



Select Committee on the Long-Term Sustainability of the NHS

Corrected oral evidence: The Long-Term Sustainability of the NHS

Tuesday 1 November 2016

10.10 am

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Members present: Lord Patel (Chairman); Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Baroness Redfern; Lord Turnberg; Lord Warner; and Lord Willis of Knaresborough.

Evidence Session No. 12

Heard in Public

Questions 129 - 134

Witnesses

I: Professor Alan Manning, Member, Migration Advisory Committee; Professor Ian Cumming, Chief Executive, Health Education England; Professor Wendy Reid, Director of Education and Quality, Health Education England; and Danny Mortimer, Chief Executive, NHS Employers

USE OF THE TRANSCRIPT

1. This is an corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of witnesses

Professor Alan Manning, Professor Ian Cumming, Professor Wendy Reid and Danny Mortimer

Q129 The Chairman: Good morning. Thank you for coming today to give us evidence. We have a rather long morning today, with several evidence sessions, so we will try to keep the questions and answers brief and to the point, because there are a lot of issues we want to explore with you.

This session is being broadcast. Committee members will declare any particular interest that has not been declared before in a written statement. If you have a statement you want to make or say anything before we start the session, please do so. Otherwise, can you introduce yourselves?

Professor Alan Manning: I am Alan Manning. I am a member of the Migration Advisory Committee and a professor of economics at the LSE.

Professor Ian Cumming: Good morning. I am Ian Cumming. I am the chief executive of Health Education England, the body responsible for education, training and development of the current and future workforce of the NHS.

The Chairman: I do not know you at all, Wendy.

Professor Wendy Reid: Lord Patel, I am Wendy Reid. I am the medical director and director of education quality at Health Education England. By background, I am a gynaecologist.

The Chairman: Yes, I know Professor Reid because she is an obstetrician.

Danny Mortimer: Good morning. My name is Danny Mortimer. I am the chief executive of NHS Employers. We are the organisation that represents the NHS in England on workforce matters.

Q130 The Chairman: Thank you very much. Do any of you have any statements you want to make? No, so I will kick off. Obviously, you know that the workforce has become a major issue. This Committee is looking at the future sustainability of health and social care in England, where workforce planning for the future is the key issue. It is right, I think, to say that, hitherto, we have never got workforce planning right, so we are relying on you to tell us what part you have been playing to get this right.

What work is being undertaken on the long-term planning over the next 15 to 20 years for the health and social care workforce, and how far ahead is the current planning looking? How much planning have you done in the headcount which will be required, particularly with all the rhetoric about the seven-day NHS, and what that would mean for future workforce planning? What other organisations, apart from you, are responsible for thinking about long-term planning for the health and

social care workforce? We have heard evidence about not only the problems in healthcare workforce but serious problems in the social workforce. Who would like to start?

Professor Ian Cumming: If I may, I will disagree slightly with your statement that we have never got workforce planning right. The bit that we have never got right is the correlation between workforce planning and service planning. The workforce that our predecessors in strategic health authorities planned for is what has been produced. The challenge has been that the NHS has changed very quickly. As a result of Mid Staffordshire, for example, the NHS suddenly needed an extra 25,000 nurses in the space of two years. That is why we have a shortage of nurses at the moment. It is not because the numbers that were being planned for at the time were wrong but because there was recognised to be a serious issue with the quality of care being delivered, which required a large increase in nurses. If you require an extra nurse, I can produce one for you in four years.

The Chairman: So you mean that there is no joined-up thinking between the service providers and you?

Professor Ian Cumming: No. The joined-up thinking is there, but things happen which take the service in a direction that is perhaps unexpected, which could be the impact of new technology or a different way of providing healthcare. The plans many years ago assumed a much greater shift of delivery of healthcare from hospitals into the community than has actually happened. The workforce plans that our colleagues and predecessors in strategic health authorities put together were based on that higher level of care delivery in the community, and that pace has been much slower. Therefore, the workforce plans matched the service plans, but the way in which care is delivered has not run in line with the service strategy.

Danny Mortimer: I would echo the point that Ian has made, and would actually go slightly further on the planning problem that we have had. The mismatch has been between the financial assumptions that the NHS has been forced to make and the service assumptions that it makes as a result, and then the workforce plans to support that.

My last job was as a director of strategy in an acute hospital in the Midlands and, within two years, we had closed 100 beds because that is what our commissioners had told us we would need to do—that they would manage demand and reduce demand for our services. Two years later, we had opened 150 of those beds, because actually the service plans had not been delivered. The financial assumptions that sat behind them totalled up, and workforce and service planning became a product of a figure at the bottom right-hand corner of the spreadsheet, but actually it was not realistic. I know that one thing that you are wrestling with is that longer-term financial settlement for the NHS as well as for our colleagues in social care. That uncertainty around that financial planning drives some perverse decisions around services which, in turn,

has meant that we have made some mistakes in workforce planning as well.

Lord Kakkar: I declare my interest as chairman of University College London Partners. To be clear, to ensure appropriate long-term workforce planning, what needs to happen to the rest of the planning in the NHS?

Professor Ian Cumming: As Lord Patel has said, you need to make sure the service and workforce planning are properly joined up, so we need commissioners' intentions aligned with those who will be delivering the service, aligned with workforce planning. We also need to recognise that workforce planning has to be a very long-term strategy. The question that Lord Patel asked was about the next 15 to 20 years. Of course, medical students entering university this year will become consultants in about 13 to 15 years, so the plans we are making at the moment on the numbers entering medical school will not have an impact on the workforce until 2030-31.

We have produced a document called *Framework 15*, which takes a 15-year forward look, specifically designed around the medical workforce, to ask what we believe patients' needs will be in 15 years' time, and how we make sure that we are training doctors and other healthcare professionals to work in that timescale and not training people to work in the health service that we have today—because it will look very different.

Lord Kakkar: If you have that document, where does it go now and how does it influence what the medical schools are going to do with their intake from next year?

Professor Ian Cumming: It is available and is being shared with all our partners. It was produced last year. We have not produced paper copies of it, because it will be wrong, because nobody can accurately predict 15 years ahead. So we are updating it on an annual basis, reflecting changes that happen, and we share that with medical schools. As part of our responsibility, we fund the clinical placements for undergraduate medical students and, through doing that, we make sure that we have those clinical placements in the right areas where we need them to get the geographical spread. With the recent announcement by the Secretary of State of up to an extra 1,500 medical students, we are now working with colleagues in the Higher Education Funding Council, the DfE and the Department of Health over how we place those to make sure that we produce the medical workforce we need for the future.

Lord Willis of Knaresborough: I declare an interest as a consultant working for Health Education England. It seems to me that we build in automatic inflexibility in that we commission on the basis of what we see now and we expect those people, in seven years in the case of a doctor or four years for a nurse, to deliver a care pattern which is going to change radically over that period of time. The one area that you have not spoken about, particularly with medics, is the fact that the royal colleges trump virtually everything you say, because they have responsibility for saying what these medical students actually do. Where are we going to

get the flexibility into the system to deliver a much more proactive workforce, both of medics and nurses?

Professor Wendy Reid: We have tried to influence it through the young people leaving medical school, so we have radically changed the foundation programmes. For the first two years that doctors spend after graduating, 45% of them now are doing a psychiatry job, which was not happening before. In the old days, it was six months' medicine and six months' surgery and then you were out. Everyone does a general practice attachment and everyone has to do an emergency or acute medicine attachment, so we have already changed the mind-set of those young people leaving medical school. The questions we ask are about preparedness to work, and they are expecting to work for two years in a very different environment.

We work very closely with the colleges. For example, one of our biggest investments, and a sea change in surgery, will be the work that we will pilot from 2017-18 onwards on the new acute emergency general surgeon. It is a six-year, coherent programme. So the colleges are prepared to look at the needs of patients, and we can facilitate that.

The Chairman: Do you think that our model of five years at university, followed by two years of foundation, followed by a decade of training is an old model that requires thinking out of the box a little?

Professor Wendy Reid: Yes.

The Chairman: So why do we not do it?

Professor Wendy Reid: I think we are doing it. The Shape of Training, under David Greenaway, proposed a generalist approach. The way to do that is to engage the medical profession and deliver it collaboratively. If we try and force the medical profession—

The Chairman: Why do we need to engage with them? Why do we not just do it?

Professor Wendy Reid: Lord Patel, of all people, you know that collaboration is better. You are talking about sustainability. We want people to feel that this is real. Many of us have done pieces of work that sit around, over or on top of the medical profession—for example, the Hospital at Night project, which I led. What we want is coherent leadership from all branches of the medical profession. Therefore, things such as the Search project and the work we are doing with the Royal College of Physicians to create the chief resident model are the ways in which you change it. It is not particularly glamorous, but it is good, thought-through work that is grounded on what patients need, and we sit in the middle of those conversations.

Baroness Redfern: First, I declare that I am a leader of a local authority. I think that you mentioned a shortage of 25,000 nurses, or the full-time equivalent of that.

Professor Ian Cumming: No, the increase in demand for the NHS in a two-year period was 25,000 over and above the normal demand. We train about 22,000 nurses a year. That big surge in demand for nurses is what we are now trying to catch up on, with the commissions coming through the system.

Baroness Redfern: Of those, how many fully trained nurses do you lose when they go on to be bank nurses?

Professor Ian Cumming: I do not have that figure. We know that there are approximately 550,000 nurses on the nursing register in England, of whom about 100,000 are not actively working in healthcare. Those are the figures of registered nurses in this country.

Baroness Redfern: I am just trying to look beneath those figures.

Baroness Blackstone: I want to talk about medical education and the issue of flexibility. Why has there been so little pressure on medical schools to provide more places for graduates? There are a huge number of graduates with science degrees wanting to study medicine, and their opportunities for getting on to a four-year course are very small because there are at least five to one applicants to places. What are you are doing in your discussions with universities to get more of them to introduce four-year courses? You would then get people out into the medical workforce a bit faster and save good graduates from the frustration of going back and starting right at the beginning.

Professor Ian Cumming: There are a number of issues here. Undoubtedly, some of the four-year courses for people with a first degree have been very popular and have produced very high-quality doctors at the end of them, because they are people who have a different perspective when starting the course. Certainly, as we get into allocating the additional 1,500 places, we will want to look at a range of models and not simply at how we increase the number of 18 year-olds entering medicine. As we move through that consultation, we expect to have a significant debate about that and potentially other areas, possibly including part-time medical degrees for people who are already working in a different profession in the healthcare system.

There are a number of challenges in making sure that the course can be completed in four years and that people get the necessary levels of exposure, but a number of the courses at the moment have demonstrated just how well that can be done.

The Chairman: But in the United States they do it in three years, and there is no evidence that their doctors are any worse.

Professor Ian Cumming: But we also have some challenges around accessing student loan funding. If you have accessed student loan funding for a first undergraduate degree, you cannot then access it for a second undergraduate degree, so it makes the funding route somewhat trickier as well.

Q131 Bishop of Carlisle: You have already mentioned some of the factors that are driving the need for change in the workforce, such as the quality of care and the emphasis on care in the community, and a brief mention was made of technology. I wonder if we could develop this a bit and think about some of the other factors that are driving this need for change and some of the things that are making it very difficult to take those on board.

Professor Ian Cumming: In answering that question, perhaps I could deal with the point that Lord Patel asked about—workforce planning over the next 20 years. I have certainly started talking about producing the future workforce. The first thing that we have to remember is that the majority of people who will be working for the NHS in 20 years' time are in employment at the moment, so more than 50% of the people who we will have delivering care are actually our current employees. One mistake that we must not make is just to focus on the future workforce, and people coming through the education and training system. If we are to deliver transformation, we must focus on the people whom we currently employ, and I do not think we have given that enough attention. That is why perhaps the pace of change has not been as quick as we would like it to be. In looking at how we do that, we need to properly pick up issues around multi-disciplinary and multi-professional learning. The global drivers of change affecting how healthcare is delivered are the economic situation; the impact of the genomic revolution on the delivery of healthcare; the impact of informatics, which is going to be absolutely enormous on how healthcare is delivered over the next 15 to 20 years; and the demographic changes, both in the population and the workforce, as people are having to work potentially through into their 70s. I would argue that those are the four biggest drivers of change that we are going to see in that 20-year period. We need to make sure that we do not allow those to happen and then seek to respond and that we are actually proactive in preparing the workforce for each of those challenges.

The Chairman: Wait a minute. That is the completely wrong thinking, is it not? How a doctor whom you have trained, who comes out of a medical school, or a specialist whom you have trained, who comes out six years later, practises then bears no relation to how they might practise 20 years later; they pick up developments, as they occur.

Professor Ian Cumming: They do.

The Chairman: How can you plan for future developments, when you do not even know what they will be, for the workforce?

Professor Ian Cumming: We know what some of the changes are going to be. On the impact of genomics, for example, we have been ensuring that all undergraduate curricula for all healthcare professionals have a genomics component within them, and that is something that would not have happened otherwise. Yes, it is there in medicine, but it will not impact only on medicine—it will impact on all allied health professionals.

The other issue is how we prepare people to be more responsive to change. There is plenty of published evidence that shows that new technology and new ways of doing things take about 15 years to be in widespread use and adopted across the NHS. I would argue that we do not have 15 years, and that we need to increase the pace of that, which is where more of a focused emphasis on education and training for the current workforce will help to speed it up.

Bishop of Carlisle: Do you think people are taking this seriously enough at the moment?

Professor Ian Cumming: Yes, I do. However, when money is tight, sometimes, in some organisations, the education and training budget is seen as an area that can be easily diverted into spending on direct patient care. I completely understand that, but part of our responsibility in our organisation is to make sure that we keep that focus on education and training so that we can speed up the pace of delivering change and on doing things more efficiently.

Lord Warner: You are bound to be blown off course from time to time, in that timescale. Whose job is it to ensure that there are some contingency plans, if you do get blown off course, and whose job is it to ensure that the existing workforce do retrain, rather than it just being wishful from HEE?

Professor Ian Cumming: To answer the second part first, it is a joint responsibility. Continual professional development and lifelong learning are an individual's responsibility, an employer's responsibility, and our responsibility with others in producing the sort of NHS that we want and the people with the skills that we need. So it is a three-way responsibility.

To break that down into a specific example, we have been doing some work on dementia awareness and work on genomics awareness across the whole of the NHS and the current workforce. An individual maintaining their professional registration and the CPD that they require to do that is an individual's and an employer's responsibility, but they come together in those specific areas.

We are supposed to be more strategic when it comes to the current workforce, but we respond by providing educational material and programmes, if needed, on a big scale. Through our organisation, working with colleagues such as NHS Employers, NHS Improvement and NHS England, we have local workforce action boards that sit at a more local footprint level. They would help to determine the needs of the workforce in specific local geographies, and we fund them to be able to deliver some of those activities on a more local footprint.

Overall, the responsibility for setting our mandate sits with the Department of Health, which would hold us to account for delivery against that mandate, which would include regular monitoring against those areas.

Lord Warner: Where are the contingencies? You cannot possibly believe your own plan for 15 years ahead, as you are bound to be blown off course. Whose job is it to deal with that? Is it yours, or is it somebody else's?

Professor Ian Cumming: It is our role to ensure that the NHS has the workforce that it needs for the future. The challenge, of course, that we are dealing with at the moment is the change in the system. The last ever commissions made by Health Education England for nurses and AHPs have now started at universities, with one or small exceptions. From next year, Health Education England will not commission any undergraduate places, because the funding transfers to the Student Loans Company and universities will be marketing their own courses and programmes. Our role will change significantly from being a direct commissioner to an organisation that has responsibility for market management and market intervention when our intelligence suggests that we may be short of podiatrists or nurses or whatever it may be.

Professor Wendy Reid: I will give a very specific example of the sort of just-in-time contingency planning. We are aware of the welcome focus on mental health; there is a real lack of perinatal psychiatrists, so we have agreed the NHS England funding with the college and have found 10 psychiatrists who are willing to be credentialed and skilled up in perinatal mental health. They will be out in the system far earlier than if we had started a learning programme to train them from the beginning. So we can respond, and indeed have responded, to specific service needs with collaboration across all parties.

Lord Mawhinney: I go back to Baroness Blackstone's question about training the 1,500 new students and the possibility of graduates. Given that Professor Reid is here, I should admit to having taught in the Royal Free Hospital School of Medicine a number of years ago.

Professor Wendy Reid: I remember it well, Lord Mawhinney.

Lord Mawhinney: When you went to the Government and said, "You are restraining our ability to produce better doctors because you will not allow medical students access to loan funding a second time around", what did the Government say?

Professor Ian Cumming: We have not specifically had that debate with the Government. The issue of the 1,500 medical students came about as a result of being asked a specific question: if England is to be self-sufficient in the production of medical students, how many do Health Education England believe we need? Currently, we have a gap between medical school output and postgraduate training input of about 500. Predominantly, that falls in general practice, where we have a gap this year of about 250, plus in psychiatry and one or two others. We currently import about 1,000 doctors a year from other countries into postgraduate training. That is where the 1,500 came from.

The Chairman: But the first part of the question was important. If

nobody has a conversation with the Student Loans Company about graduates going into medicine and getting a loan for the second degree, it is never going to happen.

Professor Ian Cumming: Certainly, that is something we would be interested in exploring—the ability for people to take out a greater student loan. But we also have to recognise that the level of debt that an individual student would then incur would be very large indeed.

Lord Kakkar: I would add a further interest, as Professor Reid has mentioned it. I was a member of the Greenaway review panel and, until a few weeks ago, a member of the General Medical Council. What relationship does HEE have with the regulators, and how could the regulators develop in future to ensure that the flexibility that Lord Patel mentioned could be achieved in the adaptation of the workforce?

Professor Ian Cumming: We have a very close working relationship with all the regulators, particularly the GMC because we deliver postgraduate medical training that is regulated by the GMC and we undertake a number of joint inspections and joint accreditation of postgraduate medical education training. On undergraduates, three parties are involved in somebody becoming a doctor. There is the medical school itself, which is responsible for delivering the education, academic standards and awarding the degree. There is the GMC, which is responsible for patient safety—that the doctor who is going on to the medical register at the end of their degree is safe to do so. Then there is our role, which can best be described as: are we producing people who are fit to work in our NHS of the future, because we know that 95% of our graduates are going to work predominantly full-time in the NHS? We are responsible for the workforce of the NHS and making sure they have the skills they need, the universities for the academic component and the GMC for patient safety.

Q132 **Lord Kakkar:** I turn to the question of the United Kingdom leaving the European Union, focusing on two things. What kind of planning has taken place with regard to the potential shortfalls that might occur in a very short period of time in the health and social care workforce, with that particular move? What consideration is being taken in recruiting from non-EU countries or, indeed, as you have alluded to, the development of home-grown candidates?

Danny Mortimer: Both the Department of Health and the arm's-length bodies, Health Education England and others, are pulling together processes that take forward the planning that you described. For ourselves, as employers, we have convened a coalition across health and social care, with statutory and non-statutory organisations, charities and others, trade unions included. That coalition is about 31 strong, and working together to understand the implications across health and social care, across the 2 million or so people who work across health and social care.

Our initial analysis suggests three things. First, we accept that there is much more that we can do domestically. The organisations we represent, particularly in the NHS, are probably the largest employers in any single community or part of the country, and there is clearly much more that we can do to provide opportunities, particularly to young people, to work in our services.

Secondly, those 150,000 staff who are EU nationals working in the NHS and in social care need indefinite leave to remain. There is no way that the NHS or our colleagues in social care could provide sustainable services without the input of that 6% or 7% of our workforce. There is geographical variation in that, so it is 10% or 15% of the workforce in London and it is less in other parts of the country, but that is essential to us.

Thirdly, as employers, along with trade unions and others, we want to see a system for managing migration policy that is flexible and responsive to skills shortages. We have touched in the discussion this morning on the need for contingency, and some contingency will be needed there. What that cannot be, we accept, is the “get out of jail free” card that the Migration Advisory Committee has rightly criticised us for playing in this last few years because we have not planned our services properly or planned our workforce properly. We need sufficient flexibility, as do other sectors of the economy—we accept that entirely. We need to see a more thoughtful process on migration, which does not necessarily just look at salary as a measure of value and contribution to the economy, which present migration policy does at times outside the EU, but looks at social benefit and contribution to the health and wealth of the country.

Professor Alan Manning: I would make a few points. First, the share of EEA workers in health and social care is lower than the national average, so this is not actually a sector which is hugely exposed. Health and social care disproportionately employ non-EEA nationals currently, many of whom become British citizens but were not born here.

It is also important to distinguish between the stock and the flow. A lot of talk is about whether people already here are going to be asked to leave, and there is uncertainty and anxiety around that. The mood music is that restricting future inflow is more where things will happen. Even in that case, as the inflow gets restricted, probably the outflow will go down, so actually you end up with a larger stock. One should not exaggerate the consequences for health and social care of further restrictions on the EEA. It is hard to plan for, because there is uncertainty at the moment.

When we did the nurses review six months ago, we found that quite a lot of NHS employers very much preferred non-EEA nurses over EEA nurses. They had experimented with employing Spanish nurses, but they found that, because they had free movement, they could move from one trust to another, and the salary differentials between here and Spain are much smaller, so they tended to go home. To a non-EEA nurse from India or the Philippines we are offering them a lot more money than they could

make at home, and they do not have freedom of movement within the UK, so a trust that has paid the cost to hire them gets to keep them and gets the return from them. That is currently the situation.

The Chairman: So they are bound workers, are they?

Professor Alan Manning: I think that is a slightly emotive phrase. They do not have freedom of movement—

The Chairman: That is bondage, is it not?

Professor Alan Manning: It is a form of it, yes. In all countries, typically, migrant workers have fewer rights to change employers than other workers.

The Chairman: Yet we need them. They fulfil our need, so we have them in bondage. Is that what you are saying?

Professor Alan Manning: No. I think that is a slight exaggeration. We are also offering them, in many cases, a higher standard of living than they could have. Hopefully, there is mutual advantage in this. They are free to move if they can find another employer to sponsor them, so they are free in that sense. But it is a practical matter, and the evidence suggests that they are much more likely to stay with the employer who initially sponsored them.

Professor Ian Cumming: From our perspective, we believe that, as the fifth-largest economy in the world, we have a moral duty to produce the healthcare workforce that we require for our National Health Service, and we should not be reliant on recruiting from other countries. That is absolutely not the same as saying that we do not welcome the opportunity for people from other countries to come and learn here and work with us. In the same way, we strongly encourage, through the Global Health Exchange, which is part of our own organisation, people who have trained in this country to go and spend some time overseas to learn a different skill set and to have experience with different pathologies. We strongly encourage and welcome that flexibility, but it has to be from a starting point that we believe that we are training enough.

There are 15% more nurses entering training this year than three years ago, and we have the 1,500 extra junior doctors starting. But we also have to recognise, as Danny has touched on, that many of the people who are delivering hands-on care are at the less highly qualified level—the healthcare support workforce. So it is about how we make sure that we attract people from our own country into those jobs, in the health and care sector. Some of the initiatives, such as allowing people to train from nurse associate through to registered nurse, which Lord Willis will be familiar with, while working for us—giving people a different training route—will encourage more people to pick up on some of the areas where, in future, the same supply of people into those caring roles may not be available.

Baroness Blackstone: What Alan was saying is all very well, but you have to look also at the specialist end of the NHS. At the hospital that I chair, 25% of its medical staff are EU nationals, and they come because they want to come to an institution that is doing high-end research. They are the brightest and the best, and they are from European countries. If we were to cut off that kind of mobility, we would certainly be losing out in the quality of our medical and indeed our nursing workforce.

Danny Mortimer: We could not agree more. Clearly, there is a very important aspect of healthcare in this country, particularly related to research and academia, which is part of a global market. We want the very best of our people to be able to go and practise and learn abroad and colleagues from across the world to come and practise in this country, so that there is mutual exchange of benefit. There is a real risk that we, unintentionally perhaps, might lose some of that. But you are right that there is a complexity in different areas of our workforce, in its interface with the global market.

Baroness Blackstone: You understand that, but do the Government?

Danny Mortimer: I think they do. Clearly, there is a huge reset of policy following the referendum result, but there is an understanding of that. We are all, clearly, awaiting the outcome of the Brexit discussions and what the new settlement will be in migration policy. As the professor touched on, there is uncertainty in this period, both for the people who are here already and for people who may be thinking about coming and working in our institutions in future. What we all want is a reasonable end to that uncertainty.

Q133 **Lord Willis of Knaresborough:** What we are trying to do here, rightly, is to look ahead to roughly 2030. The fundamental question for all of you is whether you feel that, given the current state of our policies, we will have a sufficient workforce in 2030 to meet the demographic and other needs that you identified earlier. I need just a very quick yes or no.

Professor Ian Cumming: Yes, with caveats.

Lord Willis of Knaresborough: Let us explore a caveat. I will concentrate mostly on nursing and the care workforce. Despite all the conversation that has gone on in the Committee this morning, virtually no mention has been made of this huge workforce. The majority of the people working within the NHS are nurses, allied professionals and care workers. Yet in nursing, we see a move to the DfE commissioning them through the university and the UCAS system and a new move to employers commissioning them through the apprenticeship levy and grants. HEE has no control over those, because employers from now, provided they can get them on to the register, can actually have all their nurses going through an employment route—or, in fact, universities can recruit independently. Given that scenario, how can we make any clear prediction about a workforce in 2030?

Professor Ian Cumming: That was one of my caveats. We need to look at the impact of the Student Loans Company moving into the market, as that starts to play out. Certainly, there are no indications at the moment that we have picked up that any universities intend significantly to reduce the number of nursing places for next year. In fact, a number of universities are talking about significantly increasing them. Overall, we have no evidence for next year that the number of places will be reduced. Of course, what we do not know about is the impact on applications, because those are still working through the process at the moment.

What we have done—as you will be familiar with, Lord Willis—is to build alternate routes to nursing. One of those that we are exploring is, effectively, the apprentice route. We do not want to move away from, or dilute, the degree-level registered nurse qualification, but we believe that there are different ways that people may be able to gain that degree. Entering as a healthcare support worker, completing a care certificate, which we introduced about 18 months ago, as a standard assessment of competencies for a healthcare support worker, progressing on to a nursing associate training programme, which will last about two years—we have just announced the first 2,000 places on those programmes—and then continuing from that to being a nurse, while working and studying at the same time, we believe would open up an alternate route. That could access the apprentice levy and build a separate pipeline, in addition to the degree-level programme that people will continue to follow.

As to how we deal with any potential market challenges—for example, if somebody does decide to reduce the number of nurses—we are retaining clinical placement funding for nurses and AHPs. We are consulting on how to do this; we intend to work with the NHS to use that clinical placement money to incentivise particular geographical areas, particular professions or particular specialties, if we start seeing that there is a reduction in one geographical area or particular profession.

Lord Willis of Knaresborough: Danny Mortimer, do you have concerns, as employers, about this new fluidity, which is coming into this key area of supply?

Danny Mortimer: Starting with the second question, we believe that the approach is being introduced quite quickly, which is a concern for us; the political decision has been made, and it is being introduced very quickly. However, on balance, I think that employers see opportunities for a better quality of supply. The specific concerns are around the choices that might be made. For example, will we see a massive growth in paediatric nursing and not enough people applying to be mental health nurses because, if they cannot get a place on a paediatric course, they may choose to pursue a different path? In nursing, we have relied on people having second or third careers, particularly in mental health nursing, and we need to make sure that we maintain some of those things. On balance, I think people think that there are some opportunities there.

On your first question, and whether we have confidence in 2030, the honest answer is no, we do not. It comes back to our original discussion. If we continue to have a situation where there is active disinvestment in social care and the health service is having to expand its services to compensate as a result, we will always be developing plans based on false assumptions. We need to have some better settlement of how we fund and plan health and social care services together so that we can properly plan our workforce across health and social care. I do not think we have ever resolved that properly. The STP process that we are currently embarked upon is the best attempt there has been in my 25-year career in the NHS, but we need to see that come to fruition.

Lord Willis of Knaresborough: Where I think you have singularly failed, both as employers, as well as the Department of Health and now Health Education England, is in looking at this issue of the levels of attrition, which would be unacceptable in any business. I cannot get any figures from anyone. Even though it is part of the mandate, I am still not given any figures in attrition from training courses, which HEE is pouring money into, and the universities will not give them to us, other than through HESA which you have to pay for. If we do not have this data about what is happening to the workforce, when they go on to the register—I am talking particularly about nurses—there is no way of knowing how long they stay or why they leave. We cannot have this leaky bucket syndrome whereby we pay £79,000 to recruit somebody and train them and we do not even know what happens to them afterwards.

The Chairman: This is an important question, so do we have the figures?

Professor Ian Cumming: We can certainly give you all the figures for attrition from higher education right the way through. We cannot give you the figures for employment, because we do not keep those in HEE, but we have the figures for attrition from higher education and we can give you those.

The Chairman: So you will be able to give us those figures?

Professor Ian Cumming: Yes.

The Chairman: You said that you cannot give the figures from the employers' point of view. Are the employers able to give those figures?

Danny Mortimer: There are some data available of turnover and attrition, but we do not track where nurses go between employers, whether they move between the NHS and social care, for example, or the NHS and the private sector, or whether they leave caring entirely and pursue other things. We do not necessarily know how many choose to join a bank or an agency or whatever it may be.

Lord Willis of Knaresborough: But it matters.

Danny Mortimer: I accept entirely that it matters. That criticism of how we track and understand the investment that we are making in those people is a very fair one. I also accept entirely that there is much more that we need to do in retaining the workforce that we have, but there are also examples where actually the competition for our people is really fierce. For example, one of the areas that we have had recent problems with is around paramedics. Paramedics are fantastic clinicians with a really good set of skills. Many of them have been recruited to work in programmes set up by the DWP to assess disability because they have such a fantastic set of clinical skills. The NHS never planned for that and the HEE did not know that the DWP would start to recruit our paramedics so actively, so there are other things going on as well that we need to understand.

Lord Warner: I have been sitting here listening to this, and it sounds all very reassuring. In London, on your own figures, the shortfall in sub-medical is enormous. The same story is coming out of social care. This is the hub of economic development in this country. What are your game plans for dealing with London? We know that the attrition rates are appalling, so what is your game plan for 2030 for London?

Professor Ian Cumming: Perhaps it will help reassure the Committee to know that on our current projections against employer demand and the people who are in the system at the moment—just to stick with nurses—we will have a surplus of between 25,000 and 80,000 nurses by 2020. That is on the basis of people currently going through training programmes and the demand that the NHS is currently saying it needs. If that demand changes, those figures will amend, but we are seeing a surplus. That is not evenly distributed geographically, as Lord Warner correctly says, and London is a particular challenge. For example, the figure for all non-medical jobs that are vacant in the NHS across the country is about 5.3%. Last year, that was 7.1%, so we are moving in the right direction. But the figure for north, central and east London, for example, is 15%, so we are seeing a very significant distortion in certain parts of the country. That is to do with the fact that a lot of people like to train in London and then move elsewhere and with other economic factors, not least of which are the cost of housing and the cost of living, and people wanting to move elsewhere to settle down and bring up families. That will be a consistent challenge.

We are working with NHS Improvement and other organisations to look at issues, and Jim Mackey talked to a committee recently about affordable housing in London for people, but it is a real challenge. It is one of the challenges that the London Ambulance Service repeatedly talks to us about, as it describes somewhere in the region of a 20% vacancy for paramedics, whereas, for example, in the West Midlands the figure is all but zero.

Danny Mortimer: I have two very quick points to make. We have done a piece of work with our trade union colleagues and employers in London, the details of which I can share with the Committee. We have made some

very specific asks of the Mayor, which relate to affordable housing and the prioritisation of that for NHS staff, as well as on transport costs in London. We are seeing NHS staff moving further and further out of London, as the average cost of a house now in London is about 15 or 16 times the average salary of a nurse, which is completely unaffordable for them. So those things have to be tackled. We will provide some information to the Committee.

Professor Alan Manning: We need to recognise that London weighting, which has not changed greatly, is simply too low at the moment. Saying you are going to deal with the problem by affordable housing is putting the cost of dealing with it onto the people who provide the housing rather than putting the cost on to the NHS. At the very least, it needs to be considered whether pay levels are sufficient to attract, recruit and retain staff in London. It would seem that they are not.

Baroness Redfern: Following on from Danny about how tracking is really important, particularly when staff leave, can I just focus on workforce development and planning? Do you think that is fully embedded in the STPs, or is there not enough focus on that?

Danny Mortimer: I think the focus is increasing. There is some variation across the 44 different areas, but the structure that Ian has described where the localities are being brought together to look at the workforce implications and plans—

Baroness Redfern: So you think there is more work to be done to enhance that?

Danny Mortimer: There is more work to be done, yes.

The Chairman: Who is responsible for looking at the long-term needs of the workforce in social care?

Professor Ian Cumming: We are not, so it is not a responsibility of Health Education England. The Department of Health has a responsibility and other organisations, such as Skills for Care, which works closely with the very large number of private employers in social care. But there is not an organisation like HEE for social care.

The Chairman: Is that a disadvantage?

Danny Mortimer: Yes, it is absolutely a disadvantage.

The Chairman: So what would you suggest be done?

Danny Mortimer: One thing that we are learning through the coalition that we formed around the post-EU settlement is that we share a lot of common interests with our colleagues in social care. But there needs to be an overseeing organisation with a mandate to intervene, if necessary, as Ian and his colleagues do, in equivalent terms for the social care workforce. It is such a fundamental risk area, frankly, for us as the question we are wrestling with over the next 15 years.

Q134 **Baroness Blackstone:** What is your key single suggestion for change that this Committee could recommend, which would support the sustainability of the NHS?

Professor Alan Manning: If one is focusing on long-term sustainability and the workforce side, I worry that pay gets determined as a residual. There is a bit of temptation to think, "This is the health service we would like to provide, this is the amount of money we have been given and, therefore, this is what we can afford to pay our workforce". In the long run, you have to pay your workforce what makes these professions attractive to recruit and retain them, given the other choices that people have, and you cannot control how much those other choices pay. I think that is why, over quite a long period, the NHS has gone through cycles of boom and bust in which short-term financial pressures, which I am sure are terrible to deal with, lead to a short-term approach to the workforce issue. That is what I would think about—that you have to pay your workers sufficient to make this an attractive career for them, relative to the alternatives that people have in the long term, and not exploit their ability in the short term.

Professor Ian Cumming: This is a one and a half answer because the answer has to be a continued focus on producing a national health service and not a national sickness service, so what more are we doing about prevention, what more are we doing to get upstream with the inexorable rise in diabetes, et cetera, because that is proving to be the biggest single financial challenge we have in the NHS, so that is the half.

Moving on to the actual, I am very privileged in that I travel a lot around England in this job and I see best practice all over the place. We have to find a way of bottling that best practice and disseminating it, stopping this resistance to somebody else's idea being adopted and embracing, in particular, the end of paternalism in the delivery of healthcare.

The Chairman: How?

Professor Ian Cumming: By investment in education and training for the current workforce—and it is not necessarily about money; it is about time. We have people so busy doing their day job that we never give them the time to think about how they could do it differently, and how they could step back, redesign and take on board things that somebody is doing elsewhere in the country. That, for me, would be the number one thing to do, along with using technology in a different way.

Professor Wendy Reid: I will not repeat what Ian has said, but, if we do not start valuing and developing primary and community care, the overwhelming push into the acute sector will continue. I would like to see parity of esteem and the focus of professionals being on primary and community care, to stop this divide.

The Chairman: Do you think our current model of primary and community care is ideal for the long-term sustainability?

Professor Wendy Reid: I think it is a good model when it works well, which goes back to Ian's point. When you see it working well, in an integrated fashion, with local authorities, social care and, indeed, the acute sector, it works really well. But that is not what we see everywhere.

The Chairman: Anecdotally, it is all right, is it?

Professor Wendy Reid: I think there is evidence that, when it works well, it works very well, and it is where the majority of patients and public contact exist.

The Chairman: Your answer to Lady Blackstone's question?

Danny Mortimer: If there is to be a long-term plan, there needs to be a single plan for health and social care.

The Chairman: Thank you very much for coming today. If you have any other material, apart from the figures you are going to send us, please feel free to do so and we will gladly receive it as evidence.