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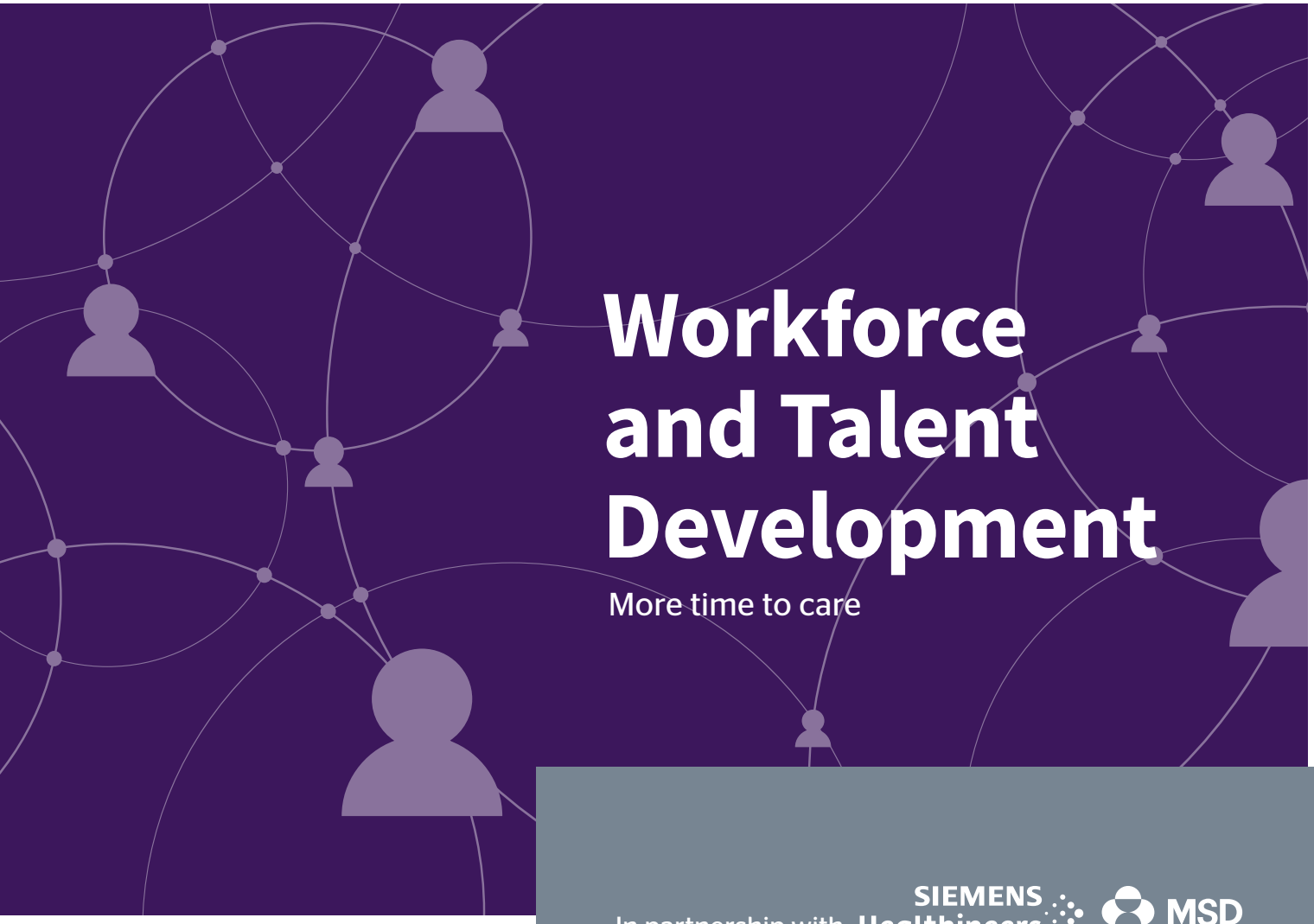

Workforce and Talent Development

More time to care

In partnership with SIEMENS Healthineers MSD

State of the Nation 2021

About Public Policy Projects

Public Policy Projects is an independent policy institute committed to global public policy reform. We bring together expert policymakers, stakeholders, academics and business leaders with a common interest in the future of public policy. PPP promotes policy reform through evidence-based research and ongoing analysis into healthcare, life sciences, environment, energy and international diplomacy. We promote a progressive, global and inherently liberal world view through a diverse portfolio of policy papers, publications, events and thought leadership.

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Acknowledgements

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Roundtable one: Getting in – Recruitment and diversity

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Roundtable two: Getting on – Development and innovation

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Roundtable three: Getting through – Wellbeing and retention

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- **Doctors in Distress**
- **East Sussex Healthcare NHS Trust - advocated by NHS Employers**
- **Anchor Hanover Group**

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Foreword: Professor Mike Bewick

Former Deputy NHS England Medical Director
Chair, Workforce and Talent Development, Public Policy Projects

The unprecedented demands faced by the health and care system during the Covid-19 pandemic laid bare the need for radical reforms to the way the workforce is planned, led, developed and supported. Chronic staff shortages, a failure to plan for future demand and a lack of attention to the mental and physical wellbeing of health and care workers combined with the pandemic to push the system and its people to the limits.

However, the response of health and care staff also showed what could be achieved, with multidisciplinary teams learning new skills and utilising new digital tools, innovations in care being rapidly trialled, assessed and scaled up, and volunteers mobilised to support staff.

This report aims to help build momentum for reform by laying out a series of policy recommendations across three key areas of workforce policy: getting in (recruitment and diversity); getting on (development and innovation); and getting through (wellbeing and retention). It brings together ideas ranging from how the health and care system should plan for future workforce needs to how it should develop digital skills and support the mental wellbeing of its staff.

The ideas have been developed through a series of roundtables with a wide range of experts from across the health and care system, who have generously given their time and insights, and builds on our interim report, Workforce and Talent Development, published in 2020.

While this report focuses primarily on the NHS, we have also highlighted the importance of, and connections with, social care. It is one of the key weaknesses in workforce planning that the NHS and social care are considered separately.

We hope these proposals will help stimulate long-overdue action to develop an approach to health and care that is fit for the digital age and values staff wellbeing alongside the care of service users.

Recommendations

Getting in – Recruitment and diversity

Ending the workforce planning blight

1: The government needs to commit to publishing regular projections of the demand for health and social care staff up to around 15 years ahead alongside a plan for how that demand will be met.

2: In the absence of a government commitment, the King's Fund, Health Foundation, Nuffield Trust and other stakeholders, such as the royal colleges and NHS Employers, should collaborate in producing their own long-term projections of the demand for health and care workers.

Turning on the training taps

3: Health Education England (HEE) and NHS England – which is soon to absorb HEE's functions – should work with the Medical Schools Council (which represents the UK's medical schools), Council of Deans of Health and the Royal College of Nursing (RCN) to develop options for government to increase substantially the number of doctors and nurses in training.

4: The government must ensure that a healthcare workforce strategy includes investment in educational capacity, particularly to recruit and retain medical and nursing staff in universities.

Retaining students and trainees

5: HEE the Medical Schools Council, Council of Deans of Health, RCN and UNISON should collaborate on researching and addressing the reasons why medical and nursing trainees quit before they have completed their training, and the Nursing and Midwifery Council (NMC) should consider whether to reduce the current requirement to complete 2,300 hours of clinical placement during training.

6: The government should encourage recruitment by increasing financial support for student nurses, midwives and allied health professionals.

Widening access

7: HEE and other stakeholders should aim to grow the number of medical apprenticeships significantly and continue to focus new medical school places in 'under-doctored' areas, as part of the drive to widen access to medical training.

Ethical recruitment from overseas

8: Employers need to recognise that it is a moral imperative to treat overseas staff with fairness and dignity, and reflect this in practical steps, such as ensuring fairness in promotion and development and providing intensive support for new staff. Fairness and dignity will also help retain overseas recruits and encourage them to reach their full potential.

9: The NHS, the Department of Health and Social Care (DHSC), NHS Employers and Care England should make clear that they regard the code of practice for the international recruitment of health and social care personnel as a mandatory requirement for all employers.

Getting on – Development and innovation

Preparing the workforce for digitally driven healthcare

10: The NHS should work with the royal colleges and other stakeholders, such as the Faculty of Clinical Informatics, to implement HEE's recommended development of standardised job roles for hybrid digital clinician positions, such as clinician-informaticians, to meet demand for a wider range and greater number of clinicians with digital skills.

Developing the digital skills of care workers

11: As integrated care systems develop, there needs to be parity in training and development across health and social care, particularly in ensuring digital readiness among all staff through joint training programmes.

Developing innovative clinical roles

12: Organisations should view redesigning roles as a potential route to liberating scarce clinical time and talent. It provides an opportunity to think about quality, the patient experience and how to use the skills and maximise the productivity of each member of the team. During the pandemic there were many inspiring examples of pathway redesign and staff developing their clinical roles and acquiring new skills. This capacity for highly effective innovation by clinical teams should strongly influence future training and leadership programmes.

Regulating the professions

13: Developments such as the growth of multidisciplinary teams and the increasing use of digital tools to support clinical decisions need to be fully reflected in regulations that are currently built around individual judgement and reflected in professional development and licensing programmes. New professional roles need to be recognised and their place in clinical teams clarified by improved professional regulation.

The right role for virtual training

14: While online learning and tools such as simulation offer many advantages, HEE and other stakeholders must implement them in ways that maintain or improve the quality of learning and widen access, ensuring they support rather than disadvantage groups of students such as those with fewer financial resources or students with disabilities.

Volunteers and reservists

15: The NHS nationally and locally, in collaboration with voluntary sector organisations, should build on the momentum from volunteering during the pandemic to build a significant cadre of volunteers to support NHS professionals while improving the patient experience. Volunteer posts should always be complementary to, not instead of, paid staff members.

16: While chronic workforce shortages persist, the NHS needs to maintain and expand a national register of retired clinical professionals and those who have left the profession mid-career who are willing to return to work at times of high pressure, making it easy for them to come forward at short notice.

Getting through – Wellbeing and retention

Supporting mental wellbeing

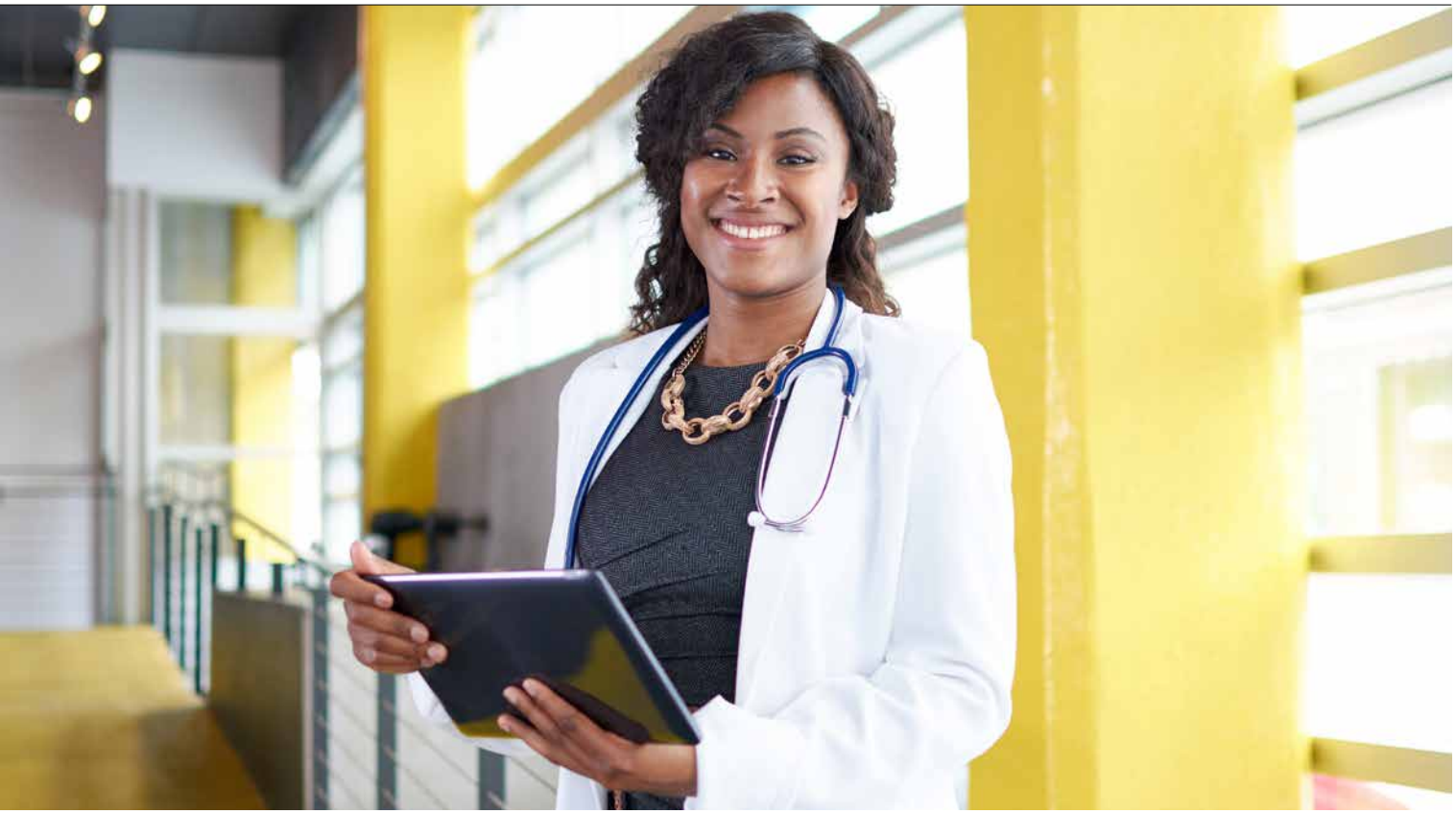
17: It must be recognised that the health and wellbeing of staff is of primary importance in building resilience in the health and social care workforce. The boards of provider organisations should engage with their staff to ensure early intervention to maintain the mental and physical health of each member of staff. This requires visible and persistent leadership to send a clear message that seeking help is the right thing to do and will be respected and celebrated. Staff who need help must be supported with professional advice and care.

18: Commissioners and providers should agree a common set of metrics to ensure that maintaining mental and physical health and resilience is monitored and acted on. This should include data on rates of sickness absence, availability of recuperation facilities and staff feedback. Ethnic and cultural diversity should be considered in designing the responses to such feedback.

19: Adverse working patterns that are known to increase burnout and stress, such as excessively long shifts, should be phased out.

Addressing discrimination and inequality

20: Health and care organisations must be held internally and externally accountable for their equality, diversity and inclusion statistics. Boards must embed clear measurable time-limited goals and the Care Quality Commission methodology must be strengthened to ensure that NHS Trusts and care organisations demonstrate serious progress on equality in order to receive a Good or Outstanding.



Current state of the health and care workforce

The NHS workforce

The NHS employs around 1.3 million people in England,[1] while there are more than 1.5 million working in adult social care.[2] Together they represent around 8.6 per cent of the working age population.[3]

About one in 10 NHS posts in England are vacant, amounting to more than 100,000 full-time equivalent (FTE) vacancies. Many of these roles are filled by locums and agency staff, contributing to the £200 million every month the NHS spends on temporary staff.[4]

Between 2010 and 2018 the number of doctors working in the NHS increased by 15 per cent while the number of FTE nurses hardly changed. During that time the amount of care provided by the health service grew by a third.[5] Quality and safety are compromised as nursing numbers are increasingly outstripped by activity levels.

Nurses

NHS Digital data shows a vacancy rate for nurses in England of 10.3 per cent in June 2021, around 39,000 vacancies.[6] About 17 per cent of nurses come from outside the UK.[7] There are considerable differences between places and specialties. For example, before the pandemic mental health trusts had a vacancy rate of 16 per cent, while London's overall rate was 15 per cent.[8]

In March 2020, the National Audit Office (NAO) reported that there had been a 5 per cent increase in students starting undergraduate nursing degrees between

2017 and 2019, compared with a target of 25 per cent. Among specialties particularly badly hit by workforce shortages, the NAO reported a 38 per cent drop in the number of learning disability nurses between 2010 and 2019.[9]

Doctors

There were around 9,700 vacant medical posts in June 2021, around 7 per cent of the total.[10] This ranged from 4.6 per cent in the south west to 9.4 per cent in London. While there were relatively few vacancies in specialist posts, numbers were particularly high in mental health, with vacancy rates of almost 20 per cent in the Midlands and 14 per cent in the north west and south west.

According to research by The BMJ, the number of doctors retiring early has more than trebled since 2008. While 401 GPs and hospital doctors in England and Wales took early retirement in 2007/08, 1,358 did so in 2020/21 – an increase of 239 per cent in 13 years. Problems of workload and burnout have been exacerbated by the risk of pension tax bills totalling tens of thousands if doctors continue working.[11]

The social care workforce

The social care workforce of 1.5 million includes 895,000 care workers, 34,000 registered nurses and 23,000 social workers (including around 3,000 employed by the NHS).[12] It is striking that there are more nurses than social workers in social care.

While dementia services account for the greatest proportion of jobs, large numbers of staff also work in learning disabilities and/or autism, and mental health. In the table below, the total number of roles substantially exceeds the workforce total because an establishment may offer services for people with multiple needs.

Estimated jobs by care and support need and sector, 2020–21

	Dementia	Learning disabilities and/or autism	Mental health
All sectors	890,000	735,000	610,000
Local authority	64,000	59,000	54,800
Independent	820,000	635,000	545,000
Direct payment recipients	4,600	42,000	9,800

Source: Skills for Care

According to Skills for Care, there was a vacancy rate of 7.3 per cent in August 2021, with 105,000 vacancies being advertised on a typical day in 2020/21.[13] About 24 per cent of jobs in the sector were zero-hours contracts, 27 per cent of the workforce were aged 55 and above, and the turnover rate averaged 30.4 per cent. This meant that 430,000 staff had left in the previous 12 months, two thirds of them to other roles in adult social care. Median hourly pay for care workers in the independent sector had risen by just 12 per cent between September 2012 and March 2020, from £7.60 to £8.50.

While the NHS is planned and run as a single system in each of the four nations, in England the adult social care workforce is distributed across 18,500 providers.[14] Since 2012 there has been a 33 per cent decline in the number of nurses working in social care, representing a loss of 17,000 staff.[15]

The NHS People Plan and the Future Doctor

We are the NHS: People Plan 2020/21 – action for us all, published in July 2020, was organised around four pillars: [16]

- Looking after staff, with the aim of providing universal health and wellbeing support
- Tackling discrimination
- Developing new ways of working and delivering care
- Improving recruitment and retention.

This plan was followed up in the operational planning guidance for 2021/22, which included: [17] [18]

- The stipulation that occupational health and wellbeing support should be available to all staff, including rapid access to psychological specialist support, backed by national investment to develop mental health hubs for staff in each integrated care system (ICS)
- The development of improvement plans based on the Workforce Race Equality Standard (WRES),[19] notably to improve diversity through recruitment and promotion practices
- The development of ICS local workforce supply plans, with a focus on both recruitment and retention, emphasising collaboration between employers to increase supply. The plans should include support for a major expansion of integrated teams in the community built around the primary care networks (PCNs). Local workforce plans should cover all sectors, which the guidance defines as mental health, community health, primary care and hospital services – social care is not included.

The King's Fund described the NHS People Plan as "another interim stop-gap and falls a long way short of the workforce strategy the NHS so desperately needs." While the focus on issues such as developing inclusive and compassionate leadership cultures and addressing race inequalities was welcomed, the King's Fund noted that "warm words will be worth little without a credible implementation plan", and said it required long-term investment and concrete commitments to recruit doctors, nurses and other staff.[20]

Following the People Plan, HEE unveiled the Future Doctor Programme, a "vision for the future clinical team", looking at the role of the doctor in the context of multidisciplinary teams, and how doctors interact with the evolving roles of other healthcare professionals.[21] This highlighted the need for greater partnership with patients, a greater breadth of generalist skills to enable the delivery of care for multiple conditions, a culture of working in "multi-professional" teams where each member is respected, valued and empowered, using technology as an enabler for change, and having flexibility in training and working, with access to portfolio careers.

It is important to note that the government does not have a workforce plan for either health or social care. With the sectors competing for both clinical and non-clinical staff, and the need for local health and care systems to think holistically about workforce requirements, there needs to be a national workforce strategy across the health and care sector.

Impact of the pandemic

The pandemic had a profound impact on every member of staff in health and social care. An inquiry by the House of Commons Health and Social Care Select Committee into workforce burnout in the NHS and social care highlighted how the unprecedented challenges of the pandemic had affected staff wellbeing.[22] Pressures included:

- Increased hours and workload
- The pressures of working with increased infection controls and accessing and using personal protective equipment (PPE)
- The emotional strain of seeing large numbers of patients dying
- Anxiety about their own and loved ones' health and infection risk
- Guilt experienced by those shielding or working from home
- Worries about being able to provide high-quality care
- Working in unfamiliar locations or with unfamiliar teams – according to the NHS staff survey, 18.5 per cent of staff were redeployed[23]
- Fears of working beyond their skills or knowledge
- Fears of dealing with an unfamiliar disease
- Increased safety risks because of reduced staff ratios
- Not knowing who to turn to for help
- Dealing with rapidly changing guidance.

There is compelling worldwide evidence of health and social care staff suffering from depression, anxiety and insomnia during the pandemic.[24] In June 2020, 92 per cent of 157 NHS trusts in England told NHS Providers that they were concerned about staff wellbeing, stress and burnout.[25] Burnout is described by the World Health Organization (WHO) as chronic workplace stress that has not been successfully managed. It is characterised by exhaustion, feeling mentally detached from or cynical about one's job, and a feeling of being unable to make a meaningful difference.[26] In an April 2020 survey of 1,000 people working in social care in Scotland, four in five reported that their mental health had been damaged by their work during the pandemic.[27]

Social care staff had to cope with feeling abandoned in the early weeks of the pandemic and feeling heartbroken at the death toll among the people they cared for. Care England told MPs during the inquiry into burnout that social care staff had to take the place of relatives and loved ones in helping residents isolate in their bedrooms and comforting them as they died.

The inquiry was presented with compelling evidence of the disproportionate impact of the pandemic on Black, Asian and Minority Ethnic (BAME) staff. This included higher death rates, a lower likelihood of being trained in using PPE, a higher likelihood of having a request for PPE refused, and BAME staff feeling more pressured to work with Covid-19 patients than their white counterparts. The first 10 doctors in the UK named as having died from Covid-19 were all from BAME backgrounds. According to The BMJ, 63 per cent of healthcare workers who died from Covid-19 were from BAME backgrounds.[28]

By late autumn 2021 NHS staff were still highlighting the pressures facing them. A poll of 1,008 by NHS Charities Together and YouGov found 96 per cent believed the pressures of Covid-19 would continue for years, while 83 per cent felt pressure on services was still growing significantly.[29]

The pandemic has also caused severe disruption to recruitment, training and development. A UNISON survey found that about 70 per cent of final-year student nurses and midwives who responded said they had missed out on key learning opportunities because of the pandemic.[30] With academic learning and clinical development disrupted, many did not feel prepared for their new career. Some reported relentless pressure to complete their training in time, including 50-hour weeks to make up required hours in clinical practice.

The pandemic had a substantial impact on the two-year foundation training programme for newly qualified doctors. In April 2020, final-year medical students graduated early and received early provisional General Medical Council (GMC) registration to start working with patients. Four foundation doctors who were part of this group described in Clinical Medicine Journal how mandatory teaching was reduced – partly to comply with social distancing requirements – and that they were often compelled to attending teaching sessions virtually on their mobile phones while still on the wards.[31]

While there were certainly positive experiences for these doctors, such as feeling part of a team that was learning together, they were deprived of important learning opportunities. There was less variety of clinical cases, many clinics became telephone or virtual – which minimised interaction with patients and reduced bedside teaching of clinical signs and examination skills – and they had less experience of communicating with both patients and families.

The pandemic caused considerable disruption to health and social care recruitment, as can be seen in a sharp drop in advertised vacancies between March and June 2020. NHS Digital was reporting continuing evidence of disruption in June 2021.[32]

The pandemic is worsening the global battle to attract and retain healthcare talent. Before Covid-19, the World Health Organization (WHO) projected that there would be a shortage of 18 million health workers by 2030, compared with demand for 80 million.[33] While lower- and middle-income countries would feel most of the pain, no one would escape.

In 2020, Italy passed an emergency decree to license migrant medical staff as it struggled to contain the pandemic, with France, the United Arab Emirates and several US states among those taking similar steps. Meanwhile countries who have traditionally supplied nurses and doctors have been taking measures to hold on to staff, such as increasing pay and requiring newly qualified personnel to work in that country for a set period.[34]

The pandemic looks likely to attract some people into healthcare careers while driving many out. In the UK, inspirational stories about the contribution of nursing to the pandemic response has led to applications for nursing degrees jumping by 21 per cent this year, with large rises also recorded for disciplines such as midwifery and physiotherapy.[35] This includes surges in both school leavers and people looking for a mid-life change of direction. In autumn 2021, almost 27,000 students were due to start a nursing degree, the highest number over the past decade and an 8 per cent increase over 2020.[36] The number of students beginning medical and dentistry courses is up 16 per cent on the previous year to 11,220. These numbers have been influenced by substantial increases in A level grades due to the unique circumstances of the pandemic.

Pandemic pressures are a symptom, not the cause

While many of the challenges of the pandemic have been unique, the underlying causes have often been long-term, systemic weaknesses in the way the health and care system manages its workforce.

The risk of the NHS being overwhelmed was exacerbated by the relatively low number of acute and intensive care beds compared with other major economies, the relatively low number of staff posts and the high number of vacancies. England has around 2.8 doctors per 1,000 people, while the average in comparable Organisation for Economic Co-operation and Development (OECD) EU countries is 3.7.[37] At the current rate of increase, the British Medical Association (BMA) claims it will take England 25 years to reach that average. The UK has around 7.8 nurses per 1,000 population compared with 13.2 in Germany, 10.8 in France and 12.9 in Ireland.[38]

Even before the pandemic, every part of the NHS – from primary care to acute services – was running 'hot', with growing difficulties accessing GP services, growing waiting lists for elective care and growing waiting times in A&E.

UNISON research just before the pandemic among healthcare staff on the impact of staffing shortages on their own health and wellbeing found this included dehydration and poor diet, poor concentration, being impatient and irritable, feeling drained, anxious and stressed, feeling inadequate, feeling pressurised into taking extra shifts, and dreading going into work.[39]

Getting in – Recruitment and diversity

Ending the workforce planning blight

A fundamental weakness in health and social care is the failure of successive governments to plan for and meet future workforce needs. This has resulted in many years of chronic understaffing, persistently high levels of vacancies and dependency on overseas recruitment.

Since it takes 13 years for a new medical student to become a consultant, the NHS does not have the luxury of working to short timescales and quick fixes – long-term planning is essential.

A survey by NHS Providers in 2019 found fewer than one in five trusts was confident of having the right numbers, quality and mix of staff in two years' time.[40] Shortages affect virtually all disciplines, from midwifery to emergency medicine. In some parts of the country hospitals struggle to provide safe staffing levels.

Primary care is a growing concern. In August 2021 there were 27,600 FTE fully qualified GPs, representing a headcount of 37,000. The number of patients per practice increased from 7,465 in September 2015 to 9,223 in March 2021. During that time the number of fully qualified FTE GPs decreased by 4.4 per cent, or 1,307 doctors.[41] The difficulties have been increased by growing numbers of doctors opting to work fewer hours.

Yet despite growing demand for services, the growing scale and complexity of the services being delivered, the chronic shortage of posts in the NHS and the high level of vacancies, there are still no official projections of long-term staffing requirements for doctors, nurses or allied health professionals published by the government, NHS England or HEE.

The DHSC has overall responsibility for the NHS and social care workforce. HEE oversees workforce planning, education and training and funds providers to host clinical placements. NHS England and NHS Improvement provide general oversight of the NHS workforce and lead on much of the policy development and implementation. By 2023 NHS England will absorb HEE's functions.[42]

The NHS workforce has a substantial and direct impact on two of government's biggest and most high-profile responsibilities – spending and immigration. It is difficult to understand how any government can make informed decisions about these two areas without robust analysis and projections around the NHS workforce.

Informed debate on workforce planning is constrained by the refusal of NHS England to publish the recommendations it has made to HM Treasury for the workforce needed to deliver the NHS Long Term Plan published in January 2019.[43]

The King's Fund, Health Foundation and Nuffield Trust have proposed placing a duty on HEE to publish annual projections of the future supply and projected demand for the healthcare workforce for a 15-year period, consistent with the long-term projections of healthcare spending produced by the Office for Budget Responsibility, along with a similar requirement on the Secretary of State for Health and Social Care to publish projections for the social care workforce.[44] Proposals along these lines have also been made by the Academy of Medical Royal Colleges and the Royal College of Nursing (RCN). But the government refused to accept an amendment to the Health and Care Bill[45] introducing a duty to estimate or plan for future workforce needs.

Refusing to accept the need for workforce planning may save ministers from difficult choices about recruitment and costs, but it will not save them from dealing with the highly public consequences of staff shortages. With the system running at full capacity, the growing demand from an ageing population means the NHS will constantly be struggling to cope. As well as failing to meet the needs of patients, this will also drastically curtail the ability of the health service to introduce transformational changes such as moving care into the community, focusing more on prevention and early intervention through primary care, and digitising services.

Particularly in the aftermath of the pandemic, current staff need to believe there is a credible plan for finally addressing the chronic staff shortages. If they do not believe there is any respite in sight, there is a serious risk that many more will choose to leave their profession.

Recommendation 1: *The government needs to commit to publishing regular projections of the demand for health and social care staff up to around 15 years ahead alongside a plan for how that demand will be met.*

Recommendation 2: *In the absence of a government commitment, the King's Fund, Health Foundation, Nuffield Trust and other stakeholders, such as the royal colleges and NHS Employers, should collaborate in producing their own long-term projections of the demand for health and care workers.*

CASE STUDY – MEDICAL WORKFORCE PLANNING IN THE NETHERLANDS

In his book Human: Solving the global workforce crisis in healthcare, Mark Britnell says the Netherlands has used a demand-led forecasting model for many years to enable centralised decision making about the appropriate number of medical and specialist training places for doctors, after a looming shortage of GPs and medical specialists became apparent in the 1990s.[46]

The model looks about 15 to 20 years ahead. Elements it attempts to assess include labour market migration, sociocultural developments, changes in working practices, technological developments, and the movement of tasks within and between professions. It involves extensive consultations with professional bodies, employers, universities and health insurers, and uses a wide range of data sources. On the back of all this, the health ministry decides how many training places to fund.

An independent study points to impressive results in reducing the unmet demand for GP care from 5 per cent to almost zero over a decade. The challenges include meeting the needs of different parts of the country and reflecting the growing tendency of tasks to shift between professional groups and health organisations in the face of new care practices and cost pressures.

CASE STUDY – LANCASHIRE COUNTY COUNCIL: CARE STAFF RECRUITMENT AGENCY

In April 2020, faced with the pandemic and its implications for care staff, Lancashire County Council set up an internal staffing agency – the Lancashire Temporary Staffing Agency (LTSA). This has successfully built capacity for care workers, easing the burden on care providers' management teams to ensure they can focus on frontline activities. The agency was staffed by county council employees whose own services had been stood down because of the pandemic.

Lancashire launched a local recruitment campaign through LTSA to meet demand for residential care roles, the first part of the care service to feel the impact of the pandemic. This campaign received 1,454 expressions of interest, including 738 in the first two weeks. By autumn 2021 the agency had 160 care workers on its books, and had supported 60 residential care homes for older people.

Initially recruits were trained in care homes run by the county council, but as LTSA gained the support of private care providers, they began to help too. Once candidates were trained and cleared, they were put into the agency pool and deployed to care homes as needed. Many candidates have remained working in the homes where they underwent training, but they are sometimes deployed elsewhere, depending on demand, while adhering to infection control requirements.

The council also created a 'care capacity tracker'; a team called care providers each day to assess capacity, and then fed this through to LTSA as an early alert to identify gaps in rotas.

The agency was initially established as an emergency measure, but the council is holding discussions with key services in the county to understand whether it is something that could benefit local people long term.

Turning on the training taps

Recruitment agencies target staff in developing countries to move to wealthier nations. One company soliciting staff in India for "lucrative pay and a high-quality lifestyle" cites the UK, Israel, Ireland, Norway, Canada and UAE as countries that would "extend a warm welcome to overseas healthcare workers".[47]

There is a serious risk in the coming years that wealthy countries such as the UK further ramp up their recruitment from developing ones, exacerbating the problem of what has been described as "reverse aid".[48] The UK already recruits around 28 per cent of its doctors and 17 per cent of its nurses from abroad.[49] As well as being ethically highly questionable, it is also an unreliable source of staff when international competition is so high.

The UK needs to increase substantially the number of doctors and nurses it trains. Although the sharp increase in students beginning medical and nursing degrees in the aftermath of the pandemic will help, training needs to be expanded further. Nursing numbers need to meet the demands of both the NHS and social care.

Until August 2017, nursing recruitment was encouraged by the provision of NHS bursaries for students on nursing, midwifery and most allied health degrees. The government then abolished bursaries in England and moved these students to the standard student loan system.[50] The impact on nursing degree applications and enrolment was immediate and substantial. From 2014 to 2016, applications from people in England exceeded 50,000 each year. For the three years after the abolition of bursaries, degree applications varied from about 35,000 to 40,000. In the three academic years from 2014/15 to 2016/17, annual enrolments exceeded 25,000, but they dropped to under 23,500 in each of the following two years.[51]

In response to calls to reinstate the bursaries, from September 2020 new and continuing nursing and midwifery students have received a nonrepayable maintenance grant of £5,000 a year.[52]

England has taken a step towards training more doctors by establishing five new medical schools. Importantly, these have been set up in areas that have traditionally struggled to attract sufficient medical talent, including East Anglia, Sunderland and Lancashire. The total number of medical students starting in 2021 will be close to 9,000.[53]

The government has also declared its intention to make it easier for healthcare professionals to move between professions, such as a physiotherapist training to be a doctor in fewer than the standard five years.[54]

Training a doctor is expensive, costing the taxpayer around £163,000 (a cost of over £200,000 is often quoted, but that includes the repayable student loan).[55] In addition, it imposes a significant burden on hospitals and their staff. But the UK needs to expand substantially its pool of home-grown talent in medicine and nursing if it is to reduce the high rates of vacancies and our dependence on overseas staff.

Recommendation 3: *HEE should work with the Medical Schools Council (which represents the UK's medical schools), Council of Deans of Health and the RCN to develop options for government to increase substantially the number of doctors and nurses in training.*

Recommendation 4: *The government must ensure that a healthcare workforce strategy includes investment in educational capacity, particularly to recruit and retain medical and nursing staff in universities.*

Retaining students and trainees

Despite the commitment in time and resources to train doctors and nurses, many quickly leave the profession. Nursing training has a worryingly high dropout rate, with 24 per cent of student nurses quitting compared with a higher education average of 6.5 per cent.[56]

Around 300 medical students drop out each year, with significant variations between medical schools.[57] Data from 2019 revealed that only 37 per cent of doctors completing their foundation years went straight into training for their chosen specialty, such as surgery or general practice, compared with 71 per cent in 2011.[58] Many will return to training later, but around 5 per cent are lost for good.

Reasons cited for why students fail to complete training include financial worries, poor mental health, struggles academically or in placements, and excessive workload.[59] Students can find themselves exhausted by trying to earn money alongside their student placements in the NHS, while staff shortages are putting pressure on students to contribute to the general running of wards and other services rather than being supernumerary. This can be unsafe and detracts from opportunities to learn and has become a bigger issue during the pandemic.[60] The Nursing and Midwifery Council (NMC) has been considering whether the current requirement for student nurses and midwives to complete 2,300 hours of clinical placement while training should be reviewed.[61]

Recommendation 5: *HEE, the Medical Schools Council, Council of Deans of Health, RCN and UNISON should collaborate on researching and addressing the reasons why medical and nursing trainees quit before they have completed their training, and the NMC should consider whether to reduce the current requirement to complete 2,300 hours of clinical placement during training.*

Recommendation 6: *The government should encourage recruitment by increasing financial support for student nurses, midwives and allied health professionals.*

Widening access

As well as expanding overall trainee numbers, healthcare professions need to attract candidates from a wider range of backgrounds, to ensure they are reaching the best talent and reflect the communities they serve.

Around 45% of medical student applications and acceptances come from London and the south-east. About 7% of children in the UK are educated in private schools but in 2016 they accounted for 27% of medical school entrants in England.[62]

HEE recognises this issue and is taking steps to address it. The 1,000 new places for medical students in the five new medical schools in 'under-doctored' areas are an example of this, with about 40 per cent of the students attending the new course in Sunderland coming from the north east. Other stakeholders are giving support, with Sunderland City Council providing free transport for students and bursaries for books and equipment.

HEE is working with the BMA, Medical Schools Council and GMC to develop medical apprenticeships. There would be around 100 places each year, with the aim of creating a new pathway to becoming a doctor for people who cannot afford to fund a degree or stop working to study. The aim is to "make the profession more accessible, more diverse and more representative of local communities while retaining the same high standards of training".[63]

New approaches to training are typically going to attract people who are the first generation in their family to go into higher education, are from lower socioeconomic groups and attend schools with low progression into

higher education. The apprenticeship degree may prove to have advantages because of the high level of patient contact and the way it will embed the idea of multidisciplinary working.

A significant difficulty in broadening access to medical training is that the idea of pursuing a medical career often begins at a young age. New medical schools and new routes such as apprenticeships should provide opportunities for educational institutions to develop links with local schools and encourage ambition.

Recommendation 7: *HEE and other stakeholders should aim to grow the number of medical apprenticeships significantly and continue to focus new medical school places in 'under-doctored' areas, as part of the drive to widen access to medical training.*

Ethical recruitment from overseas

As well as the ethical questions about recruiting doctors and nurses from overseas, there are also questions about how well overseas staff are treated in the UK.

For nurses, there are concerns about whether there is a focus on overall numbers at the expense of matching skills to need. There is compelling anecdotal evidence that many nurses find themselves being assigned to roles for which they are not well suited, which undermines quality and safety and impacts career progression and retention. The quality of the information they receive from their future employer prior to arrival in the UK is highly variable, particularly around how care is delivered and the cultural norms in the workplace. Too few overseas nurses make it to leadership roles, which is a disincentive for others to come to the UK.

A literature review of the experiences of overseas nurses in the UK highlighted the challenges of adapting to different cultures of clinical practice, the immense amount of paperwork in the UK, feeling isolated from other staff, language barriers, feeling that they were often given the most difficult tasks, a lack of career development opportunities, patient aggression towards non-British staff and a feeling of helplessness if they perceived they were being unfairly treated.[64] All this is in addition to the pressures felt by many NHS staff, and wider issues around racism and discrimination in the NHS, such as staff from BAME backgrounds being less likely to be shortlisted for a job and more likely to enter a formal disciplinary process.[65]

In February 2021, the DHSC, supported by NHS Employers, published a code of practice for the international recruitment of health and social care personnel, which reflects the WHO code of practice.[66] However, the code is not enforced.

Recommendation 8: *Employers need to recognise that it is a moral imperative to treat overseas staff with fairness and dignity, and reflect this in practical steps, such as ensuring fairness in promotion and development and providing intensive support for new staff. Fairness and dignity will also help retain overseas recruits and encourage them to reach their full potential.*

Recommendation 9: *The NHS, the DHSC, NHS Employers and Care England should make clear that they regard the code of practice for the international recruitment of health and social care personnel as a mandatory requirement for all employers.*

Getting on – Development and innovation

Preparing the workforce for digitally driven healthcare

In 2019, a National Audit Office investigation into the digital transformation of the NHS concluded that specialist technology skills were in short supply and sufficient plans were not in place to improve the digital skills of the healthcare workforce.[67]

One measure of digital maturity in healthcare is the eight-stage scale (0–7) established by the Healthcare Information and Management Systems Society (HIMSS) in the US. By June 2021, only six hospitals in England, such as Sunderland Royal Hospital, Alder Hey Children's Hospital and Cambridge University Hospitals NHS Foundation Trust, had reached level 6 or 7.[68]

In 2019, HEE estimated that about 40,600 to 53,900 people – 4–5 per cent of the NHS workforce – worked in informatics and said that far more digital staff were needed. It also highlighted the difficulty of gaining a reliable understanding of digital skills in the NHS because there were no recognised qualifications or accreditation.[69]

Informatics specialists such as data engineers are now mission-critical staff in NHS organisations, but uncompetitive salaries, the slow pace of technological change and the widespread use of obsolete systems make the health service an unattractive option for digital talent. This means that as well as raising the skills of all clinical staff, the government's workforce strategy needs to address the growing need for digital experts.

In March 2021, HEE published its projections of the requirements for the health Informatics workforce up to 2030.[70] It estimated that around 32,000 more digital staff would be needed – an increase of about 69 per cent – particularly in information

management and clinical informatics, bringing the total to approximately 78,000. This implies that the workforce costs for these staff will increase from around £2 billion to £5.2 billion. Current staffing trends indicate that there is likely to be a shortfall by 2030 of almost 18,000 informatics staff.

Among HEE's recommendations is the development of many more hybrid job roles spanning clinical work and informatics. These are exactly the sort of roles that need to be developed, supported and funded in a comprehensive workforce strategy.

> ***Recommendation 10:*** *The NHS should work with the royal colleges and other stakeholders, such as the Faculty of Clinical Informatics, to implement HEE's recommended*[71] *development of standardised job roles for hybrid digital clinician positions, such as clinician-informaticians, to meet demand for a wider range and greater number of clinicians with digital skills.*

Developing the digital skills of care workers

Workforce planning around social care needs to be about far more than addressing issues such as pay and vacancies. It needs to be preparing for the care workers of the future, looking at opportunities such as remote monitoring of care home residents and people at home, and supporting care workers in more active management of people's health and wellbeing. For example, care staff are now using technology to take measurements, such as blood pressure and heart rhythm, and sharing the results with the person's GP, an approach to care that proved its worth during the pandemic.[72] This requires raising the level of digital skills.

> ***Recommendation 11:*** *As integrated care systems develop, there needs to be parity in training and development across health and social care, particularly in ensuring digital readiness among all staff through joint training programmes.*

Developing innovative clinical roles

When it comes to recruiting staff, the NHS should not simply be employing more people to perpetuate existing care models and ways of working but developing roles that support the development of new approaches, particularly around patient-centred care and digitally-enabled care.

Clinical nurse specialists, which have now been firmly established in the NHS over many years, exemplify how innovative roles can significantly improve the patient experience, improve the effectiveness of treatments, use resources more efficiently and ensure the time of medical specialists is focused on doing what only they can do.

There are about 20,000 clinical nurse specialists across England. They generally have a postgraduate education and extensive experience in their chosen field. They manage care as well as deliver it. As treatment pathways for many diseases, such as cancer and diabetes, become more complex, having a named, expert key worker alongside the patient to manage and coordinate their care as part of a multidisciplinary team is becoming essential. Patients like having an accessible professional who can answer their questions and take action to address their concerns.

Studies indicate that clinical nurse specialists reduce length of stay, emergency admissions – sickle cell care being a striking example[73] – and readmissions,[74 75] although there is a need for further research and greater clarity on how the roles are defined and success measured.[76 77]

Clinical nurse specialists play a vital role in care quality and safety and managing risk – coroners' reports frequently identify poor care planning and poor coordination of care as underlying reasons for avoidable deaths.

About 3,000 clinical nurse specialists work in oncology. A review of 150,000 records for patients being treated for lung cancer indicated better outcomes for patients who had a clinical nurse specialist managing their diagnostic pathway, with better access to treatment.[78]

Despite this, their value is often doubted. They are typically paid at band 6 or 7, even before the pandemic they were often asked to work on wards and take on other duties, and they are constantly being reviewed to prove their worth, which undermines morale and retention. The role is not properly codified, which means there is significant variation in the qualification and experience of nurses with the title of clinical nurse specialist, and inconsistent professional development.

Josie Roberts, Macmillan lung cancer nurse specialist, Rotherham NHS Foundation Trust

"When we look at safety, quality and efficiency, we are looking at the whole pathway for these patients and their families. Since the introduction of the national optimal lung cancer pathway, we are supporting patients through the investigations in the clinic, often taking part in those investigations, then a key part of our role is to be present when the patient is given their diagnosis, and to provide ongoing support. Clinical nurse specialists are at the fulcrum of the care pathway at one of the most stressful times of their lives.

"Good communication skills are critical, helping patients understand their illness and their often complex treatment and what might happen next. There are nurse-led clinics, nurse-led follow-ups, with a lot of telephone calls and providing a ready point of access so that urgent issues can be addressed through the pathway, for example, rather than through an emergency admission.

"On other occasions they are actually triggering an emergency response, but they can then meet that patient and manage the interaction between the emergency admission and the pathway.

"Clinical nurse specialists have an important role to play in helping patients understand and manage side effects and complications. They can prescribe, saving a visit to the oncologist or GP. They are also an important point of contact for other staff, such as ward staff, community nurses and GPs.

"There needs to be better access to training and more modules for nurses trying to get into these roles and developing them."

CASE STUDY –
LUNG CANCER NURSING UK: SUPPORTING THE DEVELOPMENT OF NURSE SPECIALISTS

Lung Cancer Nursing UK (LCNUK) was established in 1998 to provide networking and support for nurses specialising in the care of people with lung cancer. It supports its members in four key areas:

- Clinical: providing clinical support, sharing information, knowledge and best practice to improve the care lung cancer patients receive

- Developmental: keeping members up to date on the latest lung cancer news and developments, and encouraging regional participation in LCNUK
- Educational: creating a forum to share and disseminate new skills, treatments and practice through educational programmes, events and publications, and encouraging members to be involved in and lead lung cancer-related research and audit
- Professional: encouraging networking, championing and campaigning for recognition of the role, providing a voice on clinical and strategic issues, and representing UK lung cancer nurse specialists on national and international bodies

In 2020, research among LCNUK members showed the extent of the pressures faced by lung cancer nurse specialists, including the lack of a clear route for professional development. After extensive consultation with nurse specialists, their managers and employers on the skills, knowledge and training that lung cancer nurse specialists needed as they progressed in the role, in November 2021 LCNUK launched a framework that identified the competencies required to provide safe and personalised patient care, considered the capabilities required to provide the highly complex care that lung cancer patients need, and identified the career possibilities for these nurse specialists. The work was supported by Incisive Health and MSD.

NHS England sees the redesign of workforce roles as an improvement tool creating significant benefits for patients, individual staff and teams by raising the quality of patient services, providing solutions to staff shortages and increasing job satisfaction.[79] It encourages organisations to think about redesigning roles when:

- Team members are not making full use of all their training and skills
- Teams do not have enough time to care for patients
- There are not enough staff to provide safe, timely and effective care
- Existing roles are not designed around patient needs
- Teams are not making full use of available technology to support service delivery.

There are three main categories of innovative roles: [80]

- Extending administrative roles to release clinical staff to spend more time on patient care
- Assistant practitioners – healthcare workers with a level of knowledge and skill beyond traditional healthcare assistants or support workers, undertaking tasks previously handled by registered professional staff
- Advanced practitioners – people such as clinical nurse specialists who have developed their knowledge and skills to a high standard. They make important decisions about care, have a high degree of autonomy and often have their own caseload. Advanced practitioners would typically have a master's degree and have skills that encompass leadership and management, the ability to analyse complex problems and to work as a member of a multidisciplinary team to enhance people's experience of care and improve outcomes.[81]

Redesigning roles encourages organisations and teams to think about how clinical time and talent can be freed to provide more time to care and to see clinical work from the patient's perspective rather than the organisation's.

> ***Recommendation 12:*** *Organisations should view redesigning roles as a potential route to liberating scarce clinical time and talent. It provides an opportunity to think about quality, the patient experience and how to use the skills and maximise the productivity of each member of the team. During the pandemic there were many inspiring examples of pathway redesign and staff developing their clinical roles and acquiring new skills. This capacity for highly effective innovation by clinical teams should strongly influence future training and leadership programmes.*

Regulating the professions

For many years there has been broad agreement among professionals, regulators, the government and patient groups that the regulation of healthcare professionals in the UK needs to be overhauled. The current patchwork of regulators and rules is rigid and complex, fails to provide a strong framework for ensuring patient safety and service quality, and is inhibiting the NHS from meeting future workforce challenges such as developing multidisciplinary working or encouraging staff to move from one profession to another.

It also fails to take into account lessons learned from recent investigations, such as the Francis Inquiry into Mid Staffordshire NHS Foundation Trust[82] or the Kirkup and Ockenden investigations into midwifery at Furness General and Shrewsbury and Telford hospitals.[83] [84]

In 2014, the law commissions of England and Wales, Scotland and Northern Ireland proposed a comprehensive package of reforms to consolidate and simplify the legal framework and give the regulators more flexibility to amend their rules without the need for parliamentary approval.[85]

in March 2021, the government consulted on proposals for reform of regulators such as the GMC, NMC and the General Pharmaceutical Council, including issues such as registration, fitness to practise and education and training standards.[86] Some proposals are included in the Health and Care Bill going through Parliament in autumn 2021.[87] If the regulation of healthcare professionals is to facilitate modernisation of the workforce rather than hold it back, comprehensive reforms are vital.

Recommendation 13: *Developments such as the growth of multidisciplinary teams and the increasing use of digital tools to support clinical decisions need to be fully reflected in regulations that are currently built around individual judgement and reflected in professional development and licensing programmes. New professional roles need to be recognised and their place in clinical teams clarified by improved professional regulation.*

In years to come, it might become clear that there should be a single register for healthcare professionals that can accommodate, for example, both a junior doctor and an advanced nurse practitioner of many years' experience. The emphasis would then shift to regulating for skills rather than job titles. The Professional Standards Authority for Health and Social Care already argues that creating a single regulator would be the best way to address the problems with the current system.[88]

The right role for virtual training

The pandemic triggered a massive increase in online training as staff learned about new procedures and guidance and enhanced their skills as they moved into new roles or adopted new ways of working. Between 2019 and 2020 the number of people in health and social care who accessed HEE training material jumped from about 750,000 to 1.8 million. Online learning is now routine.

This acceleration of digital learning is driving innovation, notably around the use of simulation, which is encouraging a move towards blended learning for students and professionals. This in turn is helping to create a growing community of educators and education technologists and to strengthen relations with businesses that are interested in meeting the educational needs of the health and care sector in the UK. Until now, many products have been designed primarily for the US market, but the speed and scale of adoption in the UK is encouraging the development of products that meet our specific requirements.

Professional regulators are taking an open-minded approach to digital learning, such as the number of simulation hours that can be included in training.

CASE STUDY – SIEMENS HEALTHINEERS: REMOTE MRI SCANNING SUPPORT

Magnetic resonance imaging (MRI) scanners are sophisticated and expensive pieces of equipment that require a radiographer trained in their use to undertake imaging investigations. Many MRI scans will be routine while others require more expertise and patient support. Specialist, experienced radiographers are therefore needed to provide guidance and support for more complex procedures.

InHealth has three MRI scanners across Frimley Park Hospital, with experienced radiographers supporting and supervising their less experienced colleagues. This support requirement could result in bottlenecks as staff moved between locations.

GenesisCare specialises in cancer treatment, with MRI scanners at multiple sites in the UK. A superintendent needed to travel 40 miles between sites to oversee scans, also creating bottlenecks and constraints on the types and timing of certain scans.

The solution in both cases was syngo Virtual Cockpit[89] software from Siemens Healthineers, designed to assist the sharing of knowledge and management of scanning procedures from a distance. Expert colleagues are given access to workstations on several scanners in the same network, so they can provide timely 'over-the-shoulder' or live coaching support to staff without having to be physically on site.

Using this technology, remote radiographers from InHealth and GenesisCare can now virtually connect with their on-site radiographers in real time, discussing cases through headsets, conference speakers or chat. In-room cameras and workstations mean images of patients, injectors and the workflow can be seen by experts, enabling them to seamlessly provide verbal guidance or take control of the scanner.

Training of new and less experienced radiographers can be conducted more quickly through hands-on or remote, high-quality training. There is the potential to reduce onboarding of staff from 90 days to 30 days.

Recommendation 14: *While online learning and tools such as simulation offer many advantages, HEE and other stakeholders must implement them in ways that maintain or improve the quality of learning and widen access, ensuring they support rather than disadvantage groups of students such as those with fewer financial resources or students with disabilities.*

Volunteers and reservists

There was a huge surge in volunteering during the pandemic, with about 12.4 million volunteers coming forward to support vulnerable people in the community and help with the vaccination programme.[90]

Volunteering is becoming part of NHS workforce planning. The NHS Cadets programme with St John Ambulance seeks to recruit 10,000 people aged 14–18 by 2023, particularly among communities currently under-represented in the NHS.[91] As well as supporting personal development, it is hoped the programme will attract people into healthcare careers.

Volunteers have always had an important role to play in hospitals and communities, but they are complementary to permanent staff, not a substitute. Volunteering can be a pipeline for recruiting permanent staff – a national survey of volunteers in February and March 2021 found 11 per cent of them were looking for a job in health or social care. The NHS and many voluntary organisations are exploring ways to build on the opportunities presented by volunteering during the pandemic.

Volunteers and voluntary sector organisations have been instrumental in providing extra capacity during the pandemic, such as supporting hospital discharge and getting people home safely, and, in the case of St John Ambulance, providing auxiliary ambulance capacity.

Volunteering has its risks and therefore needs to be properly resourced and managed. Volunteers need to be trained to carry out safety-critical tasks such as helping patients eat. It can add to the workload of nurses and other professionals if they have to supervise a constantly changing group of helpers. While volunteers provide important emotional support to patients and people in the community, emotional support will always be an intrinsic part of nursing and cannot be left to volunteers. There is also the risk of volunteers being out of their depth and experiencing stress and anxiety from being unsure what to do, where the boundaries of their role lie and who they can turn to for help.

The key to a smooth relationship between, for example, hospital staff and volunteers, is getting the set-up period right – ensuring volunteers are properly trained, setting the boundaries and making sure there is good communication.

Recommendation 15: *The NHS nationally and locally, in collaboration with voluntary sector organisations, should build on the momentum from volunteering during the pandemic to build a significant cadre of volunteers to support NHS professionals while improving the patient experience. Volunteer posts should always be complementary to, not instead of, paid staff members.*

CASE STUDY – ROYAL VOLUNTARY SERVICE: NHS VOLUNTEER RESPONDER PROGRAMME

In March 2020, NHS England created the NHS Volunteer Responders programme in partnership with the Royal Voluntary Service (RVS) and GoodSAM Cardiac Volunteers.[92]

Around 700,000 registered volunteers provided support during the pandemic, including the vaccination programme. Volunteers use the GoodSAM app to turn on or off duty. Volunteers are matched to local people who need practical support such as shopping or welfare calls, and the NHS books them for tasks such as picking up a patient or dropping off equipment.

Volunteering has been found to be a gateway to a job or career in the NHS. An RVS survey of 1,000 volunteers in early 2021 found that: [93]

- One in five said volunteering had make them think about a career in health or social care
- Over one in 10 said they were actively seeking a job
- One in 12 said that thanks to their volunteering they now had a job or career in health or social care.

There are also other workforce benefits:

- 53 per cent of frontline staff said volunteers "helped to reduce my workload"
- 71 per cent of nurses agreed that receiving support from volunteers helped them feel less stressed
- 32 per cent of staff felt volunteers "free up staff time to be able to focus on clinical care".

CASE STUDY – BRISTOL CITY COUNCIL: SUPPORTING THE COMMUNITY WITH VOLUNTEERS DURING THE PANDEMIC

When the country went into lockdown in March 2020, the focus of local authorities was on managing the health crisis while keeping key services open. Bristol City Council mobilised community leaders and community groups, residents, and council staff redeployed from suspended services, alongside staff from the council's Communities and Public Health Directorate.

About 3,000 residents responded to a call from the mayor for volunteers. These were organised around a network of 26 community hubs, drawing in local voluntary groups. This particularly helped meet the needs of people who were shielding or isolating, and those who were struggling with loneliness, finances, food, and other essentials.

Under the badge of #WeAreBristol - the city's community cohesion initiative - a freephone hotline was established for any resident needing help. IT databases were pulled together, identifying who needed help with what, and how they could be matched with volunteers. Around 5,000 referrals were made.

Depending on the path the pandemic takes, the scheme will keep running until 31st March 2022. The city council is working with Voluntary, Community and Social Enterprise partners to explore how Bristol can build on the pandemic experience and the energy, goodwill and success of volunteering, to support the Adult Social Care service but also to support residents to connect to their wider community.

Reserve clinicians

As well as volunteers, the pandemic response was supported by thousands of former healthcare professionals returning to work. In April 2020, NHS England reported that 4,800 doctors, nurses, midwives and other healthcare professionals had returned to work.[94]

By July 2021, the GMC had granted temporary registration to additional doctors under its emergency pandemic powers, including 15,000 doctors who had given up their registration or licence to practise within the last three years, nearly 7,000 doctors who had given up their registration between three and six years ago, and 12,000 doctors who were GMC registered but who did not hold a licence to practise. Approximately 28,000 of these doctors chose to remain on the register.[95]

However, the process for retired staff and others re-joining the register was far from straightforward. There were reports of excessive bureaucracy around issues such as vaccination certificates from many years ago, and many of those who came forward were never called, despite the obvious need for their services. These barriers need to be resolved, such as by using the technology behind the 'staff passport' being trialled in the NHS, which is essentially a QR code containing a professional's registration and other information so that they can move seamlessly between NHS organisations.

> ***Recommendation 16:*** *While chronic workforce shortages persist, the NHS needs to maintain and expand a national register of retired clinical professionals and those who have left the profession mid-career who are willing to return to work at times of high pressure, making it easy for them to come forward at short notice.*

Getting through – Wellbeing and retention

Supporting mental wellbeing

Research by the King's Fund in 2020 found that the proportion of nurses and health visitors leaving their posts in hospitals and community services in England within three years of joining had increased by 50 per cent since 2013/14 to 28 per cent. Reasons given included 12-hour shifts, exhaustion, burnout, stress, lack of food and drink at work and relentless pressure. This had been exacerbated – but not caused by – the pandemic.[96]

It has long been understood that the NHS is poor at looking after the physical and mental wellbeing of its staff, but, despite many investigations and reports, little has changed.

In 2009, the Boorman review of NHS health and wellbeing concluded that "the health and well-being of its staff should no longer be a secondary consideration, but needs to be at the heart of the NHS mission and operational approach".[97] It highlighted that the NHS was losing around 10 million working days a year to sickness, and said the prerequisites for delivering an effective service were:

- board commitment to staff health and wellbeing, top management leadership and staff engagement
- embedding staff health and wellbeing as the core business of the organisation as part of what it means to be a good employer
- proper resourcing of health and wellbeing services, with a clear understanding that this represents investment that will deliver long-term savings and improved patient care
- agreeing consistent measures of the effectiveness of staff health and wellbeing programmes, which can be used for board and national reporting.

Twelve years later, none of this has been implemented. In 2010, Invisible patients, a report for the government on the health of NHS professionals, found that: [98]

- 45 per cent of NHS staff taking sick leave had musculoskeletal disorders; this was a particular risk for nurses, physiotherapists, occupational therapists, radiographers and paramedics.
- levels of depression and anxiety were higher in health professionals than other groups of workers
- rates of suicidal thoughts and suicides were significantly higher in doctors, dentists, nurses and pharmacists.
- there were higher rates of substance misuse in health professionals compared with other groups of workers, with the BMA estimating that 7 per cent of doctors had some form of drug or alcohol dependence in their career.
- barriers to seeking help included workload, fear of stigmatisation and discrimination, fear of jeopardising career prospects – particularly for mental health problems – and concerns about lack of confidentiality and privacy.

In 2017, a BMA review of workplace bullying and harassment of doctors noted that the NHS England staff survey showed staff with disabilities were more likely to experience workplace bullying or harassment – 32 per cent compared with 20 per cent of staff without disabilities.[99]

In 2018, a Society of Occupational Medicine report on improving UK doctors' mental health of highlighted that doctors are at greater risk of work-related stress, burnout and mental health problems, such as depression and anxiety, compared with the general working population.[100] The report concluded that the risk of suicide, especially among GPs, psychiatrists and trainees, and among women, was high compared with the general population. The report also highlighted the risk of mental health problems among trainees and junior doctors.

The same report found GPs were more vulnerable to burnout – particularly emotional exhaustion – work-related stress and common mental health problems than doctors in most other specialties, which was linked to the increasing demands placed on primary care, along with diminishing financial and staffing resources.

It pointed out that bullying and harassment were factors that increased the risk of mental health problems, and again emphasised how poor working conditions contributed to poor retention and high turnover in the medical workforce, particularly among GPs. The 2018 report concluded: "The poor mental health evident in UK doctors should be of grave concern to the various stakeholders in the healthcare sector and action is urgently required."

A 2019 report by Professor Michael West and Dr Dame Denise Coia for the GMC, Caring for doctors, caring for patients, concluded that patient safety depends on doctors' wellbeing, adding: "Medicine is a tough job, but we make it far harder than it should be by neglecting the simple basics in caring for doctors' wellbeing."[101]

The report cited studies that found doctors with high levels of burnout had between a 45 per cent and 63 per cent higher likelihood of making a major medical error in the following three months compared with those with low levels of burnout.[102] Nearly one in four doctors in training in the UK said they felt burnt out to a high or very high degree because of their work.[103] The report pointed out the link between poor staff wellbeing and poor retention.

West and Coia said that to ensure wellbeing and motivation and minimise stress, staff have three core needs, which they called the ABC of doctors' needs:

- Autonomy/control – the need to have control over their work lives and to act consistently with their work and life values. This means introducing mechanisms for doctors to influence the culture of their organisations and decisions about how medicine is delivered, along with minimum standards for basic facilities in every organisation, such as places and times to rest and sleep, and access to nutritious food and drink. Shifts need to enable breaks and take account of fatigue.
- Belonging – the need to be connected to, cared for, and caring of others around them in the workplace and to feel valued, respected and supported. This requires compassionate leadership.
- Competence – the need to experience effectiveness and deliver valued outcomes, such as high-quality care. This requires tackling the fundamental problems of excessive workload, such as programmes to develop alternative roles to enable doctors to use their skills to the full, supported by effective multidisciplinary teams.

In 2021, the BMA said one in five doctors felt they did not have access to the help they needed to ensure their physical, mental and emotional wellbeing. Its research indicated that in May 2020, as the NHS was struggling to cope with the first wave of the pandemic, 45 per cent of doctors were suffering from depression, anxiety, stress, burnout or other mental health conditions relating to, or made worse by, the Covid-19 crisis. Doctors felt they were risking their lives due to a lack of sufficient PPE, and experienced feelings of guilt for leaving colleagues behind at the end of their shift to go home and rest.[104] The BMA said the "stigma associated with mental health means that doctors are often hesitant to disclose any problems and suffer in silence."

It demanded that employers made supporting the mental and physical health of doctors and other staff a top priority, pointing out they have a responsibility to provide a safe working environment and to make reasonable adjustments to meet the specific needs of individuals. The BMA noted that health and wellbeing services could be disjointed and there were wide variations in provision across the country. It stressed the importance of support services being inclusive, accessible and meeting the needs of users, highlighting that BAME doctors were more likely to say they could not access the wellbeing support they would like.

The key feature of all these reports, and many others over more than a decade, is that the NHS needs to invest in, and care for, its staff. Actions need to include rapid access to treatment for physical and mental health, managing workload, tackling racism, and ensuring staff with 'protected' characteristics such as a disability are appropriately supported. The reports identify that the NHS is in danger of losing the confidence of its workforce and needs to act urgently. Yet absence rates, staff dissatisfaction and rates of early retirement have continued to rise.

NHS England and the DHSC need to accept the thrust of the recommendations in all these reports – that actively supporting the health and wellbeing of its staff should be core business for the NHS, which will ultimately lead to a higher quality and more productive service – and develop a plan to implement them. The NHS People Plan goes a long way in terms of aspirations, but it is unclear how these will be delivered. With every part of the system running 'hot' for the foreseeable future, health and wellbeing needs to be at the core of service resilience. This reflects what is sometimes known as the 'quadruple aim' of healthcare – enhance patient experience, improve population health, reduce costs, and improve the work life of healthcare providers.

Even before the pandemic there was evidence that rates of depression, anxiety and stress were increasing among healthcare staff, notably clinicians. The NHS Staff Survey revealed a growing proportion of staff experiencing stress – the proportion of respondents reporting feeling unwell as result of work-related stress grew from 36.8 per cent in 2016 to 40.3 per cent in 2019, while fieldwork during the pandemic indicated a rate of around 44 per cent.[105] Evidence from the King's Fund links poor staff wellbeing to higher patient mortality in the acute sector.[106]

Nurses and doctors are among occupational groups at increased risk of suicide.[107] [108] Office for National Statistics (ONS) data published in 2017 showed the risk among female health professionals of suicide was 24 per cent higher than the female national average, largely driven by a higher suicide rate among female nurses.[109]

A 2019 BMA report, Mental health and wellbeing in the medical profession, found that although the stigma around mental health is decreasing it still exists in medicine, and many doctors fear that a mental health diagnosis would affect the perceptions of their peers and their career progression.[110] There is "still the perceived link between professional competency and being able to cope emotionally and mentally."

In October 2020, UNISON surveyed 14,000 healthcare staff, mainly from the NHS but also nursing homes, care homes, private contractors and charities. Almost half of respondents said they had not coped well mentally during the pandemic. The biggest reason for their decline in psychological wellbeing was fear of getting sick (60 per cent), being unable to socialise with friends and family (55 per cent) and increased workload (49 per cent). Other factors included spending more time with very sick patients, financial worries, difficulties taking holiday and having to live away from home to protect their family from Covid-19 infection.[111]

In evidence to the House of Commons Health and Social Care Select Committee, Professor Michael West spelt out the impacts of excessive workload and describing it as the number one predictor of staff stress, intention to quit and patient dissatisfaction, as well as being highly associated with clinical errors.[112]

Each group of staff has its own unique needs. For example, junior doctors need support in the months following the transition from being a medical student and as they move between clinical teams and organisations. The pandemic brought home the particular pressures on staff recruited internationally, who even in normal times endure long periods isolated from their families and friends.

Staff in every position and from every background are at risk of finding reasons not to ask for help. A medical student or junior doctor might feel that it would jeopardise their career. A male surgeon might think it appears weak. A clinician who has joined the NHS from overseas might feel that asking for help would give the impression that they cannot cope with the job and the culture.[113] Staff with drug or alcohol problems might be concerned about being stigmatised.

A strong message needs to be embedded in clinical culture from the first days of training that reaching out for help early on is a sign of strength and a mark of professionalism. The idea that a deterioration in mental wellbeing is a sign of weakness, particularly among doctors, needs to be banished.

Ensuring access to specialist support should entail a great deal more than simply signing a deal with a contractor. Whether the service is provided in-house or externally, it needs to be built around a deep understanding of the needs of different staff within the organisation and be integrated into the mainstream of its workforce strategy and day-to-day culture and operations.
The NHS is moving from an organisation where essentially you were either fit for work or you weren't, to one where there is a greater recognition of the need to make reasonable adjustments for staff who do not meet the criteria for a formal disability. This should be encouraged.

Recommendation 17: *It must be recognised that the health and wellbeing of staff is of primary importance in building resilience in the health and social care workforce. The boards of provider organisations should engage with their staff to ensure early intervention to maintain the mental and physical health of each member of staff. This requires visible and persistent leadership to send a clear message that seeking help is the right thing to do and will be respected and celebrated. Staff who need help must be supported with professional advice and care.*

Recommendation 18: *Commissioners and providers should agree a common set of metrics to ensure that maintaining mental and physical health and resilience is monitored and acted on. This should include data on rates of sickness absence, availability of recuperation facilities and staff feedback. Ethnic and cultural diversity should be considered in designing the responses to such feedback.*

Recommendation 19: *Adverse working patterns that are known to increase burnout and stress, such as excessively long shifts, should be phased out.*

CASE STUDY – MANCHESTER UNIVERSITY NHS FOUNDATION TRUST: PROVIDING COMPREHENSIVE HEALTH AND WELLBEING SUPPORT

When Manchester University NHS FT decided to develop a comprehensive package of health and well-being support as the pandemic hit, it began by reviewing the available international research on factors evidenced to be associated with improved psychological outcomes in healthcare workers during infectious disease outbreaks such as SARS and Ebola. A stepped

care model of support was then devised including factors identified as most strongly protective of staff well being:

- Camaraderie – peer support networks
- Psychologically savvy managers
- Being 'well prepared' including infection control training and training for new skills
- Rotation from high to low stress areas and time off work
- 'Watchful waiting' with early assessment and intervention.

Workplace factors associated with poorer psychological outcomes, such as time spent in quarantine or isolation, moral injury and redeployment, were considered.

Stepped care model overview

The trust's wellbeing campaign for its 28,000 staff has full support from the trust's Board with the Deputy Chief Executive, featuring in videos about her own mental health. Health and well-being champions throughout the organisation reflect the diversity of the Manchester workforce and targeted interventions have been provided to specific groups known to be at higher risk such as critical care areas and anaesthetics.

However, it became clear that pandemic related social restrictions were impacting on both camaraderie and work life balance and a different approach was needed. The Create Connect Unwind+ project was the result of a partnership between the Employee Health and Wellbeing Service and Lime, an internationally acclaimed arts and health organisation with nearly 50 years' experience delivering arts and well-being projects in healthcare settings. The project offers a series of creative workshops aiming to enrich mental

wellbeing, support peer interaction and normalise discussion of both mental health and illness. The programme is delivered in collaboration with Manchester's leading cultural organisations such as Manchester Art Gallery, Whitworth Art Gallery and Milapfest, the Institute for Indian art. Project funding was secured from Arts Council England, charities connected to the trust and NHS Charities Together Trust.

Phase One of the programme ran from July 20-July 21. A total of 254 employees attended 42 online workshops and evaluation showed (196 completed forms);

- **93 per cent** reported 'a greater sense of wellbeing'
- **92 per cent** agreeing their workshop 'helped them to relax'
- **95 per cent** believed that accessing arts activities through work was important
- **93 per cent** felt more valued by their employer because of the creative programme
- **84 per cent** view their employer more positively after attending the workshop

Phase two (Feb 21-May 22) will continue to explore the theme of stigma through theatre, dance, music and visual art. The programme includes 96 workshops, a fringe festival, two exhibition areas and has an overall audience reach of 17,000 MFT staff at a direct cost of £90,000.

CASE STUDY – IMPERIAL COLLEGE HEALTHCARE NHS TRUST: ESTABLISHING A MULTIDISCIPLINARY WELLBEING GROUP

The impact of Covid-19 on staff brought the need for a robust and comprehensive wellbeing offer into sharp focus. It had to support a spectrum of wellbeing needs, from facilitating basic requirements, such as nutrition, hydration, sleep and breaks, to tailored specialist wellbeing support.

The trust established a multidisciplinary wellbeing reference group of 30 clinical and non-clinical staff members, which included representation from different ethnicities, ages, bandings, disciplines and departments. The group met regularly to share intelligence, sense-check wellbeing interventions and discuss ways to improve support.

A three-phase model was implemented:

- Critical phase – supporting immediate practical, physiological and psychological needs to keep staff healthy, happy, and safe
- Aftermath phase – addressing trauma, moral distress and post-traumatic stress disorder (PTSD)
- Recovery phase – re-engagement back into the individual's role, the future and the longer-term impact of the pandemic on staff.

The trust conducted equality impact assessments for all its wellbeing interventions to assess if they met the needs of minority staff groups. This was brought about after it was pointed out that the hairdresser brought on site to enable staff to get haircuts during the pandemic did not have the skills to work with Afro hair.
The trust has seen an increase in staff interest in its wellbeing offer and uptake of different health and wellbeing interventions. It has invested in a legacy fund to extend staff counselling services and other interventions to ensure wellbeing remains a priority after the pandemic.

CASE STUDY – DOCTORS IN DISTRESS: THE BLACK MEDICS FORUM

Doctors in Distress, with its programme Reflective Spaces, has been providing safe, confidential groups for a variety of medical and healthcare professionals for the past 18 months. Although the charity was set up prior to the pandemic, the need for these peer-support groups increased exponentially in mid-2020 and will continue well into the future, irrespective of Covid-19.

Doctors in Distress believes that clinical staff find it harder to reach out for support, seeing it as a sign of weakness or worrying that others will perceive it this way. Doctors and nurses see themselves as giving care, not getting care.

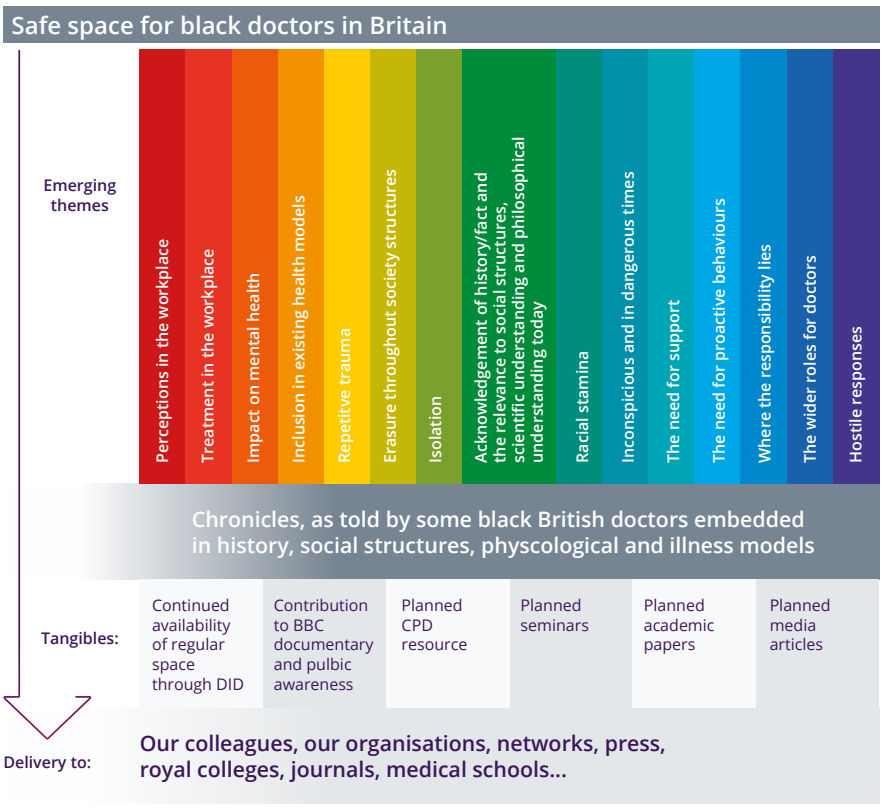


Image Source: Doctors in Distress[114]

The Black Medics Forum was established as part of this work. A forum member explains: "It has been a unique and powerful experience for those who have attended. We have created a safe place where isolated doctors have been able to have in-depth conversations about their experiences, feelings, and subsequent impacts on [their] health … Doctors have been able to explore issues that have remained taboo for decades of their lives." These conversations have taken place in the context of historical and current societal and structural issues.

Ultimately, Doctors in Distress aims to reduce stress and anxiety, help to reduce burnout and reduce the rate of suicide in the medical profession.

Addressing discrimination and inequalities

Among NHS staff in England, about 77.9 per cent are white, 10.7 per cent are Asian, 6.5 per cent are Black, 2.6 per cent come from other ethnic groups, 1.9 per cent have mixed ethnicity and 0.6 per cent are Chinese.[115] In social care, at least 21 per cent of the workforce are from a BAME background. There are particularly high proportions of BAME staff in London, a pattern reflected in other groups of key workers. Research among BAME staff during the pandemic identified their top challenges, by a wide margin, as: [116]

- Racism, including institutional and systemic racism – 45 per cent
- Progression and representation – 24 per cent
- Health issues, including Covid-19 risk and mental health – 24 per cent.

The Health and Social Care Select Committee inquiry into workforce burnout and resilience in the NHS and social care highlighted the challenges faced by staff from BAME backgrounds. The BMA noted that BAME doctors "feel particularly unable to speak out and are more likely to be blamed. There is a lot of evidence that they experience worse inequalities in the NHS".[117]

Evidence from the Royal College of Midwives indicated that 42 per cent of midwives had reported experiencing discrimination based on their ethnic background.

CASE STUDY – MANCHESTER UNIVERSITY NHS FOUNDATION TRUST: PROMOTING WORKFORCE DIVERSITY

One in five of the 28,000 staff at Manchester University NHS Foundation Trust is from an ethnic minority background, reflecting the population of Great Manchester from which the trust recruits 80 per cent of its staff. However, representation is not evenly distributed across pay bands. Half the staff in band 1 are from an ethnic minority background compared with one in 10 at bands 8a and above.

The Removing the Barriers programme to improve workforce diversity addresses under-representation on two fronts: tackling the systemic barriers to getting in and getting on in the trust; and empowering ethnic minority staff through leadership development and talent management. It includes:

- The diverse panels scheme – a mandatory requirement for recruitment panels for jobs at bands 8a and above to be ethnically diverse

- The reciprocal mentoring scheme between ethnic minority staff members and executive directors
- E3 secondments – secondment opportunities (job rotation) for ethnic minority staff providing 'stretch' assignments.[118]

Progress is monitored using the electronic staff record. Human resources (HR) directors agree 'stretch targets', which are monitored regularly, and HR teams conduct promotional campaigns where under-representation is identified. A workforce strategic equality group provides oversight and scrutiny through the HR Scrutiny Committee. A 12-month communication plan is in place to spread good practice and video testimonials are being developed.

Senior managers at the trust provide high-profile leadership for the diversity campaign, and it is understood that this is a long-term programme of cultural change that will take time.

In the first six months of the programme, the number of ethnic minority staff at bands 8a and above increased by 27, from 9.9 per cent to 10.8 per cent of staff. Around 87 per cent of recruitment panels were diverse, and the reciprocal mentoring scheme has been setting up another pairing every week, with questionnaires and interviews to make matches between individual staff and directors. There have been six secondments under the E3 scheme.

The Black, Asian and Minority Ethnic Staff Network is a key stakeholder in the programme. It is updated regularly on progress against targets. This engagement has ensured that the people leading the programme understand how staff are receiving it.

CASE STUDY – EAST SUSSEX HEALTHCARE NHS TRUST: SUPPORTING BAME COLLEAGUES THROUGH THE PANDEMIC

With the disproportionate number of Covid-19 related deaths in the BAME community during the pandemic, East Sussex Healthcare NHS Trust wanted to increase support for its BAME staff. In May 2020 the trust set up Covid-19 clinics specifically for BAME staff in the clinically vulnerable category. These were a safe space for them to:

- discuss their physical and emotional wellbeing and the impact of Covid-19
- have their BMI, waist size and blood pressure measured
- learn about the benefits of vitamin D, diet, exercise and low alcohol intake
- be signposted to counselling services
- learn about existing support available.

In total, 165 BAME staff were contacted and 95 attended the clinic and were provided with information for risk assessments. About a dozen people took part in interviews and focus groups to gather intelligence on what health and wellbeing support looked like for BAME colleagues during the pandemic, establish whether current psychological support was sufficient, explore the language used around services for BAME staff, and identify any missing areas for support and the specific needs of overseas staff.

This resulted in increased engagement between BAME staff and the wider organisation, enabled inclusive conversations around health and wellbeing, and provided data for the trust's wellbeing and equality, diversity and inclusion (EDI) metrics.

Recommendation 20: *Health and care organisations must be held accountable for their equality, diversity and inclusion statistics. Boards must embed clear measurable time-limited goals and the Care Quality Commission methodology must be strengthened to ensure that NHS Trusts and care organisations demonstrate serious progress on equality in order to receive a Good or Outstanding.*

Improving the social care environment

Many social care staff are poorly paid, and a serious risk identified by employers is that staff shortages coupled with rising wages in the leisure sector could lead to an exodus of staff. Salaries have to be competitive, taking into account the intensity of the work.

Years of austerity have stripped out many middle managers in social care. They have been seen as an expendable cost, but the lack of managers and learning and development roles leaves social care staff with much less professional and personal support. During the pandemic it has become clear that organisations with high levels of supervision are better able to retain and motivate staff.

The endless cuts to the support around social care staff has undermined productivity. The three key factors supporting productivity and social care are on-the-job career development, good supervision and a supportive organisational culture.[119] Productivity is measured through aspects such as reductions in falls, safeguarding referrals and referrals to hospital.

In raising the status of social care workers, a good place to start would be greater respect from health staff. There is some evidence that social workers who operate alongside health workers frequently detect a lack of respect from their colleagues. Greater movement between health and social care, such as secondments, could go a long way to breaking down these barriers and improve mutual understanding.

Social care needs to reward continuity of care, with financial recognition for someone who spends many years working with the same group of service users.

Social care providers struggle to compete with the terms and conditions offered by the NHS for nurses, such as multi-year pay deals. A comprehensive social care workforce strategy needs to ensure that social care has sufficient access to nurses. That cannot be separated from the issue of social care pay.

CASE STUDY – ANCHOR: DEVELOPMENT PROGRAMMES FOR CARE STAFF

Anchor is England's largest not-for-profit provider of housing and care for people in later life. It provides retirement housing to rent and to buy, retirement villages and residential care homes, including specialist dementia care.

Anchor serves more than 65,000 residents in 54,000 homes across 1,700 locations. Its residential care services employ most of the 9,000-strong workforce, providing services to residents at 114 care homes.

Difficulties in recruitment often stem from a misconception that the care sector is low skilled and low paid and offers little in the way of career progression. Many people with the correct skills and values to work in care will choose to pursue a career in the NHS. To address this, Anchor has developed a series

of training and development programmes that offer new and current staff a range of learning and development opportunities. There is a clear career path aimed at encouraging staff to stay with the organisation.

By autumn 2021 there were 486 staff on Anchor's learning programmes, an increase of 23 per cent on the previous year.

There is a big emphasis on apprenticeships. The main apprenticeship programme aims to recruit people into entry-level roles, running over 18 months to build the skills and experience for a career in care, learning alongside more experienced team members.

Typically, 70 per cent of those who complete the programme will go on to secure a permanent role with Anchor. Of the 100 learners on the 2020–21 programme, so far 79 remain with Anchor; of these, 31 have already secured a permanent position, and all of them continue to work towards their qualification.

Since September 2020, 113 apprentices have achieved their qualification and a further 40 are set to complete the programme by December 2021.

Keeping and developing talent

With chronic high vacancy rates and the service under stress, retaining its existing staff is obviously crucial for the NHS. But despite much discussion of the issue, retention – as measured by staff turnover rates – has not improved in recent years either in many institutions or in the NHS as a whole.[120] It also compares badly with the rest of the UK workforce.[121]

A wide range of factors influence retention rates, including the age of the workforce (retirement accounts for roughly a fifth of all leavers), pay, the quality of leadership, the stress of the job, opportunities for career advancement, whether staff feel they are working in a supportive environment, patterns of immigration and emigration, and competition between providers.

Pay is an inescapable issue. After many years of sustained progress on raising nurses' relative pay, ground was lost during the years of austerity. With many

areas of the economy experiencing significant staff shortages, there is a danger that nursing salaries will appear uncompetitive when people look at the balance between pressures and rewards in different careers.

There are several measures that individual organisations can take to attract, retain and develop staff:

- Flexible working – around the time, location and pattern of work. Staff still struggle to work in a way that suits their personal circumstances. Many employers have still not adopted basics such as self-managed e-rostering
- Adapting job roles for older workers – encouraging workers to work for longer rather than take retirement by adapting the role to meet their needs[123]
- Career development – it is not just about the race to the top. Some employees are looking for lateral development and to acquire new skills and experience as well as promotion
- An open and supportive environment – such as staff feeling engaged and listened to, and working in supportive teams that encourage open discussion of workplace issues
- Good occupational health – such as annual physical and mental health checks
- Coaching and mentoring – such as providing 'preceptorships', which are structured periods of transition for newly qualified health and social care professionals.[124]

Conclusion

The need for comprehensive reform of the health and social care workforce is now critical. Priorities include a comprehensive strategy for workforce planning, driving up digital skills and supporting the mental and physical wellbeing of every member of staff.

The NHS and social care are still seen by government and many stakeholders as separate entities with independent workforces that only integrate at their margins. Bringing the workforces of these two sectors together is key to providing the high-quality, integrated health and care service that we all aspire to, with shared programmes of recruitment, training and retention to build system-wide resilience. The new integrated care systems provide the opportunity to make this happen.

Among the many lessons from the pandemic in the UK and globally, we have seen how a resilient health and care system is built on the interdependency of different skills, the ability to adapt in challenging environments, a willingness to break down barriers between services, teams and professions, and a determination to keep quality and safety at the centre of everything we do.

But current approaches to training do not reflect the needs of an integrated care system. Traditional professional norms predominate, to the detriment of seamless care. Roles such as nurse specialists, allied health professionals and pharmacists make a vital contribution, but they are often overlooked by system leaders and workforce planners.

We still lack a workforce strategy that is fit for purpose in this digital age. Society is far ahead of the health and social care system in its acceptance of the digital future, and those responsible for workforce and technology planning need to reflect this urgently in action to improve digital readiness, infrastructure and training. Digital systems offer a new relationship with the citizen that can encourage self-care and community resilience while driving up the capacity and quality of services.

In recent years health and social care staff have experienced unprecedented pressures, not just from the pandemic but through additional demand from an ageing population, whose increasingly complex care needs have not been matched by appropriate investment in staff, infrastructure and capacity. There is an immediate need for health and social care organisations to reflect on the harm experienced by staff in these extraordinary times, and to ensure there are suitable support programmes in place to aid recovery.

Alongside the valiant efforts of key workers, the pandemic has reminded us that volunteerism is a major feature of our society that brings out the best in our communities. Volunteering needs to be supported and developed, while remembering there are clear limits to what volunteers can do. Without a comprehensive workforce strategy, our health and care system will continue to struggle to meet the country's needs. Planning, investment and reform are vital and urgent.

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