HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Workforce: recruitment, training and retention in health and social care, HC 115

Tuesday 24 May 2022

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Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Rosie Cooper; Dr Luke Evans; Taiwo Owatemi; Sarah Owen.

Questions 198 - 305

Witnesses

I: Shawn Charlwood, Chair, General Dental Practice Committee, British Dental Association; Ravi Sharma, Director for England, Royal Pharmaceutical Society; Dr Denise Chaffer, President, Royal College of Nursing; and Gill Walton, Chief Executive, Royal College of Midwives.

II: Ian Trenholm, Chief Executive, Care Quality Commission; and Simon Williams, Director of Social Care Improvement, Local Government Association.

III: Danny Mortimer, Chief Executive, NHS Employers; Dr Navina Evans, Chief Executive, Health Education England; and Professor Em Wilkinson-Brice, Acting Chief People Officer, NHS England.

Examination of witnesses

Witnesses: Shawn Charlwood, Ravi Sharma, Dr Chaffer and Gill Walton.

Q198 **Chair:** Good morning. Welcome to the Health and Social Care Committee's fourth evidence session in our inquiry into workforce: recruitment, training and retention in both health and social care. Today, we are going to focus on training. We will also look at areas other than doctors and nurses, which are often a traditional focus. We want to make sure that we look at the other professions. We will hear from the NHS, Health Education England and NHS Employers, and we will look at social care.

First, we are going to look at dentistry, pharmacy, nursing and midwifery. I would like to give a very warm welcome to Dr Denise Chaffer, the president of the Royal College of Nursing; Shawn Charlwood, who is chair of the British Dental Association's general practice committee, which represents the interests of 30,000 high-street dentists in the UK; Ravi Sharma, who is the director for England at the Royal Pharmaceutical Society; and Gill Walton, who is well known to this Committee and is the chief executive of the Royal College of Midwives. Thank you all very much for joining us.

I would like to start with dentistry. I am delighted that we have listening to today's session our parliamentary MP dentist, Paul Beresford, who is joining us in the gallery. Shawn, could you let us know in headline terms what is happening to the size of the dentistry workforce, what the trend has been, and whether that size is linked to the fact that so many people are finding it so much harder to access NHS dentistry?

Shawn Charlwood: Certainly. Thank you, Chair, and thank you, Members.

We actually have the largest number of dentists on the General Dental Council register that we have ever had. The issue is that not enough of those dentists want to work in the NHS dental system. In fact, in the last two to three years, during the pandemic, we have had 3,000 fewer NHS dentists available to treat patients, although the numbers on the GDC register have increased. In NHS dentistry, in particular, we are facing a crisis the like of which I have not seen in my 35 years in the profession. NHS dentists are genuinely struggling to see the light at the end of the tunnel, and they are voting with their feet. That is affecting the workforce available to see patients.

Thousands of dentists have already left the NHS dental service. Millions of patients are struggling to secure the care they need. Undoubtedly, Covid and the pandemic have exacerbated the problem, but the problem existed before the pandemic. The NHS workforce was declining. My NHS colleagues feel chewed up and, frankly, spat out by the system they work to—the NHS dental service. Dentists are severing their ties with a failed NHS system.

To give you some context, last week I was approached by a young dentist who has gone through five years of training, with £70,000 of student debt. He said that one day he earned £9 because of the perverse way the current NHS contract is structured. Many of my colleagues talk about how the only thing that is keeping the NHS going is the ethical responsibility that the dentists feel towards their patients, but that can only last for so long. Obviously, we cannot have NHS dentistry without NHS dentists. It does not come as a surprise to us at the British Dental Association, and I do not think that it should come as a surprise to this Committee, that we have a genuine crisis. Unless the Government deal with it urgently, the situation will worsen.

To conclude, back in 2008 this very Committee reported that the contract was unfit for purpose and recommended reform to the Government. Here we are, 14 years later, and, in essence, nothing has been done by the Government on NHS dental reform. It has been allowed to wither on the vine, and today's crisis is the result. This must not continue. Your advice—your report—must not be ignored again, otherwise this crisis will continue. We need a new, non-UDA contract for NHS dentistry by April 2023 at the latest.

Q199 **Chair:** This is obviously a very big issue, and we have made a commitment as a Committee to look more deeply into dentistry. In fact, we have said that we would like to complete a report on dentistry that was started by our predecessor Committee in the last Parliament. Without going into too much detail, in a bite-sized way, can you say what type of contract we need to move to in order to stop dentists moving out of the NHS system?

Shawn Charlwood: The Government need to work with the British Dental Association to develop a contract. We have presented a paper to them with some very clear ideas. Those are structured around capitation for dentists. A dentist in a practice, a bit like a general medical practice, would look after a group of patients. It would allow dentists to provide the care that their patients need and the care that they have been taught to deliver at dental school. Most importantly, it would allow dentists to provide prevention. All the diseases that we treat day in, day out—dental caries and gum disease—are completely preventable, but the current UDA system does not allow and remunerate practices to provide prevention.

Within that capitation system, we can provide weighted capitation. That would address areas of deprivation and inequality, which is really important. We must address that. There is current evidence that the patients who are least able to access NHS dental care are from some of our most deprived communities, and that inequalities in dental health are widening. None of us wants that. It must be addressed.

Q200 **Chair:** Thank you. We will come back to you. Ravi Sharma, what is your perspective on what is happening to the pharmacy workforce?

Ravi Sharma: Thank you, Chair. From a pharmacy workforce perspective, the General Pharmaceutical Council has stated that there are over 61,000 pharmacists and over 24,000 pharmacy technicians across the UK. We have a diverse workforce that works in different areas of practice. Over 60% of pharmacists work in community pharmacy. Approximately 9% of pharmacists work in primary care, general practice or primary care networks. Around 22% of pharmacists work in hospital services. The rest work across academia, industry and other areas of practice.

According to the General Pharmaceutical Council, 18% of pharmacists are independent prescribing clinicians and deliver patient care services in different areas of practice. Over the last few years, there has been a growing number of people in the pharmacy workforce, with approximately 2,000 pharmacists newly joining the register year on year.

Q201 **Chair:** Generally speaking, is the situation satisfactory from your point of view?

Ravi Sharma: We know that pharmacists have gone above and beyond over the last two years, through the Covid-19 pandemic, doing absolutely incredible work on the frontline. The great example of that is the success of the Covid-19 vaccination roll-out programme.

One of my biggest concerns throughout the pandemic is burnout for pharmacists and the pharmacy workforce: 89% of pharmacists are at risk of burnout. A third of the profession have considered leaving the profession in the next 12 months. When we think about the NHS wanting to make better use of pharmacists and their clinical skills, and of independent prescribing pharmacists in the future, it is absolutely pivotal that we look at how we support the workforce to be able to deliver the increasing demands and needs of patient populations and to contribute further to the NHS, particularly in the areas of Covid-19 recovery, but also to deal with the backlog of important care for patients and the population. The real risk for me is around burnout and people leaving the profession, potentially, over the next 12 months.

Q202 **Chair:** What would be top of your list as something that the Government could do to support the pharmacy workforce?

Ravi Sharma: There are a few things, if I can elaborate on them. There are some really quick wins that the Government could do in the very short term. One would be to pass policy to ensure that all pharmacists were able to get protected learning time to support their continual professional development in a structured way. I would also like to see a commission from the Government to look at workforce wellbeing pressures in relation to pharmacy, with a focus on how we prevent poor workforce wellbeing occurring in our working environments. What are the levers, the changes, the solutions and the plan that need to happen to support the workforce?

I would like to see a comprehensive workforce strategy for pharmacy that embeds structured career development for pharmacists wherever they may be working, particularly those in primary care, general practice and community pharmacy, to ensure that they excel, have greater job satisfaction and are able to build their competencies and abilities to deliver more patient care services. Lastly, we should have more comprehensive workforce data for pharmacy and pharmacy teams. We should change that workforce data into intelligence to help us to plan the current needs of the workforce for the future needs of the workforce, to deliver better population health.

Q203 **Chair:** I will go to everyone once and then open it to my colleagues for some questions. Dr Chaffer, can I come to you to talk about the nursing situation? The Government are very proud that we have increased the number of nurses in recent years. There is the big 50,000 additional nurses target, which Ministers say we are on track to deliver. We also know that there is a 10% vacancy rate and that there are stories similar to the ones Ravi has been telling us about—worries about burnout. What is your perspective on the overall health of the nursing workforce, where we are at and where we should be?

Dr Chaffer: Good morning, everybody. Before I start, I want to say that in my current day job I am the director of safety and learning for NHS Resolution. I am here only in my capacity as Royal College of Nursing president.

The situation for nursing is quite critical at the moment. We have 39,652 vacancies—as you said, over 10%. We have a huge problem with retention. Last week, the Nursing and Midwifery Council published figures on the increase in the number of nurses who are leaving the profession. The retention issue is probably the most critical. We need to understand why nurses are not staying. We saw more people wanting to become nurses during the Covid pandemic, when there was a slight increase in applications, but we are also seeing a number of nurses leaving. Not only is that really difficult for nurses working in all fields of nursing, but it majorly impacts on safe staffing levels. If nurses are not able to give safe care, it is very bad news for patients. Our concerns are particularly for the harm that can be caused for patients by not having enough nurses there. We do not want to see any of the scandals that we have seen in the past when we have had such severe shortages.

We have to do both. We have to do something to really improve recruitment to nursing and do something about the financial burden for student nurses coming into the profession. We need to retain nurses once they have qualified. We still lose a percentage of nurses during the training period. When they are in the profession, we need to make sure that they are provided with the support that they need to continue. That requires, in addition to the support, being able to practise safely, having enough staff to supervise and ensure that there is safe practice. They must have access to further education as well.

Q204 **Chair:** Apart from the pay issue, what other things would make a difference to retention?

Dr Chaffer: We cannot get away from the pay issue. I am quite sure that you have seen the pretty comprehensive evidence that we gave the pay review body on the scale of the problem. We have nurses who are unable to pay their rent, unable to afford petrol to get to work and unable to get a mortgage. We have spoken to a number of members who cannot get a mortgage. They rely on food banks. Clearly, pay is absolutely critical. We cannot move away from that.

In addition, there are quite a lot of things that we can do. We really need a longer-term workforce strategy. We have been through a period of increasing, then decreasing and then increasing. We need a much longer-term strategy. The needs of patients are very complex these days. They are very different from when I started on my first ward as a newly qualified staff nurse. The patients we have on the wards now are extremely complex, with extremely complex needs. That needs nurses who are highly skilled, so we need to recognise the complexity of nursing in many, many areas of specialty.

The other thing that we need to do at Government level is to provide more support. We have some international recruitment, but we need to look after those international recruits when they arrive in this country, so that they are not subject to poor conditions and do not have to pay additional fees, and are supported in the workforce. We need to provide better support for training for the nurses we have, so that they have access to training. Many staff are paying for their own further education training. Being released and back-filled to undertake training is incredibly complex.

Recognition on workforce strategy is very important, but there are wider pieces of work that we could do across the whole system organisationally, around improving the culture of our organisations, making places good places to work, having fair processes and making sure that there are fair recruitment processes, that we are promoting a learning organisation and that our nurses feel very valued for what they do.

Q205 **Chair:** Thank you. Finally, I turn to Gill Walton. A year ago we published our report into maternity safety. You helped us to identify, using the Birthrate Plus tool, that we were 2,000 midwives short. The Government said that they would consider that recommendation and subsequently accepted it when the Ockenden inquiry was published. A year on from that, are we any better off?

Gill Walton: Good morning, Chair. I wish I could say yes, but the answer is no. The midwifery workforce is very fragile. There is still a huge shortage. In fact, there are fewer midwives in practice this year than there were last year. It is the same with the NMC figures that came out recently.

There has been a lot of negative attention on the maternity workforce, so morale is really low. I support what Denise has just said. Retention is a really important thing. How are we going to keep the midwives we have while we recruit more? There is an increase in student numbers, but we know from surveys the Royal College of Midwives has done that in the first five years of qualifying an increasing number of those midwives express their intention to leave the profession. Retention is really important.

If I were to pick a key thing that could make a massive difference, it would be flexibility when working in maternity services. That is the flexibility to be able to plan your work. We already know that over 60% of midwives, and, I suspect, nurses as well, have caring responsibilities, not just for children but for elderly relatives, so being able to plan their work is important to them.

The other thing is pay, obviously, and valuing midwives for the work that they do. It is tough. It is a really tough job. The complexity of maternity services and the focus on them is increasing. Every woman deserves a midwife who can provide safe and quality care. In order to support them to do that, we need to think of all the ways that we can to support them to stay in practice.

Q206 **Chair:** I am sorry—were you going to say something else?

Gill Walton: I was just going to add something about bringing people in. There has been an increase in the number of student midwives, but we are seeing attrition from their training. Some of that is because of the bursary issue in England and the fact that they have very expensive childcare issues, for example. There are solutions to that with apprenticeships, but the supply needs to be looked at, as well as the retention. That is key.

Q207 **Chair:** In your evidence, you warned us that measuring vacancy rates rather than workforce needs can lead to what you describe as "a double whammy of vacancies (without sufficient people to fill them) but also not enough actual jobs." Can you explain what you meant by that?

Gill Walton: I certainly can. A lot of organisations have had vacancies for some time. With the increase in the number of students coming out of their education, the vacancy rates go down, so students cannot get jobs because there is not enough money within the maternity service to pay them. It is about being able to ring-fence the money in maternity services to recruit students when they come out of training.

I had a real-life example last week of a student who could get only part-time hours after her training because the organisation did not have enough funding in its budget. It is important that services set the appropriate establishment for midwifery to provide a safe midwifery workforce and that that money is not taken away for cost improvement while they are waiting for students to come out of training.

Q208 **Chair:** Do we have enough midwives now for the funded jobs that there are?

Gill Walton: No. They are still short because they are leaving. There are still vacancies. Directors and heads of midwifery tell us that they have 20% to 30% vacancy and are struggling to attract people into those posts. It is a vicious cycle. If you are short of midwives and cannot deliver quality, safe care, you feel anxious and you leave. There are also people who retire early. How do we attract them back to support midwives, particularly junior midwives, in practice, and make it easy for them to do so?

Chair: Let me bring in my colleagues. Rosie, would you like to come in?

Q209 **Rosie Cooper:** May I put some questions about dentistry to you, Mr Charlwood? Every newspaper article that I read says, "Where have all the NHS dentists gone?" We are very clearly moving into a two-tier system where, if you can pay, you have decent teeth, but if you cannot, and you cannot get on a list somewhere, you are abandoned by the NHS.

Before the pandemic—as it was getting going—Sara Hurley was really angry at my description of dentistry, which I described as having gone back to prehistoric times, when it was extraction or bust. I am not seeing a great deal of change in that. During the pandemic, my bridge broke. The answer was extraction, to extract what was left. At the dental hospital a consultant said to me, "We can save that tooth, but we can only save it here." Another consultant did absolutely brilliant work. It took him nine hours, and that saved a tooth, which made everything else so much easier.

You described a dentist who earned only £9 in a day. The consultant who treated me said that, for his nine hours of unbelievably precise work to save that tooth, he would be paid the same as he would get for one unit of care. You have described somebody who could earn £9 in a day. Can you explain to us what that really means? You are describing the end of dentistry as we know it, if that continues.

Shawn Charlwood: I absolutely agree with you. This is what we as a profession, on behalf of patients, are deeply concerned about. Is this the end, the slow death, of NHS dentistry? It may not be that slow, to be honest, based on some of the figures we have seen.

The unit of dental activity—UDA—system is fiendishly difficult to explain to anybody, but I will try. Tell me when you would like me to stop.

Q210 **Chair:** Can you be brief? I am sorry. I know how important it is.

Shawn Charlwood: I will try to be brief. The top and tail of it is that a dentist will be paid the same for 10 fillings as for one filling. They will be paid the same for three extractions as for one extraction. Those particular treatments fall into a certain band—one of three bands—and the band determines what you will be paid.

The important implications of that are that new patients are disincentivised from joining a practice because new patients often have higher levels of disease. They may not have been to a dentist for many years and may arrive with a number of different oral health issues, whereas patients who have been seen regularly are more likely to have been managed and their clinical health will be more stable. The UDA system does not allow dentists to deliver prevention. It pays for targets, rather than patient care. It is easy for the Treasury to measure. It confines the budget. It does not allow new practices to open. It does not allow successful practices to expand their patient list. Most importantly, it disincentivises NHS dentists from seeing new patients, because once they have reached their allocation of UDAs for the year there is no more funding.

If you have a stable NHS dental practice, you will be inundated with inquiries from new patients to be seen.

Q211 **Chair:** Can I jump in? To cut to the chase, are we basically having rationing by the back door when it comes to dentistry? Is that what is happening?

Shawn Charlwood: Yes, I am saying that.

Q212 **Chair:** Who is losing out? Tell the Committee which patients lose out most with the system we have.

Shawn Charlwood: The patients who lose out are, broadly, the 50% of the population who do not routinely access NHS dental care but wish to access it on an intermittent basis. Traditionally, NHS dentistry has been commissioned for only 50% of the British population. I think that is wrong, and the crisis we are seeing now in NHS dentistry is to do with the NHS contract and, frankly, not enough commissioned service.

As I touched on earlier in the session, the people who are most vulnerable to not accessing NHS dental care are often those who most require care and are in the areas of most deprivation. For whatever reason, access is difficult; for example, they cannot access the internet to get appointments. There has been some research that indicates that people in those areas are struggling the most.

Of course, as I said earlier, that propagates inequalities of health. We are not just talking about dental caries—dental decay—and gum disease; it is about oral cancers and malignancies. All those things have obviously been continuing throughout the pandemic. The later they present, the less favourable the outcome often is. Treatment is more complex.

Q213 **Rosie Cooper:** If I may, I want to add one controversial point. How did we get here? Governments do not start by saying straight off, "We want to do this." There is a financial part. Let's address the elephant in the room. Some bad behaviour by a tiny number of dentists has led the profession to be seen as greedy. Therefore, you get to the situation where you have this £9, units and all the rest of it. How do we address

getting the taxpayer good value for money, while also making sure that dentists prosper and patients are really looked after? We are not going to sort this out unless everybody acknowledges each other's position. That elephant is in the room.

Shawn Charlwood: That's fine. To address the elephant in the room, dentists are not moving away from the NHS in order to earn more money. They are moving away from the NHS in order to work in a system where they can deliver patient care as they deem appropriate; as I explained earlier, through prevention and having the time to deal with patients as they wish.

Morale among NHS dentists is very low. The more NHS commitment they have, the lower their morale. The UDA system arrived. It was pulled apart very early on—as I said, in 2008 by this Committee—and we have had years and years of under-investment in NHS dentistry. We have seen a 40% decline in real terms in NHS dentistry over the last decade. No other element of the NHS has seen that level of decline. NHS dentistry does not feel part of the NHS. It has not had the level of investment. Frankly, it has not been loved like other elements of the NHS. It is time that NHS dentistry was fully integrated into the NHS system and was loved again.

Q214 **Rosie Cooper:** Absolutely. How would you persuade the Government to invest in more than 50% of our teeth?

Shawn Charlwood: I can put the argument. I look at the MPs in the room. Your postbags are routinely inundated with patients and constituents saying, "I can't access NHS care." For me, this is a really high-profile political problem. I am sure that it is for people on this panel. It is plainly obvious to me that it is not acceptable for a service to be commissioned for 50% of the population. It is as fundamental as that. Fund the service. Provide an NHS dental contract that NHS dentists wish to work in. We can retain, then we can recruit, and we can build the service again.

Chair: Thank you.

Q215 **Taiwo Owatemi:** Ravi, by 2027 newly qualified pharmacists will be able to prescribe. Can you explain the impact that would have on the workforce and in addressing some of the wider workforce shortages in the NHS?

Ravi Sharma: Thank you for the question. It is a really exciting time for pharmacy initial education reforms at the moment. As you said, by 2026-27 we will have newly qualified pharmacists who will all be independent prescribers, with an opportunity to enhance patient care by utilising their clinical skills to be able to deliver better services.

While that is exciting, there needs to be some real thought about how we establish it for the future in the NHS. As I mentioned, there are 61,000 current pharmacists, but only 18% of them are independent prescribers.

There is a task about how we train all pharmacists to become independent prescribers in the NHS.

The second bit for me is ensuring that there is access to supervisors and that there is parity of tariff systems so that there are equitable systems in remuneration and funding in place to allow supervision of pharmacy teams to become independent prescribers. I mentioned earlier the need to have structured protected learning time to develop an independent prescribing workforce.

Lastly, once you have all these fantastic independent prescribing pharmacists, do we have the services for them to utilise their full clinical potential? We have seen incredible efforts from primary care network pharmacists and general practice pharmacists over the last five years, prescribing and optimising medicines, and delivering really good patient care, working as part of a multidisciplinary team. We need that in community pharmacy to be able to unlock the potential for reducing pressure on general practice, urgent care for minor illnesses for instance and better utilisation of hospital pharmacy work, as you know only too well, to utilise their prescribing qualifications to do not only work in hospital but outreach to primary care to support integrated care systems.

Q216 **Taiwo Owatemi:** What impact do you think that would have on the current workload pressures that the NHS is facing? What I am trying to get at is, do you think that the NHS will benefit from having more independent clinics that are led by pharmacist prescribers?

Ravi Sharma: I practise in general practice, and I have worked in general practice for the last nine years. I am a pharmacist prescriber working in general practice, so I can speak from my own first-hand experience.

Pharmacists who are clinically skilled and can adapt to utilise their qualifications enable you to optimise the workload that healthcare staff are able to experience. Stuff that would be done by other healthcare professionals could equally be triaged and utilised by pharmacy teams. This will not only improve access to care for the population but ensure better use of medicines. We know that one in 16 admissions to hospital is related to medicines. That is all avoidable. Having pharmacists who are experts in medicines to optimise treatments and look after clinical care would be fundamentally important to the NHS from both a capacity perspective and a clinical service perspective.

Q217 **Taiwo Owatemi:** Earlier, you spoke about the need for a structural career pathway for pharmacists. What do you think can be done to ensure that a community pharmacist, a hospital pharmacist or an academic pharmacist all have the necessary training to be able to meet the workforce challenges within the NHS?

Ravi Sharma: I mentioned earlier, similarly to Denise, that there needs to be a comprehensive workforce strategy for pharmacy teams to use

wherever they might be working, and to ensure that there are, in that workforce strategy, structures for professional career development so that pharmacists are able to do more and extend their competence and their abilities to do more. That requires the adoption and development of advanced practice curricula and credentialling opportunities to ensure that pharmacists are able to do more in that space, and to allow career-structured development for pharmacists to go from registration to advanced-level practice to consultant-level practice across the system. That requires investment and resource so that implementation of that career pathway occurs, particularly in primary care where, as I mentioned, there is a real lack of structure.

According to some of the survey work that we have done, it is one of the key reasons why pharmacists in primary care are considering leaving the profession over the next 12 months. There is a lack of career development opportunity and a lack of job satisfaction because they are unable to use the clinical skills that they have.

Q218 **Taiwo Owatemi:** I have one more question on retention. During the pandemic, many of the pharmacists I spoke to talked about experiencing abuse. I know it has been a massive issue in the community pharmacy workforce. What do you think we can do to better protect pharmacists who work in the community?

Ravi Sharma: There should be absolutely zero tolerance of any form of abuse that any NHS staff are facing, wherever they might be working. I mentioned, as part of some of the asks around what the Government could do quickly, looking at the reasons why pharmacists are leaving the workforce, and in particular looking at ways in which we can prevent those issues and find solutions for them. There needs to be a stricter policy around abuse of any healthcare teams and what we should do with patients. I also think, realistically, that we need to engage with patients and the population to understand the fantastic role that pharmacists and pharmacy teams play, and that they are actually there to help patients and the population, and to respect that as well.

There are a number of different areas that we will be looking at from a prevention/solution perspective, and having a zero tolerance approach from an NHS perspective, to enable that to happen.

Q219 **Taiwo Owatemi:** If there was one change that the RPS would ask for, what would it be? What is the one thing that the RPS would like to see for pharmacists?

Ravi Sharma: From a workforce retention perspective, and to attract people to the profession, one of those bits would be to pass a policy to ensure that all pharmacists were able to get protected learning time to develop, right here, right now. That would be a very quick win. It is one of the key factors in what pharmacists are saying to us would improve their wellbeing. It would improve their opportunities to stay, but it needs

to be properly resourced and structured, and equitable across other healthcare professionals.

Taiwo Owatemi: Thank you so much, Ravi.

Chair: Of course, it helps having the occasional MP who is herself a pharmacist. From a pharmacist to a GP.

Q220 **Dr Evans:** I have three questions for the panel and three distinct issues to pick up from what you have talked about. Ravi, could I start with you? Community pharmacy and pharmacy in general seems to be the only place in the NHS putting its hand up to say, "Give us more work. We want to do more." Is that a fair characterisation?

Ravi Sharma: It is absolutely fair. The pandemic has highlighted that when you give community pharmacy, in particular the pharmacy workforce, opportunities to deliver important NHS healthcare services, they step up to the plate and are able to do it effectively.

Of course, we want pharmacy to proliferate and to support the NHS as one of the largest healthcare workforces that has great skills and knowledge around medicines and the ability to support people with long-term conditions more effectively. I think that is an absolutely true reflection of the valiant efforts of the profession, despite them being very exhausted. They want to continue to support the NHS, the Government and the populations we serve.

Q221 **Dr Evans:** Denise, you talked particularly about flexibility in retaining nurses working. Do you think there is a role for apprenticeships in nursing to allow people to earn and learn? We heard this talked about in the workforce side of the medical training aspect. Do you think that is appropriate for nursing?

Dr Chaffer: There are apprenticeship schemes. What you can see is that there are a number of different routes into nursing. What you cannot do is stop the requirements that you need to meet the standards to become a registered nurse. There are many different routes into nursing, including that. We should be attracting people and giving them the support that they need to do that, without a doubt.

If you are saying, would we need to do something fundamentally different, we have standards to meet and our patients expect that. They expect to have the best qualified nurses, and we need to maintain that.

Q222 **Dr Evans:** Shawn, to be clear, you are saying we have more dentists than ever before but fewer in the NHS. What does that mean for the whole picture of dentistry across the UK?

Shawn Charlwood: You touch on an interesting point. Although we have the highest number of people on the register, we do not have a lot of detail about whole-time equivalents. The nature of the profession has changed over the last 25 years. For whole-time equivalents we do not

have any accurate data. We have not really had effective workforce planning.

Yes, it is true that there are more people on the register. There are declining numbers of dentists in the NHS, but in terms of whole-time equivalents we just do not know. We have been asking for this for a long time. Without the whole-time equivalent data, it is very difficult to assess what level of service can potentially be provided if you see improvements in the NHS contractual piece. We need that information.

Q223 **Dr Evans:** Are people who cannot get into the NHS choosing not to go to the dentist, or are they choosing to go private?

Shawn Charlwood: There is both going on.

Q224 **Dr Evans:** Do you have a feel for which is more, or any data to support which way people are choosing?

Shawn Charlwood: In some areas, we have what people describe as NHS dental deserts; there is no NHS dental provision. In Portsmouth, for example, they lost a quarter of their dentists within 18 months. To me, it seems to be a process that is gathering momentum. We have done some surveys at the BDA. Increasing numbers of dentists say that, unless there is rapid change by April, they will leave the NHS. For every dentist who has left the NHS, there are 10 dentists who are reducing their NHS commitment.

There are two things going on. Some patients are accessing private dental care, when they can afford it. Some patients are not accessing any care. We have heard increasing stories of DIY dentistry, which is completely inappropriate, and something out of Victoriana, frankly. People are extracting their own teeth and filling their own teeth. It is patently not acceptable and not appropriate.

The other story is people having to travel much further to access NHS dentistry. That touches on the inequality piece. We cannot assume that everybody is able to travel large distances. I come from a rural community. Rural transport links, as we know, are not optimal. I come from a place not far from your constituency. People are not able to travel large distances, so there are all sorts of inequalities.

Q225 **Dr Evans:** I have one final question on this. There is a difference, when we bring in doctors internationally, in the process they have to go through, from dentists. Should that be brought in parallel? I gather that India has an excess of dentists, so there is a question about whether we should be looking to provide support or a pathway through to help deal with this. Do you have an opinion on both of those points?

Shawn Charlwood: Yes. There are a couple of things. I think the Minister was correct in saying that we have enough dentists, but we just do not have enough dentists who want to work in the NHS. That is the first point. I think we need some accurate workforce planning.

We then have the overseas examination, which, at the moment, has broadly 2,000 overseas dentists waiting to go through the process. The process is too long. Some people have been time-barred because it has taken them so long. That needs to be looked at. The process of actually adding overseas graduates to a performer list is taking far too long as well. There are some specific matters of detail that could be ironed out quite quickly, in my view, that would help the situation.

Q226 **Dr Evans:** Could you write to us with them? It would be useful to have those specifics for our report.

Shawn Charlwood: We can do that. Absolutely.

Dr Evans: Thank you.

Q227 **Sarah Owen:** I have a couple of questions for Denise and a couple of questions for Gill. I will try to get through them as quickly as possible.

Denise, we have danced around the elephant in the room, which is pay, when it comes to recruitment and retention. Did you ever envisage a time when six NHS trusts would have to have food banks to support their workforce?

Dr Chaffer: No, I really did not. When we talk about pay, we are also talking about safe care for patients. Clearly, we need a nursing workforce that feels valued, supported and is the best that it can be. The cost of harm is very expensive as well. When we get things wrong—we just heard about dentistry—there are unintended ongoing costs for additional treatments. One of the worst examples is people falling out of bed. We need to make sure that we have preventive strategies to stop people getting hurt. That costs a lot of money, and the temporary workforce costs a lot of money.

We know for nursing in particular that pay has certainly been behind the curve for some time, and it is in a degree of catch-up. It is very important. We cannot afford not to address it. I want to be part of a profession that I am proud to be in. I have many friends and family who are nurses, but they just cannot do it anymore. That is what we are seeing; people are walking. That is probably the biggest risk we have, particularly after the pandemic and after how hard everybody worked in every aspect of nursing. They are now on their knees.

The worst thing for any of us as nurses is working when we do not have safe staffing levels. We are in a circular problem. We need to pay nurses to keep safe staffing levels and keep patients safe. It is absolutely a top priority.

Q228 **Sarah Owen:** Thank you. My second question relates to that. The NHS has always been proudly international. You mentioned earlier how we welcome and support overseas workers. Could you talk a little about the impact of the visa costs, and whether you think the IHS refund scheme has been successful in supporting overseas NHS workers over the last

two years?

Dr Chaffer: On international recruitment, one of the most interesting documents to read is from the International Council of Nurses, "The global nursing shortage". Reliance on international recruitment is not the solution going forward, without a doubt. Their predictions are extremely frightening. They forecast potentially an international worldwide shortage of up to 7 million. There is also the risk of everybody relying on international recruitment, which will not be a solution going forward. As a country, we have to focus on our own solutions. That is No. 1.

In answer to your question about whether things have improved, at the moment that is not what we are hearing. We hear from our international nurses who are suffering huge types of financial difficulty. It is not just financial difficulty when they are working here; it is also discrimination, as well as their opportunities for promotion and educational development. All of this is a big, circular argument when the real solution comes back to a robust workforce strategy for our nurses here.

We have to tackle the fact that we are losing nurses. We cannot afford to lose a single nurse. We are all going to be patients and we have families. We want people to be there for us. We want people to be able to respond to our families.

Q229 **Sarah Owen:** Thank you, Denise. Gill, in previous Committees Professor Dunkley-Bent talked about the importance of continuity of care. I can guess the answer to this, but how far off are we from having enough midwives to provide continuity of care for patients?

Gill Walton: We are very far off. The evidence from the Cochrane review of midwifery continuity to improve outcomes, as well as the working experience of midwives, is quite clear. When you try to implement that without enough staff, it is not helpful. It creates inequity within services. Therefore, that increases the stress.

The Royal College of Midwives believes that the gold standard is what every woman needs, but until there are enough midwives in the system, it is not possible to implement that in the way that is envisaged. That is a really sad state of affairs.

Q230 **Sarah Owen:** One of the shocking reports that Birthrights has just released from its inquiry is that black women in the UK are four times more likely to die during childbirth and pregnancy than a white woman, and an Asian or mixed-race woman twice as likely. What do you think is being done to tackle that inequality? When will ethnic minority mothers and pregnant women be as safe in this country as a white woman?

Gill Walton: I have just read the Birthrights report. Obviously, there have been other reports. The pandemic highlighted issues for black, brown and Asian mothers. We absolutely must focus on that group of women and really listen to them. We have heard a lot recently about how important it is to listen, to understand and to act.

If there is extra funding available, focusing midwifery continuity, for example, on those women, and other vulnerable women, is so important to improve outcomes. The role of the midwife can make a massive difference to future population health. That is why it is so important, which I know you know. It is a really important part of the role of the midwife.

Q231 **Sarah Owen:** One of the suggestions has been about improving diversity in recruitment for midwives. What do you think could be done to improve diversity in our midwife workforce?

Gill Walton: I can say that it is definitely at the top of our list. It is a golden thread through the work of the Royal College of Midwives. We call it Race Matters. The most important thing is to make people feel valued and to understand the contribution that every single midwife can make to the care of women. Recruitment locally, and services locally, need to reflect the population. For that, you have to be able to attract people appropriately into the profession. Midwives say, "They need people to look like them." That is so important. Work is being done. I have seen some really good examples, but there is much more that needs to be done. We are all committed to that.

Q232 **Sarah Owen:** On that last point about getting more people into midwifery and how we retain them, last week or the week before we heard from a medical student about burnout for medical staff. Is that a reality facing student midwives?

Gill Walton: Yes, it is. It is a hard course because they work 50% in practice and 50% learning. The learning is hard. There is a lot to learn with new future midwife standards and proficiencies. That is quite impressive, but it is also very costly for them. There is the stress of having to fund themselves, fund their childcare and travel to units. Sometimes they go miles to their placements. That is additional stress in learning to be a midwife and I think it is the one thing that might make a difference for the future.

Q233 **Lucy Allan:** Following on from that, Denise, perhaps we could go back to student nurses, who face the same challenges that Gill has just articulated. I have met student nurses, particularly during the pandemic, suffering from burnout and drop-out. What more can we do to support student nurses so that they can go on to fulfil their potential in much needed roles?

Dr Chaffer: I think it is very similar to what we have just heard from Gill. It is very simple. Obviously, there are some practical things. The financial burden on students is enormous. There is a requirement to go to clinical placements, and it is not an easy role for a student nurse to get another job in the summer holidays. It does not work like that. That makes them distinctly different from a lot of other students who are able to top up. They need to be available for shifts and they need to be able to do that. We find that all of those issues, with childcare and so on, are big.

It is also about value. We talk more generally, but it is important that we think about valuing the role of nursing and midwifery, and recognising their incredibly complex roles. I think that goes to students because the students are our nurses of the future. It is value in every part of the workplace, feeling valued by society but particularly feeling valued, supported and mentored. The whole circular argument is that if you do not have enough staff to care for patients, it makes it very difficult to have enough staff to supervise students. Students really suffer when we are up against significant pressures.

We have had unprecedented pressures over the last couple of years, but the problems were here before the pandemic. They have just become exacerbated during this period. You need support to learn. You need to be in a supportive environment, and you need to be free from all the additional stresses that we are describing.

Q234 **Lucy Allan:** Gill, is it the senior or junior midwives that we have the most difficulty in recruiting, or is it both? I am looking at your face.

Gill Walton: It is both.

Q235 **Lucy Allan:** There is no particular differential with experience.

Gill Walton: There are slightly different issues at both ends. Some of the students coming out of their education are so anxious about working as a midwife that they choose not to work full time, as they did in the past, so that they can manage. That is one thing. You might have 10, but they are only working the equivalent of seven. That is an issue.

Midwives have a different pay structure from nurses, but band 6 is the majority of clinical midwives. It is difficult to recruit them and attract them back after they have had their family, for example. That again is about flexible working, as I said earlier.

We need senior midwives. We need that seniority. We need to make it attractive for them to work, so that they stay, but also so that if they leave they come back and do something important like supporting newly qualified midwives, because they are experienced midwives. Again, it is about flexibility and changing the culture of maternity services so that everybody feels valued. It will, hopefully, make a difference if we can all do that—the Government, the NHS and professional associations. We all need to put our attention on that.

Q236 **Lucy Allan:** It is about recognition, reward and responsibility, effectively.

Gill Walton: Career structures are important. That is one thing that has been lost in midwifery. The number of senior posts and the opportunity to be a clinical academic, for example, instead of getting more and more is getting less and less. The number of consultant midwives, for example, in England has got less and not more. Career structure is important to keep people in the profession because it gives you something to strive for.

Lucy Allan: Absolutely. Thank you.

Q237 **Taiwo Owatemi:** Ravi, would you be able to write to the Committee with answers to the following questions? Is there a shortage of pharmacists? What does the RPS think about big change, unilaterally closing pharmacies all over the country due to a pharmacist shortage? What does the RPS think about the current structures in place? Currently, there are no provisions to withhold payments from pharmacy companies that choose to close a company. Due to the impact this is having on patients, do you think we will benefit from moving to a GP model in which, when a GP surgery shuts, the GP surgery can be taken over?

Ravi Sharma: I am more than happy to provide that to the Committee.

Q238 **Chair:** Thank you. We have slightly overrun on this session. I have a very last question for Shawn. The whole debate in healthcare is about moving to prevention rather than cure. How would you sum up progress on that agenda when it comes to dentistry?

Shawn Charlwood: Outside the NHS, prevention and dentistry are progressing quite well, but, as I alluded to earlier on, the contractual system by which NHS dentists are engaged does not reflect prevention. The whole direction of travel of the NHS is not reflected in a very outmoded, outdated contractual system. That is what needs to change.

Chair: Thank you. It has been an absolutely fascinating session. I am sorry we have had to squeeze so many questions into such a short time. A very big thank you, Shawn, Denise, Ravi and Gill, for your evidence this morning. We are very grateful. We are now going to move to our second panel, which will focus on social care.

Examination of witnesses

Witnesses: Ian Trenholm and Simon Williams.

Q239 **Chair:** I welcome for our next panel Simon Williams, who is the director of social care improvement at the Local Government Association, and Ian Trenholm, who is the chief executive of the Care Quality Commission. Thank you both for joining us. This inquiry is about workforce, particularly workforce shortages. Simon, can you tell us where you think we are at with the social care workforce?

Simon Williams: Thank you. I think where we are at is a workforce that is under enormous pressure. I am sure this Committee will have seen some of the numbers. We have a turnover rate of about 28% and vacancy levels that have gone from just under 6% to 10% in about a year. There is a lot of evidence about staff feeling exhausted. Morale is quite low. We would say that we are in a really difficult place with the workforce.

The reasons for that are partly to do with pay, which I am happy to elaborate on if the Committee would like me to. Beyond pay, there are other issues about recognition and lack of a career structure and access

to training. There are opportunities for central Government, local government and providers to work together and I would be happy to talk about that.

Q240 **Chair:** Let's just talk about pay. I will ask you a question—I am speculating—that maybe a Treasury economist might ask you on pay. If we had had a discussion about pay and social care five years ago, the argument would have been to pay more to attract more people into the profession and reduce the vacancies. Given that we have vacancies in all industries at the moment, and the lowest levels of unemployment for 40 years, is increasing pay going to address the issue this time, or is it primarily about retention?

Talk us through how you would try to solve the problem. Everyone on our Committee would say that people in the care sector deserve more pay. We hear week in, week out about the brilliant work they do. That is not in question. To actually solve the problem, how would you go about it?

Simon Williams: I won't talk only about pay, but the issue about pay is the comparator level, not the absolute level. I agree that we are seeing pay inflation across all sectors and industries. The average care worker is paid £16,000. The entry point for "Agenda for Change" band 2 is about £18,500. Retail workers are now paid more than care workers, and that is a bit of a first. I agree that it is not an absolute thing, but we need to look at comparative levels, given that these are difficult and demanding roles.

Q241 **Chair:** Do you have any numbers that you could send the Committee from the LGA? It would be very helpful for us to know what people are getting in retail compared to the NHS and the care sector.

Simon Williams: We have given some information in our written response, but we would be very happy to follow that up with some further information.

Q242 **Chair:** To go to the retention side of things or, to put it another way, the non-pay side of the equation, what would be top of your list from the feedback you are getting from LGA members?

Simon Williams: Obviously, we get feedback from our members but I have been privileged to work a lot with social care providers as well, particularly during the pandemic. A lot of my intelligence comes from them.

What we would say is that the first issue is perceiving this as an attractive, worthwhile and high status career to work in. We have a lot of work to do, particularly to convince young people that that is the case. I think there may be things we can do. Secondly, it is about access to training to ensure that people feel well equipped to do these difficult jobs. There are some good training offers, but we face issues about take-up.

Thirdly, we need a career structure that works for people, particularly around retention. We should offer a career in social care that suits various types of aspiration that people might have. Some people will want to carry on being a frontline worker all their career, but may want to specialise in supporting people with autism or dementia, and they should be recognised for those skills. Some people may want to move into management. Some people may want to major on technology and the role that could play. It is thinking about how we open up those career structures to people.

Q243 **Chair:** Thank you. Ian Trenholm, first of all, could you give a quick comment about what your adult social care inspectors are finding on the ground in terms of the quality and safety of care that care users are actually experiencing?

Ian Trenholm: It is a very complex picture. When we talk about quality and safety in relation to individual adult social care locations, what we see, as Simon alluded to, is that people are working incredibly hard. Standards of care in a number of places are staying high. In other cases, people are struggling because of workforce.

Adult social care needs to be seen in the context of the system. When we talk about quality and safety in adult social care, we need to talk about quality and safety in the system. What I mean specifically by that is the way in which adult social care providers as private businesses are managing their business. If they cannot recruit staff, in order to stay safe, they reduce capacity. Reducing capacity means that there are fewer beds for people to be discharged to from hospital. In turn, that means hospitals cannot move patients through as quickly as they would like. That in turn leads to ambulances queueing up outside, and putting increasing pressure on general practice.

When we talk about quality and safety in adult social care, we need to talk about it at system-wide level and not just at individual provider, individual care home, level. We can broaden the conversation into mental health, learning disability or autism, if that is helpful.

Q244 **Chair:** I will broaden it in one particular way, which is the introduction of ICSs or ICBs under the new Health and Care Act. How is that going to impact the social care sector?

Ian Trenholm: I hope that it will impact the social care sector in a really positive way. I think it will bring all of the partners to the table—the local authorities, the NHS and so forth—and give them a rallying point as to how to deliver the best possible care for the people who live in that place.

One of the big challenges that my inspectors see, and that I see when I go and talk to providers, is the variation in the challenges from place to place. The issues in the south-west are very different from the issues in London, different from the issues in the north-west and so on. I think ICSs will bring a sense of place. They will bring a sense of co-ordination

and collaboration. If you are an individual worker or a potential worker, it will help you find your place in the place in which you live.

Q245 **Chair:** Let me ask about what you are picking up about staff training. These are some of the issues that Simon was talking about—people being able to move between the NHS and care systems. Are you noticing staff shortages in some parts of the sector, with some providers, having a significant detrimental effect on the quality of care that patients are receiving?

Ian Trenholm: We are. What we see is that the safety and quality component of staff shortages displays itself particularly in mental health, learning disabilities and services for autistic people. In those services in particular, the quality of the relationship with an individual is absolutely vital. If there are staff shortages, it translates into services being kept open using agency staff. Those agency staff may be well intentioned but do not know the individuals well. That then translates into excessive use of restraint and seclusion. Individuals who are, in some cases, potentially able to go out and live in the community suffer and do not make the improvements that they could make to enable them to live full lives in the community. We find that people are not having safe care in some of these locations. That then translates in turn, when we look at those locations, into us sometimes closing them down or restricting the numbers of people who can be looked after by those places, which means that people end up in the community and cannot have the therapy that they need. Again, it is a bigger picture than, "Is a place safe or not?" It has a big backwash into the community.

Chair: Thank you.

Q246 **Lucy Allan:** Simon, could you say a little bit more about the challenges that local authorities face in delivering social care?

Simon Williams: The challenges on the ground that we are seeing right now are about both internal workforce and the commissioned workforce. If we start with the internal workforce, they are mainly social workers and occupational therapists, people who assess people's needs and help them find solutions. We are seeing a vacancy rate of about 10%, but in the recovery from the pandemic the Committee may be aware of the survey that ADAS published last week where we see an increasing waiting time for people to be assessed and to have their needs assessed and reviewed. That is really worrying because, coming over the horizon, we have a lot more demand on those people as self-funders come into view.

Q247 **Lucy Allan:** What do local authorities do?

Simon Williams: I will come to the commission side and then come back to what local authorities can do. The issues we are seeing are lack of capacity in the commissioned workforce, as Ian was referring to. That again features in the ADAS survey or in other evidence, as in pathway 1 for people who are not leaving hospital as soon as they should.

What can local authorities do? Obviously, you would expect me to say that this is subject to adequate funding. We see that as a necessary but not sufficient condition for moving forward. No. 1, local authorities can use their local partnerships to create a proper recognition and profile for social care. That is working with the NHS, clearly, and with other partnerships such as local economic partnerships, thinking about apprenticeships and how further education is commissioned and working in schools to attract young people in. The first thing is to use all those local levers to attract people.

The second thing we can do is to think about how we commission care, which is a journey that we are on. If our practice is to micro-commission care and tell providers, "You have to do exactly this every day, no more, no less," it is a joyless place to work for both the staff and the end users of social care. What we are doing is trying to empower providers and staff to have more flexibility within the overall budget allocated to someone, basically from week to week and day to day to be able to flex what people may want. We all want different things every week. There are things we can do as local authorities to work with our providers to commission in that different way.

The final thing would be around recognition and training, and to use the place of local authorities and local authority members to enhance the profile of social care workers at local level. There are so many things we can do. I know we ask central Government to do things, but there is enormous scope just for the office of a mayor in a local authority, for example. There are so many things we can do to work actively.

Q248 **Lucy Allan:** There were 400,000 people waiting for assessment at the end of November 2021. What can a local authority do? They are going to have to look after those people in some form or other, even if they have not had a proper assessment. They have needs, so what happens to them?

Simon Williams: We are doing a piece of work right now, as you would expect us to do, to support local authorities to manage the position. One of the key things, if people have to wait, is how we ensure that they are safe. That means we prioritise people, but we also need to give them a means to get back in touch with us if their needs change and become more severe. That might be the person who needs social care or it could be the carer.

Secondly, we may need to find some different ways to assess and review people. Sometimes it might be right, as long as it is safe and appropriate, to ask providers to do some of that on our behalf or, as we work with the NHS so much, to look at the scope for doing that. Thirdly, we probably need to look at ways of streamlining some of our processes, frankly. I remember very well from the days when I worked as a director that the ratio of time that staff spent actually in contact with people to sitting in the office, inputting to records, was not the ratio I wanted. That is something we need to continue to challenge ourselves on.

Q249 **Lucy Allan:** Presumably, the 400,000 people waiting for an assessment are putting more burdens on local authorities. It is an added challenge for them because not only do they have people who have been assessed to care for, but they also have the unassessed people they have to manage.

Simon Williams: And the danger is that people will end up coming into crisis, and quite apart from the catastrophic impact on the people concerned, that is more expensive for the local system.

Q250 **Lucy Allan:** Ian, presumably these long waiting times for assessment are unsafe.

Ian Trenholm: Yes, on face value they definitely would be. To extend your question, essentially what we would argue is, "What is the cost of failure?" Again, the cost of failure pushes back across the system. One of the reasons why GPs are so busy at the moment is that relatives are filling some of the gaps and supporting people at home. They are going to GPs and turning up in accident and emergency and so on. There is a whole range of other things.

My opening point was that this is a system problem and not an adult social care problem. I think the thing with the adult social care market is that it is a market, and therefore it controls itself in a way that the NHS cannot. If somebody turns up at the front door of an accident and emergency department, they are seen. It may take a while, but they are seen. If they turn up to see a GP, they are seen. That does not have to happen in adult social care. What adult social care providers do is try to manage their service internally, but the consequences of that on those around them are significant.

Lucy Allan: An important point. Thank you.

Q251 **Rosie Cooper:** Carrying on from that last point, I would not for one minute want to look at a social care provider who was not good, but when you take action against them you know what is going to happen. What can you do to be part of that system and almost enable the system to pick up the slack? What happens when you make that decision?

Ian Trenholm: It depends on the circumstances. It depends on the type of care. If you look at the way the adult social care market operates, 60 providers provide about a quarter of the care. Then there is an awfully long tail, which goes down to owner-operator domiciliary care businesses and all points in between.

If a care home in your constituency has gone to "Requires improvement" and it is part of a larger care home group, it is likely that the group leaders will come in and support that care home to improve. If it is an owner-operator, husband and wife team, running a very small care home in a rundown building, they have to work that out for themselves. As a regulator, we try to talk to them about other places that they can go to see on an informal basis. We do not have a formal role to deliver tangible improvement support, in the way that NHS England would do in the event

that there was a failing hospital. They would intervene in a very practical way.

It is undoubtedly a gap in the market. The very practical challenge is that the NHS operates as a large corporate entity, but 14,000 social care providers operate as 14,000 individual businesses. There isn't a formalised improvement apparatus that sits around that, unless individual businesses choose to get consultancy support or team up with other people. In some cases, the trade associations offer limited support, but I do not think any trade association would suggest that they are set up to offer hands-on tangible support.

Q252 **Rosie Cooper:** In that place-based world we talk about, there is a big gap because they are just falling off. The system is then required to pick up the slack, but we cannot leave it as it is. It is something that we should look at.

In a challenged care home or a challenged social care provider, if they are beginning not to do so well and they start to lose staff, how does that lack of staff retention enable the business—I wouldn't call it a business; it is a service—to release members to be trained? How do they get the momentum back to recovery as opposed to the slide to the bottom and then disappearance altogether?

Ian Trenholm: It is really difficult. As Simon was saying, local authorities are cost constrained. They are very tight in terms of what they are prepared to pay. People who are private payers are also very cost conscious. In some parts of the country, the cost of dementia care, for example, is £1,300 or £1,400 a week. They are enormous costs. If a provider is genuinely struggling, they will see training as something that is an overhead. It is something that will be pushed down the road because they need to do other things.

We also need to think of training as not being a classroom-based activity. What we see with the better providers is that they do some set-piece classroom-based learning, but they also do event-driven learning. Do they have a manager who will say, "Look, that didn't go so well, so let's have five minutes to reflect"? That is training and it adds enormous value from a safety and quality point of view.

What we see in social care, probably more so than in healthcare, is that if the manager of the care home changes, it can have a dramatic impact over a very short period of time on standards of quality. It can be up or down, but generally speaking if a place is starting to slide and if the manager changes, because of the relatively small team-based nature of a care home, it can often lead to improvement. I do not think there is a simple answer, certainly not as a regulator.

Q253 **Chair:** We need to move on. I have a final, quick question for both of you. Simon had something he wanted to come in on. Let me ask you this first, Simon. I want to reflect on our Committee's report into social care,

published two years ago this September. We said that the adult social care budget needed to rise by £7 billion a year by the end of the Parliament. Current Government plans will see it going up by about £2 billion a year, so there is a big gap.

I want to get to the heart of it when we are talking about workforce issues. Is it the case that we are not going to crack this, when it comes to adult social care, unless there is a significant increase in the funding available to local authorities, much higher than they currently receive?

Simon Williams: Yes, that is absolutely the case. I said that funding is a necessary, if insufficient, condition. Local authorities will not be able to afford to pay providers the rates that providers need to pay and retain staff unless funding is sorted out. We are in an exercise with Government at the moment around the fair cost of care, which we support. In fact, we are already doing things about supporting local government to work out what a fair rate is. In the autumn there will be a chance for all of us to reflect on what we have learnt from that exercise. What does it take to pay providers to enable them to pay their staff properly? We should know that by then. I really hope that we can collectively learn from that review, but we absolutely agree that we are not there yet on funding by a long way.

Q254 **Chair:** Ian, could I ask you a final question? We have been focusing in this panel on social care, but obviously you have much broader responsibilities at the CQC. Can I ask you about the NHS for a moment? When you are rating hospitals and GP surgeries, do you find that workforce shortages are becoming one of the bigger reasons for giving people a lower rating than they would otherwise get?

Ian Trenholm: That is a difficult question to answer at this point in the post-pandemic cycle. We have done less rating over the last year than we would normally do in a typical year, so I would be reluctant to agree entirely with that statement.

Perhaps I could answer the question in a slightly different way. We have been carrying out an exit interview when people leave the market. They are predominantly adult social care providers. When we used to speak to people as they left and deregistered, we would just be told, "Well, it is about my time, I'm retiring." Workforce is now something that comes up again and again as a reason for deregistration.

Ultimately, that reduces capacity. It stresses the system, which ultimately drives challenges on safety and quality. Indirectly, yes. I do not think I could point to a reduction in ratings that directly links to workforce, but workforce is the dominant conversation. I have been in five or six providers in the last fortnight, and workforce has been at the top of the conversation.

Q255 **Chair:** Finally, when I was Health Secretary, I introduced something called the care certificate. If that care certificate became externally accredited and passportable so that you could use it right the way across

the NHS and care system, would that be a helpful thing in retention of workforce?

Ian Trenholm: I think it would. A commonly, nationally accredited and, most importantly, portable qualification is really important. What we find with the care certificate is that it is not consistently delivered, and that translates into providers wanting somebody to do it again, which seems faintly ridiculous.

I think, though, that there is something really important around staircasing. I think some of the witnesses in the previous session were talking about this. It is about trying to make it exciting for an 18-year-old to work in care. It is about making going into care an exciting thing to do and drawing them a picture that enables them to see how they become the chief executive of the local care home group, or how they become a senior manager in the NHS and how their career can zig-zag somewhere in care in their place.

It is about attracting people back to the care workforce, away from retail, logistics and elsewhere. How do we make it exciting? That is about base-level qualifications, but it is also about more specialist qualifications. It is about learning, leadership and management—those sorts of qualifications—so that we generate a group of managers. One of the biggest determinants of good-quality care in a care home is the manager. They set the tone. How do we get those individuals through as well?

Q256 **Chair:** Simon, do you have a comment on the care certificate?

Simon Williams: We think it is great. We completely support having something externally validated, recognised and portable. The one caveat is as long as it does not mean that social care becomes the feeder for the NHS. That is the danger of portability. We would like to see people moving in two directions across—

Q257 **Chair:** People say that if you could use it in the NHS, that might attract people into the social care system because there would be that career structure.

Simon Williams: Yes. We support it.

Chair: Thank you both very much for joining us. We really appreciate it. That concludes our second panel. We are very grateful for your time, Ian Trenholm and Simon Williams.

Examination of witnesses

Witnesses: Danny Mortimer, Dr Evans and Professor Wilkinson-Brice.

Q258 **Chair:** I welcome our final panel this morning. Professor Em Wilkinson-Brice is the acting chief people officer for the NHS and a registered nurse; Dr Navina Evans is the chief executive of Health Education England; and Danny Mortimer is the chief executive of NHS Employers. Thank you all very much indeed for joining us.

I want to start with you, Navina, if I may. I see that you are getting your papers ready. As you know, this Committee has long supported the principle that we should have independent workforce projections that say how many doctors, nurses, midwives and other specialists we are going to need in every field for the next 10, 15 or 20 years. That has been rejected by the Government time after time, both in the House of Lords and the House of Commons.

What they say is that they want to do this work—they want you to do this work—but they are not prepared for it to be independently verified. I do not want to re-fight that battle this morning, but I want to ask you whether you are, indeed, in the process of doing projections for the number of people we are going to need in all these different areas over the next five, 10, 15 and 20 years.

Dr Evans: Thank you for the question, Chair. I will try to be brief. We are doing the work, absolutely. The way in which we are approaching this work is, first of all, to ask ourselves what the population needs and then, working from that, what kind of service do we need to provide, what is the work that needs to be done to deliver that service and who, and in what way, can deliver that service? Is it automated? We have to think about digitals. What do our existing staff need to do? Do they need new skills? Do they need to be trained differently? Also, do we need to create new roles and expand existing roles?

Q259 **Chair:** To drill down, you are a big expert in mental health, and you ran one of the most successful mental health trusts in the country when I was Health Secretary. I think it was the first outstanding mental health trust, from memory. Is that right?

Dr Evans: Neck and neck.

Q260 **Chair:** Okay. Let's talk about mental health as an example. Are you looking at the growth of people with eating disorders and then thinking, "How many therapists, how many mental health nurses and how many psychiatrists are we going to need, looking at that growth, in five, 10, 15 and 20 years' time?"

Dr Evans: We are looking at it through these different lenses: the pathway, the place and the professions. That is a really important way in which we need to do workforce planning. If we take that particular disorder and condition, that is exactly what we need to do. We can do it right now for people who need help in the immediate, but also three, five, 10 and 15 years. Then we have the strategic framework that we have developed, which is actually about us thinking way into the future. It is a different way of thinking about workforce planning.

Q261 **Chair:** Framework 15 is the document. That is what it is called.

Dr Evans: Yes.

Q262 **Chair:** When that is published, will it have those numbers? Will it say, "This is the number of psychiatrists that we are going to need in 15

years' time"?

Dr Evans: It will not exactly have numbers because the further out you go, the less certainty you have. It would become rather difficult to predict that. What it will have is the ability to use the framework to start thinking differently about how—

Q263 **Chair:** Sorry. I am going to challenge you on this. I know that you are not a Minister, and you have to do what you are asked to do by Ministers, but surely if you are going to make sure that we have enough psychiatrists in 10 or 15 years' time—it takes 10 years to train a psychiatrist—you have to have a central projection: "This is the number of psychiatrists that we think we are going to need." There will be a funnel. Will the central projection of the number of psychiatrists that we are going to need in 15 years' time be in Framework 15?

Dr Evans: It won't be in the framework, but we will be looking—

Q264 **Chair:** It is not going to be published.

Dr Evans: The number—

Q265 **Chair:** Sorry. Let's be absolutely clear. I know it is not your decision, but we are not planning to publish the number of psychiatrists that we are going to need in 15 years' time.

Dr Evans: What we will intend to do is predict a range.

Q266 **Chair:** But are you going to tell us the central case? "This is the number of psychiatrists, the number of obstetricians and the number of GPs that we think we are going to need." It will be with a plus or minus funnel, but are you going to publish that number, or are you at the moment being told, "No, we don't want you to put any numbers in this document"?

Dr Evans: We will be able to give numbers for the nearer term. There will be a plan.

Q267 **Chair:** But not for 15 years?

Dr Evans: For 15 years it becomes more difficult, but we will be able to give a range.

Q268 **Chair:** A range with a central case? I think this is really important. The reason is that, to state the blindingly obvious, unless you have what you think we are going to need, given that it takes 10 years to train a psychiatrist or whatever specialist doctor it might be, we are not going to know whether we are training enough. What I want to know is, will this document tell us whether we are training enough psychiatrists, enough obstetricians and enough GPs for what we will need in 10 years' to 15 years' time?

Dr Evans: It will not tell us exact numbers, but it will tell us how we need to be thinking about and looking into what is required as a continuous, iterative process.

Q269 **Chair:** I understand that it is not your decision. I put on record that I am deeply sceptical of publishing a framework. That is like saying, "We're going to publish an algorithm, but we're not actually going to tell you the answer." The answer that this Committee wants to know, and I think the whole NHS wants to know, and you know this, is very simple. Are we training enough doctors for the future? Are we training enough nurses for the future?

Correct me if I am wrong, but you are basically saying that this document will not give us an answer to that question. It might guide us a bit and help us a bit, but it will not actually tell us that.

Dr Evans: This document will tell us how we want to think about—

Q270 **Chair:** How we should think about it, but it won't tell us yes or no, are we training enough doctors?

Dr Evans: It will depend on how we want to think about supply, how we want to think about how many enter the profession, how many people we need to make sure we retain and how people can work flexibly. The whole thing about workforce planning is not just about supply and not just about training.

Q271 **Chair:** I am sorry to come back. As I say, I am not trying to point the finger at you personally. Isn't it basically useless to publish a document on the biggest crisis facing the NHS if it does not give a simple answer that the public can understand as to whether or not we are actually training enough doctors or nurses for the future?

Dr Evans: I do not think it will be useless because I do not think the answer is a simple one. The answer is a complex one. We need to—

Q272 **Chair:** It is a complex one. When you are looking at someone giving a diagnosis of someone who has an eating disorder, that is a complex issue, but in the end you have to make a decision as to what someone's treatment is, based on all that complexity. I think when we have shortages in nearly every specialty in the NHS, people are entitled to know what your judgment is, even if there is a range of answers and even if there is a range of factors. Unless I have got this wrong, I think you are basically saying that this document will not broadly tell us whether we are training enough GPs for 15 years' time.

Dr Evans: We also have the strategy, which is—

Q273 **Chair:** But I do not want a strategy, a framework, an algorithm or a way of thinking about it. You are the expert. Broadly, do you think we are on track? Are we training enough GPs for 15 years' time? Will the document tell us that answer, broadly, yes or no?

Dr Evans: So—

Q274 **Chair:** Could you give us a yes or no, please?

Dr Evans: We will not be talking about—

Q275 **Chair:** So the answer is no, is it?

Dr Evans: We will not be talking about just the number of GPs, but the skill mix in primary care. That is what we need to be looking at.

Q276 **Chair:** Of course, but taking account of the skill mix, and taking account of all these things, you are not actually going to give us an answer, in your judgment. If I was Secretary of State, I would be sitting across the table from you and saying, "Just tell me broadly, on the basis of what you can see now, are we training enough doctors in all these specialties?" I think you would be able to tell me that answer. Are you going to put that answer in this document? This is my last time. If you do not answer it directly, I am going to assume that the answer is no.

Dr Evans: My last answer is that we are going to say we need more, and we need different.

Q277 **Chair:** But you are not going to say how many.

Dr Evans: It is not possible to say how many.

Chair: I am going to bring in Rosie. I would normally ask everyone to chip in, but I will ask Rosie to follow this up.

Q278 **Rosie Cooper:** If I may, because I am getting quite agitated. This is not directed at you, Dr Evans, but at the greater audience in the Department of Health or Government who are listening.

The answer is complex. I get that, but it is one we have never managed to date. As vice-chair of a health authority and having been chair of a hospital, I know. I sat there in the 1990s. One year I would be short of gynaecologists. Then the next year I had nurses who were panicking because they were in training and there were going to be no jobs for them: "What are we going to do?" Nurses were coming to me saying, "I need to go and do something else in that case." Then the next year we did not have enough nurses.

I hear everything that the Chair has said to you, trying to drive you to a position where we can say to people, "We know what we need, or roughly what we need, and let's use that as a marker." You have not been able to say that. My question to you is, how on earth can you assure yourself that the answers that you are going to get will be better than the rubbish that has been served up every year since then?

Dr Evans: We are working in partnership and very closely with our colleagues in the NHS. We can be more certain the closer we are. In the immediate, we can be much more certain.

Q279 **Rosie Cooper:** I will ask you a mad question. Do we have enough doctors today for seven years from now, in 2029? That is close. Today, do we have enough staff for 2029?

Dr Evans: If we are delivering services exactly in the same way as we are delivering them today, the answer will be no. The expectation is that

we must be delivering services that meet people's needs, according to what people in seven or 15 years need and want. Therefore, the model of service will be different. We need to be able to be flexible in our workforce planning to meet those needs.

Q280 **Rosie Cooper:** Will it go up or down?

Dr Evans: We will have a range. What we know is that we will not be delivering care in 15 years' time in exactly the same way as we are delivering care right now. I am a clinician myself. The way we are delivering care now is completely different from the way we were delivering care when I qualified and when I started working. It is our responsibility—

Q281 **Chair:** I am not going to go on about this with you. I will bring in Danny Mortimer and Professor Em Wilkinson-Brice. The issue is that if you were going to produce a document that said, "On the current model of care, in 10 years' time we will need an extra 12,000 GPs, but because we are going to be recruiting over that period of time an extra 8,000 practice nurses and an extra 6,000 mental health specialists to work in GP practices, we think the actual number we need is 9,000 GPs and we are indeed training enough for 9,000 GPs," we would have confidence that there was a plan. I think what you are saying is that you are not actually going to put those numbers in the document, so we will not actually know whether we are recruiting enough GPs for 10 years' time.

Dr Evans: For 10 years' time, we could be doing that in the work that we are doing for this autumn.

Q282 **Chair:** You will publish that number?

Dr Evans: We will be able to have some predictions of what we will need, depending on the service model. This is where it is really important—

Q283 **Chair:** The Secretary of State told us that it was called Framework 15 for a reason: because we would actually know how many doctors we are going to need in 15 years' time. What you are saying this morning is that you are not able to tell us. I am not going to do any more with you because I need to bring in Danny Mortimer. What are your thoughts on this?

Danny Mortimer: There are a few things. The first, as you have already acknowledged, Chair, is that ultimately the decision about what numbers are published in a variety of documents is a political one. It is often a political one outside the Department of Health and Social Care. We have talked here before about the dynamic in England between the DHSC and the Treasury.

I represent the organisations that employ people in the NHS. We see three things happening this year. We would have preferred it if they had all come together, but that is not the decision that the politicians have made. There are to be three parts to this story.

The first is a framework that sets a long-term direction of travel for the workforce that makes clear assumptions about services and about things that may or may not make a difference. It will give us some sense of ranges. We have never had something like that before. Previous versions of the document have not gone as far or as deeply and have not engaged with health and social care as extensively. That context setting is really important.

The second thing we will have is a refresh of the long-term plan. NHS England will be clear about where they stand in terms of service priorities and giving us a sense of longer-term demand for services. It will help the politicians, we hope, set priorities around our services. The third thing, which we will have in the autumn, is the workforce strategy—the plan that will give us a much shorter to medium-term sense of the numbers we require. Again, we have not had a document like that for some significant period of time.

The level of numbers that are included on trends over the last 20 years, trends over the last 10 years in decisions that you and others have made to invest in the workforce, and what trends we anticipate we will need to meet going forward are political decisions. Again, I think we have talked about that here before.

Q284 **Chair:** I understand that. Thank you for that artful description of what is happening. The question that we want to know, and the public want to know, as well as everyone in the NHS, is very straightforward. Are we training enough doctors, nurses and midwives in every specialty for the future, given that it takes 10 years to train a doctor, and in particular for the 10 to 15-year period looking ahead? My question to you, Danny, is when those three bits of work are done, will we actually know the answer to that question?

Danny Mortimer: What we want to see, what our members want to see, are answers to that question but also a clear sense of where the priorities and risks are, Chair.

Q285 **Chair:** Can you just tell me? I don't think we are going to get an answer to that question. We are going to get a framework or an algorithm or some sort of way we should be thinking about the problem, which sounds a bit bullshitty to me, to be honest. We are going to have a refresh of the long-term plan, which will be very important, and then a short-term workforce strategy, but the big question is whether we are training enough, particularly for the things that take a long time to train, where you can only get the decision right now. Of course, we know the model of care is going to change. Are we training enough specialist doctors for 10 to 15 years' time? I think the way you have described those three pieces of work does not mean that we are going to have an answer to that question.

Danny Mortimer: Framework 15 is not the work you have described, Chair. It is not a complete answer. The other two pieces of work are really—

Q286 **Chair:** Even with the three pieces of work, are we going to have a complete answer? That is my question.

Danny Mortimer: If your colleagues in Government will allow my colleagues in the arm's length bodies to publish the data, yes, I think we will have a much clearer picture. Once we have that data, we have some very difficult discussions to have in the health service, with our friends in social care and with political leaders about where we prioritise investment and what choices we make. The Government have made some choices already on medical school expansion and the prioritisation of 50,000 nurses, but we need to drill down and identify where the areas of greatest need are. If we in the health service are allowed to share that data and to share that analysis, we will come pretty close to meeting what you have described. It is about all those three things together, and all of them have value.

Q287 **Chair:** I totally understand that. Thank you. Let me bring in Professor Em Wilkinson-Brice for your thoughts on the discussion we have had.

Professor Wilkinson-Brice: Thank you, Chair. I do not want to repeat what my colleagues have said. What is very clear, as Navina and Danny describe it, is that we are talking about skills perhaps more than roles, and that will be important because it gives us flexibility within the workforce. We have seen throughout the whole pandemic how people worked extensively in different settings and redeployed to different teams. That is the other point I would make. We have to think about the team structure that is going to be in place. If we put patients and citizens at the centre and really build a care team around the person, that will challenge much of the way care is delivered today.

While I hear everything that you said, I suppose the complexity is in the assumptions we are going to make over the 15-year period, and then we will need to be able to test those assumptions. Is technology having the impact that we think it will have? Do we think that there is a different care model and a different workforce model? Having gateway posts along those 15 years where we can test those assumptions will be really important.

Q288 **Chair:** You are kindly stepping in on an interim basis to the chief people officer role, so you will be very aware of how low morale is on the frontline. Many professionals feel they are not able to deliver the care they want to deliver because there are not enough of them to deliver it. That, most people would say, is the biggest problem in the NHS at the moment.

Does it not feel to you a little bit hollow to be saying to those people—this morning we have had the word "burnout" used a lot of times—"We cannot really tell you too much about how many more people we need

because medicine is changing so fast and we are going to change the model of care, so I am sorry"? Do you not understand that that will feel to people like a political fudge?

I understand Danny's point. If you are not allowed to publish those numbers because the politicians will not tell you, say so, and then it is absolutely a political decision. If you sit there and say, "This is how it has to be, and I'm afraid I just can't really tell you. It doesn't really matter if we are training enough doctors and nurses because the medicine model is changing so much," many people will feel that is spin.

Professor Wilkinson-Brice: I hope that is not what any of us have said. I listen to and speak to staff all the time. In fact, last week I was at Guy's Hospital and at University Hospitals Plymouth, and on both of those visits staff were talking about the creative ways they are changing the workforce already, such as virtual wards and some of the developments that we have seen over the pandemic in outpatient models. I do not think there is any suggestion that people are not aware of the fact that we need more, but I want to underscore that we need different as well.

Q289 **Chair:** You are a doctor, I presume.

Professor Wilkinson-Brice: No, I am a nurse.

Q290 **Chair:** You are not. Okay, you are a nurse. Where did you do your training?

Professor Wilkinson-Brice: I did my training at the Royal Devon and Exeter.

Chair: Okay. The Royal Devon and Exeter has to make a decision as to how many nurses they are going to start training next September—or this September, but let's say it is all sorted for this September and they are thinking about next September, probably. We all know the model of care around nursing is changing, and we may need slightly more or slightly fewer nurses for different roles in five years' time when those nurses come out at the other end, but they have to make a decision now as to how many people they are going to train from next September. What no one is prepared to tell us is whether it is enough, and that is what I think people find frustrating. I want to throw this open to my colleagues.

Q291 **Dr Evans:** Thank you, Chair. I would like to go to the here and now, if that is all right. Professor, could I start with you? At the start of May, a letter went out to the NHS to try to keep doctors, particularly, from retiring. Why was there a need to do that?

Professor Wilkinson-Brice: You have heard in the previous panels that the skill and experience of the workforce who have trodden the boards for many years—I could probably say that I am fast entering that category—is really important. We can keep attracting new people into the NHS, and we are; in only the last six weeks we have seen 2,300 healthcare support workers introduced to care, of which 50% are new to care. It is not that

we are taking people from social care and bringing them into the NHS; these are people coming into the NHS and care sector for the first time. We need to make sure that we get the balance right between more people coming in as new to the NHS, and we have already heard repeatedly that how they are looked after and cared for and nurtured—

Q292 **Dr Evans:** I am interested in that top end because there is a here and now.

Professor Wilkinson-Brice: But that is how we do that. We have to marry new people coming in with the experience, support and supervision of more senior staff.

Q293 **Dr Evans:** You cannot say we want to delay people retiring. One of the biggest problems particularly for doctors at the top end is the pensions issue. What is your understanding of the pensions issue, and why is it not resolved, because that is a big side when we are trying to deliver the backlog? Do you have any thoughts?

Professor Wilkinson-Brice: We hear repeatedly that pensions are very complex to understand and that there are some aspects of pensions that are prohibitive for people to stay. We have worked with the Department of Health to give them our intelligence in order for them to put forward a case to the Treasury. Danny may want to come in.

Q294 **Dr Evans:** I was going to ask Danny what he thought was responsible. Danny, what are your thoughts? Can you explain the short-term impact of the pensions side? This has been rumbling for a number of years. It has raised its head yet again, especially when we are dealing with the backlog, which fundamentally, from where I am sitting, seems to be on the critical side. It is all very well talking about the future workforce in 15 years' time. We have the biggest backlog we have ever had in front of us.

The retiring elements, the 21,000 doctors who are potentially going to walk out, are key to hold on to for as long as we can. If the pensions issue seems to be so divisive, particularly for the elective backlog, what can we do, where is that unstuck, and how can the Committee unstick it?

Danny Mortimer: We faced a position some years ago, as you know, when senior members of staff, particularly senior clinicians, were unexpectedly getting tax bills based on their pension growth. The Government stepped in. The present Secretary of State, when he was the Chancellor, changed the tax regulations in response to that, and that meant that the vast majority of consultants—not all—were taken out of that tax implication, based on their NHS earnings. People obviously earn money elsewhere, as is their right.

That disincentive that people had around working extra and it tipping them over into a tax liability was removed. The toxicity of that situation remains though. The direct experience that people had and the stories that they tell their colleagues remain. We are doing a lot of work with

various organisations to try to put up-to-date information in front of people.

There is a second issue, which is about the nature of retirement in particular. There are multiple different pension schemes. We can give information on that offline if that is useful. There are some temporary measures that were introduced by the Government during the pandemic that made it much more attractive for older members of staff, particularly doctors, but other staff as well, to work for longer. They would not be disadvantaged in terms of their pension.

That has been extended for a temporary period, and both NHS England and we believe that it should be made a permanent change to help those people take their pension and return without disadvantage. It is a very specific category of people, but it is a hugely practical and helpful change that we believe will make a difference.

Q295 **Dr Evans:** I appreciate that, and I do not want to dwell on it. As a general organisation, the NHS is a big employer and there are many levels to get through, as we have heard. You are sitting at the top. How easy is it for you to draw a list? As a clinician, I can draw a list of things that I would love to see that would make a day-to-day difference. The problem is that it has to go through so many different channels, and the NHS is no different. How receptive is it to getting that change through, and how quickly are you able to drive that change through? Do you feel you are heard?

Danny Mortimer: In terms of pensions in particular, employers are interested in a reform of the pension scheme that would give all staff much more control of what they pay into the pension scheme.

Q296 **Dr Evans:** I'm sorry to cut you off. What I am getting at is this. You can spot the problems with the pensions and it takes a long time to sort out. There will be an umpteen number that you will be able to identify with your expertise. How quickly do you think they can get through the organisation to deal with this backlog?

Danny Mortimer: Using that as an example?

Dr Evans: Yes.

Danny Mortimer: Painfully slow. Using the previous example that I gave you, of the change that was made during the pandemic that has been extended, albeit temporarily, the Government acted pretty quickly to extend it. We would like that extension to be made permanent. In terms of the example I gave you around pension scheme reform that would help all staff—the lowest-paid staff as well as the highest-paid staff—it will be painfully slow.

Q297 **Dr Evans:** This is really interesting. Where do you feel that urgency is? In the pandemic, we heard both creatively at the ground and in terms of Government policy and Department policy that things were moving

lightning quick. Sitting here on a Committee trying to work out what we can recommend, how do we install that lightning-quick response to the difficult pressures that not only staff but our constituents and the public are facing day in, day out? What do you see? Is there anything that you could give us as an example that we can focus on to do that?

Danny Mortimer: There are two things. The first is that there are lots of things that leaders in the NHS do themselves. They do not need permission from Government or action from Government. In the example that I gave you about pension scheme reform, what we saw in the pandemic was an alignment between different parts of Government, and in particular alignment between the Treasury, the various committees that have responsibility for public sector pay and reward, and the Department of Health and Social Care, being at the pointy end of what needed to happen. It is that alignment and that recognition between different parts of Government, particularly between the Treasury and our service, in terms of the potential of that kind of reform. In my experience, those very specific examples are where things slow down and silt up.

Q298 **Dr Evans:** Professor, do you want to come in?

Professor Wilkinson-Brice: This is just a thought that it might be helpful to share with the Committee. We regularly survey staff about why they are leaving and why they want to leave. The top five reasons are retirement, end of fixed-term contract, work/life balance, relocation, and pay and reward. When you start getting into each of those, there are things that individual organisations do, and we are supporting individual organisations, particularly with things like flexible working. Flexible working is not just about going part time; 30% of the total workforce have caring responsibilities. How we support people with a real focus on health and wellbeing has been an enduring focus throughout the pandemic.

I reflect back on 33 years of being in the NHS. I have never seen so much focus on health and wellbeing, and we must make sure that continues, with things like health and wellbeing conversations, the relationship between a line manager and a member of staff, and feeling that that person really is invested in you as a whole person. We have about a million dynamic health and wellbeing conversations happening all the time at the moment. They are highly evaluated. It extends beyond just physical and psychological health and wellbeing. It is talking about what your career aspirations are and how you are managing your home, your life and your work.

Earlier, we heard people talking about value and how we value staff. We hear extensive feedback that those single conversations—"I am going to give you my time and I am going to really listen to what you are telling me"—are a massive value statement to staff. We have some great examples across the whole of the NHS where there has been a response from leaders and managers to those requests from staff. There are things

like health and wellbeing rooms, connection days, with people coming back together, and making sure we have time for proper restorative supervision.

We absolutely need to recognise that the pandemic has affected everybody in some way—it will not have affected everybody in the same way—and make sure that people have time to process what they have been through, really develop a sense of team spirit, and go back to their host teams. All of those things sound small, but they are very impactful when you talk to staff.

Q299 **Rosie Cooper:** While listening to this, I looked up a story that I was aware of, but I wanted to check the detail. It continues the thing on pensions. In April this year, a significant number of senior doctors on a board at Liverpool University Hospitals trust, a very challenged trust that really needs every bit of help it can get—using your analogy about keeping experience and helping a trust through—rejected proposals to introduce pension recycling, a scheme that you have acknowledged is nationally endorsed and that you would like to see extended. Amanda Pritchard said it was a problem. I hear that other trusts are finding workarounds. Why are we fiddling? You are in a senior position. Why aren't you fixing it?

Danny Mortimer: There are several important questions there. There is absolutely a desire on the part of employers in the NHS to have a better pension scheme, as I explained to Dr Evans. Ultimately, the decisions around that sit with Government, with the Treasury in particular. There is a real appetite to have a better NHS pension scheme, and to have a pension scheme that speaks to the lowest-paid staff. We see far more staff at our entry-level grades who cannot afford to be members of the pension scheme, and we think that problem will get worse. Of course, we also have problems at the top end—people on much bigger salaries who are worried about tax implications. We want to see that reform.

The BMA, specifically for consultants, wants to see a situation where the employer's pension contribution is available to doctors. If they chose to opt out of the pension scheme, they would then get the employer's contribution on top. That is something we may well pick up in national negotiations with the BMA. It was in place three or four years ago when we were experiencing the tax problems that Dr Evans and I talked about. It was a solution pending the solution that the Government then introduced, but actually it is a solution that benefits most doctors in terms of their annual tax liability.

There is then a final risk for our senior doctors, which is that the Government, in setting tax policy around pensions, have frozen the lifetime cap on pension liability. For our highest earners, the value of their pension pot is much greater, and they are worried, particularly doctors because of what they earn and what they pay into their pension scheme, that they will face tax bills at the end of their career.

Again, that is not a matter of the design of the pension scheme, although if we could give people more control of their pension and allow our highest-paid or our lowest-paid staff to choose to pay in half of their salary—at the moment you are all in or all out—it might give them some ability to mitigate that. Tax policy around the lifetime allowance for your pension, how much you are allowed to have in your pension pot, is a matter for the Chancellor in terms of overall tax policy rather than the three of us in terms of the NHS pension scheme.

Q300 **Rosie Cooper:** I genuinely hear you. Tax policy has to be fair to those at the bottom and at the top.

Danny Mortimer: Yes.

Rosie Cooper: Having said that, we cannot sit in this room and talk lots of warm words all day and say, "We need to keep this person. We need to do this. We need to get more people into work. We need to retain them. We need to make life cuddly," and then when we have a problem like this we do not actually look to finally resolve it. We fudge. When I talked to Simon Stevens, I used to say, "Every time you hear fudge, I hear cheat and I hear mess. I don't hear a solution." When will we see a solution here, or is it just going to go on and on? People will fall off and we will live with the results.

Danny Mortimer: Some of those questions are ultimately questions for politicians, not for us. The case for reform of the NHS pension scheme, and other public sector pension schemes, to give employees much more control over what they pay in, is very clear. It is ultimately a decision for politicians, not for me. The issue around tax policy, particularly as it relates to lifetime allowance for pensions, is very material now, particularly for my medical colleagues. That ultimately is a decision for the Chancellor in what he can do.

For our part, we are providing a much better quality of information for people about the benefits of the pension scheme. There is particular work that Em and her colleagues are doing to give doctors much better access to independent guidance about the benefits and disadvantages of their commitments to the pension scheme. That is really important. It is challenging. Our trade unions work very closely with us, but some trade unions also have objectives that they are seeking to achieve through the discussion.

The BMA would like an entirely separate pension scheme for consultants that is tax exempt, as is in place for judges, so that doctors would, in effect, withdraw from the pension scheme benefits that they enjoy alongside everyone else. That is not something we support as employers. I do not think it is something other trade unions support. Again, it is something that would be in the hands of the Government, not necessarily us.

Chair: Thank you.

Q301 **Lucy Allan:** Following on from what we have been discussing, my biggest issue in aspects of dealing with the NHS is around accountability and responsibility. We have heard today from senior people in the NHS that it is the Treasury that is standing in the way, that it is not the responsibility of you or your team, and that you are not accountable.

I find that very difficult to believe. If it is the Treasury standing in the way, the answer is simple; it just means we have the Health Secretary in front of us and we ask, "Why aren't you changing the pension arrangements for senior doctors so that they don't leave the workforce because we need them to stay?" That would be quite easy. My question to each of you is this. Are you responsible for recruitment, retention and workforce in the NHS, or are you not?

Danny Mortimer: In terms of the very specific conversation around pensions and the design of the pension scheme, I was being very clear about where the accountability lay.

Q302 **Lucy Allan:** It is with the Treasury. If we have questions, we need to go to the Secretary of State. End of.

Danny Mortimer: Ultimately, yes. In terms of some of the other aspects that you touched on, particularly around retention, there is a huge responsibility for my members, the people who are employers in the NHS, and I share that responsibility with them. On supply, there is shared responsibility. There is national action that colleagues need to take that relates in part to the plan. There is political action that needs to be taken that relates in part to the plan. There is also an enormous amount that my members are doing in their systems and in their places to promote careers, to support degree apprenticeships and to try to find ways for people to join the health service and social care in any way they can. There is shared accountability. With pensions, it tilts much more towards the Government.

Q303 **Lucy Allan:** Retention and recruitment. Where do accountability and responsibility lie?

Professor Wilkinson-Brice: To build on what Danny said, of course there is a responsibility for individual organisations to make sure that they can deliver the very best patient outcomes, which means they have to have a workforce to do that. The role that we have played, particularly through retention, is to share best practice; create really good data so that people can understand from a data perspective; actively listen to what staff are telling us, right down at grassroots level—it happens at a national level; to engage with staff and interpret what they are telling us; and then to act.

We can demonstrate that it is a partnership, and that is not a fudge. It is genuinely a partnership between what data we can provide nationally down to individual organisations and what policies and frameworks we can create to support consistently across the NHS. Ultimately, what will retain a member of staff is probably how they feel about their day-to-day

work in their local organisation. On your point about leadership, we have spent a lot of time developing the leadership resource that is available, and we will welcome the Messenger review, when it is published, to further strengthen leadership at all levels throughout the NHS.

Q304 **Lucy Allan:** Do you have anything to add, Dr Evans?

Dr Evans: Yes, I do. Absolutely, it is our responsibility collectively planning for the workforce to be responsive to what the service needs, which is responsive to what people need. In doing that, training and education is key, but it is not the only route that we have to consider for supply. We need clarity about all the different routes for supply now and in every period right into the long term, and then we can plan accordingly.

Chair: Thank you. Rosie, I see you are burning, so a last quick one.

Rosie Cooper: It is not really a question; it is a very quick statement. We have listened to you all today earnestly doing your jobs to the best of your ability, but I look backwards at workforce planning over the last 20 or 30 years that I have been involved, and it has been a failure. When we get to the point when we see that it is a failure, all the people involved are long gone and have moved onwards and upwards into other jobs.

Chair: Some of them have become Select Committee Chairs.

Lucy Allan: It is a rotating wheel.

Rosie Cooper: My real plea to you is that we need those numbers because we need to know that we are on the right trajectory. Warm words and all of this framework stuff just sounds like it is more and more and we're not getting there. You won't be there in 10 or 15 years. How do we make it better?

Q305 **Chair:** It is a good note to end on. I have a final practical question for Professor Wilkinson-Brice. This is a much more detailed thing. The Royal College of Nursing told us as part of their evidence to us that "Agenda for Change" needs an urgent review because it is "frequently out of step with the reality of the skills, knowledge and accountability of the safety critical roles that nursing staff deliver." Do you agree with that?

Professor Wilkinson-Brice: We absolutely need to make sure that all of our staff are fairly paid. If there is a natural point to review something that has been in existence for a long time, it would seem fair to do that. Again, I am going to ask Danny to have a view on that.

Danny Mortimer: There is a process that we are following with all the trade unions to review the particular issues that the RCN has raised about the profiles for nursing. That is under way.

We said on behalf of employers in our evidence to the pay review bodies that, while starting salaries for our graduates prior to the present cost-of-

living crisis were competitive, our end points for salaries for our graduates—nursing is obviously the largest of our graduate-entry professions—are not as competitive in the market, and we believe that there is a need for the Government to invest more in those graduate entry roles, which speaks in part to some of the concerns that Pat and her colleagues at the RCN have. We are going through a process of reviewing the profiling for nursing.

Chair: Thank you. It has been a very interesting and important session. I want to finish, if I may, by stressing that none of the comments made or questions asked was personally directed. We recognise that you are operating within the constraints of your jobs, and you have to, in a democracy, follow the lead you are given by your political masters. We understand that. I was one of those, so I bear my own share of responsibility for some of the challenges that we face at the moment.

I hope you can also understand our frustration that in nearly every report we have published in this Parliament we have highlighted the lack of a long-term workforce strategy, and the lack of anything that gives confidence to people on the frontline that we are training enough of them for the future. We still have not had that strategy and we feel very frustrated about that.

We are really grateful to you for answering as best you could all our questions this morning, so thank you very much for joining us. That concludes our session.