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Health and Social Care Committee

Workforce: recruitment, training and retention in health and social care

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Report, together with formal minutes relating to the report

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Health and Social Care Committee

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Executive summary

1. The National Health Service and the social care sector are facing the greatest workforce crisis in their history. As of September 2021, the NHS was advertising 99,460 vacant posts: for social care, it was 105,000.[1] New research by the Nuffield Trust suggests that the NHS in England could be short right now of 12,000 hospital doctors and over 50,000 nurses and midwives.[2] The number of people on a waiting list for hospital treatment rose to a record of nearly 6.5 million in April 2022, and the 18-week target for treatment has not been met since 2016.[3] Yet demand on the health and social care sector continues to grow relentlessly with an extra 475,000 jobs needed in health and 490,000 jobs needed in social care by the early part of the next decade.[4]

2. In the face of this, the Government has shown a marked reluctance to act decisively. The workforce plan promised in the Spring has not yet been published and will be a 'framework' with no numbers, which we are told could potentially follow in yet another report later this year. There has been progress towards the 50,000 nurses target but at the same time the then Secretary of State admitted to us he was not on track to deliver the 6,000 additional full-time equivalent GPs promised in the Conservative party manifesto—the NHS lost 717 FTE GPs between March 2019 and March 2022.[5] The persistent understaffing of the NHS now poses a serious risk to staff and patient safety both for routine and emergency care. It also costs more as patients present later with more serious illness. But most depressing for many on the frontline is the absence of any credible strategy to address it. It is time to stop photographing the problem and deal with it.

3. The refusal to do proper workforce planning also risks the Government's principal objective for the NHS at the moment, namely, to tackle the Covid backlog. The Health Foundation estimate the NHS will need over 4,000 more doctors and almost 19,000 more nurses to do so,[6] and almost nine in 10 BMA members think that the Government's aim to tackle the Covid backlog is either "totally or mostly" unachievable with the existing workforce.[7]

4. These pressures have a real human impact on the health and care workforce. In August 2021 alone, the NHS lost two million full-time equivalent days to sickness, including more than 560,000 days to anxiety, stress, depression, or another psychiatric illness.[8] The result is that many in an exhausted workforce are considering leaving—and if they do pressure will increase still further on their colleagues.

1 House of Commons Library, 'NHS key statistics: England, February 2022', 15 February 2022. Skills for Care (RTR0034)
2 William Palmer (Senior Fellow at The Nuffield Trust) (RTR0163)
3 House of Commons Library, 'NHS Key Statistics: England, June 2022', 30 June 2022
4 Skills for Care (RTR0034), The Health Foundation, 'Summary note: workforce projections', February 2021
5 Q242, NHS Digital, 'General Practice Workforce, 30 April 2022', May 2022
6 The Health Foundation, 'Government must be realistic about the time and resources needed to clear the NHS backlog', 6 January 2022
7 British Medical Association, 'Viewpoint surveys', 31 May 2022
8 British Medical Association (RTR0070)

Recruitment

5. In our inquiry we heard that almost every healthcare profession is facing shortages, including in intensive care, emergency medicine, ophthalmology, anaesthetics, neurology, microbiology and infectious diseases, speech and language therapy, respiratory medicine, dietetics, rheumatology, surgery, general practice, haematology, dermatology, paediatrics, pathology, nursing, midwifery, sexual and reproductive healthcare, occupational health, psychiatry, radiology, oncology, dentistry, pharmacy, and obstetrics and gynaecology.[9] Despite this, the Government rejected out of hand the recommendation to improve the supply of new staff with an independent analysis of the shortage in every specialty, voting it down three times in the recent Health and Care Bill.

6. The situation is regrettably worse in social care. One in three care workers left their job in 2020–21, a serious setback to the continuity of care which is so essential to those who receive social care.[10] In December 2021, Care England reported that 95% of care providers were struggling to recruit staff, and 75% were struggling to retain their existing staff.[11] Care workers often find themselves in under-paid roles which do not reflect the value to society of the service they provide. Without the creation of meaningful professional development structures, and better contracts with improved pay and training, social care will remain a career of limited attraction even when it is desperately needed.

7. The clearest and most urgent need is action on workforce planning. The Secretary of State promised us a workforce strategy with short and long-term workforce projections would be published in Spring 2022. The strategy has been pushed back to the Autumn, and the Secretary of State said that the publication of any numbers will be subject to "cross Government agreement".[12] The Government's refusal to readily make public this data means that the basic question which every health and care worker is asking: *are we training enough staff to meet patient need*? will remain unanswered. Without transparency on these numbers, there can be little confidence amongst the public, and little confidence amongst the NHS and social care workforces, that the Government has got a firm grip on the crisis in which it finds itself.

8. In the absence of an independent mechanism to assess the increase necessary, we accept the recommendation of the Medical Schools Council and the Academy of Medical Royal Colleges that the number of medical school places in the UK should be increased by 5,000 from around 9,500 per year to 14,500. This increase is a long-term solution to bolster the ranks of the NHS and increase overall headcount, but more immediate short-term actions must also be taken to address the current crisis.

9 The Faculty of Intensive Care Medicine (RTR0002), Royal College of Emergency Medicine (RTR0011), The Royal College of Ophthalmologists (RTR0013), Royal College of Anaesthetists (RTR0024), Association of British Neurologists (RTR0031), British Infection Association (RTR0032), Royal College of Speech and Language Therapists (RTR0040), British Thoracic Society (RTR0042), British Dietetic Association (BDA) (RTR0043), British Society for Rheumatology (RTR0045), Royal College of Surgeons of England (RTR0049), Royal College of General Practitioners (RTR0051), British Society for Haematology (RTR0062), British Association of Dermatologists (RTR0066), Royal College of Paediatrics and Child Health (RTR0087), Royal College of Pathologists (RTR0094), Nursing and Midwifery Council (RTR0097), Faculty of Sexual and Reproductive Healthcare (FSRH) (RTR0117), The Royal College of Psychiatrists (RTR0131), Royal College of Radiologists (RTR0133), Cancer Research UK (RTR0098), British Dental Association (RTR0101), Royal Pharmaceutical Society (RTR0110), Royal College of Obstetricians and Gynaecologists, 'RCOG Workforce Report 2022', February 2022.

10 Skills for Care, 'The state of the adult social care sector and workforce in England 2021', p13

11 Care England (RTR0069)

12 Q370

9. Whilst shortages in any area pose patient safety risks, these are particularly pressing in maternity services. In July 2021, we recommended that NHSE needed an additional 2,000 midwives and 500 obstetricians to operate at a level that the staffing tool Birthrate Plus considered safe. This recommendation was supported by the Ockenden report and accepted by the Government. However, despite this, the NHS in England lost 552 midwives between March 2021 and March 2022. We asked the Secretary of State for a deadline by when the shortfall would be addressed but as yet no date has been set. It is essential this is published so expectant mothers can have confidence their maternity services are heading towards safety.

10. Reforms must be made to the Health and Care visa scheme to ensure that it meets the needs of care workers and care providers. The Government should consider helping with international recruitment to social care by waiving the cost of sponsorship certificates and licences for one year and other similar measures.

11. As part of the expansion of medical schools, the cap on the number of medical school places offered to international students should be lifted by allowing full registration at the end of the Primary Medical Qualification and asking international students to fund the cost of their foundation year placements. The General Medical Council should ensure that placements in primary and secondary care are available for all medical school places offered.

12. Administrative barriers are often placed in the way of talented international medical graduates who wish to work in the NHS and could make an important contribution. To streamline this process, and boost recruitment into the NHS, the GMC should introduce a "green list" of countries with reputable medical training and education whose doctors are given an automatic right to practise in the UK following the minimum necessary checks.

13. We believe that the GMC's emphasis on acquiring competency in postgraduate training, rather than focusing on "time-served", is correct. The Government should commission an independent review of all postgraduate medical training to consider whether it is possible to reduce the time it takes to obtain a postgraduate qualification, whilst maintaining rigorous patient safety and professional standards.

14. Many health care assistants could make excellent nurses but are unable to afford the training because of the lack of bursaries and the affordability of hospital-based childcare. This needs to be addressed because their experience often makes them valued additions to the nursing workforce. The prospect of career progression would also help to keep them in the sector.

Retention

15. A radical review of working conditions is needed to reduce the intensity of work felt by many frontline professionals and boost retention. This should start with an overhaul of flexible working to encourage NHS workers to retain permanent NHS positions whilst being able to choose working arrangements better suited to their lifestyles. This would mean they were not forced to join agencies or become locums to gain control over their working lives. The NHS should commit that within 12 months, all regular NHS staff should be able to opt for similar flexibilities to those enjoyed by locum or agency staff. This should include making reduced or flexible hours available to everyone, but especially

those with caring responsibilities and those nearing retirement, with increased flexibility for home working using technology. Rota management will need to be done carefully to ensure adequate cover in anti-social hours, but this should be easier with improved overall retention.

16. New doctors and graduates are unlikely to be receiving the quality or intensity of training they require whilst in locum positions. We recommend that no newly qualified doctor should undertake full-time locum work for two years after their qualification and that incentives should be put in place to progressively reduce the number of newly qualified postgraduate doctors who choose to go straight into locum work. Guaranteed flexibility in salaried contracts would help to deliver this.

17. NHSE should develop a national NHS "retire and return" policy to replace ad hoc local schemes. This should include greater flexibility in the role that more senior members of the workforce can play, including around late-night and on-call working. The NHS should develop and implement a national menopause strategy which is focused on the retention of senior staff who may be reducing their hours, leaving management or supervisory roles, or retiring earlier than intended, because of a lack of support around menopause.

18. It is a national scandal that senior doctors are being forced to reduce their working contribution to the NHS or to leave it entirely because of NHS pension arrangements. We accept the Government has made some progress in this direction with changes to the taper rate of the annual allowance. But the problem persists and having rejected calls to establish a tax unregistered scheme the Government must act swiftly to establish an alternative scheme and prevent the early retirement of Consultants from the NHS.

19. There are also serious issues around the abatement rules that prevent retired nurses working additional hours when they are willing to do so. These should be addressed in order to improve the supply of highly experienced nurses who could make a big difference to nursing shortages.

20. We were deeply disappointed to hear evidence of racism within the NHS, with workers subjected to racist bullying, harassment, and abuse from colleagues and patients. This behaviour goes against the founding values of the NHS and more effort should be made to eliminate it. There should be greater accountability from NHS senior management for the reduction of incidents of racist discrimination amongst staff, between health workers, and from the public.

Social care

21. The value of continuity of care in social care settings, particularly amongst those who care for adults with autism or other severe learning disabilities, is something we heard about a great deal about, but it can only be addressed by improving retention in the sector. We repeat our recommendation that annual funding for social care should be increased by £7 billion by 2023–24.[13] This will account for demographic changes, uplift staff pay in line with the National Minimum Wage and protect people who face catastrophic social care costs.

13 Health and Social Care Committee, 'Social Care: funding and workforce', 13 October 2020, HC 206

22. Witnesses to this inquiry left us in no doubt that pay is a crucial factor in recruitment and retention in social care. Social care providers are consistently being outbid by the retail and hospitality sectors. A long-term, sustainable strategy is needed with the prospect of pay progression, professional development, and career pathways.

23. New regulations should be introduced by 2023 in which care workers initially employed on zero-hours contracts are offered a choice of contract after three-months of employment. The new regulations should state that time allocated for travel and care must be clearly set out in the contracts of domiciliary care workers.

24. The Government should introduce an externally validated care certificate which is transferable between social care providers and between social care and the NHS. The Government should bring forward clear progression paths for those who want to continue professional development who enter social care and provide standardisation between training received in the sector to allow such progress and recognition.

1 Workforce planning

Health and Care Act

25. On three occasions during the passage of the Health and Care Act 2022, the Government voted against amendments which would have required the Secretary of State to publish independently verified assessments of current and future workforce numbers every two years. These amendments had broad support from over 100 health and social care stakeholders.[14] As Professor Dame Helen Stokes-Lampard, Chair of the Academy of Medical Royal Colleges and Professor of GP Education at the University of Birmingham, told us:

> No organisation should fear a report just because it does not like the outcome, and because it suggests that we might need more of something. It does not hinder planning in other areas of our life and society. We create plans. We look to the future. Even if we cannot resource them to the hilt right now, at least we can plan and we know where we are aiming to get to.[15]

Our Expert Panel evaluated the Government's commitment to "ensure that the NHS and social care system have the nurses, midwives, doctors, carer and other health professionals that it needs" and found overall that the Government's progress against this commitment had been inadequate.

26. The then Secretary of State, Rt Hon Sajid Javid MP, told us that under the Health and Care Act 2022, he has a duty:

> To publish at least every five years what was referred to as a healthcare workforce accountability report and a similar report for adult social care. I really want to make something of that. It is a new thing and has not been published before. You will have the NHS 15-year strategy, but it is important to have periodic accountability reports on workforce that talk about progress, numbers, gaps, and all of that.[16]

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

14 Royal College of Physicians, 'Strength in Numbers - another opportunity to push on workforce planning in the Health and Care Bill', 5 April 2022
15 Q40
16 Q371

Framework 15 and the NHS workforce strategy

28. Framework 15 is a long-term strategic framework for the health and social care workforce which was commissioned by the Government and developed by Health Education England. Submissions to this inquiry generally agreed that Framework 15 was "an important starting point" but that it did not constitute "a nationally coordinated, fully costed and funded long-term workforce plan".[17]

29. Framework 15 was first published in 2014 and updated in 2017.[18] When the Secretary of State gave evidence in November 2021, he said that a refreshed Framework 15 would be published in Spring 2022.[19] During this inquiry, he told us that the Framework would be published in Autumn 2022.[20]

30. We received contradictory accounts of whether the research going into Framework 15 encompasses current and projected workforce numbers and whether those numbers will ever be made public. When asked whether Framework 15 would publish the number of psychiatrists needed in 15 years' time, Dr Navina Evans, Chief Executive of Health Education England, told us: "we will be able to give numbers for the nearer term … for 15 years it becomes more difficult, but we will be able to give a range".[21]

31. Amanda Pritchard, Chief Executive Officer of NHS England, told us that the Secretary of State "has committed to sharing the headlines of that plan in the autumn" and when pressed on whether the numbers would be shared, she said:

> In terms of transparency in the publication of data and figures, we are completely committed to that … The plan we will be developing with HEE will have numbers in it. I suspect there is a conversation you will want to have with the Secretary of State about what will then be made public.[22]

32. Danny Mortimer, Chief Executive of NHS Employers, told us that "the decision about what numbers are published in a variety of documents is a political one", but that "if your colleagues in Government will allow my colleagues in the arm's length bodies to publish the data … I think we will have a much clearer picture."[23]

33. The Secretary of State appeared to confirm that Framework 15 will contain no numbers. He told us that "what you will get in Framework 15 is not numbers" but "the drivers of the workforce".[24] However, he confirmed that he has commissioned a workforce strategy which "will include the numbers for different professions", which he expects to be completed "by the end of this year", telling us "once that is complete, we will certainly publish the conclusions of that outcome".[25] Later, he suggested that the publication of the "full report" of the workforce strategy, which "will include the gap analysis and what is

17 NHS Providers (RTR0012). See for example: The King's Fund (RTR0099), Royal College of Physicians (RTR0053), British Society for Rheumatology (RTR0045), and Royal College of Emergency Medicine (RTR0011).
18 Health Education England, 'Framework 15: Health Education England Strategic Framework 2014–2019', February 2017
19 Q203
20 Q307
21 Qq266–267
22 Q326
23 Qq283–286
24 Q338
25 Qq339–341

needed in each profession" would be "subject to cross-Government agreement".[26] This lack of clarity on if and when data on workforce shortages will be published is deeply troubling to anyone concerned about whether the NHS is training the right people in the right numbers in the right specialties. To take just one example, the Royal College of Anaesthetists has already warned that there is a danger that "less high-profile" specialties could be overlooked because of the focus on high-profile public commitments on the numbers of GPs and nurses.[27]

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

26 Q370
27 Royal College of Anaesthetists (RTR0024)

2 Recruitment in Health

Recruitment into nursing

35. Analysis from The King's Fund suggests that the Government is on course to recruit its target of net 50,000 nurses by 2024, but that "current recruitment doesn't seem to be having any meaningful impact on the true scale of nursing shortages", and that "hitting the target will not solve the issue of workforce shortages".[28] "Demand for nurses is increasing more quickly than supply", and there are particular shortages in Greater London, the Midlands, and the North East and Yorkshire.[29]

36. The Royal College of Nursing "is clear that recruits to nursing higher education in England must increase significantly, and that there must be no financial barriers for anyone wanting to undertake a nursing degree."[30] In 2017, the Government discontinued the nursing bursary. This led to "an immediate significant decline" in the number of applicants to nursing courses (51,840 in 2016 to 40,060 in 2017).[31] In January 2020, the Government introduced a £5,000 maintenance grant for nursing students (£8,000 in some limited circumstances).[32] The number of applicants rose by 5,800 (18%) between 2019 and 2020.[33] The Royal College of Nursing writes that "this suggests the introduction of the grant is a part of a necessary and effective measure to support new recruits".[34]

37. The Royal College of Midwives wrote to tell us that the cessation of the Government bursary scheme has had a particular impact on older entrants, as they are "less likely to be able to afford to train unwaged", but that younger entrants have a "higher attrition rate through early careers".[35] The Royal College of Midwives advocates for targeted recruitment for midwifery to older entrants in the South East and rural areas "because they are more likely to stay", and say that a bursary "would significantly improve our chances of attracting those applicants".[36] Both the Royal College of Midwives and the Royal College of Nursing support the reintroduction of a bursary or grant for nursing and midwifery.[37]

38. At a roundtable hosted at an NHS Acute Trust, we heard from one senior nurse that his department is missing 30% of their nursing staff, and as such, they are reliant on agency staff who are paid double or triple what his permanent staff are paid. Some of these agency staff have been employed in the same wards for several years. Although we heard that "nobody wants to employ an agency nurse" and that "we use agency only as a last resort", we also heard that agency staff are employed "pretty much every day" to ensure that safe care is provided to patients. The staff were keen to tell us that this practice "isn't because people are malicious" but because of the debt that student nurses incur during

28 The King's Fund, 'Is the NHS on track to recruit 50,000 more nurses? Hitting the target but missing the point', April 2022
29 The King's Fund, 'Is the NHS on track to recruit 50,000 more nurses? Hitting the target but missing the point', April 2022
30 The Royal College of Nursing (RTR0092)
31 The Royal College of Nursing (RTR0092)
32 The Royal College of Nursing (RTR0092)
33 The Royal College of Nursing (RTR0092)
34 The Royal College of Nursing (RTR0092)
35 The Royal College of Midwives (RTR0126)
36 The Royal College of Midwives (RTR0126)
37 The Royal College of Midwives (RTR0126), The Royal College of Nursing (RTR0092). See also Methodist Homes (MHA) (RTR0116), Turning Point (RTR0123)

their training. It was suggested to us that if nurses had better bursaries during their training, with a guarantee of graduating with little to no debt in exchange for "guaranteed work in the NHS", it would solve the problem of nurses graduating and moving straight into agency work. At the same roundtable, we heard about talented Healthcare Assistants (HCAs) who would make excellent nurses but are unable to afford to train because of a lack of funding and a lack of affordable childcare. The introduction of a bursary would ensure that HCAs are able to progress into a career in nursing, should they choose to do so.

39. Under the previous rules, a full NHS bursary would pay a student's tuition fees (up to £9,000) and give both a non-means-tested grant (£1,000) and a means-tested bursary (between £2,207 and £3,191).[38] We believe that if the Government were to reinstate this system, readjusted for inflation, but with the caveat that nurses in receipt of the bursary had to commit to working in the NHS Trust in which they had received their training for three years after they had graduated, the NHS would save significantly on agency fees. This bursary would also help to encourage older applicants, and to retain nurses in areas which are under-served by healthcare professionals.

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

Re-recruitment of those who have voluntarily surrendered their medical licence

41. The Royal College of Surgeons of Edinburgh described "those who have recently voluntarily surrendered their medical licence" as "a potential source of recruitment which the NHS cannot afford to ignore" and advocated an approach of "actively headhunt[ing], rather than the passive appeals thus far undertaken".[39] Those who have surrendered their licence fall into two broad categories: retirees and those who have left the profession early for other reasons. 68.5% of clinicians who surrender their medical licences do so for reasons of "stress, burnout, bullying, or poor workplace culture", with 7% of doctors doing so within three years of qualifying.[40]

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

38 Department of Health, 'The NHS bursary scheme new rules', Fifth edition, May 2016. Figures given are for the academic year from 1 September 2016 to 31 August 2017.

39 The Royal College of Surgeons of Edinburgh (RTR0096)

40 The Royal College of Surgeons of Edinburgh (RTR0096)

Re-entry programmes for secondary care

43. Whilst there is a formal re-entry programme for primary care doctors who wish to return to work after a long break, no similar programme exists for secondary care. We have received submissions suggesting that there is an "urgent need" to develop such programmes.[41] NHS Professionals argue that returner pathways are viewed as "onerous, time-consuming and costly", particularly because skills date quickly.[42]

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

Training to task

45. Nicola McQueen, CEO of NHS Professionals, told us that during the pandemic:

> We were fortunate enough to stand up 16,000 vaccinators for the national vaccine programme … In that same campaign, we interacted with a quarter of a million people who were NHS curious … Yet very often our recruitment processes screen them out … Five people go for the job, and four people get disappointed. We still need those four people, thank you very much. How do we nurture them into our process? Some of that is through training and access to training.[43]

46. As Nicola McQueen argued, this innovation was possible, because "we changed the law on training to task".[44] This legal change was the emergency powers introduced in the Coronavirus Act 2020, which allowed the registration of health associates without the usual provisions relating to education and training.[45]

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

Maternity services recruitment

48. England remains one of the safest places in the world to give birth, but it has become clear during the course of this inquiry that the maternity workforce is under serious pressure. As one attendee to a roundtable held at an NHS Acute Trust put it: "I think our unit is very safe, I think we cope with it very well, but we are on the edge of being able to cope, and our juniors are burnt out." We heard from Gill Walton, Chief Executive of the Royal College of Midwives, that the midwifery workforce is "very fragile", that there is "a

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41 Dr Cliona Ni Bhrolchain (Retired at Retired) (RTR0029); Royal College of Paediatrics and Child Health (RTR0087)
42 NHS Professionals (RTR0091)
43 Q51
44 Q51
45 Nursing and Midwifery Order 2001 (SI 2002/253), s.9A(10) (as amended by the Coronavirus Act 2020, Schedule 1, s.2(1))

huge shortage" of workers, and that "morale is really low".[46] The Nursing and Midwifery Council wrote to us about the "impact of vacancies and low staffing levels on patient safety and staff resilience", explaining that the solution was "effective and sustainable workforce planning".[47]

49. The Ockenden report states "it is absolutely clear that there is an urgent need for a robust and funded maternity-wide workforce plan, starting right now, without delay and continuing over multiple years" because "only with a robustly funded, well-staffed and trained workforce will we be able to ensure delivery of safe, and compassionate maternity care locally and across England".[48] The Department of Health and Social Care funded the Royal College of Obstetricians and Gynaecologists (RCOG) to develop a workforce planning tool which will calculate the number of obstetricians required both locally and nationally across England and Wales. This tool was meant to be in place by Autumn 2021, but work was still ongoing when the RCOG published their annual workforce report in February 2022.[49]

50. In July 2021, as part of our inquiry into *The safety of maternity services in England*, we recommended that the budget for maternity services be increased by £200–350m per annum, and that this funding increase be kept under close review as more precise modelling is carried out on the obstetric workforce and as Trusts continue to undertake regular safe staffing reviews of midwifery workforce levels.[50] This recommendation was seconded by the Ockenden report and accepted by the Government.[51]

51. As part of the same inquiry, we heard that the NHS needed an additional 1,932 midwives and 496 obstetricians to operate at a level that Birthrate Plus considered the minimum safe for women and babies.[52] The then Secretary of State told us the Government is "committed" to delivering these workforce levels.[53] In a letter from the then Parliamentary Under Secretary of State for Primary Care and Patient Safety, Maria Caulfield MP, we heard that NHS England and Improvement have "invested £95 million to support the recruitment of 1,200 more midwives and 100 obstetricians and to support multi-disciplinary team training": this target is 732 midwives and 396 obstetricians short of the minimum levels Birthrate Plus says is needed to make maternity services in England safe.[54] Despite this investment and in the face of steady growth in the profession since 2009, NHSE lost 552 midwives between March 2021 and March 2022.[55]

52. The consequences of workforce shortages on pregnant, labouring, and post-natal women are potentially devastating at a time when they should be receiving the best care possible. The Royal College of Midwives told us that "for women, this means they have a 20% chance of being left alone in labour or shortly after birth, antenatal care is often

46 Q205
47 Nursing and Midwifery Council (RTR0097)
48 Findings, conclusions, and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust, 30 March 2022, xi
49 Royal College of Obstetricians and Gynaecologists, RCOG Workforce Report 2022, February 2022
50 House of Commons, Health and Social Care Select Committee, The safety of maternity services in England, 29 June 2021, HC 19, p15
51 Findings, conclusions, and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust, 30 March 2022, p160
52 House of Commons, Health and Social Care Select Committee, The safety of maternity services in England, 29 June 2021, HC 19, p15
53 Q356
54 Letter from Maria Caulfield MP, 6 May 2022
55 NHS Digital, NHS Workforce Statistics, 26 May 2022

disjointed and postnatal care poor".[56] For midwives, it can mean working for long hours without a break, working "through stress and fatigue, aware of the implications that had for safe practice", being unable to seek advice from colleagues, and not being able to spend time building trust with women before, during, and after birth.[57]

Improving diversity in maternity recruitment

53. In 2021, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK) reported that black women in the UK are over four times and Asian woman two times more likely than white women to die in the perinatal period (pregnancy and the year after giving birth).[58] Research has also shown that black, Asian, and mixed race women are more likely to experience baby loss, become seriously ill, and have worse experiences of pregnancy care than white women.[59] When asked what is being done to tackle this inequality, Gill Walton told us that the pandemic "highlighted issues for black, brown, and Asian mothers", and that "focusing midwifery continuity" on this group "is so important to improve outcomes".[60] Walton told us that "top of our list" is improving diversity in the recruitment of midwives:

> Recruitment locally, and services locally, need to reflect the population. For that, you have to be able to attract people appropriately into the profession. Midwives say, "They need people to look like them." That is so important … We are all committed to that.[61]

Many respondents to the call for evidence for the Birthrights report into racial injustice and human rights in UK maternity care "described receiving more respectful and personalised care from Black, Brown or minority ethnic staff."[62]

54. In an effort to support pregnant women from black and minority ethnic backgrounds, the NHS Long Term plan commits to ensuring that by 2024, 75% of pregnant black and minority ethnic women will receive care from the same midwife before, during, and after they give birth.[63] Continuity of care is proven help reduce pre-term births, hospital admissions, the need for intervention during labour, and to improve women's overall experience of care.[64] We applaud the ambition of this recommendation, and do not doubt that it will improve the experiences, and indeed save the lives, of pregnant, labouring, and postnatal women and their babies. However, it is difficult to see how the NHS will be able to deliver continuity of care to this standard with its current workforce shortages.

55. When asked about ethnic disparities in maternity safety rates, the Secretary of State told us: "we will leave no stone unturned to make sure that we improve maternity care in this country and every woman feels safe, no matter what her background."[65]

56 The Royal College of Midwives (RTR0126)
57 The Royal College of Midwives (RTR0126)
58 MBRRACE-UK, Saving lives, improving mothers' care: Lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2017–19, November 2021
59 Birthrights, Systematic racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care: Executive summary, May 2022, p9
60 Q230
61 Q231
62 Birthrights, Systematic racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care: Executive summary, May 2022, p81
63 NHS, The NHS Long Term Plan, January 2019, p41
64 NHS, The NHS Long Term Plan, January 2019, p41
65 Q355

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

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

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

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

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

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

International recruitment

62. The NHS is dependent on the service of highly qualified and dedicated overseas staff. One in seven current NHS staff reports a non-British nationality.[66] 47% of new GP trainees are international medical graduates.[67] Just over 50% of new registrants to the GMC register are international graduates.[68] This level of international recruitment is not sustainable in the context of a global shortage of health professionals, and it is abundantly clear that more needs to be done to bolster domestic recruitment into the NHS. However, more also needs to be done to make the NHS an attractive, welcoming, and supportive place for international healthcare staff.

63. Several witnesses wrote to call for better arrangements with other countries for the mutual recognition of medical qualifications.[69] We heard from researchers at the University of Plymouth about the particular difficulties that international doctors have in joining the GP or specialist register both at the time of initial entry and further on in their careers.[70] In 2009, 3,860 doctors moved to the UK to practise.[71] By 2014, 11.6% had joined the speciality register.[72] By 2019, the figure was just 27.2%.[73] There is clearly an issue preventing internationally trained doctors from receiving accreditation as specialists.

64. The Certificate of Eligibility for Specialist Registration process was widely condemned by witnesses to this inquiry. It was described as "lengthy and opaque", "complex, difficult and expensive with potential inconsistencies", and in need of "regulatory reform" to make it "proportionate and streamlined" to "assist in ethical overseas recruitment".[74]

65. Many witnesses to the inquiry were concerned with how to undertake international recruitment ethically, particularly when recruiting staff from low-income countries.[75] We note the existence of the Medical Training Initiative (MTI), a training scheme which recruits a number of international medical graduates to work and train in the NHS for a maximum of 24 months.[76] The "primary purpose" of the MTI is "to contribute to improving the quality of healthcare in developing countries" and thus it prioritises the placement of the citizens of developing countries in the allocation of placements.[77] The Royal College of Surgeons of Edinburgh administers a similar programme called the International Postgraduate Deanery.[78] Several submissions to the inquiry called for the MTI to be expanded.[79]

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66 House of Commons Library, 'NHS staff from overseas: statistics', 20 September 2021
67 Royal College of General Practitioners (RTR0051)
68 Q145
69 The King's Fund (RTR0099), BUPA (RTR0130), General Medical Council (RTR0132), Sue Ryder (RTR0055)
70 University of Plymouth (RTR0081)
71 University of Plymouth (RTR0081)
72 University of Plymouth (RTR0081)
73 University of Plymouth (RTR0081)
74 Royal College of Paediatrics and Child Health (RTR0087), Faculty of Sexual and Reproductive Healthcare (FSRH) (RTR0117), Royal College of Radiologists (RTR0133), Academy of Medical Royal Colleges (RTR0046). See also Q161.
75 See, for example: Association of British Neurologists (RTR0031), Dr Emma Hayward (Senior GP Specialist Educator at University of Leicester Medical School) (RTR0028), The Health Foundation (RTR0124), Norfolk County Council (RTR0122)
76 Academy of Medical Royal Colleges, Medical Training Initiative
77 Academy of Medical Royal Colleges, Medical Training Initiative
78 Royal College of Surgeons of Edinburgh, 'International postgraduate deanery', accessed 23 June
79 Royal College of Physicians and Surgeons of Glasgow (RTR0026), Academy of Medical Royal Colleges (RTR0046), Royal College of Surgeons of England (RTR0049)

66. We heard that international medical graduates face difficulties with getting stable and secure visas for them and their dependants, including adult dependants.[80] Dr Latifa Patel, Interim Chair of the BMA representative body, told us:

> If there were one thing that you were going to sort out for our international medical graduates, it would be their visas. It would not be visas just for them … Our visa requirements make it very difficult for them to bring their parents over here.[81]

67. The Royal College of Nursing told us that their members "report difficulties in bringing family members to the UK through Sole Responsibility and Adult Dependency routes because of the high burden of evidence that is required by the Home Office".[82] This can potentially leave nurses separated from family members who need their care, and "contribute to ongoing recruitment and retention challenges within the UK".[83]

68. Since October 2020, health and care professionals who have entered the country on the health and care worker visa have been exempted from paying the immigration health surcharge (IHS). However, healthcare professionals, including MTI doctors, who enter the country on a Tier 5 visa must pay the IHS and then seek to reclaim it.[84]

GP visas

69. The Royal College of General Practitioners wrote to us to explain that current visa regulations mean that international medical graduates (IMGs) who train to be a GP in the UK "face significant bureaucracy if they wish to remain in UK general practice".[85] When GPs finish their three-year training course, they must find an employing practice to act as a sponsor in the short time before their visas expire. This is a significant burden on the NHS and on the "hundreds of GPs [who] need this support each year".[86] GPs are particularly disadvantaged because IMGs can apply for indefinite leave to remain after five years in the UK: every other medical specialty has training which lasts more than five years, which means most IMGs can secure indefinite leave whilst still sponsored by their training body.[87]

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

80 The Royal College of Nursing (RTR0092), Q20
81 Q167
82 The Royal College of Nursing (RTR0092)
83 The Royal College of Nursing (RTR0092)
84 Royal College of Surgeons of England (RTR0049), Academy of Medical Royal Colleges (RTR0046)
85 Royal College of General Practitioners (RTR0051)
86 Royal College of General Practitioners (RTR0051)
87 Royal College of General Practitioners (RTR0051)

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

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

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

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

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

3 Retention in Health

Workplace facilities

76. We received written evidence about "quick wins" which could immediately improve retention within NHS hospitals. This included practical suggestions about the physical safety and comfort of staff, including the provision of hot food and drinks 24/7, free parking for hospital staff, and facilities for staff to rest, change, shower, store their belongings, and take breaks with colleagues.[88]

77. Dr Latifa Patel told us:

> To give you my personal circumstances, I am a mother—I have just been on maternity leave—and childcare provisions are incredibly expensive, particularly for those working shift work. Going back into the NHS, we have very poor services, not just for mothers but for wellbeing in general. Rest facilities are not very common … Parking is expensive. We don't have 24-hour access to hot food or hot drinks. I am a mum who is breastfeeding, and there aren't facilities for me to express. If you are going to think about how you want to retain members of the workforce who are leaving and keep people within the NHS, work on our terms and conditions. It is not rocket science; it is the really simple things.[89]

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

Childcare

79. At a roundtable hosted at an NHS Acute Trust, we heard about the difficulties that some staff had in securing affordable childcare that was available in line with hospital shift patterns. The hospital nursery did not take children under three years of age, its regular hours were 8am until 6pm Monday to Friday and it was not open during Bank Holidays or weekends. This left parents who worked outside those times to make their own alternative arrangements. As one roundtable participant said: "We're currently a female-led workforce. Who can get childcare from 6 o'clock in the morning until 8 o'clock at night?"

80. A lack of affordable childcare particularly impacts lower-paid health and social care workers. At the roundtable, we heard about Healthcare Assistants who were entitled to two days of free childcare a week but only until 3pm, which limited which shifts they could take on. Professor Carol Atkinson, Professor of Human Resource Management at Manchester Metropolitan University, told us that "in the summer holidays, we often see a mass exodus of zero-hours contract care workers so that they can care for children

88 See, for example: Dr Daniel Darbyshire (NIHR Doctoral Fellow at Lancaster University Medical School) (RTR0016), Royal College of Physicians (RTR0053), Academy Trainee Doctors' Group (RTR0056), Royal College of Paediatrics and Child Health (RTR0087)

89 Q172

because they do not get the salary levels or other forms of support in terms of guaranteed hours contracts to facilitate childcare."[90] We received numerous submissions urging better access to flexible and affordable childcare for health and social care workers.[91]

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

Flexible working

82. Since September 2021, changes to NHS terms and conditions mean that every staff member has a day one contractual right to request flexible working for any reason.[92] Flexible working might include, but is not limited to, reduced or compressed hours, flexible start and finish times, and working from home. As Professor Em Wilkinson-Brice, Acting Chief People Officer at NHS England, explained, "flexible working is not just about going part-time", but it is true that in the NHS in particular, more and more people are choosing to work less-than-full-time, and this trend is likely to increase.[93] In 2019, 30% of paediatrics trainees chose to work less-than-full-time.[94] In 2021, it was 39%.[95] The Royal College of Paediatrics and Child Health forecast that this will increase to over 60% by 2040.[96] Less-than-full-time working is more common in some specialties than others. An average of 24% of consultants in medical specialties work less-than-full-time, but in palliative medicine, it is 69%.[97]

83. The trend towards less-than-full-time working is driven by several factors. As Professor Dame Helen Stokes-Lampard said: "there has been a generational trend between people valuing home life and life outside work more highly" but also that "people are looking to reduce the amount they are working, just to keep sane and to look after their mental health and wellbeing".[98] Professor Stokes-Lampard made the case that "flexibility improves retention in the system" and said that whilst "historically, the NHS has not been good at accommodating flexibility."[99] She continued:

> Some people, particularly those reaching the later part of their career, do not want to take on some of the more high-risk, high-adrenaline, four-in-the-morning parts of the job, but they are really happy to do the other core, very complex, sophisticated parts of the job. Good employers are nurturing that.[100]

90 Q108
91 See, for example: Royal College of Physicians (RTR0053), Breast Cancer Now (RTR0073), Royal College of Paediatrics and Child Health (RTR0087), University of West London, College of Nursing, Midwifery and Healthcare (RTR0090), Sue Ryder (RTR0055), British Medical Association (RTR0070), The Royal College of Midwives (RTR0126)
92 NHS Employers, 'Flexible working in the NHS', June 2021
93 Q298
94 Royal College of Paediatrics and Child Health (RTR0087)
95 Royal College of Paediatrics and Child Health (RTR0087)
96 Royal College of Paediatrics and Child Health (RTR0087)
97 Dr Polly Edmonds (Consultant in Palliative Medicine at King's College Hospital NHS Foundation Trust); Dr David Brooks (Consultant in Palliative Medicine at Chesterfield Royal Hospital NHS Foundation Trust); Dr Amy Proffitt (Consultant in Palliative Medicine at Barts and the London NHS Trust, President APM); Dr Mike Jones (Medical Director at Joint Royal College Postgraduate Training Board) (RTR0015)
98 Q58
99 Q59
100 Q59

84. Chris Hopson, Chief Executive of NHS Providers, described the NHS as feeling “like it is 10, 15, 20 years out of date in its ability to offer the kind of flexible working patterns that we see in other parts of the economy”.[101] Attributing this to “the degree of pressure that we are under”, he warned “if we do not do that, we are going to lose the workforce of the future”.[102] The Royal College of Physicians described access to less-than-full-time working as “essential for recruitment and retention”, arguing that “making less-than-full-time working and flexible training more accessible will make the workplace more attractive and accessible to ensure equality, diversity and inclusion of the workforce”.[103]

85. Gill Walton told us that the “flexibility to be able to plan your work” could “make a massive difference” to retention in midwifery.[104] She went on to say that “over 60% of midwives … have caring responsibilities, not just for children but for elderly relatives.[105] Professor Em Wilkinson-Brice told us that “30% of the total [NHS] workforce have caring responsibilities.”[106]

86. Flexible working will also be an important part of retaining older workers. Dr Vish Sharma, Consultant Cardiologist at Royal Liverpool and Broadgreen University Hospital NHS Trust, Chair of the BMA Consultants Committee and Chair of the BMA Pensions Committee, gave the example of people in their late fifties who are still on on-call rotas and are therefore doing “incredibly complex work late at night [which] becomes much more difficult for some people when they get older”.[107] He told us:

> The NHS is not good at recognising that and saying: ‘You have so much that you can offer, why don’t we change your role a little bit so that you can be involved in more teaching, training, or things like that?’ and allow people to work a bit longer without the intensity.[108]

87. Without an increase in overall NHS headcount, the NHS will be unable both to offer flexible working to the extent that will drive retention and to offer continuous service and care to patients. Average rates of less-than-full-time working, and what “less-than-full-time” means varies greatly between specialties and at different grades: as Professor Stokes-Lampard explained, “for one person [less-than-full-time] will be a 90% contract, and for another it will be a 70% contract.”[109] The Royal Colleges are supportive of the trend for less-than-full-time working, but are concerned for what it means for the workforce headcount. As the Royal College for Paediatrics and Child Health put it: “this flexible approach is welcome and encouraged. However, it is a concern with regards to paediatric trainee whole-time-equivalent numbers if the current cap on the number of trainee places is not reviewed.”[110] What is needed is a workforce plan which can consider rates of less-than-full time working amongst other factors to predict the number of professionals which must be trained in each speciality in five, 10, and 20 years.

101 Q61
102 Q61
103 Royal College of Physicians (RTR0053)
104 Q205
105 Q205
106 Q298
107 Q87
108 Q87
109 Q59
110 Royal College of Paediatrics and Child Health (RTR0087)

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

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

Pay

90. A 2021 NHS Staff Survey showed that just 36.7% of staff were satisfied with their level of pay, and over half of staff reported working additional unpaid hours on a weekly basis.[111] We received several submissions highlighting the need for enhanced pay to improve recruitment and retention across a range of occupations in the health and social care sector.[112]

91. Pay was felt to be a particular issue for nursing staff.[113] Dr Denise Chaffer, President of the Royal College of Nursing (RCN), told us about "nurses who are unable to pay their rent, unable to afford petrol to get to work and unable to get a mortgage" and who were even reliant on food banks.[114] In their written submission, the RCN told us that around six in 10 of their members reported that their pay band or level was inappropriate, mainly because it was felt that "pay levels have failed to keep up with increases in the cost of living" and a "perceived failure to reward nursing staff fully for their effort and contribution, and dissatisfaction with organisational pay structures".[115] Between 2011 and 2021, the average basic earning of an NHS nurse fell by 5% in real terms.[116] The RCN is currently calling for a pay award of 5% above inflation for 2022–23.[117] The RCN and the Health Foundation

111 The King's Fund (RTR0099)
112 See, for example, Royal College of Pathologists (RTR0094), British Dental Association (RTR0101), Association of British Neurologists (RTR0031), British Society for Haematology (RTR0062), The Chartered Society of Physiotherapy (RTR0072)
113 The Royal College of Nursing (RTR0092), The Royal College of Surgeons of Edinburgh (RTR0096), Macmillan Cancer Support (RTR0102)
114 Q204
115 The Royal College of Nursing (RTR0092)
116 The Health Foundation, 'Where next for NHS nurses' pay', 14 June 2022
117 Royal College of Nursing, 'NHS pay: RCN demands pay rise of 5% above inflation', 7 March 2022

called for a review of the job descriptions used for nursing roles under Agenda for Change because, in the words of the RCN, they are "frequently out of step with the reality of the skills, knowledge and accountability of the safety critical roles that nursing staff deliver".[118]

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

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

Pensions

94. We have heard clear evidence of senior medical staff both reducing their NHS hours and retiring earlier than they would otherwise because of concerns about pensions. In a recent survey, the Royal College of Surgeons of England found that 69% of respondents had reduced the amount of time they spent working in the NHS as a direct result of changes to pension taxation rules.[119] In 2019, the Royal College of Physicians found that over 50% of the 2,800 doctors surveyed had retired earlier than previously planned, with most citing pensions concerns as a reason.[120] The BMA has warned that without decisive action on pensions, more than 10% of the consultant workforce (and a similar proportion of GPs) are likely to retire within the next 18 months.[121] Mr Wayne Jaffe, Consultant Plastic and Reconstructive Surgeon at University Hospital of North Midlands NHS Trust, described his retirement as happening "almost against his will" in the context of "a cull of senior doctors" faced with "unfair and punitive additional taxes which I have to pay each year because of my seniority."[122] He told us that he was "paying tens of thousands of pounds additional tax each January due to pension growth, which I cannot do anything about."[123]

95. Dr Vish Sharma explained that the fundamental problem is with the way the NHS pension interacts with taxation policy, the result of which is that an NHS employee can be "financially worse off" for working "for longer or by not reducing hours worked": all of which creates a situation in which senior healthcare professionals "are in effect prevented from contributing further or continuing to remain within the healthcare sector."[124]

96. Danny Mortimer suggested that "the case for reform of the NHS pension scheme … to give employees much more control over what they pay in, is very clear".[125] He said that employers in the NHS have "a real appetite to have a better NHS pension scheme, and to have a pension scheme that speaks to the lowest-paid staff".[126]

118 Agenda for Change is the main pay system for NHS staff, with the exception of doctors, dentists, and senior managers. The Royal College of Nursing (RTR0092), The Health Foundation (RTR0124)
119 Royal College of Surgeons of England (RTR0049)
120 Royal College of Physicians (RTR0053)
121 BMA (British Medical Association) (RTR0149)
122 Q75
123 Q76
124 BMA (British Medical Association) (RTR0149)
125 Q300
126 Q299

97. The Secretary of State suggested that the taper rate he introduced during his time as Chancellor had solved the pensions issue because "something like 96% of GPs and doctors were inside the £200,000 level".[127] It is evidently not the case that this issue has been solved. We have heard evidence from numerous sources clearly demonstrating that the NHS is, in the words of Mr Wayne Jaffe, "haemorrhaging senior staff" over pension concerns.[128]

98. There is a misconception that this issue impacts only "the highest earners in the NHS" and a corresponding argument, made by the Secretary of State, that any solution must be "well balanced with nurses, for example, who are earning more average wages".[129] We heard at a roundtable at an NHS Acute Trust about nurses who had "retired and returned" to come back and help with the pandemic backlog but who were unable to take up additional shifts because according to abatement rules they are not allowed to earn more than the sum total of their pension plus their original salary. The pensions issue can be felt by any staff who "retire and return", including nurses, many of whom are potentially unable to work the shifts that they want to, and thus ease pressure on the NHS to the extent that they otherwise could.

99. The Secretary of State suggested that because changes made to the pensions taper rate were made for everyone "for equality reasons", any further changes made to NHS pensions would have to be made for everyone.[130] However, the Government was able to recognise the crisis facing the judiciary and make an exception for judicial systems by setting up a tax unregistered scheme for judicial pensions: an exception which allowed judges facing prohibitive tax bills to keep working.[131] Dr Vish Sharma advocated that a similar scheme be set up for the NHS, describing it as "fundamentally fair" for both the taxpayer and for doctors, and arguing that "rather than costing the Treasury money" it would "generate money" saved on "agency spends, locum spends, and pensions that you are now not paying".[132] The Government has dismissed the so-called "judge's solution" on the basis that judicial appointments are unique and judges cannot work in private practice after taking up office.[133] Danny Mortimer noted that this solution might not be supported by all trade unions.[134]

Retire and return

100. One way of recruiting recent retirees is through "retire and return" policies. However, these policies have not always been available to everyone who wants to use them. The Royal College of Physicians writes that "many of our recently retired members frequently say they have been unable to retire and return, despite wanting to", blaming Trusts for being "unwilling to allow this" or "stipulat[ing] unreasonable conditions in a new contract".[135] The Royal College of Surgeons of England has called for "clarity and consistency" around these politics, writing that there should be a "nationally agreed process" as opposed to

127 Q354
128 Q75
129 Q354; Q346
130 Q345
131 House of Commons Library, 'Judges' pension schemes', 14 September 2021
132 Q91. See also Q77
133 David Linden, 'Question for Treasury: Pensions, tax allowances', 12 May 2021
134 Q300
135 Royal College of Physicians (RTR0053)

"local ad hoc schemes".[136] The Royal College of Surgeons of Edinburgh argue that "urgent review" is needed of the current "overly complex" arrangements, as there is "confusion and variability" on how the policy is adopted and "a perceived unfairness in how it is enacted in many Trusts", resulting in "a feeling of ageist behaviour and being treated as 'second class'".[137]

101. Dr Vish Sharma told us that people recruited through "retire and return" are often "offered inferior terms compared to what they left on" and compared to colleagues of a similar age, including lower pay scales, and short-term contracts.[138] He suggested that part-retirement schemes in which one can flexibly access one's pension would be welcome.[139]

102. During the pandemic, emergency measures were introduced which made it easier for some NHS medical staff to work for longer or return to work without disadvantaging their pension.[140] Following a consultation, these measures were extended until 31 October 2022.[141] The Royal College for Paediatrics and Child Health and the Royal College of Pathologists have called for the GMC's return to practice registration easements to be made permanent.[142] Danny Mortimer told us that NHS Employers and NHS England would support these changes being made permanent.[143] We note that the fact these changes were necessary at all suggests that the taper was ineffectual in remedying the problem as decisively as the Secretary of State proposed.

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

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

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

136 Royal College of Surgeons of England (RTR0049)
137 The Royal College of Surgeons of Edinburgh (RTR0096)
138 Q87
139 Q87
140 NHS Business Services Authority, 'Covid-19 guidance on support for retired members', accessed 21 June
141 NHS Business Services Authority, 'Covid-19 guidance on support for retired members', accessed 21 June
142 Royal College of Paediatrics and Child Health (RTR0087), Royal College of Pathologists (RTR0094)
143 Q294

Dentistry

106. Shawn Charlwood, Chair of the General Dental Practice Committee at the British Dental Association, told us that NHS dentistry is "facing a crisis the likes of which I have not seen in my 35 years in the profession".[144] Although the General Dental Council Register has the largest number of dentists in its history, the number of dentists doing NHS work is decreasing: during the pandemic, there were "3,000 fewer NHS dentists available to treat patients" than before.[145] In 2020–21 alone, there was a decrease of 951 dentists with NHS activity in England, which, as the Association of Dental Groups points out, is "the near equivalent of the whole dental student intake target for this year".[146] This brings the headcount of primary care dentists in England to its lowest level since 2013/14.[147]

107. Units of Dental Activity (UDAs) were introduced as a measure of dental activity and as the basis of renumerating dentists employed by the NHS in 2006, and they proved immediately problematic. Our predecessor Committee advocated for reform to NHS dental contracts in 2008, noting that the introduction of UDAs "has proved extremely unpopular with dentists" and that many of the targets were "unrealistic".[148] Shawn Charlwood stated that in the intervening 14 years "nothing has been done by the Government on NHS dental reform", arguing: "we need a new, non-UDA contact for NHS dentistry by April 2023 at the latest".[149]

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

Pharmacy

109. By 2027, all newly qualified pharmacists in England will be independent prescribers.[150] The figure is currently 21.5%.[151] Ravi Sharma, Director for England at the Royal Pharmaceutical Society, told us that this development will be "fundamentally important to the NHS from both a capacity perspective and a clinical service perspective" because it will "optimise the workload that healthcare staff are able to experience … improve access to care for the population [and] ensure better use of medicines."[152] However, Mr Sharma was also clear that "there needs to be some real thought about how we establish [this practice] for the future in the NHS."[153] We have heard that pharmacists who have prescribing qualifications currently lack opportunities to utilise these skills in the community sector, which can lead them to leave community pharmacy in favour of a setting which allows them to use their enhanced skills.[154]

144 Q198
145 Q198
146 Association of Dental Groups (RTR0010)
147 British Dental Association (RTR0101)
148 House of Commons, Health Committee, Dental Services, Fifth Report of Session 2007–8, Vol I, 2 July 2008, HC 289-I
149 Q198
150 Q215
151 Duncan Rudkin (Chief Executive and Registrar at General Pharmaceutical Council) (RTR0160)
152 Q216
153 Q215
154 Emily James (Policy & Programmes Manager at The Community Pharmacy Workforce Development Group) (RTR0134)

110. Ravi Sharma suggested that "from a workforce retention perspective and to attract people to the profession", protected learning time is "one of the key factors in what pharmacists are saying to us would improve their wellbeing".[155] Most important is a "comprehensive workforce strategy for pharmacy teams" with clear structures for professional career development "so that pharmacists are able to do more and extend their competence and their abilities to do more".[156] A lack of career development opportunities, and "a lack of job satisfaction because they are unable to use the clinical skills that they have" is "one of the key reasons why pharmacists in primary care are considering leaving the profession over the next 12 months".[157]

111. ***There is an opportunity to better utilise the pharmacy workforce, and in doing so, to optimise workloads across primary care, reduce pressure on general practice and hospitals, and support integrated care systems. This optimisation will not be possible without an integrated and funded workforce plan for pharmacy which must be developed and laid before Parliament within 12 months. The plan must ensure that all pharmacists have adequate access to supervision, training, and protected learning time, along with clear structures for professional career development into advanced- and consultant-level practice. The workforce plan for pharmacy must consider that by 2027 all newly qualified pharmacists will be independent prescribers and ensure that these graduates are given protected learning time, adequate supervision, and career development opportunities.***

155 Q219

156 Q217

157 Q217. See also Emily James (Policy & Programmes Manager at The Community Pharmacy Workforce Development Group) (RTR0134)

4 Training in Health

Undergraduate training

112. International staff have been and always will be an important part of the NHS. We are grateful to them for their service, particularly during the pandemic. It has, nonetheless, become apparent during this inquiry that the level of international recruitment in which NHSE is currently engaging is unsustainable: particularly given that there is a global shortfall of healthcare workers which the World Health Organisation predicts will reach 18 million by 2030.[158] There needs to be a more focused effort made on recruiting and retaining the UK's domestic workforce, and although that starts with the retention of the current workforce, the long-term strategy includes increasing the number of students admitted to medical school each year.

113. Witnesses from the GMC, BMA, Medical Schools Council, and Royal Society of Medicine were unanimous that the UK is not training enough undergraduate medical students to support our current model of care.[159] The UK's doctor to population ratio is 3.0 doctors per 1,000 people.[160] This is less than most other countries in the Organisation for Economic Co-operation and Development.[161]

114. There are approximately 9,500 places to study medicine available across the UK every year.[162] In 2022–23, there were 7,571 places available to study medicine in England.[163] The number was temporarily increased to 10,461 in 2020–21 to accommodate the number of students who achieved their medical school offer after summer exams were cancelled, students received teacher- or centre-assessed grades, and the number of A* or A grades went up.[164] The Government said the increase was both a "response to this year's unprecedented situation" and "in the long term [to] help boost our future NHS workforce".[165]

115. Record numbers of people are applying to medical school: there were 28,690 applicants in 2021, a 21% increase on 2020.[166] The Medical Schools Council reports that there are approximately three times as many applicants to medical school as there are places available.[167] In response to the increasing number of applications, the BMA called for a temporary expansion of medical school places to 20,471 per annum between 2022–2025, arguing that this could "bridge the workforce gap as soon as 2030".[168]

116. Professor Malcolm Reed, Lead Co-Chair of the Medical Schools Council told us that the Medical Schools Council has "suggested increasing [the number of medical school places] by 5,000 a year" but that even this would not be "quite enough to bring us up to 100% sustainable".[169] An increase of this size would mean increasing the number of

158 World Health Organisation, 'Health workforce', accessed 22 June
159 Q144
160 OECD, 'Doctors', 2020
161 OECD, 'Doctors', 2020
162 Medical Schools Council, 'Admissions to Medicine in 2021', accessed 22 June
163 Office for Students, 'Medical and dental target intakes for entry in 2022–23', accessed 22 June
164 Office for Students, 'Medical and dental intakes', accessed 22 June
165 Department for Education, Department of Health and Social Care, 'Extra places on medical and dentistry courses for 2021', 5 August 2021
166 British Medical Association (RTR0070)
167 Medical Schools Council, The expansion of medical student numbers in the United Kingdom, October 2021
168 British Medical Association (RTR0070)
169 Q144

medical school places in the UK by 5,000 from around 9,500 (7,571 of which were in England for entry in 2022–23) per year to around 14,500. This figure is supported by the Academy of Medical Royal Colleges.[170] The Royal College of Physicians, Royal College of Physiatrists, and the BMA have previously called for medical school places to be increased to 15,000 per year.[171]

117. As we heard from the BMA, any expansion of medical school places:

> Will require a clear long-term strategy and investment to ensure there is enough teaching space, enough educators, enough support for students and enough clinical placements. These medical graduates will subsequently require places on the compulsory two-year national Foundation Programme. A sizeable proportion of them will then go on speciality training to become GPs or consultants, which will also need to be resourced.[172]

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

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

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

New medical schools

121. We have heard that there are some parts of the country where it is particularly difficult to recruit medical staff. As part of the long-term response to this crisis, five new medical schools have been opened in traditionally “under-doctored” areas.[173]

122. As Professor Dame Helen Stokes-Lampard said:

> The point of putting these medical schools in areas that were traditionally hard to recruit was that we would get local people going in because we know that people frequently stay and work quite close to where they trained, and

170 Medical Schools Council, ‘MSC and AoMRC statement on the expansion of medical student numbers’, October 2021

171 British Medical Association (RTR0070)

172 British Medical Association (RTR0070)

173 House of Commons Library, Medical school places in England from September 2018, 29 March 2017

> certainly where their professional higher training is, so you put the medical schools in the under-doctored, understaffed areas, and largely people will stay there.[174]

123. Lara Akinnawonu, co-Chair of the BMA Medical Student Committee, suggested that doctors choose foundation training places for a variety of reasons, including location, or, "that area being where their family and support networks are, the work-life balance they can have, and their social life".[175] She emphasised that "their welfare and the community of individuals around them" are particularly important factors for individuals from ethnic minority backgrounds, who "may want to be in an area where there are ethnic minority groups".[176]

124. Professor Scott Wilkes, Head of School of Medicine and Professor of General Practice and Primary Care at the University of Sunderland, said that "students generally work where they train, or where their families come from", and told us:

> In terms of widening participation, we have had a success story in Sunderland. In sitting the medical school in a place where we had difficulty recruiting and retaining doctors, we have managed to recruit from our local population. We have some 900 triple A students, and half of our intake is from that cohort … We are recruiting local students, but we are also recruiting students from socioeconomically disadvantaged backgrounds. So the experiment, if you like, has certainly succeeded.[177]

125. Sunderland medical school has "seven applications for every place", with 100 places available each year.[178] Professor Scott Wilkes told us: "we could easily accommodate more [students]" and advocated for investment in "parts of the country where we still have gaps" and "in the 2018 cohort" and "in new schools" such as "Chester, Brunel, and Three Counties".[179]

126. Professor Dame Helen Stokes-Lampard warned that a lack of funding to new medical schools could lead them to over-recruit international students, explaining "you do not get the same effect and benefit" of having medical schools in under-doctored areas if their cohort is not predominantly made up of local students.[180]

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

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

174 Q63
175 Q195
176 Q195
177 Q177
178 Q189
179 Q189, Q191
180 Q63

Tariffs

129. Professor Malcolm Reed told us:

> The thing that goes wrong and is blocking expansion is the tariff money that gets paid by Health Education England to trusts to provide clinical placements. It is 10 times as much almost for a medical student as for a nursing student, and it cannot cost that much extra. It makes up a large component of the £200,000 or so that it takes to produce a medical graduate and is a barrier to expansion from a Treasury perspective, but also in many ways from the trusts' perspectives because they get that money, and it is not hypothecated. It is a top-up, if you like.[181]

130. For 2022–23, the undergraduate medical tariff is £30,750 for an undergraduate medical student, and £5,000 for a nursing, midwifery, or pharmacy student.[182] Professor Malcolm Reed told us that "HE are doing a really valiant job of making that accountable and transparent, but there is a long way to go", and that the disparity between tariffs "makes it very expensive to expand the number of medics compared with the number of nurses. You can have 50,000 nurses or 5,000 doctors effectively".[183]

131. We heard evidence that the undergraduate medical tariff was too high, but also that tariffs for other professions were too low. Dr Emma Hayward, GP and Clinical Teacher at the University of Leicester, told us that "if a nursing student goes into primary care, I think the practice gets about £70. That covers nothing in terms of their supervision".[184] The tariff for Dental Therapy and Hygiene was described by the Dental Schools Council as "woefully inadequate" to an extent which threatened the "necessary diversification of the workforce".[185] Ravi Sharma said that it was essential to ensure "parity of tariff systems" to allow supervision of pharmacy teams to become independent prescribers.[186]

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

Postgraduate training

133. When the UK was a member of the EU, the length of medical under- and postgraduate training was governed by the EU's mutual recognition of professional qualifications directive.[187] The directive stipulates that it takes 5,500 hours and at least five years in training to become a doctor, as well as minimum periods of three to five years for some postgraduate specialty training.[188] Since Brexit, the UK is no longer bound by the Directive,

181 Q145
182 Department of Health and Social Care, Education and Training Tariffs: Tariff guidance and prices for the 2022 to 2023 financial year, 31 March 2022
183 Q146
184 Q19
185 Dental Schools Council (RTR0030)
186 Q215
187 General Medical Council (RTR0132)
188 General Medical Council (RTR0132)

and the GMC argues that there is an opportunity to recast how requirements are set, so they are focused on outcomes achieved, rather than time spent in training.[189] The GMC say that their under- and postgraduate curricula are now "based on the principle that we should be assessing capability, not on how long people train for or on the number of times they repeat a skill."[190]

134. Assessing the acquisition of competence, rather than time spent in training, is one of the key recommendations of 'Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England'. The Review states that focusing on time spent in training disadvantages trainees working less-than-full-time, who tend to be women, which can cause a pay gap to open up between full-time staff and their less-than-full-time colleagues.[191] It also suggests that there could be an "unconscious bias amongst peers, recruiters, and ever the wider health and care community" that makes them perceive those on less-than-full-time contracts as less skilled or experienced than their full-time colleagues.[192]

135. There is an opportunity to reform postgraduate curricula, and work is underway to do so. Professor Colin Melville, Medical Director and Director of Education and Standards at the GMC, told us that the GMC is "already looking at education reform, particularly in the postgraduate area, and we are working with the academy and the Royal Colleges on whether we have created curricula for each speciality and an assessment programme that is actually fit for the 21st century".[193] However, Professor Hazel Scott, Dean of the School of Medicine at the University of Liverpool, warned that whilst:

> There is the potential to look at shortening postgraduate training in terms of an outcome-focused training curriculum … it only works when the NHS prioritises education to the same degree as it prioritises service delivery in respect of medicine … There needs to be time for senior colleagues to mentor and nurture our foundation trainees.[194]

136. There are some risks to this approach. Moving out of line with EU rules may make the UK a less attractive place to study, train, and work for EEA nationals, who would risk their UK qualifications not being recognised in their home country.[195] Any changes which put UK qualifications at risk of not being recognised by the Irish regulator could have a corresponding impact on the delivery of cross-border healthcare provision on the island of Ireland.[196]

137. ***We believe that the General Medical Council's emphasis on acquiring competency in postgraduate training, rather than focusing on "time-served" is the right way to go. The Government must commission an independent review of all postgraduate training to consider whether it is possible to i) reduce the time it takes to obtain a postgraduate qualification, whilst maintaining rigorous patient safety and professional standards; ii) ensure that those who train less-than-full time are not penalised for doing so; and***

189 General Medical Council (RTR0132)
190 General Medical Council (RTR0132)
191 Department of Health and Social Care, Mend the Gap: The independent review into gender pay gaps in medicine in England, December 2020
192 Department of Health and Social Care, Mend the Gap: The independent review into gender pay gaps in medicine in England, December 2020
193 Q148
194 Q177
195 General Medical Council (RTR0132)
196 General Medical Council (RTR0132)

iii) and to provide an independent assessment of how many training places are needed for each specialty. Once this review is completed, the Government must implement its findings, including committing to funding the number of training places required.

Training for bank and temporary staff

138. Bank and temporary staff are an important source of cover for NHS vacancies. The Nuffield Trust estimates that approximately four in five current NHS vacancies were being covered by a temporary, bank, or agency staff member.[197]

139. Nicola McQueen told us that:

> If every single one of our bank members did just one more shift a month, that would be an additional 10,000 FTEs into our system. Very often, the restriction for that is that they are not quite skilled to do something, so they do not have as many shifts available to them.[198]

140. Professor Dame Helen Stokes-Lampard went on to say:

> I wanted to shout out "Amen", Nicola, when you talked about training our flexible workers. There are lost tribes of people out there who would like to do more, who would like to advance, who would like to take on new skills and are artificially banned from doing so. These are things we can address. Education and training are vital.[199]

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

197 William Palmer (Senior Fellow at The Nuffield Trust) (RTR0163)
198 Q51
199 Q60

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

142. This chapter will deal with several aspects of how the NHS and social care sectors could build more positive and inclusive working cultures, including through measures to improve the experience of black and ethnic minority staff, the experience of women, staff undergoing the complaints process or referral to the GMC, bullying and harassment, and ways to counter unnecessary bureaucracy and provide headspace to staff.

The experience of black and ethnic minority staff

143. 21% of the social care workforce and 22.1% of the NHS workforce is black, Asian, or minority ethnic, compared to 15.7% of the population of England.[200] As Nina Hemmings, Researcher in Health Policy at the Nuffield Trust, told us, discrimination against ethnic minority staff is "prevalent at every stage of the career pathway" in health and social care.[201] According to the NHS Workforce Racial Equality Standard (WRES), racism impacts many parts of working life in the NHS, from pay (as NHS pay bands increase, the proportion of ethnic minority staff within the pay band decreases), to career development (white applicants are 1.61 times more likely to be appointed from a shortlist than ethnic minority applicants), to the likelihood of being subject to disciplinary action (ethnic minority staff are 1.14 times more likely to enter a formal disciplinary process than a white staff member).[202]

144. A recent survey by the BMA showed that 76% of respondents had experienced racism in their workplace on at least one occasion in the last two years, and 17% experience racist incidents "on a regular basis".[203] 71% of doctors who experienced racism chose not to report it due to a lack of confidence that the incident would be addressed or a fear that they would be labelled as "troublemakers".[204] The British Association of Social Workers described "institutional and systemic racism inherent within social care" as "a blight on our profession", and 9% of survey respondents had experienced racism from colleagues or managers at least five times in the previous twelve months.[205]

145. The NHS WRES shows that ethnic minority staff experienced higher levels of harassment, bullying, or abuse than their white colleagues from patients, relatives, or the public in 72.3% of Trusts and from staff in 92.7% of Trusts.[206] Dr Wen Wang, Associate Professor in Human Resource Management, Data Analytics, and Interpretation at the University of Leicester, told us: "discrimination from the public is disheartening, but

200 Skills for Care, The state of the adult social care sector and workforce in England, October 2021, p18, Gov.uk, 'NHS workforce', 26 January 2021, House of Commons Library, Ethnic diversity in politics and public life, November 2021
201 Q113
202 NHS, NHS Workforce Race Equality Standard, March 2022, p17, p20
203 BMA, Delivering racial equality in medicine, June 2022, p6
204 BMA, Delivering racial equality in medicine, June 2022, p6
205 Community Care, 'Over a quarter of social workers faced racism from colleagues or managers in 12-month period, finds survey', 18 March 2022
206 NHS, NHS Workforce Race Equality Standard, March 2022, p17, p20

it is more disheartening from managers and co-workers."[207] She described evidence gained during her research of doctors, nurses, and care workers treated in a way that was "demeaning, disheartening, and destroyed their confidence. Shift patterns were different and less favourable. They were watched doing their tasks. They were timed, and they said there was extra stress."[208] Dr Wang testified to us that "discrimination from managers and co-workers" was a "direct cause of burnout" for ethnic minority workers.[209]

146. International ethnic minority staff in health and social care can be poorly treated by patients and colleagues. Prema Fairburn-Dorai, Director of Primary Homecare, told us that when she employed new staff from India her "existing all-UK staff [were] intolerant, judgemental and unhelpful to the new recruits" and that "clients in the community have been overtly racist in some of their comments and have refused to allow overseas staff to care for them."[210] Dr Wen Wang told us that the NHS employs 200,000 Filipino nurses, but "at the beginning of the pandemic, they were considered as carriers instead of carers. They were attacked because of Covid."[211]

147. There is no easy "one-size-fits-all" solution to racism, and we are conscious of the different experiences of individuals, of different racial groups, within racial groups, and at different Trusts across the country. However disparate these experiences, what unites these individuals and groups is an urgent need for action to improve working conditions for ethnic minority staff in the NHS and social care in order to protect and retain these vital members of the workforce. It has been suggested to us that greater accountability is needed on the part of senior and middle management in relation to the reduction of discrimination among staff. Dr Wen Wang suggested using the NHS WRES to monitor staff experience, "with reduction rates related to senior managers' pay, promotion and performance. That will work because we know what gets measured gets done."[212] She went on to suggest that greater training is needed for middle managers and team leaders on how to "deal with race and to have acceptable conduct among staff".[213] Nina Hemmings suggested that "given that addressing inequalities is a cross-government priority", a What Works centre could be established to "look at issues of discrimination in public sector workforces and grow an evidence base around initiatives that have been trialled and tested".[214]

148. A year-long pilot social care Workforce Race Equality Standard (SC-WRES) began in 18 local authorities in April 2021.[215] In a joint blog post to mark the launch of the pilot, Mark Harvey, interim join Chief Social Worker for Adults at the Department of Health and Social Care, and Nimal Jude, Practice Development Consultant at the Social Care Institute for Excellence, said that to date, "the pace and visible action" on tackling racism in social care "has, if we are honest, hardly set the world on fire" but that the SC-WRES pilot was "a positive step forward and one many years in the making—especially for those colleagues most impacted by institutional racism."[216] The introduction of the WRES to

207 Q112
208 Q112
209 Q112
210 Q111
211 Q112
212 Q118
213 Q118
214 Q122
215 Community Care, 'Councils selected to pilot equality standard to tackle "institutional racism" in social work', 4 January 2021
216 Mark Harvey and Nimal Jude, 'Respecting diversity in social care: we must do better', 16 December 2020

social care is to be celebrated, and we hope that the pilot is extended and made permanent in all local authorities. However, Skills for Care estimates that in 2020/21 only 7% of jobs in adult social care were employed by a local authority, whilst 79% were employed by the independent sector (the other 14% are either employed by the NHS or by direct payment recipients).[217] As such, only a tiny percentage of care workers will have their views captured by the SC-WRES if it is only rolled out to local authorities.

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

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

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

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

Ethnic disparities in referrals to the disciplinary process

153. The GMC wrote to us to say that doctors from a minority ethnic background are "twice as likely to be referred to the GMC by their employers for fitness to practise concerns than white doctors" and the referral rate for doctors qualifying outside of the UK is "three times higher" than that for UK doctors.[218] In their introduction to the NHS Workforce Racial Equality Standard 2022, Professor Em Wilkinson-Brice and Anton Emmanuel, Head of the WRES, write that there has been a "steady decline in the race disparity in staff being referred into the disciplinary process (especially in some regions)" but there remains "50% of organisations where this disparity persists".[219] In 2016, ethnic minority staff were 1.56 times more likely to enter a formal disciplinary process than white staff.[220] This figure has steadily declined, and ethnic minority staff are now 1.14 times more likely to enter formal disciplinary processes, but at 50% of trusts, the figure is 1.25 times.[221]

217 Skills for Care, The state of the adult social care sector and workforce in England, October 2021, p35
218 General Medical Council (RTR0132)
219 NHS, NHS Workforce Race Equality Standard, March 2022, p3
220 NHS, NHS Workforce Race Equality Standard, March 2022, p4
221 NHS, NHS Workforce Race Equality Standard, March 2022, p4

154. Some Trusts have managed to make improvements in this area. Nina Hemmings told us about the Coventry and Warwickshire Partnership Trust, which has an "investigation team to look more closely at cases of formal disciplinary action".[222] The team has "managed to reduce the number of staff suspended, reduce the amount of time each case takes and make savings of around £150,000 on things like agency cover as a result."[223]

155. The WRES 2022 notes that there has been "notable improvement" in this indicator in the East of England following "concerted action on debiasing processes related to disciplinary referral."[224] This example was also drawn to our attention by Professor Colin Melville who told us: "there's been some interesting work from the NHS in England recently … [suggesting that] 'if you anonymise cases to a medical director, it reduces referrals to the GMC on the basis of race'."[225] Professor Melville was referring to a practice, piloted in some East of England Trusts, of setting up of independent panels to review anonymised case information before cases are formally referred to the General Medical Council, which Anton Emmanuel told the GMC's annual conference has resulted in parity of referral between ethnic minority doctors and their white colleagues.[226]

156. The GMC has introduced new targets to eliminate disproportionate complaints from employers against ethnic minority doctors by 2026 and to eradicate disadvantage and discrimination by 2031. Professor Colin Melville commented: "we want to be part of providing a solution" on changing the broader culture on referrals to the regulator, but particularly on the disproportionate referrals of ethnic minority doctors.

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

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

The experience of women

159. We heard from Professor Carol Woodhams, Professor of Human Resource Management at the University of Surrey, that the NHS is "certainly sexist, and certainly in some specialties".[227] She told us that this tendency can be exacerbated in certain specialities, for example in surgery, because although many female medical students "set

222 Q122
223 Q122
224 NHS, NHS Workforce Race Equality Standard, March 2022, p15
225 Q155
226 British Medical Journal, 'Fewer ethnic minority doctors are referred to GMC after cases are anonymised', 6th May 2022
227 Q100

off to undertake" a surgical training path, they are "actively discouraged" from doing so whilst in medical school, suffer from a lack of role models, and face "micro aggression during training".[228] This point was echoed by The Royal College of Surgeons of England, who told us that the NHS should develop a strategy to attract and retain more women into surgery.[229] At present, just 34% of surgical trainees and 14% of consultant surgeons are female.[230]

160. We also heard from Professor Woodhams that the gender pay gap persists in medicine, with a larger gender pay gap in primary care than in Trusts.[231] She called for "greater transparency in how people are paid and much more consistency across general practice in allocating a wage".[232] 'Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England', published in December 2020, showed a basic gender pay gap of 24.45 for HCHS (mostly hospital) doctors, 33.5% for GPs and 21.4% for clinical academics.[233]

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

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

Menopause

163. Menopause usually occurs between the ages of 45 and 55.[234] The NHS workforce is 76.7% female, and a quarter of the total NHS workforce is aged 45–54.[235] In spite of this weighting, Jacqui McBurnie described NHS colleagues in this cohort who "do not always feel as visible", arguing "there must be an ageist leaning in that regard that does not see this as a real issue around a cohort of staff that hold all that experience, intelligence, and organisational memory."[236]

164. The BMA report, 'Challenging the culture on menopause for working doctors' found that "a significant number" of the 2,000 doctors surveyed had "reduced their hours, left management roles or intend to leave medicine altogether, despite enjoying their careers, because of the difficulties they faced when going through menopause".[237] The BMA described it as "extremely concerning" that:

228 Q100,Q104
229 Q100, Royal College of Surgeons of England (RTR0049)
230 Royal College of Surgeons of England (RTR0049)
231 Q105
232 Q105
233 'Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England', December 2020, v
234 NHS, Menopause, accessed 21 June
235 NHS, 'Equality and diversity in NHS Trusts and CCGs March 2022', accessed 30th June
236 Q101
237 The BMA, 'Challenging the culture on menopause for working doctors', 2020, p1

> Some women may be permanently stepping back from senior positions in medicine—a key cause of the gender pay gap—and the health service may be losing highly experienced staff because of inflexibility and a lack of support during a relatively short phase of life."[238]

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

Complaints

166. We have heard evidence that some doctors are living in fear of being subject to a vexatious patient complaint or a referral to the GMC.[239] Dr Peter Davies, a sessional GP in Halifax, wrote to us to say that a clinician can "all too easily become the second victim of the complaint", and that "good supportive complaints officers are worth their weight in gold".[240] Dr Emma Hayward told us that "complaints, even if they are spurious or vexatious, still take time and heartache to deal with", commenting that a colleague had told her "we currently have a ludicrous situation whereby the most difficult complaints to deal with are the ones where nothing has gone wrong."[241] She suggested that GPs in particular are vulnerable to complaints about their personal appearance (which may amount to discrimination), following surgery communications, and the provision of clinical advice or treatment with which the patient may have disagreed.[242] Professor Clare Gerada told us: "I have had more complaints in the last two years than in 40 years. Even at my seniority, complaints cause such grief and such mental distress".[243] She told us that having a better process for dealing with complaints from patients was a staff wellbeing issue.[244]

167. It is important to stress that the vast majority of referrals made to the GMC do not result in any serious action being taken, and those which do result in action are complaints of the most serious kind. Professor Colin Melville explained that of the 8,000 complaints made a year to the GMC, 6,000 are dismissed, and "five or less cases come to tribunal": these are complaints made on the basis of "criminal conviction, sexual misconduct and misconduct".[245] Professor Melville argued that GMC "processes [can] seem complicated, convoluted and long" which "doesn't help those people who find themselves in [them]".[246] He suggested that this was a result of changes made to the "long, old" Medical Act 1983, which, if it could be "made simpler" whilst "ensur[ing] there is accountability", it would be "a real opportunity" to "add more reassurance to the profession, while also reassuring the public".[247]

238 The BMA, 'Challenging the culture on menopause for working doctors', 2020, p8
239 Dr Emma Hayward (Senior GP Specialist Educator at University of Leicester Medical School) (RTR0028), Dr Peter Davies (GP at Sessional GP in Halifax) (RTR0125), Dr Emma Hayward (GP and clinical teacher at University of Leicester) (RTR0143)
240 Dr Peter Davies (GP at Sessional GP in Halifax) (RTR0125)
241 Dr Emma Hayward (GP and clinical teacher at University of Leicester) (RTR0143)
242 Dr Emma Hayward (GP and clinical teacher at University of Leicester) (RTR0143)
243 Q82
244 Q85
245 Q156
246 Q156
247 Q156

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

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

Bullying

170. In March 2022, the NHS Staff Council's Health, Safety, and Wellbeing Partnership Group reported that 18.7% of staff had experienced bullying or harassment from colleagues in the last year.[248] Black and minority ethnic staff, and bisexual or gay staff are more likely to report being subject to bullying or harassment from colleagues.[249]

171. In oral evidence, Professor Clare Gerada told us that she believes that the levels of bullying in the NHS are a "symptom of the underlying problem".[250]Dr Vish Sharma said that whilst there was "true bullying … most of it is just transference" as a result of pressure and moral injury as a result of "the guilt [you feel] when you see people suffering and you cannot do what you need to do to provide the care they need".[251]

172. We received several written submissions calling for a zero-tolerance approach to bullying, harassment, and discrimination in the workplace.[252]

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

Headspace

174. It is important that clinicians and frontline workers have the headspace they need, both for welfare reasons, in order to process the intensity of the working day, and so they have time and capacity to innovate and adapt to changes. Dr Chris Hopson, talked about there being "no headspace other than to run at 110 miles per hour to keep the existing system upright".[253] Beccy Baird, Senior Policy Fellow at the King's Fund, giving evidence to out inquiry into the Future of General Practice, commented: "when people are stressed and do not have the headspace to really think about change management, the redesign of processes, and how it is actually going to work, that is when it falls down".[254]

248 NHS Employers, 'Tackling bullying in the NHS infographic', 30 March 2022
249 NHS Employers, 'Tackling bullying in the NHS infographic', 30 March 2022. See also Q113, Q115
250 Q69
251 Q72
252 See, for example: Parkinson's UK (RTR0067), British Medical Association (RTR0070), Royal College of Physicians and Surgeons of Glasgow (RTR0026), Professor Rachel Jenkins (Professor Emeritus at Kings College London) (RTR0052)
253 Q55
254 Q147

175. The BMA wrote to us to say that "a huge amount of doctors time continues to be taken up with administrative tasks" such as "filling in forms, dealing with correspondence, writing discharge summaries, [and] completing mandatory coding and compliance sections on computer systems".[255] They suggested that ways should be found for "other staff [to take on] on appropriate work from doctors" and "[to reduce] unnecessary bureaucracy".[256] Several others wrote to us suggesting that ways should be found to reduce the administrative burden of frontline staff, particularly doctors.[257]

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

255 British Medical Association (RTR0070)

256 British Medical Association (RTR0070)

257 See for example, Dr Emma Hayward (Senior GP Specialist Educator at University of Leicester Medical School) (RTR0028), Royal College of Surgeons of England (RTR0049), Dr Peter Davies (GP at Sessional GP in Halifax) (RTR0125), Royal College of Pathologists (RTR0094), Cancer Research UK (RTR0098),

6 Retention in Social Care

Pay

177. The key message from many social care witnesses to the inquiry was articulated by Rachael Dodgson, Managing Director and incoming CEO of Dimensions: "Pay is the fundamental issue. We cannot ignore that. It really is. If you look at what other sectors pay compared with social care, it is a real challenge."[258] Anchor highlighted in their submission that 44% of those who leave the care sector do because of pay.[259] UNISON highlighted that there is "widespread poverty pay" in the sector, with "three-quarters of care workers paid less than the real living wage".[260]

178. The average pay of a care worker in the independent sector is £17,900: £3,500 less than similar roles in the NHS.[261] Yet, social care's primary competitor is not the NHS, but retail and hospitality, where staff can have "better pay and less responsibility".[262] According to Skills for Care, historically speaking, care workers median hourly pay has tended to be higher than other low-paying jobs (as defined by the Low Pay Commission), but by 2020–21, the gap had narrowed.[263] In 2012–13, sales and retail assistants earned 13p less per hour than care workers, but in 2020–21, they earned 21p more.[264] As Dimensions put it: "Try bringing your family up on £9.50 per hour, knowing you could earn £10.50 working at a supermarket, starting tomorrow".[265] Dr Carolyn Downs, Senior Lecturer at Lancaster University, reported that in the course of her research she has heard care managers saying: "I dread hearing Aldi opening up nearby, as I know I will lose staff".[266]

179. A lack of pay progression was also identified as an issue in social care. Lara Bywater, Registered Manager and owner of LDC Care, told us that "our managers and senior staff are paid very small amounts more than our new-to-sector people. That has a huge impact."[267] A social care worker with over five years of experience will earn on average just six pence more per hour than a social care worker on their first day in the job.[268]

180. Pay is important, but it is only one part of the picture. The Local Government Association (LGA) has argued that any improvements made to terms and conditions will only be effective if they are "linked to pay, reward and career progression".[269]

181. **Witnesses to this inquiry left us in no doubt that pay is a crucial factor in recruitment and retention in social care. Social care providers are consistently being outbid by the retail and hospitality sectors. However, whilst pay increases are sorely**

258 Q27
259 Anchor (RTR0038)
260 UNISON (RTR0077)
261 Skills for Care, The state of the adult social care sector and workforce in England, October 2021, p104
262 Papworth Trust (RTR0095). See also Rapport Housing & Care (RTR0014), Mortimer Society (RTR0041), ARC (Association for Real Change) (RTR0019), Alzheimer's Society (RTR0050), Homecare Association (RTR0104), Sense (RTR0080), SeeAbility (RTR0076), Care England (RTR0069), Association of Directors of Adult Social Services (ADASS) (RTR0047)
263 Skills for Care, The state of the adult social care sector and workforce in England, October 2021, p103–104, Q204
264 Skills for Care, The state of the adult social care sector and workforce in England, October 2021, p104
265 Dimensions (RTR0025)
266 Dr Carolyn Downs (Senior Lecturer at Lancaster University) (RTR0021)
267 Q15
268 Skills for Care, The state of the adult social care sector and workforce in England, October 2021, p20
269 Local Government Association (LGA) (RTR0035)

needed, merely raising wages is not enough. A long-term, sustainable strategy is needed which includes the prospect of pay progression, professional development, training, and career pathways.

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

Funding

183. Increases in pay and improvements in terms and conditions will not be possible without an increase in social care funding. The LGA told us that the Government's recent white paper states that funding will be provided to "support councils to prepare their local markets for reform, including moving towards paying providers a fair rate for care which reflects local costs, including workforce".[270] They went on to say that councils have faced a "£15 billion real terms reduction to core Government funding between 2010 and 2020" which makes it "likely that the funding allocated for reform will be insufficient to achieve all of the Government's stated priorities".[271]

184. Pay is inexorably linked to funding. Simon Williams, Director of Social Care Improvement at the Local Government Association, said that "local authorities will not be able to pay providers the rates that providers need to pay [to] retain staff unless funding is sorted out".[272] He was hopeful that the results of the Fair Cost of Care exercises (due in September 2022) would provide an opportunity to find out "what [it takes] to pay providers to enable them to pay their staff properly".[273] Sense point out that the terms of reference for the exercises make no reference to *fair* pay, and they are concerned that the cost of care should not be calculated on "the basis of the low pay that is already commonplace in the sector".[274] Written evidence to the inquiry suggested that the duties and responsibility of a social care worker are equivalent to an NHS Band 3 Health Care Assistant role, which starts at £20,330 per annum, or "approximately £11.50" per hour.[275]

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

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

270 RTR0035
271 Local Government Association (LGA) (RTR0035)
272 Q253
273 Q253
274 Sense (RTR0080)
275 NHS. 'Agenda for change - pay rates', accessed 1 July 2022. Association of Directors of Adult Social Services (ADASS) (RTR0047). See also, Methodist Homes (MHA) (RTR0116), SeeAbility (RTR0076), Homecare Association (RTR0104),

Continuity of care

187. We have heard evidence that staff shortages are having an impact on the ability of social care staff to provide good-quality care to the people they support. Lara Bywater told us that in the 20 years she has been running her organisation, she has "never seen a staff shortage impact like this".[276] She emphasised that:

> For the people I support, who have complex needs around autism, learning disabilities and mental health, one of the keys to providing good-quality care for them is continuity and consistency of staffing.[277]

Lara Bywater explained that the impact of staff shortages on quality is "not necessarily the skillset but the relationships that people build with those they are supporting".[278] She went on to say: "it can take months for people to become used to a new face if they have additional needs", and that a lack of trust in the people looking after them "can make people less keen to participate in their normal activities, and perhaps more worried about going out into the community".[279] It can also cause "huge anxiety" for family members if their relatives are not cared for consistently by the same person.[280] Both Lara Bywater and Rachael Dodgson emphasised the importance of staff being able to recognise non-verbal communication, particularly when supporting people with autism and complex needs: this is particularly difficult without continuity of staff.[281] Ian Trenholm, Chief Executive of the Care Quality Commission, told us that staff shortages in mental health, learning disabilities, and services for autistic people mean that these services are kept open through the use of agency staff who:

> May be well-intentioned but do not know the individuals well. That then translates into excessive use of restraint and seclusion. Individuals who are, in some cases, potentially able to go out and live in the community suffer and do not make the improvements that they could make to enable them to live full lives in the community.[282]

188. Chevonne Baker, a care worker at Right at Home UK, was keen to challenge the categorisation of care work as unskilled labour. She said:

> We take a really holistic approach to our clients. We really look at every single need they have, and we try to make sure that clinical needs, mental health needs, and companionship needs are all treated the same. Social care workers are trained to walk into any situation and deliver the best standard of care possible, really build a meaningful relationship with clients, and see them progress and well looked after. You cannot say that is unskilled.[283]

276 Q1
277 Q1
278 Q1
279 Q2
280 Q3
281 Q3
282 Q245
283 Q387

189. Social care witnesses at our first oral evidence session and many written submissions emphasised that social care suffers because of a lack of value generally, and in particular a lack of parity with the NHS.[284] As Papworth Trust put it: "We argue that social care staff need parity with their colleagues in the NHS. It's not simply about pay, but also about terms and conditions and benefits that go with the role."[285] Several written submissions highlighted that whilst NHS workers can access discounts at shops, restaurants, and some tourist attractions through their blue light card, there is "very little of the same for those who work in social care"; this was also raised as a concern during a Committee site visit to a social care provider.[286] Sarah McClinton, Vice President of the Association of Directors of Adult Social Services, told us: "People in the social care sector feel there has been a huge dedication and commitment and not always a sense of value. Striving for parity of esteem, essentially, with NHS colleagues would be one thing I would argue for."[287] Our Expert Panel evaluated the Government's commitment to "listen to the views of social care staff to learn how we can better support them—individually and collectively" and found that progress against this commitment was "inadequate".

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

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

Training

192. Training is an important part of both retention and recruitment. Dr Carolyn Downs wrote to us to say that "lack of training [is] a particular issue in job retention" because staff feel "ill-equipped for their role".[288] Both Simon Williams and Ian Trenholm argued for the creation of career structures that "suit various types of aspiration" in social care.[289] Mr Trenholm described the importance, for example, of making it "exciting for an 18-year-old to work in care" by "enabl[ing] them to see how they become the chief executive of the local care home group".[290] He argued that this could be achieved through base-level qualifications but also through specialist qualifications, as this is something that social care can offer that their competitors in retail and logistics cannot.[291]

284 Q15, Q25, Q27, Q35. See for example: The Royal College of Nursing (RTR0092), Papworth Trust (RTR0095), Nursing and Midwifery Council (RTR0097), Care Association Alliance (RTR0111), Methodist Homes (MHA) (RTR0116), Norfolk County Council (RTR0122), Dimensions (RTR0025), Local Government Association (LGA) (RTR0035), The Working Group of the Adult Social Care APPG (RTR0037), Anchor (RTR0038), Association of Directors of Adult Social Services (ADASS) (RTR0047), Coproduce Care CIC (RTR0057), Care England (RTR0069), Sense (RTR0080),

285 Papworth Trust (RTR0095), Care Association Alliance (RTR0111), Dimensions (RTR0025).

286 Papworth Trust (RTR0095)

287 Q35

288 Dr Carolyn Downs (Senior Lecturer at Lancaster University) (RTR0021). See also Q242

289 Q242

290 Q255

291 Q255

193. We have heard that whilst training is available to care workers, "the reality is that time and funding constraints make it difficult to access."[292]

194. Training is one way in which social care staff lack parity with the NHS. Dr Carolyn Downs suggests that care workers are "very aware that if they worked in the NHS, they would be able to access comprehensive training, higher status and wages".[293] The Care Association Alliance reports that social care staff used to have free access to the same NHS training as community health colleagues and suggest that this could be reinstated.[294]

195. 75% of care home managers come from within the sector, but they report low levels of support and training, as well as poor job satisfaction.[295] Professor Carol Atkinson suggested that "management training is often lacking" and that many run establishments "based on their caring experience with little wider management development".[296] The Government has said it wants to support Registered Managers by "funding Level 5 diplomas for those without relevant qualifications in addition to creating a bespoke support programme for new registered managers where turnover is particularly high".[297]

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

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

Care certificate

198. The Care Certificate aims to equip social care workers "with the knowledge and skills which they need to provide safe and compassionate care".[298] It comprises 15 standards and must be completed within 12 weeks of beginning the process.[299] In the Government's 2022 social care white paper, it committed to investing in a portable Care Certificate "so that care workers do not need to repeat the Care Certificate when moving roles" as "a key part of our offer".[300]

199. At present, care workers who move roles are finding that providers want them to re-do their Care Certificate.[301] This practice, along with the fact that the Care Certificate is not externally validated, means it is seen "as of little value".[302] Ian Trenholm explained that this is down to inconsistencies in the way that the training is delivered, but nonetheless described the practice as "seem[ing] faintly ridiculous".[303] Mr Trenholm said that "a

292 Manchester Metropolitan University (RTR0059). See also Norfolk Care Association (RTR0004)
293 Dr Carolyn Downs (Senior Lecturer at Lancaster University) (RTR0021)
294 Care Association Alliance (RTR0111)
295 Social Care Leaders Scheme (RTR0009)
296 Manchester Metropolitan University (RTR0059)
297 Department of Health and Social Care (RTR0140)
298 NHS Employers, 'Care Certificate', 29 January 2021
299 NHS Employers, 'Care Certificate', 29 January 2021
300 Department of Health and Social Care, People at the Heart of Care: adult social care reform, 18 March 2022
301 Q255, see also Papworth Trust (RTR0095), Dr Carolyn Downs (Senior Lecturer at Lancaster University) (RTR0021)
302 Dr Carolyn Downs (Senior Lecturer at Lancaster University) (RTR0021)
303 Q255

commonly, nationally accredited and, most importantly, portable qualification is really important".[304] Simon Williams said "we completely support having something externally validated, recognised and portable" but with the caveat "as long as it does not mean that social care becomes the feeder for the NHS."[305]

200. The Disabilities Trust wrote to us to explain how a "standardised, reformed and accredited Care Certificate", which provided "a gateway to career development" would "support parity of esteem between health and social care" which in turn would " attract new talent and improve recruitment prospects for the sector."[306] The Care Association Alliance explained that a "truly portable" Care Certificate would need to be delivered through "a quality assured provider at no cost to providers".[307]

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

Domiciliary care commissioning model

202. Some local authorities have moved towards commissioning domiciliary care in 15-minute increments: this is called "time and task" commissioning. The Homecare Association wrote to tell us that "the way care is commissioned has a direct relationship with the terms and conditions that providers can offer and with job satisfaction".[308] Sue Ryder concurred that this commissioning model "is not conducive to "good quality care" and it doesn't attract people into the profession".[309] The Nuffield Trust wrote that the time and task model "dominates much of social commissioning with impacts on the type and quality of care which can be delivered. No amount of staff training can make up for this."[310]

203. The Homecare Association told us that "time and task" work can be "de-motivating for care workers whose priority is supporting the service user" because workers can "feel like they have to work through an inflexible checklist of tasks, clock in, clock out and move on as quickly as possible to fulfil their contract."[311] Professor Carol Atkinson explained to us that 15 minutes is not long enough "to offer what care workers consider to be good care" which is care that is both relational and task-based.[312] Isaac Samuels, health and social care community campaigner and social care recipient, told us that "as long as you have a system that assesses based on "finish a task in 15 minutes of activity", you will have people like myself not getting the care and support we need".[313] Chevonne Baker told us that "it can very quickly take a toll on you if you are constantly running around on the go for 15-minute visits, half-hour visits, with no real building of that relationship".[314]

304 Q255
305 Q255
306 The Disabilities Trust (RTR0088)
307 Care Association Alliance (RTR0111), Methodist Homes (MHA) (RTR0116),
308 Homecare Association (RTR0104)
309 Sue Ryder (RTR0055)
310 The Nuffield Trust (RTR0114)
311 Homecare Association (RTR0104)
312 Manchester Metropolitan University (RTR0059)
313 Q140
314 Q388

204. The time and task commissioning model has a wider impact on terms and conditions in the sector. Professor Carol Atkinson told us that when it comes to:

> Low pay … lack of travel time, zero-hours contracts, and poor career pathways and limited training … many care providers would say that they are almost forced into those terms and conditions, particularly in the domiciliary sector, because of the way that care is commissioned and procured. They themselves tend to have low and insecure funding streams. They then pass that risk on to their workforces.[315]

205. It is not unlawful not to pay care workers for travel time, as long as their total pay averages out at or above minimum wage once travel time is factored in.[316] However, for some workers, travel time between appointments means that their average pay does drop below minimum wage.[317] We have heard evidence that workers are expected to be available to work over 12-hour periods, but are only being paid for work in 15-minute increments "at periods such as breakfast, lunch, dinner, and bedtime".[318] Analysis from the Department for Business, Energy, and Industrial Strategy of the Annual Survey of Hours and Earnings 2019 estimates that more than 17,000 jobs in the social care sector are paid below the minimum wage.[319] In his annual strategy, Interim Director of Labour Market Enforcement, Matthew Taylor suggested that the most common issue of non-compliance in the sector in the underpayment of the national living wage, particularly in relation to working time, with "employers failing to pay for overtime, breaks and shift handovers": this is complicated because of "confusion around what constitutes working time in the care sector".[320] The Nuffield Trust suggests that HMRC "could be more proactive in enforcing the minimum wage, particularly for homecare workers' travel time between appointments".[321] Insufficient pay for travel time can result in "call-clipping", a practice in which "already brief visits are further shortened to allow for travel time".[322] This practice poses a clear risk to the safety of service users and to the continuity and quality of care.

Zero-hours contracts

206. If care providers "are only paid for the minutes of direct care delivered", it "makes it difficult to run a financially viable business model without the use of zero hours contract employment."[323] So-called "zero-hours" contracts, under which an employer is not obliged to provide any minimum working hours to an employee, are widely used in the social care sector. 24% of the total adult social care workforce is employed on a zero-hours contract.[324] This equates to 380,000 jobs, the majority of which (310,000, 81.5%) of which are care worker roles.[325] In domiciliary care services, 55% of care workers are on a zero-hours contract.[326]

315 Q98
316 Low Incomes Tax Reform Group, 'Issues facing paid care workers', 21 April 2022
317 UNISON (RTR0077)
318 Manchester Metropolitan University (RTR0059)
319 HM Government, United Kingdom Labour Market Enforcement Strategy 2020/21, December 2021, p30
320 HM Government, United Kingdom Labour Market Enforcement Strategy 2020/21, December 2021, p31
321 The Nuffield Trust (RTR0114)
322 Manchester Metropolitan University (RTR0059)
323 Homecare Association (RTR0104)
324 Skills for Care, The state of the adult social care sector and workforce in England, October 2021, p48
325 Skills for Care, The state of the adult social care sector and workforce in England, October 2021, p48
326 Skills for Care, The state of the adult social care sector and workforce in England, October 2021, p48

207. Zero-hours contracts offer some benefits to employers because they can help manage fluctuating demand for services or be used as a temporary solution to staff shortages due to turnover or sickness.[327] However, they offer "no guarantee of work or financial security" to workers.[328] As Dr Carolyn Downs argues, zero-hours contracts do "nothing to support staff feeling valued and [are] another factor contributing to low recruitment and high attrition rates".[329] UNISON suggest that zero-hours contracts may impact the ability of individuals to plan ahead and their ability "to raise concerns due to fear that their work will dry up".[330]

208. A social care provider's turnover rate increases if their workers are on a zero-hours contract (32.1% turnover) compared to if they are on a different kind of contract (22.6% turnover).[331] Turnover increases in social care during the school summer holidays because zero-hours contract care workers cannot afford childcare, so they must leave to look after their children,[332] a point raised earlier in this report.[333]

209. Professor Carol Atkinson described zero-hours contracts as "a double-edged sword" which give both employers and staff flexibility, as guaranteed-hours contracts sometimes do not give staff the kind of shift patterns that they need.[334] In 2018, the Welsh Government introduced new rules under which domiciliary care workers must be offered a choice of contract after three months of employment, which balances the needs of workers who enjoy the flexibility of zero-hours contracts with those who would prefer the stability of a guaranteed-hours contract.[335]

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

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

212. ***It is completely unacceptable that the practice of not paying for travel time means that some domiciliary care workers are effectively working for less than the minimum or living wage. The Department for Business, Energy, and Industrial Strategy, with the support of HMRC must re-examine sector-specific guidance to address complexities in national minimum wage and national living wage guidance for the care sector, and***

327 Skills for Care, The state of the adult social care sector and workforce in England, October 2021, p48
328 Sue Ryder (RTR0055)
329 Dr Carolyn Downs (Senior Lecturer at Lancaster University) (RTR0021)
330 UNISON (RTR0077)
331 Skills for Care (RTR0034)
332 Q108
333 Para 80
334 Q108
335 Welsh Government, ''New requirements to ensure care workers are treated fairly come into force', 2 April 2018

reissue new, clarified guidance to employers and employees. The HMRC National Minimum Wage / National Living Wage enforcement body must be proactive in ensuring that all domiciliary care workers are receiving at least the minimum wage or living wage for all the time they spend working, including time spent travelling to appointments.

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

7 Recruitment in Social Care

Regional challenges in recruitment

214. Ian Trenholm told us that:

> One of the biggest challenges that my inspectors see … is the variation in the challenges from place to place. The issues in the south-west are very different from the issues in London, different from the issues in the north-west, and so on.[336]

215. We have heard that local housing markets can have "a very significant impact" on recruitment and retention in both health and social care, and that if "staff cannot afford to live within a reasonable distance, a care provider will struggle".[337] Although there are some "high price" areas, such as the South East, where low-paid staff may obviously struggle to find housing, the gaps are not always in obvious places. The Care Home Alliance wrote to us to say that "in many seaside towns care workers live in holiday caravans or chalets and are at risk of becoming homeless for the summer months."[338] There are also issues in rural areas.[339] The NHS Confederation wrote to us to say that there are recruitment and retention issues in "rural and coastal locations" as well as the South West and the Lake District "given the cost of living rising and lack of affordable housing in these locations".[340] There are "significant" nursing shortages in Cornwall and Devon, "most particularly due to the effects of local housing stock".[341] In the last 12 months, the average house price in Cornwall has doubled, and the impact has been that organisations which successfully recruit nurses are finding that the new recruits have nowhere to live.[342] We also heard that a lack of public transport options can hamper recruitment to more remote areas.[343]

216. Offering key worker status to those working in social care so they can access affordable rental housing from local authorities and registered providers on the same basis as public sector employees would be one way of ensuring that social care workers can afford to live in these locations.[344] Sue Ryder suggested that the Government might offer "collaborations with housing companies" in order "to offer affordable housing cost options" to the health and social care workforce.[345]

217. The LGA emphasised the importance of ensuring that national social care recruitment campaigns are aligned to local campaigns "so people are not lost between two systems."[346] They suggested that national recruitment campaigns for adult social care have had "limited success", and that "local messaging is what is needed".[347] The LGA suggested that a local recruitment campaign is likely to "take account of local care and health workforce

336 Q244
337 Care Association Alliance (RTR0111)
338 Care Association Alliance (RTR0111)
339 Norfolk County Council (RTR0122)
340 NHS Confederation (RTR0105)
341 NHS Confederation (RTR0105)
342 NHS Confederation (RTR0105)
343 Academy of Medical Royal Colleges (RTR0046), SeeAbility (RTR0076), Sue Ryder (RTR0055), Care Association Alliance (RTR0111).
344 SeeAbility (RTR0076), Care Association Alliance (RTR0111)
345 Sue Ryder (RTR0055)
346 Local Government Association (LGA) (RTR0035)
347 Local Government Association (LGA) (RTR0035)

gaps, demand and drivers" by "develop[ing] tailored recruitment messaging" whilst "reduc[ing] competition" between the NHS and social care.[348] Skills for Care agree that the Government's workforce recruitment and retention funds should be "passed efficiently to providers for targeted use".[349]

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

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

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

International recruitment

221. One in five of the adult social care workforce in England were born outside of the UK (approximately 250,000 people), about 113,000 of whom are from the EU.[350] In December 2021, on the advice of the Migration Advisory Committee, Care Workers and Home Carers were made immediately eligible for the Health and Care Worker Visa and their occupations were placed on the Shortage Occupation List.[351]

222. The minimum salary requirement for care workers to be eligible for the visa is £20,480. We have received numerous submissions noting that this salary is much higher than average pay in the sector and suggesting that the salary requirement be re-evaluated because it is limiting the usefulness of the visa as a recruitment tool.[352] BUPA suggests that the salary constraint makes it "impossible" to use the visa to recruit for many roles, whilst Rapport Housing and Care describes it as "unaffordable for most providers".[353] The salary requirement is higher than a full-time National Living Wage salary, and higher than the average salary for an independent sector care worker, which is around £17,900 per year.[354] When asked about the salary requirement, the Secretary of State told us: "if you are asking me whether I think it is the right level, I do."[355]

348 Local Government Association (LGA) (RTR0035)
349 Skills for Care (RTR0034)
350 British Medical Association (RTR0070)
351 Department of Health and Social Care, Home Office, 'Biggest visa boost for social care as Health and Care Visa scheme expanded', 24 December 2021
352 NHS Confederation (RTR0105), The Health Foundation (RTR0124), The Nuffield Trust (RTR0114), Skills for Care (RTR0034), NHS Providers (RTR0012), Rapport Housing & Care (RTR0014), UNISON (RTR0077), Sue Ryder (RTR0055), British Medical Association (RTR0070), Q34
353 BUPA (RTR0130), Rapport Housing & Care (RTR0014)
354 Royal College of General Practitioners (RTR0051), Skills for Care, The state of the adult social care sector and workforce in England, October 2021, p95
355 Q349

223. At present, social care worker, care assistance, and home care worker roles have only been put on the shortage occupation list for one year. The Homecare Association and NHS Providers argue that given the extensive shortages in the sector, care workers should be put on the Health and Care Worker Visa scheme indefinitely or permanently.[356]

224. The Health and Care Worker Visa has reduced some costs in relation to attaining a visa, for example, exemption from paying the immigration health surcharge.[357] Yet migrants who come to work in the social care sector must complete "many administrative steps" and pay "fees which may total several thousand pounds across the worker and their family".[358] The costs for care providers can also be prohibitive: running "up to £7,000" with "potentially thousands more in staff time".[359] The Nuffield Trust point out that "many small social care providers will find this difficult compared to NHS Trusts."[360] NHS Providers suggest that "funding constraints and the prescriptive nature of a regulatory and administrative process which requires in-house expertise" mean that "many organisations cannot capitalise on international recruitment."[361] Further improvements could be made in this area. Care England suggested that the Immigration Skills Charge should be waived for care workers.[362] There are also opportunities for greater collaboration within Integrated Care Systems on international recruitment. The National Care Forum suggested that "local systems, including Integrated Care systems, Local Authorities, and CCGs, work together to support the recruitment of international social care staff"[363]

225. At present, care workers who obtain a Health and Care Worker Visa are only granted a one-year visa. The normal length of the visa for other occupations is five years. As the Care Association Alliance put it: "a one-year visa is simply not attractive to most overseas immigrants wanting to relocate".[364] The BMA has urged the Government to introduce "a long-term visa which provides a path to settlement for social care workers".[365] The Secretary of State said he was "not convinced at this state that the one-year limit is stopping people from abroad applying to come and work in the UK as adult social care workers."[366] As with other international workers, the fact that it is difficult for care workers to bring their dependants, including adult dependants, with them, limits the attractiveness of the UK social care sector.[367]

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

356 Homecare Association (RTR0104), see also NHS Providers (RTR0012)
357 Homecare Association (RTR0104)
358 The Nuffield Trust (RTR0114)
359 Homecare Association (RTR0104)
360 The Nuffield Trust (RTR0114)
361 NHS Providers (RTR0012)
362 Care England (RTR0069)
363 National Care Forum (RTR0071)
364 Care Association Alliance (RTR0111)
365 British Medical Association (RTR0070)
366 Q350
367 The Nuffield Trust (RTR0114)

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

Exploitative practices in international recruitment

Repayment clauses

228. Gamu Nyasoro, Clinical Skills and Simulation Manager at Kettering General Hospital NHS Foundation Trust, told us:

> I know somebody who got here and applied for a visa for her husband and four kids. Her husband and three kids were given visas. Her 19-year-old son was not given a visa because, in this country, he is an adult, but where they come from, he is still a child. The youngster is still at school and doing A-Levels and so he was left behind. The mum is here with the dad, and now they are thinking about going back, but they cannot leave because they have been given exploiting contracts that you cannot leave until you pay them something like £10,000.[368]

229. We discussed how difficult some international workers find it to obtain visas for their adult dependants earlier in the report. The second practice that Gamu Nyasoro describes is the use of repayment clauses, which stipulate that a worker must pay a fee if they leave before their agreed contract term ends. Repayment clauses are used in contracts by the private care sector and by some NHS Trusts. UNISON wrote to us about the use of "repayment clauses, which are being used to exploit migrant workers and to intimidate them into staying with poor employers".[369] An investigation by the reporter Shanti Das showed that in some extreme cases, nurses are "tied to their roles for up to five years" and face fees of up to £14,000 if they want to change job or return home early.[370] Patricia Marquis, Director for England at the Royal College of Nursing said the RCN are "very concerned" about this practice, describing the clauses as "punitive".[371]

Modern slavery

230. The use of repayment clauses is not unlawful, but they are being used in the context of a wider picture of worsening exploitation of international workers in the social care sector. The United Kingdom Labour Market Enforcement Strategy 2020/21 identified social care as a "high-risk" sector for labour exploitation and non-compliance with labour laws.[372] Kate Terroni, chief inspector of adult social care at the Care Quality Commission (CQC), said there has been a "notable rise" in referrals to the CQC for modern slavery in 2022, with 14 referrals by mid-June 2022: double the number for 2021, and almost five times the number for 2020.[373]

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368 Q20
369 UNISON (RTR0077)
370 *The Observer,* Shanti Das, 'Overseas nurses in the UK forced to pay out thousands if they want to quit jobs', 27 March 2022
371 Matt Farrah, 'Are repayment clauses causing retention issues for international nurses?', 11 April 2022
372 HM Government, United Kingdom Labour Market Enforcement Strategy 2020/21, December 2021
373 Shanti Das, 'Migrant care workers came to help the UK. Now they're trapped in debt bondage', 18 June 2022

231. In 2019, the Modern Slavery Evidence Unit (MSEU) at the University of Nottingham identified that international workers in social care were at risk of

a) Debt bondage: in which a person must work to pay off money borrowed to secure employment in the UK.

b) Renumeration risks: the withholding of wages, or excessive deductions from wages for food or rent.

c) Recruitment and selection risks: recruitment and selection checks that fall short of regulation guidelines.

d) Occupational risks: care workers employed to act as personal assistants and paid through direct payment "were found to be particularly vulnerable to excessive overtime, the threat of physical violence, and the risk of sexual abuse."[374]

232. Researchers at the MSEU said these findings were of particular concern due to "the lack of applicability of Section 54 of the 2015 Modern Slavery Act (MSA) to public sector procurers", "a fragmented care industry sector which leaves the majority of firms operating below the MSA's £36 million threshold for transparency in supply chains reporting", and "the introduction of Direct Payments" which "raise concerns over the gaps in the regulatory protection of workers which may exist in this part of the industry".[375] They recommended that local authority commissioners evaluate the risk of modern slavery in their supply chains, throughout the commissioning and during performance monitoring, as well as offering modern slavery training to adult social care employees including agency staff and ensuring effective information sharing to reduce occupational risks.[376] After the MSEU paper was published, the law was changed to require Local Authorities to issue Modern Slavery statements.

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

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

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

374 Dr Caroline Emberson and Dr Alex Trautrims, 'Modern slavery risk in the adult social care sector', May 2019
375 Dr Caroline Emberson and Dr Alex Trautrims, 'Modern slavery risk in the adult social care sector', May 2019
376 Dr Caroline Emberson and Dr Alex Trautrims, 'Modern slavery risk in the adult social care sector', May 2019

Conclusions and recommendations

Workforce planning

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

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

Recruitment in Health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Retention in Health

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

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

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

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

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

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

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

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

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

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

29. *There is an opportunity to better utilise the pharmacy workforce, and in doing so, to optimise workloads across primary care, reduce pressure on general practice and hospitals, and support integrated care systems. This optimisation will not be possible without an integrated and funded workforce plan for pharmacy which must be developed and laid before Parliament within 12 months. The plan must ensure that all pharmacists have adequate access to supervision, training, and protected learning time, along with clear structures for professional career development into advanced- and consultant-level practice. The workforce plan for pharmacy must consider that by 2027 all newly qualified pharmacists will be independent prescribers and ensure that these graduates are given protected learning time, adequate supervision, and career development opportunities.* (Paragraph 111)

Training in Health

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

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

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

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

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

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

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

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

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

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

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

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

41. *We welcome the roll-out of a pilot Social Care Workplace Racial Equality Standard to some local authorities and encourage the Government to extend the Social Care*

Workplace Racial Equality Standard across all local authorities. However, we also recognise that the Social Care Workplace Racial Equality Standard will not capture the experience of the majority of social care workers, who are employed in the independent sector. The Government must fund Skills for Care to pilot the Social Care Workplace Racial Equality Standard in the independent sector within 12 months. (Paragraph 152)

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

43. *We welcome the General Medical Council's new targets to eliminate disproportionate complaints from employers about ethnic minority doctors (by 2026) and eradicate disadvantage and discrimination in medical education and training (by 2031). The Nursing and Midwifery Council must introduce parallel targets to eliminate disproportionate complaints from employers about ethnic minority nurses and midwives and to eradicate disadvantage and discrimination in nursing and midwifery education and training by the same dates.* (Paragraph 158)

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

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

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

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

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

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

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

Retention in Social Care

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

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

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

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

Continuity of care

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

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

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

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

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

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

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

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

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

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

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

Recruitment in Social Care

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

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

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

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

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

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

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

73. *Local Authorities must evaluate the risk of modern slavery in their adult social care supply chains and ensure that the risk of modern slavery is assessed as part of the due diligence processes at the commissioning and contracting stage and in performance monitoring. They should ensure that there is effective information sharing between*

Local Authorities staff, recruitment agencies, and care workers to reduce occupational risks such as non-enforcement of minimum and living wage, and threats of physical or sexual violence. (Paragraph 235)

Formal minutes

Wednesday 20 July 2022

Members present:

Jeremy Hunt, in the Chair

Rachael Maskell

Taiwo Owatemi

Draft Report (*Workforce: recruitment, training and retention in health and social care*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 235 agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjourment

Adjourned till Tuesday 6 September at 11.00am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 1 March 2022

Dr Emma Hayward, GP and clinical teacher, University of Leicester; **Gamu Nyasoro**, Clinical skills and Simulation Manager, Kettering General Hospital NHS Foundation Trust; **Lara Bywater**, Registered manager and owner, LDC Care Q1–20

Jane Ashcroft CBE, Chief Executive, Anchor Hanover; **Rachael Dodgson**, Managing Director and incoming CEO, Dimensions; **Oonagh Smyth**, Chief Executive, Skills for Care; **Sarah McClinton**, Director of Health and Adult Services at the Royal Borough of Greenwich and Vice President, Association of Directors of Adult Social Services (ADASS) Q21–39

Chris Hopson, Chief Executive, NHS Providers; **Nicola McQueen**, Chief Executive Officer, NHS Professionals; **Professor Dame Helen Stokes-Lampard**, Chair of the Academy of Medical Royal Colleges and Professor of GP Education, University of Birmingham Q40–66

Tuesday 22 March 2022

Wayne Jaffe, Consultant Plastic and Reconstructive Surgeon, University Hospital of North Midlands NHS Trust; **Dr Vishal Sharma**, Consultant Cardiologist, Royal Liverpool and Broadgreen University Hospital NHS Trust, Chair, BMA Consultants Committee, Chair, BMA Pensions Committee; **Professor Dame Clare Gerada**, Medical Director, NHS Practitioner Health, Chair, Doctors in Distress Q67–95

Professor Carol Atkinson, Professor of Human Resource Management, Manchester Metropolitan University; **Professor Carol Woodhams**, Professor of Human Resource Management, University of Surrey; **Jacqui McBurnie**, Chair, NHS England and NHS Improvement Menopause Group Q96–109

Prema Fairburn-Dorai, Director, Primary Homecare in Suffolk; **Nina Hemmings**, Researcher in Health Policy, Nuffield Trust; **Shilpa Ross**, Policy Fellow, The King's Fund; **Dr Wen Wang**, Associate Professor in Human Resource Management, Data Analytics and Interpretation, University of Leicester Q110–128

Wednesday 11 May 2022

Trevor Wright, lived experience witness; **Isaac Samuels**, Health and social care community campaigner and social care recipient; **Sophie Weaver**, Town councillor and social care recipient Q129–143

Professor Roger Kirby, President, Royal Society of Medicine; **Professor Colin Melville**, Medical Director and Director of Education and Standards, General Medical Council; **Dr Latifa Patel**, Interim Chair, British Medical Association (BMA); **Professor Malcolm Reed**, Lead Co-Chair, Medical Schools Council Q144–177

Lara Akinnawonu, Medical Student and Co-Chair of the BMA Medical Student Committee, Cardiff University; **Professor Hazel Scott**, Dean of the School of Medicine, University of Liverpool; **Professor Scott Wilkes**, Head of School of Medicine and Professor of General Practice and Primary Care, University of Sunderland Q178–197

Tuesday 24 May 2022

Ravi Sharma, Director for England, Royal Pharmaceutical Society; **Dr Denise Chaffer**, President, Royal College of Nursing; **Gill Walton**, Chief Executive, Royal College of Midwives; **Shawn Charlwood**, Chair, British Dental Association General Practice Committee Q198–238

Ian Trenholm, Chief Executive, Care Quality Commission (CQC); **Simon Williams**, Director of Social Care Improvement, Local Government Association Q239–257

Danny Mortimer, Chief Executive, NHS Employers; **Dr Navina Evans**, Chief Executive, Health Education England; **Professor Em Wilkinson-Brice**, Acting Chief People Officer, NHS England Q258–305

Tuesday 7 June 2022

Amanda Pritchard, Chief Executive, NHS England; **Professor Stephen Powis**, National Medical Director, NHS England Q306–331

Rt Hon Sajid Javid MP, Secretary of State, Department of Health and Social Care; **Matthew Style**, Director General for NHS Policy and Performance Group, Department of Health and Social Care; **Michelle Dyson**, Director General for Adult Social Care, Department of Health and Social Care Q332–380

Tuesday 28 June 2022

Chevonne Baker, Care Worker, Right at Home UK Q381–389

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

RTR numbers are generated by the evidence processing system and so may not be complete.

1 APPG on Bladder and Bowel Continence Care (RTR0065)

2 ARC (Association for Real Change) (RTR0019)

3 Academy Trainee Doctors' Group (RTR0056)

4 Academy of Medical Royal Colleges (RTR0046)

5 Allergy UK (RTR0148)

6 Alzheimer's Society (RTR0050)

7 Anchor (RTR0038)

8 Anonymised (RTR0061)

9 Association of British Neurologists (RTR0031)

10 Association of Dental Groups (RTR0010)

11 Association of Dental Hospitals (RTR0068)

12 Association of Directors of Adult Social Services (ADASS) (RTR0047)

13 Association of Directors of Public Health (RTR0136)

14 Association of Mental Health Providers (RTR0113)

15 Association of the British Pharmaceutical Industry; and Association of Medical Research Charities (RTR0075)

16 BMA (British Medical Association) (RTR0149)

17 BUPA (RTR0130)

18 Bhrolchain, Dr Cliona Ni (RTR0029)

19 BookJane (RTR0036)

20 Boots UK (RTR0121)

21 Breast Cancer Now (RTR0073)

22 Brewster, Dr Liz (Senior Lecturer in Medical Education, Lancaster University); Lambert, Dr Michael (Postdoctoral Fellow in Social Inequalities, Lancaster University); Rowlingson, Mr Barry (Research Fellow in Spatiotemporal Modelling, Lancaster University); Rycroft-Malone, Professor Jo (Dean of the Faculty of Health and Medicine, Lancaster University); Sedda, Dr Luigi (Senior Lecturer in Spatial Epidemiology , Lancaster University); and Shelton, Dr Cliff (Senior Clinical Lecturer, Lancaster University) (RTR0048)

23 British Association of Dermatologists (RTR0066)

24 British Dental Association (RTR0101)

25 British Dental Association (RTR0157)

26 British Dietetic Association (BDA) (RTR0043)

27 British Heart Foundation (RTR0137)

28 British Infection Association (RTR0032)

29 British Medical Association (RTR0070)

30 British Psychological Society (RTR0135)

31 British Society for Haematology (RTR0062)

32 British Society for Rheumatology (RTR0045)

33 British Thoracic Society (RTR0042)

34 Cambridge Boxhill Language Assessment (RTR0044)

35 Cancer Research UK (RTR0098)

36 Care Association Alliance (RTR0111)

37 Care England (RTR0069)

38 Care Quality Commission (RTR0100)

39 CareTech, CEO Jonathan Freeman (RTR0009)

40 Centre for Care (University of Sheffield) (RTR0103)

41 Chantler, Cyril (RTR0153)

42 Company Chemists' Association (RTR0162)

43 Company Chemists' Association (RTR0158)

44 Coproduce Care CIC (RTR0057)

45 Coventry University (RTR0112)

46 Darbyshire, Dr Daniel (RTR0016)

47 Davies, Dr Peter (RTR0125)

48 Dementia UK (RTR0074)

49 Dental Schools Council (RTR0030)

50 Department of Health and Social Care (RTR0161)

51 Department of Health and Social Care (RTR0140)

52 Diabetes UK (RTR0079)

53 Digital Healthcare Council (RTR0093)

54 Dimensions (RTR0025)

55 Downs, Dr Carolyn (Senior Lecturer, Lancaster University) (RTR0021)

56 Edmonds, Dr Polly (Consultant in Palliative Medicine, King's College Hospital NHS Foundation Trust); Brooks, Dr David (Consultant in Palliative Medicine, Chesterfield Royal Hospital NHS Foundation Trust); Proffitt, Dr Amy (Consultant in Palliative Medicine, Barts and the London NHS Trust, President APM); and Jones, Dr Mike (Medical Director, Joint Royal College Postgraduate Training Board) (RTR0015)

57 Edwards Lifesciences (RTR0108)

58 Efe, Dr Sureyya Sonmez (Post Doctoral Research Associate and Lecturer in Political Science, University of Lincoln) (RTR0150)

59 Eno, Dr Allswell (RTR0023)

60 Faculty of Sexual and Reproductive Healthcare (FSRH) (RTR0117)

61 Fairburn-Dorai, Prema (Director, Primary Homecare Ltd) (RTR0147)

62 GMB (RTR0089)

63 General Medical Council (RTR0132)

64 General Pharmaceutical Council (RTR0160)

65 Hayward, Dr Emma (RTR0143)

66 Hayward, Dr Emma (RTR0028)

67 Health and Social Care Workforce Study Research Team (RTR0039)

68 Homecare Association (RTR0104)

69 Hospice UK (RTR0118)

70 Independent Healthcare Providers Network (IHPN) (RTR0063)

71 James, Emily (Policy & Programmes Manager, The Community Pharmacy Workforce Development Group) (RTR0134)

72 Jenkins, Professor Rachel (RTR0052)

73 Konig, Dr Dirk (General Practitioner, The Bosmere Medical Practice) (RTR0006)

74 Local Government Association (RTR0156)

75 Local Government Association (LGA) (RTR0035)

76 Macmillan Cancer Support (RTR0102)

77 Mallon, Mr David (RTR0022)

78 Manchester Metropolitan University (RTR0059)

79 Manchester and Trafford Local Care Organisation (RTR0078)

80 Marie Curie (RTR0129)

81 McQueen, Nicola (CEO, NHS Professionals) (RTR0151)

82 Medical Protection Society (MPS) (RTR0054)

83 Melville, Professor Colin (Medical Director, Director, Education and Standards, General Medical Council) (RTR0154)

84 Methodist Homes (MHA) (RTR0116)

85 Michael, Dr. (RTR0007)

86 Monk, Dr Barry (RTR0005)

87 Mortimer Society (RTR0041)

88 NHS Confederation (RTR0105)

89 NHS Professionals (RTR0091)

90 NHS Providers (RTR0012)

91 NHS Resolution (RTR0060)

92 National Care Forum (RTR0071)

93 National Pharmacy Association (RTR0107)

94 Norfolk Care Association (RTR0004)

95 Norfolk County Council (RTR0122)

96 Nursing and Midwifery Council (RTR0097)

97 Nyasoro, Gamu (Clinical skills and Simulation Manager, Kettering General Hospital NHS Foundation Trust) (RTR0144)

98 Papworth Trust (RTR0095)

99 Parkinson’s UK (RTR0067)

100 Pritchard, Amanda (Chief Executive, NHS England and NHS Improvement) (RTR0152)

101 Profiles4Care Limited (RTR0127)

102 Prostate Cancer UK (RTR0064)

103 Rapport Housing & Care (RTR0014)

104 Relatives & Residents Association (RTR0138)

105 Royal College of Anaesthetists (RTR0024)

106 Royal College of Emergency Medicine (RTR0011)

107 Royal College of General Practitioners (RTR0051)

108 Royal College of Midwives (RTR0126)

109 Royal College of Nursing (RTR0092)

110 Royal College of Obstetricians and Gynaecologists (RTR0058)

111 Royal College of Ophthalmologists (RTR0013)

112 Royal College of Paediatrics and Child Health (RTR0087)

113 Royal College of Pathologists (RTR0094)

114 Royal College of Psychiatrists (RTR0131)

115 Royal College of Physicians (RTR0053)

116 Royal College of Physicians and Surgeons of Glasgow (RTR0026)

117 Royal College of Radiologists (RTR0133)

118 Royal College of Speech and Language Therapists (RTR0040)

119 Royal College of Surgeons of Edinburgh (RTR0096)

120 Royal College of Surgeons of England (RTR0049)

121 Royal Pharmaceutical Society (RTR0110)

122 Royal Pharmaceutical Society (RTR0159)

123 Royal Society for Public Health (RTR0139)

124 Scott, Professor Hazel (Dean of the School of Medicine, The University of Liverpool) (RTR0155)

125 Scott, Vikki-Jo (Senior Lecturer, University of Essex) (RTR0001)

126 SeeAbility (RTR0076)

127 Sense (RTR0080)

128 Skills for Care (RTR0145)

129 Skills for Care (RTR0034)

130 Sue Ryder (RTR0055)

131 Sumner, Dr Rachel (Senior Research Fellow, Cardiff Metropolitan); and Kinsella, Dr Elaine (Lecturer in Psychology, University of Limerick) (RTR0027)

132 The Chartered Society of Physiotherapy (RTR0072)

133 The Disabilities Trust (RTR0088)

134 The Faculty of Intensive Care Medicine (RTR0002)

135 The Health Foundation (RTR0124)

136 The King’s Fund (RTR0099)

137 The Nuffield Trust (RTR0114)

138 The Nuffield Trust (RTR0163)

139 The Practice Management Network (RTR0109)

140 The Society of Occupational Medicine (SOM) (RTR0141)

141 The Working Group of the Adult Social Care APPG (RTR0037)

142 Thomas, Meirion (RTR0017)

143 Thomas, Meirion (RTR0142)

144 Turning Point (RTR0123)

145 UK Council for Psychotherapy; and British Association for Counselling and Psychotherapy (RTR0119)

146 UK Faculty of Public Health (RTR0018)

147 UNISON (RTR0077)

148 University of Plymouth (RTR0081)

149 University of West London, College of Nursing, Midwifery and Healthcare (RTR0090)

150 Wang, Dr Wen (Associate Professor in HRM data analytics and Interpretation, University of Leicester); Seifert, Professor Roger (Honorary Professor in Employment Relations, Keele University); and Thelwall, Professor Michael (Professor in Cyber-metrics Research, University of Wolverhampton) (RTR0106)

151 Wang, Dr Wen (Associate Professor in Human Resource Management, Data Analytics and Interpretation, University of Leicester) (RTR0146)

152 Waterworth, Miss Mary (RTR0020)

153 Weatherhead, Marion (RTR0128)

154 Work Foundation (RTR0115)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2022–23

Number	Title	Reference
1st	Pre-appointment hearing for the Government's preferred candidate for the role of Patient Safety Commissioner	HC 565
1st Special	Cancer Services: Government Response to the Committee's Twelfth Report of 2021–22	HC 345
2nd Special	Government Response to the Expert Panel's Report on Government commitments in the area of cancer services in England	HC 346

Session 2021–22

Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20
2nd	Workforce burnout and resilience in the NHS and social care	HC 22
3rd	Pre-appointment hearing for the Chair of the Food Standards Agency	HC 232
4th	The safety of maternity services in England	HC 19
5th	The treatment of autistic people and people with learning disabilities	HC 21
6th	Coronavirus: lessons learned to date	HC 92
7th	Supporting people with dementia and their carers	HC 96
8th	Children and young people's mental health	HC 17
9th	Clearing the backlog caused by the pandemic	HC 599
10th	Pre-appointment hearing for the position of Chair of NHS England	HC 1035
11th	Pre-appointment hearing for the position of Chair of the Care Quality Commission	HC 1091
12th	Cancer services	HC 551
13th	NHS litigation reform	HC 740
1st Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England	HC 18

Number	Title	Reference
2nd Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England	HC 612
3rd Special	Supporting people with dementia and their carers: Government Response to the Committee's Seventh Report	HC 1125
4th Special	Expert Panel: evaluation of the Government's commitments in the area of cancer services in England	HC 1025

Session 2019–21

Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the National Data Guardian	HC 1311