Consultation on a draft health and care workforce strategy for England to 2027

Response from NHS Providers

About NHS Providers

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has 99% of all trusts in membership, collectively accounting for £74 billion of annual expenditure and employing more than one million staff.

Our response

We welcome the opportunity to respond to the consultation on behalf of NHS trusts and foundation trusts. Our response is informed by three key sources.

- Our report, *There for us: a better future for the NHS workforce (There for us)*, published in November 2017. We drew on a year long dedicated programme of member engagement, alongside analysis of publically available data and evidence, to develop a comprehensive report looking at the key workforce challenges facing the sector and recommendations for how the government and national bodies could start to address these. We have included all of the *There for us* recommendations, grouped into short, medium, and long term, at Annex A.

- Our written evidence to the 2018/19 pay rounds of the NHS Pay Review Body and the Review Body on Doctors’ and Dentists’ Remuneration. This was informed by *There for us*, our regular member engagement, and a survey of HR Directors in November 2017. We have now also given oral evidence to both bodies.

- Engagement with trust leaders over the past three months – including chairs and chief executives and the March 2018 meeting of our HR Directors Network – specifically about the analysis, proposals, and questions in the workforce strategy consultation document.
Overview

Many provider trusts – hospital, mental health, community, and ambulance services – are struggling to recruit and retain the staff they need to deliver high-quality care for patients and service users. There are very significant and persistent gaps in the workforce in some places. The most recent NHS Improvement quarterly performance report of the NHS provider sector suggested there were 100,000 vacancies across the sector as a whole.¹

For There for us, two thirds (66%) of trust chairs and chief executives cited workforce as the most pressing challenge to delivering high-quality healthcare at their trust.² This workforce gap is a fundamental strategic issue which is undermining provider sector performance and risks preventing the delivery of service transformation.

In addition, 90% of trust chairs and chief executives said they are worried or very worried about whether the Department of Health and Social Care (DHSC) and its arm’s length bodies’ approach to workforce strategy, planning, and policy will support their trust to recruit and retain the staff they need.³ This shows there is a fundamental mismatch between what providers need on the ground and the appropriateness of the national level response to date.

In There for us, one of our key recommendations was that, “The Department of Health and its arm’s-length bodies, Health Education England, NHS Improvement, NHS England, and the Care Quality Commission, need to acknowledge the scale of the workforce gap and develop and communicate a coherent and credible workforce strategy with plans and policies to support provider trusts to recruit and retain the staff they need.”

We therefore welcome the consultation document as a step towards the national bodies recognising the scale of the challenge and developing and communicating a more coherent approach. We particularly appreciate that the consultation document seeks to set out a frank assessment of the workforce challenges facing the NHS and recognises that workforce planning for some staff groups, notably doctors, needs to be done with a decade’s long view.

At the same time, however, we consider that there is a great deal of work to be done to turn the consultation document into a final strategy – with vision, desired outcomes, and how we will get there – and a realistic framework which genuinely support trusts to recruit and retain the staff they need to care for patients.

We also consider that alongside a proper focus on the long term, there must be a real sense of urgency given the scale of the workforce challenges facing the NHS and the impact on performance,

² NHS Providers (2017): There for us: a better future for the NHS workforce
³ Ibid
finance, and aspirations to transform the way services are delivered. In There for us we detailed action that can and should be taken by the government and the national bodies within one year, including:

- Confirmation of the right to remain of European Economic Area (EEA) staff working in health and social care

- Commitment to an immigration policy which supports trusts to recruit staff internationally

- Funding an end to pay restraint

- Reversal of cuts to national funding for workforce development, and

- Work with trusts, higher education institutions, and unions, to ensure the intended 25% increase of nursing students from 2018 is delivered and that any risks to application rates or the number of places set to be offered are identified, monitored, and addressed as required.4

There needs to be a commitment to action in the short term as well as over the next decade.

Of course, much of what needs to be included in the final strategy need not be revolutionary thinking. Much of what is required has already been detailed in various reports, including There for us, the Health Foundation’s Rising pressure: the NHS workforce challenge5 and the Public Accounts Committee’s report Managing the supply of NHS clinical staff in England6. It is striking in fact that HR in the NHS Plan: more staff working differently7, published back in 2003 by the then Department of Health, set out “four pillars” which very much still resonate today – making the NHS a model employer, ensuring the NHS provides a model career through offering a skills escalator, improving staff morale, and building people management skills.

As we set out in further detail below, the final strategy must address the following elements in order to support trusts to recruit and retain the staff they need to care for patients:

- Architecture and funding – national and local – to support implementation

- The priority of making the NHS a great place to work

- Realistic plans to grow the domestic workforce

4 Ibid
5 The Health Foundation (2017): Rising pressure: the NHS workforce challenge
6 House of Commons Committee of Public Accounts (2016): Managing the supply of NHS clinical staff in England
7 Department of Health (2002): HR in the NHS Plan: more staff working differently
• Recognition of the continued importance of international recruitment

• Identifying and overcoming barriers to new ways of working.

The final strategy should reflect the six principles for better workforce planning set out in the consultation document and the national bodies should put them into practice and also support trusts to do so too.

Also, we are clear that, while we have focused our response on the provider sector, the final workforce strategy needs to take account of challenges and solutions across the wider health and social care workforce, including public health and the Fit for the future\(^8\) review, primary care, third sector organisations, and, of course, the ‘informal workforce’ of family and friends who contribute so much to the care of loved ones. All these components of the health and care workforce are interrelated and vital to a genuine health and care workforce strategy.

**What the final strategy must include**

From our discussions with the provider sector we consider that the final strategy must include the following elements if it is to support trusts to recruit and retain the staff they need to care for patients.

**Architecture and funding – national and local – to support implementation**

The final strategy must, as we called for in *There for us*, clearly set out who is responsible for what and how accountability will be exercised. A key concern of trusts is the confusion stemming from fragmentation of responsibilities and a lack of coordination. We note that the DHSC has committed to review the workforce responsibilities of its arm’s length bodies.

• At the national level, there must be greater transparency about the strategic leadership role and work of the Minister of State for Health’s Workforce Steering Group.

• The final strategy should initiate discussion between the national bodies and trusts about enabling local areas – potentially in the shape of sustainability and transformation partnerships (STPs) – to take on greater ownership of workforce strategy and planning over time, together with the associated resources. While trusts want some issues, notably pay, terms, and conditions, to remain at the national level, there is appetite for workforce planning, education and training commissioning, and workforce development to be subject to greater local leadership. Trusts feel that some of this was lost with the changes to the original 13 local education and training boards (LETBs) from 2014, and that the current arrangements of four regional LETBs and local workforce action boards linked to STPs do not sufficiently enable greater local leadership on workforce.

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\(^8\) Public Health England (2016): *Fit for the future: public health people*
• Health Education England should strengthen partnerships with provider trusts at the devolved or local level to support the delivery of locally-owned workforce strategies and plans that support service sustainability and transformation through provision of timely and tailored workforce planning insight and data. Locally led workforce planning with national support has the potential to deliver better outcomes than has nationally led workforce planning.

• We recognise that there is a need to support trusts to develop additional capabilities and capacities to take on this enhanced role, and this should be a long term outcome of the final strategy, building on the lessons from the original plans for LETBs with strong provider leadership.

• It is essential that commitments in the final strategy are fully funded and also that, from now on, service, financial, and workforce planning are aligned, both at the national level and in terms of the national level’s expectations of trusts locally. The absence of such alignment can lead to the requirement to develop unrealistic plans that produce the right number locally – for example as has been reported to us has been the case with the template issued to STPs for the mental health five year forward view – but which do little to provide confidence locally about workforce needs and requirements in the future.

• We welcome the proposed Workforce Impact Assessment and consider it should be used for any new proposals for nationally led initiatives, identifying the impact on the number of staff, the skills staff will need, and extra resource required.

• To support better workforce planning we need an authoritative and publicly accessible source of timely and accurate national-level, regional, and trust-specific key workforce data on vacancy rates and leaver rates and other key workforce indicators. It is helpful that NHS Improvement has recently begun to publish sector wide vacancy data and but this should be done for leaver rates and other data too.

• We also need the national bodies to be more open with workforce planning insight and forecasts, for example timely publication of national and regional demand and supply forecasts for the different staff groups, together with the assumptions that underpin them.

The priority of making the NHS a great place to work

The NHS needs to be a well-led, model employer, with an attractive brand. Making the NHS a great place to work was a central theme of There for us and is key to keeping the staff we already have and reducing leaver rates, which is one of the factors that can be influenced in the short term. This is something to which trusts have told us the final strategy should give much greater prominence. If the final strategy is to support trusts to recruit and retain the staff they need to care for patients, it cannot simply, or even mainly, be a long term workforce plan.

We accept that first and foremost trusts, as employers, have a responsibility to make their organisations great places to work. Trusts are, for example:
• Developing positive and inclusive cultures and working to eliminate bullying at all levels of their organisations, recognising the link to inclusive and high-quality care for patients, and publishing gender pay gap reports for the first time

• Implementing the Workforce Race Equality Standard, which has powerfully shone a light on the experiences and career opportunities of BME staff

• Making best use of e-rostering and offering more flexible working, including enhancing staff banks and developing collaborative banks

• Addressing non-contractual issues highlighted by the junior doctor contract dispute, drawing on Eight high impact actions to improve the working environment for junior doctors which we produced together with The Faculty of Medical Leadership and Management and NHS Improvement.

These are just some of the areas where trusts are continuing to make progress. This must continue, but we know there is much more to do.

At the same time, as we argued in There for us, there are critical factors affecting staff experience which are largely outside of provider trusts’ control, notably the work pressure created by the fundamental mismatch between what the NHS is being asked to do and the resources made available, cuts to workforce development budgets, and the impact of seven years of pay restraint.

• Staff need to feel that the job is ‘doable’ and that they can care for patients and service users safely. In the face of rising demand for services and minimal funding growth, the NHS is reliant on the discretionary effort of staff to an unsustainable level, with staff more likely to suffer burnout and leave the service. The national bodies should set out how they will support trusts to address the issue of work pressure. Ultimately, until a realistic view is taken of what is asked of the NHS and the resources the service is allocated, it is extremely difficult for trusts to adequately address this work pressure and burnout.

• Trusts also want to see the reversal of cuts to the workforce development funding distributed by Health Education England. In 2015 it was £205m but in 2017 year it was £83m⁹. This funding is crucial for making staff development opportunities available that will help staff see a long term career in the NHS, and more broadly for developing the workforce. There should be recognition from the national bodies that it is not credible to expect trusts to make up the shortfall in the current financial context. We note that the national bodies plan to “Consider new ring-fenced workforce development funding for priority areas” and “Produce a system wide approach to agreed investment in CPD”, but underpinning this needs to be an appropriate level of funding, and this needs to be addressed as a priority.

⁹ Nursing Times (September 2017), ‘Exclusive: Funding for training ‘vital’ for nurse retention’
• We strongly welcomed the recent deal with unions for a fully funded end to pay restraint for Agenda for Change staff. Trusts have long told us that the continuation of the pay cap was damaging their ability to recruit and retain staff, and we were one of the first organisations to call for it to be scrapped. It’s something we had been arguing was needed for some time. We would also like to see the government quickly confirm an end to pay restraint for doctors, but again it must be fully funded if it is to be affordable for trusts.

• We also welcome that the DHSC and the Social Partnership Forum plan to “Review reward package”. Trusts tell us they want to be given greater flexibility in respect of reward, such as being able to offer greater upfront pay, particularly as this may be helpful in attracting younger generations of workers for who the prospect of a pension may seem a long way off, meaning it is less of a factor in deciding whether to take or stay in a job early in their career. This review could serve as a starting point.

• Trusts would also welcome a joined up national recruitment campaign for the NHS, promoting the NHS as a great place to work and helping to balance the negative national narrative that so often accompanies public debate about the NHS. We understand a campaign is being developed as part of the NHS 70th birthday celebrations and would be pleased to support it.

• The national bodies must continue to implement Developing People, Improving Care, recognising that action is needed to secure the pipeline of future leaders and ensure that once in post they are supported to lead trusts to address the challenges faced. In particular, the national bodies need to publicly value frontline leaders’ roles, acknowledging the pressure they are under and take a realistic view of what can be achieved and support them to deliver it. We welcome the expansion of Leadership Academy schemes to 20,000 per annum and of the graduate training management scheme to 500 places by 2020.

**Realistic plans to grow the domestic workforce**

As we demonstrated in There for us, sufficient numbers of staff have not been trained to meet the current levels of demand for services and to comply with public and regulatory expectations of safe staffing following past failures of care. The number of staff working in the NHS has grown, but not by enough. Unsurprisingly then, when asked for the biggest challenges to recruitment and retention at their trust, 93% of trust chairs and chief executives included staff supply shortages.10

The final strategy must therefore be supported by realistic plans to grow the domestic workforce. Trusts do not yet feel the consultation document fully grasps the challenges of delivering on recent pledges from ministers. As we argued in There for us, these plans must take account of the time taken to educate and train new staff, build on the existing mental health, cancer, and emergency care workforce plans, and take
a frank view of the impact of the introduction of student loans for healthcare students and the pace and scale at which trusts are able to deliver more apprenticeships.

Expanding university education of nurses

There is a specific and urgent need for the national bodies to work with trusts, higher education institutions, and unions, to provide strategic leadership to deliver the previously announced 25% increase of undergraduate nursing students from 2018. At present, it is unclear to trusts that the expansion will be realised, which is concerning both because of the national shortage of nurses and because the opportunity of increasing student numbers was a key argument for replacing bursaries with student loans for healthcare students. Key issues include confirming how the extra clinical placement funding will be distributed so that higher education institutions and trusts can plan ahead, how to maximise the number of applications for places in the absence of bursaries, and agreeing how and by who the number of applications will be monitored and reported on so that emerging risks can be identified and addressed and misinformation can be corrected.

Expanding numbers of apprenticeships

There also needs to be realism about the number of new staff that will be trained through the apprenticeship route in the short term. Higher education institutions and trusts report challenges with procurement contracts and that the limited supply of clinical educators and mentors is a constraining factor. Also, crucially for trusts, the rules for what funds raised through the apprenticeship levy can be spent on are limiting the capacity of trusts to significantly expand the number of apprenticeships. We would urge the national bodies to better support trusts to make more extensive use of the apprenticeship levy and support them to scale up their programmes. These issues and other issues need to be quickly identified and addressed through the planned review of first year use of the apprenticeship levy.

Medical education and training

While trusts have welcomed the expansion of medical student places, there is continuing concern from many trusts about the allocation of junior doctor training places. There is particular concern that some areas of the country and some specialties may be missing out and that current distribution is inequitable.

We need to both train more doctors, but also ensure that there is effective distribution of training places across the country. Junior doctors often stay in the same location where they undertook training, and therefore poor distribution of training posts can lead to local consultant shortages in future. Junior doctors also have a crucial role to play in service delivery, so where trusts are short of junior doctors this puts pressure on those they do have in the form of rota gaps. We note the national bodies plan to “Review distribution of postgraduate medical training places by specialty and geography”. This must be
transparent, take place as soon as possible, and we would happy to contribute and facilitate engagement with trusts.

**Recognition of the continued importance of international recruitment**

As is often pointed out, growing the domestic workforce will take time. Improving retention and increasing return to practice have a role to play, but so does international recruitment. 85% of trust chairs and chief executives told us that it will be important or very important for their trust to recruit from outside the UK over the next three years.\(^{11}\) As we stressed in *There for us*, immigration policy – both the existing non-EU system and a future EU system – and professional regulation – in particular language requirements – need to be a support rather than a hindrance.

- The final strategy must therefore set out how trusts will be supported to recruit internationally to fill vacancies that cannot currently be filled from the domestic workforce. International staff also bring a diverse range of skills and experience. In particular, in the immediate term, we need to see a solution to the current problem of trusts being unable to gain certificates of sponsorship for clinical staff such as doctors who have been recruited from outside of the EEA. Where trusts cannot get certificates of sponsorship doctors often decide to go and work elsewhere, often leaving the trust to fill the vacancy on a temporary basis by paying premium locum rates. International recruitment is expensive and it is deeply frustrating when staff offered jobs are unable to take them up due to lack of visas.

- Trusts also want the Nursing and Midwifery Council to continue to progress at pace its review of language requirements for the registration of non-UK nurses, maintaining patient safety and engaging with provider trusts and other stakeholders. Trusts appreciate that the Nursing and Midwifery Council now accepts the Occupational English Test as proof of language competence, but also want to see changes to requirements to the use of the more widely sat International English Language Testing System (IELTS) to better reflect the reality of UK nursing practice.

- We welcome the expansion of The Global Learners earn, learn, and return programme, positioning the NHS in England as a global centre of excellence for healthcare education and helping mitigate domestic workforce shortages. This can be a really helpful option for some trusts. However, this programme cannot be seen as a substitute for immigration policy that supports trusts to recruit staff internationally on a permanent basis.

- It is also important – as we move towards exiting the EU – that international staff already working in health and care know that they are valued and we want them to stay and that messages from the national bodies continue to convey this.

\(^{11}\) Ibid
Identifying and overcoming barriers to new ways of working

As we highlighted in *There for us*, the response to the workforce challenges the NHS faces is not only about numbers. Having the right mix of staff and skills is essential for the delivery of high-quality care. In the context of the wider health and care sector increasingly working together across organisational boundaries, trusts are redesigning the workforce to meet the needs of their population and deliver new models of care. This workforce redesign has also been part of the solution in some areas and specialties to the absence of sufficient numbers of nurses and doctors. These changes to skill mix in teams and the way in which staff work together can therefore deliver improvements for patients, staff and an organisation’s finances.

- Developing new roles can also enhance multidisciplinary team working, free up others’ workloads and reduce agency spend on hard to recruit to positions. It can also be used to offer new and engaging careers to staff, providing there are clear pathways of progression. Examples of these new roles include: assistant nurse practitioners screening patients in emergency departments, nurse-led intravitreal injection services, nursing associates that bridge the gap between registered nurses and healthcare assistants, nurse angiographers (coronary angiography is an X-ray test which uses dye to check for blocked or narrowed coronary arteries), and prescribing pharmacists.

- The national bodies, notably the Care Quality Commission, professional regulators, and professional associations should support and enable provider trusts’ efforts to introduce new roles at scale and pace and develop the existing workforce to work differently, by aligning professional and institutional regulatory approaches and offering professional support.

The process of finalising the strategy

Given that there is a great deal of work to be done to turn the consultation document into a final strategy, we consider that it will be important that the national bodies engage with trusts and other key stakeholders on a draft of the strategy before it is finalised and published in July 2018. We are ready to help facilitate this. Without this additional engagement there is a significant risk that the final strategy will not take account of all relevant issues or adopt a realistic view of the way forward, in which case it would be likely to lack credibility and buy in from trusts.

There is also a need for the national bodies to clarify what kind of document the final strategy will be - a document in which the health and care system sets out what we plan to do and what we need from government or a document with cross-government sign-off on issues such as immigration and funding. Clarity on this will help manage trusts expectations and inform further comments they may make as part of additional engagement on a draft of the strategy.

We believe the six principles for better workforce planning set out in the consultation document are sensible and uncontentroversial. What is vital is that the final strategy reflects these principles and that the national bodies put them into practice and support trusts to do so too.
Contact for further information or questions

For further information or questions, please contact Paul Myatt, Policy Advisor – Workforce, at paul.myatt@nhsproviders.org.
Annex A (taken from *There for us: a better future for the NHS workforce*)

**WHAT NEEDS TO HAPPEN TO SUPPORT TRUSTS TO RECRUIT AND RETAIN THE STAFF THEY NEED?**

Provider trusts recognise that to close the workforce gap they must make their organisations great places to work, develop the workforce to deliver STPs and new care models, and enhance workforce productivity.

Yet there are also important changes needed at the national level to support trusts to recruit and retain the staff they need and close the workforce gap.

Throughout the report we have set out recommendations for key parts of the system.

**Short term (within one year)**

**Provider trusts should:**

- prioritise making their organisations great places to work, fostering positive and inclusive cultures, eliminating bullying at all levels, and delivering progress against the workforce race equality standard;

- continue to make the most of opportunities to develop the workforce and improve workforce productivity;

**The government should:**

- take a realistic view of what is asked of the NHS and the funding they are allocated in order to alleviate the stress and pressure on NHS staff which is contributing to the workforce gap. Staff need to feel that the job is ‘doable’ and that they can care for patients and service users safely. We have previously backed calls for an Office of Health and Social Care Sustainability which could promote a realistic assessment of what is needed.

- set out a plan to deliver the promised end of pay restraint during this parliament. According to the Institute of Fiscal Studies, the cost of a 2% pay award for the NHS would be £1bn annually. This level of funding cannot currently be absorbed within the existing financial allocation for the NHS. Therefore this must be fully funded;

- urgently confirm the right to remain for the 60,000 EEA staff working in the NHS and provide a straightforward and inexpensive way for them to establish this right;
• commit to a future immigration policy supporting trusts to recruit and retain staff from around the world to fill posts that cannot be filled by the domestic workforce in the short to medium-term.

The Department of Health and the NHS national bodies should:

• reverse the cuts to workforce development funds distributed to trusts by Health Education England, to support staff retention and the delivery of STPs and new care models;

• work with trusts and unions to deliver a national recruitment campaign for the NHS, promoting healthcare careers and helping to balance the negative national narrative that so often accompanies debate about the NHS;

• work with trusts to develop an international recruitment programme that trusts can pay to opt into if they want to, rather than undertaking their own individual recruitment campaigns. The Global Health Exchange *Earn, learn, and return* pilot programme is a sensible place to start and could be run on an indefinite basis, positioning the NHS in England as a global centre of excellence for healthcare education;

• work with trusts, higher education institutions, and unions, providing strategic leadership, to ensure the intended 25% increase of nursing students from 2018 is delivered and any risks to application rates or the number of places set to be offered are identified, monitored, and addressed as required. The experience of 2017 has shown we cannot assume an announced expansion of students will actually happen;

• recognise the pressure on provider trust leaders, take a realistic view of what can be achieved, support them, and publicly value their roles;

• continue to support provider trusts with programmes to:
  
  • reduce leaver rates and improve retention rates;

  • enhance workforce productivity by reducing agency spend and implementing the workforce elements of Lord Carter’s productivity review and GIRFT;

  • publicly value frontline leaders’ roles, acknowledging the pressure they are under, take a realistic view of what can be achieved and support them to deliver it;

  • work with provider trusts to address the leadership pipeline, building the national framework for improvement and leadership development, the aspiring chief executive programme, and the wider work of the NHS Leadership Academy;
The Nursing and Midwifery Council should:

• continue to progress at pace its review of language requirements for the registration of non-UK nurses, maintaining patient safety and engaging with provider trusts and other stakeholders.

The NHS national bodies, professional regulators, and professional associations should:

• support and enable provider trusts’ efforts to introduce new roles at scale and pace and develop the existing workforce to work differently, by aligning professional and institutional regulatory approaches and offering professional support.

**Medium term (within two years)**

The Department of Health and the NHS national bodies should:

• develop and communicate a coherent and credible strategy for the health and social care workforce, setting out what they think the future workforce needs to look like given the *Five year forward view*, STPs, and new care models and what will be done, by who, and by when to at the national level to develop that workforce;

• ensure the existing ministerial board on workforce is recognised as the forum to coordinate and own this strategy, in collaboration with provider trusts and other stakeholders. It needs to communicate effectively about its work, seek input from a wide range of opinion, be transparent about its work programme and be seen to engage effectively with provider trust leaders;

• develop a measurable plan with timetables to grow the domestic supply of clinical staff, taking account of relevant factors such as changes to the funding of healthcare education, the apprenticeship levy and targets, the expansion of nursing, and the recent workforce plans for mental health and emergency care workforces. This plan will link to and support the strategy;

• take action to ensure there is an agreed and publicly accessibly source of timely and accurate national-level, regional, and trust-specific data for key workforce data such as vacancy rates and leaver rates;

• provide greater transparency of its workforce planning insight and data, for example timely publication of national and regional demand and supply forecasts for the different staff groups, together with the assumptions and any funding constraints that underpin them;

• work with provider trusts at the sub-national level – for example, devolved, groups of STPs, or STP as appropriate – to support the delivery of locally-owned workforce strategies and plans that support service transformation through provision of timely and tailored workforce planning insight and data.
Long term (within three to four years)

The Department of Health and the NHS national bodies should:

- work with provider trusts and other stakeholders to explore the opportunities and risks of devolving elements of workforce responsibility and funding – for example medical education and training commissioning, distribution of clinical placement funding. This could be at devolved, groups of STPs, or STP level;

- develop the capability and capacity of provider trusts to take on this greater role, building on the lessons from the original plans for local education and training boards with strong provider leadership. The return on this investment could be a more engaged, responsive, and productive workforce;

- build and value local leadership and autonomy as crucial for the success of STPs and new care models.