HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Workforce: recruitment, training and retention in health and social care, HC 893

Tuesday 1 March 2022

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Watch the meeting

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

Questions 1 - 66

Witnesses

I: Lara Bywater, Registered Manager and Owner, LDC Care; Dr Emma Hayward, GP and Clinical Teacher, University of Leicester; and Gamu Nyasoro, Clinical Skills and Simulation Manager, Kettering General Hospital NHS Foundation Trust.

II: Jane Ashcroft CBE, Chief Executive, Anchor Hanover; Sarah McClinton, Vice President of the Association of Directors of Adult Social Services, and Director of Health and Adult Services at the Royal Borough of Greenwich; Rachael Dodgson, Managing Director and incoming CEO, Dimensions; and Oonagh Smyth, Chief Executive, Skills for Care.

III: Chris Hopson, Chief Executive, NHS Providers; Nicola McQueen, Chief Executive Officer, NHS Professionals; and Professor Dame Helen Stokes-Lampard, Chair of the Academy of Medical Royal Colleges, and Professor of GP Education, University of Birmingham.

Examination of witnesses

Witnesses: Lara Bywater, Dr Hayward and Gamu Nyasoro.

Q1 **Chair:** Good morning and welcome to the first evidence session of the Health and Social Care Select Committee's inquiry into "Workforce: recruitment, training and retention in health and social care." This inquiry is about the biggest single issue facing the NHS and social care sectors: namely, how to ensure that we have the right number of well-motivated and well-trained staff to deliver the levels of care that we all want to see.

This morning is an introductory session in which we are going to look at all aspects of the crisis, but particularly the challenge of recruitment. Subsequent sessions will look at retention, issues facing minority ethnic staff and women, reforms to medical education and training. We will finish with a session with the Minister from the Department of Health and Social Care.

We have a packed session today. We have three panels. In our first panel we are going to hear from people with experience of the challenges of recruitment, retention and staff shortages on the frontline. I am very pleased to welcome Lara Bywater, who is a registered manager and owner of LDC Care, which provides supported living and residential care to people with learning disabilities and complex needs. Dr Emma Hayward is a GP and clinical teacher at the University of Leicester Medical School. We will welcome shortly Gamu Nyasoro, a registered general nurse who works at Kettering General Hospital.

Perhaps I could start by asking you, Lara and Emma, to talk about the impact of staff shortages on your day-to-day work and the effect it has on the people you are looking after.

Lara Bywater: Good morning and thank you. I have never seen a staff shortage impact like this and I have been running the organisation that I own for over 20 years. For people I support, who have complex needs around autism, learning disabilities and mental health, one of the keys to providing good-quality care for them is continuity and consistency of staffing. Once you start to take away that consistency, it has an impact on the quality in terms of not necessarily the skillset but the relationships that people build with those they are supporting. For the first time ever in all the years that I have been working in social care, we are having to use agency staff to supplement our staff shortages. They are qualified and experienced, but they do not have the same level of commitment to the job.

Q2 **Chair:** I think we probably all understand the point you are making, but just explain what the impact is on an autistic person or someone with a learning disability of being seen by different staff week in, week out, as opposed to developing a regular relationship with someone who gets to know them.

Lara Bywater: I will try. I can only reflect on how I observe people, so to get a truer understanding it would be helpful for you and colleagues to

speak to people who live with those conditions. Certainly, from my observations, it takes a long time, particularly for people who have been "through the system". They may have been through secure settings and a range of providers, so it takes time for them to build up trust with the people who are looking after them. It can actually take months for people to become used to a new face if they have additional needs. Talking in very general terms, it can make people less keen to participate in their normal activities and perhaps more worried about going out into the community because they do not have rapport and trust with the people who are supporting them. They are great members of staff, potentially; it is just the relationship stuff.

Q3 **Chair:** Is there an issue with the ability to understand a client's needs and what they are trying to express that is more difficult to get right when you have a big changeover of staff?

Lara Bywater: In the social care sector we have come a really long way. We have very professionally written, detailed care and support plans. Every organisation has a slightly different way of wording them, but we have wonderful documents outlining the needs of those people. Ultimately though, humans develop relationships. It is about the cues that might not necessarily be written. It is about the slightest change in mannerism that can be an indication to the support team that the person needs a drink, is getting fed up, or is too hot or too cold. It is the more subtle things that take time to understand. We, of course, can follow specialist diets or people's medication requirements. All of those task-oriented needs can be very easily met, but it is far more important for the individuals to have the soft relationships and their soft needs met in terms of the unspoken stuff.

For families, it is really important that they have confidence in the people who are supporting their loved one. It can cause huge anxiety if families see different faces around their son, daughter, sibling or other family member.

Q4 **Chair:** What do you think is the root cause of your difficulty in being able to recruit full-time, regular staff?

Lara Bywater: I do not think there is a root cause. It is a perfect storm of lots of challenges. Social care, if I can be blunt, has always been bottom of the pile. It is not uncommon historically to refer to people working in care as "Just carers. It's what you do when you can't get a job somewhere else." The pandemic accelerated the pressures on that, and more people left the sector.

There is a huge issue around it not being well enough respected as a career and a valued job out in the world. Even though there are some magnificent career opportunities for people in social care, we do not champion them. We do not see it as a great career opportunity. When I speak to people, it is still seen as what you do when nowhere else will take you. There is the unwritten expectation that people do it because

they are good people and it is a vocation, so financial remuneration should not be as important as it would be for other people; but ultimately, everybody has bills to pay, so of course they should not be penalised for doing a caring job.

There are lots of other pressures. Because of the pandemic, people were exhausted and fed up. There was the impact of the vaccination and mandating thereof. There is also an element from the impact of overseas workers not being as available as they were. There has been a whole range of factors and probably some others that I have not mentioned.

Q5 **Chair:** Thank you. We will come back to you, if we may, Lara, but can I move over to you, Emma? I know you think a lot about the challenge of GP recruitment, so could you start by talking about what the impact is for practices up and down the country at the moment when they are not able to recruit enough staff?

Dr Hayward: Thank you for the opportunity. I agree with what Lara said; we are in the middle of a perfect storm. I have never worked harder or faster in my whole career, and this was coming before Covid. We cannot blame Covid for this crisis. This has been coming for a number of years. It has an impact obviously on our patients who cannot get hold of a GP in a timely manner, and that is so frustrating for us as GPs because we want to follow up our patients, we want to provide continuity of care, and there simply are not enough hours in the day for us to get all the patients through. It is incredibly stressful that, despite us working as hard and as fast as we can, we still cannot keep up.

There are other impacts. It impacts our ability to be good trainers. It impacts our ability to be good role models for medical students. Medical students are coming through and seeing a stressed and burnt-out workforce, and are deciding against general practice. I spoke to my tutees yesterday—year 1 and year 2 students. Many of them have already dismissed general practice as a career because of what they have read and experienced personally. This is a massive problem that we have to address, and I have some suggestions that perhaps I will share later.

The other thing I have seen is the human cost of GPs having to work in this highly pressurised environment. I have never seen so many of my colleagues so close to burnout or working while burnt out as in the last couple of years. One of my friends the other day described a day in general practice as like being pelted with rocks, because you never know which rock is going to come and hit you, and hit you hard. We are left carrying all the risk for systems failures. People get inappropriately discharged to the care of a GP. How am I supposed to keep a suicidal patient alive when they should be in a mental health facility? If that person takes their life, I will be the one justifying myself in court for their actions.

There is a history, with the case of Dr Bawa-Garba, of one person taking the rap for a whole system that failed. We have no confidence when the

GMC says that circumstances will be taken into account because that is not what we have seen in the past. It is like a sword of Damocles. When I walk into the building at 7.30, I have no idea what is coming my way, but I know that by the end of the day I am going to be physically, mentally and emotionally exhausted. I have sometimes worked for 12 to 13 hours with two five-minute breaks. Three people are waiting outside my room to ask questions; things are coming up on the screen; I am looking at my patient list getting longer and longer; I am supervising medical students; I am debriefing trainees; I am answering nurse queries. I am not just seeing my patients.

It is exhausting and we have a massive problem. I am just recovering from several months of burnout. You have to start asking yourself the question: why would I continue in a profession that hurts so much?

Chair: Thank you.

Q6 **Dr Evans:** You passionately articulate the problem in primary care, and I hear that from my colleagues. The bit that struck me the most and what I have tried to pull out of this is that sword of Damocles hanging over your head, and the fact that GPs care a lot but feel that if they make a mistake there is all hell to pay and their career is over. When we have put that to the likes of the GMC and other litigation, because we have just done an inquiry on it, they say the culture has changed, and that GPs get it and they are doing more education. What would you say to that from the frontline? Is that something you see?

Dr Hayward: We do not feel that reassurance because, even recently, there was a case when a doctor was criticised for providing inadequate care when he was working on a Covid ward and being pulled in all different directions. It is words, but we are not seeing it played out in practice.

Q7 **Dr Evans:** One of the pushbacks we got was, "Well, people know where the boundaries are." Could you say no?

Dr Hayward: GPs cannot say no. It seems like every road leads to the GP at the moment—people who have fallen through the cracks with social care, and people who are discharged inappropriately. On pretty much everything it is, "Well, see your GP about that." We cannot shut the doors. We can try, but it causes all sorts of grief, and then people make complaints about us and say that we are not trying hard enough.

Q8 **Dr Evans:** Can you explain that grief? On the one hand, you are overworked so you want to protect your workload. On the other hand, what is the impact when you say you get grief? Can you explain to the Committee what that looks like?

Dr Hayward: Complaints, even if they are spurious or vexatious, still take time and heartache to deal with. They take up staff time. We have to employ admin staff to deal with the complaints. Where I work locally, there was a Facebook group set up to complain about our practice. We

had to meet them and work with them, and that was slightly constructive. Nevertheless it is really distressing when you read people vilifying you on social media. My friend said it was like being pelted with rocks. That barrage never stops. When we are off duty, we see in the papers and on social media how we are lazy, greedy and incompetent.

Q9 **Dr Evans:** If I can put that all together, the pandemic has exemplified the problems coming in; you then have a sword of Damocles because you never know what is coming in as a GP, and it is getting more complex and tough. On top of that, you do not have the time or the ability to limit your work. You are getting complaints, but when you go through the complaints procedure you are ultimately worried about losing your livelihood. It is the system's fault and you do not have the back-up. Is that the whole picture that you are feeling?

Dr Hayward: That is a very good summary. That is the umbrella over us just trying to do the day job, just trying to see patients and do the best we can to hold their hand in difficult times, and to make good and accurate diagnoses to try to keep people out of hospital. If you could do anything to alleviate some of those wider pressures so that we can just do the job that we are trained to do without all of that stress going on, it would make things a good deal easier.

Q10 **Chair:** Can I ask you about recruitment in your practice? Have you been trying to recruit additional GPs to get extra support?

Dr Hayward: Yes. It is nigh on impossible, and the people we have recruited have left very swiftly.

Q11 **Chair:** For those of us who are not GPs, can you give us a sense of how things have changed over the last five to 10 years when you are trying to recruit people to join a practice?

Dr Hayward: I think there is reluctance among newly qualified GPs to make longer-term commitments to a practice. We have seen an increase in people working as locums. Something I considered when I was signed off was locuming because I see that as potentially the only way you can cap your workload. As a new GP, you are still on a bit of a learning curve when you first become an independently qualified general practitioner. It makes sense to locum—to do a morning or afternoon session so that you have time to gather your thoughts. I am a salaried doctor so I am not part of a partnership. All the paperwork gets divided between the permanent members of the practice. If you have fewer and fewer permanent people, they are taking a larger and larger proportion of things like blood test results, letters and so on.

Q12 **Dr Evans:** Have you seen the culture change on that, because, historically, it has been a vocation? I hear stories and know at first hand about new salaried doctors coming in saying, "I will only do one visit," or, "I will only see 15 patients in a clinic." They are doing that to protect themselves. As you rightly point out, that also means the partners still have to do the work. Is that something you recognise?

Dr Hayward: Yes. For too long, we have just assumed that we can carry on working and working and it is somehow unprofessional to say no, but the reality is that if you cannot protect your own mental and physical health, you end up leaving. I am quite old for a female GP. Most of my colleagues leave by the age of 35 because it is impossible for many people to balance working as a GP and family responsibilities or other things.

Q13 **Chair:** Emma, you said you had some solutions. If you were Health Secretary for a day, what would be the things that you would like to change?

Dr Hayward: I am not going to say that these solutions will be easy. You have demand up here and GP capacity down there, and somehow you have to match them up. The first thing you need to do is stop the bleeding. You need to somehow change things so that we are not losing as many qualified GPs, because training more GPs will take a long time. There is a problem with the pension tax thing. I do not understand it. It currently does not apply to me, but it is something that could be swiftly resolved, I believe, if there was the willpower to do so.

You need to do something to improve the work-life balance of the GP workforce; otherwise you are going to continue to haemorrhage staff. I am returning to work, ironically, on 1 April to give GP one last chance, but if I cannot manage it, you will lose me. You have to do something that protects us. It is not about finance. It is about having a work pattern that is sustainable, because up until the time I burnt out I was just saying, "This isn't sustainable; I cannot maintain this level of concentration for this number of days a week." You need to do something to stop the bleeding, and then we need to think about how to train and encourage more people. Unless you make it an appealing career choice, people will continue not to choose general practice.

I suggest that in the short to medium term you need to do something to rapidly decrease the demand on general practice. There is an excellent submission to one of your other inquiries—I think it is the primary care inquiry—by Dr Holden. He makes about 50 very sensible suggestions about decreasing demand. We cannot increase the number of GPs, so we have to bring demand down. That means reducing the number of functions that a general practice is expected to deliver.

Q14 **Sarah Owen:** Emma, following on from some of those points, GP capacity is not the same issue across the country. It differs greatly between cities and towns. How would you go about encouraging GPs to go to areas where there is greater demand, for example? When I spoke to some young medical students who had just qualified, they did not want to stay in their home town. They wanted to go to London; they wanted to go to Brighton; they wanted to go to where they had been to university. How do we encourage GPs to come back to the towns where they were born and raised and make sure that capacity is more equally spread?

Dr Hayward: It comes back to encouraging good working conditions and having adequately resourced general practice. In Leicester, lots of people come back because they have family ties. To increase the workforce, you need to make it an appealing sort of profession. There are a couple of ways you could make things more appealing. You can look at it from two aspects. You can look at the public and you can look at the doctors. If you are looking at the doctors, I have already spoken about resolving some of the medico-legal issues, but you also need to improve their working conditions.

It needs the public-facing stuff to be done right. Unjust accusations against GPs and untrue information about us needs to be swiftly and robustly rebutted by people in power who know what they are talking about. Journalists and politicians play a big part in this. For example, there is the myth that GPs are lazy because they work three days a week. That is 36 hours. It is not a short working week. Things like that need to be swiftly corrected because at the moment people are being given the impression that a lot of the problems in general practice are due to GPs themselves, when actually they are workforce issues. That is not something I can control; yet it is the GPs who seem to take the flak for that.

We need to celebrate general practice. General practice really is the backbone of the NHS. When GP is adequately resourced and working well, everything else works more smoothly. People around the world envy our system of primary care because it works so well, but we never see celebration of general practice in the media at all. We only ever see the negatives, and that is what my medical students pick up on.

Q15 **Sarah Owen:** Lara, when it comes to social care, you talked about the need for continuity. We know that a social care worker with five years' experience will, on average, get just 1% more than somebody on their first day; on average, that is an extra 6p an hour. Do you think that that level of pay and the lack of progression in the pay scales for social care is one of the reasons you are struggling for retention and recruitment?

Lara Bywater: It is one of the reasons. You make an excellent observation, and there is a complex reason why that has happened. When we set out and were awarded our contracts as providers, we had a plan, but of course we have had the additional pressure of costs the same as everybody, for reasons beyond our control, but also the national living wage and minimum wage increases. That means that we have a set price contract for a number of years, yet our managers and senior staff are paid very small amounts more than our new-to-the-sector people. That has a huge impact.

One of the things that we have talked about nationally and locally is the need for something equivalent to the NHS pay scales to be rolled out across social care in some way. It is not an easy solution, but at least it would give some sense of fairness and equality to those people and parity with colleagues in the NHS. People gain huge amounts of valuable

experience and, rightly, want to progress their career, but are then exiting social care and either going out of the sector entirely, which is a devastating loss for the sector, or moving across to the NHS, which is great for the NHS but leaves us constantly with a deficit of support workers and qualified people in our sector.

Q16 **Chair:** Before we close this panel, I want to bring in Gamu, if I may. I know you have struggled on the tube this morning, so thank you very much for battling all the way down from Kettering. We are discussing workforce shortages in the NHS and care system. You are a nurse at Kettering General Hospital. Do you experience nursing shortfalls, and what do you think the cause of the problem is?

Gamu Nyasoro: I think it is a multifaceted issue. Since I have worked and qualified as a nurse, there has always been a shortage of nurses. I have been a nurse for almost two decades and there was never a year when we had enough nurses on the shop floor. We have always worked without enough of us. The changes and the demands that come with the job, governance issues, and a lot of other things that are thrown at us as nurses to do, mean that we have more paperwork to complete and not enough staff to look after the patients we need to be looking after. We will be completing a lot of paperwork so that we tick a box that we have done this or prove that I have given this lady some medication or whatever.

We never have enough time. There has never been a time since I have been working when we had an adequate workforce that meant I could spend time to get to know my patients and look after them holistically, which we should be doing. We end up being task focused because we do not have time to talk to them or get to know the other things that we could help them with to prevent them coming into acute settings so that they can stay at home.

Q17 **Chair:** What do you think the cause of the problem is and do you have any thoughts about what a solution might be?

Gamu Nyasoro: We cannot ignore that our population is ageing, so there are a lot of people who need help from all of us. The demands from the advancement of medicine mean that some diseases or illnesses that could not be cured can now be cured, which means that people are living longer. There are more things that we can do to preserve life. It means that we do more but there are still fewer of us. When you look at recruitment into universities for people to train to become nurses, the numbers have been dropping.

When I trained, there was the NHS bursary, which helped when we were going through training. The bursary meant that I would get something every month that was at least as meaningful as for other university students. When you are a nursing student, you are expected to work the same hours a qualified nurse does, and it puts a toll on you, your finances and your family. People have to really think hard about getting

into nursing. The press has not been good to nurses. They always say bad stuff about us. They always talk about the bad things or when we make mistakes.

We know that when we make mistakes they can cost lives, so we do not make a lot of mistakes. When we do, that is what the press focuses on. They do not look at all the other good things that we do. I have been there to help a lady deliver. I have held patients' hands when they could not handle whatever was happening. They do not look at that; they always look at the negatives. A lot of people then do not want to come into nursing.

There is also the pay. People say, "If I worked in Aldi, I would earn more than a nurse," which in some circumstances is true. We need to be paid fairly for the care that we are giving to the population.

Q18 **Chair:** Thank you. A quick final point from all of you, if I may. Is there anything you would like to add that has not been covered so far? Lara?

Lara Bywater: It is really important—you mentioned it—not to blame Covid and the pandemic for a lot of what we are seeing. A lot of the issues have been accelerated by the fact that we have been through the pandemic, and it has shone a light through the media, good and bad, on health and social care. It is really important not to try to shy away from the fact that these problems have been kicking around for many years across the entire system.

I do not think we should underestimate the impact of how things are going to go. I support about 80 people, which does not sound like a lot, but we support those people with 14,500 hours of care a week. That is 1,800 hours a day of care that we are giving those 80 people. We are one of the few organisations in Kent that can do that for the complexity of the people. I am now at the point where I am having—I hate the phrase—to hand those people back to the local authority because we cannot produce the staff. The crisis is real. If we do not sort out recruitment and retention, I do not know what will happen to those people. Ultimately, they could end up back in secure settings or in prisons or on the streets. The impact on those individuals will be devastating. It is real if you come out there.

Q19 **Chair:** Thank you. Emma?

Emma Hayward: I would like to talk about undergraduate training in primary care. We can do more of it. At Leicester, we completely rewrote our curriculum and almost doubled the amount of exposure that our students had to general practice, just because we were cognisant of the workforce issues and needed to encourage them to give them meaningful placements in general practice. If we are to continue that and to further expand training in primary care for undergraduates, we need to pay attention to the practical issues.

General practices are dispersed and not easily accessible by public transport. Sometimes, our students pay something like £400 in bus fares over the course of eight to 12 weeks, and that is an extraordinary thing to ask our future doctors to do. We need to pay more attention to travel and accommodation for those dispersed placements. There needs to be investment in practice premises. Some practices say, "I could take an extra student, but I don't physically have the consulting rooms for them to practise in."

We need to think about that, and we need to think about investing more in our teachers because we need them to be trained by properly qualified GP teachers. If we want to expand the number of nursing and pharmacy students in primary care, we have to work out a tariff that compensates their teachers for it. At the moment, if a nursing student goes into primary care, I think the practice gets about £70. That covers nothing in terms of their supervision. A whole new budget needs to be established because otherwise we are never introducing nursing and pharmacy students to the concept of primary care. Thank you.

Q20 **Chair:** Thank you very much. Gamu, is there a last point you would like to make?

Gamu Nyasoro: I agree with my colleagues. What happens in primary care settings affects us in hospitals. As you say, Lara, you will be sending people back to local authorities. We have super-stranded patients in NHS hospitals. Some of them have stayed in the NHS for months, not having a bed to go outside because social services might not have enough funding, or things are not there for them to be looked after.

I know that we are currently actively recruiting outside the United Kingdom so that we can plug part of the gap, but that is not the whole solution. We need to encourage our youngsters to go into these professions. We have to make the jobs attractive enough for them to go into. When we recruit our international nurses, we need to pay them a little bit more attention than just getting them here because we have some hostile immigration policies that make it difficult for people.

For example, I know somebody who got here and applied for a visa for her husband and four kids. Her husband and three kids were given visas. Her 19-year-old son was not given a visa because, in this country, he is an adult, but where they come from he is still a child. The youngster is still at school and doing A-levels, so he was left behind. The mum is here with the dad, and now they are thinking about going back, but they cannot because they have been given exploiting contracts that you cannot leave until you pay them something like £10,000. We are exploiting the people we are bringing in to work for us to help us in our health and social care sector.

The skills of the people who are coming in are not recognised by the NHS, which means that they are taken on as if they are newly qualified. Some of them have been running hospitals and some of them have done a lot

of things, but when they come into the UK they are taken on as a newly qualified nurse coming from university. When they have experience, we need to honour that experience and we need to pay for that experience. If you want to retain some of us who are still in the NHS and others who are there, we need to feel that we are valued.

Clapping for us does not pay the council tax. The council tax is still going to increase. We work every week. Surveys have come out that say that every week, on average, a nurse gives about 30 hours free to the NHS that we do not claim back because, "I cannot go home. I need to help little old Betty do this, and the staff are short. I need to help them out," and we never claim that money back. We get exhausted because if we keep going like that again and again, we are burnt out. We need help. If we are to get the right help, we need to put things in place that mean that the people who are coming want to stay here and help us and look after us. We need to look at it as a whole thing, from social care to the NHS trusts, and find workable solutions. If people could speak with us on the ground floor, they would know some of the things that could help change the things that could make a difference in our services. Thank you.

Chair: Thank you very much indeed, and thank you again for battling through the public transport system to get here from Kettering. Thank you for coming down from the midlands, Emma, and thank you, too, Lara for coming. That concludes our first panel. We are very grateful to you for sharing with us those experiences.

We now move on to our second panel where we are going to focus on social care. Thank you very much to the people who helped us with the first panel.

Examination of witnesses

Witnesses: Jane Ashcroft, Sarah McClinton, Rachael Dodgson and Oonagh Smyth.

Q21 **Chair:** I welcome Jane Ashcroft, who is chief executive of Anchor Hanover, which provides housing and care for older people; Sarah McClinton from ADASS; Rachael Dodgson from Dimensions, which supports people with learning disabilities and autism and complex needs; and Oonagh Smyth, chief executive of Skills for Care. Welcome to you all and thank you for joining us.

Oonagh, can I start with you? Could you give us a sense of the scale of shortages facing the social care sector?

Oonagh Smyth: Yes, of course. In our research, we gathered data on about half of the social care workforce, and it tells a story over a number of years. Vacancies have not really fallen below 6% over the last five years, and that is about double the national average. Recruitment and retention have been issues for a long time in social care.

In terms of the pandemic and what we are seeing immediately, last year our data said that there were around 105,000 vacancies every single day in social care. That was up until March last year. Since then, vacancy rates are higher than they were pre-pandemic, and that masks more significant vacancy rates, particularly in roles such as registered nurses and frontline carers. You heard from Lara about the human impact of those vacancies and that challenge. That is the short-term issue.

We also know that we are going to need 500,000 additional people working in social care by 2035. We have a workforce about a quarter of which is likely to retire in the next 10 years, and we do not get enough young people coming in to work in social care and stay in social care. That gives a sense of the short-term issues, but also the long term.

Q22 **Chair:** We heard from Lara earlier what some of the issues were, but what is your assessment of the biggest single reason why we have that 100,000-plus gap in the workforce?

Oonagh Smyth: Social care is countercyclical. We know that as more people register as unemployed in the country, vacancy rates in social care increase[1], so there is a real tie between the labour market and social care. We know that one of the big issues is perception of the role.

Social care is a wonderful place to work. There is a real breadth of roles and opportunities. Sometimes there is an assumption that it is only older people's residential care, and that is a really important part of the sector, but the sector is much broader and wider. The perceptions are quite challenging and damaging, particularly perceptions around career development, value and pay and reward. Somebody made the point in the earlier panel that the pay differential between the most experienced care staff and the least experienced is about 6p an hour. Ten years ago, if you worked in retail, you would be paid about 12p an hour less than somebody working in social care, and now you would be paid 21p an hour more. Those wider labour force issues have a big impact on social care.

We cannot forget about retention. Recruitment is really important, but we also need to keep the skilled people who work in social care now with exactly the right values. We are hearing that people are struggling coming out of the pandemic, and they are feeling tired. It is the sense of whether we are valued and whether we have a future in social care, particularly for our young people coming into social care who are not thinking about care as a career.

Q23 **Chair:** Thank you. Jane Ashcroft is joining us remotely. Jane, you employ a lot of people at Anchor Hanover. Are you finding that people are choosing retail or hospitality over a career in social care?

Jane Ashcroft: Yes. We are a large organisation. We have about 9,500 colleagues. To Oonagh's point, we offer a range of services. Our focus is

[1] Note by witness: Oonagh Smyth meant to say "vacancy rates in social care decrease"

older people. We have a range of housing: housing with care, extra care-type settings and residential care.

Across that range of services, we have a mix of very long-serving colleagues. We have some amazing people who have worked with us in the organisation for over 20 years, but we have new joiners all the time with a very strong apprenticeship scheme. We find that people more and more are looking at the competitive market and the opportunities to work in retail. Oonagh highlighted the average figure for the difference in pay.

The other issue is the demanding nature of working in social care. There are many upsides, and people who enjoy working in social care get a degree of personal recognition from the work they do. The work is important, skilled and critical. Increasingly, as well as needing the up-front skills of empathy, compassion and being brilliant communicators, people have to be fully trained and aware of things like the Mental Capacity Act. In our sector they have to be really au fait with dementia care and the latest thinking around dementia. They have to understand safeguarding. They have to understand nutrition. Those are all absolutely critical in providing great person-centred care. That range of demands, if somebody is looking for a role where they can feed their children, pay their bills and have some flexibility, which is increasingly important for people—the ability to have a flexible working environment—and the disconnect between the level of expectation for the social care workforce and what might be required in retail means it is increasingly competitive.

Q24 **Chair:** Thank you. We will come back to you if we may, Jane. I want to bring in Rachael Dodgson. Dimensions supports a lot of people with learning disabilities and autism. What is the impact of the workforce shortages on the people who need care and support, in your experience at Dimensions?

Rachael Dodgson: In some ways I feel uncomfortable about speaking on their behalf without somebody with me, but I understand that that is how things are. I will say a little bit about Dimensions first.

We support over 3,000 people and we have a workforce of over 6,000 colleagues. The difference in the younger adult sector is that often people have a much higher level of support needs. If you compare us to Anchor, which I mention because Jane is here today from Anchor, we have a much higher ratio of colleagues to the number of people we support. We support people who might have come out of assessment treatment units with very high levels of need, as well as people who are slightly more independent and might just need a few hours of support a week with budgeting, shopping and those kinds of things.

I absolutely align myself with the points that Lara made earlier about the impact of consistency and continuity. Particularly when we are supporting people with autism and complex needs, there are challenges with consistency of staff who really understand how you communicate, what things might show that you are upset and are going to need support in a

different way, particularly if people do not communicate with words. The staff shortages we face at times mean that we are not able to do the extra things in people's lives. We are able to do the things that keep people well and keep people safe, but at times our staffing shortages mean we cannot do the extra things in people's lives. If you are a younger, working-age adult, some of those things are really important. It might be about learning new skills to get a job, or the things that would help you in the future to need less support because you have developed your skills.

I will say some of the things that Oonagh said. We have always been very proud of our turnover level in Dimensions, and our vacancies have been quite low, but our voluntary turnover in the past year has risen from 16% to 22%, higher than we have ever known. We still do very well compared to the sector in general, but it is high for us. Our vacancy rate is at 10%. We had 10,000 vacant hours a year ago—hours of support we are commissioned for but do not have the staff in place for—and we now have 26,000 vacant hours, so there is a real increase.

The impact on people's lives is in those things. They cannot necessarily do all the things they want and they do not have consistency. We try to use regular agency workers, but that is not always easy. Those are the impacts on people.

Q25 **Chair:** Thank you. Can I bring in Sarah to give the perspective from ADASS? You are looking at this from the perspective of local authorities that have an incredibly difficult challenge. They have to deal with the funding pressures and so on. What for you are the issues, and what are the solutions that you would most like to see put in place to deal with the kinds of pressures that we have been hearing about?

Sarah McClinton: As we have heard, recruiting staff is getting even harder. Recruitment and retention are long-standing issues. Colleagues across London saw a 33% turnover in staff over the last year. There are obvious costs associated with recruitment, but there are also issues about continuity of care and quality of care for people, which we have already heard about.

Over the last decade or so, we have seen reductions in funding. We have come to rely on a largely female, low-paid, undervalued workforce. Over half of home carers are on zero-hours contracts, and we are an industry that is reliant on minimum wage. Carers are looking after people who have higher levels of acuity and more complex needs; people who might previously have had care within the NHS, be that older people or working-age adults with more complex needs, so the job is getting harder as well. As Jane said, people need to be as skilled at working with people with dementia in an NHS dementia ward in the community as they would be in a social care setting like a nursing home, for example, but those staff will not get the same level of pay or job security, and the mandatory vaccinations have compounded that.

In ADASS, with directors across the country, we did a snap survey in September last year, and it was repeated in November. We estimate that now half a million people are waiting for care, waiting for assessments or care packages. More than 1.5 million hours of commissioned home care could not be provided as a result of lack of staff. A number of councils are having contracts handed back or homes closing as a result of the pressures.

Chair: I want to cut to the chase a bit. We have often had discussions with ADASS about the level of funding for social care. This Committee has said that we thought the annual funding for social care should go up by £7 billion a year by the end of the Parliament, and that is not going to happen. We recognise your concerns about that, but if you had the extra funding, are there the additional people to recruit to the care sector? When we talk to NHS colleagues, they say it is not just about the funding; they say there are not the people out there to recruit. How is it for the care sector?

Sarah McClinton: It is challenging, but one of the strengths of the care sector is that from the point of identifying somebody, recruiting them, training them and them being able to deliver in that role, it is a relatively short period of time. With investment and valuing of the workforce, we would be able to attract more people and retain them.

One of the things that is really important is the parity with the NHS that we have talked about and colleagues have talked about. ADASS has advocated that we need a minimum care wage that is equivalent to NHS band 3. That would also enable opportunities for career progression, for people to move around different parts of the system but not necessarily losing social care staff to the NHS, which was referred to earlier.

Chair: Thank you.

Q26 **Barbara Keeley:** Can we talk about the Government's adult social care White Paper, which included a strategy for the social care workforce? That was just 11 pages compared with the NHS People Plan, which was 52 pages. The funding allocated is equivalent to, as the Chair has just said, £100 per social care staff member over the next three years.

The White Paper has come under quite fierce criticism, not least from ADASS, for not going far enough, so perhaps I could start with you, Sarah. Do you think what you have described as the issues of recruitment and retention and pay can be fixed with the plan included in the White Paper and the level of funding announced so far? You have just touched on it, but can you expand that?

Sarah McClinton: We support the ambitions set out in the White Paper and the funding that has been allocated to workforce for improving training, support for wellbeing and recruitment campaigns. All that is good. It probably does not go far enough on the challenges that we have heard about in terms of the workforce that we are going to need in the future. We think it needs a proper workforce strategy that can plan for

the different roles that will be required in future as we move to different models of care, with more housing support and technology, as well as the different roles that we need, so more detailed, longer-term planning will be really important. It is hard to see how the White Paper takes us from where we are now to where we are going to be in the future. More detailed, longer-term planning is essential.

Q27 **Barbara Keeley:** Perhaps we could focus on what a workforce plan should include. Oonagh?

Oonagh Smyth: The White Paper definitely sets a lot of the foundations that we would want to see for a social care workforce plan. Setting real clarity on what we need in knowledge and skills and investing in and building knowledge and skills is really important. It talks a lot about career pathways, and we talk a lot about that in social care. It is not necessarily that they do not exist; it is that they are not always clear. There is a focus on wellbeing of staff. We talk a lot about productivity, but a happy workforce is a productive workforce, so focusing on how we support people with their wellbeing is really important.

The fair cost for care initiative in the White Paper is also important. When I think about what needs to be in a broader workforce strategy, a lot of those elements would be in it. We need to address pay, terms and conditions and reward. We need more clarity on workforce planning at a national level, at a system level, and at a local level. The integration White Paper goes some way to talk about workforce planning at system level, but we need it for social care at national level, particularly if we want to realise the ambitions of the Care Act around personalisation, prevention and wellbeing. We need to think differently about how we get people into work in social care, how we reward them, how we keep them, and then how that gets broken down at the different levels and the different roles of national Government and local government providers. That is the bit that is really important in a workforce strategy.

Rachael Dodgson: I agree. The points in the White Paper are a good start, but whether it goes far enough is the question. Pay is the fundamental issue. We cannot ignore that. It really is. If you look at what other sectors pay compared with social care, it is a real challenge. From personal experience, we found that some people joined us during the pandemic as hospitality and retail closed down. Those people have moved back into those other sectors because the pay is higher, so they have not stayed with us. It has not provided a long-term solution.

We have an unprecedented challenge. Pay is challenging for us as a national provider because different local authorities pay different rates, and there are conditions attached to funding that often say, "You must use this to pay this rate of pay in our area." While I understand that, it creates a postcode lottery for our colleagues. I might be able to pay Oonagh £1 an hour more five miles down the road from Sarah, even though they are working for the same organisation. Pay is a fundamental challenge that we cannot ignore.

We need a proper annual workforce plan, rather than just one every Parliament. There needs to be a proper approach to that. Digital literacy is something we need to think about. It is not something that is particularly strong necessarily in our workforce, and we need more people to be doing more of that. They are using all sorts of digital support planning and digital care records, so it needs to focus on that. There are the bandings around pay. We have talked about parity with the NHS, and whether you could have some of the bandings and qualifications there. I am sure Skills for Care could have a role in overseeing some of that. Those are the things that I think we need to do.

Q28 **Barbara Keeley:** Thank you. Could I come to you, Jane? Your organisation said in your submission to us that 44% of people leaving do so because of pay, and that funding reform must tackle issues affecting pay. How do you think we are doing on that front?

Jane Ashcroft: We were quoting from the National Care Forum survey at the end of last year, which found that for 44% of people leaving the social care sector the decision was pay based, and for 50% it was based on wellbeing and stress issues.

At Anchor, we were able to move to the Living Wage Foundation rates from December last year, reflecting Rachael's point about being a national provider and the challenge of working in different local authorities with different constraints around pay. The point about a system-wide approach in a workforce plan for pay and other issues is important.

We also see the criticality of investing in appropriate terms and conditions. I am constantly struck by how many of my colleagues are also carers in their personal life, and they need flexibility and decent holiday entitlements. All of those things come with a cost. That is an invisible cost from the outside. Giving somebody extra holiday does not look as if it has a cost attached, but the Committee will understand that hours of care have to be covered, so there is a double cost. Increasingly, to be competitive employers, it is about the whole area of appropriate terms and conditions and what kind of wellbeing support we can provide for our workforce.

We were fortunate over the last couple of years at Anchor in that we have been able to put in place a wide variety of wellbeing assistance, whether that is counselling, helping people with their finances, or discount schemes when they go shopping. That has a cost to us as an employer, but it is a huge benefit for the people who work for us. On the pay and reward issues, a whole-system workforce plan recognising the need to invest in the workforce, and therefore the savings on retention, can then help us.

To pick up an earlier point about whether there are enough people, we have to attract people from groups who have not typically worked in care. In our organisation, we put a huge focus on diversity and inclusion. That

is important both for the people we work with and provide services to, and so that we can draw as widely as possible into the workforce. A national workforce plan—a really strategic approach—needs to shift our perception of the people who work in the care sector and understand how we reach out more widely.

Barbara Keeley: If I can, Chair, I want to ask Rachael a couple of questions about working-age, disabled adults.

Chair: Sure, and then we will go on to Sarah.

Q29 **Barbara Keeley:** Rachael, you said that the people you work with at Dimensions have higher support needs. How do you think the current plans serve the needs of working-age disabled adults? Could you expand what you said earlier? You told us that needs are going unmet. Could you specifically address that?

Rachael Dodgson: If we think about how working-age adults are supported, the model of support is often different. A number of the people we support live on their own, or they might live in a house with two other people. It is a smaller setting than older people's care, not all of it, but different from how older people's care is traditionally seen, so the model of support is quite different. From a staffing perspective, if someone is not able to come into work that day, you could have a whole house of people—two or three people living together—who are not able to get support. In a larger setting, there is a team of people, and it makes it easier. The funding clearly is different for working-age adults. There are very few self-funders. It is all local authority funding, so that is different. People's packages are bespoke. Those are some of the differences.

Q30 **Barbara Keeley:** If we think about the workforce crisis, I know that you have worked with people who have been in ATUs. This Committee has been very concerned about the 2,000 people stuck in those in-patient units and not able to move into the community. What impact is the workforce crisis having on the quite appalling number of people with learning disabilities or autism who cannot move out of those units because there is no support for them?

Rachael Dodgson: Thank you for the clarification. There is a significant impact. I could tell you numerous stories of where we have successfully supported people from those settings into ordinary lives, ordinary housing and ordinary communities.

We are in a position where we are not able to take forward some of the referrals that we are getting from people because the transition for people is very complicated and quite long and drawn out, for obvious reasons. You need a really stable staff team to support people coming out of an ATU. We have examples of people who when they first came to us perhaps had three or four people at a time working with them. As they settle into their new surroundings and get used to their team, you can reduce that level of support.

It would be very irresponsible to try to bring somebody out of an ATU into a setting where we did not feel we could offer the stable support that people need early on. The impact for us is that there are times when we have to say that we are not going to be able to support a person, much as we would like to, because we would not be setting them up for success.

Q31 **Sarah Owen:** I have two questions. The first is for Oonagh and Jane. You talked about pay, reward and recognition being important to solving the workforce crisis when it comes to social care—absolutely rightly so—but investment is also important to the social care workforce. Do you think the £500 million that has been allocated from the health and social care levy to train the social care workforce is enough to meet demands over the next few years?

Oonagh Smyth: Skills for Care is the workforce development body. It will not surprise you if I tell you that you could double or treble that sum, and we could definitely use it in social care. It is the largest investment that we have had in the workforce, though. It is a real recognition that we need to recognise that these roles are professional. We hear people talking about social care as an unskilled role. These roles are incredibly skilled. It is up to us in the sector to really use that investment to make a case for more investment, and to do that we have to use the investment really well. We have to be clear about the impact that we are trying to make and we have to show that we have made that impact.

We know from our predictive analysis that one of the factors in whether people will stay in an organisation is whether they are developed. If you train someone, they are more likely to stay. The more you train them, the more likely they are to stay. People with a social care qualification are less likely to leave than people without one. We can quite confidently say that those initiatives should make a difference. I am hopeful that that will allow us to make a case in the future for more investment.

Q32 **Sarah Owen:** Thank you. Jane?

Jane Ashcroft: I completely concur with Oonagh's view that it is a helpful start. We need to spend the money to maximum impact and I concur on the importance of the issue about career pathways and development. We have a grow our own scheme for our management group. The management of social care is such a critical skillset, and we have been fortunate that by using our internal development activity, over half of our managers in our care home settings have come through our internal development.

We utilise the apprenticeship schemes very extensively and have many hundreds of colleagues who have joined us through apprenticeships and stayed with us. We have done a lot of work investing in the first 12 months that somebody works with us. Exactly to Oonagh's point, if people feel supported with the best possible training and the best support, they are much more likely to stay, because people take pride in

doing a good job, and they are very anxious if they do not feel they can do a good job.

The overall quantum of money, how that money is spent and how it is delivered to the frontline—how it has impact—will be very important. As Oonagh said, I hope that we can see the impact of that investment and then make a case for further investment because, at the end of the day, a saving is generated when we fix the workforce issues.

Q33 **Sarah Owen:** Thank you both. Rachael and Sarah, Gamu in our previous panel talked about the impact of the hostile immigration policies on international recruitment and retention. The visa requirements for social care at the moment require you to earn at least £20,500 to qualify for a 12-month health and care visa. Sarah, you talked about 33% turnover of staff in London. How much is this a block on international recruitment?

Sarah McClinton: Clearly, the minimum salary requirement does not help us in terms of the wider social care workforce. It is important to make the point that while we are focusing very much on the provider workforce, we also increasingly have challenges in being able to recruit social workers, occupational therapists, commissioning staff, and so on. International recruitment has historically been used to recruit more social workers. I am not aware that colleagues across either councils or the provider sector, where Rachael can probably say more, are putting lots of energy and resources into big international recruitment campaigns at the moment.

Rachael Dodgson: We have not been pursuing international recruitment campaigns as such. I totally echo Sarah's point. You need to pay somebody £10.50 an hour. The national living wage is £9.50 an hour from 1 April. We have talked about the difference there. It is clearly going to be a barrier if people want to pursue that. I do not pretend to know the technicalities around it, but there are other things that apply that make it quite complicated. There are some barriers for the sector.

Q34 **Sarah Owen:** Oonagh, do you want to come in on that point? Rachael is absolutely right; it is not just the visa requirements, but things like the immigration health surcharge as well and the very high cost for visa applications.

Oonagh Smyth: When we think about recruitment, you only have four choices in social care. We can recruit people who typically work in social care—mostly women who have had caring responsibilities and older people; the average age is 44. The problem is that there are not enough of those people. You can try to attract, as Jane said, people who typically have not been attracted to social care—men, for example. Only 18% of the workforce are men. You can radically change terms and conditions to make the role more attractive; or you can recruit from abroad. Those are our choices. In all likelihood, you have to do a combination of those.

Adding care workers to the shortage occupation list was really welcomed, but there are barriers. The salary level is much higher than for the average care worker; 85% will not be on that rate. The one-year visa is a barrier. We are doing a lot of support for employers to help them navigate the rules themselves, because the rules are quite complex. The webinars that we have been running, and the very practical support, have been really welcomed by the sector. Some providers are using that route. We hear that they use it particularly for registered nurses in social care. We have to be quite careful ethically about how we do that. We need to support people when they come over to work in the UK in social care and think about how we support them with their family, and get registered with a GP and get settled in. Employers need support to take that route. It has to be considered.

Q35 **Chair:** Thank you. We are going to have to move on to our next panel, but I have one last question which perhaps I can ask you all to give a brief answer to. Many of the suggestions that you have made this morning involve extra funding for the social care sector. We agree with you on that. As a Committee, we wanted a much bigger increase in funding than the Government were willing to give, but the funding settlement has now been made for the rest of the Parliament.

If you were going to make one suggestion that did not involve extra funding for the sector, but was something that the Health and Social Care Secretary could do immediately that would help ease the workforce pressures, what would it be? Let me ask each of you in turn. I appreciate that it is a very difficult question to answer. Let me start with Sarah, if I may.

Sarah McClinton: Obviously, pay is a reflection of value. People in the social care sector feel that over the last two years there has been huge dedication and commitment and not always a sense of value. Striving for parity of esteem, essentially, with NHS colleagues would be the one thing I would argue for.

Q36 **Chair:** Thank you. Rachael?

Rachael Dodgson: I would make a very similar point to Sarah's. We have a fatigued workforce who have worked really hard for the last two years. The Government need to show how they are valued. That might not just be financially, but there is the parity point and demonstrating how much we appreciate our workforce who have kept social care going through a really tough two years. It is about how we demonstrate that to people.

Q37 **Chair:** Thank you. Jane?

Jane Ashcroft: If it is not about money, it is about culture. There are a couple of things. As we move forward with the integration agenda, it is about making sure that the social care voice is in the room for all of those conversations and is in the system at the right place. Perhaps we should

talk about social care and health instead of health and social care. It is a minor issue, but it might just shift the dynamic.

Q38 **Chair:** Thank you. Oonagh?

Oonagh Smyth: I agree with what everybody else has said. We need to remember that, of all the people leaving social care in the year, two thirds remain within social care; they change employers. We should support people to feel valued and support positive cultures. Around a quarter of providers have a turnover of less than 10%, and what they do is really focus on wellbeing and culture. If we can build value and respect into every sentence when we talk about social care, particularly when we talk about health and social care, and make people feel valued—it does not have to cost a lot of money—in the system, and if we can stop people leaving and really focus on keeping them motivated and well, that would make a huge difference.

Q39 **Barbara Keeley:** Can I ask one very quick thing? You have talked about parity of esteem and feeling valued. Bonuses were paid to social care staff in Wales and Scotland, I think. How does something like paying a bonus—£500 or £1,000—stack up? Is that sort of thing helpful? It is easier to persuade a Government to do a one-off thing.

Chair: Let's ask one person to answer this. Why don't we ask Jane as she has 9,500 employees?

Jane Ashcroft: We did, actually. Last Christmas, we made a one-off bonus payment to our workforce because we needed to recognise their contribution. We think that helped with some retention, and we think it helped people to feel valued in the organisation. Interestingly, the people using our services also really welcomed it because they could see that the people who are so critical to them were being recognised. We would never disagree that financial recognition would be well received.

Chair: Thank you all very much for coming and giving evidence to the Social Care and Health Select Committee, as we should now rename ourselves. We appreciate you coming, and it has been a very important evidence session, so thank you very much for sparing your time.

Examination of witnesses

Witnesses: Chris Hopson, Nicola McQueen and Professor Stokes-Lampard.

Q40 **Chair:** We move to our final panel this morning. I welcome Chris Hopson, chief executive of NHS Providers, and Professor Dame Helen Stokes-Lampard, the chair of the Academy of Medical Royal Colleges, representing all the medical royal colleges. They are both well known to this Committee. I welcome to the Committee for the first time, I think, Nicola McQueen, who is chief executive of NHS Professionals, which supplies temporary or bank staff to nearly a quarter of NHS trusts in England. She is also chief executive of Doctors Direct, the locum service for NHS professionals. Thank you all very much for joining us this

morning. We have to stop at half-past 11 because we have questions with the Health Secretary, and we want to put directly to him all the things that you put to us in the next 45 minutes. We really appreciate your joining us.

I want to start by asking Helen and Chris to talk very practically about an amendment to the Health and Care Bill that is going to be debated in the House of Lords this week and has been strongly supported by this Committee and by you both. It would require the Government to ask a body to produce independent projections of the requirements for the health and care workforce every couple of years for the next 10, 15, 20 years. The Government rejected the amendment when I and a number of my colleagues put it forward at the Commons stage of the Bill. The reason is that the Treasury thought it would cost too much money, putting it very bluntly. What reason would you give to the Treasury as to why this time round when the amendment is put forward by Baroness Cumberlege and Lord Stevens they should change their mind? Let me start with you, Helen.

Professor Stokes-Lampard: Thank you so much for this opportunity, particularly to address that quite critical point. First and foremost, I urge our colleagues in the Lords to back the amendment, because it seeks to give us a road map and a plan for how we can address the workforce shortages of the future. We are here together today because we have a crisis of our workforce throughout health and social care.

In healthcare, we have suffered over the decades because we do not have a robust, independent and transparent plan that we can rely on. We cannot all sing from the same hymn sheet when we are talking about numbers. That is because things are collected in multiple ways. No organisation should fear a report just because it does not like the outcome, and because it suggests that we might need more of something. It does not hinder planning in other areas of our life and society. We create plans. We look to the future. Even if we cannot resource them to the hilt right now, at least we can plan and we know where we are aiming to get to.

The advantage of having a plan is that we will all be singing from the same hymn sheet. It brings together multiple sources that are trustworthy; by having independent verification and a transparent process, we could all trust it and work to it. It is something that all health bodies are seeking. There are over 90 organisations that have come together to back this. It is not some whinging frippery; it is a well thought-through, careful amendment that we believe will be highly supportive to the Department of Health and Social Care, and indeed to the whole of Government, and ultimately, to the whole of society. All of us want an NHS that functions to the highest capacity, is of the highest calibre, and is staffed by the right sort of people. We are not calling for specific numbers of this or that; we want somebody independent to say, "This is the right plan."

Q41 **Chair:** At the start of this session, before you came, we heard very powerful evidence from Dr Emma Hayward, a GP who very bravely told us that she was burnt out, and has had to take time off work and is planning to go back in April, just because of the pressure of being a GP in the current circumstances. What signal do you think it is going to send to staff who are feeling desperate and pretty exhausted at the moment if the Government reject the opportunity to have an independent workforce plan?

Professor Stokes-Lampard: First, I am truly sorry to hear what Emma is going through. I am a general practitioner still at the frontline. I was working in my practice till late last night, and I see colleagues feeling the pressure day in, day out, as they are throughout the entire system. This is not a primary care issue; it is the whole system, the NHS and social care. The message is very confusing for people. On the one hand, we have a narrative that the UK population love the NHS, they respect it hugely, and it is one of our jewel institutions, yet the Government are not prepared to be honest about what is required. We are not saying you have to fund it straightaway. If we do not know what we are dealing with, it is a frustration for everybody. I am being generous when I say I believe healthcare professionals are bewildered and do not understand why we have not heard a legitimate justification as to why a plan is a bad thing.

Q42 **Chair:** Thank you. We will come back to you, Helen. Chris, you have been one of the loudest voices in the sector arguing for this change. The other thing the Government say, apart from their worries about the cost, is that they think they are going to cover all of this in what they call Framework 15, which is the plan that DHSC says will be coming out shortly. What are your concerns about what the Government say they are planning to do as compared to what you have been campaigning for?

Chris Hopson: Framework 15 will be helpful because it will lay out very clearly what is needed to create an effective workforce plan. It will effectively set out, for example, that we know that we are going to need to transform care, we know that technology will make a significant difference, and we know that we need to introduce new roles, but the crucial thing about Framework 15 is that it will not have actual numbers in it, and that is the real issue.

We need to be very blunt, Chair; we have now reached a point where workforce shortages are very clearly impacting on the quality of care, despite the best frontline efforts, that the NHS is currently providing. If you look at the issues we have on the urgent and emergency care pathway, which are very significant at the moment, it is clear; they are significantly due to workforce shortages. We are simply not able to recover the care backlogs that have built up because we do not have enough staff to do so. There is a very direct link between workforce shortages and the quality of care we are able to provide. All of us in the service—100 different organisations, you, former chief executive of NHS England Simon Stevens, former chair of NHS Improvement Dido

Harding—have been very clear that we simply cannot run the NHS effectively or efficiently unless we have a long-term workforce plan.

If I may, I want to address the Treasury directly because you have been very clear, and Simon and Dido have been very clear, that this is where a significant part of the problem lies. The Treasury is forever saying to us, "You have a responsibility, the NHS, to maximise taxpayer value for money." The answer is that at the moment we are spending billions of pounds that we do not need to spend on agency and locum staff instead of the full-time staff we desperately need. We have reached a pretty absurd and extraordinary position where the NHS is saying, "We need this long-term workforce plan to maximise taxpayer value for money, but the Treasury is stopping us and preventing us from doing so." That cannot make sense. I am hoping that their Lordships at this end of the Houses of Parliament will pass the amendment either today or on Wednesday. Then when there is debate between the Commons and the Lords, if that is what happens—the famed ping-pong—the Government face a really important choice about whether they are going to work with people like you and us to try to find a sensible way to get that workforce plan in place because, boy oh boy, do we need it.

Q43 **Chair:** Thank you. Back to Helen, if I may. We have heard the impact on continuity of care talked about a lot this morning, and the fact that workforce shortages mean that people see a different professional at different times when they interact with the system. What is your impression of the impact that is having on the quality of patient care?

Professor Stokes-Lampard: It is hugely variable around different disciplines and different parts of care. In areas where we have very transient staff, where we have huge staffing rota gaps and we have to rely on people who are locum or temporary to fill vacancies, continuity goes straight out of the window. It is the first thing to be sacrificed when there are problems. You then get the challenges, whether it is bringing people in externally to help or whether it is cross-covering from other teams. That goes, and what goes with it is the culture, wellbeing and support that comes with being part of a regular team.

If we are with colleagues with any degree of continuity—just one to one with our colleagues, let alone the relationship with the patients—it is better for morale and retention, and it gives people confidence. You then have the complexity of long-term relationships, particularly disciplines that rely on long-term care. General practice is the obvious one, where we know people and we know their families. When you have a transient workforce, it is affected badly. Morale gets affected. Patients hate it. Patients regularly tell us, "I don't want to keep telling my story time and time again." That is inefficient.

There are new ways of working through the NHS that involve wider teams, so I do not want to imply that continuity is everything. There are creative ways of working that involve excellent notetaking and working in small teams who interact well with each other, often multidisciplinary

teams. You can counteract some of these things by careful planning and factoring it in, as it were. You do not have to be full time and you do not have to be in one organisation permanently, but being part of a team, providing care to patients who know you and you know them is helpful, efficient, safe, more effective, and cost-effective to the system.

Q44 **Chair:** Thank you. Can I bring in Nicola? You heard Chris talking about the £6 billion a year that we spent on locum and agency staff pre-pandemic. NHS Professionals helps about a quarter of trusts to use bank staff, so it is much better value for money and there is more continuity of care because it is people who are from the same organisation. Why is it that with the services that NHS Professionals offer we are still spending £6 billion a year on locum and agency staff?

Nicola McQueen: I want to set some context about what is categorised as a flexible workforce in the NHS, which would include bank, agency and off-framework agency because there is a big distinction when we start to think about high-cost locums. Seventy-six per cent. of all nursing vacancies today are filled by this flexible working group, and over 80% of doctor vacancies are filled by this group. It is a significant part of the NHS workforce, but it very often gets sent into one bucket of "expensive locum agents." A bank nurse on a standard band 5 rate would cost less than a substantive nurse in the NHS. It is not about cost when we refer to bank workers.

We have a very unique lens on it because we support, as you mentioned, more than 50 trusts with all of their vacancies. We have 180,000 bank members that we mobilise in and out of different environments, and it is an increasing number every single week. Through the pandemic it rose by 50,000. The key thing for me is that there is a significant rise in people choosing a career-flexible work path. More than 60,000 of the bank membership just in NHSP's reach do not work substantively in the NHS and they do not have a voice in our service. It is about giving that population a voice. It is a significant part of our workforce. They play different roles in different parts of their career.

The personas within our bank or our agency workforce will be flexi-retired—I love that term. One of the nurses I spoke to very recently at a trust said, "I am flexi-retired. My priority is picking up my grandchildren from school, and every hour that I do not need to be doing that I can spend at my local trust." There is real continuity of care with people like that because they very often go back to the same ward with the same set of patients and the same teams around them. We need to keep people like that in bank membership.

There is also the career flexible worker who chooses to only work flexibly because from one week to another they do not quite know what hours they can do. Those people still need access to training and development, and they get absolutely sidelined when it comes to that. When we think about this as a community growing and providing a service to us across the NHS, we need to think about how we keep their skills relevant and

adaptable to become more relevant as the system moves and shifts with the new roles that we are creating. We have our vocational carers, and we have talked a bit about that through the panels today. These are people who want to come in and care. Very often, those on the banks who do this have worked in the NHS for many years, perhaps at band 8 or band 9 in management roles, but they do not want that any more: "I just want to come in and care. I want to spend my time with patients."

We have a very unique lens on this flexible workforce. We need to start changing the narrative about high expense agency locums because a lot of the workforce is not that. There is a tiering that we need to be mindful of because we have a lot of very good agencies that support us in our hours of need and have the ability and the capacity to speak to individuals and ask them to go into particular shifts. While it is slightly more expensive than you would pay for a bank nurse, the actual margins are minuscule in this population. Private sector agencies working on our frameworks across a system often work between 2% and 6% mark-up. That is tiny. In the mandate, we put a lot of pressure on enhanced compliance standards and very difficult scenarios when mobilising workforces from one trust to another that might have different criteria.

Q45 **Chair:** Let me ask you about that. You explained very helpfully how a properly organised bank can make a very big difference to a hospital, and how there is a valuable role for framework agencies. When people think about the extortionate rates that are sometimes paid, those are to the off-framework agencies that are there for people when they are absolutely desperate and have no alternative. Is it the case that some companies that run a framework agency set up an off-framework agency under a different brand name and then migrate some of their staff from the framework rates to the off-framework rates where the margins are higher?

Nicola McQueen: It is absolutely true that there are groups of recruitment businesses that have on-framework and off-framework agencies. Very often they provide a completely different service, but they can toggle between the two. There is absolutely a need for a break-glass shift that will pay an off-framework agency an enhanced rate to get the right person into their ward. To allow that, what very often happens is that they might send a taxi to pick the person up to take them to a rural location that they might not be used to travelling to. They might give them enhanced training. They might be thinking about how they induct them. It is not all high-cost agencies exploiting us in our hour of need. Sometimes they come with an additional service wrap, but not always.

Q46 **Chair:** Can we talk about the "not always"? That is the bit I am concerned about. The frameworks were set up basically—let's not beat about the bush—to stop the NHS being ripped off when it is desperate for staff. We said the deal is that if you pay framework rates we will put you on a roster and you will be the people we come to the vast majority of the time. If the same agencies are setting up an off-framework agency

under different branding—the thing that feels very odd—with higher margins, doesn't that give them a conflict of interest because then they can make more money by supplying people off-framework than framework?

Nicola McQueen: I am sure it absolutely does because we are mobilising the same workforce around the system. The big thing for me in this is making sure that we utilise the tiering and the cascade appropriately. Some trusts do this incredibly well. Substantive staff fill the roster first. Then we go to bank. They fill as much of the rest of the roster as they can. We then go out to agency, and then we have off-framework agency. Where it is set up incredibly well is where one is allowed to bump another. We call it agency bumping. If a particular bank worker wants to work a shift on that ward at that time and there is already an expensive agency worker booked into that shift, they can bump them out. Where we have good set-ups and good arrangements to be able to work through the tierings, you can start to control it. Where that is not in place, there can be the opportunity to exploit it through off-framework.

Q47 **Chair:** Thank you for shedding light on that, Nicola. If you were Secretary of State for a day, what would you do to stop that abuse?

Nicola McQueen: I would make sure that all trusts have the ability to cascade accordingly. That is through good technology and the ability to be able to bump out and put in the appropriate people. At the end of the day, we want our bank members to have the best access to work, so they should take priority over agency and off-framework. The next thing that I would think about doing is ensuring that we have full visibility of all the shifts and that we can book our bank staff into longer lines of work, because very often this is about fastest finger first—the agencies call it fastest finger first. A shift will be released: "What agencies can go around?" You would want to take some of that out of the system, for sure.

Q48 **Chair:** Would you just ban framework agencies from being part of the same ownership and same organisations as off-framework agencies?

Nicola McQueen: It is certainly one that some trusts already do—they will not allow off-framework agencies to operate in their trust—and many of them do it incredibly well. The framework agencies are the ones that we need to support. They often get a very bad rap. I have talked about the fact that their margins are very squeezed. We are not encouraging as many agencies as we would like to be on-framework at the moment.

Q49 **Chair:** Thank you. Let me bring in Chris Hopson.

Chris Hopson: I deliberately did not use the £6 billion figure because that would have implied that all of the money, effectively, is poor value. Nicola has made the point, which is an important one, that we know that there are some people who want to work in bank and agency work, so having an appropriate avenue for them to do so is important.

However, the issue is that where we currently are with workforce shortages and the degree of pressure that the service is under means that we are driving what should be full-time members of staff into positions where the only way they can effectively stay involved is to work shorter shifts and take a much more flexible approach. We need to absolutely ensure that we make NHS roles attractive, appropriately well paid, and appropriately flexible. Doing that requires us to fundamentally address the underlying problem of the workforce shortages we have. If I can use a bit of a phrase, there is good agency in bank, in a sense. It allows people who would not otherwise be in the workforce a degree of flexibility. There is bad agency in bank when, effectively, people are forced into doing it because that is the only way we can keep them involved in the workforce. Fundamentally, it is about addressing the workforce shortages.

Q50 **Chair:** I understand that, but is it also the case that some of your members do a better job than others in making it possible for people to work flexibly without having to join an agency? To give a totally different example, an air steward for British Airways or Virgin Atlantic can go on to an app and book their shifts month by month completely on the basis of their own family commitments and what suits their lifestyle. They do not have to become a temp to do that; the airline has that system set up. I know that some NHS trusts do that, but not all NHS trusts do it. Is that one of the ways we could make it easier for people to work flexibly without having to join an agency?

Chris Hopson: Yes, absolutely. We have acknowledged that there is a degree of variation where some trusts are better at doing that than others. You are absolutely right to identify that, for those who are using modern technology to allow a match between shifts being available and people who wish to work for them inside the organisation, it is making a big contribution.

Q51 **Chair:** Thank you. Do you want to come in on that point, Nicola?

Nicola McQueen: I want to come back to training because it is a really good point. We should be able to book people straight into the roster. The banks do that. Providers that do that really well will allow their bank staff to book straight into the roster for whatever hours they want, like the Virgin and British Airways staff, and that works brilliantly. We need to give those people the same access to training.

One of the recommendations that I would love to see come forward is investigating using the apprenticeship levy, which we spend millions on and cannot get access to, for this temporary, flexible workforce. If we could use some of that to keep their training up to date and relevant for future roles, we could mobilise that workforce much more frequently and they could book into more shifts across the roster, and that is really important. If every single one of our bank members did just one more shift a month, that would be 10,000 additional FTEs into our system. Very often, the restriction for that is that they are not quite skilled to do

something, so they do not have as many shifts available to them. That is the first point.

Secondly, through the pandemic, we saw some brilliant innovation around recruitment. We were fortunate enough to stand up 16,000 vaccinators for the national vaccine programme, but that was made possible because we changed the law on training to task. We were able to bring people into the system from other sectors who ordinarily would not be able to work in the NHS, trained them to task and deployed them. In that same campaign, we interacted with a quarter of a million people who were NHS curious. That is what we called them. They wanted to work for us. They wanted to be part of our system, yet very often our recruitment processes screen them out: "Do you have these skills? Match, yes or no." Five people go for the job, and four people get disappointed. We still need those four people, thank you very much. How do we nurture them into our process? Some of that is through training and access to training. That is a big point.

Chair: It is a very important point. Thank you.

Q52 **Dr Evans:** My questions are based mainly to Chris to start, if that is okay. Chris, this is a workforce and training inquiry. Who should pay and employ junior doctors?

Chris Hopson: That is an interesting question. It has to be, in some senses, a shared responsibility between the Government with appropriate input from Health Education England, but also the employee trusts while the doctor is training.

Q53 **Dr Evans:** That is what I want to unpack. You are right; it is that at the moment. It is 50% either way, Government and the trust. The argument might be put across that part of the problem is who is responsible for the welfare of the workforce, and this is fundamentally what we have heard time and time again in two previous panels and every time we go into this. We know we have a workforce planning issue, but we have to get more out of the workforce we have now and look after them and protect them. What do you think about changing that so that they would be employed solely by your organisations because then you are responsible for the welfare and the training and what that looks like, clearly supported by Health Education England? Your organisations would be solely responsible for the welfare and everything that goes on with those junior doctors and junior staff.

Chris Hopson: Part of the issue is the fact that people develop their skills and training by doing a series of rotations and moving between individual organisations. Certainly, what we consistently hear is that there is often a problem at the point when you get handed from one organisation to another, and, therefore, that is the element where having some kind of appropriate umbrella beyond the trust helps with a degree of continuity of welfare. It has to be a partnership between individual employing organisations and—

Q54 **Dr Evans:** I am going to play devil's advocate on that. The flip side is that hospitals and trainers can sit there going, "I know I am going to rotate my junior doctors out." They are in for four months, six months, a year. That leaves a vulnerability because staff will say, "I can't raise my concern. What's the point? I'm out of here." You hear time and time again from consultants, "I don't even know who my junior is because we don't have a teams-based system any more, so there's no follow-up." They are signing them off, going, "They didn't cross my path in a bad way, so they must be all right." What is your response to that?

Chris Hopson: I am still in the same place, which is that, effectively, organisations need to recognise their responsibility to their junior doctors. That is something we know from the junior doctors' strike, which was probably uppermost in the mind of your Chair at that particular point. Organisations need to do the job of looking after their junior doctors more effectively. My argument would be that you do not have that element of continuity in terms of asking an organisation like Health Education England to, at the same time, take responsibility to ensure that when the rotations happen the transition is as smooth possible. There has to be an element of both.

Q55 **Dr Evans:** Let's widen it a little bit further. How would that look? We have heard from multiple trusts and clinicians that headspace has been one of the hardest things that people can find. In the pandemic, they were given free rein to think and rearrange the way processes looked, and we have heard that that is starting to creep back in and that is going on. How do we provide clinicians and management the headspace to think about how to improve their systems? Do you have solutions for that?

Chris Hopson: If you don't mind, I am going to come straight back to where we started. You may or may not know that I worked for a FTSE 100 plc and I worked in HMRC, Her Majesty's Revenue and Customs, at board level, and I have never seen a system that is under the degree of operational pressure that we are, where exactly there is no headspace other than to run at 110 mph to keep the existing system upright. Part of the issue is—I am sorry I am going to bang the drum—going back to the need for a sensible, long-term workforce plan where we know we have the size of workforce with the skills that they need.

Q56 **Dr Evans:** I appreciate that. What I am looking for, and I will lead on to a couple more questions about this, are the short-term things that we can try to get more out of. We heard here that, if we had just one extra session, we could get 10,000 extra FTEs. What can we do for our clinicians now to give them the welfare and the headspace to think and improve the system, but also the chance to say, "I may well want to take on more work"? I do not know a single clinician at this point in time who will put their hand up and say, "I would like to take more work on." They are all trying to offload.

In the five-year gap between a workforce plan and the med schools

coming through, we have to come up with a way that allows people to be more flexible. We could book in and simply put in legislation to say a GP can only see 15 patients in 20 minutes in the morning, or limit it, but the problem is that there is fallout because the demand is so out there. Is protected headspace or paid headspace something useful? Should we be bringing back messes much more into the centre of the hospital so there is informal welfare there? Should the NHS be providing hot meals so that people feel looked after? What are the things that we could do in a short-term plan from your organisation that you think would make a difference?

Chris Hopson: We created a plan of short-term actions that we think could help in the junior doctor context, and they are exactly the kinds of areas that you were talking about, which is ensuring that junior doctors have a named senior person, and that there are messes and hot meals. There is a set of things that clearly could be done, but the issue is the fundamental context of the gap between the demand and the capacity that we currently face.

Q57 **Dr Evans:** Let me press one point—

Chair: Last one, Luke.

Dr Evans: I have asked every clinician who has been in front of this panel how much time they spend on simple IT, and they say between about 10% and 15% chasing issues—paperwork, admin and referrals. One of the big buffers from that is the interface between primary and secondary care. You represent basically the secondary care side. I hear GP colleagues saying there is always a fundamental problem. The BMA are very hot on this. What is your answer to addressing the rub of accountability between primary and secondary care?

Chris Hopson: That is what hopefully ICSs, integrated care systems, are here to do—to build much more effective links between primary care and secondary care. You are right to mention technology being an absolutely key part of it. The Secretary of State talked last week about the need to ensure that 80% of trusts have electronic patient records systems as soon as possible. We know that those help in creating the interface single care records that then link up primary care with secondary care. There are a number of practical things that can be done. That is exactly why Claire Fuller is in the process of doing a review, or a stocktake, at the moment to try to identify exactly how we use the advent of integrated care systems to start to get that interface more effective.

Chair: Thank you.

Q58 **Barbara Keeley:** Can we go back to recruitment? We have talked a bit about the need to accommodate flexible working and people who want to do less than full-time working. How should the workforce plan respond to that trend? Perhaps I could come to you, Professor Stokes-Lampard. It seems as if the system, as Nicola described it, changes around people's needs, and that is right, but how can a national workforce plan for the NHS accommodate the increasing trend of people wanting to work flexibly

and wanting to work less than full time?

Professor Stokes-Lampard: Certainly, there has been a generational trend between people valuing home life and life outside work more highly, and there is quite a lot of evidence and research that allows us to make predictions for the future. We also know that we are currently in a very stressed system, as Luke and others have alluded to. We have a workforce that is very tired, burnt out and stressed, and people are looking to reduce the amount they are working, just to keep sane and to look after their mental health and wellbeing. We have research and evidence that we can base it on.

Q59 **Barbara Keeley:** I want to ask you about that point before you leave it because it is important—the impact that workforce burnout is having. The normal reaction would be to say, "Okay, I can't cope with this. I'm burnt out. I'm just going to give up some shifts."

Professor Stokes-Lampard: Many people are reducing what they do rather than stopping. We are talking about people who are fundamentally incredibly dedicated and care for their patients. They want to deliver the best, but if they know it is damaging their own health or it is damaging their relationships and their families the first thing they try to do—one of the big built-in survival things—is to dial down the amount they do to allow themselves to get sleep, to get headspace, to take time out, and that involves flexible working.

I love the idea of flexi-retired. It is wonderful. It is going to enter the lexicon. Flexibility improves retention in the system. The biggest thing we can do right now is value and retain our workforce in every part of health and social care because that is the quick win—factoring in flexibility and accommodating it. Historically, the NHS has not been good at accommodating flexibility. I represent doctors. One of the most inflexible bits has been doctors. So many specialties are now far better at recognising that we should allow people to work more flexibly. For one person, that will be a 90% contract, and for another it will be a 70% contract. That is okay. Some people, particularly those reaching the later part of their career, do not want to take on some of the more high-risk, high-adrenaline, four-in-the-morning parts of the job, but they are really happy to do other core, very complex, sophisticated parts of the job. Good employers are nurturing that.

Q60 **Barbara Keeley:** The 4 o'clock-in-the-morning part of the job—

Professor Stokes-Lampard: It has to be done.

Barbara Keeley: How do you plan for that? That is the point. I fully recognise what is going on, but how on earth do you plan for it?

Professor Stokes-Lampard: There is a lot of research out there. The beauty of an independent plan is that you pull together all the strands that we have. We have data from the General Medical Council and the various equivalent bodies. We have data from the provider trusts. We

have data from the royal colleges. We have a huge amount of data within NHS England and Health Education England. We need to pull it together because there is a remarkably vivid picture. We collect a lot of data. What we do not do is join it up.

My plea would be to use what we have. We do not need to reinvent wheels. Let's pull together what we have. Let's mandate people working together to share data. Historically, we have not been good at sharing data across the different divides. We also need to be very realistic about what the healthcare needs of the future population are going to be. I will not reiterate where our population is going in terms of ageing, increasing multi-morbidity and so on. I am taking it as a given that we can factor that in as well. We have the epidemiology and public health data to help us with that.

We must also recognise societal changes and the shifts in the way people want to work. The generation going into medical school now looks at my generation, and I suspect even Luke's generation in the middle, and says, "I don't want to work like that. I'm not putting everything else on the line for this, but I still care passionately." We have to factor that in. Just telling people to work and do things differently will not change it. We created the society that they are coming into. We created the system, so we have to own the solutions and be flexible, creative and transparent and welcome these incredibly talented younger people and give them the opportunity to flourish.

I would like to pick up on the training point. I wanted to shout out "Amen," Nicola, when you talked about training our flexible workers. There are lost tribes of people out there who would like to do more, who would like to advance, who would like to take on new skills and are being artificially banned from doing so. These are things we can address. Education and training are vital. To the question Chris was posed about who should employ trainees, there is an issue in that, if you move all employment of healthcare professionals in training to NHS trusts, the trust will be under massive pressure to deliver on the backlog in service, and education training will be de-prioritised, so the service pressures will be prioritised over training, which will lead to a bulge and backlog, and you will not get people evolving to the higher level of professions they can reach and that we ultimately need. Training and delivery must go in parallel. We dare not sacrifice one for the other. Thank you.

Q61 **Barbara Keeley:** Chris, do you have anything to add on how the national workforce plan copes with the flexible element?

Chris Hopson: The real advantage of the people plan that we produced in the NHS about a year and a half ago was that it absolutely identified that this is not just a numbers game; it is actually a big cultural, behavioural and leadership challenge that the NHS has.

I recognise what Helen is saying. As the Chair knows, my wife is one of the country's leading experts on flexible working, and she makes the

point that the NHS feels like it is 10, 15, 20 years out of date in its ability to offer the kind of flexible working patterns that we see in other parts of the economy. It is partly because of the degree of pressure that we are under. Effectively, it is the headspace to design new ways of doing things. If we do not do that, we are going to lose the workforce of the future, which is a real problem.

Q62 **Barbara Keeley:** My second question is about recruitment, how it varies in geographical regions and what impact that has on health outcomes in the parts where it is hard to recruit. Can you talk about that? What is being done and what can be done to get over recruitment problems in understaffed regions?

Chris Hopson: We know—the evidence is really clear—that there are particular regions in the country and areas in the country that are significantly under challenge because they are unable to recruit, particularly a medical workforce that meets their needs. There are two or three things that are happening.

The first is that we are trying to increase the number of medical places that are available in places where there are shortages on the ground; the Chair was instrumental in that. People tend to stay in the places where they train. The second thing is that we are trying to move training places around the country. My colleagues at Health Education England said how difficult it is even to persuade trusts to say, "Can we move one or two places that are currently with you to a trust that really needs them?" Because of the workforce shortages, the trust that would lose those places is saying, "No, absolutely not." We are working on that at the moment.

The third issue is that there is absolutely no doubt that individual organisations are working incredibly hard in areas that are hard to recruit to to make them attractive places to come and work. I was having a very interesting conversation with a doctor in east Kent the other day who was talking about the work they had been doing to make their trust a much more attractive place to work. That included making offers to the rest of the family and the partner of the person they were seeking to employ, helping them—

Chair: Chris, I am sorry to interrupt. Barbara, do you have a last question? We have to wrap up before oral questions start.

Q63 **Barbara Keeley:** No, just the point about regional recruitment.

Professor Stokes-Lampard: I am going to share my prop that I brought along. This week's *British Medical Journal* cover is "Why the new medical schools are targeting international students". There is a challenge. We have invested in the places you created for additional medical students. We need many more, but that is a side point. We have these new medical schools and we do not have the funding to have local students to go to them.

The point of putting these medical schools in areas that were traditionally hard to recruit to was that we would get local people going in because we know that people frequently stay and work quite close to where they trained, and certainly where their professional higher training is, so you put the medical schools in the under-doctored, understaffed areas, and largely people will stay there. The problem is that, if you then fill the medical schools with people who have come from overseas, you do not get the same effect and benefit. We actually need those places funded so that we can fill them. It is just a quick plug for that story. It is perfect timing. There are many other issues as well.

Q64 **Barbara Keeley:** A final point, Nicola?

Nicola McQueen: A final point from me—one that has not come up—is how we now protect tactically our burnt-out workforce, and there are some things that we can start to do that enable flexible working. A good example is that we were inundated with frontline nurses applying for roles to work on Test and Trace when we ran that programme for recruitment. We recruited 10,000 clinicians to Test and Trace. They got to work from home. They had headsets. We trained them to contact trace, and our clinicians loved it, except we did not want them doing that; we wanted them in our hospitals. There is some respite for our workforce if we can get this right, where we can mobilise our workforce out of being in hospitals five days a week, 12 hours a day to do one day from home, 111 services and 999 services. We need clinicians in this country across the board, and I think we can do more to move them around.

Q65 **Chair:** Thank you. Before we wrap up, I want to ask Chris and Helen one question each on issues that we are going to cover later in the inquiry. Chris, a word from you on the pensions issue. Are you getting feedback from your members that they are losing a lot of senior doctors because of the way the pensions system is structured?

Chris Hopson: We are getting an increasing number of issues of that being raised. It is not at the same volume and intensity that it was a couple of years ago, but it is definitely coming back up the agenda. What is particularly worrying is that, if you look at what we need to do in terms of backlog clearance, we absolutely need senior clinicians to work extra shifts, and it is clear they are worried about the impact on pensions. That is something we need to look at.

Q66 **Chair:** Helen, do we need to have a fundamental rethink about medical education, the curriculum and how it works? It is something that is often discussed by the royal colleges. Is it time for a big re-look at how medical education works?

Professor Stokes-Lampard: No, I do not think we need a radical rethink. We have a very good system that could certainly be improved and should constantly be evolving and improving. There is some amazing innovation already. Some of the newer medical schools are doing great

things and there is some great thinking already done. I do not think we need revolution there at all, but evolution of course.

We need increased numbers, increased throughput, and creative ways of looking. Nicola mentioned the apprenticeship model, but that still involves medical schools, training and the same exit assessments. Ultimately, we need highly qualified doctors the population can trust to deliver excellent care, and that needs to evolve, but we do not tear up what we have now.

Chair: Thank you. It has been a really interesting session. The thing that I have taken away from it is not just the importance of a long-term workforce plan, which I think all of us agree with anyway, but the concept that flexible working needs to be seen as the solution and not the problem. You have given us a lot of food for thought. Chris, Helen, and Nicola, thank you very much for joining us. That concludes this morning's session.