House of Commons

Health and Social Care Committee

Government Response to the Committee's Report on Workforce: recruitment, training and retention in health and social care

Sixth Special Report of Session 2022–23

Ordered by the House of Commons to be printed 18 April 2023

HC 1289
Published on 21 April 2023
by authority of the House of Commons

Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health & Social Care.

Current membership

Steve Brine MP (*Conservative, Winchester*) (Chair)

Lucy Allan MP (*Conservative, Telford*)

Paul Blomfield MP (*Labour, Sheffield Central*)

Paul Bristow MP (*Conservative, Peterborough*)

Martyn Day MP (*Scottish National Party, Linlithgow and East Falkirk*)

Chris Green MP (*Conservative, Bolton West*)

Mrs Paulette Hamilton MP (*Labour, Birmingham, Erdington*)

Dr Caroline Johnson MP (*Conservative, Sleaford and North Hykeham*)

Rachael Maskell MP (*Labour (Co-op), York Central*)

James Morris MP (*Conservative, Halesowen and Rowley Regis*)

Taiwo Owatemi MP (*Labour, Coventry North West*)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/hsccom and in print by Order of the House.

Committee staff

The current staff of the Committee are Joanna Dodd (Clerk), Sandy Gill (Committee Operations Officer), Libby McEnhill (Senior Committee Specialist), James McQuade (Committee Operations Manager), Stephen Naulls (Clinical Fellow), Anne Peacock (Media and Communications Manager), Yohanna Sallberg (Second Clerk), Emma Stevenson (Committee Specialist), Katherine Woolf (Parliamentary Academic Fellow), and Catherine Wynn (Committee Specialist).

Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is hsccom@parliament.uk.

You can follow the Committee on Twitter @CommonsHealth

Sixth Special Report

The Committee published its Third Report of Session 2022–23, *Workforce: recruitment, training and retention* (HC 115), on 25 July 2022. The Government response was received on 12 April 2023 and is appended below.

Appendix: Government Response

I am submitting the government responses to the Committee's and expert panel reports on Workforce Recruitment, Training and Retention in Health and Social Care published on the 25th of July 2022.

I would like to thank you, the Committee and the expert panel for addressing theissues around recruitment, training and retention in the health and social care workforce. I would also like to take the opportunity to thank Professor Dame Jane Dacre and her colleagues from the Health and Social Care Committee's Expert Panel on their evaluation of workforce commitments. Further, I personally want to thank you for your patience whilst the Department worked diligently to provide acomprehensive response to the important issues raised by the Committee alongside working on the Long Term Workforce Plan.

The Department has carefully considered all recommendations within the report. Growing and supporting the workforce remains a priority for this Government, and,as you are aware, the Department has commissioned NHS England to develop a long-term workforce plan for the next 15 years. This plan is due to be published shortly and will help ensure that we have the right numbers of staff, with the right skills to transform and deliver high quality services fit for the future.

I look forward to continuing to work with the Committee as we make progress to support and develop the health and social care workforce.

WILL QUINCE MP

MINISTER OF STATE

Introduction

On 25th July 2022, the Health and Social Care Select Committee published its report 'Workforce: recruitment, training and retention in Health and Social Care'.

The Committee's report explored a wide range of issues across the NHS and Social Care workforce, including:

- Workforce Planning
- Recruitment in Health
- Retention in Health
- Training in Health
- Working cultures including the experience of ethnic minority health and care workers
- Retention in Social Care
- Recruitment in Social Care

The Committee made 73 recommendations in relation to recruitment, training and retention of the health and adult social care workforce. We have considered the Committee's recommendations carefully, in light of ongoing policy development and this is our formal response. The structure of this response directly corresponds to the recommendations in the Committee's report. Where appropriate we have grouped recommendations and responded to these collectively.

The pressures on many parts of the health and social care workforce have been and remain very high. Responding to the pandemic, and now working to deliver service recovery, the workforce continues to operate under sustained pressure as we recover from the pandemic. NHS and social care staff have been our most vital asset in responding to the challenges brought about by COVID-19 and have worked tirelessly to continue providing world class care to those who need it. We are hugely thankful to and incredibly proud of all the NHS and social care staff who have given so much for patients and people who use social care over the last three years.

The NHS workforce has grown over the last decade and this continues to be a key focus to ensure we meet continued increases in in demand for health and care services.

The Government delivers its workforce programmes through NHSE—following the merger of Health Education England (HEE) and NHS—working with its partners to plan, recruit, educate and train the health workforce. Through this work, the Government ensures that the workforce has the right skills, behaviours and training, and is available in the right numbers, to support the delivery of excellent healthcare and drive improvements. HEE merged with NHSE on 1 April 2023; the initial 2023/24 budget allocation of £5.3bn for education and training also transferred to NHSE.

The government, in its document, *Our Plan for Patients*, set out how it would help expand the Health and Care workforce—including by supporting retention of senior staff, using existing staff to the full extent of their professional qualifications, making registration simpler, and stepping up domestic and international recruitment of social care staff.

We are currently on track to deliver the 50,000 more nurses manifesto commitment, and we want to further solidify our training pipelines to secure more workforce for the future.

The government has also funded an additional 1,500 undergraduate medical school places each year for domestic students in England—a 25% increase over three years from 2018 to 2020. In addition, the Government temporarily lifted the cap on medical school places for students who completed A-Levels in 2020 and in 2021 and who had an offer from a university in England to study medicine, subject to their grades. As a result of the government's action, we have seen record numbers of students accepting a place at a medical school. Since December 2021 there are now over 20,000 (3.1%) more professionally qualified clinical staff working in NHS trusts and Integrated Care Boards (ICB).

Whilst work to support existing staff has been in train since before the pandemic, we have increased efforts over the last two and a half years to help ensure that the existing workforce is well supported and looked after. Retaining NHS staff is a priority and the NHS priorities and operational planning guidance 2023/24 is clear that the wellbeing of the workforce is crucial. The 2020 NHS People Plan sets out a comprehensive range of actions to improve staff retention. It provides a strong focus on creating a modern, compassionate and inclusive NHS culture by strengthening health and wellbeing, equality and diversity, culture and leadership and flexible working. In addition, the NHS Retention Programme is continuously seeking to understand why staff leave, resulting in targeted interventions to support staff to stay whilst keeping them well.

We also want staff to maximise their career potential and have opportunities for professional development whilst working in the NHS. HEE has established the Centre for Advancing Practice to oversee the workforce transformation of advanced level practice, by establishing and monitoring standards for education and training, accrediting advanced level programmes, supporting and recognising educational and training equivalence, and growing and embedding the advanced and consultant practice workforce. Since 2020, all eligible nurses, midwives and allied health professionals working in the NHS have been able to access £1,000 funding over three years for Continued Professional Development (CPD). Between 2020/21 and 2022/23, more than £480 million of CPD funding has been provided for these frontline NHS staff.

We are clear that the social care workforce should be recognised alongside their NHS colleagues, and we want all those working in adult social care to feel valued for their work. However, the structure of the social care sector is distinct from healthcare. It is a market of over 17,000 employers, dominated by independent SMEs, in which over a third of care is privately funded.

Furthermore, we published our Integration White Paper in February 2022 and have committed to work with national and local partners to identify opportunities to remove barriers to collaborative planning and working, to create joint career pathways, and joint learning and training opportunities for the health and social care workforce.

We recognise the pressure that the adult social care workforce continues to face. That is why we have taken measures to improve capacity in the sector. We are investing in adult social care this winter through a £500m fund for local areas to support discharge from hospital into the community, which can be used to bolster local workforce capacity. We launched our latest domestic national recruitment campaign Made with Care on 2 November, and we continue to work with the Department of Work and Pensions to promote adult social care careers to jobseekers.

We are also investing in international recruitment opportunities. In February, we made care workers eligible for the Health and Care Visa and added them to the Shortage Occupation list. The latest data published by the Home Office on 23rd February shows that there were a total of 56,900 visa grants for care workers and senior care workers in 2022. We are investing £15m to support local areas to further access overseas recruitment opportunities and to help ensure ethical recruitment practices.

Whilst we have taken measures to support local areas recruit and retain care staff now, we are also taking significant steps to address some of the structural challenges facing the care workforce. These include limited career progression opportunities, a relatively low take-up of professional qualifications, and limited access to learning and development. Addressing these problems will help improve the sector's ability to recruit and retain staff in the longer-term, improving its resilience to meet increasing demand. We are committed to progressing the proposals in our People at the Heart of Care white paper, including in training and technology.

We are making available up to £2.8 billion of additional funding in 23–24 and up to £4.7bn in 24- 25 to support adult social care. On top of this, on 1 April 2023, the Government will increase the National Living Wage (NLW) for workers aged 23 years and over by 9.7% to £10.42, meaning a full-time worker on the NLW will see their annual earnings rise by over £1,600. This is likely to benefit hundreds of thousands of care workers across the country.

Further information and commitments relating directly to the mental health, cancer and maternity workforces have already been captured in responses to the expert panel evaluations on these specific workforce groups and the government's progress against its policy commitments. Our responses to the expert panel can be found here:

- Cancer workforce response
- Mental Health workforce response
- Maternity workforce response

We are taking decisive action to develop the workforce that health and social care needs, with the right staff, with the right skills, and in the right places. That also means looking ahead to the future and working to improve long term workforce planning.

The HEE Strategic Framework for workforce (Framework 15) will look at the key drivers affecting workforce supply and demand over the next 15 years and will set out how they may impact upon the required shape of the future workforce, to help identify the main strategic choices facing us. This represents a significant step forward for integrated workforce planning as it also includes, for the first time, regulated professionals working in social care, like nurses, social workers and occupational therapists. Following this, we

have commissioned NHS England (NHSE) to develop a Long Term Workforce Plan. It will build on the key priorities set in HEE's Framework 15, supporting these ambitions and seeking to ensure that we have the right numbers of staff, with the right skills to transform and deliver high quality services fit for the future.

The Long Term Workforce Plan will build on the foundations of the NHS People Plan as well as support delivery against the ambitions and commitments in the NHS Long Term Plan. This work will also help support Integrated Care Bords (ICB) by setting out what they can do to grow and support the workforce, looking beyond the NHS to take a 'one workforce' approach. The government has committed to publishing an independently verified workforce plan this year.

Both the Long Term Workforce Plan and Framework 15 are designed to ensure the workforce we invest in today is fit for the future and that the NHS makes the most of every pound spent on NHS staff.

The government has recently published Our Plan for Patients, which sets out ministers' priorities for the health and social care system for this winter, and next. The plan contains a number of commitments in relation to supporting and expanding the workforce, including: increasing pension flexibilities to retain senior clinicians, ensuring that we use staff to the full extent of their professional qualifications, making it more straightforward for staff train overseas to register, and expanding our recruitment of social care workers, domestically and internationally.

The government is committed to the 10-year vision for adult social care set out in the People at the Heart of Care white paper. This is a vision created and shared with people who draw on, work in, and provide care and support.

We have made good progress on implementing this vision since the white paper was published, including by increasing workforce capacity through domestic and international recruitment. The government will shortly publish a plan for adult social care system reform that will build on our progress so far. This will have support for the adult social care workforce at its core, and will enable care workers to develop their skills, progress in their careers and get the professional recognition they deserve.

Workforce planning

Recommendation 1: ***We welcome the previous Secretary of State's determination to meet his duties under section 41 of the Health and Care Act. To meet these duties, the new Secretary of State must lay before Parliament objective, transparent and independently audited reports on workforce projections for health, public health, and social care that cover the next five, ten, and twenty years. The reports should state current staffing levels, future staff projections, and an assessment of whether sufficient numbers are being trained in each profession, specialty, and sub-specialty. Demand should be modelled on demographic changes in the patient population and amongst staff, and should consider the role of technology, and changes to costs and treatments.*** (Paragraph 27)

Recommendation 2: ***Without full and frank transparency on projected workforce gaps, the public and NHS staff can have little confidence that the Government has grasped the depth of the workforce crisis, and little confidence in Framework 15 or the NHS workforce strategy. The Government must authorise arm's length bodies to publish data on workforce gaps to restore public confidence, to increase transparency, and to facilitate parliamentary scrutiny of the Government's plans. It must publish the full report of the NHS workforce strategy complete with gap analysis and workforce projections for the next five, 10, and 15 years for each profession by the end of 2022.*** (Paragraph 34)

Response

Recommendations 1 and 2 have been grouped together for an overarching response to the Committee. We agree this recommendation.

We agree with the need for robust, long term, workforce planning and have commissioned two large pieces of work to support this ambition: the Health Education England (HEE) led long term strategic framework (Framework 15) for workforce and the NHS England Long Term Workforce Plan. The Long Term Workforce Plan will include independently-verified projections for the number of doctors, nurses and other professionals that will be needed in 5, 10 and 15 years' time, taking full account of improvements in retention and productivity. We have committed to publishing the Long Term Workforce Plan shortly.

HEE's work in developing Framework 15 has already supported the development of the Long Term Workforce Plan. Framework 15 is designed to help ensure the workforce we invest in today is fit for the future and makes the most of every pound spent. This will be achieved through setting out clarity of service ambitions and shared, explicit assumptions about the likely impact of key drivers of change on both demand and supply for the health and regulated social care workforce.

The development of HEE's Framework 15 commenced with a large-scale public 'Call for Evidence' to identify the factors that may have the greatest impact on demand for the health and regulated social care sector over the next fifteen years, and what they might mean for workforce supply. HEE and partners subsequently held over a thousand different conversations, including deliberative events creating the time and space for people to develop a vision for the future and identify the workforce required to deliver it.

In addition, HEE held a series of round tables to explore in more depth particular issues or perspectives, including the views of users, patients and people who need care and

support, the NHS youth forum, students, learners and trainees in health and social care, plus science, technology, and industry experts. An advice and challenge expert group of leading international thinkers from a range of sectors and disciplines was established to challenge and inform our thinking.

The details and reports from this comprehensive process of engagement are supplemented by a review of around two thousand documents and data sources, to ensure that any propositions are supported by an evidence-base and reflect wider views. All of the conversations, deliberations and evidence that HEE have collated during this process have enriched the thinking and ensured the robustness of the Framework 15 report, and in turn fed into development of the Long Term Workforce Plan.

Drawing upon an extensive engagement process including a call for evidence, extensive deliberative events, roundtables and literature reviews, Framework 15 will set out:

- where we are now
- what people tell us they want from the future of care, work, and education
- the likely impact of key drivers of change on future demand and supply such as demographics and disease, science, and technology
- the shape of the workforce required to deliver our ambitions for 2037
- some actions we can all take now to bring the desired future closer
- the big strategic choices that need to be made nationally if we are to realise a fundamentally different future vision rather than just roll forward the past

It is important to note that for workforce planning to be effective it must be integrated with activity and financial planning, all derived from the service delivery model. Framework 15 recognises these interdependencies and will inform the development of integrated workforce planning across the NHS, including within Integrated Care Systems (ICS) as Integrated Care Boards take on their role on workforce planning.

The merger of NHSE and HEE will help ensure that workforce is placed at the forefront of the national NHS and social care agenda and that workforce planning is fully integrated with both the service and financial planning. It will simplify the national system for leading the NHS, including the work on planning for specific service pathways ensuring a common purpose and strategic direction.

Building on this work NHSE has been commissioned to deliver a Long Term Workforce Plan, that will set out the actions needed to ensure that there are sufficient numbers of staff, with the rights skills to meet the vision described in HEE's strategic framework.

Getting this plan right is crucial in order for the NHS to deliver the government's ambitions and commitments in the NHS Long Term Plan, to meet population health needs, and to transform and deliver high quality services fit for the future. We know that workload is one of the key factors driving burnout amongst staff, and so this workforce plan builds on the work of the NHS People Plan 2020 to 2021, to grow the workforce to meet rising demand for healthcare services, to implement new ways of working that make the best possible use of the knowledge and skills of the workforce we have and to ensure the NHS is the best possible place to work for all staff, characterised by a compassionate and inclusive culture as described in the NHS People Promise.

The Long Term Workforce Plan is being undertaken with input from independent think tanks to test and refine the methodology as well as consulting with many other stakeholders including royal colleges, trade unions, regulators, system leaders, Patient Voice and representation from the wider workforce.

Developing a comprehensive long term plan, and long term projection modelling for the workforce is a complex process. It is not sufficient to base long term workforce planning on workforce growth alone; instead, we must also look at how we can work and deliver care differently. Anticipated future health and care needs must also be factored in, and projections over longer term time horizons become less certain than predicting workforce need in the short term. As such, dealing with the complexities involved in effectively developing a long term plan requires careful planning, extensive engagement, and robust modelling – all of which necessarily take time to accomplish.

This substantial programme of work to improve long term workforce planning will be complemented by the report provided for by Section 41 of the Health and Social Care Act 2022, which places a duty on Secretary of State for Health and Social Care to publish a report detailing the system in place for assessing and meeting workforce need, helping to increase transparency and accountability in the workforce planning process. It is important to recognise that adult social care is a devolved sector, largely delivered by independent employers many of whom are, at least in part, privately funded. It therefore requires a different approach to top- down central planning. Local government has a key role to play in supporting recruitment and retention in their areas, utilising their oversight of local systems to identify workforce shortages to develop workforce plans. This should include joint workforce planning across health and social at ICS/place-based levels to ensure that the vision for the workforce set out in the white papers People at the Heart of Care and Health and social care integration: Joining Up Care for People, Place and Populations is achieved. We welcome the practical examples of good, innovative practice in integrated workforce planning that are already beginning to emerge across the country.

Our People at the Heart of Care White Paper sets out our strategy for the care workforce, which will support and enable local authorities and care employers to boost the sector's ability to recruit and retain staff, as well as improve the recognition of our vital adult social care workforce.

Furthermore, we published our Integration White Paper in February 2022 and have committed to work with national and local partners to identify opportunities to remove barriers to collaborative planning and working, to create joint career pathways, and joint learning and training opportunities for the health and social care workforce.

Recruitment in Health

Recommendation 3. ***The Government's current target of recruiting 50,000 NHS nurses is not having any meaningful impact on the true scale of nursing shortages. The Government must introduce a new bursary scheme comprising full coverage of tuition fees, a non-means tested grant of at least £1,000, and a means-tested bursary. In addition, nursing and midwifery students who take up this bursary should be guaranteed, where possible, at least 3 years of work in the NHS Trust in which they trained, to eliminate the need for them to seek agency work after graduation.*** (Paragraph 40)

Response

We do not agree with this recommendation.

We have committed to deliver 50,000 more nurses in our NHS by the end of this Parliament. We will achieve this through a combination of investing in and diversifying our training pipeline, recruiting, and retaining more nurses in the NHS.

The Nurse 50K (N50K) programme is monitored against Hospital and Community Health Services (HCHS) nurses and nurses in GP practices. The programme represents the most rapid growth in HCHS and GP practice nursing numbers in recent times (2009 onwards). The growth rate seen during the N50K programme is the highest-level annual growth in recorded (NHS Digital) data.

Since September 2020, all eligible nursing, midwifery and allied health profession students have received a non-repayable training grant of a minimum of £5,000 per academic year. Students with child dependants can access a further £2,000 per academic year. A further £1,000 per year of non-repayable funding is also available for studying certain courses—for example, mental health nursing and learning disabilities nursing. Students also received support with travel and accommodation costs and have had access to an extreme financial hardship fund. This is a non-repayable and non-means tested support package that enables healthcare students to focus on their studies and placements and helps alleviate financial pressures students might be facing.

This is in addition to maintenance and tuition fee loans provided by the Student Loans Company, whose loan repayments are made only when graduates earn above a certain threshold and any outstanding debt is written off after 30 years with no detriment to the borrower.

University and College Admissions Services (UCAS) end of cycle data shows for the third consecutive year, over 26,000 acceptances to undergraduate Nursing and Midwifery programmes in England. There were 3,700 more acceptances in 2022 than in 2019—a 16% increase. This shows the continued appeal for people to enter the nursing profession.

We are growing apprenticeship opportunities from entry level to postgraduate advanced clinical practice. A person can join the NHS as an entry level healthcare assistant apprentice with a view to eventually qualifying as a registered nurse. Apprentices are treated as employees and therefore receive a salary throughout their period of learning. As apprentices are already employed this also allows for a smooth transition into the NHS

workforce. There has been substantial expansion of nursing apprenticeships (Registered Nurse Degree Apprenticeship), with more than 3,400 starts in 2021/22, compared to more than 1,000 in 2018/19.

This shows the continued appeal for people to enter the nursing profession.

We are growing apprenticeship opportunities from entry level to postgraduate advanced clinical practice. A person can join the NHS as an entry level healthcare assistant apprentice with a view to eventually qualifying as a registered nurse. Apprentices are treated as employees and therefore receive a salary throughout their period of learning. As apprentices are already employed this also allows for a smooth transition into the NHS workforce. There has been substantial expansion of nursing apprenticeships (Registered Nurse Degree Apprenticeship), with more than 3,400 starts in 2021/22, compared to more than 1,000 in 2018/19.

DHSC works closely with HEE/NHSE and other system partners on reducing the rate of student nursing attrition, ensuring that nursing students receive high quality support whilst in training and on clinical placement. This includes work to ensure newly qualified nurses transition into the workforce as smoothly as possible.

Looking at the workforce of the future, NHS England (NHSE) are developing a Long Term Workforce Plan, to build on the important work already delivered through the NHS People Plan.

Recommendation 4. ***It will not be possible to re-recruit those who have voluntarily surrendered their medical licences without addressing the factors which caused them to do so. For many retirees, this means addressing pensions and the development of "retire and return" policies, for others, this means addressing poor workplace cultures. We will return to these issues later in the report.*** (Paragraph 42)

Response

We agree that this is an issue and have initiatives either in development or review to address the issues the Committee have raised.

NHSE are delivering a retention programme including employers making flexible employment offers to staff, engaging their high earners on pension tax issues and promoting the value of the pension scheme.

As part of this, NHSE are developing comprehensive communications and have piloted seminars to engage staff on flexible retirement options and pension tax, with the full schedule of activities to be rolled out in the coming months.

In 2022, DHSC consulted on proposals to extend temporary retire and return easements, which were introduced as part of the government's response to the pandemic, due to the expected increased demand on NHS services over winter. During consultation, a number of respondents argued that the suspension of Special Class Status (SCS) abatement should be extendedbeyond the proposed extension date of 31st March 2023. We have listened to those concerns and intend to extend the suspension of SCS abatement to 31st March 2025.

DHSC has recently concluded a consultation process on a package of new retirement flexibilities, including proposed amendments to the regulations to allow members of the 1995 Section to partially retire but continue working and building up further pension, and provision for pensionable re-employment for those who have already retired and then returned to work. The consultation also proposed the permanent removal of the 16-hour rule from the 1995 Section from 1 April 2023. From 1stApril 2023, NHS Pension Scheme members who have put their 1995 Section benefits into payment can re-join the scheme and build further pension if they return to work.

Recommendation 5. ***Formal re-entry programmes, akin to those which already exist for primary care, should be developed by the NHS, Health Education England, the General Medical Council, and other relevant bodies for secondary care doctors who wish to return to work after a long break.*** (Paragraph 44)

Response

The Government accepts this recommendation in principle.

Although the General Medical Council (GMC) does not have a direct role in the re-employment or recruitment of doctors, it does provide guidance to organisations to ensure that there is proper evaluation and support of doctors who wish to return to practice, to ensure they are able to do so safely: Return to work—GMC (gmc-uk.org). The GMC has also adapted its free Welcome to UK Practice programme (which is delivered across the UK) to be inclusive to returners. The Academy of Medical Royal Colleges and HEE have provided guidance and support for doctors returning to work. At employer level, the Responsible Officer (RO) regulations place responsibility on RO's to consider the fitness to practise of individual doctors and for support to be provided or captured in individual development plans. HEE/NHSE also support doctors returning to training after time out through their SuppoRTT offer which was developed to enable trainees to have a safe, supported return to work by offering a wide range of learning and support resources to suit individual needs.

It is the professional duty of the doctor to ensure that their skills and knowledge are up to date, that they are competent and safe to return to practice. Doctors must seek to identify and address issues arising from absence and help set in place the necessary processes to support them to update their skills and knowledge.

Recommendation 6. ***Given the success of training to task during the pandemic, the Government must consult with relevant bodies to explore further opportunities to mobilise this willing group of volunteers. They must also consider whether further changes to the law are necessary in order to allow more volunteers to work on a temporary basis on specific tasks in the NHS.*** (Paragraph 47)

Response

We agree with this recommendation in principle. Volunteers are an important resource that are deployed to help reduce pressure on services and staff across the NHS and social care and multiple workstreams are already underway to maximise the use of volunteers where they can be most effective, including helping to improve patient flow and supporting accelerated discharge from hospitals. NHSE is the primary body that

organises and commissions the use of volunteers and volunteer organisations across the healthcare sector. We are working with NHSE to look at: (1) shorter term actions that will deliver more volunteers; and (2) longer-term work with NHSE to investigate whether legislative change is required in order to facilitate more effective use of volunteers. Where possible, workstreams that relate to volunteering are being looked at in in conjunction with increasing volunteer activity in Adult Social Care.

Volunteers are an important resource that are deployed to help reduce pressure on services and staff across the NHS and social care. As the COVID-19 pandemic has shown, volunteers also play a vital role where the health service is under extraordinary pressures. Before the pandemic there were an estimated 100,000 volunteers providing support within NHS hospital and ambulance trusts. However, during the pandemic there were times where significant additional capacity was needed, either because of staff absence due to Covid-related sickness, or because of additional emergent needs, such as for the vaccination programme. Programmes such as NHS volunteer responders enabled large numbers of volunteers to step forward quickly to provide support where it was needed most. In these instances, training to task has been beneficial to ensure that large numbers of volunteers can be mobilised.

Unpaid volunteers should not be seen as an alternative to a paid, substantive NHS workforce, but rather an important supplementary resource that supports paid clinical roles in the provision of health and care services. We are exploring opportunities to streamline recruitment processes and remove barriers which can impede quick mobilisation of willing health and social care volunteers in times of need. We are also looking to investigate whether changes to the law would enable volunteers to undertake other specific tasks that could be helpful.

The NHS already has a volunteer reserve base, with hundreds of thousands volunteering each week either directly within the NHS or for charities that work with the NHS to provide support. This has been bolstered by the introduction of the NHS volunteer responders programme, during the pandemic, which has retained a pool of volunteers willing to continue to support the NHS.

In addition, the NHS reserve programme is a nationally supported and locally delivered contingent staffing service. Having learned the lessons from earlier in the pandemic, the NHS has adopted a franchise model with a national framework and funding to support implementation. The approach was initially piloted in 2021 with all Integrated Care Boards (ICBs) establishing a local service in April 2022.

Recommendation 7. ***Maternity services in England and Wales are under unsustainable pressure. We welcome the commitments that the Government has made in response to the Ockenden report, whilst recognising that these changes will come too late for some mothers and babies. The Government must intervene with immediate action on recruitment and retention to relive pressure from the system and ensure positive birthing experiences for everyone, regardless of their racial or socioeconomic background.*** (Paragraph 56)

Response

We agree with this recommendation.

NHS England has invested significantly in maternity services with £165m of recurrent funding announced since 2021 to support maternity and neonatal services including to boost maternity workforce numbers and support retention. NHSE has funded initiatives including:

- Growing midwifery and obstetric staff numbers.
- Providing each maternity unit £50k (a total of circa £8m across England) in 2022/23 to continue to enhance supernumerary support to midwives, including newly qualified and return to midwifery practice learners with a continued focus on retention and pastoral support activities.
- The Maternity Transformation Programme has provided transformation funding to Local Maternity and Neonatal Systems (LMNS) with several deliverables including ensuring that every LMNS has an adequate workforce plan in place such that each provider is taking appropriate steps to achieve and maintain identified maternity staffing requirements. The plans should include compliance with National Institute for Health and Care Excellence (NICE) Guideline [NG4] (safe midwifery staffing for maternity settings) and that obstetric staffing levels are sufficient to meet the Ockenden recommendations.

This is alongside the existing model of midwifery supervision, A-EQUIP and the associated role of the Professional Midwifery Advocate (PMA), the aims of which include to build personal and professional resilience of midwives and enhance the quality of care for women and babies. and the associated role of the Professional Midwifery Advocate (PMA), the aims of which include to build personal and professional resilience of midwives and enhance the quality of care for women and babies.

Building on existing programmes of work, including The National Education and Training Survey (NETs) and the Reducing Pre-registration Attrition and Improving Retention (REPAIR) programme, HEE/NHSE are currently developing plans to undertake work to develop a clear understanding of the experience of learners in Maternity services. This work will enable us to develop a clear vision of what good looks like, share and adopt good practice and address challenges within the system regarding experience and attrition from programmes and conversion into the NHS workforce.

Recommendation 8. ***In July 2021, we recommended that NHS England needed an additional 1,932 midwives and 496 obstetricians to operate at a level that Birthrate Plus considered safe. Rather than adding to their headcount, NHS England has lost 552 midwives between March 2021 and March 2022. This indicates a clear problem with midwifery retention. Despite requests to NHS England and the Secretary of State for a date by which these safe staffing levels would be reached, no date has been set. This failure to respond demonstrates a lack of responsibility taking and is absolutely unacceptable. Without a clear workforce plan for midwifery staffing, and the wider maternity workforce in general, the public can have no confidence that the Government or the NHS has grasped the seriousness or scale of the situation in which it finds itself. We urge the Government and the NHS to publish a plan for recruiting the recommended additional midwives and obstetricians needed to create safe staffing levels in maternity services.*** (Paragraph 57)

Response

We agree with this recommendation in principle and have set out plans for recruiting the additional midwives and obstetricians needed in maternity services below.

Midwifery workforce

There are several initiatives in place to increase the midwifery workforce supply with £165m of recurrent funding announced since 2021. The Ockenden Report recognised that the investment package had already begun to support the supply of midwifery workforce with work still ongoing.

The primary supply route for midwifery is the domestic undergraduate pipeline. There is an existing commitment to increase the undergraduate pipeline by expanding training places by 3,650 from 2018/19 to 2022/23 with an increase of 650 in 2019/20 and 1,000 over subsequent years. The target to date has been overachieved and HEE remains confident of achieving the additional 1,000 this year. It is anticipated that the impact of increased numbers of newly qualified midwives enter the system will be felt for the first time this year. HEE are currently mapping proposals for the extension of the current pre-registration Midwifery Training expansion programme.

Table X: Acceptances to Midwifery Courses in England 2011 to 2021

2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
1,970	2,170	2,265	2,295	2,380	2,395	2,600	2,680	3,105	3,630	3,720

Source: UCAS end of cycle 2021

Whilst domestic supply routes are important to meet the future maternity workforce needs, interventions to improve retention, international recruitment, and the recruitment of support workers in maternity are also vital. HEE secured additional national funding to support 300 places per year for nurses to train as midwives via the postgraduate midwifery programme. There is significant demand for this shortened route to the register, which takes 20 months on average.

On retention, NHSE has invested £8m in additional supernumerary capacity for each unit to enable all newly qualified midwives and returning midwives access to support that aims to reduce burnout and mitigate the impact of the pandemic on the workforce. Implementation of the Nursing and Midwifery Retention Self-Assessment Tool began in July. This tool will support all NHS organisations in England to undertake an evidence-based retention self-assessment. The tool will also provide opportunity for benchmarking across organisations and systems.

More broadly, NHSE has a strong focus on improving staff wellbeing and workplace experience. This includes: a national package of support for staff health and wellbeing; promoting flexible working across the NHS; fostering an increased sense of belonging in the NHS; and targeting support at different stages of people's careers to boost retention.

DHSC and NHSE are working to open new international recruitment markets, to support the arrival of up to 500 international midwives in 22/23.

A national recruitment campaign for support workers in maternity services is underway.

NHSE has also established a Safer Midwifery Staffing Steering Group (SMSSG) with the purpose of reviewing staffing establishment workforce tools to examine their validity, reliability and usability as well as their sustainability in maternity services in England. This will include an academic review of the Birthrate plus tool to analyse the evidence-base and underpinning methodology.

In 2022 we saw the first graduates from midwifery apprenticeship programmes. Anecdotal evidence suggests that attrition from this training route is low and that trainees have a positive learning experience. There is evidence of demand for this training route, but this needs to be supported by healthcare providers if it is going to be a sustainable route for new midwives.

Obstetric workforce

In 2021 to 2022, a national investment to increase the establishment of obstetric roles by 100 full time equivalent (FTE) was built on by trusts to further increase establishments to +208 FTE obstetric roles, with +181 FTE extra obstetricians employed in March 2022 (compared to April 2021). Additional investment in obstetric roles will be made in 2022 to 2023.

The primary supply route for obstetric doctors is the obstetrics and gynaecology (O&G) specialty training pipeline. The NHS has created an additional 40 obstetrics and gynaecology training posts in both 2022 and 2023 to grow our future workforce. For O&G medical speciality training recruitment in 2020 there were 230 posts, 224 accepted, fill rate of 97.39%. Consultant obstetricians complete at least seven years of speciality training; however, there is a diversity of roles within the medical O&G workforce—specialty, specialist and locally employed doctors play a pivotal role in delivering O&G services.

There is not an obstetric equivalent to Birthrate Plus, the midwifery workforce planning tool. The Royal College of Obstetricians and Gynaecologists (RCOG) has been commissioned by the DHSC to produce a workforce tool to provide a more thorough assessment of the staff required. This workforce tool is nearing the end of its development and will calculate the number of obstetricians required nationally at all grades and will specifically aid trusts in assessing how many obstetricians are required.

On retention, in addition to work to improve staff experience and staff retention in general across the NHS, the establishment of an obstetric clinical leaders' network is being coordinated between NHSE and RCOG as part of a wider leadership strategy. This initiative provides a quarterly forum for senior leaders in NHSE and RCOG to share and discuss updates on current priorities for maternity services as well as providing a support network for clinical directors and obstetric clinical Leads to share experiences and challenges on the ground with each other.

Each NHS organisation, if not already doing so, from July 2022 is prioritising the delivery of five high impact actions that will impact on early career, experience at work, and late career staff, maximising the retention and experience of nursing and midwifery staff.

Trusts should have in place retention action plans, including improvement metrics and leaver rate trajectories approved by boards which will provide the focus for local improvement plans.

The 2020 NHS People Plan sets out a comprehensive range of actions to improve staff retention. It provides a much stronger focus on creating a more modern, compassionate and inclusive NHS culture by strengthening health and wellbeing, equality and diversity, culture and leadership and flexible working. Looking after the health and wellbeing of NHS staff remains a priority and there are a range of initiatives to support staff wellbeing:

- asking all organisations to introduce a wellbeing guardian role, which helps ensure board level scrutiny of staff health and wellbeing;
- a focus on healthy working environments and safe spaces for staff to rest and recuperate;
- empowering line managers to hold meaningful conversations with staff to discuss their wellbeing;

In 2022/23, over £45 million was invested to support the continuation the national health and wellbeing support offer for NHS staff, which includes embedding a preventative approach by delivering a training programme to equip line managers and organisations in holding safe and effective wellbeing conversations. Further to this we also provided all NHS staff access to the staff text helpline (SHOUT), which has supported over 4,000 staff with a range of mental wellbeing concerns such as anxiety/stress, depression, isolation etc.

Recommendation 9. ***There is an urgent need for a robust and funded maternity-wide workforce plan, which must be delivered without further delay. The Government must commit to funding, recruiting, and retaining the workforce at the level set out by the forthcoming report of the Royal College of Obstetricians and Gynaecologists. Once this report has been published, the Government must set out a plan within six months for how it intends to recruit the number of people to deliver the level of staffing that the Royal College deems necessary to deliver safe and compassionate care to mothers and babies.*** (Paragraph 58)

Recommendation 10. ***The Government has accepted the recommendation, first made by this Committee and then by the Ockenden report, that maternity services should be funded by an additional £200–350 million per annum. The Government must lay before Parliament, within six months, a plan for this spending increase, detailing exactly how much additional investment will be made, where the investment will be made, and plans for the next one, five, and 10 years of spending.*** (Paragraph 59)

Response

Recommendations 9 and 10 have been grouped together for an overarching response to the Committee.

We disagree with these recommendations. We are taking forward Donna Ockenden's specific recommendations, including expanding the workforce, with £165m recurrent funding invested since 2021 to support maternity and neonatal services including to boost maternity workforce numbers and support retention.

We will consider the forthcoming report of the Royal College of Obstetricians and Gynaecologists once published, and will keep further funding under review.

Recommendation 11. ***Improving diversity in the recruitment of midwives will improve the standard of care that black, Asian, mixed-race, and minority ethnic women receive throughout pregnancy, birth, and the post-natal period. Health Education England should set forth a recruitment plan with clear targets to increase the ethnic diversity of people going into midwifery.*** (Paragraph 60)

Response

We agree with this recommendation in principle. Improving diversity in the recruitment of midwives will contribute to improving the standard of care that black, Asian, mixed-race, and ethnic minority women receive. There is a package of measures currently in place to improve diversity in the recruitment of midwives, which are set out below.

The Nursing and Midwifery Council's (NMC) education and quality assurance (QA) processes help to ensure that approved education institutions (AEIs) comply with their standards around equality diversity and inclusion. There are robust recruitment and training processes for NMC appointed QA visitors to ensure that they are appropriately trained to have the right conversations and ask the right questions during approval and monitoring activities. Through monitoring, approved education institutions are required to provide additional detail around various themes, for example attainment gaps and their plans for addressing these gaps, as well as how they ensure that users of services and carers involved in the delivery of programmes are representative of their local populations. The NMC has recently published its Equality, Diversity and Inclusion (EDI) objectives for 2021–2025[1] which future EDI activities within QA will be aligned to. We believe this will fulfil the Committee's overall aim to improve the diversity in the recruitment of midwives over time.

All Local Maternity and Neonatal Systems are required to produce a Workforce Race Equality Standard (WRES) analysis for midwifery staff and take action to improve race equality in the workplace, in line with NHSE's Equity and Equality Guidance (priority 4d, intervention 3, pp. 30, 33–34). The WRES supports continuous improvement through robust action to tackle the root causes of discrimination experienced by staff in the workplace. Implementing the WRES is a requirement for NHS commissioners and providers through the NHS standard contract.

In addition, NHSE is working in partnership with the NHS Confederation and the NMC to agree how to promote and embed anti-racism in professional practice and create an anti-racist environment.

Recommendation 12. ***NHS England must publish interim figures reporting on how close it is to achieving its target of 75% of women from black and minority communities and a similar percentage of women from the most deprived groups receiving continuity of care from their midwife throughout pregnancy, labour, and the postnatal period by 2024.*** (Paragraph 61)

1 https://www.nmc.org.uk/about-us/equality-diversity-and-inclusion/our-edi-aims/our-edi-objectives/

Response

We disagree with this recommendation.

Rollout of Midwifery Continuity of Carer (MCoC) must go hand in hand with the maintenance of safe staffing levels and sustainable recruitment to midwifery vacancies. This is why all providers have been given flexibility to establish individual trajectories for achieving MCoC as the default model of care, linked to the essential recruitment of midwives.

NHS England recently wrote to Trusts to inform them that in the light of the continued workforce challenges that maternity services face, there will no longer be a target date for services to deliver Midwifery Continuity of Carer (MCoC) and local services will instead be supported to develop local plans that work for them. This will reduce the burden on services while still protecting those who benefit most from continuity of carer.

Recommendation 13. ***Administrative barriers are often placed in the way of talented international medical graduates who wish to work in the NHS. In particular, it can be difficult for them to join the specialist register. To streamline this process, and boost recruitment into the NHS, the General Medical Council should introduce a "green list" of countries whose doctors are given an automatic right to practise in the UK following the minimum necessary checks. In the short-term, the General Medical Council should undertake a review of the Certificate of Eligibility for Specialist Registration processes to ensure that the demands being made on international medical graduates are fair and proportionate.*** (Paragraph 70)

Response

We partially agree with this recommendation.

DHSC has been working with the GMC to amend legislation to ensure that routes to registration for international medical graduates are streamlined and proportionate, however, to ensure public protection and patient safely international doctors should not be given an automatic right to practise in the UK. The GMC is hugely grateful for the contribution overseas doctors make to healthcare in the UK. It is committed to maintaining the flow of doctors into UK practice and avoiding unnecessary delays for doctors who want to work here. However, systems and processes must be in place to provide public assurance that those who join the register are fit and safe to practise in the UK.

There are routes to registration in place for all international doctors wanting to work in the UK. These routes have allowed increasing levels of overseas-trained doctors to join the register and contribute to the NHS medical workforce. During 2022, the GMC granted registration to approximately 13,400 doctors who qualified outside of the UK. This is about twice as many as it granted to UK graduates. All doctors who join the register have demonstrated their clinical knowledge and skills through clinical exams or other routes to registration.

Ensuring CESR processes are proportionate

The GMC has several programmes of work underway to increase capacity on international registration routes. The eligibility criteria for the award of a Certificate of Eligibility for Specialist Registration (CESR) are defined in the Postgraduate Medical Education and Training Order 2010 while the evidential and other formal requirements for a properly made application are set out in the GMC (Applications for General Practice and Specialist Registration) Regulations 2010. DHSC has worked with the GMC to agree amendments to both these pieces of legislation. The resulting Order, which will come into force on 30 November 2023, provides the GMC with flexibility to expand the range of evidence that it can accept from doctors, including those from overseas, seeking to join the GP and specialist registers outside of the approved training pathway. This will allow the GMC to explore the introduction of new registration pathways around the same standards, making the process more adaptable to an individual's knowledge, experience and skills. These changes may potentially enable more specialists and GPs to gain registration and work at a senior level in the NHS.

Pathways to full registration

The Professional Linguistic Assessment Board test (PLAB) is the clinical exam that assesses doctors who qualified abroad to assure us they have the right skills and knowledge to practise safely in the UK. The GMC has expanded its clinical assessment capabilities and significantly increased capacity in 2023. In 2021, the GMC registered approximately 5,000 doctors who demonstrated their knowledge and skills through clinical exams. This represents an almost three-fold increase to the number granted in 2012. Passing the PLAB test is not the only pathway to registration for international medical graduates. The GMC introduced a new Acceptable Overseas Registration Exam (AORE) pathway that recognises overseas registration exams from Australia, Canada and the US. The AORE pathway was introduced on an interim basis in January 2021 and has been used by approximately 530 doctors to gain registration.

International medical graduates can also apply directly for registration if they hold an acceptable postgraduate medical qualification (PGQ) or if they are accepted onto a GMC approved sponsorship scheme.

The GMC accept over 25 separate postgraduate qualifications as evidence that a doctor has the necessary knowledge, skills and experience to practise in the UK and work is underway to update this list, with a view to accepting a wider range of qualifications. In 2021 the GMC granted registration to approximately 2,700 doctors via the PGQ pathway representing more than a five-fold increase from 2012.

To qualify for the sponsorship pathway, a doctor must hold a certificate of sponsorship from a GMC approved sponsor, indicating that the applicant has the knowledge, skills and experience necessary to practise in the UK. The GMC recognises over 60 sponsoring bodies in the UK—mainly hospital trusts in England and medical Royal Colleges. In 2021, it granted registration to approximately 1,250 doctors via sponsorship. This is more than a three-fold increase from 2012.

Recommendation 14. ***International recruitment from the developing world must be done in an ethical way, and the Academy of Medical Royal Colleges' Medical Training Initiative, which recruits international medical graduates to work in the NHS for a fixed-term period with a specific remit of improving the quality of healthcare in developing countries is the gold standard of this practice. The Government should invest in and expand the Medical Training Initiative.*** (Paragraph 71)

Response

We agree with this recommendation that international recruitment must be done ethically. That is why we have our recently republished Code of Practice for the Recruitment of Health and Care Staff, reaffirming our commitment to supporting health and care workforce globally. We agree that the Medical Training Initiative (MTI) provides a valuable, ethical and sustainable opportunity for doctors from low- and middle-income countries to develop their skills in the NHS, before returning home with more experience and skills. The scheme increased its intake from 1,000 to 1,500 doctors per year in 2018, sponsored by the Academy of Royal Medical Colleges. These roles are not designed to fill substantive vacancies but offer a valuable training opportunity. As the scheme is not yet operating at capacity, we have no plans to expand the MTI, however we will continue to keep it under review.

Recommendation 15. ***Many health and social care workers have caring responsibilities, including for adult relatives. The Government must commit to revising the amount of proof that must be provided to bring an adult dependant into the UK through the Sole Responsibility and Adult Dependant visa routes to ensure that it is not acting as a deterrent to the recruitment and retention of health and social care staff.*** (Paragraph 72)

Response

We do not agree with this recommendation. The policy responsibility for Sole Responsibility and Adult Dependent routes sits with the Home Office rather than the DHSC.

Home Office has advised that we remain committed to ensuring that the immigration system is fair and sustainable; it is also important that no unfair burden is placed on the taxpayer and our health services as a result of these policies. Our position remains that all family migration to the UK must be on a properly sustainable basis which is fair to both migrants and the wider community. This includes migration via the adult dependent relative route.

The Rules are stricter than they were before July 2012 and deliberately so, to promote a policy aim whereby only those who have a genuine need to be physically close to and cared for by a close relative in the UK settle here. Those who do not have such care needs can continue to visit their relatives in the UK and be supported financially in the country in which they live by their relatives in the UK.

Adult dependent relatives can continue to visit a family member in the UK (for up to six months) but must return home at the end of their visit; we do not allow visitors to switch into other immigration categories while in the UK and the adult dependent relative category is not an exception.

The Home Office continues to keep the Immigration Rules for adult dependent relatives under review and make adjustments in light of feedback on their operation and impact. However, our overall assessment is the rules represent a fair deal for the UK taxpayer and are helping to ensure public confidence in the immigration system by providing assurance migration to the UK is not based on access to public services or welfare systems.

Recommendation 16. ***The practice of requiring medical staff entering the country on Tier 5 visas to pay and reclaim the NHS surcharge should be scrapped.*** (Paragraph 73)

Response

We do not agree with this recommendation.

Unfortunately, it is not technically possible for the Home Office to identify medical staff on Tier 5 Visas at the point of visa application and IHS payment. This is why DHSC have worked with NHS Business Service Authority (BSA) and the Academy of Medical Royal Colleges to set up a bespoke scheme to ensure that Tier 5 Doctors on the Medical Training Initiative (MTI) receive a refund of their Immigration Health Surcharge (IHS). This bespoke scheme has been running since February 2022 and DHSC is currently considering how it can be extended to other health cohorts on the Government Authorised Exchange Programme to enable eligible staff such as dentists to receive refunds of their IHS.

Recommendation 17. ***All international medical graduate GP trainees should be offered leave to remain in the UK upon successful completion of GP speciality training. This would encourage them to live and work in the UK, protecting the NHS's investment and boosting the GP headcount.*** (Paragraph 74)

Recommendation 18. ***There should be more support both for newly qualified international GPs and their would-be employers. There should be a default visa extension for six months after the international medical graduate's expected GP training completion date, to give them time to find an appropriate employer. The Home Office and UK Visas and Immigration should work with the NHS to support GP practices to become sponsors for international medical graduates. Further support should be provided to support the integration and retention of international GPs in the UK, including making it easier for them to bring immediate family members to the UK.*** (Paragraph 75)

Response

Recommendations 17 and 18 have been grouped together for an overarching response to the Committee.

We agree with the principle of these recommendations; we recognise the important role that international medical graduates (IMGs) play in helping to grow the GP workforce, and the barriers that they can face upon successful completion of GP Specialty Training. We are working with the Home Office to increase the number of GP practices registered as Home Office sponsors.

HEE has created an International Medical Graduate (IMG) support programme in GP training with SR funding. This includes enhanced induction, enhanced and targeted support.

https://heeoe.hee.nhs.uk/general_practice/transition-project

https://wessex.hee.nhs.uk/trainee-information/trainee-journey/international-medical-graduates/

Work is underway by NHSE which has improved the service to match newly qualified international GPs with practices across England. This has enabled better local planning and direct support to IMGs to find a recruiting practice in their area.

NHSE is also improving awareness amongst IMGs on the steps they need to take to prepare for entering the workforce. Guidance was published for IMGs to improve understanding of what they should be doing and when, in terms of applying for roles and visas, including in relation to dependent visas.

The two-year General Practice Fellowship supports newly qualified GPs, including IMGs who have completed their training. This programme guarantees the opportunity to receive funded mentorship, funded continuing professional development (CPD) opportunities of one session per week, and rotational placements within or across Primary Care Networks (PCN) to develop their experience and support their transition into the workforce in a local area.

Retention in Health

Recommendation 19. ***The NHS must ensure that all staff have access to adequate facilities. At the minimum, all staff should have access to 24/7 hot food and drinks, free parking, and places to rest, store their belongings, shower and change, and take breaks with colleagues. The NHS should conduct a welfare provision assessment to consider how to move towards this.*** (Paragraph 78)

Response

We agree with this recommendation but local employers are best placed to determine how best to meet the welfare needs of staff collectively and individually and the best mix of services and support to do so. All employers are under an existing duty to protect the health, safety and welfare of their employees. Welfare provisions should be identified and responded to during regular and routine assessments of risk. These should cover the basic needs of staff. There is existing guidance which includes welfare provisions here.

The NHS Health and Wellbeing (HWB) Framework provides guidance on how organisations can create a sustainable wellbeing culture for their workforce, including a focus on healthy environments to allow staff to rest, recover, and to stay hydrated. In-need groups currently benefit from free car parking.

The New Hospital Programme (NHP) aims to provide a better working environment for staff, enabling increased efficiency and well-being. Lessons learned from the pandemic will be implemented to incorporate the health and wellbeing needs of the staff that use the new hospitals. This will be reflected in the designs, with particular detail around staff spaces such as rest rooms, wellbeing spaces and changing areas. This will ensure designs reflect interactions with members of the workforce, using them to ensure they are fit for purpose in hospitals not only now, but in the future.

The Government committed to introducing free hospital car parking for in-need groups in England, as part of the 2019 manifesto. This includes blue badge holders, parents of children staying overnight, frequent outpatient attenders and NHS staff working overnight. 99% of NHS trusts that charge for car parking have implemented the free parking manifesto commitment.

Recommendation 20. ***The Government should review the provision of affordable and flexible childcare for people working in the health and social care sector and assess whether it is possible to improve it.*** (Paragraph 81)

Response

We do not agree with this recommendation as we already have a series of flexible working initiatives in place, which support healthcare staff with caring responsibilities including childcare.

NHSE have published a suite of resources to support employers in enabling flexibility at work in the NHS. Providing employees with flexible working opportunities ensures that staff can make arrangements that are right for the individual. From September 2021,

contractual changes took effect for employees covered by the NHS Terms & Conditions of Service Handbook which includes the right to request flexible working from day one without the need to provide a justification. The definition and principles complement these changes.

In partnership with the NHS Staff Council, NHS Employers, and Timewise, NHSE published a guide to help managers and leaders put structures in place so that flexible working is an option for all, including for staff looking to work flexibly to accommodate caring responsibilities. NHS Employers have also published a range of case studies on supporting staff with caring responsibilities.

NHSE encourages employers to implement the Working Carers Passport to support timely, compassionate conversations about what support would be helpful, including establishing and protecting flexible working patterns.

The vast majority of ASC staff are employed by independent organisations, who are responsible for setting terms and conditions of employment including access to childcare support. The Government is committed to supporting families with the cost of childcare and to improving the cost choice and availability of childcare. This includes spending more than £20 billion over the last five years to support families with the cost of childcare through education entitlements, tax- free childcare and Universal Credit. We also announced in the summer a package of measures to further increase childcare support for parents, boost the number of childminders and drive take up of childcare offers, to address rising costs take-up of childcare support and reduce the costs and bureaucracy facing providers.

Recommendation 21. ***Managed well, the trend towards less-than-full-time and flexible working will be a powerful force in making the NHS a more attractive employer. However, in order to maintain standards of care for patients and offer truly flexible working to staff, the NHS will have to increase its overall staff headcount. It is impossible to say by how much or where this increase will have to take place because the Government's workforce modelling has been wholly insufficient and has failed to consider the impact that less-than-full-time working is having on headcount in different specialties. What is needed, most of all, is a long-term workforce plan for the NHS, which takes the trend for less-than-full-time working into account when predicting the number of people that the NHS needs to train in each specialty in five, 10, and 20 years' time.*** (Paragraph 88)

Response

We agree with this recommendation, including the need to take flexible working into account in the Long Term Workforce Plan.

The issues of less than full-time working (also known as participation rates) across both health and social care and their current and potential future impacts (taking into account generational aspirations and trends) are considered in Framework 15. We also consider the impact of less than full-time education and training on the pipeline. All of these feed into the modelling work being undertaken as part of the Long Term Workforce Plan.

As part of becoming an attractive modern employer, the NHS is prioritising improving the flexibility of its employment offer and has recently published a flexible working toolkit

for staff and line managers. The impact of this will be factored into the workforce plan. Alongside this, NHSE is working to roll out e-rostering to promote flexible working in line with modern workplace practices.

Less than full time Training

Postgraduate doctors in training can apply to train less than full time (LTFT). Historically, LTFT training was only available to those with caring or health needs (Category 1), or those with unique opportunities for personal development (Category 2). In 2017, HEE piloted a new LTFT option called Category 3. Category 3 LTFT allows postgraduate doctors to opt to train on a LTFT basis for individual professional or lifestyle needs. That choice is not subject to the judgement of anyone else and is only limited by service considerations.

LTFT Category 3 was initially piloted in Emergency Medicine. The pilot then expanded to include Obstetrics and Gynaecology (O&G) and Paediatrics. Then, as a well-being response to the pandemic, LTFT Category 3 roll-out was accelerated during the 2021/22 training year to enable all postgraduate specialty trainees to apply, initially 0.8 full time equivalent for a period of 4 months, in order to mitigate pressure on service and rotas. From August 2022, all specialty doctors in training have been able to request to train LTFT. Plans for introducing LTFT for foundation programme doctors are currently in development.

In January 2022, HEE held a series of meetings with doctors in training to raise awareness of Category 3 and to enquire about challenges faced when applying for or undertaking LTFT training. There were over 800 individuals in attendance and there have been over 1400 views of the event on YouTube. HEE has been working with partner organisations across the education landscape to review challenges and identify solutions to the challenges highlighted, many of which related to having adequate workforce numbers.

Recommendation 22. ***Whilst we welcome changes made to the NHS contract that give every NHS worker a "day one" right to request flexible working, it is clear that this has been insufficient to make flexible working a daily reality in the NHS. No NHS employee should be choosing to locum or work for an agency to regain control over their working life. The NHS must commit to a review of flexible working arrangements in all Trusts, with a view to ensuring that within 12 months all NHS staff have similar flexibilities in their working arrangements to those enjoyed by locum or agency staff. Reduced or flexible hours must be made available to everyone, but especially those with caring responsibilities or those nearing retirement, and investment should be made in technologies which make home-working or remote consultation possible.*** (Paragraph 89)

Response

We agree in part with this recommendation and recognise that while many organisations will have flexible working policies that includes different types of flexible working arrangements, this is an area where organisations may still need support.

'We work flexibly' is one element of the People Promise, which the NHS is committed to delivering for staff by 2024/25. As one component of retention, it is important to many NHS staff to have the opportunity to work flexibly, regardless of role, team, organisation, grade, or eason. NHSE is responsible for the implementation of the People Promise, and

initiatives include:

Development of a range of flexible working interventions and resources nationally to support local organisations to adopt flexible working practices across their organisations:

- A published flexible working definition and set of aspirational principles for all staff.
- Publication of two toolkits to support line managers in leading flexible workplaces for all and to help staff to prepare for positive conversations in requesting it.
- Dedicated programmes with several organisations to review their approaches to flexible working and make change
- Support to organisations in the implementation of effective use of e-rostering systems, accelerating roll-out where possible.
- NHSE also encourages employers to implement the Working Carers Passport to support timely, compassionate conversations, including on flexible working.

Work-life balance and flexibility around retirement are key concerns for NHS staff. Recognising this, the Department of Health and Social Care (DHSC) will consult this Autumn on changes to the 1995 Section of the NHS Pension Scheme designed to incentivise staff to remain in the workforce. The changes will allow staff to take their pension and carry on working. Those who return to the NHS after retirement will be able to re-join the 2015 Scheme and build further pension benefits.

Allowing staff to re-join the Pension Scheme will help them retire gradually, plugging any potential income gaps which for many staff may be several years, between receiving their 1995 Section pension benefits and their State Pension.

In addition, NHS England and the DHSC are developing a national policy on recycling employer pension contributions into the pay of staff for whom opting out of the NHS Pension Scheme, due to pensions tax may be a sound financial decision. The aim is to incentivise staff to extend their working lives, helping to tackle the backlogs and support their less experienced colleagues.

Recommendation 23. ***It is unacceptable that some NHS nurses are struggling to feed their families, pay their rent, and travel to work. To reflect the crucial work that they do to keep the NHS running, and to improve recruitment and retention, the Government must give all NHS staff employed under Agenda for Change a pay award that takes adequate account of the cost-of-living crisis.*** (Paragraph 92)

Response

We agree NHS staff employed under Agenda for Change (AfC) should receive a pay award in 2023/24 that, alongside other factors, takes into account the cost of living.

On 16 March 2023, after constructive talks with Health Unions, the government put forward a best and final offer for more than 1 million NHS Staff on the Agenda for Change contract. Under the offer, Agenda for Change staff would receive a non-consolidated award of 2% of an individuals' salary for 2022–23. This is on top of the pay increase they

received for 2022–23 last year, as recommended by the independent Pay Review Body process, worth at least £1,400. In addition, they would receive a one-off 'NHS Backlog Bonus' which recognises the sustained pressure facing the NHS following the pandemic and the extraordinary effort staff have been making to hit backlog recovery targets.

The recovery bonus would be worth at least £1,250 to full-time staff and would be determined by an individual's pay band. The average full-time nurse in pay band 5, for example, would receive £1,350. For 2023–24, the government is offering Agenda for Change staff a 5% consolidated increase in pay, worth at least £1,065 to full-time staff. As a result of this package, a newly qualified nurse would see their salary go up by more than £2,750 over two years from 2021–22 to 2023–24, on top of this they would also receive over £1,890 in one-off payments in the financial year 22/23 year. In addition, the lowest paid staff would see their pay matched to the top of band 2, resulting in a pay increase of 10.4%.

Unions are formally balloting their members on whether they wish to accept or reject the offer. If the offer is accepted by the unions, the Government will move to implement it. If union members vote to reject the offer, we will likely look to the NHSPRB to make pay recommendations for Agenda for Change staff for 2023/24.

Recommendation 24. ***The NHS must review the job descriptions used for nursing and midwifery roles under Agenda for Change to ensure that nurses and midwives are being paid fairly for the safety critical roles that they deliver.*** (Paragraph 93)

Response

We accept the recommendation to review nursing and midwifery job descriptions and the work is already underway. The AfC contract is underpinned by the Job Evaluation Scheme. This is designed to ensure that staff receive equal pay for work of equal value. In June 2021, the Royal College of Midwives and Royal College of Nursing requested the NHS Staff Council, who oversee the Job Evaluation Group (JEG), review the nursing and midwifery job family profiles. The Staff Council has agreed to do this, and have built it into their work programme. It is expected to take 18–24 months, subject to capacity.

The project has now started with engagement activities being undertaken with stakeholders. Evidence will include up to date job descriptions from a variety of employers. Once sufficient evidence has been received by JEG, they will then undertake a review of this evidence to ascertain if amendments to the current profiles are needed to reflect the change in nursing and midwifery roles since the last review.

Recommendation 25. ***It is a national scandal that senior medical staff are being forced to reduce their working contribution to the NHS or to leave it entirely because of NHS pension arrangements. Clearly, the Government's changes to tax regulations have not gone far enough to remedy this crisis. With mounting waiting lists and ever-increasing demands, the NHS cannot afford to lose staff who are willing and able to work, and urgent action is needed to reform NHS pensions and prevent the haemorrhage of senior staff. The Government must act swiftly to reform the NHS pension scheme to prevent senior staff from reducing their hours and retiring early from the NHS.*** (Paragraph 103)

Response

We do not agree with the premise that the pension tax system is unsuitable to the NHS workforce. However, we are committed to ensuring the NHS has the staff it needs to deliver services.

The vast majority of NHS Pension Scheme members can build their pensions tax-free, but the generosity of the scheme means that a small proportion of high earners will exceed their allowances for tax-free pension saving.

As announced by the Chancellor at Budget, the annual allowance will increase from £40,000 to £60,000 from 6th April 2023, and the lifetime allowance will be removed. Estimates based on projected pension scheme data indicate that around 22,000 senior NHS clinicians could exceed the previous £40,000 annual allowance in 2023/24, and that around 31,000 clinicians had reached at least 75% of the £1.073m lifetime allowance.

These measures will ensure that the vast majority of doctors in the NHS are not disincentivised from remaining in their roles and taking on extra hours, enabling them to treat as many patients as possible and helping to deliver on the government's NHS commitments.

Pension tax should not impact on take home pay, as the Scheme Pays facility is a proportionate means of allowing members to meet the cost of an annual allowance charge without needing to find cash up front, and the lifetime allowance charge is automatically deducted from the pension pot.

Staff nearing the end of their career have the option to retire and return. This allows them to put their pension benefits into payment and re-join the NHS workforce without restriction. Many staff choose to do this. Data from the Electronic Staff Register shows that around 40% of staff who retired from the NHS in each year since 2020 have returned to work.

Recommendation 26. ***The temporary suspension of regulations governing the administration of NHS pensions, made under the Coronavirus Act 2020, helped to ameliorate this issue during the pandemic. The Government should consider ways to achieve the same outcome now the pandemic is behind us.*** (Paragraph 104)

Response

We do not agree with this recommendation, as the Coronavirus Act 2020 did not contain measures on pension tax.

Section 45 of the Coronavirus Act 2020 did not contain any measures regarding the impact of pension tax on senior clinicians in the NHS workforce. Instead, Section 45 suspended rules in the NHS Pension Scheme to allow retired and partially retired staff to return to work or increase their working commitments without having their pension payments reduced or suspended.

Section 45 expired in March 2022 but the temporary retire and return easements were continued to 31st October 2022 via temporary amendments to NHS Pension Scheme regulations. In 2022, DHSC consulted on proposals to extend temporary retire and

return easements, which were introduced as part of the government's response to the pandemic, due to the expected increased demand on NHS services over winter. During consultation, a number of respondents argued that the suspension of Special Class Status (SCS) abatement should be extended beyond the proposed extension date of 31st March 2023. We have listened to those concerns and intend to suspend the suspension of SCS abatement to 31st March 2025.

DHSC has recently concluded a consultation process on a package of new retirement flexibilities, including proposed amendments to the regulations to allow members of the 1995 Section to partially retire but continue working and building up further pension, and provision for pensionable re-employment for those who have already retired and then returned to work. The consultation also proposed the permanent removal of the 16-hour rule from the 1995 Section from 1 April 2023. From 1stApril 2023, NHS Pension Scheme members who have put their 1995 Section benefits into payment can re-join the scheme and build further pension if they return to work.

Recommendation 27. ***NHSE should develop a national NHS "retire and return" policy to replace ad hoc local schemes. In the short term, the Government should instruct NHS England to require NHS Trusts to follow pension recycling guidance it has already issued to help deal with the short-term impact of the pension problem.*** (Paragraph 105)

Response

DHSC has recently concluded a consultation process on a package of new retirement flexibilities, including proposed amendments to the regulations to allow members of the 1995 Section to partially retire but continue working and building up further pension, and provision for pensionable re-employment for those who have already retired and then returned to work. The consultation also proposed the permanent removal of the 16-hour rule from the 1995 Section from 1 April 2023. From 1stApril 2023, NHS Pension Scheme members who have put their 1995 Section benefits into payment can re-join the scheme and build further pension if they return to work.

As announced in Our Plan for Patients, we are working with NHS England to encourage NHS Trusts to explore local solutions for senior clinicians affected by pension tax charges, including the option of employer pension contribution recycling.

Trusts don't need permission from the centre to do this, and we are supportive of those who have taken this step.

NHSE are collaborating with NHS Employers to publish new guidance on retire and return this September to help system leaders identify the opportunities and benefits of encouraging staff who retire, to return to a substantive NHS post rather than join the temporary workforce.

NHSE are delivering a retention programme focused on employers making flexible employment offers to staff and promoting the value of the pension scheme. As part of this, NHSE are developing comprehensive communications and piloted seminars to engage staff on flexible retirement options, with the full schedule of activities to be rolled out in the coming months.

NHSE's retention plan is driving the national work on retire and return and aims to educate employers on the approaches that they can take to retire and return policy for their staff. The retention programme will be updated to reflect the benefits of the partial retirement flexibilities which are expected to be introduced to the scheme from 1st April 2023.

Following publication of the guidance, NHSE will encourage all NHS organisations in England to review their current arrangements and update/develop a retire and return policy in order to help increase capacity.

NHSE continues to identify barriers to offering staff flexible working patterns/contracts, including anxieties about pensions tax charges. Our aim is to continue to collaborate with our partners (e.g. NHS Employers and system leaders) to agree practical interventions that employers can adopt to encourage staff to stay longer or return to the NHS after retirement.

Recommendation 28. ***The current UDA-contract system is not fit for purpose, and urgent reform is needed to boost recruitment and retention in NHS dental services. We will return to this issue in a forthcoming inquiry into dental services.*** (Paragraph 108)

Response

We announced a package of initial improvements to the NHS dental system on 19 July 2022 (Written statements—Written questions, answers and statements—UK Parliament) and in 'Our Plan for Patients' published 22 September. NHSE fully engaged the profession and patient representatives through an Advisory Board, Technical Groups and engagement events from May to September 2021 to fully understand the issues and potential actions to deliver improvements to the current dental system. These changes are the first, but crucial, steps in our work to support NHS dentistry and patients in areas where they continue to struggle with access. Changes we made included to the Units of Dental Activity (UDA) system, to better recompense dentists for the more complex work they do as well as introducing a minimum UDA value for England. We are also working with HEE on a programme to reform dental education to make it more flexible and widen access and participation to help retain staff. We are working with the sector to consider further, more significant changes, including further changes to remuneration to support higher needs patients, measures to improve access for new patients and to urgent care and the potential for further workforce and payment reforms. Over the last 10 years we ran a number of pilot and prototypes to test alternative models including remuneration based on a capitation approach. While they did not provide the access, new patient or inequalities outcomes to enable us to rollout nationally,, these pilots provided good insight and learning to feed into our next phase of reforms.

Recommendation 29. ***There is an opportunity to better utilise the pharmacy workforce, and in doing so, to optimise workloads across primary care, reduce pressure on general practice and hospitals, and support integrated care systems. This optimisation will not be possible without an integrated and funded workforce plan for pharmacy which must be developed and laid before Parliament within 12 months. The plan must ensure that all pharmacists have adequate access to supervision, training, and protected learning time, along with clear structures for professional career development into advanced and consultant-level practice. The workforce plan for pharmacy must consider that by***

2027 all newly qualified pharmacists will be independent prescribers and ensure that these graduates are given protected learning time, adequate supervision, and career development opportunities. (Paragraph 111)

Response

We do not agree with this recommendation for a specific pharmacy workforce plan. However, we are working across the system to ensure that the future role of the pharmacy workforce is considered as part of the Long-Term Workforce Plan, to be published later this year. We do agree with the ambition to better utilise the pharmacy workforce. Pharmacists already provide pharmaceutical services across the NHS and are both employed by the NHS and private contractors that provide NHS services.

We set out in the Community Pharmacy Contractual Framework 5-year deal (2019 to 2024) a clear vision for how pharmacists and their teams employed in community pharmacy would become more integrated into the NHS, improving patient experience and choice and become the first port of call for minor illness – freeing up GP appointments and helping to deliver the NHS Long Term Plan. We and NHSE remain committed to maximising the use of the skills of the whole pharmacy team in realising the vision set out in the 5-year deal.

We are committed to supporting community pharmacy professionals' career development, working with employers and partners to deliver fulfilling roles across all sectors, for new and existing registrants. We are working on pathways for pharmacists to demonstrate post- registration capabilities, including advanced and consultant level practice. This will enable pharmacists to undertake a HEE approved advanced clinical practice course or demonstrate equivalence through a supported portfolio route. This will develop pharmacists with knowledge and skills across all four pillars of practice: clinical, education, leadership and research, and lead improvements in patient pathways through better use of skill mix in primary care.

As part of reforms to pre-registration training pathways, from 1 September 2022, Pharmacy is added to the list of professions eligible for the clinical tariff giving access to funded, high quality clinical placements during initial education and training. NHSE has also announced it is investing up to £15.9 million to support the education and training of frontline pharmacy professionals in primary care over the next four years, to meet the needs of patients and local communities. This includes 3,000 funded places for independent prescribing to upskill the existing pharmacist workforce, complementing new registrations who will have this qualification from 2026. Furthermore, HEE recently announced new, fully funded, NHS clinical examination skills training for community pharmacists. This new offer will build on community pharmacists' existing clinical examination and consultation skills—to assess, treat and manage common health problems—10,000 module places will be available until March 2024.

Furthermore, NHSE are currently developing guidance to support the introduction of shared workforce models between PCN and other pharmacist employers, mitigating short-term local supply issues and aiding longer-term retention. NHSE are establishing a pilot to incorporate independent prescribing for patients in primary care, to identify the optimum process, governance, safe practice, funding and IT required to enable

independent prescribing in community pharmacy. This pilot will also inform the professional development needs of community pharmacy and wider workforce strategy for pharmacy professionals and will start later this year.

Training in Health

Recommendation 30. ***In the absence of an independent mechanism to assess the increase necessary, we agree with the recommendation of the Medical Schools Council and the Academy of Medical Royal Colleges that the number of medical school places in the UK should be increased by 5,000 from c.9,500 per year to 14,500. This increase is a long-term solution to bolster the ranks of the NHS and increase overall headcount, but more immediate short-term actions, detailed elsewhere in this report, must also be taken to address the current crisis.*** (Paragraph 118)

Recommendation 31. ***As part of the expansion of medical schools, the cap on the number of medical school places offered to international students should be lifted by allowing full registration at the end of the Primary Medical Qualification and asking international students to fund the cost of their foundation year placements.*** (Paragraph 119)

Recommendation 32. ***Should the Government increase the number of medical school places, they must consider an appropriate increase in the size and resourcing of medical schools, including in their facilities and faculty, as well as increased numbers of clinical placements spread throughout the country, and more speciality training positions for the increased number of graduates produced.*** (Paragraph 120)

Response

Recommendations 30–32 have been grouped together to provide an overall response.

NHSE is currently developing a Long Term Plan for Workforce that will include independently verified projections for the number of doctors that will be needed in 5, 10 and 15 years' time, taking full account of improvements in retention and productivity. This will provide a revised view on future demand and training numbers for doctors in England and we will review the above recommendations in light of the findings from the Long Term Workforce Plan. Training numbers in Scotland, Wales and Northern Ireland are matters for each Devolved Government.

Over recent years we have funded an additional 1,500 undergraduate medical school places each year for domestic students in England—a 25% increase over three years. This expansion was completed in 2020. In addition, the Government temporarily lifted the cap on medical school places to accommodate students who completed A-Levels in 2020 and 2021 who had an offer from a university in England to study medicine, subject to their grades. As a result of the government's action, we have seen record numbers of students accepting a place at a medical school. The cap on the number of international students to whom Government-funded medical school places can be allocated is set as a percentage of each medical school's annual intake target by the Office for Students. It ensures that the great majority of Government-funded places—approximately 94%—are allocated to domestic students.

We do not agree that international applicants to the Foundation Programme should be required to fund their clinical placements. All doctors must undertake the Foundation Programme in order to become eligible for GMC registration and license to practise medicine. Since the Foundation Programme is a position of employment within the NHS and Foundation doctors make a significant contribution to patient care, it would not be

appropriate to ask any Foundation Doctor to fund the cost of their employment.

We do agree that, in the event of any expansion of Government-funded medical school places, medical schools should be appropriately funded and that there would need to be the appropriate number of clinical placements throughout the country and specialty training places subsequently made available for graduates.

Recommendation 33. ***The 2018 cohort of medical schools are proving a success story in terms of widening participation, and in producing cohorts of local doctors who are more likely to stay local to their training centre once they have graduated. The Government must commit to expanding the number of places available at the 2018 cohort of medical schools, starting in the academic year 2023–24.*** (Paragraph 127)

Recommendation 34. ***If the 2018 cohort are dependent on international recruitment, the benefit of their placement in under-doctored areas is likely to be eroded. The Government must ensure that the 2018 cohort, and all medical schools, are appropriately funded to train UK students.*** (Paragraph 128)

Response

The government is committed to ensuring that the number of medical school places is in line with England's workforce requirements.

Recommendations 33 and 34 have been grouped together to provide an overall response.

The Government welcomes the success of the five new medical schools which opened as part of the 2018–2020 expansion. They have contributed significantly to our ambition of widening participation in the medical profession and ensuring that doctors train and practice in the parts of the country that need them most,

The Government has also taken wider action to widen participation and ensure an equitable distribution of doctors across the county. In January 2023 Health Education England announced the creation of nearly 900 additional medical specialty training posts for this year. Many of the additional posts will be specifically targeted to tackle health inequalities and to ensure there is a more equitable distribution of training places and therefore more equitably distributed medical workforces across the country.

Also in January, HEE announced funding for the first 200 medical apprentices to start training as doctors over the next two years. This initiative aims to provide an alternative route into medicine that makes the profession more accessible and helps ensure a diverse workforce that is more representative of local communities.

HEE has also developed a range of initiatives with a variety of partner organisations to support students who are underrepresented in the medical profession to successfully apply to medical school. An example is the programme 'Future Quest' that supports 350 students from disadvantaged backgrounds to develop knowledge of pathways into medicine and healthcare as well as focus on intrapersonal reflection and self-belief in order to build confidence for applications and interviews.

We agree that the Government must all ensure that the 2018 cohort, and all medical schools, are appropriately funded to train UK students.

The location of the new medical schools which were opened as part of the 25% expansion in Government-funded places from 2018–2020 was a key step in ensuring that doctors train and work in the parts of the country that need them most. These places were available only to domestic students and received full Government funding.

The Government is also supportive of international students and doctors, who have always played a key role in the NHS and continue to do so. There are also considerable benefits from an international student population, including the breadth of experiences and knowledge they bring and wider economic benefits both nationally and to local areas.

Recommendation 35. ***The Department of Health and Social Care must commit to reviewing the process by which student clinical placement tariffs are set to establish why there is such a large difference between medical and non-medical clinical student tariffs. This review should be completed with the goal of understanding how tariff money is spent and establishing a transparent evidence base on which to inform decisions about how tariff rates will be set and how tariff money will be spent in the future.*** (Paragraph 132)

Response

We agree with this recommendation. Working with HEE, DHSC reviews the education and training tariff prices on an annual basis.

HEE is undertaking a range of work to increase transparency and understanding spend, allow better planning and targeting, and ensure accountability for how education and training funding is used.

Recommendation 36. ***We believe that the General Medical Council's emphasis on acquiring competency in postgraduate training, rather than focusing on "time-served" is the right way to go. The Government must commission an independent review of all postgraduate training to consider whether it is possible to i) reduce the time it takes to obtain a postgraduate qualification, whilst maintaining rigorous patient safety and professional standards; ii) ensure that those who train less-than-full time are not penalised for doing so; and iii) and to provide an independent assessment of how many training places are needed for each specialty. Once this review is completed, the Government must implement its findings, including committing to funding the number of training places required.*** (Paragraph 137)

Response

We agree that competency-based development is appropriate for a doctor's progression through the training pathway.

Reducing the time to obtain a postgraduate qualification

HEE have led work with the GMC, devolved nations and Medical Royal Colleges to create greater flexibility in training progression and the point of time in training at which competencies are gained. Some of the curriculum requirements were also reduced. This reduced the need for extensions to training, and there are ongoing discussions between the GMC and Medical Royal Colleges about which of the curricular derogations that

reduced requirements we could safely continue after the pandemic.

Less than full time training

We agree that it is important that doctors who train less-than-full-time (LTFT) are not penalised for doing so. We are committed to increasing flexibility in postgraduate medical training. A key theme of the HEE Enhancing Junior Doctors Working Lives programme of work has always been increasing flexibility within postgraduate medical training to prevent burnout and wellbeing. HEE has promoted LTFT and worked to ensure that those who make this lifestyle choice are not penalised for doing so. In 2017, HEE piloted a new LTFT option called Category 3. Category 3 LTFT allows postgraduate doctors to opt to train on a LTFT basis for individual professional or lifestyle needs. That choice is only limited by service considerations.

This has been welcomed by trainees, though pilots of LTFT highlighted a feeling of cultural opposition to working LTFT in some specialties. HEE is working with flexible training champions to address this, aligned to the work of the People Directorate in NHSE. However, service pressures are such that many departments are concerned about their ability to cover the workload and allow the less than full time flexibility. This was affecting access to the initiative so in January 2022, HEE held a series of meetings with doctors in training to raise awareness of LTFT training and to enquire about challenges faced when applying for or undertaking LTFT training. NHSE (following the merger with HEE) is working with partner organisations across the education landscape to review the challenges and identify solutions.

Medical Specialty Training

NHSE (following the merger with HEE is responsible for determining how many specialty training posts are available each year, and in which specialties. This is based on considerations including spending review allocations and strategic priorities for training the medical workforce. The merger between HEE and NHSE provides a timely opportunity to review and strengthen the systems and processes which are in place for determining the numbers of training places available in each specialty.

Any future expansion in postgraduate training should be made on the basis of need within certain specialties.

To support longer term workforce planning DHSC has commissioned NHSE to develop a long- term workforce plan, which the government has committed to publishing next year.

Recommendation 37. ***NHS England must ensure that temporary, bank, and agency staff are given full access to NHS training to allow them to level up their skills, to ensure that they are able to sign up for additional shifts.*** (Paragraph 141)

Response

NHSE has a well-established temporary staffing function which is responsible for the development of regulatory oversight standards and improvement approaches that support NHS providers to achieve value for money and development of local services. In 2022, NHSE refreshed its assurance requirements and has produced a number of tools to support

NHS organisations further develop their temporary staffing services and expand the use of collaborative banks. A core element of this is maximising the use of technology to make accepting shifts seamless.

Training and education standards for individuals that work only bank shifts is a focus area for NHSE. Work will be progressed to ensure that developmental opportunities are available for these workers.

Accounting for the desire of both Government and the NHS to reduce the use of agency staff, NHSE will not be encouraging providers to deliver developmental Continuing Professional Development to agency workers as this is likely to impair the service's ability to make in house bank work more attractive. Mandatory and statutory training for this group will continue to be the responsibility of the agency providing the staff to the NHS.

Working culture, including the experience of ethnic minority health and care workers

Recommendation 38. ***We were horrified to hear clear evidence of racism within the NHS, with some staff subjected to racist bullying, harassment, and abuse from colleagues and patients. This behaviour is unacceptable anywhere, and we condemn it expressly here. Tackling racism is a recruitment and retention issue, and the NHS and Government must take it extremely seriously.*** (Paragraph 149)

Response

We agree with this recommendation. Racist bullying, harassment and abuse is completely unacceptable, and we are taking steps to address it. We know from the Workforce Race Equality Standards (WRES) and NHS Staff Survey that the experiences of ethnic minority staff are not always positive. We are constantly monitoring and reviewing our initiatives to see what more could be done to ensure that staff from minority backgrounds and communities are treated equally and fairly in the NHS. There is a range of targeted initiatives to foster inclusive workplace cultures across the NHS, including:

- Line managers should ensure that staff health and wellbeing conversations are inclusive and culturally sensitive.
- Recruitment and promotion practices are being overhauled to improve inclusivity and ensure that the NHS workforce at all levels reflects the diversity of the communities it serves and to increase minority ethnic representation at senior levels across the NHS.
- Pro-active engagement with relevant staff networks continues to ensure their voice is heard in decision-making processes.
- Senior and executive leaders must be accountable for developing and delivering urgent plans to eliminate inequality in their organisations.
- Resources, guides and tools have been published to help leaders and individuals have productive conversations about race, and to support staff to make tangible progress on equality, diversity and inclusion (EDI) for all.
- NHSE and the WRES team have launched a joint training programme for Freedom to Speak Up Guardians which aims to support proactivity in seeking out input from ethnic minority staff who may be more reticent in volunteering their views.

Recommendation 39. ***There should be greater accountability from NHS senior and middle management for the reduction of incidents of racist discrimination amongst staff. This should include explicit equality, diversity, and inclusion responsibilities in senior leadership job role descriptions, against which the performance of senior leaders is reviewed, and to which their pay and promotion is linked.*** (Paragraph 150)

Response

We agree with this recommendation. Leadership for a Collaborative and Inclusive Future, accepted in full by the government, includes seven recommendations to improve leadership and management throughout health and social care. The review recommended:

(1) Targeted interventions on collaborative leadership and organisational values, including a mid-career programme for managers

(2) Positive equality, diversity and inclusion (EDI) action

(3) Consistent NHS management standards delivered through accredited training

(4) A simplified, standard appraisal system for the NHS

(5) A new Career and Talent Management Function for managers

(6) Effective recruitment and development of Non-Executive Directors (NEDs)

(7) Encouraging top talent into challenged parts of the system

A mid-career training programme for managers, consistent management standards, and a new simplified appraisals system will ensure greater accountability from NHS senior and middle management to tackle discrimination. Whilst a specific recommendation, EDI is also an embedded priority throughout all seven recommendations, to ensure a continued focus on improving inclusive workplace cultures as the responsibility of all staff throughout health and social care. Implementation is being taken forward by NHSE, in partnership with Skills for Care.

NHSE is finalising its Leadership Competency Framework. This sets out specific competencies expected from senior leaders across the NHS, including for EDI. The framework will support the recruitment and appraisal of NHS board members, underpin the Fit and Proper Person Test (FPPT) 'fitness' attestation, and help to identify potential support and development interventions.

The intention is to set expectations and strengthen the accountability on NHS leadership to tackle discrimination between staff. The six competencies are as follows:

- Creating a compassionate and inclusive culture
- Leading for social justice and health equality
- Setting strategy and delivering long term transformation
- Driving high quality, sustainable outcomes
- Providing governance and assurance
- Building trusted relationships with partners and communities

Leaders are therefore accountable for creating a compassionate and inclusive culture and leading for social justice and health equality. ICB Chair and CEO appraisal frameworks are being developed currently, linking to the six competency domains as well as appraising performance.

DHSC is working with NHSE as it produces a very senior manager pay framework. This framework is expected to reference equality considerations, including the Public Sector Equality Duty. Trusts should have this in mind when undertaking performance management and should already ensure EDI is embedded in appraisal conversations.

Recommendation 40. ***The NHS is not the only public sector organisation which finds itself facing the challenge of tackling racism. Given that addressing inequalities is a cross- government priority, the Government must commission a What Works Centre to research issues of discrimination in public sector workforces, to collate an evidence base around existing initiatives, and to co-ordinate learning across the public sector.*** (Paragraph 151)

Response

We do not agree with this recommendation on the basis that the we have already set out a comprehensive action plan to tackle negative disparities in the workplace in Inclusive Britain, the response to the Commission on Race and Ethnic Disparities, which was published in March 2022.

We agree that it is crucial that everyone is treated fairly in the workplace, so that they can thrive and reach their full potential. We recognise that employers stand the best chance of achieving this when they focus their efforts on effective actions which have been proven to increase fairness in the workplace.

Inclusive Britain therefore announced the creation of an Inclusion at Work Panel, bringing together academics and practitioners to develop and disseminate resources to help employers target their efforts in creating more inclusive workplaces. The Civil Service and other public sector employers will lead by example in adopting evidence-based practices and new approaches, and this action goes further than recommendation 40 and will extend to the private sector too. Evidence from the Inclusion at Work Panel will be used to develop a new 'Inclusion Confident' scheme for employers designed to improve race equality and progression in the workplace.

Inclusive Britain also includes actions aimed at improving equality of opportunity and experience for health sector staff, including ensuring that the Care Quality Commission's inspection process holds healthcare providers to account for any ethnic disparities that exist in their workforce, and commissioning a new Ethnicity Pay Gap research project for NHSE.

Recommendation 41. ***We welcome the roll-out of a pilot Social Care Workplace Racial Equality Standard to some local authorities and encourage the Government to extend the Social Care Workplace Racial Equality Standard across all local authorities. However, we also recognise that the Social Care Workplace Racial Equality Standard will not capture the experience of the majority of social care workers, who are employed in the independent sector. The Government must fund Skills for Care to pilot the Social Care Workplace Racial Equality Standard in the independent sector within 12 months.*** (Paragraph 152)

Response

We welcome the Committee's feedback on the Social Care Workplace Race Equality Standard (SCWRES). We encourage all local authorities to create plans to ensure staff from ethnic minority backgrounds are treated equally, feel included and valued, their health and wellbeing are prioritised, and have access to culturally appropriate support.

We want to ensure that the care workforce receives the acknowledgement and appreciation it deserves.

We do not agree with the Committee's recommendation to pilot the SCWRES in the independent sector within 12 months. Whilst we are committed to exploring ways we can help combat inequalities across the care workforce, we are mindful that the independent sector is structured differently to local authority settings and may benefit from different activity.

We are committed to tackling inequalities that the workforce faces. We are currently reviewing the lessons from the initial roll-out of the SCWRES, as well as the recommendations made by the Review of health and social care leadership in England and the Equality and Human Right's Commission inquiry—Experiences from health and social care: the treatment of lower-paid ethnic minority workers—to which we will respond in due course.

Recommendation 42. ***The NHS has shown through the pilot scheme in the East of England that setting up independent review panels to review anonymised case information before cases are formally referred to the General Medical Council results in parity of referral between white and ethnic minority doctors. This practice must be rolled out to all NHS Trusts as a matter of urgency to ensure that the referral process is operating fairly and equally for everyone.*** (Paragraph 157)

Response

It is our aim to implement independent screening to support decision-making when considering a formal local disciplinary process or referral to the GMC. This will be delivered by independent panels reviewing cases in an anonymised fashion and making a recommendation to the decision maker or RO in each trust.

The national WRES team will establish and coordinate a group of clinicians nationally who will be drawn upon for the anonymised and objective screening process, acting as a virtual network. This group will be constituted to provide independent, culturally competent, expert and plural advice to the RO at Trust/PCN level, creating the option to make this screening process part of their own wider education and awareness raising. The process to identify such a group and the governance rules to formalise their function is being developed as a priority in the WRES team at NHSE.

Recommendation 43. ***We welcome the General Medical Council's new targets to eliminate disproportionate complaints from employers about ethnic minority doctors (by 2026) and eradicate disadvantage and discrimination in medical education and training (by 2031). The Nursing and Midwifery Council must introduce parallel targets to eliminate***

disproportionate complaints from employers about ethnic minority nurses and midwives and to eradicate disadvantage and discrimination in nursing and midwifery education and training by the same dates. (Paragraph 158)

Response

The Government accepts this recommendation in principle.

The Nursing and Midwifery Council (NMC) is committed to tackling discrimination and inequality and to promoting diversity and inclusion. The EDI Plan sets out the NMC's objectives and the steps it is taking on these important issues.

Analysis has highlighted discrimination in fitness to practise referrals from employers and the NMC has taken steps to address this, including issuing guidance to employers on how to conduct fair investigations and when to refer issues to the regulator, however they recognise there is much more to do.

In August 2022, the NMC published the second phase of its Ambitious for Change research. This research examines why some professionals are less likely to revalidate and/or more likely to be referred to fitness to practise and sets out stakeholder views on what can be done to address these differences. The research shows that some employers refer more professionals who are black and/or male compared to the make-up of its workforce and of the NMC register. Professionals working as bank or agency staff or in settings such as care homes or GP practices, are particularly affected. NMC revalidation data indicates that certain groups, such as black and overseas-trained professionals, are over-represented in these settings compared to the proportions on its register. The NMC has committed to taking steps to address these issues, including working with individual employers to address disproportionate patterns of referrals and, where necessary, considering whether formal action by the NMC or another regulator is required.

The NMC is taking steps to better understand and address issues of disadvantage and discrimination in the education of nurses, midwives and nursing associates. The NMC standards for education set clear expectations for institutions around equality of opportunity and inclusive learning cultures. All education institutions must demonstrate they meet these standards before they can provide nursing and midwifery education and institutions are actively monitored through NMC quality assurance processes. The NMC currently collects data on equality, diversity and inclusion in recruitment and admissions, reasonable adjustments for students, and how equality, diversity and inclusion is embedded within the curriculum. A data- driven approach to quality assurance is being introduced, which will allow student progression to be broken down by protected characteristics, to determine where regulatory intervention may be required.

The NMC will consider the Committee's recommendation to introduce specific targets in the context of its EDI Plan, Ambitious for Change research, and existing commitments.

Recommendation 44. ***Talented women are missing out on the opportunity to become surgeons because of a lack of support and role models. The NHS should develop a strategy to attract and retain more women into surgery.*** (Paragraph 161)

Response

HEE supports initiatives which further attract and retain more women into surgical careers and accept this recommendation.

HEE has delivered a number of initiatives that have supported recruitment and retention of female doctors in training in general, through its Enhancing Junior Doctors Working Lives programme. These initiatives include Supported Return to Training (SuppoRTT), Out of Programme Pause (OOPP) and expansion of less than full time training.

It is recognised that the numbers of both female consultant surgeons and female surgical trainees are increasing steadily. The number of consultant female surgeons has risen from 3% in 1991 to 13.2% in 2020[2].

The Royal College of Surgeons has undertaken various initiatives to support careers in surgery for women, including the development of a Women in Surgery network and a new flagship programme—Parents in Surgery.

The Royal College of Surgeons Edinburgh (the majority of members are in England) has focussed on addressing bullying and discrimination, with an annual conference and number of initiatives around this theme.

The government recognises that there is more to do to encourage more talented female consultants into under-represented specialties such as surgery. National Clinical Impact Awards (previously known as Clinical Excellence Awards) are a key retention tool to keep top- performing consultants in the NHS.

The NHS consultant workforce is diverse, and the government wants to ensure that the NCIA scheme fully reflects this. That is why, in 2022 the government reformed the scheme following a public consultation in 2021, the reforms aimed to broaden access to the scheme and make the application process fairer and more inclusive.

The initial trends of the new scheme's implementation are positive, with greater numbers of applications from female and ethnic minority consultants in 2022 (33% and 37% respectively) compared to 2021 (26% and 33% respectively).

Recommendation 45. ***It is unacceptable that the gender pay gap persists in medicine. The Government should make a report on progress made against recommendations on how to close this gap made in 'Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England".*** (Paragraph 162)

Response

We are committed to reducing the gender pay gap in the NHS. As part of that commitment, we established the independently chaired Implementation Panel. The Panel brings together key leaders and stakeholders from across the health system including NHSE, HEE, the British Medical Association, the Hospital Consultants and Specialists Association and the Medical Women's Federation. The purpose of the Panel is to oversee, direct and support the implementation of the recommendations that have emerged from the Gender Pay Gap in Medicine Review. The members first met in September 2021 and agreed the work

2 https://www.rcseng.ac.uk/careers-in-surgery/women-in-surgery/statistics/

programme. They have subsequently met quarterly to monitor progress.

The work of the panel underpins our ambition to embed gender pay gap considerations into policy development. There are already success stories, such as the reform of the National Clinical Excellence Awards—now National Clinical Impact Awards. The reforms built on recommendations made within the review and include the removal of pro-rated awards, changes to assessment domains and moving to a non-stratified application process. These reforms have been implemented with the aim of broadening access to the scheme, making the application process fairer and more inclusive, and ensuring the scheme rewards and incentivises excellence across a broader range of activity and behaviours. The Panel is making positive progress on multiple recommendations across all 7 themes identified in the review, and will continue work on recommendations throughout 2023.

We all lose out if talented women feel unable to continue working in healthcare so the government remains dedicated to removing barriers to make the NHS a truly diverse and inclusive employer.

Recommendation 46. ***NHS England should develop and implement a national menopause strategy focused on the retention of senior staff who may be reducing their hours, leaving management or supervisory roles, or retiring earlier than intended, because of a lack of support around menopause.*** (Paragraph 165)

Response

We agree with this recommendation. National guidance on menopause was launched in November 2022. In July 2022, trusts were asked to develop a menopause policy / guidance or add to existing policies and action plan or amend their policies and take action to ensure availability of menopause support.

There is a national Menopause Improvement Programme in place led by NHSE, which is committed to improving the experiences of perimenopausal and menopausal women*, both within the NHS workforce where 75% of staff are female, and among the wider population.

Working in collaboration with stakeholders and key partners, The Menopause Improvement Programme has an approach of population health management consisting of a comprehensive workforce support package is being developed, which includes national menopause guidance, an e-learning for health module about the menopause, and a public-facing awareness campaign.

The programme is also developing an optimal clinical pathway for menopause care which will become best practice for all health care professionals, NHS providers and other organisations. Due to supply chain issues and a national shortage of HRT—which is prescribed to around 10% of menopausal women—implementation of some aspects of the work may be delayed.

Last year, NHSE published an internal menopause policy which includes specific guidance on how line managers can support their staff experiencing the menopause, whether that's allowing flexible or home-based working or making changes to the work environment, such as making the temperature cooler or ensuring easy access to cold water and bathroom facilities. Just as important is the need to normalise conversations about menopause

support in the workplace.

Signing the Menopause Workplace Pledge is the next step in NHSE becoming a more supportive organisation. Led by the charity Wellbeing of Women, the campaign is drumming up support from all employers across all sectors up and down the country, and the NHS is proud to be part of transforming the conversation around menopause.
*women refers to people affected by perimenopause and menopause, including non-binary, transgender and intersex people.

Recommendation 47. ***The NHS should look to improve its complaints procedure to ensure that doctors are supported throughout any investigation or inquiry, including to the General Medical Council, and are protected in particular from spurious, vexatious, or discriminatory complaints.*** (Paragraph 168)

Response

We agree with this recommendation in principle. The GMC have been working with DHSC on plans for regulatory reform which will improve our regulatory processes including Fitness to Practise (FtP). The GMC wants its FtP processes to be streamlined and proportionate and so that they can better support doctors to deliver excellent care for patients.

The GMC has developed a suite of guidance to support its staff to investigate and make decisions about complaints. The guidance is specific to each stage of the GMC's processes, rather than the type of complaint, and sets out how allegations are considered.

The GMC has a number of processes in place to support the fairness and transparency of its investigation process and its fitness to practise (FtP) decisions. The GMC routinely commissions independent audits as part of an ongoing programme of work to ensure that the application of its fitness to practise procedures are fair, consistent and robust and, in July 2021, published an independent audit of the fairness of its fitness to practise decisions.

Being investigated by the GMC can be a stressful experience for doctors. The GMC has commissioned the BMA to run the Doctor Support Service. This service offers doctors under investigation emotional support from another doctor who is experienced in providing peer support and is completely independent from the GMC. The service is confidential, free, and available for all doctors.

Recommendation 48. ***The Government should consider whether reforms can be made to the Medical Act 1983 to ensure that General Medical Council regulatory processes can be simplified to reassure both the public and clinicians, without the loss of accountability.*** (Paragraph 169)

Response

We agree with this recommendation.

As set out in our response to the *Regulating healthcare professionals, protecting the public consultation*, published on 17th February 2023, the Government remains committed to reforming the legislation of each of the 9 UK healthcare professional regulators.

These proposed changes will provide all professional regulators a modern, fit for purpose regulatory system, with broadly consistent powers to carry out their functions of registration, fitness to practise, education and training and governance. One of the key changes the reforms will deliver will be to modernise the regulators' Fitness to Practise processes. This will introduce Fitness to Practise procedures which are less adversarial and will support and facilitate the safe and quick conclusion of many cases without the need for expensive and lengthy panel hearings.

These reforms will start with legislation that will introduce the regulation of anaesthesia associates and physician associates under the GMC, which we intent to lay before Parliament by the end of 2023.

We are also committed to modernising the regulatory framework for doctors as a top priority and intend to start working soon with the GMC and other key stakeholders later this year to develop the legislation that will reform the regulatory framework for doctors, and which will establish the future legal basis for the GMC to recognise specialist and GP qualifications.

These changes are complex and will involve the interaction of multiple pieces of existing legislation and our expectation is that it will take several years before the new legislation is in place and fully implemented.

Recommendation 49. ***The NHS must commit to the creation of positive working cultures and inclusive work environments. They should do this through creating and enforcing zero tolerance policies for harassment, discrimination, and bullying towards all staff, with targeted policies for staff who may be particularly vulnerable to these behaviours, and online behaviours.*** (Paragraph 173)

Response

The safety, health and wellbeing of NHS staff is paramount, and we accept this recommendation for the most part. However, NHSE do not use the language of 'zero tolerance' as it implies both intent and capability. The greatest proportion of violence, discrimination and bullying towards NHS staff, as reported through the Staff Survey, comes from patients, carers and families, some of whom may be suffering from mental illness or have a disability, which is a driver of their behaviour.

Work is underway with pilot ICB areas and Liverpool John Moores University to update the staff training and educational offer to include awareness of appropriate responses to patients/carers who may lack capacity. In addition, NHSE is working with Oxehealth, one of the NHS Innovation Accelerator programmes, to understand learnings from their remote monitoring OxeVision in mental health settings where early evaluation is seeing around a 25% reduction of violence to staff, as well as improved patient care.

NHSE's commitment to creating positive, safer and inclusive working cultures and work environments is delivered through its national health and wellbeing programmes of Civility and Respect programme and Violence Prevention and Reduction.

A Civility and Respect toolkit has been published, and introduces actions to promote and encourage employers to adopt just and restorative culture approaches to help them become fair, open and learning organisations where colleagues feel they can speak up.

The NHS Violence Prevention and Reduction Standard was launched in 2021 and delivers a risk-based framework that supports a safe and secure working environment for NHS staff.

Ambulance staff disproportionately experience acts of aggression. To protect them, £8.4 million has been invested into the ambulance sector for 3-year body worn camera trial. NHSE is currently funding a 2 year initiative with the creation of the Violence Prevention Hub with the Association of Ambulance Chief Executives (AACE) which is driving implementation of the NHS Violence Prevention and Reduction Standard, sharing learning and improving consistency of support across the sector. NHSE and AACE are extending the #workwithoutfear campaign through the winter months and an evaluation will follow in spring 2023. Lastly, NHSE and AACE have jointly commissioned a review to look at restrictive practices and appropriate training and models going forward.

NHSE is improving data collection in this area. The WRES and Workforce Disability Equality Standards, which are ongoing, collect information about how ethnic minority staff and staff with disabilities are affected by negative behaviours, and how this may differ from their counterparts.

Recommendation 50. ***In this context, it is important that the Government looks at ways of improving short term efficiency to promote positive mental health and headspace for all frontline workers. It could do this through looking at ways to reduce bureaucracy—perhaps through the use of technology—and reducing the time that frontline workers spend on administrative tasks. This could be achieved through reinstating administrative support staff and by investing in adequate ICT infrastructure. The cumulative effect of these measures would be to help give clinicians and frontline workers the capacity for headspace.*** (Paragraph 176)

Response

The People Digital Portfolio, as part of the Future NHS HR and OD programme is seeking to deliver the digital actions set out in **The future of NHS human resources and organisational development**. Within the portfolio of actions being undertaken there are efforts to use Robotic Process Automation and a focus on using technology to minimise the administrative burden on staff across all roles.

As a recent example, in one Ambulance Trust, 210 clinical team leads each spend a minimum two days per month manually checking payroll information across rostering, bank and timesheet systems, in addition to HR and payroll teams' time. Reducing this to half a day per month through automation could save one ambulance trust £1.6 million in released time for registered paramedics.

This is a real-world case of using digital tools to reform and improve processes that give time back to staff, time which can be used to secure the headspace for the reflective thinking the Committee recommends.

Retention in Social Care

Recommendation 51. ***Witnesses to this inquiry left us in no doubt that pay is a crucial factor in recruitment and retention in social care. Social care providers are consistently being outbid by the retail and hospitality sectors. However, whilst pay increases are sorely needed, merely raising wages is not enough. A long-term, sustainable strategy is needed which includes the prospect of pay progression, professional development, training, and career pathways.*** (Paragraph 181)

Response

We agree with the Committee's recommendation that a long-term strategy for the adult social care workforce is needed to improve recruitment and retention in the sector. Our People at the Heart of Care White Paper, published in December 2021, sets out our vision and strategy for the care workforce.

We recognise that pay is also an important factor influencing recruitment and retention decisions. Most care workers are employed by private sector providers who set their pay and terms and conditions, independent of central government. Local authorities work with care providers to determine fee rates, which should take account of wage costs, based on local market conditions.

On 1 April 2023, the Government will increase the National Living Wage (NLW) for workers aged 23 years and over by 9.7% to £10.42. A full-time worker on the National Living Wage will see their annual earnings rise by over £1,600, which is likely to benefit hundreds of thousands of care workers.

In addition, last winter we made £462.5 million available to local authorities through the Workforce Recruitment and Retention Funds (WRRFs). These supported local authorities to work with providers to boost staffing and support existing care workers until March 2022. Funding was provided to local authorities to support a range of measures to help recruit and retain staff. This included provision to enable local authorities and providers to bring forward planned uplifts relating to pay for the adult social care workforce in advance of the new financial year. The WRRFs helped to inform the design of the £500m discharge fund for this Winter. The fund can be used to boost general adult social care workforce capacity through recruitment and retention, where that will help to reduce delayed discharges

Recommendation 52. ***NHS England employs 104,000 people in adult social care jobs. NHS England must undertake a review of pay in their social care jobs. In the review, NHS health and social care roles must be compared based on the skills, competencies, and levels of responsibility shown in various roles in each sector to ensure that social care roles are being paid fairly.*** (Paragraph 182)

Recommendation 54. ***We welcome the Fair Cost of Care exercises as an opportunity to address the underfunding of the social care sector. However, these exercises must not be used as an excuse to reinforce the low pay which is endemic in the sector. The Government must ensure that the cost of care is calculated on the basis of paying care workers the same rate as equivalent NHS roles: Band 3 on Agenda for Change.*** (Paragraph 186)

Response

We have combined our responses to recommendation 52 and recommendation 54.

We are incredibly proud of our health and social care workers. However, we disagree with recommendation 54. Unlike in the NHS, care worker pay is the responsibility of independent care employers, who will consider local market conditions when agreeing fee rates with local authorities.

We also reject recommendation 52. Whilst social care staff may be employed by NHS trusts or organisations, NHSE itself does not directly employ an adult social care workforce or directly commission care delivery from this sector. Integrated Commissioning Boards (ICB) may directly employ social care staff to deliver care and define the terms of employment. In the main ICBs would commission sustainable care under contract with a social care provider. The ICB would work with the individual in receipt of Continuing Healthcare and the commissioned Provider to ensure the care needs could be met as to the care and support plan and within the terms and conditions of the contract.

There is a further method of commissioning an ICB may use and that is a Personal Health Budget (PHB). In this situation the individual in receipt of the PHB would either employ a personal assistant directly and would need to consider the terms of employment or commission a social care provider.

Recommendation 53. ***We reiterate the recommendation made in our 'Social care: funding and workforce' report that annual funding for social care should be increased by £7 billion by 2023–24. This will account for demographic changes, uplift staff pay in line with National Minimum Wage and protect people who face catastrophic social care costs.*** (Paragraph 185)

Response

We do not accept the recommendation that the annual funding for social care should be increased by £7 billion by 2023–24. As announced in the Autumn Statement, the Government is making available up to £2.8 billion of additional funding in 23–24 and up to £4.7bn in 24–25 to support adult social care and discharge. This is the largest increase in funding for social care in history and this will put the adult social care system on a stronger financial footing and improve the quality of and access to care.

We are still taking forwards our ambitious reform reforms to the social care system. That involves investing in the workforce, better data and technology, and increasing the oversight of the social care system. These will improve access and quality of care, while also building long- term resilience in the sector.

The funding announced in the Autumn Statement includes £1 billion of new grant funding in 23- 24 and £1.7 billion in 24/25, as well as £1.3 billion in 23–24 and £1.9 billion in 24–25 which will be distributed to local authorities through the Social Care Grant. The funding announced also includes further flexibility for local authorities on council tax. Local authorities will be able to increase council tax to 3% per year from April 2023, and local authorities with social care responsibilities can increase the ASC precept by up to 2% per year.

Our sustained, long-term investment has helped local government steadily increase their spending on adult social care which reached £20.7 billion in 2020/21. This is an average increase of 2.3% per year in real terms since the introduction of the Care Act 2014. Previously, in the Local Government Finance Settlement for 2022/23 we supported local government by making available an additional £3.7 billion of funding for councils for 2022/23, which includes £1bn specifically for social care. DLUHC's intention is to publish the provisional Local Government Finance Settlement for 2023/24 as soon as is reasonably possible this winter.

Continuity of care

Recommendation 55. ***We have heard evidence that staff shortages are having an impact on the ability of social care staff to provide good-quality care to the people they support. Lara Bywater told us that in the 20 years she has been running her organisation, she has "never seen a staff shortage impact like this". She emphasised that:*** (Paragraph 185)

Response

This is not a recommendation but the issues raised are covered in our responses below.

*In the Committee's response recommendation 56 is a duplication of recommendation 54, we have therefore excluded this recommendation from our response.

Recommendation 57. ***The work that social carers do is essential to the lives of those who are cared for, and to their families. It is vital that they are treated by the Government and by wider society with the same respect as their NHS colleagues. It is not until parity of esteem between the NHS and social care is achieved that recruitment and retention in the social care sector will improve.*** (Paragraph 190).

Response

We agree with this recommendation. We are incredibly proud of all our health and care staff and recognise their extraordinary commitment—working day and night, putting our care and safety at the centre of everything they do. The dedication of the workforce during the pandemic has helped to shine a bright light on the importance of care workers.

Our vision is for an ASC workforce where people feel supported, recognised, that their wellbeing is prioritised, and there are opportunities to develop and progress. Our People at the Heart of Care White Paper published in December outlined our strategy for the workforce, backed by a new programme of reforms.

Recommendation 58. ***The value of continuity of care in social care settings, particularly for people who rely on non-verbal communication, is undeniable. It is essential that the Government acts swiftly to implement the findings of this report to improve retention in the sector.*** (Paragraph 191)

Response

We agree with the Committee that continuity of care is vitally important to good quality of care.

We are committed to working with local authorities and independent providers to address the recruitment and retention challenges in the adult social care sector. We are incredibly proud of the care workforce and we want all those working in adult social care to feel valued for their work.

Our People at the Heart of Care White Paper outlines our strategy for the social care workforce and represents a huge step towards reforming the adult social care workforce.

Recommendation 59. ***Better training and career development pathways in social care will be an essential part of driving recruitment and retention in the sector. The Government must commit to restoring social care staff free access to the same NHS training as community health colleagues by July 2023.*** (Paragraph 196)

Response

The Government agrees with recommendation 59, insofar that better training and career development pathways in social care will be an essential part of driving recruitment and retention in the sector.

In the White Paper People at the Heart of Care, the Government committed to improve social care as a long-term career choice by improving knowledge, skills, health and wellbeing and recruitment policies.

Through our continued funding of Skills for Care, the Government provides a range of resources and practical toolkits for social care providers to help them attract, train and retain staff. This includes distributing funding annually through the Workforce Development Fund, which enables employers to bid for financial support towards the training and development of their staff.

New learning opportunities, for example, training and online resources to build digital skills in the care sector, are also being provided.

Furthermore, we published our Integration White Paper in February 2022 and have committed to work with national and local partners to identify opportunities to remove barriers to collaborative planning and working, to create joint career pathways, and joint learning and training opportunities for the health and social care workforce.

Recommendation 60. ***It is clear that some care home managers lack the training and support they need to stay in post. We welcome the Government's commitment to fund Level 5 diplomas for those who need them, and we urge the Government to publish a fully costed plan for doing so by the end of the year.*** (Paragraph 197)

Response

The Government broadly agrees with recommendation 60 and has published plans for workforce reform in 'People at the Heart of Care: adult social care reform white paper. We are continuing with our system reform programmes and progressing the proposals in the People at the Heart of Care white paper, including in training and technology. We recognise that reforms to the adult social care system will be crucial to building long-term resilience in the sector to increasing demand. We will set out more detailed plans in due course.

Recommendation 61. ***By 2023, the Government must introduce a new, mandatory Care Certificate which is i) subject to a formal assessment process, ii) externally offered and accredited, iii) offered at no cost to providers, and iv) portable between social care providers and between social care and the NHS.*** (Paragraph 201)

Response

The Government broadly agrees with recommendation 61 and has published plans for workforce reform in 'People at the Heart of Care: adult social care reform white paper. These include plans to reform how the Care Certificate is delivered, to ensure that it is fully portable, allowing care workers to carry it with them throughout their careers. We will set out more detailed plans in due course.

Recommendation 62. ***The practice of "by-the-minute" commissioning is having a devastating impact on the continuity of care offered to service users and the terms and conditions under which workers must provide care. The reality is that some care is commissioned in this way because social care is chronically underfunded by central Government. It is within the Government's gift to remedy this situation by providing adequate funding to the social care sector.*** (Paragraph 210)

Recommendation 63. ***The Government must commit to providing sufficient funding for the social care sector so that Local Authorities and private providers are able to end the practice of "by the minute" commissioning of homecare. Local Authorities and private providers in turn must commit to paying workers in advance to provide care that is both relational and task- based and is focused on achieving outcomes. This will improve the quality and continuity of care offered to service users as well as terms and conditions for care workers.*** (Paragraph 211)

Recommendation 64. ***It is completely unacceptable that the practice of not paying for travel time means that some domiciliary care workers are effectively working for less than the minimum or living wage. The Department for Business, Energy, and Industrial Strategy, with the support of HMRC must re-examine sector-specific guidance to address complexities in national minimum wage and national living wage guidance for the care sector, and reissue new, clarified guidance to employers and employees. The HMRC National Minimum Wage / National Living Wage enforcement body must be proactive in ensuring that all domiciliary care workers are receiving at least the minimum wage or living wage for all the time they spend working, including time spent travelling to appointments.*** (Paragraph 212)

Response

Responses 62–64 have been grouped. Local authorities are best placed to understand and plan the care and support needs of their local population. That is why, under the Care Act, local authorities are tasked with the duty to shape their care market to ensure a diverse range of high quality, sustainable, person-centred care and support services are provided. This includes planning the balance of services which should be directly provided by the local authority or contracted to external care providers.

We disagree with the conclusion (recommendation 62) that social care is 'chronically underfunded'. Sustained government investment has helped local authorities steadily increase their spending on adult social care, which reached £21.4 billion in 2021/22. This is an average increase of 2.5% per year in real terms since the introduction of the Care Act 2014. The Local Government Finance Settlement for 2022–23 made available an additional £3.7 billion to councils through Local Government Finance Settlement in 2022/23, including over £1 billion of additional resource specifically for social care.

In the Autumn Statement we announced that we are making available up to £2.8 billion of additional funding in 23–24 and up to £4.7bn in 24–25 to support adult social care and discharge. This includes £1 billion of new grant funding in 23–24 and £1.7 billion in 24/25, further flexibility for local authorities on council tax, and having heard the concerns of local government, savings from delaying the rollout of adult social care charging reform from October 2023 to October 2025. As always though, the Government will continue to work closely with local authorities to understand the pressures Local Authorities' and the social care sector are facing.

The choice of commissioning model is for Local Authorities to determine, within their statutory responsibilities. We disagree with the conclusion of recommendation 63; as above, the government has provided sufficient funding to meet these duties.

We disagree with recommendation 64 that new guidance is required on travel time. All social care workers are entitled to be paid at least the National Minimum Wage or National Living Wage for the work that they do. Time spent caring for clients, travelling between appointments, and waiting to start the appointment must be included in the pay calculation.

Recommendation 65. ***New regulations should be introduced by 2023 in which care workers initially employed on zero-hours contracts must be offered a choice of contract after three months of employment. The new regulations should state that domiciliary care workers must be paid for their time spent travelling between appointments, and that time allocated for travel and care must be clearly set out in the contracts of domiciliary care workers.*** (Paragraph 213)

Response

The Government disagrees with this recommendation. We expect employers to engage properly and meaningfully with their workforce and representatives, and to consider the best contract for both parties. The Government is clear that businesses should always treat their workforce and partners fairly, and ensure they are fulfilling their legal responsibilities. The Government recognises the case for a range of employment models in social care, including full time, part time and zero hours contracts. With current vacancy levels in social care we are encouraging providers and local authorities to consider how their contracts help recruit and retain staff, including when it makes sense to offer more certainty on hours. However, some care workers choose to stay on a zero hours contract in order to maintain flexibility and balance work around other commitments such as childcare and study.

The Government remains committed to introduce a right to request a more predictable contract and we will bring forward legislation on this when parliamentary time allows. This right will allow a qualifying worker to make an application to change their existing working pattern if it lacks predictability in terms of hours they are required to work, the times they are required to work, and / or the duration of their contract.

Existing minimum wage legislation already protects a worker's right to be paid for time spent travelling from one work assignment to another, for example where a care worker is driving from one client to another between appointments. This time is considered working time for minimum wage purposes and workers must be paid at least the minimum wage

for this time. In addition, any associated expenditure incurred by a worker in respect of that travel must be reimbursed.

The government takes enforcing the minimum wage seriously. We are clear that anyone entitled to be paid the minimum wage should receive it and take robust enforcement action against employers who do not pay their staff correctly. HMRC, who are responsible for minimum wage enforcement, consider all complaints from workers, conduct proactive enforcement activities and deliver educational activity to support employer compliance. Since 2015 they have ordered employers to repay £100 million to 1 million workers.

Recruitment in Social Care

Recommendation 66. ***Wider market forces, including the rising cost of living, a lack of affordable housing, and a lack of public transport in remote locations are having an impact on the recruitment and retention of health and social care workers. These issues manifest differently across the country, and it is clear that without action to address these wider issues, the NHS and social care sectors will continue to struggle to recruit and retain staff.*** (Paragraph 218)

Response

The Government agrees with this statement. The government understands the pressures people are facing with the cost of living and has taken further decisive action to support people with their energy bills. The government's Energy Price Guarantee will save a typical British household around £700 this winter, based on what energy price would've been under the current price cap – reducing bills by roughly a third. This support will be in place from 1 October 2022 until 31 March 2023. A review will be launched to consider more targeted measures to support households with their energy bills after this period. This is in addition to the over £37bn of cost of living support announced earlier this year which includes the £400 non-repayable discount to eligible households provided through the Energy Bills Support Scheme.

Employers across the NHS are making an effort to support their staff with the cost of living challenge, encouraging staff to have conversations about financial wellbeing and highlighting the range of employee benefits already available to many NHS employees. Many NHS organisations are already providing a range of support on issues such as travel, childcare and housing and will continue to adapt these offers to meet the needs of staff going forward. NHS Employers have published a guide for employers here on how they can support their staff on the cost of living challenge.

The provision of affordable housing is part of the Government's plan to build more homes and provide aspiring homeowners with a step onto the housing ladder. Our £11.5 billion Affordable Homes Programme will deliver thousands of affordable homes for both rent and to buy right across the country.

Many local authorities and providers are looking at innovative ways of providing transport for care workers, some have provided access to e-scooters and e-bikes or supported with car insurance costs where a vehicle is required for work. This is likely to have aided the retention of care workers in the sector. Furthermore, we made available an additional £3.7 billion of funding for councils for 2022/23, which includes £1 billion specifically for social care.

Recommendation 67. ***Social care workers should be designated as key workers on the same basis as public sector employees so they can access affordable rented housing from local authorities and registered providers.*** (Paragraph 219)

Response

We are committed to supporting access to affordable housing, be it for sub-market rent or low- cost home ownership. There is no single national definition of key workers for affordable housing, but instead the Government empowers local authorities to take these decisions in the best interests of their areas and residents.

Recommendation 68. ***Local providers are best suited to understand the recruitment challenges in their local areas. The Government must pass recruitment and retention funds directly to providers to be invested in local recruitment campaigns.*** (Paragraph 220)

Response

We disagree with this recommendation. We believe that local health and care systems are best placed to understand workforce recruitment and retention challenges within their area. This is consistent with the duties placed upon local systems in the Care Act, and the strategic oversight role set out in the Integration White Paper. It is for this reason that we provided our workforce funds and latest discharge fund to local systems, which can be used on local recruitment campaigns—which all providers can access, as well as other measures as deemed appropriate.

Through the Workforce Recruitment and Retention Funds (WRRFs) we made £462.5 million available to local authorities to support local authorities to work with providers to boost staffing and support existing care workers through the winter until March 2022. We expected local authorities to work closely with adult social care providers to determine how funding should best be spent, including passporting funding directly to adult social care providers where appropriate. Subject to the grant conditions being satisfied, local authorities could choose to pass some or all of their funding to care providers within the local authorities' geographical area to meet pressure on staff capacity due to winter pressures. Local authorities, through engagement with care providers, are best placed to decide how the funding should be used to address workforce pressures. The learning we have taken from the WRRFs has helped to inform the design of the £500m discharge fund for this Winter.

Additionally, we have launched our new domestic National Recruitment Campaign, Made with Care, on 2 November running until March 2023. The campaign advertising will appear on catch up TV and social media. The campaign will reach millions of people this winter, highlighting the amazing work staff across the adult social care sector do and celebrating the way they empower the people they support. The campaign is a proven, established, and sustainable recruitment marketing model supported by the sector, operating across streaming platforms, radio, and digital advertising.

Recommendation 69. ***The Government should report on how many care workers have been issued with Health and Care Worker visas since the scheme was launched. The salary requirement for the visa should be decreased to the average salary for a social care worker. Care workers should be considered skilled and added to the shortage occupation list.*** (Paragraph 226)

Response

On 15 February 2022 we added care workers to the Health and Care Visa and the Shortage Occupation List (SOL), enabling these roles to be recruited from overseas. On 23rd February 2023 the Home Office published a breakdown of visas issued in the last year as part of their regular quarterly migration statistics. There was a total of 56,900 visa grants for care workers and senior care workers in 2022. This is comprised of 34,800 grants to care workers and home carers and 22,100 to senior care workers. These figures demonstrate the scale of the uptake of international recruitment into the adult social care sector since care workers were added to the Shortage Occupation List.

We do not agree with the recommendation to reduce the minimum salary requirement for care workers. Salary thresholds are a fundamental cornerstone of the Points Based System. The minimum salary requirement helps to drive positive employer behaviour and practice and protects the welfare of people, recruited internationally, who come and work in the social care sector—a view shared by the independent Migration Advisory Committee.

Recommendation 70. ***International recruitment is too expensive for some social care providers. The Government should consider helping by waiving the cost of sponsorship certificates and licenses, including the immigration skills charge, for care workers and their sponsors for two years, and other similar measures.*** (Paragraph 227)

Response

The government does not consider it reasonable to waive the cost of sponsorship licences and certificates. Employers will need to factor in these costs when considering whether to recruit internationally. Current indications, however, are that adult social care providers are responding positively to the inclusion of care workers on the Shortage Occupation List in February 2022.

The government is working actively with the adult social care sector and local authorities to help promote collaborative approaches to international recruitment. We have announced £15 million investment in a support fund to help establish local support arrangements, with the aim of reducing the cost and complexity of the process for individual providers and promoting ethical recruitment and employment practices. We will announce more details of the fund shortly.

Recommendation 71. ***The NHS must undertake a review of its recruitment processes to ensure that no international health and care staff are being subject to punitive repayment clauses in their contracts. Those who are subject to repayment clauses must be released from them, and future NHS contracts must not contain repayment clauses.*** (Paragraph 233)

Response

NHSE requires all trusts to follow the UK Ethical Code of Practice when employing international health and care staff, which is clear that applicants must not be required to pay any fees in order to gain employment and that the exact terms of a candidate's contract—including those relating to circumstances in which advances may be reclaimed—must

be clearly explained in writing. The Code has recently been updated to ensure that all repayment clauses are transparent, proportionate, flexible and must taper down overtime.

NHSE will continue to explore with partners across government and the health system what further guidance is required to support employers and employees regarding this issue.

Recommendation 72. ***Labour Market Enforcement bodies must work closely with external partners in social care to find ways to disseminate information and raise awareness about employment rights and the enforcement powers of Labour Market Enforcement bodies among employers (including those receiving direct payments), workers, and Local Authorities.*** (Paragraph 234)

Recommendation 73. ***Local Authorities must evaluate the risk of modern slavery in their adult social care supply chains and ensure that the risk of modern slavery is assessed as part of the due diligence processes at the commissioning and contracting stage and in performance monitoring. They should ensure that there is effective information sharing between Local Authorities staff, recruitment agencies, and care workers to reduce occupational risks such as non-enforcement of minimum and living wage, and threats of physical or sexual violence.*** (Paragraph 235)

Response

Recommendations 72 and 73 have been grouped together to provide an overarching response to the Committee.

We agree with these recommendations. We encourage Local Authorities to evaluate the risk of modern slavery in their adult social care supply chains and ensure that the risk of modern slavery is assessed, as per this report's recommendation.

We take any reports of unsafe and illegal employment practices in the social care sector very seriously. Any accusations of illegal practice will be fully investigated by the Gangmasters and Labour Abuse Authority.

The Labour Market Enforcement bodies (Employment Agency Standards Inspectorate, Gangmasters and Labour Abuse Authority, and HMRC's National Minimum Wage Team) have an active programme of engagement with external partners, including those in the care sector, to help make sure workers know their rights and employers understand their obligations. This activity includes working with partners such as the Care Quality Commission, industry representative groups, unions and the Local Government Association (amongst others). This is an ongoing programme, examples of activity so far include webinars, and working directly with LA's, alongside the development of publications to assist those working or operating within the care sector.

Labour Market Enforcement bodies have an active programme of engagement with external partners including the Local Government Association and LAs.