PGMDE Integration – Response to Consultation Document

This response has been compiled by staff working in a variety of areas over LPGMDE.

1. Summary

Staff have a huge number of concerns relating both to these proposals and to the process through which they are being implemented.

These include, but are not limited to:

- Lack of transparency – typified by the sudden revelation at the end of a lengthy process that staffing levels face a 41% cut.
- Lack of detail – for such significant changes, the relevant document is both extremely brief and extremely vague.
- Lack of evidence – the document is underpinned by assumptions for which the research has either not been published or has simply not been conducted.
- Lack of concern for staff – both in terms of the trauma of the consultation / appointment / redundancy process itself AND the massively increased workforce those surviving staff face, typified by the extra responsibilities loaded onto the new job descriptions.
- Lack of concern for trainees – where is the evidence that their needs and wishes have been taken into account.
- Lack of concern for public safety – put simply, if the capacity to safely train junior doctors is reduced, there will either be less of them, or they will be less capable, with both options presenting an unbelievably serious risk to the general public.

In summary, staff believe that the central argument of these proposals – that it is possible to preserve the quality of training while reducing costs – is not supported by the evidence provided.

2. Introduction

The project to integrate the Postgraduate Medical and Dental Education (PGMDE) functions undertaken by the London Operations department and KSS began in April 2015.

However, barring the occasional 'engagement workshops' and staff briefings, the process has remained remarkably opaque.

Prior to the release of the document in question, HEE have been reluctant to respond substantial questions with any detail, most notably with regard to the initial 30% figure. When asked whether this meant **headcount**, it was stated that it referred to an overall reduction in costs, with the obvious implication that the headcount reduction would be less. In fact, as has now been revealed, the figure is an **astonishing 41%.**

There is no explanation in the documents provided as to why this figure has now been arrived at and there is no evidence given to show that the organisation will be able to function with these huge cuts in staffing numbers.

This not only shows a total lack of concern for staff, as we cannot constructively contribute to a consultation which is totally lacking in detail and evidence, but also to our various stakeholders, as the consultation document gives no evidence that the new structure will be workable or lead to a

better service for them. We believe that this process has been flawed from the outset and could seriously jeopardise the functioning of the department if the current proposals are implemented.

We therefore believe that public safety is ultimately being put at risk by these proposals. The capacity to safely train junior doctors will be undermined, as our ability to recruit and see them through their trainee journey will be seriously jeopardised by the cuts being put forward.

Our different areas of concern are summarised below.

3. Lack of concern for staff

Throughout this process the organisation has shown little interest in communicating with staff the totality of the cuts that were being considered. Prior to the release of the consultation documents, HEE had been reluctant to respond to any questions regarding the 30% reduction in costs that were initially quoted. They merely said that this figure related to overall costs and therefore implied that the actual loss of staff in terms of headcount would be lower that this figure. However, once the consultation documents were finally released it transpired that the proposed cuts would be an astonishing 41% reduction in overall staffing numbers. This has led to staff feeling that over the last year while the integration project has been running they were being deceived.

One of the main justifications for cutting staffing levels to such an extent has been the planned introduction of Matrix working. Whilst there is an argument to be made that over time staffing levels will naturally stabilise as the new structure is imbedded, many organisations have actually seen a need to increase staffing levels in the short term to cope with the early stages of change implementation. A rapid decrease in staffing numbers at just this juncture is thus extremely dangerous. We propose that these changes are implemented over a period of 12 - 18 months to ensure that the structure is given a greater chance of being successful. If the cuts are implemented as planned, there is a very real risk to the basic functioning of the department as a whole, which would not only lead to us providing a less than satisfactory service to our stakeholders but could ultimately put patient safety at very real risk.

The future that the consultation document envisages is a vastly reduced workforce deployed across departments at the point when each is most busy. However, at the moment there are parts of the organisation which are already running at close to full capacity. In the Operations department many managers have been working above and beyond their contracted hours simply to try and keep on top of the work required of them. In addition, they are also currently relying on average on an extra 126 hours a week from members of the recruitment team to help this work. When the 41% of cuts have been implemented we will no longer have the flexibility to provide extra resource on this scale. It has not been explained how we are expected to cover all the work within the department. Is it really feasible to say that 'technology' and the removing of 'unnecessary duplication' is going to reduce our workload so much that at busy periods like this we will have enough staff to work on all the business functions of the department. The cuts being proposed are going to put at risk the successful implementation of the new structure as there will simply not be enough staff to complete the work involved.

An overworked and reduced workforce is likely to be placed under massive amounts of pressure to maintain organisational capacity. If these cuts are implemented in full the senior management team will be forced to compete with each other to secure enough staff to complete the business functions under their responsibility. Surely the most sensible course of action would be to ensure that all functions of the business can operate under this new structure and then start to reduce the

workforce naturally. Otherwise the working environment could become especially fraught for staff caught between competing demands. This could lead to an even bigger crises in staffing numbers as stress increases the number of hours lost to illness, or staff simply leave.

If we are expected to constantly balance very limited resources across the department we could lose sight of what we are actually trying to achieve as an organisation. One of the design principles is 'better services for customers', but how are we expected to achieve this if we will be spending most of our time fully stretched trying to cover the basic functions of the department? There will be no extra capacity to provide better 'customer' service for any of our stakeholders. The cuts being proposed have the potential to vastly reduce the service that we provide and could lead to a scenario where all stakeholders receive is a skeleton service.

From the very limited amount of information that we have been given about the new structure it is clear that it cannot work with the 41% staffing cuts being proposed. There is a very real risk to the service that we provide and to patient safety in general. In addition, the vastly reduced workforce will place undue pressure on the remaining staff, leading to an extremely stressful working atmosphere.

The current proposals will involve holding the selection interviews over some of the busiest periods for staff. Level 4 interviews are scheduled from mid-November, which will clash with the beginning of round 1 recruitment. As a consequence most of the recruitment team will not have adequate time to prepare for the interviews and this will clearly both add to their stress levels at an already pressurised time of year and be manifestly unfair. The interview schedule should be indefinitely postponed until these issues have been resolved.

4. **Lack of concern for external stakeholders**

Throughout the consultation document there is very little detail on how these huge cuts are going to affect HEE's external stakeholders. It is rather worrying that despite one of the four design principals being 'Better services for customers' there seems to be a distinct lack of detail about how the service to our stakeholders will actually be improved by cutting nearly half of the overall workforce.

There has been no real detail given in the consultation document nor through any of the recent engagement workshops about how the new structure will help us provide better customer service. We have consistently been told that technology will help us introduce a new standardised system that will help trainees access the information they need without the need to engage with staff at HEE, thus saving staff time. However none of this technology has been tested nor have we even been told what the majority of this new technology will be. There is therefore no way to guarantee to stakeholders that this different method of delivery is actually going to improve the service that they receive.

In addition, nowhere in the consultation document has it been shown that this is the type of service that trainees actually want. It is therefore disingenuous for you to suggest that this will provide 'better customer service' when you have neither tested the new technology that you propose to implement and nor have you even consulted with trainees to find out what service they would actually like to receive.

5. **Risks**

The proposed new structure and streamlined processes would pose huge risks to the successful completion of projects, which would affect negatively staff, trainees and other stakeholders.

The generic job descriptions in the consultation pack state that staff will be working on a variety of areas at one time. For example in the new structure an administrator in recruitment will be expected to have knowledge of recruitment, alongside doing applicant enquiries work and subject access requests, and dealing with fitness to practice declarations, confidential enquiries and immigration enquiries. This would mean the loss of the specialist knowledge and skills that have been built up by staff in these areas.

There could also be an issue here in terms of the quality of customer service delivered and ensuring consistently quality standards are met in all of these areas. The consultation document does not lay out how staff will be trained to support work in all these areas and how staff will be kept up to date with changes to processes, changes to legal frameworks or other developments. This way of working will put undue demands on staff and inevitably contribute to higher stress levels and increased rates of sickness absence.

The proposed new structure will negatively affect trainees in specific areas such as fitness to practice and confidential enquiries. The enquiries that are received by these services are primarily related to doctors who have fitness to practice issues or have disabilities The London recruitment process at present ensures that any information that trainees or applicants share with these services is kept strictly confidential. This ensures a fair and equitable recruitment process, and that the applicant feels secure in the knowledge that confidential information is shared among a select group of staff. These changes mean that the specialist knowledge staff have developed in these areas will be lost in the new structure. In addition, the proposals before us indicate that in future enquiries of this nature would be managed by a wide range of staff, meaning that confidential details will be shared among a wider group. This will be concerning for applicants who may not wish to share this information with a wider group, and also poses legal risks in terms of data protection.

6. Lack of Evidence

The transition project is based on the premise that it is possible to preserve the quality of training for postgraduate medical and dental trainees while reducing costs. However, this is not supported by the evidence provided in the consultation pack and PGMDE integration meetings.

The new structure is based purely on a theoretical assumptions and we have not been provided with satisfactory evidence or research to demonstrate how the model will work in practice. The consultation pack proposes a new structure that will lead to significant changes in how the department is organised and how work is completed across the department. The consultation pack, though, is both extremely brief and vague on why and how the management believe that this new structure will function successfully. For example, the graph regarding peaks and troughs across the department has no reference point, and there are no examples of the actual technology that will be introduced to improve efficiency.

At the PGMDE integration meeting for all staff across the department on 25 July 2016 we were shown a Power Point slide showing activity throughout a calendar year across the department. The graph purported to show how matrix working could function successfully with flexible employees. Yet there was no reference to confirm the statistics these figures were based on, no indication as to whether the figures were based on the workload across KSS and London, or even clarity as to what year (2015 0r 2016) the figures refer to, and whether they take into account the prevailing trends

across the department. Also on the bar chart the workload for recruitment for the month of May does not reflect actual workloads across the team, as May is a relatively busy month for the team completing projects and issuing expense claims.

In addition, we do not understand whether the graph takes into account the new business that has been won by the department to manage pharmacy and foundation recruitment, but it seems clear to staff that the department is not only going to be expected to cope with its old workload with a massively reduced headcount, but will be actively encouraged to seek and take on 'new business', further increasing the burden on those remaining staff.

There is also a lack of evidence to demonstrate how new technology will be effectively employed to complete all projects in a more efficient manner. One of the key principles of the transition project is 'Improved value for money', namely that 'standardising and integrating processes, alongside the use of better technology should support cost efficiencies'.

The use of the word 'should' confirms that there is little factual evidence to support this statement. Surely if this is a principle underlying the transition then there should be something more definitive here. There is no detail in the consultation pack about which technologies will be employed, how and when employees will be trained to use this new technology and whether there is a contingency plan if the new technology is not developed within the proposed timeframe. We do not believe that the consultation process is meaningful when the there is no evidence or research that has been shared with staff to demonstrate exactly what the technology will be, how it will work in practice and whether it has been piloted on a large enough scale to ensure that it is smoothly implemented across the department with no delays or hiccups.
Furthermore, the consultation pack has not provided any evidence that the needs and wants of trainees have been taken into account. We would like to know when and if postgraduate medical and dental trainees were consulted about the service that they would like to receive, and if so we would like to be provided with the evidence.

7. **Conclusion / Alternate Proposals**

As shown throughout this document there is a need to introduce a longer implementation period to allow the organization to smoothly transfer to the new matrix system of working. We propose extending this by 12 – 18 months to ensure a safe transfer to the new organizational structure, with current staff remaining in their posts. There is currently no evidence that the proposals in their current form are actually workable, and considering the potentially huge risks involved if the organisation ceases to function properly it is imperative that a safe transition is implemented. This can only be achieved by removing the threat of compulsory redundancies, ensuring that the new structure is robust enough to cope with the business needs of the department. A longer implementation process would allow for voluntary redundancy and natural wastage to ensure that no compulsory redundancies would be necessary.

Relating to this, there needs to be an acceptance that (given the information and arguments presented here) this level of staff reduction is not feasible, and therefore any cuts need to be far less stringent that envisaged here.

There should be a recognition that with extra 'business' being sought, this needs to come with additional resource (ie more staff) attached.

HEE should also commit to return to its funders and challenge the initial assumptions underlying the 'organisation's wider aim to achieve a required 30% target saving in the Education Support budget for London and the South East' – which is totally disproportionate in terms of the savings required by 'flat cash investment', even before it is translated into the even more draconian 41% cut in staffing levels.

There needs also to be a recognition that given current shortages (http://www.bbc.co.uk/news/health-35667939) MORE trainees are going to be required. HEE nationally has been tasked with recruiting more junior doctors and we have also seen a 60% rise in unfilled vacancies between 2013 and 2015. As a consequence the capacity needs to be there to support them.

There should be a further recognition that the cost to the NHS is likely to be much higher if (as a consequence of these cuts) less trainees can be processed and thus the NHS is left to rely more than ever on expensive agency staff.

We are also seeking an implementation extension so that a proper audit can be run. This would mean that the department may be able to identify other potential areas of savings rather than just proposing an arbitrary 41% cut in staffing. We recommend that this audit also takes into account the hours given back to society and the taxpayer by the doctors and health service, which staff at HEE help to provide. This would, for example, show how many hours and therefore tax would be lost to businesses and society at large, were absences from work increased because of longer waiting times and fewer GPs.

In addition, the interview and selection schedule for the new staffing structure should be indefinitely postponed until the issues flagged above re timing have been resolved.

8. Questions relating to the four 'design principles' underpinning the project

1. Better services for customers (*ensuring business processes are centred around the needs of Trusts and trainees)*

Have trainees been surveyed as to what their needs actually are and what they would consider to be a better service?

Have Trusts been surveyed as to what their needs are or what they perceive to be a better service?

Have the Royal Colleges been surveyed as to what their needs are or what they perceive to be a better service?

Have lay representatives been surveyed for their opinion regarding the proposed changes? What are the results of such canvassing? Do staff affected by and involved in implementing these changes have a right to see them?

What evidence do you have to suggest that a 41% reduction in head count will lead to a better service? Do you have any empirical evidence to support such a claim or is it a risk?

If it is a risk, is that risk justified, given the potential implications of serious problems arising as a result of the change?

Has a risk assessment been made on the impact to service?

Have trainees been informed, for example, that Applicant Enquiries are to have their remit vastly reduced and that a more automated system is to be introduced?

Is a more impersonal service likely to be viewed as 'better' by the trainees we serve?

Is a more automated system more stakeholder-centred?

If work is to be more varied or ad-hoc from day to day, is it not going to make it more difficult to form and maintain consistent lines of communication between the department and Trusts and other stakeholders?

Surely such a potential blurring of communications will lead to a downgrading in these crucial relationships which is highly unlikely to lead to the perception of better services?

Will the 41% reduction in headcount mean an increase in the use of temporary/agency staff?

Have the potential ramifications of an increase in the use of temporary/agency staff on recruitment and training processes been thought out?

Have the costs and hours involved in training new temporary staff been made?

Will the increase in temporary staffing lead to diminishing levels of expertise in the relevant areas, with potential negative consequences for the reputation of LASE?

2. Simplified, standardised, transparent processes across the integrated team (*although both teams have effectively supported trainees around the same processes in different parts of the geography, they have done this in different ways*);

On what scale has the new technology been piloted?

What risk assessments have been made regarding the stress levels and other stress related illnesses of staff whilst they try to maintain their quality of work, in the full knowledge that they face the real possibility of unemployment in a precarious labour market? Is this likely to lead to a further demise in staff morale?

Has the organisation anticipated and planned for the impact of the probable resignations that will occur throughout the consultation process? If vacancies are not filled (as there appears no intention to do so), then the burden of that work will be distributed amongst a diminishing workforce with morale at an all- time low.

Besides the four short paragraphs found underneath the heading 'Matrix Working', there is no evidence / details of how this will work in practice, or how these processes will indeed be simplified or more transparent. How can we be sure that this is workable?

3. Improved value for money (*standardising and integrating processes, alongside the use of better technology should support cost efficiencies*);

The use of the word '*Should*' in the above design principle gives the impression that there is little factual evidence to support this statement. Surely if this is a principle on which the organisation is moving through transition then there should be something more definitive here.

How cost effective has the transition period proven to be so far?

How many savings have been made?

What has been the cost of voluntary redundancies throughout this period?

What is the anticipated cost of voluntary and compulsory redundancies?

On what scale has the new technology been piloted?

Are there any precedents both positive and negative for the overhaul of such technology leading to a seamless transition to a better service within the NHS?

What is the previous budget?

What will the new budget look like?

Where is the sense that senior management have sought to fight HEE's corner in budget negotiations with government?

How can some at HEE go so far as to welcome the Government's flat cash settlement when it involves the slashing of 41% of its workforce in a crucial area? The potential impact on the staff involved and their dependants is not something that should be welcomed.

4. Better quality work for HEE staff (*because we are not using technology and joined-up or automated systems across the department as much as we need, a lot of staff time is tied up with data entry, checking or dual running. We want to release this time to use the expertise of our staff in more value-adding tasks*).

Under the current proposals 41% of the affected staff will have no standard of work.

For the 59% of staff that remain, the consultation pack is remarkably short on detail regarding how the work will be of "better quality". What is undeniable is that there will certainly be vastly increased amounts of work for the fortunate 59%. How can this be described as better?

How many days have been lost to stress related incidents at work under the current working arrangements in the last financial year?

What risk assessments have been made regarding the impact of the extra workload on the 59% off remaining HEE staff?

Can we see the risk assessment?

Undoubtedly some time will be freed up from data entry as a result of the new technology, but as this has only been piloted on a minute basis, is it possible that HEE could be overstating the case?

What training will be provided for staff regarding the implementation of the new technology?

When will this training take place given that between the end of consultation and the end of the financial year is the busiest time for many within the Operations department?

What are the likely costs in terms of training?

If we currently have too many staff, why do we continue to use agency staff?

Has an audit been conducted in terms of hours LPGMDE staff spend per trainee? If the 41% reduction means that trainees have less time dedicated to them by our staff, have the potentially litigious consequences been audited?

What are the potential ramifications for staff thus far not affected by the 41% cut? If there are 41% less staff, then will this have a knock on effect on other important departments, for example Human Resources? What are the ramifications for those employees who depend upon flexible working arrangements in order to look after dependants? Will they be disproportionately affected?

What are the ramifications for staff currently on maternity leave? How do you ensure that they will not be discriminated against in the new process?

9 Additional questions

There is a recognition that in order to fill training posts, an increase in the recruitment of doctors from overseas is inevitable. Why therefore is specialised immigration knowledge being downgraded?

We have previously been informed that you wish to treat staff on fixed term contracts the same as everyone else. Why not then employ them on permanent contracts for the consultation period as this would ensure they were not simply disposed of at the end of their current contracts? You must recognise that they have less protection in their jobs than staff on permanent contracts?

Some members of staff have been on secondments for years, you have previously promised to place these members of staff on permanent contracts to ensure their protection. Why has this not been done yet?

With regards to the person specification for the Officer role, it requires “Experience of line management responsibilities and/or leading a team in a similar environment”. We suggest that ‘a similar environment is elaborated on in time for any interview process.

Although the responsibilities have multiplied within the new person specifications, this is not reflected in the pay-scales. Why not?

All staff who currently work on a flexible basis should have those arrangements guaranteed prior to the interview process – will this be done?

BAME are already vastly underrepresented at management level within HEE, how will you ensure that they are not discriminated against in this process?

How will you ensure that trade union members are not disproportionately discriminated against?

How will you ensure that those employees on fixed term contracts will not be discriminated against?

Why have you not first sought candidates for voluntary redundancy prior to threatening staff with compulsory redundancy?

Why have you not considered temporary lay-offs?

Why have you not sought staff for early retirement?

Lack of concern for trainees – where is the evidence that their needs and wishes have been taken into account?

Have trainees been surveyed as to what their needs actually are and what they would consider to be a better service?

Have lay representatives been surveyed for their opinion regarding the proposed changes? What are the results of such canvassing?

Can the assessment centre be failed or does this count towards a final ranking for the 59% of remaining posts?

Who will the panel for the interview process consist of (will both KSS and London be represented)?

Within the FAQ's it states under 5.1 that the proposed single pool of posts allows "individuals the opportunity to apply for any role or roles that they are best qualified for" however it also states in 5.3 "staff will automatically be assessed for roles at their current band/grade" – what does this mean in practical terms? Does this mean that there will be no need to submit an application form? Will we have to declare an interest in that role? How will we be expected to do this and what is the time scale?

Is it that we need to enter applications for all the roles to which we need to be considered at one time?

Will there be preferencing prior to the applications stage? If so can these preferences be amended after interview?

On the person specifications there appears to be several contradictions relating to the management of administrators, as this appears on both the officer and senior officer person specifications? Who do the administrators report to in the new structure?

We were informed that the JD's were generic across each pay grade, however the criteria in both the JD's and Person specs appears to be weighted towards the Workforce department? Are members of the recruitment team therefore unfairly positioned to gain employment?