WESTMINSTER
HEALTH FORUM

Priorities for the health and social care workforce and Health Education England: recruitment, leadership and the impact of Brexit on the NHS
9th February 2017

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About this Publication

This publication reflects proceedings at the Westminster Health Forum Keynote Seminar: Priorities for the health and social care workforce and Health Education England: recruitment, leadership and the impact of Brexit on the NHS held on 9th February 2017. The views expressed in the articles are those of the named authors, not those of the Forum or the sponsors, apart from their own articles.

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Westminster Health Forum Keynote Seminar:
Priorities for the health and social care workforce and Health Education England: recruitment, leadership and the impact of Brexit on the NHS
Timing: Morning, Thursday, 9th February 2017
Venue: The Caledonian Club, 9 Halkin Street, London SW1X 7DR

WESTMINSTER HEALTH FORUM

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11.35 - 11.40 **Session Chair's opening remarks**
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12.25 - 12.55 **Priorities for Health Education England and the current and future workforce**
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Baroness Cumberlege, National Maternity Review, NHS England
Matthew Bradberry, Forum Lead, Westminster Health Forum

Westminster Health Forum closing remarks
Matthew Bradberry, Forum Lead

Good morning.

I'm Matthew Bradberry, Forum Lead of the Westminster Health Forum and it's a pleasure to welcome you all to today's seminar. Just a quick couple of housekeeping points from me before we can get started.

You will see from the agenda today there are a number of opportunities throughout the day for questions and comments to be taken from the floor. If you would like to ask a question during one of these sessions we would ask you to catch the attention of our Chair by raising your hand, and if you could start by giving your name and organisation for the purpose of our transcript.

We are tweeting today's seminar as #WHFEvents Could I just ask everyone to turn their phones to silent to avoid disrupting proceedings from the front.

I will now pass you over to the Chair for the first session, Malcolm Dean. Thank you.

Session Chair's opening remarks
Malcolm Dean, Associate Member, Nuffield College, University of Oxford and former Assistant Editor, The Guardian

Good morning, can you all hear me? Great.

Well I've come to update myself, and we couldn't have a more impressive list of experts to talk to us. So Michael Gove, hang your asinine head in shame and come and hear about the challenge which these four speakers have been given is a mere 10 minutes, but don't forget how far you can run in 10 minutes and because we've got seven in this session, we are going to start with five, and then there's going to be a break of 25 minutes for questions, and then the last two before coffee.

So I've come to learn as much, rather than just to Chair. I hope you've all been listening to this amazing BBC Week on the health service, the Today programme, the news programme and online, huge amounts of material, so it's a very appropriate time to be having one.

Let's pull out some very quick facts most of you might know. Yes, there was some increase in the funds for the NHS, but nowhere what was needed to cover the rise in the number of patients participating, particularly the older people. Simon Stevens, the CEO for the NHS said this week that the NHS service was looking after 1 million more over 75s than 5 years ago, and in the next 5 years there will be another million coming in, and if you remember that the average 60 year old costs 2.5 times as much as the average 30 year old, and the average 85 year old costs 5 times as much.

We have a Prime Minister and Chancellor who seem to have been in complete denial to the crisis in the community care, but can I remind you that David Cameron, when he was Prime Minister, did say he was going to move on proper integration and community care if he could.

The biggest challenge, I think, at the moment is to reverse this decline in social care homes, it's been going on for a decade, there was, if you remember, the Southern Cross provider who had 750 homes and sold them all thinking they could rent them back, and then went into decline because they couldn't. A parable for what can happen once profit usurps social mission. Then in November 2015 the organisation for care homes went through George Osborne the Chancellor in 2015, pleading for more money to be invested in the system. That year alone there has been 1,500 beds lost in the social care system, and then the end of last year the CQC had a report from the Care Quality Commission that it had revealed that 500 care homes, 500 in London had closed in the last decade.

You will know about the community care budget, the King's Fund and Nuffield Trust last September suggested 4 out of 10 older people pay for their own social care in their own home, but there were 300,000 fewer older people getting care through the local authorities. They've been hit by the cuts to their budget, where once 80% of their finance was from Government, it had been slashed by 58%.

The Local Government Association who are representing 370 local authorities, estimate there will be a 2.6 billion shortfall for community care by 2020 unless more is provided.

The BBC reported this week the number of days lost due to delayed discharges had doubled since 2010 to 200,000 a month and yesterday's Guardian reported that the Nuffield Trust Think Tank was issuing a report suggesting the real number of patients trapped in hospitals, despite being fit to leave, was three times as big as the official figure.

Two late developments need a quick note. Ministers were clearly becoming increasingly embarrassed by an increasing number of local Conservative leaders publicly declaring that they couldn't continue as they have been doing. Then we had yesterday's Parliament question where it looked as though a sweet deal was being given to Surrey who was thinking of having a referendum for a tax increase. And leaks this morning to the BBC

that the A&E 4 hour target for assessment and treatment had been achieved by only 82% of hospitals, compared for the target of 95%, which was the lowest since they started 13 years ago.

So, let's get to the experts shall we?

So first Anita, Anita Charlesworth, you've got her biography, all these people have very impressive biographies, will talk to us on key trends, challenges and opportunities for improving patient care.

The NHS workforce: key trends, challenges and opportunities for improving patient care

Anita Charlesworth, Director of Economics and Research, The Health Foundation

Thank you.

So I'm going to focus on the workforce issues and a bit on the link to funding.

So the first thing, just to provide a little bit of context for this, is that although we now spend about the European average in terms of a share of GDP on healthcare, whatever we spend that on, it isn't buying large numbers of doctors and nurses. So we run our system hot, as Malcolm's introduction clearly showed, we work the resources that we've got, the beds and the staff incredibly hard compared to other systems, and that relies on everything working very smoothly and there are really being no blockages in the system, which is something I will come back to, I think.

So doctors per thousand population, the UK has 2.8, France 3.3, EU 15, that's all the countries that were members of the EU before the fall of the Soviet Union really, Sweden and Germany have about 4.1 and many countries that have a low number of doctors, and there are quite a few, often have a different staffing model which means that they have a higher number of nurses per head. Where I think we are unusual is that our low number of doctors per head is matched by a comparatively low number of nurses per head as well. So we have 8.2 nurses, this is 2014 data, 8.2 nurses per thousand population and again you can see the EU average of 9.4 but Sweden, Germany… not be emulated, they have an incredibly long length of stay, but many countries with more nurses.

Now part of the nursing position may be that we moved, you know, to a single tier of nursing and an all graduate nursing profession and many other countries still have two tiers of nurses, but nevertheless I think what is important to note is that it's both doctors and nurses, so two of the most important clinical staffing groups that are below average.

The funding issues then that I want to talk about really are how important these workforce issues are to the funding challenge we're facing, just a quick reminder, and this is to some extent how I most get my head round the nature of the funding challenge.

So this is how much the NHS spends per person, so for every man, woman and child in England. Once you've allowed for a bit of inflation. So in 2016/17 spent just shy of £2,200 for each of us in the country, and in 2020/21 we will be spending just shy of £2,200 for every man woman and child in the country. So the funding increases keep pace just with inflation and with pure population growth. What that means is that we are looking to efficiency savings, to absorb all of the additional cost of that 1 million extra over 75s, all the additional costs of new technologies and as people will be aware with things like the Hepatitis C drug we are entering a period now where actually a lot of drugs are coming to market which are very expensive, but cost effective, and rising expectations and rising burden of chronic disease.

So all of these things have to be absorbed by efficiency, and that's why we've got this challenge of 22 billion. And just… I put the 22 billion up there, this is the NHS England's figures from last year about how that breaks down, because workforce is really critical to the delivery of the efficiency savings here. So we've got 22 billion of which about a third is of which nationally delivered, this is one of the most strange euphemism for pay restraint, so about 5 billion of that is holding down NHS pay awards. So there's a very direct impact on the efficiency savings from continued pay restraints.

The remainder 15 billion is to be delivered locally, that's the local efficiency savings. NHS thinks it's already got a billion in the bag of that, so it's got 14 billion left, and again that breaks down in two ways. One is kind of changing the demand side, which is a mix of the sort of vanguards and new models of care, and then this right

care programme which has looked, it's Professor Sir Muir Gray's work, he's at Oxford, which has looked at the variation in what is provided that is unrelated to need. So big variations in hip replacement rate, things like that, across the country unrelated to need, and identified efficiency savings that could come if we redeployed resource that is currently going on that unwarranted variation in essence to support some of the new and effective technologies.

But the big bulk of the saving is this £8 billion that comes from the secondary care sector improving its productivity, and that's what… doing what we are currently doing, broadly speaking, better. And over two-thirds of the cost of secondary care providers is their pay bill, is staff, yes. So actually this is often referred to as back office savings, it's an utter misnomer, the vast bulk of the savings here don't come from changing procurement, important though that is, they come actually from teams in the NHS working differently to unlock productivity improvements.

So this is as much a staffing challenge as that pay restraint, but obviously this is quite difficult to do in our workforce context. One way you've got a lot of pay restraint, so people are finding it hard in terms of pay, but secondly where you've got very high vacancy rate, and very high churn rate, so you've got an awful lot of temporary staff in wards. I don't understand how, as a ward, you say redesign all your shift patterns using Patrick Carter's analysis on e-rostering systems, for example, if 1 in 5 of the people on the ward each day is a different person, yes. So how you redesign some of the care pathways, if that is the case, and that is the case in London. If your senior nurse on the ward, instead of talking to everybody about how we might do some of the things differently, has spent most of the day trying to work out how to get enough nurses for the following day, and whether or not various clinics can actually run, and dealing with the consultants who understandably are pretty angry about that. So that workforce stability, having the right people in the right place, motivated and engaged, is fundamental, absolutely fundamental to realisation of that 8+ billion, and I would say to most boards that I think the workforce issues, the inability to recruit, retain and engage staff is the number 1 financial risk to the 22 billion, it is the make or break, but I meet very few boards who see it in that way and who discuss those issues at that board level in that way.

Just to reinforce, this is ONS data that looks at how did we get through in the first few years of austerity in the NHS without busting the budget, and really what we did was we shrunk labour inputs, yes, but they are creeping back up. Most importantly as well, we cut the number of training places which is one of those things that really does come back to bite you.

But the other thing is around… so productivity matters… workforce matters for productivity and the efficiency challenge, but I would also say that one of the things, that until we started really digging into the workforce I hadn't properly understood, is how rapidly we are going through a major skill mix change in the NHS and how little we have talked about how to adapt the way we provide care and design our services and pathways in recognition of that skill mix change.

So this is just 6 years, this is 6 years where austerity hit and the NHS had no money. I'm amazed at how many people don't know, I didn't know actually until… that we increased the number of consultants that we employ in the NHS by over 20% in that 6 years, we are going through a period of massive change in our skill mix, but nurses, where are you nurses, there, by less than 1%. So we are going through a fundamental change in the balance between consultants and nurses, and I can see very little around, in terms of the discussion, about how you deliver care and design services and work as a team when you've got such a profound change in your skill mix.

On the productivity piece, though, this is the evidence to date on what we are doing. So that 8 billion that I talked about that NHS providers have to deliver, equates to around 2% a year in annual productivity improvements. The NHS actually has a pretty credible track record on productivity over the longer term, it's got a bit bad over the last, well couple of years, but over the longer term and the longest run of data suggests about 1.4%, but the most recent data from Monitor, and then NHS Improvement as they now are, shows productivity, well again it was at 1.4, but with the latest data it's down to 1%. This is quite good compared to what's happening to the wider economy at the moment, and quite good for a service industry, but we have to double that. So actually, you know, over the next 4 years we've to double that, we've not just to continue to

find those savings which get harder each year, in some ways because you've already done the things that are obvious, we actually have to double what we've been doing in terms of productivity. And again I don't see the recognition of that, and that means workforce productivity, basically, having to double.

Against the backdrop, obviously, of the very tight pay, and this just shows you what's happened to date, which is that inflation cumulatively since pay restraint has risen by 12% and NHS headline pay risen by 3%, so NHS staff have taken a 10% real terms pay cut and another similar pay cut is due, possibly even greater because inflation is expected to pick up. So this is going to get harder and harder to do, and then we add Brexit into the mix, and although we have employed a lot more doctors and nurses, lots of them have come, obviously, from the EU and we are very dependent obviously on international workforce, so almost a third of the doctors in the NHS were foreign trained and 12% of nurses.

Which brings me to my final slide. So we can't do a lot within the NHS about the pay envelope, we can't do a lot about inflation and Brexit, yes, but the thing we can do is to use the staff we've got really well, engage them and motivate them, and most people don't come to work for the NHS for… if they are purely motivated by pay, yes, but obviously the pay environment is difficult, so all those other things that really matter to them that were why they chose to work in the NHS in the first place, we need to make very real for everybody, and we need to make it possible for people to do a good job every day.

We are haemorrhaging leavers, I think, you know, which is shooting ourselves in the foot, so we really do need to get workforce issues much higher up the agenda. It is our key asset, it's fundamental to delivering the quality of care but also it's at the heart actually of delivering the efficiency savings that are needed, given the finances of the NHS.

Thank you.

Malcolm Dean: Absolutely brilliant, thank you very much. Now we have Stephen Dorrell, you will all know him, he was an MP for 30 years, he was Health Secretary, he was a Chair of the Health Select Committee. Stephen, they've got your full biography in their papers.

Workforce morale, leadership and representation

Rt Hon Stephen Dorrell, Chair, NHS Confederation; Chairman, LaingBuisson and former Secretary of State for Health (1995-1997)

Thank you very much Malcolm, and thank you for the invitation to come and following Anita's, as you say, brilliant summary of the challenges facing the health service.

I think the agenda, the title of the day that we've been asked to come and talk about today is specifically the workforce issues and specifically again the workforce issues in the context of Brexit.

So I've been invited to come and speak here as Chair of the Confed and that's what I shall do, but in the interests of openness I should also tell you that I also Chair the European Movement, so my views on Brexit are a matter of record, I shall try to approach the subject from the perspective of the NHS rather than the perspective of a campaigner against Brexit, but I think it's unavoidably true that the challenges we face within the health and care system are made more difficult by the impact of Brexit, but perhaps we can come to that in discussion rather than what I say by way of introduction.

What I want to say really picks up and develops Anita's points. The core challenge facing the health and care system, and I will link the two together for reasons that I will develop, the core challenge is that demand is rising, for all the reasons that we know, and the resources are not rising fast enough for us to meet that demand without a truly startling improvement in the measured productivity of the health and care system. Anita's figures, I'm not going to… there are different versions of this, but let's use one set of numbers. In order to meet demand we have to deliver 2% productivity gain across the health and care system, in fact if you include the social care system with the budgets that are available in social care, then the productivity challenge is even greater than the one that Anita set out, we need to deliver startling improvements in productivity gain in order for us to be able to meet the projected levels of demand that we know are going to manifest themselves in the system between now and 2020 and beyond, it's also worth making the point that we have to achieve those productivity gains merely in order to deliver the quality standard that we have grown used to in recent years, whereas most of us would actually have the ambition, not merely to meet a rising demand trend, but also to be able to deliver a rising quality experience for people who use the health and care system, and that's an even further challenge… that represents an even greater productivity challenge.

So the core issue is how to deliver… how to meet rising demand, how to deliver the aspiration of improving quality within resources that will not accommodate that without a startling improvement in productivity. That's proposition number 1.

Proposition number 2 is that health and care services are a people business, this productivity gain isn't going to be delivered by new gismos that are delivered in other parts of the economy, there are opportunities sometimes to use technology to deliver startling improvements in productivity. That opportunity doesn't exist in the same way in health and care services, so it is about how we enable people to use their skills differently, organise work patterns differently. The productivity in health and care services is about how the user experience, the patient, citizen experience of these services, is delivered by people working differently. So it's no good talking about workforce issues on one day and productivity challenges the next day, they are one and the same thing, and that's something that Anita brought out, that it's key for us to understand that productivity challenges in the health and care system are challenges about how the skill… the committed workforce of the health and care system deliver those services.

And that comes therefore to questions about models of care, the way in which these services are delivered, and the skills that are available to the workforce working within that system. Let me take those two points separately.

First of all new models of care. One of the core facts in my view about the health and care system is that the structures within which we operate, the siloes that separate out the hospital service, the primary care service the community health service, the social care service, the social housing service, and actually the rest of public

services beyond the health and care system, many of which are also motivated by the desire to make… to support citizens in a way that delivers, not merely additional life years, but quality additional life years. Those siloes reflect the history of the services and the technologies of a previous era, they don't reflect either the changing nature of the demands placed upon it by today's and tomorrow's generation, nor do they reflect the opportunities that are available to us to work differently to meet those demands. So that productivity, in the way that we measure it, the delivery of that objective requires us to rethink the way these services are delivered, to break down traditional siloes, to use the jargon word, to integrate, to join up the different aspects of public service in order to deliver different models, and that's something that Ministers, health policy specialists, have talked about for as long as anyone in this room can remember, even you Malcolm, for as long as you can remember, when I Chaired the Health Committee I used to talk regularly about the need to break down the distinctions between the different siloes in health and care services, and one of the reports, there was an expert who was helping us with this report, and I asked him the night before we were due to sign it off, could you find me the oldest quote from a Secretary of State making the case for shifting resource out of the hospital service into community services, into prevention, early intervention, rather than waiting for avoidable acute cases to arise and he came back the following morning, he said I'm sorry I'm working away from home so I was relying on Wikipedia and Google and the oldest quote I could find was Dick Crossman in 1968, is that old enough? An I said well it at least makes the point that for as long as any of us can remember, we've talked about the need for different care models.

Now let me give you some statistics about how the reality reflects the rhetoric, or doesn't reflect it. In the 10 years, 2005 to 2015, during which time Ministers of all political complexions, have talked about the need to shift resources out of hospital into prevention and early intervention, during that time social care spending, despite rising demand, has flat lined in real terms, it's gone up 0% over a decade in real terms. Spending on community services and primary care services has gone up by 5% in real terms. Spending on the acute sector has gone up by 31% in real terms. That reflects the precise opposite of what the Ministerial rhetoric has suggested should be the priority in the system.

So delivering efficiency, delivering better care experience to citizens does, in my view, demand more effective delivery of the aspiration of early intervention prevention services, avoiding unnecessary acute episodes, recognising the National Audit Office analysis that says that 30% of hospital beds on any day in the year are filled by cases and people who wouldn't be there if we had taken the opportunity to support them effectively though effectively organised public services, and the challenge is to staff services to change the skill mix, to change the structure of those services in a way that doesn't deliver over the next decade a further relative shift of resource into the acute sector, and actually starts to convert the aspiration that all of us have as citizens, none of us want to be in an acute hospital.

So often this argument is presented as a financial challenge, actually it's not a financial challenge, it's a human challenge. Please, I would prefer, as I get older as a citizen, to be supported in an enjoyable and fulfilling life, rather than rely on a public service structure which waits for me to be sufficiently ill to qualify to get into an acute hospital, that's actually how we run these services currently and that's what needs to change.

Malcolm Dean: Thank you very much Stephen, we've had two really good pieces with Anita at the hard facts and the man who has had to handle all this in different positions. We now move on to Steve West, Vice-Chancellor and President and Chief Executive, University of West of England, talking about higher education and the health workforce. The floor is yours Steve.

Higher Education and the health workforce

Professor Steve West, Vice-Chancellor, President and Chief Executive Officer, University of the West of England and Chair, UUK Health Education and Research Policy Network

Well, thank you very much.

So I'm looking at it from the perspective of universities and we titled this looking across the bridge, but actually we are part of one family when we're trying to deal with some of the challenges that we're facing. So I want to build on the two previous speakers, first of all we are not in a transactional relationship, universities and the health service, we are working together, and we have to work together and join things up both in terms of research, innovation and development, but also in terms of trying to think through our workforce demands and solutions.

Now, I've been in the system for 35 years, I'm a Clinician by background, and for 35 years we've talked about trying to rethink the workforce, to rethink the system, shift things in terms of where the emphasis should be, and we've tried to control workforce planning as part of that. And I suspect that we'd all agree we haven't made a particularly good job of it yet, because we haven't solved the problem.

So it is a high value interaction between universities and the health system, both are going through some very turbulent times at the moment. The NHS and the social care system is challenged, and the university sector is going through significant change. Not least the HE Bill and Research Bill that's going through, which is going to completely shift some of the thinking in universities and in particular, put an emphasis on quality of provision learning and teaching alongside research, but also open up the opportunities for new providers to enter the market place. I think health will be one of those areas that new providers might well look at and either, engage with at various levels, or go, *'it's too difficult we're not going there',* the ones that know about it might take the latter option.

We're seeing some shifts, undergraduate education for medical student numbers are increasing, next year there will be an additional 500 and then after that, 1000. This is designed to try to begin to replace some of the demand that is currently being met by European doctors and international doctors coming in. So there are some signs of some expansion, but it takes a hell of a long time to get a practitioner from training out into the workplace, so I doubt it's going to have a significant impact in the short to medium term. And, of course, some of those areas in medicine are going to be attractive to new providers, new providers coming in, so it won't just be about increasing numbers in current medical schools. There may be new medical schools opening with a different flavour of training – maybe towards general practice, community medicine, mental health and older persons care.

We're also seeing significant reforms in nursing, midwifery and allied health professions. Two big things that are happening at the moment, one is are view of the standards for nursing and midwifery and a whole rethink about what's required of practitioners. But the second one is of course the big reform associated with funding nursing, allied health professions, midwifery are all no longer going to be funded and supported through their education by NHS funding through Health Education England, they are going to be treated the same as any other student, they will take out a student loan and they will begin to repay back that loan once they graduate and are earning over £21,000 per year. I'll come back to that shortly.

And of course the impact of Brexit, in the unknown world that we are in at the moment, is giving rise to significant concerns in terms of that workforce that is currently the European workforce, 58,000 NHS workforce, 90,000 within social care, and these are the numbers that we sort of put a question mark, because they could be a lot bigger and of course a significant proportion of our medical workforce, 6.6%. So a huge amount of turbulence in a system that is already challenged and I think we just need to understand that the challenges are significant and impact on organisations and individuals

Simon Stevens and Health of course have done well in terms of convincing Treasury for additional funding, but actually it's not enough, previous speakers have identified this. The health sector is facing two significant challenges, only two would be great, but actually there's a lot more than that, but two big ones. Workforce and of course finances, and I think I would add in the combination of those two things in trying to meet increasing demand from an ageing population. And that really is a very difficult set of equations to balance.

The NHS has a plan, the Five Year Forward View and of course the CSR funding settlement that was associated with that. We also now have the sustainability transformation plans, 44 plans in England designed to try and bridge social care and health, and begin to look at a local level at what is possible.

In my patch, of the West of England, there are three STPs, we are really struggling and scratching our heads to work out, are these things real, and are they deliverable in the time frames set. We have to be honest with ourselves and the public and at some point we may have to say, wow maybe the emperor has no clothes, let's have a serious conversation with the public and stop messing around at the edges. And of course the pressure is mounting this week in the BBC and the general discourse in parliament is beginning to change and accept we have to think and act differently. I think the population and certainly the Parliamentarians are beginning to recognise we need a serious cross party and cross house conversation to solve some of these problems for the long-term.

In the workforce, we see shortages both on the health side and the social care side. And I think we have to join the two things, I absolutely agree that, you can't look at one without looking at the other, you cannot look at acute without looking at community and social care. We know that there is competition across those two divides at the moment and if you were looking down from Mars you would have to ask the big question well who the hell invented this, why have you compartmentalised in this way, when actually we should be thinking about people and patients at the heart of the system.

I think the shortages we are seeing are real. I do a lot of work in the acute trusts and it's very clear that they are struggling to fill posts in particular specialities and they are looking internationally to do that, but often the international workforce is transient, it comes for a while and disappears, and so we see quite a high turnover. And when you're trying to restructure and re-profile your workforce and services, it's difficult when you haven't got a stable workforce. We are also seeing similar pressures in the community medical and non-medical workforce.

We are also seeing of course massive changes to contracts, we've been through the junior doctor contract, we're about to go into I guess some heavy weather in terms of the consultant contracts, and all of that alongside the shortages begins to hit morale and cause increasing problems.

We've talked a lot over 30 years about changing the workforce mix, we've talked a lot about new roles, we've talked a lot about extending roles, we've talked about skill mix that tries to accommodate the needs of our health and social care demands. And we've made some progress, but not I suspect enough.

I've touched on the medical student increases, so this is a 25% increase in current medical school places, but the output from that is a long way off, the output really is ten years plus before you have practitioners out there who are going to make a significant contribution. We also know that the impact of the reforms for nursing, midwifery and allied health professions, UCAS data just published for this cycle, so this is intakes in September 2017 to universities, nursing is 23% down in terms of applications against this time last year, some of the professions are nearer 35%, 40% down. Now, those numbers are significant and importantly, it's impacting in particular on mature entrants into those professions, and in particular in nursing.

So we're seeing a decline in the attractiveness of students coming in and hopefully progressing and graduating. It's patchy across the country so there are some hotspots that look more worrying than other parts of the country and we're having to work really hard now to make sure that we convert these students and get them into the health and social care system, and then retain them. And in that respect we're in this together, 50% of their learning is occurring in practice. If we can't make sure that we nurture them in practice we'll

haemorrhage staff, so we'll not only haemorrhage from existing qualified staff, we'll haemorrhage from the future healthcare professions population, so we have to work hard to resolve that.

Finally, the last thing to say is that we are looking for new pathways, we are trying very hard to find new routes into the healthcare, the apprenticeships might offer a part solution. But we also have to understand we need highly competent practitioners, the complexity that we're now dealing with, whether it be in the acute service or in, community services, because we have an ageing population, are placing significant demands on our practitioners. We need people who know what they're doing, we need people who can work in teams and we need to ensure that we deliver safe care within an increasing demand and complexity that we're seeing within our ageing communities.

So it's not as simple as just saying, well we'll have a load of cheaper people who can be the doers and we don't need to have the thinkers in there, we actually need to combine the two. I want somebody treating me who knows what they're doing and can deal with the consequences of the complexity that I might present with.

So I think in conclusion all I want to say is we're in it together, we haven't solved all of the problems yet. I seriously think Parliamentarians, universities, clinicians and the NHS and social care sector need to sit down and have a serious conversation with our population, with us, about what we can afford and how we might be able to deliver care together.

Thank you.

Malcolm Dean: Thank you very much indeed, Steve. We now move onto Martin Hart, next steps for developing post-graduate healthcare training, which fits in neatly with Steve's.

Next steps for developing post-graduate healthcare training
Martin Hart, Assistant Director of Education, General Medical Council

Right, thank you.

Just to pick up a couple of points from previous things, I was really pleased Stephen mentioned quality, as you will imagine a big thrust of my presentation this morning will be about keeping up the quality in education and training. And also picking up one of Steve's points, I'm talking largely about those in post-graduate training, they represent about a third of the medical workforce, roughly one in three doctors is still going through training as you meet them, really important that we look after that group.

I'd like to start with a historical quote as well, I can go further back than 1968, this is one of my favourite GMC quotes, this is John Marshall who was President of the GMC about 130 years ago. You can read what he says, but what he's essentially saying is I don't think the GMC should be too busy looking at the shortcomings of doctors, because it will undermine the profession. I am very pleased to say that things have moved on a lot since then.

What we do now very clearly is about protecting the public and we see our role very much focused on the public, - not doctors, not Governments, but the public. We keep up to date the register of doctors who is on or not on the register, we encourage good medical practice, we promote high standards of education and training, which I will talk about, and yes, we do now deal firmly with that very small group of doctors whose fitness to practice is in doubt.

This slide makes the same point, but I think just stresses that those functions are interlocked together, so for us, the standards of medical practice is the heart of what the GMC is about and as I've said, really important that we continue to focus on that. We do now revalidate doctors, so people do have to confirm via their medical director that they are fit for practice and up to date. We deal with education, which I will talk about. We maintain the register, which is a really important role for the GMC, so that the public know when they meet a doctor they are dealing with someone who is registered with the statutory body. And yes, we deal with the fitness to practice issues.

I want to focus obviously mostly on education and training and what we're about, and I think obviously I'm talking from a medical point of view, but a lot of what I say works across all the professions as well. It's about developing professionals and delivering excellent patient care, the two are indivisible and again, Stephen made this point about the workforce being key to this.

I am focusing on post-graduate, but I just wanted to illustrate the continuum of the GMC's role, so at the under-graduate stage where we set the standards for medical schools and define the outcomes that the graduates need to meet, through to foundation training that important first two years after a student has graduated and become a doctor, there we get involved with approving the curriculum, what they actually learn and their assessment. That carries on into speciality and GP training and where we've also started now to look at some of the generic skills that all doctors need. And I'll talk a bit more about that.

Crucial to all this, is where it interacts with the service and having an environment that supports education. We all know that when times are hard one of the things that it's very easy to cut back on is education and training. And I really do want to stress that as we move forward with all these innovations that we don't lose sight of that. And we work with others, including HEE who we're going to hear from later, to move forward and hold those providers to account.

I do want to talk briefly about our standards, we now have one set of standards covering that whole continuum, it's called Promoting Excellence. You won't be able to see the detail of this slide, but it's essentially ten standards under five themes and if imitation is the sincerest form of flattery, I am genuinely very pleased that HEE have taken these five themes, they've added a couple of their own to make a framework that applies to all the professions that HEE covers.

But very briefly, learning environment and culture is absolutely crucial, that the place where our trainees and our students are focused on teaching them what they need to know. Educational governance and leadership is also crucial, we do know that when organisations have an interest in education, and I'm not talking about the medical schools or the post-graduate deans, I'm talking about the clinical situations where they focus on education and have an interest in it, and realise its importance, that is vital to good standards.

We have to support the learners, whether they're students, or whether they're trainee doctors, or indeed any other profession. We have to support those who are teaching them as well and I think this gets often forgotten, busy clinicians with heavy clinical load many of them are also delivering the education and training of the doctors of the future, and we do have to make sure they're supported in doing that.

And then finally, developing and implementing curricular and assessment systems that are relevant to whatever course they're following.

On the outcomes side, we have two I just want to draw attention to. One is the clear outcomes for graduates for medical school and then the outcomes for full registration, so doctors who complete the first year of the foundation programme to get fully registered with the GMC. In the post-graduate world what we've tried to do is actually try and decide what are the key things that all doctors need, the history of post-graduate education is of Royal Colleges developing their own curricular largely in isolation, PMETB, the predecessor body tried to bring some order to this. But we've tried to take it further to say that these things are the things that every doctor needs, whether they're a pathologist, a paediatrician, a surgeon or a general practitioner and hopefully, provide a consistent approach so that all these professionals can make a valid contribution to the service.

How do we do this? So, on the left-hand side you have a setting out our standards and on the right-hand side the assurance that our standards are met. But we do visit, we do go and talk to students and trainees and staff. Visits can be a controversial part of the work, they are very resource-intensive both for the body visiting and the body being visited, but I do think there is a real value in sitting across the table from people and hearing what is it really like.

We approve curricular assessment systems and programmes across the country. We do monitoring, we hear regularly from post-graduate deans and from medical schools as to the way things are going. Evidence I'll talk a bit more about, because I think that's one of the real game-changers of the world we're in now. We do have a process called Enhanced Monitoring, which is to deal with those places that are having particular difficulties in delivering training. And I think it's a measure of the times that the number of places we have on that enhanced monitoring list is growing fairly rapidly, out there it is undoubtedly increasingly difficult to deliver good quality education and training.

But I also want to mention good practice, we can get into a bit of a spiral of, if not depression, certainly negativity in this debate, out there every day there are good people coming up with good ideas, new innovative ways of training and I think it is a role for the GMC to spot those, to see if they are transferable and to share them. And I think that's an important part of what we do.

And at the heart of what we do, back to my very first point is patient safety. Who do we do this with, the GMC can't do it alone and we have this model of quality, what we call a three-layer model with us providing the quality assurance, the quality management has to come from the medical schools and from the post-graduate bodies, HEE, NES in Scotland, the local deans, and we work very closely with them and the royal colleges to make that work, but it has to start at the level where the training is being delivered, the quality control in every single clinical setting where a student or trainee is being taught. I really think it's really important we hold onto these principles going forward.

I just wanted to touch on evidence, I think one of the big changes that we're starting to see now is a real wealth of data available for us to do our work here and the GMC and the Health Foundation and others are really starting to get some really valuable data that we are putting out there. I'm a huge believer that data

should be put out there for everyone. And these are just some of the examples, so exam pass rate in post-graduate exams by medical school, graduate trends in practice, which schools are delivering doctors into which specialities. As many of you know we survey all 50,000 trainee doctors every year and we can ask them how prepared are you for practice and we can break that down by school. We're getting a real richness in our quality data that I think we have to use if we're going to manage this going forward. And I mention quality and safety concerns obviously being able to map those makes it much easier to see where the problems are around the country.

So very briefly, key priorities for us, protecting the quality of training through enhanced monitoring through surveys. I haven't mentioned this, but it's important ensuring that training is fair and variation is reduced. This is why we're talking about introducing a medical licensing assessment in the UK for the end of medical school. And a lot of work around differential attainment, why people with different protected characteristics move forward the system at rates. Flexibility, it's inherently inflexible at the moment for trainees to move from one speciality to the other, we have been asked in typical rapid style, to bring a recommendation to Ministers by March to see if we can unblock that so we can enable people to move around their careers. And shaping the future of post-graduate training, I've talked about professional capabilities and the work we do around standards and curricular.

I'll just end with this one slide, I don't expect you to take it all in, but what I do want to make the point is that a lot of the work we're doing now is upstream, to be honest if we get to fitness to practice issues and some of the things to the right of the red line here, we have failed. We need to get our interventions, some of which I've talked about much earlier in the process.

Thank you very much.

Malcolm Dean: Thank you very much indeed. And then finally in this pre-question period we've got Grant Fitzner, Economics Director at NHS Improvement.

Delivering improvement, quality and safe staffing guidelines
Grant Fitzner, Economics Director, NHS Improvement

Thank you.

I'll start by pointing out that this presentation is relatively narrow in scope, just focusing on the safe staffing work that we do. NHS Improvement is involved in a whole range of other workforce-related issues, which I'll be happy to pick up in the Q&A afterwards.

Okay, so let's talk about safe staffing first. Some of you will be familiar with this and others not, but essentially this body of work was initially picked up by NICE some years back and they managed to publish guidance on the adult acute and maternity workforces. Responsibility was then transferred to NHS England, who during their period of ownership published a mental health staffing framework. It has now come to NHS Improvement where our executive nursing director, Ruth May, is overseeing this work on behalf of the Chief Nursing Officer and the National Quality Board.

For those of you who are unfamiliar with the National Quality Board, imagine all the national NHS organisations sitting around a table discussing this and other frameworks and documents. In July of last year the NQB published a new national framework for safe staffing, which replaced their previous 2013 guidance. For those of you who haven't seen it I would recommend you have a look at it there's a lot of good stuff in there. And, certainly, for those of you on boards there's a lot about board accountability and what you should be doing to ensure safe staffing in your organisation; I would encourage you to read that document closely.

Having set out that overarching framework, NHS Improvement was tasked with looking at seven care specific settings, and applying this effectively in an evidence-based way to those care settings, so let's turn to that. Before we do that, this is the overall framework. Someone came up with the phrase 'triangulation' – what they meant by that is if you look at the three boxes down the bottom, there are three expectations: right staff, right skills, right place and time. What that approach really means is to focus on those three areas and make sure they're all coming together to provide safe and sustainable staffing in the relevant care setting. It's fair to say this is fairly high level and in some ways fairly obvious.

In this area, as in many other areas of workforce that I have been involved in, these kinds of exercises are really about codifying good management practise and common sense. Unfortunately, good management and common sense are not universal across the NHS –if they were then many of the workforce challenges we currently face would be a lot less serious.

So, how have we gone around setting specific guidance? Well, here are the seven care specific settings. You may not be able to read all of this, and I understand that the presentations will be circulated later, so I'm not going to read them all out. But, essentially it's about applying the 2016 national framework to specific care settings. Those workstreams are being led by system leaders, not by NHS Improvement or other arm's-length bodies, and it's been focused around a couple of things. Firstly, 'measure and improve' not 'guide and apply'. We accept that different organisations are going to be at different places in terms of their levels of staffing, so this is really more about an improvement journey rather than compliance with a specific standard.

Our approach is very much evidence-based. One of the things I wasn't surprised to find was that as the seven workstreams developed their safe standards, we found major evidence gaps. The further you move away from hospitals the less evidence there is about the NHS workforce. Again, that shouldn't be a surprise to anyone, but we know a great deal about what happens on a hospital ward and much less about what happens in, for example, community settings. We really need to plug some of those evidence gaps if we're going to have a proper evidence-based approach to understanding and improving the NHS workforce.

Again, the point is about provider boards being accountable for safe, sustainable and productive staffing, so the challenge with this sort of document is on the one hand, you want something which is clear enough and simple enough to be applied at a ward level or say by a district nurse, but also tells boards what they need to

do to be held to account for safe staffing. There has been a lot of stakeholder engagement in developing and commenting on these documents, and that is ongoing. There has also been a strong focus, which I'll turn to in a moment, about outcomes. I could have shown you a diagram showing the process required to develop them, but as you would expect to try and achieve some degree of consensus means a lot of discussions and iteration – it's not a quick process.

So if you're wondering why these improvement resources have taken a while to emerge, the first two of the seven were published in draft form just before Christmas. They not only had to go through the National Quality Board, but prior to that were also independently reviewed by NICE, the Care Quality Commission and Sir Robert Francis.

We have five more care setting specific improvement resources coming through over the next few months: mental health, district nursing, maternity services, children and young people and urgent and emergency care. Now, that doesn't cover the entire health and social care workforce, or even the entire NHS workforce. On community, for example, there's been a decision by that workstream to focus on district nursing for now, but that clearly leaves other elements of the community health workforce unexamined. There's a good chance that we will add to the list of care settings over time, but these are the seven that we're focusing on for now.

By the spring of this year all of those documents will be out in at least draft form, and there will be extensive stakeholder engagement. For those of you that work in any of those five care settings that are coming through, I would strongly encourage you to read the draft improvement resource and also to fill out our online survey to tell us what you think and what the likely impact will be.

As an economist, one of my areas of responsibility was to assess what will the likely impact of these will be, and whether or not they require an Impact Assessment. The approach that we took was that as people out in the system know more about how these specific improvement resources would affect their daily practice than we do, we conducted an online survey and asked them.

There were a whole bunch of questions in the survey, but the ones that are most pertinent were along the lines of question 5 down the bottom, which if you can't read says: 'As a direct result of this improvement resource do you anticipate that registered nurse or midwife staffing levels in your trust will….' and then we had a classic five item Likert scale: 'increase a lot', 'increase a little', 'stay about the same', 'decrease a little', or 'decrease a lot'ittle. I realise that won't provide a hard number, but we thought it was unreasonable for somebody having just read a draft document to say, well we're going to need 3.7% more nurses. There is always the danger of false precision in these kinds of exercises. We wanted to get a sense of what the overall impact would be. We asked not just about the registered nursing or midwifery workforce, but also about other clinical support workers and other clinical staff. That would include allied health professionals, doctors etc.

This is what we got when we asked about the adult acute inpatient workforce. Again, you may not be able to read the wording along the bottom, but with the three column charts here, the first one is about the nursing workforce, the second is about clinical support and the third is about other clinical staff. The assessment of the 87 stakeholders who filled out the survey was that in most cases they thought staffing levels would stay about the same, about 10% thought they would increase a little, and a few people thought they would either go up or down a lot.

Our overall assessment for the draft adult acute inpatient improvement resource was that there was likely to be no significant impact on clinical staffing levels, but about a third thought there would be a change in staffing deployment or skill mix.

Turning to the learning disability survey, we found a similar effect, although the 'increase a little' bars are a little are a bit higher. We'll be taking the same approach for the other five care settings. In terms of what happens next, if in any of these stakeholder surveys indicate there could be a significant increase in clinical staffing levels we will engage with stakeholder to try to understand what's driving that, and estimate the likely impact. There's more data in the annex if you like.

Questions and comments from the floor

Malcolm Dean: Thank you very much. Now it's your turn to ask questions. Can we get one more chair up here? And those that want to ask, can they put their hand up and say who you are when you're called. There was one here. Any more over here? Two. Three. So, starting over here. And you can either direct your question to specific speakers or make it general. I think I'll take all three in one go and then we can come back to the panel.

Camilla Pallesen: From Cancer Research UK.
With all of the changes that you've mentioned in all your talks around changing to STPs, changes to the nursing bursaries, moving from HE outside of that and kind of the wider perspective on NHS providers taking a bigger role in how staffing is provided, who do you see currently to be the ultimate body that's accountable? I know it's a horrible question to ask this early in the morning, but who I guess is the ultimate body that's responsible or accountable to making sure that we have the right workforce with the right skills and values employed?

Malcolm Dean: Excellent question. There were two more. Yes.

John Drew: From McKinsey.
Grant, you mentioned I think in passing that if organisations were led and run differently a lot of these problems would be less. And I'd be interested in the panels view on the importance of how individual organisations are led and run, the culture, the leadership, because that hasn't really come through and I think when we aggregate the kind of whole picture we missed that. I'd be interested to know how big a part of the answer you think that might be and what needs to happen.

Malcolm Dean: And third.

Maria Crowley: Head of Mental Health in NHS England, South East.
My question is around the new models of care and we know we've got six pilots in mental health that are working their way through these and we await the outcome. But you made some reference to the expenditure on beds and community, which seem disproportionately high, 20% or 5%. So, I wanted to check is that for all services, because I don't recognise it for mental health in terms of bed increases, we do seem to have developed more in IAPT, we're developed in the transformation plans in CAMHS so it would be useful to look at that and if there are variables, can we learn, can acute learn from mental health, so that's a two part question.

Malcolm Dean: Thank you very much. So, who wants to have that first.

Grant Fitzner: Well, in an ideal world Gavin Larner, who's the Director of Workforce at the Department of Health, would be here. There are a lot of people 'doing workforce' in the NHS, but there is no one ultimately who seems to be responsible for coordinating those efforts. Ultimately, that role would go to the Department of Health to at least

coordinate and ensure strategic agreement on priorities and aligning effort across the system. But as someone who's been working in this area for five years it's always felt somewhat disconnected, with different organisations to some extent doing their own thing. A key gap is for an agreed workforce strategy, with arm's length bodies cooperating and aligning their priorities a little more to produce a better and more cohesive approach to workforce. But to my mind the biggest gap is not the organisations that are doing something like Health Education England or NHS Improvement; it's more the lack of focus on the existing workforce. If you look at new care models, for example, yes we can train new doctors, nurses, advanced nurse practitioners, physician associates and all the rest, although that will be with some delay, but most of the people who will be delivering the new care models, ACOs, or integrated frameworks are the existing NHS workforce. There is surprisingly little focus on upskilling and reskilling the existing workforce – for example, to move from acute to community settings, or to deliver different service pathways. That's probably the biggest gap in current workforce strategy which would need to be addressed in order for new care models to be successful.

Malcolm Dean: Fine. Thanks. Steve, to you.

Professor Steve West: Two things really, the first is we have to understand that the movement is towards more local decision-making. So the first priority has got to be that the organisations that are delivering care have to understand what they want to see in terms of their workforce in order to deliver their plans, and that's a big part of the STP agenda. So, of course, standards will be set in terms of outputs from the universities for all of the professions, and those standards are the starting place. The other thing to remember, now we've sort of lost the workforce planning equilibrium balance piece the input, output model, these reforms mean that universities can take as many students as they can possibly find to come into particular professions, and we all know that some professions are easier to recruit to than others. So there isn't this workforce magic number that is going to be driving the system, it's going to be very much about understanding the employability and the prospects that will determine how easy or hard it is to start recruiting students into any particular area. And therefore, the relationships that universities will have will be around placement capacity, they'll be around employability, because that's how universities are going to be measured in terms of their success or otherwise. And a local system that needs to determine for itself, how are you going to deliver care pathways that are cost effective, high quality and do you have a workforce to be able to do it. I absolutely agree the biggest priority has to be the existing workforce, which is currently being pretty ignored in terms of development and progression. And that's why when you compound it alongside the stress and the pressures on the system, people are feeling a bit miserable. So local, now that then brings you to, is there adequate leadership to allow this to happen? Now, I think we have pretty poor system leadership, which crosses domains of individual organisations and the reforms frankly, have fragmented national leadership, because of the way everything is disconnected now it's very difficult to see how you join bits up. So

not only have we got a national problem, we've got a local regional problem. And leadership matters every single time, I was on the SHA for almost ten years and it's very clear when you have very strong good leadership you have good services, you have good finance and you have great control, and good staff. And where you don't have that, things go wrong, the money goes wrong, the workforce goes wrong and the quality of the provision goes wrong. And you see it time and time and time again.

Malcolm Dean: Thank you. Any panel members want to answer Maria's question on mental health?

Rt Hon Stephen Dorrell: Well yes, I would like to pick that up actually because you ask, does the system more widely have something to learn from the experience of mental health. To which I give an unqualified answer, yes because if you look across the broader health and care system over the last 30 years I made the point that we endlessly talk about intervention and early intervention prevented activity moving services into the community. The one part of the health and care system where imperfectly, but significantly, that has happened over the last 30 years is mental health. So yes, I do think that both in terms of change management and in terms of improved links between the NHS and the broader public service in a place broader range of public services that the rest of the health and care system does have something to learn from mental health. And while I've got the floor if I may.

Rt Hon Stephen Dorrell: I'd like to pick up what Steve was just saying and the point about culture that we were asked, because I think that's at the heart of this. There is a tendency always on these sort of occasions to say, which bit of the forest should be dig in to find the silver bullet. There is no silver bullet, what we need to move away from is believing that there is a single answer to these questions and if we keep looking assiduously enough, we'll find it. Actually, this is about embracing the concept that change is a way of life and that what we need to do is to develop a culture to pick up that work that recognises the demands placed upon us, the opportunities, we need to facilitate change to get comfortable with the proposition that the answer tomorrow will be different from the answer today. Which is why I think the building on the STP answer is a much more credible answer to the culture question, than finding some version of a national plan that will actually finally get all these silos to work. We've been trying to do that forever and there comes a point when you have to say, that's not going to work, should we not try a different approach. And I think the development of place-based solutions that build on some of the mental health experience, is actually much more likely to be effective than the umptnineth version of the national plan.

Malcolm Dean: Yes, I agree. Thank you. And the McKinsey questions came, that was posed to you, Grant do you want to say anything briefly?

Grant Fitzner: Yes, my team's recently written two research reports, one was on nursing workforce retention and the other one was on medical. So much of it comes back to culture and leadership in the relevant Trusts. You see enormous variation in leaver rates across the NHS, and a lot of that appears to be due to good or bad leadership. You

may not have seen the national leadership and improvement framework that we published just before Christmas, but there is a lot going on in this space. For an economist who likes numbers and charts, culture and leadership has always been seen to be a fuzzy area which lacks hard metrics. But because it's a bit less hard edged, the number crunchers in the NHS including my dear colleagues in the Department of Health and Treasury, have not tended to focus on it as much as perhaps they should. So it's good that the system is giving due recognition to culture and putting more emphasis on leadership. Just picking up on the point of STPs, there has been a strong focus on either Trust level leadership and management, or national, so it's encouraging to see that we're seeing local STP-level leadership starting to develop and play a bigger role. The health workforce typically doesn't map neatly across Trust catchment areas, but many local labour markets do map reasonably well across STP footprints. So if you're talking about where your local workforce are and how you can collaborate with other providers – nursing recruitment would be a good example – that's probably about the right kind of geography to start having those conversations. I'm hoping that the emergence of STPs will see greater local cooperation and collaboration of workforce than we've seen so far.

Malcolm Dean: Thanks, Grant. I'm going to choose just as a Chair, because there were three really important things to me that stood out this morning. First, was the 20% increase in consultants versus a 1% in nursing in Anita's. Second, the fact that we've had inflation at 12%, but only pay rises of 3%, 10% reduction in pay what does that do. And, perhaps most important, somebody did make, I think I've heard on the radio, but not seen anything in the papers about this NAO report on the integration programmes, saying it wasn't saving any money. And my instinct is to say it's far too early isn't it? Do any of you three want to come on, how do we face the first one, the 20% increase in consultant, if you were back in your chair, Steve as Health Secretary, when somebody gave that to you, what would you do?

Rt Hon Stephen Dorrell: Presumably that includes GPs as consultants does it? Is it all hospital-based consultants? This is at a time when we're supposed to be developing community-based services. Clearly, it's another illustration of, and I quote a different set of statistics which is about the relative spend in the hospital sector as against the community services. To some extent, we have to recognise that is a result of choice, so one of the things I quite often talk about at the moment it's a perverse consequence of ring-fencing the NHS spend and saying, that's health's spend so we'll safeguard it. Actually, I quote the example in order to provoke a thought, when we cut library services the result sometimes manifests itself in A&E attendances, because if you cut a library service in a community you remove a meeting place, you enhance isolation, isolation leads to mental health issues, 20% of all physical health problems arise originally from mental health roots. So the connection between the range of public services and the acute hospitals sector is one that isn't sufficiently recognised in public policy. And part of the answer to that I think lies in more localised decision-making, so that, for example, when the local authority reduces spending, or make choices about spending, whether it's library services, or housing services, or the range of

support arrangements for young people, regarding that as a holistic public service spend most of it actually motivated by a desire to enable citizens to live more enjoyable fulfilling lives, that is health spending. And the default instinct that says, it's the television picture editor version of health policy that says at eight o'clock I've got a health story coming up at ten o'clock can I have some pictures, please. What's always served up is a surgeon in scrubs, that's illness policy, that's not health policy. And thinking about the development of proper health policy is a cultural failure of public policy making, which I think is better addressed through empowered local Government than it is through trying to get the silos to work together.

Malcolm Dean: Anita.

Anita Charlesworth: Yes, I think we've talked about silos and I think silos are really important. The work on new models of care, the work on workforce, and the work that's done on funding, I mean very often does look like it's happening on slightly parallel universes when you look back over time, so there's a real clear need for alignment of that. And I think we need to recognise that we need to do that at two levels, actually given the lead times with a lot of these issues, and the range of bodies involved, some bodies nationally looking at this are really important. And whilst we do know how the national body on the flow in, in terms of Health Education England is not aligned with social care and workforce planning, I mean how in the modern age does that make any sense at all and that it still feels quite separate from service design. But quite clearly and most importantly, that doesn't join up either organisation, but increasingly important, on health economy basis. And the STPs provide an opportunity, but I've had the pleasure of reading most of the 44, and I think I did something very bad in a past life, and they're all full of new service models. I don't understand how you change a service model without it being about how people work and the sort of people, most have got maybe a page which is broadly some head count numbers of how many doctors and nurses we need. Some that are more aware kind of say and we do realise that actually this is about people and we're not very good at it, and we'll do some further work. So the balance of effort on let's design a new payment system for a new model of care, and I research payment systems and they very rarely change anything, versus the balance of effort on the workforce change that you need actually to shift care, just bears no relationship I think really to reality. I have a sense that the NHS is going that's wrong, yes, and is in a bit of a moment where it's moving, and these things are moving centre stage, of course it takes ages doesn't it and a lot of the people who have developed into leadership posts because they're good at performance management targets, payments it's all those sorts of things, rather than the people change aspect, so that's where the kind of work on leadership support, you know people don't do this stuff because they go to work every day bloody-mindedly determined not to do the right thing you know, so they do need the support. This is hard stuff, it's really hard stuff.

Malcolm Dean: You wouldn't close it down?

Anita Charlesworth: No.

Malcolm Dean: Marta, do you have anything?

Martin Hart: Just a couple of observations on the structure of medicine, I think doesn't help with this, the rise in consultant numbers that we have specialities, we reward doctors for getting increasingly more and more specialised, yet we talk about this ageing population who will have many conditions. I will be interested to hear what Mark Porter says next actually. But I think we may have to look at what we want from our doctors from a patient-centric point of view, and I think that's quite a big challenge. Just coming briefly back to the culture point, there used to be a statistic, Anita probably has the latest one that the average tenure of CEO in an acute trust was about 18 months.

Anita Charlesworth: Yes.

Martin Hart: We have to; and also there are various initiatives, there's one at the moment about encouraging clinicians to become CEOs of Trusts as well. There's a problem there, no one, or very few people are going to go and take on one of these roles if their tenure is so insecure. And I think we do have to think about what we want from our leaders, really important people doing these jobs to make sure, of course they have to be held to account, but that kind of turnover isn't healthy for, literally healthy for anyone.

Malcolm Dean: I saw somebody wanting to ask, the gentleman right at the back.

Professor Stjohn Crean: I work in HEI and I'm a Faculty Executive Dean and I look after a number of specialities, pharmacy, medicine, dentistry and so forth. And like any Faculty Dean I'm going to lobby the Vice-Chancellor if that's okay, he'll be used to that. But the question of course covers a spectrum because my ears pricked up when you were talking about, it's my interpretation less than enthusiastically, about the emergence of apprenticeships. Do you think apprenticeships across this particular sector are going to have the effect that's being proposed, simply because the counterargument of the 23% reduction is going off and having a look at the apprenticeship, so I'd be interested to see what your feelings were and then I can quote you around the rest of the country?

Professor Steve West: My starting place is that apprenticeships are another pathway and of course, my university has got a lot of experience of running apprenticeship degrees, both at under-graduate and post-graduate level for engineering and aerospace industry sectors with big providers. The challenge of course with the apprenticeships is first of all, not to create them as second class routes and that the outcomes must be equivalent, they've got to meet the standards, and they've got to deliver the quality to ensure that we're not creating second tier routes. But a really big part is, not so much is the university ready and able to support apprenticeships, it's is the employer ready to support the apprenticeships, because the amount of facilitation, mentorship, coaching and teaching that needs to happen within the workplace setting in order to create a really good apprenticeship

experience, is really, really important. And so you have to have a structure that can make that work. And the people that do that very well, so aerospace have been doing it a long time, have dedicated teams and have developed and supported their workforce to become the educators. And so, we've got to get that bit right, there's no point throwing a load more people, vulnerable apprentice student into a setting that is highly pressured, where support may not be for the students there, they will become quickly disillusioned and miserable and that's not going to help. So, there's something about, I'm really for apprenticeships, and I argued from day one that frankly, in my head what we're doing at the moment broadly is apprenticeships, 50% of the education for nursing is already in the workplace it's a partnership. But we already know that that environment is highly pressured and for our nurses allied health, they're signalling back to us in all of the audits, for many of them they don't think they're getting the experience that they need or deserve in that workplace setting. So we've got to find a model that works and then absolutely, I'm for them.

Malcolm Dean: Can I come back to you, What would you do about the Audit Commission Report in terms of it saying that they're not working?

Rt Hon Stephen Dorrell: The Better Care Fund Audit Commission Report?

Malcolm Dean: Yes.

Rt Hon Stephen Dorrell: Or National Audit Office. The criticism of the Better Care Fund is that it hasn't delivered the kind of joined up service that we talk about, which is true, and that it hasn't delivered financial savings. I think the financial savings point is worth taking head on it doesn't deliver financial savings because it's the Government's policy, rightly in my view, that we shouldn't be saving money in health and care spending. The question is not, whether it saves money, we know that there is, and most of the argument this morning has been, that it's a real challenge to deliver the service we want within the current budget, so nobody is in favour of reducing the spending, it's a question of what you deliver with the spending. And so, it's often said that if you invest in community services, health prevention, early intervention there's no evidence it's said, to support the view that that relieves pressure in the hospitals. Well, actually what happens is that effective early intervention improves the experience for the citizen and because we don't take money out of the hospitals, the hospitals end up when it's successful treating different people, that's a completely different point from is this is a good idea. And I guess the best way of answering that question, is to consider the counterfactual, does the National Audit Office really think that it's a good idea for us to go on building more and more hospitals and not invest in prevention and early intervention as a citizen. Do I want a health and care system that doesn't support me in normal life, just waits for me to be acutely ill, avoidably acutely ill, if that's public policy then I'm a Dutchman.

Malcolm Dean: you're the only practising policy boss, what would you do about the 20% in consultants and 1% increase in nurses, is there anything the Secretary of State can do?

Rt Hon Stephen Dorrell: Well, I think I tried to answer that previously by saying I think the right answer to that is the development of locally based solutions, rather than trying to work out a national plan, we've been trying to do it since Dick Crossman and failed, so that's why I'm in favour of the STP approach.

Malcolm Dean: Brilliant. Will you give the famous five a bit of applause, please.

We've got two more speakers before coffee. They were all very good.

So we kick off with Kamila and she is going to address key issues within the General Practice Forward View.

Addressing key issues within the General Practice Forward View
Professor Kamila Hawthorne, Vice Chair (Professional Development), RCGP

So good morning everyone and thank you for having me.

I was delighted to find the subject of my talk today would be GP Forward View, ensuring delivery to frontline GPs. The timing really couldn't be more pertinent, for us as a college, as we've just released our interim assessment on the GP Forward View, which sought to answer this very question. So my name is Kamila Hawthorne, I'm Vice Chair of the Royal College of GPs, where I lead on Professional Development for GPs. I'm also a part time GP in Cardiff, and Professor of Medical Education.

So as you're all aware the GP Forward View was published back in April 2016. Our college warmly welcomed the plan, which we saw as an answer to our Put Patients First Campaign, in which we'd been calling for significant new investment in general practice, and more GPs, as well as urgent measures to stabilise the profession.

Just to explain our strong our support was, the college co-badged the document, and Maureen Baker, then Chair of College, called the GP Forward View, perhaps the most significant piece of news for our profession since the 1960s. However, the college was always clear that this was not the end of our campaign, and that we wouldn't celebrate until the GP Forward View Pledges were implemented on time, and in full, and were making a difference to GPs on the front line.

The college pledged to our members, that we would hold the collective feet the flame, through annual assessments of the delivery of the GP Forward View, and through our network of RCGP Ambassadors, of whom there are 33 across England appointed in part for this purpose.

So the college's support was always contingent on quick support being provided to stabilise general practice, we could see that urgent help was needed. We've always maintained that there cannot be transformation before sustainability.

In addition, we knew that local level delivery was going to be critical in many areas. The GP Forward View, needed to be reflected in the STPs, that we've been talking about this morning. So for these reasons, the college decided to carry out an interim assessment, which you can get online, before the end of the first year of the GP Forward View. And its aim was to assess progress on the short-term pledges, that were due to be implemented in year one, we rag rated these to red, amber, green rated.

We also considered those pledges that are slightly longer term, where progress should have been made, although we haven't rag rated those. We also wanted to analyse the 44 STPs, so I can see that we're not the only people in the room who've read all 44 STPs, to consider whether they implement the GP Forward View in their areas, and in particular whether they plan for investment in general practice. So this interim assessment is purely a factual analysis of the information that was available. We're due to discuss it in council towards the end of February, and develop our action plan after that.

So what did we find? Here are some of the rag rated short term pledges. It's not all of the pledges, and to really understand our assessment I recommend reading the interim assessment in full, here it is. So there's been some excellent progress on some short-term pledges. So for example, very positive changes have been made to the induction and refresher scheme for GPs returning to English general practice. And we now have, apparently over 200 doctors on that scheme, most of whom have joined since November 2016.

There's also been a new scheme successfully launched, to provide immediate protection against the rising costs of medical indemnity for GPs. And on investment, NHS England reports that the 4.4%, or £322 million uplift in primary medical allocations in 2016/17 is on course to be invested in full. However, there are areas where we are very concerned.

Critically, the full 16 million allocated to practice resilience hasn't been spent, and as of December, only 2.5 million of it had been spent, which means that support isn't reaching practices that urgently need it. This is money that is intended to support practices, for example, that are struggling to recruit. And as far as we know of the 1,453 practices identified as struggling, only 219 have received support.

And just to illustrate this with a case, I received an email on 7th February from a GP, in which he says, our award-winning service for alcohol is being axed by our CCG, because alcohol is the responsibility of the local authority and not the CCG. They're ignoring feedback from GPs, patients and billing data evidence. A sad state of affairs, he says, reflects the crazy thinking that goes on, when a CCG is deep in debt, and being managed, inspected by NHS. Coupled with an uninterested, he feels, and overly critical CQC report on our practice, and the recruitment crisis, because it's a husband and wife practice and they cannot recruit, we're verging on giving up, and struggling to keep any enthusiasm.

Now it so happens I know this GP. He was the brightest boy in my year at medical school. He was bubbly, he was enthusiastic, he was all for patients, and it is so sad to see this happen to one of our best. One of the best in the country, I would say.

So just to get back on track. As mentioned, the other aspect of the analysis was of the 44 STPs, so these local level plans are key to the future shape of the NHS, and in particular they're intended to shift care out of hospitals, and into communities. So general practice must be a major focus of STPs, and STPs must plan to implement the GP Forward View locally.

But we found that the STPs were a mixed picture. Some, have really worked hard to implement the GP Forward View locally. For example, we're really impressed with Surrey Heartlands STP, which reproduces the ten actions the college called for STPs to make, and it indicates what they're doing to achieve every single one of them. But we have a number or concerns with other STPs. So while a small number of STPs have done a significant amount, others fail to mention it at all. The GP Forward View is not mentioned in five STPs of the 44, and only in passing in others, and this was a shock for us, and really disappointing.

Many STPs are driven by the need to tackle large acute trust deficits, we know that, and a number treat general practice as a solution to the problems in secondary care, without planning to adequately stabilise and support it. And this is despite official guidance for STPs, that they should develop and implement a local plan, to address the sustainability and quality of general practice, including workforce and workload issues. And NHS England recommends that 15% - 20% of STP funds should be allocated to general practice, so to have at least five STPs in England who don't mention general practice at all, is really upsetting.

We were also alarmed to find that a number of STPs appear to plan for a reduction in the number of GPs, leave aside remain… keeping the status quo. So overall, while the college supports the concept of STPs, more work is needed on many of the plans, to ensure that the GP Forward View is delivered locally. And we feel that a significant proportion of these plans should be rejected by NHS England.

So the college has made ten recommendations in this report, aimed at the Government, NHS England HEE, STP, footprint leaders, and CCG, so they're on the next two slides, this one and the next one, which you will get later. But I want to talk just about a couple of the most important ones. The first is that, NHS England and HEE, must ensure that any GP Forward View pledges that are not on track, are delivered by the end of the first year of the GP Forward View, and that any money that is not spent is rolled over to the new financial year. And this is particularly true for the pledges that we've rated as red.

One of the major challenges, seems to be a communication challenge. While there's appetite from the centre for the delivery of the GP Forward View, there is a challenge, in both ensuring that GPs know about the opportunities, and how to access them, and that the NHS locally understands the importance of implementing the GP Forward View.

So we've also recommended, at the local level, STP Footprint Leaders, should ensure that their STPs include a plan for implementing the GP Forward View locally, including planning to invest in general practice. CCGs should also have plans for implementing the GP Forward View locally. And NHS England and HEE, must further develop their communications, to ensure that key messages on the GP Forward View reach front line GPs, because there are many who aren't getting them.

As I mentioned, this interim assessment was just part of the college's efforts to hold the Government, NHS England HEE, and the NHS locally to account, for delivery of the GP Forward View, it is a factual analysis, and it will be discussed in council, towards the end of February. But in addition, our RCGP Ambassadors are continuing to monitor progress locally, and we will be publishing a full annual assessment of the GP Forward View, which will consider all the pledges, and will include information from an IPSOS Moray survey of GPs.

It's become clear that we, the college, also need to do more to ensure that there's effective communication with front line GPs, about the GP Forward View, to help them make the most of programmes, so this is going to be a key priority for us.

So the GP Forward View Interim Assessment is available on our website, it includes a huge amount of analysis, which I've only been able to begin to touch upon, so I encourage you to read the documents, and I'm very happy to take any questions.

Thank you.

Malcolm Dean: Thank you very much indeed. And then we have Dr Mark Porter, from the BMA.

Working towards meeting workforce priorities in secondary care
Dr Mark Porter, Council Chair, BMA

And good morning everybody. And of course, when you're sitting at the back listening to that sort of thing, you think, actually I was going to talk about some other things. I've only got a quarter of an hour, I can't put that in. Well, we'll see what comes out in questions, we'll see where we get to.

So my name is Mark Porter, I am the Chair of the British Medical Association's Council. We represent all types of doctors, GPs, Junior Doctors, Academics, Public Health Doctors, Consultant, and so forth, a lot of others as well, all around the UK. But I've been asked to come, specifically, today to counterpoint Kamila, in talking about the pressures on the secondary care workforce, and so that's what I'm going to do.

And as it happens, by background, I am a Consultant Anaesthetist in the NHS, and I shall be on labour ward tomorrow, in emergency theatres on Sunday. And to a certain extent, because of all that, I know whereof I speak, in terms of direct experience as well as going through and representing our members.

Now we've heard a little bit about the increase in size of the secondary care workforce of late, and it's absolutely true that there are a lot of secondary care doctors, and more than there used to be. I would point out that there are some interesting, very long term trends, going back across the entire history of the National Health Service. The number of consultants in the NHS, has broadly, but very closely matched the increase in gross domestic product, in every time period since the NHS was first established in 1948.

And the increase since then, has mirrored the increase in the size of the economy, in terms of the investment going into health services. Such that, today, we get to the point where there are something like, across the entire United Kingdom, something like 55,000 consultants, and a few thousand more junior doctors, about 16,000 SAS doctors, who together make up the medical workforce, the vast bulk of the medical workforce in hospitals.

And that increase, particularly in the consultant staff, has been out of proportion to any of the other increases of staff we've seen in other sectors of the NHS, including general practice, including nursing, including therapy staff, and so forth, over the last few years. A matter which doesn't necessarily put strain anywhere else, but certainly, and quite rightly, makes people look to the investment that secondary care sucks in, and wonder whether we're diverting things in the wrong direction.

Of course, I would submit that that's possibly a more relative position, than an absolute position. Perhaps we've been lucky and maintained better in the secondary care sector. But then again, perhaps not. If we look at the international comparators, for example, across the European Union there's one doctor for every 288 people, as an average.

In this country, there is one doctor for every 360 people. And you'll see suddenly that we are under-doctored compared to the EU average. It depends on what you do with doctors, how you count them, what we need them for etc., but we have fewer than the EU average. And this is also supported by other figures, that look across international comparators. We have nearly, sorry, just over one third the number of acute hospital beds, per head of population, as they have in Germany.

We spend less than almost every other leading European economy, except Italy, we spend less than them in terms of head of population on our healthcare and social care services. We spend a lower proportion of our gross domestic product, as well as less per head of population. And those international comparators remind us that, though some sectors may be more protected than others within the health services, we certainly are not, necessarily, investing to the level that we're swimming in cash in the NHS.

And I wouldn't want anybody to get the impression that the differential investments automatically mean that certain sectors are necessarily feather bedded. Certainly, if we look back at what the workload is, that's gone along with this sort of rise, we have seen an increase in the number of hospital doctors over the last ten years,

as I've mentioned. But in addition, we've seen an increase of 28% in acute hospital admissions over the last ten years. We've seen an increase of 22% in attendances at emergency departments.

Now this needs to be set against similar increases in sectors, such as general practice, that have not been matched by increases in the numbers of GPs, or indeed the proportion or the amount of resources going into general practice. But nevertheless, it's important to have those comparators in mind, when you're thinking about where we actually are at the moment.

So where are we? We are, I think, in a very difficult position. And the reason we're in a difficult position is because we can look at these number of staff working in the NHS at the moment, and match it against workload. We can also try to look forward to the future, and look at who is coming along to replace me when I retire in a few years' time, to replace my colleagues, to augment our workforce and so forth.

We have a large number of junior doctors in training, but we have fewer applicants this year, for medical schools, than previously. An interesting start of a trend, perhaps, and perhaps something that's exacerbated by recent changed in university access anyway, changes in grant and bursary structure, changes to the way in which Government treats and talks about the future workforce in medicine and elsewhere.

We also find fewer applicants, many fewer applicants, coming from the European Union, we can't dismiss the effects of Brexit. But altogether, I'm not saying we're going to not fill our university places, it's just an interesting trend to start to watch.

But let's look at what happened when people come out of the other end, and graduate from universities. We've had a gradual declining proportion of doctors deciding to go into specialist training, and I include GP and hospital specialist training in this, over the last few years. Such that, on the latest figures available, only about 50% of doctors graduating off the foundation programme, that is to say, completing their undergraduate education, becoming based as doctors, and registering with the General Medical Council, only about half of them are now going into specialist training.

Where are the others going? That's harder to answer. Some are going abroad. Some are taking on less traditional careers. Some are leaving medicine altogether. Some are hedging their bets, and doing locum jobs, rather than going direct into specialist training. And it is true to say that there is an increased transactionalism amongst the, if I might be forgiven as somebody with grey hair, and a beard, and a balding head, will refer to as the modern generation.

A, sort of, a view of careers, that isn't necessarily the view that I and my colleagues might have predominantly have when, well, I graduated 28 years ago, and a transactionalism today that doesn't push people straight into careers from medical school, and follow the traditional path. But nevertheless, at the same time, there's a really worrying trend of people who have been literally driven out of medicine, when they look at what is available in the future, and the way in which conditions over the next few years may indeed come to change.

So the Government's response to this, we saw at the Conservative Conference in late September, early October, whenever it was last year. I was present at the event in Birmingham, where the Secretary of State made the announcement about the Government's response to Brexit, and that was to increase the number of places at medical school by 1,500, and also to impose a four year mandatory service obligation, upon doctors graduating from medical school, in order to stop the drain to Australia, or wherever it is people are going. Famously, a number of MP's children have emigrated to Australia recently, or graduated as doctors, for example.

So where does this leave us? I have to say, as a response to the problems we have today, it's completely and totally irrelevant. Not one of those additional medical students will become a GP, conceivably, before the year 2028. Not one of them will become a consultant before the year 2032. That's how long it takes to feed through medical school, to train in post graduate training, and then to qualify into one of the career roles.

In addition, of course, that's not necessarily going to be the same speciality mix as we require. At the moment, it's absolutely true that we need to try to divert, encourage, and enthuse people about working in a non-traditional speciality. If you will forgive me including general practice as non-traditional, because it's not necessarily a traditional choice for doctors, who spend most of their student years being exposed to secondary care, rather than to primary care, and the satisfaction that that can bring. And so people make their choices, go into specialities that aren't necessarily the ones we want them to work in.

So even if we get the numbers right, it's the balance, and the choices that people make, that are important that go alongside that. And I don't think the 1,500 a year, welcome though it is, is going to address that in any way. Of course, that would also need to be matched by things like, an increase in the capacity we have for teaching. The academic teaching staff in medical schools at the moment are under enormous pressure, and simply increasing the number of students by 25% is not exactly going to improve, or entrench the quality of medical training.

The four year mandatory service obligation, I can't say very much about that, because we have no idea what any of the details of this are going to be, when it's going to come in, when the consultation is going to be, how it's going to be put through, etc. etc.

I did note with interest that the Government of Scotland a day or two ago, announced a consultation on a mandatory service obligation that would be voluntary to enter into, and be accompanied by a bursary, paid to medical students, to encourage them to enter into this obligation. But that's not the same thing as has been talked about for England and how it's going to work, I don't think anybody knows.

The key thing about it though is, what I've found myself saying into camera, at the time of the Tory Party Conference, which is, that what we really want is a National Health Service that doctors want to work for, not an NHS that they have to be made to work for.

And of course, you will be aware that there's been very recent, and very high profile dispute between junior doctors, represented by us, and between the Secretary of State for Health over whether or not there's a requirement for a new contract, to make and require junior doctors to work at weekends, which, of course, when I go in on Sunday, I'll be surrounded by consultants and junior doctors who are working at weekends. But that is something of a different story, unless, of course, anybody wants to go into it.

The other thing that we have to bear in mind, is that we're in serious danger, having gone through the Brexit vote, and talking about the way we do about the way we interact and relate to Europe and the rest of the world, we're in serious danger of demoralising our workforce, 30% of whom, in medical terms, 30% of whom come from overseas, half of them come from the European Union.

And many of them are really quite frightened and anxious at the moment, about whether thy have a welcome place in this country, and indeed whether they will literally be deported from this country, when the Government achieves its Self-Sufficiency in Doctors Policy, that it announced a few years ago. Some of them don't have the permanent right to remain at the moment, and we believe that, in order to give security our workforce, they should be given that right to remain, perhaps as a one-off measure, and regardless of the current five year thresholds, and so forth.

We also think it's very important to address the serious instability experienced by people who have arrived here to qualify as medical students. Of course, they haven't even started building up their eligibility for permanent right to remain yet, and yet we recruited them, from perhaps the European Union, at a time when they had a right to work in this country. They're now in the middle of their courses, and wondering about whether they're even going to be able to complete those courses by working in the NHS. There are some serious instability issues in the way in which we talk to people, that we really need to try and address and make better.

I mentioned seven day services briefly. I think it is worth registering that the staff we have, that I talked about the numbers earlier, the workload, the staff we have are effectively delivering the service we have at the

moment. One key thing that I think it's important to note is that, if we're going to expand the services we offer, we'd need to also expand the resources we have.

Now that's not just as easy. One or two people say to me, well, okay, we work a five day week at the moment, adding an extra two is a 40% increase, so we increase resources by 40%, we're fine. It's not as easy as that. And the reason it's not as easy is that is because in large respect, we already deliver a very good weekend service to urgently ill patients. But we don't do it well enough, we don't do it consistently enough.

And the key thing that any of us who work in that weekend service know is that the main reason for that is lack of resources, and priority being placed elsewhere, for all sorts of reasons, not only traditional working practices, but also things, such as, the billing system within the English NHS, which is to say that you get paid far more for doing an elective, relatively, for doing an elective case on a Monday, than you do for doing an emergency case on a Saturday, even if the patient's need is far greater on the Saturday, and the resources that they suck up is also far greater in order to treat them.

And we need to address the perverse incentives that exist in the system at the moment, and make sure that that goes along with a properly increased investment, rather than just saying, well, here's a 40% bill. Because even I wouldn't try to place that sort of bill on something. What we need to do instead, is have an intelligent look at the need patients express at weekends, and try to pull it back from the things that we see in public discourse, that have so demoralised our workforce, medical and otherwise.

I will never forget, having spent a very long time, one Sunday lunchtime, not working this time, but briefing a journalist from the Daily Mail about doctors' working practices at the weekend. Only to open the newspaper the next day, and find the headline, doctors to be dragged off golf courses and made to work at weekends. Aha, okay, well, we'll get there in the end. Actually, her father was a consultant physician, who works weekends as well, which really surprised me about it.

There's a number of problems that we could address at the moment, and not easily, but need to be addressed. And those would include things like addressing the rota gaps, the reliance on locums that we have. Something like £3 billion a year being spent on locums, throughout the health service at the moment. That's not necessarily a sign of failure, it's not necessarily a problem that we don't have every single permanent post in the NHS filled to full establishment, because people do move around. We have to be able to cope in a huge and complex situation, with people doing that.

But the problems we have at the moment is that, part of the demand that leads the employment of locums, is the increase in workload that hasn't been matched by appropriate increases in the permanent staff establishment. And in particular, by the enormous deficits being faced by much of the provider arm of the NHS, which provokes responses, such as, closing down all permanent recruitment, or establishing barriers, such as special authorisation, and Board meetings, and so forth, before we can proceed to recruit permanent staff. That sort of thing is what's driving the locum bill. Not, while I don't think we should let them off the leash, not, I think, profit gouging by the locum agencies. We need to keep an eye on that, but that's not the key driver here.

Other things we need to do, and probably just to finish up on, is to talk about the way in which we need to address, control, and keep on top of, the stress and burn out, that we know is increasing in our workforce, generally, and that as a BMA we particularly know is increasing in the medical workforce at the moment. We're trying to negotiate new contracts, famous if you read the newspapers at the moment, and we're trying to put in, we're trying to agree with, I should say, a very sympathetic NHS Employers, provisions to make sure that the pressures that make people overwork are limited.

So perhaps, in a little while, a new contract for consultants will exchange the famous veto we have over elective work at weekends, and exchange it for controls over weekend working, that will render the job somewhat more civilised, while preventing the Government being able to talk about how we're allowed to refuse to work at weekends.

The new contracts for junior doctors, includes an exception reporting mechanism, that allows them to report breaches of the work schedules, that are supposed to have been put in place for them. And we will always carry on trying to help and protect our members, to be able to do this, despite the pressures around us, and the very human feeling that we all have, about making sure that we continue giving the best service that we can, to the patient in front of us at any one time.

So I'll finish there. Obviously, very happy to take part in the discussion, and we'll see where we go. But I hope it's been a useful run through some of the pressures and problems, and potential solutions that we have, in the secondary care system at the moment.

Thank you.

Questions and comments from the floor

Malcolm Dean: Questions, You start. Name and where you're from.

Tristan Godfrey: I work for Health Education England and Kent County Council as well. We have an interesting course in East Kent, sort of, clinical leaders in commissioning, sort of, trainee GPs, giving them a taste of what their future commissioners will do. But that's not necessarily always as fully taken up as possible. So I wondered if you thought that the glorious prospect of being part of a CCG was a temptation or a hindrance to people going into general practice?

Malcolm Dean: Would you both like to have a go at that?

Professor Kamila Hawthorne: Well, I think the problem is that, we're starting leadership training too late, and I think it ought to start in undergraduate curricula in medical schools. And be a vertical theme, that gradually is built upon, and students get a chance to see the sort of leaders that they will become, with role models, and with examples of good leadership, and also perhaps some cases of where leadership hasn't worked. And that, then, you should find then that your trainees are much keener to get involved in leadership training.

Dr Mark Porter: I think, if I may, I wouldn't in any sense decry the cadre of professional managers that we have in the health service, they're probably some of the people under the greatest pressure I've ever seen. And you can always tell them, some of you will work as middle managers in the NHS, you can always tell a really good one, because while they're doing their existing job, they're always given responsibility for another department as well, as sort of a general process. But many doctors, like many other staff, want to take part in management, are enthused to do so as a means of being able to help direct the wider resources of the teams they work with, and apply them for patient care and benefit. The big problem with that, and I think the big problem at the moment with CCGs, and particularly their involvement in the STPs, that Kamila was talking about earlier, the big problem at the moment is that, quite often, people who go into that, take up that sort of responsibility, feel that they're simply being used as the vehicle to deliver a government economic policy, that is more to do with public sector cost control, and less to do with enhancing the quality of services locally. And that is the single biggest turn off to clinicians being involved in management and director level jobs.

Malcolm Dean: Other questions? Yes, well, take the one at the back, and then we'll take this one. Anita, afterwards.

Philip Farrar: From Hill Dickinson.
My question also relates to CCGs, and it followed the observations about their role, and what they might do. Where is the role, or the performance of the members of the CCGs? They're talked about as organisations, but their membership, the big idea was to bring in clinical leadership through that route. I don't know what your feelings are about that?

Professor Kamila Hawthorne: Well, again, I'm fairly conversant with the five CCGs in Surrey, and they vary hugely in terms of size. But clinical leadership is very clearly apparent in all of them. Are you talking about accountability? Yes, again, you know, through reporting, and from what I see coming through the STP for Surrey Heartlands, which I was talking about earlier, there's very good evidence that there can be very good clinical leadership, which is really taking account of community's needs, and putting things into play that we hope, obviously, it's early days yet, will produce dividends. But there are clearly other CCGs that are not doing as well, and I think, again, it's a bit like you always know a good school, if you've got a good Headmaster or Headmistress, you know, a good ward if you've got a good Matron, or Senior Nurse on the ward. It's the same idea, really.

Dr Mark Porter: I think it's probably worth reflecting that, along with many other commentator organisations, and so forth, the British Medical Association opposed the Health and Social Act, when it was originally being talked about, and when it came in. Part of the reason for that being that we felt that the, let's throw it all up in the air and see where it falls down approach, to establishing CCGs, was not the right thing to do. The immense variability in their sizes, the difficulty of starting them up as new start leadership organisations, but suddenly with vast responsibilities. And if I might comment as a hospital doctor, the almost complete exclusion of secondary care doctors from involvement in the leadership of CCGs because apparently, they'd have some sort of interest in the local healthcare economy, was… all were steps almost designed to make them fail. And it's perhaps a really astounding testament to the…

Professor Kamila Hawthorne: I hate a start a primary/secondary care war here, but STP's have got the opposite argument, that many have been taken over by hospital doctors.

Dr Mark Porter: Because of the pressure on the acute sector at the moment, absolutely right. But what I was going to finish off with by saying was that, the fact that so many of them are actually able to cope, and able to keep their heads above water, and indeed some of them provide some very good examples, I think is testament to the thing that we always see, and must always remember is seen, and is probably always going to be seen throughout the health service, a lot of talented individuals, who really are imbued with the values of public service, and want to apply it. I was looking over the guest list for this seminar earlier, many of you are in that category, and long may it remain so.

Malcolm Dean: And then, just Anita.

Anita Charlesworth: Thank you very much. I was just going to pick up Stephen Dorrell's points this morning, around new models of care. And there's almost near universal support for the Five Year Forward View, and the direction of travel a modern health service should go in, to meet the needs of the population. But delivery of that will only happen, won't it, with significant changes in our workforce mix, and the way the workforce, the clinical workforce and medical workforce, works with

other parts of the system. As both of you are in leadership positions, what would you think would be the thing that could make most difference around the medical workforce, I mean, it's interesting that you're here as two separate siloes, you know, almost, kind of, competing at…

Professor Kamila Hawthorne: No, we do talk, honestly.

Anita Charlesworth: And you both talked about CCGs representing one siloes, and STPs… you know, the pull of the traditional way of working, of the slightly competitive model of way of working, within professions, and then between professions is a very strong centre of gravity in our system. What would you do, having been in leadership positions, in part of that, to really start to make that change, so that what everyone believes in in the Five Year Forward View, could move forward more quickly?

Professor Kamila Hawthorne: Well, I think it's… a lot of it is about good communication, and about respecting each other. And we do, as a profession, have a tendency to denigrate whatever section of the profession isn't ours, and I think that needs to change. You certainly see it in examples of good practice, CCGs and STPs, where there is across the board involvement, and I think this is… you know, it is all down to getting to know the people on your patch, in the locality, which is how it was intended to be. It's just, I think, we are all human, and it doesn't always work that way, and there are sometimes unforgotten wars and rivalries that have to somehow work their way out. But I've seen some excellent examples of working at scale, Birmingham, Manchester, it's really very inspiring. They came to talk at our Annual Conference, last year, and I followed up one of them one of the leaders from Birmingham, and rang him up and said, what is it about your leadership style that works, I mean, why does it work? And he was a bit surprised, and you know, being a bit coy at first said, oh, I don't really know. But I fact, when we boiled it down, it came to two things. One, was the vision, and the real desire to see that vision implemented. And the second thing was really interesting, he said that he sought out the naysayers, and went to talk to them, and listened to them, and listened to see why they said, no, and what it was that put them off joining in. And eventually, they together found ways of making it work. And I thought that was just a really interesting observation.

Dr Mark Porter: Of course, one cynical view of medical leadership, that I've come to realise over the last few years is, it's basically like trying to transport frogs in a wheelbarrow.

Malcolm Dean: It's normally herding cats, isn't it?

Dr Mark Porter: Yes, but herding cats is the metaphor anybody knows, anybody who wants a really good laugh, go and look on YouTube for the herding cats videos, there's a professionally made one about ten years ago, it's hilarious... Cowboys herding cats, it's called. Anyway, to seriously answer the question, and to add to, and to build on, the remarks that Kamila made, with which I would agree. I think it is important to note and register a couple of things. The first thing would be, that there

are good examples, throughout the service that visionary leaders are present, and have been for a very long time. And if I, just off the top of my head, pick almost something at random, I'm not going to pick out an individual, but I'm going to look at the way that, in large areas of the country, care of people who are having acute stroke, acute heart attack, and level one trauma care, and so forth, vascular surgery would be another example, are things that have been transformed over the last ten years, led by groups, occasionally by individuals, who have set out with a vision as to how things should be, worked out a path to get there and in large part, managed to succeed by enrolling the support of the rest of the service in that. And I say that's important, because it's absolutely important for us not to get trapped into the thought that nothing changes, it can't do, and actually we've got war encounters, that never talk to each other, it's always been like that, because it's not entirely an accurate representation of where we are. However, when you talk to people at the moment, about what they want to do to improve things, and particularly to be able to respond to the enormous pressures that we have, that we've all, in various ways, described today. One of the key things at the moment is that, it's almost impossible to get your head out from under the pile. I get, in my role as a consultant anaesthetist, I get a daily silver briefing, silver command briefing, about the number of beds in the hospital we don't have, about the number of patients waiting on trolleys in corridors to be assessed. We even have corridor teams, who are tasked with looking after these patients, in makeshift wards that don't exist, because we can't get them through the rest of the hospital because of the pressures that you all know about. the ability to stand back, reflect on our current service, and make it better, is deluged by the current workload pressures in the NHS, and that's really important to hang onto.

Malcolm Dean: There's just one last question, at the back.

Professor Cathy Jackson: I'm the Head of a Medical School, I'm a GP by background, and I also declare my colours as the mother of a junior hospital doctor. So I have an interest in many areas.
Whilst we welcome the increase in medical student numbers going through, it would seem to me that the biggest waste of resource we have, is the resource of trained manpower. So you say that there's a 50% drop off rate in terms of applying for training, there's also a drop off rate at the other end, with people taking early retirement. And if you put those together, it seems to me that the quickest solution, is looking for a solution to keeping those people within the workforce. So I'm interested in both your thoughts, of how we can retain our current trained experienced professionals, particularly as the more I hear about junior hospital doctors, the more I'm not surprised that they are leaving in droves, and the working conditions they currently have. So I'm very interested in your thoughts.

Dr Mark Porter: I shall point out that medicine is unusual. I mean, one of the slogans of the British Medical Association, is 'By Head, By Heart, and By Hand.' The route word of surgery comes from the Greek word for hand. And I think there is something interesting about the careers of doctors, whether in general practice, or in various forms of hospital practice, that, no matter how senior they become, how far they

progress, they continue, as I do, as you do, continue giving direct patient care. Whereas, many other career paths with the NHS, involve, not necessarily withdrawing from patient care, but taking up roles that don't involve the same sort of commitment that one has to look forward to delivering until one's really quite old. The famous example is, would you like your surgery, your aneurysm brain surgery, to be done by a 68 year old neurosurgeon, who is wondering whether he can control his tremor for the next five hours, because he has to carry on working. And that's an example, I think, of the way that we need to put some serious attention into, if we're going to be having people working longer, later in life, we need to put more attention, than we have at the moment, into how you support those careers, rather than just saying, you have to stick at it, and accept that there's a burn out rate. As you say, I think that's the wrong thing to do. That's not necessarily to say that every older doctor has to be able to slide into non-clinical roles. But we have to be able to find ways to support people, to be able to continue modified clinical roles, as they become older, and we've just not been very good at that so far.

Professor Kamila Hawthorne: So I'll start at the other end of the spectrum. So with the retiring ones, the people who are retiring early, certainly in general practice, we're finding that a lot of people are retiring early because of the bureaucracy. And actually what they would like is the clinical practice and not the bureaucracy. And finding ways to keep them being clinical, and seeing patients, and enjoying what they do, and maybe mentoring younger doctors coming into practice, all of these ideas are now being put into play with the GP Forward View, they're all in there somewhere. I think, for the younger generation, people's expectations have changed as well as the fact that the NHS isn't as pleasant a place to work in as it used to be. And I think that that generation have different priorities, to perhaps you and I. Certainly, when I finished my training, I got onto the, sort of, training and career ladder as quickly as I could, and felt that time was against me. I must confess that I also have a child who is now in Australia, and when she isn't in A&E, she's in the sea. So you know, it is a very different approach to life, and we need to… we're going to have to accommodate to that.

Professor Steve West: Thank you very much.

Session Chair's closing remarks
Malcolm Dean, Associate Member, Nuffield College, University of Oxford and former Assistant Editor, The Guardian

And you're not going to hear a summing up by me because I've had a very good morning, I've learnt an awful lot from all of you, but can we give the dynamic two a round of applause.

And we have a coffee break and we are meant to be back at 11.35.

Session Chair's opening remarks
Baroness Cumberlege, National Maternity Review, NHS England

Good morning everyone. It's really good to see you here. I gather you've had a very stimulating morning, full of interest and I'm not surprised considering the number of interesting speakers you have had. We have also got a very stimulating group we are going to start off with Beverley, who has very unfortunately broken her arm in two places.

One cannot help thinking about the NHS, as it is continually in the news and on social media. We are facing a very interesting and challenging time and today we are talking about, the workforce which is crucial to the success of the NHS, together with the impact of brexit.

we are going to start with Beverley, who I have already mentioned. Beverley Harden, is a physiotherapist. And Associate Director of Education and Quality for the South in Health Education England, in addition to working for NHS England. She's had wide experience working with big organisation is a Clinical Lead for physiotherapy.

Developing the role of allied health professionals in supporting care services

Beverley Harden, Associate Director of Education and Quality, South and Lead, Allied Health Professions, Health Education England

I'm living there, the physiotherapy rehabilitation, the orthotics provision of splint, the fantastic extended nurse practitioner who saw me in ED, looked at my x-ray, gave me the splint, I am the living example of multi-professional workforce delivering excellent patient care so I feel I am here to champion the cause this morning, so thank you very much indeed, thank you for your time.

Apart from being captivated by the visual image of a wheelbarrow full of frogs from this morning, I think the key thing for me and the message that I want to convey today is about understanding how we do actually get the best from the money that we are spending across the system because we have a whole wealth of workforce opportunity within our system.

We also have quite a lot of unexploited opportunity and I think the challenge is that the unexploited opportunity is so obvious often, we don't see it and so my challenge today is how do we really do that, how do we overcome the silos and that gravitational pull that was spoken about this morning between the professions? How do we move beyond culture, history and tradition, we've always done it this way, what can you offer that's different and I've trained to do this, so what can you do and it's not one profession guilty of that, we're all guilty of that. We spent a fabulous day yesterday with Orthotist's and prosthetist's talking about skill mix and it took me back in time ten years, the conversations we had in physiotherapy about skill mix. So we've got a lot of work that we need to think about across the system.

But we have the fabulous opportunity of the Five Year Forward View to offer to the system which is about thinking about how do we put that prevention, that wellbeing at the heart of what we do, so we do become that health service, not the sickness service that we talked about this morning? Some absolute challenge to us, so how do we exploit the wider workforce and everything I say today is going to be through the lens of Allied Health Professions because that is my brief but it's absolutely pertinent to healthcare science, to pharmacy, to some of my nursing colleagues about how do we actually blow the dust of these staff to let them work to the level that they are capable of, so that is our challenge.

And the STP opportunity, the place based approach is key because it enables us to think about workforce pathways around the competencies required to deliver care and health and wellbeing to that population, which moves us beyond the argument of three nurses, six doctors, four and a half physiotherapists and an ophthalmologist. So we've really got to think about how do we think very, very different.

And from an AHP perspective we're trying to model the piece of working across the arm's length bodies to intelligently focus energy where we can get some really good early return for people.

So that's the Allied Health Professional family as it stands at the moment. I see there's some psychology representation in the room and I just want to say that again the same messages stand for you, you are perhaps the most unexploited profession I think in healthcare as we think towards delivery of the Five Year Forward View but today that is our family that we are looking at, huge variety, huge opportunity because each one is utterly under exploited in the current frame.

So AHPs are the third largest workforce group, that means that you have got hidden around those professions a vast number of people, they are not very well understood I think it would be fair to say, people don't really know what an Orthotist and a Prosthetist does let alone what and Orthotist and a Prosthetist could do, so we've got a huge knowledge gap and we talked this morning, Stephen talked this morning about the need to educate the system to the art of the possible with these professions. The challenge we have in the STPs is we do not have many leaders of these services present in those forums where these conversations are playing through, so we haven't really got the opportunity to have representation of people who really do know the art

of the possible, so again my challenge to the system is and again some of the work we're modelling through HEE with the STPs is how do we get that voice really into the right place to have the right conversation, a huge challenge.

And so often this is not about more, this is about using what we've got differently. So often these professions are stuck in the wrong part of a pathway, often at the end when a person has become either disabled by their challenge or they're out of work or they're no longer able to care or fulfil their social activities that keep them netted into a community and keep their wellbeing to a point where actually isolation, loneliness, is not a problem to them.

So we've got some huge challenge to really understand how do we move people in a pathway when we live in the world of silos, isolated payment system and the history and tradition as we've always done it this way; an enormous challenge. And if you think about it, if my physiotherapy service for example is seeing patients at a different part of the pathway and saving money somewhere else in the pathway, that's great if it cost no more money; if it cost £7.50 more to put that physiotherapist at the front of the pathway but they save a huge amount of opportunity and resource downstream, if that £7.50 comes from a budget that doesn't benefit from that downstream saving, nobody is interested because it suddenly becomes too hard for me to work out where I am going to get my extra £7.50 from.

So we've got some huge challenge around the silos holding back excellent patient care, sensible ways of using money and sensible ways of using practitioners. These people are bright clever people who are desperate to live up to their full potential. We lose them to private practice because this group of professionals are all trained to work autonomously, we do not need a referral from a doctor to work. And a lot of my staff at the moment will, on a Saturday, work in a clinic completely autonomously, seeing patients from off the street within days of their injury.

On a Monday morning they go to the hospital to see patients who have had to see a GP first of all, and then often wait 8-12 weeks for their treatment before they can actually start treatment by which time their condition is chronic. The therapist then spends the next 6-12 weeks getting them better, I mean this is job creation scheme, it's lovely, thank you very much for keeping us all in employment, I really appreciate that; however, there's far more to that. And think about that human being that's stuck in that system, we've really got to think differently about how we work.

And those new models of care are out there, there's no new thinking to be done, there's no new work to be done, the vanguards are showing us quite beautifully the fact that this is all possible and actually doesn't require massive commissioning upheaval, doesn't require an awful lot of workforce change, it's about being courageous and changing how we've always done it.

And the point this morning that Grant raised about this being about the existing workforce, there is so much unexploited opportunity in the existing workforce and it doesn't actually take a huge amount to up-skill a lot of the staff that we have. There is still a piece where we could up-skill even further because the scope of practice is potentially huge for these staff, we haven't even begun to think in that space, well we have but the system hasn't yet because people don't know because the people who know the stuff are not around the table having the conversations, huge, huge piece of thinking we've got to do about how we change that.

So a lot of this, and we've seen with pharmacy who have launched a very courageous spread of clinical pharmacists in primary care which has the opportunity to support primary care incredibly well, but also improve patient experience beautifully. And we're seeing some lovely results coming out of that work but that came from a courageous systemic spread of a workforce model because things have been tried, it doesn't happen small scale, it remains piecemeal small scale pieces of work, we've got to think about courageous systemic spread of this work to exploit that scope of practice. And if it was easy, let's face it, we would have done it by now, so this is not easy, this is as I say cultural change, absolutely fundamentally.

And when you think about chapter two of the Five Year Forward View, prevention in its widest sense, think about the Care Act's definition of prevention, primary prevention, you stop me thinking about smoking, getting

fat, I need to exercise more, secondary prevention you're thinking about how you work with me to make sure I'm taking my medicines to stay well, to prevent the complications of my diabetes, you keep me thinking about how I stay socially and integrated in society so I don't get lonely, we've established that loneliness is a huge challenge.

Tertiary prevention, I've got some really great care planning wrapped around me that means when I am poorly I don't ricochet into ED because I don't want to, I want to stay at home but at night I'm breathless, I'm scared, I'm going to be in an ambulance going to ED because I've got nothing else wrapped around me. So we've really got to think intelligently about what does prevention mean; it's not just primary prevention, it's a huge wealth of preventing people getting worse than where they are now. And that's a huge shift for health, social care get it, we've got to think about how health really do start to understand and work with that.

And the AHP community are trained as self-care prevention experts in that wide definition of that prevention word. So we've really got to think about how we do differently.

And there's huge workforce myth about what we can, what we can't do, can we prescribe, can we not prescribe, what can we do, let's ask the questions and if the answer is no, let's think about how we could enable that to happen if that's what the people and population require of our services.

So huge number of AHPs can prescribe, huge number of AHPs have got a huge set of workforce skills and there are a lot of them around and if you look at the Comprehensive Spending Review and the opportunity for professions to come in to the market place, some of the Allied Health Professions have the opportunity to grow their workforce quite interestingly, so we need to watch.... I'm giving all my trade secrets away.

So train to assess, diagnose, treat people without reference necessary to a medic, obviously always within a multi-professional team, we're not saying we're mavericks who can go this alone, we work as a team, we play to the strength of that team.

We've talked about the fact that we've got scope of practice unexploited, so many OTs live in the world of health and social care, they can translate, they're bilingual in the world of health and social care, why are we not exploiting them more around the integration agenda? And I want you to think about these are clever people who want to do more and we're losing them because they can't.

An example, musculoskeletal care, currently if you think about the DH work health agenda, keeping people in work, we've touched on the fact that by repositioning the physiotherapist, the osteopath or the podiatrist to the front of that pathway we have the opportunity to change the outcomes. The evidence is growing and it's showing absolutely unequivocally that you get increased supported self-management, better staying at work, better retention of physical activity in the health promotion benefits of that, staff satisfaction is huge; GPs have time to spend on their patients.

If you think about the fact that between 10-30% of GP workload is primary musculoskeletal compromise, overnight we could have a huge impact on GP numbers going through their services. In a recent study from Wakefield, it showed that of a thousand patients, 840 of those would have seen a GP but were seen by a first point of contact clinician who was not a GP. So you think about that impact on a thousand patients going through a GP surgery in a week, it's a huge potential impact, why are we not doing this everywhere, Scotland is, Scotland has 90% of primary care environments working like this and Wales 70%.

The myths are that this increases waiting times, it makes more treatment need, it doesn't, it reduces secondary care, it reduces radiology referrals and it keeps people in work. And it keeps patients safe and it keeps patients happy with their services. There are huge numbers of other opportunities in every walk of the AHP world there is opportunity, and there is opportunity we haven't even visioned yet. All the ones on the list and slides you will get have an evidence base growing behind them that this is safe, effective, fantastic patient care, it helps workforce shortfall, why are we not doing it, it's because we've got to think about how we spread this intelligently.

So the opportunity is significant, this workforce is there, less impacted by Brexit than most workforces, we just need to think about how we use them intelligently and effectively and ask the questions rather than assume that the workforce myth is the truth.

Thank you very much indeed.

Baroness Cumberlege: Beverley, thank you very much indeed, how very stimulating. I came across a quote from Warren Buffett who was saying "the rear view mirror is always clearer than the windshield ".

I think we tend to look back and do more of what we've done in the past, and we know we've got to do things differently going forward. So we are moving on now to Janet Davies who is the Chief Executive and General Secretary of the Royal College of Nursing. She is the voice of nursing across the UK and indeed she is the voice of the largest professional union of nursing staff in the world. A powerful lady and representing a huge workforce that is critical to the NHS.

Challenges for the nursing workforce: recruitment, retention and leadership

Janet Davies, Chief Executive and General Secretary, Royal College of Nursing

Thank you very much, and it's really good to be here, in what is a very strange week for our National Health Service. And sorry I missed the early part, I was at Sky News, along with half the people that we all know who seemed to be lined up to give our opinion on what was happening at the moment.

And it's a bit depressing, I think, at the moment, that we're just sitting listening to the same old stories, that we all know anyway, and it's not really getting us anywhere. But actually throughout all that coverage, there's some really good examples of some fantastic care that's being given, and we need to hold onto that at the moment, I think.

We know we've got problems, but actually the majority of what's happening at that interface with us as professionals, and our patients, is incredibly high quality, particularly considering the pressure we're under. So I think I'd like us to hold onto that, as we look at where we go in the future.

I've been asked to talk about nursing but obviously, nursing does not sit in a vacuum, we are part of the wider team that provides healthcare. But actually we provide healthcare, but we also provide public health, we provide preventative care. And we need to look more widely, at where our professional groups are.

Nursing's significant, because it's the largest professional group. And that has its strength, but it also has its weaknesses, because there is no one typical nurse, and there's no one typical set of skills and knowledge that a nurse might have. A nurse trains in a very broad and generalist way, so when a nurse is qualified, at the end of their university programme, they've got a lot of skills which can be used in a broad setting. And it really isn't until that nurse qualifies, that they start to develop their practice, and they start to develop their speciality. And we need to support that, to ensure that we get the best out of our professionals.

And there's very, very broad, very blurred and broad boundaries for nursing. One of the things that happened in nursing, quite some years ago, but I'm old enough to remember it happening is, was that the predecessor to the Nursing and Midwifery Council started to talk about the scope of professional practice. So rather being tied by a set of tasks that nurses were or were not allowed to do, they talked about the scope of professional practice, bringing nurses into being a profession, who could determine where they would move their practice to, determine whether it was safe, and take responsibility for their own acts.

And it had quite a significant effect on the profession, because what began to happen is that, nurses really started to develop practice, but they were developing it based on the patient's need that was in front of them, and in what was happening in the ward. Not because someone had designed it, or told them, they could see there was a real clinical need.

And we started to see these new roles emerging. Nobody was saying, you can or can't do it, they started to emerge, and these were some of the early specialist roles. I mean, the original specialist roles were things such as stoma care, and continence care, the things that people, other people, didn't really want to do.

But at this point, we started seeing things such as respiratory nurse specialists. There was a real need for skills to maintain people with chronic conditions in their own home, to monitor them, to care for them, to manage the pathway. And some of these roles started developing, and they didn't develop because somebody had designed it centrally, they developed it because there was an issue with those patients, and they moved to do it as part of a multi-professional team. It wasn't nurses going ahead on their own, it was in partnership with their medical teams, where there are Allied Health Professionals. And they started to take on new skills and they started to take on new roles.

And whilst that was, I think, has been amazing, because it was… advanced practice has never been regulated. And the jury's out, I think, and certainly my opinion is, I'm not sure whether it's a good thing, or it's not. There needs to be recognition, and people need to understand what it is. But the problem with regulation is, it limits things. And when we look at the Australian model, and they had… they defined it, and then started doing it, there are very few advanced practitioners. There are thousands in the UK, some might not quite be that, but many of them are doing those jobs.

And when you look at where nurses are working, you know, is there a similarity between a nurse in an intensive care unit, with a nurse practitioner caring for the homeless, with someone in a family nurse partnership, with someone who is doing smoking cessation clinics, obesity clinics. There is a common theme, but it is that whole diversity, and it's probably that diversity that creates us the biggest problem, in trying to articulate what the benefit to nursing is, as a profession.

And of course, the sad thing about us is, that everybody else thinks they understand it. There has never been a profession that has so much interference in what we should look like, and what we should be doing. But leave it to us, and we'll start doing some marvellous things. And when I say, leave it to us, I don't mean, leave it to the Royal College of Nursing, because I think we would get in the way just as much.

It's about actually enabling people to work to the top of their licence. And that's what the Americans call it, working to the top of the licence. So we do need to encourage more advanced practice, but we need to be really careful that we don't design out the desire to do it, or actually limit the potential of what we might be able to do.

The Consultant Nurse was well hailed. Some of you will remember the Consultant Nurse, it came as a big shock to the profession. I was, actually at the time, as the Director of Nursing in Liverpool, and Tony Blair, who was then Prime Minister, announced we were having them. Nobody knew about it, not even the Chief Nurse, he'd seen some and he thought, this is great, so we're all going to have them. And it was a ripple of shock along the profession of, what on earth are they? And then, we all rushed to have them, because it all looked fantastic. But they've, sort of, disappeared, there's some fantastic ones around, and they've disappeared because it was something you had to go through all these hoops to be a Consultant Nurse, rather than actually do it for your patients.

So my message today is, beware of setting too many frameworks, too many pathways, that people have to jump through, that actually prevents you from seeing the patient in front of you, and just becomes something to do.

But saying that, we do need career frameworks, we need abilities for people to be able to do that, ongoing CPD. My message to Health Education England would be, think about the nurses we've got now think about the nurses in the future, think about the nurses in the next eight years. And not necessarily on their own, we're not precious about that, most of the work we do nowadays at the college, is not, you know, professionally, we do it with the whole team, or the people who want to do that work with us, it's much more powerful that way. But think about how we put that framework in, that doesn't limit, but actually enables innovation.

So I was asked to talk about recruitment and retention, and I know I've only got ten minutes, I could talk, probably, for about ten hours on this subject. We are short of nurses at the moment, and that does mean we've got a problem. We're probably, from our estimate, which everybody seems to think is about right, and that's because we've examined everywhere in nursing, it's probably about 25,000 short. Which, is huge, but if you think about the whole size of the health and social care system, and where nurses work, it's a manageable number, if we can get the solutions right.

But we must remember, it's no accident. The reason we're short of nurses is that we didn't commission enough nurse's places, because we continuously plan a workforce for what we can afford, not what we can need. And then, hey, look, it's more expensive to have bad care, we need more, and we go through these cycles, and we need to get a grip at some point, of the fact we need to plan our workforce, or not plan, as it

looks like it's going to happen at the moment, with the way that universities have moved. But actually we need to be careful that we don't keep doing this, because we're going to get much more need in the future.

So it isn't an accident, we must remember that. We mustn't just suddenly go, oh gosh, how did that happen? We know exactly why it happened, and it mustn't happen again. And of course, it's more stark in community settings. So you look at the workforce shortage, you look at what's happened in nursing, it is actually in community settings. And the reason for that, they have been reorganised about every three years, because they were always part of the STPs, before that they were part of CCGs, all these things that we've had, which keep being recognised, that's where the hit's been felt. Hospitals sail through it, and everything change around them, they are absolutely affected.

A District Nurse I met recently has had about six badges. She's done the same job, but for different employers, and it gets in the way of innovation, and it gets in the way of development. Because they're too busy focusing on the next contract, the next restructure, rather than on the clinical need of the people in their area. So my other message would be, be very careful to not disrupt that again. And we know that every time the contract is renewed, they look to take more nurses out, so I'd be very careful about that.

So long term solutions, what we should be focusing on. That's what I would encourage Health Education England to do. Be careful of the quick fixes. The Nurse Associate, of course, we've been wanting for a long time our support workers to be regulated, that is really good news. We should not have people caring for our most vulnerable, with no regulation at all. But we need to be careful how we use them, they are support to the multi-professional teams, and they are support, they're not substitute. And we know from the research that substitution can actually be more expensive, because the outcomes are worse.

So learn from the past. No quick fix. And let's have a look what do we need into the future. Lots more I could talk about, maybe they will come out in the questions. But ten minutes, hopefully, it's given you a bit of an overview about where we are.

Thank you.

Baroness Cumberlege: Thank you very much indeed Janet. I've been doing a review of maternity services for England and we've been going round to some European countries to see how they do things and I was very interested in Holland where we met the Head of the Midwifery Workforce, and she said to me in English, "I'm a Jack of all trades, but a master of one" and I thought that was interesting because thinking of caesarean section she knew exactly who was going to do what but she was the master of one. I think what we've heard from both our speakers this morning is how we have to open up the workforce, and I thought Janet was insightful on regulation. We have to be very careful that we don't kill the initiatives that are out there.

Our next speaker is Sharon Allen, Sharon is the Chief Executive Officer of Skills for Care and she's worked in the public and voluntary sectors, particularly on housing. On Tuesday we had a Government White Paper on housing, housing is broke, we're told, Governments like phrases like that because then it's got to be fixed and they are going to fix it, we hope. Housing is so crucial to all this, at the present time. Sharon you are going to be talking to us about being the Chief Executive officer, Skills for Care in 2010.

Improving integration and co-ordination of health and social care services
Sharon Allen, Chief Executive Officer, Skills for Care

Okay thank you very much; thank you for the opportunity to be here today and what I'm actually going to talk to you about is about how we can achieve a workforce for integration, just as an aside, I'm also in my spare time a board member of my local housing association and when we talk about integration, I think it's absolutely essential we see this as a kind of three legged stool of social care, health and housing, I absolutely do not understand how you can talk about wellbeing if people don't have somewhere secure and safe and affordable to live.

So I want to just share four points with you for things for us to think about in how we achieve a workforce for integration.

Firstly, that social care needs to be seen as, and treated as, an equal partner in any discussions about how we bring services together. Yesterday I was at a meeting and one of our Skills for Care fellows, somebody called Clenton Farquharson, I don't know if any of you know Clenton, he's someone who has lived experience of care and support services, he employs his own team of support workers. And he was talking about the need to make sure people see social care's primary purpose as being about supporting him and others like him to have a life, it's not just about helping sort out the NHS' problems, important as it is that we work together on that, our primary purpose is to ensure citizens in our communities can live a fulfilled and enriching life. And as one of my colleagues recently said to me in terms of trying to get a seat around the table in conversations around the STPs, around the local workforce advisory boards, of transforming care partnerships, we need to be there to help shape the agenda not just brought in to say will we put our logo on it when everybody else has sorted it out.

The second reason that we need to be equal partners is because ours is a very big workforce, we employ 1.43 million people doing 1.55 million jobs in adult social care and we are projecting, based on the national minimum data set for social care, we're going to need another 275,000 by 2025. All those people work for 19,300 organisations, many of them small businesses employing less than 50 people. If we're not engaging them and getting their expertise and intelligence around the table then we really are missing a trick.

Thirdly our big workforce has a huge amount to offer both in terms of skills, in terms of experience and in terms of ideas and I am not just talking about the regulated professionals, much as we love our social workers OTs and nurses in social care, there are about 70,000 of them out of the 1.43 million people I talked about.

And if you take one thing away from what I say today, please whenever you're in conversations, challenge anybody who talks about social care being an unskilled or low skilled workforce, low pay, low skill are not the same thing, they are hugely skilled, if you haven't been out and seen them in action, go see what they do, what they need to know and be able to demonstrate.

And frankly we know that the simple fact is that people in our communities who need care and support could care less what uniform somebody is wearing or indeed if they are wearing a uniform or who commissions the service, what they want to know is, is that person coming through my front door capable, skilled and caring and going to provide the care and support I need in the way I want it at the time I need it, that's what matters to them.

And so a question we need to ask ourselves is are all these professionals, and again please let's talk about the professional workforce, the issue of whether the workforce is regulated or not is another matter, maybe something we want to talk about, they are all professionals. Are they having those conversations together focused on the needs of the person that we're meant to be providing care and support to?

And my fourth point is the one that I started with, that we must break away from this notion that integration is just about social care and health, people in our communities also need to have a good and secure roof over

their head, they need to be able to get on a bus or a train, they need to be able to use leisure facilities, go to the library as we heard well-articulated earlier this morning.

So we know that integration is meant to be providing better outcomes for citizens and I hope, although the report from the National Audit Office is kind of questioning, and people have questioned this for some time about whether it can actually achieve savings, maybe what it can do is stop us spending more, I don't know but it is actually really important for people because what they want is a seamless service, they do not want to be passed from pillar to post having to tell their story over and over and over again. We are often involving ourselves in people's lives, in their worst of times so we need to be really good at it and we need to be efficient and effective and make sure that they get the right care in the right place at the right time.

I want to give you an example, a colleague of mine was telling me about his father who was diagnosed with Motor Neurone Disease, six weeks after his diagnosis he was a frightened man lying in an expensive hospital bed telling people every day he just wanted to go home; that's where he wanted to be. He couldn't go home, you'll know the reason for this because they couldn't put in place the care that he needed, so that took six weeks. When he did get home the great news is that the care and health provision he needed was provided in a really wonderful way and he and his family were thrilled with the service that they received. Because as a team of professionals from the consultant, the GP, the nurses, the care workers, they all genuinely worked as a team and when sadly he died a short time after, some of those care workers went to his funeral on their day off, something that actually happens a lot, we hear a lot about how people are not caring and abusive in our sector, got no time for any of them, we want them out fast but they are not representative of what goes on day in, night out, across our sector.

So we had the example of somebody who wanted to die at home whose family wanted him to be at home stuck in a hospital bed because we weren't able to sort ourselves out well enough to give him what he needed; and I'm not telling you that to encourage us all to be outraged or fed up, what we need to do is learn from these things because we also do know how to do it really well, we're seeing that across the country, what we need to do is make sure that we're all applying that more consistently.

So I just want to give you some examples of the work that Skills for Care is doing to try and play our part in joining all this up and help us achieve a workforce for integration. And I'm using that language and terminology deliberately rather than an integrated workforce because as people have already articulated, we have a huge amount of skill and knowledge and resource in the current workforce, what we're not talking about is squidging everybody together and making them into a jack of all trades and master of none. What we do need is people who can work together to bring their different skills and expertise to meet citizens' needs.

So in Greater Manchester as part of the Devo Manc approach up there, our head of area sits on the strategic workforce board for that partnership with other social care employers making sure that we're representing the views and the offer from social care into those conversations and specifically that we are providing data on the workforce throughout national minimum data set. So all of the ten local authorities in Greater Manchester have now prepared local integrated workforce plans to help meet service objectives and the strategic board is now preparing key themes from those workforce plans to identify what support the partnership can give to address them. If we look at the southeast of the country we've been able to use our significant employer engagement down there to connect social care employers with health colleagues to put in a pilot bid for the nursing associate programme in Devon and that bid was successful and we are moving well ahead with progress there.

The other thing we need to get better at is sharing learning, so we don't constantly reinvent the wheel or start with a blank piece of paper because it's never a blank piece of paper is it. So a piece of work that we did with our colleagues in Skills for Health was to look at intensive workforce support to the integration pioneer sites to help them with that work, that work was commissioned by Health Education England and we were working with them to look at how they could put a workforce at the heart of all the changes that they're trying to achieve because that is essential, they are the people who will make it work or stop it working. And we're now in conversations with colleagues in NHS England in the vanguard team on how we can better support them

with the roll out of the Enhanced Health in Care Homes Programme focusing on the workforce elements of that.

So everything we've done we put on our website, the tools are there, we can share with people what works and make that available for other people to take up, not in a cookie cutaway, just saying well that worked in Devon so it will work in Derby, taking the principles and making it fit local context and solutions.

And I just want to end with this thought from a colleague of mine who visited a project in Stockport called REaCH which aims to create integrated packages for people who are in the last days of their lives. And the aim is that everybody who wants to is able to die at home; and he was struck by the joint meeting that happens there where everyone included in providing care and support to that person is sat around the table as equal partners, from nurses to advanced practitioners, social workers and paramedics, everyone with an equal voice and the only aim of that integrated team is to breakdown any barriers that exist that will prevent somebody from having a good death in their own home. So the strategic interventions we are making are important and are working in the final analysis it will all come down to the goodwill of good people out there and our job is to enable them to flourish.

Thank you.

Baroness Cumberlege: Thank you very much indeed Sharon, I think you're absolutely right that it is about the goodwill of good people and what they achieve. Thinking about the Today Programme recently where the National Audit Office was coming in and saying that the NHS really isn't making good use of all its funds, what interested me was they weren't looking at the vanguards. Later on they had Wakefield and what was going on there and it was very interesting because what the National Audit Office was saying was that the Better Care Fund simply didn't work. I think what they missed was that it was about better care, if you can get some financial savings as well, that's good, and Wakefield have. One thing that has been missing this morning is the use of the voluntary sector and I think of Care UK of which I'm involved with, and in Wakefield the Care UK was actually helping people get home.

Questions and comments from the floor

Baroness Cumberlege: It's over to you and it's questions to this very interesting number of speakers that we've had today, and if you could identify yourself. and if there's somebody in particular on the panel you would like to put a question to, I'd welcome that, thank you. Yes, lady here.

Maria Crowley: Hi yes, I was quite interested in all those presentations and they seem to really connect back to mental health, my area of passion.

Baroness Cumberlege: And who are you?

Maria Crowley: I'm the Head of Mental Health working in NHS England South East.
I suppose my question… the question is, but actually I will give you a little bit of background first. I've worked in healthcare as many of us have probably 35 years now and what I've noticed more recently, and I think it links to the conversations this morning is we haven't got that join up, we all used to criticise back then the national service framework, it's telling us all how to do something but actually we all did it, now we're told go forth and deliver, be innovative, go out and do it all; however, what I am searching to find is that we're getting a lot of free reign policies but actually to really enable clinicians, social care and health to work together, there does need to be some direction on implementation…

Baroness Cumberlege: So is that your question?

Maria Crowley: No, the issue that really this touched on was the transforming care agenda; so we were asked to support people to move from forensic services into the community, we all knew that requires a really joined up strategic approach and we were absolutely frustrated that we didn't get that support to join up. So my question is, sorry, how can we influence the policymakers to support a joined up implementation plan alongside the strategic delivery plans?

Baroness Cumberlege: Janet you are trying to influence policymakers daily.

Janet Davies: Yes absolutely, and I mean I think there is a fundamental rethink about what health is and that's health, mental health and physical health. And it's more than actually having those plans, it's about actually how we get true integration and I do think we need a proper conversation. I think at the moment we're trying initiative after initiative to actually patch things up; and actually we probably need to have a total think about what health and social care looks like and that includes preventative, it includes health. Because what is good housing if it's not beneficial to health, so I absolutely agree with what I heard about housing, we need a bigger conversation than we're having at the moment. So I think no matter which plan it is, unless we have a proper integrated service you are always going to fall between that and I think in mental health we see it more than others although mental health have done it better traditionally. I think if you look at the work supporting people particularly those people with severe mental health problems, if you look at the way the different services work around them, it is far more seamless in other

areas, so actually I think we can learn a lot from mental health and sometimes it's about needless, you know, dare I say, it's not about breaking the rules, we do it better when we break the rules. And where we've seen it is particularly in terms of, you know, how do we get those systems, if the systems don't talk to each other and I mean the clinical systems, the computer systems, then it tends to be particularly mental health they find a way around it that doesn't break the law but we do need to make sure that we think differently I think.

Baroness Cumberlege: Sharon, do you want to come in?

Sharon Allen: Yes I think one of the really important things is to involve people who are providing services at a local level early on because they have ideas and they have innovation and I know that one of the things that social care providers find very frustrating about the whole transforming care approach is that they don't feel that they are being given sufficient opportunity to engage. And in part that's because there's this sort of ambivalence because some of them are private providers and I think we've got to get over that and actually look at the quality of what people are providing rather than kind of where they sit in any kind of organisational structure; and also involve families and people with learning disabilities in that particular case or mental health issues. Because very often they have the best ideas and we need a bottom up and top down approach; so we need the national framework for the consistency you talked about but we need to involve local people.

Baroness Cumberlege: Beverley, do you want to come in?

Beverley Harden: My hope for the STPs is that that's exactly where this adult conversation needs to be happening about how the whole system wraps together but it's about playing to the strength of the local system because the problem with national rollout is that not everywhere needs to be exactly the same so it is about the national framework but it's about having those absolutely adult conversations at system level and putting in a solution that works for the people in that place involving all partners. So we've just got to get to that point and that challenge as we chase the money, not the conversation, we need to flip it and chase the conversation that will drive the money.

Baroness Cumberlege: I see that Wendy Reid is here and I don't want to cut her session short, so if I could take another two questions for this panel. Yes, gentleman over there.

Dr William Palmer: From the National Audit Office, who have had quite a few mentions so far today.
I didn't work directly on that study but it's probably worth clarifying a few issues about the Better Care Fund piece of work, that we don't question policy and we certainly didn't in this one, you know. That report wasn't about a question whether integration was a good idea or not but it did raise some concerns around the assumptions that were made around the Better Care Fund and the expected benefits that were put around that. But it's well worth going on our website and reading the full report. As I've got the microphone, I will ask a

question as well; and I guess the talks here were around sort of the skill mix and trying to improve those, and I just wonder how we know when this is working well in a measurable way?

Baroness Cumberlege: One more question so if you could, no, no, no, not just yet, get it ready. Right okay, yes lady over here.

Camilla Pallesen: Cancer Research UK
We're doing some more research into skills mix and thinking especially within cancer setting but interesting with, especially with, I guess the focus is away from the medical professions and looking at the other professions and talking about sharing best practice you mentioned STP's but are there any other ways you think sharing best practice, the best ways of getting that out there and how you can go on making sure it's done in a way that can be local but also could be rolled out nationally?

Baroness Cumberlege: Thank you very much, so would you three like to just address either of those questions.

Sharon Allen: Right, well I'll try and answer them both quickly. So I think we've got some fantastic examples of skill mix and where it's working and I'll just give you one, which is an example where a paramedic service who was getting regular blue light calls from people who actually didn't need an emergency service, has employed a newly qualified social worker and the referrals for the people who actually need social support go to that social worker who is then able to do all the things that they need to do and guess what it's reduced the number of inappropriate calls to that service. And I could give you lots of other examples but time is tight so I won't but if you want to have a look at them we've got something on our website which goes to your point called Learn from Others where we encourage employers who are doing work that is achieving results to share that so that we can quickly get people to adopt things that we know are working.

Baroness Cumberlege: Janet.

Janet Davies: Yes, I mean, I think measuring skill mix is about measuring outcomes and what a difference it's made or not made, I think that's really key. I think first of all it's why we're changing the skills, is it because it gets better care or is it because it saves money and we just have to be really careful that we don't just chase the money and end up with poorer outcomes, so I would say outcomes are absolutely key to that. And in terms of learning from best practices, two way process as well I think so you know if you want to start something, if you want to look at something, you look where best practice is, it's actually not that difficult to find particularly now with social media with websites, it is quite easy to find, it's not necessarily going to come to you, it's sometimes about looking for it.

Baroness Cumberlege: Beverley.

Beverley Harden: And for me the… how will we know when we're doing it, I think the challenge is that everything we're doing needs to have some evaluation around it to make sure that we do know that we are

delivering impact, and that needs to be at quite a granular level, we can't necessarily evidence this at that high level, you might be able to but for us in service it's about how do we evidence that what we are doing is both an improvement in experience, in outcome, but also generally money comes out of that too.

And how do we spread good practice? It is the age old challenge and we're all struggling with that across the patch. And the issue for me is that we need to make sure that the groups of staff and that bits of sector know because actually we don't even share it within those environments often. We need to understand that the CCGs, the commissioners, the STPs know of the opportunity. And we need to know that society knows of the opportunity because actually often our service users are the biggest driving force for service change often, because they can see it could be done better. How involve them in the co-production of service improvement is absolutely key. And I think what we're trying to do is join things together more because actually we can all have a fabulous way of sharing our work but that means I have to go 4,012 different portals to find out things behind a password, I don't have time for that. So how do we work with people like Right to Care who are doing some fabulous work around evidence based models of service delivery that goes straight to the heart of the CCGs about delivering improvements to service. How do we upload to them the evidence of these examples of fabulous practice that they can then carry out into CCGs but knowing that they are evidence based, because actually this is about improving all of that triple aim that the new Five Year Forward View is asking us to look at, outcomes, experience, money but also staff outcome too. So let's measure all those four, let's take the evidence and let's spread it systematically but to the people who are a) delivering service and b) commissioning service and receiving service as a c).

Baroness Cumberlege: Thank you very much.

I would like to thank our three panellists. Wendy Reid is a formidable person. She is the Medical Director and Director of Education and Quality at Health Education England, Wendy it's over to you.

Priorities for Health Education England and the current and future workforce

Professor Wendy Reid, Medical Director and Director of Education and Quality, Health Education England

Text to be submitted by speaker

Priorities for Health Education England and the current and future workforce
Questions and comments from the floor

Baroness Cumberlege: Right Wendy, thank you so much for that. What an enormous canvas that she and Health Education England have to cover. Would anybody like to ask Wendy a questions.

John Drew: From McKinsey.
I thought that was a very interesting talk and I want to pick up on one of your comments right at the end, and I think it fits with themes from what others have said about the kind of local system taking a greater leadership role, rather than looking for national policy to figure it out, and you said Health Education England is ready to be, and needs to be kind of more permissive. What examples are there and what appetite are you seeing from STPs to ask more of you in terms of delegating budgets or responsibility to figure things out locally.

Professor Wendy Reid: So not at the budget level as yet, but I think there's emerging quite interesting conversations about workforce mix, particularly… I think probably the best example is around pharmacy at the moment, STPs wanting to use pharmacists in the front line much more, so we are seeing some of that, some emerging conversations, as Sharon said, down the West Country around mix of health and social care and using staff across those boundaries. So it's early days but it's happening and I would just make the point, it's not just HEE being active but it's making sure that we use our regulatory colleagues appropriately and try and make regulation what it's supposed to do, keep patients safe, but not be so slow to react to these changes. So I think we are a facilitator in that as much as anything.

John Drew: Thank you.

Session Chair's and Westminster Health Forum closing remarks
Baroness Cumberlege, National Maternity Review, NHS England

I'm just going to say very quickly some of the messages that I've heard today, and I'm only choosing one from each speaker.

First of all I was very interested what Beverley was saying about how people in the NHS often work to the private sector, because they can work autonomously, and I think that autonomy is absolutely crucial and it does reflect very much on professionalism. I do think we need to loosen up a bit and let people be professional in the way they want to deliver their services.

Janet told us, and I thought very succinctly, that we have to learn from the past. There are no quick fixes in the present and we have to think of the future, and that is so true.

Sharon was telling us about health and social care and housing and how they are hugely interlinked, and how social care is a very, very highly skilled workforce. I used to Chair Social Services and I absolutely agree with that.

Wendy gave lots of hard messages about delivering more for less, that huge remit of what we have to do for the workforce. At the end of her talk she mentioned leadership and I think it's something that we don't concentrate enough on. I was thinking, as she was speaking, about leadership, I was thinking of a powerful Viscount Slim. "Leadership isn't the spirit composed of personality and vision, it's practice is an art. Management is more a matter of the mind, a matter of calculations, statistics, timetables and routines, its practice is a science. Managers are necessary but leaders are essential", and I really believe that.

It's been a fantastic second half of the morning, and thanks very much to my speakers, and thank you all for coming and for your questions. Matthew, I think you just want to sum up a few words.

Westminster Health Forum closing remarks
Matthew Bradberry, Forum Lead

Many thanks Baroness Cumberlege. I won't keep you long.

I would just like to pay tribute to Baroness Wall of New Barnet on behalf of the Westminster Health Forum, as some of you may know, Baroness Wall was down to Chair the first half of this seminar prior to her passing. We like to honour her commitment to the health sector, and particularly as a leader in secondary care. She was very much an active supporter of our work as a Patron and we are extraordinarily grateful for her contribution. We wish her family our condolences and support at this difficult time.

Just to let you know, the transcript from today's event, along with speaker presentations will go out to you all within the next 10 working days, there are details in your delegate packs as to how you can have articles included in the transcript, we would ask for them to be no longer than 600 words and sent over in the next couple of days.

The transcript will go to everyone here today, as well as a wider range of decision makers.

If you could drop off your badges, and particularly any completed feedback forms at our front desk on the way out, that would be really kind.

I would like to thank our core sponsors, Boehringer Ingelheim and Optimity Advisors for their continued support.

And finally, just to echo the words of Baroness Cumberlege, on behalf of all of us at the Westminster Health Forum, including my colleague, Stephanie Thomson who helped to produce today's conference. I would like to thank all of our speakers and our Chairs today and hope you all join me in showing your appreciation.

Thank you.

List of Delegates Registered for Seminar

Sumayya	Allam	Policy Advice and Support Officer	BMA
Sharon	Allen	Chief Executive Officer	Skills for Care
Juliet	Anderson	Assistant Director of Education and Quality, Thames Valley	Health Education England
Abigail	Attrill	Finance Policy Sponsor	DH
Sarah	Baxter	Associate Dean Accreditation & Quality	Coventry University
Dr Iain	Beith	Head of School, Faculty of Health Social Care & Education	Kingston University & St George's, University of London
Amelia	Bell	Senior Workforce Policy Officer	RCGP
Frances	Beresford	Admin Officer	DH
Bridget	Bineham	Case Manager, Specialised Commissioning	NHS England
Alistair	Bridge	Director of Strategy	General Optical Council
Dr Paul	Bridges	Deputy Director Legal Services	Government Legal Department
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Frances	Carey	Government Lawyer	DH
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Michele	Charles	Head of Department Adult Nursing Health and Social Work	University of Hertfordshire
Anita	Charlesworth	Director of Economics and Research	The Health Foundation
William	Chick	Student	University of Birmingham
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Maria	Crowley	Head of Mental Health, Specialised Commissioning	NHS England
Baroness	Cumberlege	National Maternity Review, NHS England	House of Lords
Professor Ian	Cumming	Chief Executive	Health Education England
Dr Katherine	Curtis	Associate Professor and Head of Department Nursing and Clinical Sciences	Bournemouth University
Ann	Cysewski	Associate Dean	University of Wolverhampton
Natasha	Dare	Policy Manager	Nursing and Midwifery Council

Janet	Davies	Chief Executive and General Secretary	Royal College of Nursing
Sali	Davis	Chief Executive	Optometry Wales
Malcolm	Dean	Associate Member, Nuffield College/Former Assistant Editor, The Guardian	University of Oxford
Giles	Denham	Director of Strategic Partnerships	Health Education England
Dr Catherine	Dooley	Chair of Workforce Planning Committee	British Psychological Society
Rt Hon Stephen	Dorrell	Chair/Chairman/former Secretary of State for Health (1995-1997)	NHS Confederation/LaingBuisson
Tony	Douglas	Head of Business Management, Education	Central and North West London NHS Foundation Trust
John	Drew	Expert Principal	McKinsey & Co
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Tracey	Eckersley	Section Head Registration Policy	DH
Katrina	Emerson	Health Sciences Lecturer & Associate Dean	University of East Anglia
Hannah	Farndon	Policy Advisor	British Psychological Society
Philip	Farrar	Partner	Hill Dickinson
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Jenny	Ford		
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Lihini	Gunawardana	Associate Medical Director	Change, Grow, Live
Lynne	Hall	Senior Nursing Policy Manager	Health Education England
Liz	Hamilton	Full Time Home Carer	
Beverley	Harden	Associate Director of Education and Quality, South	Health Education England
Colleen	Hart	Head of Workforce Planning	Hastings and Rother Clinical Commissioning Group
Martin	Hart	Assistant Director of Education	General Medical Council

Professor Kamila	Hawthorne	Vice Chair (Professional Development)	RCGP
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Sean	Jones	Health Spending Principal	HM Treasury
Chris	Kent	Deputy Director	DH
Payal	Khamar	Policy Advisor	HM Treasury
Katerina	Kolyva	Executive Director	Council of Deans of Health
Chris	Lamb	Business Intelligence Director	Your World Recruitment
Ben	Lawrence	Sales Director	Your World Recruitment
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Alex	Lipton	Professional Officer - MRI	The College of Radiographers
Dr John	Lowe	Director of Education	Central and North West London NHS Foundation Trust
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Margaret	McDonagh	Lawyer	Government Legal Department
James	McLean	Deputy Dean of Quality, Education	Health Education England
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Peter	Milburn	Director, Institute of Medical Sciences	Canterbury Christ Church University
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Camilla	Pallesen	Policy Adviser	Cancer Research UK
Dr William	Palmer	Audit Manager, Health Value for Money Audit	National Audit Office
Lord	Patel		House of Lords
Adrian	Poole	Partner	Porter Dodson
Dr Mark	Porter	Council Chair	BMA
Dr Jan	Quallington	Head of the Institute of Health and Society	University of Worcester
Professor Wendy	Reid	Medical Director and Director of Education and Quality	Health Education England
Hazel	Richards	Director of Nursing	NHS England
Abi	Rimmer	Reporter	BMJ Careers
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Jess	Ruben	Strategy Director	Network Locum
Cristina	Sarb	Senior Policy Officer	Nursing and Midwifery Council
Cris	Scotter	Head of Strategic Supply	DH
Katie	Sears	Economist	DH
Julie	Seddon	Workforce Planning and Development	Health Education England
Libby	Sedgley	Senior Programme Manager, Education Commissioning	Health Education England
Fiona	Peskett	Deputy Director of Strategy	Barking, Havering & Redbridge University Hospitals NHS Trust
Dr Sanjiv	Sharma	Deputy Medical Director for Medical Education, (PGME Dept)	Great Ormond Street Hospital
Saira	Silie	Scientific Team Leader	Virgo Health
Lisa	Gould	Deputy Director of Nursikng	Change, Grow, Live
Ash	Summerfield	Economist	DH
Theresa	Titchener	Programme Leader	University of Hertfordshire
Professor Louise	Toner	Associate Dean, Faculty of Health, Education & Life Sciences	Birmingham City University
Tim	Tonkin	Staff Writer	British Medical Association
Rose Marie	Topping	Lawyer	Government Legal Department
Rosemarie	Topping	Lawyer	Government Legal Department

Hanna	van den Berg	Lawyer	DH
Angela	Walker	Policy Manager - Mental Health	DH
Ruth	Warden	Assistant Director - Development and Employment Team	NHS Employers
Professor Steve	West	Vice-Chancellor, President and Chief Executive Officer/Chair	University of the West of England/UUK Health Education and Research Policy Network
Dr Andy	Whittingham	Audit Manager	National Audit Office
Clare	Williams	Deputy Director	NHS Frimley Health Foundation Trust
Rachel	Winch	Workforce Projects Lead	Royal College of Paediatrics and Child Health
Mariana	Wieske	GP Forward View Leap	NHS England
Lisa	Gould	Deputy Director of Nursing and Clinical Practice	Change, grow, live (CGL)

Contributor Biographies

Sharon Allen, Chief Executive Officer, Skills for Care
Sharon has worked in the public and voluntary sector social care and supported housing sectors for more than 30 years. A qualified social worker and housing professional, Sharon became Chief Executive Officer of Skills for Care in 2010, having previously been CEO of a large social care and supported housing organisation. Sharon is a member of the Think Local, Act Personal (TLAP) Programme Board, Vice Chair of ACEVO and member of the board and Chair of Operations Committee of the CHS Group (Housing Association) in Cambridge. She has recently qualified as a coach, achieving Diploma in coaching.

Anita Charlesworth, Director of Economics and Research, The Health Foundation
Before joining The Health Foundation in May 2014, Anita was Chief Economist at the Nuffield Trust (2010-14) where she led the Trust's work on health care financing and market mechanisms. Prior to that she had roles as Chief Analyst at the DCMS and Chief Scientific Advisor at DCMS (2007-10), Director of Public Spending at the Treasury (1998-2007), where she led the team working with Sir Derek Wanless on his 2002 reform of NHS funding and worked as an Economic Advisor at DH and for SmithKline Beecham pharmaceuticals. She has also worked as a non-executive director in the NHS - for Islington PCT (2007-2011) and The Whittington Hospital (2011-2016). Anita routinely gives evidence to Select Committees and advises and contributes to work at the OECD, ONS, DH and NHS national bodies. This expertise was recognised most recently when the House of Lords appointed her as their specialist advisor for the work of the Select Committee on the long-term sustainability of the NHS. Anita has an MSc in Health Economics from York University and is a Trustee of Tommy's, the baby charity.

Baroness Cumberlege, National Maternity Review, NHS England
Baroness Julia Cumberlege CBE was Parliamentary Under-Secretary of State for Health from 1992 to 1997. She founded Cumberlege Connections in 2003 and Cumberlege Eden and Partners in 2013. Both Companies specialise in training and consultancy to the health sector. Julia started her career in Local Government, as Leader of the Lewes District Council and Chair of Social Services for East Sussex. She has served on many public bodies and has produced two reports for the Government. She is an Honorary Fellow of five Royal Colleges. She chaired the Brighton District Health Authority and the South West Regional Health Authority before being appointed to the House of Lords and a Junior Health Minister in 1992. Julia has chaired working parties for the Royal College of Physicians - which led to the *Doctors in Society* (2005) and *Future Physicians: Changing Doctors in a Changing World* (2010) reports. She is a Patron of the National Childbirth Trust and Vice President of the Royal College of Midwives. In the 1990s she also led a major review on maternity care, producing the Changing Childbirth report for the Government. Baroness Cumberlege has recently chaired, completed and is now implementing a Review of the National Maternity Services (*'Better Births' - improving outcomes from maternity services in England*, 2016) and has a wealth of experience in healthcare leadership.

Janet Davies, Chief Executive and General Secretary, Royal College of Nursing
Janet Davies is the Chief Executive and General Secretary for the Royal College of Nursing. The Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations. Janet along with RCN Council and the RCN President are collectively responsible for the delivery of the RCN's strategic and operational plans. The RCN assists and supports the membership to be the voice of Nursing in an ever-changing health climate and help shape the future of Healthcare. The key priorities for the Royal College of Nursing are to represent nurses and nursing, promoting excellence in professional and Trade Union practices and helping to shape health and social care policies. This also includes representing members in high degrees of challenging situations and providing a high degree of support as required. Prior to this appointment, Janet was one of the Executive Director's at the Royal College of Nursing (joining in September 2005) and had the strategic lead for nursing and service delivery to its members. The team comprised Nursing (which included a team of Learning & Development professionals), Employment Relations, Policy & International, Member Support Services and RCN Direct departments. Previous to joining the RCN, she had a long career as a Nurse within the NHS. She was Director of Nursing in West Lancashire and Liverpool and Chief Executive of Mersey Regional Ambulance Service. Janet holds a BSc (Hons) Degree and MBA. She is a qualified RGN & RMN and a Fellow of the RCN.

Rt Hon Stephen Dorrell, Chair, NHS Confederation; Chairman, LaingBuisson and former Secretary of State for Health (1995-1997)

Stephen Dorrell is a Senior Adviser to KPMG supporting the Global Health and Public Sector practices. He is also Chair of the NHS Confederation and Chairman of LaingBuisson. He was a Member of the UK Parliament from 1979-2015, serving as Secretary of State for Health 1995-97. Stephen was the first elected Chair of the House of Commons Health Select Committee 2010-14 developing the role of the Committee as an authoritative cross-party voice on health and care policy, in particular arguing for greater integration of the health and social care systems. Other positions he has held include Secretary of State for National Heritage, Government Whip, Junior Health Minister and Financial Secretary to the Treasury. From 2005 to 2010 he was Co-Chair of the Conservative Policy Group on Public Service Improvement established by David Cameron to develop Conservative policy for public service reform. From 2008 to 2010 he was also a member of the cross party Commission on Public Service Reform convened by the Royal Society of Arts. In addition to his political life, Stephen has had an active business life both as a company director and chairman and in a consultancy role, working with many of the major private equity houses. Born in 1952, he was educated at Uppingham School, and Brasenose College, Oxford.

Grant Fitzner, Economics Director, NHS Improvement

Grant Fitzner is an economics director at NHS Improvement. Prior to that he was director of analytics at the Centre for Workforce Intelligence, responsible for a team of analysts and modellers advising the NHS on workforce planning. He was also an interim consultant at Monitor in 2011-12. Grant was previously chief analyst and chief economist at the Department for Communities and Local Government, and a director at the Department for Business, Energy and Industrial Strategy. Grant has also worked in senior economic and analytical roles for Jones Lang LaSalle, HSBC Bank and the Australian government. He has a Masters in Commerce from the University of New South Wales.

Beverley Harden, Associate Director of Education and Quality, South, Health Education England

Beverley works as the Health Education England lead for the Allied Health Professions, Associate Director for Education and Quality across the South for Health Education England, and as a Clinical Associate to the New Care Models Team at NHS England. As a physiotherapist, Beverley has worked extensively as a leader of large, cross sector multi-professional services. She has undertaken a variety of Allied Health Professional leadership roles at local, regional and national level and is skilled in workforce transformation and organisational development.

Martin Hart, Assistant Director of Education, General Medical Council

Martin is Assistant Director, Education at the General Medical Council. In this role he oversees the GMC's responsibilities to promote high standards of basic medical education and training so that patients, now and in the future, can be confident they will receive safe, high quality medical care. He oversaw the 2009 review of Tomorrow's Doctors (the GMC's standards and outcomes for undergraduate medical education) and the development of the Gateways guidance (providing advice to medical schools on admitting students with disabilities). He is now leading on the development of a medical licensing assessment that would be taken by all new doctors joining the medical register with a licence to practice. He is a member of the Corporation (governor) of Oaklands College in Hertfordshire and a Governor of Abbot's Hill School, Hemel Hempstead. Prior to joining the GMC, he was Head of Commercial Policy at Ofcom, the regulator for the UK communication's industries. Earlier in his career he worked for the Independent Television Commission, the BBC and ITV. He is a Fellow of the Royal Television Society (RTS).

Professor Kamila Hawthorne, Vice Chair (Professional Development), RCGP

Professor Hawthorne is a general practitioner of 28 years' standing, and an academic medical educator. Her research interests and publications include access to health services for Black and Minority Ethnic and other disadvantaged groups in the UK (with special application to Type 2 Diabetes), the development of social responsibility in health care professionals, and equality and diversity in medical education assessments. She is Associate Dean for Medicine at the University of Surrey. Her clinical practice is in a deprived multi-ethnic inner city district of Cardiff. Her remit at the RCGP is to oversee Training, Examinations and Revalidation, Quality in general practice and Professional Development at all stages of the medical life course (from school students to retention of GPs in their last years of professional work).

Dr Mark Porter, Council Chair, BMA

Dr Mark Porter was elected as the chair of BMA Council in 2012. As the leader of the BMA he represents the views of more than 150,000 BMA members, and the medical profession as a whole. He is a consultant anaesthetist at the University Hospitals Coventry and Warwickshire NHS Trust. Appointed in 1998, with a focus on obstetric anaesthesia, he also practises in general emergencies including at night and weekends. He was the chair of the hospital's medical staff local negotiating committee from 2007-12. He was a clinical director of his department from 2000-02 and had an important part in designing and occupying the acute care areas of the new hospital build. Mark was appointed as Honorary Colonel of 202 (Midlands) Field Hospital, Royal Army Medical Corps in 2014. He was elected to BMA Council as a consultant in 2004. Before being elected chair of Council he was chair of the BMA Consultants Committee from 2009-12, and its deputy chair responsible for pay and contracts from 2006-09. While he was a junior doctor he was the chair of the BMA Junior Doctors Committee as well as serving on Council. Mark took part in the negotiations around the New Deal in 1992, and the new specialist registrar grade in 1996. He helped negotiate the Working Time Regulations for the NHS in 1998, the 2003 consultant contract and the 2012 implementation of medical revalidation. His ambition is to re-establish medical professionalism within the NHS.

Professor Wendy Reid, Medical Director and Director of Education and Quality, Health Education England

Professor Reid MBBS FRCOG trained at the Royal Free in London and was appointed a consultant Obstetrician & Gynaecologist there prior to moving into Postgraduate Medical Education as, firstly, an Associate and then Post-Graduate Dean in London. Wendy has held several national roles including that of Clinical Advisor to the DH on the European Working Time Directive, a contributor to the Temple Report, a former Vice President of RCOG, and former President of NAMPS. Appointed as National Medical Director of Health Education England in 2013, Wendy subsequently took on the additional role of HEE's Executive Director of Education & Quality. Wendy now enjoys this multi-professional role and the opportunities it gives HEE to deliver a better healthcare workforce and health improvements to the patients and public of England through high quality education and training.

Professor Steve West, Vice-Chancellor, President and Chief Executive Officer, University of the West of England and Chair, UUK Health Education and Research Policy Network

Professor Steve West took up the post of Vice-Chancellor of the University of the West of England Bristol in 2008 at the age of 46. Steve trained as a Podiatrist and Podiatric Surgeon in London and developed his research interests in Lower Limb Biomechanics and the Diabetic Foot at King's College London. He holds a number of national and international advisory appointments in Higher Education in his discipline, healthcare policy and practice. Steve is the Chair of the West of England Academic Health Science Network (WEAHSN). He is also a Board Member of Universities UK and Chair of the Universities UK Health Education and Research Policy Network. Steve is also the Higher Education representative on the West of England Local Enterprise Partnership Board. He is President of Business West and Chair of the Bristol Chamber of Commerce and Initiative and Vice-Chair of the Confederation of British Industry (CBI) South West. Further information can be found on the VC's profile page.

All biographies provided by speakers

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The Boehringer Ingelheim group is one of the world's 20 leading pharmaceutical companies. Headquartered in Ingelheim, Germany, Boehringer Ingelheim operates globally with 142 affiliates and a total of more than 47,400 employees. The focus of the family-owned company, founded in 1885, is researching, developing, manufacturing and marketing new medications of high therapeutic value for human and veterinary medicine.

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Optimity Advisors

Optimity Advisors is an international consultancy based in Europe[i] and the USA, providing policy advisory and strategy, service and technical transformation. For over 25 years, our health policy practice has carried out numerous evaluations and impact assessments, as well as economic analysis, data analytics and data visualisation assignments. We focus on engaging collaboratively with organisations to enable them to navigate change, mitigate risk and succeed in an industry that is re-inventing itself at its very core.

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