NHS Confederation

Workforce: recruitment, training and retention

January 2022

About us

The NHS Confederation is the membership organisation that brings together, supports, and speaks for the whole healthcare system in England, Wales, and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care, and reducing health inequalities.

We understand from the Committee's description for this inquiry that the workforce shortage problem is well known. Our response focuses on the steps which can be taken and options available to make a positive change. This is an area of great importance and concern for all of our members. Last year we engaged with members from across all parts of the sector as part of Health Education England's work to develop a long-term strategic workforce plan for health and social care. The key messages have been included in this submission.

Executive summary

- A **long-term strategy and funding plan is needed** to cover the entirety of health and social care workforce based on service and population requirements. Furthermore, a clear account of the impact on workforce numbers of existing interventions (e.g., medical school expansion, increased undergraduate intake for other professions, and international recruitment) needs to be urgently provided to systems.
- This plan needs to be triangulated with service delivery plans and **underpinned by a long-term workforce funding settlement**.
- Integrated Care Systems (ICS) provide the sector with the **opportunity and the mechanism to plan for the workforce in partnership,** at a local level and deliver a different outcome for the future. They must, however, have access to the analytical resource that exists in the system to work with primary care, social care and the NHS to construct plans to support population health, which are underpinned by long-term investment to ensure it can be delivered.
- Demand for healthcare training is high. To convert this interest requires **additional capacity for training and placements**, including increasing the types of places that people can be trained in the community, primary care, social care, the independent and voluntary sector as well as explore opportunities to scale up evidence-based approaches to virtual and augmented reality learning, where relevant: this will need

significant investment in training infrastructure and supervision capacity. If we can achieve this, we envisage not only increasing the UK supply into employment, but it can also act as an enabler to delivering care differently.

- **International recruitment has a positive contribution to make** to the supply of some health care professionals and forms an important strand to short, medium and longer-term plans. It complements plans to train and employ those from the UK resident population and can be flexed according to different factors.
- Employers are taking **action to support retention.** Their sustained work should be acknowledged, and recognition given to the limits to what employers can do to support staff to have a good experience and be retained in the sector without recruiting and training more people.
- **Capital investment** to make improvements to the physical places in which people work and ensure they have access to the tools needed to do the job well and productively can be a contributory factor to retention.
- **Civility and respect**: health and care staff, working in all settings, have been subject to increased levels of abuse from the public and some parts of the media which must not be tolerated. Recruitment activity needs to be matched with equal action to value, support, develop people to have jobs where they are safe, valued, developed and retained.
- The decision to merge HEE and NHS England must provide the mechanism for the alignment of service and workforce planning and the long-term funding settlements for the NHS's education budgets.

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 summary, the following range of actions are needed to recruit the extra staff needed across health and social care. Many of the factors are well known and/or are being delivered already; however, what is consistently lacking is clear long-term planning and investment. We continue to support proposed amendments to the Health and Social Care Bill, which would require the Secretary of State for Health and Social Care to regularly publish workforce plans.

2. There needs to be a clear plan to expand undergraduate programmes beyond the 'one off' expansion during the pandemic and the 15,000 additional medical school places.

3. This should be complemented by significant commitment to apprenticeships across health and social care, including to supporting the additional costs of degree apprenticeships.

4. There needs to be significant action to support workforce development and investment in the social care workforce. NHS organisations support urgent action to invest in rates of pay and terms and conditions in the social care sector to make those roles more attractive.

5. As our evidence to the NHS Pay Review Body will show there is a need to invest in entry level roles in the NHS and to enhance pay rates to make key graduate entry roles competitive in the challenging labour market.

6. The government should build upon the recent welcome change to migration policy in adding social care workers to the Shortage Occupation List by extending the time periods available for visas.

7. The statutory regulation of medical associate professionals (MAPs), and subsequent authorisation for prescribing, is now long overdue and is a key requirement in expanding new professions as part of the healthcare team.

8. For their part our members recognise the actions they must take to improve supply and are focused on:
    - Building their engagement with their local communities whether through formal work on 'Anchor Institutions' or other programmes
    - Working collaboratively to develop shared approaches to education and development. In Leeds, for example, public sector employers run a joint academy to deliver a shared delivery of apprenticeships
    - Identifying groups under-represented in the NHS workforce and building programmes to help access this under-utilised talent. For example, 112 NHS organisations use the Step into Health programme (created by the NHS with armed forces charity Walking with the Wounded and supported by the Royal Foundation of the Duke and Duchess of Cambridge, now commissioned by NHS England)
    - Building programmes which help young people gain access to careers in the NHS. For example, 146 organisations from across health and social care have engaged with The Prince's Trust, who are working with people aged between 16-30 to access pre-employment programmes, training and employment in the sector
    - Working collaboratively to maximise international recruitment of nurses, at system and regional levels
    - Expanding capacity to provide clinical placement opportunities for undergraduate courses, and delivering preceptorship to support newly qualified practitioners
    - Broadening how training is delivered to both attract and increase retention and course-completion including maximising opportunities for blended learning, use of technology enhanced learning, short courses and offering flexibility around study hours
    - Promoting working in health and social care through national and local awards and partnerships with the media
    - Aligning member recruitment activities with the national NHS and social care campaigns.

9. Further actions to support health and social care with recruiting extra staff in the short term are:
    - supporting employers, further education providers, and higher education institutes to flex the 'NHS experience' entry requirement until the NHS can offer work experience again
    - undertaking research to understand the depth of concern around the impact of COVID-19 on recruitment, particularly on ethnic communities
    - increasing opportunities for care workers, clinical support workers and technicians to access career pathways to registered roles: supporting the development of the existing workforce and demonstrating the career potential to those considering a career in health and care that there is opportunity beyond the entry level post, should this be a route people want to take
    - implementing streamlined processes to improve time-to-hire, vacancy rates and candidate/staff experience

- encouraging collaboration with other organisations to recruit across a larger footprint; for example, at an ICS level to maximise the options for rotations, offering experience in different settings.
- Recognising the limitations of shared programmes in the face of fundamental under-supply but also the need for ongoing support, particularly in primary care where the education and practice development infrastructure is lighter than found in statutory providers.

10. Considerations to support health and social care with main steps to recruit extra staff in the long term are listed below but require action to be taken in the immediate term to have an impact in the longer term:
    - Continue the national recruitment campaigns for health and social care and to prioritise areas of greatest need and which the public may not so familiar with, for example, in social care, community, primary care and mental health
    - Address inequity in the geographical distribution of some healthcare course availability; for example, for mental health and learning disability nursing and some of the smaller allied health profession training
    - Similar action is needed to redistribute medical training posts away from the capital (and has already been commenced by HEE)
    - Alongside distribution, prioritise investment to grow future supply and incentivise activity to address long-standing workforce gaps in mental health and learning disability services
    - Long term funding allocation to support the operational delivery costs of running higher level clinical apprenticeships as part of a workforce strategy: for example, backfill costs for placement and supervisory capacity in scaling up apprenticeships. We also recommend tracking and publishing return on investment data as part of a long-term commitment
    - Sustain COVID-19 temporary policy changes made to apprenticeship delivery and sign off and to health regulator processes as these have reduced the time it takes from course completion to gain registration and be able to start work in the role they have trained for
    - additional funding for infrastructure development to support the growth of training delivery by increasing capacity for supervision and support for all training.

HEE: Long Term Strategic Framework for health and social care workforce planning

11. The work announced last summer provided the opportunity to deliver a whole system workforce plan. The work is due to conclude in the Spring; however, we are concerned that this will not result in providing system leaders with an output and data that helps to address the practical workforce supply issues for the short and long term.

12. Following engagement with members, the NHS Confederation responded to the first phase of the work. Our evidence was clear about the work employers are doing and will continue to do and in 15 years' time, we hope to be able to say the health and social care system has changed for its workforce and leaders so that:
    - we can model health and care workforce needs based on the needs of the communities we serve
    - we retain staff and students because they have had an excellent experience
    - we have eliminated discrimination and exclusion from the NHS and social care workforce, including within educational settings
    - we create a working environment that balances employee autonomy and operational efficiency to improve staff experience and engagement.

13. Our evidence reflected views that there are particular areas of the workforce that would be impacted by increased demand over the next 15 years and highlighted that we start this process in largely a deficit position, despite significant resources invested in recent years to support workforce growth. Without continued efforts to reach a 'stand-still' position in many areas it is likely that these challenges will be exacerbated further over the next five, ten, or 15 years. These include:
    - social care including domiciliary care workforce
    - primary care
    - adult mental health and learning disability services
    - children's service in community and mental health (CAMHS)
    - diagnostic services.

14. We also highlighted specific occupational groups with pre-existing challenges to meet existing demand:
    - Medical workforce: general practitioners and consultants in oncology, acute medicine, care of the elderly, interventional radiology
    - Nursing: mental health, learning disability and adult nurses based in community and social care
    - Wider healthcare professional team: paramedics, sonographers, operating department practitioners, podiatrists and radiographers.

15. In the submission we describe that understanding the workforce supply needs for the longer term is something employers have been calling for, for some time.

16. The lack of data available in the public domain around the current workforce training pipelines or the projected need makes it very difficult for employers and system leaders to develop an understanding of what is happening now and whether decisions that might be taken are the right decisions to take with finite funding, to bridge the gap rather than exacerbate it. This must be addressed as a matter of urgency.

The move to ICS

17. Enabling the ICS model work as intended, a partnership across a place to provide improved outcomes for the local population, provides a new opportunity to plan for an integrated workforce to meet the needs of its population.

18. Place will be the key delivery level, although recognise that this looks different in different ICS contexts. We need to ensure that local authorities are fully involved and that there is effective working between other public and civic institutions such as universities and further education providers. The NHS Confederation outlines the opportunities of re-imagining our relationship with universities in a joint publication with the Civic University Network[1] . It focuses on working together to utilise the respective skills and strengths for greater impact by aligning training, employment and place in a way which delivers mutual benefit.

19. In practice this could lead to new relationships delivering on shared goals. For example, the University of Bradford, Yorkshire Universities, and the West Yorkshire and Harrogate ICS are collaborating to develop a Workforce Observatory. The platform will help guide decisions around health and social care workforce management, including skills and learning needs.
20. The NHS Confederation has also developed additional resources to identify and support working together around workforce at system and place level:

[1] https://www.nhsconfed.org/sites/default/files/2021-11/Reimagining-the-relationship-between-universities-the-NHS.pdf

- Knowing who to call supporting integrated care systems to influence the local labour market[2]
- Creating the workforce of the future: a new collaborative approach for the NHS and colleges in England[3]
- Unlocking the potential of new community funds[4]

21. The question of adapting to new care models is too often focused on undergraduate course content and there needs to be policy and practice which focuses on the existing as well as future workforce.

22. The work employers are progressing with further education in line with the policy intent described in the Government's paper 'Skills for Jobs' creates a different set of relationships and networks at place and system level which can ensure that in principle, the sector is able to adapt to change.

23. More responsibility is being placed on employers to invest in education and training and there are several routes into education and training available for the existing and future workforce, these include pre-employment programmes, apprenticeships, and clinical training programmes, all of which include working local education providers and delivering supervised placements.

24. We know that by increasing the skills of adults we can widen access to good quality work for people from diverse backgrounds. Helping to improve health outcomes and meet some of the supply needs of the NHS and social care as employers of large numbers of people in our local communities.

25. To deliver on this requires:
    - a permissive and supportive regulatory and governance environment
    - regular and systematic workforce planning
    - long term investment decisions to match the long-term decisions needing to be made to create growth in the workforce which is sustained over time.

The importance of regular and systematic workforce planning is to be reinforced

26. Too often in the past targets have been set to increase the numbers of one profession or occupation in one part of the sector, without addressing the need to grow the training pipeline to deliver on the objective: as a consequence, it often depletes another part of the local health system. For example, recruiting healthcare support workers in the NHS and additional paramedic roles in primary care.

27. On a practical level there are actions that can be taken to set out how workforce planning will operate in this new landscape what is needed in terms of investment. The absence of a long-term plan which set out what is needed to meet population demand at 3, 5, 10 and 15 years, and which is regularly reviewed in light of changing circumstances, is a significant gap.
28. It difficult to know whether the people we are recruiting and training now will be enough, are in the right places and that we are training the new and existing workforce to be able to meet the immediate future demands. The publication of a plan is essential, and this plan need to be informed by providers, at an ICS level.

[2] https://www.nhsconfed.org/publications/knowing-who-call
[3] https://www.nhsconfed.org/publications/creating-workforce-future
[4] https://www.nhsconfed.org/publications/unlocking-potential-new-community-funds

Funding

29. If we can achieve the desired state of having a published strategy and the commitment to review on a regular basis, then the financial settlement to the NHS, and similarly for social care, needs to include as standard, long-term funding to support the development of the current workforce and rapid evaluation of impact.

30. Currently, the development and scaling up of new roles, advanced practice, new training pathways to increase the numbers of people into registered professions, investment in pre-employment programmes, is left to individual organisation decision making. Sometimes national funding is provided for 1 or 2 years, and this often means we struggle to progress possible developments at the scale needed to make a difference and evaluation of impact is scant, or late in coming.

Retention and the NHS Pension

31. Retention of the workforce, especially those in later stage of their career is an essential component of having a functioning workforce plan. The NHS Pension Scheme is a key part of the total reward package that NHS organisations use to attract and retain their workforce.

32. Pension changes made in March 2020, to increase the annual allowance pensions tax threshold, was a welcome concession made by government to support the NHS to recover from the pandemic and to address the issue that disincentivised senior staff from taking on additional work and leadership opportunities. However, our members are still concerned about the impacts of pension taxation on higher earners, such as consultants and senior doctors and on the flip side the affordability of pension contributions for lower earners. Therefore, the NHS Pension Scheme and the NHS reward offer need to remain attractive and a strong tool for recruitment and retention.

Technology

33. Technology is pivotal in health and care and is at the core of the NHS Long Term Plan with NHSX wanting to drive the largest digital health and social care transformation programme, with more than £1 billion invested annually.

34. Opportunities to innovate, upscale and deliver digital healthcare are increasing the support the NHS can provide people to maintain their independence and their health and wellbeing. Technology is also enabling people to stay up to date with the latest information relating to their care and treatment plans and access a wide range of healthcare services from their homes. For some NHS organisations, effective use of digital technology is easing demand on services, reducing costs in some areas and supporting professionals to treat patients with the greatest and most urgent needs first.

35. The COVID-19 pandemic has evidenced the case for digitally provided services in the future, as social distancing and infection control measures have meant the NHS has seen the benefits of connecting with, and supporting, patients digitally. From the outset, it was clear that technology would have a major role to play in the NHS response to the pandemic. From GP surgeries to outpatient clinics, there has been a significant acceleration of the adoption of new technologies. It has the potential to save lives, enable remote working and provide the information needed to deliver the best possible care for patients.

36. Achieving this ambition requires substantial investment in the training of healthcare professionals to develop specialist digital skills, as well as the creation of new roles. It

also requires a thorough understanding of where and how technology-enabled care enhances both patient and staff outcomes so that it is used to best effect. Not only will technology enhance care provisions, the use of technology such as virtual reality and simulation are being used more and more to train members of staff, resulting in less pressure on service demands and capacity for placements.

37. Addressing skills gaps is not as simple as slotting in a new system and sending staff on a training course. Teams will need the time, space and resources to adapt ways of working and make the most of new technology. As teams learn more about the art of the possible it should maintain flexibility to ensure no parts of the community get left behind. For examples of the generic digital skills required across the health workforce and the support needed for teams to make progress.

38. National workforce strategies must address the workforce, skills and infrastructure needs of health and social care to successfully exploit new and established technologies over the long term. Ensuring the NHS has adequate IT and equipment to make the most of new technologies was also the top priority in a recent survey of NHS staff by The Health Foundation.

39. Ensuring this takes place across the NHS, including primary care, will deliver against health inequalities and population health management. With greater investment in digital skills development across the sector and the right conditions to encourage innovation, the sector may unlock a whole raft of achievable innovations that will help improve patient outcomes but will likely have an impact on the size and shape of the future workforce.

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

40. The recruitment of individuals into health and social care who have trained and gained experience outside the UK makes a significant contribution to the whole sector – however, it is more relevant for some roles and professional groups than others.

41. For example, in recent years, the programme to increase GP numbers has seen very few people recruited from overseas due to the way in which training and services are different in the UK to other countries. In contrast, recruitment to adult nursing has seen almost 10,000 new entrants to the NMC register in the first six months of 2021-22, building on around 10,000 new entrants during 2020-21. All of this has been achieved with additional support and funding provided through NHSEI to employers.

42. We know that within the allied health professions there are some paramedics and radiographers that have come to the UK to work either as part of organised programmes or who have applied directly to posts in the UK.

43. The Health Foundation (2019) suggested that 5000 nurses would be needed from overseas up to 2023-24 and work by the Nuffield Trust describes that international recruitment will continue to be a major pipeline in the short and medium term. It works alongside efforts to train more people through UK training routes to reach the government goal of 50,000 more nurses by 2024.

44. NHS Employers has continued to support the NHS develop their international recruitment programmes through dedicated advice and produced resources such as the International Recruitment Toolkit and good practice examples. These highlight the

work employers are doing to develop businesses cases for international recruitment which include dedicated pastoral support and ensure robust professional development to improve retention.

45. As part of an overall strategy for the sector, it may be sensible to build in percentage assumptions for the level of overseas recruitment over a three, five and ten period, for the roles where this is feasible, for example in nursing, and it becomes a known and planned quantity alongside other supply routes. In the absence of a published national plan, it is hard to be clear as to proportions of domestic and international recruits which should be attached to particular staff groups.

46. In terms of social care, the sector has a limited ability to use international recruitment as it currently stands. While senior care workers can make use of the Health and Care Visa, until the recent Government announcement, care workers have not been eligible despite being in major and long terms shortage. We welcome the government reacting quickly and positively to the urgent recommendation made by the Migration Advisory Committee to place care workers on the shortage occupation List. This is a significant recognition of the profound workforce challenges facing colleagues and services across social care, and the need to resume meaningful recruitment of staff from outside the UK. There will be some concern however that the salary threshold for this move is higher than the government's own minimum wage requirements, given that the government has yet to deliver long-term investment in the social care workforce, including in rates of pay.

47. This crucial role has a high number of vacancies and future forecast demand from Skills for Care shows an increased need for these roles. Providers in London and South East are reporting increasing difficulties in properly staffing services, given their previous reliance on labour sourced from the EEA and the continued lack of a long-term plan for social care.

48. In defining the longer-term view for workforce demand/supply as well as the immediate and medium term need the long-term plan needs to articulate the place of immigration to deliver the plan and be clear how it interfaces with the UK labour market and supports and complements other interventions to meet workforce supply and demand needs in health and social care. This detailed and long terms workforce planning work should be able to inform and shape UK immigration policy.

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?

49. In the last five years there has been a lot of work undertaken by DHSC, Home Office and professional regulators to improve access to international recruitment, for example, the inclusion of health occupations and soon to be added social care worker, to the shortage occupation list. Visa and regulatory registration processes have been streamlined which has enabled the time between recruitment and starting employment to be, in many cases, dramatically reduced. This has been matched by investment from the DHSC and NHS England in increases to international recruitment for nursing.

50. While there is support for the prompt response from Government to the Migration Advisory Committee recommendation to add care worker to the shortage list, there is some concern that the salary threshold for this move is higher than the government's own minimum wage requirements given that the government has yet to deliver long-

term investment in the social care workforce, including in rates of pay. The Cavendish Coalition, which is co-chaired by NHS Employers, is well placed to support government in the shaping the detail behind the policy commitment to ensure this can work for social care providers.

51. There has also been a significant overhaul to the Code of Practice for the international recruitment of health and social care personnel. It outlines the guiding principles and best practice benchmarks for ethical international recruitment into the sector. The Code stipulates that health and care employing organisations and recruitment agencies will not actively recruit from countries on the World Health Organisation's Support and Safeguard List 2020, which is a list of counties with the greatest workforce needs. The UK government also recently added Kenya to the Amber list of the Code, due to growing workforce pressures.

52. Alongside this, the creation of Memorandum of Understandings (MoUs) between the UK Government and Malaysia, the Philippines and Kenya are useful tools as they enable the movement of health and care personnel in a managed, transparent and supported way.

53. There is also a long-running scheme in place that provides medical training in the UK for up to two years for a cohort of overseas trained doctors seeking additional skills training. The Medical Training Initiative (MTI) is valued by individuals and employers and supported by medical Royal Colleges. Employers who use this programme reinforce it is a valuable route for both the NHS trust and trainee. Continued support for, and expansions of this programme would be welcomed.

54. However, individuals who currently come through this route are treated differently in relation to the payment of the health and care visa. We would support a change so that MTI doctors are treated the same as those coming to the UK through the tier 2 visa route. We now have more efficient transactional processes alongside managed international recruitment routes that support the individual, the source country and the UK. The cross-government working that has enabled the policy changes to date and creation of MoU's has been central to this. We would strongly support a continuation of this approach to ensure a review of progress and adaptation and/or new arrangements can be expedited quickly.

55. The next part of the process improvement plan was the upgrade to the points-based system's employer sponsorship system. Improvements to this platform were planned to follow the UK's exit from the European Union. While responding to the priorities of the pandemic have taken obvious priority, upgrading the system to simplify the number of processes required is much needed and will save valuable time. This will be welcomed by all employers and especially for those smaller employers such as social care providers and GP practices.

56. In summary, we would recommend the following actions:
    - continue the cross-Whitehall working on policy development, government/government agreements and system and process improvement.
    - Progress improvements to the Home Office PBS employer sponsorship system
    - Provide continued support for the MTI scheme and to introduce the waiver for the health and care visa fee for MTI doctors
    - Work with the Cavendish Coalition on how the new inclusion of social care, care worker, to the shortage occupation list will work

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?

57. The introduction of student financial support to help with living costs and additional investment in training places has been helping. The funding commitment is short term, and the need is long term.

58. We have previously articulated the need for long term investment, matched to areas and professions with the greatest needs, linked to a clear and regular published workforce plan

59. All students training to be doctors, nurses, midwives and allied health professionals in the NHS are required to undertake clinical placements in health and social care to gain the skills and competencies they need to become a registered healthcare professional and complete their studies. In 2016 when the decision was made to move away from NHS funded undergraduate programmes there was a perception that this would enable many more healthcare professionals to be trained as universities would be able to increase places exponentially – the reality is that for many courses the student is required to spend up to 50% of their time in practice placement and therefore increasing the numbers of people onto courses could only be done by increasing the amount of placement capacity.

60. Employers and ICS leads tell us that funding for placements makes a significant positive difference and the numbers underpin this. UCAS data from 2020[5] shows there were 30,000 nurses accepted onto programmes, an increase of 6000 from the previous year and a number which had remained at around 22,000-23,000 for the five years prior to that.

61. COVID-19 has made this even more difficult and has caused quite a bit of disparity in offering a range of different placements. For example, those who have to have a clinical placement to become a regulated professional have been prioritised over those that might want a pre-employment programme placement, work experience or a T Levels placement. This impact of prioritisation has meant that people who may already be a distance from the labour market get pushed even further away as they've not been able to access work experience.

62. As well as the capacity element, the way in which students are trained should be considered. The review on learning from changes brought in to manage Covid-19 should provide important insights into what can be retained and what should not. Changes have been made in local settings. Publishing the learning and identifying what improvements can be adopted at scale will be helpful to providers.

63. Focus has also now turned to supporting student to transition back to supernumerary clinical placements, so that they can complete their studies and be ready to join their relevant registers in due course. Support from HEE and education institutions is very valuable and members may need for this to remain an area for HEE oversight as students work through their undergraduate studies to become registered

[5] https://www.ucas.com/data-and-analysis/undergraduate-statistics-and-reports/ucas-undergraduate-sector-level-end-cycle-data-resources-2020

professionals. We have a shared goal that we support and retain as many people as we can through their training to becomes registrants.

64. We do not underestimate the challenge of ‘catch up’ for people already on programme; providing high quality preceptorship to newly qualified practitioners, expanding training numbers and trying to do this whilst managing the ongoing challenges of COVID-19 and bringing other services back on stream.

65. Our members are committed to building apprenticeships into their workforce strategies to address skills shortages, as well as a means of attracting new talent, developing and upskilling existing staff, and retaining their existing workforce. However, concerns have been raised about the level of investment in apprenticeships and their affordability to employers which is creating barriers to their potential.

66. A concerted effort from the NHS to make best use of apprenticeships requires a significant increase in the proportion of learners in the workplace, adding to the capacity concerns of the service to support an increase in placements and supervision for these learners, in clinical roles which require a large amount of supervision and assessment within the workplace, typically provided by registered healthcare professionals working alongside the apprentice learner.

67. Although the 20 per cent ‘off-the-job’ training requirement is valued as a key component of an apprenticeship, for healthcare-specific standards such as the nursing degree apprenticeship, there is a much larger off-the-job requirement of over 50 per cent. This time is supernumerary and means that when the apprentice is in the workplace, undertaking tasks within their competency and scope of practice, they cannot be considered as part of the workforce or included in safe staffing figures. Employers must provide backfill for this element of their training, which represents a significant cost, in addition to apprentice salary and the supervision and mentoring time required.

68. Long term sustainable investment is required to support with the backfill and placement capacity issues surrounding the service, if the training of staff is to increase to meet the workforce demands. It would also be useful for our members to see much greater clarity on the impact that recent interventions, including the expansion of medical schools, the target for 50,000 more nurses and the increased uptake of undergraduate education will have in the years to come. Understanding this will help the NHS to plan more realistically, and better identify the staffing supply and demand gaps that risk the future delivery of the NHS long-term plan.

69. We are confident that the curricula and education standards are regularly reviewed by the regulators and professional bodies where applicable. While these are important to keep under review as the world of healthcare changes, they are not a principal driver to increasing the numbers in the workforce. We would go further to say that having the right balance of academic and practical activity is critical for all our healthcare students and trainees. How we deliver training and in what setting are possible options to be explored. Employers are not asking to reduce the length of time it takes to train registrants.

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

70. The leaving rate in the NHS has risen in the last year and there is some evidence of a likely upsurge once COVID-19 comes to an end. Data from the NHS Staff Survey showed a considerable percentage of staff saying they would not leave during the pandemic possibly out of staff "solidarity in adversity". External polling and staff side organisation surveys indicate there is a substantial group of staff who will leave once the COVID-19 crisis subsides and this includes staff who delayed retirement as well those who returned from retirement or other roles.

71. Given the scale of vacancies in the NHS and rising demand in leaver rates is undermining the progress that has been made in increasing staff numbers and derail progress toward the high profile 50,000 increase in nurse numbers. Issues of retention in General Practice have already led to the abandonment of the target for increasing their number. At present healthcare has not been caught up in the "Great Resignation" sweeping the wider economy but it could easily be caught in the backdraft unless urgent action is taken by employers.

72. The main source of data on why staff leave is exit interviews conducted by trusts with data recorded on the Electronic Staff Record (ESR). Around 50 per cent of leavers take part in the interviews and the data does give some indication of trends in reasons for leaving and the principal factors driving staff to leave the health and social care sectors have remained stable over the past decade. Retirement has remained the main cause of staff leaving.

73. Since 2015/16, NHS Employers (part of the NHS Confederation) has supported NHS trusts to identify and resolve retention issues (in partnership with teams at NHS England). The NHS Employers guide for employers, due to re-published shortly, has identified the key actions that can be taken by employers:
    - leadership and culture: using staff feedback and data to identify if changes to the organisational culture are a contributor to staff leaving
    - Understand your local data: this will help identify areas for further exploration and jointly agreed action with teams
    - Communications and engagement: using existing or creating bespoke mechanisms to understand
    - Review and evaluate - this is not a one-off exercise, actions to support staff retention require. From working with employers, we identified four core areas for action:
    - supporting new starters and those new to a role
    - career development opportunities
    - flexible working
    - later career support

74. The medical workforce has also seen a shift in recent years in how doctors want to train and work. There has been a gradual increase of new initiatives to allow doctors in training to work less than full time (LTFT) and take breaks out of their training, to retain doctors within the NHS workforce who are unable to train on a full-time basis and to promote work/life balance. Most recently there has been an expansion of category three LTFT which means that any doctor in any specialty can request to work LTFT without needing to give a reason. There has also been the introduction of

a new out of programme pause, which allows doctors to pause their training to either take a break entirely or work in a different specialty and gain experience elsewhere.

75. At overall level the NHS has developed the NHS People Promise with the aim of creating a workplace that supports retention. Its visibility outside of the large NHS provider part of the sector is patchy and something for the whole sector is missing.

76. Health and wellbeing support and access to flexible working have been the focus in 2020 and 2021.

77. There have also been changes to the NHS Terms and Conditions Handbook which came into effect in September 2021. These are designed to help give NHS staff greater choice over their working patterns to encourage staff to continue their careers in health. This is complemented by focused work on helping staff at later stages of their careers understand and appreciate the NHS Pension Scheme and how it can support flexible retirement. There is a great deal of support for continuing the further flexibilities introduced during the pandemic as a temporary measure.

78. Providing employers with the ability to self- assess their progress against others and access networks to share and learn from others is greatly valued and should be sustained. The progress on reducing nurse leavers, prior to the pandemic, shows that with the right package of support and focus, national programmes with targeted support and funding can support local improvement.

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

79. Mental health nursing is a vital and varied profession, accounting for over a third of the mental health workforce in England. Yet the numbers choosing to study to join the profession are unable to meet sharply rising demand. With one in four people likely to be affected by mental or neurological conditions at some point in their lives, and the pandemic potentially leading to a rise in mental health conditions, it is more important than ever that people have access to good mental health care by qualified professionals. There is also a widely known shortage of learning disability nurses in NHS posts and the role they play in reducing the often-fatal health inequalities affecting people with learning disabilities and autistic people.

80. It is likely that there will need to be opportunities for all routes in all parts of the country, to ensure that NHS-funded services have sufficient people, from a broad range of backgrounds, and there is a mixed pipeline of people applying for wider nurse education. Regional provision for some of these courses is disperse. For instance, there are currently under 40 universities with postgraduate and only 14 with dual (including mental health) courses. This may be particularly problematic given mental health nursing has typically attracted older students who may have less flexibility to travel. Also, given that students will likely work in the same region in which they have studied, the current unbalanced geographical distribution of courses is not ideal.

81. There are a number of recommendations available to make improvements, especially in terms of raising awareness and understanding of the role. Investment is required to promote the valuable contribution that mental health nurses have made to the service, especially during and post COVID. To do this detailed region plans should be provided, outlining the capacity and detailing plans for a review on pay, conditions and

career pathways and progression for the various psychological professions to ensure they are fair and consistent with the roles, education and geographical requirements.

82. In order to get more people to consider mental health nursing as a career, a coordinated effort is required to provide access to positive personal experiences of and exposure to mental health services and staff, including by sharing good practice on work experience and outreach work and promoting the role widely. Mental health nursing needs to be encouraged across the breadth of the population, including different genders, ethnicities and socioeconomic statuses, recognising that attitudes towards both the mental health and nursing aspects of the role may differ across societal groups, especially in under-represented groups.

83. As for location, we hear issues regarding recruitment and retention for geographical locations in rural and coastal locations, plus more recently a rise in problems in areas such as the South West and the Lake District given the cost of living rising and lack of affordable housing in these locations. Due to the pandemic, these issues have got worse as more people are now choosing to staycation, so these areas are becoming popular holiday destinations or regions for people from other areas of the country to move to affecting both availability and cost.

84. Cornwall and Devon in particular are suffering from significant nursing shortages, most particularly due to the effects of local housing stock. We have heard that when organisations are successfully recruiting to nursing vacancies, the new recruits are unable to find anywhere affordable to live and are then having to turn down the offer of employment. Over the last 12 months the cost of an average house in Cornwall has now doubled to an unaffordable level and there are very small numbers of rental properties available. As such, several teams are suffering with nursing shortages but also cannot recruit students to these posts as they do not have staff available to act as assessors and supervisors.

85. In the North of England, the issues are around the remoteness of their regions. Some NHS trusts can serve a large geographical area and with transport links and connectivity issues, this limits on the local community available to be in the workforce.

86. There are pockets of good practice available, for example some NHS Trusts are recognised as the biggest landlord in their area and have bought the available housing in their vicinity to rent out to NHS staff, which is essential for relocators, international recruits or on call staff. We have also heard of ICS networks working together as health and social care to use of local spaces and getting funding from local authorities to create housing for health and social care staff out of unused office or retail locations. These ideas need to be generated on a larger scale and supported by funding through Government in order to fill shortage roles or locations.

87. Additional support is required to recruit GPs and other primary care roles across many areas of the country. For small practices in areas such as coastal communities, GP and non-clinical workforce shortages are having a huge impact on the ability to deliver care to their local populations. Alongside recruitment incentives and national campaigns NHSEI and the government should explore more innovative approaches e.g., at scale provision, remotely delivered care by third parties.

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?

88. Investment to grow future supply and incentivise activity to address long standing and critical workforce challenges (especially in social care) is the crucial and presently underdeveloped strategic theme. The NHS workforce was already carrying close to 90,000 vacancies prior to COVID-19, with a further 112,000 vacancies in social care. COVID-19 has shown that the physical and mental health and wellbeing of the workforce is more important than ever. Without a healthy workforce, the NHS cannot provide the high quality and effective service that is so essential to helping tackle the backlog of patients requiring care that has built up during the pandemic.

89. It is expected that many staff will continue to need support to deal with the toll the pandemic has had on their health. Staff burnout is a major concern for the longer term. The success of measures to support staff to remain physically and mentally well is key to the recovery of the health service and building and retaining a resilient workforce for the short, medium and long term.

90. The annual NHS Staff Survey points to improvements in areas including health and wellbeing, but it highlights that there remains some way to go. It highlights the need for a renewed focus on tackling work-related stress. The results also show that around a third of staff are considering leaving their jobs, of which nearly one in five are thinking of quitting the health service entirely. Some of our members are also concerned about the impact on retention of the student workforce who have experienced a pandemic and significant demand pressures early in their careers. Adjusting employer-led preceptorship programmes to account for the context created by the pandemic is an important consideration for members to ensure we support and retain the newly qualified workforce.

91. Managing current and escalating demand, particularly for urgent care across primary and secondary care, reducing the sizeable backlog of elective procedures that has been exacerbated by the pandemic; and continuing to manage the ongoing threat from COVID-19, which requires frontline services to operate with much reduced capacity due to the need for infection prevention and control measures, are major challenges for the NHS.

92. There is also significant additional long-term and ‘new’ service demand as a result of the pandemic. Booster vaccination is likely to be a long-term feature of primary and community care, long-covid is emerging as a significant demand on primary and specialist services and the health inequalities so starkly exposed by the pandemic will result in the need for additional services and public health interventions.

93. Population health status alongside reducing health inequalities is another influencing factor on demand for health and care services. It is also the case that many communities have poorer access to healthcare and poorer outcomes. Correcting such inequalities may reduce demand and dependency in the longer term but is likely to require greater intervention in the immediate term. The health and care system needs to invest in increasing health promotion, health prevention and educating the public in managing their own health. This will also mean educating the workforce to ensure they are supporting individuals to take on some responsibility for their health and signposting them to how and where to do this.

94. The lack of a long-term strategy for social care is particularly concerning as this will only exacerbate the pressure on health services, it may also impact on the roles required in the NHS and the way in which NHS community services are delivered. The service is also predicting demand for mental health support to increase above pre-COVID-19 levels and to remain high for some time. Our mental health provider members are seeing patients with more significant needs; a higher proportion of patients are accessing services for the first time; and there are increased Mental Health Act presentations.

95. The sector needs government investment to transform and support the introduction of new ways of working across pathways and organisational boundaries that will enable it to fully restore services, and the understanding of the public while it adjusts to changes and deals with a large backlog of patients needing care.

96. Public messaging on NHS capacity needs to be honest and realistic. The commitment of staff to do their best for the public has been demonstrated many times over during the pandemic. Government and national bodies need to support the NHS to manage the realities of recovering services, not set unrealistic targets and impose financial penalties.

97. Financial clarity is essential so that NHS organisations can make key decisions on how many staff they can hire and how much they can invest in their elective capacity to reduce the backlog. For example, the NHS Confederation provider members are telling us that the current uncertainty means they are unable to plan beyond 12-month fixed term contracts for key skilled professionals, meaning they are more likely to go elsewhere, or not apply at all as the roles are not permanent. They are also unable to plan for overseas or large-scale recruitment projects that require additional up-front investment.

98. This puts in to focus whether organisations are doing enough on longer-term sustainability. But to do that, they must better understand the risks of the impact of the pandemic on people and plan for what is genuinely needed based on data, demand, capacity and capital requirements. There must therefore also be a long-term plan for social care that sets the priorities for investment and transformation of services and systematically addresses the workforce challenges. To tackle vacancy rates, high turnover and low retention of staff, there are some fundamental issues on pay and conditions that need addressing alongside the need for an improved career structure and training that better reflects the skills and importance of care work.

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?

99. NHS terms and pay structures were updated through agreement with trade unions as a result of significant investment by the government between 2018 and 2021. Further targeted investment would assist the pay offer to graduate entry roles. It is also the strong view of employers that enabling greater flexibility would benefit take up of, and confidence in, the NHS Pension Scheme and support retention of all staff groups. Finally, there is the need to better publicise and explain the total value of the employment package offered in the NHS.

100. Closer working between different types of health and care organisation has raised the issue of employment models and differences in contract. While this may be

something to return to in the longer term, there are many other issues to address outside of which experience shows increase recruitment, training opportunities and improve retention outcomes, which are covered in the responses to other questions in the submission.

101. Pre-pandemic, there were examples of ICS' and STP's developing models to offer training of nursing associates, co-ordinating healthcare assistant and care worker recruitment across an STP, two-year rotations for midwives to work across different units. We have seen more cross-organisational working through the pandemic to show that this can be achieved by organisations working together across a system

102. There is also contractual variation within the independent primary care sector. For example, general practice nursing is facing particular challenges. Around 25k nurses work in primary care but the majority are not on agenda for change due to GP independent contractor status. This means that they do not benefit from the same terms and conditions as other colleagues in the NHS and primary care leaders report that this is having a detrimental impact on recruitment, retention and opportunities for development. We need therefore a short and long-term plan for how we attract and retain more nurses in primary care. Investment is needed through the GMS contract but needs to be targeted and protected and protected for non-medical clinical staff, including nurses.

103. In social care, the issue of low pay in parts of the sector continues to be a consequence of the absence of a long-term plan including funding for the sector.

104. Being able to raise the levels of pay for those people on the lowest salary would be an attractive benefit to attract and retain. The sector will still face high levels of competition for its workforce from other sectors but the ability to improve the offer via central funding will help providers to be more competitive and better reward the contribution of social care staff. NHS Leaders strongly endorse the call made by ADASS to significantly increase rates of pay for social care 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?

105. There is clear consensus across the NHS Confederation's membership that the future of health and care must be based on collaboration and partnership working at a local level. It is an essential enabler to the integration of healthcare services. The legislation and architecture need to support partnership working and reduce unnecessary bureaucracy and in relation to workforce, needs to make provision for workforce planning to be strengthened, in support of a regular and published national workforce plan. As our 2019 report on the role of ICSs in workforce planning made clear, the centralised system of workforce planning needs to shift to one which is informed and led by systems. To draw out and update the key recommendations: -
    - System leaders need access to analysis which shows the assumed benefits to their system of the steps taken to date by the government (medical school expansion, undergraduate expansion, overseas recruitment)
    - Systems need investment in capacity and capability to meet the expectations being placed on them to produce integrated workforce plans; at present investment is too often leaving systems to consultancy firms
    - National decisions on investment in education need to take proper account of system priorities

- The unequal distribution of training and educational resource between geographies should be acknowledged and a plan agreed to correct
- The underlying problems facing the social care workforce require national action and investment.

106. The COVID-19 crisis has required the health and care system to operate differently. Our members transformed clinical practice in days and weeks on a scale that would ordinarily take several months and years. Change happened at an extraordinary pace in every part of the health and care system, built from the bottom up by leaders who united around the shared challenges presented by the pandemic. This was facilitated, in no small part, by the removal of various bureaucratic stumbling blocks that have previously hindered progress, including in improving patient care. Whatever the governance and regulatory environment looks like for the sector in future, it does create some uncertainty around the size and shape of the future workforce.

107. Many of the positive ways of working in response to COVID-19 was based on local public sector and health and care leaders coming together at pace to radically redesign services for their communities. At the same time, the emergency response to COVID-19 has provided a glimpse of how the NHS could be, if duplication in reporting and assurance were stripped away and the system united behind a common cause. Services were transformed in days, rather than years, and frontline clinicians from

108. Addressing health inequalities entails increasing access for underserved groups, ensuring care takes place as close to the population served as possible, and enabling population health management and partnership-working within communities.

109. We know that many communities still experience poorer access, experience, and outcomes in relation to their healthcare. This is seen especially in many ethnic minority communities and in deprived and underserved wards and communities.

110. One of the important and well-known determinants of health inequalities within society is the availability and nature of employment. Employment is linked to the fundamental causes of health inequality due to the unequal distribution of income, wealth and power. As the largest employer in the country, the NHS has a key role as an anchor institution in helping to tackle inequalities locally in its employment and apprenticeship opportunities. By opening routes to employment for people who may not have previously considered or been aware of the variety of roles and careers available in the NHS, the sector is helping to ensure the workforce reflects the diversity of local populations. Building a workforce that is more representative on the local area can help to design and deliver inclusive services and respond to patient need, it also helps to grow local workforce supply.

111. The NHS People Plan explicitly recognises the NHS's responsibility, as an anchor, to support employment opportunities for local communities by creating new job pathways and making the NHS a more inclusive work environment and a better employer for more people. Many of our members are already working alongside local councils, colleges and local enterprise partnerships (LEPs) on initiatives to increase recruitment in their local communities, such as the Kickstart scheme, apprenticeships, traineeships, restart scheme and working with The Prince's Trust. Co-ordinated national action continues to be required to ensure that access to undergraduate education, as the key gateway to many careers is diverse and inclusive. Initiatives like

these will be key drivers for workforce supply now and into the future. Furthermore, the expansion of primary care through PCNs and the Additional Roles Reimbursement Scheme is a route of employment and training, for both clinical and non-clinical roles, at the community level.

112. What is needed is a long-term strategy and continued support to increase placement capacity. Through ICSs there is an opportunity for a joined up and local approach to managing the growth of placements, for example across the NHS, social care, hospices, primary care, independent and private providers, to ensure the availability of clinical placements is not a bottleneck in the training pipeline both now and in the future.

113. In all cases, the ways of working and governance structures underpinning ICSs remain a work in progress. There is no blueprint for developing an ICS. In contrast to many previous attempts at NHS reform, national NHS bodies have so far adopted a relatively permissive approach, allowing the design and implementation of ICSs to be locally led within a broad national framework. As a result, there are significant differences in the size of systems and the arrangements they have put in place, as well as wide variation in the maturity of partnership working across systems. The advantage is that it enables systems to create arrangements that are suited to their local context and build on the strengths of their existing relationships and local leadership. However, this approach leaves some uncertainty around what the end state of the changes will be, and variation across the country can make these reforms more difficult to understand and plan a national strategy for workforce.

114. Our members report that the main challenges when seeking to plan, develop and deliver new integrated place-based and neighbourhood-level approaches to health and care are current workforce shortages (with primary and secondary care competing for the same clinical ARRS roles), future workforce availability, and resources to support the development of staff to work in the evolving system. This is especially pertinent for small providers that lack HR and/or L&D support functions, such as PCNs. A greater focus is needed on the health and care workforce. There is only a duty on the Secretary of State to set out how workforce planning responsibilities are to be discharged once every five years. This alone is insufficient and not frequent enough.