NHS Confederation

Designing a public services workforce fit for the future

February 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 1.6 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.

Our response to this Public Services Committee's inquiry focuses on the health, and to a lesser extent, social care workforce, and considers the parts of the inquiry scope we can offer the most expertise on as the membership body for the whole of the NHS system.

While it focuses on the NHS, we know that by working with other public service employers, as anchor organisations within local communities, we can harness our collective influence and work together differently to improve the health and social outcomes for our citizens as well as drive economic development and prosperity in local communities by providing good work. In turn, these both contribute to improving health outcomes and reducing health inequalities.

Summary

Workforce pressures continue to be the single biggest challenge facing our National Health Service. Currently, there are nearly 100,000 vacancies in the NHS[1], and social care leaders repeatedly tell us they are struggling to recruit.

We have long supported efforts to amend Clause 35 of the Health and Care Bill to mandate the regular publication of independent assessments of current and future workforce

[1] NHS England, 2022, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2021-experimental-statistics

numbers. Without this legislative measure, it will be impossible to assess and meet population need in the long term.

Training expansion for the health and care workforce is currently not meeting the demand and we see this across a range of public services. Whilst there have been a number of helpful initiatives and funding commitments from Government, longer-term funding to underpin a workforce strategy for health and social care is required.

We highlight examples below of where the NHS has been working with other public service employers, at local level, to improve the outcomes and experience for the citizen. Our members will continue to explore opportunities to do this however meaningful and transformation change in how health and social care is delivered, and extending that to wider public service employers, can only be achieved by investing to bridge the existing gaps and grow the workforce.

Integrated Care Systems (ICS) are due to be put on a statutory footing from July 2022. We believe this provides a significant opportunity for more local workforce planning that can be shaped to meet the needs of local communities. Primary Care Networks (PCNs) need more flexibility to ensure they can build and strengthen community-based workforces that meet local needs.

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. 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, scaling up of apprenticeships leading to registered health and care profession status and international recruitment) needs to be urgently provided to systems.

2. 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.

3. Therefore, the NHS Confederation supports the amendment to Clause 35 of the Health and Care Bill, tabled by Baroness Cumberlege ahead of Report Stage in the House of Lords[2], which would mandate the regular publication of independent assessments of current and future workforce numbers.

How might training change to maximise the number of public services professionals and improve their skills?

[2] Royal College of Physicians (RCP), 2022, https://www.rcplondon.ac.uk/guidelines-policy/strength-numbers-stronger-workforce-planning-health-and-care-bill

4. 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.

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

6. Our members are committed to building apprenticeships into their workforce strategies to address skills shortages, as well as a means widening participation and offering opportunity to attract 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, especially in nursing, which is creating barriers to scaling up their potential.

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.

What would be the outcomes of better integration between public services workforces? 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?

8. 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. 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.

9. 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
    - 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.[3]

[3] NHS Confederation, 2019, https://www.nhsconfed.org/sites/default/files/media/Defining%20the%20role%20of%20integrated%20care%20systems%20in%20workforce%20development_0.pdf

10. 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.

11. In a July 2021 survey, 8 in 10 ICS leaders told us they were quite or very confident about delivering a 'one workforce' approach across their footprint by July 2022.[4] In Humber, Coast and Vale ICS, there is a Health and Social Care Workforce Consortium, an alliance of health and social care partners and educators focused on the recruitment and retention of support staff across the ICS area that reduces duplication of this work.[5]

12. Place will be the key delivery level, although we recognise that this looks different in different ICS. 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[6] .

13. 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.

14. ICS boards (ICBs) and associated Integrated Care Partnerships will be made up of individuals from across health services, local authorities, the voluntary sector and social enterprises who are working in local communities. This provides the opportunity to facilitate more cross-service working. To link to a previous inquiry of the committee, ICS will be able to work at place to ensure decisions about funding, staffing and operational issues relating to vulnerable children are made in a way that ensures the most effective possible provision and reduces the risk of children falling between the gaps between different services.

15. ICSs can work to address workforce issues by ensuring duplication of roles and priorities are reduced, and thus competition for particular skills and resources in a local area. The Black Country and West Birmingham ICS has taken a system-wide approach to delivering solutions in people and workforce planning. Through developing the Black Country and West Birmingham People Board, a driver diagram (that illustrates a 'theory of change') was produced, allowing partners to look at the problems they were facing as a local area and then provide a standardised, system-wide approach to recruitment. This has allowed the ICS to offer a system-wide apprenticeship prospectus, better utilise apprenticeship levy funding, develop a system-wide EDI strategy and establish a COVID-19 digital scheme to improve the validation of staff who needed to move between trusts to meet peaks in demand.[7]

16. The NHS Confederation has also developed additional resources to identify and support working together around workforce at system and place level:

[4] NHS Confederation, 2022, https://www.nhsconfed.org/publications/state-integrated-care-systems-202122
[5] *Ibid*
[6] NHS Confederation, 2021, https://www.nhsconfed.org/sites/default/files/2021-11/Reimagining-the-relationship-between-universities-the-NHS.pdf
[7] NHS Confederation, 2021, https://www.nhsconfed.org/case-studies/taking-system-wide-collaborative-approach-people-and-workforce

- Knowing who to call supporting integrated care systems to influence the local labour market[8]
- Creating the workforce of the future: a new collaborative approach for the NHS and colleges in England[9]
- Unlocking the potential of new community funds[10] 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.

17. In all cases, the ways of working and governance structures underpinning ICSs remain a work in progress. 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. It is critical that ICSs have flexibility to do this, and we have continuously lobbied against laborious duties on ICBs as the Health and Care Bill has passed through the legislative process.

18. 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 PCNs clinical Additional Role Reimbursement Scheme (ARRS) roles competing with vacancies in secondary care), 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 Learning & Development support functions, such as Primary Care Networks (PCNs). A greater focus is needed on the health and care workforce.

19. Furthermore, there needs to be greater flexibility for primary care providers to recruit the right skill-mix to meet the needs of their population. Currently, funding is provided to PCNs to recruit roles including social prescribers, care coordinators and physician associates, to keep people well and out of hospital. But there is too much bureaucracy and prescription around how these roles are filled. This constrains the ability of PCNs to strengthen a community-based workforce that can be built to address local needs.[11]

How can leaders of public services drive and incentivise any cultural change necessary to achieve integration between organisations? Are there examples of best practice?

20. The NHS can, alongside other public service employers, be an anchor institution in local communities.[12] This means NHS organisations can positively influence the social, economic and environment conditions in an area to support healthy and prosperous people and communities, and due to their nature and size, are unlikely to move out of the local community.

[8] NHS Confederation, 2020, https://www.nhsconfed.org/publications/knowing-who-call
[9] NHS Confederation, 2020, https://www.nhsconfed.org/publications/creating-workforce-future
[10] NHS Confederation, 2021, https://www.nhsconfed.org/publications/unlocking-potential-new-community-funds
[11] NHS Confederation, 2021, https://www.nhsconfed.org/news/pcns-call-more-funding-support-and-autonomy-shore-health-and-wellbeing-their-local-communities
[12] Health Foundation, 2021, https://www.health.org.uk/news-and-comment/charts-and-infographics/the-nhs-as-an-anchor-institution

21. A critical part of this is in relation to the NHS's role as an employer. The NHS employs 1.6 million people in the UK and is a critical source of economic opportunity for local communities and in some areas is a major driver of employment in a regional economy.[13] In turn, this drives better health outcomes and narrows inequalities due to the strong link between work and health. Building a workforce that is more representative of the local area can also better respond to patient's needs.[14]

22. ICBs are well-placed to support anchor institutions and their partners to innovate and develop system-wide approaches to social value and workforce development. For example, in Newcastle upon Tyne, the Collaborative Newcastle Partnership provided a forum for partners to come together to proactively design and establish the Integrated Covid Hub North East, creating over 1,000 new jobs for local people and investing in research and development in the city. Provider collaboratives (where providers collaborate plan, deliver and transform specific services), will provide a further important forum for anchor collaboration, for example, via training opportunities through working at scale across the NHS, looking creatively at the collective estate to support community initiatives or aligning sustainability strategies.[15]

What role can digital tools play in increasing the accessibility of public service workers to service users, and in improving the quality of work?

23. 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.

24. 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.

25. 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 increasing capacity for placements.

[13] Health Foundation, 2019, https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution
[14] *Ibid*
[15] NHS Confederation, 2022, https://www.nhsconfed.org/articles/anchor-institutions-innovating-through-partnership-challenging-times

How can digital technologies be used most effectively for training and up-skilling the workforce?

26. 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.

27. 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.[16]

28. 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.

[16] Health Foundation, 2021, https://www.health.org.uk/publications/long-reads/securing-a-positive-health-care-technology-legacy-from-covid-19