HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Harding Review of health and social care workforce, HC 2226

Tuesday 4 June 2019

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Angela Crawley; Diana Johnson; Johnny Mercer; Andrew Selous; Dr Paul Williams.

Questions 1 - 113

Witnesses

I: Baroness Dido Harding, Chair, NHS Improvement; and Sir David Behan, Chair, Health Education England.

Examination of witnesses

Witnesses: Baroness Harding and Sir David Behan.

Chair: Welcome to the Health and Social Care Select Committee. It is great to have Baroness Dido Harding, chair of NHS Improvement, and Sir David Behan, chair of Health Education England, here this afternoon.

Several of us have personal declarations of interest that we would like to make. I would like to start, because we are considering the NHS workforce, by setting out on the record that my husband is an NHS consultant forensic psychiatrist, and I have two daughters who are junior doctors working in the NHS.

Dr Williams: I am employed by a GP practice for two days a month and my partner is employed by a GP federation.

Andrew Selous: I have a daughter who is about to start working for the NHS, on 1 August, and another one halfway through medical school.

Q1 **Chair:** Thank you very much for letting us have a copy of the report yesterday, Baroness Harding. In opening today, would you like to make some general comments about what you found and the scale of the challenge?

Baroness Harding: Sure. Maybe I can start by explaining the process we have gone through to develop this interim plan. My commission was to produce a final people plan within two months of the comprehensive spending review later in the year, and an interim plan in the spring, so this is an interim, a stepping-stone along the way.

The primary lesson I think we have learned is that we need to elevate people management—people planning—to the same level as financial and operational management in the NHS. That is the core of what we are saying. It is self-evident that we are going to need more people working in health and in social care over the course of the next decade as the service grows, but we do not just need more; we need different. We need to transform the way people work in the NHS: the tools they have, the roles they have, the way they work together and, most fundamentally, the culture, to make the NHS a much better place to work. I think it could be the best place to work in England, but that is going to require real focus to change what it is like to work there.

Q2 **Johnny Mercer:** I am interested in the workforce challenges at the moment. Picking out the headline terms, what would you say were the key headlines around workforce at the moment? To people watching today, what is the scale of the challenge around workforce in the NHS?

Baroness Harding: We can talk numbers, but I would also like to talk culture in terms of the scale of the challenge.

Q3 **Johnny Mercer:** Can we talk culture and can we talk percentages as

well?

Baroness Harding: Of course.

Q4 **Johnny Mercer:** Numbers do not mean an awful lot to your average person on the street. In terms of how many, are we where we should be? How far off are we? Are we getting there and things like that?

Baroness Harding: Yes. Today, the NHS operates with 10% of all roles vacant; 80% of those vacant roles are filled by temporary staff, either agency staff, locums or staff working overtime. We call it bank staff in the NHS.

Johnny Mercer: Yes, locums.

Baroness Harding: There is 10% vacancy, and 80% of that 10% is filled. If we do not change, in 10 years' time that gap will widen to 15%, so we need to change the way we think about our people and the way we manage this. We really recognise the scale of the challenge, because it is significant.

Q5 **Johnny Mercer:** What is driving the opening of the gap?

Baroness Harding: Partly it is the growth. As I said, demand for healthcare is growing. Our workforce is also growing, but it is not growing as fast as we need it to, at all levels. We need to improve our retention rates. We need to make the NHS a better place for people to work so that they want to stay and work longer with us. We also need to make the NHS a more attractive place for people to join, both people living in England and people from overseas.

Q6 **Johnny Mercer:** Which is the bigger of those two challenges? Is it retention or is it recruitment?

Baroness Harding: If I could answer that in a slightly different way, the area where we can make the most immediate difference is retention. The most immediate way we can improve the workforce challenges we face is by retaining more of our existing staff and creating an environment where more of them want to work more time with us.

Q7 **Johnny Mercer:** Are you 100% confident in the data that you are getting for this? The data you have is reliable, is it?

Baroness Harding: With a workforce of 1.3 million people—

Q8 **Johnny Mercer:** It is going to be tough, right?

Baroness Harding: Nothing is ever going to be 100% accurate, so I am not going to pretend that.

Q9 **Johnny Mercer:** But you are comfortable that it is there or thereabouts.

Baroness Harding: It is there or thereabouts. One of the reasons why this is an interim report is that we need to do more work, bottom up, in local health economies, not just nationally top down, to validate the

detailed numbers. That is one reason why you probably do not have as much detail in the report at this stage as you would like.

Q10 **Johnny Mercer:** Sure. What are the main factors making people want to leave the NHS and at what sort of stages are they leaving? You will get the natural sort of wear at the end of a career, but I presume there are plenty of people leaving before that point. What are the key factors driving that at the moment?

Baroness Harding: You are absolutely right, first, that it is at all stages of people's career, so we have to look across the board. Staff tell us in a number of ways—in the staff survey, in focus groups and in feedback as we have developed the plan—that they leave if they feel that their careers are not being developed, that they do not have an opportunity to get on. They leave if they feel that they are not valued by their direct line manager and the people they work with. They leave if they feel—it is an awful management word—disempowered and that they do not have control over what they are doing.

Some of that is the basics of being a good employer, and some of it is about providing clearer career paths for people at all stages of their career. I know that might sound very simplistic, but it is what makes for a great employer. When the NHS does that, people love it, and lots of people love working in the NHS; but we do not do it consistently well enough.

Q11 **Johnny Mercer:** A lot of other companies worked out 20 or 30 years ago that if you look after people, they will stay for longer, and all this empowerment stuff and the rest of it.

Baroness Harding: Yes.

Q12 **Johnny Mercer:** Who bears responsibility for the current situation?

Baroness Harding: The truth is that you see huge variation across the NHS. There are pockets of absolutely brilliant leadership and management in the NHS where there are high retention rates and very happy and engaged colleagues doing a great job, but that is not the norm, I am afraid. Retention rates in the NHS are lower than the average for the economy, and sickness and absence rates run at 2.4% higher than the rest of the economy. I am afraid that we all bear the responsibility—those of us in leadership roles across the NHS—that we have not taken people management and people leadership as seriously as we should. That is the core message in our plan.

Q13 **Johnny Mercer:** How long have you been in the job?

Baroness Harding: For 18 months.

Q14 **Johnny Mercer:** This has not happened just over the last 18 months.

Baroness Harding: No.

Q15 **Johnny Mercer:** Has Health Education England been asleep on the job or

not?

Baroness Harding: I should let my colleague speak for Health Education England, but I do not think you can say that the culture of the NHS is down to one element of a national body, whether either of our organisations. We have all conspired—leaders at all levels in all parts of the country—to create a wonderful national institution that, bluntly, could do a lot more to look after its people. That is what we need to focus on to shift the dial.

Q16 **Johnny Mercer:** Sir David, what do you think? How has this situation transpired? If we are looking at stress points in the process as to who has not seen this coming, what are the sort of areas or who bears responsibility?

Sir David Behan: I am six months into this role. If you look back over the history of workforce planning, I do not think there has ever been a high watermark when people felt confident that predicting and forecasting the future workforce was sorted. As Dido said, there are a number of very complicated and complex reasons for that. There have been numerous initiatives over the past 20 years around workforce to try to secure a safe pipeline for the future workforce, and there have been incredible challenges in predicting the future.

One of your questions earlier was around turnover rates. If the turnover rates for nursing had stayed at the 2012 level, we would have 16,000 more nurses in the NHS. The contribution Dido has just made about the importance of culture and retention is hugely important when you have those kinds of numbers.

Q17 **Johnny Mercer:** What are you saying? Has it just dropped off in the last seven years?

Baroness Harding: Yes.

Sir David Behan: Yes, to the point that turnover has increased to such a level that if it was back to the 2012 level, just on nurses alone, we would likely have had 16,000 more nurses in the NHS. In retention, issues around value and about investing in people's development, their satisfaction around teamwork, issues around bullying and harassment and the culture of the organisations they work in become hugely important. As Dido said, we all have a responsibility to create the conditions that ensure that people feel valued, and that they want to stay and continue to make a contribution to the work that is undertaken.

Baroness Harding: There are some specific national policies that are also making the NHS a less great place for people to work.

Q18 **Johnny Mercer:** What like?

Baroness Harding: While we were waiting for you, we were talking to a group of doctors in the corridor—they are just behind us—about pensions and how one of the unintended consequences of pension policy means

that senior clinicians come under very penal tax rates, and actually their tax advice is to work less in the NHS.

Q19 **Chair:** In fact, we are going to come to that specifically later on, if that is all right.

Baroness Harding: Okay.

Q20 **Johnny Mercer:** In terms of workforce planning, the way it looks to your average sort of person in the street is that clearly you see the frontline of the NHS and amazing hospitals and things like that, but there are a lot of other people making the systems work. You get paid a lot of public money to make these systems work, yet the most deprived people who use doctors and the NHS, more than me or anybody else, in places like Plymouth, are not one or two doctors short, but 30 doctors short—30. Your average person on the street is going to think, "Why are you guys taking home so much money from the public purse when you cannot even plan the workforce properly?"

It is not as if this is a shock. These guys take, what, nine years to get through training? It is not as if we woke up and this suddenly happened. It has been happening for a long time. People want to know how the hell this has happened in the first place when there are some really intelligent people who get paid a lot of money to meet these problems, and how we are going to stop it happening in future.

Baroness Harding: As you rightly say, it takes nine to 10 years to develop and train a doctor, and three years to train a nurse through university. One of the things we have to do is change the way we train and develop our clinicians so that we are able to build more flexible career paths for them. As to planning and modelling, I keep saying I cannot tell you how many radiologists we will need in Scunthorpe in 10 years' time, or in Plymouth for that matter. We need to build more flexibility.

Q21 **Johnny Mercer:** Forgive me, but that is the kind of complex end of it. We are talking about basic stuff—GPs.

Baroness Harding: Even there, demand is growing but it is not growing at exactly the same rate and in exactly the same way for each clinical profession in each part of the country, so one of the things we are recommending is that we need to devolve more of the workforce planning responsibility to local health economies, because the danger of believing that you can get all of this right at 10-year increments in the centre, in Whitehall, is that you just get the estimates wrong.

Q22 **Johnny Mercer:** Absolutely, but it is not as if we just missed the target. We are way out of range.

Baroness Harding: But there are also significantly different regional variations. One of the things we need to do is allow local health systems to plan their own workforces more, rather than try to dictate from the centre.

Chair: I am conscious that we have a lot to get through, but Ben and Diana both want to ask a quick supplementary.

Q23 **Mr Bradshaw:** Isn't one of the simple explanations for the workforce shortfall that you have not mentioned the conscious decision by the Government after 2010 to cut funding for—and therefore the number of—places in training?

Baroness Harding: There are a number of quite complex reasons why the growth in workforce has not kept up with the growth in demand.

Q24 **Mr Bradshaw:** Do you accept that those cuts happened?

Baroness Harding: I agree.

Q25 **Mr Bradshaw:** Do you think they were helpful to the situation you are in now?

Baroness Harding: Our review has not focused on the history. It has focused on what we can do going forward.

Q26 **Mr Bradshaw:** You were asked about the reasons for the current shortfall, and I noticed that you did not mention the very significant cuts to training that the Government implemented in 2010 as part of their austerity programme.

Baroness Harding: It was more that our review simply has not focused on looking at the past. It has looked at being honest about where we are now, which is that we absolutely have significant workforce shortages and we need to change the way we manage things to address that.

Q27 **Mr Bradshaw:** But surely, in order to understand the present, you need to understand the past—the reasons for the shortfall.

Baroness Harding: Yes, but, as we said, the reason for the shortfall is about more people leaving and us needing to grow our pipeline in both international and domestic recruitment.

Q28 **Mr Bradshaw:** And cuts in training places by that Government.

Baroness Harding: The most crucial gap we have at the moment is actually nurses, not doctors. All the medical professions—the doctors—would agree with us that nursing is where we need to focus urgently now.

Q29 **Mr Bradshaw:** Sure, but there were cuts in nursing training places as well, significant cuts, in 2010.

Baroness Harding: Not in the figures I have, though I might have to come back to you. As I say, I have not looked at particular dates.

Sir David Behan: This plays to the previous question. You asked why we are in the position we are in. My assessment, as I said, six months into my role, is that we have had a separation between service planning, workforce planning and financial planning. I have come to HEE at a time when we have a £20 billion investment in the development of services

that will pay for more staff, but the investment in the training required to ensure those staff have the skills to do the job is not there. We have a misalignment—I cannot do the history as well, Ben—in the investment.

Chair: We are going to come to the difficulties about where the funding streams come in a minute.

Q30 **Diana Johnson:** Baroness Harding, you said that it would be impossible to know how many radiologists would be needed in Scunthorpe in 10 years' time. However, the long-term plan makes that very clear about prevention and about cancer treatments and all of that. What is worrying me is this. Are you saying that the local health economy in the Scunthorpe area will be designing how many radiologists they need in the future? That worries me, because I think there is no idea of national acceptance that we have to plan and we actually have to get across all the different parts of the NHS. There has to be working together rather than leaving it to local areas.

Baroness Harding: Let me explain why I used the specific example. There are two big trends for radiology. The first is that artificial intelligence will mean that the standard reading of images will increasingly be done by the technology. That would lead you to believe that you will need fewer radiologists in 10 years' time. However, interventional radiology is a brilliant and fast-expanding specialism that means you will need more radiologists.

Knowing where those two curves cross, even at national level, is very hard to predict for 10 years' time. You are more likely to have local knowledge about your local population to be more accurate in the local assessment, but even locally you will not be able to do that completely accurately. Therefore, we will need to train our future radiologists and our current ones to be more flexible in their careers, so we may not get the estimate accurately; in fact, I am pretty certain we will not. We want to have doctors and other medical professionals who are able to do great work in adjacent specialties as demand and supply change.

It is a mistake to believe that you can sit in the centre, however smart you are, however well paid you are, and be able to estimate that accurately. We need to change the way we think about medical training and career paths to give these fantastic people more opportunity to fill the need as it arises.

Chair: Thank you. We are going to move on to the subject of Brexit, obviously a complicating factor in all this.

Q31 **Dr Williams:** We know the numbers. We know that one in 10 doctors is from an EU country, and one in 20 nurses; 8% of the social care workforce are from EU countries. How important has Brexit been in the current staff shortages?

Sir David Behan: We know there has been a falling off of nurses in particular coming through, but the number of doctors coming through

from the EU has pretty much held up from 2017 through to 2018, so its impact is quite differential, and we will continue to monitor that as it comes through. Alongside that, as Dido said earlier, the importance of investing in international recruitment more generally has been one of the priorities. We developed about 600 nurses last year and we are looking to increase that number over the next 12-month period, so looking at recruiting both from Europe and more broadly than Europe is a key part of the strategy.

That does not provide—as regards the challenge that came up earlier—the longer-term solutions that we require. The brand NHS is incredibly strong, and doctors and nurses will want to come and experience training in the NHS because they know the clinical experience they will get is of the highest standard. How we can create a future that sees learn, earn and return opportunities—I think that is the phrase being used—for people both from Europe and globally is where the focus has been, and that is where the international focus will be for my colleagues at HEE, to ensure that we can recruit people from abroad.

The learn and earn bit is key, but so is the return bit. That is the issue about ethical policy. Making sure that people go back to their home country is a particular issue. There has been important discussion about the ethics of this. There are examples that I was learning this morning of a number of northern healthcare trusts that have come together to put together a deal with universities and hospitals in southern India to create exactly that package of learn, earn and return, where nurses will come and work in this country, but the plan is that the majority of them will go back to India and take back that experience. That is driving some increased numbers for us.

Q32 **Dr Williams:** But we have seen a massive reduction in registrations from nurses and midwives from EU countries since our decision to leave the EU.

Sir David Behan: Yes.

Q33 **Dr Williams:** We have seen a doubling of the number of nurses from EU countries leaving the register as well, and that has not been compensated for by nurses and midwives coming from non-EU countries, has it? Brexit is a significant contributing factor to our current staff shortages.

Sir David Behan: Yes, and I think the issue is complicated within that by the impact of things like the recession in southern Europe on people coming in, and the impact of revalidation.

It comes back to this. The challenge in doing this work, without overcomplicating it, is appreciating the sheer number of influences that take place in relation to affecting those numbers. But you are absolutely right, Paul, that the numbers are down, and there is no getting away from the numbers being down. We have been dependent over the past

four or five years on nurses from EU countries coming in and being part of the workforce in the NHS.

Q34 **Dr Williams:** Way back in 2001-2002, we had 16,000 international registrations, so we have been dependent for a very long time.

Sir David Behan: Yes. They went up, didn't they, in the 1990s and they are coming down again? But, as I say, analysis demonstrates that there are a number of different impacts, but the end result is that there are fewer nurses in particular coming from the EU, and we need to adjust our figures, going back to the plans, about how we recruit from abroad.

Q35 **Dr Williams:** Are EU nurses an important part of the future NHS workforce?

Sir David Behan: As we were saying at the beginning, we need to be growing our own nurses in England. We need various routes in. We need to promote social mobility from our communities. The success of the nursing associate programme, where we have increasing numbers of nursing associates being grown from within England, is part of that, and an important part of securing the future supply of nurses will be recruitment of nurses from abroad. Yes, it is both those things—how we develop supply from within England, multiple different routes, not just graduate nursing, but blended nursing degrees, nursing associates, healthcare assistants coming through—

Q36 **Dr Williams:** And the social care workforce as well, I am sure.

Sir David Behan: It is critical. I know from my own background just how critical nurses working in care homes are to ensure the quality of care for people in care homes.

Q37 **Dr Williams:** The key question is, what is needed from future immigration policy in order to enable the NHS and the social care system to be able to recruit from EU countries and non-EU countries the nurses and social care workers we need for the future?

Sir David Behan: My view is that we need to ensure that there are no barriers to recruiting clinical staff from abroad.

Q38 **Dr Williams:** Do you consider the £30,000 proposed salary threshold as a barrier?

Sir David Behan: I understand there is a consultation and I think there needs to be a debate. If I may say so, you are better placed to have that debate in this place than I am from where I am, but if you were to say that something needs to be done to ease some of the rules around how we can secure the future supply of the workforce, that would help immensely.

Q39 **Mr Bradshaw:** You are both capable as individuals and as leaders of your organisations to respond yourselves to those consultations. There is nothing stopping you responding to those consultations.

Sir David Behan: That is what I am trying to do here today.

Q40 **Mr Bradshaw:** Right, and Baroness Harding will be doing the same, I imagine.

Baroness Harding: Yes, absolutely. As David has just said, there is no single silver bullet for this, no single solution. We need to be a welcoming employer for more people who are born and bred in England, and more people from the EU and from other countries in the world. We need to look at all of those pools of talent to grow our health workforce over the course of the next five years. We need to pull all those levers.

Q41 **Mr Bradshaw:** Sir David, you just outlined a scenario where you hope to recruit extra nurses from southern India. Can you explain the logic of depriving a country like India of nurses that I imagine they can ill afford to lose, to replace nurses from EU countries where there is a surfeit of nurses who have been coming here readily for years and years contributing to the NHS? It does not seem to make sense to me.

Sir David Behan: No, it is difficult, and I agree with you that it is difficult, but the team at HEE that has been leading some of the work on international recruitment has taken the ethics of recruitment incredibly seriously. In Kerala, an agreement has been signed with the Keralan Government in relation to the development of that partnership. It is about the operation of the partnership; there is a reciprocity about the arrangement that is in place. It is learn, earn and return, and I think it is important that the "and return" is in there, so that the individuals from India are enriched by experience in the NHS and the reputation that it has internationally and worldwide.

We benefit from qualified nurses coming over and working in the workforce, but the ethics, as you say, of taking other people's nurses and keeping them is dealt with by the "return" element. It is about mutuality and reciprocity, where the English NHS benefits from an increase in its nurses but Kerala, in this case, will benefit from those nurses returning. A lot of the work that HEE colleagues are undertaking is on the basis of partnership work with Governments, so it is not running the risk of being somehow exploitative and being just "take"; there is the element of reciprocity.

Q42 **Mr Bradshaw:** Of course, Brexit has not only been disastrous in terms of workforce; it has also been disastrous in terms of the physical situation. Baroness Harding, I notice that you were quoted in the *Health Service Journal* yesterday saying that you were confident that money would follow your workforce plan, that the Treasury would cough up. What makes you so confident, given the fiscal hole that is going to be left by Brexit, particularly if, as looks likely under the new Conservative Prime Minister, we go for a crash-out, no-deal Brexit?

Baroness Harding: What makes me confident is that I think our country cares deeply about the NHS and wants us to have the world-class health service that we can be. It is absolutely clear that to deliver that we are

going to need more people working in the NHS over the next five years. There is no doubt about that. If we are to have more people working in the NHS, we need to train them, so we need to find the money to train and develop our clinicians and our non-clinician workforce. I do not think you can get away from that. Regardless of the party politics, you cannot have a functioning service that is at its heart all about the people without training them. That is why I am confident that the money will be forthcoming to train and develop our staff.

I would also say that we need to invest in the transformation of the way people work, so we need to invest in capital, both human capital, with training, and capital investment in the technology, the tools that people use in the NHS, and the buildings in which they work—otherwise you simply will not be able to deliver the healthcare that we have set out, the vision that we have set out in the long-term plan.

Q43 **Mr Bradshaw:** When you came before us for your confirmation hearing, you will remember that you declined our request to relinquish the Conservative Whip in the House of Lords, unlike your ex-Conservative colleague Lord Prior, who acceded to our request. I assume you are still taking the Whip. Are you still participating in any Brexit-related business whatsoever in the House of Lords?

Baroness Harding: If you remember, the reason I declined your request is that, unlike Lord Prior, I am married to a Conservative MP and I felt it would be disingenuous to pretend not to be. That has not changed. I remain married to him and, therefore, I think it would be wrong to pretend that I am unaligned when I am. That is why I have done that. It is a personal choice. I respect the Committee's opinion and view, but that was the choice I needed to make wholly for myself.

Q44 **Mr Bradshaw:** Are you still participating in Brexit-related matters in the House of Lords?

Baroness Harding: I gave my commitment to this Committee that I would not participate in health-related matters in the House of Lords, which I have abided by. That's it.

Q45 **Mr Bradshaw:** I asked you about Brexit-related matters. Given what we have heard about—

Baroness Harding: It has to be said that there has not been very active debate recently in the House of Lords on the subject, or voting, and I have not spoken on the subject, but that is not really relevant to my job in health.

Q46 **Mr Bradshaw:** Given what we have just heard about the impact of Brexit on the NHS and recruitment, do you not think it is relevant?

Baroness Harding: I stand by what I said two years ago. I will rescind myself from all health-related matters in the House of Lords, but I do not feel it appropriate to pretend to be someone I am not.

Q47 **Chair:** We have an awful lot to get through, but can I ask you to clarify something, Sir David? You said you thought that this Committee should comment on the earnings threshold for immigration purposes.

Sir David Behan: I am sorry, Chair; that was not what I meant.

Q48 **Chair:** I want to clarify what you meant.

Sir David Behan: There is an important conversation to take place about future immigration policy and the way it impacts on the NHS. I thought that had begun by the conversation about the threshold.

Q49 **Chair:** Both of you have looked at this in some detail. Have you come to a view about what that earnings threshold should be?

Sir David Behan: Personally, I have not.

Baroness Harding: Personally, not at this stage.

Q50 **Chair:** Do you think it would be a helpful thing to do, given that you are looking in detail at the workforce? As a Committee, we would be interested to hear your views on it.

Baroness Harding: It is certainly something we can take away as we develop the final plan.

Q51 **Chair:** One of the particular concerns that has been expressed to this Committee is the impact on the social care workforce, for example, if we do not have an earnings threshold that allows for that, because of the impact it then has on NHS staff. I know you have not looked in detail, as I understand it, at the social care workforce, but a commentary from yourselves as feedback to future development of policy and thresholds would be very helpful.

Baroness Harding: The commission I was given for this plan was for the NHS, although we are very mindful that, in trying to address these very serious issues for the NHS, we must not do harm in social care; they are intertwined. I do not have a specific remit to look at the social care workforce on its own, but we can consider it as part of the final plan.

Q52 **Chair:** It is not just the actual salary threshold; it is the ability to bring in family members. Have you looked at whether or not there is a disincentive for people to come to the UK if future arrangements mean they cannot bring their families?

Baroness Harding: We have not looked at that level of detail yet.

Q53 **Chair:** You have not looked at that in any detail.

Baroness Harding: No.

Q54 **Chair:** Can I turn to another area around funding? There are clearly huge challenges facing the NHS not only on workforce but on funding. Have you made an assessment of how much money would be needed, and over what period of time, to bring the NHS up to a point where it is fully

staffed? How much of this is financial rather than to do with other issues?

Baroness Harding: We have done some initial modelling, but the reason we have not put detailed financial or people numbers in the report is that there is a lot more work to be done. There is a very complex set of interrelated issues.

We need to take the NHS long-term plan to establish what the demand will be for different roles as the skill mix changes, but we also need to overlay with that the changes in technology that are freeing up time for certain types of roles and overlay that again. All of that needs to be done at local as well as national level. As I said earlier, it is a mistake to think that we can do all this planning nationally and get it right. I am sorry. That was a rather long-winded way of saying that we have started the work, but at this stage we do not have definitive numbers that would stand scrutiny in a public forum.

Q55 **Chair:** Obviously, this is an interim plan, but when you develop your final plan will you have much more detail in it, for example about the impact of pay on both recruitment and retention, to give a clear steer of what is needed? We are in the run-up to the spending review.

Baroness Harding: Absolutely.

Q56 **Chair:** That brings me to a related point. It is very difficult for Health Education England to make plans if you do not know how much you will receive in the spending review.

Sir David Behan: That was the point I was making earlier about the need to align service planning, workforce planning and financial planning. At the minute, they are not aligned. Investment of £20 billion is going into developing cancer, maternity and mental health services. We will see that run on, and then we need to make sure that the workforce plan, to go back to your earlier question, Sarah, is in place to ensure that that plan can be delivered.

Currently, we are on track to deliver on the training of people in IAPT. We are making good progress towards achieving the target for mental health staff working in schools, but there are other ambitions in the mental health plan that need to be factored into the education and training plan.

Going back to nursing numbers, we know that the acute shortages are in learning disabilities and mental health. How we can take positive action in relation to encouraging people to select a career in learning disability nursing, for instance, becomes an important issue. Those are the issues we will need to set out in the longer-term plan. As Dido says, that is where we will build the case for investment.

The HEE budget has had a reduction; it is at 96% of what it was three years ago, compared with the increase of £20 billion in the NHS ring-fenced budget, so we have increasing demand that is being responded to by increased development of services, but we do not have follow-through

in the arrangements for the education and training of the people who will be working in those services in future. That is the alignment we need to secure, and that is the investment case we need to set out.

Q57 **Chair:** Will you be making a very detailed investment case in the run-up to the spending review?

Baroness Harding: Yes.

Q58 **Chair:** To take one of the areas we looked at as a Committee—the nursing workforce—when we heard evidence, access to CPD was a huge factor in why people leave, yet that budget has been completely slashed in Health Education England, hasn't it? How are you going to be able to develop CPD if you do not know how much money you will have to work with?

Sir David Behan: The high water mark for the HEE budget was in 2013-14 when £205 million was spent on what we called workforce development—upskilling and the ability to fund people to go on diplomas, masters courses and so on. That was reduced to £85 million a couple of years ago, because the money went into buying additional nursing placements; it was a choice, a trade-off, between whether it went into CPD or extending the nursing workforce, which was effectively what happened.

It is easy to be wise in hindsight and I am not going to do that, but as 50% of the current workforce will still be working in the NHS in 20 years' time, and given the point Dido made about advances in science and technology, we need to be thinking hard about a workforce development budget that upskills our staff as science and technology come in. That will be a critical issue.

Q59 **Chair:** Are you making a detailed case to the Treasury in advance of the spending review about the areas where there are big gaps?

Baroness Harding: Yes.

Q60 **Chair:** The danger is that the narrative will be that the NHS has had all its money, and people will forget that none of that covered HEE, social care, capital or public health, so we have huge gaps.

Baroness Harding: Exactly right.

Q61 **Chair:** If you take that budget as a whole, rather than looking at just NHS England, the uplift has not been as generous as it has been portrayed. You will be fighting a headwind that says, "The NHS has had its cash," so you will need to produce a very detailed case about how none of this is going to work unless you get funding in those other areas too. I want some reassurance that you are doing that work.

Baroness Harding: You are 100% right; I could not put the case better than you have just done, Sarah. What we have done over the last three months is unite all the different parts of the NHS that focus on our

people. We are working together on that detailed case for the Treasury. You could not get a cigarette paper between David and me on this.

We need to make sure that we invest in the training and development of the people we need to bring in and retain in the NHS. The vast majority of the additional revenue funding agreed last year for the NHS will go on the pay of those people, but if we do not train and develop them we cannot help them do the jobs, so we have to do that. We will not be able to create the ways of working and the careers that our people want, and our patients deserve, unless we invest in the capital infrastructure and tools that they use. We have to make that case, and you should feel assured that we are making it together.

Q62 **Chair:** You are making it. Are you going to make those figures public?

Baroness Harding: You have more experience than me of how best to navigate a spending review. There will obviously be a time at which that needs to be made public, but it is not yet.

Chair: We have an awful lot to get through, so we will come on to organisational responsibilities.

Q63 **Andrew Selous:** Could you tell us how you see, first, integrated care systems and, secondly, primary care networks? What role will they both have in workforce planning and making sure that there are sufficient and suitable medical staff in their areas of responsibility?

Baroness Harding: We see both playing a hugely important role. One of the main themes of the interim plan is to set out a new operating model, if you will, with clarity of what needs to be done at which level in the system—what needs to be done by individual organisations, whether individual GP practices or individual NHS trusts; what needs to be done at a local system level; and what needs to be done regionally and nationally.

Directionally, we need to push more to a local primary care network or integrated care system, because that is the community where people tend to work and live. There is already good evidence of our more advanced integrated care systems doing that, whether they are systems that have pooled their apprenticeship levy, which enables smaller employers in the NHS to benefit from the training programmes and systems that larger trusts have in integrated care systems, as is happening in Yorkshire, or whether it is creating staff passports that mean members of staff do not have to go through the same mandatory training if they want to work for multiple NHS organisations in their local geography.

Thirdly, it is about starting genuinely to plan how many more nurses, allied health professionals or doctors we need in our local areas. There is a lot of work that I think is best done in local health economies, or integrated care systems, to use the healthcare jargon. That is not to say that everyone is ready to do that now or that nothing needs to happen

nationally. There is a lot that we have to lead nationally as well, to set policies and support local integrated care systems as they develop. It will not all happen instantly, but they will be essential if we are to manage our people better.

Q64 **Andrew Selous:** You explained the work you are doing nationally, which we absolutely understand, and that is vitally important. How is that going to mesh with the integrated care system and the primary care network at local level? What is the interface? Where and how are those conversations held to make sure it works in Dunstable and Leighton Buzzard?

Baroness Harding: To repeat what David said, we need to mesh not just people planning locally, regionally and nationally, but people planning and operational and financial planning. The key piece of work over the course of the next six months, which we will be asking all integrated care systems to work on, is their detailed plan to implement the vision of the long-term plan published in January. That needs to be a people plan, a financial plan and an operational delivery plan all together, not separate.

The goal of our interim people plan is to set that out and, as we brief the NHS over the next few weeks on that implementation planning process, to support local systems. The job of our combined regional teams is to support the local systems and ensure that there is learning from each other; check and challenge; and then aggregation regionally and nationally. This is complex, but it probably should be for the most important service in the country with the largest workforce.

Andrew Selous: Thank you.

Q65 **Diana Johnson:** I want to ask about leadership and culture and how far that is to blame for some of the shortages we see now. I want to ask you specifically about a media report yesterday about the chief executive in a trust that seemed to be failing who seems to have been moved into another job in the NHS. I do not want to get into the details of that, but when senior managers in the NHS seem able to be moved around with impunity, how does that fit with a workforce where morale is low?

Baroness Harding: I have given evidence to you before, and you know how I feel about these issues. Leadership and culture in the NHS are absolutely fundamental to solving the problem. The more we talk to frontline staff, the more convinced I am that it is the real core we need to address. It is not soft and fluffy. It is difficult to shift cultures, but I am convinced that there is an awful lot we can do nationally, regionally and locally both to make the NHS a much better place to work and to support and challenge our leaders.

I do not like at all the NHS's historical practice of moving people around the system, but I also do not like the absence of a means of properly evaluating the culture and leadership of organisations. One of the recommendations in the interim plan is that we intend to work with the

CQC to change how we hold providers and systems to account in the way they lead. That is what the CQC would call their well-led domain, which at the moment is very heavily focused on governance rather than leadership culture. We can do a lot in the questions we ask when we oversee organisations and the behaviours we expect from individuals. I think we can shift this.

Q66 **Diana Johnson:** But in the meantime things are just carrying on as normal, aren't they?

Baroness Harding: No. I do not want to get into individual instances; I do not think that is fair. A lot of it is about developing fair HR processes that treat individuals with respect, but with a proper learning organisation. This is going to take time, but we can move cultures in organisations quite quickly when we support the right leaders to do the right things. There are ample examples in the NHS where brilliant leaders have gone in and shifted cultures remarkably quickly, without changing very many of the people, if any, working in the organisations.

About nine months ago, I was at an outstanding-rated hospital that six years previously had been inadequate and in special measures. I was talking to a group of about 400 of their senior managers. We did a show of hands, and about 380 of them had been with the organisation for that entire period. They were simply being led in a way that enabled them to be their best. I do not think we should assume that changing culture takes forever; we have to start changing it now, and that requires a change in the organisations we lead.

Q67 **Diana Johnson:** Can I ask you about that? Do you feel there is a bullying culture in the leadership of NHS Improvement or NHS England? Do you think that is a problem?

Baroness Harding: Nationally, 20% of our staff in the NHS say they have experienced bullying at least once in the year. It is pretty hard to get away from the stark fact that our people think we have quite a bullying culture nationally. The statistics for NHS England and NHS Improvement are worse than the average for the NHS.

Q68 **Diana Johnson:** There is a bullying culture in the top leadership of the NHS.

Baroness Harding: We need to change—all of us. My colleague David Prior, chair of NHS England, would agree with me that the regulators have to change. One of the recommendations in our plan is to institute 360-degree feedback on the regional and national teams in NHS England and NHS Improvement, asking providers and commissioners and the local systems we oversee to give feedback on how we behave. That has never been done before. We have to work out how to do it in a way that is respectful of people, but we have to allow organisations to tell us when we are behaving inappropriately, so, yes, I acknowledge that.

Q69 **Dr Williams:** Like you, I have seen brilliant leadership and fantastic

cultures in some NHS organisations, and poor leadership and toxic cultures in others. How are you going to influence that and realise the ambition of having every organisation with a better culture?

Baroness Harding: It is about two very complementary things. I am stealing shamelessly from an NHS leader, a chap called Peter Homa, who has been chairing the NHS Leadership Academy. Referring to the US, Peter talks about the east coast and west coast of leadership, by which he means that, if you were to caricature life on the east coast, it can be very rigorous and structured. In NHS terms, that means our very best organisations have an east coast approach to leadership, which is an improvement methodology and approach to allow everyone working in the organisation to spot the opportunities to improve and, in a structured and rigorous way, implement change. You need the east coast, but you also need the west coast, which is a kind, compassionate, caring and coaching approach to learning that allows people in that very structured approach to improvement to feel safe and admit that something has gone wrong and things could get better. You need both.

The way we will develop that is through a whole series of initiatives at both national and local level where we should expect all NHS organisations over time to have a genuinely structured and rigorous approach to driving improvement. If you look at the outstanding-rated organisations in the NHS, they all have one. There is no reason why every single one could not have that, if we set our minds in the centre, the regions and locally to deliver it.

Likewise, all outstanding-rated organisations have a compassionate leadership style and approach, and we need to do more to train and develop and performance-manage that. I would like the first conversation a trust has in its quarterly review with its NHS Improvement and NHS England regional team to begin with, "What are you doing to develop the line managers in your organisation? What training and development have your line managers had on being good managers and on coaching and developing their people? What have you done about the whistleblowing complaints you have had in your trust?" If we at the centre start to focus on that first, and the operational performance and finance second, operational performance and finance will get better.

Q70 **Dr Williams:** I led an organisation that had a culture lead. Do you envisage every organisation having a people or culture lead at board level?

Baroness Harding: I think the culture lead is called the chief executive, and we need to hold our leaders to account for doing that important work. We also need to do more to encourage our HR teams, our people teams, themselves to be proud of the work they do, and to feel they have a voice in their organisation. One of the things we did was a quick audit of a number of trusts' board papers. You do not see enough discussion of people issues in NHS boardrooms.

Q71 **Dr Williams:** A lot of primary care HR has been outsourced to Capita. Do you think that is a mistake?

Baroness Harding: I should declare that I do not have a huge amount of knowledge of Capita contracts, so I have to be careful of the territory I am on.

Routine processing is often best done in a single larger support centre. People management is not something anybody should be outsourcing. You should not actually be outsourcing it to an HR team; it is about teaching and developing your line managers.

Q72 **Dr Williams:** The experience in primary care is that a lot of systems and processes have been too inflexible and they have then had an impact on people.

Baroness Harding: Yes, and primary care networks will play an important role in being able to improve that.

Q73 **Chair:** Can I come on to a large section of your report—the nursing workforce? What impact has the removal of nursing bursaries had on nursing shortages?

Baroness Harding: If you look at page 24 of the report, you can see the unique applications to UCAS and the reduction at the point at which the nursing bursary was taken away. Can I prove cause and effect? No, but you can absolutely see the reduction around that timing. There are a number of different factors in nursing, so you have to be careful in drawing that conclusion. None the less, there is a particular issue.

It is interesting to look at the recently published Augar report into higher and further education. It looks to be the same with mature students in other degree courses beyond healthcare. The removal of maintenance grants and, in the case of nursing, bursaries for mature students has had a particularly big effect. That is particularly concerning for us for our mental health nursing workforce, our community nurses and our learning disability nurses, all of whom tend to have come in at an older age. That is something we have to look at very carefully.

Q74 **Chair:** One of the particular issues is that the attrition rate traditionally was lower for mature students.

Baroness Harding: Absolutely.

Q75 **Chair:** You are losing a particular group that was less likely to leave once they were there.

Baroness Harding: Absolutely.

Q76 **Chair:** It has huge implications. Are you going to make recommendations that bursaries are returned for mature students?

Baroness Harding: I forget the exact wording. We need to look at what the right solution is to support mature students so that they can afford to

retrain as nurses. It might not be a straight bring-back of what we had before, but we have to look at how we are going to support people who have a mortgage and/or a family to support and want to become nurses.

Q77 **Chair:** We know from the historical evidence that bursaries work. What other mechanisms are you looking at that might also help to encourage that particular group not only to apply but to stay?

Baroness Harding: It is looking at how you develop a targeted approach that genuinely solves that specific problem. We have to do that work over the course of the next few months and explore the most efficient and effective means of doing it.

Q78 **Chair:** When we see you again, for the full workforce review, you will have a worked-up plan for all the different routes to make sure that we can incentivise people to come into these key shortage specialties.

Baroness Harding: Yes.

Q79 **Mr Bradshaw:** I am pleased you have acknowledged that there has been a significant shortfall. When the previous Secretary of State came before us, he denied it was happening in spite of the fact that we warned him it would. But, again, you appear reluctant to recommend a policy solution to Government Ministers. I am worried that you do not want to embarrass them for having made policy mistakes in the past. This is clear; it is staring you in the face. It has not happened in Scotland. Why not just recommend that the Government reverse that disastrous policy?

Baroness Harding: Simply because this is an interim report where we have not worked up the detail and costed it yet. I want to be able to recommend a proper, concrete proposal that addresses the problem and is funded and clear. We will do that when we publish the final report. There is no attempt to duck whether or not this is the right policy, but we need a proper worked-up proposal, and at this stage we do not have it ready yet. That's it.

Q80 **Chair:** We seem to have a sort of inverse care law going on, where the groups who need it most are the most deprived of the workforce they need, as well as geographically.

Baroness Harding: I completely agree with you.

Q81 **Chair:** The Committee would like an assurance that we will see some properly worked-up and costed proposals for how we can tackle it for the most vulnerable groups.

Baroness Harding: I am very happy to commit to that.

Sir David Behan: As Dido said earlier, we have worked together on this, and I intend to continue to do that. Going back to the earlier question, one of the ways you can change the culture is by modelling different sets of behaviour about working together. It is not about one organisation blaming another. What is important on this particular issue is to

distinguish applicants and acceptances as we go forward. What is clear, as Dido said, is that the fall-off has been in mature students coming through. It is essential that we bring forward policy proposals, to pick up the point Ben is making, as part of the final report about what can be done to encourage multiple routes.

Sarah, your earlier question was about what more could be done. We need to continue to drive apprenticeships as a way of working, because that brings people from local communities into the workforce. As part of the interim people plan, HEE has committed to look at blended nursing degrees, with some online work as well as people working alongside. Nursing associates have been a huge success, with a number of nursing associates converting to full nursing qualification training. What we are doing is introducing greater flexibility of routes into nursing, and they are beginning to convert. That is what we also need to bring forward as part of the final plan, because it will be critical to how we generate and ensure we have supply in the future.

Chair: We are going to come on to GPs and primary care.

Q82 **Andrew Selous:** In September 2015, the previous Secretary of State for Health committed to getting an extra 5,000 doctors in general practice by April 2020. Health Education England produced the "General Practice Forward View" in April 2016, committing to that. Not only have we not advanced towards that, we have actually gone backwards, with 1,848 fewer full-time GPs, less the retainers and trainers, between September 2015 and March 2019. Why has it gone so terribly wrong, from a commitment to 5,000-plus to a negative of 1,848? Why should we have any more confidence in the current plan before us this time, given that it went so disastrously wrong last time?

Sir David Behan: What we have is an increase in general practitioners coming through training. We were set a target last year of 3,250, and we are at about 3,400 for last year. The target this year is again for 3,250 coming through, and we anticipate that we will exceed that number for this year as well, in terms of applicants for training going into general practitioner training.

Two issues are going on. There is a question about why people are leaving and not being retained in the workforce, and then we have the issue about the commitments to bring more people into the workforce. The retention bit has struggled, as your figures pulled out, and there is a combination of issues. Pensions will be one of the issues that people talk about. In terms of ensuring future supply, we have generated a future supply that will end up converting into the workforce.

Q83 **Andrew Selous:** Do you have any idea how many additional migrant GP registrations there have been in England and Wales between 2015 and 2017, looking at the demand side?

Sir David Behan: I am sorry, not off the top of my head.

Q84 **Andrew Selous:** It is 1.5 million additional migrant GP registrations, according to the Office for National Statistics, in England and Wales alone. I have checked those figures from the ONS. Those are additional migrant GP registrations at a time when the GP workforce in England has gone down by 1,848. I am sorry to say that I do not feel that there is quite a full understanding of the seriousness of the situation in general practice. It is excellent that you are getting more in at the bottom end, but we are losing them in enormous numbers, at a rate that we simply cannot afford. Could you tell us more about how you are going, first, to have additional overseas recruitment and, secondly, to help the GPs we have to stay in the workforce? Could we have a little bit more detail on those two areas, please?

Sir David Behan: I am not looking to absolve myself of any responsibility, but the HEE's role is to ensure the education and training of the workforce coming through.

Q85 **Andrew Selous:** Yes; perhaps Dido could respond to that.

Sir David Behan: Let me stay with it. I am sorry that I did not know the migrant registrations—I now understand what you mean. It is an artefact of increasing demand that there are more of us in England who require access to GPs.

Q86 **Andrew Selous:** At a time when we have far fewer GPs. I want you to understand the seriousness; you have to look at supply and demand.

Sir David Behan: Sorry, I did not understand the question, but I understand the principle behind the point you are making. Again, it is more for NHS England. The GP contract, which was renewed, is seeing an investment of over £4.5 billion in general practice over the next period of time. The issue about growing general practice is not just about growing the number of general practitioners; it is about seeing an increase in things like clinical pharmacists.

Q87 **Andrew Selous:** I absolutely get the importance of the team around the GP, and I know that is vital, but for now I want to focus on GP numbers alone. While you are getting additional numbers in at the bottom end, you are losing them at a much faster rate while they work, so the net situation is very serious.

I have two questions. First, what are you doing on overseas GP recruitment? Secondly, how are you going to help hard-pressed GPs working in practices up and down the country now to stay and not leave?

Baroness Harding: Let me pick up the second of those questions. As David just said, the recently launched new GP contract sets out significant additional resources to wrap around GPs. I agree with you, Andrew, that we also need to face into the fact that we are losing too many GPs for whom the current deal is not working. It is good news that the Government have heard a lot of that feedback on pensions.

Q88 **Andrew Selous:** I shall come to pensions in a second, if I may.

Baroness Harding: It is an important element, and we hear consistently from GPs that that is one of the reasons why slightly older GPs are retiring early. We need properly to address that through the consultation that the Government announced yesterday.

We also need to face into the fact that a lot of GPs—particularly, but not only, younger GPs—want to work in a different way. They want to work more flexibly. They do not want to own their own practice; they want to be salaried GPs as part of a network. We need to redesign in primary care, just as much as we need to do in secondary and tertiary care, to recognise what being a modern employer looks like.

Q89 **Andrew Selous:** When is that going to happen? In my view, it is really urgent.

Baroness Harding: I agree, and that is why setting up primary care networks is fully in train as we speak and why NHS England announced, before the publication of this report, the new GP contract and the recruitment of additional people. That is why the pensions consultation was announced yesterday. I would argue that a lot of action is happening as we speak. When you talk to GPs working in primary care networks that are beginning to thrive, they describe a very different job from the old role; they describe something that is much more enjoyable and that they want to keep doing.

Q90 **Andrew Selous:** I am pleased that you have talked about practices that are thriving, because some of them are. The Committee went to see Larwood house in Worksop, which is outstanding, and I have recently been told about Thistlemoor in Peterborough, which is also an outstanding practice. But where GP practices are failing, it seems to me that there are very few levers that either the CCG or NHS England can use to do anything about it. In conversations I have had, people said, "You'd better not push them too hard or they might hand the contract back." For an absolutely key frontline service, which our constituents probably care about more than anything else, I simply do not think that is acceptable, when huge amounts of taxpayers' money are involved.

What is happening in the NHS centrally to make sure that we can come alongside and support, with a bit of direction occasionally, GP practices that are seriously failing? From my work in this area, I do not think you have the tools in your kitbag to help failing GP practices. Is that of concern to both of you as well?

Baroness Harding: We have to be a bit careful that our people plan does not overreach into being an entire NHS care plan. At this stage, the work we have done together over the last three months has not got into that level of detail.

Q91 **Andrew Selous:** Whose responsibility is it? Is it for Simon Stevens and NHS England?

Baroness Harding: Yes, although it is a very fair challenge, and we have been working hard over the last three months to make sure that this is a people plan for everyone working in the NHS, and that it takes into account the issues in primary care. It is a fair challenge for us to work through in the final plan. I just do not feel that, at this stage, David and I have enough detail to be able to answer that question.

Q92 **Andrew Selous:** No, but I would comment that, in your interim plan, the first mention of GPs is on page 37, and they get about two pages.

Baroness Harding: I am happy to answer that. You will find that for every clinical specialism you can do roughly the same thing. We have worked really hard not to feel that the way to be inclusive is to list every clinical specialism. It is not actually part of the change. The cultural change we need to make in the NHS is to celebrate people working in multidisciplinary teams and recognise that we are genuinely trying to include everyone. The way we do that is not by listing everyone by name; we do it by addressing the underlying issues together.

Q93 **Andrew Selous:** I want to come on to the pensions issue, which we touched on briefly earlier. Has what the Chancellor did yesterday been sufficient to deal with the issues?

We have had the utterly ridiculous situation where not only the annual allowance but the lifetime allowance means that we will not hit the 18-week target in our hospitals because consultants are doing less work as it is financially disadvantageous for them to do it, and GPs are being advised to do fewer sessions every week not to get an additional tax liability. That is, frankly, bananas, and we should never have allowed it to happen. Is what the Chancellor did yesterday sufficient to deal with that issue for both consultants in hospitals and GPs in general practice?

Baroness Harding: It is a beginning, and it is very important that we listen carefully to all the different stakeholders during the consultation to make sure that it genuinely addresses the issues. From our perspective, we need to be honest with Government that this is a really big problem. I am pleased that the Government have announced the intention to make changes, but I want to make sure that it is a proper consultation.

As you were having your pre-briefing, we were having a debate outside with 10 fantastic doctors, who are sitting behind me, on their concerns about whether it will or will not actually deliver what they need. We need something that prevents the disincentives but is also fair to taxpayers and fair to other professions whose pensions are being capped.

Q94 **Andrew Selous:** I understand that. I just think, along the line of questioning that Ben was progressing earlier, that there are clear policy recommendations. I do not think any of us are out to advantage well-paid people, but when the public are being significantly disadvantaged in a key, frontline public service that they really care about, it is complete madness that the tax/pension tail is wagging the public service provision.

Baroness Harding: I completely agree with you. Had we not had an announcement yesterday from the Government, we would have been very clear that there was an urgent need to address the pensions policy issue.

Q95 **Andrew Selous:** It is still serious.

Baroness Harding: I agree with you.

Q96 **Andrew Selous:** As my last point, I encourage you to shout quite loudly about this. Some of us have been doing that for some time. I have raised it twice at Prime Minister's questions in the last couple of months, but I have been a bit of a lone voice, and we all need to shout a bit more loudly.

Baroness Harding: The other thing is that we need to recognise that we need to get this done quickly. We need to run a consultation and have real, concrete changes going into the next tax year, otherwise we will be sitting here in a year's time still losing fantastic people who have a huge financial disincentive to work for us.

Q97 **Chair:** Before we come off the area of primary care, it used to be much easier in the NHS for people who had gone down the specialist route to change into primary care. It used to be possible to do that without going right back to the beginning of training. This is an issue that I have brought up every year since I have been an MP, which is nine years. I am told that it is the GMC, HEE or the royal colleges. There are many easy wins that we could use, but we seem to have these barriers. Is that something you are going to get to grips with, in your plan?

Sir David Behan: Yes; there is an important debate about future medical careers. One of the important aspects of the work that has gone on over the past few months is that a lot of the work that was being undertaken in HEE now has more visibility. Some of the issues are about making medical careers much more flexible—Dido used the word "agile" earlier—which would allow people to move from one setting to another and one speciality to another.

One of the things we will do this year, to come back to the theme of what we are doing now to address these issues, is to look at the idea of credentialling—people securing qualifications that allow them to develop new skills and knowledge, and work in a different way. It has involved agreements with the GMC to take that forward. We are beginning to see some of the changes that will allow for exactly the agility that will be required in the future.

Q98 **Chair:** Will you have the levers to insist that some of those things happen? It seems to take an awful long time to bring changes about.

Sir David Behan: We will have the power of influence and persuasion, and I am going to champion those issues during the period that I am at HEE.

Q99 **Chair:** For nine years I have been asking about this, and nothing seems to change.

There are other things as well. You talk about credentialling, but there is the issue of attracting doctors back who have perhaps done some training overseas—British graduates who work abroad for a few years. We seem to be ridiculously missing out in attracting them back, because even if they have worked in a place like Australia, or a similar set-up, they cannot actually count any of that experience when they come back. It is a real disincentive to getting them to return. Are you going to be much more agile about allowing that experience to count?

Sir David Behan: Again, unless we create more flexible ways of employing our staff in the future, we will continue to experience conversations like the one we are having this evening.

Q100 **Chair:** Yes, we have been having them every year for some time. There is also the issue of things like Skype interviews, actually expecting people to fly halfway around the world for an interview, rather than allowing them to be interviewed by Skype, and things like that. Are we going to be much more flexible in trying to attract people back to the UK who have worked abroad for a few years?

Sir David Behan: I would like to think we are, and HEE will do its best to influence the way that others are operating, including ourselves and how we operate.

Q101 **Chair:** Yes, influence is one thing, but are you actually going to be able to bang the table and make some of these sensible changes happen?

Baroness Harding: If you look at what we have written in the plan, one of the things we firmly believe is that banging the table is not the best way to drive change in a people system like this. We need to bring people with us.

I wanted to make the case for why change will happen now, to give you a positive reason to be hopeful after nine years of raising this. It is partly that there is a genuine shortage, which we have to acknowledge needs sorting. We have a burning platform, which means we need to do something different. In my experience, change happens when you have a real burning platform, and when you also have something that is much more appealing to move towards. If you spend time, as I know many of you do, with young doctors and nurses and allied health professionals, you see that our young people coming in want to work in a different way. They want their careers to develop in a different way. It is not just that we have to change because we cannot find enough people; our people want us to work differently, and our patients want us to work differently.

You have a number of positive reasons, and you have a process-positive reason. This is the first ever people plan that the NHS has had, and we genuinely have all the different tribes in the NHS working with us on it. No one disagrees with your vision of a more agile, clinical—

Q102 **Chair:** No one has been disagreeing for the last nine years, but nothing has changed. That is the difficulty we have.

Baroness Harding: The proof of the pudding will be in the eating.

Q103 **Chair:** Right, I shall ask you this again next year. Let's see whether it has changed by then.

Sir David Behan: We look forward to it, Sarah.

Q104 **Chair:** On allied health professionals, one issue that has been specifically raised by paramedics is that they cannot access the learning support fund. I know historically why that has not happened, because it was not a change from bursaries, but the issue of whether we should widen access to the learning support fund has been specifically raised.

Baroness Harding: There is a more general issue of lack of awareness and understanding of the learning support fund in general, which we would want to look at as part of getting to our final recommendations. I shall take the specific about paramedics back into that work.

Chair: We are now going to come on to public health, and sexual health.

Q105 **Diana Johnson:** On the issue of agility, do you think that the barriers that were recognised by, I think, the predecessor Committee of this Select Committee about local government and the NHS are still there? Do you think there is more ability or agility to move between local government and the NHS?

Baroness Harding: It varies hugely across different parts of the country, just as the maturity of our integrated care systems varies hugely. There is an awful lot more work to do for individual people to feel that they can move seamlessly. We are a long way from its being best practice everywhere.

Q106 **Diana Johnson:** I am sure that you know that the Committee has recently published a report on sexual health. One of the key concerns we had was around workforce planning, recruitment, development and training. Commissioning of sexual health services was a problem, as were fragmentation and cuts to budgets. They all created a perfect storm in terms of workforce. What are your views on the need for a specific piece of work around the sexual health workforce?

Baroness Harding: I read your report, and it struck me that you had a case study that is, sadly, representative of lots of other parts of our health system. The way we have approached this plan is not to do individual siloed planning for each specialty, but instead to try to build an integrated view of what we need to change in the system as a whole. That is not to say that we do not need to do detailed work in sexual health, because we do, but your report showed a perfect example of the broader problem we are trying to highlight.

Q107 **Diana Johnson:** Yes, but it is a real problem because of the involvement

of local government as well as the NHS.

Baroness Harding: Absolutely. That is why, as I said, we have to bind that in. It is one of the reasons why planning for workforce needs to be done more at a local health economy level; it has to be done with local government fully part of the development of the plans. You demonstrated in your work on sexual health exactly why we are recommending a new operating model that devolves more responsibility to local systems.

Q108 **Diana Johnson:** In terms of the interim report, what was the involvement of local government in putting it together?

Baroness Harding: On our steering group, we have tried to be as inclusive as we possibly can, so we have had people from the Local Government Association involved with us. We have had Skills for Care sit around the table, to make sure that social care was fully represented. It is not perfect, but we have tried to be as inclusive as possible, and we are looking to expand our engagement with local government in the next phase of the work.

Sir David Behan: The work at the ICS level is critical for making sure you have those interfaces. In the more mature ICSs, that is exactly what you see.

Q109 **Diana Johnson:** There are lots that are not very mature, as I understand it.

Baroness Harding: Absolutely.

Sir David Behan: I think that is a variation point, which we would acknowledge. But the better, more mature ones, are driving a much more coherent conversation about what the future workforce for that locality is going to be, what skills are required and how they can be secured.

Chair: Thank you. We come on to the first 1,000 days of life and social care in a bit more detail.

Q110 **Angela Crawley:** The Committee did a power of work on the first 1,000 days of life, and the report made the case for a "holistic workforce plan for services." Can you see the case for that recommendation?

Sir David Behan: On the first 1,000 days of life, work has been undertaken on the maternity plan. Maternity is a key component of the long-term plan. Work to develop the future workforce associated with the maternity plan was published a couple of months ago—I cannot remember the exact date—when we set out the ambitions and plans in relation to the development of the maternity and midwifery workforce.

Q111 **Angela Crawley:** I personally was not a part of the Committee's inquiry at that time, but from the work of the Committee that I have seen, part of it is around integration of services and looking at a more holistic approach, not just primarily healthcare provision in terms of maternity but the wider framework.

That brings me to my next question. You will be aware that in Scotland health and social care have been integrated, and you can already start to see the benefits. What account have you taken of social care in preparing for your interim plan, considering the impact that healthcare and social care have on each other?

Baroness Harding: As I said, we looked to include local government and social care organisations in the development of the interim plan. My specific commission from the Prime Minister and the Secretary of State was for the NHS workforce rather than the social care workforce. We have described it, as a project team, as the core of the commission being like the inside of a photo frame, the picture itself; the stuff that is out of scope is not in the frame, and social care is on the frame itself. We cannot ignore it as we develop a plan for the workforce for the NHS, but I do not have a specific remit to make recommendations for the social care workforce.

Q112 **Angela Crawley:** It is fine saying that you are engaging with local government and social care providers, but how much involvement have you really had in scoping your priorities? I appreciate that your remit is for the NHS, but, ultimately, how much are you listening to them? Are you taking on board their points? Are you working together?

Baroness Harding: We are including them in our working groups and making sure that we understand the consequences of our recommendations so that they are not detrimental to social care. As David has just said, a lot of the work is at a local system level. A number of the best practice examples are when we create an employment pool that is both NHS and social care, whether that is the passport that allows you to work in multiple organisations, both social care organisations and NHS, or pooling the apprenticeship levies so that everyone can access more of their levy. There are a number of different initiatives that we are looking to highlight and encourage as local systems develop their plans. We are trying to be as mindful and inclusive as we can without straying beyond our brief.

Q113 **Chair:** Is there anything either of you has not been asked about this afternoon that you want to say before you leave?

Baroness Harding: It has been pretty comprehensive.

Chair: Thank you very much for the work so far, and we look forward to hearing your final report.