

Unite response to ‘The Future of the Healthcare Science Workforce – Modernising Scientific Careers’

This response is submitted by Unite the Union. Unite is the UK’s largest trade union with 2 million members across the private and public sectors. The union’s members work in a range of industries including manufacturing, financial services, print, media, construction and not for profit sectors, local government, education and health services.

The health sector membership of Unite includes approximately 38,000 of the 55,000 NHS Healthcare Science workforce. This membership is spread across all of the different Healthcare Science occupations that Modernising Scientific Careers (MSC) will impact upon.

Overall, Unite is the third largest trade union in the National Health Service and represents approximately 100,000 health sector workers. This includes seven professional associations - the Community Practitioners and Health Visitors’ Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA) – and members in occupations such as allied health professions, health care science, family of psychology, counsellors and psychotherapists, the family of dental professions, audiology, optometrists, opticians and building trades, estates, craft and maintenance, ancillary support staff, IT and Ambulance workers.

Executive Summary

- Many Unite members stated they found it difficult to provide detailed comments on MSC because of the lack of detail in the consultation document.
- Unite urge the Government and the devolved administrations to work alongside Unite in taking a proactive approach to ensuring there will be proper partnership working at a regional and local level should it come to any implementation of the final MSC programme.
- It is clear that any changes need to be fully thought through and fully funded:
 - Rushing changes to the structure of Healthcare Science training is a concern - dismantling successful training programmes without appropriate programmes to replace them would cause huge disruption to the development of the HCS workforce.
 - Unite are concerned that there are no costings in the MSC consultation document and that no business case has been made for the proposed changes.
- There is a tendency to view the Healthcare Sciences as a relatively homogenous bloc - the disciplines covered by MSC are extremely diverse. Unite feel the demarcations made in the document are arbitrary and do not reflect the reality of how Healthcare Scientists work and the current training routes.
- There is a failure to acknowledge the tension that exists between the breadth and depth of knowledge and experience that is being sought.
- There is a failure to mention how proposed courses would achieve the necessary accreditation.
- The section on workforce planning is opaque and fails to explain what is wrong with the current method of workforce planning.
- The Health Professions Council has argued for registration for aspirant Healthcare Science groups on the grounds of public safety; Unite support this position.
- It should be clear in MSC documentation that the Agenda for Change job evaluation process is the only process by which jobs can be evaluated in the NHS.

- There is clear support from Unite for the NHS to 'grow its own' Healthcare Scientists.
- Unite would expect to see a series of rigorous Equality Impact Assessments taking place as proposals begin to be detailed.
- Unite members felt the document was extremely England centred.

Contents

Introduction	4
Fully thought through and fully funded	5
Funding	6
Retaining specialists in the future and workforce planning for Healthcare Science	6
Training paths	7
Commissioning of training and workforce planning.....	9
Registration of the workforce.....	9
Managing change – transitional arrangements	11
The outcome after scientific careers have been modernised.....	12
Future career paths	12
Equality Impact Assessments.....	13
A UK wide proposal?.....	13
Conclusion	14

Introduction

- 1.1 The Unite response to the Modernising Scientific Careers (MSC) consultation has been drawn together following a mass consultation exercise of Unite Healthcare Science membership. This has been conducted through Unite regional, sector and workplace representative structures across the country.
- 1.2 A positive thread in the MSC document is the due recognition it gives to the important contribution made by Healthcare Scientists to the effective functioning of the NHS and the quality of care that patients and service users receive. At least 70% - 80%¹ of clinician decisions over treatment are a result of tests performed by Healthcare Scientists and a dialogue between the clinician and scientist. Many Healthcare Scientists not only perform diagnostics but also provide direct treatment to patients. Yet too often NHS staff are viewed as being either doctors and nurses.
- 1.3 Unite recognise the MSC consultation document is the beginning of a process and that it is intended as a broad framework for discussion. However, many members raised they found it difficult to provide detailed comments because of the lack of detail in the consultation document. The lack of details prompted areas of concern – and in some cases anxiety – and a great number of questions. It was also commented that given the audience for the document is the scientific workforce in the NHS the document was remarkable for the lack of supporting evidence for many of its proposals and assertions. Examples of this are provided throughout the Unite response below.
- 1.4 Unite have reflected these comments from members in this response document, highlighting issues that Unite wish to explore in greater detail through discussion with the Department of Health and the devolved administrations rather than answering the specific set questions. Members raised both professional issues relating to the future of their discipline(s) and industrial issues relating to the impact on colleagues and their working lives.
- 1.5 The MSC project ahead will require close partnership working at every level of the NHS. Unite is committed to playing a full role in this process. It is also hoped that alongside partnership working there will be additional rounds of consultation, such as the publication of this MSC consultation document where concrete

¹ See 'Report of the Review of the NHS Pathology Services in England', Chaired by Lord Carter of Coles, paragraph 1, page 5.

proposals can be subject to public scrutiny. Currently partnership working varies dramatically in its quality and frequency between regions and between England and the devolved administrations. Unite urge the Government and the devolved administrations to work alongside Unite in taking a proactive approach to ensuring there will be proper partnership working at a regional and local level should it come to any implementation of the final MSC programme.

Fully thought through and fully funded

- 2.1. Whatever the final MSC programme that emerges from the process of consultation and partnership working ahead it is clear from the start that any changes need to be fully thought through and fully funded. Funding should not be at the expense of other areas of the health service.
- 2.2. Unite believe that the MSC proposals are not fit for purpose. There is no recognition that the current training routes for many professions are successful and some have undergone recent reviews – such as Audiology - that benefits are now being reaped from. Unite believe dismantling these programmes with no clear replacement would be seen as a retrograde step for the service.
- 2.3. It is crucial that the details for the concrete next steps for MSC are carefully worked out, spelt out and widely consulted on. The current lack of detail in the consultation document, as noted above, has raised concerns that a situation similar to 'Modernising Medical Careers'² is being lurched towards. A common concern raised by Unite members was that changes to the structure of Healthcare Science training would be rushed. A dismantling of successful training programmes without appropriate programmes to replace them would cause huge disruption to the development of the HCS workforce and have a detrimental impact on the quality of the HCS services to the NHS. This would impact on patient safety. Unite has a strong desire to avoid a situation where the Government and devolved administrations implement MSC and then finds this plan has to be seriously amended because it was not sufficiently thought through and planned beforehand.

² Modernising Medical Careers reformed postgraduate medical education. As a result of concerns over the new training process in April 2007 an inquiry into MMC was led by Professor Sir John Tooke. The final report, 'Aspiring to Excellence', was published January 2008. The report stated that "the distress caused to the next generation of specialists and senior doctors must never be repeated", page 12. See www.mmcinquiry.org.uk for full details.

Funding

- 2.4. Unite are concerned that there are no costings in the MSC consultation document and no business case has been made for the proposed changes. Sufficient funding needs to be put in place for the final MSC plan to be successfully implemented and realised. Full funding should be made available from Government and devolved administrations that is ring-fenced when it is handed down to Strategic Health Authorities, Trusts and Health Boards. Without this there are concerns that any final MSC plan would not be properly implemented and at a regional and local level. Given the complexity and large scale nature of a project such as MSC non-implementation of particular section(s) or cutting corners in its implementation can undermine and derail the whole enterprise with disastrous consequences. Unite are seeking clarification on the funding that will be made available and assurances that sufficient funding will be guaranteed to avoid such a situation. Such funding should take into account all facets of implementation, including for example administration support that will be required for proper partnership working at every level.
- 2.5. Unite is also concerned that without sufficient funding there will be pressure on Trusts to manipulate the workforce numbers and the shape of the workforce to what is cheaper rather than what is best for patients and service users and achievement of benefits the final MSC plan may bring. This is discussed further below.

Retaining specialists in the future and workforce planning for Healthcare Science

- 3.1. There is grave concern over how the MSC consultation document has a tendency to view the Healthcare Sciences as a relatively homogenous bloc. The disciplines covered by the MSC document are extremely diverse and a 'one size fits all' is unlikely to achieve optimum service level. Unite feel the demarcations made in the document are arbitrary and do not reflect the reality of how Healthcare Scientists work and the current training routes.
- 3.2. There is a failure to acknowledge the tension that exists between the breadth of knowledge that is being sought by the Government and the devolved administrations – in order that there is greater flexibility in the workforce – and the depth of knowledge and experience that is also being sought to meet the

increasing complexity of Healthcare Science in the future and the need for innovation. There is no hint about how these two objectives are to be reconciled.

Training paths

- 3.3. Healthcare Science is likely to become increasingly specialised in future as new technologies develop, fields of knowledge expand and new specialisms emerge. These trends would appear to argue against a generic Healthcare Science worker or training. There are concerns about how feasible it is to train a person to be of a high standard of competency in more than one discipline.
- 3.4. Members also raised serious concerns that in the current document the Healthcare Science Practitioner (HCSP) does not appear to have any recognised educational level. This carries negative implications on getting the workforce registered to practice and attaining competencies. There does not appear to be any formal career progression within a chosen discipline – earlier in MSC an Advanced Practitioner level was identified but that has now disappeared. The lack of detail makes it unclear as to the practical training programme and the assessments of competence. The suggestion of a generic Healthcare Science degree and training programme raises the possibility of a longer period in training overall before a person reaches a competent standard in their chosen specialism. However, the consultation document seems to point the other way.
- 3.5. It is suggested that there would be a supernumerary training programme within one of the three scientific groups – implying practical competence in all areas. This seems unachievable in a 1-2 year training programme across potentially 20 areas of scientific disciplines. Even if only one specific discipline was the suggested route, this document does not suggest professional examinations of competence, or the training route for further academic and practical skills to produce a high quality competent workforce. This proposal would deskill and lessen the current route of a BSc (Hons).
- 3.6. At the same time it is difficult to comment on the quality of proposed training programmes or learning outcomes because there are no details of these available. This lack of detail extends to a failure to mention how such courses would achieve the necessary accreditation or mention the accreditation body in Higher Education, the Quality Assurance Agency (QAA). The document fails to

recognise the current successful and accredited training programmes that exist for many disciplines.

- 3.7. The issue of the equivalence of qualifications has not been addressed and how this fits in with the European Qualification Recognition Agreement.
- 3.8. Presumably a greater burden of training students up to a competent standard in their specialism will fall on the NHS if there is to be more workplace training and generic degrees. This raises serious concerns given the demonstration staff were given in 2006-07 about how valued training is in the NHS when money becomes tight. When investigating the NHS deficits the House of Commons Health Select Committee found that *“Trusts are making major savings. The workforce budget and the education and training budget have made the main contribution to reducing deficits”* and that *“Moreover, amalgamation of the training budget with other SHA budgets is likely to lead to more reductions in that budget”*³.
- 3.9. It should also be borne in mind that those on the proposed Scientist Training Programme who have a PhD would not receive LEA funding and equivalent funding streams in devolved administrations to undertake a Masters qualification, as it is a lower qualification. In the document it is implied the only route to a Masters qualification is through part time study; there is experience that in some disciplines within the NHS full time study is the better option. Both routes are valid options and Unite wish to see this recognised.
- 3.10. In this area the spectre of Modernising Medical Careers⁴ must again be raised – training people to be flexible to work in different areas according to NHS needs was not successful. Indeed, it is difficult to imagine motivating a workforce when people are pushed into areas they do not wish to specialise in.
- 3.11. Additionally, when people have a strong idea about which area they wish to specialise Professor Mark E Lutman has noted that “Experience of rotational schemes adopted in the past suggests that trainees resent the time spent on the ‘unnecessary’ disciplines”⁵. Unite also believe that the groupings of the disciplines eradicates the possibility of cross specialisms.

³ House of Commons Health Select Committee, First Report of Session 2006-07, 'NHS Deficits', page 4. The Report goes into greater detail in the Education and Training section, pages 60-63

⁴ See footnote 2 in this Unite document and www.mmcinquiry.org.uk for further details.

⁵ See comments from Mark E Lutman, Professor of Audiology, University of Southampton in the British Academy of Audiology magazine, January 2009, page 30.

Commissioning of training and workforce planning

- 4.1. There are concerns over the placing the responsibility for training and workforce planning in the hands of SHAs and Trusts in England. Unite has experience of some SHAs and Trusts simply not commissioning sufficient training places in other occupations, for example, Health Visiting, where this has contributed to an acute shortage of Health Visitors. This possibility of under-capacity is not mentioned in the MSC consultation document.
- 4.2. There is therefore a concern that Healthcare Science generally may experience such a problem where there is little understanding about what many of the disciplines involve. This concern increases in relation to some of the smaller disciplines. SHA exposure to smaller disciplines, and therefore their understanding, will be limited. For example, tissue banking is a small discipline and approximately 40% of activity takes place in Liverpool. In the rest of the country an SHA may just have one relatively small tissue banking centre. Sleep physiology is based in just a couple of specialist centres nationally. In some of these smaller disciplines it may be more appropriate that workforce planning is conducted either at a national level or at a local level rather than regionally.
- 4.3. At the same time, however, the MSC document fails to articulate what is wrong with the current method of workforce planning where training place numbers and the required workforce numbers are calculated within each discipline nationally. Instead it is asserted that there are “several major aspects of current training and career pathways for healthcare scientists mitigate against the workforce being flexible, responsive and able to rise to the new challenges...”⁶ Overall, the section on workforce planning in the future is opaque.
- 4.4. Unite fear that the proposal to pass this responsibility to commissioners within SHAs and Trusts is a product of the wider rolling out of commissioning responsibility to SHAs and Trusts in England across the NHS rather than what may be the best method of workforce planning for the NHS.

Registration of the workforce

- 5.1. It is noted that the Health Professions Council is not mentioned in the MSC consultation document. Alongside many members in registered disciplines Unite represent many members who work in professions which are aspirant to the

⁶ Chapter 2: The Healthcare Science Workforce: The Case for Changing Training and Careers, paragraph 22, page 8.

Health Professions Councils' register. Unite supports those members in their aspirations – the HPC has recommended the following groups for registration to the Secretary of State;

- Clinical perfusionists (September 2003)
- Clinical physiologists (October 2003)
- Clinical technologists (May 2004)
- Medical illustrators (May 2004)
- Maxillofacial prosthetists and technicians (September 2005)

5.2. The HPC has argued for registration for these groups on the grounds of public safety; Unite support this position and believe it is extremely irresponsible to hold the registration of these groups up. Unite believe that it makes sense for the registration of Healthcare Science professions – currently only Biomedical and Clinical Scientists must be registered – to be dealt with as part of the MSC process rather than delayed further.

5.3. Unite believe that registration is an important factor in protecting members from being forced by irresponsible Trusts who are solely concerned with budgetary constraints from instigating inappropriate grade mix. In this way the public would receive protection. For example, Unite has been successfully involved in preventing GPs instigating procedures where receptionists had not received appropriate training from a registered professional to take blood samples, under the pretext of making it easier for the patient. Such initiatives show a total lack of understanding of the skills involved in the taking of blood samples and are to the detriment of patient care.

5.4. The MSC consultation document mentions that the future of protected titles will be subject to future consultation and makes clear the job titles given to roles in the consultation document are 'working titles'. The HPC is an independent regulatory body established under statute - statute that also requires the HPC to consult over any changes to the register. Unite represents a large number of people working under 'protected titles' in the NHS and would expect to be involved in any future discussions in this area alongside the HPC.

Managing change – transitional arrangements

- 6.1. The lack of detail has led many members to express deep concerns over the possible transition period as the current arrangements for the Healthcare Sciences give way to the future plan for Healthcare Sciences that will come out of the MSC process. It is unclear at the present moment what the proposed timeline for the implementation of the final MSC plan is and to what extent there will be assimilation of the old and new career structures and what sections may run in parallel for a period of time.
- 6.2. It needs to be clear in documentation published by the Department of Health and the devolved administrations that the Agenda for Change job evaluation process is the only process by which jobs can be evaluated. It is this process that will establish pay band outcomes and how these new roles will be mapped against the current roles that exist. There is a danger of the MSC document straying onto questions of staff terms and conditions which are the property of the NHS Staff Council. Unite understand the numbering in the MSC consultation document refers to proposed 'career framework stages'. However, the numbering of stages from 1-9 has caused confusion and misrepresentation and therefore these stages should be re-labelled⁷.
- 6.3. The diagram of the MSC Model states that the size of the boxes are not proportional to the size of the workforce⁸. The MSC consultation document does not give indicative workforce numbers and enable comparison with present workforce numbers at each career stage.
- 6.4. The equivalence (or not) of different training routes must also be subject to this Agenda for Change process to establish how they fit into the Knowledge and Skills Framework. Many people in Healthcare Science arrive in their current position via a range of different routes. Those working in electronics and mechanical engineering areas of medical physics, for example, are largely recruited from industries outside of the NHS and thought needs to be given to how all of these different experiences can be recognised.
- 6.5. Assimilation and transitional arrangements will be dealt with through these established AfC job evaluation and negotiating processes. Partnership working

⁷ Chapter 5: Proposed Training and Career Pathway, page 13

⁸ Chapter 5: Proposed Training and Career Pathway, page 13.

will be particularly important during this transitional stage to ensure there is no disadvantage to the current workforce.

The outcome after scientific careers have been modernised

- 7.1 As mentioned above, the lack of detail on the training courses meant that it was difficult for people to provide detailed comments and has raised concerns over what training is exactly being proposed. It was also commented that it would be useful to understand the reasoning behind how and why the themed rotational training programmes have been grouped in the way they are⁹; without this information it appears arbitrary.
- 7.2 References to future multi-disciplinary teams are made¹⁰, but again without any proper explanation of what this means and what is envisaged. Unite is concerned this could become a smoke screen for the introduction of inappropriate band mix in the future.
- 7.3 There is clear support from Unite for the NHS to 'grow its own' Healthcare Scientists. Presently many Trusts and Health Boards recruit people as support staff and develop them up to scientist level. Multi-level access and the ability to 'grow their own' has been a driver for many Trusts and Health Boards to invest in training to develop the Healthcare Science workforce. This was a feature there was strong support for continuing.

Future career paths

- 7.4 The proposed structure appears to end blockages in the career structure and there is strong support from Unite for this. However, there was concern that a new ceiling may be inadvertently introduced at the top of the Healthcare Scientist Practitioner grade. This ceiling may form as people would need to resign their post before taking up a training place with the SHA. At the beginning of the Healthcare Scientist career they could then be posted anywhere there is a need or available position. Unite believe this will automatically make it much harder for people who have spent a great deal of time training and working and are therefore likely to have begun a family in a particular locality. They would be faced with a choice of possibly up-rooting their family – which may not be possible because of their partner's work – or continuing their career. While acknowledging this is a

⁹ Chapter 5: Proposed Training and Career Pathway, page 17

¹⁰ Chapter 3: The Vision for Healthcare Science, page 10

model that some sciences recognise – such as physicists and some of the physiological sciences - Unite believes this section of the proposed career structure needs to be re-thought and notices that it is an issue not considered in the Department of Health's Equality Impact Assessment.

7.5 Unite have experienced many instances of Trusts deciding how many staff they want at each level with the determining factor the budgetary restraints rather than service needs. This has led to staff 'standing still' in their career path. It is a reflection of the lack of communication that some Trusts and SHAs have exhibited during the buffeting and upheaval many NHS staff have experienced in recent years that there is now a great deal of scepticism and cynicism that there will be a straight career path upwards as portrayed in the document¹¹. Instead there is a great deal of concern that despite high academic achievement on the lower rungs of a persons career Trusts will put the lid on aspirations and potential because the shape of the workforce and access to training will be restricted by budget concerns rather than a drive to develop a high-quality service and develop scientific knowledge. This is a fear compounded by the lack of statement on how the MSC programme will be funded.

Equality Impact Assessments

7.6 Additionally, given the lack of detail in the current MSC document being consulted on Unite would expect to see a series of rigorous Equality Impact Assessments taking place as proposals begin to be detailed. Concerns have been raised that the proposals for competitive entry in the current form provide too many opportunities for favouritism, and therefore discrimination, to occur.

A UK wide proposal?

8.1. As outlined above, Unite conducted an internal consultation exercise that included all the English regions and the devolved administrations. The view from Wales, Scotland, England and Northern Ireland was that the document was extremely England centred. For example, references to 'employers and health commissioners' is a reference to a division that will not exist in Wales from October 2009¹². Indeed, commissioning is an NHS England creation from the central Department of Health rather than a path being followed by the devolved administrations.

¹¹ Chapter 5: Proposed Training and Career Pathway, page 19

¹² See Chapter 3: The Vision for Healthcare Science, page 10

Conclusion

- 9.1. As mentioned above, Unite recognise this document represents the beginning of the process but the lack of detail contained in the proposals has led to staff feeling concerned about the future of the Healthcare Science workforce.

- 9.2. Unite is committed to partnership working with the Department of Health and the devolved administrations, but it must be a two-way street with staff concerns taken on board. Unite members in the Healthcare science workforce have a wealth of information and knowledge about how training, career paths and service delivery can be improved within the NHS in each of the four countries. This must be recognised and actively drawn on by the Government and devolved administrations in altering, developing and refining their plans for the future of the Healthcare Science workforce.

5th March 2009

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