Survey 2011.*

Hospital	Top 20 per cent	Above average	Total high scores	Bottom 20 per cent	Below average	Total low scores
The Royal Wolverhampton Hospitals NHS Trust	10	18	28	0	7	7
University Hospitals of Morecambe Bay NHS Foundation Trust	10	12	22	4	5	9
The Dudley Group of Hospitals NHS Foundation Trust	7	14	21	1	8	9
York Teaching Hospital NHS Foundation Trust	10	11	21	4	6	10
Blackpool Teaching Hospitals NHS Foundation Trust	7	11	18	1	7	8
Mid Cheshire Hospitals NHS Foundation Trust	8	10	18	2	7	9
Dartford and Gravesham NHS Trust	9	9	18	1	11	12
Hull and East Yorkshire Hospitals NHS Trust	8	7	15	5	9	14
Burton Hospitals NHS Foundation Trust	3	9	12	0	13	13
Isle of Wight NHS PCT	2	8	10	2	10	12
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	6	4	10	9	8	17
Buckinghamshire Healthcare NHS Trust	3	6	9	14	4	18
Worcestershire Acute Hospitals NHS Trust	1	7	8	10	13	23
Medway NHS Foundation Trust	3	3	6	13	10	23
George Eliot Hospital NHS Trust	0	6	6	16	9	25
United Lincolnshire Hospitals NHS Trust	0	4	4	26	6	32
Shrewsbury and Telford Hospital NHS Trust	0	3	3	23	9	32
North Cumbria University Hospitals NHS Trust	2	0	2	22	10	32
Northampton General Hospital NHS Trust	0	1	1	17	14	31

Better for less

Reform's case studies of more for less in public services have demonstrated how to achieve better productivity and quality from institutions' human capital.[8] Doctors and nurses achieve more when they are made accountable for performance and engaged in the objectives of their employer. Flexible use of clinical staff ensures that professionals are used effectively. Staff will achieve better quality and better productivity through effective performance management and use of incentives.

Strong management

Good organisations need strong management and leadership.[9] As the recent King's Fund Commission on leadership found: "High-quality leadership and management at all levels is a prerequisite for a National Health Service that delivers both the highest possible quality of care to patients and the best possible deal

8 Moreforless.reform.co.uk. Last accessed November 2012.
9 Robinson, P., and Tyndale-Biscoe, J. (2011), *What makes a top hospital?*, CHKS.

for the taxpayer."[10] A recent survey of healthcare in seven countries found that improved management practices in hospitals resulted in better patient care and better financial performance.[11] The *Management matters* project, led by the London School of Economics and McKinsey & Company, found effective management can reduce variation in services, manage the performance of staff and recognise and develop talent.[12]

Leadership both empowers front line staff and holds staff to account. In particular, effective managers can identify and reward strong performance, but also address poor performance. Excellent leadership is essential to articulate a vision and mission for healthcare organisations, and develop shared values and objectives. Leadership is also key in taking on vested interests to implement service change and innovation in delivery.

Stable leadership is also important, with the most effective chief executives remaining in post for several years.[13] For example, many of England's top performing hospitals, such as University College London Hospital, Salford Royal and Chelsea and Westminster, have had the same chief executive in place for over a decade. Strong governance at Board level is also an important driver of performance. A recent survey of US hospitals found that Boards with greater expertise and experience, that prioritise quality improvement and regularly review data on quality, deliver better results.[14]

Cultures of excellence

Many of the world's best healthcare providers have patient-centred cultures and workplaces that prioritise quality improvement. Often better organisations have clear mission statements such as "becoming the safest hospital in the NHS" or "eradicating needless blindness", and have a clear commitment to patient-centred care such as "patients first" or "the needs of the patient come first". There is mounting evidence that these cultures have higher levels of staff engagement and achieve better results. A study of variations in treating heart attacks in American hospitals found that all hospitals used similar protocols and processes, yet staff at high performing hospitals shared a common vision of quality improvement.[15] As well as improving clinical outcomes, organisations with stronger morale and patient-centred values improve the patient experience and the compassion with which they are treated.[16] Positive cultures also are more receptive of patient feedback and staff are more open about raising concerns about quality and safety. Strong organisations do not simply develop a mission and a culture of excellence, but also work intensively to promote these values in the workplace. New staff are often selected according to their attitudes and shared values, while induction for new recruits is also used to promote the values of the organisation.

Empowering the front line

Strong management and workplace cultures are essential to empower front line staff. As well as having capable leaders at the top, effective hospitals also have distributed leadership where responsibility and authority is devolved to the front line.[17] This model of leadership also ensures better "followership" among staff.[18] The development of service line management in NHS hospitals has been most successful where Boards have devolved responsibility to the front line, supported the judgement of clinicians and held them to account.[19]

A culture of excellence will ensure all clinicians take ownership and responsibility for clinical quality.[20] This will also promote greater professionalism among clinicians. Positive workplace cultures that promote quality and patient care give staff "the power and moral authority" to go the extra mile.

10 The King's Fund (2011) *The future of leadership and management in the NHS: No more heroes*.
11 Dorgan, S. et al. (2010), *Management in Healthcare: Why good practice really matters*, McKinsey & Company and Centre for Economic Performance at the London School of Economics.
12 Dowdy, J. et al. (2005), *Management matters*, McKinsey & Company and Centre for Economic Performance at the London School of Economics.
13 Chambers, N., Pryce, A., Li, Y. and Poljsak, P. (2011), *Spot the difference: A study of boards of high performing organisations in the NHS*, Manchester Business School.
14 Jha, A., and Epstein, A. (2010), "Hospital Governance and the Quality of Care", *Health Affairs*, Vol. 29:1.
15 Curry, L. et al. (2011), "What Distinguishes Top-Performing Hospitals in Acute Myocardial Infarction Mortality Rates?: A Qualitative Study", *Annals of Internal Medicine*, Vol. 154: 6.
16 Goodrich, J. and Cornwell, J. (2008), *Seeing the person in the patient: the Point of Care review paper*, The King's Fund.
17 The King's Fund (2011) *The future of leadership and management in the NHS: No more heroes*.
18 Grint, K. and Holt, C. (2011), *Followership in the NHS*, The King's Fund.
19 Foot, C. et al. (2012), *Service-line Management: Can it improve quality and efficiency*, The King's Fund.
20 The King's Fund (2012), *Leadership and engagement for improvement in the NHS*; Bohmer, R. (2012), "The instrumental value of medical leadership: Engaging doctors in improving services"; The King's Fund; Clark, J. (2012), "Medical engagement: Too important to be left to change", The King's Fund.

In particular, a common "habit" of high performing systems is clinical leadership.[21] With doctors responsible for many of the spending decisions and the use of resources in healthcare, clinical leadership has the advantage of aligning clinical and financial responsibility. Effective models of clinical leadership typically give professionals autonomy to lead quality improvement initiatives but make them accountable for results. Clinicians have the expertise to implement improvements in healthcare delivery and securing their "buy-in" is essential to deliver change on the front line.

Measuring to manage

Measuring and integrating data with performance management and quality improvement is another key "habit" of high performing systems.[22] Modern information technology and real time data have strengthened the ability for hospital leaders to effectively manage staff performance. University Hospitals Birmingham in England has invested in a purpose built system that tracks decision making on the front line.[23] Trust leaders can monitor performance of individual clinicians and wards in real time and can locate, analyse and address outlying performers. With every decision taken by a clinician electronically recorded, the system creates an audit trail which informs accountability. Senior managers are able to use the rich and detailed data created by the system at staff meetings and reviews to highlight cases of sub-standard care and identify areas for improvement.

Successful organisations have also embraced transparency, releasing data on the outcomes achieved by doctors and nurses to drive up performance.[24] Cleveland Clinic publishes its clinical outcomes for each major disease area, allowing the hospital leaders to benchmark clinicians in order to drive quality improvement.[25] As part of its "High Performance Medicine" initiatives, Partners Healthcare in Massachusetts developed a sophisticated information and technology infrastructure to transform physician behaviour.[26] Electronic patient records are used to capture the data on clinical performance and patient outcomes. Data on performance has been very effective in influencing the behaviour of doctors, with publishing results leading to a reduced variation for referrals and use of tests.

Right reward

Getting more from doctors and nurses demands active performance management. Reforms to pay, using flexible contracts and bonuses, have been used successfully to improve the output and quality of clinical workers. Paying doctors based solely on output, such as through "fee for service" arrangements, has caused concerns that clinical judgement was being distorted by financial incentives and also encouraged unwarranted admissions and activity. However innovative providers have developed sophisticated payment mechanisms that both incentivise output and quality outcomes.[27] The need to encourage team working can also be incentivised through performance pay, whether through "team reward" or making individual clinicians' bonuses based on their role as a team leader.

At Geisinger in Pennsylvania, 20 per cent of doctors' salaries are linked to performance. Nearly half of this bonus is linked to team performance and quality improvement, such as patient satisfaction, complication rates from surgery and whether doctors applied the best clinical practice.[28] An effective approach is to combine peer pressure and financial incentives. At Kaiser Permanente, doctors are monitored and ranked in real time on a wide variety of clinical outcomes.[29] The data is accessible by all doctors who can see how they are performing relative to peers in their physician group and across the region. Kaiser's doctors also have a performance element to their pay based on their performance across different clinical targets. These targets are regularly raised. These hospitals have effectively leveraged the competitive nature of doctors to improve performance across the system. Other high performing systems, such as the Cleveland Clinic, pay staff only through salaries. To ensure doctors are meeting the needs of the employer, salaries only last one year and are subject to review and renewal.[30]

21 Mountford, J. and C. Webb (2009), "When clinicians lead", *McKinsey Quarterly*; Lee, T. (2011), "Turning Doctors into Leaders", *Harvard Business Review*.
22 Bohmer, R. (2011), "The Four Habits of High-Value Health Care Organizations", *New England Journal of Medicine*, Vol. 365.
23 Cawston, T. et al. (2012), *Healthy competition*, *Reform*.
24 Porter, M. (2010), "What is value in healthcare?", *New England Journal of Medicine*, Vol. 363.
25 Cawston, T. et al. (2012), *Healthy competition*, *Reform*.
26 Lee, T. and J. Mongan (2009), *Chaos and Organisation in Health Care*.
27 Darves, B. (2011), "Physician Compensation Models: Big Changes Ahead", New England Journal of Medicine Career Centre.
28 Paulus, R., Davis, K. and Steele, G. (2008), "Continuous Innovation in Health Care: Implications of the Geisinger Experience", *Health Affairs*, Vol. 27:5.
29 Kluger, J. (2009), "Is there a better way to pay doctors?", *Time Magazine*, 26 October; Paulus, R., Davis, K., and Steele, G. (2008), "Continuous Innovation in Health Care: Implications of the Geisinger Experience", *Health Affairs*, Vol. 27:5.
30 Cawston, T. et al. (2012), *Healthy competition*, *Reform.*

Public-private partnerships, such as Coxa Hospital and the "Alzira model" in Valencia, have often given leaders greater flexibility to implement performance related pay.[31] The Coxa Hospital in Finland was able to move away from national terms and conditions and introduce incentives schemes for staff. As well as improving productivity and ensuring the hospital was able to recruit the best surgeons, Coxa has been ranked as one of the best workplaces in Finland for staff satisfaction.[32] In Valencia, workforce flexibility has allowed providers to significantly increase productivity.[33] New providers on a ten year contract inherited the public sector workforce but have moved a growing proportion of staff on to new contracts with new terms and conditions. 61 per cent of staff are now employed directly by the Hospital de Manises, with 39 per cent of staff still on civil service contracts.[34] Employed staff salaries' are performance related, and staff often work longer, for less, compared to public sector workers. Workforce productivity is 25 per cent higher in the Hospital de Manises, with staff working on average 200 hours more a year, and absenteeism is 3 per cent, compared to 12 per cent in the public sector.[35]

Flexible professionals

Traditionally the delivery of healthcare has been based on individual practice. However the modern needs of health systems demand pooling a diverse range of skills and expertise. Better healthcare relies on the competence of teams and team ethic, and not simply the competence of individuals.[36] High performing organisations are those that can most effectively create team-based care which brings together different healthcare practitioners to better meet the needs of patients. Effective integrated models of healthcare can bring together practitioners from different professions and specialities, as well as shift staff to different care settings outside the hospital. High performing systems such as the Cleveland Clinic have organised their doctors around patient needs rather than medical speciality.[37]

Innovative providers have also challenged professional assumptions about what functions different health workers can perform and sought to reduce the distinctions in status between staff.[38] These providers use a skill mix that makes the greatest use of the most expensive and highly skilled practitioners by focusing doctors and senior nurses on the most complex tasks.[39] Functions that can be safely and effectively provided by non-medical staff are shifted to other clinicians.[40] This has been shown to improve efficiency while also delivering high quality care. A recent literature review by the Health Foundation found that nurses working in advanced roles delivered the same quality of outcomes as doctors, while also being more effective at providing information and advice to patients.[41]

Quality improvement at Salford Royal NHS Foundation Trust

Salford Royal NHS Foundation Trust is one of England's highest performing Trusts. Standardised mortality is among the best 10 per cent of hospitals in the country, 92 per cent of patients receive harm-free care and 95 per cent of patients would recommend the hospital to friends and family.[42] This performance has been achieved through staff engagement and performance management. According to the latest NHS staff survey, staff satisfaction at Salford is the highest in the NHS two years running.[43]

The hospital leadership has engaged front line staff in its ambition to make Salford the safest hospital in the NHS and save 1,000 lives over three years. Making care "safe, clean and personal" is a shared ambition for all staff.[44]

Clinical leadership has been actively promoted and developed.[45] A new vision for clinical leaders was developed by senior management and hospital consultants. The new role was based on accountability for

31 Bassett, D. et al. (2011), *It can be done*, *Reform*; Bassett, D. et al. (2011), *Reformers and wreckers*, *Reform.*
32 Cawston, T. et al. (2012), *Healthy competition*, *Reform.*
33 Bassett, D. et al. (2011), *It can be done*, *Reform.*
34 Cambridge Health Network/Bupa study visit 08/11/11.
35 Ibid.
36 Lawrence, D. (2002), *From chaos to care: the promise of team-based medicine*.
37 Cawston, T. et al. (2012), *Healthy competition*, *Reform*.
38 Ehrbeck, T. et al. (2010), "The emerging market in health care innovation", *McKinsey Quarterly*; Centre for Health Market Innovation (2012), healthmarketinnovations.org; International Partnership for Innovative Healthcare delivery (2012), ipihd.org.
39 Ehrbeck, T. et al. (2010), "The emerging market in health care innovation", *McKinsey Quarterly*; Centre for Health Market Innovation (2012), healthmarketinnovations.org; International Partnership *for Innovative Healthcare delivery* (2012), ipihd.org.
40 All-Party Parliamentary Group on Global Health and Africa All-Party Parliamentary Group (2012), *All the Talents: How new roles and better teamwork can release potential and improve health services*.
41 Laurant, M. et al. (2010), *Revision of professional roles and quality improvement: a review of the evidence*, The Health Foundation.
42 Salford Royal NHS Foundation Trust (2012), *Quality Accounts 2011-2012.*
43 Ibid.
44 Salford Royal NHS Foundation Trust (2008), *Quality Improvement Strategy 2008-2011.*
45 NHS North West (2012), "Salford Royal NHS Foundation Trust: Clinical leaders development programme", eWin Good Practice Case Study.

results and autonomy to lead a quality improvement project. An assessment process was developed in partnership with occupational psychologists, and of the 42 consultants who applied 15 were appointed as clinical directors, divisional chairs or clinical lead. Pre-existing appointments to these roles ceased.

Salford's leadership team has also measured staff performance based on achievement and values in a nine box grid that ranks employees from "role model" to "unsatisfactory".[46] As well as creating shared cultures and measuring performance, the hospital has also sought to create a system of reward and consequence for staff. The hospital management has used the discretionary elements of national contracts and additional measures beyond the agreed contract to reward appropriate staff behaviours. For example, the hospital has moderated the granting of "supporting professional activities", additional programmed activities and study and training opportunities to incentivise appropriate behaviour among doctors.[47]

For non-medical staff the hospital has also used pay increases to manage performance. Unlike nearly all other NHS Trusts, Salford Royal has also linked the awarding of Agenda for Change staff pay increments to performance and quality improvement.[48]

Salford has improved the quality of nursing care through the Nursing Assessment and Accreditation System.[49] This sets clear expectations for Ward Sisters and drives quality improvement. The quality of nursing care is assessed on 13 quality key standards and ranked, with each ward assigned a red, amber, green or blue rating. Securing a blue rating enables the Ward Sister to be promoted to Ward Matron with greater ability to influence organisation wide change and for the ward to operate with a higher level of autonomy. A ward with consecutive red ratings will have targeted support and intervention and subsequent failure to improve will most likely result in the ward sister being reassigned. The targets for each quality indicator are regularly raised.

The Mayo Clinic

The world-renowned Mayo Clinic in the United States has developed a patient-centred workplace culture.[50] The organisation of the workforce reflects and reinforces Mayo's primary value: "the needs of the patient come first". This ethos is emphasised during orientation for new recruits but also throughout the working environment and through career development. Such values also empower staff to increase their productivity and go the extra mile.

As Berry and Seltman have described, "Mayo employs highly capable doctors and other caregivers, but so do other healthcare organizations. What distinguishes Mayo is effective medical staff team work. The Clinic excels in *pooling* talent for the benefit of patients."[51] Mayo's leaders were quick to recognise that no one clinician could master all medical knowledge so the patient's best interest was best served by having access to a cooperative and multidisciplinary team. This spirit of team work is possible because the organisation's focus on respect between colleagues and making doctors salaried, rather than fee for service, also means there are no incentives not to work collaboratively with other professions. Shared clinical records also enable constant peer review and ongoing accountability. In addition, Mayo actively seeks to recruit doctors and nurses that are team players.

Clinical leadership is also at the heart of Mayo's success. Doctors are "partners" and have a professional interest in the organisation, as well as being involved in setting the direction and management of the Clinic. Mayo has developed a shared management structure, where senior doctors are partnered with administrators, and management decisions are made collectively. This empowers clinical leaders and also improves communication between leaders and the front line. It also creates a "healthy tension" between doctors advocating the needs of their patients and the financial and administrative concerns of managers.

The Clinic has also invested significantly in ensuring it hires the best people. This is not simply based on talent, but on the level of commitment, work ethic and shared values. Mayo's focus on recruiting staff that will "fit" its culture and structure, as well as a strong working environment, has meant that staff turnover is only 5 per cent. The turnover for doctors is 2.5 per cent.

46 NHS North West (2012), "Salford Royal NHS Foundation Trust: Performance Framework", eWin Good Practice Case Study; Reform study visit to Salford Royal, 24 August 2012.
47 *Reform* study visit to Salford Royal, 24 August 2012.
48 Dalton, D. (2012), Speech at *Reform* conference on *High quality healthcare*, 16 May.
49 Salford Royal NHS Foundation Trust (2012), *Quality Accounts 2011-2012.*
50 Berry, L. and K. Seltman (2008), *Management Lessons from Mayo Clinic: Inside One of the World's Most Admired Service Organisations*; McCarthy, D. et al. (2009), "Mayo Clinic: Multidisciplinary Teamwork, Physician-Led Governance, and Patient-Centered Culture Drive World-Class Health Care", Commonwealth Fund.
51 Berry, L. and K. Seltman (2008), *Management Lessons from Mayo Clinic: Inside One of the World's Most Admired Service Organisations*.

Care management teams in North America

To achieve greater coordination of services North American providers have used clinical staff in non-traditional roles.[52] The Senior Care Options programme in Massachusetts uses nurses, retrained by the Senior Care Options provider, to deliver care management to at risk individuals. These care managers are responsible for coordinating care with different clinicians and providers for a case load of 50 patients and are responsible for monitoring their condition and supporting to better self-manage. The Your Healthcare Plus programme in Illinois also takes a team based approach to care.[53] Medicaid patients at the greatest risk of hospitalisation are assigned to a care team which takes a holistic approach to a patient's total wellbeing and help them live quality and independent lives. The care team includes nurses, mental health specialists, physical therapists, lay counsellors and pharmacists, and is led by a non-medical care manager.

An extended case study of Senior Care Options can be found at moreforless.reform.co.uk

Role shift in India

The greater scarcity of healthcare workers in the developing world is stimulating innovation in professional roles.[54] At Narayana Hrudayalaya heart hospital consultant surgeon productivity is maximised through using their time effectively and the support of lower skilled staff.[55] Junior surgeons open and close surgical procedures while consultants would only do the most complex part of the operation. This allows them to spend one hour on a six hour operation. Surgeons can do between 1-5 operations and 70-100 consultations a day.

Aravind Eye Care System has developed unique healthcare roles. Doctors' time is maximised through the use of highly trained support workers.[56] Ophthalmic assistants receive a two-year bespoke training programme, and are trained to excel in particular roles in the patient pathway. They specialise in outpatient services, attending wards, assisting surgeons, refraction, patient counselling, housekeeping and medical records. Doctors at Aravind are recruited primarily on their level of commitment and are intensively trained in the ophthalmological procedures needed by Aravind. While most healthcare providers have staff that are trained at a wide range of organisations, 80 per cent of the medical workforce is trained at Aravind.

At LifeSpring maternity hospital in Hyderabad, they have standardised clinical services to maximise the value of human capital.[57] All clinical and non-clinical tasks have been standardised and set out in over 180 protocols. This has allowed LifeSpring to use less expensive and less experienced nurses. Demand for Auxiliary Nurses and Midwives is also much lower than for fully qualified midwives. While doctors first resisted the development of strict protocols as it was perceived to undermine their professional autonomy, they soon supported procedures once they saw the benefit. LifeSpring maximises the time of doctors through high volumes and relieving doctors of non-clinical duties, allowing them to spend more time with patients.

An extended case study of each of these institutions can be found at moreforless.reform.co.uk

52 Cawston, T. et al. (2012), *Healthy competition, Reform.*
53 Cawston, T. (ed.) (2012), *Rising to the Nicholson Challenge*, *Reform*.
54 Task Force for Scaling Up Education and Training for Health Workers (2008), *Scaling up, saving* lives; Crisp, N. et al.(2008), "Training the healthcare workforce: scaling up, scaling lives", *The Lancet*, Vol. 371, Issue 9613.
55 Bassett, D. et al. (2011), *Reformers and wreckers*, *Reform*.
56 Ibid.
57 Ibid.

When clinicians fail

While high performing systems share common management "habits" to get better care, there are a number of prominent factors that have been found to lead to poor quality. Organisations that have not delivered high quality care often lack the key ingredients of effective workplace cultures. Medical unions have frequently argued staff shortages are the principal cause of poor quality. Yet inputs are a poor indicator of quality. A recent report by the Health Ombudsman found that "extra resource alone will not help the NHS to fulfil its own standards of care."[58] Successive reviews and inspections have identified what leads to a poor quality workforce:

- Poor leadership and ineffective management "from board to ward";
- Weak communication in the organisation;
- Poor measuring, benchmarking and reporting of performance;
- Absence of an organisational culture that prioritises patient care and values patient feedback;
- Closed cultures, with staff unlikely to come forward to report poor quality;
- Lack of understanding in the organisation of what good care "looks like" and indifference of staff to poor standards of care;
- Dismissive attitudes towards process, procedure and patient concerns;
- Poor clinical governance, audit and accountability, poor team relationships and multidisciplinary working;
- Failure to reward right behaviour, train staff effectively or ensure staff maintain skills.[59]

While NHS and professional leaders have claimed episodes of poor quality care are isolated, the weight of evidence points to systemic factors.[60] Regulatory and system level failure are a critical feature in understanding poor quality care. National levers should incentivise organisations to deliver quality to patients and hold these organisations to account; organisational culture and leadership needs to support clinicians to deliver quality care; clinicians as professions need to take ownership and responsibility for quality; and clinicians as individuals need a professional focus on quality.[61] In his evidence to the Francis Inquiry, Sir Bruce Keogh, National Medical Director of the NHS Commissioning Board, argued:

> "It's not the managers who see the patient. It's not the managers who actually nurse the patient. It's not the managers who diagnose the patients or offer them choice of treatments. Hospitals are an aggregate of different service lines, each of which is serviced by various tribes of clinicians, doctors, nurses, physiotherapists and managers, all of whom are professional in their own right, and actually when I look at this kind of failure, what I see is a failure of clinical leadership and professionalism."[62]

58 Parliamentary and Health Service Ombudsman (2011), *Care and compassion?*
59 Commission for Health Improvement (2004), *Lessons from CHI Investigation 2000-2003;* Healthcare Commission (2009), *The Healthcare Commission 2004-2009: Regulating healthcare – experience and lessons*; Parliamentary and Health Service Ombudsman (2011), *Care and compassion?*
60 For example the preliminary verdict of the Public Inquiry into Mid Staffordshire Hospital. In his closing remarks the Counsel of the Inquiry rejected the evidence of Sir David Nicholson who suggested "that no other hospital failed so profoundly and persistently in this period, serves to emphasise the singular rather than the systemic nature of this case." In contrast, Tom Clark QC argued that "this seems to us to be a very dangerous attitude to take. The assumption is that any other hospital providing such poor care would have been uncovered by the systems in place. That, frankly, is a naive assumption and one which places reliance on a regulatory system which has been demonstrated to have failed in a significant way."
61 Keogh, B. (2011), Evidence given to The Mid Staffordshire NHS Foundation Trust Public Inquiry, 20 September.
62 Ibid.

2
More doctors, more nurses

Some healthcare providers in the NHS have adopted the habits of better workforce management. However, across the health service the management of the workforce is focused on quantity of doctors and nurses over quality and productivity of the workforce

Health spending doubled in the last decade, rising from £54 billion in 2000 to £103 billion in 2011.[63] The unprecedented growth in spending drove the largest expansion in the health workforce since the creation of the NHS. More doctors, more nurses and better pay increased labour costs in healthcare.[64]

Rise in numbers

Table 3: NHS Headcount, England
Source: The Information Centre for Health and Social Care (2012), *NHS Staff 2001-2011 Overview*

	2001	2011	Growth, headcount	Growth, per cent	Average Annual percentage change
All doctors	100,319	143,836	43,517	43.4	3.7
Total qualified nursing staff	320,345	370,327	49,982	15.6	1.5
Total qualified scientific, therapeutic & technical staff	110,241	152,216	41,975	38.1	3.3
Qualified ambulance staff	14,855	18,687	3,832	25.8	2.3
Support to clinical staff	298,116	347,064	48,948	16.4	1.5
NHS infrastructure support	179,783	219,624	39,841	22.2	2.0
Other GP practice staff	84,473	101,270	16,797	19.9	1.8
Other non-medical staff or those with unknown classification	999	266	-733	-73.4	-12.4
Total	1,109,131	1,350,377	241,246	21.8	2.0

The growth in the NHS workforce has been the largest in the public sector. From 2001-11 headcount has grown by 22 per cent, rising from 1.109 million to 1.350 million.[65] This increase in the workforce was partly driven by targets for increasing numbers, but the growth in headcount has far exceeded the targets. For example, the *NHS Plan* target for increasing nursing numbers by 20,000 between 1999 and 2004 was exceeded by some 340 per cent.[66] The largest increases have been in medical roles, where the number of doctors has increased by 43 per cent. The number of hospital doctors has increased significantly; with the number of consultants rising by 52 per cent and the number of registrars by 194 per cent.[67]

The increase in the number of doctors in the NHS over the last decade was greater than most other developed countries. OECD data suggests that the number of doctors in the UK grew twice as fast as in the United States and nearly four times as fast as in Germany. Only Korea achieved a greater increase, but from a much lower base.[68]

63 Health Select Committee (2010), *Public Expenditure on Health and Personal Social Services 2009*, 2008-09 prices.
64 Office for National Statistics (2011), *Public Service Output, Input and Productivity: Healthcare.*
65 The Information Centre for Health and Social Care (2012), *NHS Staff 2001-2011 Overview.*
66 Health Select Committee (2007), *Workforce Planning.*
67 The Information Centre for Health and Social Care (2012), *NHS Staff 2001-2011 Overview.*
68 OECD (2011), *Health data.*

This focus on quantity of staff has come at the expense of quality of workforce. In her evidence to the Public Inquiry into Mid Staffordshire Hospital, Christine Beasley, the former Chief Nursing Officer, suggested that the expansion of the workforce was a significant cause for poor quality nursing and a perception that nursing had "lost its way".[69]

Top heavy

The expansion of the NHS workforce over the last decade has seen the ratio of nurses to doctors and consultants decline. In 2003, the ratio of nurses to doctors in the NHS in England was 4.0, by 2011 this had fallen to 3.1. For consultants, the ratio of nurses fell from 11.2 to 8.3. The ratio of clinical support staff to nurses has remained stable over the same period. This trend is continuing. Between September 2010 and September 2011 the number of NHS employees fell by nearly 20,000, or 1.4 per cent.[70] The number of managers fell by 12.9 per cent, support to doctors and nurses fell by 2.9 per cent and nursing staff fell by 1 per cent.[71] The allocation of training commissions for this Parliament suggests that the NHS workforce will become more top heavy, with pre-registration nursing cut by 10 per cent in 2011.[72] By contrast the number of doctors in training and employed in the NHS is still increasing. Since September 2010 the number of consultants working in the NHS has increased by 1,336, the number of registrars by 733 and the number of GPs by 371.[73] In 2011 the Centre for Workforce Intelligence identified the need to reduce the supply of doctors in hospital based specialities and suggested that the current growth of GPs was insufficient to meet the forecast need.[74]

Same role, same place

Doctors and nurses have been slow to embrace new models of care and often resisted attempts to move services into different settings. The expansion in the NHS workforce over the last decade has seen more staff work in the same places. Despite successive initiatives to develop community care and move services out of hospitals, excluding primary care, the vast majority of medical and clinical professional work in acute providers. In 2011, 15 per cent of the nursing workforce was registered in the community, compared to 25 per cent in 2003.[75] The relative decline has been hastened by the absolute reductions in traditional community nursing roles. The number of district nurses fell from 13,292 in 2003 to 8,167 in 2011, while the number of health visitors fell from 12,984 to 9,830.[76] In primary care, the number of practice nurses has increased, but declined as a relative proportion of the nursing workforce between 2003 and 2011, from 4.5 to 4.2 per cent.[77]

Clinicians have also resisted moving care out of hospitals. When senior managers have sought to move patients to the home or community environment doctors often challenge the decision on the grounds of safety.[78] Senior doctors in particular often have considerable interest in resisting closures, mergers or takeovers.[79] Organisational change can be seen to disrupt doctors' routines or threaten their independence. Consultants therefore occupy considerable authority in a hospital and their buy-in to service change is essential. In contrast to hospital chief executives, who on average spend less than two years in post, consultants enjoy the benefit of a "job for life" and rarely move between hospitals.[80]

Working practices have also frustrated the coordination of care around the needs of patients. Professional and organisational boundaries between primary, community, secondary and social care have undermined meaningful integration.[81] Successive studies have highlighted the professional tensions between generalists

69 Calkin, S. (2011), 'Nursing "lost its way" in bid to recruit numbers, says CNO', *Nursing Times*, 8 September.
70 The Information Centre for Health and Social Care (2012), *NHS Staff 2001-2011 Overview*
71 Ibid.
72 Buchan, J. and I. Seccombe (2011), "A decisive decade – mapping the future NHS workforce", Royal College of Nursing. Also see for example, NHS East of England (2011), *Multi-Professional Education and Training Investment Plan 2011/14* which announced a 10 per cent reduction in non-medical commissions in 2011/12 and NHS East Midlands (2011), *Workforce and Education Investment Plan 2011/2012*, which announced a 11 per cent reduction in non-medical commissions in 2011/12.
73 The Information Centre for Health and Social Care (2012), *NHS Staff 2001-2011 Overview.*
74 Centre for Workforce Intelligence (2011), *Shape of the medical workforce.* The CfWI identified Anaesthetics, General Surgery, Obstetrics and Gynaecology, Trauma and Orthopaedic Surgery, Otorhinolaryngology and Renal Medicine would require fewer training commissions in the future.
75 Department of Health (2004), *NHS Staff 2003 (Non-medical)*; Information Centre for Health and Social Care (2012), *NHS Staff 2011 (Non-medical).*
76 Ibid.
77 The Information Centre for Health and Social Care (2012), *NHS Staff 2001-2011 Overview.*
78 For example, *Mail on Sunday* (2012), "You must stop A&E cuts: Powerful lobby of 140 top doctors sign damning letter to PM", 7 October.
79 Corrigan, P. et al. (2012), *Takeover, Reform.*
80 Ibid.
81 Corrigan, P. (2010), "Next steps in integration of health services for NHS patients in England", Presentation at Monitor/Nuffield Trust conference, September.

and specialists.[82] Specialist doctors have also been reluctant to work in community settings. The latest Royal College of Physician consultant census found that 78.5 per cent of consultants were not involved with community-based services and 95.4 per cent had no experience of telemedicine.[83] The archetypal doctor still emphasises solitary practice and hierarchy over team work.[84] In addition, the information asymmetry between medical staff and social care professionals has also undermined effective partnership and coordination.

Inflexible professionals

The training of healthcare workers in the NHS continues to reflect rigid professional silos and an emphasis on pre-registration training. The UK has a large number of medical specialities (61 approved specialities and 34 approved sub-specialties) compared with many other health systems. This high differentiation has been reinforced to some extent by competing Royal Colleges. Training pathways for doctors are also inflexible, and it remains very hard for trainees to change speciality; and very few do.[85] Although a number of Government reports identified the need to develop the role of non-consultant grade doctors, the medical training pathway continues to prioritise preparing doctors for "individual practice" over alternative medical roles and team-based working.[86] The recent review of the Foundation Programme for junior doctors also found that "the distribution of [Foundation Trainee] placements by speciality does not reflect the current and future needs of the NHS."[87] The review identified that medical training still prioritised acute illness over long term conditions and working in community settings. Similarly, in nursing and allied healthcare professions the emphasis continues to be placed on pre-registration training.

National training for employer needs

The recruitment and training of doctors and other clinical staff has been led by national organisations rather than employers. Workforce planning has been led by the centre, with the number of training places set to meet expected demand.[88] Training of clinical professionals and doctors has been shaped by national accreditation standards and not employer needs.[89] Medical education has been nationally organised. As well as being the monopoly employer of doctors, the NHS also has a monopoly over the training of doctors. Recruitment to the Foundation Programme, the two year course that all trainees undertake between medical school and specialist training, is organised nationally with its curricula developed by the Academy of Medical Royal Colleges.[90] Training for medical and clinical professionals is funded through a £4.9 billion national budget.[91] Nearly 60 per cent of the Multi-professional and Training Budget goes to medical placements and the payment of providers of training is "anachronistic and anomalous". The Health Select Committee's report on training found: "Payment is only partially based on student or trainee numbers; it is not linked to quality; it is unjustifiably inconsistent between different professional groups, parts of the country and types of provider; and there is an almost total lack of transparency about how it is spent."[92]

What professionals do

Professional boundaries between different types of clinician continue to frustrate more innovative use of human capital. Initiatives to expand the roles of clinicians, such as nurse prescribing, have taken decades to be introduced and were strongly resisted by other professionals such as doctors.[93] While a number of healthcare providers have expanded the use of healthcare assistants to provide functions that have previously delivered by nurses, this has been resisted by the nursing profession.[94] The review of nursing under the last Government recommended that "urgent steps must be taken to protect the title 'nurse' and limit its use to

82 Marshall, M. (1999), "How well do GPs and hospital consultants work together? A survey of the professional relationship", *Family Practice*, Vol. 16.1; Royal College of General Practitioners (2012), *Medical generalism: Why expertise in whole person medicine matters*; OnMedica (2011): *Primary and secondary care relationships*
83 Royal College of Physicians (2011), *Census of consultant physicians and medical registrars in the UK, 2010: data and commentary.*
84 Lawrence, D. (2002), *From chaos to care: the promise of team-based medicine*.
85 Tooke, J. (2008), *Aspiring to Excellence: Findings and Final Recommendations of the Independent Inquiry into Modernising Medical Careers.*
86 Donaldson, L. (2002), *Unfinished business,* The Department of Health; Department of Health (2003), *Choice and opportunity: Modernising medical careers for non-consultant career grade doctors*.
87 Collins, J. (2010), *Foundation for Excellence: An Evaluation of the Foundation Programme*, Medical Education England.
88 Imison, C., Buchan, J. and Xavier, S. (2009), *NHS workforce planning: limitations and possibilities*, The King's Fund.
89 General Medical Council (2011), *The state of medical education and practice in the UK.*
90 The Foundation Programme website, foundationprogramme.nhs.uk. Accessed October 2012.
91 Health Select Committee (2012), *Education, training and workforce planning.*
92 Ibid.
93 BBC News (2002), "Nurse prescribing 'poses threat'", 30 May.
94 Royal College of Nursing (2007), *The regulation of health care support workers*.

nurses registered by the Nursing and Midwifery Council."[95] The regulation of healthcare professionals has also limited shifting roles between clinicians.[96] Professional regulation sets entry standards for healthcare practitioners that continues the emphasis on pre-registration training.

Old school

Despite advances in medicine and demand for doctors and nurses to engage patients in their care, traditional models of professionalism prevail. Doctors have traditionally seen themselves as "heroic" sole healers. A practitioner-centred model, as opposed to a patient-centred model, is also still prevalent. Studies highlight doctors believing patients were not "emotionally ready or willing to participate" and clinicians unable to make time to engage patients in shared decision making.[97] Moreover, while counsellors, psychologists, allied healthcare professionals and nurses were the most likely to promote self care, doctors were the least likely.[98] King's Fund authors found that doctors failed to consider what patients want as they "simply do not view diagnosing patient preferences as an important part of their work".[99] This model of the consultation disengages and disempowers the patient. Doctors hold the balance of power in a patient consultation and are trained to solve problems, not to help patients build confidence and the ability to manage their conditions.[100]

Unwilling leaders

Successive Governments have championed clinical leadership but doctors and nurses remain largely disengaged.[101] The King's Fund commission on leadership and management found that "one of the biggest weaknesses of the NHS has been its failure to engage clinicians – particularly, but not only, doctors – in a sustained way in management and leadership."[102] Surveys of professionals have shown an "ingrained scepticism among clinicians about the value of spending time on leadership".[103] A medical career continues to underreward and underrate the importance of leadership. Many doctors feel they lack the knowledge and skills in finance, performance management and understanding the wider NHS environment.[104] Surveys have also shown that, in contrast to many other health systems, few hospital chief executives in the NHS have a medical degree.[105] While a number of Royal Colleges and deaneries have started to promote leadership training, it is still a very much a secondary and optional feature of their curricula.[106]

A key cause of cause for the limited engagement of clinicians in senior leadership in the NHS has been the resistance to greater accountability. Being a consultant confers status and influence with only modest accountability. Doctors can also avoid taking responsibility for making difficult decisions on allocating resources, rationing or being transparent about performance. Taking on these responsibilities would bring few benefits and considerably more professional risk.

Speaking at a *Reform* conference, one hospital chief executive discussed the difficulty in engaging clinicians in financial management: "when you talk about the financial situation and that there is a £20 billion problem in the NHS, the clinical response is: 'blimey, haven't the managers got a challenge.'"[107]

Wasted talent

The NHS has some of the most highly trained and expert professionals in the whole UK workforce. However the structure of organisations and working cultures often meant that this talent is not always put to best use. Consultants, the best trained and experienced doctors, have considerable autonomy to determine which roles they undertake in the hospital. Consequently they are more likely to work on rarer clinical episodes that will benefit their research rather than providing triage services where their level of knowledge and judgement can be put to best use.

95 Prime Minister's Commission on the Future of Nursing and Midwifery in England (2010), *Front line care*.
96 International Partnership for Innovative Healthcare Delivery (2012), *A neglected resource: Transforming healthcare through human capital*.
97 Coulter, A. (2009), *Implementing shared decision making in the UK*, The Health Foundation. Also see, da Silva, D. et al. (2011), *Helping people help themselves*, The Health Foundation.
98 Wallace, L. et al. (2012), *Co-creating health: Evaluation of the first phase*, The Health Foundation.
99 Mulley, A. et al. (2012), *Patients' preferences matter: Stop the silent misdiagnosis*, The King's Fund.
100 Health Foundation (2010), "The patient will see you now", *Health Service Journal*.
101 Department of Health (2008), *High quality care for all*: *NHS Next Stage Review*.
102 King's Fund (2011) *The future of leadership and management in the NHS: No more heroes*.
103 Mountford, J. and C. Webb (2009), "When clinicians lead", *McKinsey Quarterly*.
104 Lemer, C. et al. (2012), "Improving NHS productivity : The secondary care doctor's perspective", The King's Fund.
105 Dorgan, S. et al. (2010), *Management in Healthcare: Why good practice really matters*, McKinsey & Company and Centre for Economic Performance at the London School of Economics.
106 The King's Fund (2012), *Leadership and engagement for improvement in the NHS*.
107 Cawston, T. (ed.) (2011), *A lot more for a lot less*, *Reform*. Susan James, Chief Executive, Derby NHS Foundation Trust.

The new consultant contract, despite its high cost, has undermined productivity. The focus on hours-worked rather than output has led to a concern that doctors are more likely to "clock watch".[108] The 2003 consultant contract allowed doctors to spend almost a quarter of their time undertaking "supporting professional activities" outside direct patient care.[109] Over 70 per cent of consultants found it "very easy" or "fairly easy" to go on study leave.[110]

Junior doctors also feel hospitals and senior doctors fail to make full use of their skills. One survey found that 77.3 per cent of junior doctors felt "not valued at all" or only "sometimes valued" by their hospital.[111] Despite a desire to contribute to improving services, the junior medical workforce "feel that the environment in which they work is not sufficiently receptive to their skills."

Disconnected hierarchies

The workforce culture is based on disconnected hierarchies between management and front line staff. Healthcare organisations have multiple overlapping structures, with separate hierarchies existing for doctors and nurses. The professional culture for doctors and nurses, of only being accountable to a doctor or a nurse, has traditionally meant that these professions have resisted being accountable to other professions or managers. These disconnected hierarchies have compounded divisions between managers and clinicians and between "board and ward", while "top-down" management cultures can lead to poor quality and low productivity. While high performing organisations have a shared culture of improvement, 50 per cent of NHS staff felt that senior managers were not committed to patient care.[112] The latest NHS staff survey found a growing divide between higher performing Foundation Trusts and struggling hospitals in achieving high levels of staff engagement.[113]

- 51 per cent of staff would recommend their trust as a place to work;
- 26 per cent of staff believe communication between senior managers and staff is effective;
- 46 per cent of staff felt that healthcare professionals and managers worked well together.

Moreover, while more staff feel part of a team, front line staff continue to feel isolated from senior management and only 37 per cent of staff say that they received "clear" feedback on how they were doing in their job from their line manager.[114]

An unhealthy workplace

Poor staff satisfaction can be seen in the high rates of absenteeism. According to the most recent figures available, 4.4 per cent of working days were lost to sickness absence in the NHS.[115] This is compared to just 2.6 per cent across the public sector as a whole, and almost treble the sickness rate of private sector employees for the same period.[116] A recent study found that such high rates of absenteeism are "the single biggest cause of lost productivity in the NHS."[117] Absenteeism in the NHS is the highest among the most junior members of the clinical team and also those who have limited interaction with patients.[118] Burnout among clinical staff is a frequently cited problem. Not only is absence costly in and of itself, but the need to draft in agency staff to fill clinical roles reduces the quality and continuity of service for patients.[119] There is also considerable variation between providers in absenteeism levels, with higher levels in community, mental health and ambulance services, compared to acute Trusts. High performing organisations also have lower levels of absenteeism. In London, for example, University College London Hospital had a rate of 2.3 per cent in March 2011, compared to South London Healthcare NHS Trust, Epsom and St Helier University

108 Lemer, C. et al. (2012), "Improving NHS productivity: The secondary care doctor's perspective", The King's Fund.
109 *Health Service Journal* (2010), "NHS Trusts issue wake-up call on consultant productivity", 15 April.
110 Royal College of Physicians (2011), *Census of consultant physicians and medical registrars in the UK 2010: data and commentary.*
111 Gilbert, A., Hockey, P., Vaithianathan, R., Curzen, N. and Lees, P. (2012), "Perceptions of junior doctors in the NHS about their training: results of a regional questionnaire", *BMJ Quality and Safety*, Vol. 21:3.
112 Picker Institute (2012), *NHS Staff Survey 2011.*
113 Ibid.
114 41 per cent of staff either disagreed or strongly disagreed that senior managers involve staff in important decisions, 42 per cent staff either disagreed or strongly disagreed that communication between senior management and staff is effective, and 42 per cent of staff either disagreed or strongly disagreed that different parts of the trust communicate effectively with each other. Picker Institute (2012), *NHS Staff Survey 2011.*
115 The Information Centre for Health and Social Care (2012), *Sickness Absence Rates in the NHS: October-December 2011.*
116 Office for National Statistics (2012), *Sickness Absence in the Labour Market- 2012.*
117 Walker, V. and Bamford, D. (2011), "An empirical investigation into health sector absenteeism2", *Health Service Management Research*, Vol. 24:3.
118 The Information Centre for Health and Social Care (2012), *Sickness Absence Rates in the NHS: October-December 2011.*
119 Care Quality Commission (2012), *Market Report: Issue 1: June 2012.*

Hospital NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust, which all had absenteeism rates above 4.0 per cent.

Unhealthy cultures can also be seen in the high level of bullying that is reported in the NHS. There is considerable evidence of junior doctors being bullied by senior doctors. One survey found that half of bullying experienced by junior doctors came from consultants. Those that report bullying often find consultants sexist, unfair, unreasonable or arrogant.[120]

Poor staff retention

While the NHS invests significant resources into training clinical staff, the NHS often fails to retain key professionals. The latest NHS staff survey found 31 per cent of staff often felt like leaving their employer, with 22 per cent saying they would probably leave in the next twelve months.[121] For 2008-09, the last year for which figures are available, the NHS lost 8.5 per cent of its non-medical staff, with the highest rates of drop out in non-consultant grade doctors.[122] Midwifery in particular suffers from high rates of drop out in the first five years of practice, suggesting that students are not adequately prepared for the profession.[123] High rates of early retirement also suggest problems of retaining experienced staff, with over 25 per cent of hospital doctors intending to take early retirement due to pressures of work and nearly 15 per cent because of dissatisfaction with the NHS.[124]

Poor management

Doctors and nurses have shown an aversion to management. While reforms to staff contracts were intended to improve performance management hospitals have failed to make effective use of these powers. The National Audit Office has found that very few Trusts integrated the Knowledge and Skills Framework, which was introduced with Agenda for Change, with performance management.[125] The NHS staff survey also suggests that employees are dissatisfied with their management. While 80 per cent of staff had appraisals in the past 12 months, only 35 per cent of staff felt appraisals were well structured. Fewer than half of nurses felt that they received adequate praise and recognition for a job well done.[126]

The medical profession has been particularly resistant to better performance management. Doctors have seen themselves as their patients' sole advocates and viewed their autonomy to practice as crucial to the quality of care. In the NHS achieving a Certification of Completion of Training is seen as a "grant of freedom" for individual practice and autonomy. The collegiate culture of consultants obstructs accountability to employers and allows individuals to resist measurement and management. In particular, there is a perception that management will be based purely on financial concerns to the detriment of patient interests. Hospitals themselves have also been reluctant to better manage doctors or challenge their autonomy. The National Audit Office reported that few hospitals have effectively used consultant job planning, which remains primarily a "diary exercise" and is yet to be linked to staff appraisal or tailored to hospital needs.[127]

Disciplining or firing staff is also rare. If doctors have their contracts terminated by their employer it is most often because of poor attitude and behaviour and not concerns over fitness to practice. To sack a doctor, hospital chief executives need to accumulate a wealth of evidence to prove poor performance, take on very strong union representation and risk negative publicity. The process can also be very lengthy and doctors can appeal the decision.

120 BBC News (2002), "One in four junior doctors bullied", 26 September; Paice, E. and Smith, C. (2009), "Bullying of trainee doctors is a patient safety issue", *The Clinical Teacher*, Vol. 6:1; Field, T. (2002), "Those who can, do; those who can't, bully", *British Medical Journal*, Vol. 324:786.2; Powell, L. (2011), "Bullying: common in healthcare", *Student BMJ*, Vol, 19:d1514.
121 Picker Institute (2012), *NHS Staff Survey 2011*.
122 The Information Centre for Health and Social Care (2008) *Staff Turnover Statistics 2007-2008*.
123 Dunkley, L. and Haider, S. (2011), *Workforce risks and opportunities- Nursing and Midwifery*, Centre for Workforce Intelligence.
124 Royal College of Physicians (2011), *Census of consultant physicians and medical registrars in the UK 2010: data and commentary.*
125 National Audit Office (2009), *NHS Pay Modernisation in England: Agenda for Change*.
126 Ball, J., Pike, G., Griffiths, P., Rafferty, A. and Murrells, T. (2012), *RN4CAST Nurse Survey in England*, National Nursing Research Unit.
127 National Audit Office (2011), *Management of NHS hospital productivity*.

Poor productivity

While the number of staff in the health service has grown significantly, the Office for National Statistics and others have shown that productivity has declined. The best data available from the Office for National Statistics suggests quality adjusted productivity fell by 0.3 per cent on average each year from 1995-2008.[128] Over the same period private sector productivity increased by 2.3 per cent each year.[129]

Over the last decade, crude consultant productivity declined, with more hospital doctors seeing fewer patients.[130] Compared to other health systems, crude doctor productivity in the NHS is low. In the United Kingdom doctors undertake 5.0 consultations per capita, compared to the OECD average of 6.4. German doctors undertake on average 8.4 consultations.[131]

Table 4: Nursing and medical staff to occupied beds, England
Source: The Information Centre for Health and Social Care (2012), *NHS Staff 2011 detailed results;* Department of Health (2011), *Average daily number of available and occupied beds open overnight by sector, October to December 2011.*

	Occupied beds	All nursing staff to occupied bed			All medical staff to occupied bed		
England	117,713	2.60			0.84		
			Variation by acute trust			Variation by acute trust	
			High	Low		High	Low
North East	7,849	2.46	2.64	1.38	0.71	1.16	0.49
North West	17,733	2.68	3.98	1.50	0.79	1.31	0.53
Yorkshire and The Humber	12,388	2.61	2.58	1.70	0.80	1.06	0.63
East Midlands	9,283	2.53	2.64	1.47	0.72	1.10	0.59
West Midlands	13,052	2.54	2.44	1.20	0.75	1.03	0.48
East of England	11,539	2.44	3.28	1.73	0.78	1.28	0.72
London	19,432	2.66	4.24	1.82	1.07	2.05	0.78
South East Coast	8,258	2.54	3.60	1.71	0.84	1.35	0.57
South Central	7,538	2.64	2.65	1.85	0.90	1.12	0.80
South West	10,640	2.65	3.00	1.65	0.86	1.35	0.68

There is considerable evidence that suggests that there is significant variation in the productivity of the NHS workforce. Assessing the ratio of staff to occupied beds suggest that there is wide variation between acute hospitals. While the number of nursing staff to occupied beds ranges by 9 per cent between regions, within regions it varies by nearly 100 per cent on average. The greater number of doctors in London and the South East means that regional variation of medical staff to occupied beds is greater, ranging by 50 per cent. Across acute Trusts the variation of the ratio of medical staff to occupied beds is over 100 per cent. The Audit Commission has identified a wide variation in the cost per bed, the number of nurses per bed and unexplained variation in grade mix, that cannot be "entirely explained by the speciality mix, case mix or conditions of the patients".[132] As well as a wide variation in staff to occupied beds, over the last decade the intensity of staffing in hospitals has increased. Between 2000-01 and 2010-11, the ratio of general and acute nursing staff to general and available acute beds grew from 1.1:1.0 to 1.5:1.0.[133]

128 Office for National Statistics (2010), *Public Service Output, Inputs and Productivity: Healthcare*.
129 Office for National Statistics (2010), *Statistical bulletin*.
130 The Information Centre for Health and Social Care (2012), *NHS Staff 2001-2011 Overview*; The Information Centre for Health and Social Care (2012) "Hospital Episodes Statistics", total Finished Consultant Episodes.
131 OECD (2011), *Health data*.
132 Audit Commission (2010), *Making the most of NHS front line staff*.
133 The Information Centre for Health and Social Care (2012). *NHS Staff 2011 detailed results*; Department of Health (2010), *Average daily number of available and occupied beds open overnight by sector, 1987-88 to 2009-10*; Department of Health (2012), *Average daily number of available and occupied beds, Timeseries. Q1 2010/11 to Q4 2011/12*.

Most of the available statistics of productivity in the NHS relate to acute care. In contrast, there is only limited data on the productivity and quality in community and mental health services, as well as primary care. However, there is considerable evidence to suggest poor value for money in these services. The Audit Commission has shown considerable variation in bed use for mental health services, while analysis by Beacon UK has shown that 50 per cent of patients admitted to hospital could have been treated in a community setting.[134] Beacon's analysis also found that one in four patients were not seen by a consultant psychiatrist in the first week of admission. There is also evidence to suggest that crisis resolution and home treatment (CRHT) teams are not operating at their full potential.[135] In community services there is wide variation in the number of visits made by district nurses and health visitors.[136]

A cottage industry

Spending on primary care services in England was £8.3 billion in 2010-11, with 80 per cent of spending going on workforce costs.[137] While there has been greater shift towards group practices, primary care remains a cottage industry dominated by small independent organisations.[138] There is considerable evidence to suggest that the quality and efficiency of services is highly variable, while primary care services are poorly measured and consequently poorly managed. There is also considerable opportunity to improve productivity in primary care. McKinsey & Company has shown that low-performing GPs can spend less than 30 per cent of their contracted hours actually seeing patients.[139] The quality of care in primary care is also highly variable. As a King's Fund commission found, wide variation in the rates of referral and prescribing by GPs.[140] Despite recent reforms to GP contracts and the introduction of the Alternative Provider Medical Services contract, the majority of partner GPs are contracted under the national GMS contract and there remain very few non-NHS or even non-GP providers which are delivering primary care services.[141] Consequently, GPs' monopoly of primary care services largely remains intact and it is very hard to exit poor quality GP practices. While improving the quality of care out of hospital also demands more flexible and responsive primary care services, several studies have highlighted GP contracts as a major barrier to integration.[142]

Pay not performance

Over the last decade the rise in pay in the NHS was greater than the private sector and across the public sector. While pay rises were meant to deliver productivity, the rise in pay in the NHS was far in excess of productivity improvement. The last Government introduced three major pay reforms for NHS staff: the 2003 Consultant Contract, the 2004 GP contract and Agenda for Change for all non-medical staff. Successive National Audit Office reports have demonstrated that pay deals did not represent value for money.[143]

134 NHS Confederation (2011), *Efficiency in mental health services: supporting improvements in the acute care path*.
135 Audit Commission (2010), *Maximising resources in adult mental health*; Beacon UK (2012), *Are mental health patients getting the right treatment*.
136 Crump, H. (2009), "Variation shows NHS community services ripe for efficiencies", *Health Service Journal,* 13 August.
137 Taylor, K., George, R. and Hammett, S. (2012), *Primary care: Today and tomorrow: Improving general practice by working differently*, Deloitte Centre for Health Solutions.
138 Ibid.
139 McKinsey & Company (2009), *Achieving World Class Productivity in the NHS 2009/10 – 2013/14: Detailing the size of the opportunity*, Department of Health.
140 Goodwin N., Dixon A., Poole T., Raleigh V. (2011), *Improving the quality of care in general practice*, The King's Fund.
141 Ellins, J. et al. (2009), "Opening up the primary medical care market", *British Medical Journal*, Vol. 338.
142 Dixon, A. (2011), "Is the GP contract a barrier to integrated care?", The King's Fund blog, 4 November.
143 National Audit Office (2009), *NHS Pay Modernisation in England: Agenda for Change.*

Table 5: Key NHS staff, average earnings for public and private sector, 2002-09, England, cash terms
Source: The Information Centre for Health and Social Care (2011), *GP Earnings and Expenses Time Series 2002-03 to 2009-10*; Health Select Committee (2010), *Public expenditure on Health and Personal Social Services.*

	Consultants	GP Partners	Qualified Nursing Staff
2002-03	£88,222	£75,106	£25,702
2003-04	£101,331	£84,795	£26,342
2004-05	£106,772	£103,564	£27,967
2005-06	£109,338	£113,614	£28,784
2006-07	£114,330	£111,695	£29,912
2007-08	£115,926	£110,139	£31,106
2008-09	£119,729	£109,590	£32,763
2009-10	£121,200	£109,416	£33,450
Total change, per cent	37.4	45.7	30.1
Average annual increase, per cent	4.7	5.9	3.8

As *Reform* has previously documented, higher paid members of staff – i.e. registrars, consultants, GPs and managers – have done especially well from pay rises. The GP contract saw the earnings for GP partners increase by 58 per cent in cash terms between 2003 and 2005.[144] English GPs are now the second best paid in the world with earnings 3.6 times the OECD average.[145] While the new contracts for GPs were intended to improve productivity, productivity fell by 2.5 per cent for the two years after the contract was introduced.[146] Consultant pay increased by 15 per cent in 2003-04 following the new consultant contract and, as the National Audit Office reported, resulted in consultants working fewer hours and morale declining.[147] The Agenda for Change contract has also failed to encourage new ways of working and greater efficiency that was expected. Incremental pay increases for staff that were meant to be up to the discretion of the employer are now largely automatic. As well as reinforcing "mediocrity", the annual cost of increments and pay drift has been estimated at over 2 per cent.[148]

Table 6: Rise in NHS pay bill 2001-10, England
Source: NHS Pay Review Body (2012), *Twenty-Sixth Report.*

	Revenue increase (£billion)	Pay bill increase (£billion)	Per cent of revenue increase on pay bill	Per cent of revenue increase on pay bill prices	Per cent of revenue increase on pay bill volume
2001-02	4.6	2.4	51.4	31.6	19.8
2002-03	4.6	2.4	51.1	25.1	26.0
2003-04	6.5	2.6	40.9	20.7	20.1
2004-05	5.0	4.5	90.6	65.1	25.4
2005-06	7.3	2.5	34.4	20.4	14.1
2006-07	4.3	1.3	30.2	42.1	-11.9
2007-08	7.9	1.3	16.3	18.5	-2.1
2008-09	4.4	2.6	59.8	27.6	32.3
2009-10	7.1	2.7	38.6	10.8	27.8
2010-11	3.3	1.6	48.5	37.3	11.2
Average	5.5	2.4	46.2	29.9	16.3

144 National Audit Office (2007), *Pay Modernisation: A new contract for consultants in England.*
145 OECD (2011), *Remuneration of doctors (general practitioners and specialists).*
146 Public Accounts Select Committee (2008), *NHS Pay Modernisation: New contracts for General Practice services in England.*
147 National Audit Office (2007), *Pay Modernisation: A new contract for NHS consultants in England*
148 *Health Service Journal* (2011), "The mediocre will be the only losers if pay is reformed fairly", 15 December.

The workforce is the single biggest budget in the NHS, with staff costs representing 70 per cent of hospital expenditure on average.[149] As table 6 shows the rise in the pay bill absorbed nearly 50 per cent of the rise in healthcare spending over the last decade. On average pay growth and recruitment cost £2.4 billion each year between 2001 and 2010. Pay increases in the NHS were the dominant factor, contributing approximately twice as much as the expansions in the workforce to staff costs.

Two major bonus schemes were introduced for doctors in the last decade. The Quality and Outcomes Framework (QOF) for GPs is an incentive scheme that was introduced as part of the 2004 contract. Around £1 billion is paid out each year under QOF but for modest improvements in quality care that were in line with previous trends.[150] Practices are rewarded for meeting quality measures across four domains: clinical, organisational, patient care experience and additional services. Compared to similar pay for performance mechanisms in other health systems, the thresholds for achieving QOF points were set low. Consequently GP performance exceeded the Department of Health's predictions, with practices achieving 91 per cent of measures in the first year, compared to an estimate of 75 per cent.[151] In 2009-10, the average was 94 per cent, with less than 15 per cent of practices achieving under 90 per cent.[152] A major review of the QOF, published in 2011, found that the scheme "provided strong financial incentives for general practices, but these have not necessarily resulted in changes in clinical activity, improved health outcomes, or reduced health inequalities."[153]

The current system of Clinical Excellence Awards (CEAs) was introduced in 2003, replacing the previous system of distinction awards and discretionary points.[154] CEAs are awarded to doctors that "go above and beyond the norm" and are made of 12 levels, ranging from £2,597 to £75,769, with a total spend of £400 million.[155] The awards last five years and currently 55 per cent of the consultant population are receiving one.[156] To obtain a CEA, consultants have to apply to the employer awarding committee, whose membership is made up of at least half consultants from that hospital. While CEAs can be withdrawn following an unsatisfactory review, pay protection means that the consultants will not lose the financial award.[157] Consultants that move into general management are not eligible for CEAs.

149 Imison, C., Buchan, J. and Xavier, S. (2009), *NHS workforce planning: limitations and possibilities*, The King's Fund.
150 Gillam, S. (2010), "Should the Quality and Outcomes Framework be abolished? Yes", *British Medical Journal*, Vol. 340:2710. National Primary Care Research and Development Centre (2007), *What should happen to the Quality and Outcomes Framework?*
151 National Audit Office (2008), *NHS Pay Modernisation: New Contracts for General Practice Services in England*.
152 Audit Commission (2011), *Paying GPs to improve quality*.
153 Dixon, A., Khachatryan, A., Wallace, A., Peckham, S., Boyce, T. and Gillam, S. (2011), *Impact of Quality and Outcomes Framework on health inequalities*, The King's Fund.
154 Stephenson, J. (2010), "Clinical excellence awards", *BMJ Careers*, 14 April.
155 CEAs are divided by Local and National Awards. Local Awards (1-9) are decided by local committees at the employer level and National Awards (10-12) nationally on the recommendation of the Advisory Committee on CEAs (ACCEA) and its regional sub-committees. Local awards are funded by employers and national awards by the Department of Health. Department of Health (2010), *UK Wide Review of Compensation Levels and Incentives for NHS Consultants*, *Evidence to the Review Body on Doctors' and Dentists' Remuneration*.
156 Ibid.
157 Ibid.

3
The unreformed workforce

The NHS workforce is the largest and most expensive in the public sector. It is also in the greatest need of reform. Delivering more for less and reforming the service to better meet the new healthcare needs demands reform to the front line. However the NHS workforce is falling behind other public services that are embracing reforms to staff.

While the Coalition Government has been determined to reform the structure of the NHS by introducing clinical commissioning and creating an economic regulator, it has failed to take on the workforce. This unwillingness to challenge the status quo is shared by regulators, employers and professional associations.

What workforce reforms work?

Effective reform to the workforce would increase the flexibility of clinical professionals, make staff more accountable to employers and modernise terms and conditions to deliver value for money. A consistent package of reforms would also move the focus from staff inputs to staff outcomes.

Other public service departments have delivered effective reforms. Tom Winsor's review of terms and conditions for police officers remains the only comprehensive workforce review commissioned by the Coalition. The current system of terms and conditions for police officers is complex, restrictive and represents extremely poor value for money for taxpayers.[158] As over 80 per cent of police force budgets are spent on the workforce, the Home Office have recognised that Chief Constables should have far greater freedom to recruit, pay, manage and structure their workforces as they see fit in order to effectively meet local demand.[159] The Review has identified a number of ways in which to make the police workforce more flexible and sustainable.[160] In January 2012 the Home Secretary announced the majority of the Review's Part 1 proposals on overtime, incremental pay progression and special payments would be accepted. Home Office Ministers have also effectively moved the debate away from the numbers of staff. Speaking at a *Reform* conference in August 2011, the Home Secretary Theresa May argued that "what matters is not the total number of officers employed, but the total number of officers deployed, and how effectively they are deployed."[161]

The need for modernisation

Recent international studies have demonstrated that 20th century approaches to workforce design and training are ill-suited to the needs and pressure of the 21st Century. The Commission on the Education of Health Professionals for the 21st Century found that "curricula rigidities, professional silos, static pedagogy" are leading to "the mismatch of professional competencies to patient and population priorities".[162] The Commission identified that changing medical needs, the "explosive growth" of medical knowledge and the advent of modern technology and communications are putting new pressures on health workers.[163] The shifting focus of health systems to care management of chronic conditions requires unprecedented levels of team work, while practitioners will need to adopt to new roles and skills in prevention and management, instead of a focus on diagnosis and cure.[164] The World Health Organisation listed five new "competencies" for health workers: patient centred care, partnering, quality improvement, ICT and public health perspective.[165]

While the needs of the system and advent of modern technology and precise medicine demand new ways of working, the career expectations of clinical professionals are also changing. Young doctors increasingly want a better work-life balance and are less concerned with a "job for life" that is currently offered in consultant contracts.[166] The rising proportion of women entering medicine has also led greater demand for

158 Association of Chief Police Officers (2005), *Draft ACPO vision for workforce modernisation: The missing component of police reform*.
159 HM Inspectorate of Constabulary (2010), "*Where are the police*?"
160 Winsor, T. (2012), *Independent Review of Police Officer and Staff Remuneration and Conditions*.
161 May, T. (2011), "The urgent need for police reform", Speech to *Reform*, 16 August.
162 Frenk, J. et al. (2010), "Health professionals for a new century: transforming education to strengthen health systems in an independent world", *The Lancet*, Vol. 376, Issue. 9756.
163 Bhutta, Z. et al. (2010), "Education of health professionals for the 21st century: a global independent Commission", *The Lancet*, Vol. 375, Issue. 9721 and Frenk, J. et al. (2010), "Health professionals for a new century: transforming education to strengthen health systems in an independent world", *The Lancet*, Vol. 376, Issue. 9756.
164 Pruitt, S. (2005), "Preparing the 21st century global healthcare workforce", *British Medical Journal,* Vol. 330:637.
165 World Health Organisation (2005), *Preparing a health care workforce for the 21st century*
166 The King's Fund (2010), *The 21st-century doctor*: *Understanding the doctors of tomorrow*; Stanton, E. (2012), "Seven habits of emerging medical leaders", in Cawston, T. (ed.), *High quality healthcare*, *Reform.*

greater flexibility in working hours and the training pathway.[167] Studies have also suggested the next generation of doctors have greater appetite for team work and professional management.[168]

New approaches to workforce management, training and professionalism are needed and wanted.

What went wrong with the NHS workforce?

Under the last Government workforce planning and reforms to the terms and conditions of staff was led by the centre and not by employers. While successive government reports called for greater flexibility in recruitment, training and clinical roles, national planning continued to focus on increasing the headcount of individual professions. Consequently, insufficient attention was given to workforce mix and changing healthcare and employer needs.[169]

Subsequent policies sought to increase the role of employers and prioritise team work.[170] Yet as the King's Fund argued in 2009, "the current workforce planning system will continue to drive investment towards 'more of the same'...this will not change the supply-led, single profession approach that has dominated the NHS, and contributed to its inefficiencies and past problems of 'boom and bust'."[171]

The last Government introduced new contracts for doctors and other clinical staff that were designed to increase productivity. However the National Audit Office has found that these contracts have yet to deliver value for money, with the average cost of incremental pay drift estimated at over 2 per cent.[172]

Key initiatives and publications since the election

2010	NHS White Paper: *Equity and Excellence*, Department of Health[173]	Government sets out proposals to introduce GP commissioning, a national commissioning board and greater freedoms for providers.
	Review of Clinical Excellence Awards, Doctors and Dentists Pay Review Body[174]	The Doctors and Dentists Pay Review Body begins review of doctors' Clinical Excellence Awards to ensure the system is "effective and affordable".
	Spending Review, HM Treasury[175]	A two year pay freeze is introduced for all public sector staff with salaries above £21,000.
	Liberating the NHS workforce, Department of Health[176]	The new workforce strategy sets out proposals to introduce local provider "skills networks" to lead workforce planning and development, with a new national body – Health Education England – providing oversight and leadership.
	Revalidation: A Statement of Intent, General Medical Council[177]	The General Medical Council outlines the process of revalidation for doctors starting in late 2012.
	Foundation for Excellence: An Evaluation of the Foundation Programme, Medical Education England[178]	The evaluation finds that the programme provides a good curriculum and provides a vehicle for assessment, however training still prioritises acute and hospital based services over long term conditions and team based care.
	Time for Training, Medical Education England[179]	Professor Sir John Temple's independent review on the impact of the European Working Time Directive found that quality training can be delivered under reduced available hours. However the review also finds that hospitals remain too reliant on junior doctors and recommends a "consultant delivered service".

167 General Medical Council (2011), *The state of medical education and practice in the UK*.
168 Christmas, S. and Millward, L. (2011), *New Medical Professionalism,* The Health Foundation; Royal College of Physicians (2005), *Doctors in society.*
169 Health Select Committee (2007), *Workforce Planning.*
170 Department of Health (2008), *High quality healthcare for all*.
171 Imison, C. et al. (2009), *NHS workforce planning,* The King's Fund.
172 National Audit Office (2007), *Pay Modernisation: A new contract for NHS consultants in England* ; National Audit Office (2008), *NHS Pay Modernisation: New contracts for general practice services in England*; National Audit Office (2009), *NHS Pay Modernisation in England: Agenda for Change*;
173 Department of Health (2010), *Equity and Excellence: Liberating the NHS*.
174 Department of Health (2010), "Consultant pay rewards scheme to reviewed", Press release, 20 August.
175 HM Treasury (2010), *Spending Review 2010.*
176 Department of Health (2010), *Liberating the NHS: Developing the Healthcare Workforce*.
177 General Medical Council (2010), *Revalidation: A Statement of Intent.*
178 Collins, J. (2010), *Foundation for Excellence: An Evaluation of the Foundation Programme*, Medical Education England.
179 Temple, J. (2010), *Time for Training: A Review of the impact of the European Working Time Directive on the quality of training*, Medical Education England.

2011	*Enabling excellence: Autonomy and Accountability for Health and Social Care Staff,* Department of Health[180]	Sets out proposals to reform regulation of health and care workers, simplifying the legislative framework for regulators, constraining the costs of regulation and introducing a system of voluntary registration for healthcare assistants.
	Shape of Training[181]	A review of medical training to better ensure doctors are equipped to meet changing healthcare needs. The review will produce a final report by June 2013.
	Response to *Front line care*, the independent report of the Prime Minister's Commission on the future of Nursing and Midwifery, Department of Health[182]	The Government recommends greater autonomy for nurses and midwives, a contractual right for staff to raise their concerns with CQC and strengthening the role of ward sister.
	*2011 Autumn Statemen*t, HM Treasury[183]	Government announces a review of national pay bargaining for public sector workers, excluding doctors and dentists.
	Francis Inquiry into Mid Staffordshire Hospital closures	The final report of counsel of the inquiry suggests the possibility of minimum nurse staffing levels and the regulation of healthcare assistants.[184]
2012	*Developing the NHS workforce: From design to delivery*[185]	Sets out the framework for education and training framework for the NHS. The Department of Health sets the outcomes for the system, Health Education England oversees strategic planning and allocates resources, Local Education Training Boards will enact this vision on behalf of local employers.
	Workforce planning, training and education, Health Select Committee[186]	The Health Select Committee welcomes the Government's reforms to training and education, yet argues that "without greater clarity and detail from the Government, coupled with a greater sense of urgency about their implementation, the success of new arrangements is at risk."
	Evidence to the NHS Pay Review Body on Market Facing Pay, Department of Health[187]	The Department of Health finds "there is a prima facie case for the introduction of more Market Facing Pay for AfC staff" and recommends extending existing flexibilities to supplement pay in high cost areas.
	Nursing and Care Quality Forum, No 10[188]	The forum's initial recommendations include ensuring nurses are recruited on caring nature, the importance of maintain staffing levels and skill mix and the importance of nurse leadership.

Right diagnosis, wrong reforms: National planning

This Government has recognised that staff should be more flexible to meet changing healthcare needs and that employers need greater say. In the foreword to the Department of Health's workforce strategy, former Secretary of State for Health, Andrew Lansley said:

> "We want to empower healthcare providers… to plan and develop their own workforce. They know what services their patients and local communities require – and they know what staff they need to deliver excellent, responsive healthcare. Therefore they are best placed to commission the education and training that will achieve the right workforce."[189]

However, the final version of the reforms have seen national planning and management of the workforce continue. The Health and Social Care Act ensured "the education and training system will remain

180 Department of Health (2011), *Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff.*
181 Medical Education England (2012), "Chair of the Independent Review of the Shape of Training appointed", Press release, 28 February.
182 Department of Health (2011), *The Government's response to the recommendations in Front Line Care: The report of the Prime Minister's Commission on the Future of Nursing and Midwifery in England.*
183 HM Treasury (2011), *Autumn Statement 2011.*
184 Kark, T. et al. (2011), "Closing submissions of counsel to the inquiry", The Mid Staffordshire NHS Foundation Trust Public Inquiry.
185 Department of Health (2012), *Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery.*
186 Health Select Committee (2012), *Education, training and workforce planning.*
187 Department of Health (2012), *Evidence to the NHS Pay Review Body on Market Facing Pay.*
188 Department of Health (2012), "Nursing and Care Quality Forum make recommendation to Prime Minister", Press release, 25 May.
189 Department of Health (2010), *Liberating the NHS: Developing the Healthcare Workforce*.

accountable to the Secretary of State", while the Secretary of State has a duty to "maintain a system for professional education and training as part of the comprehensive health service".[190]

The workforce strategy calls for "sector-wide oversight of key aspects of workforce planning, education and training".[191] While Local Education and Training Boards will be responsible for commissioning services in the interest of local providers, they will be accountable to Health Education England that will "provide national leadership and oversight…and allocate education and training resources". The Department of Health will "set the education and training outcomes for the system as a whole" through a detailed Education Outcomes Framework that will link resources to "quantifiable" outcomes.[192] Moreover, "the new framework for education and training reaffirms the central role of professionals in future arrangements".

Right diagnosis, wrong reforms: National pay

The NHS White Paper argued that "pay decisions should be led by healthcare employers rather than imposed by the government".[193] However central action has continued to determine pay. The 2010 Spending Review introduced a two year pay freeze for public sector workers with incomes greater than £21,000.[194] This pay restraint has contributed 40 per cent to the QIPP initiative to deliver £20 billion of savings by 2014.[195] In the 2011 Autumn Statement the Chancellor announced that any public sector pay increase would be capped at 1 per cent for two further years from 2013.[196]

When Agenda for Change was established it was agreed that a comprehensive review of the system would take place in 2011.[197] This has not happened. Instead the Chancellor announced a government review of national pay bargaining across the public sector to better ensure pay and conditions reflect local market conditions.[198] While pay for doctors has been excluded from the review the NHS Pay Review Body is assessing reforms to Agenda for Change. The Department of Health has backed the initiative; however rather than overhauling the national contract, it advocates the use of existing flexibilities for employers to supplement pay in high cost areas and centralised pay differentials.[199]

In the Coalition Agreement the Government announced that it would renegotiate the GP contract and the White Paper announced the Department of Health will "seek over time to establish a single contractual and funding model to promote quality improvement, deliver fairness for all practices, support free patient choice, and remove unnecessary barriers to new provision."[200] The negotiations have focused on improving the consistency of care and standardisation of services under a single contract that would see the locally negotiated PMS contract replaced.[201] The national GMS contract and Quality and Outcomes Framework continue to be negotiated nationally between the BMA and the Department of Health. In October 2012 the Government's proposals included a 1.5 per cent increase in funding for 2013-14 alongside replacing many existing measures for the Quality and Outcomes Framework, introducing new quality measures and phasing out the minimum income guarantee for practices.[202]

In August 2010 the Secretary of State announced a review of doctors Clinical Excellence Awards (CEA) to ensure the system was "effective and affordable" and "in line with other public sector pay and incentive schemes".[203] Evidence presented as part of its review demonstrated that no other country offers incentive schemes comparable to the CEA, while employers lacked control over awards and perceived a disconnect

190 Health and Social Care Act 2012.
191 Department of Health (2010), *Liberating the NHS: Developing the Healthcare Workforce*.
192 Department of Health (2012), *Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery*.
193 Department of Health (2010), *Equity and Excellence: Liberating the NHS*.
194 HM Treasury (2010), *Spending Review.*
195 Health Select Committee (2011), *Public expenditure .*
196 *Health Service Journal* (2011), "Pay awards to be held at 1pc for two years", 29 November.
197 South West Pay, Terms and Conditions Consortium (2012), *Discussion Document: Addressing Pay, Terms and Conditions.*
198 HM Treasury (2011), *Spending Review.*
199 Department of Health (2012), *Evidence to the NHS Pay Review Body on Market Facing Pay.*
200 HM Government (2010), *The Coalition Agreement: Our Programme for Government*; Department of Health (2010), *Equity and Excellence: Liberating the NHS*.
201 *Health Service Journal* (2012), "Standardised GP contract by 2015 is 'naïve'", 16 February.
202 *Health Service Journal* (2012), "Government seeks significant change to GP contracts", 23 October.
203 Department of Health (2010), "Consultant pay rewards scheme to be reviewed", 20 August; BBC News (2010), "Call to abolish NHS 'lifetime bonuses' for consultants", 13 October.

with performance, appraisal and job planning.[204] The Review Body on Doctors' and Dentists' Remuneration produced its report in July 2011 however the Department of Health is yet to publish the report or set out recommendations.

What are the professions doing?

This Government's reforms have reaffirmed national leadership and control of the workforce, but have also meant the professions have maintained their central role in determining workforce flexibility.

Reforms to training

The Health Select Committee has argued that "an acid test of the effectiveness of the new education and training arrangements will be their ability to deliver the more flexible medical training programmes which were described by Professor Tooke and endorsed by the NHS Future Forum."[205] However the medical training is in the hands of the profession. In June 2011 Medical Education England announced a further review of postgraduate medical training.[206] The Shape of Training review will consider a more flexible and broad based approach to training, as well as the balance between specialism and generalism.[207] While the Royal Colleges are increasingly aware of the need to allow greater flexibility and the commonalities between specialities, the evolution of medical curricula is very slow.[208] This is due in part to vested interests among Royal Colleges in retaining professional boundaries, and inflexibility in regulation of specialist training and accreditation. Professional groups have also campaigned to protect old and traditional titles such as "consultant" and "surgeon" and have resisted suggestions of introducing a "sub-consultant" grade.[209]

Reviving professionalism

Professional groups such as the Royal Colleges have a key role in raising the bar of clinical practice. In recent years the government has become involved in using professionalism to improve the quality of care. In response to concerns that nursing had "lost its way" the Government commissioned two independent reviews, one by the Chief Nursing Officer and another by the then Prime Minister, Gordon Brown, to revive professionalism.[210] The decision to introduce degree level entry into nursing sought to raise the standing of the profession and move nurses into more advanced roles.[211] Policymakers have also sought to strengthen the responsibility and accountability of senior nurses for care quality. In 2012 the Prime Minister set up the Nursing and Care Quality Forum of nursing leaders to provide "strong national leadership, to spread best practice care across the NHS".[212] The interim report highlighted the importance of nursing leadership, ensuring that nurses spend enough time delivering patient care, greater use of patient-centred approaches and recruiting nurses for their caring nature and compassion.[213]

Staffing ratios

The Royal College of Nursing and other professional leaders have called for mandatory nurse staffing levels.[214] While amendments to the Health and Social Care Bill to mandate nursing ratios were withdrawn, the final report of the Independent Inquiry into Mid Staffordshire Hospital is expected to raise the issue.[215] The Department of Health has not yet endorsed mandatory nurse-patient ratios, however in June 2012 it was reported the NHS Trusts will have to report nurse-to-bed ratios as a key measure of clinical quality.[216]

204 Evans, D. (2011), *Compensation Levels and Incentive Systems for Medical and Dental Consultants: International Experience*, Capita/ Office of Manpower Economics. NHS Employers (2010), *NHS employers submission to the pay review body on doctors' and dentists' remuneration on the review of clinical excellence and distinction award schemes for NHS consultants*: "it is our considered view that the scheme is no longer fit for purpose at a time when the NHS is looking for large-scale cash releasing savings. To be awarding extra money to what is already (to all practical purposes) the highest-earning staff group in NHS hospital and mental health Trusts at a time that more junior members of staff are threatened with redundancy is not appropriate." Also see, Guy's and St Thomas' NHS Foundation Trust (2010), *Evidence to the Review Body on Doctors' and Dentists' Remuneration – Review of Clinical Excellence Awards:* "We believe that the current Clinical Excellence Award is not sustainable in the long term and it needs a radical review. The current system of individual performance payments is out of place in an era of team based working and despite the changes that have been made to the Scheme over the past decade; the system is still perceived as unfair and lacking in transparency".
205 Health Select Committee (2012), *Education, training and workforce planning.*
206 The Shape of Training website http://www.shapeoftraining.co.uk. Accessed October 2012.
207 Medical Education England (2012), "Chair of the Independent Review of the Shape of Training appointed", Press release, 28 February.
208 The Academy of Medical Royal Colleges has established a Flexible Careers Committee to coordinate the efforts of Royal Colleges.
209 Royal College of Surgeons (2012), "Patients misled by inappropriate use of the job title surgeon", 15 July.
210 Maben, J. and P. Griffiths (2008), *Nurses in society: starting the debate*, National Nursing Research Unit; Prime Minister's Commission on the Future of Nursing and Midwifery in England (2010), *Front line care*.
211 Department of Health (2010), "Nursing set to become all graduate entry by 2013", 12 November.
212 Department of Health (2012), "PM announces new focus on quality and nursing care", 6 January.
213 Nursing and Care Quality Forum (2012), Letter to the Prime Minister, 18 May.
214 For instance, a minimum ratio of nurses to patients in wards for elderly patients at 1:5-7, up from 1:9-10. The RCN and other leaders from the profession have highlighted a correlation in North American between nurse staff levels and patient outcomes.
215 "The Department of Health should consider providing or endorsing guidance on minimum nurse staffing levels". The Mid Staffordshire NHS Foundation Trust Public Inquiry (2011), *Written submissions from Counsel to the Inquiry.*
216 *Nursing Times* (2012), "Nurse ratios to be published by Trusts for first time", 26 June.

Both good and bad care exists where there are high and low staff patient ratios. Despite the dramatic rise in staff numbers over the last decade there are still incidences of poor quality. A review of recent studies from North America found that "mandatory ratios, if imposed nationally, may result in increased overall costs of care with no guarantees for improvement in quality or positive outcomes of hospitalization".[217]

NHS leaders have also challenged nurse-patient ratios. In evidence at the Francis Inquiry, Christine Beasley, the former Chief Nursing Officer, warned that mandated staffing and skill mix levels oversimplify workforce planning decisions as guidelines could be interpreted as the maximum standard, rather than a baseline from which to work.[218] Regulating staff levels also shifts responsibility away from those properly accountable for care quality, the professionals and managers, while also significantly curbing the freedom of managers to allocate resources according to clinical need. Harry Cayton, the Chief Executive of the Council for Healthcare Regulatory Excellence (CHRE)[219], has also warned:

> "Minimum staffing levels are an example of inflexible regulation and a distraction from the proper questions that should be the focus and concern of managers and clinicians. They are an example of a fig-leaf performance measure – one which diverts attention away from what the real indicators of good performance are. Mandating staffing levels will not make a bad service better; it may make a good service worse."[220]

What are the regulators doing?

Many of the clinical professionals that work in health and care are regulated by one of nine professional regulators, including the General Medical Council and the Nursing and Midwifery Council. Effective regulation should ensure minimum standards from healthcare professionals in the patient interest. However bad quality regulation can also serve professional interests and become confused with performance management.

Revalidation

Formal revalidation of doctors was first proposed in 2000 by the GMC and in 2007 the Government issued a White Paper calling for all healthcare professionals to complete a process of revalidation.[221] In 2010 the GMC released proposals for consultation and in October 2012 the Department of Health announced that revalidation will begin in December 2012.[222] Going forward all doctors will need to undertake annual appraisals based on the GMC's core requirements for good medical practice and be required to be formally revalidated every five years. As part of the revalidation of doctors, Responsible Officers, themselves senior doctors, will make recommendations as to whether doctors should retain their licence to practice. Revalidation of doctors has been criticised by doctors, claiming that it will damage the medical morale and create an administrative burden for doctors.[223] Royal Colleges have also urged that the revalidation process should focus on doctors trained outside the UK and for those with non-standard careers.[224]

Extending regulation

Recent cases of poor quality in the NHS have also led to calls for greater regulation of healthcare professionals. In particular a number of organisations, including the Royal College of Nursing, have called for statutory regulation of healthcare assistants, currently the largest professional group in the NHS workforce.[225]

The Government has proposed a voluntary system of registration for healthcare professionals, and set out plans to develop a code of conduct and minimum training standards for healthcare support workers and adult social care workers in England.[226] As the Command Paper, *Enabling Excellence*, states:

217 Welton, J. (2007) "Mandatory Hospital Nurse to Patient Staffing Ratios: Time to Take a Different Approach", *The Online Journal of Issues in Nursing.*
218 Beasley, C. (2011), Evidence given to The Mid Staffordshire NHS Foundation Trust Public Inquiry, 8 September.
219 CHRE will become the Professional Standards Authority for Health and Social Care in late 2012.
220 Cayton, H. (2012), "Mandating staffing levels is not the answer to reducing poor care", *Health Service Journal*, 15 March.
221 Health Select Committee (2011), *Revalidation of doctors.*
222 Department of Health (2012),"New checks for doctors in world first patient safety boost", Press Release, 19 October.
223 *Pulse* (2008), "Revalidation will damage morale, GPs believe", 18 August.
224 Royal College of Surgeons of England (2011), "Select Committee revalidation concerns echo College", RCS Statement, 8 February.
225 Royal College of Nursing (2007), *The regulation of health care support workers.*
226 Department of Health (2011), "Scheme to support healthcare assistants unveiled", 15 November.

> "Centralising responsibility for the complexity of managing the risk of millions of daily interactions between staff and those using services may provide an apparently neat and tidy central solution. It can never realistically supplant the individual, team and organisational commitment, harnessed to local people and local communities."[227]

As the Council for Healthcare Regulatory Excellence has argued, statutory regulation for healthcare assistants "only serves to shift responsibility from where it truly lies."[228] Commissioners and managers are accountable for quality to the health system through national levers and the Care Quality Commission. Healthcare assistants are also supervised and delegated to by nurses and doctors, who hold greater responsibility for clinical and care quality, as well as being professionally regulated. However, in a number of cases being on a statutory register has not stopped doctors and nurses performing improperly. The responsibility for care quality is more effectively enforced by the professionalism of staff and the governance of the organisation, not through statutory regulation.

A light-touch regulatory approach, set out by the Council for Healthcare Regulatory Excellence, suggests that regulation should be proportionate, consistent, targeted, transparent, accountable and agile.[229] Such a risk-based approach shows the limited effect that statutory regulation of healthcare assistants has on maintaining and, more importantly improving quality.[230]

Regulatory overreach would also stifle innovation on the front line. Healthcare assistants are increasingly being used to directly deliver care, taking over roles traditionally performed by nurses.[231] Many hospitals and healthcare providers are using healthcare assistants to deliver care in different ways, that are cheaper and better quality. Greater regulation of clinicians is often due to the desire to control boundaries between different staff, as well as improving their prestige and value.[232] Regulating healthcare assistants would restrict role shift from nurses to other professionals. In addition, given that healthcare assistants are very mobile, statutory regulation, and the related costs, will therefore severely constrain supply of these workers.

Overreach

While regulation should be used to set a minimum standard, healthcare regulation is often seen as a driver of quality improvement. However regulation is an ineffective and inefficient mechanism to improve quality in healthcare. Research has shown that "staff model their behaviour on peer norms rather than in response to external factors such as regulation".[233]

Regulation is not a substitute for good management and leadership. As the Council for Healthcare Regulatory Excellence has argued, regulators should set the minimum standards to practice, professional groups should raise the bar and employers should manage the performance of staff and provide education and support in the workplace.[234]

Regulatory overreach has often led to poor quality regulation. A recent review by the Nursing and Midwifery Council highlighted major failings where the regulator had underperformed on both public protection duties and inspiring confidence in the professions.[235] The NMC suffered from "confusion over its regulatory purpose" and sought to develop the roles and capabilities of nurses and midwives. Lobbying to expand its regulatory oversight to healthcare assistants also "distracted from its core functions". The Care Quality Commission has also struggled to define its core mission, with its functions including inspections, licensing and quality improvement.[236]

What are the employers doing?

Better, safer and more productive models of healthcare should be led by employers. However hospitals and other providers have only taken a limited role in workforce management. Few NHS organisations have invested in the HR capacity to better manage the performance or costs of staff. Few hospitals or healthcare

227 Department of Health (2011), *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Worker and Social Care Workers*.
228 Cayton, H. (2011), "Letter to Anne Milton", 6 July, Council for Healthcare Regulatory Excellence.
229 Council for Healthcare Regulatory Excellence (2010), *Right touch regulation*.
230 Ibid.
231 NHS Institute for Innovation and Improvement website, *Quality and Service Improvement Tools: Role Redesign*,www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/role_redesign.html. Accessed October 2012.
232 International Partnership for Innovative Healthcare Delivery (2012), *A neglected resource: Transforming healthcare through human capital*.
233 Cayton, H. (2011), "Letter to Anne Milton", 6 July, Council for Healthcare Regulatory Excellence.
234 Council for Healthcare Regulatory Excellence (2012), *Strategic Review of the Nursing and Midwifery Council: Interim Report*.
235 Ibid.
236 Department of Health (2012), *Performance and Capability Review of the Care Quality Commission*.

providers have a designated human resources director at Board level. While many of the elements of national contracts for NHS staff are at the discretion of the employer very few organisations have made use of these options, such as the Knowledge and Skills Framework and granting pay increments for staff.

There is already considerable flexibility allowing NHS Trusts and Foundation Trusts to break from national contracts to improve staff productivity.[237] However before 2010 only one NHS hospital had developed alternative terms and conditions.[238] Greater financial pressures have made a growing number of Trusts consider adapting Agenda for Change and national contracts through reducing staff sick pay, annual leave entitlements and restricting the number of "supporting professional activities" in consultant contracts.[239] Hospitals such as the John Radcliffe in Oxford are recruiting new staff on "zero-hours" contracts, while Salford Royal now grants pay increments to Agenda for Change staff if employees meet the required level of performance.[240] Financial pressure also means that nearly all NHS providers are planning workforce reductions. Acute Foundation Trusts had planned to reduce their workforce by 6 per cent between 2012 and 2014, however in 2012 the workforce increased by 1 per cent. Planned workforce reductions are now due to take place at the end of this Spending Review.[241]

In the South West a consortium of 20 employers has announced plans to reform pay and conditions to reduce costs. The proposals, which will affect 60,000 staff, include ending overtime for nights, weekends and bank holidays, reducing paid leave and sick pay, making staff work longer shifts and cutting pay as much as 5 per cent.[242] Other hospitals are also considering renegotiating staff contracts using existing flexibilities.[243]

While some employers have made use of existing flexibilities and are considering adapting national contracts, most continue to call for central action by the government to manage workforce costs. NHS Employers, the organisation that represents the interests of employers during pay negotiations, has recently called for discretionary pay increments to be frozen and for the NHS pay freeze to be extended into a third year.[244]

Playing the numbers game

The failure to reform the workforce and to move the focus on how effectively staff work and the outcomes of the service has meant that the policy debate is still based on staff numbers. This Government and previous Governments have introduced reforms to the NHS that would move the focus to the outcomes the service achieves over the inputs it receives. Following the general election in 2010 the then Secretary of State for Health, Andrew Lansley, argued that "the NHS must be focused on achieving continuously improving outcomes for patients – not inputs or processes, but results."[245] The NHS White Paper, *Equity and Excellence*, promised a "relentless focus on clinical outcomes".[246]

However despite the emphasis on healthcare outcomes, politicians and NHS leaders continue to measure the value of healthcare by the number of doctors and nurses. Health Ministers have challenged claims that front line staff are being cut by arguing that the number of clinical staff are increasing.

In May 2012, the Royal College of Nursing claimed that over 60,000 nursing posts were at risk. In response the then Health Minister Simons Burns argued: "There are only 450 fewer qualified nursing staff in England than in 2009 and in 2011-12 we expect to train 2,300 community nurses and health visitors."[247]

In August 2012, numbers released by the NHS Information Centre suggested that the number of qualified nurses had fallen by nearly 5,000 since the election. The then Health Minister Anne Milton responded by suggesting: "There are 2,400 more clinical staff working in the NHS than there were two years ago in May 2010, including over 3,700 more doctors, and over 900 extra midwives."[248]

237 Capsticks (2010), *Achieving workforce savings*.
238 Southend University Hospital NHS Foundation Trust left Agenda for Change in 2006 to improve the competitiveness of the hospital in the local labour market, see Bassett, D. et al. (2009), *The front line, Reform*.
239 *Health Service Journal* (2010), "Foundation Trusts seek to halt automatic pay rises", 23 September; *Health Service Journal* (2011), "Luton and Dunstable FT looks at radical workforce savings", 24 February; *Health Service Journal* (2011), "Foundation Trusts consider moving away from national pay deal", 14 September; *Health Service Journal* (2012), "Burton FT considering local pay proposals", 19 January.
240 *Health Service Journal* (2012), "Trusts pursue pay curbs for staff sickness", 15 March; *The Independent* (2012), "Health warning over army of NHS 'temps'", 3 September.
241 *Health Service Journal* (2012), "Acute FTs push their workforce reductions back to 2013-14", 18 October.
242 *The Sunday Times* (2012), "Thousands of doctors face sack", 15 July.
243 *Health Service Journal* (2012), "South West pay consortium chief predicts other regions will copy model", 4 September.
244 *Health Service Journal* (2012), "Exclusive: NHS employer backs pay freeze", 2 October.
245 Lansley, A. (2010), "A shared ambition to improve outcomes", 2 July.
246 Department of Health (2010), *Equity and Excellence: Liberating the NHS.*
247 *The Independent* (2012), "Government 'is cutting nursing numbers by stealth'", 14 May.
248 *The Guardian* (2012), "NHS figures reveal 5,000 fewer nurses since 2010", 21 August.

4

A more productive workforce

Reforming the workforce will be essential to improving the quality of healthcare. Pioneers of healthcare excellence are already demonstrating how to effectively manage and motivate clinicians to deliver better quality services. Government now needs to ensure all providers can adopt the lessons of high performing organisations. However the Government's reforms to the structures of the NHS have not challenged the status quo of the workforce.

Successful workforce reform will put employers in charge. Yet while many NHS hospitals have the powers to develop their own terms and conditions for staff, with few exceptions, nearly all have continued to use national contracts. With hospitals facing greater financial pressure, this is starting to change and a growing number are looking to exploit the flexibilities they have always had. The Government needs to give a clear mandate to all employers to take the initiative and use tighter health spending to drive reform.

The new employers

Tighter budgets now and in the future will mean more health and social care employers will need to make the best of all the available tools to improve workforce performance.

Although NHS organisations have the flexibility to develop their own terms and conditions, they have often sought national action and reform to national contracts to manage workforce costs. Even large Foundation Trusts have been reluctant to take on national unions or risk negative publicity by exploiting their freedoms. Yet national policies to control costs, such as freezing pay, undermine the drive for a more productive workforce; by preventing employers from using their discretion to change working practices or incentivise performance.

To improve the quality of healthcare and get better value for money from the NHS workforce, employers need the motivation and freedom to be better leaders and employers. Where organisations have taken the initiative to develop to improve the quality of their workforce, through better performance management or organisational culture, the quality of care has been improved. National efforts that seek to improve quality, such as greater regulation, often shift responsibility away from providers and crowd out local initiative.

Empowering the leaders

The Government should encourage employers to develop their own terms and conditions. But it has been inconsistent in its support. The July 2010 White Paper *Equity and Excellence* announced that "all individual employers will have the right, as foundation Trusts have now, to determine pay for their own staff. However, it is likely that many providers will want to continue to use national contracts as a basis for their local terms and conditions."[249] In Parliamentary debates on the South West Consortium, the then Secretary of State for Health said that he "did not believe reduction of pay in the NHS to be necessary" and that the Department of Health "should do everything we can to support NHS employers to have the flexibilities in the pay framework" through national negotiations under the Agenda for Change.[250]

Ministers' criticism of job cuts and focus on raising the headcount of doctors and nurses has also made it harder for providers to innovate with the skill mix of their workforce. Despite the financial challenges facing Hinchingbrooke hospital, Circle, the private provider that has taken over management of the Trust, has limited freedom to reform the workforce.

The Government needs to establish a clear mandate for all NHS providers to innovate with terms and conditions. Monitor, as the economic regulator of NHS providers, should also encourage the sector to take risks. As in other sectors such as education (in the case of academies and free schools), autonomy to develop independent terms and conditions is not sufficient. Backing the South West Consortium and setting out an ambition to abolish national terms and conditions will send a clear message to NHS providers that they should take the initiative. National Clinical Excellence Awards (CEAs) are in urgent need of reform and currently crowd out employer led performance-related pay for doctors. Abolishing CEAs will open the door for providers to introduce policies that better meet their needs.

249 Department of Health (2010), *Equity and Excellence: Liberating the NHS.*
250 Hansard (2012), 16 July, Col. 748.

The new labour market

While in the past the supply of doctors has been constrained by national workforce planning, the significant expansion in medical training over the last decade will mean many more doctors will enter the workforce in future years. The number of UK medical students has increased from 2,000 in 1960 to 8,000 in 2010 and there is no sign that the number of students undertaking medical degrees will fall.[251] In addition, the number of overseas medical graduates has also increased, with three times as many applications in 2010-11 than in 2009-10.[252] Consequently, the Foundation Programme is now oversubscribed and this has led to pressure from professional groups to fund further expansion in medical training.[253]

Already the UK is heading towards a surplus of doctors. The Centre for Workforce Intelligence has recently forecast that the number of consultants will rise by 60 per cent by 2020.[254] If existing pay structures were maintained it is estimated that the rise in consultants will cost the NHS an additional £2.2 billion. Yet the surplus creates an opportunity to drive down pay and review medical ranks. A number of organisations have started to discuss reforming doctor's career structure with a more multi-tiered consultant grade. Already NHS Trusts are using the surplus of doctors to employ new staff on contracts that limit the number of hours for "supporting professional activities".[255] More hospitals are now introducing non-consultant positions for fully qualified doctors, with the number of "sub-consultant" posts being advertised and accepted quadrupling in four years.[256]

The Government should encourage hospitals to take full advantage of this growing surplus and resist calls from the profession to protect the traditional boundaries. The Government should also relax immigration rules for doctors. While the number of doctors qualified outside the UK peaked at 40 per cent in 2005, that number has started to decline due the requirement made on any NHS Trust wanting to employ a doctor from outside the European Economic Area to show that the post could not be filled by a doctor who qualified in the UK or the EEA.[257] In the past workforce planning and medical training was concerned with avoiding medical unemployment. In the future all healthcare providers should have the freedom to decide how they will recruit and reward doctors and other clinical staff.

The new primary care

The primary care workforce urgently needs to be reformed. Despite evidence of the variation in quality and productivity national contracts have preserved a virtual GP monopoly over primary care. While there has been a move towards larger practices, primary care largely remains a cottage industry with many small and inefficient practices delivering substandard or patchy care quality. Compared with the acute sector, primary care is subject to little performance management and oversight. Much of primary care is unmeasured and consequently unmanaged. Local commissioners who want to reconfigure services or negotiate directly with primary care practices in order to get better care at a lower cost are stymied: after the Government's reforms primary care services will be commissioned by the National Commissioning Board, not Clinical Commissioning Groups (CCGs).

To improve the quality and productivity of primary care, and also ensure that out of hospital care is more coordinated, it is essential to break the GP monopoly. This, in turn, will mean moving from national GP contract negotiations to local contracting arrangements. CCGs should commission local primary care services through locally determined contracts. While there was a concern that GP commissioners would have a conflict of interest in commissioning primary care services, it is increasingly clear that the new CCGs largely resemble PCTs, with the majority being led by professional commissioners.

Local commissioning and local contracts will allow CCGs to change the shape of service provision and bring in alternative and more cost effective providers. CCGs need the ability to performance manage and potentially exit GP providers. Future models of primary care such as retail clinics, walk-in centres and large practice groups, as well as community and social care services delivered by a diverse range of public, private and charitable providers, also need to be encouraged. Many of these organisations have the scale to standardise clinical practice, measure outcomes and manage individual clinicians.[258]

251 Temple, J. (2010), *Time for Training, Medical Education England.*
252 General Medical Council (2011), *The state of medical education and practice in the UK.*
253 Jacques, H. (2011), "Foundation programme is oversubscribed for second year running", *BMJ Careers*, 27 October.
254 Centre for Workforce Intelligence (2012), *Shape of the medical workforce: Starting the debate on the future consultant workforce.*
255 Jacques, H. (2011), "Consultants condemn deterioration of terms and conditions", *BMJ Careers*, 5 July.
256 White, C. (2012), "Number of 'subconsultant' posts has almost quadrupled in four years", *BMJ Careers*, 16 August.
257 General Medical Council (2011), *The state of medical education and practice in the UK.*
258 Swansen, S. et al. (2010), "Cottage industry to postindustrial care – The revolution in health care delivery", *New England Journal of Medicine*, Vol. 362. Cawston, T. et al. (2012), *Healthy competition, Reform.*

The new professional leaders and regulators

Professional leadership should be leading reform of the workforce. However it often blocks more innovative use of healthcare professionals and alignment of clinical roles with employer needs. The Royal Colleges' traditional role has been to promote high standards and develop the curricula for specialist training. However, recent campaigns by the Royal Colleges have been focused on protecting the standing of the profession, such as maintaining boundaries between clinicians and traditional curricula.

Employers, not national institutions, are the strongest influence on professional performance and behaviour in the workforce. The Royal Colleges are now amongst a host of organisations such as the Health Foundation, the King's Fund and even business schools that are involved in quality improvement among clinicians. Young professionals in particular are looking to different organisations to further their career and practice. To better serve patients and their members, Royal Colleges need to encourage this change.

Reforms to professional regulation have made regulators more accountable to patients and encouraged a light touch approach.[259] This Government has set out an ambition for further reforms through reviewing the legislative framework and the process of appointing members to the regulators.[260] However, the UK's system of professional regulation, with separate regulators for each profession, continues to protect professional silos. By contrast, other health systems have also reformed regulatory structures to move away from regulating professional silos and protecting the highly stratified professional hierarchies, and created over-arching regulations to encourage greater role shift and team based care.[261] If the NHS is to deliver accountable, flexible, high value care in austere times, it will have to modernise.

259 Council for Healthcare Regulatory Excellence (2010), *Right touch regulation*.
260 Department of Health (2011), *Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff*.
261 International Partnership for Innovative Healthcare Delivery (2012), *A neglected resource: Transforming healthcare through human capital*.

References

Aiken, L. et al. (2011), "Importance of work environments on hospital outcomes in nine countries", *International Journal for Quality in Health Care*, Vol. 23:4.

Aiken, L. et al. (2012), "Patient safety, satisfaction and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States", *British Medical Journal*, Vol. 344:e1717.

All-Party Parliamentary Group on Global Health and Africa All-Party Parliamentary Group (2012), *All the Talents: How new roles and better teamwork can release potential and improve health services*.

Association of Chief Police Officers (2005), *Draft ACPO vision for workforce modernisation: The missing component of police reform*.

Audit Commission (2010), *Making the most of NHS front line staff*.

Audit Commission (2010), *Maximising resources in adult mental health*.

Audit Commission (2011), *Paying GPs to improve quality*.

Ball, J., Pike, G., Griffiths, P., Rafferty, A. and Murrells, T. (2012), *RN4CAST Nurse Survey in England*, National Nursing Research Unit.

Bassett, D. et al. (2009), *The front line, Reform*.

Bassett, D. et al. (2011), *It can be done*, *Reform*.

Bassett, D. et al. (2011), *Reformers and wreckers*, *Reform*.

BBC News (2002), "Nurse prescribing 'poses threat'", 30 May.

BBC News (2002), "One in four junior doctors bullied", 26 September.

BBC News (2010), "Call to abolish NHS 'lifetime bonuses' for consultants", 13 October.

Beacon UK (2012), *Are mental health patients getting the right treatment*.

Beasley, C. (2011), Evidence given to The Mid Staffordshire NHS Foundation Trust Public Inquiry, 8 September.

Berry, L. and K. Seltman (2008), *Management Lessons from Mayo Clinic: Inside One of the World's Most Admired Service Organisations*.

Bhutta, Z. et al. (2010), "Education of health professionals for the 21st century: a global independent Commission", *The Lancet*, Vol. 375, Issue. 9721.

Bohmer, R. (2011), "The Four Habits of High-Value Health Care Organizations", *New England Journal of Medicine*, Vol. 365.

Bohmer, R. (2012), "The instrumental value of medical leadership: Engaging doctors in improving services" The King's Fund.

Buchan, J. and I. Seccombe (2011), "A decisive decade – mapping the future NHS workforce", Royal College of Nursing.

Cambridge Health Network/Bupa study visit 08/11/11.

Capsticks (2010), *Achieving workforce savings*.

Care Quality Commission (2012), *Market Report: Issue 1: June 2012*.

Cawston, T. (ed.) (2011), *A lot more for a lot less*, *Reform*.

Cawston, T. (ed.) (2012), *Rising to the Nicholson Challenge*, *Reform*.

Cawston, T. et al. (2012), *Healthy competition*, *Reform*. .

Cayton, H. (2011), "Letter to Anne Milton", 6 July, Council for Healthcare Regulatory Excellence.

Cayton, H. (2012), "Mandating staffing levels is not the answer to reducing poor care", *Health Service Journal*, 15 March.

Centre for Health Market Innovation (2012), healthmarketinnovations.org.

Centre for Workforce Intelligence (2011), *Shape of the medical workforce*.

Centre for Workforce Intelligence (2012), *Shape of the medical workforce: Starting the debate on the future consultant workforce*.

Chambers, N., Pryce, A., Li, Y. and Poljsak, P. (2011), *Spot the difference: A study of boards of high performing organisations in the NHS*, Manchester Business School.

Christmas, S. and Millward, L. (2011), *New Medical Professionalism,* The Health Foundation.

Clark, J. (2012), "Medical engagement: Too important to be left to change", The King's Fund.

Collins, J. (2010), *Foundation for Excellence: An Evaluation of the Foundation Programme*, Medical Education England.

Commission for Health Improvement (2004), *Lessons from CHI Investigation 2000-2003*.

Corrigan, P. (2010), "Next steps in integration of health services for NHS patients in England", Presentation at Monitor/Nuffield Trust conference, September.

Corrigan, P. et al. (2012), *Takeover*, *Reform*.

Coulter, A. (2009), *Implementing shared decision making in the UK*, The Health Foundation.

Council for Healthcare Regulatory Excellence (2010), *Right touch regulation*.

Council for Healthcare Regulatory Excellence (2012), *Strategic Review of the Nursing and Midwifery Council: Interim Report*.

Crisp, N. et al.(2008), "Training the healthcare workforce: scaling up, scaling lives", *The Lancet*, Vol. 371, Issue 9613.

Crump, H. (2009), "Variation shows NHS community services ripe for efficiencies", *Health Service Journal,* 13 August.

Curry, L. et al. (2011), "What Distinguishes Top-Performing Hospitals in Acute Myocardial Infarction Mortality Rates?: A Qualitative Study", *Annals of Internal Medicine*, Vol. 154: 6.

Da Silva, D. et al. (2011), *Helping people help themselves*, The Health Foundation.

Dalton, D. (2012), Speech at *Reform* conference on *High quality healthcare*, 16 May.

Darves B. (2011), "Physician Compensation Models: Big Changes Ahead", New England Journal of Medicine Career Centre.

Department of Health (2003), *Choice and opportunity: Modernising medical careers for non-consultant career grade doctors*.

Department of Health (2004), *NHS Staff 2003 (Non-medical)*.

Department of Health (2008), *High quality care for all*: *NHS Next Stage Review*.

Department of Health (2010), *Average daily number of available and occupied beds open overnight by sector, 1987-88 to 2009-10*.

Department of Health (2010), "Consultant pay rewards scheme to be reviewed", 20 August.

Department of Health (2010), "Consultant pay rewards scheme to reviewed", Press release, 20 August.

Department of Health (2010), *Equity and Excellence: Liberating the NHS*.

Department of Health (2010), *Liberating the NHS: Developing the Healthcare Workforce*.

Department of Health (2010), "Nursing set to become all graduate entry by 2013", 12 November.

Department of Health (2010), *UK Wide Review of Compensation Levels and Incentives for NHS Consultants*, *Evidence to the Review Body on Doctors' and Dentists' Remuneration*.

Department of Health (2011), *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Worker and Social Care Workers*.

Department of Health (2011), "Scheme to support healthcare assistants unveiled", 15 November.

Department of Health (2011), *The Government's response to the recommendations in Front Line Care: The report of the Prime Minister's Commission on the Future of Nursing and Midwifery in England*.

Department of Health (2012), *Average daily number of available and occupied beds, Timeseries. Q1 2010/11 to Q4 2011/12*.

Department of Health (2012), *Evidence to the NHS Pay Review Body on Market Facing Pay*.

Department of Health (2012), *Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery*.

Department of Health (2012),"New checks for doctors in world first patient safety boost", Press Release, 19 October.

Department of Health (2012), "Nursing and Care Quality Forum make recommendation to Prime Minister", Press release, 25 May.

Department of Health (2012), *Performance and Capability Review of the Care Quality Commission*.

Department of Health (2012), "PM announces new focus on quality and nursing care", 6 January.

Dixon, A. (2011), "Is the GP contract a barrier to integrated care?", The King's Fund blog, 4 November.

Dixon, A., Khachatryan, A., Wallace, A., Peckham, S., Boyce, T. and Gillam, S. (2011), *Impact of Quality and Outcomes Framework on health inequalities*, The King's Fund.

Donaldson, L. (2002), *Unfinished business,* Department of Health

Dorgan, S. et al. (2010), *Management in Healthcare: Why good practice really matters*, McKinsey & Company and Centre for Economic Performance at the London School of Economics.

Dowdy, J. et al. (2005), *Management matters*, McKinsey & Company and Centre for Economic Performance at the London School of Economics.

Dunkley, L. and Haider, S. (2011), *Workforce risks and opportunities- Nursing and Midwifery*, Centre for Workforce Intelligence.

Doctor Foster Intelligence (2011), *Inside your hospital.*

Ehrbeck, T. et al. (2010), "The emerging market in health care innovation", *McKinsey Quarterly*.

Ellins, J. et al. (2009), "Opening up the primary medical care market", *British Medical Journal*, Vol. 338.

Evans, D. (2011), *Compensation Levels and Incentive Systems for Medical and Dental Consultants: International Experience*, Capita/Office of Manpower Economics.

Field, T. (2002), "Those who can, do; those who can't, bully", *British Medical Journal*, Vol. 324:786.2.

Foot, C. et al. (2012), *Service-line Management: Can it improve quality and efficiency*, The King's Fund.

Frenk, J. et al. (2010), "Health professionals for a new century: transforming education to strengthen health systems in an independent world", *The Lancet*, Vol. 376, Issue. 9756.

General Medical Council (2010), *Revalidation: A Statement of Intent*.

General Medical Council (2011), *The state of medical education and practice in the UK*.

Gilbert, A., Hockey, P., Vaithianathan, R., Curzen, N. and Lees, P. (2012), "Perceptions of junior doctors in the NHS about their training: results of a regional questionnaire", *BMJ Quality and Safety*, Vol. 21:3.

Gillam, S. (2010), "Should the Quality and Outcomes Framework be abolished? Yes", *British Medical Journal*, Vol. 340:2710.

Goodrich, J. and Cornwell, J. (2008), *Seeing the person in the patient: the Point of Care review paper*, The King's Fund.

Goodwin N., Dixon A., Poole T., Raleigh V. (2011), *Improving the quality of care in general practice*, The King's Fund.

Grint, K. and Holt, C. (2011), *Followership in the NHS*, The King's Fund.

Guy's and St Thomas' NHS Foundation Trust (2010), *Evidence to the Review Body on Doctors' and Dentists' Remuneration – Review of Clinical Excellence Awards*.

Hansard (2012), 16 July, Col. 748.

Health and Social Care Act 2012.

Health Foundation (2010), "The patient will see you now", *Health Service Journal*.

Health Market Innovation (2012), healthmarketinnovations.org.

Health Select Committee (2012), *Education, training and workforce planning*.

Health Select Committee (2010), *Public Expenditure on Health and Personal Social Services 2009*.

Health Select Committee (2011), *Public expenditure*.

Health Select Committee (2011), *Revalidation of doctors*.

Health Select Committee (2007), *Workforce Planning*.

Health Service Journal (2010), "Foundation Trusts seek to halt automatic pay rises", 23 September.

Health Service Journal (2010), "NHS Trusts issue wake-up call on consultant productivity", 15 April.

Health Service Journal (2011), "Foundation Trusts consider moving away from national pay deal", 14 September.

Health Service Journal (2011), "Luton and Dunstable FT looks at radical workforce savings", 24 February.

Health Service Journal (2011), "Pay awards to be held at 1pc for two years", 29 November.

Health Service Journal (2011), "The mediocre will be the only losers if pay is reformed fairly", 15 December.

Health Service Journal (2012), "Acute FTs push their workforce reductions back to 2013-14", 18 October.

Health Service Journal (2012), "Burton FT considering local pay proposals", 19 January.

Health Service Journal (2012), "Exclusive: NHS employer backs pay freeze", 2 October.

Health Service Journal (2012), "Government seeks significant change to GP contracts", 23 October.

Health Service Journal (2012), "South West pay consortium chief predicts other regions will copy model", 4 September.

Health Service Journal (2012), "Standardised GP contract by 2015 is 'naïve'", 16 February.

Health Service Journal (2012), "Trusts pursue pay curbs for staff sickness", 15 March.

Healthcare Commission (2009), *The Healthcare Commission 2004-2009: Regulating healthcare – experience and lessons*.

HM Government (2010), *The Coalition Agreement: Our Programme for Government*.

HM Inspectorate of Constabulary (2010), *Where are the police*?

HM Treasury (2010), *Spending Review*.

HM Treasury (2011), *Autumn Statement 2011*.

HM Treasury (2011), *Spending Review*.

Imison, C., Buchan, J. and Xavier, S. (2009), *NHS workforce planning: limitations and possibilities*, The King's Fund.

International Partnership for Innovative Healthcare delivery (2012), ipihd.org.

International Partnership for Innovative Healthcare Delivery (2012), *A neglected resource: Transforming healthcare through human capital*.

Jacques, H. (2011), "Consultants condemn deterioration of terms and conditions", *BMJ Careers,* 5 July.

Jacques, H. (2011), "Foundation programme is oversubscribed for second year running", *BMJ Careers*, 27 October.

Jha, A., and Epstein, A. (2010), "Hospital Governance and the Quality of Care", *Health Affairs*, Vol. 29:1.

Kark, T. et al. (2011), "Closing submissions of counsel to the inquiry", The Mid Staffordshire NHS Foundation Trust Public Inquiry.

Keogh, B. (2011), Evidence given to The Mid Staffordshire NHS Foundation Trust Public Inquiry, 20 September.

Kluger, J. (2009), "Is there a better way to pay doctors?", *Time Magazine*, 26 October.

Lansley, A. (2010), "A shared ambition to improve outcomes", 2 July.

Laurant, M. et al. (2010), *Revision of professional roles and quality improvement: a review of the evidence*, The Health Foundation.

Lawrence, D. (2002), *From chaos to care: the promise of team-based medicine*.

Lee, T. (2011), "Turning Doctors into Leaders", *Harvard Business Review*.

Lee, T. and J. Mongan (2009), *Chaos and Organisation in Health Care*.

Lemer, C. et al. (2012), "Improving NHS productivity: The secondary care doctor's perspective", The King's Fund.

Maben, J. and P. Griffiths (2008), *Nurses in society: starting the debate*, National Nursing Research Unit.

Mache, S., Vitzthum, K., Klapp, B., and Groneberg, D. (2012), "How to improve the quality of medical hospital treatment and person-centered care: working conditions and job satisfaction as preconditions for satisfying medical care in German hospitals", *International Journal of Person Centered Medicine*, Vol. 2:2.

Mail on Sunday (2012), "You must stop A&E cuts: Powerful lobby of 140 top doctors sign damning letter to PM", 7 October.

Marshall, M. (1999), "How well do GPs and hospital consultants work together? A survey of the professional relationship", *Family Practice*, Vol. 16.1.

May, T. (2011), "The urgent need for police reform", Speech to *Reform*, 16 August.

McAlearney, A. (2011), "Opportunities for High Performance Work Practices (HPWPs) to Improve Quality of Care", Health Innovation Program Seminar, University of Wisconsin, 24 October.

McCarthy, D. et al. (2009), "Mayo Clinic: Multidisciplinary Teamwork, Physician-Led Governance, and Patient-Centered Culture Drive World-Class Health Care", Commonwealth Fund.

McKinsey & Company (2009), *Achieving World Class Productivity in the NHS 2009/10 – 2013/14: Detailing the size of the opportunity*, Department of Health.

Medical Education England (2012), "Chair of the Independent Review of the Shape of Training appointed", Press release, 28 February.

Milisen, K., Abraham, I., Siebens, K., Darras, E. and Dierckx de Casterlé, B. (2006), "Work environment and workforce problems: a cross-sectional questionnaire survey of hospital nurses in Belgium", *International Journal of Nursing Studies*, Vol. 43:6.

Moreforless.reform.co.uk.

Mountford, J. and C. Webb (2009), "When clinicians lead", *McKinsey Quarterly*.

Mulley, A. et al. (2012), *Patients' preferences matter: Stop the silent misdiagnosis*, The King's Fund.

National Audit Office (2007), *Pay Modernisation: A new contract for NHS consultants in England*.

National Audit Office (2008), *NHS Pay Modernisation: New Contracts for General Practice Services in England*.

National Audit Office (2009), *NHS Pay Modernisation in England: Agenda for Change*.

National Audit Office (2011), *Management of NHS hospital productivity*.

National Primary Care Research and Development Centre (2007), *What should happen to the Quality and Outcomes Framework?*.

NHS Confederation (2011), *Efficiency in mental health services: supporting improvements in the acute care path*.

NHS East Midlands (2011), *Workforce and Education Investment Plan 2011/2012*.

NHS East of England (2011), *Multi-Professional Education and Training Investment Plan 2011/14*.

NHS Employers (2010), *NHS employers submission to the pay review body on doctors' and dentists' remuneration on the review of clinical excellence and distinction award schemes for NHS consultants*.

NHS Institute for Innovation and Improvement website, *Quality and Service Improvement Tools: Role Redesign*,www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/role_redesign.html. Accessed October 2012.

NHS North West (2012), "Salford Royal NHS Foundation Trust: Clinical leaders development programme", eWin Good Practice Case Study.

NHS Pay Review Body (2012), *Twenty-Sixth Report*.

Nursing and Care Quality Forum (2012), Letter to the Prime Minister, 18 May.

Nursing Times (2012), "Nurse ratios to be published by Trusts for first time", 26 June.

OECD (2011), *Health data*.

OECD (2011), *Remuneration of doctors (general practitioners and specialists)*.

Office for National Statistics (2010), *Public Service Output, Inputs and Productivity: Healthcare*.

Office for National Statistics (2010), *Statistical bulletin*.

Office for National Statistics (2011), *Public Service Output, Input and Productivity: Healthcare*.

Office for National Statistics (2012), *Sickness Absence in the Labour Market- 2012*.

OnMedica (2011), *Primary and secondary care relationships*.

Paice, E. and Smith, C. (2009), "Bullying of trainee doctors is a patient safety issue", *The Clinical Teacher*, Vol. 6:1.

Parliamentary and Health Service Ombudsman (2011), *Care and compassion?*.

Paulus, R., Davis, K. and Steele, G. (2008), "Continuous Innovation in Health Care: Implications of the Geisinger Experience", *Health Affairs*, Vol. 27:5.

Picker Institute (2012), *NHS Staff Survey 2011*.

Porter, M. (2010), "What is value in healthcare?", *New England Journal of Medicine*, Vol. 363.

Powell, L. (2011), "Bullying: common in healthcare", *Student BMJ*, Vol. 19:d1514.

Prime Minister's Commission on the Future of Nursing and Midwifery in England (2010), *Front line care*.

Pruitt, S. (2005), "Preparing the 21st century global healthcare workforce"*, British Medical Journal,* Vol. 330:637.

Public Accounts Select Committee (2012), *Department of Health: Securing the future financial sustainability of the NHS*

Public Accounts Select Committee (2008), *NHS Pay Modernisation: New contracts for General Practice services in England*.

Pulse (2008), "Revalidation will damage morale, GPs believe", 18 August.

Reform study visit to Salford Royal, 24 August 2012.

Robinson, P., and Tyndale-Biscoe, J. (2011), *What makes a top hospital?*, CHKS.

Royal College of General Practitioners (2012). *Medical generalism: Why expertise in whole person medicine matters*.

Royal College of Nursing (2007), *The regulation of health care support workers*.

Royal College of Physicians (2005), *Doctors in society*.

Royal College of Physicians (2011), *Census of consultant physicians and medical registrars in the UK, 2010: data and commentary*.

Royal College of Surgeons (2012), "Patients misled by inappropriate use of the job title surgeon", 15 July.

Royal College of Surgeons of England (2011), "Select Committee revalidation concerns echo College", RCS Statement, 8 February.

Salford Royal NHS Foundation Trust (2008), *Quality Improvement Strategy 2008-2011*.

Salford Royal NHS Foundation Trust (2012), *Quality Accounts 2011-2012*.

South West Pay, Terms and Conditions Consortium (2012), *Discussion Document: Addressing Pay, Terms and Conditions*.

Speroff, T., Nwosu, S., Greevy, R. et al. (2010), "Organisational culture: variation across hospitals and connection to patient safety climate", *BMJ Quality and Safety*, Vol. 19:6.

Stanton, E. (2012), "Seven habits of emerging medical leaders" Cawston, T. et al. (ed.) *High quality healthcare, Reform*.

Stephenson, J. (2010), "Clinical excellence awards", *BMJ Careers*, 14 April.

Swansen, S. et al. (2010), "Cottage industry to postindustrial care – The revolution in health care delivery", *New England Journal of Medicine, Vol. 362*.

Task Force for Scaling Up Education and Training for Health Workers (2008), *Scaling up, saving lives*.

Taylor, K., George, R. and Hammett, S. (2012), *Primary care: Today and tomorrow: Improving general practice by working differently*, Deloitte Centre for Health Solutions.

Temple, J. (2010), *Time for Training: A Review of the impact of the European Working Time Directive on the quality of training*, Medical Education England.

The Foundation Programme website, foundationprogramme.nhs.uk. Accessed October 2012.

The Guardian (2012), "NHS figures reveal 5,000 fewer nurses since 2010", 21 August.

The Independent (2012), "Health warning over army of NHS 'temps'", 3 September.

The Independent (2012), "Government 'is cutting nursing numbers by stealth'", 14 May.

The Information Centre for Health and Social Care (2008) *Staff Turnover Statistics 2007-2008*.

The Information Centre for Health and Social Care (2012) "Hospital Episodes Statistics", Total Finished Consultant Episodes.

The Information Centre for Health and Social Care (2012), *NHS Staff 2001-2011 Overview*.

The Information Centre for Health and Social Care (2012), *NHS Staff 2011 (Non-medical)*.

The Information Centre for Health and Social Care (2012), *Sickness Absence Rates in the NHS: October-December 2011*.

The Information Centre for Health and Social Care (2012). *NHS Staff 2011 detailed results*.

The King's Fund (2012), *Leadership and engagement for improvement in the NHS*.

The King's Fund (2010), *The 21st-century doctor*: *Understanding the doctors of tomorrow*.

The King's Fund (2011) *The future of leadership and management in the NHS: No more heroes*.

The Mid Staffordshire NHS Foundation Trust Public Inquiry (2011), *Written submissions from Counsel to the Inquiry*.

The Shape of Training website http://www.shapeoftraining.co.uk. Accessed October 2012.

The Sunday Times (2012), "Thousands of doctors face sack", 15 July.

Tooke, J. (2008), *Aspiring to Excellence: Findings and Final Recommendations of the Independent Inquiry into Modernising Medical Careers*.

Van Bogaert, P., Meulemans, H., Clarke, S., Vermeyen, K. and Van de Heyning, P. (2009), "Hospital nurse practice environment, burnout, job outcomes and quality of care: test of a structural equation model", *Journal of Advanced Nursing*, Vol. 65:10.

Walker, V. and Bamford, D. (2011), "An empirical investigation into health sector absenteeism2", *Health Service Management Research*, Vol. 24:3.

Wallace, L. et al. (2012), *Co-creating health: Evaluation of the first phase*, The Health Foundation.

Welton, J. (2007) "Mandatory Hospital Nurse to Patient Staffing Ratios: Time to Take a Different Approach", *The Online Journal of Issues in Nursing*.

White, C. (2012), "Number of 'subconsultant' posts has almost quadrupled in four years", *BMJ Careers*, 16 August.

Winsor, T. (2012), *Independent Review of Police Officer and Staff Remuneration and Conditions*.

World Health Organisation (2005), *Preparing a health care workforce for the 21st century*.

£20.00

Reform
45 Great Peter Street
London
SW1P 3LT

T 020 7799 6699
info@reform.co.uk
www.reform.co.uk

ISBN number 978-1-905730-86-5