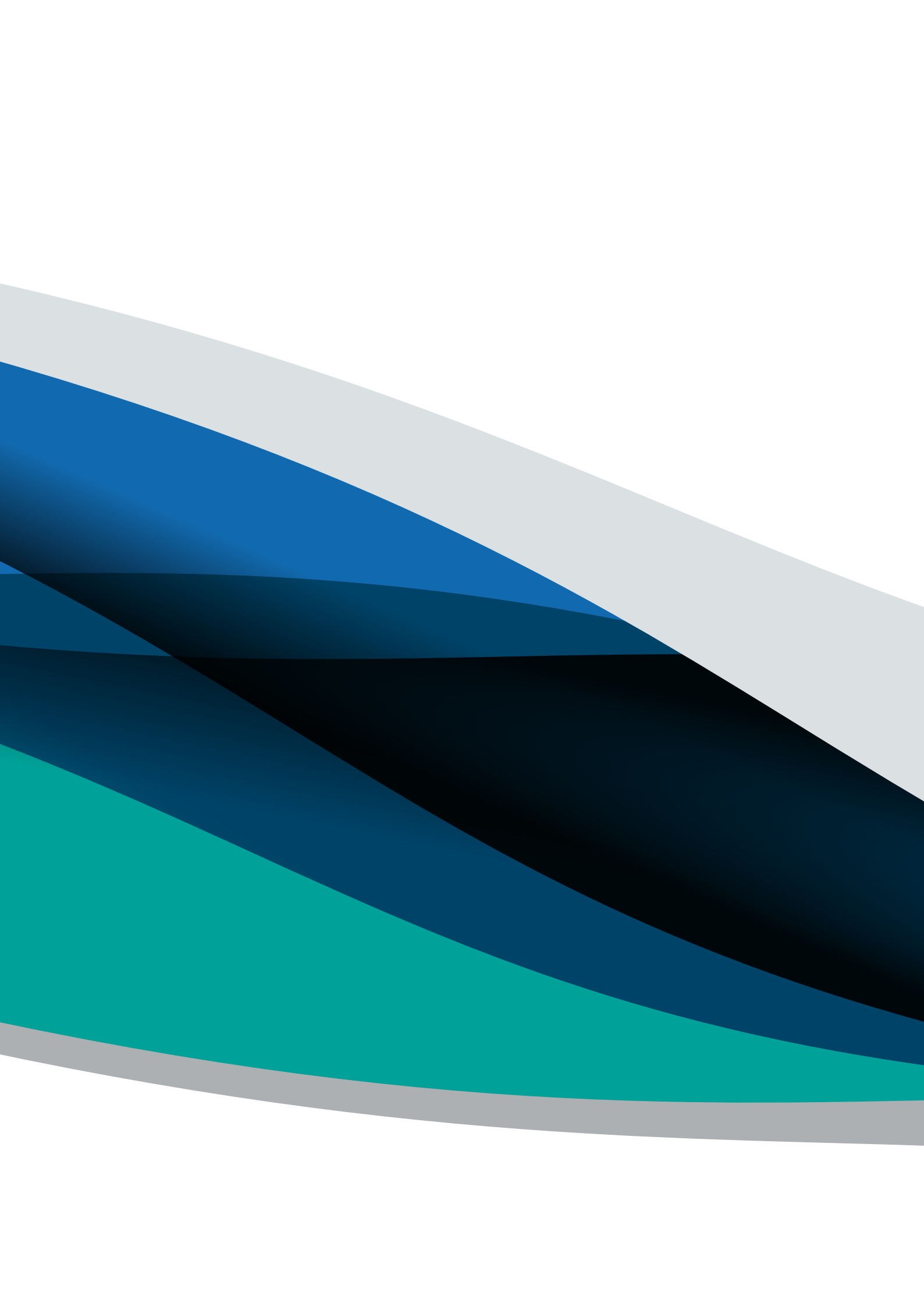




THERE FOR US

**A better future
for the NHS workforce**



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A better future for the NHS workforce

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SUMMARY

The NHS workforce provides healthcare, free at the point of use, to over 55 million people in England. As pressure on services and staff mounts, a workforce gap has developed. A fresh approach to the workforce is needed.

Our diagnosis

- **Mounting pressure**

Rapidly rising demand and constrained funding is leading to mounting pressure across health and social care services.

- **The workforce gap**

Many provider trusts – hospital, mental health, community and ambulance services – are struggling to recruit and retain the staff they need to deliver high-quality care for patients and service users. There are very big gaps in some places. This workforce gap is a fundamental strategic issue which is undermining provider sector performance and risks preventing the delivery of service transformation. Two thirds (66%) of trust chairs and chief executives told us workforce is the most pressing challenge to delivering high-quality healthcare at their trust. There are three key factors contributing to the workforce gap.

- **Supply**

Supply of new staff has not kept pace with rising demand for services and a greater focus on quality. There is a gap between the staff provider trusts need and the staff that have been trained. When asked for the biggest challenges to recruitment and retention at their trust, 93% of trust chairs and chief executives included staff supply shortages.¹

- **Recruitment and retention**

Provider trusts are the employers of staff and have a responsibility to make their organisations great places to work. There is more that trusts can do. But recruiting and retaining staff has become more difficult as the job gets harder, training budgets are cut, and prolonged pay restraint bites. When asked for the biggest challenges to recruitment and retention at their trust, 60% of trust chairs and chief executives cited work pressure and 38% cited pay and reward. There is a gap between the staff available for recruitment and retention and the staff trusts can persuade to work for them.

- **Funding**

Even if there were no supply shortages of staff, and provider trusts had no difficulty recruiting and retaining staff to work for them, trusts may still be unable to afford to employ the staff they need to deliver high-quality services given low growth in the public funds the provider sector has been allocated relative to rising demand for services.

Closing the workforce gap

- **Domestic supply**

The supply of domestic staff needs to grow substantially. The government has recognised this and plans to expand medical education, boost the number of nurses and other healthcare students, and open up new routes into healthcare careers such as apprenticeships. However it is not yet clear that these initiatives will close the workforce gap and, in any event, it will be several years before we see significant numbers of extra staff available for provider trusts to recruit and retain.

- **International supply**

In the absence of quick fixes to domestic supply, there is a continued need for provider trusts to recruit and retain staff from the EU and the rest of the world to mitigate the workforce gap. In a recent survey, 85% of trust chairs and chief executives told us that it will be important or very important for their trust to recruit from outside the UK over the next three years. Uncertainty linked to Brexit was seen by chairs and chief executives as the main barrier to the recruitment of non-UK staff over the next three years with more than one in three (38%) mentioning this issue. This is followed by professional regulatory requirements, including language testing (32%), and then current immigration policy and charges (16%). There is opportunity for NHS-wide cooperation on international recruitment.

- **Making the NHS a great place to work**

Provider trusts must do all they can to foster positive and inclusive cultures, tackle bullying, improve the experiences of black and minority ethnic staff, and offer staff greater flexibility. At the same time, action at the national level is needed to address growing work pressure on staff, reverse cuts to training budgets, and to adequately fund the promised end to pay restraint. There is an opportunity for national promotion of the NHS as a great place to work.

- **Workforce development and productivity**

The answer to the workforce gap is not only about more staff. It is also about providers delivering services in new ways with staff working differently and more flexibly. The workforce gap is not static and can be narrowed, though not eliminated, by trusts undertaking workforce development and improving productivity. National-level support is needed for trusts to make changes at pace and scale.

- **Leadership development**

Provider leadership capability is being stretched thinner and thinner, just at a time when it's most needed, to maintain and improve current performance, help close the workforce gap, develop the workforce and enhance productivity, and deliver service transformation. National-level action is needed to secure the pipeline of future leaders and ensure that once in post they are supported to lead trusts to address the challenges faced.

Ensuring a coherent and credible approach

- **A coherent and credible approach to workforce at the national level**

The Department of Health and its arm's-length bodies, Health Education England, NHS Improvement, NHS England, and the Care Quality Commission (the NHS national bodies), need to acknowledge the scale of the workforce gap and develop and communicate a coherent and credible workforce strategy with plans and policies to support provider trusts to recruit and retain the staff they need. In our recent survey, 90% of trust chairs and chief executives are worried or very worried about whether the Department of Health and the NHS national bodies' approach to workforce strategy, planning, and policy will support their trust to recruit and retain the staff they need. This is deeply concerning. If the ministerial board on workforce is to be the key forum overseeing and coordinating NHS workforce strategy, planning, and policy, it needs to communicate effectively about its work, seek input from a wide range of opinion, be transparent about its work programme and be seen to engage effectively with provider trust leaders.

- **A new partnership between the national and local levels**

There is a big question for the longer term about which elements of workforce strategy, planning and policy are best dealt with at the national level and which would be better devolved to a more local level. The answer to this is not yet clear. But, in light of the current challenges, this needs to be explored at speed and opportunities for a more responsive and flexible workforce identified and realised.

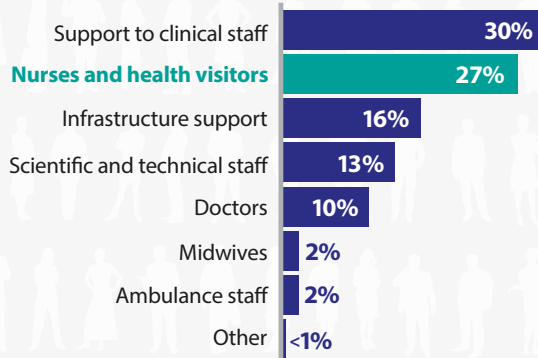
THE NHS WORKFORCE

provides healthcare, free at the point of use, to over 55 million people

1.2 million

people currently employed by the NHS in England. Equivalent to the entire populations of Manchester and Leeds combined.

27% ARE NURSES OR HEALTH VISITORS

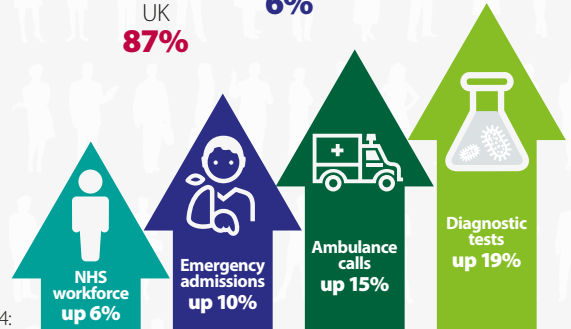


13% ARE FROM OUTSIDE THE UK



THE NHS WORKFORCE IS GROWING BUT SO IS DEMAND FOR SERVICES

Compared to March 2013/14:



THE NHS WORKFORCE IS MORE STRETCHED THAN EVER

In a recent survey of chairs and chief executives:

66% said workforce is the most pressing challenge to delivering high-quality healthcare

The top 3 challenges to recruitment and retention

2 Pressure of work

1 Staff supply shortages

3 Pay and reward

85% said it would be important to recruit from outside the UK over the next 3 years

THREE KEY RECOMMENDATIONS



Tackling the domestic supply gap

The Department of Health and NHS national bodies should develop and communicate a coherent and credible strategy for the health and social care workforce.



Maintaining international supply

The government should commit to a future immigration policy supporting trusts to recruit and retain staff from around the world.



Supporting trusts to develop the current workforce

The NHS national bodies, professional regulators and royal colleges should support trusts to introduce new roles and ways of working at scale and pace.

Sources: NHS Digital workforce statistics March 2017, June 2017. NHS England performance data March 2017. NHS Providers survey October 2017

INTRODUCTION

The NHS in England employs around 1.2m people.² They fulfil a wide variety of roles and are working hard day in, day out to deliver safe and high-quality care for patients and service users in the face of mounting pressure.

Rapidly rising demand and constrained funding are leading to increasing pressure across health and social care services.

In the NHS provider sector this is visible as trusts struggle to achieve performance targets such as the four-hour waiting target for A&E and the 18-week referral-to-treatment target,³ and in the continuing challenge of achieving financial balance.⁴ This is apparent across hospital, mental health, community and ambulance services.

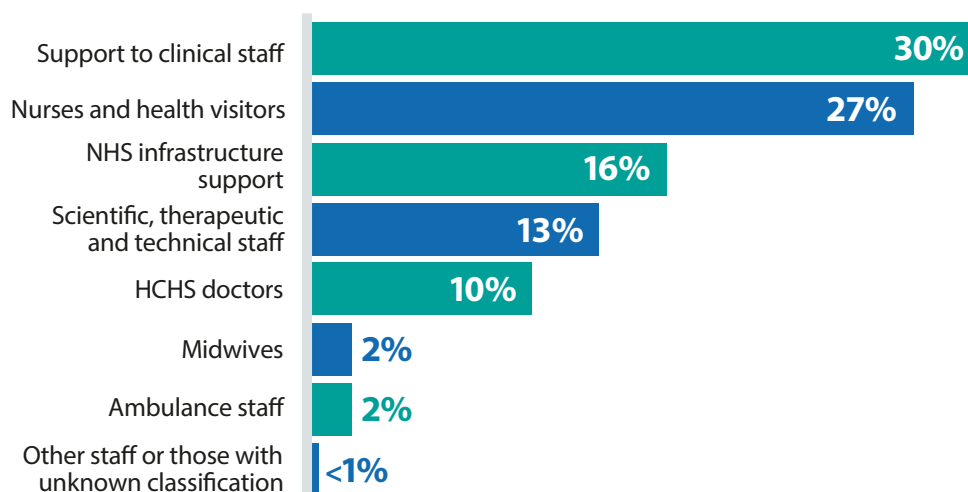
Beyond the provider sector mounting pressure can be seen as GPs struggle to maintain patient access⁵ and the Care Quality Commission warns that adult social care is “approaching tipping point”.⁶ Tied up with these performance and finance challenges, the NHS provider sector faces a set of growing workforce challenges.

There is a gap between the workforce that provider trusts need to deliver high-quality services and the workforce they have. In 2014 Health Education England reported a staffing shortfall of 5.9% or 50,000 clinical staff. This has almost certainly widened since then. The workforce gap is most obvious in respect of clinical staff, resulting in closures of some services, for example A&E⁷ and children’s services,⁸ restricted opening hours for others, and pressure on staff required to put in extra hours as they seek to maintain quality of care.⁹

Figure 1 illustrates the role composition of the NHS workforce. Around 54% (564,000) of NHS staff in England today are clinically qualified – nurses/health visitors, scientific, therapeutic, and technical staff, doctors, midwives, and ambulance staff.

Figure 1
Composition of the NHS workforce by role (full-time equivalent) as of June 2017

Based on data from NHS Digital, June 2017 (n= 1,045,146 FTE)



The number of clinical staff has increased over the last seven years – with a growth of 26.2% for doctors, 1.8% for nurses and health visitors, 13.3% for ambulance staff, and 10.1% for scientific, therapeutic and technical staff.¹⁰

Yet this growth in staff has not kept pace with rising demand for services, greater patient acuity, and increased demand for staff generated by the push for and regulatory focus on higher staffing levels and care quality. A workforce gap has developed.

THE WORKFORCE SUPPLY CHALLENGE

2

Having enough staff with the right skills and values is a fundamental strategic issue for the provider sector. In a recent survey, two thirds (66%) of trust chairs and chief executives told us workforce is the most pressing challenge to delivering high-quality healthcare at their trust.

Generally, the most difficult shortages are of clinical staff, though there are significant challenges in respect of the wider workforce too.

Medical staff shortfalls

While it is widely accepted that the NHS faces shortages of clinical staff, there is no definitive measure of its scale. Authoritative, public, timely data on vacancy rates for clinical staff at a national level is still widely unavailable. In addition, there is a lack of insight into regional variation and differences between different staff groups.

The medical consultant shortfall rates summarised in figure 2 show variation by medical specialty and region.¹¹ Shortfalls of 6% or less are coloured green, shortfalls of between 6% and 10% are coloured amber and those of 10% or more are red (there are some exceptions to this which are due to the rounding up or down of numbers).¹²

Figure 2
Provider expressed shortfall from demand for medical consultants at March 2015

	Staff in post	England	North	Midlands and east	London and south east	South
Small specialties	508	13%	14%	9%	16%	9%
Accident and emergency	1509	13%	13%	15%	11%	10%
Acute care	4087	10%	12%	14%	8%	6%
Pathology and lab	1917	10%	16%	9%	6%	8%
Psychiatry	3963	8%	13%	7%	3%	9%
Cancer services	4724	8%	11%	9%	6%	4%
Ophthalmology	1026	7%	10%	5%	10%	2%
Other medicine	4393	6%	8%	7%	3%	6%
Surgery	7302	6%	8%	5%	4%	4%
Anaesthetics and intensive care medicine	6533	5%	5%	4%	8%	1%
Obstetrics and gynaecology	2069	4%	4%	3%	5%	1%
Paediatrics and paediatric cardiology	2977	4%	8%	4%	3%	2%
All	41557	8%	9%	7%	6%	5%

Adapted from a table within the Review Body on Doctors' and Dentists' Remuneration Forty-Fifth Report 2017, which in turn was adapted from a table within written evidence submitted by Health Education England.

It is clear that the north and, to a lesser extent, east and midlands are generally faced with higher shortfalls than London and the south east and the south.

There are well-known shortfalls of accident and emergency consultants across all regions of the country and, outside of London, shortfalls in psychiatry. Notable shortfalls are also found in acute care, pathology, cancer services, ophthalmology, and within the small specialties taken as a whole.

Similar regional and specialty patterns can be seen in recent analysis by the British Medical Association of specialty training fill rates.¹³

The NHS national bodies have published an emergency care workforce plan,¹⁴ together with the Royal College of Emergency Medicine, which mainly focuses on growing the emergency medicine workforce over the next two years and beyond, and a mental health workforce plan, which aims to grow the mental health workforce, including psychiatrists, by 2021.¹⁵ The government has also announced an expansion of medical school places – 500 extra places from 2018 and an additional 1,000 more from 2019 – with the aim of making the NHS ‘self-sufficient’ in terms of doctors. It will be six or seven years before these extra medical students start to graduate.

Other clinical staff shortfalls

The shortfall rates for other clinical staff summarised in figure 3 also show variation by staff group and region.

Figure 3
Provider expressed shortfall from demand for non-medical clinical staff at March 2015

Staff group	England	North	Midlands and east	London and south east	South
Nursing and midwifery	9%	7%	8%	12%	10%
Allied health professionals	7%	6%	6%	9%	6%
<i>Of which qualified ambulance staff</i>	7%	6%	8%	9%	5%
Healthcare scientists	6%	6%	4%	9%	7%
Other qualified staff	6%	6%	9%	5%	2%
All	7%	6%	7%	9%	6%

Adapted from a table in the National Health Service Pay Review Body 30th report: 2017, which in turn was adapted from a table within written evidence submitted by Health Education England.

There are shortfalls of nurses, allied health professionals such as radiographers and occupational therapists, paramedics, and healthcare scientists. Inevitably the aggregate nature of these figures hides specific shortages of some staff such as psychologists in mental health services.

London and the south east has the highest shortfalls across all staff groups except in the category of other qualified staff. Trusts in and around the capital tell us that the high cost of living, particularly housing, is a barrier to recruiting and retaining staff and that the current high cost area supplements do not adequately mitigate it.

London and the south east, closely followed by the south, also have a particularly high shortfall of nurses, although the north and the midlands and east are experiencing notable shortfalls too. As the data is more than two years old it probably understates the current nursing shortfall; the Royal College of Nursing's latest estimate is that there is a shortage of 40,000 nurses across England.¹⁶ This severe mismatch of supply and demand of nurses can be explained by rising demand for services and a greater focus on safety and staffing levels resulting in greater demand for nurses from trusts.¹⁷ Worryingly, analysis by The King's Fund shows that the number of nurses working in the NHS in England has begun to fall for the first time in three years.¹⁸ There are also specific concerns about community, learning disability, and mental health nursing, where falls in staff numbers and high shortfalls are masked by the overall numbers.¹⁹ The nursing shortfall is now the focus of an inquiry by the health select committee.²⁰

Following the government's reform of healthcare education funding, nursing and other clinical students now fund their own education through the student loan system. This means that in principle there is no cap on the number of students who can be educated, whereas in the past the number of students was capped at the number of bursaries for which the government made funding available. However, in practice, healthcare students will require clinical placements at provider trusts and so the number of students is limited by the number of clinical placements that trusts have capacity and funding to deliver. Also, any extra healthcare student places that are offered can only be filled if enough students of the right quality and with the right values can be attracted to apply to courses. As part of its reforms, the government has committed to 10,000 more healthcare students by 2020. There are particular concerns from trusts about the viability of some learning disability nursing courses where students have tended to be more mature and may be more likely to be discouraged by needing to take out a student loan.

The government has also recently announced funding for a 25% increase in nursing clinical placements, to support a 25% increase in nursing students (just over 5000 more), from 2018. This is welcome, but there is much work for trusts and higher education institutions, with national-level support, to do if the extra clinical placement capacity is to be realised and sufficient people are to be attracted to apply for and take up the extra nursing student places.²¹ However, there are other routes into nursing. A small number of new nursing apprenticeships (less than 50) are beginning in 2017 with more to come

in 2018. Postgraduate nursing diplomas are another route but funding arrangements for these courses from 2018 are still to be confirmed, making it difficult for higher education institutions to attract students.

While these initiatives are welcome, it remains far from clear that they will together add up to the answer to the current staffing shortfalls. In addition they will take time to boost the domestic supply of staff – for example nursing degrees take three years and nursing apprenticeships take four years – and so it is essential that the NHS is able to continue to recruit staff from outside the UK for the foreseeable future to mitigate the workforce gap.

Wider NHS workforce

The wider NHS workforce makes an invaluable contribution in supporting the delivery of patient care. Staff work in a great variety of roles such as security, healthcare support, estates, porters, and administrators at various levels.

There are no national shortfall rates available for other NHS staff, but trusts tell us that for particular roles it is difficult to recruit and retain sufficient staff, for example in IT, estates, and clinical coder roles, and again there is of course variation in particular regions of England.

As a report by the Health Service Journal highlighted last year, there is much more to be done to support and promote the wider NHS workforce staff.²²

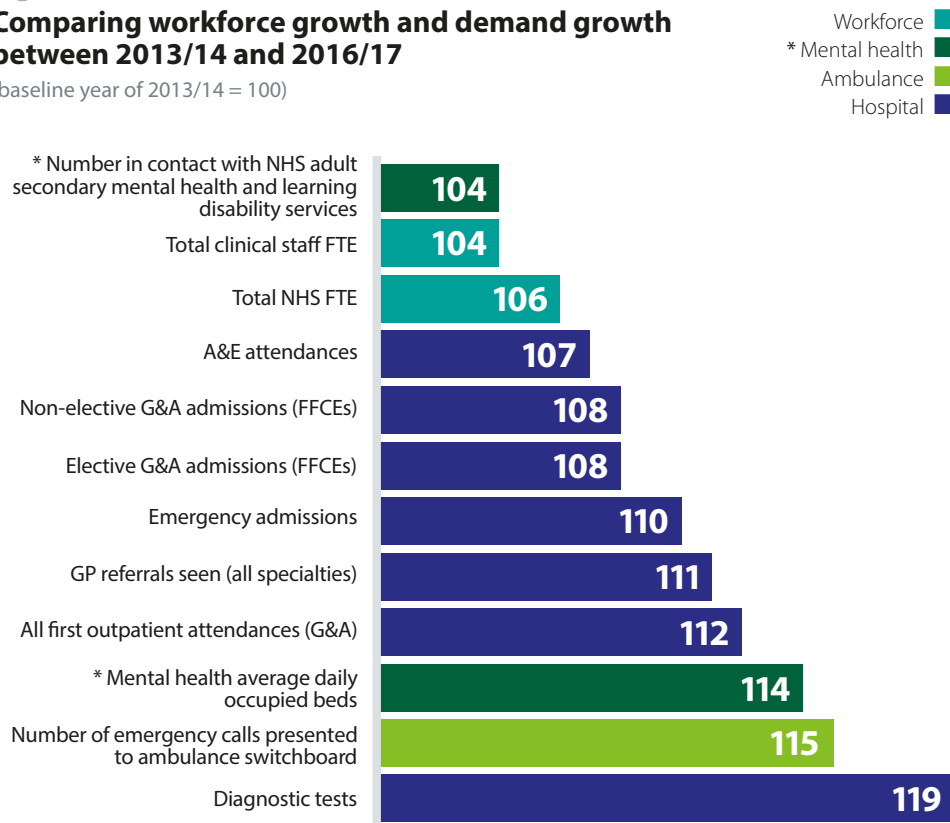
Comparing workforce growth and demand growth

When considering whether the NHS has enough clinical staff, what is key is not whether there are more or less staff today than there were in the past, but rather whether we have the number of staff with the skills and values we need to meet the level of demand for services and expectations of quality we face today and expect to face in the future.

Figure 4 uses indexing with 2013/14 as the baseline year to illustrate that almost all demand metrics across the hospital, mental health and ambulance sectors (we do not have demand metrics for the community sector) have grown more quickly than the workforce has grown in the last four years.

Figure 4
Comparing workforce growth and demand growth
between 2013/14 and 2016/17

(baseline year of 2013/14 = 100)



G&A refers to general and acute.
 FFCEs refers to first finished consultant episodes.

* Mental health data is based on comparison of 2013/14 to 2015/16 rather than 2016/17 due to this being the latest available data at the time the analysis was conducted. Therefore, this may be an under-representation of the growth in this demand metric.

The NHS has more clinical staff, overall, than ever before. Since 2010 there has been an increase in the number of staff in all groups except managers and backroom support staff.²³ But the fact is, as figure 4 illustrates, staff numbers have not kept pace with rising demand for services. Increased patient acuity is also a factor. And, crucially, following high-profile failures of care there has been a push for higher staffing levels and a corresponding regulatory focus and rapid rise in demand for nurses from provider trusts.²⁴

International supply and Brexit

Faced with the current workforce gap, and in the absence of domestic supply quick fixes, there is a continued need for the NHS to recruit from the EU and the rest of the world to mitigate clinical staff shortfalls. 85% of trust chairs and chief executives told us that it will be important or very important for their trust to recruit from outside the UK over the next three years.

Yet the outlook for international recruitment by provider trusts is uncertain. When asked for the biggest challenge to recruitment of non-UK staff for their trust, 38% of chairs and chief executives cited uncertainty linked to Brexit as the biggest barrier, 32% pointed to professional regulatory requirements, including language testing, and 16% suggested current immigration policy and charges.

The NHS has one of the highest levels of reliance on overseas staff in the OECD. Around 29% of doctors and 13% of nurses in the UK were trained in another country, compared to OECD averages of 17% and 6%. The UK has greater reliance on both doctors and nurses trained overseas than Germany, France, Spain, Canada, and the USA.²⁵

These staff make a vital contribution of delivering NHS services. Some 12.5% (138,000) of NHS staff in England are non-British nationals, and 5.6% (62,000) are from the EU.²⁶ Social care also depends on a big contribution from non-British staff, with 7% of workers (95,000) from the EU and 9% (125,000) from the rest of the world.²⁷

Again, in the NHS, the picture varies by staff group, between trusts, and across regions of England – for example in London around 12% of staff are from the EU, whereas in the north east it is around 2%.²⁸

Clearly, it is essential that people from the EU already working in the NHS have certainty over their right to remain and a straightforward process for establishing that right as soon as possible. All the indications from the government, not least the secretary of state for health,²⁹ are that this is what they want, but until it is finally confirmed, the uncertainty and anxiety for EU staff will inevitably continue.

As one trust leader put it: “We would not be able to maintain high-quality care for the people we serve without our diverse workforce. The current lack of progress in the Brexit negotiations is creating unhelpful uncertainty in an already challenging workforce environment.”

Until such a time as the NHS has significantly increased the numbers of clinical staff trained domestically and successfully recruited and retained them within the NHS, then any significant reduction in the number of staff from overseas is likely to have a serious adverse impact on service availability and quality. The pipeline of international staff must remain open.

At present, individual provider trusts undertake their own campaigns to recruit staff from overseas. While some may want to continue to do so, the time seems right for a sector-wide international recruitment programme to be created which trusts can pay to opt into if they wish. There may be economies of scale and opportunities to better support non-UK staff to meet professional regulatory requirements.

Language requirements for professional registration for nurses from outside the UK

The introduction of a new language requirement in January 2016 has affected the number of EU nurses working in the NHS. The number of nurses from the EU registering to work in the UK has dropped by 96% in less than a year. In July 2016, 1,304 EU nurses came to work in the UK; this fell to 46 in April 2017*. While this was widely linked in the media to the Brexit vote, provider trusts tell us that the introduction of a language requirement for EU nurses was by far the largest contributing factor to the fall. Trusts are concerned that the language requirement has been set in a way that has acted as a barrier to recruitment (this has been the situation for some time in the case of international applicants and latterly for EU applicants as well). We welcome the Nursing and Midwifery Council's (NMC) current review of its approach in this area, its engagement with provider trusts, and are working closely with the regulator to feed in provider perspectives and evidence. Positive changes have already been made**. Careful consideration needs to be given to guaranteeing patient safety, which was the reason language tests were introduced, and the patient safety implications of not being able to fill high vacancy rates with high-quality nurses from abroad. We urge the NMC to continue the review at pace.

* Health Foundation, June 2017, Election briefing: A sustainable workforce – the lifeblood of the NHS and social care

** NMC, <https://www.nmc.org.uk/news/press-releases/nmc-amend-english-language-requirements-applicants-trained-outside-the-uk/> [accessed 23 October 2017]

Supply – what needs to happen

The government should:

- urgently confirm the right to remain for the 60,000 EU staff working in the NHS and provide a straightforward and inexpensive way for them to establish this right;
- commit to a future immigration policy supporting trusts to recruit and retain staff from around the world to fill posts that cannot be filled by the domestic workforce in the short to medium term.

The Department of Health and the NHS national bodies should:

- work with trusts, higher education institutions, and unions, providing strategic leadership, to ensure the intended 25% increase of nursing students from 2018 is delivered and any risks to application rates or the number of places set to be offered are identified, monitored, and addressed as required. The experience of 2017 has shown we cannot just assume an announced expansion of students will actually happen;
- work with trusts to develop an international recruitment programme that trusts can choose to pay to opt into, rather than undertaking their own individual recruitment campaigns. The Global Health Exchange *Earn, learn and return* pilot programme is a sensible place to start and could be run on an indefinite basis, positioning the NHS in England as a global centre of excellence for healthcare education.

The Nursing and Midwifery Council should:

- continue to progress at pace its review of language requirements for the registration of non-UK nurses, maintaining patient safety and engaging with provider trusts and other stakeholders.

MAKING THE NHS A GREAT PLACE TO WORK

3

Recruitment and retention as well as the supply of new staff is a vital factor in understanding and closing the workforce gap.

Provider trusts are employers and have a responsibility to make their organisations great places to work. There is certainly more that trusts can do. At the same time, retention is becoming increasingly difficult given the mounting pressure the sector as a whole is under.

National data shows that across staff groups there is a common trend of rising leaver rates since 2010-11. Figure 5 illustrates the increase for doctors (14.4% to 15.5%), nurses and health visitors (8.6% to 10.4%), midwives (7.4% to 10.0%), ambulance staff (4.8% to 7.6%), support to clinical staff (10.6% to 11.2%), and scientific, therapeutic, and technical staff (9.3% to 11.2%).

Figure 5
NHS leaver rates by staff group between 2010/11 and 2015/16

Leaver rates	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Doctors	14.4%	14.6%	14.5%	15.1%	14.5%	15.5%
Nurses and health visitors	8.6%	10.1%	9.7%	9.5%	10.1%	10.4%
Midwives	7.4%	8.0%	8.4%	8.7%	9.5%	10.0%
Ambulance staff	4.8%	5.0%	6.0%	6.8%	7.4%	7.6%
Scientific, therapeutic and technical staff	9.3%	11.2%	10.7%	10.3%	11.1%	11.2%
Support to clinical staff	10.6%	12.3%	10.6%	10.5%	11.1%	11.2%

Based on NHS Digital data for trusts and clinical commissioning groups in England.

The publicly available retention data cannot be broken down by region and importantly does not distinguish between staff who leave one NHS organisation to work in another and those who leave the NHS altogether.

What is clear is that there is no point training and recruiting staff to work in the NHS if they then leave and do not return.

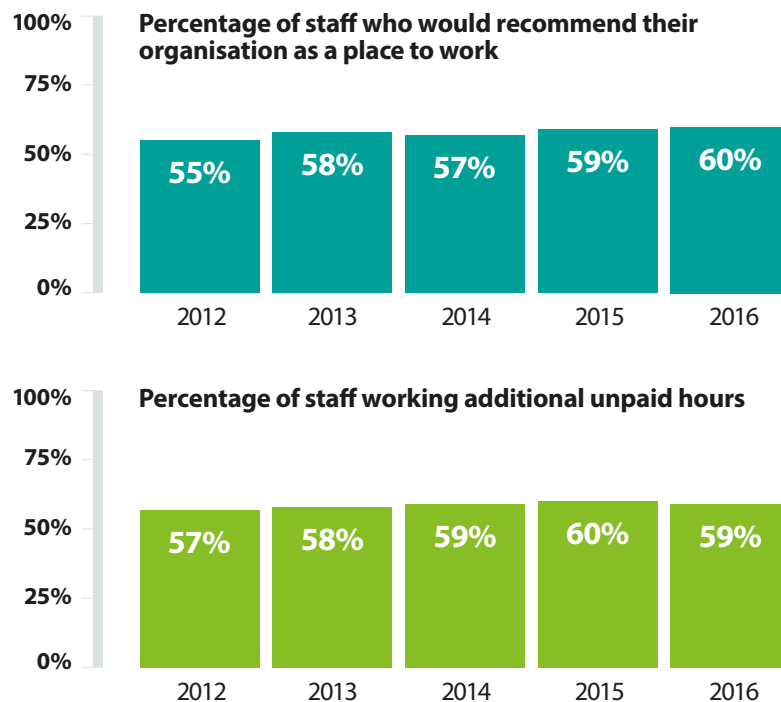
The challenge for provider trusts

Provider trusts recognise this and have had a sustained focus on making their organisations great places to work. NHS Employers has a programme to support trusts to improve retention and has recently launched a new toolkit.³⁰

Figure 6 illustrates that the proportion of staff who would recommend their organisation as a place to work has actually increased between 2012 and 2016.

Figure 6
NHS staff survey responses between 2012 and 2016

Based on NHS staff survey data



Yet there is much more that provider trusts need to do to make their organisations great places to work.

Bullying remains a real concern. In the 2016 NHS staff survey, 25% of staff reported experiencing harassment, bullying or abuse from fellow staff, similar to recent years.³¹ Black and minority ethnic (BME) staff are more likely to experience harassment, bullying, or abuse. The workforce race equality standard has powerfully shone a light on the experiences and career opportunities of BME staff and trusts must demonstrate progress on developing positive and inclusive cultures and valuing and improving the experiences of BME staff.

There is also a great deal that trusts can do to improve junior doctors' experience of working and training in the NHS. Following the acrimonious junior doctor contract dispute, many trusts, in addition to implementing the new contract, have begun to make changes to address non-contractual day-to-day issues. NHS Improvement has helpfully collected some case studies.³²

More widely, there is also a need for a new psychological contract for generations of younger workers who are looking for a different employment relationship, as highlighted by *Mind the gap: Exploring the needs of early career nurses and midwives in the workplace*, commissioned by NHS organisations in Birmingham and Solihull with Health Education England.³³

'Generation Y' (born 1980-94) make up an increasing proportion of the NHS workforce, as earlier generations reach retirement age or take early retirement. Also known as 'millennials', these younger workers tend to be career motivated and want support from their employer to achieve. They value flexibility and work-life balance is a must. They also tend to be prepared to seek work opportunities elsewhere if their needs are not met.

Meanwhile, 'Generation Z' (born 1995-2012), who are only just beginning to enter the NHS workforce, tend to be less likely to engage with traditional work environments, are likely to move jobs, and are fully immersed in digital technology.³⁴

If the NHS wants to recruit and retain younger generations, it will have to adapt its employment offer or they will go elsewhere. The secretary of state recently announced pilots of new apps to improve flexible working for NHS.³⁵ Greater flexibility is a good starting point. Yet while there is a lot of discussion of working generations within the NHS, it is yet to translate into widespread practical action on the ground, and there is a sense that other sectors of the economy have been quicker to adapt their employment offers.

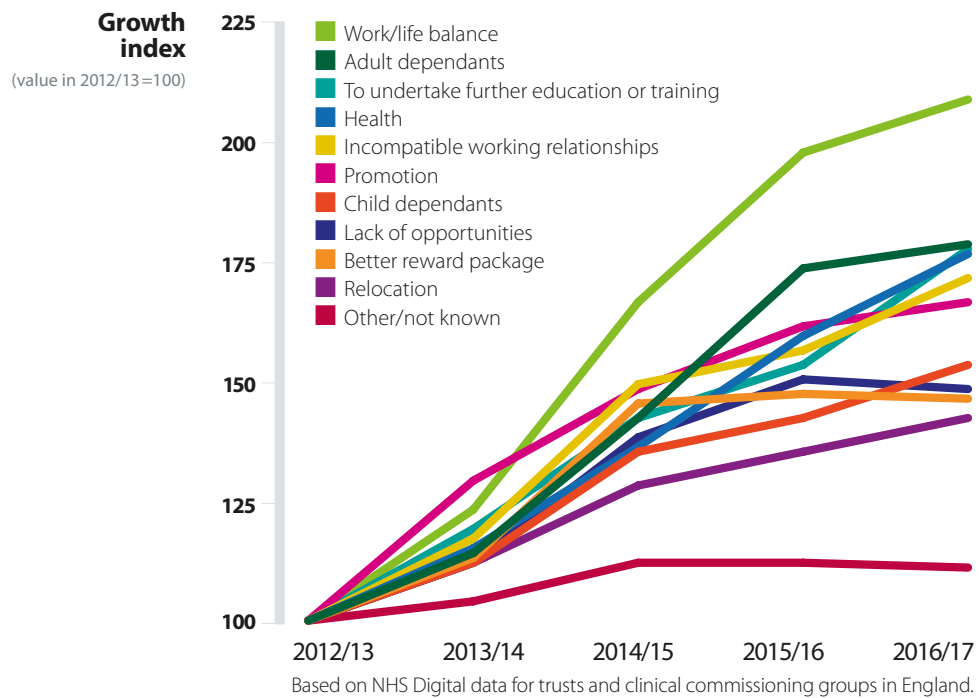
National-level factors influencing staff experience

There are, however, critical factors that are largely outside of provider trusts' control. In particular, it has become increasingly difficult to retain staff as the job gets harder, workforce development budgets are cut, and real pay continues to fall.

As one trust leader put it: "The NHS is significantly dependent on the 'heroic' efforts of clinical and non-clinical colleagues in responding to increasing service demand within an environment of ever-challenging financial constraints (including pay/reward controls) that compromises work/life balance, learning and development and overall job satisfaction."

Figure 7 illustrates that work-life balance is now the fastest growing reason for voluntary resignation of NHS staff.

Figure 7
Growth in reasons for voluntary resignation
between 2012/13 and 2016/17



The growth in work-life balance as a reason for leaving the NHS probably reflects the impact of the discretionary effort staff are being asked to put in. This was shown in the 2016 NHS staff survey, illustrated in figure 6 above, where 59% of staff reported working additional unpaid hours, up from 57% in 2012. It may be reasonable to ask staff to occasionally work extra hours, but to ask them to do so regularly as at present is not sustainable. When asked for some of the biggest challenges to recruitment and retention at their trust, 60% of trust chairs and chief executives cited work pressure.

NHS Employers analysis of its staff retention programme that it delivered with provider trusts has found career development and ongoing training were key reasons for staff choosing to stay in or leave their jobs. Yet the workforce development funding (often used for continual professional development) distributed among trusts by Health Education England (HEE) has been cut. In 2015 it was £205m but this year it is £83m.³⁶ The cuts reflect reductions to HEE's own budget, but it has left a funding gap that provider trusts are unable to fill given the pressure on their finances. These cuts to workforce development funding also have an adverse impact on retention and hamper trusts' efforts to make their organisations great places to work for staff who value career development.

Between 2010 and 2017 the real value of NHS staff's pay has also fallen by 6% (while in the economy as a whole pay has fallen by only 2%)³⁷ and pay restraint has begun to bite in terms of recruitment and retention. When asked about the biggest challenges to recruitment

and retention at their trust, 38% of trust chairs and chief executives cited pay and reward. According to the Institute of Fiscal Studies, the cost of a 2% pay award for the NHS would be £1bn annually.³⁸ This level of funding cannot currently be absorbed within the existing financial allocation for the NHS. Therefore an end to pay restraint must be fully funded. Even then, there is a serious risk that ending pay restraint eats up most or all of the extra NHS £8bn promised in the Conservative manifesto. This cannot happen when we have so many other pressing demands. Difficult decisions will need to be made and it is particularly important that such decisions are made with rigour and careful thought. Trusts support the pay review body mechanism as the best way to ensure this.

Provider trusts believe that more could be done at a national level to promote the NHS as a great place to work and make the most of the resonance of the NHS brand across the country. National campaigns have been used for school teachers and the armed forces.

Making the NHS a great place to work – what needs to happen

Provider trusts should:

- continue to prioritise making their organisations great places to work, fostering positive and inclusive cultures, eliminating bullying at all levels, and delivering progress against the workforce race equality standard.

The government should:

- take a realistic view of what is asked of the NHS and the funding that trusts are allocated in order to alleviate the stress and pressure on NHS staff which is contributing to the workforce gap. Staff need to feel that the job is 'doable' and that they can care for patients and service users safely. We have previously backed calls for an Office of Health and Social Care Sustainability which could promote a realistic assessment of what is needed;
- set out a plan to deliver the promised end of pay restraint during this parliament. According to the Institute of Fiscal Studies, the cost of a 2% pay award for the NHS would be £1bn annually.³⁹ This level of funding cannot currently be absorbed within the existing financial allocation for the NHS. Therefore this must be fully funded.

The Department of Health and the NHS national bodies should:

- reverse the cuts to workforce development funds distributed to trusts by HEE, to support staff retention and the delivery of sustainability and transformation partnerships and new care models;
- work with trusts and unions to deliver a national recruitment campaign for the NHS, promoting healthcare careers and the NHS as a great place to work;
- continue to support provider trusts with programmes to reduce leaver rates and improve retention rates.

WORKFORCE DEVELOPMENT AND PRODUCTIVITY

4

The response to the workforce gap provider trusts face is not only about numbers. We also need a clinical workforce that is skilled and equipped to work in new ways to support service transformation to deal with the changing needs of the population. Sustainability and transformation partnerships (STPs) are a placed-based approach to delivering integrated care and addressing the mounting pressure the NHS faces. STPs are intended to improve quality, health and wellbeing, and help local care systems achieve financial balance.

To achieve this, STPs are expected to deliver new care models, developing more integrated workforces to move care closer to home, with much focus currently on accountable care organisations and accountable care systems.

As the original *Five-year forward view*, which began the move towards new care models and ultimately STPs, recognised: "We can design innovative new care models [and, we could add, STPs], but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it".⁴⁰

As one trust leader put it: "We are trying to transform services at a time when the pressures on daily delivery have never been greater. We therefore face both a capacity and capability gap across all areas. This gap is being managed by staff working harder and longer and we have to question how sustainable this position is."

Today's workforce is to a large extent tomorrow's workforce. And so workforce development has to be at the heart of STPs and new care models.

Local workforce action boards (LWABs) have been set up across England by Health Education England (HEE) to lead the workforce element of STPs, but trusts tell us that as yet their progress is mixed. It is not yet clear that most STPs have been able to develop robust workforce plans.

One promising example of how HEE can support the development of a regional plan through the local workforce action board is Greater Manchester. The workforce strategy and 2017/18 implementation plan developed by Greater Manchester Health and Social Care Partnership (GMHSCP) and HEE takes a joined-up, long-term, and practical approach to developing the health and social care workforce the region needs.⁴¹ The GMHSCP strategic workforce board is the LWAB as part of a unique memorandum of understanding agreement.

Greater Manchester Health and Social Care workforce strategy

The Greater Manchester Health and Social Care Partnership is overseeing the devolution of responsibility for the region's £6bn health and social care budget. Greater Manchester's (GM's) workforce strategy* is a key enabler of their ambition to transform, integrate and improve healthcare for their population. It provides a compelling strategic vision and practical plan to develop the capacity and capability of the workforce of today and in the future. The strategy identifies key priorities based on local needs and outlines system-wide implementation plans. Priority areas include investing in talent development and system leadership, growing their own staff, improving the employment offer and brand, and filling staff shortages. By working closely with Health Education England, NHS England and NHS Improvement, the GM region has demonstrated how an innovative approach to working with national bodies as well as local stakeholders can support the design and delivery of an integrated health and social care workforce strategy. The new mayor has also identified the NHS and wider workforce as a key priority. This joined-up approach to workforce planning is a promising example of devolved strategic workforce planning across a geographic footprint. However, it is important to note that organisations in this region have been working collaboratively for years, which supports change at pace and at scale.

* Greater Manchester Health and Social Care Partnership, https://greatermanchester-my.sharepoint.com/personal/rionagrainger_gmhsc_org/_layouts/15/guestaccess.aspx?docid=0487f66c0279a45bc8eba6e6e99cd8160&authkey=AeJeiMRRyUycOahbGIta1jI [accessed 23 October 2017]

The Nuffield Trust report, *Reshaping the workforce to deliver the care patients need*, commissioned by NHS Employers, sets out how trusts can develop the workforce in these ways to support new care models and meet the changing needs of patients. The report includes helpful case studies of how changes have been successfully made.⁴²

Examples of workforce development

Having the right mix of staff and skills is essential for the delivery of high-quality care. In the context of the wider health and care sector increasingly working together across organisational boundaries, trusts are redesigning the workforce to meet the needs of their population and deliver new models of care. This workforce redesign has also been part of the solution in some areas and specialities to the absence of sufficient numbers of nurses and doctors. These changes to the skills mix in teams and the way in which staff work together can therefore deliver improvements for patients, staff and an organisation's finances.

Developing new roles can also enhance multidisciplinary team working, free up others' workloads and reduce agency spend on hard to recruit to positions. Examples of these new roles include:

- assistant nurse practitioners screening patients in A&E departments
- nurse-led intravitreal injection services
- nursing associates that bridge the gap between registered nurses and healthcare assistants
- nurse angiographers (coronary angiography is an X-ray test which uses dye to check for blocked or narrowed coronary arteries)
- prescribing pharmacists.

However, provider trusts need support from the NHS national bodies and professional bodies to successfully develop, embed and scale up the expansion of these new roles. The royal colleges have a role to play in not only acknowledging the potential of these new roles but also taking a brave step forward and supporting trusts to embed them in all their flexibility. Regulation, at an appropriate level, is required to give the professional bodies this confidence and to enable trusts to fully adopt and benefit from these new roles. Both trusts and the professional bodies need national understanding, support and agreement from the Care Quality Commission and NHS Improvement. The regulators need to appropriately incorporate these new roles into their regulatory approach where necessary. Although trusts recognise that this may need changes in the law that are unlikely in the short term, there is a real need for national support to enable trusts to redesign the workforce and provide patients with the best quality care.

It's concerning, however, that as noted previously, workforce development funding for non-medical clinical staff distributed by HEE has been cut 60% in two years. It is not reasonable to expect staff to work in new ways and in new settings, such as in the community, when there is little funding for training to support them to do so. The cut to this funding is a barrier to workforce development and the delivery of new care models and STPs.

Productivity

The response to the workforce challenges provider trusts face also involves improving workforce productivity to narrow the workforce gap.

Lord Carter's productivity review identified a potential £2bn saving from the NHS workforce budget through better use of clinical staff, including skill mix changes described above, reducing agency spend and absences, and adopting good people management practices.⁴³

The clinically-led *Getting it right first time* (GIRFT) programme also points to better patient outcomes leading to potential workforce productivity improvements. A pilot, focused on orthopaedic surgery, delivered a £50m saving over two years.⁴⁴ GIRFT is now being rolled out to other clinical areas. It is estimated that £160m annually could be saved through applying GIRFT to general surgery.⁴⁵

Trusts have already worked with NHS Improvement to reduce agency spend by almost £1bn since the introduction of price caps and rules.⁴⁶ In part this has been achieved through better use of e-rostering for clinical staff.

Improving workforce productivity is an important part of how the provider sector can address the current workforce challenges. Trusts must do all that they can, with support from the NHS national bodies. However, productivity is not the whole answer and on its own will be insufficient to close the workforce gap providers face.

Workforce development and productivity – what needs to happen

Provider trusts should:

- continue to make the most of opportunities to develop the workforce and improve workforce productivity.

The NHS national bodies, professional regulators, and royal colleges should:

- support and enable provider trusts' efforts to introduce new roles at scale and pace and develop the existing workforce to work differently, by aligning professional and institutional regulatory approaches and offering professional support.

The Department of Health and the NHS national bodies should:

- continue to support provider trusts with programmes to enhance workforce productivity by reducing agency spend and implementing the workforce elements of Lord Carter's productivity review and GIRFT.

LEADERSHIP AND CULTURE

Effective leadership and a positive and inclusive culture are fundamental to the success of the NHS – nationally and locally. This is even more the case at a time of mounting pressure with the need to improve performance, transform services, and close the workforce gap.

Staff engagement is impacted by leadership – at all levels – and culture within trusts, and these together, as the Care Quality Commission has recognised, are linked to care quality.⁴⁷

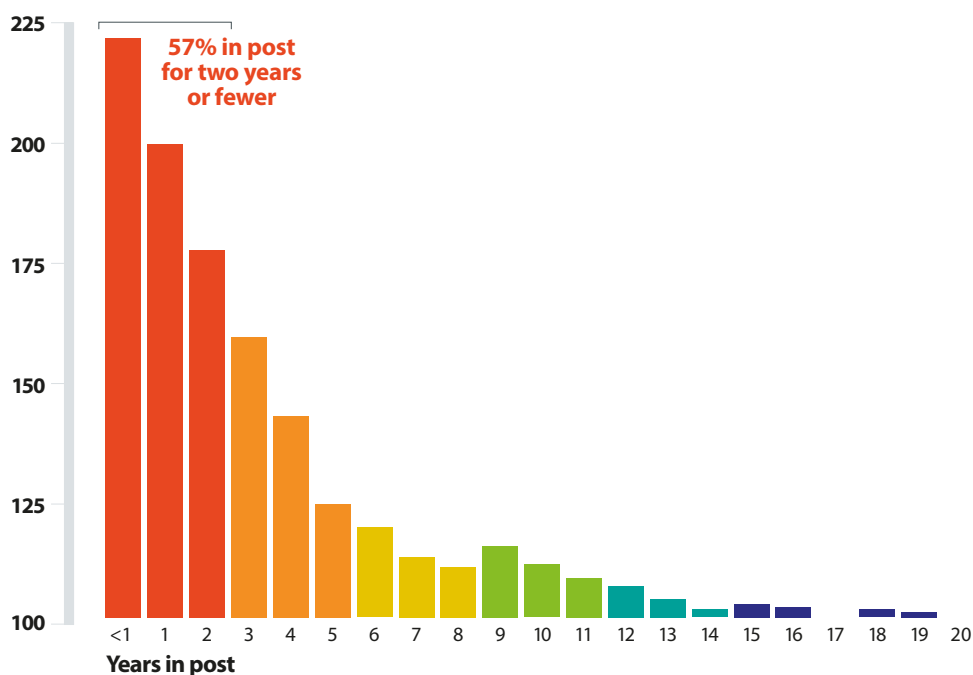
Valuing and developing the NHS' diverse workforce – which supports inclusive and high-quality care – requires positive and inclusive cultures and leaders with the values and skills to foster them. Leadership is not just limited to board level. Line managers at all levels hold the responsibility of sharing the vision, values and activities of the team, department and organisation and have a huge impact on engagement and retention. This is key to the challenge of eliminating bullying at all levels of trusts and improving the experiences of black and minority ethnic staff.

Yet provider trust leadership capacity and capability is being stretched thinner and thinner. Trusts tell us they are finding it more and more difficult to recruit and retain board-level leaders to provide the stability and sustained focus required. Chief executive roles, in particular, are hard to do and difficult to fill, especially at trusts facing the greatest performance challenges.

Figure 8 illustrates the results of our most recent board remuneration survey, and reveals that 57% of provider trust executive directors had been in post for two years or fewer.

Figure 8
Executive directors – time in post as of November 2016

Based on data from NHS Providers board remuneration survey for 2016 (n=943)



Provider trusts are expected to meet a wide and ever-growing range of objectives and priorities. There is a need for much greater honesty and realism on what it is reasonable to expect trust leaders to deliver given the complexity and extent of the strategic challenges providers face. The Department of Health and the NHS national bodies need to be much clearer on what really are the priorities to enable the matching of available leadership capacity to these.

NHS national bodies also need to recognise that their primary role is to support provider trust leaders – modelling the compassionate leadership they want to see. This support must be much better balanced with the present ‘regulate and hold to account’ approach. While NHS trust boards must be held to account for delivery, including an appropriate degree of performance stretch, removal of senior leaders should always be the last resort. They also need to publicly communicate the valuable role played by provider trust leaders and acknowledge the difficulty and complexity of these roles in the current environment.

Investment in leadership skills and capacity is vital. The leadership pipeline needs to be addressed, building on the national framework for improvement and leadership development,⁴⁸ the aspiring chief executive programme,⁴⁹ and the wider work of the NHS Leadership Academy following its incorporation within Health Education England.

Leadership and culture – what needs to happen

The Department of Health and the NHS national bodies should:

- publicly value frontline leaders’ roles, acknowledging the pressure they are under and take a realistic view of what can be achieved and support them to deliver it;
- work with provider trusts to address the leadership pipeline, building the national framework for improvement and leadership development, the aspiring chief executive programme, and the wider work of the NHS Leadership Academy;
- continue to support provider trusts with programmes to develop positive and inclusive cultures that empower staff to deliver safe and high-quality care for patients.

FRAGMENTED RESPONSIBILITY

The workforce gap has developed in plain sight. The fact that such a large problem has developed in this way suggests that NHS strategy, planning, and policy-making structure and approach in this area is flawed and needs urgent review.

This has been widely recognised. In June 2016 the House of Commons health select committee in its report on managing clinical workforce supply, concluded that:

“The Department of Health and its arm’s-length bodies have provided ineffective leadership and support, giving trusts conflicting messages about how to balance safe staffing with the need to make efficiency savings. In addition, overseas recruitment and return-to-practice initiatives, which could help address current shortfalls, have been poorly coordinated. The national bodies need to get a better grip on the supply of clinical staff in order to address current and future workforce pressures.”

More recently, the House of Lords select committee on the long-term sustainability of the NHS said in its report of April 2017:

“We are concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10-15 years. In our view this represents the biggest internal threat to the sustainability of the NHS. Much of the work being carried out to reshape the workforce is fragmented across different bodies with little strategic direction from the Department of Health.”

And in the run up to the recent June 2017 general election, the independent think tank the Health Foundation, in its pre-election briefing, concluded:

“The NHS still has no overarching strategy for its workforce. Piecemeal policymaking, however well intentioned any individual initiative might be, is not serving the NHS well.”

Figure 9
Examples of disjointed workforce strategy, planning, and policy

National decision	What trusts need/needed
Announcement in August 2017 of extra clinical placement funding for healthcare student places due to start in autumn the same year	More notice to allow trusts and higher education institutions to plan to increase student numbers
Immigration policy that makes international recruitment more difficult and expensive	Support for international recruitment that recognises a lack of domestic supply and does not impose financial charges
Cuts to workforce development funding	Protected or enhanced workforce development funding which recognises the links to retention and transformation of services
Pay restraint for NHS staff	Fully-funded end to pay restraint that recognises the impact it is now having on staff retention and morale
Roll out of seven-day services	Workforce impact assessment and communication of implications to trusts and staff

Yet, the Department of Health and the NHS national bodies have been slow to respond and the action that has been taken has been piecemeal, creating confusion among provider trusts and staff as to what the overall strategy is and a lack of confidence that the array of initiatives that have been announced will succeed in closing the workforce gap. According to our recent survey, 90% of trust chairs and chief executives are worried or very worried about whether the Department of Health and the NHS national bodies' approach to workforce strategy, planning, and policy will support their trust to recruit and retain the staff they need. This is deeply concerning.

There has also been an over-focus on the pipeline of future staff. The supply of future staff is essential. But too often issues and actions that need to be addressed in the short term have been overlooked, with the NHS expected to hang tough until the longer-term actions come to fruition. More energy and money needs to focus on shorter-term ways of mitigating the workforce gap.

A coherent approach

There has been a lack of joined-up thinking and action due to the fragmentation of responsibility for workforce strategy, planning, and policy across the national bodies within the Health and Social Care Act landscape. While the Department of Health is ultimately accountable, responsibility for workforce strategy and policy is shared across the various NHS national bodies.

Figure 10
Responsibility for NHS workforce strategy, planning, and policy

	Department of Health and wider government	Health Education England	NHS Improvement	NHS England	NHS Employers	Provider trusts
Overall approach and accountability	●					
National pay awards and contracts	●				●	
Relations with unions					●	●
Employers association					●	
Workforce planning		●				●
Immigration policy	●					
NHS staff survey and staff wellbeing				●		●
Workforce equality standards				●		●
Culture and leadership development			●			●
New safe staffing resources			●			
Reducing agency spend and workforce productivity			●			●
Workforce development		●				●

The Department of Health, recognising this fragmentation, and the need for a more coordinated approach, has established a ministerial board on workforce. It brings together senior leaders from the NHS national bodies. While it is not in itself a problem, and is to some extent inevitable, that the various national bodies have workforce functions to fulfil, it is a problem when there is no overall agreement on what they want to achieve and how they will exercise their respective functions to do so. The ministerial board has an opportunity to develop and communicate a coherent and credible workforce strategy with plans to close the workforce gap.

If the ministerial board is to be the key forum overseeing and coordinating NHS workforce strategy, planning and policy, it needs to communicate effectively about its work, seek input from a wide range of opinion, be transparent about its work programme and be seen to engage effectively with provider trust leaders. While NHS Employers membership of the board is welcome, this is not a substitute for the above.

A credible approach

The piecemeal and lack of overall approach to workforce strategy and policy at the national level also reflects the political difficulty of acknowledging and addressing the funding gap linked to the workforce gap. In order to ensure sufficient supply, the training of future staff must be adequately funded. And, crucially, trusts must also be adequately funded to employ the levels of staff that they need to deliver high-quality care.

The migration advisory committee made this point in its conclusion to its partial review of the shortage occupation list in respect of nurses in March 2016:

"It is clear to us that the current shortage of nurses is largely of the health, care and independent sectors' own making. The sector's failed to train enough nurses or failed to make provision to train their own nurses should the supply of publicly-funded nurses fail. They have taken either no or insufficient account of the needs of other sectors when making their planning assumptions. They restricted pay growth. They have complex institutional structures, which blur the decision-making process and lead, among other things, to poor information and data making it difficult for them (and us) to understand and respond meaningfully to labour shortages. They did not learn the lessons from the late 1990s and early 2000s when a similar shortage (and reliance on foreign nurses) occurred. Almost all of these issues relate to, and are caused by, a desire to save money. But this is a choice, not a fixed fact. The government could invest more resource if it wanted to."

Decisions at the national level have often been swayed by resourcing decisions. In the case of pay restraint this is very clear. But it is also seen in the cutting of the workforce development budget at a time when the NHS is attempting to transform services.

A failure to face up to the funding gap at the national level also trickles down through the system to decisions made by provider trusts. As the Health Foundation put it in its report *Staffing matters, funding counts*:

“Effectively aligning staffing objectives with funding streams is also vital, but has often not been the case. This is not a direct result of technical shortcomings in the workforce planning approach (although sometimes ‘poor workforce planning’ has been a convenient excuse) but relates more to poor strategic coordination and conflicting political, funding and planning objectives and cycles.”⁵⁰

When preparing workforce plans, provider trusts are required to forecast their future demand for staff. While they may know how many staff they need to deliver high-quality care for patients, they will also know how much money they have been allocated to deliver services and will be expected to ensure they do not demand and employ more staff than they can afford. It would not be surprising therefore if some trusts submitted ‘affordability adjusted’ demand forecasts for clinical staff. To the extent that national-level forecasts of demand for staff are developed on a bottom-up basis, this can mean they understate the staffing levels that will be needed.

Efforts to close the workforce gap

The Department of Health and the NHS national bodies are taking action. There has been a somewhat bewildering array of announcements. But so far this has appeared piecemeal and it is not clear that the various initiatives will add up to the answer to the workforce gap the NHS faces. It doesn’t help that, as of October 2017, the 2017/18 workforce plan for England has still not been published and we are halfway through the financial year.

As one trust leader put it:

“Our staff are really our greatest asset and definitely go the extra mile for our patients but consistent workforce availability is vital to safety and quality and drives the money. It feels like there is no national focus or coherent plan. This is not something each trust can resolve on its own”.

As figure 11 illustrates, many of the initiatives will also take several years to bear fruit, whereas the NHS also needs action with short-term payoffs to address the workforce gap in the meantime, including international recruitment and decisions on issues that affect recruitment and retention.

As another trust leader put it:

“Extra training places resulting in more staff in three or five years does not solve the crisis.”

Figure 11
Recent workforce initiatives and when extra staff will be available

Initiative	When will extra staff be available
500 more medical students from 2018.	Graduate from 2023 and start postgraduate training, working in the NHS as junior doctors.
Another 1000 more medical students from 2019.	Graduate from 2024 and start postgraduate training, working in the NHS as junior doctors. Potentially 7500 medical graduates a year from 2024.
More clinical placement funding to enable an extra 25% (5,170) nursing students from 2018.	Enlarged cohort graduate from 2021 and available for recruitment into the NHS. Potentially 25,850 nurses a year graduating from 2021.
Small numbers of nursing apprentices starting in 2017 (less than 50) with more to come in 2018.	Less than 50 graduate from 2021. Second group, probably larger but of uncertain size, graduate from 2022.
2000 nursing associates in training at pilot sites with 5000 more to start in 2018 and 7500 to start in 2019.	First 2000 qualify from 2019. Cohort of 5000 qualify from 2020. Cohort of 7500 qualify from 2021. Potentially 14,000 qualified nursing associates working in NHS by 2021.
NHS Improvement retention programme launched in June 2017 aims to bring down leaver rates by 2020.	No hard targets for 2020, but NHS Improvement expects to see an impact on retention rates by then, including as required by the mental health workforce plan.
Mental health workforce plan launched August 2017.	By 2021 aims to have delivered 11,000 extra qualified mental health staff.
Emergency care workforce programme launched October 2017.	400 people entering emergency medicine training for a period of four years from 2018 as compared to 300 in 2017. Action to grow use of advanced clinical practitioners and physicians associates with emergency care.

Empowering provider trusts to lead on workforce

What our research and discussions with trusts has shown is that any workforce strategy will only work if there is a coherent and credible planning and policy-making structure that links and aligns what needs to be done at national level, regional level, and at an individual institutional level.

The current structure and approach clearly needs review. Trusts have lost confidence in current arrangements and there is a question as to whether a radical rethink is necessary.

Greater national coherence and credibility is part of the answer. But there should also be an important debate about what should be better done at the regional and institutional level. We are already seeing trusts and groups of trusts beginning to take greater responsibility for solving their current challenges and closing the workforce gap. But while they are increasingly taking on responsibility where national arrangements are seen to have fallen short, they have not yet been given the resources or developed the capability to support them to do this job effectively on a large scale.

There is a strong argument that appropriately resourcing trusts to take on greater workforce responsibilities, within STPS or other aggregated footprints, is the right direction of travel and needs to be encouraged and accelerated. Yet it raises big questions:

- What is best done at national, regional, and institutional level?
- If more is to be done below national level, what resources should be devolved and what should the regional or sub-regional footprint and infrastructure look like?
- What sub-national capability will need to be developed?

These are big questions but we think there should be a review to test the idea that the NHS should genuinely devolve more responsibility and resources for more workforce issues to the sub-national level. For example, there could be work on workforce planning and distribution of training budgets at the regional level, with trusts working closely with higher education institutions, while there may also be opportunities to address issues affecting staff wellbeing and recruitment and retention such as affordable housing for NHS staff. There is at present little appetite for regional pay arrangements. It is vital that provider trust leaders are fully involved in the review. Changes of this magnitude would need to be carefully thought through.

Fragmented responsibility – what needs to happen

In the medium term, the Department of Health and the NHS national bodies should:

- develop and communicate a coherent and credible strategy for the health and social care workforce, setting out what they think the future workforce needs to look like given the *Five-year forward view*, STPs, and new care models and what will be done, by whom, and by when to at the national level to develop that workforce;
- ensure the existing ministerial board on workforce is recognised as the forum to coordinate and own this strategy, in collaboration with provider trusts and other stakeholders. It needs to communicate effectively about its work, seek input from a wide range of opinion, be transparent about its work programme and be seen to engage effectively with provider trust leaders;
- develop a measurable plan with timetables to grow the domestic supply of clinical staff, taking account of relevant factors such as changes to the funding of healthcare education, the apprenticeship levy and targets, the expansion of nursing, and the recent workforce plans for mental health and emergency care workforces. This plan will link to and support the strategy;
- take action to ensure there is an agreed and publicly accessible source of timely and accurate national-level, regional, and trust-specific data for key workforce data such as vacancy rates and leaver rates;
- provide greater transparency of its workforce planning insight and data, for example timely publication of national and regional demand and supply forecasts for the different staff groups, together with the assumptions and any funding constraints that underpin them;
- work with provider trusts at the sub-national level – for example, devolved, groups of STPs, or STP-level as appropriate – to support the delivery of locally-owned workforce strategies and plans that support service transformation through provision of timely and tailored workforce planning insight and data.

For the longer term, the Department of Health and the NHS national bodies should:

- work with provider trusts and other stakeholders to explore the opportunities and risks of devolving elements of workforce responsibility and funding – for example medical education and training commissioning, distribution of clinical placement funding. This could be at devolved, groups of STPs, or STP level;
- develop the capability and capacity of provider trusts to take on this greater role, building on the lessons from the original plans for local education and training boards with strong provider leadership. The return on this investment could be a more engaged, responsive, and productive workforce;
- build and value local leadership and autonomy as crucial for the success of STPs and new care models.

WHAT NEEDS TO HAPPEN TO SUPPORT TRUSTS TO RECRUIT AND RETAIN THE STAFF THEY NEED



Provider trusts recognise that to close the workforce gap they must make their organisations great places to work, develop the workforce to deliver STPs and new care models, and enhance workforce productivity.

Yet there are also important changes needed at the national level to support trusts to recruit and retain the staff they need and close the workforce gap.

Throughout the report we have set out recommendations for key parts of the system. Here we recap what needs to happen.

Short term (within one year)

Provider trusts should:

- prioritise making their organisations great places to work, fostering positive and inclusive cultures, eliminating bullying at all levels, and delivering progress against the workforce race equality standard;
- continue to make the most of opportunities to develop the workforce and improve workforce productivity.

The government should:

- take a realistic view of what is asked of the NHS and the funding they are allocated in order to alleviate the stress and pressure on NHS staff which is contributing to the workforce gap. Staff need to feel that the job is 'doable' and that they can care for patients and service users safely. We have previously backed calls for an Office of Health and Social Care Sustainability which could promote a realistic assessment of what is needed;
- set out a plan to deliver the promised end of pay restraint during this parliament. According to the Institute of Fiscal Studies, the cost of a 2% pay award for the NHS would be £1bn annually.⁵¹ This level of funding cannot currently be absorbed within the existing financial allocation for the NHS. Therefore this must be fully funded;
- urgently confirm the right to remain for the 60,000 EU staff working in the NHS and provide a straightforward and inexpensive way for them to establish this right;
- commit to a future immigration policy supporting trusts to recruit and retain staff from around the world to fill posts that cannot be filled by the domestic workforce in the short to medium term.

The Department of Health and the NHS national bodies should:

- reverse the cuts to workforce development funds distributed to trusts by HEE, to support staff retention and the delivery of STPs and new care models;
- work with trusts and unions to deliver a national recruitment campaign for the NHS, promoting healthcare careers and helping to balance the negative national narrative that so often accompanies debate about the NHS;

- work with trusts to develop an international recruitment programme that trusts can pay to opt into if they want to, rather than undertaking their own individual recruitment campaigns. The Global Health Exchange *Earn, learn and return* pilot programme is a sensible place to start and could be run on an indefinite basis, positioning the NHS in England as a global centre of excellence for healthcare education;
- work with trusts, higher education institutions, and unions, providing strategic leadership, to ensure the intended 25% increase of nursing students from 2018 is delivered and any risks to application rates or the number of places set to be offered are identified, monitored, and addressed as required. The experience of 2017 has shown we cannot assume an announced expansion of students will actually happen;
- recognise the pressure on provider trust leaders, take a realistic view of what can be achieved, support them, and publicly value their roles;
- continue to support provider trusts with programmes to:
 - reduce leaver rates and improve retention rates;
 - enhance workforce productivity by reducing agency spend and implementing the workforce elements of Lord Carter's productivity review and GIRFT;
- publicly value frontline leaders' roles, acknowledging the pressure they are under, take a realistic view of what can be achieved and support them to deliver it;
- work with provider trusts to address the leadership pipeline, building the national framework for improvement and leadership development, the aspiring chief executive programme, and the wider work of the NHS Leadership Academy.

The Nursing and Midwifery Council should:

- continue to progress at pace its review of language requirements for the registration of non-UK nurses, maintaining patient safety and engaging with provider trusts and other stakeholders.

The NHS national bodies, professional regulators, and professional associations should:

- support and enable provider trusts' efforts to introduce new roles at scale and pace and develop the existing workforce to work differently, by aligning professional and institutional regulatory approaches and offering professional support.

Medium term (within two years)

The Department of Health and the NHS national bodies should:

- develop and communicate a coherent and credible strategy for the health and social care workforce, setting out what they think the future workforce needs to look like given the *Five-year forward view*, STPs, and new care models and what will be done, by who, and by when to at the national level to develop that workforce;

- ensure the existing ministerial board on workforce is recognised as the forum to coordinate and own this strategy, in collaboration with provider trusts and other stakeholders. It needs to communicate effectively about its work, seek input from a wide range of opinion, be transparent about its work programme and be seen to engage effectively with provider trust leaders;
- develop a measurable plan with timetables to grow the domestic supply of clinical staff, taking account of relevant factors such as changes to the funding of healthcare education, the apprenticeship levy and targets, the expansion of nursing, and the recent workforce plans for mental health and emergency care workforces. This plan will link to and support the strategy;
- take action to ensure there is an agreed and publicly-accessible source of timely and accurate national-level, regional, and trust-specific data for key workforce data such as vacancy rates and leaver rates;
- provide greater transparency of its workforce planning insight and data, for example timely publication of national and regional demand and supply forecasts for the different staff groups, together with the assumptions and any funding constraints that underpin them;
- work with provider trusts at the sub-national level – for example, devolved, groups of STPs, or STP as appropriate – to support the delivery of locally-owned workforce strategies and plans that support service transformation through provision of timely and tailored workforce planning insight and data.

Long term (within three to four years)

The Department of Health and the NHS national bodies should:

- work with provider trusts and other stakeholders to explore the opportunities and risks of devolving elements of workforce responsibility and funding – for example medical education and training commissioning, distribution of clinical placement funding. This could be at devolved, groups of STPs, or STP level;
- develop the capability and capacity of provider trusts to take on this greater role, building on the lessons from the original plans for local education and training boards with strong provider leadership. The return on this investment could be a more engaged, responsive, and productive workforce;
- build and value local leadership and autonomy as crucial for the success of STPs and new care models.

CONCLUSION

The NHS has a talented and dedicated workforce, providing care to patients 24 hours a day, 7 days a week and 365 days a year. But it is struggling to cope with growing and changing pressures. We have now reached a tipping point: workforce concerns have become the single biggest risk facing services.

We need clarity and honesty about who is responsible for delivering a sustainable workforce, how we achieve the right balance between national, regional and institutional roles, and how we can work to overcome the challenges we face.

- The gap between the workforce that providers need and the staff they are able to recruit and retain is now unsustainable, putting patient safety and quality of care at risk. It may also undermine much-needed schemes to transform and modernise services.
- There are plans to increase domestic supply but it is far from clear this will be enough to meet current and future demand and new staff take several years to train. We will have to continue to recruit from the EU and the rest of the world. We need to be honest about the workforce supply gap we are facing.
- Trusts must continue to do all that they can to recruit and retain staff, making their organisations great places to work, with positive and inclusive cultures where bullying is not tolerated and staff from diverse backgrounds are valued and empowered to succeed. Providers must also take opportunities to develop the workforce to deliver care in new ways and improve workforce productivity.
- Finally we must be clear that the existing workforce is under substantial pressure. Staff are feeling overstretched and undervalued. We need to look at all the factors which are contributing to staff leaving the NHS, from pay to working conditions. Trust leaders, performing difficult and complex roles in highly pressured and challenged organisations, need support from the national level to do this.

NHS provider trusts can only go so far in tackling these challenges. A change of approach is urgently needed from the Department of Health and the NHS national bodies. Trusts do not have confidence in the current national approach, which lacks a coherent and credible strategy to support trusts in tackling the workforce challenges facing the NHS.

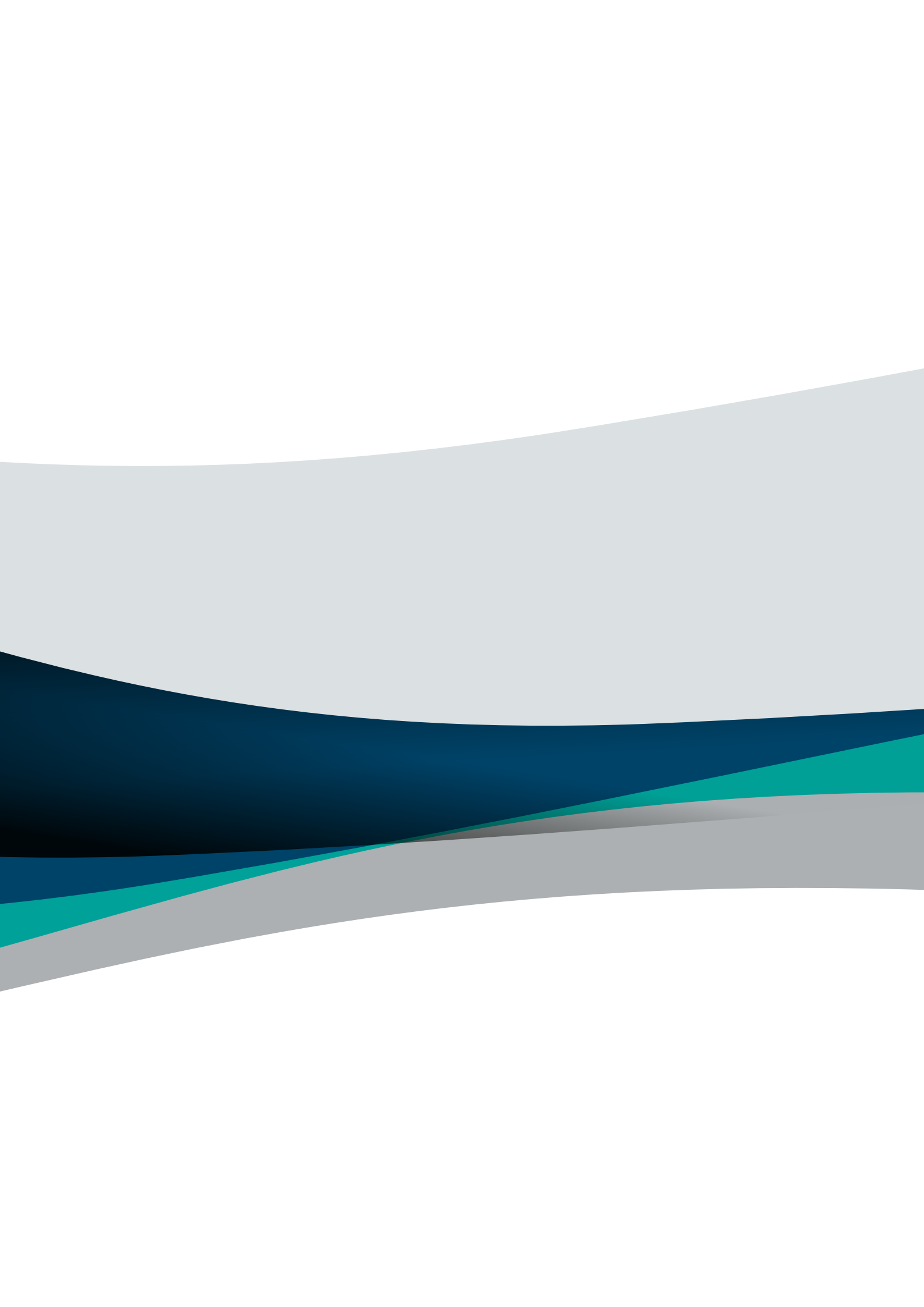
While our focus has been on the provider sector we recognise that these challenges need to be seen in the context of the wider health and social care workforce, including primary care, third sector organisations, and of course, the 'informal workforce' of family and friends who contribute so much to the care of loved ones. All these components of the health and social care workforce are interrelated. Sustainability and transformation partnerships and new care models offer an opportunity to take a more holistic approach to workforce strategy, planning, and policy. But we must act now to address these challenges.

This report is just the starting point and we look forward to working closely with trusts, the NHS national bodies, the Department of Health, and other stakeholders to ensure the provider sector has the workforce needed to deliver high-quality care.

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NHS Providers has 98% of all trusts in membership, collectively accounting for £74bn of annual expenditure and employing more than one million staff.



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