



# Select Committee on the Long-Term Sustainability of the NHS

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

Tuesday 8 November 2016

10.05 am

Watch the meeting

Members present: Lord Patel (The Chairman); Lord Bradley; Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Evidence Session No. 15

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Questions 150 - 157

### Witnesses

[I](#): Candace Imison, Director of Healthcare Systems, Nuffield Trust, Dr Graham Willis, Head of Research and Development, Workforce Analysis, Acute Care and Workforce, Department of Health; and Professor James Buchan, School of Health Sciences, Queen Margaret University.

## Examination of witnesses

Candace Imison, Dr Graham Willis, and Professor James Buchan.

Q150 **The Chairman:** Good morning. I am extremely grateful to all of you for coming today to help us with our inquiry. We are looking forward to your evidence. Although we have some questions, feel free to say anything else you wish to add. It would be helpful before we start if you will introduce yourselves, and if you represent any body please say so. If you want to make an opening statement, please also do so. During this session, members of the Committee may well declare their interests before they ask their questions.

**Professor James Buchan:** Thank you and good morning everyone. My name is Professor Jim Buchan. I am a professor at Queen Margaret University in Scotland, the country just north of here.

**The Chairman:** We know where it is, yes.

**Professor James Buchan:** Most of the work I have been doing recently has been international. I spent a couple of years working in Australia for the federal Government Health Workforce agency. More recently I have been working as a consultant to various organisations such as the World Health Organization, World Bank and, within England, mainly with the Health Foundation.

I was aware that I was able to make a brief statement and I have three short points that were very much in my mind when I received the invitation. Obviously much of the focus on sustainability is driven by the recent funding and financing issues. We are all looking at a sector that is labour intensive, and the reality is that it is partly about money but it is really about workforce and staffing. Therefore, the sustainability of funding is also about the sustainability of the workforce. We can look at the demand side and look at population growth and population complexity driving the process, but the solutions very much have to come from the workforce side.

On that basis I have three points. First, if you look around the world there is, generally speaking, a correlation between how much countries spend on health and the size of the health workforce in relation to population. A few countries vary, but generally speaking that holds. That does not mean that the country has the best workforce or the workforce with the right skills or that qualifications are in the correct place.

I know you are looking today at the skill mix, and probably my main message would be that we need to look at building the current workforce, enhancing its skills and enabling it to work effectively in teams. I am saying that against the background of recognising that according to the Council of Deans of Health we are currently looking at a reduction in CPD budgets of somewhere between 13% and 45% for the current workforce.

I cannot see how we can improve and enable skills of the current workforce against that type of funding cut.

Thirdly, there are challenges in planning and health workforce planning in the UK, but the reality is that the government policymakers in England have their hands on more policy levers when it comes to health workforce than in virtually any other country. We fund health professional training. We employ virtually all health professionals when they are in place. We decide how much to pay them and up to a point we decide where they should work. The policy levers are there if the Government of the day wish to use them. Part of that is obviously also about the level of funding given to the NHS.

**Dr Graham Willis:** Good morning. My name is Dr Graham Willis. I am head of research and development in the workforce analysis branch at the Department of Health. Prior to that, six months ago, I was also head of R&D in the Centre for Workforce Intelligence. I believe that some of the work we have been doing is of interest to the Committee. It might be helpful to lay out the background to our thinking at the CfWI. The approach we are taking is that we are dealing with a complex and large health and care system. We know that. We have tried to avoid trying to forecast workforce supply and workforce demand. Instead, our approach was to think more about the different ways in which the future might unfold in order to understand the forces and factors driving it. They are going to be different today from what they were six months or a year ago, because they are constantly changing.

We then develop a set of scenarios for the different ways in which the future might unfold. You can think of those as plausible but challenging. Once you have that idea you can use it to test your plans, your policies and your options to see how they perform across this range of futures, and hopefully to create an option that is robust in the sense that it works best across that set. I think this gives you a broader range of insight, because you will see that some futures are more desirable and some are less desirable; some you might have control of and you can use levers in, as Jim was saying, and some you cannot. It is about recognising that trying to predict 15 to 20 years ahead is going to be very difficult. A better approach is to think about the uncertainty of the future, use scenarios to stress test your ideas and then strive for robustness rather than perfection, because there is no perfect solution.

**Candace Imison:** Good morning. I am Candace Imison. I am director of policy at the Nuffield Trust. I have a long-standing interest in workforce in a policy context which began when I worked at the Department of Health where I led their contribution to the Wanless review on the workforce. That modelling, maybe for the first time, tried to include skill-mix changes. I worked with Anita on that. I then worked at the King's Fund with Jim on a review of workforce planning. We looked internationally at that, and what it really tells us is that workforce planning is a very difficult thing. No country gets it right, but I would support Jim's point that this is about thinking about it in a much broader

way than predicting numbers; it is about managing the whole workforce. Also at the King's Fund I did a major piece of work looking at future trends, and again we thought about the future of the workforce. Since coming to the Nuffield Trust, we have done a major review of the opportunities relating to skill-mix change.

As an opening comment, I would echo Jim's welcoming of the fact that you pay good attention to the workforce because without it there is no healthcare, so it absolutely fundamental. Recognising that we are not alone in the challenges that we are facing with the workforce, I was really struck by a chief executive of a big chain of German hospitals who said that we are moving from an era where we are competing for patients to an era where we are competing for staff. The pressures that we are facing are felt across the board. There is a rising concern about whether staff are equipped with the necessary skills. A big OECD review looking at the workforce recently said that we are seeing a shift from a focus on numbers to skill mix. That, again, would underline the need to develop the skill mix in the current workforce.

My final point is to recognise the current productivity challenge, which, while you may see it as a short term issue, is a very real threat to the long-term sustainability of our workforce. We are seeing threats to morale and numbers across the piece that will not be easy to repair. The raiding of the workforce training budget in order to support revenue budgets I see as a very short-sighted and very risky manoeuvre.

**The Chairman:** Thank you for your opening statements. Of course they have prompted questions that members of the Committee may wish to ask you. I know Lord Willis wants to ask a question, but I hope he will hold his fire until he gets to his question, because your statements have raised some issues. I am going to pick up on one of them now. I would like to know what you think are the workforce issues that are the greatest threat to long-term sustainability. This is about looking into the future. I hear what you said, Dr Willis, that it is difficult to predict what is required in the future, but we need to know with some degree of certainty how many, who and how we should train people to provide the workforce that will be needed. I also hear that other health services also have this problem, and while I hear that I have to say that it is not our problem. We need to fix our problem. So that cannot be the excuse for not trying to get it right. On that basis, who would like to pick that up?

**Professor James Buchan:** The starting point for future assessments clearly has to be: what is the likely demand for healthcare going to be? In that regard it is possible to have a greater degree of if not precise accuracy at least a direction of travel against which you can then match funding and workforce. It is apparent, not just in the UK but in most high income countries—OECD countries—that population growth, population ageing and more people living at home are all pointing not just to a growth in demand for healthcare but to a growth in types of complexity of demand, home care, chronic disease, musculoskeletal, et cetera. You

can put approximate numbers against those, and you can with some degree of certainty look ahead at what that means.

The bigger unknown is how much funding is going to be allocated to try to meet those needs and how you translate that into workforce. One of the points I made in my introduction is that I would be concerned if the focus of skill mix and workforce planning were just calibrating that we need more of the same. A recent example of that is the announcement of 1,500 more doctors to be trained. I am not aware of what the planning behind that assessment has been, but meeting that from current budgets means that there is an opportunity cost somewhere in the form of what will not happen because of that decision. Therefore, it is not just more of the same, but equally it is not just looking at introducing new roles or new types of worker as the solution.

The NHS has not had a good track record over the last 20 years in introducing and enabling the effective use of new types of worker. The physician's assistant is one example. Another is the associate practitioner. We are now hearing about nursing associates being introduced. Having spoken to people and read what is going on, my understanding is that the introduction has not been very effective so far.

Guiding yourself between those two problematic areas, just looking at more of the same or just focusing on new types of worker, a lot of the emphasis has to be on enabling the current workforce to be as productive as it can. That is, in part, about looking at enhancing its skills, enabling it to work more effectively in teams. I am aware that in some ways that is a low-tech solution and perhaps not one that is so attractive to Governments, because you cannot pronounce it so easily on the front page of a newspaper. However, if we do not put effort into those areas, the real concern is that we will be using the limited funding in the least effective manner, not just for workforce growth but for workforce productivity increase.

**Dr Graham Willis:** I will pick up on the comments that I made earlier about uncertainty. This does not mean that you cannot plan, but when we do our modelling we see that demand changes across the workforce groups, and for some workforce groups in the future we see a much bigger rise in demand than for other workforce groups. That would give you a focus of attention. We also see the rise and the changes being more uncertain in some areas for some workforce groups and less uncertain in others. You can use this to think about which workforce group you should focus your attention on. They might be the ones where we see the biggest growth in demand but are perhaps the most uncertain about how big that growth is. It is a way of focusing your attention.

**The Chairman:** Give me some tangible examples. If you were looking at what workforce we may require in 2030, both in healthcare and social care, what does your model tell you?

**Dr Graham Willis:** That leads us onto the Horizon 2035 modelling. Would it be helpful if I start explaining that?

**The Chairman:** Yes, please.

**Dr Graham Willis:** In Horizon 2035 we were asked to look at the whole health and care system, which is health, social care, public health and informal and voluntary care. That is the whole system involving about 11 million people if you include 5 or 6 million people in informal care. We looked at it to answer the question: how might skills change in 20 years' time, and what does that tell us for policy? We developed a framework to think about how skills might evolve in the future. We looked at a number of different sources of demand that were driving those skills, i.e. long-term physical conditions, long-term mental health conditions, learning disability and acute oral health. There are about seven or eight different categories.

We know what the workforce is doing today and we mapped that to a skills framework. When we run the model we see that the demand for skills changes in the future. We see some workforce groups having a much larger increase in the demand for their skills than others. It is very polarised around the lower level of skills, so the largest increase is around informal care, level 1, which is basically unskilled. The skills increase for all groups, but it is much bigger for level 1 and level 2, which is some small training. It decreases as you go up the skill levels. We see that about 90% of that demand comes from an increasing and ageing population. It is driven particularly by long-term physical conditions, which is the biggest driver followed by long-term mental health followed by learning disabilities. Taken altogether, the overall picture shows an increase of about 35% between 2014 and 2035. We are using 2014 data; we do not have the up-to-date data.

**The Chairman:** Is this workforce in healthcare, not in social care?

**Dr Graham Willis:** It is the whole lot.

**The Chairman:** So it is a 35% increase from what it was in 2014.

**Dr Graham Willis:** Yes, across health, social care and informal care—a whole system increase.

**The Chairman:** What does that look like in numbers?

**Dr Graham Willis:** We have to do an translation, which we do not do again through a forecast. We quantify some of the parameters we need for our modelling by getting expert panels together and they tell us what they think the answer is, but they also tell us how uncertain they are. We ask them to think about where the future might be but we only use that as a kind of reference point. We have created a set of scenarios and we ask them to quantify the range of scenarios. We have a spread of uncertainty here, 35% in terms of skill hours, which is the unit of currency that we use in the modelling. It is not numbers of workforce; it is an hour that a skilled professional is using to deliver a service. It is an increase of over 3 billion skill hours, which is roughly equivalent to 2

million FTE people. That is across the whole system, which includes informal care.

**The Chairman:** Some 3 million full-time equivalent people.

**Dr Graham Willis:** It is 3.5 billion skill hours, but equivalent to about 2 million FTE people across the whole system, which includes informal care.

**The Chairman:** Roughly you are saying that this is not a tablet of stone, but from the models it looks as though we will need 2 million more people working full time in health and social care by 2035.

**Dr Graham Willis:** You can use the term "work", but of course some of these people are informal carers, so it is not paid work.

**The Chairman:** Is that not work?

**Dr Graham Willis:** It is not paid work in that sense. Also, the population is increasing in that same period. I think it is about a 14% increase in population from 2014 to 2035, which is roughly 7.8 million.

**The Chairman:** That will depend. Candace, do you have any comment?

**Candace Imison:** The point I would like to get across about future sustainability to leave in the Committee's heads is the degree of skills mismatch that we currently have in the workforce. A very powerful study was done across the whole OECD that showed that 51% of doctors and 43% of nurses felt they were underskilled for what they are currently doing, whilst 76% of doctors and 79% of nurses felt that elements of their role were overskilled. That tells us that our roles are not designed correctly for the skills of the staff that sit within them. There is a major challenge going forward in understanding what skills are needed in a role and then being much more intelligent about aligning staff to that.

Another worrying point is that, of the healthcare support workforce, nearly 20% have said that in this country they are being asked to do things beyond their scope of competence. There is a big role redesign piece there and that comes back to the need to have adequate money to invest in training and development of staff and really understanding what those staff need. A classic example would be what we are currently expecting junior doctors to do. This is not good training for junior doctors, and often does not result in good outcomes for patients either. We have not adequately thought about the roles in hospitals to deliver good outcomes for both staff and patients. I would commend that as being something to take away.

On the workforce planning piece, when you look across the challenge of workforce planning not enough attention is played in understanding the current position. Workforce plans tend to take the current position and roll it forward rather than thinking about how we get the current position to be the place that we need it to be. As Jim said, when we have done skill-mix change in the past we have tended not to do it very well. We have tended to layer roles on rather than, coming back to role design,

thinking about how the whole team works. Often you find that roles that were hopefully substituting end up supplementing. As I described earlier, support workers are left doing things that are beyond or below their competence, because the team does not understand what each other's roles are in care.

**The Chairman:** Thank you very much. Before I open the question up—Lord Willis, Lord Warner and Lord Lipsey have supplementary questions—Dr Willis, you gave me a figure that included unpaid workers, the carers.

**Dr Graham Willis:** Yes.

**The Chairman:** Can you give a figure that is solely based on paid employed people, and what that number will look like in 2035?

**Dr Graham Willis:** I do not have that figure in my head, but we have it from the models.

**The Chairman:** I would be very grateful if could let us have it.

**Dr Graham Willis:** Yes, no problem.

**Lord Willis of Knaresborough:** I should declare my interests, as we have been asked to do. I am a consultant for HEE and the Nursing and Midwifery Council, and I chair the graduate apprentice nursing implementation programme and the Yorkshire and Humber collaboration for leadership in applied health research and care.

Professor Buchan, I was particularly interested in your opening comments, and one that you slipped into your opening comments, about the amount of CPD resource that is actually available, given that roughly 50% of the current workforce will be operational in 2030. At the moment, somewhere in the region of 90% of a roughly £5 billion budget is spent on medics on their training and continuous professional development in order to operate. That, in many ways, answered Candace's comment that at least they have an opportunity constantly to be up to date through that programme.

However, the amount of money spent on the bulk of the workforce—the nursing, midwifery and other allied health professionals, forgetting the care assistants just for the moment, which is another huge issue—is incredibly small, yet that has been cut by between 10% and 40% in some cases. What is your solution to that? There is a large pot of money, which is being allocated in a traditional way yet needs a constant change in order to move it forwards. I would be very interested in the panel's view on how we shift that money.

**Professor James Buchan:** There are two elements that I would suggest need to be given more consideration. First, my experience as to how the current budgets are allocated is not dissimilar to yours. It tends to be historical and it tends to be targeted at certain groups. It is not driven very much by identification of needs for training as set against our skills deficits or what the new skills that are required to deliver healthcare are

going to be. We need to look at how we can turn that around so that the budget allocation is driven much more by training needs assessment. That has to be across the workforce, partly because of the issue you have raised about whether or not there is currently fair allocation. But, more importantly, there is a need to look at allocating this funding so that it encourages team-based working.

The second question is: is the relative size of that budget compared to other funding streams appropriate given the level of challenge in improving the skills of the current workforce? To my mind that leads to the answer that we need to look carefully not so much at reducing it but probably at increasing it.

**Lord Warner:** I declare my interest as the Minister responsible for workforce planning 10 years ago, so probably some of the disastrous decisions I took then have led to where we are now. However, I would question whether in reality we have quite as many levers in Richmond House.

I would like to explore this 2 million more care workforce people or full-time equivalents. At the moment there are only about 3 million paid staff in the health and social care workforce, so how much of that 2 million is, as the Chairman asked, equivalent to the 3 million that we currently have as paid workforce? You may not have these numbers to hand, but we also need to know what the numbers are at the higher levels—the doctors—and at the level of the nurses and the scientists. Dare I say it, we also need to know a bit more about the managers, those much-maligned people who on the whole make a lot of these systems work. Is your system for Horizon 2035 going to give us that kind of data? What we say about that paid workforce is going to be very different from what we could say to the Government about the unpaid workforce and the role of families. If we have that data, that will be critical to the Committee's work.

**Dr Graham Willis:** If we were to plot the data on a graph as to where that 2 million goes, the line on the graph would go up. On the left would be the lowest increase at the highest level of skills—trained hospital doctors and consultants. The biggest increase would be level 2. Then there is level 1, which is informal care, untrained care workers. Where does the bulk of that 2 million go? It goes down to the bottom end, because the graph goes up. It is not a straight line, so it may be that 80% or 90% of that 2 million is seen at those level 1 and level 2 skills.

**Lord Warner:** Are they in our current system, or are we talking about families and volunteers?

**Dr Graham Willis:** Yes, you are. Our modelling for 2035 was tasked at looking at the whole system, including informal and voluntary care—people caring for people at home. Because you are dealing with a lot of people delivering care to relatives, the numbers are large, but our knowledge of what they are actually doing and the detail needed to put it into a model is not as good as it should be. However, it shows you in

broad terms that the lower the level of skill, the greater the increase. That is where the bulk of the 2 million goes.

Since we know that the numbers coming out are so skewed, in other words that the biggest increase is at the lower level of skill, and that the increase is driven primarily by three areas of demand—long-term physical health, mental health and learning disabilities—we could look at those areas and try to put more detail in. We could perhaps break the groups down more. Perhaps rather than dealing with long-term physical conditions as a big lump you might break it down into diabetes, heart disease or whatever. In the same way we can look at the lower level of skill, level 1, which is informal care—care at home, if you like—and perhaps do more work in that area, because that is where the big increases are seen. That would allow us to put more detail and hopefully get more accuracy in the model.

**Lord Warner:** I think that would be extremely helpful to the Committee.

**The Chairman:** Would you be able to let us have those details?

**Dr Graham Willis:** Yes, we have the details. I should give two health warnings, if you like. One is that the numbers we have run the model on are from 2014 data, which we are currently updating to 2015. The other is that this is for what we call the reference future, which is the future that our expert panels have said they think is the way things will be. We tend not to think of it as a forecast; we tend to think of it as a point at which we ask them how that might vary across a range of scenarios. We use the reference future as the starting point. We say to them, "You said it was this in the reference future. In scenario 1, how does it change?"

**The Chairman:** Who are these expert panels?

**Dr Graham Willis:** They are between five to eight people. When we were at the CfWI we put them together for their expert subject matter knowledge, and we asked them to quantify certain parameters that we need for our modelling that we do not want to guess. If we want to know for a particular scenario in the future how might productivity change—

**The Chairman:** You said they are experts. Experts in what?

**Dr Graham Willis:** They are experts in a particular field about which we are asking the question. If we are asking about future productivity we will gather five to eight people together, which is generally about the right number, who can help us to answer that question. It is important to understand that the experts not only tell us what they think the answer is, they give us a range of uncertainty, which goes into the model, and they give us their reasoning as to why they said it was that. It is very much as the ONS might do population forecasts: you clearly have to put a number on what birth rates and mortality rates might look like in 20 years' time. They ask experts, they get the uncertainty, but they also get the reasoning.

**Lord Lipsey:** I am sorry, but this probably seems to you to be an

incredibly innocent question. As I read these documents I felt as though I was cast back into Stalin's Russia looking at the 10-year plans. Of course, in practice they do not work out at all, partly because of contradictions, so we are now going to train many more nurses because you projected that we need more nurses, but we are going to take away the subsidies for training and substitute loans in a way that will give a very big disincentive to become a nurse. I see very little in any of this about prices. If there is a shortage of social care workers, you do what you badly need to do anyway, which is increase their wages. There will be certain consequences, but you increase their wages. You will then very soon deal with the workforce gap. Why are we doing all this centralised planning?

**Candace Imison:** It is really important to spot the gaps that might be coming. A good example is the US, where they looked forward and saw prospective huge gaps in their nursing workforce. They upped training and have now brought their nursing workforce back into balance. For me, that is what workforce planning is about. However, it is also about thinking intelligently about the sort of questions that Lord Willis was talking about. Where are you deploying your training budget? I do not think we have had nearly enough debate about that. High-level figures are that the NHS spends £627,000 training a specialist. The specialists themselves will end up spending over £100,000 on their fees and living expenses, whereas after the bursary introduction we spend £19,000 on training a nurse while we are expecting the nurse to pick up £60,000 of cost. The equivalent investment on a nursing associate is £13,500. You can see this incredible imbalance. A lot of the investment in doctors actually comes from the subsidy that is paid to providers who host the doctor for their post-university period. That can very quickly accumulate to a large sum of money. I do not think we have thought deeply enough about how we deploy that. It also creates a scenario where trusts become very dependent on junior doctors for service which is of questionable benefit anyway, as I was saying earlier. I think there are some really profound issues to look at there. These are big sums of money.

**Lord McColl of Dulwich:** When dentists qualify as dentists, they are fully competent and get on with the job. That used to be the case with medical students, so when they qualified they had actually been doing all the practical things and it was not a big change. With nursing, again, by the time they qualified as a nurse they were fully qualified to do things because we had the apprentice system. Do you see any way of us getting back to that?

**The Chairman:** Yes or no? It is not in the plans, is it? The answer is no.

**Lord McColl of Dulwich:** Thank you.

**Lord Willis of Knaresborough:** That is not quite so. We are bringing apprentices back. The nursing workforce will be apprentice-led, as will the care workforce, as in fact will the junior doctors soon because they are going to be apprentices in reality because they will be claiming through the levy. It is a very pertinent question, because the use of the levy of

0.5% of your workforce payroll will have a significant effect on the issues that we are talking about.

**Candace Imison:** Yes, that is a very good point.

**Lord Willis of Knaresborough:** I am sorry to answer that question.

**Lord McColl of Dulwich:** Thank you very much.

**Lord Willis of Knaresborough:** It is nice to be of help.

**The Chairman:** Can we get back to the witnesses? Do you have any comments?

**Candace Imison:** The increasing focus on growing your own in the workforce is really positive. Pulling in people from your local community and using the healthcare workforce as a means of training and advancing people has health benefits of its own. I sit on the board of a large acute trust and what we are having to pay out for the apprenticeship levy versus what we get back in again does not seem to work. It is not creating quite the incentives that you would want in an ideal world. My sense is that we are potentially losing out from the apprenticeship levy, although clearly there is an incentive to make the most of it. It is costly and difficult for trusts to manage the apprenticeship through.

Q151 **Bishop of Carlisle:** I was going to ask a question about the rationale for changing the skills mix. You have already gone quite a long way down the track of answering that. I have a further question about what kind of composition would make most sense for the future. Dr Willis has already indicated, if I have understood it correctly, that we are going to need many more at the informal lower end and fewer skills at the higher end. Focusing back on this question of levers, Professor Buchan, you mentioned that the Government have the levers. Lord Warner asked if they were really there and said that there might not be as many as we think. If we are determined to change the skills mix in the workforce, how can it best be done?

**Professor James Buchan:** First, I think I was very careful to say that the Government have more levers than in most other countries. That does not mean that they have used them or have necessarily always used them effectively. However, I think they are there. When it comes to a skill mix change, I would start from the point I made earlier about looking at how we can enhance and improve or update the skills of the current workforce rather than look at completely new roles.

Picking up on what Graham said about projections of where future demand will be, it is very clear, if we are looking particularly at significant growth in the provision of care to the elderly, many of them at home, that the focus, also in relation to the so-called informal or unpaid workforce, will have to be on primary care and community care. Despite the message of the last 20 years that that has to be the policy focus, we still seem to be running with a system that is very much focused on secondary care, even where new workers are being trained to function

initially. In recent years, there has been no significant growth in community nursing, for example, compared to growth in acute nursing. The number of district nurses has dropped radically.

There are opportunities to allocate funding to try to trigger more training of those types of worker or to trigger current budgets to retrain nurses in the acute sector, for example. Again, my emphasis would be on looking at how we can shift to more primary care and more community care. Much of the management of care and of carers will have to come from nurses and others in allied health who are working in primary care teams. That points particularly to supporting many more nurses to work in advanced roles such as nurse practitioner. We are developing relatively quickly in that area, but we have a long way to go if we compare ourselves to the United States, for example, which has proportionately many more nurse practitioners working and has been doing it for much longer. We have some way to travel. The focus for me is primarily on building up the skills of the current workforce rather than looking at introducing radical new roles, because they take so long to have an impact here.

**Bishop of Carlisle:** Do we have the capacity? Do we have the people around who can do that kind of training?

**Professor James Buchan:** I am always surprised that the education sector seems to find capacity when there are budgets available. That is a slightly facetious response, but there are constraints if you look at some education staffing in some schools, colleges and universities. The age profile of nurse educationalists is very old, for example, so there is a replacement challenge there. The other challenge is the bottleneck in clinical placements and effective, well-managed and well-supervised clinical placements. However, I think that innovative solutions can be developed and introduced there.

**Candace Imison:** I would certainly echo those points. The nursing workforce in particular is an area that has been underinvested in as a country. I was really struck when comparing our growth in the nursing workforce to that across the OECD. Our nursing workforce has grown by 10% since 2004, but across the OECD it has doubled. We are way out of that. Our 1:8 nursing ratio compares to 1:4 to 1:6 in America and Australia. Those are very crude figures, but my sense is that currently on the wards today we do not have enough nurses. We need more advanced nurses. In our skill mix report we mapped out the skills by level, and the top levels, as Jim was saying, are like a skinny tree at the top, with very small numbers. Again, we underinvested in the support workforce underneath who can be a productive support to nurses, particularly in an out-patient setting, in primary care or in the home, but they are not a substitute for nurses on the acute wards, which is a big issue.

On the levers for changing the workforce, we have a really big problem with the productivity challenge. The comments made by the Migration Advisory Committee were interesting. They questioned why we had not thought of pay as a lever in trying to address some of the shortages. We

are now in this vicious cycle of paying large amounts of agency fees to cover our vacancy level. Might it not be more cost productive just to pay better? As we head into a period of what looks like continuing austerity, I worry enormously about this. Staff have paid the price for austerity. They have paid it in real-terms cuts to pay. They have paid it in the extra work that they have had to take on. They are facing five more years of it. They are already showing signs of burnout and we are asking them to do more.

The problem with some of these levers is that they are very interdependent with finance. If you have strapped finance, you cannot start to use some of these other more creative levers.

**Bishop of Carlisle:** Are you suggesting that having another 1,500 doctors or whatever might not be the best way forward?

**Candace Imison:** Yes.

**Bishop of Carlisle:** Thank you very much.

**Candace Imison:** We were talking about it outside, but I have not mentioned here what £1 million buys. A £1 million straight headcount will buy you either seven doctors or 23 nurses or 45 healthcare assistants. People do not think nearly enough about the opportunity cost of making global decisions to invest in doctors. In fact, that doctor figure is probably an overestimate, because the reality is that doctors come with a lot of on-costs associated with them and can actually be a driver of demand as much as a meeter of demand. There are really important reflections that we need to make. We made some drives about 24/7 working in the absence of evidence that tells you that more intense consultant staffing helps outcomes, whereas we have very good evidence that more intense nursing staff improves outcomes.

**The Chairman:** At that point I should declare an interest. I am a professor of obstetrics, chancellor of the University of Dundee, fellow of several medical Royal Colleges, fellow of the Academy of Medical Sciences and fellow of the Royal Society of Edinburgh.

**Professor James Buchan:** I have a couple of points to reinforce what Candace said. Obviously the timeline to get a well-trained doctor into the workforce is 10 years plus, four years for nurses and a few months for a care assistant. We have to factor that into the process.

To pick up on the point about pay, we also have to recognise that there is almost a generation of nurses who have never worked apart from under a pay freeze, but they have worked in an economy where there has been low inflation and we are now beginning to see inflation picking up. That will add to the pressure on hard-pressed staff and the extent to which they can continue to be well motivated in that circumstance.

Q152 **The Chairman:** Candace, we have received evidence from medical royal colleges, the GMC and others about the tremendous shortage of and the need for primary care GPs, and the need, therefore, to train more doctors

who will become GPs, psychiatrists, geriatricians or others. What is your response to that?

**Candace Imison:** If we carry on working the way we are currently working, there will be very obvious gaps in the medical workforce. You have heard from all of us this morning that there are ways of thinking differently about how you work. In primary care we know that there is really good use to be made of pharmacists, physiotherapists, mental health nurses, children's nurses. You can go for a very different skill-mix model in primary care. When I sat on the Primary Care Workforce Commission I was very struck by practices that had gone down that different skill-mix route—I have to say because they were forced to—but actually they ended up in a better place. They ended up feeling that they were better meeting the needs of their patients and often had a double win from this richer skill mix. We went to one practice that was making use of a pharmacist, and the pharmacist was also driving a broader improvement programme in that practice. I was struck by the energy and sense of, "We can improve things for patients. We can do things differently". That is a very real issue.

In hospitals, there are some very profound issues about how we are currently managing the acutely sick patient, and that is driving up the need for more medical staff in hospitals. At the Nuffield Trust we are doing a very interesting piece of work on this in smaller hospitals. We are discovering that in smaller hospitals we have now created multiple doors into the hospital and multiple rotas, which is magnifying the number of doctors who you potentially need. To staff each of those rotas we need many more doctors. This goes back to my earlier point that we need to think much more profoundly about the roles that we need in our different care settings and how we might do that. In my view, there are real opportunities to use staff other than doctors to manage patients who are acutely sick and in the community. We need to go back and have a really profound look at it.

**The Chairman:** Are you saying that we fundamentally need to look at the systems of delivery of care as we have it?

**Candace Imison:** Absolutely.

**The Chairman:** The model of the NHS that has obtained for so long needs to be looked at again.

**Candace Imison:** I would not stretch it to the model of the NHS. I would certainly say that you have an interdependence with the staff you need and the way in which you expect them to work. We have not thought profoundly enough about that, in my view, which means that we are often asking staff, as I said earlier, to do things that do not align to their skillset and are fundamentally inefficient. In a very resource-constrained environment we need to think much more sensibly about it.

Q153 **Lord Warner:** We have been over Horizon 2035, and I would like to build on some of that in my question. First of all, how fit for purpose is

the architecture of all the players in education and training, given that you are all saying that we need to emphasise much more the retraining and reskilling of the existing workforce? Secondly, if the education and training budgets are very vulnerable, as I agree they are, when there is a financial crisis, how do you protect the education and training budgets?

**Candace Imison:** Interestingly, my observation would echo a comment that Jim made earlier, that there are some really positive collaborative arrangements currently in play between higher education and trusts trying to do role redesign and new ways of working. It seems to me that the education side of the equation is actually able to respond very positively to demands made upon them. Again going back to the trust where I am a non-executive, I am seeing really positive collaborative arrangements around developing the roles of nurses and other workers within the trust.

What is much more of an issue is the resource that is available to support the training in those environments and in trusts themselves. I see a lack of capacity in trusts themselves to support and develop staff. The HR function in NHS trusts has traditionally been a bit of a pay and rations function as opposed to something that thinks more broadly about workforce development and planning. However, protecting training budgets is a political issue, it seems to me, and, sadly, the current Government have singularly failed to do that. We have seen a decimation of them in a way that we had not anticipated.

**Lord Warner:** Just pursuing that, government has never really controlled how much individual trusts under your model spend on education and training, for example.

**Candace Imison:** No, but they are controlling the overall pot. We have seen now that the pot available through the broader central functions offered by HEE has been completely cut back, and it is that pot that trusts have called upon and certainly, going back to my own trust, used positively to help to develop these new roles.

**Lord Willis of Knaresborough:** Picking up Lord Warner's point here, whilst we accept that there is a central pot that goes into the training and post-graduate budgets, the trusts themselves surely have a much more significant responsibility for the training of their staff. It costs £78,000 to train a nurse. Roughly half of them have left within three years of taking up their post, so the trust has to go abroad to find people at a 25% premium or recruit new people from scratch. I do not understand why the health economics model does not come into play here to say that if we actually invest in our staff more we will keep them and they will be more productive to us. That does not seem to form the equation; it is "Give us more money from somewhere else".

**Candace Imison:** The more money bit is when you are trying to get something very novel. The approach of managing your staff well is something that trusts need to do for themselves. However, I go back again to the interdependence with the broader financial environment.

When budgets are squeezed as tightly as they currently are, the amount of flexibility is very limited, and those budgets can be very vulnerable to cutting.

**Lord Warner:** Going back to my original question, what should this Committee say about protecting education and training budgets to give the capacity to reskill and retrain existing staff in the system? That is the exam question.

**Candace Imison:** At the very least you should be signalling that what is currently there is protected, but actually it should grow. You counterbalance that with investment in understanding those training needs. That is the bit of the equation that has been missing from our workforce planning environment. It is double-edged.

**Dr Graham Willis:** We talk about the skill mix and what skills workforces should have. However, the skill mix depends on the model of care you are employing. For different models of care you might need different skill mixes. A constant here is that we have talked a lot about team working and possibly different roles. Flexibility in the future will be important. One of the key areas for training is interprofessional skills, whereby you have people working together in mixed teams who can share their skills, decision-making and the burden of the work. It is an area of great interest and much debate in other countries, but we have less debate in this country about the scope of practice and interprofessional skills. A lot of the professionals at the higher skill levels are trained in their profession, but they may not be trained as much in how to work with other professions in joint decision-making. This is a big area of debate in other countries. I mention that, as it might be helpful.

Q154 **Lord Scriven:** Before pursuing that point, I declare my interests. I am a member of Sheffield City Council, and a managing partner of Scriven Consulting, whose clients include Carillion plc and Cumberlege, Eden & Partners. I also have a lapsed declaration that I have kept on for transparency, which is Maximus UK.

I have listened very quietly as you have talked about workforce planning and training being by organisation rather than by place or where people actually live, which I think is about patients rather than about organisation, which would lead to some of the kinds of changes that we need of the existing workforce. Would you like to explore that a bit further with us and say whether you see any potential in that rather than it being under the existing structure, which just seemed to replicate the status quo?

**Candace Imison:** I would completely support that. A piece of work we are thinking about doing as a trust is about what a place-based approach to workforce planning would look like. The STPs offer an opportunity into that. My sense is that they have actually had difficulty grasping that opportunity, so the aim of our work is to try to understand what the obstacles to that have been and how they might be overcome. You are right that that is the basis on which you should look at the workforce.

When Jim and I did our original work on workforce planning, the big mantra was to go from uni-professional workforce planning to multi-professional, but now it is look across the whole care pathway and then to think about things in a much broader way. You are completely correct.

**Q155 Lord Bradley:** I will declare some interests before I ask about international comparisons. I am a non-executive director of the Pennine Care NHS Foundation Trust, independent chair of Manchester, Salford and Trafford NHS LIFT Company and independent chair of Bury, Tameside and Glossop NHS LIFT Company.

You have referred to comparable countries overseas and the work they are doing on workforce planning. Are there good examples that compare to the challenges facing the NHS? What lessons could we learn from those international comparators to influence how we go forward in our own workforce planning?

**Professor James Buchan:** First, I would echo the Chairman's point earlier that arbitrarily looking abroad and assuming that what one country does is translatable here is risky at best. However, there are examples that are worthy of consideration, given how our system looks and what the challenges are.

Picking up on some of the debate that we have had in the last 10 minutes on the primary care workforce, the national approach to workforce planning in the Netherlands is developing from single profession to looking across the piece. In particular, they are beginning to look at an approach that is not just, "We will need X number more general practitioners", but, "We can have Y number of general practitioners, but we are also looking at nurse practitioners and the balance across the piece and calibrating roughly that the nurse practitioner can safely do about 70% of what a GP does but at lower cost and lower timing". That is an example of where a country is beginning to break down the barrier between different parts of the workforce. At the national level, people around the table who are stakeholders discuss and debate not just "We will have X GPs and Y nurse practitioners", but, "We will look at the best mix for the future training of these goods".

**The Chairman:** Are you saying, Professor Buchan, that we need to look at our current model of primary care?

**Professor James Buchan:** No. That should drive the workforce, not the other way round. The example I am giving is just a technical approach to planning, which is looking at GPs and nurse practitioners as two roles that currently exist, but doing it in a more rounded fashion than is the case now in the UK.

The other example I was going to give was more about the roles and scope of practice and looking at how different professions and other workers in healthcare can interact more effectively because each of them is clear about their role, their role boundaries and where the overlaps are. I think the best examples in that field are in Canada, which is

probably a world leader in that area of work at the moment. Their healthcare system has some differences from here, but issues relating to health professional education, role delineation, getting the different professions and other stakeholders around the table to agree what should be done in this space are worth considering.

**The Chairman:** What about the retention of nurses, for instance? We see figures that tell us that the percentage of nurses leaving increased from 6.8% to 9.2% in 2014-15. What are the issues for the retention of all staff?

**Candace Imison:** Those figures almost certainly relate quite strongly to the workload issues that I talked about earlier. However, we also have evidence from initiatives such as the Magnet hospitals in the US that if you invest heavily in nurse leadership and management in a trust, you can have a very significant impact on your retention rates. Crucially, and interestingly, you also have to invest in the continuing professional development of staff. That is a critical retention factor.

**Lord Willis of Knaresborough:** I am very interested in this whole issue of retaining staff, because we appear to have a leaky bucket. Clearly we have a shortage of staff. However, we cannot continue to have people drain at the current rate. I wonder whether it is just a matter of morale. Is it just a matter of pay? Is it a matter of training? How do we actually change all that? That is the frustration for me. I would like to see every trust being held to account for its retention of staff, not simply its recruitment of them. What are the answers here, Jim?

**Professor James Buchan:** I agree with your analysis. When a specialist nurse leaves a trust, the cost equivalent is about two years' salary. That gives you a metric for lost productivity and the time to replace them and bring someone up to the same level of contribution. We talked about costs earlier, and that cost is never articulated effectively. There is no budget to address the retention issue in the way there is to address initial training, for example. If we can get that metric into the decision-making, that would help a lot.

Looking at any health system and at any healthcare labour markets, you can see that some employers are better than others at retaining and motivating their staff. Irrespective of the external labour market conditions, when you analyse what is going on there and what makes a good employer, you can see that in the kinds of examples that Candace gave, such as Magnet hospitals and participation in decision-making, effective management, access to continuing professional development, flexible hours, working with peers who respect you, reasonably good pay, the ability to feel that you are contributing and continue to contribute and that your concerns are being addressed. On one level it the sorts of things that you would expect from any good employer in any sector. It is just that in healthcare in the NHS there is a spectrum, a continuum. Some are very good, some employers are less good. In part, that is about how effective management is, but it is also to an extent the external labour market conditions varying across the NHS. London is very

different from Cumbria in the opportunities to move and work anywhere else, for example.

- Q156 **Lord Warner:** This morning has been very interesting. So far we have tended to look very much at what workforce planning and development should be done at the national level. What has come out for me from the answers you have been giving has been the whole issue of the key role more locally of employers and local health economies. Is there any evidence that we should start to consider something like a percentage of budget that should be spent in local health economies or local employers on education and training in order to try to get some coherence in their roles, particularly with STPs coming along?

**Candace Imison:** That is a really interesting idea. I am aware that in the private sector people have a set of benchmarks that they often work to. They feel it is very important that a percentage of their budget is invested in HR in the same way in which a percentage should be invested in technology. We have not talked at all this morning about the interdependence with technology in the workforce, which is also a big issue and a big morale issue. Grappling with the early implementation of technology is not easy in a healthcare setting.

**Dr Graham Willis:** One thing that we have not really talked about this morning is self-care. We have seen increases in the demand for informal care in the system and the impact that self-care could have perhaps on reducing demand.

**Lord Bradley:** I note the international comparisons between national, regional and local decision-making. Do you think that the devolution of health and social care budgets is an opportunity to look at how the workforce can be developed across pathways of care in a particular area?

**Dr Graham Willis:** There are probably great opportunities to do further work in that area, definitely.

- Q157 **The Chairman:** The key theme for this inquiry is the long-term sustainability of the NHS, so we are looking beyond 2025, 2030, 2035. Focusing particularly on today's discussion about the workforce, if I were to ask you to tell us what one recommendation you might have for the inquiry that would impinge on the whole of the issues related to workforce that may focus our minds on the future sustainability of the NHS, what would you say? What would your recommendations be?

**Professor James Buchan:** That is a difficult one. I apologise in advance. It would be to focus less on workforce numbers and more on the skills that are required.

**Dr Graham Willis:** I would say that it is to focus on the big drivers of future demand and long-term thinking about what we might do to reduce them by interventions.

**Candace Imison:** I would build on Jim's point by making the point that we need to have a much deeper understanding of what we are asking our

workforce to do and what patients need. A really good starting point would be to get that understanding. Then you can build a way forward from there.

**The Chairman:** Thank you all very much for coming today. Dr Willis, you said you will send us some figures. If any of you have anything that you think about, please do send it to us. You will get a transcript of today's evidence. You cannot change it, but if there are any glaring mistakes or accuracies, feel free to let us know. Thank you for coming today it has been very helpful.