Health and Social Care Committee: Workforce: recruitment, training and retention in health and social care

Submission by NHS Providers, 13 January 2022

NHS Providers is the membership organisation for the NHS hospital, mental health, community, and ambulance services that treat patients and service users in the NHS. NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

Key messages

- To recruit and retain sufficient staff, roles in the NHS and social care have to be appealing. Pay, flexibility, work/life balance, job satisfaction, and continuing professional development (CPD) can be improved with additional funding and focus. Wider pension reform is needed to avoid incentivising early retirement and instead retain experienced staff, and additional investment is needed to ensure that pay is not a factor in staff choosing to leave health and social care during this period of exceptionally high service demand.

- To ensure the NHS and social care workforce is sustainable, a fully costed and funded multi-year workforce plan is needed, covering both sectors. This plan must be based on local-level input and give the workforce numbers needed to not only address existing vacancies, but also to build flexibility into the system to enable the system to cope with fluctuations in demand. We hope that Parliament will ultimately support the proposed amendment to the Health and Social Care Bill to this end, along with NHS Providers and a broad coalition of health and care organisations who back the amendment.

- The adult social care reform white paper marks an important step towards a much-needed national vision for the social care workforce. However, there is insufficient funding attached to this ambition. Recruitment of social care staff would be helped by working towards the creation of a pay framework in social care that is either fully integrated with Agenda for Change (AfC) in the NHS or offers comparable rates. Progression in social care, and higher quality training offers, should also be addressed. This will require significant additional investment.

- There was no specific funding rise for the department of Health and Social Care (DHSC) workforce budget in 2021, and therefore no detail on what the upcoming Health Education England (HEE) budget will be. Protecting workforce training and development funding among the ringfenced NHS England and NHS Improvement (NHSE/I) budget will be vitally important when HEE merges with NHSE/I in 2023, though we recognise the benefits of integrating the function.

- There should be a focus on the long-term sustainability of recruitment practices, with both domestic and international recruitment recognised as important routes for health and social care, especially given the growing demands on the sectors.

- We welcome the addition of care workers and home carers to the Health & Care visa, and the Shortage Occupation List. We would encourage this to be enacted as soon as possible and would support this as a permanent change following the initial 12-month trial.

- Widening societal inequalities will continue to create uneven demand for services across the country, exacerbated by areas of high deprivation already struggling to recruit staff. Investment which makes those areas attractive places to work is key to narrowing inequalities by improving employment opportunities, which trusts can play a key role in as anchor institutions.

What are the main steps that must be taken to recruit the extra staff that are needed across the health and social care sectors in the short, medium and long-term?

1. In September 2021, NHS trusts were facing over 99,000 vacancies.[1] In October 2021, Skills for Care estimated that the adult social care sector had 105,000 vacancies on any given day across 2020/21.[2] This is immensely worrying, particularly given increasing service demand across health and social care.

2. Roles in the NHS and social care must be appealing to recruit and retain sufficient staff. Pay, flexibility, work/life balance, job satisfaction, and continuing professional development (CPD) can be improved with additional funding and focus.

3. Short term action to take includes the NHS staff pay rounds for 2022/23. It is not enough to ring-fence the five-year funding settlement (which covers staff pay). Additional funding should be allocated for pay awards to ensure they are not a factor in staff choosing to leave the service during this period of exceptionally high demand.

4. Another immediate consideration is the budget for Health Education England (HEE). Whilst additional funding for the NHS in the October 2021 spending review settlement was welcome, there was no specific rise given for the workforce budget (which sits outside the NHSE/I ringfence and spending review settlement). [3] This is concerning given it has declined by around £1bn in real terms since HEE's first settlement in 2013/14, when there were significantly fewer staff in the NHS than there are now. This means that the training and workforce development budget is spread far too thinly. Addressing this would require upfront investment for medium to long term gain in workforce numbers. Protecting workforce training and development funding within the ringfenced budget will be vitally important when HEE merges with NHS England in 2023, though we recognise the benefits of integrating the function.

5. Pay and terms and conditions of service in the social care sector should also be reconsidered. Tangible, fully funded measures to improve pay and tackle high vacancy levels in the social care workforce are needed, alongside reform with sustainable funding to support the provider market, increasing access and quality of care.[4] In the short term, the government could fund a retention bonus of £500 for all 1.54m social care staff,[5] and provide funding for them to be on the living wage before it becomes law in April. The government commitment of £300m to the

[1] NHS Digital: NHS Vacancy Statistics England April 2015 – September 2021 Experimental Statistics: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2021-experimental-statistics

[2] Skills for Care: The state of the adult social care sector and workforce in England, published October 2021: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx

[3] NHS Providers: On the day briefing, "Autumn Budget and Spending Review 2021", 27 October 2021: https://nhsproviders.org/media/692396/october-2021-budget-and-csr.pdf

[4] NHS Providers briefing, "People at the Heart of Care: adult social care reform white paper", 2 December 2021: https://nhsproviders.org/media/692697/nhs-providers-next-day-briefing-social-care-reform-white-paper-final.pdf

[5] Skills for Care, "The state of the adult social care sector and workforce in England", published October 2021: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx

adult social care workforce on 17 December 2021 fell significantly short of the £1.5bn which the Association of Directors of Adult Social Services (ADASS) said was needed to mitigate financial, workforce and capacity issues in adult social care this winter.[6] In the medium to longer term, working towards the creation of a pay framework for social care staff that is either fully integrated with Agenda for Change (AfC) in the NHS, or offers comparable rates, would be of significant help in improving social care staff recruitment.

6. Long term, the adult social care reform white paper provides a welcome ambition to improve recruitment in the social care sector by developing a skills and knowledge framework, supporting wellbeing and ensuring staff value and recognition. However, the £500m allocated to social care workforce training from the funding raised by the health and social care levy over the next three years equates to only £100 per staff member.[7]

7. Fundamentally, however, we need a fully costed and funded multi-year national workforce plan for the health and care sectors in order to properly assess, recruit, and retain the extra staff that are needed to deliver services sustainably. The long-term ambition must be to detail how enough health and social care staff will be trained, recruited and retained in the coming years, with the levels of funding necessary to enable this. This plan must be focussed on numbers needed in the workforce, not only to address existing gaps, but to build flexibility and resilience into the system. The point on flexibility is particularly important but often overlooked in discussions on national-level workforce planning. Running services with staffing levels below or equal to those needed to complete business as usual means that when additional demands are placed on the system, it is extremely challenging to meet them. Staff suffer when this happens, with increased workloads and heightened risk of burnout, and service users suffer from the resultant impact on the system's ability to provide care. The COVID-19 pandemic has been a clear example of this and has highlighted the importance of investing in the health and social care workforce to build flexibility into staffing levels. To this end, NHS Providers and a broad coalition of health and care organisations support an amendment to the Health and Care Bill which calls for the secretary of state to publish, every two years, independently verified assessments of current and future workforce numbers consistent with the Office for Budget Responsibility long-term fiscal projections. We hope that Parliament will ultimately also support this important amendment.

What is the best way to ensure that current plans for recruitment, training and retention are able to adapt as models for providing future care change?

8. Collaborative, cross-organisational approaches to the NHS workforce are being codified with the Health and Care Bill, through the implementation of local people plans, and through NHSE/I's direction that integrated care boards (ICBs) should adopt a "one workforce" approach. Such joined up recruitment and workforce planning has the potential to ease workforce shortages by a degree and improve service delivery, with staff shared more evenly across organisations. The "one workforce" approach could also be used as a basis for a national health and social care workforce plan, emphasising a multidisciplinary workforce and delivering more care in the community.

[6] Association of Directors of Adult Social Services (ADASS), "ADASS Submission to the Budget and Comprehensive Spending Review", September 2021: https://www.adass.org.uk/media/8873/adass-sr-2021_final-submission-30_9_21_.pdf

[7] Association of Directors of Adult Social Services (ADASS), "ADASS responds to: funding to help with retention and recruitment of the adult social care workforce": https://www.adass.org.uk/adass-responds-to-funding-to-help-with-retention-and-recruitment-of-the-adult-social-care-workforce

9. Career pathways need to be considered for all roles, with more staff taking non-linear routes through their training and careers. We are interested in the development of HEE's "generalist training", based on the 2020 Future Doctor report, and how this might be implemented for other staff groups. There has also been notable increase in career flexibilities to combat the trend of early retirement and instead retain experienced staff, with an upswing in "retire and return" schemes, and different roles (such as mentoring) offered to eligible staff. This could be harnessed to support future career change, retaining experienced staff in strategic roles which implement and develop new ways of delivering services.

10. New roles, such as medical associate professionals (MAPs), nursing associates, and healthcare support workers hold potential to expand recruitment, bring new skills and ways of working to the NHS, and improve service delivery. However, they have been significantly underutilised to date. Restrictions to fully incorporating these staff members into workforce planning include: perceived lack of flexibility over skills mix; inadequate access to training and development; and uncertainty, caused by a lack of regulation (for physician associates) and incomplete professional guidance (for nursing associates). The unreliability of time-limited funding for many of these roles is also a stumbling block. National support for new roles would be helpful – nursing associates have benefited from this, but physicians associates (for instance) have not had the same focus. It was disappointing to see further delay of the General Medical Council's regulation of physician and anaesthesia associates to 2023.[8] Once this regulation begins, the breadth of their work can increase – prescribing rights for physician associates will be particularly useful.

11. To ensure that plans for recruitment, training and retention can adapt, communication between arm's-length bodies, government, and organisations providing health and social care needs be regular and comprehensive. The update to HEE's Long-Term Strategic Framework for Health and Social Care Workforce Planning[9] is an important starting point but, the health and social care sectors need a nationally coordinated, fully costed and funded, long term workforce plan.

What is the correct balance between domestic and international recruitment of health and social care workers in the short, medium and long term?

12. We do not believe there is a "correct" balance between domestic and international recruitment. The focus should be on sustainability of recruitment practices as a whole, which meet needs across a system, are properly funded, and recognise the importance of internationally recruited staff to service delivery.

What can the Government do to make it easier for staff to be recruited from countries from which it is ethically acceptable to recruit, with trusted training programmes?

[8] GMC, Bringing physician associates and anaesthesia associates into regulation, 15 November 2021: https://www.gmc-uk.org/pa-and-aa-regulation-hub/map-regulation

[9] Health Education England, Long-Term Strategic Framework for Health and Social Care Workforce Planning: https://www.hee.nhs.uk/our-work/long-term-strategic-framework-health-social-care-workforce-planning

13. There is potential to liberalise the current approach to regulation of international applicants. There have been concerns raised by the health and social care sectors that the application process for international staff is overly burdensome, causing many potential staff to withdraw their applications. Streamlining regulation and paperwork for international applications and NHS registration would be a positive step in reducing barriers to international recruitment.[10]

14. The cost of international recruitment can be significant for providers, through visa sponsorship and other charges. Many organisations cannot capitalise on international recruitment due to funding constraints and the prescriptive nature of a regulatory and administrative process which requires in-house expertise to navigate. Local partnerships which have existing expertise tend to do better at recruiting and retaining international staff.

15. We welcome the Home Office's recent acceptance of the Migration Advisory Committee's (MAC's) recommendations to add care workers and home carers to the Health & Care visa, and to the Shortage Occupation List dependent upon a minimum salary level of £20,480.[11] We would encourage this to be enacted as soon as possible and would support this as a permanent change following the initial 12-month trial. The trial period must evaluate the minimum salary level, given many care worker salaries fall below this figure.

What changes could be made to the initial and ongoing training of staff in the health and social care sectors in order to help increase the number of staff working in these sectors? In particular:

To what extent is there an adequate system for determining how many doctors, nurses and allied health professionals should be trained to meet long-term need?

16. There is currently no adequate system for determining how many doctors, nurses and allied health professionals should be trained to meet long-term need. The health and social care sectors need a nationally coordinated, fully costed and funded, long term workforce plan. Much work has already been done by HEE, think tanks, Royal Colleges and other bodies to this end, so this endeavour would not start from a blank page.

Should the cap on the number of medical places offered to international and domestic students be removed?

17. Trust leaders support the removal of the cap on medical school places, which would significantly increase recruitment of doctors in the medium term, contingent on additional funding for expanded medical school and foundation training placement capacity.

What are the principal factors driving staff to leave the health and social care sectors and what could be done to address them?

[10] NHS Providers, professional regulation consultation response, June 2021: https://nhsproviders.org/resource-library/submissions/nhs-providers-professional-regulation-consultation-response

[11] Home Office letter to the Migration Advisory Committee, 24 December 2021: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1044828/Minister_Foster_to_Brian_Bell_-_Social_Care_Workers_241221.pdf

18. Wellbeing, morale, and workplace culture can be significant hindrances to retention. The NHS People Plan 2020/21 makes a "People Promise", regarding inclusivity, recognition, physical health and wellbeing, flexible working, and teamwork.[12] We support the Plan's commitment to prioritise staff health and wellbeing and make the NHS a great place to work, but more investment is needed to make this a reality. To sustainably protect the wellbeing of the NHS and social care workforce, more staff are needed not only to cover existing workforce gaps in both sectors, but to build flexibility into the system. Wellbeing is often spoken of at an individual level, but by building a resilient system, staff will be far better protected by realistic workloads, regular and reliable breaks, and better work/life balance. NHS and social care staff should be able to expect this. Similarly, the Academy of Medical Royal Colleges (AoMRC) has highlighted the importance of "getting the basics right" to improve staff experience with facilities for rest, space for non-clinical work, easily accessible food and drink, a fully funded occupational health service, and efforts to stamp out bullying.[13] These initiatives will improve staff retention, but need appropriate funding levels.

19. In addition, more staff are taking non-linear routes through their training and careers, with increased movement between roles, organisations, and specialties. The People Plan recognises the increasing preference for flexible working among staff.[14] This is likely to be mirrored in social care and requires rethinking across both sectors in terms of roles, development, and retention. Many trusts are undertaking innovative work in rethinking career advancement, but are often limited by the structures of training programmes, experience requirements, and pay scales. There needs to be flexibility at a national as well as local level to facilitate this work.

20. There has been a notable increase in career flexibilities in recent years to combat the trend of early retirement. Improvements have also been made to the pension scheme, following the adverse impact of tax free annual and lifetime pension growth limits on senior staff. The raising of annual thresholds, and changes which reduce the impact of the taper on higher earners, have been welcome. The previously widespread issues of senior staff turning down additional work due to the pension tax bills it would incur has been somewhat mitigated, but pensions remain a significant issue to staff retention in the NHS. Wider pension reform is needed to ensure that the unaltered lifetime allowance charges, and other upcoming changes to pension taxation, do not incentivise early retirement, but rather, retain experienced staff.

21. Increasing demand for flexible working options is also likely to be due to unsustainable workloads. The 2020 NHS staff survey found that over half of staff worked additional unpaid hours that year, three quarters regularly faced unrealistic time pressures in their jobs, and two thirds did not feel there were enough staff in their organisation to enable them to do their work.[15] A larger workforce would ease workload pressures and also give greater scope to employers' ability to offer flexible working as standard when advertising roles – as per the ambitions of the NHS People Plan 2020/21.[16]

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[12] NHS England and NHS Improvement, "Our People Promise", 30 July 2020: https://www.england.nhs.uk/publication/our-nhs-people-promise/

[13] The Academy of Medical Royal Colleges, A dozen things the NHS could do tomorrow to help the medical workforce crisis, 6 December 2021: https://www.aomrc.org.uk/wp-content/uploads/2021/12/A_dozen_things_NHS_could_do_tomorrow_061221.pdf

[14] NHS England and NHS Improvement, "We are the NHS: People Plan for 2020/21 – action for us all", 30 July 2020: https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

[15] NHS Staff Survey results 2020, March 2021: https://www.nhsstaffsurveys.com/results/

[16] NHS England and NHS Improvement, "We are the NHS: People Plan for 2020/21 – action for us all", 30 July 2020: https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

22. HEE's CPD funding is well below where it needs to be for the NHS. The additional £150m for CPD, announced in 2020, was to be spread across three years via £1,000 personal development budgets, with strict caveats regarding how they could be spent. It is difficult to invest in advance practice training due to this. Chronic underfunding and lack of time for staff to undertake CPD (due to staff shortages and increasing demand) has hindered the developmental aspect of the NHS staff offer, and addressing this should be a government priority. CPD funding must increase in real terms, rather than staying level or continuing to reduce. This would yield significant return on investment and increase retention. It is vital to consider health careers as an ongoing whole when it comes to policy and funding, rather than focussing solely on recruitment. This issue is mirrored in the social care sector, with the MAC's annual report stating that retention issues in social care "are mainly due to pay, poor terms and conditions, and lack of progression in the sector".[17] Alignment to AfC help address the lack of progression in social care, and should come alongside higher quality training offers, including CPD.

23. Different incentives for staff across different organisations have a knock-on effect to service delivery as a whole. Oversight across a given area, drawing local approaches into one coherent plan, is key. This oversight ensures systems collate and categorise the needs that are assessed locally by different organisations, meaning that local workforce plans become an aggregation of those needs. This takes considered implementation and planning – for instance, there is concern surrounding the direct employment of paramedics in PCNs, which not only puts further demand on a key staff group for ambulance trusts, but also causes issues given the lack of training and guidance which PCNs can offer to paramedics. A "one workforce" approach, with integrated care boards playing a key convening role, needs to be centred around supporting staff to continually develop for a long-lasting career in the NHS, as well as being centred on service delivery.

Are there specific roles, and/or geographical locations, where recruitment and retention are a particular problem and what could be done to address this?

24. National difficulties in filling vacancies in acute specialties are amplified for many trusts operating smaller sites in rural areas, with rural trusts struggling to recruit across junior doctor, middle grade and consultant staff groups.[18] Junior doctors are often more inclined to work in urban centres to train in large teaching hospitals.[19] The lack of financial incentives that support junior doctors' relocation to rural areas is a large factor in this, along with perceptions about a lack of high-end specialist provision in rural areas. These issues discourage applications from or retention of clinical staff hoping to build expertise, and instead leads to a reliance on expensive locum and agency staff. Given their geographical isolation, there is a push for rural trusts to implement workforce pipelines in their own communities, utilising their status as anchor institutions. This is, however, challenging given lack of resource and expertise to set up such pipelines among smaller health and care organisations.

25. Community and mental health trusts across the country struggle to recruit to particular disciplines where there is heightened service demand, such as nurses specialising in learning disabilities. In 2019, Skills for Care also found that large distances being required for travel to

[17] Migration Advisory Committee (MAC) annual report 2021, 15 December 2021: https://www.gov.uk/government/publications/migration-advisory-committee-annual-report-2021/migration-advisory-committee-mac-annual-report-2021-accessible-version

[18] Future Healthcare Journal, "The problems of smaller, rural and remote hospitals: separating facts from fiction", 2020: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7032574/

[19] NHS Providers, "Trusts operating in a rural environment", April 2021: https://nhsproviders.org/trusts-operating-in-a-rural-environment

work was a key factor in low take up of care worker roles.[20] These national workforce pressures are again particularly exacerbated in rural areas.

26. Societal inequalities also create uneven demand for services across the country, exacerbated by areas of high deprivation already struggling to recruit staff. Cyclically, this results in further widened inequalities. Investment to make those areas attractive places to work is a key way of narrowing inequalities by improving employment opportunities. HEE could be instrumental here in directing workstreams to attract underrepresented communities to take up careers in health. New roles such as the medical doctor apprenticeship, which is currently in development, could be useful to this end. Addressing workplace inequality and addressing health inequalities is symbiotic. Improving recruitment, support and opportunity for minority ethnic staff in the NHS will improve care for minority ethnic populations. Organisational focus and resource (including adequate staffing levels for public health and data analysis) to address health inequalities is therefore vital, alongside funding for local councils and businesses in areas of high deprivation, to invest in communities and improve employment opportunities (which trusts can play a key role in as anchor institutions).

What should be in the next iteration of the NHS People Plan, and a people plan for the social care sector, to address the recruitment, training and retention of staff?

27. The main aspect missing from the NHS People Plan is a focus on workforce numbers. To address the recruitment, training and retention of staff in health and social care, a long-term workforce plan which covers both sectors is needed. Whether this sits within or outside the NHS People Plan, any further iterations will be of limited value without it.

28. The current iteration's focus on improving equality, diversity and inclusion within the NHS workforce should be retained and strengthened. Investment in culture and wellbeing is key to achieving this and will in turn improve quality of care. The current People Plan's requirement for increased diversity in the workforce over the next four to five years is an important ambition, but it will be difficult to deliver in some areas without significant intervention by HEE on student recruitment practices to increase the diversity of potential applicants.

To what extent are the contractual and employment models used in the health and social care sectors fit for the purpose of attracting, training, and retaining the right numbers of staff with the right skills?

29. Given that there are over 99,000 vacancies in NHS trusts[21] and roughly 105,000 in adult social care,[22] arguably the contractual and employment models in the health and social care sectors are not fit for the purpose of attracting, training, and retaining the right numbers of staff with the right skills.

[20] Skills for Care, "Rural adult social care workforce information", March 2019: https://www.ncrhc.org/assets/downloads/Rural_v_Urban_report.pdf
[21] NHS Digital: NHS Vacancy Statistics England April 2015 – September 2021 Experimental Statistics: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2021-experimental-statistics
[22] Skills for Care: The state of the adult social care sector and workforce in England, published October 2021: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx

30. A key barrier to service integration is the lack of parity in pay and terms and conditions of employment for different roles across the system. For example, a multi-disciplinary team with staff from primary care, community services and social care which delivers domiciliary care services would see significant differences in pay between team members. This is directly impacted by national policy such as the September 2019 announcement of a £1,000 nursing CPD package, which transpired to be for NHS nurses only, excluding social care nurses. These instances negatively impact staff morale and retention in multi-disciplinary teams.

31. Improving contracts and employment models requires a national approach, so that one area of the system is not drawing staff away from another. This is already an issue for social care, where employment terms are largely less favourable than those of AfC. This could be addressed through the creation of a pay framework for social care staff that is either fully integrated with AfC in the NHS or which offers comparable rates – these measures have also been proposed by the Local Government Association and ADASS.[23] The MAC's 2021 annual report notes "little evidence of pay progression over time for care workers".[24] Alignment with AfC would go a long way to resolving this. If implemented, these measures must be fully funded centrally, as increasing workforce costs will either reduce capacity or undermine the viability of existing providers.

32. The MAC's annual report also notes that care workers are more likely to work on-call, evenings and night shifts than competing occupations.[25] This is also prevalent for AfC staff, with staff shortages meaning that anti-social hours have to be worked more frequently by smaller groups of employees. These increased workloads also mean that time for training and development is harder to prioritise. Improving contractual and employment models for health and social care staff would help recruitment, giving more capacity to the system and aiding the retention of existing and additional staff.

What is the role of integrated care systems in ensuring that local health and care organisations attract and retain staff with the right mix of skills?

33. ICBs will become the principle organising function for workforce planning moving forwards, coordinating a "one workforce" approach across each system (as per the People Plan 2020/21).[26] ICBs will hold responsibility for clinical and non-clinical staff working in primary and community care (alongside secondary and tertiary care), supporting and collaborating with providers of wider community services (including local government, public services, and the voluntary sector). If undertaken with full input from constituent partners, the process of fulfilling this responsibility may be a useful grounding – not a replacement – for national-level health and social care workforce planning, as it should capture levels of local need and opportunities for collaboration.

34. However, some aspects of staffing are not possible at system level. The ICS people function guidance explicitly "does not prescribe a 'one size fits all' approach to establishing, developing

[23] Health and Social Care Committee, "Social care: funding and workforce", 22 October 2020, paragraph 53: https://committees.parliament.uk/publications/3120/documents/29193/default/
[24] Migration Advisory Committee (MAC) annual report 2021, 15 December 2021: https://www.gov.uk/government/publications/migration-advisory-committee-annual-report-2021/migration-advisory-committee-mac-annual-report-2021-accessible-version
[25] Migration Advisory Committee (MAC) annual report 2021, 15 December 2021: https://www.gov.uk/government/publications/migration-advisory-committee-annual-report-2021/migration-advisory-committee-mac-annual-report-2021-accessible-version
[26] NHS England and NHS Improvement, "We are the NHS: People Plan for 2020/21 – action for us all", 30 July 2020: https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

and delivering the ICS people function". Rather, the guidance is intended to "support local flexibility", recognising that systems have different approaches and levels of collaboration on workforce activity, and that each ICS will need to proceed "according to their particular circumstances".[27] This is an important aspect to note, given that local providers remain the principal employer of their staff, and therefore responsible for staff satisfaction and other aspects of employment.

35. Whilst ICBs will hold primary responsibility for workforce planning, constituent organisations within an ICS still have a significant role to play in attracting and retaining staff. The focus should therefore be on supporting structures which enable regional and system people boards to align correctly, with a mix of organisational representatives inputting into the workforce planning process for their area.

[27] NHS England and NHS Improvement, "Building strong integrated care systems everywhere: guidance on the ICS people function", 1 August 2020: https://www.england.nhs.uk/wp-content/uploads/2021/06/B0662_Building-strong-integrated-care-systems-everywhere-guidance-on-the-ICS-people-function-August-2021.pdf