House of Lords Public Services Committee: Designing a public services workforce fit for the future

Submission by NHS Providers, 24 February 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

- Long-term workforce planning for the NHS workforce must focus on how enough health and social care staff will be trained, recruited, and retained in the future. Fundamentally, a fully costed and funded national workforce plan is needed to secure the correct focus and funding for the NHS to properly assess, recruit, and retain the number of extra staff that are needed to deliver services sustainably.

- Roles in the NHS have to be appealing. Pay, flexibility, work/life balance, job satisfaction, and continuing professional development (CPD) can be improved with additional funding and focus.

- Investment in culture and wellbeing is key to improving equality, diversity and inclusion within the NHS workforce. Whilst the NHS is the UK's largest employer of Black, Asian and minority ethnic people, it is not always a good employer of people from minority communities. Improving recruitment, support and opportunity for minority ethnic staff in the NHS will in turn improve quality of care, particularly for minority ethnic populations. Organisational focus and resource to address health inequalities is vital.

- Internationally recruited workers are integral to NHS delivery of care. We welcomed 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 Worker visa, and to the Shortage Occupation List dependent upon a minimum salary level of £20,480. 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.

- COVID-19 has accelerated collaboration across the health and care system, helping to meet the unprecedented levels of demand, and as a result. Trusts across the country are continuing to push themselves to do the best for their staff, with innovative and future-facing approaches to workforce planning, management, and deployment. However, a lack of workforce capacity constrains further progress. The only sustainable solution to workforce challenges in the NHS is sufficient focus and investment in staff pay, recruitment (including training) and retention, via a national workforce plan.

RECRUITMENT, RETENTION AND TRAINING

Question 1: It is difficult to predict accurately how the public services workforce will need to change in the long term, and yet it is necessary to prepare now for the future. What is an appropriate approach to long-term planning for workforce needs

and demand in public services, and how should current training adapt, not just at the point of employees' entry into the workforce but throughout their careers?

1. Staff availability to meet the current levels of demand the NHS is experiencing is the biggest challenge healthcare providers are facing. As of September 2021, NHS trusts were facing over 99,000 vacancies.[1] Moreover, trust leaders report that many people within the NHS workforce are exhausted and overstretched. Staff are the bedrock of the NHS. Rapid solutions to a range of workforce issues – such as training, pension taxes and staff pay, terms and conditions – are therefore vital. Greater flexibility and appealing career pathways are also needed, along with policies that support the NHS in building a committed workforce and increasing supply.

2. The long-term ambition must be to focus on how enough healthcare staff will be trained, recruited, and retained in the future, and ensuring the availability of the levels of funding that will be necessary to make this happen. Without necessary additional funding to create and realise a comprehensive workforce plan across health and social care, vacancies will keep increasing, and patient care will be impacted. As such, a fully costed and funded national workforce plan is needed to secure the correct focus and funding for the health and social care sectors to properly assess, recruit, and retain the number of extra staff that are needed to deliver services sustainably.

3. This workforce plan must be based on local-level input regarding need and must be focussed on the numbers needed in the workforce not only to address existing vacancies, but to build flexibility 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.

4. In order to improve training, there needs to be better access to continued professional development (CPD). There is currently no detail on what the upcoming budget will be for Health Education England (HEE) in 2022/23. This is concerning given that this budget, which was around £4.5bn in 2021/22, has declined by roughly £1bn in real terms since its first settlement in 2013/14, when there were significantly fewer staff in the NHS than there are now. This has meant that the HEE training and workforce development budget is spread far too thinly, as well as being under strict limitations regarding what it can be spent on. Addressing the issue of the HEE budget would require upfront investment for medium to long term gain in terms of workforce numbers. We are aware that HEE is due to merge with NHS England and NHS Improvement (NHSE/I) in 2023 and protecting workforce training and development funding among the ringfenced NHSE/I budget will be vitally important.

5. Barriers to the use of funding, as well as a lack of flexibility in the system to allow for protected time to undertake CPD training, are also ongoing issues. Trust leaders continue to cite the difficulty of releasing staff for training and development given considerable capacity constraints, even in instances where money is available to spend on CPD. This is concerning given that access to CPD is crucial to retention and career progression.

6. Ultimately, roles in the NHS have to be appealing in order for trusts to recruit and retain sufficient staff. Pay, flexibility, work/life balance, job satisfaction, and continuing professional development can be improved with additional funding and focus, but to sustainably protect the NHS workforce, a fully costed and funded multi-year workforce plan is needed.

[1] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2021-experimental-statistics

Question 3: What are the hurdles to joint training between services? Do siloed approaches to attaining professional qualifications prevent joint training? How might better data-sharing improve joint training?

7. During the pandemic, final-year medical and nursing students were fast-tracked and given temporary registration to begin clinical work. The contribution of these students has been invaluable over the course of the COVID-19 outbreak, and we have repeatedly heard trusts praising their contributions. Trusts have also highlighted the potential advantages of additional clinical practice at this stage of students' careers. Health education institutions should therefore consider expanding trainee settings to more types of trust and should retain clinical placements for final year students. Mandatory training should also be reviewed with the objective of giving trusts greater discretion over what can be taught through on-the-job practical learning.

8. The redeployment that was seen during the pandemic has also provoked questions about how staff are trained – there is much that can be undertaken on the job, and there are other skills which have been shown to need centralised or theoretical training. For example, one trust told us that staff were waiting weeks to complete an online training module before being redeployed, when they could have been taught more efficiently through hands-on experience. Empowering trusts to have greater discretion over delivery of staff training in this regard would accelerate staff deployment. It will be helpful for education bodies, in partnership with trusts, to review which training needs to be delivered online, and which can be undertaken on the job, maximising benefits from the learning gained by trusts during the first peak of the pandemic.

9. We are also 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. Given increasing prevalence of complex needs among the population, as well as growing staff preference for career pathways which do not follow traditional, linear routes, an approach to training such as this could support both staff development and whole-person approaches to care delivery.

Question 6: How can providers of public services recruit a more diverse workforce? How should they improve their recruitment of BAME people, people with disabilities, older people and people who use public services and live in the communities that providers serve?

10. Investment in culture and wellbeing is key to improving equality, diversity and inclusion within the NHS workforce, which in turn improves quality of care. Whilst the NHS is the UK's largest employer of Black, Asian and minority ethnic people, it is not always a good employer of people from minority communities. This is reflected by the NHS Staff Survey finding unacceptably high levels of bullying and harassment of staff linked to racial discrimination, and low levels of Black, Asian, and minority ethnic staff in senior positions (found by the 2020 Workforce Race Equality Standard report), among other indicators.

11. The NHS People Plan 2020/21[2] is clear that a sense of belonging for staff in the NHS is crucial, and that this should be underpinned by changes to ensure the workforce reflects local, regional and national communities, and to remove biases in systems and processes at work. There is a push for these trusts to implement workforce pipelines in their own communities, utilising their status as "anchor institutions". This is challenging given lack of resource and expertise to set up such pipelines among smaller health and care organisations. Further still, the current People

[2] https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

Plan's requirement for increased diversity in the workforce over the next 4-5 years is an important ambition but will be difficult to deliver in some areas without significant intervention by HEE on student recruitment practices, to increase diversity of potential applicants. It would be good to see more consideration of these issues in the next iteration of the Plan.

12. HEE and the national NHS bodies can play an instrumental role 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 vital, alongside funding for local councils and businesses in areas of high deprivation to invest in communities and improve employment opportunities.

TRANSFORMING WORKFORCE EFFECTIVENESS

Question 8: How can digital technologies be used most effectively for training and up-skilling the public services workforce?

13. New innovative digital ways of working – from advanced robotics right down to simply upgrading computing hardware – have the potential to free up staff to spend more face-to-face time with patients. Along with other transformations underway, this will lead to a more sustainable health service, but the basics must be in place first, which includes building true multi-disciplinary teams that breakdown silos between IT, clinical and strategy. However, when it comes to delivering digital transformation, health and care providers face multiple ongoing challenges.

14. For example, in recent years, the pattern of digital investment across the NHS has tended to make large national pots of capital funding available for specific programmes that trusts have to bid for. This encourages a feast and famine cycle that incentivises one-off expenditure on systems and 'solutions', while inhibiting long term, strategic approaches that provide sustained operational funding for teams. In turn, this has created a situation where many trusts still lack basic core infrastructure. Since the pandemic, we have repeatedly heard from trust leaders about ambitious digital agendas that will support the recovery and transformation of service. However, it is proving difficult to embed this work when basic issues, such as ensuring reliable Wi-Fi across all buildings, remain unsolved.

15. Our Digital Boards development programme is designed to support boards in leading the digital transformation agenda. Delivered in partnership with Public Digital and supported by Health Education England and NHSX as part of their Digital Readiness Programme, the programme aims to build board understanding of the potential and implications of the digital agenda and increase confidence and capability of boards to harness the opportunity that digital provides. HEE's wider Digital Readiness programme is seeking to address the challenges of delivering digital transformation by creating an uplift of digital skills, knowledge, understanding and awareness across the NHS workforce.

Question 10: What have been the effects of the COVID-19 pandemic and Brexit on the public services workforce? Have these events created opportunities for workforce reform?

16. The COVID-19 pandemic has added considerable and sustained pressure on the NHS and its workforce, as a result of increased COVID-19 cases and hospitalisations, the rolling out of an unprecedented national vaccination programme, and dealing with a significant care backlog. As COVID-19 community infections rates rose, increasing numbers of staff needed to self-isolate, exacerbating existing pressures. This intense and sustained pressure on staff has led to increasingly worrying reports that colleagues are considering leaving the profession. For example, the General Medical Council's report on the state of medical education and practice in the UK found that one in 10 doctors were considering leaving the profession.[3] In responding in an NHS Providers survey last summer, nearly half of trusts also say they are seeing staff leaving due to early retirement, burnout, and other impacts of working through the pandemic.[4] Trusts have been working to improve the employment offer for their staff and implement the NHS People Plan, but the only way to truly protect the wellbeing of the NHS workforce is to ensure that there are enough staff not only to fill workforce gaps but to build flexibility into the system.

17. Flexibility in the scope of staff roles and deployment in the NHS have traditionally been limited. The work and responsibilities given to staff correlate closely to a specific job description within a specific area. However, greater flexibility over workforce deployment (while maintaining safety measures around competence and training) can be beneficial for staff, developing wider skillsets and increasing motivation. During the first peak of COVID-19 in England, staff movement between employing organisations and different clinical settings was made significantly more straightforward by reduced bureaucracy, such as the wider implementation of the digital NHS staff passport enabling staff to begin new posts more quickly and avoid repeated (time-consuming) training. Some localities also created system-wide staff banks, enabling workforce gaps to be filled more efficiently. In our 2021 submission to the Pay Review Body, we further highlighted the need for codifying and adopting flexible practices around deployment seen during the early stages of the COVID-19 pandemic.[5]

18. COVID-19 has accelerated collaboration across the health and care system, helping to meet these unprecedented levels of demand, and as a result, collaboration across organisations and teams has improved, particularly in areas where the foundations of system working and integration had already been laid. However, a lack of workforce capacity constrains further progress. The only sustainable solution to workforce challenges in the NHS is sufficient focus and investment in staff pay, recruitment (including training) and retention, via a national workforce plan. Investing in staff pay is a key aspect to staff retention. Without it, there will be an increase in staff attrition, and it will also be harder to recruit to roles. This will directly impact the quality of patient care, and the ability to meet demand. This year, in the face of sharply increasing costs of living and burnout from two years of pandemic pressures, additional funding should be allocated to the NHS budget to ensure that pay is not a factor in staff choosing to leave the service during this period of exceptionally high service demand.

19. Internationally recruited workers are integral to the NHS. The points-based immigration system which has been implemented following Brexit is largely favourable for trusts' ongoing recruitment of healthcare staff from overseas. We welcomed 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

[3] https://www.gmc-uk.org/-/media/documents/somep-2020_pdf-84684244.pdf?la=en&hash=F68243A899E21859AB1D31866CC54A0119E60291
[4] https://nhsproviders.org/media/691644/nhs-providers-survey-on-operational-pressures-covid-19-winter-and-recovery-plans.pdf
[5] https://nhsproviders.org/resource-library/submissions/nhs-pay-review-body-202122-written-evidence-from-nhs-providers

dependent upon a minimum salary level of £20,480. 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.

TRANSFORMING EXISTING WORKFORCE STRUCTURES

Question 12: How might voluntary and private sector workforces be involved in the delivery of integrated public services?

20. Service models have been adopting more collaborative, cross-organisational approaches to workforce for several years. This is now being codified in the Health and Care Bill, and with NHS England and NHS Improvement's direction that integrated care boards should adopt a "one workforce" approach – developing shared principles across the NHS, local authorities, the voluntary sector, and other partners.

21. Eventually, integrated care boards (ICBs) will become the principle organising function for workforce planning. ICBs will hold responsibility for clinical and non-clinical staff working in primary and community care (alongside secondary and tertiary care) and will be expected to support and collaborate with those who provide wider community services, including in local government, other public services and in the voluntary sector. If undertaken with full input from constituent partners, the process of fulfilling this responsibility may be a very useful grounding – but not a replacement – for national-level workforce planning, as it should capture levels of local need and opportunities for collaboration.

22. In order to support the move towards this "one workforce" approach, local partners should discuss the development of Service Level Agreements and sharing overheads and management costs for shared staff. The NHS People Plan 2020/21 also states that ICSs will be expected to support cross-organisational working going forwards, with an initial action that requires local people plans to be developed. Such joined up recruitment and workforce planning is a useful alternative to previously established recruitment practices aimed at a limited pool of staff. This has the potential to ease workforce demand by a small degree and improve service delivery, with staff shared more evenly across organisations.

Question 13: What are the barriers to achieving better workforce integration (including integration with the voluntary and private sectors), and how can any such barriers be overcome? How can leaders of public services drive and incentivise any cultural change necessary to achieve integration between organisations? Are there any examples of best practice?

23. The recently published integration white paper, *Joining up care for people, places and populations*, includes proposals that aim to remove barriers to collaborative planning and working across the NHS and social care.[6] This includes reviewing the regulatory and statutory requirements that prevent the flexible deployment of health and social care staff across sectors and strengthening the role of integrated workforce planning at ICS and place. Trust leaders fully support the government's ambition, as indeed, a number of trusts are already successfully leading the integration of services, more integrated staffing models and pooled budgets with

[6] https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations

their local authority partners across a range of services. However, while the aspirations for a more integrated health and care workforce is welcome, the paper fails to acknowledge the scale of staff shortages in the NHS and social care sector and the national action required to tackle them. Systems need to be supported with much better national planning and information on workforce needs. There is a welcome emphasis on the potential of passporting, but no recognition of – or solutions to address – the practical, legal and contractual challenges that act as barriers to implementation.

24. In order to achieve better workforce integration and service delivery, improving contracts and employment models requires a national approach, so that one area of the system is not drawing staff away from another area. This is already an issue for social care, where employment terms are largely less favourable than those of Agenda for Change (AfC). The government could ensure improved pay in the social care sector by providing funding for all staff to be on the living wage before it becomes law in April 2022 and working towards the creation of a pay framework for care staff that is either fully integrated with AfC in the NHS or offer comparable rates. The MAC's annual report notes that there is "little evidence of pay progression over time for care workers," so alignment with AfC would go a long way to resolving this. These measures have already been proposed by both the Local Government Association and the Association of Directors of Adult Social Services.[7] If implemented, these measures must be fully funded centrally, as increasing workforce costs will either reduce capacity or undermine the viability of existing providers. This investment would not only be in social care staff, but also in the NHS. By increasing recruitment and retention of social care staff, and thereby increasing the sector's capacity, delays in NHS discharges and wider impacts on patient flow will be less prevalent.

25. As well as its effects on recruitment and retention, a key barrier to 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 operates to deliver domiciliary care services would see significant differences in pay between members of the team. This is directly impacted by national policy which can be rather silo-ed in focus, such as the government announcement of a £1,000 continuing professional development package for nurses in September 2019, which transpired to be for nurses working in the NHS and was not made available to social care nurses. These instances can have a negative impact on staff morale and retention in multi-disciplinary teams and across systems. A more holistic and integrated approach to national policy making would therefore have benefits at the frontline.

Question 14: What tools do good leaders use to incentivise and challenge their workforces to transform service delivery? Are there any examples of best practice?

26. The ongoing COVID-19 pandemic has presented the biggest challenge in the history of the service, requiring staff to work at increased risk and in vastly different ways. Trusts across the country are continuing to push themselves to do the best for their staff, with innovative and future-facing approaches to workforce planning, management, and deployment.

27. Recent transformational work undertaken by trusts includes:

    a. **Cross-organisational working between North East Ambulance Service NHS Foundation Trust (NEAS) and North Tyneside Clinical Commissioning Group (CCG).** The North

[7] Health and Social Care Committee, "Social care: funding and workforce", 22 October 2020, paragraph 53: https://committees.parliament.uk/publications/3120/documents/29193/default/

Tyneside area was facing a lack of dedicated home visiting capacity at the start of 2019, increasing the demand on primary care and impacting GPs' availability to deliver face-to-face assessments in practices. To address this, North Tyneside CCG and NEAS worked together to develop additional home visiting capacity by utilising the paramedic workforce in a new way. As such, a dedicated rotational paramedic workforce model was implemented. Four advanced practitioners would be available at any point to provide home visits traditionally undertaken by a GP. By operating as an integrated part of community services across North Tyneside, NEAS's staff became mobile resources able to deliver up to 32 home visits per day. Surveyed patients have found the service excellent, with an average 99% approval rating.[8]

b. **Supporting staff for the long term at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB).** Like many trusts, UHDB faces an on-going challenge to recruit and retain staff across a number of shortage occupations. As such, UHDB have been pursuing a range of retention initiatives that are transferable to the wider workforce and align to the People Strategy. For example, UHDB initiated an internal transfer programme to retain their younger nursing staff which had a big impact on both retention and wider workforce wellbeing. Staff working in busy departments could access the transfer programme, which offered them the opportunity to move to different ward or clinical specialty in order to share their skills and develop learning. The trust saw a reduction in leavers for colleagues under 35 years old, from 38% of all leavers down to 26%. Moving forward, the challenge lies in developing an appropriate system of recording and monitoring requests for flexible working.[9]

c. **Building a truly equal, diverse and inclusive workforce at Dorset County Hospital NHS Foundation Trust (DCH).** DCH and the wider South West region is increasingly dependent on people of colour to deliver services to patients. The board at DCH were therefore clear on the fact that for DCH to realise ICS ambitions to drive change on health inequalities, the organisation must celebrate diversity and put inclusion at its core. Operationally, this shift in attitude meant that equality, diversity, and inclusion was no longer an HR-led initiative, but a board commitment to improving their organisation. In addition to refreshing the trust's strategy to align with the ICS commitment to reduce health inequalities and improve social value, staff at DCH started work to overhaul people practices – specifically around recruitment, appraisals, talent management, performance management, and disciplinary action. Equality, diversity and inclusion require a continual and honest focus, right across the organisation, and by committing to disrupting an existing culture, real change can be delivered for the benefit of staff and patients alike.[10]

[8] https://nhsproviders.org/providers-deliver-recruiting-retaining-and-sustaining-the-nhs-workforce/north-east-ambulance-service-nhs-foundation-trust

[9] https://nhsproviders.org/providers-deliver-recruiting-retaining-and-sustaining-the-nhs-workforce/university-hospitals-of-derby-and-burton-nhs-foundation-trust

[10] https://nhsproviders.org/providers-deliver-recruiting-retaining-and-sustaining-the-nhs-workforce/dorset-county-hospital-nhs-foundation-trust