

## **CIVITAS: Online Briefing – July 2007**

### **NHS Staff: too many, too fast.**

Following the targets for additional staff set out in the [NHS Plan \(2000\)](#) and later in [Improvement, Expansion and Reform \(2002\)](#), the number of people - both clinical and administrative - employed by the NHS has increased rapidly. There are now over 1.3 million people working in the NHS, a staggering increase of nearly a third since 1999:

<b>Staff Group</b>	<b>1999</b>	<b>2006</b>	<b>Change (absolute)</b>	<b>Change (%)</b>
<b>Total NHS staff</b> <i>(excluding retainers)</i>	<b>1,097,376</b>	<b>1,338,140</b>	<b>240,764</b>	<b>22</b>
<b>All doctors</b>	<b>94,953</b>	<b>126,251</b>	<b>31,298</b>	<b>33</b>
-Consultants	23,321	32,874	9,553	41
-GPs (excluding retainers)	29,987	35,369	5,382	18
<b>All qualified nurses</b>	<b>329,637</b>	<b>398,335</b>	<b>68,698</b>	<b>21</b>
-Nurses, midwives and health visitors	310,142	374,538	64,396	21
-Practice nurses	19,495	23,797	4,302	22
<b>All scientific, therapeutic &amp; technical staff</b>	<b>102,391</b>	<b>134,498</b>	<b>32,107</b>	<b>31</b>
-Allied health professionals*	53,105	67,483	14,378	27
-Other qualified st&t staff	49,286	67,015	17,729	36
<b>Ambulance Staff</b>	14,783	16,176	1,393	9
<b>Support to Clinical Staff</b>	296,619	357,877	61,258	21
<b>NHS infrastructure support</b>	171,205	209,387	38,182	22
-Managers & Senior Managers	24,287	36,751	12,464	51
<b>Other non-medical staff</b>	88,760	96,255	7,495	8

Source: The Information Centre, *NHS Staff 1996-2006, April 2007 (headcount)*

<http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1996--2006>

Extra staff was seen as necessary to properly utilise the extra funding at the NHS' disposal; to increase its capacity, cut waiting times, improve the service and compensate for historic underfunding – estimated at £267bn in the [Wanless Report](#).

Extra weight is given to these arguments by the fact that the number of clinical staff employed in the NHS has typically lagged behind OECD countries in general, and those of comparable development in particular. Indeed, while increases in the number of nurses has enabled the UK to maintain a ratio of nurses to the population comparable to the OECD-27 average of 9.2, *the UK still remains well below the OECD-27 average of 3.2 for the corresponding ratio of practising physicians:*

	Practising Nurses per 1,000 population (Headcount)	
	1999	2005
<b>Australia</b>	10.6	10.4*
<b>Canada</b>	10.1	10.0
<b>France</b>	6.5	7.7
<b>Germany</b>	9.3	9.7
<b>Italy</b>	5.2	7.0
<b>Netherlands</b>	12.7	14.5
<b>Sweden</b>	9.7	10.6*
<b>Switzerland</b>	-	10.7*
<b>United Kingdom</b>	8.3	9.1
<b>United States</b>	7.9	7.9*
<b>OECD-27</b>	8.1	9.2

\*2004 figure

Source: OECD, OECD Health Data 2007

[http://www.oecd.org/document/16/0,2340,en\\_2649\\_37407\\_2085200\\_1\\_1\\_1\\_37407,00.html](http://www.oecd.org/document/16/0,2340,en_2649_37407_2085200_1_1_1_37407,00.html)

	Practising Physicians per 1,000 population (Headcount)	
	1999	2005
<b>Australia</b>	2.4	2.7*
<b>Canada</b>	2.1	2.2
<b>France</b>	3.3	3.4
<b>Germany</b>	3.2	3.4
<b>Italy</b>	4.2	3.8
<b>Netherlands</b>	3.1	3.7
<b>Sweden</b>	3	3.4*
<b>Switzerland</b>	3.4	3.8
<b>United Kingdom</b>	1.9	2.4
<b>United States</b>	2.2	2.4
<b>OECD-27</b>	2.9	3.2

\*2004 figure

Source: OECD, OECD Health Data 2007

[http://www.oecd.org/document/16/0,2340,en\\_2649\\_37407\\_2085200\\_1\\_1\\_1\\_37407,00.html](http://www.oecd.org/document/16/0,2340,en_2649_37407_2085200_1_1_1_37407,00.html)

This might imply that yet more doctors are needed in the NHS, particularly given that [OECD work](#) suggests, with other things equal, the number of physicians per capita is inversely associated with avoidable mortality. Added to this is the fact that increased female participation and the EU Working-Time Directive (both associated with working fewer hours), has meant that the overall supply of physicians in the UK has had to increase purely for the same amount of 'physician hours' to be provided. The average number of hours worked by full-time physicians in the UK fell substantially from 57.2 hours in 1992 to 51.3 in 2001, according to the [OECD](#).

### **Not so fast**

Nonetheless, there is a good case to be made that the NHS is now living beyond its means and employing too many staff, when efficiency gains would have been more desirable.

Significantly, the rate of growth in the NHS workforce far exceeded the targets and projections laid out in the [NHS Plan](#) for most groups, and *by an astonishing 340% in the case of nurses*:

<b>Staff Group</b>	<b>Projected new staff: 1999-2004 (NHS Plan)</b>	<b>Actual new staff: 1999-2004</b>	<b>Variance</b>
<i>Consultants</i>	7,500	7,329	-3%
<i>GPs</i>	2,000	4,098	+105%
<i>Nurses</i>	20,000	67,878	+340%
<i>Allied Health Professionals</i>	6,500	11,039	+69%

Source: House of Commons - Health Committee, *Workforce Planning, 2007*

<http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/171/171i.pdf>

This bears no small relation to poor planning on the part of the DH, in the sense that:

*‘...in 2001 the DH had issued workforce expansion targets that would have increased the size of the NHS workforce in headcount terms by almost 120,000 people by 2008. At the same time, the financial settlement arising for the DH from the Spending Review settlement was sufficient to fund workforce growth about two and a half times greater than this’.*

John Sargent, former CEO of Greater Manchester WDC  
House of Commons Health Committee, Workforce Planning, March 2007

As we have seen, this disproportionate workforce growth is exactly what happened, yet – as will be argued – it often hasn’t made much sense either in terms of patient care or for NHS organisations’ finances. To take one initial example, the [Healthcare Commission](#) has found that it is the quality of nursing matters more than quantity:

*‘Employing more experienced and skilled staff, as apposed to simply more staff, has the more positive influence on the experience of the patient...spending more per staff member therefore represents better value for money’.*

Healthcare Commission, Ward Staffing, June 2005

It’s not that the numbers laid down in the [NHS Plan](#) should have been sacrosanct, but with a wealth of extra cash it has more often than not proved much easier for NHS to engage in what the think-tank [Reform](#) have termed ‘human resource planning by silo’ – in essence throwing new staff into the task of meeting government targets – rather than making efficiency improvements. As a result:

### **Little attention was paid to long-term costs when expanding the workforce.**

A recent [report](#) by the House of Commons Health Committee revealed an alarming lack of integration between workforce planning and financial planning, describing ‘shocking examples of failures at the local level...[and] national level...[with] workforce and financial planning done by separate teams in separate places with little done to bring the two processes together’ (p.50).

Given that around 70% of NHS funding goes on staffing, this is worrying to say the least. Indeed, there is a general consensus that *“the overshooting of workforce growth targets was a major cause of the deficits that emerged in the NHS from 2004-5 onwards, which have in turn driven the sudden downturn in workforce size.”* ([HC, 2007](#))

There now appear to be job cuts at the same time as recruitment drives; the latest statistics on public sector employment released by the [ONS](#) reveal that employment in the NHS actually fell by an estimated 9,000 between 2006 (Q1) and 2007 (Q1). SHAs have also begun to cut training commissions and reports of medical unemployment are rife. Figures released by the [Department of Health](#) in July 2007 show that of the c.9,000 nurses that qualified between May-September 2005, only 69% were employed in the NHS 6 months later. Physiotherapists had it even worse, with 52% left *unemployed*.

### **Inadequate attention was paid to getting the best staff mix.**

Demand still significantly exceeds supply in some specialities, which, with the fact that staff are now being laid off, suggests that expansion has not occurred in the right areas. This is particularly acute in the case of midwifery. For example, a survey by the Royal College of Midwives in May 2007 revealed that three-quarters of Heads of Midwifery considered that they did not have the staffing levels needed to cope with the number of births, which has increased by 12.5% since 2001. This is supported by statistics available in the Statistical Analysis of the Register, which shows that the number of working midwife hours per week has actually fallen:

	Number of working midwife hours per week			
	1994	2004	Change	% change 1994 - 2004
<b>Total hours per week</b>	1,103,693	952,943	-150,750	-13.7%

Source: Bosanquet et. al., *Staffing and human resources in the NHS – facing up to the reform agenda*, Reform, April 2006

<http://www.reform.co.uk/filestore/pdf/Staffing%20and%20human%20resources%20in%20the%20NHS,%20Reform,%202006.pdf>

A [recent report](#) by King's College London has shown one effect of this: that maternity support staff in numerous hospitals carried out work they were not trained to do, and that midwives should have been doing.

Studies have also found shortages in the number of radiologists, radiographers and *specialist* nurses (for example see: [Dodwell et al., 2006](#); [Reform, 2005](#); [CPG, 2005](#)) and there is evidence to suggest that the current trend of job reductions *has ignored future service and*

workforce requirements. For example a number of specialist breast cancer nursing posts had been frozen, in spite of recent demand for breast cancer services' ([HC, 2007](#)).

Temporary nursing is another case in point. The [Healthcare Commission](#) has shown that a higher proportion of registered (i.e. higher grade) nurses vis-à-vis temporary nurses is associated with higher patient turnover on medical wards, lower incidence of pressure ulcers, lower numbers of accidents and incidents, less sickness absence and more satisfied patients. The [NAO](#) has also identified potential savings of between £25m and £50m through Trusts merely improving their management of demand for temporary nursing staff. Yet the NHS continues to spend increasing amounts on temporary nursing:

	1999/2000	2004/05	% increase
<i>Expenditure on temporary nursing (£million)</i>	795	1,098	38%

Source: House of Commons – Public Accounts Committee, DH: *Improving the use of temporary nursing staff in NHS acute and foundation trusts*, June 2007

<http://www.publications.parliament.uk/pa/cm200607/cmselect/cmpublicacc/142/142.pdf>

### **Little attention was paid to getting the best out of NHS staff.**

Massive pay increases were given to hospital doctors and GPs even before new contracts were introduced for them, in 2003 and 2004 respectively, that attempt to link pay to performance:<sup>1</sup>

	Average earnings			
	2001/02	2003/04	2005/06	% increase 2001/02 – 2005/06
<b>GPs</b>	56,510	72,752	95,350	69%
<b>Consultants</b>	86,746*	99,168	109,974	28%**

\*figure for 2002/03

\*\*figure for 2002/03 – 2005/06

Source: House of Commons - Health Committee, *Workforce Planning*, 2007

<http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/171/171i.pdf>

<sup>1</sup> Nurses also received above inflation increases in pay, before the Agenda for Change agreement was phased in during 2005/06, which aims to provide 'equal pay for equal value'. The DH estimates that 33% of the extra funding given to the NHS since 2000 has gone on pay increases.

The effectiveness of these contracts, and Agenda for Change (that covered all other NHS staff, except managers), is also under intense scrutiny. The DH estimates that the pay reforms themselves have cost some £540m more than expected in 2004/05 alone. This can be attributed in no small means to:

- a. Local managers negotiating higher than expected numbers of programmed activities and higher on-call availability supplements for consultant contracts ([NAO, 2007](#));
- b. The DH overestimating how challenging the targets set out in the Quality and Outcomes Framework (QOF) for GP practices would be. The fact that practices received an average of 91% of QOF points in the first year of the contract's operation resulted in larger than expected bonus payouts ([HoC, 2007](#)).
- c. Managers rushing contract negotiations through, under pressure from the DH to change to the new systems ([NAO, 2007](#), [King's Fund, 2007](#)).

Both contracts have also been criticised for actually causing a fall in activity. For example, surveys conducted by the National Primary Care Research and Development Centre at Manchester University revealed that GPs on average reported a four-hour reduction in their working week, with a £15,000 increase in pay. This is supported by results of the GPs' Workload Survey, trailed by the [Sunday Times](#), which will reveal that GPs are now working on average about 15% less hours since 1992 despite being paid nearly 25% more.

With regard to the consultant contract, the [NAO](#) concluded in a recent report that: 'there is little evidence that ways of working have been changed...[and] few trusts have used job planning as a lever for improving participation or productivity'. A similar point was made by the [King's Fund](#) concerning Agenda for Change: 'For some NHS trust managers, transferring staff to the new system became an end in itself rather than a way to achieve the longer term benefits of treating patients more quickly and providing a higher quality of care'. It concluded: 'there are few signs yet that it has delivered increased productivity'. On both contracts, it seems as though NHS organisations assumed that simply paying consultants and nurses more would cause them to become more efficient.

### **What has gone wrong?**

The blame for much of the above criticism has often been laid at the feet of managers. Certainly management in the NHS is far from perfect – while there are some very good managers, there are equally some that are bad, and as the [NHS Confederation](#) have written, there is 'much more concern about the quality of middle management'. Middle management

has also been attacked by other commentators for being excessively bloated (e.g. [Sikora, K. April 2006](#)). That the number of managers at all levels has increased at over double the rate of clinical staff since 2000 has made resentment worse; vitriolic attacks from the media and others, are far from uncommon (e.g. [The Sun, 2003](#)). There is some academic weight behind this too: in a pamphlet for the [Centre for Policy Studies](#), Dr Maurice Slevin reported that the ratio of managers to nurses was four times higher in the NHS than in a comparative private hospital – suggesting the increase in management has been folly.

Yet, it would be equally folly to rile managers without considering the system they are working in. The fact is that managers and administrators are necessary. But in the NHS managers, administrators and staff as a whole have tended to increase for the wrong reasons and in the wrong places: to meet the latest government targets (the NHS Plan alone laid out some 121 targets and objectives) and central direction, rather than to add value to patient care.

As Gerry Robinson writes in his introduction to the recent [NHS Confederation report](#): ‘there has never been a clear message from the centre about the role of management – to lead an organisation, not to administer it’. Hence we need to look at why NHS organisations, for example, prioritised just getting consultants onto the new contracts without considering intended benefits. Here we should recognise that it was the DH that negotiated the form of the contract, under-estimated the costs of them, and offered guidance to NHS organisations implementing it that was often issued late, lacked clarity and was rushed ([NAO, 2007](#)). In such an environment the result is less surprising.

The same reasoning can be applied across the NHS – pressures to meet an explosion of central direction has forced managers to focus on targets and financial pressures, creating an upward-looking service with short-term goals, rather than one which is truly patient-focused and able to match supply and demand ([NHS Confed, 2007](#)).

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