

Training our NHS Health Workers

Should the UK train more of its staff?

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Summary

This report aims to inform upon, and investigate, the current training policy for healthcare assistants, nurses and doctors in the UK. It explores increasing reliance on overseas recruitment and the high use of agency and locum practitioners. The NHS's present high utilisation of overseas trained health workers, it is argued, may reduce service quality and patient safety in the UK. Overseas recruitment also has an extremely harmful effect on healthcare provision in the often poorer, developing countries from which these health care professionals are recruited.

The report further contends that the current number of staff being trained by the NHS is inadequate. Also, that fears of possible unemployment amongst medical professionals, were training to be increased, are unjustified. The report holds that an increased number of UK trained staff might in fact bring increased competition for posts and thereby help fill persistent vacancies in less desirable specialities and in more remote locations around the country. Such an increase of trained personnel could also ensure that the NHS is not 'held to ransom' by some staff refusing to accept permanent NHS contracts, opting instead to work for agencies or adopting locum shift patterns at inflated rates of pay. The report proposes that, should NHS training places be increased, it could be stipulated that, in recognition of taxpayer funding, newly qualified staff must work for a set period within NHS institutions before being free to seek employment elsewhere. The NHS currently spends around £2.5 billion employing temporary staff each year. The report suggests that allocating even a proportion of this sum to the training of UK based permanent staff would in fact save money, as the resultant increased competition for NHS posts would cause healthcare professionals to feel less secure in working for agencies, and thus seek permanent positions as demand for temporary staff is reduced.

Introduction

The UK's patient demographic is changing fast. Ever more patients are presenting with chronic illness, and multiple comorbidities;¹ often, ironically due to the increasing success of earlier interventions (meaning that patients who survive with one ailment get a second, third, or more) and a generally ageing population.² To cope with this increased demand, the NHS's reliance on the recruitment of staff from overseas has been described as a 'band aid' covering the major problem of understaffing which has been exacerbated by a chronic shortage of staff training in the UK.³ The NHS is consequently using proportionally more agency staff and locum doctors, year on year.⁴ This report will examine the current training of NHS staff and suggest how this might be bolstered as part of an effort to improve care quality and efficiency. This report looks at three representative specialties in our healthcare workforce. Within the lower pay bracket, and with the least time required for training, are health and social care assistants; also known as nursing auxiliaries or auxiliary nurses (in this report we shall call all staff at this level healthcare assistants). This group may receive from only a few hours, to several weeks of training before beginning to deliver unsupervised patient care. In the middle pay bracket are qualified nurses who complete a three year degree course implying that they are highly qualified and able undertake many of the key responsibilities of patient care. In the highest pay bracket are doctors who must undertake an extremely long period of formal education which continues until consultant level is reached. Staff of all levels of experience must periodically pass competency tests.

It is apposite, for the purposes of this report, to investigate whether we are training and incentivising our workforce sufficiently and whether we are encouraging them to go into those specialties that are currently short of staff, such as is the case with GPs⁵ and A&E; where currently one in every five emergency medicine consultant posts are vacant.⁶ Studies show that patients are eight per cent more likely to die on wards where fewer nurses are working and 10 per cent more likely to die if there are more HCA's on duty than registered nurses.⁷ Questions need to be asked as to whether the NHS is therefore training enough appropriate level staff to maintain sustainable, safe healthcare.

Healthcare assistants

About

The institution of a universal, mandatory training programme for staff at healthcare assistant level has been advocated by stakeholders such as the Royal College of Nursing for many years.⁸ Healthcare assistants undertake duties such as washing and dressing patients, serving meals, helping people eat and be mobile, taking them to the toilet and making their beds, as well as monitoring patient condition; for example by regularly recording temperature, pulse and respiration rates.⁹ Indeed this group currently provide around 60 per cent of hands-on-care.¹⁰ The work this group does is essential therefore to patient safety and wellbeing and thus it comes as little surprise that the Willis Commission concluded its report of 2012 by declaring that it was 'unacceptable that staff whose competence is not regulated or monitored are caring for vulnerable citizens, notwithstanding the significant challenges involved'.¹¹ This observation was made all the more relevant by the subsequent review of the failings of Mid-Staffordshire NHS Foundation Trust.¹² Together these conclusions provoked ministers to commission the Cavendish Review which was published in July 2013.

The Cavendish review

The Cavendish Review, directed by the former *Times*' associate editor - Camilla Cavendish, aimed to advocate a possible training structure capable of linking that of healthcare assistants to that of nurses, so that all members of healthcare teams would be 'speaking the same language'.¹³ Currently there exists no compulsory training for healthcare assistants; each provider implements their own programmes, often leading to a costly duplication of training procedures.¹⁴ A wide variety of job titles for these auxiliary roles also exists; with a resultant confusion for patients which might both affect their safety and make them feel ill at ease. Current ambiguities regarding job responsibility and appropriate training also cause registered nurses significant anxiety (due to their being unsure of what tasks might be appropriately designated to auxiliaries)¹⁵ and severely limits career progression opportunities for healthcare assistants themselves as it is at present impossible to be simply 'promoted' into nursing.¹⁶ The Cavendish Review stresses the need for healthcare assistants to see caring as a career (rather than simply as a temporary job), with conscientious auxiliary staff being able to progress into therapy, social work and registered nursing if they so wish. It seemed therefore obvious that action

needed to be taken to prevent the current high turnover rates of healthcare assistant level employees.¹⁷ The Review proposed the introduction of a 'Certificate of Fundamental Care': a centrally approved, universally accepted, mandatory training course and qualification, providing all essential and appropriate skills for this work group.¹⁸

Following the review

The Cavendish Review has led to the instigation of a collaborative project by *Health Education England, Skills for Care* and *Skills for Health* with the purpose of developing what is termed a 'Care Certificate'.¹⁹ A draft for this was completed before the spring of 2014,²⁰ and it was originally tested as a pilot within 29 organisations across both the health and social care sectors. A further 85 employers have tested the certificate since.²¹ To obtain it, newly employed healthcare assistants have twelve weeks from the start of their employment to complete all 15 key 'standards' including those for 'duty of care', 'fluids and nutrition' and 'privacy and dignity'.²² This new certificate will replace the existing 'Common Induction Standards' and 'National Minimum Training Standards'²³ and will come into effect in April 2015.²⁴ It will become 'a key component of the overall induction which every employer must legally provide' in order to meet the required standards set by the Care Quality Commission (CQC).²⁵ There are high hopes that the introduction of the Care Certificate will lead to improved standards and homogeneity in the quality of care across the entire NHS. However, concerns have been raised in relation to the fact that individual providers will deliver the Care Certificate courses 'in house', themselves. This implies that 'standards are not in any way being accredited or assured'.²⁶ An additional 'Shape of Caring Review' released by NHS Education England in March 2015 contains a blueprint for future training emphases, relevant for nurses and healthcare assistants.²⁷ The report emphasises the importance of flexibility in workforce training and enhancing work based routes for professional development. It advocates making it easier for healthcare assistants to gain extra qualifications and move up payment bands, as well as facilitating their advancement into nursing if they so wish.²⁸

It seems likely that the new Care Certificate will enhance care for patients, enable nurses to feel confident about which tasks to delegate to healthcare assistants and ensure that they themselves feel confident in their work and have potential to advance in their careers over time, improving their motivation. Improvements inside

this workforce, with such regular and intimate contact with patients, are likely to rapidly translate into better quality healthcare across the system.

Nurses

About

There are currently many more people wishing to train as nurses than can be accepted; 54,000 applications for only around 20,000 places.²⁹ At present, those wishing to become nurses must complete a three year degree in one of four branches of nursing specialisation: adult, child, learning disability or mental health. It is sometimes possible to combine two of these specialities in a four year course.³⁰ Once the degree is completed nurses register with the Nursing and Midwifery Council and can then take a nursing post.³¹ Recently, attention has been paid to both the high numbers of nurses from overseas being recruited by the NHS,³² and the large numbers of agency staff being used in the many wards finding themselves dangerously short staffed.³³

Recruitment from overseas

Nurses and midwives trained abroad currently make up around 10 per cent of the total workforce.³⁴ Providers are increasingly recruiting from abroad, for example Addenbrooke's Hospital has recruited 185 staff members from overseas since the start of 2014,³⁵ with a further 100 recruits starting this month; 72 of these come from Asia, commonly from the Philippines.³⁶ Many other hospitals recruit large proportions of their staff from overseas, however not often on such a scale as does Addenbrooke's. Currently, Mid Yorkshire Hospitals NHS Trust is seeking to recruit 50 nurses from Spain and 70 from India.³⁷ The Department of Health defends this practice by claiming that despite overseas recruitment, in the past 5 years the proportion of British staff working for the NHS has increased from 88.9 per cent to 89.1 per cent.³⁸ Assessments of the quality of non-EU trained staff are now being made by computer based exams, replacing former three month supervised probationary periods. These latter were deemed to cause difficulties for employers who need to recruit urgently needed personnel quickly. In principle, overseas recruitment should not affect British people obtaining nursing posts, as the system for non-EU workers only allows them to enter the country when there is a vacant position that needs filling.³⁹ However it is claimed that NHS recruitment trips abroad cost significant amounts of money and are often unsuccessful, with one in

four such recruited nurses returning home in less than a year (and some trusts losing the majority within the year).⁴⁰ Some recruitment trips can fail to attract anyone, despite being made as far away as India, involving up to 8 members of staff, and costing as much as £100,000.⁴¹ These trips are increasing in number year on year with many trusts permitting staff to stay in five star hotels at taxpayers' expense and paying substantial fees to overseas recruitment agencies.⁴² The cost to the NHS of recruiting foreigners has been put at the very least at over £70 million a year, despite many remaining less than six months.⁴³

Agency staff

By the end of this year NHS trusts will have spent around £1 billion on agency staff.⁴⁴ In a survey of 168 responding trusts, the Royal College of Nursing (RCN) found spending on agency staff has risen from £270 million in 2012-13, to £485 million the following year, and to £714 million in 2014-15.⁴⁵ If the same level of spending was estimated as applying to non-participating trusts the total would amount to £980 million.⁴⁶ This figure is deemed to be sufficient for the employment of over 28,000 new full-time-equivalent nursing staff, both senior and junior with varying specialist skills.⁴⁷ Other estimates, which include the cost of other non-permanent staff such as locum doctors, have put combined fees for temporary staff at £2.5 billion.⁴⁸ Increased efficiency drives have been called for in NHS England's '5 Year Forward View' review, and thus it is imperative that such wasteful spending cannot continue.⁴⁹ The RCN has blamed this monumental increase in spending on temporary staff as being the result of a 'payday loan attitude towards workforce planning' and a failure to think in the long term when planning staff cuts.⁵⁰

Training numbers

The Department of Health has claimed that there are nearly 8,000 more permanent nurses employed in the NHS since the Coalition came into power in 2010.⁵¹ Nevertheless, in the 5 years since, nursing training places have been cut steadily. In 2010-11 there were 25,904 places on nursing degree courses in the UK. By 2012-13 this had decreased by 13.6 per cent to 21,529;⁵² a worrying trend given that almost half (45 per cent) of nurses in England, Northern Ireland and Scotland (where data is available) are over the age of 45 and approaching retirement.⁵³ As the RCN very accurately puts it: (the cuts) 'put... short term monetary concerns above the health needs of the population'. The UK currently has a rapidly growing healthcare demand, the result of an ageing population, and thus cannot afford to have its supply line of NHS staff 'choked off'.⁵⁴ Many of the major political parties

are promising increased provision for the training of nurses (for example, Labour's Ed Miliband has promised that over 10,000 new nurses will be employed over the term of his mandate).⁵⁵ The increase of 827 pre-registered nurse training places (see figure 1.) promised by the Coalition to be offered in the 2015/16 year (a four per cent increase) has been described as only playing 'catch up' when compared to the rapidly increasing demand for services.⁵⁶ We currently have a total of only 20,033 nurse training places in the country and this proposed increase is not nearly enough to tackle the scale of current staffing shortages.⁵⁷ School nursing will also be given a boost in the coming year by the allocation of 142 new training places (a rise of 70 per cent); due to this speciality having an extremely high vacancy rate.⁵⁸

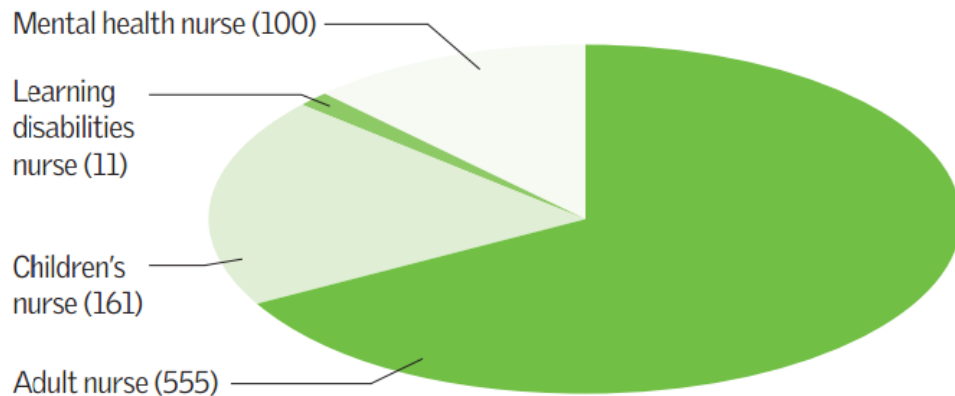


Figure 1. The new training places across England by branch⁵⁹

Health Education England wisely emphasises the need to invest in current staff (in order to retain and develop existing health workers) and attempts to attract previously fully trained staff who have left back into NHS employment. It maintains that this strategy is much less costly than that of recruiting abroad or engaging locums and can alleviate short staffing crises more rapidly.⁶⁰

Training reforms

Criticism has been raised against current nursing training as regards its suggested neglect of the caring and compassionate - 'one on one' - aspects of the role. This concern led, in 2013, to the proposal of a mandatory year of employment as a healthcare assistant before candidates would be allowed to begin nurse training programmes.⁶¹ However, this suggestion has proved unpopular with many stakeholders and has not been introduced by the present government. In fact, the NHS's current system of nursing education has remained relatively unchanged for

25 years.⁶² There have consequently been concerns that nurses are not now receiving the depth and breadth of modern technical knowledge that they require, regardless of specialisation. To remedy this, it is possible that in the near future nurses may receive a longer generic foundation programme of two years before specialising in one of the four divisions mentioned earlier for their final year of training.⁶³ In addition, a compulsory year of preceptorship (guidance by a registered nurse who has been given the formal responsibility of supporting a newly qualified nurse in order to enhance their competence and confidence)⁶⁴ might be introduced before newly trained nurses would assume autonomous responsibility in their duties.⁶⁵

Doctors

About

Currently to become a doctor you need to undertake a five or six year undergraduate degree course, or an accelerated (normally 4 year) graduate course.⁶⁶ When this initial study has been completed, students embark on a two year Foundation Training programme during which they are employed in a broad range of clinical settings for the first year, narrowing to four chosen three month placements in the second.⁶⁷ Doctors are paid during their foundation years (around £23,000 for year one (F1) and £28,000 for year two (F2)). On completion of their foundation training new doctors are expected to either choose which speciality training they wish to pursue or enter general practice (GP) training. Admission to both speciality and GP training programmes is competitive and lasts three years for general practice and five to seven years for other specialities (depending on how quickly doctors wish to work through the required 'competencies').⁶⁸ Once these specialist programmes have been completed, doctors may apply for consultant posts or become a fully qualified GP (see figure 2). However, with obtaining these posts, full responsibility for the welfare of each patient is transferred to them.⁶⁹ All doctors must also, regularly, be revalidated in order to demonstrate that they are up to date with their colleagues and are fit to practice. This costs the taxpayer over £97 million per year and has been criticised due to being estimated to prevent a mere 0.75 per cent of cases of death, severe harm or moderate harm per year.⁷⁰ In summary, 'doctors' refer to all those who have qualified from medical school; after

this, to become a GP or a specialist, individuals must complete a long series of postgraduate training, relevant to their intended area of expertise.

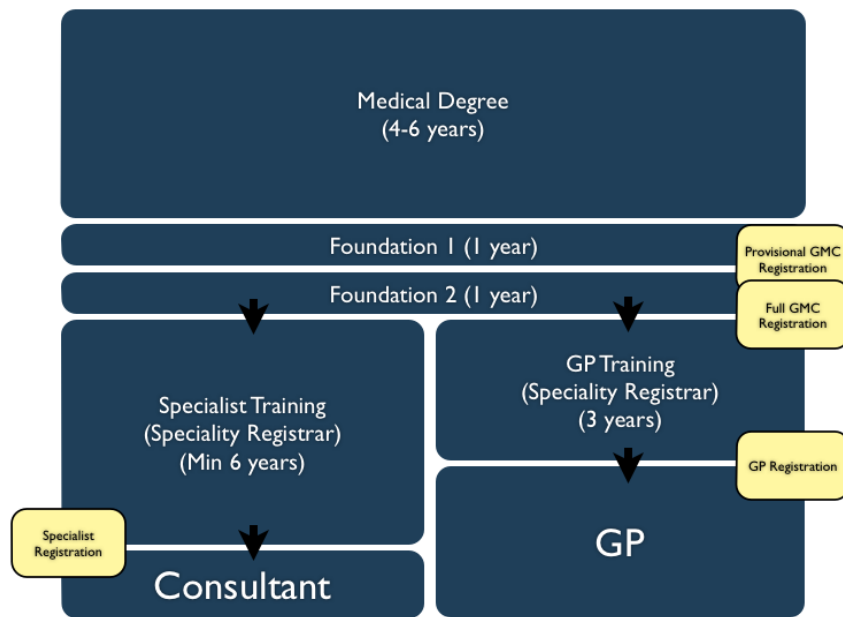


Figure 2. Diagram of medical training options in the UK. Training is competency based and so often takes longer than the minimum times displayed. Training can also be extended by means of research fellowships, or by training in dual specialities.

Training numbers

At present, there are not enough trained doctors to fill vacancies. For example, Northern Lincolnshire and Goole Hospital Trust currently requires around 83 doctors.⁷¹ Surprisingly, the Department of Health recommended in 2012 that fewer students should be admitted to medical schools from the following year to avoid ‘a glut of NHS consultants in the future, which would, it held, be a waste of taxpayers’ money’.⁷² The Department therefore reduced medical school intake from 6195 places in 2012 by 124 places in both 2013 and 2014.⁷³ This was justified as an attempt to ensure that the UK does not finance doctors through medical school only, despite the evidence, to have no jobs for them at the end of their training. At present there are around 82,500 applications for these few places at British Medical Schools. As a consequence, overseas medical student numbers have been limited to only 7.5 per cent of admissions⁷⁴ and some medical schools do not offer places to those overseas students whose countries of origin can offer first degree courses in medicine.⁷⁵ It may be true that recently there has been a

'scramble' to find sufficient junior doctor posts to accommodate all those graduating from medical schools,⁷⁶ but subsequent to this initial career stage there seemingly exists plentiful vacancies throughout the NHS. Although the British Medical Association (BMA) has voiced fears of possible medical unemployment in the future, government figures suggest the need for 27,000 more doctors by 2025,⁷⁷ the high and growing levels of recruitment from overseas⁷⁸, soaring employment of locum doctors⁷⁹ and the projected growth in demand for healthcare in the UK⁸⁰, all suggest that doctors are and will be in short supply. There also exists a mismatch between the 6,071 places English Universities were allowed to offer for medical training in 2013-14 and the 13,000 doctors the General Medical Council (GMC) registers each year, a lacuna probably presently filled by overseas trained staff.⁸¹ To perhaps make matters worse, budgets are presently being cut for postgraduate medical training (e.g. for junior doctors) with larger specialities such as general surgery or trauma and orthopaedics being hardest hit as compared to smaller reductions in training budgets for obstetrics or gynaecology.⁸² Nevertheless, it must be acknowledged that as a whole the NHS has been steadily employing more doctors year on year, for example as compared with 2002 there are now, on average, 49 per cent more doctors in any given speciality. In the case of A&E, which often struggles to recruit staff, the increase is now 77 per cent.⁸³ Although this sounds an obvious improvement, as far as UK training is concerned, it is highly likely that many of these additional qualified doctors have been recruited overseas.

The use of overseas doctors

In point of fact 3,000 doctors in the past year have been recruited from overseas and⁸⁴ currently 26 per cent of NHS doctors are foreign nationals,⁸⁵ coming from a multitude of countries both inside and outside the EU. Dr David Rosser, medical director of Birmingham University Hospitals, states that 'we aren't training enough doctors in the country so we are dependent on foreign trained doctors' and it seems obvious that poor future workforce planning has caused the current mismatch of training to demand.⁸⁶ Sadly, recent tightening of visa rules means that many doctors recruited from abroad find it hard to stay in Britain long enough to complete advanced training (often a reason for wishing to work in the UK).⁸⁷ These overseas doctors, who used to make up an integral part of the NHS's workforce, now rapidly move on to other countries where they can be certain of being able to train to consultant level. Concerns have also been raised regarding the performance of foreign trained doctors as compared to those trained in the UK. 63

per cent of the 669 doctors who were struck off or suspended from their posts in 2012 had been trained overseas, a great overrepresentation compared to the proportion they make up of the workforce (26 per cent).⁸⁸ Additionally, a British Medical Journal (BMJ) study by researchers at Durham University investigating 53,436 UK based trainee doctors found that foreign trained medical graduates who had passed the required Professional and Linguistic Assessments Board (PLAB) examination in order to gain registration in England, performed worse in their Annual Review of Competence Progression (ARCP) than did UK graduates, even after positive adjustment for sex, age, years of UK practice, and ethnicity had been made.⁸⁹ It has been proposed therefore that the pass mark for the PLAB exam should be raised from 63 per cent to 76 per cent to ensure the competence of overseas trained doctors.⁹⁰

Locum doctors

As is the case with nurses, there are difficulties in recruiting doctors to permanent posts, with a small but growing number simply choosing to work as locums for fees of up to £1,760 per day, leaving many unfilled permanent posts in less desirable specialities.⁹¹ The fact that some consultants (who cost £400,000 of public money to train) are then leaving the NHS to work on an agency basis for very substantial fees is particularly worrying at a time when the NHS is experiencing a large budget deficit. Understandably the House of Commons' Public Accounts Committee has suggested that a requirement is introduced whereby doctors trained with public money agree to work for the NHS for a set minimum period.⁹²

Training Reforms

An independent review from 2013, 'The Shape of Training', which has received much recent attention, recommends that full doctor registration should be awarded earlier, at the point of graduation from medical school (instead of following the second year of foundation). The report further recommends making speciality training more 'broad based' (in terms of skills learned), and that it should last four to six years instead of six to eight years as is currently the case.⁹³ The purpose of these changes would be to try and enhance care for increasing numbers of elderly patients with chronic and multiple conditions by training more doctors 'capable of providing general care in broad specialities across a range of different settings'.⁹⁴ Such a move could also enhance integrated treatment by enabling doctors to better follow patients through the entire pathway of their care.⁹⁵ The review goes on to recommend that doctors be more comprehensively trained in management

and leadership, skills often required of senior doctors in addition to their involvement in direct patient care. Critics of the review, however, warn that these proposed changes would lead to doctors being awarded 'consultant' status much earlier in their careers, reducing the standard of expertise presently associated with such a title, thereby reducing care quality and patient safety.⁹⁶ There are also concerns to the effect that as it is the role of consultants to train junior doctors, if consultant skills are less developed, this will have a knock-on effect for the subsequent generations of doctors that they teach.⁹⁷ The British Medical Association (BMA) has denounced these proposed changes holding that there is a lack of evidence for any ensuing benefits.⁹⁸ No decision has so far been taken by the Department of Health to implement any of the review's recommendations. The Department states that any proposed changes would only be implemented following a lengthy consultation process.⁹⁹

Female and male mismatch

Another discussion point regarding training for the medical profession concerns the mismatch between males and females accepted onto courses, with currently more females being accepted than males. As young females achieve slightly better grades than males at A-level, and also on average mature earlier, it is thought by some that they might therefore present themselves better to medical school admission committees at the age of 17.¹⁰⁰ At present, 61 per cent of doctors under the age of 30 are female, revealing a possible trend of feminisation amongst UK doctors, a proportion which will advance into older age groups over time.¹⁰¹ Despite the positive implications this phenomenon represents for gender equality in the medical profession, Dame Carol Black, of the Royal College of Physicians, has expressed concern at the much higher numbers of female doctors who choose to enter general practice, as well as the higher numbers working part time. She states that 'the issue is not whether women doctors could do their job properly, but whether they were willing to devote time beyond their clinical responsibilities to activities such as committee work and research'.¹⁰² In relation to the high cost of medical training, Professor J Meirion Thomas, of Imperial College London, argues that such female working patterns do not represent good value for the taxpayer's money.¹⁰³ However, in light of the current 'recruitment crisis' in general practice, some may welcome the fact that increasing numbers of female doctors choose to enter this unpopular field¹⁰⁴ which is perceived to more easily accommodate the domestic responsibilities that many part time female GPs have when not at work. Such responsibilities are not, in general, equally shared by men.¹⁰⁵ However, in

reality, flexible working in GP practice is influenced by each worker's status in the practice and the relationships between partners. Health Education England's GP Taskforce have expressed concerns with female working patterns, stating that 65 per cent of GP's currently in training are women, however 40 per cent of the women leaving general practice each year are under the age of 40, with data not available as to how many re-join the workforce later on.¹⁰⁶

The European Working Time Directive

A final issue said to hamper the efficient training of doctors is that of the European Working Time Directive (EWTD). Its implementation represented one of the largest changes for UK doctors' work and training patterns in several decades,¹⁰⁷ restricting doctors' weekly working hours to 48. This rule has in fact applied to consultants since 1998 (although often disregarded), but for junior doctors it did not come into force until 2009.¹⁰⁸ The Directive makes mandatory a period of 11 hours of continuous rest within each 24 hour working shift. Indeed this is why all NHS shifts are now limited to a maximum of 13 hours and all teaching hospitals have had to ensure their employment conditions for doctors in training comply with the EWTD.¹⁰⁹ Although the Directive was welcomed by most doctors, some, in specialisations requiring the mastery of complex practical procedures, have protested at the harmful impact shortened hours might have on the amount of cases treated by juniors and the consequent reduced opportunities to obtain vital skills.¹¹⁰ New job vacancies and 'rota gaps' have appeared due to the implementation of EWTD during the same period in which trainee numbers have been reduced. This is one reason why locum doctors are being employed ever more frequently.¹¹¹ In a 'free text' opinion survey of nearly 2,500 doctors 11 per cent made unprompted reference to the EWTD, citing its adverse effect on training opportunities and claiming that some hospitals were even persuading junior doctors to collude in the inaccurate reporting of their compliance.¹¹²

Issues for the whole workforce

Staff shortages in emergency care and general practice

As stated in the introduction, A&E departments are finding it increasingly hard to obtain and retain (especially experienced) staff. The number of specialist emergency medicine training post vacancies is huge. At present only half of these vacancies are being filled and this will, it is claimed, eventually result in a 'lost

cohort' of consultants.¹¹³ It is therefore imperative to address training problems in this speciality to avoid a serious lack of senior doctors in emergency medicine in the near future.¹¹⁴ Such a lack would be dangerous. Junior doctors often need to discuss cases with more senior staff before they can make appropriate decisions on how to proceed.¹¹⁵ A lack of senior staff available for consultation might mean that patients requiring rapid intervention were attended more slowly. A favourable ratio of consultants to trainees is also necessary to ensure that a correct diagnosis is reached and that appropriate tests and procedures are conducted. A&E departments are the point where a large number of patients first come into contact with health services even if they are subsequently referred to other parts of the health system.¹¹⁶ Understaffing and inexperience in A&E could lead to bad quality treatment and poor decisions, affecting detrimentally the rest of the health system and wasting money.

In 2014 Health Education England's GP Taskforce concluded without doubt that there is a GP workforce crisis in certain areas.¹¹⁷ Currently only 60-70 per cent of GP training places are filled in some parts of the country,¹¹⁸ in fact, applications for GP training fell by 15 per cent in one year¹¹⁹ and 12 per cent of GP post-training positions remained vacant.¹²⁰ It is also, the taskforce claimed, proving hard to retain many GPs within the specialisation for their whole career. As many in the current GP workforce are approaching retirement age or taking early retirement the situation has become critical, though the extent of staffing issues varies between regions.¹²¹

Safety issues with language barriers and training differences of overseas staff

Cases have come to light where 'language barriers', differences in training, or differences in carrying out standard procedures have resulted in overseas trained staff causing serious harm to patients. Healthcare professionals who are citizens of the European Economic Area (EAA) currently must have their home country qualifications legally recognised in the UK and not therefore be subject to the same stringent language and competency tests as are non-EAA applicants.¹²² In 2008, a German Doctor: Daniel Ubani, killed a Cambridgeshire patient by administering 10 times the appropriate dose of morphine.¹²³ This tragedy occurred after Ubani had failed to be approved to work in Leeds due to his poor English language skills.¹²⁴ He had, he also claimed, managed only a 'few hours' sleep since flying from Germany to Britain the night before the patient's death occurred.¹²⁵ Since this

event, providers have been given the legal responsibility of ensuring that the competence in English of their staff is adequate before offering them employment.¹²⁶ As stated earlier, the higher proportion of doctors struck off or suspended who were trained overseas is of current concern in the UK, language problems often appear as a significant factor in such cases.¹²⁷ New European laws mean that language competence in medical staff will now be checked by external regulators rather than by the employers themselves (presently employers undertake this on a case by case basis, in relation to the work a particular individual is expected to undertake).¹²⁸ A new category of 'fitness to practice' has been implemented by the GMC where 'doctors must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK'.¹²⁹ The GMC has also raised the scores in the International English Language Testing System that doctors must achieve in order to be allowed to practice, and can even require doctors from the EEA to undergo a language assessment if it is thought to be required to assess their fitness to practice; a power they did not enjoy previously.¹³⁰ Nevertheless, under European law, systematic language testing of *all* applicants is still not permissible.¹³¹ However, more stringent language checks for EEA professionals are expected to come into effect by the end of 2015.¹³²

What effect is our overseas recruitment having on the countries involved?

Dr Peter Carter, the RCN's general secretary, has claimed that 'reductions in the numbers of training places, since the coalition government came to power, has led to employers raiding the nursing workforces of poorer countries'.¹³³ Dr Rosser, medical director of Birmingham's university hospitals, neatly reiterates Carter's point when he writes: '(we) get the offer of high-class trainees subsidised by their countries' government and so come at a much lower cost than training our own employees'.¹³⁴ The migration of medical professionals from developing countries to the developed world has huge 'knock on effects'; reducing the resources of the already grossly underfunded and staff depleted health systems of these countries and thus widening the worldwide health and poverty gap that exists between low and high income economies.¹³⁵ Sub-Saharan Africa for example suffers 25 per cent of the global disease burden but has only 3 per cent of the world's healthcare workers.¹³⁶ This region, and other similar developing areas around the globe, cannot afford to lose their trained staff. Economically developing countries waste an estimated \$500 million each year on the education of health workers who

subsequently leave their home countries to work in developed nations.¹³⁷ Four countries: the USA, the UK, Australia and Canada are the principle destinations for these workers, between them employing 72 per cent of foreign trained nursing staff and 69 per cent of foreign trained doctors.¹³⁸ Chronic underinvestment in staff training has been cited as one of the main reasons why developing countries are recruiting from overseas while a lack of career development opportunities, poor remuneration, and poor working environments have been cited as 'push' factors for staff wanting to leaving developing countries.¹³⁹ Efforts to achieve worldwide millennium development goals, such as to have skilled attendants at 80 per cent of births are thereby being hampered.¹⁴⁰ Carter states that 'it is perplexing that on the one hand nursing posts are being cut and training places being reduced, while on the other desperate managers are raiding overseas workforces'.¹⁴¹

It should be recognised however, that some developing countries have been able to turn this 'skill drainage' problem to their advantage. For example the Philippines now trains health workers specifically to 'export' overseas, thereby reaping financial benefits in the form of remittances (money sent back home from workers abroad).¹⁴² Nevertheless, the Philippines is the *only* health-worker-exporting country amongst the top 20 remittance receiving economies in the world (by money received), and is virtually unique in having a surplus of health workers available to export in this way.¹⁴³ By contrast, losses due to skill migration for most developing countries are huge. For example over a 30 year career it is thought that in real terms, Kenya loses \$517,931 for every doctor who emigrates, and \$338,868 for every nurse.¹⁴⁴ By 2011, Sub-Saharan Africa was estimated to have lost \$2.17 billion in terms of its investment in medical staff training while the UK has benefited from recruiting overseas personnel to a value of around \$2.7 billion during the same period.¹⁴⁵ It seems that managers and policy makers are turning a blind eye to the ethical consequences attached to recruiting its workforce from overseas, simply to remedy the urgent understaffing problem that exists in the UK.

Are we training people in the right areas?

As discussed earlier, the future of British healthcare, and indeed of global healthcare will involve planning for the needs of an ageing population; one where people survive a previously fatal or untreatable condition to live on to develop subsequent such conditions. These patients, with high comorbidities, will require a more general and holistic emphasis to their care. Thus it seems obvious that increased numbers of doctors specialising in general medicine and/or geriatrics will

be needed in the near future. Positively, in the most recently released statistics from the Royal College of Physicians, it is seen that Geriatric medicine now represents the largest speciality amongst consultants at over 1,250 practitioners.¹⁴⁶ This speciality also appears to be expanding and to have a relatively young consultant age base.¹⁴⁷ In the future, improved access and speedier access to GPs combined with an increased availability of home visits could ensure that the general public, especially the elderly, will be looked after well *in* the community, preventing diseases progressing to a crisis point where costly complications and emergency admissions to hospital become necessary.

Allied Health Professionals

Allied health professionals (AHPs) are ‘a group of autonomous practitioners who work with many other professionals at many points along the care pathway’.¹⁴⁸ This staff group is sometimes thought to be the ‘key to rescuing the NHS’¹⁴⁹ and improving healthcare generally. There exists a consensus on the necessity of moving healthcare out of hospitals into the community and promoting preventative medicine and the role of the various AHPs is often specifically to aid disease prevention, make diagnoses and provide support and treatment in the community.¹⁵⁰ AHPs are trained as specialists such as chiropodists/podiatrists, dieticians, drama, art and music therapists, occupational therapists, orthoptists, paramedics, physiotherapists, prosthetists, orthotists, radiographers and speech and language therapists. This heterogeneous mix of distinct specialities, each with diverse roles within it, has not been considered in this report due to this discipline fragmentation and the fact that even collectively AHPs total only 6 per cent of NHS staff. A study of them and the effectiveness of their functions can easily provide the content for many reports in itself. Easily accessible information systems to gather data regarding the various roles of AHPs are presently being developed.¹⁵¹ Public Health England has commissioned Sheffield Hallam University to study the impact of AHPs on public health.¹⁵² This detailed investigation, when published, will be very welcome and may well point the way to future effective care pathways within the community.

Conclusion

Do we need greater workforce competition?

As stated earlier, each year NHS trusts spend substantial amounts on the employment of temporary staff. Agency nurses alone are thought to cost almost £1 billion annually (equivalent to the regular employment cost of 28,000 full time equivalent nurses of varying seniority). If all non-permanent staff, importantly including locum doctors are included, overall annual employment costs reach around £2.5 billion. Thus, although it is true that training staff in the UK does cost the taxpayer considerable sums of money: at around £51,000 for every nurse¹⁵³ and approximately £200,000 to put a medical student through medical school (excluding costs borne by the student themselves), it may still represent good value.¹⁵⁴ The numbers of agency staff employed are steadily rising while demand for medical care is increasing due to an ageing population harbouring increasing levels of chronic disease.¹⁵⁵ More healthcare professionals are and will be needed. This demand will have to be met either through training permanent staff in the UK, or by using overseas trained professionals, agency staff and locum doctors. It should also be recognised that even small but sustained decreases in numbers training will multiply cumulatively the level of patient to professional shortfall through successive years, and thus have an increasingly detrimental effect on NHS services.¹⁵⁶

Some estimate that the NHS requires 20,000 more full time equivalent nurses than it presently employs. Current annual NHS spending on agency nurses (not including locums and other temporary staff) could fund three years training for around 19,600 new nurses. Such investment in training could therefore bring substantial savings in subsequent years, especially if these newly trained nurses could be required to work for the NHS for a set number of years in return for the cost of their training. Though any sudden termination of agency staff employment is unlikely, increased NHS staff training would pay for itself over time. In their recent report, Parliament's Public Accounts Committee state that the typical charge for a consultant from an agency is £1,760 per day.¹⁵⁷ This translates to an annual salary of £459,096. Compare this to the salary of an NHS consultant of between £75,249 and £101,451¹⁵⁸ and we see that four consultants could be employed by the NHS for the price of one agency staff member. Therefore trusts finding themselves in regular need of agency staff, for example in A&E where so many consultant vacancies (one in five)¹⁵⁹ currently exist, need to be able to fill all vacant

positions if they are to make themselves more cost effective. Increasing competition could make this possible. Agency nurses are also extremely expensive. Thornbury Nursing Services, a leading staffing agency, sets its basic pay for standard nurses in South England and Wales (excluding London) on weekdays, in the daytime, at £29 per hour, equating to an annual salary of £56,702,¹⁶⁰ while another agency, Ambition, offers £24.54 which still equates to an annual wage of £47,982. Compare this to the salary for NHS band 5 nurses of between £21,478 and £27,901 and we see once again a large mismatch between agency staff costs and the costs of NHS staff. We must also remember that agency fees will be higher than the amount each nurse is actually paid. At times, for a single shift nurse agency fees can amount to well over £1,000, in some cases reaching the equivalent annual salary of around £230,000 were a Trust to employ an individual full time in the same role.¹⁶¹ All the above further suggests that training more staff in the UK will prove cost effective by increasing competition for NHS jobs between graduates and also by encouraging temporary agency staff to seek permanent NHS employment.

Permanent staff are always therefore preferable for any Trust, both in terms of cost effectiveness and in terms of cumulative in house gained experience. As mentioned above, increased NHS training of staff might also encourage those working for agencies to seek permanent NHS contracts fearing future unemployment should they remain too long working on a temporary basis. Such 'pressure' ought to provide the NHS with a pool of ready trained staff to fill vacancies, thereby also freeing the budget formerly paid to agency staff to be used for other purposes, not solely staff training.

Issues with F1 and F2 training for doctors

In 2012, 96.8 per cent of the 7369 F1 places and 92.4 per cent of the 7111 F2 places were already filled at the start of the academic year with the remainder being filled later.¹⁶² Consequently, there are concerns that soon there will be insufficient places on foundation courses to accommodate all students completing a medical degree.¹⁶³ It is a basic requirement that these students should be given the opportunity to immediately advance their training in order to qualify as a doctor. Therefore, it is essential that sufficient investment in Foundation training occurs if numbers training as doctors are to be increased. With increased numbers, after F1 and F2 are completed, competition for specialist training spaces should ensure that

less favourable specialities such as emergency care and general practice become fully staffed.

Trained staff leaving the NHS

A concern could be voiced that if staff training were to be increased, and subsequent competition for NHS posts, many staff would leave their positions to work abroad or choose to work in the non-practicing sector (such as in healthcare consultancy or research). To counter this possible problem, NHS 'in house' training could be undertaken with the understanding that newly trained staff be required to work for the NHS for a set period of time before being permitted to work elsewhere. If policy makers were unwilling to impose such a measure, the cost of training might be shared through mandatory contributions from those private companies employing NHS trained staff, perhaps on an employee by employee basis. The Benenden Healthcare Society has recently also suggested that, in the case of NHS trained doctors, staff could finance such payments themselves, should they wish to work privately.¹⁶⁴ Such measures seem a fair return for the taxpayer funding of training which should lead to a fulfilling and secure career with the possibility of a good income and regular advancement. Currently, however, some question the security of a career in medicine in light of the high frequency of the General Medical Council's 'Fitness to Practice' investigations. At present, every doctor can expect to face at least one Fitness to Practice investigation during their career.¹⁶⁵ These investigations take many months to be concluded, often demand restricted practice during the investigatory period and can result in not just the loss of a job, but the loss of a whole livelihood. More needs to be done to examine the effect these investigations are having on training rates, especially in different specialisations (where there are different probabilities of Fitness to Practice investigations being brought against doctors).¹⁶⁶ We need to enhance support and guidance for doctors undergoing such investigations, the transparency of the investigative process and also review the necessity of such serious and in depth investigations being carried out in so many cases. The process can lead doctors (completely acquitted of any wrongdoing) to become disillusioned with the medical profession, and thus, to take early retirement or permanently leave clinical practice.

If wards and departments, even in formerly unpopular specialisations, become, due to increased training, fully staffed with permanent employees, it seems reasonable to predict that quality of care and working conditions would improve, making those working for the NHS more likely to stay. Although the GMC records

around 4,700 'Certificates of Good Standing' (documentation needed for medics to seek work abroad) being issued each year,¹⁶⁷ it is hard to tell how many medics are actually using them for this purpose. The certificate is easy to obtain online and thus can only reveal, in the absence of official statistics, how many medics are *thinking* of working in other countries. It could also be the case that those applying might only have worked in the UK for a short time before returning home or deciding to practice in another country. It should also be remembered that many NHS trained staff who leave Britain might return to the UK in the future, often with enhanced experience or training provided by another country.¹⁶⁸

The concern that increased competition might cause medical staff to leave clinical practice in any form seems unlikely to be justified. Ten years after graduation only 3 per cent of doctors abandon medicine as a career, an extremely small proportion.¹⁶⁹ This could be due to personal reasons, not just professional ones, and the medical qualifications of such individuals could lead them to contribute to society in other important ways. At present, there are no available statistics to show how many of these individuals return to medical practice later in life. A 2013 cohort study of 2006 medical graduates found that only 4 out of 472 participants (0.8 per cent) had left medicine as a career and out of 352 participants who answered a questionnaire none stated that they regretted having become a doctor, and only 3 (1 per cent) stated that they had a 'weak' desire to practice medicine¹⁷⁰ revealing that in general medics want to remain medics! Medical staff have dedicated large amounts of time and expense to obtain their qualifications, thus it seems likely they would want to remain in clinical practice for at least a substantial amount of time after qualifications, if not the rest of their working lives. Wards, adequately staffed with permanent employees, seem likely to further encourage this.

Key Points

- At present, British healthcare policy makers seem reluctant to invest in training substantially larger numbers of staff despite increasing need. They raise concerns such as the risk of future medical unemployment as being the cause of this reluctance. It is also true that places on doctors' foundation training years are insufficient. However, subsequent to these foundation years, there seems little evidence of insufficient permanent posts being available. It would therefore seem ill advised to reduce training places in the foreseeable future and indeed wise to increase them. It is evident that a lack of staff - or at least of

staff willing to enter some specialities - is currently leading to excessive spending on agency staff, locums and overseas recruitment; exhausting financial resources that could be better used in training and employing permanent staff.

- Some competition for medical placements and even the risk of unemployment within the sector might in fact prove advantageous. If numbers training for medical careers were to be substantially increased, personnel might be encouraged to embark on careers in specialities such as A&E which are currently experiencing difficulty in recruiting and retaining staff. Competition might also be engendered between staff to obtain positions in currently unpopular or remote regions. More staff would also want to work on a permanent basis (giving them increased job security) which would be far more cost efficient for the NHS. At present staff shortages in less desirable specialities are met by employing overseas trained, locum and agency staff at great expense and with a possible risk of reduced care quality and patient safety. A larger dependable permanent staff pool would result in enhanced workforce stability and patient safety.
- This report praises current efforts to ensure that all healthcare assistants throughout the country undertake a standardised training course, enhancing their skills and career prospects while increasing patient safety. This also enables them to transfer between employing Trusts or care units rapidly. It could also prove beneficial to develop ways of effectively monitoring the quality of such training so that different employers feel that they can rely on the health care assistant training provided by previous employers when hiring new staff.
- This report further recommends that recruitment of overseas doctors should be undertaken in a far more cost effective manner according to a standard, centrally approved procedure. Once in employment, more must be done to retain foreign trained health workers recruited at such considerable cost, this might in part be achieved by relaxing visa entry restrictions for health sector workers and by ensuring they get enhanced support and extra training in return for their services. Non-economic issues must also be considered when hiring staff from abroad such as the quality of previous training and language skills. Without such, patient safety within the NHS might be compromised.

- Evidence strongly suggests that the NHS's current policy of recruitment of staff from developing countries is unethical; ignoring the costs these countries incur when training their health workers. In effect we are treating their health care provision as being of secondary importance to our own. If, as some claim, it is wrong to restrict the free flow of people around the world, it would surely be just to compensate those developing nations who train health personnel who migrate to our benefit.
- It seems rational to require that applicants for health worker posts from EEA (European Economic Area) countries should be subject to exactly the same competency and language tests as those from the rest of the world. Healthcare is different to many other professions in that patient safety can be directly compromised by even the smallest differences in training or procedure or by linguistic misunderstanding.
- It seems reasonable that, in exchange for the high cost of their training, health staff should be encouraged or even compelled to work within the NHS as a contracted employee for a set amount of time before they can seek work as a locum. A stipulated minimum period of such employment would prevent a small but increasing minority of doctors 'holding the NHS to ransom' by only accepting work as, in effect, a highly paid freelancer.
- Lastly the capacity of Foundation 1 and Foundation 2 post-degree years of medical training will need to be expanded, increasing each year's capacity, if we wish to train more doctors in the future.

In almost every country healthcare workers represent a valuable and sought after resource. It seems illogical therefore that the NHS is not presently training sufficient numbers for its actual and predicted needs, and is thereby forced to recruit from other countries. Further, it seems that more could be done to retain staff once trained or recruited, especially those employed in unpopular specialities such as emergency medicine. Evidence suggests that savings could be made on agency and locum fees and on overseas recruitment if the NHS were to invest in improving working conditions in these unpopular specialities. As Dr Peter Carter, the RCN's chief executive, states: 'The NHS is under immense pressure and it is now time for serious workforce investment and sensible, long-term workforce planning. Anything less will be selling future generations severely short.'¹⁷¹

This report does not claim that increased staff training rates are not currently being implemented. For example, in the two years of Health Education England's existence it is claimed that adult nursing training places have increased by 13.6 per cent. This report's conclusion is simply that we should not be fearful of increasing NHS staff training numbers by a much larger amount for reasons of possible consequent medical unemployment. The report contends that increasing training within the NHS could save the service money in the long run while ensuring a more stable, better qualified workforce. Increased training would further ensure that all positions in the NHS are filled by permanent, UK based staff to the obvious advantage of patients.

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