HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Workforce burnout and resilience in the NHS and social care, HC 703

Wednesday 24 February 2021

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Dr Luke Evans; Barbara Keeley; Sarah Owen; Dean Russell.

Questions 179 - 248

Witnesses

I: Anita Charlesworth, Director of Research and REAL Centre, The Health Foundation; Rob Smith, Workforce Planning and Intelligence Director, Health Education England; and Oonagh Smyth, Chief Executive Officer, Skills for Care.

II: Helen Whately MP, Minister of State for Care, Department of Health and Social Care; and Prerana Issar, Chief People Officer, NHS England and NHS Improvement.

Examination of Witnesses

Witnesses: Anita Charlesworth, Rob Smith and Oonagh Smyth.

Q179 **Chair:** Good afternoon and welcome to the House of Commons Health and Social Care Select Committee. This afternoon, we are having our final evidence session on workforce burnout and resilience across the NHS and care system.

We have obviously been thinking about the enormous pressure on frontline workers in both sectors during the pandemic. We will be looking at those during this afternoon's session, and at the need for long-term solutions to the pressures faced by the health and care workforce even prior to the pandemic.

In our second panel, we will hear from Minister Helen Whately, who is the Department of Health and Social Care Minister responsible for workforce. We will hear for a second time from the NHS chief people officer, Prerana Issar. We are very grateful to both of them for joining us.

Before we hear from them, we have a panel of distinguished experts. We have heard from some of them previously, but we wanted to bring them back. They are Oonagh Smyth from Skills for Care, which is the skills organisation for the social care sector; Rob Smith from Health Education England, the Government body that is charged with doing modelling for the future needs of the health and care sector; and Anita Charlesworth from the Health Foundation. Thank you all very much indeed for joining us.

I am going to kick off, if I may, by looking at the systems whereby we work out what our long-term requirements are. Anita, you have done some very helpful modelling on the workforce gaps that we expect over the next five, 10 and 15 years. I want to ask you a more general question. We know that a lot of the pressures faced by NHS and care staff predate the pandemic. How would you rate the quality of long-term workforce planning in both the health and care sectors?

Anita Charlesworth: It is poor, but it is poor in most countries actually. A study done by the OECD back in 2013 identified a number of weaknesses in the way that countries across the OECD planned for the workforce. I will run through four of those they identified, which describe some of the key issues in our system as well.

Too often, workforce plans do not start with a proper underpinning look at what we need in the system. That means they are not deeply connected to service planning. They often do not start from where we are at the moment, with a really good understanding of current shortages. They might look forward to what we need to replace with people who are retiring, but the fact that we already have gaps is often not reflected.

They often fail to look at the labour market as a whole. That has been historically a real weakness in our system. We focused on the NHS. If we take nursing, the NHS is an absolutely critical employer of nurses. You

have Skills for Care here. The social care sector also needs nurses, and the private sector needs nurses. Much of that private capacity is used to provide NHS-funded care. If we do not think about that labour market as a whole, we will miss a whole chunk.

The plans often do not understand and look at the role of pay, and the importance of that over the long term. Very critically—this has been an absolute problem for us over 20 years—they are siloed by profession. They do not look enough at the relationship between the professions and the way that needs and technologies will change the mix of professions that we need, and therefore how one should plan for that and factor it into the work.

Q180 **Chair:** Does the recent White Paper that the Government announced on NHS reforms go any distance to addressing those issues?

Anita Charlesworth: It does very little on the workforce issues. It is going to allow more flexibility locally. It is important to think that there are issues about how we plan and co-ordinate activity nationally, which HEE has a key role in, with the Department of Health and Social Care. HEE has no remit in social care, for example. What we also need, because there is so much geographical variation in both need and supply, are good arrangements nationally mirrored in good arrangements locally. Again, our arrangements locally have almost certainly been too siloed and too dominated by specific professional focuses.

In Greater Manchester, with devolution, they are trying to bring together more of the partners, particularly involving new partners like the FE sector, which is important for things like social care, to plan for the longer term. The flexibility will be welcome, but there is very little in it about strengthening our national planning system.

It is worth saying that the system needs strengthening, but a lot of our problems do not stem so much from our system. In fact, you might argue that one of the problems is that we have reformed the system so many times that it has never had the stability to look at the long term. A lot of the issues are cultural, and they lie at the Treasury's door. We have a culture in England that is rather like what in traffic is called the M25 phenomenon, where we think, "If you build it, we will fit." For the Treasury, in order to control costs, if we train the staff, we will end up employing them and that is the biggest cost pressure in the NHS. For them, constraining the number of staff being trained is a way of controlling the system.

The other thing is that the cost of training is very clear to the Treasury. The cost of not training is less clear to the Treasury, but that came back and was so visible to us over this last decade.

Q181 **Chair:** Yes, indeed, with the locum and agency spend going now to £3.5 billion a year in the NHS alone.

Let me move to what the solution is. You have supplied evidence to the

Committee where you are very stark about what the vacancy gap is going to increase to. In the broadest terms, you say that there is going to be a gap of about 1 million vacancies in the health and care systems combined within about 12 years. That is a huge gap. Obviously, if we do not fill it, we will increase even more the pressure felt by the current staff.

I want to ask about the solution. You just talked about the Treasury view. Do you think there would be merit in having, as has sometimes been discussed, an OBR-style independent body charged with making projections as to what workforce needs will be—the numbers of doctors, nurses, endoscopists and every specialty—or ask the ONS to do independent work, working with NHS England, so that we at least get those numbers out into the public domain? At the moment, we do not even know what the NHS's own projections are.

Anita Charlesworth: It is incredibly important that we have transparent projections. We need to think hard about who does the transparent projections. That is on supply, but if you are able to understand how many staff we might have if nothing changes in terms of policy, given the external context of the labour market dynamics, you do not need to understand how those compare with the needs in the system. It is quite difficult to get a real handle on the needs in the system unless you are well linked into the NHS and the social care system. One of the challenges for the workforce is that they need dedicated attention. The NHS and the social care system are nothing if they are not the people. It needs to be well connected into the service model.

There is a debate to be had about an independent body. Even without an independent body, there is much you could do in the forthcoming legislation to strengthen independence. At the moment, there is no power for HEE, or no requirement on them, to publish long-term forecasts that have, for example, been overseen and quality assured by a chief analyst. There are things like that that you could do which would strengthen the responsibilities of HEE. These are projections if nothing else changes. The point of the projection is that you never end up in that position, and that something will change.

The advantage of it being quite embedded in the system is that there is more ownership. We tried between 2010 and 2016 to have a separate independent body—the Centre for Workforce Intelligence. It did good work, but you could argue that it was too disconnected. It may be that there are opportunities in the legislation to strengthen the quality, the frequency, the rigour and the transparency, which I think is vital, in our current system. I would like to see that mirrored in a national projection and in local ones as well. With ICSs, local accountability is going to be as important as national accountability. I want it to be NHS and social care. Sorry, I want a lot.

Q182 **Chair:** No; thank you. It sounds like you are battling a cold, Anita, so thank you very much for battling on. Let me bring in Rob Smith from Health Education England on that very point. Thank you for joining us,

Rob.

What do you think about what Anita has just said? Would it make our workforce planning more rigorous and more likely to be successful if there was a legal requirement on HEE to publish independently verified workforce projections for every specialty in the NHS every year so that we can relate that back to the number of people we are actually training, to see whether it is enough?

Rob Smith: First, I recognise the whole list of issues that Anita spoke about. We think there absolutely is merit in thinking about how we plan for longer-term secure domestic supply through training. For me, the key issues are twofold, one of which Anita touched on. That supply has to serve both the NHS and the wider health and care market. She is right; for too long, we have thought it was about planning for the NHS. That is not the way the labour market works: 50% of AHPs, 40% of nurses and 20% of doctors work elsewhere.

The key thing for me is to focus on long-term trends in demand, rather than cycles affected by fiscal policy. Supply is a slow-moving thing. I use the analogy of the supertanker. Demand is like a speedboat, but you want to set your supertanker off on the right path, with 2%, 3%, 4% a year every year. It is worth exploring how we might achieve that.

I agree about the issue of independence. We have had challenges that if you are independent you are not connected. I come back to the other point Anita raised, which is that at the heart of this is making sure that workforce plans are fully aligned with service and finance plans. That is the issue of connectivity. That is effectively what we have been trying to achieve over the last few years with our NHS England and Improvement colleagues.

If you identify what your gap is, as we have been describing, the purpose is to drive action. The purpose is to identify actions across all levers at all levels that can solve it. By that we mean service redesign, workforce transformation, and being the best employer, so that we can retain and recruit staff. On current supply actions, in the shorter term, use of international recruitment is appropriate; in the longer term, it is not.

Finally, we come back to the big lever, which is education and training of core professionals and other groups. I would like a system in which we do two things. One is that we have better integrated planning on a one-year and five-year basis that allows you to pull those levers. The second is the idea that you can set your trend for core domestic supply in the longer term.

I am not sure quite how we achieve that. You may recall that you commissioned us to look at the longer term in our draft workforce strategy, "Facing the Facts", and we produced a high-level 10-year picture of future demand. We used the OBR fiscal sustainability report to do that, because it struck us as a well-thought-through thing on

demographics, productivity and the preference of societies for healthcare. Anita, as an economist, will tell you better than I. Indeed, we had a roundtable with Anita's team and others on that. That is the kind of space I would like us to land in.

Q183 **Chair:** I do indeed remember that report from when I was Health Secretary. It was published in 2017. We were only allowed to publish it on the basis that it was a draft report. That was the only basis on which the Treasury would allow it to be published. It had very useful long-term projections. Since then, the final report was never published because the Treasury would not allow it. Even now, we are not allowed to know how many doctors and nurses the NHS thinks it will need in 10 years' time.

I know that it is not within your gift to publish those projections, Rob, and I do not want to put you on the spot on that because I understand how these things work. Let me ask you a very simple question. You must know how many nurses the NHS thinks it is going to need by the end of the Parliament. Will the increase of 50,000 promised by the Government be enough to meet that need?

Rob Smith: I do not want to disappoint you, but the reality is that because of the pandemic we genuinely do not know how many nurses we are going to need by the end of the Parliament.

Look, £20 million buys a certain amount of workforce, and the nursing numbers will increase in line with that 3% real-terms funding. Yes, 50,000 nurses will make a huge imprint on the current levels of vacancies and shortages. It will go a long way to making sure that we do not have excess vacancies. We talk about vacancies a lot, but there are contingent workforces, bank and agency and others, that we use, too.

I genuinely think that we need to revisit the demands that are going to come from the service. The services we deliver will be different, and the way we deliver them will be different over the rest of this Parliament. In consequence of that, we should look at the actions we need to take, and that will help us inform our next bid to a spending review that says those actions are fully funded. That is the kind of approach we are trying to take.

Q184 **Chair:** Rob, I am going to cut you off there, if I may. We will come back to you, because lots of people want to ask you questions. The big problem with the system we have at the moment, which I want to bring in Anita and Oonagh to comment on, is that we do not know whether 50,000 nurses is enough or not. The Government simply do not tell us how many doctors, nurses, AHPs or social care workers will be needed in five years, 10 years, 15 years or 20 years. That basically makes workforce planning a bit of a joke, despite the incredibly hard work and detailed modelling you do. At the moment, there is no way to hold the Government to account. Indeed, when the numbers are announced, as a result of the spending review, they will be the numbers that have emerged from horse trading between DHSC and the Treasury, which may

in fact not be the independent projections.

I have a quick question to Oonagh, and then I want to bring in my colleagues. Oonagh, what are your reflections on all of these issues as far as the social care sector is concerned?

Oonagh Smyth: I agree with Anita and Rob that the key is to keep planning as close to the service—social care—as possible, so that there is a deep understanding of what we need. Ownership is key at all levels. The more people know the information, the more likelihood there is that we will be thinking long term at each stage, at each level and, as Rob says, using all the levers to make it happen.

We need to have any projections anchored in a vision of what social care should be and should do for our communities, because that dictates what we want to see. For example, what is the balance between generalist and specialist skills that we want to see? While our Skills for Care projections show that we need an extra 520,000 people working in social care by 2035, that is at a very high level. The detail of what roles we need will need debate and a strategy because there are choices to make within that.

One example is that, if we want to support the move towards supporting individual employers and supporting personal assistants, it will lead to a very different projection. Having that debate anchored in what social care means to our communities, to our families and to us as individuals is the bit that I would add to my colleagues' evidence.

Q185 **Dr Evans:** If it's okay with Rob, I am very keen to explore and go through some of the more practical sides of the workforce. I want to be clear about your job description, which is workforce planning and intelligence director. Would you give us an overview of what that entails so that, hopefully, I can angle my questions appropriately?

Rob Smith: Yes, I would be happy to. Basically, HEE was set up to undertake workforce planning and to help inform future training volumes. We also have a large internal function running postgraduate medical education and all the operational intelligence that you can imagine goes with that, including how we recruit and rotate staff. That is all in my remit.

Q186 **Dr Evans:** That is very helpful. Were you in that role when MTAS was brought in—the Medical Training Application Service—round about 2007?

Rob Smith: I was at NHS London in a similar role, but working with the London deanery, as it was at the time.

Q187 **Dr Evans:** One of the concerns from the ground that I often hear is that young doctors in particular are asked to choose and specialise so early on. Within about 12 or 14 months, they have to make a decision about where they want to be in the future. I wonder how that affects and impacts on workforce planning.

In the old system, one of the benefits was that you could sit around trying to decide what kind of specialty you wanted to do, and sample lots of different areas, and then finally decide to specialise. That did not stop a cardiothoracic surgeon from the age of six going forward and progressing that way, but it meant that a lot of people were able to skill up in various areas and then finally find a specialty or indeed a generalism, like a GP, and be well versed in how other areas of medicine worked. What is your assessment of that and how MTAS, and indeed where we are now, 15 years on, fits in?

Rob Smith: I would prefer to defer to my director of medical education, Wendy Reid. From where I am, in terms of the specific question about how that kind of streaming of people affects planning, what we are trying to achieve through the alignment of service and financial workforce plans in the medium term is to say, "Look, if this is the gap, what levers do we pull?" One of the levers is about how you adapt people within that time horizon.

If you have a system in which ongoing professional development allows you to switch from one specialty to another, it will create systemic resilience in the system. We are exploring issues around generalism, how generalist skills work and how we support things like staff grade doctors and others. Either you try to get really precise in the future, or you have a more flexible system and you change your supertanker into something that can steer a bit more nimbly.

I think it is both. You may recall that we did a longer-term piece of work called Framework 15, looking at conditions for the future. I think there is a twin track, which is how you get secure domestic supply in the right kind of area, following trend; and how you make the system more responsive and agile. Clearly, retraining and career pathways are part of that agility.

Q188 **Dr Evans:** I will put my hand up. I was a GP and trained in the last 12 years or so. I have gone through that. Anecdotally, I would say that between about a quarter and a third of the VTS that I went through had all been either SHOs or indeed embarked into registrar levels in other fields such as paediatrics, obs and gynae, and swapped over.

On the one hand that is great, because obviously they bring a lot of skills to general practice. On the downside though, it leaves them never completing where you guys had planned them to be. How widespread is that anecdotal evidence in reality? How does that cause a knock-on problem for your planning?

Rob Smith: One of the things that has been really exciting over the last couple of years are the tools we have developed to track supply. We are working with the electronic staff records and our training record to see exactly how people progress through their career and what the flows are. There are a lot of myths out there: "Everyone is going to Australia," and, frankly, coming back, but nobody says the second part of that statement.

Through our HEE flow tool, we have the ability to observe those kinds of changes. That includes, because the ESR captures their specialty code, how people might migrate between different professions. It is a step up from observing that it is happening to what you do about it, but once you know at least you have a fighting chance of saying, "Therefore, if we see these flows from area X into area Y, we know we can train more here because we know it is going to feed this other specialty." That is the kind of approach we have been starting to adopt over the past two or three years.

Q189 **Dr Evans:** Could you comment on the trends between male and female doctor trainees?

Rob Smith: This is a really important thing in terms of trend demand, but it is not just trend demand we need to observe; it is trend turnover. How many FTE per person do we get in the longer term? You would want to plan that into your 10-year horizon scanning.

We are observing it, and it is absolutely real. I forget what the intake was to medical school this year. It could have been 56:44, or something in that kind of space. We should be celebrating that. On the back of the pandemic, there is something about how people can be part time and less time, which gives you some surge capacity. Let's be clear, part of the issue we have been looking at is the fact that we were up against the supply limits. There was not a great deal of contingent workforce that we could move to. A plan that trains more people but has them working part time, maybe later in their career, actually gives you inbuilt, systemic resilience.

Q190 **Dr Evans:** To try to break that down for the public who may be listening to this, could you explain what you mean by the trends and the breakdown? There are more female applicants coming into medicine and becoming doctors. Is the trend still correct that they tend not to do full-time equivalent jobs? What impact does that have? Does the evidence bear that out?

Rob Smith: I repeated a bit of a myth myself there. It is marginal, on what we have seen so far; there is not a huge disparity in the hours that different genders want to do. There may be issues about career breaks, and therefore your contribution over the lifetime of your career might be different.

There are two things. Let's make sure, first, that we are observing it and, secondly, that we are assessing its materiality. My general sense is that it is not as material as many of the common statements around it are, but I do not want to be blasé about it either.

Q191 **Dr Evans:** I have two final points. Do you think the system is fit and flexible enough to deal with the demands of a work-life balance, doing a demanding job as a nurse, doctor or carer and having a family? Given the way you have hinted the workforce is going, is the system flexible

enough to be able to accommodate that, and therefore be as efficient as it could be?

Rob Smith: It is absolutely essential that if it is not already it needs to be. When you talk to Prerana later this afternoon, she will focus on how we can be the best employer, including how we act to support people who want to work flexibly. There is a great online group called FlexNHS. They talk about the return that you get from your workforce because you look after them and meet their needs. I do not think it could be clearer. It is a totally pyrrhic victory if you say, "I need you to work X till Y," because you will lose people.

Q192 **Dr Evans:** On the flexibility side, the pandemic was fantastic for pulling retired doctors and nurses back in and getting people to come back into the service. Have you done any modelling about retaining them and allowing the flexible system to keep those people, given that roughly a quarter of all GPs are a few years off retirement or taking early retirement? How do you programme that? What is the trend, and how do you look at it to make sure that the NHS is resilient in the future?

Rob Smith: There are two things. First, we are absolutely trying to take the opportunities that presented themselves and engage with people who have expressed an interest in coming back. You will have seen that a very large number of them joined the hugely successful vaccination programme that our nurse director, Mark Radford, has been helping with on the workforce side.

Prerana and her team are thinking about how we can capitalise on that in the short term. We absolutely need to think about how we have a pandemic response strategy going forward. That will include how we use a contingent workforce and how we keep people. Some kind of reservist model should be looked at, but it needs to work. Skills atrophy. If you do not use your skills, they atrophy. There is a desire for workforce oversupply, but you have to employ them. You have to have them using their skills, otherwise they just fall off.

Part of what we will learn from this pandemic is to think about how we have a kind of surge strategy, a response strategy, and greater resilience, as well as the kind of headroom that Simon talked about at the last Committee.

Q193 **Dr Evans:** Are you positive about the workforce future for the NHS?

Rob Smith: I am absolutely positive, because we are taking these kinds of planning approaches to make sure that we are pulling all the levers. My favourite example is the mental health plan. We had an absolutely clear service strategy. We did workforce analysis that said, "You are not going to deliver it unless you take some serious action." We then created an action plan that said we needed to do better on retention; we needed to do better on service transformation and workforce transformation; and we needed to do a lot of training. Those actions were funded.

I think Claire Murdoch has reported to this Committee previously that we are making great progress against that five-year plan. That is why I have optimism. Through collaborating with our NHSEI colleagues, our Department colleagues and clinical leads, as well as social care, where they are part of so many pathways, we are making good progress in that medium-term planning space.

Q194 **Barbara Keeley:** Could we look broadly across the health and social care sectors? As we know, they are becoming increasingly integrated. How is that reflected in workforce planning across the two sectors? Clearly, with the legislation change it is going to become important.

Anita Charlesworth: Inadequately, I think is the position at the moment. We have work on an NHS people plan going on, and that is very good, but we have no commitment to a social care people plan. The NHS people plan has no remit formally to look at that.

Personally, I think social care needs its own plan. Social care should not just be a sub-paragraph to the NHS. If we could have a social care plan and an NHS plan, we could look at those together. I would like to see, in the new arrangements that are put in place after the legislation, in integrated care systems, a real bringing together of social care and the NHS.

I would like to suggest another area that I think is a priority. At the moment, we have an NHS pay review body. The NHS pay review body makes recommendations for pay for what are called "Agenda for Change" staff. At bands one to four of "Agenda for Change", many of those staff are doing jobs that have parallels in the social care system. Through that process at the moment there is no real remit to look at the impact of the "Agenda for Change" pay recommendations on the social care labour market.

If we do nothing about improving terms and conditions in social care, it will mean that further staff leave the social care system for the NHS. That is a pyrrhic victory for the NHS because this pandemic has shown very clearly how completely interdependent the sectors are. We need a proper focus on social care workforce strategy. Just because they are not employed by the state does not mean that the state does not have a role in influencing and shaping that market. It does.

We also need to make sure at local levels, and through all the levers we have, that whenever we are doing something for the NHS, we think social care as well.

Q195 **Barbara Keeley:** Oonagh, do you want to address that question? The point that has come out is perhaps making sure that integration benefits both the NHS and social care and prevents a one-way flow of staff. I think there is real concern about that.

Oonagh Smyth: I completely agree. We need a social care plan or strategy. Making sure that we understand where it aligns with the NHS

people plan will be important, but we must make sure that it is a partnership between central and local government employers and people who use care and support, working in partnership to think about a sustainable social care people plan. That has to be anchored in the vision of improving the quality of life of people who access care and support.

People as individuals should not feel the baton change between the health and social care systems. We should be planning that from the individual level, being clear on the different roles and responsibilities centrally and locally. We need to be clear on the national to local join-up, including how ICSs can use and think about workforce alongside the NHS people plan, so that we have properly integrated local strategies. They are linked, and we know from experience that there is often direct osmosis from social care into health. We need to be thinking about that in the round.

Q196 **Barbara Keeley:** There is also the issue of post-Brexit immigration policy. What risk or benefit do you think that immigration policy poses to the pipeline of NHS and social care professionals? From social care, it is largely seen as a threat and, in certain parts of the country, an even bigger threat. London is very dependent on social care staff who come from other countries.

Oonagh Smyth: It goes back to the need for a strategy and a plan. We have 112,000 vacancies on any one day in social care. You have a number of choices in thinking about long-term recruitment. We can keep speaking to people who are naturally attracted to care. We can think about people who are not naturally attracted to care, so I am always thinking about the number of men in the workforce; 18% of the workforce are men. If we wanted a strategy that got more men into social care, that could be one choice. It is all intertwined.

We have to think about the different sources of recruitment and make sure that we are planning for that in the long term. We predict that an extra 520,000 people will be needed by 2035, and that is building on the existing 112,000 vacancies a day in social care.

Q197 **Barbara Keeley:** On the point about men working in social care, clearly pay might be an issue. Is it different at the better paid end of the social care sector, because there is a better paid end of the social care sector? Are those numbers different there?

Oonagh Smyth: Yes. Men make up 18% of the workforce in general, but a higher proportion of leadership roles are held by men.

Q198 **Barbara Keeley:** Thank you. Do you have anything to add, Anita?

Anita Charlesworth: I want to emphasise that I think there is a real opportunity and a real responsibility after Covid for the Government to think about domestic recruitment. The opportunity in the NHS is the huge increase we have seen in the numbers applying for both jobs and training opportunities. If we can capitalise on that, we can make a big difference.

On social care, we also need to think that there are sectors of our economy where Covid has, essentially, fast-tracked structural changes that will leave a large number of people without employment. Many of those people have skills in customer care and in human relationships, which would be very valuable in social care. They need a job, and social care needs people with those skills, but we need to train them. At the moment, only 50% of the social care workforce has a relevant care qualification, so we need to invest in their training. We need to make sure that social care becomes not a temporary job while you are looking for the long term, but becomes a career for people where they feel valued and they can earn a decent living, so that they can pay their rent and feed their family.

Q199 **Barbara Keeley:** Rob, do you have any thoughts to add to that question about immigration policy?

Rob Smith: It is both really. I think ICSs are a huge opportunity for planning for a population across the whole part of a pathway, and are therefore a setting within which we should make sure we join up social care and health with the patient at the centre. That is really important.

The use of international recruitment, as one of the levers I talked about, needs to be measured. We come back to the question of secure domestic supply, at which point that would allow you to have a policy on migration and immigration that is your choice, to a degree. We are hugely attractive to people like doctors. Our postgraduate medical education is world class and people will want to come and learn here. It is not one picture paints all, but London has a high reliance, and different sectors like social care need to be part of the ICS level planning about how we solve the broader challenge.

It is key that we have done some good structural stuff. The nursing associate role, which we piloted with social care, has created a new flexibility in that system. Of course, we piloted the care certificate on the back of the Cavendish review, back in the day. I forget how long ago.

Q200 **Dean Russell:** I want to explore the previous topics a bit further, around education, and also touch lightly on mental health. To start off with, I am very conscious that at the start of the pandemic when we were doing Clap for the NHS, it quite quickly merged, quite rightly, into Clap for Carers. Oonagh, in the first instance, I am interested to get your view. Do you think that perceptions through the pandemic have changed attitudes towards wanting to work in social care?

Oonagh Smyth: Yes, I think they have. We saw increased awareness of social care, particularly around the Clap for Carers. We have seen new people coming into social care and, as Anita said, moving out of other sectors. The key question now is how we keep the people with the right values who are moving into social care. People have seen that social care is so important to our communities and to families. That probably was not visible before.

We have more to do to remind people that social care is about more than care homes and more than older people. We must remind people about social care's role with working-age adults, for example. There is an opportunity for us to flip the narrative around social care. It adds about £41 billion to the UK economy every year. A lot of that will go to local economies. Thinking about the potential of the role of social care when we are coming out of Covid, in terms of recovery, will be key. People being able to see themselves as part of that will be an important part of the future narrative.

Q201 **Dean Russell:** Rob, I am interested in the lead-up to people getting their careers specifically in social care and in health more broadly. In particular, how much emphasis should be put on schools and on early years education to encourage people to want to go into a career in this space? Is enough being done right now in that area?

Rob Smith: I think you can always do more. You may know that HEE hosted the NHS Careers Service for many years, and works diligently with schools and others to promote what are, let us be clear, fantastic careers. I am now 34 years in the NHS and social care, and would strongly say that these are some of the best careers in service you can do.

There is some evidence that that is working, with the number of applications to nurse training. It is not just on the back of the pandemic and the service that has been demonstrated. If that is true more widely of an interest in public service and care service, we need to be able to capitalise on it. There is something about the NHS, social care and universities and colleges acting as anchor institutions in their economies, and working collectively to promote those roles. They are great careers with good economic benefits for both the practitioner and the community. I am a big fan of promoting health and care careers.

Q202 **Dean Russell:** Related to that, last year I was involved in writing a report called "Connecting Communities", where we recommended the concept of NHS cadets. We have police cadets and Army cadets, so why not NHS cadets? I have been very fortunate over the past year—literally coming up to a year—to volunteer at my local Watford General Hospital. I have seen the inspirational figures of all the volunteers there, but especially young people who want to get careers in healthcare.

Has the red tape been cut a little bit over the past year to encourage more volunteering in the NHS and social care, in a way that perhaps was not there pre-pandemic?

Rob Smith: I think it is exactly the right thing to do, but I am not clear where people are progressing on our ability to do that. As Prerana and her team have said, let's focus on the NHS being an excellent employer. That has wider resonance about how you engage with your community and how you encourage that kind of piece.

It is very hard when people are just doing the incessant workload in front of them to think about how we plan and encourage for the future. You

have to put some effort into it, and some resource. Our HR capacity has been held, or reduced, over many years. The kinds of people who can do the reaching out to schools and local groups to have the effect that you are discussing need some support.

Anita Charlesworth: I want to emphasise that, in particular, for young people and the impact that the pandemic has had on their education, and people who have lost work in sectors that are going to be declining, we need to think a lot about not just entry to the undergraduate education route but making the apprenticeship system work really well for social care and for the NHS. Prior to the pandemic, we were struggling with numbers on apprenticeships for social care. Making sure that the apprenticeship scheme works well will be very important for our ability to reach into different communities and attract people in.

People were talking about what is known in the jargon as a skills escalator. If you start in one job that might have a relatively low qualification requirement, you can get on-the-job training and the opportunity to progress so that you can acquire your qualifications, move into the next job and up through the system.

All the evidence is that in a lot of parts of the country with vacancies—we were talking about London, but it is not the only part of the country—if you train local, people are more likely to stay. In parts of the country where we are struggling, we need to think how we can reach deep into our communities and find ways for the NHS and social care to be an option for them. That is a win-win. It is a benefit to the community and a benefit to them. It is almost certainly a benefit to the NHS and social care systems in terms of retention. That is why it cannot just be a national policy. There has to be good connection locally as well.

Q203 **Dean Russell:** You mentioned skills escalation and career progression. Do you find that at the moment it is very vertical? I have yet to see anything that really highlights that you can start a job in social care, and transition in your career over to the NHS. It feels like there are two silos. We even talk about health and social care. It is not one thing. It is always separate. Am I correct in that assumption?

Anita Charlesworth: A proportion of people move across. I will get Oonagh and Rob to talk about that. There is still quite a lot that could be done to have qualifications, and particularly skills, that were achieved in one sector passported as effectively as they could be and recognised in the other sector. We have to make sure we do that in a way that does not mean people feel that the only option for progression, if they join social care, is to leave. We need to make sure that it works both ways. There is more to be done on recognition of skills development between the two sectors.

Oonagh Smyth: I agree with Anita. There definitely are people who move between social care and health. Unfortunately, it is most often from social care to health rather than the other way around. Health is only one

of the systems that social care interacts with. A lot of people who draw on social care will not come into contact with the health system any more than I will, for example. The skills, the knowledge and the career pathways might not always be attractive to people in social care. They might want to go into a different sector, but there is more that we can do to align, acknowledge and understand the career pathways between social care and health, while also thinking about the interdependencies. When we have a drive in the NHS for more roles, we must think about the impact of that on social care. Equally, having as many people as possible who work in the health system and deeply understand social care is a real benefit, but planning in silos means that sometimes we are not thinking about the full impact.

Q204 **Dean Russell:** Finally and briefly, Rob, I absolutely applaud the work that Claire Murdoch and Nadine Dorries have done around mental health in the NHS and social care. I am keen to get your thoughts. Have there been any predictions or surveys to look at burnout there, as well as planning ahead to make sure that we are capturing any concerns now? For example, PTSD does not become a disorder unless it is not treated. Are we looking at those sorts of things right now to make sure that they do not become an issue in two or three years' time?

Rob Smith: I think you will want to take that up with Prerana in your next session. The current planning we are doing is about the recovery of staff and the recovery of services, and it is absolutely about those kinds of issues around people's experience, which is not universal—it is individual—and how we manage that and care for our people appropriately is going to be a key part.

Q205 **Sarah Owen:** I have a couple of questions that lead on from the questions that have already been raised. I would like to start with Oonagh and Anita, if I may. There has been some reluctance, as the Chair said, to talk about the actual figures and numbers when it comes to how many vacancies there are and the staff that we actually need in both care and the NHS.

Oonagh, you said it very quickly at the start, but could you repeat how short we are of carers? Anita, could you give your estimation of how short we are in nurses and NHS staff, please?

Oonagh Smyth: Our statistics indicated that before Covid we had around 112,000 vacancies on any one day. That reduced slightly, in Covid, to around 100,000 vacancies a day.

Q206 **Sarah Owen:** Vacancies are one thing, but we also have a number of people who will be off sick. Large numbers will be off with stress as well. Do you have any estimations around how many care workers are currently off work at the moment?

Oonagh Smyth: In a normal year, we usually average around 2.8% of days lost to sickness. That doubled in Covid. When Covid initially hit, it

trebled and now it has balanced out over the year at about 6% up until January this year.

Q207 **Sarah Owen:** Have you had any correspondence or feedback from care agencies, care homes or people receiving care at home on how that has been dealt with?

Oonagh Smyth: A lot of social care staff are stepping up and taking on a lot more hours. A lot of registered managers, particularly, say that they are not taking leave. They have to work a lot more hours. We have seen people recruiting more and being overstaffed, if they need to be. Generally, a lot of people are working more hours, but it is so variable because of the nature of social care.

Q208 **Sarah Owen:** Thank you. Anita?

Anita Charlesworth: Prior to Covid, we estimate that there was a shortfall of 115,000 full-time equivalent staff in the NHS in England. The last year has been something of a record year in terms of the numbers of staff employed in the NHS. Obviously, that has been accompanied by a huge increase in demand pressures. In nursing, within that 115,000, the shortfall of nurses was about 40,000. As a share of the professional workforce, nursing has one of the highest vacancies. Looking out over a decade, with no policy action—I think there will be policy action—we would expect that shortfall to increase to something like 370,000 staff. That presumes no policy action.

The modelling we did with the King's Fund and the Nuffield back in 2018 showed on nursing that we should not be fatalistic about it. It would be possible over a decade, borne out very much by the increasing number of people who have applied for nursing undergraduate degrees over this last year, to move from a system where we are chronically understaffed to one where we have a small excess supply. What we need to do is to pull all the levers. We absolutely need to train more. We need to make sure that more of those who start training complete the training. We need to make the NHS a really attractive place to work as a nurse. We need to tackle the retention issue by making sure it is a great career and a great place to work.

It requires that systemic action, and for at least a period we will need to continue to recruit from overseas. Let me be clear: nursing shortages in a decade's time will be a policy choice that we took, not an inevitability. This next spending review is the decisive moment when we will effectively bake that in, or will have used Covid as an inflection point to finally tackle the problem.

Q209 **Sarah Owen:** Following that point around overseas recruitment and being an attractive offer for people overseas, I spoke to 30 or 40 healthcare workers, in different jobs, from overseas, not from Europe or the EEA. The big problems they had were around the immigration health surcharge and the visa costs, to the extent that senior level nurses were

having to use food banks or borrow money from other nurses to pay off their immigration health surcharge. That was at the beginning of the pandemic. How are those policy areas affecting international recruitment and retention in particular?

Anita Charlesworth: With the pandemic and the constraint on travel, the numbers coming from overseas and joining the professional register for nursing in the six months up to September were 2,000, which was a third of the rate of the previous six months. In 2019, we had actually seen overseas recruitment going quite well. It shifted from Europe to other countries, but it was looking quite good.

I think those policy issues are the right ones to raise, but there had been a lot of work going on across the NHS to think very hard about when staff arrive, what their experience is like. They do what they can, but the NHS obviously needs a national policy framework around migration, as does social care, which is supportive of that. We will need international recruitment for a period, undoubtedly, even if I got everything I wished for from the Treasury in funding for education.

Q210 **Sarah Owen:** I am grateful for international recruitment, otherwise I would not exist because my mum would not have come here to be a nurse. Oonagh, could you explain whether that is the impact on social care at all, please?

Oonagh Smyth: Adult social care employs around 113,000 EU workers, and around 134,000 jobs are people not from the EU. We know that care workers are not listed as an eligible occupation in the skilled workers route. Even if they were, their salary levels are not enough to meet the rules, so they would have to be listed as a shortage occupation.

It goes back to my previous point around the importance of our understanding and choosing our workforce strategy—how we recruit and where we recruit from—if we want to fill that gap of 112,000 vacancies every day and how that is going to grow in terms of demographics. We need to be clear about where we are going to recruit people from.

Q211 **Sarah Owen:** My last question is around the professionalisation of care in particular, but also the NHS, and progression. It is all well and good recruiting people, but it is about retaining them and making sure they can progress. One of the things that we have heard throughout our Covid inquiry, particularly about the disproportionate impact on black, Asian and minority ethnic staff, is that there is still a snowy peak, as it were, in terms of management.

What would be the best way in your view to tackle that and encourage greater diversity within the management structures of both care and the NHS?

Oonagh Smyth: We know that 21% of the social care workforce comes from a black, Asian and minority ethnic background, but that does not translate into leadership roles; 17% of leaders are from a black, Asian

and minority ethnic background. We did some research with 500 people working in social care from a BAME background. What they spoke about was a lack of development opportunities, and racism in the workplace. There is a question for us as a sector around how we build more inclusive cultures, how we support people to progress and how we understand why they do not and why leadership is not proportionate to the number of people in the sector. We have a role to understand what is happening. We must take a leadership role in speaking about how important inclusive leadership is and how important cultures are in the sector.

Rob Smith: Prerana may be able to touch on the work of the workforce race equality standard. I totally recognise the issue that you have just described. As an employer, I want to reflect that the issue you are talking about is exactly what we identified as one of our top priorities in our equality and diversity work. It has to start with how you act as an employer. We are the lead agency in workforce, but if we cannot do it ourselves, we cannot speak with any kind of credibility. It is a key priority for my executive team and our board.

Chair: Thank you all very much indeed. That brings us to the end of our first panel. We will allow Anita to go and spend some more time with her Lemsip. Thank you for joining us, despite your cold. Thank you, Oonagh, for your insights into the social care sector. Rob, thank you for joining us with your very valuable insights as well. We really appreciate your time.

Examination of Witnesses

Witnesses: Helen Whately MP and Prerana Issar.

Q212 **Chair:** In our second panel this afternoon, we are going to hear from Prerana Issar, whom we have heard from previously. Prerana is the chief people officer at NHS England/Improvement. Helen Whately is the Minister responsible for all these workforce issues at the Department of Health and Social Care. She is also the Minister responsible for social care.

As always, thank you very much for joining us. I know I speak for the whole Committee in asking you to thank your teams as well, because the last year has been unbelievably busy and pressured for everyone in the health and care system. Civil servants, particularly, do not always get the thanks that frontline workers do, so a big thank you to all of your teams.

Minister, before we go on to the workforce issues that we have been talking about so far, I want to talk to you about our social care report, which we published last autumn. You gave a response to it, and I want to follow up on that response, if I might. The recent White Paper that brought forward big reforms for the NHS and the statutory structures committed the Government to bringing forward some proposals on social care by the end of this year. Is that going to be produced as part of the spending review?

Helen Whately: Good afternoon, and thank you for the report that you did last year, which is a really helpful document. It is something we are drawing on in the social care reform work that is going on.

It is probably helpful to be clear that the Health and Social Care White Paper, while it has some elements of social care reform and looks at joining up the health and social care system more effectively, with the important thread of increasing assurance and oversight of the social care system, which in its own right is a significant step in the reform journey, is not the social care reform that we are aiming at. The Government are committed to bringing forward and publishing our plan for social care reform this year, so that is still to come.

Q213 **Chair:** Can I ask you about the delay? The NHS 10-year plan was published two years ago. When I was a Minister, I talked about having a long-term plan for the social care sector that would run alongside the NHS 10-year plan. Why is it that we are still waiting for the social care reform proposals?

Helen Whately: When I was appointed a health Minister with social care as my responsibility, alongside the NHS workforce, social care reform was one of the top priorities for me to drive work on. That was almost this time last year, and then the pandemic hit. Quite realistically, my focus and the Department's focus over the last year has been on getting us through the pandemic. On the social care side, that has involved a huge amount of effort and a substantial upscaling of our social care resource within the Department. As you will know from your time as Secretary of State, there was a relatively small team at the start of the pandemic focused on social care reform. It is now nearly four times the size.

I think we have taken some important steps that will help on our reform journey. I mentioned the oversight and assurance plans in the health and social care White Paper. In the dataset that we have been able to build up about the social care sector, we have much better data now than we had at the beginning of the pandemic.

There is now some recognition in society of the importance of social care and the importance of our care workforce. It has been an incredibly tough time for those at the frontline of health and social care. It goes back to the Clap for Carers, which started off as Clap for the NHS. The concept that it is very much a Clap for Carers, and people are now talking about health and social care in one breath, is, in its own right, an important thing that we should build on as we go forward. To your point, there is a delay because of the pandemic, but we will bring forward our plans for social care reform this year.

Q214 **Chair:** I understand that. I suppose what people might say is that when it comes to words like "recognition"—as Health Secretary I was constantly saying that the social care sector is just as important as the NHS—people look to Ministers and say that actions speak louder than words. There is a lot of worry in the social care sector that they always end up playing

second fiddle to the NHS. Can you understand why the fact that, for whatever reason, there has been this delay can fuel some of the suspicion people feel that, in the end, they will never get the attention that the NHS gets?

Helen Whately: I can understand that. It is increasingly the case that we are thinking about health and social care together, which is extremely helpful. In part, it is a tribute to you that we have social care within the Department. In my role, thinking about both the NHS workforce and the social care workforce, I am constantly joining it up. Again, that is something we have done during the pandemic.

I am fully aware of things like what the sick pay is for the NHS workforce. Something we have done during the pandemic is to provide funding and strong guidance for the social care sector to make sure that social care staff should be on full pay if they are isolating for Covid. They should not be financially disadvantaged for doing something that clearly is the right thing to do when you are looking after vulnerable people. Similarly, we have put in mental health support and, as far as we can, having an offer across health and social care staff for mental health.

Q215 **Chair:** I have a couple of quick questions about the report itself, if I may. We argued that the minimum increase necessary in the annual budget that is put into social care, if we are to cover the Dilnot proposals, the changing demographics and the rise in the national living wage, would be an additional £7 billion a year by the end of the Parliament. I understand that you cannot commit to that level of funding this afternoon, but do you agree with the maths?

Helen Whately: As you rightly say, I cannot commit to that level of funding. What I would say is that in the reform work that we are doing—clearly you have to look at the funding, and the reform of funding as part of it—we are looking at what we should do about what are described as catastrophic costs of care for those who incur really high care costs.

Dilnot is clearly part of the conversation that has been going on for a long time about that. To me, that is not the whole answer. When people say that social care is broken or that it needs fixing, that is not all they are talking about. We are also looking at what we need to do to drive up the quality of care and make sure that people are getting the care they want. Oonagh was speaking a bit about that in the session you have just had. We actually need to look at what people want and need from our social care systems in the future, and our reforms need to support that. It is not just a question of the funding. It is also what systems we want and, importantly, as part of that, making sure that we have the workforce to provide it.

Q216 **Chair:** On the question of what system we want, we heard in our inquiry from both Germany and Japan. They have both found significant extra funding by increasing taxes or increasing premiums on people as they get older. Should we be honest that taxes have to rise? What do you think

generally about the approach taken in Japan and Germany?

Helen Whately: We are absolutely right to look at other countries and how they have gone about it, to see if anyone has the answer as to how best to sustainably fund the social care system. I think we can say that nobody has an answer, and it is not easy. We have to ask ourselves as a society questions about what sort of system we want.

What we need to say is, "Let's make sure that we have a sustainably funded system." Part of that conversation is where the funding comes from. Also, how do we make sure that people have what they want, which is a long and healthy life, and the kind of system that gives care early on and preventively so that people can live the way they want to, with a full quality of life, for as long as they can?

Q217 **Chair:** Let me ask about the workforce. I know you were listening to the earlier session. Do you agree that there is a fundamental problem of accountability if Parliament and the public do not know what the independent projections are as to the number of doctors and nurses the NHS and care system will need in the next five, 10 or 15 years because the Department and the Treasury are sitting on those numbers? As it stands right now, it is impossible for us to know if we are training enough doctors and nurses for the future.

Helen Whately: There was a really interesting and good conversation in the previous session about that. There is a huge amount of complexity. You will know that workforce planning is not a simple thing to do, particularly looking further out. I was involved in workforce planning, before the days of the Centre for Workforce Intelligence, in one way or another. There have been many attempts in the UK and in other countries to come up with long-term workforce plans. I am not saying that it should not be attempted, but it is not a simple job of saying, "This is what we are going to need as a system in 10 or 15 years' time." There are lots of choices involved, and there will be lots of changes in what is actually needed in practice compared with where we are now, but I do not think that should stop us looking longer term.

Another thing that was covered in the previous session is the importance of joining up the plans for the workforce with service planning and financial planning. It is the importance of connecting those things, which is exactly what is going on for the workforce planning as part of the people plan. I know that has been delayed by the pandemic, but again that work is going on and will go on, in order to be able to share the figures—

Q218 **Chair:** That is very important, as you are pointing out, but the problem for us as a Committee is that we just do not know how many doctors, for example, the NHS is going to need in 10 or 15 years' time. It is just impossible for us to know whether we are training enough.

When Simon Stevens came before the Committee, he said he thought it would be a good idea if a body had the responsibility of publishing

independent projections on a regular basis so that it was out in the open what those needs were going to be for the future. Anita Charlesworth said maybe that could become the legal responsibility of HEE as part of the new Bill. Do you think a solution like that could be positive?

Helen Whately: It is an interesting and important conversation to have. I am open-minded about the best way for us to do this. I think there were really good points. On the one hand, you make the case for independence. On the other hand, Rob Smith from HEE talked about the importance of having a close connection between the forecasts and the plans for the service. If there isn't that connection, you might not get a very helpful forecast.

I think you are absolutely right to raise it. It is one of the things that we should be looking at as we come out of the pandemic, which is in any event going to be a moment when we will have to look at our healthcare needs and the health needs of our wider population as well. It has raised huge questions about, for instance, health inequalities. It is a really good moment to take a check on that and be looking further ahead.

Q219 **Chair:** I have a couple of questions for Prerana, and then I will bring in my colleagues. Welcome back, Prerana, and thank you for joining us again.

When we spoke at this Committee in October, there was a bit of confusion about whether the workforce projections that you had been working on, which we know are only one plank of your very important people plan, would ultimately be put into the public domain. Can you give us an update? I know they are not in the domain at the moment, but when the spending review is complete will we be able to see what NHS England thinks is the number of doctors and nurses that we will need in 10 or 15 years' time?

Prerana Issar: Good afternoon, Chair, and thank you for your opening comments appreciating the work of everybody in the NHS.

The starting position, of course, is that we need more people. We need more people to stay and we need more people to come into the NHS. If I may, I would like to answer the question in two halves. The first is what we have done up until now—the piece you have just mentioned—and then what we are thinking about going forward, because everything has changed in the demand picture.

What we had been working on across HEE, as well as in NHSEI, was looking at the long-term plan and some of the workforce implications. It was not complete and there was not yet agreement about what the finalised picture looked like. There were some projections about what professions are necessary, especially for the long-term plan commitments.

For instance, we knew that all disciplines in nursing are absolutely key and that there was a gap, in adult nursing, mental health nursing,

learning disability nursing and community nursing. We also knew that primary care has gaps, for GPs as well as for other workforce and primary care. Linked to the cancer programme, there is a focus on radiography and diagnostics that we have discussed since in terms of the workforce groups most impacted.

Building on what Anita said earlier, it was fragmented and siloed. The interlinkages across some of the workforce groups were still being sorted and discussed. In terms of timeline, this was work going on in October 2019. Soon after that, we were in a pre-election period and then elections. Quite soon after that, we had the pandemic. It was not at all finalised, and some of it was pretty rough in the sense of numbers. There were some areas of focus that I have just shared. As a result of the work on doctors and nurses, the commitment made by the Government was about 50,000 nurses, 6,000 GPs and 26,000 other staff in primary care. That is what we have been focusing on.

The second half of the question is about where we are now and looking at how we align the demand picture as we exit the pandemic, as Rob and the Minister said. People have been working incredibly hard and they are tired. The recovery profile must look at banking some of the beneficial changes and innovations that have taken place, and then the workforce implications.

The last piece is that we need a national picture at profession level, but we also need a bottom-up picture, which the systems will be asked to work on. When those two dock into each other, it will be the most complete picture of workforce modelling.

Q220 **Chair:** Finally, you have a lot of experience working in UN organisations, and in Unilever before that. When you look at our long-term workforce planning in the NHS as one element of what we have to get right if your people plan is to work, which we all very much want, what do you think we need to do better? What are the things that we are getting wrong in our long-term workforce planning?

Prerana Issar: With all humility, let me say that there is nothing quite as skilled and as complex as the NHS, and the kind of impact that the NHS makes in a country. There are not a lot of parallels, but I can highlight two things. One is that we need to make some choices because there are a lot of different scenarios. Prioritisation is absolutely key. It is something that the private sector does well, but profit can be a much more simplifying model than the complexity of the public service that the NHS provides. Definitely some key choices need to be made.

The second thing is the predictability of long-term investment. Anything to do with people, but especially future training, takes a minimum of seven to 10 years. If we are looking at consultant profiles for some of the professions, it is 13 years and more. It is predictability of investment and the choices that have to be made across a large number of stakeholders.

For the workforce modelling that we were doing previously, which was not quite completed, we were talking to more than 300 stakeholders. That is all the royal colleges, HEE, the Department, staff-side representatives and service leaders. It is a large number of people across the workforce. It decides and touches everything.

Q221 **Dr Evans:** My first question is to the Minister. This is a conversation about workforce and workforce burnout. What is your assessment of how the NHS works on good will, both before the pandemic and now?

Helen Whately: First, I know this has been said many times, but it cannot be said too much: I so much appreciate and am so grateful for the extraordinary work that has been done, both in health and in social care, at the frontline during the pandemic. The workforce has gone the extra mile time and time again. It has been incredibly tough for many.

To your question about good will and how much that is part of it, people have a really important sense of pride working in health and, I hope, increasingly in social care—working for the institution of the NHS. A huge motivating factor is knowing that you are doing such an important thing for the people you look after. I know that from conversations I have had with the frontline workforce. I remember very well one with a maternity care team in an acute hospital. The strongest motivating factor was doing a good job for patients. The reason to get up each day and to get through its ups and downs was knowing that you were doing something that was really making a difference for the people that you look after. That is definitely a really important motivating factor.

Q222 **Dr Evans:** Fundamentally, the danger with that is that most doctors, nurses and care workers do not clock off at 5 o'clock if their patient needs them. The problem is when the NHS fundamentally relies on that day on day, week on week and year on year. It starts to create a problem and wears the workforce down. To what extent do you think that exists in the system that you oversee?

Helen Whately: When you have a workforce who are so motivated, that is always going to be a risk, and you need to make sure that the workforce take some downtime to look after themselves. It is an even greater risk at the moment as we come through the pandemic, because people really have gone the extra mile and have worked long shifts. For instance, some people have been unable to take the annual leave that they would usually have taken.

I am working closely with Prerana and the people team on how we support the workforce to recover and recuperate as we come out of this second wave of the pandemic, which has demanded so much of the workforce, to make sure that staff get to take their time off and that they have time out. Some of the things that have worked in the pandemic have been when teams have actively taken steps to take time out to have reflective, structured conversations. The NHS is getting better at using

some of the known good tools for supporting staff through demanding work.

Q223 **Dr Evans:** If it were the airline industry, there would be strict rules in place of what you can fly and how much you can and cannot do. The argument is constantly made to me by clinicians I have met: "Why don't we have something similar here?" There are obviously practicalities over how you get numbers to the beds that are managed, but fundamentally do you think it would be useful to have a legislative framework that says this is what is required and the maximum level you can go to when it comes to making care—with the obvious exceptions of emergencies—so that everyone works within their box? Once we know everyone works within their box, we can see where the gaps are and we know who is accountable for what.

Helen Whately: I definitely think we should continue to learn from other industries. We have already learned a great deal from the airline industry in healthcare, particularly for things that would improve patient safety. We would have an open mind about those sorts of things.

Whether legislation is the right way to go about it, versus taking steps and action at employer level, is something to look into further. The thing that makes the biggest difference for anyone's experience at work is what happens in the organisation they work in, and, even more than that, what happens in the specific team they work in and how they are treated by their line manager, if they have one, and by colleagues. That is all part of the work that Prerana is doing with the people plan. It is looking at the culture. We have to get the culture right at the top, and send signals all the way down. We also have to support every single one of the NHS employers to get the right culture and good management.

Q224 **Dr Evans:** I am pleased you mentioned that because it leads me to my next question. One of the key things is to try to retain staff. We heard from the BMA when they came that there are very few staff who want to take on extra work. It is great that there are pipelines for more nurses and doctors, and we look forward in the Committee to seeing that come to fruition, but how do we get a more productive workforce now, who are currently skilled up and want to take on more work?

I do not know whether you or Ms Issar are best placed to answer this question. What is being done to try to encourage and provide an environment where the current workforce would like to take on more work? I do not feel that practically that is the case. There is stress, and we have heard from evidence to the Committee that that is the case. What can be done to change that?

Helen Whately: I will start, and then, if the Chair will allow, we can bring in Prerana, who will be able to provide far more detail, I am sure.

Through the pandemic, and particularly now as we look towards recovery, we have been thinking about how we support the workforce to recuperate. Everyone would acknowledge that backlogs have built up,

and not as much elective care has happened as should have during the winter. Some less urgent treatments have not been able to take place. There is a build-up of patient care that needs to happen, but we also have to make sure that we look after the workforce who provide that care. The important part of the recovery planning is making sure that the recovery takes into account the needs of the workforce to recover themselves; for instance, to make sure that people take time off or have support, whether it is mental health support or other support, to be able to be at work.

The data is very strong about retention over the last year. For instance, with the commitment to an extra 50,000 nurses, we are in a good place and on track with that. There are over 11,000 more nurses in the NHS compared with a year ago, and the leaving rate has dropped. What we do not want to see is more attrition and going backwards on that. We want to build on that and keep that lower leaver rate and greater retention.

Q225 **Dr Evans:** I would like to bring in Ms Issar. The concern of anyone who works in the NHS is that, prior to the pandemic, they were already working flat out and to the nth degree. Then an emergency comes on for a year, so they are working flat out even further, if that is possible. When is there ever a break, and what can be done to make it a more attractive role to remain in service? As the lead of HR, what are your thoughts on how you are addressing that problem?

Prerana Issar: I speak to and listen to staff on a weekly basis. I have had at least two or three listening events a week since the pandemic began. I recently asked a ITU medic how she was doing. She did not want her name to be mentioned, but I will call her Sapna. She had a mask on, and I had my mask on. I asked, "How are you doing?" Her eyes welled up and she said, "I've seen more people die in the last few weeks than I have in the eight years that I have been a medic." That short exchange brought to life the kind of tiredness people are feeling. First of all, I want to say that it is very much acknowledged, and it has been the focus of my work and my team's work since the pandemic started in March last year.

We have an expert advisory group that I have convened. It has psychologists, psychiatrists, occupational health experts, experts from the military and from WHO. They have been guiding us on staff health and wellbeing throughout this year. On recovery, the focus is three or four key insights on which we are basing our support. One is that recovery is very individual. We will all need to recover in different ways, depending on what our experience has been over the year and what our family situation has been. People have lost loved ones, so it needs to be flexible.

Secondly, we need team processing and reflection time. There has been a shared experience across teams and, as the Minister said, our recovery depends on how supported we feel in our teams. Team debriefs, check-ins and some support for facilitated conversations with teams will be key

for recovery. We have 40 mental health hubs that have been made available. One third are already operational and the rest will be during February and March. They are in every system and they give access to the small percentage of people who have more serious burnout symptoms. There is a multi-professional team of mental health specialists who provide specialised support to our staff. There is a pathway from prevention, self-help, team facilitation, rest and then support for colleagues who need more support.

Having said that, one of the things that Sapna said to me is, "We need the public to back us and we need to know that we have the support of the public, first, in continuing with social distancing guidelines, et cetera, and, secondly, in understanding and acknowledging what NHS staff have been through." I want to bring that message to this Committee. Part of the recovery will be us putting our arms around our NHS and care staff as a country.

Q226 **Barbara Keeley:** Minister, I want to go back to social care, which the Chair was asking about earlier. I understand the point you make about concentrating on the Covid response, but the Secretary of State told us in September that the Government's plan for social care reform had got to quite an advanced stage then, and that was ahead of the pandemic.

Could I ask you about that a little further? Do you expect the Government to put forward a single proposal for reform or, as has been suggested in the past, a range of different options, with the Government maybe not expressing a particular preference for any one of those?

Helen Whately: We have said that we will set out a plan for social care reform. What I tried to do earlier in my answers to the Chair to be helpful was to indicate some of the areas we are looking at. We are looking not only at the very high level of costs that some people incur, but at how we can raise the quality and experience for everybody. Looking at the workforce is part of that.

Q227 **Barbara Keeley:** I see. In terms of reform, which he was also asking about, an outline of the shape of reform might be worth knowing. Do you expect that the Government will plump for one of the particular options? Will there be a range of options and then a debate about it?

Helen Whately: I am expecting us to put forward a plan, but I will also say that something we have committed to, and will do, is making sure there is substantial engagement with the stakeholders involved. That includes providers and, very importantly, those who are users of social care—their voices are really important in this—as well as, clearly, those across parties who have an interest in social care. Something we know is that, when we have such a big and complex challenge as social care reform, we want there to be a substantial level of consensus behind the approach that we take so that it will stand the test of time.

Q228 **Barbara Keeley:** I understand that, but looking for that is what has dogged us all for decades. You mentioned earlier that you are looking into

what people want from social care. That was undertaken by the Labour Government in 2009-10 before the 2010 proposals in a Green Paper and a White Paper. There is the feeling around this that we have been there before.

Do you expect the reforms to involve legislative change above and beyond what was legislated for in the Care Act? Linked to that, when might it come forward? It is an urgent issue now. We all think that after the pandemic and what hit the care sector. People need to know whether reforms are going to be enacted in the next year or so, or nearer the end of the Parliament. Do you think it will take legislative change?

Helen Whately: I do not want to speculate too much. I absolutely recognise the importance of getting on with it. In fact, there is a tension between the ambition for bold reform that addresses and provides a sustainable solution for a long-term and complex problem, which in itself takes time to do properly, versus a need—in essence, a burning platform—and a feeling that we need to do this now. To me, it is not an either/or; it is probably both. That is one reason why the health and social care White Paper includes proposals on oversight and assurance of the social care system as a step on the reform journey. That is something that we plan to legislate on and plan to move on more quickly as a step forward, while some of the reform will inevitably take longer.

Q229 **Chair:** Minister, could you clarify whether that White Paper suggests there is going to be CQC/Ofsted rating of local authorities in their social care provision?

Helen Whately: I do not think I would go as far as to talk about ratings, but what I will say is that there will be a CQC role in working with local authorities. For instance, we want there to be greater support where social care is not of the standard that people are looking for in some areas. We want to make sure that there is, as you would like there to be, more sharing of best practice and, in more areas, for it to be as good as the best.

Q230 **Chair:** Could you write to us on how that CQC role will happen? As you know, the Department has the ability to ask the CQC to go in and look at local authority provision now, so it would be good to know how it is being strengthened. If you could write to us, that would be very helpful.

Helen Whately: Sure. No problem.

Q231 **Barbara Keeley:** One other aspect of the reform is around the pay and conditions of staff. You have touched on the workforce issues, and we are talking quite a lot about those in this session.

It is important to ask how we can change from the social care sector being seen as an afterthought. That came across to us very strongly when we took evidence a little while ago from care staff, both in their pay and conditions and in things like recognition. We changed to Clap for Carers, but we were told by care staff that they did not get the priority slots for shopping that NHS staff did. There were very many aspects

where they did not come off well. They did not even get the badges that you promised them as a mark of recognition. It even got to the point that they were tutted at by people in the street as a possible infection risk when they were wearing their uniforms, which clearly they need to do if they are working in the community.

What specific proposals are you considering to provide sustainable pay increases for social care staff? If we think about the figures that Oonagh was talking about earlier, that is a very important aspect of the reform. How can we sustain better pay increases and better pay and conditions for care staff? Surely, it is the least they deserve.

Helen Whately: There are two aspects to your question. One is recognition and the other is pay. They are clearly related, but I will pick up on both of them separately.

First, coming to recognition, I am doing everything I can, and the Government are doing what they can, to increase recognition and appreciation of the social care workforce. There is a job for the whole of society to do as well. The NHS is such a recognised brand. There is a job to do to get similar recognition for care.

You referred to the care badge. We have been getting thousands of those badges out to people—I am wearing one today—to try to boost that recognition. We also worked with supermarkets during the period when it was particularly an issue to say, "Please recognise care workers. They won't usually have the same ID as an NHS worker, but please recognise that they are also doing really long hours. Please make sure they have the chance to get supplies."

We have been working really hard. I remember there was a moment when Her Majesty the Queen talked about health and social care workers when she spoke to the nation. That was an important thing in its own right. People messaged me from the sector saying, "That was a good moment." I would say there is more recognition of the social care workforce. We have further to go, absolutely.

To your point about pay, members of the Committee will know that there is not a direct parallel between the NHS and the social care system. Those working in social care are mainly working for private sector organisations. They are not generally public sector employees. Their pay is not set through the same pay process as we have for the NHS workforce. A substantial part of the funding for social care comes from people paying for their own care. The other part of it is, indeed, from people who are state funded. That is one reason why we are rightly increasing the funding that goes into social care at the moment, and we need to look at the workforce as part of the reform.

In the earlier session, Oonagh Smyth talked about some of the levels of vacancies in the social care sector. We have seen those vacancy rates fall during the pandemic, but I would like them to fall further. I would like

there to be lower turnover in the social care workforce. I would like to see social care staff having real opportunities for career progression, qualifications and all those things. For me, those are things that we need to look at and are looking at as part of the social care reform, rather than something that we can just press a button on here and now.

Q232 **Barbara Keeley:** Could I come back to you on what you are saying? Many local authorities have managed, through their commissioning role, to set pay through care charters that say, "It will not be lower than this," but we still have a quarter of our staff on zero-hours contracts, and some of them are not even being paid the minimum wage. It does not seem to me that HMRC even chases up on care staff not being paid a minimum wage. There could be an awful lot of action to get better and more sustainable pay and conditions for staff. In the end a care badge is nice, and we should have got them out to all the 1.3 million staff, but it does not pay the bills. Pay and conditions is the major issue.

Helen Whately: I would agree with you that the badge is not the answer. It is something we have done to try to increase recognition of the workforce. I should say thank you to Care England for developing the brand in the first place and letting us take it on.

Yes, I absolutely want to see better terms and conditions for the workforce. I have already tried to be really clear to local authorities that where I hear reports, for instance, of care workers not necessarily always being paid the national living wage—for example, where travel time might not be paid—that just is not right. Staff should be paid for the travel time between appointments—

Q233 **Barbara Keeley:** But HMRC could follow up on that. It is not just local authorities. Cash-strapped local authorities cannot entirely take on the role of policing the care sector. HMRC could follow up on low pay, if they are getting less than the minimum wage through not being paid for travel.

Helen Whately: If an employer is not paying the national living wage or minimum wage, according to age of the workforce, that is against the law and it should not be happening. This does not feel like the right place to have the conversation. What I want to get to is beyond that, where we have a care workforce who have opportunities for career progression and a good and rewarding career. That is the thing that I hear, for instance, talking to colleagues in DWP and work coaches about how we can support people who are looking for jobs now to get into social care.

What we need to do is more than that to make the work attractive to people. We must make it clear that it is not always about working in a care home. Oonagh mentioned that there is a real breadth of jobs in social care. As I say, we want to make sure there are more career progression opportunities.

Q234 **Dean Russell:** Thank you, Minister, and thanks as well to all the staff

who have been doing incredible work over the past year and longer.

My questions relate to mental health, a little bit on volunteering and a bit on digital, if I may. They are broad but connected. In the first instance, on the mental health side of things, I am keen to understand what measures are in place at the moment for measuring staff morale. How is that translated into people taking up the mental health support that has been offered over the past year?

Helen Whately: It may be, if you are happy, that I bring in Prerana to give more detail on that. First of all, it is something in which I take a great interest, and I feel very strongly that we should be hearing quite regularly and formally from the frontline workforce on morale, along with having informal conversations and qualitative input. I make sure that I speak to frontline NHS and social care workers all the time.

In a more structured way, there is the annual NHS staff survey on the NHS side, which will report soon. There is also the pulse survey, into which a sample of NHS staff provide regular input. Measuring morale and what people are concerned about is really important, but at least as important, and in fact arguably more important, is making sure that we act on it. That is something I am determined we do at a national level, drawing on what we learn from the staff survey, for instance, and these other sources. Local teams and local employers also need to take a regular rain check on how their staff are, and act on it too.

Q235 **Dean Russell:** Prerana, do you have any figures or data that you could share?

Prerana Issar: Indeed. As I mentioned earlier, staff health and wellbeing has been our absolute No. 1 priority since March last year, specifically related to the pandemic. We stood up a national health and wellbeing offer, with our advisory group sharing with us the end-to-end pathway that they recommended. They also asked us not to over-medicalise the support that we were offering, as well as changing a bit of the help-seeking behaviour. Research shows that health and care professionals are the last to seek help for themselves. That is something that we really focused on in communication: "It is okay not to be okay." We asked team leaders to role model the accessing of support.

I am reading some figures so that I am absolutely accurate. In March, we set up the offer for health and wellbeing apps. The way that the apps are set up is that feedback is in-built. When we go on to WhatsApp, they say, "How was this call?", or whatever; the apps ask that as well, so we were getting a constant stream of feedback about how they were helping and what else people needed. We added apps as we went along.

In April, we launched a website that has been accessed more than 400,000 times. Again in April, we added a bereavement support helpline with the Samaritans. It is 12 hours a day. We added a text support helpline, which is 24 hours a day, all free and accessible to care professionals, health and care staff. We then added a coaching offer for

primary care staff. We added a suicide prevention app. In May, we added virtual common rooms. I am saying that we added every month because it was through the feedback from listening to staff who were taking up the offer. We got themes from the Samaritans helpline about what was on people's minds. There were virtual common rooms so that people could leave a stressful situation, come in and talk about what was on their mind.

There was online yoga and support from the Association of Christian Counsellors. Faith is such an important part of so many of our lives, and places of worship were not accessible. We set up online support for our staff. We set up support for working parents and carers. The number of carers in the NHS is already high, and it went up exponentially with lockdown. We set up support for that.

In July, we commenced the people pulse that the Minister just mentioned, where 114 organisations across the NHS do a monthly pulse. Not every organisation does it every month, but we get a dataset every month. I want to highlight two headline figures. One is about feeling supported and feeling anxious. The second is the difference for BAME staff and the experience they were having.

Feeling supported had a high of 68% during the first few months that we were tracking it. It started dipping from November onwards and is now at 62%. It is still at 62%. Feeling anxious was at a low of 29% in the summer and autumn, and it is now at 40%. We have seen feeling supported come down a little bit and feeling anxious go up. We used that feedback to augment our offer and our communication. All of this complements local offers of support. Taking that data, we launched the mental health hubs in November, and they have been coming on stream. We have a bereavement support service for Tagalog speakers, for our Filipino colleagues, and an app curated by the BAME communities.

The other statistic and datapoint that I want to share from the people pulse is that there has been a difference in the experience of BAME communities. There is usually about a 10 percentage point difference on the negative side in whether BAME staff feel anxious or supported. I have listened to and talked with BAME staff network leads every six weeks since the pandemic began. Some of the additions to our helpline and our health and wellbeing offers have been informed by them, as well as the 1 million risk assessments that the NHS undertook between May and September last year, and continues to keep current. The risk assessment idea came from the BAME staff networks I was hearing from. Of course, mitigating action was taken for BAME staff.

Q236 **Dean Russell:** It would be great if you could submit that data, the up-to-date data as you get it and those statistics, please. I would love to hear more of the details, but I am conscious of the time.

I have a few other points. We often talk about the workforce, and often people think of that being the doctors, the nurses and the social care

workers, but it goes much broader than that. There are obviously the porters and the cleaners, and support for them. More broadly, I mentioned to an earlier witness that I have been very fortunate to volunteer for the past year at my local hospital, and I have seen the real power of volunteers. Minister, when we are planning for the workforce, moving forward, how much have we included volunteers in the numbers and in the support that they can provide?

Helen Whately: You are absolutely right that we should think broadly about the workforce. One of the positive things I have heard from talking to our teams during the pandemic is how some of the silos in the workforce have been broken down, and how people are working together. Who you are and what your job title is has become much less of a thing in an organisation that is traditionally pretty hierarchical. That is something we should be able to draw on and make more of as we come out of the pandemic.

You are absolutely right that volunteers do fantastic stuff in the NHS. We have also seen a surge of interest in volunteering to support the NHS. Thousands of people are coming forward to help with the vaccination programme. We saw thousands of returners—people who have worked in the NHS—coming back to support the workforce during the pandemic as well.

We need to look at all of these things as we go forward. One thing is looking at how we can continue to involve those returners—for instance, those with clinical skills—as well as the important things that volunteers do. On the social care side, something I am always thinking about is our unpaid carers. The employed care workforce say that they feel they are an afterthought compared with the NHS. I hear that even more from unpaid carers who do such an important job for those they care for. We need to think about everybody involved in care when we look at our future system.

Q237 **Dean Russell:** One of the things I am really conscious of is the technology over the past five years. We heard from Prerana about the importance of technology with regard to apps and tools for mental health.

How much does workforce planning tie into the use of technology to free people up? I have done some work in a maternity office, and the elastic bands are thicker than I have ever seen because everything is in folders and files. It takes so much time for people to do paper filing rather than what they could do in no time online. Has that been factored into planning over the next 10 or 20 years?

Helen Whately: I will say yes, and Prerana may be able to say more. Broadly, absolutely yes. We know that, where you get technology right, you can save people's time and give your healthcare professionals more time to spend doing the thing they are trained to do, which is providing patient care, and doing less of the form filling. You can also make patient

care safer if some things are automated. Using technology, there is less risk of entering data wrongly, and things like that.

There are huge opportunities with technology. We have also seen many things with healthcare that have usually been done in person being done virtually. That is not the answer for everything, but there are opportunities. We have seen greater use of technology on the social care side; for instance, care homes are able to do remote consultations with a GP using a device, and there is not necessarily the need for the GP to come in person to the care home. There are definitely opportunities. As we build the recovery plan, we need to look at how we make the most of those opportunities. That, in turn, makes the most of the workforce too.

Dean Russell: I will hand back to the Chair because I am conscious of everyone's time. Thank you so much, both of you.

Chair: Time is marching on a bit. We will move to Paul Bristow.

Q238 **Paul Bristow:** Minister, I believe that training and career progression can be a real incentive for recruitment to the social care sector. This Committee heard evidence of how, in other systems—I think in Denmark—people were able to transfer between social care and the NHS quite fluidly and easily. What is preventing us from doing that in the UK, do you think?

Helen Whately: There are two things to pick up on. One is about training and the other is the crossover between the NHS and social care workforces. First, I want us to give the social care workforce more opportunities to train and develop their careers. It is something that we already do to a certain extent. One of the things that has happened in the pandemic is that care workers have built up their skills in many areas. Infection prevention and control is one obvious area. At times, they have taken on tasks that were previously done by, for instance, district nurses. District nurses have coached care workers to do some of the things they did, when, for infection control reasons, we were trying to avoid having anyone going into a care home who did not need to.

We have seen some interesting and good progress that I would like to build on. As we look at the reform and our future workforce strategy and plans, there is a point about how we can have a stronger crossover and interaction between our NHS workforce and the social care workforce. There clearly already is some; for instance, there are nurses who work both in social care and in the NHS. We get that with other care workers as well, but we can do more and it will be a helpful part of joining up the system.

Q239 **Paul Bristow:** I am glad you mentioned training up staff to do roles that were previously the sole responsibility of more senior colleagues. The past two decades have seen tasks that were reserved for doctors, such as prescribing rights, given to nurses, pharmacists and allied health professionals. That has benefited patient access and lowered cost, but only 10% of nurses and midwives, for example, have prescribing status.

Should we be increasing that, and how can we increase those numbers and reduce pressures on doctors' time?

Helen Whately: You make a really good point. Having the workforce we need for our health and social care system is not just about saying that we need so many nurses and so many doctors. It is also looking at the skills that people have, making use of all their skills and seeing where people can step up and go further. You have described exactly some of the roles where you have prescribing nurses. My view is that it is something we should continue to look at as we look further at the opportunities for workforce reform in an incremental sense. There is more to do, in essence.

Paul Bristow: Prerana, do you have any comments on how we can transfer tasks that were previously done by doctors to other clinicians?

Prerana Issar: In the work we are doing on creating the demand picture going forward, one of the key things we are looking at is how skill mix and multi-professional teams will be part of the future of bringing the demand curve for a registered workforce into a different space. The demand for healthcare and the supply of registered healthcare professionals does not meet anywhere in the future for any country in the world. One of the ways we need to think about that is how the right roles are going to be done in the right places, and question some of the assumptions and some of the ways those tasks were done in the past.

One example already happening right now is how the vaccine is being delivered. I was at a general practice surgery in Croydon, which is one of the bigger centres for vaccine delivery. They have minutely looked at their workflow. Each task is done by the appropriate person. Intervention by the medical and nursing staff is very little, and absolutely the task that nobody else can do. For instance, the jab is being given by a team of receptionists who have been trained as medical assistants. They are giving the jab. I met this team of wonderful women who said that the best part of their career so far was being able not only to call the patients and talk to them about the vaccine, but then to give the jab as well. Seeing it in practice, we know that we need to do a lot more.

Q240 **Paul Bristow:** That is super to hear, because you are reducing the protectionism in the system.

I have seen huge disparities statistically in applicants for specialist training courses. Particular training courses such as neurosurgery are massively oversubscribed, whereas others are not having that benefit. In the NHS we have a centralised pay system. Other than pay, what can we do to fill specialties that are not getting a large number of applicants?

Prerana Issar: I do not have all the figures in front of me. There are two or three different types of disparity. One is what you have described. The second is geographical areas that are underserved. Then there are parts of our society that are not getting a route into some of the specialties that we are talking about.

There are underserved communities, both in the sense of being patients as well as being part of the workforce and the registered workforce. We need to address a multitude of disparities. Having the demand picture and the long-term workforce modelling that the Chair has been highlighting will be part of the solution. Overall, there are gaps in most professions. The task will be bringing up the ones that do not get as much attention, but I do not have first-hand knowledge of each of those professions. I want to make sure that I am giving a full and accurate answer.

Paul Bristow: I do, but I will not bore the Committee. I will hand back to the Chair.

Chair: Thank you, Paul. Last but not least, Sarah Owen.

Q241 **Sarah Owen:** I am going to direct these questions quickly to the Minister because I know that we are short of time. In the first panel, we heard that we are about 100,000 carers short. That is not an insignificant number. Sickness levels have shot up during the pandemic from 2.8% to 6%. That is being covered by existing care workers either working longer hours or not taking annual leave. In terms of burnout, it is a huge issue. How do you feel that we are going to be able to recover from this period of significant workload on care workers?

Helen Whately: It is a really important point. We have seen sickness levels follow the waves of the pandemic, as you would expect. We are seeing them come down again now. One of the steps that we have taken as a Government is to fund providers to make sure that they are paying full pay to staff who have to isolate for Covid reasons. That is a really important thing that we have done, to make sure that nobody should suffer financially for doing the right thing and isolating.

Q242 **Sarah Owen:** Are you confident that that money is getting to the care workers who are off sick?

Helen Whately: From what I am seeing, the majority of employers are paying it. I would not say it goes as far as 100%. We have provided £1.1 billion of infection control funding to go towards that, and we have given a very strong steer on it. As I tried to say earlier, there is clearly a difference between the way the NHS and social care work. They are different systems, so that reflects it.

The other thing we have done is to set up a workforce capacity fund. Some £120 million has gone to local authorities to help them help care providers have extra staff, whether it is people who have experience working in social care but are not working in social care right now, or getting new people to come to work in social care, or those who at the moment are not doing all the hours for whatever reason. That is extra funding that we have provided to boost the workforce through this difficult time.

You are right that something we are looking at, just as we are for the NHS, is what we can put in place to support the recovery of the social care workforce. There is mental health support and things like that, but we are looking at what else we can do, recognising the really tough time the workforce has been through.

Q243 **Sarah Owen:** I appreciate and welcome any extra funding coming into social care, but we can all recognise that it is a drop in the ocean in terms of the funding gaps that exist within the care system already.

In our first panel, we talked a bit about overseas recruitment and the need still for overseas recruitment to fill our vacancies. Do you think it is right that overseas care workers should have to pay the immigration health surcharge and continue to pay for the health services that they prop up and support?

Helen Whately: As I am sure you know, Sarah, NHS staff have been made exempt from the immigration surcharge—

Q244 **Sarah Owen:** Well, only for the pandemic and they are able to reclaim it, so they are not exactly entirely exempt, and it is not something that has been forthcoming. Do you think that might be a barrier? It is one of the things that we heard in the first panel might be a barrier to international recruitment, for example. I think it is an acute problem for care workers in particular, who are lower paid.

Helen Whately: Let me pick up two things. One is the international recruitment point for the NHS, particularly, and then in social care. On the NHS side, we are absolutely committed to increasing the workforce, and that is happening with nurses, doctors and others. For the increases in nursing numbers, on the one hand we are boosting the home-grown workforce. We have had a fabulous surge, both in students starting nursing degrees last year, currently in training, and in applicants for nurse training this year; we have had nearly 50,000 people apply to be nursing students. There is a real boost to the home-grown supply, which is fabulous.

We are also still seeing, which is quite remarkable in the light of the pandemic, strong levels of international recruitment for nurses to come and work in the NHS. That is really important because it is boosting teams here and now. Training up new nurses clearly takes time. That is going well, but I continue to keep a very close eye on it to make sure that it continues to go well.

On the social care side, something that is absolutely clear, and the Migration Advisory Committee was quite clear on it, is that the long-term answer to our social care workforce is not to continue to have people come here as migrants to work in our social care system. We need to make sure that working in social care is attractive and rewarding to those who are already living in the UK. That is an important ambition for the social care workforce. That is what social care careers should be. One thing that I am working with DWP on is to say, "What do we need to do,

so that those who are looking for jobs right now want to work in social care?" We have seen a fall in social care vacancies, but there is absolutely more to do.

Q245 **Sarah Owen:** Having been a care worker, I know that it is a really tough job and it is not for everybody. Not everybody is suited to being a care worker. That level of vacancies—100,000 vacancies—is not going to be solved overnight. We heard from experts in the previous panel who said that we are not going to be able to solve that problem without international recruitment.

You talked about wanting to recognise staff, wrap your arms around them, claps, badges, Queen's speeches, and improving terms and conditions. Could this be one term and condition that could be improved, alongside ensuring, as my colleague Barbara Keeley mentioned, that carers get the national minimum wage?

Helen Whately: When I talk about terms and conditions, what I am talking about is, for instance, making sure that staff get sick pay for isolating with Covid; making sure that, to the extent that a proportion of social care workers are on the national living wage, they are paid the national living wage; and having proper progression and opportunities for the workforce. I was having the conversation with Paul earlier about recognising some of the skills that the social care workforce have gained. We have seen care workers take on more tasks, and that should be recognised as well.

Q246 **Sarah Owen:** Then they should be remunerated for the additional skills. If the Government are truly recognising and valuing a workforce, such as carers in particular, do you think it is right and justifiable for care workers to pay the immigration health surcharge, as I asked just now? You did not answer.

Helen Whately: The answer I am giving on that is that we want to make sure we have a home-grown social care workforce.

Q247 **Sarah Owen:** So you do not want any international care workers coming over to this country?

Helen Whately: I would not want to be misunderstood on this. Across our health and social care system, we absolutely value those who come to the UK to support our health and social care workforce. We hugely value the input and work of international recruits, but in terms of reducing the vacancies and the gaps in the social care workforce, our focus is on encouraging and supporting those in the UK to take on those jobs.

Q248 **Sarah Owen:** I do not think you have really answered the question. It is one of the issues that came up in the panel before. It was highlighted as a barrier. It has been highlighted as a barrier to me by staff at my local hospital who are really struggling. Senior nurses have had to go to food banks. They have had to borrow money from other nurses to pay for

either visa costs or the immigration health surcharge for their children.

Helen Whately: I would not want anybody working in our health service to be struggling financially in that way, but I do not have a different answer I can give you from the one that I have already given you.

Sarah Owen: Which was not really an answer, but thank you.

Chair: That brings us to the conclusion of this panel. We have had a very wide-ranging discussion. We will now take some time to put our report together and make our recommendations. Thank you very much indeed, Minister and Prerana Issar, for joining us this afternoon. I think you will not be surprised by the themes that emerge when we publish our report. They are really important, because they underline every other report we do. They seem continually to come back to workforce issues and workforce pressures. Thank you again for your time this afternoon.