

NHS Clinical Commissioners response: HEE Consultation on Facing the Facts, Shaping the Future – a draft health and care workforce strategy for England to 2027

23 March 2018

I. NHS Clinical Commissioners

NHS Clinical Commissioners (NHSCC) is the membership body of Clinical Commissioning Groups (CCGs). Established in 2012, we now have over 91% of CCGs in membership. We therefore offer a strong national voice for our members on specific policy issues and support them to be the best they can to commission services effectively for their local populations.

We welcome the opportunity to provide a response to the HEE Consultation on *Facing the Facts, Shaping the Future – a draft health and care workforce strategy for England to 2027*. As commissioners for health services in local areas working collaboratively with system partners in STPs and ICSs to deliver a holistic patient-centred approach to health and care delivery, we are well-placed to comment on both the current workforce and the requirements for the future that will be needed to deliver new systems of place-based care.

Our response has been developed based on a survey of our membership, a member webinar that we held in partnership with HEE colleagues, and direct feedback from our membership. We also discussed the draft strategy at meetings of the NHSCC Nurses Forum, that represents commissioning nurse leaders, and the NHSCC HR & OD Leads Forum.

II. Overall comments

Our members are leading and engaged in the planning, development and delivery of new integrated place-based and person-centred approaches to health and care across England. They report that the main challenge when seeking to do so are current workforce shortages, future workforce availability and resources to support the development of staff to work in the evolving system.

There are five ways in which the strategy can address these issues:

1. The national strategy must be informed by local approaches to service development and identified challenges. It should be detailed enough to allow for planning with certainty, but also easily adaptable dependent upon the evolving defined needs of the local population and the availability of resources. If the NHS were to receive more funding it should provide a blueprint for how this should be routed to maximise impact and system benefit. Vitally it must bring together all elements and programmes that are operating at a national level, with HEE taking the lead role in coordination and planning for all workforce related programmes.
2. Our members are developing integrated approaches to health and care delivery for defined local populations. Staff will be required to work more closely with social care colleagues and the NHS must become more involved in planning for the workforce that will support the



delivery of these services. This will include working across organisations and as part of a multi-disciplinary team.

3. The defined role for strategic clinical leadership in the current commissioning structure must be highlighted and supported by a national workforce strategy. Since the establishment of CCGs, clinicians working at a strategic commissioning level have brought considerable benefits for patients as highlighted in several recent NHSCC publications¹. Over the next 10 years these roles must be retained, with development support and succession planning provided nationally to both these leaders, governing bodies and clinical leads.
4. To deliver more care out of hospital in the community there needs to be a radical upgrade in primary care. Both an increase in the number of GPs and the development of roles that can support reductions in primary care such as practice-based pharmacists, nurses and paramedics. The former could be achieved by linking medical school service contracts with the number of GPs that they produce, rewarding those that achieve the highest proportion of graduates working as GPs.
5. Within any system nurses will be vital to the delivery of quality and safe services. Community based and out-of-hospital care will need a nursing workforce to support delivery. The strategy should focus on how these roles can be supported, and outline how more Registered Nurses can be retained, trained and deployed, especially given the removal of the nursing bursary, rather than diverting resources to the creation of new roles.

III. A workforce strategy for England

In responding to the draft strategy, our members wished to frame what they believe a workforce strategy should seek to accomplish for the health and care system in England. In setting a 10 year plan any strategy must be ambitious and radical, especially within the context of the workforce and financial challenges currently facing the NHS. This is a unique opportunity for the NHS as a whole to address a significant challenge and can also act as a catalyst for national debate about what the requirements of the future NHS should be.

With the increasing focus on place-based systems of care and planning that is based on local assessment of need, a national workforce strategy should both inform local planning but also, significantly, be informed by local plans and need. It should be detailed enough to plan with certainty for future years, but also easily adaptable to local circumstances. For example, ICS and STP leaders should have the flexibility to work with local education institutions to address identified need, developing bespoke local solutions. Funding flows should be clearly detailed, with prioritisation to allow for additional funding to be routed to where it will have most impact and is most required.

The strategy should centralise the national approach to workforce planning, bringing together various programmes across the ALBs but also ensuring that it acts as the driver for the individual programmes. This would include streamlining the local structures such as LWABs, CEPNs and NHS England led programmes into one coherent system. Furthermore, although ownership of the contents should be cross-system, it is vital that the responsibility for coordination is held by HEE, which must then hold

¹ Please see: [Of primary importance: Commissioning mental health services in primary care](#), October 2017, [Supporting strategic commissioning: Collaborative working between CCGs and AHSNs](#), May 2017, [Delivering a Healthier Future](#), January 2016, [Leading Local Partnerships](#), October 2014.

other system partners to account. A coherent approach, with one version of the truth grounded in the realistic needs of the system, will result in lasting and impactful change.

The strategy, although encompassing all aspects of the NHS, should focus efforts on those areas that are in most need of support and which will be essential to the delivery of services in the future. This should mean that priority is aligned with future need rather than current shortages. Significantly the strategy should also encompass support for leadership and the commissioning workforce, totalling over 5,000 employees, who will be essential to the planning and delivery of the new systems.

Finally, as local systems develop integrated approaches to health and care delivery this must be mirrored in the workforce strategy. The social care workforce will be central to the delivery of holistic place-based person-centered care, and must be encompassed within a health and care workforce strategy.

IV. Supporting the current workforce

Primary Care

The ongoing challenges in the primary care workforce are well documented - since 2009 total numbers of GPs have fallen whilst the number of hospital consultants has risen by a third; in September 2017 there were 33,302 full-time GPs, 1,290 fewer than 2 years before; and the number of GP surgeries has reduced from 7,674 from 8,451 ten years earlier.² Modelling undertaken by researchers at Imperial College London has suggested that up to 12,000 more GPs would be required by 2020, far above the target stated in the draft strategy. This figure is also based upon running the service as it currently exists, rather than the transformed system envisioned in the *Five Year Forward View*

The workforce strategy should identify both opportunities to retain the current workforce but also recruit sufficient numbers to fill vacant posts and place primary care at the centre of the national approach. This would include increasing opportunities for flexible working, seeking to establish greater parity in pay of hospital consultants and GPs, through reductions to the former where appropriate, and supporting local areas developing innovative approaches to deployment of paramedics, nurses and pharmacists in primary care to relieve the burden on this challenged workforce. For the latter the strategy should explicitly reference how these teams will work as part of the multi-disciplinary teams locally. Finally, radical action must be taken to increase the number of GPs graduating from medical school. Funding should be linked to the proportion of graduates who are working as GPs in the NHS after leaving medical school. This would incentivise recruitment and training practises to support the primary care workforce.

Nursing

The Royal College of Nursing estimates that there are 40,000 nursing vacancies across the NHS. There has only been a 1% increase in the number of nurses and health visitors since 2010, compared to a 12% increase for doctors and 27% increase in consultants.³ Furthermore there have been major reductions in the number of nurses working in community services (-11%) and in district nursing (-45%).⁴ NHS England recently recognised the challenges in general practice nursing in *General Practice*

² The Economist, [The NHS's latest problem: a shortage of GPs](#), January 2018

³ Royal College of Nursing, [Safe and Effective Staffing: the Real Picture](#), May 2017

⁴ House of Commons Library, *NHS Indicators: England, October 2017*, [Briefing Paper 7281](#), October 2017; p18

– Developing confidence, capability and capacity: A ten point action plan for General Practice Nursing. Our members have reported considerable difficulties in the recruitment and retention of this essential component of the local workforce. A similar national approach must be taken to community and district nursing. This could include clearer opportunities for transition between roles across a system focussing on skills and competencies rather than being role-specific, for example, a primary care diabetes nurse specialist being able to transition to a role in secondary or social care setting.

The failure to support nursing career development, particularly post-graduate qualifications, is having an impact on the retention of the nursing workforce. Our members report that the decision to limit funding for qualification beyond the point of registration is impacting on the retention of staff. Furthermore, this fails to support the development of the workforce that will be required to support the new models of delivery.

Our members are clear that registered nurses will undertake those elements of direct care provision that are most required by providers and patients. They are clinical decision-makers, with degree-level knowledge and skills, considerable experience of caring for people with multiple or complex conditions, who can supervise, delegate to and educate more junior staff, and can lead a multi-disciplinary team that is an enabler for the establishment of transformed health and care services. We agree that there is a need for a role that bridges the gap between the registered nursing workforce and the care assistant role. This has considerable potential to provide support for social care and community providers, two of the most challenged sectors. However, we would suggest that current Band 4 Healthcare Assistants and Nursing Assistants should or could be carrying out these functions. We would advocate for further training and regulation of the Band 4 role, rather than an additional initiative that will stretch HEE's already limited resources to develop a role which is confusing to members of the public and may not be fully understood within the NHS.

Recruitment and Retention

To meet the increasing number of vacancies in the system HEE should work with the government to explore opportunities to secure overseas recruitment for those areas where most additional support is required. These should be developed following discussion with local areas, and crucially system leaders and commissioners, to ensure that those individuals with the skills to work in evolving systems are recruited.

Activity to improve recruitment and retention will not only address current workforce challenges, but will also ensure delivery of future systems. This would include strategies to increase opportunities for flexible working where appropriate, recognise the value of innovative technology to reduce workload pressure, especially in primary care, and positive PR campaigns to engage the future workforce. Our members feel that a positive promotional campaign highlighting the benefits of working for the NHS, especially in improving people's lives, and the variety of career journeys, alongside positive media stories about successes, will have a beneficial impact on recruitment and retention.

Our members report that the removal of HEE funding is proving to be a major issue both for staff on the frontline, and for the prospective future workforce. Significantly, this will also limit transformation, as there is no central resource to utilise in training staff in new ways of working. Piecemeal approaches

to address specific areas risk disengaging individual elements of the workforce, all of whom will be vital to the future running of the NHS.

Articulating how current roles will alter and develop with increasing out-of-hospital and community based care will allow staff to understand how their role will change, plan with certainty for the future, engage with the process of system change, and crucially be empowered to drive this system change, rather than being passive components.

V. Delivering the workforce to support future models of health and care delivery

Clinical Leadership

The 2012 Health and Social Care Act introduced clinical leadership to local health commissioning; empowering clinicians to get involved in the strategic planning and design of service delivery at a local level within CCGs. This has allowed local areas to truly focus on the needs of the local population with a clinical approach to decision-making. We believe that more needs to be done both to recognise the achievements of this key component of the workforce but also to support them through relevant training, particularly around operationalising agreed strategic plans. This is distinct from clinical leadership more broadly and the workforce strategy should outline how this senior sector will be supported and developed in the future. These individuals, both in commissioners and providers, will be vital to developing cross-organisational systems of place-based care rather than working within narrow organisational silos.

As well as developing current clinical leaders, the strategy should outline programmes to support succession planning for this group. This should include development of the wider clinical board and particularly CCG clinical leads who will become future local and national clinical leaders.

New roles and responsibilities

The workforce strategy must recognise and be developed around the future system of health and care delivery envisioned in the *Five Year Forward View*. The vanguard programme offers examples of how this will be applied in practice and the workforce that are required to deliver it. Examples include Happy Healthy at Home in North East Hampshire and Farnham, Connecting Care in Wakefield and Tower Hamlets Together amongst others. The strategy should also encompass the development of specific roles with functions that work cross-organisationally, for example, 'Extensivists' in South Somerset and Blackpool. Bespoke training opportunities must be offered to support the development of these roles and spread across the system where appropriate.

For more information

If you would like any further detail on our response please do not hesitate to contact our Head of Policy and Delivery, Julie Das-Thompson j.das-thompson@nhsc.org or Member Network and Policy Manager, Thomas Marsh at t.marsh@nhsc.org.