

Public Services Committee

Corrected oral evidence: Designing a public services workforce fit for the future

Wednesday 2 March 2022

3.30 pm

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Members present: Baroness Armstrong of Hill Top (The Chair); Lord Bichard; Lord Bourne of Aberystwyth; Lord Davies of Gower; Lord Filkin; Lord Hogan-Howe; Lord Hunt of Kings Heath; Baroness Pinnock; Baroness Pitkeathley; Lord Porter of Spalding; Baroness Sater; Lord Willis of Knaresborough.

Evidence Session No. 1

Heard in Public

Questions 1 - 7

Witnesses

I: Mark Adam, Chief People Officer, Ministry of Justice; Mike Haslam, Deputy Director, Workforce strategy, experience, and engagement, Department of Health and Social Care (DHSC); Alan Robson, Deputy Director, NHS workforce, DHSC; Rob Smith, Director of Workforce Planning and Intelligence, Health Education England.

Examination of witnesses

Mark Adam, Mike Haslam, Alan Robson and Rob Smith.

Q1 The Chair: Good afternoon everyone. I am Hilary Armstrong, Chair of the House of Lords Public Services Committee. This is our first public evidence session looking at designing a public service workforce fit for the future. We are pleased to welcome those people who have responsibility within different departments and organisations in the public sector, to give evidence this afternoon. This will help us really get into the thinking we need to get into for this inquiry.

In our first session this afternoon, we have Mark Adam, Mike Haslam, Alan Robson and Rob Smith. For our first panel, we have all men and for the second panel, we have all women—it is just the way it has worked out. Welcome to all of you. The members of the committee are mainly in the room because we have votes and we have to be here in order to vote. You are all online, but you are none the less welcome.

I will begin the questioning, and when you come in, please introduce yourselves so that Members and the public, if there is anyone watching, know who you are. You are too far away for me to see your names on your screen, and so it would be useful if I work out who you all are once you introduce yourselves.

Welcome to our first session and, as ever, I ask the first question. As we are a cross service committee, we are going to be looking for the things that link how you are all thinking about the workforce for the future. Even though we will have some specific questions for specific professions and departments, we will be looking for those things that can link workforce planning. The Government have identified staff targets for public services, including 50,000 more nurses by 2025, 6,000 more doctors in general practice, and so on. We are not looking really at numbers; rather, at the challenges that face public services, particularly in the light of the pandemic. How are you looking at what resource you need? What other things do you need to ensure that you have a workforce fit for the plans for the future? I will ask Mike to come in first on that.

Mike Haslam: Thank you very much. I will start by outlining where we are on some of the numerical commitments. While I think you are right that this is not sufficient on its own; it is important that it is part of the picture. We are making very good progress on the target of 50,000 more nurses. This is through a combination of increased domestic recruitment—that is undergraduate and postgraduate student routes in, as well as apprenticeships and a way of widening different routes into the nursing profession. We are taking action on retention and we also have a very strong international recruitment process in place. We are on track to meet the target and we will be publishing more information on this very shortly. It is helpful to note as well that we already have nurses working in the NHS who have been recruited through the 50,000 nurse programme.

Moving on to 6,000 GPs, we remain committed to growing numbers in the GP workforce and the number of doctors in general practice in particular. As of December 2021, there were just under 1,700 more full-time doctors in general practice than there were two years earlier. We are working very closely with NHS England, Health Education England and the profession to increase the size of the workforce. That includes boosting recruitment, addressing issues around retention and encouraging return to practice as well. The updated GP contract framework that came out in 2020 announced new retention schemes, as well as bolstering support for existing ones. To boost recruitment further, we have increased the number of GP training places, and in 2021-22 we have seen 4,000 trainees accepting a place, which is an increase of about 50% since 2014.

The other thing to note on this is that we have increased the number of medical places by 1,500 as of September 2020; that is a 25% increase. As part of this expansion, we have opened five new medical schools across England.

Going back to the thrust of the question, you asked whether this on its own is sufficient, and I think it is probably not. What we need is more staff, and I think that is certainly part of the picture, but we also need them to be working differently and within a supportive and compassionate culture.

Taking the latter of those things first, it is important to note first off that NHS staff have had a really challenging couple of years. We know there are a lot of them who have been suffering as a result of the pressure they have been under due to the pandemic, and it is absolutely right that we do everything we can to look after the well-being of staff across the system. The *People Plan 2020/21* prioritises the well-being of staff. It sets out a comprehensive range of actions to strengthen health and well-being support, promote flexible working and support the development of a more compassionate, inclusive culture within the NHS workplace.

The people plan is overseen by NHS England, which has established a people recovery taskforce to ensure there is a framework and a set of interventions to ensure that all NHS staff, including students and trainees, are kept as safe as possible during the pandemic. Measures include ongoing physical and mental health support through the staff mental health and well-being hubs, and particularly targeting psychological support and treatment for those that have been most affected. It includes retaining staff who have come back into the NHS to help provide additional capacity. It includes creating time and space for leaders and teams to reflect and process what they have been through over the last couple of years. It includes a strong role for well-being guardians, who are board-level leaders with a specific focus on the well-being of staff. It includes investment in well-being conversations, and strengthening the role for occupational health to deal with the increased caseload and demands.

The people priorities for both this financial year and next have been set out in NHS national planning guidance, and very prominently within that. It builds on the framework that is set out within the people plan and is informed by learning from the pandemic. That is what we are doing around supporting staff and attempting to build a more compassionate culture across the NHS.

In terms of working differently, I think it is fair to say that the challenges facing the NHS are changing. Given the demands on the NHS at the moment and given the types of demands that come in, there is an increasing need to manage people's ongoing health and care needs, rather than to fix people. Alongside that, advances in science and technology will increasingly shape health and care, and, in combination, digital technology, artificial intelligence, robotics and genomic science are all contributing now—and their impact will increase over time. Moreover, there are demographic drivers of demand coming that we cannot avoid, but we do need to face.

In response to this, in July last year, the department commissioned Health Education England to work with partners across the system and

beyond, to review and renew the long-term strategic framework for the health and care workforce. This is to help ensure that we have the right numbers, skills, values and behaviours to develop and deliver high-quality clinical service, and high standards of patient care. For the first time ever, this will include regulated professionals working in social care such as nurses and occupational therapists, as well as other allied health professionals.

It will also look at the key drivers of workforce demand and supply over the longer term, and set out how they may impact on the required shape of the future workforce, to help identify the main strategic choices that we are facing. The factors considered in this include demography, science, technology and innovation, health and inequalities, service plans and priorities, and expectations of the NHS. It requires us to work very closely with partners from all levels and sectors, and Health Education England has run events that have included up to about 300 experts from local, regional and national organisations, from both inside and outside the health and care system.

The aim is together to build a shared set of assumptions and goals that will provide a clear framework, within which more detailed workforce plans can be developed and delivered at national and local level, leading to better care and better work for all. Building on this, in January the department commissioned NHS England to develop a long-term workforce strategy, including workforce projections. We will set out the key conclusions of that work in due course.

The Chair: Thank you.

Mike Haslam: The short answer is: on their own, numbers are insufficient. However, there is other work going on to address the challenges that we are facing.

The Chair: I think we may come back to some other issues as well in a minute or two, but let me give Alan Robson the chance to contribute—if you want to, Alan.

Alan Robson: I think Rob was going to contribute to that element.

The Chair: Rob, training and education for this is going to be very important.

Rob Smith: Mike has set out quite clearly the joint approach that both NHS England and Health Education England have been taking, which is: more staff working differently in a compassionate and inclusive culture. We have really been stressing that the numbers are not enough; but they are necessary. These are not binary things, these are what we are describing as “making sure that we pull all levers at all levels”. Frankly, my perspective is that it is the co-ordination of those different efforts on the challenge that is required, and moreover required with an eye on different time horizons, because those levers are effective in different places.

As we have described, starting training of new healthcare professionals does not have an output until sometime into the future. However, some of our adaptive training can be in the nearer term. That is the kind of landscape within which we are trying to do our work, and will, I hope, inform the committee's work as you consider how that applies to the wider public sector.

The Chair: Thank you, Rob. Can I just ask very quickly, how do the professional bodies—many of which control education and training, and define what the profession is about—how are they responding to the pressures that you have in the NHS?

Rob Smith: I would be happy to come back to the committee with some more evidence from our director of education and quality, and our medical director. From my work with colleges and others, there is a really healthy dialogue about how the nature of service is changing over time, and therefore how the nature of education and training changes. As Mike referred to, the work that we are doing through the strategic framework commission is asking those kinds of longer-term questions about what is the nature of service, what is the nature of a workforce that supports that service, without being constrained by some of those more traditional roles and boundaries. We have colleagues from all of the professional groups and other staff-side representatives active in that work, as we move towards publishing that strategic framework in the next few months.

The Chair: Would either of the other NHS people like to come in on this? This is partly arising from what we are discussing in the Lords at the moment on the new Bill, that we want a more integrated service—huh—when nobody in their training for certain of the professions ever learns anything about what the other professions are doing, or sees and comes to a common language, or a common means of working across the board. Nobody seems to be addressing that. Am I just being cynical?

Mike Haslam: I will come in briefly. I think what Rob said about how the professional bodies have been responding to the strategic framework is right. They have been very closely involved and very constructive throughout. I think all of us across the system recognise the challenges that are coming, as well as some of those that you have laid out here, about how we encourage different professions to work better together than they necessarily historically have. I do not know whether Alan would like to come in on the education and training side, but if you are looking for more detail we can come back to you afterwards, Chair.

The Chair: Thank you, I would appreciate that. Rob, would you like to come in and say anything more?

Rob Smith: I do not think it is quite as black and white as we are describing there, I think you have to ask the right question to make sure we then pull the right levers and actions. One of the things that the strategic framework will do, we hope, is make that drive towards integration crystal clear. As Mike said, if we can get common drivers and

common assumptions about what future we are aspiring to, then the actions that follow from those assumptions become clearer. That is the point at which you would engage to make sure—and I think there is a lot of support from royal colleges and others in that space. I think there is an open door and there has been lots of progress in some areas, but perhaps not fast enough. We have all experienced fragmented care.

The other thing to remember, in a wider sense, is that the development of integrated care systems is specifically designed to start thinking about that in a joined-up way. I know they use the mantra “One Workforce”, for instance, as a catchphrase for the kind of integration that you are alluding to, Chair.

Q2 Lord Willis of Knaresborough: I declare some interests, as a recent consultant to both NHS England and Health Education England on workforce issues, chair of the Applied Research Collaboration Yorkshire and Humber, and now an independent consultant on workforce issues.

There are two things. First of all, I think the Chair was absolutely right to ask the question about those organisations. I think she referred specifically to the royal colleges, which have such an influence on curriculum, and to be able to actually tap into those. I will ask you very briefly—and this is specifically to Mike—whether in fact there is an intention to deal with the seven professional and the two systems regulators. They make a huge impact on the way in which integrated services can be delivered because they control independent silos, as the Chair has said.

My main question, Mike—and the others may wish to respond to this—is that I want to challenge you on the 50,000 new nurses by 2025 target. This is to be achieved in three years’ time, according to you, and you seem to think that it is perfectly possible. I have looked back at the last three years, or certainly up to September 2021, when the major figures came out. I have found that in that time, registered nurses over three years had increased by 27,000, which is great. Vacancies had fallen slightly, but during the same period of time, recruitment from overseas, which is non-EU/EEA nurses, had increased by nearly 32,000—45%. If you took away those increased nurses that had come in from non-EU countries, what we had was actually a fall in UK-based nurses of around 4,500. So if we have seen a fall of UK-trained nurses on the register over that three-year period, how on earth are you going to get 50,000 in three years, unless you tap into the world’s resources of registered nurses and denude other countries of the vital resources that they have?

Mike Haslam: I will deal with the last question first, regarding the 50,000 target. You have drawn a comparison between the 32,000 additional international nurses over the last three years and the 27,000 additional total nurses over the last three years. It is a slightly unfair comparison because it is not 32,000 and 27,000; the 27,000 is an increase in workforce numbers that also takes into account the number who have left. Over the last three years a large number of nurses will have retired. I do not know what the exact figure is, but let us say, for

argument's sake, that it is in the region of 70,000-80,000. That would then mean that is the comparable figure. Of the 70,000-80,000, 32,000 were international recruits and 50,000-odd, whatever it would be, are domestic recruits.

Lord Willis of Knaresborough: With respect, that is not the case. What I am saying to you is, from the official figures produced by the Nursing and Midwifery Council, which it had to produce in September 2021, that there were people on the register from those two different sources, and they are the real figures. It did not matter who had come and gone, they were the figures that were on the register in September 2021. I am saying in the next three years, to jump up to 50,000-plus is something which, quite frankly, this committee, I hope, does not believe.

Mike Haslam: I would encourage you to wait for the publication of the 50k update, which will be out very shortly. We hope that we will set out in more detail as to where exactly we are on this. You raise a valid challenge that we have had challenges around domestic recruitment. What we have done, partly as a result of the 50k programme, but also preceding that, was put in maintenance grants for students to start. That has encouraged very high numbers of students to sign up for nursing degrees. In fact, I think we are at record numbers at this stage who are signing up for nursing degrees and they are starting to come through into the system. That is a direct result of the 50k programme, and slightly preceding that as well. As it takes three years to train a nurse, we are in the position that if we put that in place, we get nurses coming out of the programme three years down the line, possibly later.

I think it is fair that we look at alternatives to plug the gaps in the short term. International recruitment is the very obvious one, and the international recruitment that we do meets the World Health Organization ethical standards. We do it all through ethical frameworks where we agree with the Governments of the countries where we are bringing nurses in from, what limits we can do. We manage it in such a way that it does not impact on the health systems of those countries.

Baroness Pitkeathley: I am quite conflicted about some of the things that I am hearing here. You have talked about reflecting and processing staff distress or the anxieties that they have, and being sure to care for their emotional state and so on, in particular, and we have also talked about collaboration and integration. Now we all know that all of those things take time. You cannot reflect and process in a hurry. You cannot integrate and collaborate in a hurry. Do you find any conflict between those things that take time, and the targets that you are trying to meet?

Mike Haslam: Could I ask just one question back? By targets, do you mean the elective care challenges that we have coming?

Baroness Pitkeathley: There are all kinds of targets, but we all know that there is tremendous pressure of time, particularly on health and social care services and other services too. My question, and I am sorry if it is a bit nebulous for you, but it does seem to me that the things that

you are talking about—that need to be done, I am sure we would all agree—take time, which is very, very scarce.

Mike Haslam: Again, thank you for the question. I agree that is a very fair challenge, and it is one of the difficulties that the NHS is going to face over the next few years because it is clear that demands are very high, and there is a lot of pressure across the system at the moment. First, it is not the same everywhere across the country. There are some places that have been less affected by the pandemic than others, and some places that have much lower elective care backlogs than other areas. So I think there are some places that will be able to do this more rapidly than others.

Secondly, the approach that is taken to this will again need to differ by local area. That will partly depend on the circumstance, but also on the state of the workforce in local areas. If, for example, some areas are struggling more with staff morale and staff sickness absence than others are, then it might be that they put more time upfront into supporting staff back to a more comfortable place. That will inevitably have a bit of a knock-on impact on how quickly services recover and how quickly they can process some of the backlog. Those are some of the challenges that we will be facing across the system over the next few years, and I am not going to sit here and pretend that it is easy and will be straightforward, particularly everywhere.

Lord Porter of Spalding: Out of the need for brevity, I draw attention my registered interests. If I had to list each one of them, we would be out of time to do the rest of the session, but they are largely around needing a highly skilled, well-trained workforce, or being part of the training of that workforce. Could somebody attach the relevant parts from my register of interests for the public benefit? I would like to go back to the 50,000 target. If it takes three years to train nurses, we should be able to have a good guess at how many we have coming through, by how many are being trained at the moment. If you do not have 50,000 nurses being trained at a moment, you are not going to get 50,000 in three years. How many are being trained at the moment?

Mike Haslam: I cannot give you the exact figure on that at this point. As I said, we have a publication coming out shortly updating on where we are. I would encourage you not to focus too much on the 50,000 because the 50,000 is a “more” figure, as opposed to how many we are training. We are training for both the 50,000 target but also those who will be leaving the workforce over the period of time that we are considering. It is actually significantly more than 50,000 nurses that we are training.

The Chair: We will move on to you, Mark, from the Ministry of Justice. You have been having an easy afternoon so far, but I will call on Lord Hogan-Howe to ask his question.

Q3 **Lord Hogan-Howe:** I think I have just been announced as the thing that makes it more difficult for you; but I will do my best. The question we have for you as a starter is: in addition to increasing staff numbers, what

else can the Government do to help employees resolve the resource challenges facing the justice system? We have talked a lot about the health system, but now it is about the justice system, please.

Mark Adam: Thank you. I think I share an awful lot of similarities with health colleagues on this—the more integration we have across our justice workforce, the easier it is to operate. So how do we get cross-deployability between what we do within prisons to probation, to even potentially courts and bring people through? There are very different development routes that bring all those workforces together in terms of how they operate.

Apprenticeships have been a brilliant tool for us. We have just put in place mechanisms to take service leavers out of the MoD. A lot of this is around how we get the connectivity. The other big part for us—in the same way as for all in public service—is that people join with a huge sense of purpose and it becomes very frustrating when you cannot deliver that purpose and see that through. What we have put in place around ongoing ability to progress within the organisation, development, the environment—the programme we have at the moment on rebuilds and new builds of existing prison estate provides an environment that people can actually work within.

Another pressure that we experience is that it is very difficult to be a part-time employee within the prison environment, in terms of continuity and support. Finding ways to work with our unions through more innovative contracts and flexibility are the kinds of areas that we need to tap into at the moment. Also, how we can look at providing more choice for our employees in terms of their ability to roster themselves, to be able to take their development across and actually do some cross-cutting programmes. We have had huge success with our Unlocked Graduates scheme that allows people to spend time on landings but also to step into policy roles. It is about finding those mechanisms for people to give breadth to the justice system because it is all interconnected.

The last area I will mention is the join-up that we do with the Home Office because we share an awful lot of those challenges on an end-to-end system, and how people can move between is quite challenging at the moment. They leave one organisation and join another and we have quite a lot of churn between the two. The challenge is how we can put mechanisms in place for people to have rich careers right the way across the justice environment.

Lord Hogan-Howe: That was very interesting. I want to pick up on what you just talked about. The two things that I found really interesting were the apprenticeships, and then you mentioned the Unlocked Graduates approach. Could you say a little more about both and why that helps, and what numbers are involved?

Mark Adam: We are looking to bring all our recruits for officer support grades and prison officers on to an apprenticeship scheme. At the moment, if you were to become a prison officer you would go on a 12-

week training programme. We are looking to see whether or not apprenticeship schemes can actually start to change the way we do that training. That also gives people a tie-in for two years as part of that programme and to get the breadth of their development. Similarly with Unlocked Graduates, that is taking graduates on to a programme where they are spending two to three years working with us and receiving mentored support.

The difficult challenge of being a prison officer is that you can currently spend 12 weeks in a training programme and never set foot in a prison. Then you are landed into the prison to work in real life. How do we put that wraparound support into a challenging environment? So putting in place both those schemes ensures that we have a mentoring process, and a coaching and supporting background to make sure that the people involved in incidents or in pressurised environments have outputs and chances to do that. They are the two biggest game changers for us in our ability to support and retain staff, in what can be at times really, really challenging and demanding roles.

Lord Hogan-Howe: Essentially, though, what is happening is that people are rebranding their existing training for recruits because they have lost 2% of the pay bill into the apprenticeship scheme. A way of recovering it, is to call what is existing training apprenticeships. The Chair said earlier about being cynical. I hope I am not, but there has been an awful lot that already. Why is this different? You are all smiling, by the way—I do not know if that matters.

Mark Adam: I do take your cynicism, and I would be misleading if I did not say that there is an opportunity with apprenticeships in terms of what we invest into the core training to be able to do it differently. Where I think it is different is that the apprenticeships rely heavily on that mentoring/coaching partnership relationship. That makes a difference. If you are involved in a different experience on a wing in the morning, and you need to decompress and have that conversation, you do not get that in the standard training. In an apprenticeship scheme someone will come along and say, "How was that experience? You did everything right, and next time you could do this. This is how we're going to support you".

There is a huge investment into our POELT, which is our entry-level training for prison officers, mentors to actually allow people to take that role. It is a richer role for many of our officers if they undertake that, and it gives people that support mechanism that they need coming into that environment—and that is not just a saving in the apprenticeships.

Lord Hogan-Howe: I am sorry to interrupt, but if I may just ask one further question. Regarding your fundamental point, which is about transferability of skills and other things across different parts of the criminal justice system, just how much progress has been made, or needs to be made about, for example, transportable, accredited skills; things as boring but as important as pensions and people being able to leave the public service and come back and not suffer consequences for pensions? It seems to me these are the big things that we need to make

progress on, which may not be in your gift, but I wonder what you have to say about that.

Mark Adam: They are not all in my gift, but they are live conversations. Pensions is a real challenge. Prison officers are civil servants, not public servants, and that has an impact on their ability to move around the wider public service—for policing, for example. Pensions is a hurdle that we are going to need to think about as a whole Civil Service in terms of the role they play. Pensions are always seen as the great thing to have as a civil servant, but actually they can be as much of a barrier, for some, as an incentive. Another element is that permeability between public service and civil service and being able to get that interchange.

Lord Hogan-Howe: My final question, therefore, is perhaps for all four of you. Are any of you aware of any work that is going on about that? We all aspired to it, we all understand the problem, but I have not seen anybody who is doing the work—the Treasury, or anyone else.

Mark Adam: I can chip in on this because I do have a remit to have a look at some of that work. The Civil Service Board commissioned some work on the elements of pay convergence and the concepts, and all the challenges that sit around there. While it is very early days for me to comment on it, there is a shared view right the way across that this is something we are going to have to consider for our workforce for the future.

Lord Davies of Gower: I will pick up on what Lord Hogan-Howe was asking. On these apprenticeships, taking the prison officer as an example, what transferable skills or qualifications do they get that they can take forward?

Mark Adam: It is a bespoke apprenticeship for prison officers, but as part of that they get an awful lot of the core emotional intelligence training in terms of the personal relationships. It is not dissimilar to some of the programmes of work that are done within policing and probation. It starts to go a lot further than “You are here to turn locks and make sure that you fulfil those core day activities in terms of movement and regime, driving around prisons”, to building relationships that support people’s offending behaviour and can allow them to make those changes. This starts to mean that those skills are transferable into the likes of probation, Border Force and other relationship-driven areas where de-escalation and those types of skills are really important. We are finding that it is an environment where people are coming in to build transferable skills, where previously we would have had a set-up where you became a prison officer and did that for 40 years. These programmes are giving people the chance to move and I think we just need to accept that that is part of the nature of employment now.

Q4 **Baroness Sater:** I declare that I am chair of the Alliance of Sport taskforce on physical activity and support in the criminal justice system. Mark, I would like to follow up on apprenticeships, and obviously you are making progress with that and with graduates. What is the retention of

those apprenticeships and how are you doing with that? If it is not a good outcome or it is a getting better outcome, what are the barriers that you are seeing to the retention of apprenticeships?

Mark Adam: We sit with a turnover rate of around 13% for our prison officers, which is slightly higher than it was a year ago. Some of that has come out post pandemic, and there are probably four issues that we are experiencing. Some are pay driven and the challenges that we have around pay. Even though people will go through those development programmes, and that has improved some of the retention for those on the apprenticeships, people still leave for more money. That is just the nature of what we are experiencing. It is the trade-off between the environment and the challenges of that environment, in exchange for that money and opportunities to progress.

One of the big things that we need to invest in to make the apprenticeships work is to ensure that we have career routes in which people feel they can actually grow, expand and take other opportunities. At the moment managing that within a single prison environment does not offer those kinds of options. When you come in as an officer and there are 24 of you reporting into about two line managers, for example, people work out quite quickly what their career progression options are. If we can provide as part of that apprenticeship the fact that you could move into a court environment or probation environment, or even a Border Force environment if we stretch this a bit further, that is going to help retain people. People are asking what the career progression opportunities are, as much as they are asking for the money.

Q5 Lord Hunt of Kings Heath: I will just declare as we start the committee inquiry my membership of the General Medical Council board. In the light of all the workforce pressures, plus Brexit, Covid, and the demographic challenges that many public services in particular face, do you think the conventional approach to both professional and workforce training is appropriate anymore? If not, what measures are you taking to look for more streamlined approaches?

Alan Robson: This is a great area and a great question. How we train staff, both now and in the future, is massively changing. Some of the advances in science and technology will really shape health and care training. With digital technology coming on board, AI, robotics, genomic science, they are all going to change—and are contributing now. They are impacting on health—how we treat patients—and also accelerating staff training from undergraduate level through to postgraduate level, which I will come to.

For me, there are essentially three key pillars of this. If we get the training right and it is of high quality, this prepares and equips the workforce for the long term, and a long and fulfilling future career here in the health system, and they are more likely to remain with us. It says to students that they will be well trained, offered rewarding careers and be highly valued. However, in all of this—and I think this is a key part of the question and of some of the work on this—we should not lose sight of the

fact that the end goal in any training is that it has to be delivered on patient need, and improve the health outcomes across our communities. That is going to be the key thing. Of course, workforce training, be that pre-registration or post-registration, has never really been a fixed entity. Certainly throughout my career, it has always evolved and will continue to do so, and that is a brilliant thing.

Members of the committee will know that it has been five years since we introduced the nursing associate role, and that has been a great thing. It took a little while to get it going, but that is really taking off. We are seeing great numbers come through with that. For the public sector—and Mark touched on this, and he's right, we have got great similarities across all of the public sector—we all have to realise that we are working in a competitive environment. We have to do more to attract people to come and work for us. I do not think that we have any right to expect people to come and work in the health system. We have to work hard to go and get them. Key in all of this is the workforce training officer, working alongside the regulators—the GMC and the NMC—the professions, universities, further education institutions, which we often forget about, and technology suppliers. We really have to drive this forward and at the end of the day, the NHS is the fifth-largest employer in the world, so we should be blazing a trail for this.

The other area that I would pick up on around training is that we have to ensure that we have training in the parts of the country and in the right volumes where patients need them. I am looking at doing some work on remote rural courses for communities, which are not always next to university centres of learning. The training world has moved on; people now want to do training differently. I do not think that there is one set model of training anymore, and one live example, if you like, is blended learning. The work that Health Education England has undertaken around blended learning is transformational. I would put us up there with certainly the top two or three parts of the world in terms of our blended learning offer. We have launched a nurse degree programme which mixes traditional teaching, which I think we will always have, with immersive technologies—augmented reality, virtual reality, simulation, avatars. This is not just about putting a set of slides online and teaching to the slides, this is immersive learning and I think that is where, certainly in the health system, we are really pushing back the boundaries, Lord Hunt. In five years' time—if I am still here, I am very happy to come back—I think we will have around 8,500-9,000 people going through this route.

I would also like to touch on apprenticeships. I am a great believer in apprenticeships because not everyone wants to, or can, go to university and study full-time, so we have to be flexible in the offer. The NHS has a really strong offer on apprenticeships. I think Lord Hogan-Howe asked Mark what training they get, and in the health system, if you look at the nurse degree apprenticeship, it takes four years, but they come out with the exact same nursing degree that they would get if they went with the undergraduate university training course. I am truly excited that we have just launched a medical degree apprenticeship, so people are going to be

able to become a doctor through an apprenticeship, and again it is the exact same qualification. Everyone said that it was not doable—it is doable. Working with the GMC, working with the profession, which has been brilliant on this, we have that medical degree apprenticeship off the ground.

This year we have around 25,000 apprentices in the NHS, and I think that is the largest number we have recorded. We are probably now the biggest apprenticeship employer in the system, I think we have overtaken the MoD, which was always light years ahead of us. The apprenticeship offer will allow us to adjust and it would be remiss of me not to talk about the nursing associates, as some members of the committee worked on the development of standards. I think that has been transformational and offers people coming to work—

Lord Hunt of Kings Heath: Apologies, can you please hold on a minute as we have to vote?

The committee suspended for a Division in the House.

Lord Hunt of Kings Heath: Alan, thank you very much for that response. Could you let the committee have detail of the initiatives you have spoken about, and the potential impact those will have on workforce in the health service? That would be very helpful.

Alan Robson: I would love to and I think that would be absolutely brilliant. I will touch on postgraduate as well because I know that one or two members asked earlier about the royal colleges and the regulators.

Lord Hunt of Kings Heath: Could I just come in and really focus on that to try to get a sense of how far you think we can make changes? If we talk about junior doctors, as you know, there have long been concerns that the working time directive impacted on the training of juniors—essentially that they did not get enough practical training. When they first qualified and came to work in the whole service, they felt ill prepared, and this may have had an impact on retention of those same doctors. Given that we are now outside the EU and we can make our own regulations, do you think that is an area of potential where you can start saying, well, actually there is a strong case for changing the way junior doctors are supervised and working in the health environment? Would that be part of your agenda?

Alan Robson: From a department point of view, I think we have to work with the professions, work with the GMC, and in some ways be a facilitator. You raised a great point there around junior doctors, and one of the things that came out of the pandemic, when we graduated doctors slightly earlier, was that they really stepped up and grasped that with both hands, so I think that would be a great area.

I have two quick points—and I will touch on this in the written evidence that we can send you—around things like credentials. When you make your career choice as a doctor in your 20s, the world moves on and you might want to do something else. I think credentialling opens up a great opportunity to retrain and re skill people into different careers. You can still be a doctor, but doing different specialties in the NHS.

Also regarding generalism, if you look at people with multimorbidities, population health and health disparities, looking at the generalism agenda is important. There is a brilliant paper on generalism in the *BMJ* that the Chief Medical officer and the medical director of NHS England and others from the colleges wrote, which sets up a great future for that. I think that the colleges, the professions, the GMC and the regulators are up for a conversation around it, but the department should be facilitating, not necessarily imposing it.

Lord Hunt of Kings Heath: Thank you. Mark, is there anything you wanted come in on from the MoJ point of view? You have already referred to your apprenticeship programme, but are there other areas where you really think you can make some changes to speed up and improve training, professional qualifications and development?

Mark Adam: We have talked about the parallels, and I think Alan covered many of the things that we are experiencing the same way, in terms of the art of the possible now—to have truly immersive development in a way that is not just death by PowerPoint.

The other thing that we are looking at is how we do a lot more around micro learning, and how we structure these things in such a way that we give people the maximum impact and input at the point at which they need them, in very short bursts. Some of this is driven by work we are looking at around how we reward and recognise capability. That is not just, “You do this course and we will pay you more”; there is a direct link to say, “Does that increase your ability to contribute and therefore the impact you have on our outcomes as a result of those?” Then you start to build a development programme that people are vested in and to be able to offer it at a time and place. We have suffered an awful lot with, “This course doesn’t come around until week X or three months’ time”, and that is not when people need it; they need it in the moment.

It comes back to my mentoring point: being able to put in trainers in prisons and doing that stuff on a daily basis gives people that development in the moment they need it, and it starts to move away from courses as a conventional thing. We all learn constantly in our careers, our development—how do we hardwire that into developing a learning culture?

Lord Hogan-Howe: This is probably more for the health service, but it is a general point, if you look across public service generally, more specialisation can lead to better outcomes—people know more about less, but it produces excellent outcomes. The problem is that it seems to leave the generalist having to cope with the volume that is pouring through the

door. If it is true, as I am asserting, how is that affecting your general plans? People have been dragged off into specialisms, close the door when they are no longer able to deal with diabetes numbers or whatever it happens to be, but then the generalist still has to deal with that issue; how does that play a part in your planning? It is okay if I am wrong, by the way.

Alan Robson: I can answer that and can possibly bring Rob in as well. I referred there to Chris Whitty and Steve Powis's wider paper on this, which sets the case out very well. I think we will always have specialisms, I do not think that anyone has talked about taking specialists away; we will always need specialists. What we do need, and if you look at patients coming through with multimorbidities now, what they often want to see is one person who can help with that general take. We have to celebrate the specialists that we have but we also have to welcome those who want a more generalist career. The GP is the ultimate generalist, but in hospitals we have to work with the colleges and professions to keep that generalist, broad-based skillset. Rob, do you have anything to add?

Rob Smith: I think we are all violently agreeing here. Getting the balance right between specialists who can act in the most knowledgeable, expert way is always going to be required. Then you have this second challenge, which is I do not think the system has always acknowledged, but I think we are doing now, though. HEE is running a specific generalist programme, including local generalist schools, and asking: how do you get that balance right? That is partly in response to what we are hearing from trainees who said their ambitions for their career might be different. This has a number of different factors pushing on it, but I am reasonably hopeful that we will see some really good results in the next few years, and certainly we could send you our work on the generalist programme from our medical director.

The Chair: That would be helpful.

Lord Hogan-Howe: I have one follow-up question. As an observation from the police service, the broad generalists over the country vary between two-thirds and three-quarters of the police workforce. For the Met, it is about two-thirds, and for very rural small forces, about 75% are generalists. That is that workforce. In terms of health, is there a similar spread? When does it get to the point where they cannot deliver the general; is there a critical cut-off point? Has anybody estimated that, because if they have not, how do you know when you reach it and the generalist point breaks down? It may be too hard a question, but it is one that has to be asked.

Rob Smith: I think it is a fair question, but I think it is also a question which goes to the wider multidisciplinary team, as well as the balance between generalist and specialist in the medical profession, for instance. You start by asking yourself a question and observing what is going on, and fundamentally you need to decide what your service model is that requires those different skills and then try to ensure that the supply of both types and numbers are good enough.

Q6 Lord Bichard: We have talked a lot in this session about government targets, we have talked about colleges, we have talked about professions and we have talked about trainees. I am not hearing a lot about patients and that worries me because this is a pivotal moment. We are going to recruit a lot of new people—and I am talking about health in particular—into the health profession, and we need to be sure that we are developing them so that they really do deliver around the needs of patients. I know this has been a mantra in the health service for a long time, and I do not always see it in practice, to be honest. Are we actually changing that? Are we incorporating, integrating into the development process, the real needs of patients, many of whom want specialists for a period, but they actually want all of their health and care needs to be met—are we actually delivering people who can do that?

Lord Willis of Knaresborough: Just to follow up from that, what has been really sad this afternoon is that the 2.5 million care workers who work in our health and care service have even been mentioned. I am surprised that Lord Porter is not shouting at you here because none of what you have proposed does anything for the people who give 70% of hands-on care within our hospitals, care homes and domiciliary settings. Alan, when you respond to the committee, please will you include what the proposals are to actually deliver comprehensive training, support and certification to those two and a half million fantastic people who deliver hands-on care.

Alan Robson: Absolutely, of course I will. I am a great supporter of colleagues, but that is a fair challenge from you. A lot of the apprenticeships that we do and things around nursing associates, which you have been and remain heavily involved in, have been a great boon in the social care sector as well. When I come back with the written evidence, we will include that. That was a fair challenge, I accept that.

Q7 The Chair: I will finish this session by asking—and this is true for both MoJ and the wider justice workforce, but also the health service—are you thinking of what the gaps are in your service? What is it that is not working, and how do you actually develop opportunities for a workforce that will meet some of those needs? To give you an example, coming from earlier work that this committee has done around children—and actually what Lord Bichard was asking about there—people were talking to us about navigators: people who would help people with those co-morbidities, those multiple long term-conditions, those families where there is breakdown and children are going into care or are being groomed, which involves the justice system. Who helps the receiver of the service to navigate their way around it and be the pinpoint for where they will find out about who can help them? Are you thinking about those sorts of things? That is just an example of a new role which we do not have embedded in the public sector. Are you thinking about where our service is not meeting needs? What does our workforce in the future need to look like in order to meet those needs? Who is going to be first?

Mike Haslam: I will come in first, and very briefly, yes, the strategic framework and the workforce strategy will be looking at that.

The Chair: Good, we would really appreciate anything you have on that.

Rob Smith: One of the things we have been promoting is making sure that we fully integrate workforce planning with service and financial planning, and we have most successfully done that when looking at it through the lens of a specific service pathway, including the social care and primary care elements of it. I did a lot of work with Claire Murdoch and the mental health service strategy, for instance, taking this approach, which is making sure that it is the needs of the patient that define the service. That then defines the workforce, including if that means creating new roles.

Trying to do workforce planning without that clear vision about the service users' need and the service to meet it is, frankly, doomed to failure, and I think that is a piece of learning we have done. You have to start with this being part of service planning and you have a group of people involved in the workforce community in front of you, so there is a strong challenge: how do we get into that position where we do that pathway planning to identify exactly the kinds of opportunities you have said, which we then pull the training or other levers to deliver?

The Chair: Thank you. I have not really asked you the question I was supposed to ask, which was about things other than training to maximise the number of professionals entering the public service workforce. We were also thinking about the atmosphere they are going into—and maybe you can write to us about that—what people need to really feel that this will offer them opportunities of a good work experience, where there is not bullying, where there is not a culture of whatever, that puts people off. If you have any thinking in your workforce planning on that, we would appreciate that, but I have overrun this session and I am going to blame the bells for that. Thank you very much indeed, and please if there is anything that you think, "They should have asked me about that", "Why didn't they ask us about that?", or "Why didn't I say something about this?" please let us have that information. We really would appreciate it. Thank you very much.