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Health and Social Care Committee

Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce in England

Third Special Report of Session 2022–23

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Health and Social Care Committee

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

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

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The Committee's Expert Panel

1. In 2020, we established and commissioned a panel of experts (known as the Committee's Expert Panel or "Expert Panel") to evaluate—independently of us—progress the Government have made against their own commitments in different areas of health and care policy. The framework for the Panel's work was set out in our Special Report: Process for independent evaluation of progress on Government commitments (HC 663), published on 5 August 2020. The Expert Panel published its first evaluation of the Government's progress against its policy commitments in the area of maternity services in England on 6 July 2021 (HC 18), and its second evaluation of the Government's progress against its policy commitments in the area of mental health services in England on 9 December 2021 (HC 612), and its third evaluation of the Government's progress against its policy commitments in the area of cancer services on 30 March 2022 (HC 1025).

2. The Core members of the Expert Panel are Professor Dame Jane Dacre (Chair), Sir Robert Francis QC, Professor John Appleby, Professor Anita Charlesworth and Professor Stephen Peckham.

3. We asked the Expert Panel to undertake its fourth evaluation into the health and adult social care workforce in England. For this evaluation, the core Expert Panel members were joined by health and social care workforce specialists Professor Carol Atkinson, Professor Shereen Hussein, Professor Alison Leary and Professor Jill Manthorpe.

4. We thank the members of our Expert Panel for their work and the important contribution they have made in support of the Committee's scrutiny of the Department of Health and Social Care.

The Expert Panel's evaluation

5. With our agreement, the Expert Panel focussed on the following commitments:

- Planning for the workforce: Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs.
- Building a skilled workforce: Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead; £1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities; Supporting moves towards prevention and support, we will go faster for community-based staff. Over the next three years we want all staff working in the community to have access to mobile digital services, including the patient's care record and plan, that will help them to perform their role. This will allow them to increase both the amount

of time they can spend with patients and the number of patients they can see. Ambulance services will also have access to the digital tools that they need to reduce avoidable conveyance to A&E.

- Wellbeing at work: Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services; Reduce bullying rates in the NHS which are far too high; Listen to the views of social care staff to learn how we can better support them–individually and collectively.

6. The Expert Panel's evaluation is appended to this Report. Although its evaluation was undertaken without input from the Committee, we expect the Department to respond to it within the standard two-month period for responses to Select Committee reports.

The Health and Social Care Committee's Expert Panel:

Evaluation of Government's commitments in the area of the health and social care workforce in England

Introduction

Governments often make well-publicised policy commitments with good intentions to improve services for the public. While such policy commitments can be made frequently, it is often difficult to evaluate or monitor the extent to which these commitments have been, or are on track to be, met. For this reason, formal processes of evaluation and review are essential, not only to hold the Government to account, but to allow those responsible for policy implementation to critically appraise their own progress; identify areas for future focus; and to foster a culture of learning and improvement. Such a process can also promote improvements in the quality of the commitments made.

Improvement and review are iterative processes during which the impact and success of innovations are identified, modified, and reviewed and this is already in good use within the NHS. The concept has also been used successfully in education, by OFSTED, and in health and social care, by the Care Quality Commission (CQC). To apply this approach to health policy, the House of Commons Health and Social Care Select Committee established a panel of experts to support its constitutional role in scrutinising the work of the Government. The Panel is chaired by Professor Dame Jane Dacre DBE, and is responsible for conducting politically impartial evaluations of Government commitments in different areas of health and social care policy. The Panel's evaluations are independent from the work of the Committee.

The Expert Panel produces a report after each evaluation which is sent to the Committee to review. The Panel's report is independent but published alongside the Committee's own report. The final report includes a rating of the progress the Government have made against achieving their own commitments. This is based on the "Anchor Statements" (see Annex A) set out by the Committee. The intention is to identify instances of successful implementation of Government pledges in health and social care as well as areas where improvement is necessary and to provide explanation and further context.

The overall aim is to use this evidence-based scrutiny to feedback to those making promises so that they can assess whether their commitments are on track to be met and to ensure support for resourcing and implementation was, or will be, provided to match the Government's aspirations. It is hoped that this process will promote learning about what makes an effective commitment, identify how commitments are most usefully monitored, and ultimately improve health and social care.

Where appropriate, the Panel will revisit and review policy commitments to encourage sustained progress. The Expert Panel's remit is to assess progress against the Government's key commitments for the health and care system rather than to make policy recommendations. This is the fourth report of the Expert Panel and evaluates the Government's commitments in the area of the health and social care workforce in England.

During our roundtable with stakeholders, we heard that the term "service user" was not a preferred term in the social care sector, and that we should instead refer to those receiving social care as "people in receipt of social care". We have therefore chosen to do so in the text but quotes and statistics which use the term "service user" will appear in the text

where they have done so in the original sources. Children's social care services were not included within the scope for evaluation. Therefore, in this report, when we state social care, we are referring to adult social care

Members of the Expert Panel

The Expert Panel is chaired by Professor Dame Jane Dacre DBE and is comprised of core members and subject specialists. Core panel members were recruited for their generic expertise in policy, with a broad understanding of qualitative and quantitative research methods, and the evaluation of evidence. Subject specialists were recruited to bring direct experience and expertise to the area under evaluation by the Expert Panel. All Expert Panel members have been officially appointed by the House of Commons Health and Social Care Select Committee.

Core members of the Expert Panel are:

- Professor John Appleby,
- Professor Anita Charlesworth CBE,
- Sir Robert Francis QC, and
- Professor Stephen Peckham.

Health and social care workforce specialist members of the Expert Panel are:

- Professor Carol Atkinson, Director of Research Faculty of Business and Law, Manchester Metropolitan University
- Professor Shereen Hussein, Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine
- Professor Alison Leary MBE, Chair of Healthcare and Workforce Modelling, London South Bank University
- Professor Jill Manthorpe CBE, Director of the NIHR Policy Research Unit in Health & Social Care Workforce, King's College London

Further information on the Expert Panel is set out in the Health and Social Care Committee Special Report: Process for independent evaluation of progress on Government commitments (5 August 2020).[1] The latest information relating to the Expert Panel can be found here: The Health and Social Care Committee's Expert Panel (shorthandstories.com)

Members of the Expert Panel secretariat:

- Siobhan Conway
- Nicola Fisher
- Sandy Gill

1 The Health and Social Care Select Committee, Process for independent evaluation of progress on Government commitments HC 663 (August 2020)

- James McQuade
- Yohanna Sallberg

Acknowledgements:

We would like to thank the Department of Health and Social Care, NHS England & Improvement and Health Education England for their engagement with our evaluation. We would like to extend our thanks to those who have supported our work, and especially those who took part in our roundtable discussions. The testimonies they provided have been a great asset in our evaluation process, and we thank them for their involvement and their honesty. We would also like to thank the various organisations, interest groups and individuals who provided written evidence to our evaluation, and for the quality and detail of their submissions. These submissions made a significant contribution to the Panel's evaluation of the health and social care workforce.

Executive summary

The Health and Social Care Committee commissioned a review of the evidence for the effective implementation and appropriateness of the Government's policy commitments relating to the health and social care workforce in England. This report has been produced independently of the Committee's inquiry 'Workforce: recruitment, training and retention in health and social care'. Our findings and ratings have, however, contributed to the Committee's inquiry on this topic.

The Expert Panel consists of members with recognised expertise in quantitative and qualitative research methods, and policy evaluation. This core group was complemented by experts with research expertise in, and practical experience being a part of, the health and social care workforce.

Evaluations and judgements in this report are summarised by ratings which assess the Government's progress against specific commitments made regarding the health and social care workforce. While these ratings are in the style used by national bodies such as the Care Quality Commission (CQC), the ratings in this report have been determined by us and do not reflect the opinion of the CQC or any other external agency. The commitments under review are interconnected, allowing an overall rating to be made which forms a combined assessment against all the commitments we evaluated. Separate ratings have also been given to each commitment and its main questions. All ratings are informed by a review process using a combination of established research methods, expert consensus, and consultation with communities.

Published data and other sources of evidence, including written submissions from stakeholders, and roundtable discussions have been used to provide evidence for review by the Expert Panel, and these are referenced in footnotes throughout the report. The Department of Health and Social Care and relevant non-departmental public bodies were invited to contribute to the evaluation.

Selected Commitments

The Department of Health and Social Care provided the Expert Panel with its main policy commitments in the area of the health and social care workforce in England. Using this information and wider policy documentation, we identified seven commitments across three broad policy areas. These included important and measurable ambitions for improvements for the health and social care workforce. The Expert Panel considers these commitments to provide reasonable generalisable evidence of progress against policy aspirations in the broader area of the health and social care workforce. The Expert Panel evaluated the Government's progress against these commitments. The commitments we have chosen to examine are:

Policy Area	Government Commitment
Planning for the workforce	Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs.

Policy Area	Government Commitment
Building a skilled workforce	Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead. £1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities. Supporting moves towards prevention and support, we will go faster for community-based staff. Over the next three years we want all staff working in the community to have access to mobile digital services, including the patient's care record and plan, that will help them to perform their role. This will allow them to increase both the amount of time they can spend with patients and the number of patients they can see. Ambulance services will also have access to the digital tools that they need to reduce avoidable conveyance to A&E.
Wellbeing at work	Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services. Reduce bullying rates in the NHS which are far too high. Listen to the views of social care staff to learn how we can better support them–individually and collectively.

For each commitment under review, the Health and Social Care Committee approved the main questions to guide the Expert Panel's evaluation. The Expert Panel then developed a set of sub-questions relating to specific areas of the commitment. These main questions and sub-questions were incorporated into a final framework referred to as the Expert Panel's planning grid. We invited the Department of Health and Social Care to respond to all main questions and sub-questions in the planning grid in its written response.

The Expert Panel used the key questions in the planning grid, as well as its own thematic analysis of 70 written submissions, publicly available data, and transcripts from stakeholder roundtables with 58 participants as the basis for this evaluation. Where we have used quotes from the roundtable discussions these are referenced as 'Stakeholder roundtable'. A complete list of the transcripts with hyperlinks to where they are uploaded on the Health and Social Care Select Committee's website are provided in Annex C.

The main questions set out in the planning grid are:[2]

- Was the commitment met overall? Or is the commitment on track to be met?
- Was the commitment effectively funded (or resourced)?
- Did the commitment achieve a positive impact for patients and service users (referred to throughout the report as people in receipt of social care)?
- Was it an appropriate commitment?

2 First Special Report of Session 2019–21: Process for independent evaluation of progress on Government commitments (July 2020), p. 3

The ratings for the seven commitments within the three policy areas and main questions were used to inform the Panel's overall rating for the area of the health and social care workforce. The ratings for each of the seven commitments in the three policy areas are summarised in the following table.

Overall rating across all commitments

Inadequate

Planning for the workforce

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs.	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate

Building the workforce

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead.	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Requires improvement
£1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities.	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Supporting moves towards prevention and support, we will go faster for community-based staff. Over the next three years we want all staff working in the community to have access to mobile digital services, including the patient's care record and plan, that will help them to perform their role. This will allow them to increase both the amount of time they can spend with patients and the number of patients they can see. Ambulance services will also have access to the digital tools that they need to reduce avoidable conveyance to A&E.	Requires Improvement	Requires improvement	Inadequate	Inadequate	Inadequate

Wellbeing at work

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services.	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement

Reduce bullying rates in the NHS which are far too high.	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate
Listen to the views of social care staff to learn how we can better support them – individually and collectively.	Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate

The overall rating for the seven commitments across the three policy areas evaluated is: Inadequate

This rating relates to how the Government have progressed overall against seven commitments across three policy areas based on guidance outlined in the anchor statements (Annex A) set out by the Health and Social Care Committee.

Since the Expert Panel was created, workforce has featured in each of our evaluations. Set out below are the ratings on the workforce related commitments from our previous evaluations. None of these have received a "Good" rating overall. Maternity services and mental health services received a rating of requires improvement whilst cancer services received inadequate.

Maternity services

"Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm."[3]	Overall: Requires Improvement
Target met	Inadequate
Funding/resource	Requires improvement
Impact on patients	Inadequate
Appropriateness	Requires improvement

Requires Improvement

Mental health services

"We are committed to growing the mental health workforce to achieve the ambitions set out in the NHS Long Term Plan"[4]	Overall: Requires Improvement

3 The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England, June 2021 HC18

4 The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England, November 2021 HC612

Target met	Requires improvement
Funding/resource	Requires improvement
Impact on patients	Requires improvement
Appropriateness	Requires improvement

Inadequate

Cancer services

"The Cancer Workforce Plan committed to the expansion of capacity and skills by 2021"[5]	Overall: Inadequate
Target met	Good
Funding/resource	Inadequate
Impact on patients	Requires improvement
Appropriateness	Inadequate

As we considered which commitments we were going to evaluate as part of this evaluation, we reflected on these themes which had been prevalent in our previous work. A running theme that emerged throughout our evaluations to date has been a lack of workforce planning. This in turn has led to issues with workforce shortages with subsequent impacts on the safety of people in receipt of health and social care and quality of care. Concerns around training, progression and development of staff were also frequently cited. What also became clear was that staff wellbeing suffers when there are not enough staff, and when staff do not feel valued, recognised, and renumerated appropriately. Poor behaviour amongst staff is a major issue, especially in the NHS, where bullying rates remain very high. Discrimination and harassment stemming from the race, gender, and sexuality of staff are an issue which we have chosen to highlight when looking at the overarching inequalities in the workforce in the final chapter of this report.

Apparent throughout the evaluation was the interconnected nature of planning for and building a skilled workforce, and staff wellbeing. We observe that in addition to the comments made in the planning chapter, workforce shortages have had a negative impact on all the commitments we evaluated. This is noted in the narrative, but we have been careful to assess each commitment in its own right, to prevent workforce shortages having undue influence on the other commitments. Although we evaluated these areas independently for practical reasons, the evidence we received (both written and from our stakeholder roundtables) clearly indicated that they influence and impact each other for both health and social care.

Throughout this evaluation it was also clear that the fragmented provider sector in social care compounds difficulties in evaluating the workforce. The sector is composed of thousands of independent sector home, domiciliary care agencies and residential

5 The Health and Social Care Committee's Expert Panel: evaluation of the Government's commitments in the area of cancer services in England, March 2022 HC1025

care providers among others, which are mainly for-profit companies. Social care is the responsibility of a local authority who independently decide what they will spend on social care. However local authorities do not commission all social care services, as services can be bought directly by people in need of care and their families. It was challenging to assess the experience of social care staff, due to the lack of workforce wide surveys like the one which exists for NHS staff. The fragmentation of the social care sector was highlighted as a barrier to ensuring that adequate training and career progression are provided consistently, and there was widespread concern regarding the lack of pay and recognition across the social care workforce.

The Covid-19 pandemic presented substantive issues for the health and social care workforces, and it is more urgent than ever to ensure that the planning for, development of skills, and wellbeing of both workforces is properly addressed. We recognise that the three policy areas we have evaluated had challenges prior to the pandemic, and that Covid-19 has exacerbated this.

We want to put on record our recognition of the incredible contribution from all health and social care services who have worked tirelessly during the pandemic, and continue to do so, under extremely challenging circumstances.

The rationale to support the rating and our findings are summarised below.

Planning for the workforce

Commitment: Ensure that the NHS and social care system have the nurses, midwives, doctors, carers, and other health professionals that it needs (inadequate)

- Despite some of the Government targets set for the health workforce being met, these do not seem to have been underpinned by demand modelling. We saw no evidence indicating that targets for staff numbers were linked with patient and service need. Social care stakeholders told us that there was scant evidence of workforce planning at a local or national level. Workforce planning was considered an unaddressed afterthought by Government, which was exacerbating the recruitment and retention crisis in the sectors.

- The Government has failed to provide adequate funding and resources to support workforce planning. HEE's budget is limited and set annually which impedes organisations' ability to make long-term provisions for addressing workforce planning. This results in a lack of sustainability to address pressures facing the sector. Social care stakeholders highlighted the lack of long-term funding, and funds that are made available are often short-term, have complex accessibility and ultimately, are not having the desired impact on the front-line of service provision.

- Workforce targets do not seem to be linked to service demand, and until they are, there will only ever be a limited impact on patients and people in receipt of care. Stakeholders stated that a lack of adequate workforce planning risks having

a severe impact on patients and those in receipt of care. This included safety and quality of care and the system's ability to deal with the health and care backlog generated during the Covid-19 pandemic.

- The lack of attention given to all parts of both the health and care workforce means that the ability to integrate care to maximise quality and safety is inhibited. This commitment has been undermined by a notable absence of addressing retention of the workforce. The targets themselves fell short of addressing in full the fundamental principles of being specific, measurable, achievable, relevant and time bound (SMART), and targets often lack transparency and clarity.

Building a skilled workforce

Commitment 1: Help the million and more NHS clinicians and support staff develop the skills they need, and the NHS requires in the decades ahead (Requires Improvement)

- The lack of appropriate workforce planning was recognised to negatively impact on the training and development of staff. Stakeholder evidence suggested that organisations sometimes struggle to release staff from clinical duties to complete mandatory training. Even when organisations can offer additional training, workforce shortages often prevent individuals from being able to attend. Evidence also indicated that there is unequal access to and investment in integrated training between professions and roles, which impacts co-ordinated care approaches.

- The training and development of staff is inhibited by the lack of sustained long-term funding. HEE's annually announced budget saw a real terms reduction between 2013/14 and 2019/20 despite a larger workforce, which inhibits organisations' ability to plan development opportunities appropriately and effectively. We did not receive evidence that the funding which has been made available for continuing professional development was based on demand modelling, which made it challenging to determine if the amount provided is and has been sufficient to meet professional and service need. The challenge of releasing staff to access training was identified as a barrier by stakeholders, highlighting that it is not just about providing money for development but enabling a system which can foster opportunity.

- Stakeholders were positive that the training and development of staff supports delivery of care and staff wellbeing and retention. However, stakeholder evidence suggested that there is a lack of training and development for support staff and inconsistent access for staff across professions and within specialities to access development opportunities, which is further compounded by a lack of protected time to undertake training. A positive impact on patients will only be achieved if training and development needs are considered on a systematic, interconnected and interprofessional level.

- There is no doubt that a focus on training and developing staff is important. However, this commitment lacks specificity of what it would deliver, to who, how, and deadlines for implementation. We also concluded that there needs

to be a broader consideration of the development needs for all parts of the workforce, supported by equal distribution of resources. Stakeholders told us that training strategies should consider the needs of different geographic areas and the demographics within them to reduce health inequalities, which this commitment fails to address.

Commitment 2: £1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities (Inadequate)

- The Government was not able to give us a breakdown of spending for social care, and therefore demonstrate how the £1 billion was spent on more social care staff, better infrastructure, technology, and facilities. Instead, the Government provided evidence on overall spending in the social care sector and highlighted the adult social care precept which local authorities[6] can utilise to spend on social care.

- Stakeholders suggested that as this commitment does not come with ring-fenced funding for the specific spending areas, which risks the money being spent on maintaining services, rather than supporting and developing staff.

- Service providers submitted evidence indicating that it is increasingly difficult to recruit and retain staff in the social care sector. According to the Government's own survey of providers, the main reason for staff leaving is due to there being other jobs outside the sector which have better pay. Better infrastructure and technology rely on trained staff to manage and operate it, and it is difficult to conclude that such initiatives can be successful without increased investment in staff.

- Evidence from stakeholders suggests that social care staff are leaving the sector for jobs in hospitality and retail, where they will have access to better pay and conditions. Workforce shortages and an inability to deliver care in the community and in care facilities will prevent people in receipt of care from receiving the type of care they need, and will inevitably lead to a higher bed occupancy rate in hospitals, which has a negative effect on the whole health and care system.

- Stakeholders told us that this commitment was too ambitious in what it sought to achieve in relation to the funding the Government had allocated to it.

6 In this report, local authorities or local authority are the terms used to denote the upper tier responsibility of local government. Stakeholder evidence has sometimes used the term 'council' when referring to this level of responsibility, but the two terms here mean the same thing.

Commitment 3: Supporting moves towards prevention and support, we will go faster for community-based staff. Over the next three years we want all staff working in the community to have access to mobile digital services, including the patient's care record and plan, that will help them to perform their role. This will allow them to increase both the amount of time they can spend with patients and the number of patients they can see. Ambulance services will also have access to the digital tools that they need to reduce avoidable conveyance to A&E (Inadequate)

- The potential use of digital tools was welcomed; however, access is patchy, amounting to a post-code lottery. This is compounded by insufficient interoperability of systems between sectors which impacts the ability of staff to deliver joined up care. Issues highlighted by stakeholders were that new systems are not being aligned to digital records, resulting in duplication of work, and were often not shared throughout the sectors.

- Staff need to be supported and trained to ensure that any digital tool or service is used appropriately and effectively, but there needs to be enough staff in the first instance to enable these services to be successful. There are long-standing issues with IT systems, which impact connections between community services and other sectors, and funding provisions can be restrictive, which impairs integrated working.

- Insufficient IT and digital infrastructures currently impair the benefits that stakeholders consider would be possible for patients. Patient safety concerns were raised in relation to the lack of access to GP medical records for those outside a GP practice such as dentists. We also received evidence that limited access to technology and impaired digital literacy are widening the health-inequalities divide for those from socially deprived areas.

- There currently appears to be very little understanding from the Government about the implications of introducing technology on staff. The evidence we received indicated that there is an unrecognised impact of using digital tools on staff and their working practices. Evidence, both written and oral, indicated that there are negative implications for staff wellbeing, increasing replication of work and ergonomic issues that come with using technology.

Wellbeing at work

Commitment 1: Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services (Requires Improvement)

- The Government recognises the vital importance of ensuring staff have access to the support they need but does not seem to recognise the role it has in ensuring staff have a work environment that minimises the risk of poor mental health or musculoskeletal (MSK) injuries as a result.

- Stakeholders told us about a workforce that is battling "chronic excessive workloads", and although Government interventions and wellbeing provisions were welcomed, there was a frustration over the lack of willingness to treat the underlying cause of many of the issues - the workload.
- The 2021 NHS Staff Survey paints an extremely worrying picture of staff wellbeing. Nearly half (46.8%) of staff state that they have felt unwell because of work-related stress, and almost a third (30.8%) of staff experienced MSK problems due to work activities. This suggests to us that there is still work to be done to ensure that NHS staff have timely access to services and the support that they require.
- With so many staff struggling with poor mental health or MSK related injuries due to their work, it is impossible to not conclude that unless this is tackled, it will have an inevitable negative impact on patient care and safety.
- This commitment, although commendable in intent, does not set out targets or deadlines or specify what kind of support staff will be entitled to.

Commitment 2: Reduce bullying rates in the NHS which are far too high (Inadequate)

- Rates of bullying, harassment and abuse in the NHS remain concerningly high. According to the NHS Staff Survey 2021, more than 1 in 4 (27.5%) NHS staff have experienced at least one incident of bullying in the preceding 12 months.
- Staff working in ambulance trusts were overrepresented in statistics of staff who had been subjected to harassment, bullying and abuse and to violent attacks. Statistics presented by the #WorkWithoutFear campaign shows that members of ambulance staff are attacked or abused, on average, 32 times a day.
- Although the NHS estimates that bullying costs the organisation over £2 billion a year, the investment in tackling it falls woefully short of being enough for the task at hand. Much of the evidence we have received points to bullying and poor behaviour often stemming from bad work environments and being a structural or systemic issues, rather than isolated incidents.
- Bullying and poor behaviour within staff teams has a detrimental effect on patient care, and actively puts patients at risk. It also negatively effects retention of staff, which creates gaps in the workforce and risks disrupting patient care.
- The evidence we have received clearly stresses the magnitude of the issue, but also the complexity of it. A "one-size fits all" approach of the toolkit created by the Government risks being too general in nature and overlooks the structural issues often hindering positive progress in tackling bullying.
- Initiatives aimed at tackling bullying need to be accompanied with consideration of the working environment and conditions. Staff need to have decent working conditions, a sustainable workload and get adequate rest. Staff who are over-worked, tired, hungry, and stressed are more likely to display poor behaviour.

Commitment 3: Listen to the views of social care staff to learn how we can better support them–individually and collectively (Inadequate)

- There is no national data collection of social care staff wellbeing or views, which is the case for NHS staff. Stakeholders cited the fragmented nature of the social care sector as a major challenge in collecting views to better understand this section of the workforce.
- Low pay, lack of recognition for the work that they do, and poor working conditions were identified by stakeholders as some of the primary issues facing the social care workforce. Stakeholders did not consider the Government's attempt to listen to staff views to be adequate.
- The challenges the sector is experiencing in recruiting and retaining staff is becoming increasingly more urgent. A survey carried out by the Association of Directors of Adult Social Services found that almost 170,000 hours of home care could not be delivered in the first three months of 2022 due to staff shortages.
- We are extremely concerned how this staff crisis in the social care sector is impacting on those in receipt of care. We did not receive any evidence of long-term mechanisms or processes put in place by the Government to listen to the views of social care staff, and what had previously been done regarding engagement ahead of the formulation of the social care White Paper 'People at the Heart of Care' clearly does not meet the commitment.

Method of Evaluation

Our overall approach to this evaluation was to review quantitative and qualitative data provided by the Department, alongside relevant research evidence, to establish causative links, as well as evidence from other sources via a call for written submissions. We also heard from health and social care professionals, patients and people in receipt of social care and advocates.

Our approach was not a formal technical evaluation of the impact of different interventions on the policy aspirations and should not be viewed as a substitute for Government commissioned evaluations via the National Institute for Health Research (NIHR). We received a formal response to the planning grid from the Department on 17 May 2022 (further description of the planning grid can be found in the executive summary). This response, along with information gathered during subsequent meetings, forms the basis for this report. Evidence (such as reports and published papers) from several non-governmental sources was also reviewed. Key stakeholders were identified and invited to submit their own written response to the planning grid. Responses were analysed using a framework method for qualitative analysis in health policy research.[7] The integration process of all quantitative and qualitative evidence was based on Pawson's 'realist synthesis' framework of evaluating policy implementation in healthcare settings.[8]

7 Gale, N.K., Heath, G., Cameron, E., Rashid, S., and Redwood, S. "Using the framework method for the analysis of qualitative data in multi-disciplinary health research", BMC Medical Research Methodology, vol 13 (2013) pp. 1–8

8 Pawson R. 'Evidence-based Policy: The Promise of `Realist Synthesis''. Evaluation, vol 8(3), (2002) pp. 340–358; Pawson, R., Greenhalgh, T., Harvey, G., and Walshe, K. "Realist review—a new method of systematic review designed for complex policy interventions". Journal of Health Services Research and Policy, vol 10 (2005) pp. 21–34

A full list of the written evidence we received is included at the end of the report (see Annex B).

Evidence from the Department

- Additional written information received from the Department
- Meeting with the Department, NHSE/I and HEE officials

Evidence from stakeholders:

- 70 written submissions

Roundtable discussions

- Roundtable discussions with 58 participants with practical experience of working in health and social care, patients or people in receipt of social care and advocates for patients and people in receipt of social care groups.

This report provides an analysis of all information provided. The analysis is structured around the three overall policy areas which covered seven individual commitments, and the main questions within each commitment.

1 Planning for the workforce

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
"Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs."	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate

In this section we provide an assessment of the Government's commitment on workforce planning. The following commitment was selected for evaluation:

"Ensure that the NHS and social care system have the nurses, midwives, doctors, carers, and other health professionals that it needs."[9]

Overall Commitment Rating and Overview of the Planning for the workforce commitment: Inadequate

The NHS Long Term Plan considers that the performance of the healthcare system is underpinned by the people that work within it.[10] The Health and Care Act 2022 received Royal Assent on 28 April 2022. The Act includes duty on the Secretary of State for Health and Social Care to at least once every 5 years publish a report on the system for assessing and meeting the workforce needs of the health service in England.[11] However, this duty does not extend to the social care workforce, and currently, there is not a specific national organisation that is tasked with NHS or social care workforce planning. Organisations such as Skills for Health, Skills for Care, NHS England and Improvement (NHSE/I) and Health Education England (HEE) all have a role but none of these bodies holds the overall responsibility for health and social care workforce planning in England.

The Health and Care Act 2022 legislated for a merger of NHSE/I and HEE, to create one body to align workforce, financial and service planning with education and training.[12] Currently no official date has been announced for completion of this merger. The Health Service Journal reported it is intended to be completed by the end of April 2023.[13] At present the merger is on-going and there is not a clear indication of how this will impact workforce planning directly in the future.

Under the Health and Care Act 2022, Integrated Care Systems (ICSs) have been created, which bring together to some extent NHS, local authority and third sector bodies, who hold responsibility for the resources of an area or 'system'. ICSs became statutory bodies

9 The Conservative and Unionist Party Manifesto, 2017, p.66
10 NHS England, NHS Long term Plan, January 2019
11 Health and Care Act 2022, section 41
12 HEE, Update on DHSC announcement of merger between HEE and NHSE/I, December 2021
13 Health Service Journal, Exclusive: Health Education England to be merged into NSHE, November 2021

in July 2022, which means that they are defined by law and have formal requirements for governance.[14] There are 42 ICSs covering every area of England. Two bodies make up an ICS, an Integrated Care Board (ICB), responsible for NHS services and funding, and an Integrated Care Partnership (ICP), covering broader subjects including social care. Collectively these two committees or collections of stakeholders are intended to oversee and support workforce planning within Place-Based Partnerships (PBPs). PBPs are smaller governance structures which focus on a locality within an ICS. PBPs are collaborative arrangements formed by organisations within that locality responsible for arranging and delivering health and care services including Primary Care Networks, which are groups of GP practices that work alongside other services in the community, district councils (operating in some two-tier counties) and NHS Hospital Trusts.[15]

During the passage of the Health and Care Bill, prior to it becoming an Act in April 2022, several amendments were tabled in both Houses of Parliament calling for the Secretary of State for Health and Social Care to publish regular projections for workforce numbers needed to meet demand. The amendments called for a workforce plan to be published every two years based on economic forecasting by the Office for Budget Responsibility. The Royal College of Physicians concluded that "Without it, the bill will fail to address the biggest challenge facing the NHS and social care–staffing shortages and pressures".[16] One hundred healthcare organisations wrote a letter in support of the suggestions put forward through the amendments.[17] The amendments were not passed by Parliament. In the debate on the Bill, the Government pointed to what is now section 41 of the Act which sets out a duty on the Secretary of State to report on workforce systems and that it therefore was not necessary to impose further or different reporting duties on workforce planning.[18]

The evidence we received suggested that there was a lack of cohesive and comprehensive workforce planning for social care, and Care England argued social care workforce planning was an "unaddressed afterthought".[19] This is despite the adult social care workforce comprising around 1.54 million people, of whom 1.2 million are in full-time equivalent jobs, which is similar to the size of the NHS workforce.[20]

In a March 2022 NHS Providers survey of Trust leaders,[21] respondents did not believe that the NHS had a robust plan nationally for tackling workforce shortages in the short to medium, or long term (89% and 88% of survey respondents respectively).[22] The NHS Confederation were positive towards the prospect of forthcoming strategies such as the revised Framework 15 and the new NHSE/I and HEE workforce strategy.[23] The revised Framework 15, produced by HEE, was commissioned in July 2021. Its aim is to review the long-term strategic trends that impact workforce planning, but not specific workforce

14 NHS England, What are integrated care systems?, accessed 20 June 2022
15 The King's Fund, Integrated care systems: how will they work under the Health and Care Act?, May 2022
16 Royal College of Physicians, Strength in Numbers - stronger workforce planning in the health and care bill, February 2022
17 Royal College of Physicians, Strength in numbers – a stronger workforce planning in the health and care bill, February 2022
18 HC Deb, 30 March 2022, col 904 [Commons Chamber]
19 Care England (EPW0003)
20 Skills For Care, The state of the adult social care sector and workforce in England, October 2021; NHS Digital, NHS workforce statistics – February 2022, May 2022
21 236 responses from 142 Trusts, which accounts for 67% of the provider sector (212 Trusts in England)
22 NHS Providers (EPW0011); NHS Providers, Workforce planning survey 2022, March 2022
23 NHS Confederation (EPW0048)

planning numbers.[24] The social care workforce will for the first time be included (previous framework 15 publications did not cover the social care workforce) but will only include registered professionals such as nurses.[25] The National Care Forum argued that the revised Framework 15 is not an appropriate basis for an adult social care workforce plan, as its main focus is on health care professionals rather than social care professionals.[26]

The then Secretary of State for Health and Social Care, Rt Hon Sajid Javid MP, appeared before the Health and Social Care Committee on 7 June 2022. He stated that he hoped that the new HEE and NHSE/I workforce strategy would be published by the end of 2022, with a detailed breakdown of numbers for the workforce, but that this required cross-Department agreement, which he was hopeful of obtaining.[27] As noted above, multiple stakeholder have expressed their concerns over the Health and Care Act 2022 becoming law without provisions for independent workforce planning reviews, which were frequently cited as a barrier to any future progress and achievement of plans.[28]

This commitment pledges to ensure that both the health and social care systems have the staff they require. Therefore, our assessment of the Government's progress against this commitment takes in to account our evaluation of both sectors. However, we struggled to identify targets set specifically for the social care sector and had to rely on the stakeholder evidence of the experience on the ground, as well as considering social care vacancy and turnover rates. Although the progress of the commitment in relation to the NHS workforce alone would be evaluated as 'Requires Improvement', the dire situation which the social care workforce finds itself in led us to conclude that the overall rating for the commitment is 'Inadequate'.

Was the commitment met overall (or is it on track)?

Rating: Inadequate

Assessing this commitment was difficult, as it is ambitious in aspiration but lacks specific numerical targets. Therefore, as part of our analysis of the healthcare workforce, we asked stakeholders to provide their view of the Government progress in relation to the target overall, and on some of the numerical targets the Government had set regarding the health and social care workforces. These were all from the 2019 Conservative and Unionist Party manifesto,[29] apart from the increase in medical training places which was pledged in the 2017 Conservative and Unionist party manifesto[30]:

- Increase the number of students in medical training of 1500 a year,

24 HEE, HEE looking to the future for the health and social care workforce, July 2021
25 HEE, HEE looking to the future for the health and social care workforce, July 2021; HEE, Framework 15 – Health Education England Strategic Framework 2014–2029, February 2017
26 National Care Forum (EPW0033)
27 Oral evidence taken before the Health and Social Care Committee on 7 June 2022, HC (2022–23) 115, Q341 [Sajid Javid]
28 For example: NHS Providers (EPW0011); Royal College of Physicians and Surgeons of Glasgow (EPW0015); Royal College of Anaesthetists (EPW0017); National Care Forum (EPW0033); Royal College of Pathologists (EPW0034); Royal College of Surgeons of Edinburgh (EPW0038); British Medical Association (EPW0042); Cancer Research UK (EPW0043); Association of Dental Groups (EPW0040); British Society for Haematology (EPW0045); NHS Confederation (EPW0048); Royal College of Midwives (EPW0061)
29 The Conservative and Unionist Party Manifesto, 2019, p.10
30 The Conservative and Unionist Party Manifesto, 2017, p.66

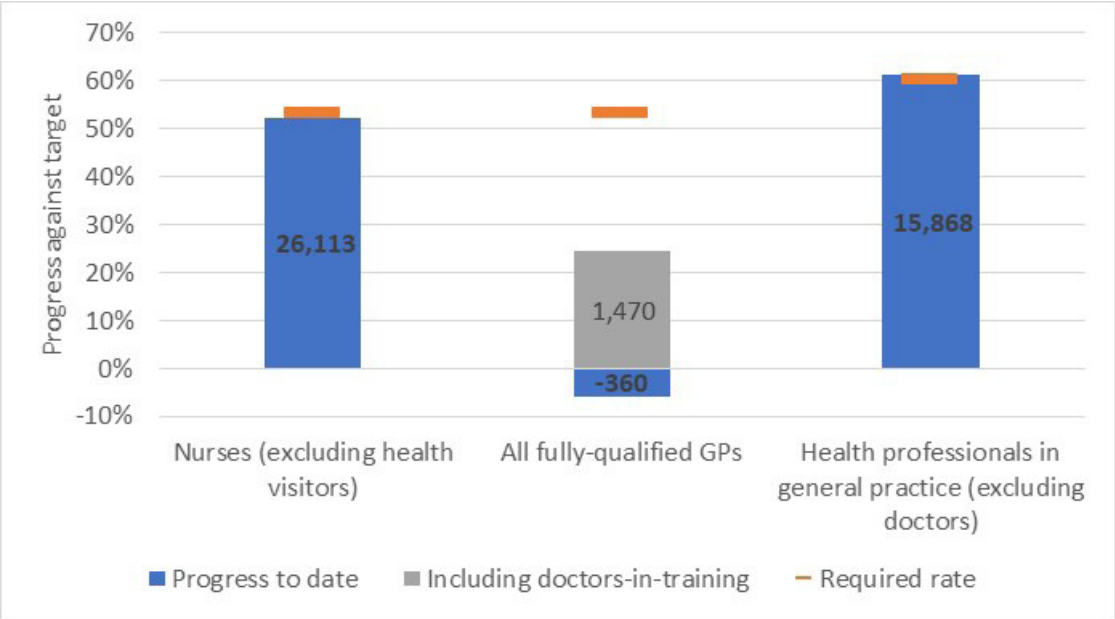
- 50,000 more nurses,
- 6,000 more doctors in general practice,
- 26,000 more primary care professionals,
- 7,500 extra nursing associates, and
- addressing the 'taper problem' in doctors' pensions.

In its response, the Government stated that workforce targets set for the NHS, apart from the 6,000 more GPs by 2024 target, were either met or on track to be met.[31] Nuffield Trust analysis shows that the NHS hospital and community health workforce in England has indeed grown by 209,501 (21%) full-time equivalent staff in the 11 years to 2022.[32] We recognise that while workforce targets may be met in principle or be on track to be met, many stakeholders characterised the targets as inadequate, inappropriate and insufficiently ambitious.[33] We have not received any evidence indicating these targets were based on demand modelling, and therefore are unable to determine if the targets are being effective.

The Government set out a target to increase the number of domestic students in medical training by 1,500 per year in England, resulting in a 25% increase over three years. In its response to the evaluation the Government states that the commitment was met in full, and that additional places were added on top of the 1,500 pledged in 2018 (an extra 630), in 2019 (an extra 690) and in 2020 (an extra 180). The Medical Schools Council argues however that the target should be 5,000 per year resulting in 14,500 qualifying doctors per year (depending on completion rates).[34] The Academy of Medical Royal Colleges Trainee Doctors' Group observed that an increase in medical undergraduate training places needs to be matched with an increase in Foundation Programme and specialty training posts to help with shortages across medical specialties.[35] Medical specialties such pathology, anaesthetists and sexual and reproductive health reported substantial vacancy levels which they argued have been over-looked in workforce planning.[36]

31 Department of Health and Social Care (EPW0062)
32 Nuffield Trust (EPW0088)
33 Dr Liz Brewster, Dr Michael Lambert, Dr Luigi Sedda, Dr Euan Lawson, Mr Barry Rowlingson, Dr Cliff Shelton and Professor Jo Rycroft Malone (EPW0007); Professor Rachel Jenkins (EPW0022); Royal College of Nursing (EPW0039)
34 Medical Schools Council, The expansion of medical student numbers in the United Kingdom, October 2021
35 Academy of Medical Royal Colleges Trainee Doctors' Group (EPW0023)
36 Royal College of Pathologists (EPW0034); Royal College of Anaesthetists (EPW0017); Faculty of Sexual and Reproductive Healthcare (EPW0029)

Figure 1: Government's progress in meeting 50,000 more nurses, 26,000 more primary care professionals and 6000 more GP target



Source: Written submission by the Nuffield Trust (EPW0088). Data up to March 2022. Non-medical general practice workforce includes those employed by Primary Care Networks (PCNs) and directly by practices.

Looking at the 50,000 more nurses, the 6,000 more GPs and the 26,000 more primary care professionals' targets specifically, there is a mixed picture (see figure 1). The Government states that the Department of Health and Social Care is currently on target to meet the 50,000 nurses manifesto commitment, with nursing numbers a little over 30,000 higher in February 2022.[37] While the number of health professionals (excluding GPs) also appear to be on track to be met, the number of fully qualified GPs has seen a net decrease.[38] Since 2016, the number of fully qualified GPs has fallen by 416.[39] Even when including doctors in training, these increases are still not sufficient to be on track to deliver 6,000 more doctors in general practice by 2024.[40]

Although the 50,000 more nurses is on track to be met, the Royal College of Nursing (RCN) and Cancer Research UK argued that there is a lack of transparency of the workforce modelling and to what extent it considers demand, which therefore meant that there was no assurance that achieving targets would be enough to improve the experience of patients and people in receipt of social care.[41] Further to this, the King's Fund states that setting targets such as the 50,000 more nurses is not having meaningful impact on the scale of nursing shortages due to increasing demand, and that achieving the 50,000 mark constitutes "hitting the target but missing the point".[42] The Nuffield Trust argues that the targets are difficult to assess and monitor due to a lack of clarity of what the base line to measure the target against is. The Nuffield Trust highlights that determining progress of the 50,000 registered nurses target began from September 2019, two months before the manifesto commitment was published. They argue that the tally of new nurses

37 Department of Health and Social Care (EPW0062)
38 Nuffield Trust (EPW0088)
39 Nuffield Trust, NHS staffing tracker, Accessed 220622
40 Nuffield Trust (EPW0088)
41 Royal College of Nursing (EPW0039); Cancer Research UK (EPW0043)
42 Kings Fund, Is the NHS on track to recruit 50,000 more nurses? Hitting the target but missing the point, April 2022

includes those who joined the permanent register between September and December 2019 (totalling 4,800 nurses), who are not 'new' nurses joining the permanent register, as they were already on training programmes and were due to graduate and enter the permanent register, regardless of the 50,000 target. As 4,800 nurses are included within the 'new' 50,000 target achievement, the Nuffield Trust has termed this as "gaming of targets".[43]

The RCN also pointed out that meeting the 50,000 more nurses target has been heavily reliant on international recruitment.[44] England has one of the highest rates of international recruitment of nurses in the OCED,[45] and recent data from the Nursing and Midwifery Council (NMC) shows that nearly half (48%) of new registered nurses in 2021/22 were trained outside the UK, which is the highest figure in two decades.[46] Concerns have been raised regarding the reliance on international recruitment, and the RCN argues that this type of workforce planning is unsustainable, and more broadly presents ethical questions about recruitment from the World Health Organisations (WHOs) red list countries.[47] Red list countries are those which have been identified as having the most severe workforce shortages and are not supposed to be targeted for systematic recruitment by the NHS or independent employers.[48]

The 50,000 more nurses' target was not inclusive of social care. Skills for Care drew attention to the recent decline of registered nursing numbers in the social care sector, down almost 17,000 jobs since 2012/13 and that registered nurses in the social care sector have a significantly higher turnover rate (38.2%) than counterparts in the NHS (8.8%).[49] Most social care staff are employed by small and medium sized private providers (around 18,200)[50] and Hospice UK argued that this provision of social care delivery is "fragmented", making workforce targets and planning particularly difficult for this sector.[51] The Nuffield Trust observed that the number of filled posts in the adult social care workforce had fallen by around 4.5% or 52,000 between March 2021 and February 2022,[52] and the Association of Directors of Adult Social Services (ADASS) stated that 170,000 hours a week of home care could not be delivered because of a shortage of care workers, a seven fold increase since Spring 2021.[53] Like many of the others who responded to our call for evidence, the Care Workers Charity called for a comprehensive workforce strategy to address workforce problems, and considered that the recent White Paper 'People at the Heart of Care' does not amount to a workforce strategy.[54] The National Care Forum described the rejected amendments for the Health and Care Act 2022 as a major missed opportunity for addressing social care workforce needs, and stated that the workforce planning needed for

43 Nuffield Trust (EPW0051)
44 Royal College of Nursing (EPW0039)
45 Health Foundation, How reliant is the NHS in England on international nurse recruitment? (health.org.uk), May 2022; The OECD stands for the Organisation for Economic Co-operation and Development, which is an international organisation consisting of 38 countries.
46 NMC, The NMC register 1 April 2021 – 31 March 2022
47 RCN, Ten-fold increase in nurse recruitment form "red list" countries, June, 2022
48 WHO, Health workforce support and safeguard list, 2020; Department of Health and Social Care, Code of practice for the international recruitment of health and social care personnel in England, November 2021
49 Skills for Care, The state of the adult social care sector and workforce in England 2021, October 2021
50 The King's Fund, Key facts and figures about adult social care, July 2021
51 Hospice UK (EPW0053)
52 Nuffield Trust (EPW0051)
53 Association of Directors of Adult Social Services (EPW0028)
54 Care Workers' Charity (EPW0025)

social care is on a far broader basis than HEE has been asked to consider.[55] The Homecare Association noted there was scant evidence of social care workforce planning at a local or national level.[56]

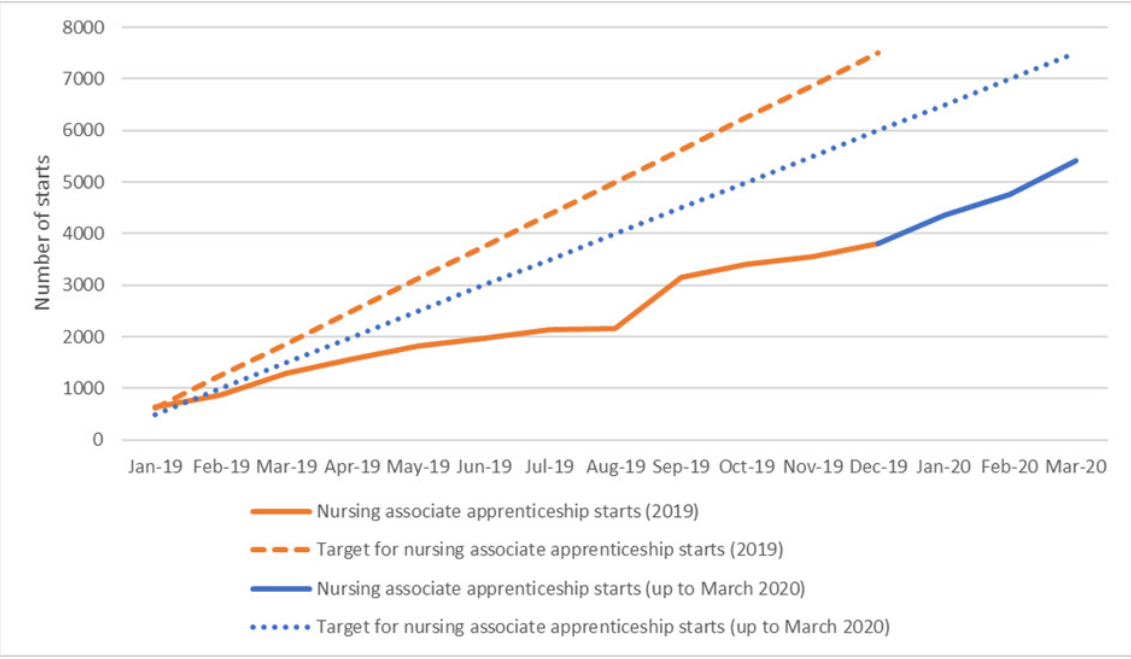
The Government's commitment to increase the number of people starting Nursing Associate apprenticeships to 7500 by 2019 was not met. The target deadline was extended to March 2020, but it was again missed. However, the Government argues that it was met "slightly later" in 2021/22. The Government's breakdown of starters each year can be found in table 1 below.

Table 1: Trainee Nursing Associates

Calendar year	Number of starts
2017	4004
2018	4577
2019	4860
2020	4232
2021	4432
Total	22105

Source: Written submission by Department of Health and Social Care (EPW0062)

Figure 2: Number of people starting Nursing Associate apprenticeships in 2019



Source: Written evidence by the Nuffield Trust (EPW0088)

55 National Care Forum (EPW0033)
56 Homecare Association (EPW0026)

Figure 2 shows the number of the number of people starting a Nursing Associate apprenticeship and includes places that have been funded through the apprenticeship levy, as well as through other means.[57]

In the NHS, doctors can access the NHS pension scheme, and there were some concerns about the impact of pension tax rules on senior clinicians and GPs.[58] One of the issues was the taper annual allowance, which works by limiting the amount of tax relief doctors get on their pension contributions, when their salary reaches a certain high threshold.[59] The Royal College of Surgeons of England argued that the pension taper was causing some doctors to reduce the number of hours they worked or retire early, impacting the retention of staff and ability to address the care backlog.[60] The target to address the issue with doctors' pension 'taper problem' has broadly been met.[61] In the Department's response to our request for evidence on the taper problem, it stated that from 6 of April 2020 the taper threshold was increased, which removed 96% of GPs and 98% of consultants from the scope of the taper.[62] However, NHS Providers and the British Medical Association (BMA) noted that while the threshold increase was welcome, there were still some underlying issues remaining including lifetime allowances which are still causing disincentives to some staff to take on additional work.[63]

However, although NHS workforce targets have broadly been met, analysis from the Health Foundation has concluded that, even if there is an increase in staff productivity and in-patient stays in hospital are shortened, the workforce will still not be able to cope with service demand.[64] Demand will remain substantial, exacerbated by the care backlog caused by the Covid-19 pandemic, however the Institute for Fiscal Studies acknowledged that the NHS was already under significant strain pre-pandemic.[65]

Stakeholder evidence from the health and social care sectors, such as NHS Providers and Methodist Homes (MHA), argued that there has been a lack of focus on retention of the workforce within targets.[66] Chronic workforce shortages were identified as a problem across professions, sectors and specialties, and evidence highlighted that the pandemic had only amplified the problems, rather than created them.[67] The ADASS observed that there were already over 110,000 social care vacancies pre-pandemic, and that the pandemic:

57 Nuffield Trust (EPW0088)
58 House of Commons Library, Pension tax rules – impact on NHS Consultants and GPs, August 2021
59 House of Commons Library, Pension tax rules – impact on NHS Consultants and GPs, August 2021
60 Royal College of Surgeons of England, Taper Trouble, June 2019
61 Department of Health and Social Care (EPW0062); NHS Providers (EPW0011)
62 Department of Health and Social Care (EPW0062)
63 NHS Providers (EPW0011); British Medical Association, End the pension tax trap for doctors, Accessed 200622
64 Health Foundation, How many NHS workers will we need over the coming decade? - The Health Foundation, May 2022
65 Institute for Fiscal Studies, Pressures on the NHS, October 2021
66 NHS Providers (EPW0011); Methodist Homes (EPW0035); Dr Carolyn Downs (EPW0001); Dr Emma Hayward (EPW0002); Prostate Cancer UK (EPW0032); Royal College of Surgeons of Edinburgh (EPW0038); Royal College of Nursing (EPW0039)
67 For example: Faculty of Sexual and Reproductive Healthcare (EPW0029); Association of Directors of Adult Social Services (EPW0028); Association of the British Pharmaceutical Industry (EPW0027); Royal College of Speech and Language Therapists (EPW0024); Academy of Medical Royal Colleges Trainee Doctors' Group (EPW0023); Professor Rachel Jenkins (EPW0022); Faculty of Intensive Care Medicine (EPW0018); Dr Emma Hayward (EPW0002); Association of Dental Groups (EPW0040); British Medical Association (EPW0042); British Society for Haematology (EPW0045); Macmillan Cancer Support (EPW0049)

> *"Exposed the fault lines which were in existence and worsening pre-pandemic."*[68]

As mentioned previously in this chapter, there was a distinct lack of targets set for the social care workforce. However, the evidence we received in relation to the social care workforce all agreed that there is a recruitment and retention crisis in the sector. Skills for Care's most recent report on the subject estimated that on average, 6.8% of roles in adult social care were vacant in 2020/21. This is equivalent to 105,000 vacancies being advertised "on an average day".[69] Evidence we received from stakeholders, including the Care Workers Charity and MHA, argued that retention in the social care sector is impacted by a lack of parity with the NHS and a lack of comparable terms and conditions, including on pay and pension arrangements.[70] Written submission and stakeholder roundtable contributions highlighted that the social care sector is often in competition with hospitality and the retail sector for staff. A statement from a director in the social care sector was cited in one of the evidence submissions we received: "I dread Aldi or Lidl opening a new store near any [of our] homes because every time four to five staff leave".[71]

Considering this commitment, we agreed its aspiration to providing the health and care system with the staff it needs was ambitious. However, the experience of stakeholders indicates that neither the health workforce nor the social care workforce currently has the staff needed to meet the demands of patients and people with care and support needs. Some targets, such as 6,000 more doctors in the General Practice workforce, have not only been missed, but is seeing a reduction in staff numbers. Therefore, we have concluded that regarding the Government's progress in meeting this commitment is 'Inadequate'.

Was the commitment effectively funded (or resourced?)

Rating: Inadequate

NHS Providers argued that HEE's annually issued budget is so limited that it forms a significant barrier to enabling employers and organisations to effectively plan for the workforce longer-term, resulting in a lack of sustainability to address the sustained pressures facing the healthcare sector.[72] Stakeholders across the health and social care sector maintained that there was a lack of long-term sustained investment to address workforce planning.[73] One stakeholder during the roundtable told us:

> *" … fundamentally the funding needs to be much more sustainable and long term reliable, not just scraping from one pot of money to another. There has been lots of different pots of funding over the last couple of years, but none of it has come with a long-term guarantee, which means that you can't do long-term planning. All you can do is use it in the here and now and then hope that something else comes along later to maybe sustain it".*[74]

68 Association of Directors of Adult Social Services (EPW0028)
69 Skills for Care, The state of the adult social care sector and workforce in England, October 2021
70 Methodist Homes (EPW0035); Care Workers' Charity (EPW0025)
71 Dr Carolyn Downs (EPW0001)
72 NHS Providers (EPW0011)
73 For example: Association of Directors of Adult Social Services (EPW0028); Royal College of Anaesthetists (EPW0017); Cancer Research UK (EPW0043); Royal College of Radiologists (EPW0056)
74 Stakeholder roundtable

There were general comments about funding for workforce planning in the evidence we received, but also on how certain specialisms are experiencing specific challenges. In its report 'Dentistry in England', the Association of Dental Groups highlighted a 10% cut in real terms of contribution of NHS funding to primary care dentistry, and stated that:

> *"Despite the Conservative Party manifesto reference "that between 2018–2023 we will have raised funding for the NHS by 29%", none of this funding has found its way to NHS Dental Services apart from an additional £50million in January 2022, which was time limited until the end of March 2022".*[75]

The NHS Confederation stated that the Additional Roles Reimbursement Scheme (ARRS) within primary care was welcomed by some stakeholders.[76] The ARRS was brought in to help fund the 26,000 more primary care professionals and enables primary care networks to recruit to roles such as clinical pharmacists, physiotherapists, physician associates and paramedics.[77] However, the Company Chemist Association argued it has had unintended consequences. It stated that the intention to recruit 6 full time equivalent clinical pharmacists per primary care network (PCN) equates to approximately 6,000–7,500 pharmacists. However, this has not been matched by corresponding efforts to train more pharmacists, and, as a result, PCN pharmacists have been drawn from existing pools. They argued that the community pharmacy sector is facing an unprecedented workforce crisis, exacerbated by PCN recruitment as a result of the ARRS.[78] The NHS Confederation stated that although additional funds in relation to the ARRS were released to support PCNs in reaching workforce targets, none of its members have been able to receive this support. It went on to state that there has been little support to embed, manage and supervise these additional roles, with no commitment to additional PCN contracts beyond 2024, which NHS Confederation states:

> *" … would lead to a chilling effect regarding recruitment and training within primary care unless this is remedied."*[79]

Social care stakeholders such as the Mortimer Society and the Residents and Relative Association (RRA) recognised the Government's Workforce Recruitment and Retention Fund allocated during the pandemic as positive, but argued this funding was in response to the increased pressures at the time, was not long term and had uneven allocation alongside complex accessibility.[80] The Care Workers Charity stated that there was a lack of sustained central Government funding and that the funds made available during the pandemic were not enough to fill the gaps in provision left by un-filled vacancies, and, moreover, that the benefits of this funding were not being felt on the front-line.[81] The Homecare Association described a mis-match of accountability of plans at local level, because mechanisms to help action these plans were based at a national level such as immigration policy, resulting in lack of progress on addressing workforce issues.[82]

75 Association of Dental Groups (EPW0040); The Conservative and Unionist Party Manifesto, 2019
76 NHS Confederation (EPW0048)
77 NHS England, Network contract directed enhanced service: additional roles reimbursement scheme guidance, December 2019
78 Company Chemists' Association (EPW0055)
79 NHS Confederation (EPW0048)
80 Dr Carolyn Downs (EPW0001); Relatives and Residents Association (EPW0008); Mortimer Society (EPW0012); Care Workers' Charity (EPW0025); Association of Directors of Adult Social Services (EPW0028)
81 Care Workers' Charity (EPW0025)
82 The Homecare Association (EPW0026)

We have concluded that due to a lack of sustained, and long-term funding for both health and social care, that this part of the commitment is inadequate.

Did the commitment achieve positive impacts for patients and people in receipt of social care?

Rating: Requires improvement

Some of the specific numerical targets set by the Government have not yet filtered through to the front-line and to patients, such as increasing medical school places, as many of those trainee doctors are not yet in practice.[83] The British Thoracic Society alongside the RCN and other stakeholders considered that the targets will only achieve meaningful impact for patients and people in receipt of social care if the targets reflected demand and service need.[84] Currently, there is no evidence to suggest that demand modelling has been used, for example, in formulating the 6,000 more GPs, and 50,000 nurses' targets.

Evidence from across the health and social care sectors highlighted that inadequate workforce planning was impairing patient or people's safety, quality of care and clearing of the backlog of work caused by the Covid-19 pandemic.[85] In their evidence, Marie Curie estimates that 160,000 more people will require palliative care by 2040, and that forecasted demand needs sufficient strategic workforce planning, which they argue is not currently the case. They pointed out that palliative care is delivered across different providers including hospices, domiciliary or home care providers, hospitals and care homes, which requires the integration of services and workforce planning across the health and social care sector. When this is not the case, it can lead to poor coordination of services and resources, which can result in "significant pain and distress" for those with palliative and end of life care needs.[86] Testimonies during our roundtable pointed to worrying trends of people in the community experiencing longer waiting times for health and care and, as a result, deterioration of their conditions or quality of life:

> *"The impact on our community is longer wait times and worsening symptoms, because Parkinson's, as I mentioned is a progressive condition. Maybe if I just end on a quote from a survey participant: "I feel abandoned by the NHS. I can't get to see my neuro-consultant for five months, and we have no dedicated specialist nurse to go for advice. My deterioration is very speedy now and it frightens me the worrying effects; the lack of sleep and the depression.""*[87]

High levels of un-met need within the social care sector were reported by the ADASS. In a May 2022 survey of its membership, the ADASS estimated that 506,131 people were waiting for assessments, reviews and/or care support to begin, and that 6 in 10 councils

83 Dr Liz Brewster, Dr Michael Lambert, Dr Luigi Sedda, Dr Euan Lawson, Mr Barry Rowlingson, Dr Cliff Shelton and Professor Jo Rycroft Malone (EPW0007); Royal College of Surgeons of Edinburgh (EPW0038)

84 British Thoracic Society (EPW0009); Professor Rachel Jenkins (EPW0022); Royal College of Surgeons of Edinburgh (EPW0038); Royal College of Nursing (EPW0039); UNISON (EPW0047); Nuffield Trust (EPW0051); Royal College of Radiologists (EPW0056)

85 For example: Dr Carolyn Downs (EPW0001); Dr Emma Hayward (EPW0002); Dr Liz Brewster, Dr Michael Lambert, Dr Luigi Sedda, Dr Euan Lawson, Mr Barry Rowlingson, Dr Cliff Shelton and Professor Jo Rycroft Malone (EPW0007); NHS Providers (EPW0011); Royal College of Anaesthetists (EPW0017); Royal College of Speech and Language Therapists (EPW0024); Homecare Association (EPW0026); Chartered Society of Physiotherapy (EPW0058)

86 Marie Curie (EPW0060)

87 Stakeholder round table

were only able to respond to assessment requests, for example, for hospital discharge, or where abuse or neglect concerns were highlighted.[88] Even where care is being provided, there are problems. Skills for Care's report on the Adult Social Care workforce concluded that registered care providers with the lowest Care Quality Commission scores had more problems retaining staff (an average turnover rate of 33.7%), compared to those with the highest scores which had an average (and still excessively very high) turnover of 29.2%.[89]

The British Association of Dermatology stated that delays in diagnosis and inequitable access to good care caused by workforce shortages are having an impact on people's quality of life.[90] The Royal College of Radiologists raised further patient safety concerns regarding workforce shortages and the ability to provide safe cancer care, pointing to 58% of respondents who, in a recent survey, stated that they lack enough staff to provide safe cancer care.[91] The Royal College of Anaesthetists highlight that:

> *"Due to factors such as an ageing and increasingly co-morbid population, demand for surgery and hence for anaesthetists, is set to increase dramatically. Based on workforce projections from the York Health Economic Consortium (YHEC), we estimate the NHS will face a staggering shortfall of 11,000 anaesthetic staff by 2040. This will prevent over 8 million operations or procedures from taking place per year."*[92]

Therefore, until workforce targets are linked to patient and population demand, we consider that this will only ever achieve a limited positive impact on patients and people with care and support needs. We therefore conclude that the impact of this commitment on patients and people with care and support needs requires improvement.

Was it an appropriate commitment?

Rating: Requires improvement

Stakeholders such as the Nuffield Trust, RCN and BMA consider that while this commitment, on the surface, was appropriate, the effectiveness of it was undermined by lack of specific investment and absence of long-term workforce projections.[93]

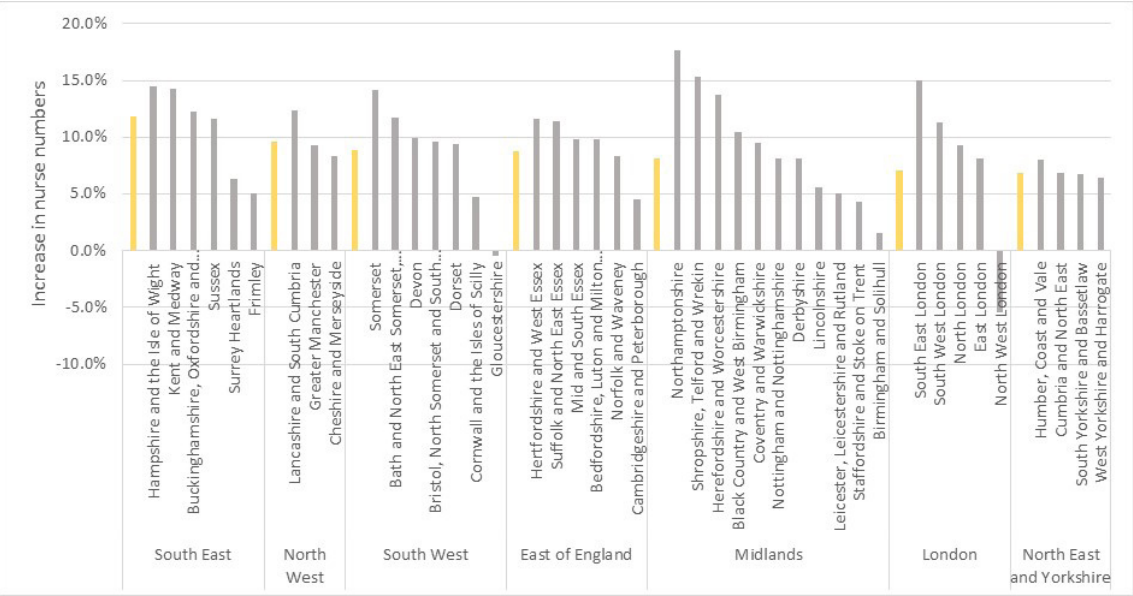
The Royal College of Speech and Language Therapy and Chartered Society for Physiotherapists pointed to a lack of specific targets and workforce planning for allied health professionals (AHPs). Both organisations argued that declining workforce numbers, and the lack of attention paid to other parts of the healthcare workforce such as AHPs is impairing the ability to integrate care to maximise patient care and safety.[94] The lack of distinction within the 26,000 primary care professionals target was also considered inappropriate. Primary care covers a broad range of professions, and, for example, it was considered a significant missed opportunity to provide more focus on dentists. Dentistry

88 Association of Directors of Adult Social Services (EPW0028)
89 Skills for Care, The state of the adult social care sector and workforce in England, October 2021
90 British Association of Dermatologists (EPW0030)
91 Prostate Cancer UK (EPW0032); Royal College of Radiologists (EPW0056)
92 Royal College of Anaesthetists, The Anaesthetic Workforce: UK State of the Nation Report, February 2022, p.2
93 Royal College of Anaesthetists (EPW0017); Royal College of Nursing (EPW0039); Nuffield Trust (EPW0051); British Medical Association (EPW0042)
94 Royal College of Speech and Language Therapists (EPW0024); Chartered Society of Physiotherapy (EPW0058)

was highlighted as the "forgotten service" with the "worst numbers of dentists in decades".[95] Recent data indicated that over 2000 dentists in England left in the last year, and the headcount has reached its lowest level since 2013/2014, which has a significant impact on access to NHS dental services.[96]

Numerous pieces of written evidence, including from the RRA, Hospice UK and the Homecare Association emphasised the lack of attention paid to social care workforce planning.[97] There are some encouraging developments, such as including registered professionals working in social care within HEE's Framework 15 considerations.[98] However, overall stakeholder evidence overwhelming maintained that actions on this commitment were not appropriate for addressing social care.[99]

Figure 3: Regional Changes in nurse number, December 2019 to March 2022



Source: Written submission by the Nuffield Trust (EPW0088), Data show the changes in the number of full-time equivalent nurses working in hospital and community health settings and general practice between December 2019 and March 2022, by NHS England region (yellow bars) and ICS (grey bars). Health visitors are excluded.

Data shows that staff numbers vary between different regions in England. Although nursing numbers overall look on track to meet the 50,000 target, there is a mixed picture across England. The Nuffield Trust concluded that these high-level national commitments risk leaving some areas of the country behind. In its analysis, the Nuffield Trust presented the example of North East and Yorkshire as regions with the lowest growth in nurse numbers (see figure 3).[100]

95 Association of Dental Groups (EPW0040); British Dental Association EPW0052

96 Association of Dental Groups, England's dental desserts: the urgent needs to "level up" access to dentistry, May 2022

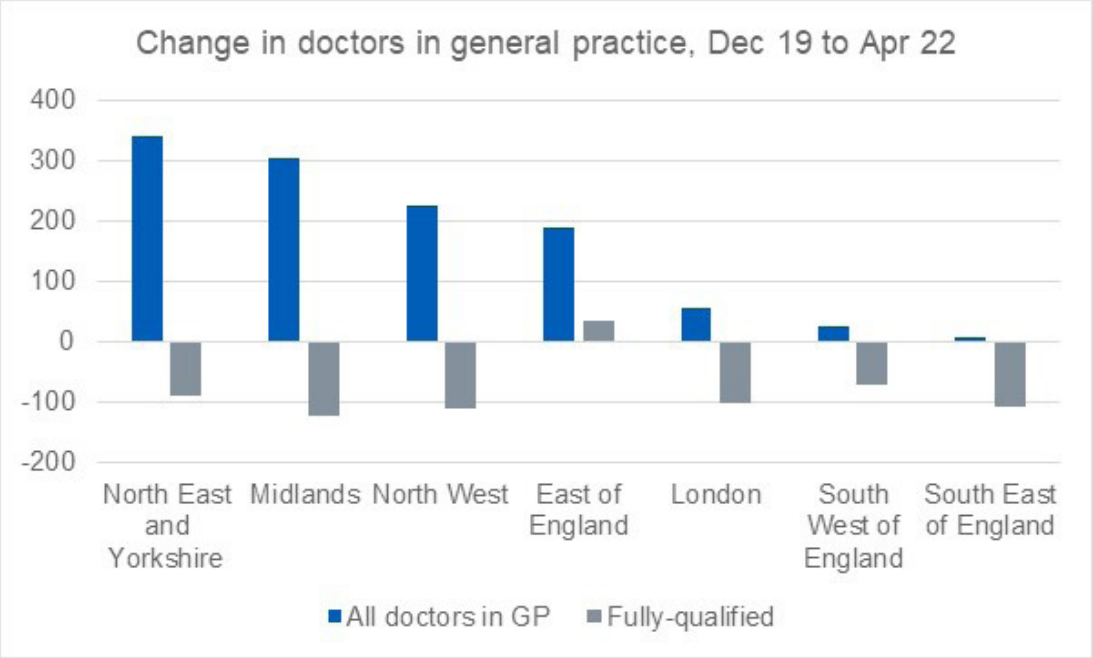
97 Homecare Association (EPW0026); Hospice UK (EPW0053); Relatives and Residents Association (EPW0008)

98 National Care Forum (EPW0033); HEE, HEE looking to the future for the health and social care workforce, July 2021

99 Hospice UK (EPW0053); Care England (EPW0003); Relatives and Residents Association (EPW0008); Mortimer Society (EPW0012); Disabilities Trust (EPW0014); Care Workers' Charity (EPW0025); EPW0028; Homecare Association (EPW0026); National Care Forum (EPW0033); Methodist Homes (EPW0035)

100 Nuffield Trust (EPW0088)

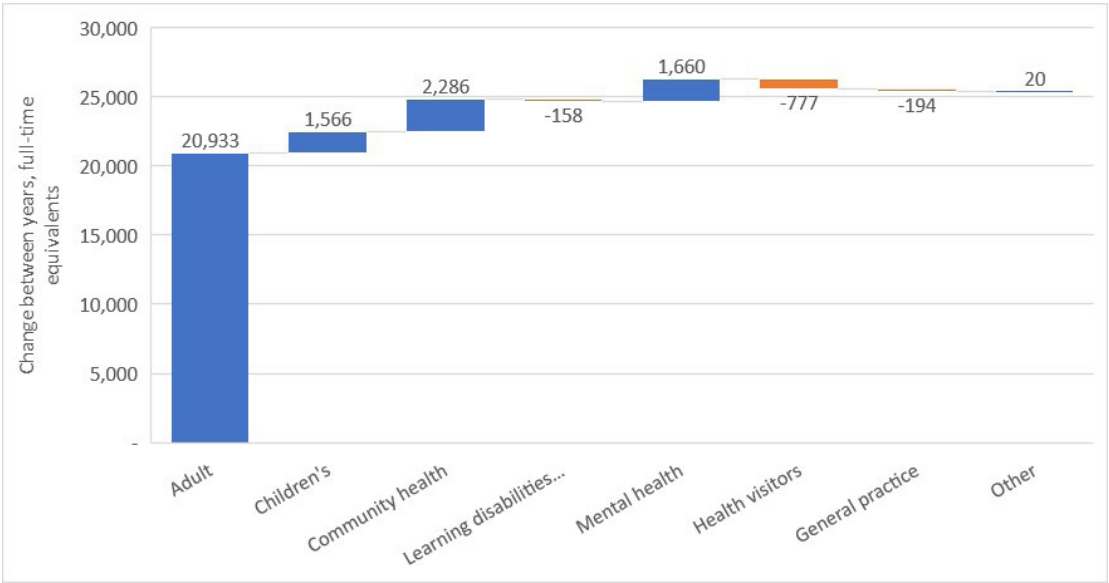
Figure 4: Change in doctors in General Practice, December 2019 to April 2022



Source: Written submission by the Nuffield Trust (EPW0088)

Similarly, as shown in figure 4, there was a significant difference in change in GP doctor numbers between regions.[101]

Figure 5: Change in nursing numbers by care setting, December 2019 to March 2022



Source: Written submission by the Nuffield Trust (EPW0088), Data show the difference in the number of full-time equivalent nurses by care setting between December 2019 and March 2022.

This regional difference can also be seen in certain specialties or care settings. For example, while the overall increase in nurse numbers is welcome, health visitor numbers, as well as those working in general practice and learning disability services, have fallen (figure 5).[102]

101 Nuffield Trust (EPW0088)
102 Nuffield Trust (EPW0088)

Stakeholders from across the NHS and social care sectors expressed the view that any workforce target needs to include a focus on retention, not just recruitment.[103] Recent NMC data highlights that while 25,028 joined the permanent register between April 2021-March22, 22,916 have left (12.7% more than the previous year) resulting in minimal impact on vacancy levels.[104] The recent 'last shift' survey from the RCN indicated that 8 in 10 (83%) of shifts are unsafe, meaning there were not enough staff to meet patient needs safety and effectively, and only 25% of shifts had the planned number of registered nurses.[105] In the NHS staff survey 2021, only 27.2% of staff said there were enough staff at their organisation for them to do their job, which is a decrease since 2020 where it was 38.4%.[106] Skills for Care 2021 stated that retention of staff was now more challenging than before the pandemic, which they consider is contributing to the higher vacancy rate (8.2%) than pre-covid (8.0%).[107]

The Royal College of General Practitioners highlighted that increasing numbers of GPs are leaving the workforce, retiring early, or reducing hours due to workload pressures and less than two thirds of the workforce work full-time.[108] This is further undermining Government efforts to recruit 6,000 more GPs.

We considered it an appropriate ambition to set targets to improve workforce numbers, but the evidence we received suggest that the targets themselves fell short of addressing in full the fundamental principles of specific, measurable, achievable, relevant and time bound, and targets and often lacked transparency and clarity. Overall, considering all the evidence, we have concluded that this part of the commitment requires improvement.

103 For example, Dr Carolyn Downs (EPW0001); Dr Emma Hayward (EPW0002); NHS Providers (EPW0011); Academy of Medical Royal Colleges Trainee Doctors' Group (EPW0023); Prostate Cancer UK (EPW0032); Methodist Homes (EPW0035); Royal College of Surgeons of Edinburgh (EPW0038); Royal College of Nursing (EPW0039)

104 NMC, The NMC register 1 April 2021 – 31 March 2022, March 2022

105 RCN, 8 in 10 shifts unsafe: RCN survey reveals shocking extent of staffing crisis | News | Royal College of Nursing, June 2022; BBC News, NHS nurse shortages a risk to safety, says Royal College of Nursing - BBC News, June 2022

106 NHS Staff Survey 2021, 2022

107 Skills for Care, The state of the adult social care sector and workforce in England, October 2021

108 Royal College of General Practitioners (EPW0059)

2 Building a skilled workforce

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
"Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead."	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Requires Improvement
"£1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities."	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
"Supporting moves towards prevention and support, we will go faster for community-based staff."	Requires Improvement	Requires Improvement	Inadequate	Inadequate	Inadequate

In this section we provide an assessment of the Government's commitments focusing on staff development and training, and the digital infrastructure of the health and social care systems. Three commitments were selected for evaluation:

"Help the million and more NHS clinicians and support staff develop the skills they need, and the NHS requires in the decades ahead."[109]

"£1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities."[110]
And

"Supporting moves towards prevention and support, we will go faster for community-based staff. Over the next three years we want all staff working in the community to have access to mobile digital services, including the patient's care record and plan, that will help them to perform their role. This will allow them to increase both the

109 The Conservative and Unionist Party Manifesto, 2017, p.68
110 The Conservative and Unionist Party Manifesto, 2019, p.12

amount of time they can spend with patients and the number of patients they can see. Ambulance services will also have access to the digital tools that they need to reduce avoidable conveyance to A&E."[111]

The NHS People Plan states that training and development of the healthcare workforce is a core component for recruitment and retention of staff, and in enhancing patient care and safety. Covid-19 has presented significant challenges for all health care staff. Many formal training pathways, such as clinical rotations and placements, were put on hold. The NHS People Plan states that employers should aim to fully integrate education and training into their plans to rebuild and restart clinical services.[112] Health Education England (HEE), responsible for the delivery of health education in England, is due to merge with NHS England and NHS Improvement (NHSE/I), which the Department states will enable long-term planning and strategy for staff recruitment and retention across the NHS.[113]

Building the social care workforce, ensuring it has adequate infrastructure, facilities, and technological capacity to meet demand, was one of the main focuses in the recent social care White Paper, 'People at the Heart of Care'. The White paper sets out the intention to establish new polices for recruitment practices, funding for the implementation and provision of the Care Certificate[114] and greater sector wide adoption of technology.[115]

The NHS People Plan sets out that staff should expect organisations and employers to focus on technology-enhanced learning.[116] The Plan encourages employers and organisations to use HEE's e-learning (online resources) for healthcare programme and an online learning hub, developed in response to the Covid-19 pandemic. Resources include training on remote consultations and triage. As part of the wider restructuring of the NHS, NHS Digital and NHSX will also merge with NHSE/I and HEE. NHS Digital design, develop and operate national IT and data services. NHSX is a transformation directorate tasked with the digital transformation of health and social care. The Government's intention is that this merger will improve co-ordination between key digital bodies and enhance the overall digital transformation of the NHS and social care.[117]

Commitment 1: NHS clinicians and support staff skill development

Overall Commitment Rating and Overview of the NHS clinicians and support staff skill development commitment: Requires Improvement

This commitment sets out to enable staff working in the NHS to access continuing professional development (CPD), so that they can do their job and meet service need. CPD

111 NHS England, NHS Long Term Plan, January 2019, p.94
112 NHS England, We are the NHS: People Plan 2020/21 – action for us all, July 2020, p.37
113 Department of Health and Social Care, Press release – major reforms to NHS workforce planning and tech agenda, November 2021
114 The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. Aspects that are covered include personal development, privacy, and dignity, safeguarding and communication. Although it is encouraged and the CQC will inspect against it, the Care Certificate is not set out as a requirement in legislation.
115 Department of Health and Social Care, People at the Heart of Care. Adult social care reform White Paper, December 2021
116 NHS England, We are the NHS: People Plan 2020/21 – action for us all, July 2020, p.34
117 Department of Health and Social Care, Press release – major reforms to NHS workforce planning and tech agenda, November 2021

is a term used to refer to learning activities which staff undertake to keep their skills and knowledge up-to date and develop professional practice to ensure that they are providing the most effective and appropriate patient care.

The evidence we received indicates that the lack of workforce planning, resulting in workforce shortages, is having a negative impact on staff training and development. NHS Providers and Macmillan highlight that the workforce shortages were increasing the challenge of staff accessing protected time to enable them to undertake training.[118] Evidence further indicated that some training resources and funding for development are available for staff, however these are not distributed evenly across and within staff groups. We did not receive evidence that enabled us to determine if CPD funding provisions were based on demand modelling, therefore it is challenging to determine whether the funds are sufficient to meet professional and service need. Stakeholders also told us that there is a lack of long-term funding, including the allocation of funds for HEE.[119] There was consensus in the evidence we received that CPD has a positive impact on patient outcomes, but only if there was adequate investment in the workforce, which is also underpinned by appropriate workforce planning. The commitment itself lacked specificity around it sought achieve, deadlines for implementation, and a clear plan for how it would be achieved. Overall, considering all areas of the commitment and evidence available, we have concluded that it requires improvement.

Was the commitment met overall (or on track?)

Rating: Requires improvement

The lack of adequate workforce planning was repeatedly recognised during our stakeholder roundtables, and in the written evidence we received, as something which negatively impacts on training and development of staff. The Royal College of Physicians stated that workforce shortages and increasing demand on the health service creates a situation where organisations and individuals are unable to find time for anything other than direct clinical care. They argue that that research, quality improvement and education and training suffer directly as a result of a lack of workforce planning.[120] A stakeholder during our roundtable told us:

> *"There isn't adequate headroom in our establishments currently to enable people to do their mandatory training, let alone do additional courses and upskilling that is needed to meet the needs of changing population. From that point, with regard to workforce planning, we also need to be thinking about how we upskill for the future needs of our patients, not just today's patients. And that isn't considered currently."*[121]

In the Department's response to our evaluation, they did not set out whether they considered that this target had been met or whether it was on track to be met. They highlighted initiatives such as the HEE's e-learning for healthcare, delivered with the NHS and professional bodies such as Royal Colleges. The e-learning programme has so

118 NHS Providers (EPW0011) Macmillan Cancer Support (EPW0049)
119 NHS Confederation (EPW0048); NHS Providers (EPW0011)
120 Royal College of Physicians (EPW0031)
121 Stakeholder roundtable

far enabled 31,000 e-learning sessions over 450 programmes.[122] We received no evidence detailing the impact of the e-learning programme on patient care and safety. The General Medical Council (GMC) were generally positive about some of the success of virtual learning environments (VLEs) and that the ease and flexibility of virtual training had positive effects on attendance and inclusivity within sessions.[123] 74% of trainees said that VLEs are being used effectively to support training, however this was not consistent across specialities.[124]

The GMC also state that there has been an improvement in managing the effects of rota gaps on training opportunities. If there are increased rota gaps, this increases the workload of a doctor and means they will be less likely to access time to fulfil training. When rota gaps are covered, workloads can potentially be reduced and more evenly distributed. Over half of all trainees (55%) said that in their post, education or training opportunities were rarely lost due to gaps in the rota, compared with 49% in 2019.[125]

The Royal College of Radiologists, the Royal College of Anaesthetists (RCA) and the British Society for Haematology all stated that there was unequal opportunity and investment in training with professions and between roles.[126] Only 58% of Ambulance staff said they had opportunities to improve their knowledge and skills, compared to a 67.2% national average of NHS staff.[127] The inequity in training and development of staff is also pointed out by Cancer Research UK as something which impairs cohesive multi-professional team development, which in turn impacts co-ordinated care approaches.[128]

Training and development are essential parts of career progression for all healthcare staff, and NHS Employers place career development as a core part of enabling staff retention.[129] The 2021 NHS staff survey shows that 52.9% of staff said there are opportunities for them to develop their career and 55.5% of staff felt their organisation acted fairly with regards to career progressions or promotion, regardless of ethnic background, gender, religion sexual orientation, disability or age. This is down from 2017, when it was 58.6%.[130] The Workforce Race and Equality Standard highlights that white staff were 14% more likely to access non-mandatory training compared to staff from ethnic minority backgrounds.[131] Considering the evidence for this area of the commitment, we conclude that it as requires improvement.

Was the commitment effectively funded (or resourced?)

Rating: Requires improvement

In the spending round 2021, the Government stated that it will provide "hundreds of millions of pounds in additional funding over the next three years to ensure a bigger and better trained NHS workforce".[132] The Government did not however make a specific

122 Department of Health and Social Care (EPW0062)
123 General Medical Council, The state of medical education and practice in the UK, December 2021, p.69
124 General Medical Council, The state of medical education and practice in the UK, December 2021, p.68
125 General Medical Council, The state of medical education and practice in the UK, December 2021, p.53
126 Royal College of Anaesthetists (EPW0017); British Society for Haematology (EPW0045)
127 NHS, NHS Staff Survey 2021, March 2022
128 Cancer Research UK (EPW0043)
129 NHS Employers, Improving staff retention, March 2022
130 NHS, NHS Staff Survey 2021, March 2022
131 NHS, NHS workforce race and equality standard 2021 data analysis report for NHS Trusts, March 2022
132 HM Treasury, Autumn budget and spending review 2021, HC 822, October 2021, p.49

spending commitment for HEE. HEE's budget is set annually, and often late in the academic year which starts in September. This year it was announced after the start of the 2022/23 financial year, 12 May 2022.[133] Analysis done by the Institute for Fiscal Studies shows that HEE's budget was reduced by 25% in real terms from £5.4 billion in 2013/14 to £4.1 billion in 2019/20, despite the workforce being larger in 2019/20 than in 2012/14.[134] NHS Providers stated that this means that funding for training and development has been spread too thinly, impairing access. Although NHS Providers recognise the potential benefits of the NHSE/I and HEE merger, they state that it is important to protect training and development funding once the merger is completed.[135] The then Minister of State at the Department of Health and Social Care, Edward Argar MP, stated that HEE will not receive a multi-year funding deal.[136] In their submission, the NHS Confederation criticise the lack of long-term funding for HEE, and argue it presents difficulties for NHS leaders to enable them to know what funding they have available to upskill their workforce.[137]

The Department's response highlighted Government investment in a CPD fund equating to £1,000 over a 3-year period for nurses, midwives, and allied health professionals. This was announced in the 2019 Spending Round.[138] The allocation of funding for CPD is managed by organisations, therefore how the £1000 per employee over 3 years is spent, will vary. While this CPD funding is welcomed in principle by stakeholders such as the Royal College of Nursing (RCN), they criticised the fact that the funding was not provided to publicly funded social care staff, public health services or nurses within general practice settings, which creates inequity of access across the profession and healthcare sectors.[139] We did not receive any evidence indicating that this CPD funding allocation was based on demand modelling, therefore it is challenging to determine if the amount provided is or has been sufficient to meet professional and therefore service need.

The Council of Deans of Health argued that on-going learning investment is needed to help retain staff.[140] This is supported by the British Psychological Society, who state that a lack of career opportunities and a downgrading of Agenda for Change bands for posts are driving staff out of the NHS into other sectors.[141] Agenda for Change bands are used to determine pay for staff in the NHS, but not doctors or dentists who have a separate renumeration system.[142] Part of the agenda for change system is the job evaluation scheme which measures the responsibilities, skill and effort required to do a job, then allocates it to a band.[143] The downgrading of a band means the pay for a role is reduced, and the RCN states that financial challenges can lead to an employer viewing down banding as a way to reduce costs.[144]

The flexibility of training pathways was raised as something which would have a positive impact on staff recruitment and retention in HEE's 'Future Doctors' report.[145] Flexible

133 Central Government Supply Estimates 2022–23, HC 396, June 2022, p.56
134 Institute for Fiscal Studies, Pressures on the NHS, September 2021, p.8
135 NHS Providers (EPW0011)
136 PQ 1556 8 [NHS: Staff], 19 April 2022
137 NHS Confederation (EPW0048)
138 HM Treasury, Spending Round 2019, CP 170, September 2019, p.2
139 Royal College of Nursing (EPW0039)
140 Council of Deans of Health (EPW0065)
141 British Psychological Society (EPW0069)
142 NHS Employers, Agenda for Change, accessed 200622
143 NHS Employers, Job evaluation Scheme, accessed 200622
144 Royal College of Nursing, Down banding in the NHS, accessed 200622
145 HEE, The Future Doctor Programme, July 2020

training pathways means doctors are able to move between specialties, take time out of training and, train on less-than-full-time basis. The Academy of Medical Royal Colleges highlights that flexible training enables better cross-specialty understanding, a more adaptable workforce to patient and service need, and can enhance the work-life balance of doctors for the benefit of their wellbeing.[146] Latest data from Health Education England's Trainee Information System shows that the proportion of doctors in Less than Full Time Training (LTFTT) in 2022 has increased to just under 17% of all doctors in postgraduate training in England (see table 2 below).[147]

Table 2: Doctors in Less than Full Time Training (note from Department: Trainee Information System is a live system, so 2022 data is subject to change)

	2015	2016	2017	2018	2019	2020	2021	2022
Total Trainees	51952	52631	51968	52190	53953	55940	58320	61511
Of which LTFTT	5238	5343	5731	6244	7164	7771	8957	10406
%	10.8%	10.15%	11.03%	11,96%	13.28%	13.89%	15.36%	16.92%

Source: Letter from the then Secretary of State for Health and Social Care Sajid Javid to Professor Dame Jane Dacre, 20 June 2022

However, NHS Providers argue that it is incredibly difficult for organisations to offer full flexibility due to staff shortages, which has been impacted by a lack of workforce planning.[148]

The Royal College of Midwives is positive about the Government investment into maternity safety training, but also highlights that it is not just about money, but that there are issues with releasing staff to enable them to access training.[149] The Academy of Medical Royal Colleges and Royal College of Physicians and Surgeons of Glasgow also recognise that releasing staff to access training is a barrier and further highlight that releasing trainers to train staff has been impaired.[150] Overall, we conclude that this area of the commitment requires improvement.

Did the commitment achieve positive impacts for patients and people in receipt of social care?

Rating: Requires improvement

NHS Providers acknowledge that training and development helps retain staff and supports wellbeing which will result in improved patient outcomes.[151] The Royal College of Surgeons of Edinburgh supports this and argues that upskilling the NHS workforce would have a positive impact on patients through increased retention, helping to increase numbers

146 Academy of Medical Royal College, Guidance for flexibility in postgraduate training and changing specialties, June 2020

147 Letter from the then Secretary of State for Health and Social Care Sajid Javid to Professor Dame Jane Dacre, 20 June 2022

148 NHS Providers (EPW0011)

149 Royal College of Midwives (EPW0061)

150 Academy of Medical Royal Colleges Trainee Doctors' Group (EPW0023); Royal College of Physicians and Surgeons of Glasgow EPW0015

151 NHS Providers (EPW0011)

of clinicians and therefore the amount of time each one is able to spend with patients.[152] The RCA points to improved patient outcomes through 'prehabilitation' programmes, which the Centre for Perioperative Care has shown can reduce post-operative (after surgery) complications by 30–80% and reduce the length of stay after surgery by 1–2 days.[153] Prehabilitation refers to increasing a patient's health before surgery through interventions such as physical exercise, psychological preparation, nutritional support, smoking cessation, and alcohol moderation advice. However, the RCA go on to say that the benefits of the prehabilitation programmes will only be maximised if investment in the training and development of staff is made across the workforce spectrum in the surgical pathway.[154] Staff who work within the surgical pathway are multidisciplinary and include surgeons, anaesthetists, nurses, operating department practitioners, surgical care practitioners, healthcare assistants, physiotherapists, and occupational therapists.

In evidence from Macmillan, they referred to a survey they conducted in 2019 looking at workforce CPD. They highlight that 76% of clinical nurse specialists (CNSs) said that having more time for continued professional development would help them improve care for people living with cancer, yet CNSs experience barriers to access training. 64% of CNS respondents to the survey said they could not access protected time in which to undertake training, with 1 in 5 having to take annual leave to attend courses. 43% cited a lack of funding as the main barrier and funding from charitable or professional grants accounted for over 54% of funding for CPD.[155] Cancer Research UK further cite inconsistent access to training and development opportunities as a barrier to service development and patient care, underpinned by workforce shortages as a result of a lack of workforce planning.[156] Overall, we have concluded that this area of the commitment requires improvement.

Was it an appropriate commitment?

Rating: Inadequate

We considered this commitment appropriate in that focusing on training and development of staff is important. However, we concluded that the commitment lacked specificity of what it would deliver and who to, deadlines for implementation, and a clear plan for how to achieve it. Furthermore, from the evidence we have received, we have had no indication that professional development such as CPD provisions have been underpinned by modelling based on either service demand or developmental demand. UNISON highlights that the People Plan pays insufficient attention to skill development for the largely unregulated patient facing support staff, such as healthcare assistants. They go on to refer to the fact that HEE have previously acknowledged that despite making up 40% of the workforce and being responsible for an estimated 60% of direct patient care, support staff only receive 5% of the whole training budget.[157] The Royal College of Surgeons of Edinburgh states that upskilling the whole NHS workforce and training

152 Royal College of Surgeons of Edinburgh (EPW0038)
153 Centre for Perioperative Care, Impact of perioperative care on healthcare resource use, June 2020
154 Royal College of Anaesthetists (EPW0017)
155 Macmillan Cancer Support (EPW0049)
156 Cancer Research UK (EPW0043)
157 UNISON (EPW0047)

new clinicians would make a meaningful improvement to patients, including reducing the elective surgical care backlog caused by the pandemic. However, they point out that the commitment is lacking any detail as to how this could be achieved.[158]

A number of professional bodies stated that there is an unequal spread of postgraduate training posts geographically, and that training strategies need to consider the needs of different geographic areas and the demographics within them, in order to help reduce health inequalities, which this commitment fails to address.[159] The Faculty of Sexual and Reproductive Health highlight that many areas in England, particularly the most financially deprived, do not have a community sexual reproductive healthcare consultant in post. They go on to state that fragmented commissioning responsibilities have created disincentives for the training and education of the specialist and non-specialist sexual and reproductive health workforce and has resulted in the responsibility for training being unclear. These training posts are 50% funded by HEE and 50% by service or local authority, and the Faculty of Sexual and Reproductive Health argue that local authorities often cannot match the 50% HEE funding locally which prevents creation of training places.[160]

The Additional Roles Reimbursement Scheme (ARRS) scheme implemented in primary care does not cover general practice nurses (GPNs) who make up around 26% of the general practice staff profile.[161] GPNs are also not under Agenda for Change, as the current primary care contract entitles GP services to set their own pay and employment contracts as independent employers. This means that the Government's CPD allocation of £1000 over 3 years per staff member does not cover general practice, and as a result there is a lack of equity in access to training and development through this fund. In conclusion, the evidence we have received indicates that here needs to be broader consideration of the development needs of all parts the workforce, supported by more equitable distribution of resources to ensure development across sectors. Therefore, we have rated this area of the commitment as inadequate.

Commitment 2: £1 billion for more social care staff, infrastructure, technology, and facilities

Overall Commitment Rating and Overview of the £1 billion for more social care staff, infrastructure, technology, and facilities: Inadequate

This commitment pledged £1 billion for social care in the year beginning April 2020, and then every year following.[162] In its response, the Government states that this has been delivered as part of the funding it provides to cover the "core pressures" such as caring for the ageing population and increasing life expectancy of working age adults with learning

158 Royal College of Surgeons of Edinburgh (EPW0038)
159 Faculty of Sexual and Reproductive Healthcare (EPW0029); Association of Dental Groups EPW0040; Dr Liz Brewster, Dr Michael Lambert, Dr Luigi Sedda, Dr Euan Lawson, Mr Barry Rowlingson, Dr Cliff Shelton and Professor Jo Rycroft Malone (EPW0007)
160 Faculty of Sexual and Reproductive Healthcare (EPW0029)
161 Sonnet, Leading the way: The role and value of nurses in general practice in England, December 2021, p.12.
162 The Conservative and Unionist Party Manifesto, p.12, 2019

disabilities and inflation.[163] However, the evidence which we have received suggests that this commitment is too vague on what it will deliver and therefore it is challenging to evaluate whether the commitment has been met and what effect it has had.

Stakeholders were not in agreement with the Government regarding its actual delivery, and many instead suggested that the funding promised had gone to maintaining current services rather than as the commitment suggests "more" staff, infrastructure, technology, and facilities. Overall, funding in line with the commitment has been delivered, however, our conclusion is that it has not delivered what it pledged to. Therefore, our evaluation of the Government's progress against this commitment is 'Inadequate'.

Was the commitment met overall (or on track)?

Rating: Inadequate

In the Government response to the evaluation, it states both that the commitment has been met and that it is on track to be met. The Government response states that £1 billion has been delivered through overall funding for local authorities, and through the subsequently announced Health and Social Care Levy, which it argues will deliver £5.4 billion over three years for a "reform programme of adult social care". Furthermore, the investment will include:

- at least £150 million to improve technology and increase digitisation across social care; and
- at least £500 million investment in the workforce.[164]

However, UNISON criticised the lack of "price tags" attached to the specific parts of this commitment.[165] The Nuffield Trust stated that the £1 billion pledged has not been used as promised. Instead of being a strategic investment in workforce and improving infrastructure, estates and technology, the Nuffield Trust concludes that it has been used to "stabilise social care services".[166] The National Care Forum stated:

> *"Funding made available over the past two years hasn't enabled more social care staff, better infrastructure, technology or facilities. It has been aimed at simply keeping the system afloat in terms of infection control measures, paying staff to isolate due to the pandemic, and attempts to recruit and retain staff in the midst of a workforce crisis […]"*[167]

Regarding the £1 billion promised for more staff, many stakeholders argued that the commitment has not been met, pointing to challenges with recruiting and retaining staff.[168] According to Skills for Care's review of the adult social care sector and workforce published in 2021, there were 105,000 vacancies advertised per day in the sector in 2020/21, and since March 2021 the vacancy rate has increased and is above pre-pandemic levels.[169]

163 Department of Health and Social Care (EPW0062)
164 Department of Health and Social Care (EPW0062)
165 UNISON (EPW0047)
166 Nuffield Trust (EPW0051)
167 National Care Forum (EPW0033)
168 Care England (EPW0003); Mortimer Society (EPW0012); Care Workers' Charity (EPW0025); British Infection Association (EPW0046); Royal College of Nursing (EPW0039); NHS Confederation (EPW0048)
169 Skills for Care, The state of the adult social care sector and workforce in England, October 2021

NHS Confederation concluded that despite financial interventions, social care services "remain under-resourced and under-staffed", due to shortage of care packages and an increased demand caused by an ageing population.[170]

Table 3: responses to "Compared to April 2021, how would you describe the current level of workforce challenges in your service or location for retaining staff?" by region

Region	More challenging
East of England	70.9%
London	56.0%
Midlands	70.3%
Yorkshire and the North East	70.5%
North West	69.5%
South West	76.7%
South East	72.4%

Source: Adult social care workforce survey: December 2021 report[171]

According to the Department of Health and Social Care's social care workforce survey of providers which ran from 13 September 2021 to 14 October 2021, 70.3% of respondents stated that retaining staff was more challenging compared to April 2021. This figure was the highest in the South West of England, where 76.7% of respondents stated that it was more challenging, and the lowest in London (56%).[172]

Table 4: responses to "Compared to April 2021, how would you describe the current level of workforce challenges in your service or location for … ?"

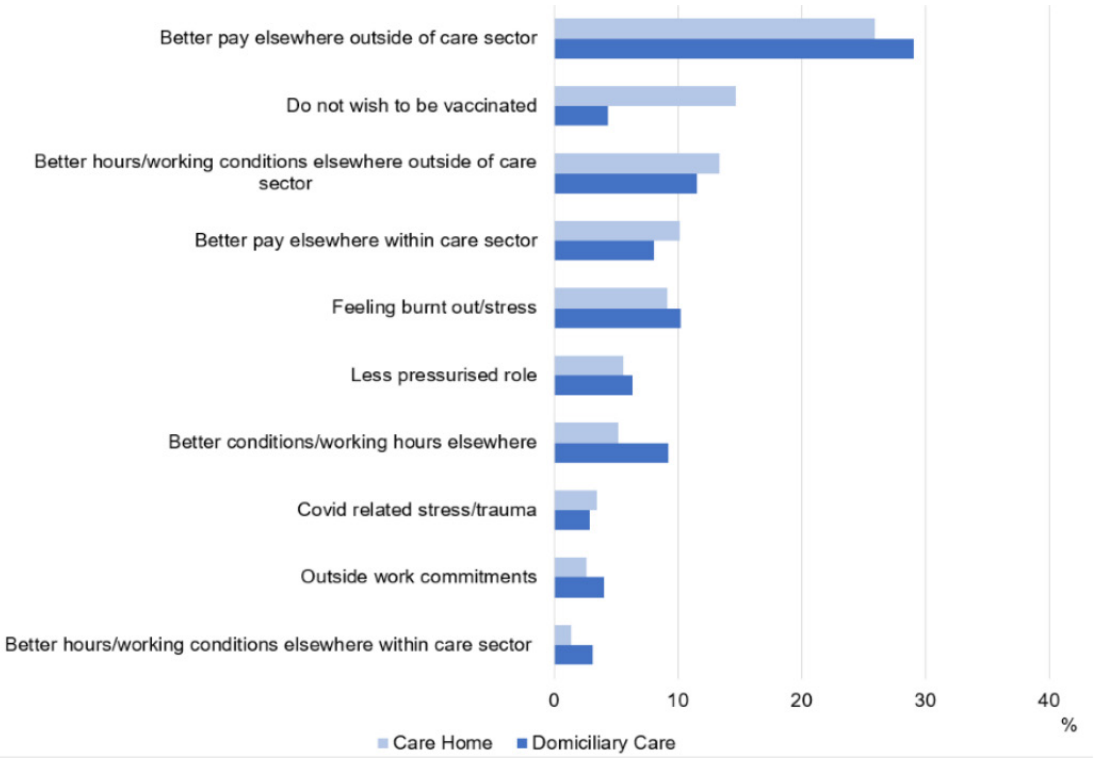
Question	More challenging	About the same	Less challenging	Response rate (with number)
Retaining staff	70.3%	25.0%	4.5%	98% (8765)
Recruiting staff	81.9%	15.1%	2.5%	97% (8677)
Maintaining morale	70.6%	24.5%	4.4%	98% (8735)
Accessing agency staff	77.9%	16.6%	2.4%	58% (5238)

Source: Adult social care workforce survey: December 2021 report[173]

Recruiting staff was the most challenging out of the workforce challenges according to respondents, with 81.9% of respondents stating that this had become more challenging.[174]

170 NHS Confederation (EPW0048)
171 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021
172 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021
173 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021
174 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021

Figure 6: responses to "What do you believe is the main cause for staff leaving?"



Source: Adult social care workforce survey: December 2021 report[175]

Pay was the primary reason given for why staff decided to leave, and another common reason was better hours and working conditions outside of the care sector.[176] Poor pay and working conditions were frequently cited in the evidence we received regarding challenges of the social care workforce,[177] and in the roundtables we ran with stakeholders. In the care home setting, retention was also impacted by a reluctance in staff to get vaccinated for Covid-19. The Department's survey estimates that 14.7% of staff who had left the profession did so because they did not want to be vaccinated.[178] The Covid-19 vaccination was made mandatory for staff working or deployed in care homes in November 2021, but the mandate was then removed in March 2022 following public consultation.[179]

Adequate staff numbers are also connected to development of professional skills, enabling greater use of technology. Some stakeholders presented examples of local initiatives which has incorporated technology into care, but these had not replicated nationally.[180] According to evidence from our roundtables, some providers are funding the implementation of technology themselves, without external financial support, for example from local authorities:

175 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021
176 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021
177 Care England (EPW0003); Disabilities Trust (EPW0014); Care Workers' Charity (EPW0025); Methodist Homes (EPW0035)
178 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021
179 Department of Health and Social Care, Coronavirus (COVID-19) vaccination of people working or deployed in care homes: operational guidance, March 2022
180 Disabilities Trust (EPW0014)

> *"Everyone is now on digital care plans in our homes, and we've made tablets accessible throughout the pandemic to connect people, but that was from our own fundraising and none of that came from anywhere else. We had to kind of go off of our own backs or draw into our income."*[181]

Care England argued that a high vacancy rates in the workforce leads to less internal development, particularly in terms of digital skills training for staff. This, Care England argues, is because a high turnover rate of staff makes it difficult to justify investment in training. Care England therefore calls for support to accommodate the workforce as a step in allowing the sector to invest in staff development.[182] The Care Certificate, a set of 15 standards for new starters in the sector to undertake, was developed by HEE, Skills for Care and Skills for Health. It is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.[183] However, as Sense points out, this certificate does not include digital skills.[184] A review carried out by Skills for Care, found that there is a perception that the adult social care sector lags behind others in the adoption of digital technology, and by association, digital skills.[185] The most recent social care White paper points to research suggesting that 23% of care home staff cannot access the internet consistently at work, and 45% of social care providers expressed concern that care staff lacked digital skills. Further to this–only 40% of social care providers have fully digitised records. The White Paper sets out a target of March 2024 for when the Government will "ensure" that at least 80% of social care providers have a digitised record in place.[186] Interim data from a 2022 survey from the Queen's Nursing Institute (QNI) shows that 79% of respondents experience poor connectivity when seeing patients, and 37% of respondents stated that they cannot access a GP electronic record to facilitate patient care.[187] The QNI interim survey findings suggest that systems are slow, with connectivity and power issues, little integration and are poorly designed, for example with different versions of care plans.[188] The RCN also pointed out that more technology in the care setting will require accompanying nursing capacity to implement it.[189]

The commitment also mentions more facilities, which we received limited evidence on. As social care is often provided by employers in facilities looked after by the employer, it is difficult to get an overall understanding of whether more money has been given to employers to improve facilities. Care homes and other residential care facilities are however regulated and inspected by the Care Quality Commission.[190] The Relatives and Residents Association summarised the situation regarding facilities in social care:

> *"Reading through CQC inspection reports, we can identify many instances of sub-standard infrastructure and facilities. These include quality of life as well as safety issues, such as uneven paving, cracked tiles, gaps around doors and windows, poor decorative order including chipped or damaged paint and wallpaper, damp, faulty appliances such as lights that no longer*

181 Stakeholder roundtable
182 Care England (EPW0003)
183 Skills for Care, Care Certificate, accessed 200622
184 Sense (EPW0050)
185 Skills for Care, Digital Skills in Adult Social Care, March 2021
186 Skills for Care, Digital Skills in Adult Social Care, March 2021
187 Queen's Nursing Institute (EPW0089)
188 Queen's Nursing Institute (EPW0089)
189 Royal College of Nursing (EPW0039)
190 Care Quality Commission, Our purpose and role, accessed 200622

> *work, dangerous appliances such as radiators that run too hot, uncompleted premises work, and general disrepair. Many of our clients report such issues to us on our helpline."*[191]

Considering all the evidence available to us, we conclude that this part of the commitment is 'inadequate'.

Was the commitment effectively funded (or resourced?)

Rating: Inadequate

According to the Adult Social Care Activity and Finance Report, England 2020/21, there has been a £1.6 billion increase in social care funding from the previous year.[192] Furthermore, the Spending Review sets out that the Government will give local authorities access to over £1 billion of spending for social care through a £300 million social care grant from central Government and "the ability to levy a 3% adult social care precept".[193] In their policy tracker, the Institute for Government concludes that the commitment has been "completed", stating that the £1 billion has been delivered, but points out that £700 million of it is raised through increased rates of council tax (the adult social care precept mentioned previously).[194] In summary, the additional £700 million to complement the £300 million of central Government funding to reach the £1 billion sum relies on local authorities raising council tax to the maximum level. 97% of local authorities with social care responsibilities utilised some or all of the social care precept in 2021/22. The average council tax increase attributable to the precept was 2.4%, with 70% of local authorities raising council tax by the full 3%.[195]

The National Care Forum (NCF) furthermore set out that of the £5.4 billion announced in the Government's adult social care reform plans for the next three years, of which £1.7 billion will be used for measures relating to the workforce, infrastructure, technology etc. This the NCF concludes is less than £1 billion per year, and states:

> "*The remainder of the £5.4bn is being used to introduce a cap on care costs, allow self-funders to ask the Local Authority to arrange for their care at LA rates (removing the self-funder cross-subsidy of the state's underfunding), and a fair cost of care for providers. There is very significant risk that these reforms may have an unintended consequence of reducing the amount of funding in the system to provide care*".[196]

We asked the Department of Health and Social Care of a breakdown for how the £1 billion extra for social care has been spent. The then Secretary of State wrote to us and set out that the extra Adult Social Care (ACS) precept which can be raised through increased council tax is to be raised exclusively to go to adult social care. The Department of Health and Social Care, and the Department for Levelling Up, Housing and Communities have previously "run assurance processes". This involves the local authority Chief Finance Officers, and

191 Relatives and Residents Association (EPW0008)
192 NHS Digital, Adult Social Care Activity and Finance Report, England - 2020–21, October 2021
193 HM Treasury, Spending Review 2020, CP 330, November 2020
194 Institute for Government, Policy Tracker, January 2021
195 MHCLG, Local Government Finance Statistical Release, Council tax levels set by local authorities: England 2021/22, 25 March 2021, p7.
196 National Care Forum (EPW0033)

this process found "no evidence of any inappropriate use of funds raised through the ASC precept". In the letter the then Secretary of State also points to the improved Better Care Fund, providing direct grants to local government. These grants are paid following a process of the local area proving how they will achieve policy objectives in line with the Better Care fund[197], and has four primary purposes:

- meeting adult social care needs,
- reducing pressures on the NHS, including seasonal winter pressures
- supporting more people to be discharged from hospital when they are ready, and
- ensuring that the social care provider market is supported.[198]

In summary, the letter we received did not include a breakdown of the £1 billion extra but pointed to long-term investments. In the letter the then Secretary of State refers to the £500 million investment dedicated to the social care workforce, and stated:

> *"This investment will be used to develop and support the workforce over the next three years, and begin to transform the way the social care workforce is supported and address what are seen to be long-term structural barriers to recruitment and retention."*[199]

The information we have been provided with, and the information available to us in the public domain leads us to conclude that the historic lack of funding means that what funding is then made available is swallowed up in supporting the care system, rather than developing it and supporting staff in it. As there is no ring fencing of money, each local authority will spend the money where it is needed, which although useful does not meet this specific commitment. We therefore conclude that the funding for this commitment is inadequate.

Did the commitment achieve positive impacts for patients and people in receipt of social care?

Rating: Inadequate

NHS Confederation argues that workforce shortages in the social care sector led to a higher bed occupancy rate in hospitals, as people in receipt of social care deemed medically fit for discharge were not able to access care and therefore had to stay in hospital.[200] In their report the State of Care, the Care Quality Commission (CQC) points to monthly data from information submitted to CQC by providers of residential care, which shows that the staff vacancy rate is increasing steadily from 6.0% in April 2021 to 10.2% in September 2021. This leads to some care homes who have been unable to recruit having to cancel their registration to provide nursing care, leaving residents looking for new homes in local areas that are already at, or close to, capacity. The CQC warns of the possible negative consequences if the recruitment and retention problems in social care are not resolved:

197 NHS, About the Better Care Fund, accessed 210622
198 Letter from the then Secretary of State for Health and Social Care Sajid Javid to Professor Dame Jane Dacre, 20 June 2022
199 Letter from the then Secretary of State for Health and Social Care Sajid Javid to Professor Dame Jane Dacre, 20 June 2022
200 NHS Confederation (EPW0048)

> *"The alternative is that the sector will continue to lose staff to the retail and hospitality industries. This will lead to reduced capacity and choice, and poorer quality care for the people who rely on social care, resulting in a ripple effect across the wider health and care system that risks becoming a tsunami of unmet need across all sectors, with increasing numbers of people unable to access care."*[201]

Table 5: responses to "What are the main consequences of a more challenging morale situation?"

Response	Care home	Domiciliary care
Staff not willing or able to take on additional hours	30.0%	38.1%
Staff less energised or aren't able to do more	22.6%	19.6%
Staff indicating thinking of leaving	21.6%	17.3%
Staff not willing or able to take on additional responsibilities	5.6%	5.9%
Staff wellbeing worries	15.8%	14.8%

Source: Adult social care workforce survey: December 2021 report[202]

The latest Adult social care workforce survey showed that 70% of respondents found maintaining staff morale more challenging than in April 2021, which in turn led to staff being unwilling to take on additional hours and being less energised or able to do more work.[203]

If this commitment was met by the Government, there is potential for great positive impact on patients and people in receipt of social care. However, although the Government argues that the commitment has been met, stakeholder consensus seems to indicate that this is not delivering this positive impact in practice. As we have emphasised throughout this evaluation, and previous ones, workforce pressures have a negative impact on the progress of the commitment. The social care sector is in crisis, and current Government effort is not adequately addressing or mitigating it. This therefore leads us to conclude that the rating for whether this commitment is delivering positive impacts for people in receipt of social care is inadequate.

Was it an appropriate commitment?

Rating: Inadequate

Based on discussions during our roundtable, and the stakeholder evidence we received, this commitment is considered unrealistically ambitious in what it seeks to include. Others term it as vague, leading to difficulty in assessing whether or not it has been met.[204]

201 Care Quality Commission, The state of health care and adult social care in England 2020/21, May 2022
202 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021
203 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021
204 National Care Forum (EPW0033); Nuffield Trust (EPW0051)

Care England stated that although it is appropriate to commit to increase funding, this commitment will not have meaningful impact without the underpinning issues such as lack of career progression being addressed.[205] The Relatives and Residents Association further states that the money attached to the commitment is insufficient to achieve its aims. In its response to the Government's social care White Paper, the Local Government Association estimates that between £7.3 billion and £8.1 billion is needed to address care worker pay enabling a move towards greater parity with the NHS, address unmet need in the community and enable local authorities to pay social care providers a 'fair rate of care'.[206] A fair rate of care is identified by the Department as a rate "which reflects local costs, including workforce, where appropriate".[207]

Overall, evidence suggests that the commitment is too broad and vague, and the money allocated to what it seeks to achieve not enough. We therefore conclude that the appropriateness of this commitment is inadequate.

Commitment 3: Community based staff and digital services

Overall Commitment Rating and Overview of the Community based staff and digital services commitment: Inadequate

This commitment is focused on enabling community staff to have greater access to digital tools such as patient records, to support people better and enable the move towards prevention of diseases. Due to this commitment lacking specificity, we have interpreted for the purpose of evaluation that this commitment relates to the NHS, however we are aware that there will be some overlap with the social care sector, for example in relation to IT, but the focus here is on the NHS.

The commitment suggests that through increasing the use of technology, staff will be able to have more time with patients, increase the number of patients they can see and address avoidable conveyances to A&E. An avoidable conveyance to A&E happens when a patient, whose health and social care needs could be effectively and safely met in a community setting, within or close to their home, is conveyed to a hospital unnecessarily. NSH England and NHS Improvement (NHSE/I) consider that avoidable conveyance can have a range of benefits including reducing cost for ambulance services and preventing increased A&E admissions.[208]

In the evidence we received, it was suggested that access to digital tools nationally was patchy, and that access could amount to a "post-code lottery". Other issues raised were around the interoperability of systems, such as with the Electronic Palliative Care Record. Evidence highlighted that there were not sufficient recourses available to enable the use of technology including appropriate training for staff. Concerns around digital literacy and the potential for digital tools to have a positive patient impact were raised, including inequitable access fostering greater health inequalities for those in more socio-economically deprived areas. The commitment itself lacked specificity, timeframes, and

205 Care England (EPW0003)
206 Local Government Association, LGA response to "People at the heart of care: adult social care reform white paper", December 2021
207 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021
208 NHS England and NHS Improvement, Safely reducing avoidable conveyance to hospital, July 2019

an indication of how it was supposed to be achieved. In the evidence we received, it was suggested there was not enough consideration given to how digital tools may alter the working practices of staff and impact their practice.

Overall, considering all areas of this commitment and evidence received, we have concluded that progress is inadequate.

Was the commitment met overall (or on track?)

Rating: Requires improvement

UNISON stated that their members working in ambulance services are positive about the potential of digital tools to help reduce avoidable conveyance to A&E.[209] However, NHS Providers state that current legacy IT systems in ambulance services reduce efficiency and impact interoperability.[210] 44% of respondents to an NHS Confederation survey stated a lack of national funding had impacted on their organisation's ability to deliver interoperability.[211] There have been positive local initiatives utilising digital tools in response to disruption to services caused by Covid-19. North West Ambulance Service for example, employed pharmacists in their NHS 111 call centres to support prescription requests, which helped people avoid going to A&E.[212] However, from our stakeholder roundtable, we heard that access to digital tools for ambulance services was sometimes considered a post-code lottery with tools unequally distributed between areas:

> *"Say, for example, we have a patient coming in from a neighbouring county and their paramedic crews are not in-sync with us, are not able to access our systems, and so they can't access us. When I say access, I mean communication of a patient who they think has a problem and who they want to ship across to us in a timely manner".*[213]

The Department's response does not specify whether the Government considers the commitment to have been met or is on track to be met. Instead, the response provides a brief account stating that the NHS Long Term plan and the operational planning guidance is committed to supporting health and care systems to 'level up' their digital maturity and ensure there is the correct infrastructure in place.[214] Our stakeholder focus groups suggested that there was a lack of community connectivity:

> *"I think technology could and would work really well, if there was more of an integration between health and social care, where we could have joined-up work and partnerships … I think generally technology would work better if we were possibly all using the same systems."*[215]

In 2016, the Government set out the intention that shared digital palliative and end of life care records, such as Electronic Palliative Care Coordination Systems (EPaCCS), would be in use across England by 2020 (and in the majority of areas by 2018). This commitment has

209 British Infection Association (EPW0046)
210 NHS Providers (EPW0011)
211 NHS Confederation (EPW0048)
212 Care Quality Commissions, The state of health care and adult social care in England 2020/21, October 2021, p.64
213 Stakeholder roundtable
214 Department of Health and Social Care (EPW0062)
215 Stakeholder roundtable

not been met. Hospice UK state that the implementation across the country of EPaCCs is patchy, and even in areas where it is used, it is not aligned to digital records, barely shared outside of general practice and not across the wider health and care system.[216] The British Society of Echocardiography notes there is no continuity of systems linking up between community and hospitals settings and referrals can be received from the community, but where a follow up echo is requested, the initial scan cannot be accessed requiring the process to start again.[217]

Overall, based on the evidence indicating that there is a lack of interoperability and inequitable access to digital tools nationally, we conclude that progress on this commitment requires improvement.

Was the commitment effectively funded (or resourced?)

Rating: Requires improvement

The British Psychological Society stated that in order for technology to be used effectively and to have a positive impact for patients, there needs to be greater support for training and education of staff to enable uptake.[218] Diabetes UK support this and state that the use of technology can only be maximised if staff have the resources and training to ensure that they are sufficiently skilled to advise on, and prescribe diabetes technology, such as wearable technology, appropriately.[219] NHS Providers argue that sufficient revenue funding is needed to meet ongoing commitments for IT developers, software licences and training for existing staff. However, they also conclude that that sufficient capital investment for interoperable computer aided dispatch systems, telephony and triage tools would improve ambulance system resilience and responsiveness.[220] Our stakeholder roundtables further indicated that training and supporting staff, including ensuring there were enough staff was important for digital development:

> "*The other important point is that any digital or data solution isn't going to work as effectively if we don't have the numbers [of staff], because the staff need to be trained, they need to be able to fully understand and explain these things to patients, and if the numbers [of staff] aren't there, then they're [Government] always going to fall short of what the tech or digital solution could potentially be.*"[221]

The Royal College of Pathologists was positive about the Government's commitment to establish 40 community diagnostic centres, which were announced in October 2021 accompanied by a £350 million funding pledge[222] but highlighted that these centres will need sufficient resources including staff, IT provision and connectivity to other systems

216 Hospice UK (EPW0053)
217 British Society of Echocardiography (EPW0066)
218 British Psychological Society (EPW0069)
219 Diabetes UK (EPW0044)
220 NHS Providers (EPW0011)
221 Stakeholder roundtable
222 Department of Health and Social Care, Press release – 40 community diagnostic centres launching across England, October 2021

such as GP practices to be successful.[223] These centres are based in a range of settings like football stadiums and enable diagnostic tests closer to home to help tackle the backlog caused by Covid-19 pandemic.[224]

However, NHS Providers argued that available funding for the community is often short-term and access routes remain opaque.[225] NHS Confederation stated that community interest companies are often excluded from national funding pots and only some providers are able to self-fund digital programmes.[226] We are encouraged that the Government response mentions new positive initiatives following the establishment of Integrated Care Systems (ICSs). These will be accompanied by a three-year front line digitisation funding allocation to support digitisation of acute, mental health, ambulance and community services.[227] Furthermore, NHS Digital and NSHX are merging with NSHE/I, and the Government states this will ensure that "the health and care sector is fully equipped to face the future and deliver for patients".[228] This may be a positive step in addressing the long-standing issues with IT systems such as the connections between primary, community and secondary care, and different employers using separate systems within the same sector.

Considering the written evidence, and what we heard during the roundtables we conclude that the funding aspect of this commitment requires improvement.

Did the commitment achieve positive impacts for patients and people in receipt of social care?

Rating: Inadequate

The Royal College of Pathologists and British Society for Echocardiography state that if the commitment was met there would be great patient benefit including faster and more accurate diagnosis and monitoring of conditions. However, they argue that the NHS does not currently have a sufficient IT and digital infrastructure which impedes the daily work and training of doctors which impacts on patient care.[229]

The British Dental Association raised patient safety concerns due to a lack of NHS dentists' access to summary care records.[230] A summary care record is an electronic record of patient information created from GP medical records, including information such as current medication and allergies. Having access to summary care records can help ensure patient safety by ensuring that dentists have access to accurate and up to date details of a patient history, which is of growing importance due to an ageing population living with multiple long-term conditions and medications.[231] One participant during our stakeholder roundtable told us:

223 Royal College of Pathologists (EPW0034)
224 Department of Health and Social Care, Press release – 40 community diagnostic centres launching across England, October 2021
225 NHS Providers (EPW0011)
226 NHS Confederation (EPW0048)
227 Department of Health and Social Care (EPW0062)
228 Department of Health and Social Care, Major reforms to NHS workforce planning and tech agenda, 22 November 2021
229 Dr Carolyn Downs (EPW0001); British Society of Echocardiography (EPW0066); Royal College of Pathologists (EPW0034)
230 British Dental Association (EPW0052)
231 Health Foundation, Our ageing population: how ageing affects health and care need in England, December 221

> *"In dental practices we don't have access to the summary care record, which is a real logjam especially when you're dealing with people with comorbidities. It delays treatment because you have to contact the medical profession to actually get some of the information that you need- and that ties them up as well."*[232]

Diabetes UK was positive about the potential use of technology to help people manage their condition, including the use of wearable technology however, they were also concerned that some people were not able to access these life-changing technologies.[233] Data from the National Paediatric Diabetes Audit has indicated a six-year widening trend of inequalities in the care of children and young people with type 1 diabetes, which includes worsening access to diabetes technology from those in socially deprived areas.[234]

During our stakeholder roundtables we also heard that there are issues to do with digital literacy of people accessing healthcare services and concerns about health inequalities as a result of people not being able to afford to maintain or access the technology required:

> *"The massive concern about reliance on digital technology to deliver healthcare is the approximately 30% of the population who will not be digitally literate or, more importantly, not be able to afford data. They cannot physically engage because they cannot afford data. And this potentially worsens health inequality. So please can we stop thinking we can solve workforce problems by putting everything to digital, because we will make the 30% who are already struggling to engage have even worse outcomes. People have phones, but they cannot afford the contracts to maintain the data required and the video consultation burns through data like you wouldn't believe."*[235]

Although the commitment itself is welcomed and has the potential to achieve positive impact for patients and people in receipt of social care, the evidence we have received has not lead us to conclude that the commitment is being met. We have therefore concluded that this area of the commitment is inadequate.

Was it an appropriate commitment?

Rating: Inadequate

There is no specificity in this commitment about who 'community-based staff' are. We have interpreted for the purpose of evaluation that this commitment relates to the NHS, however we are aware that there will be some overlap with social care. The lack of specificity makes evaluating it challenging, and there is no definitive deadline on which to evaluate progress against. The evidence we have received seems to suggest that it is was not possible to meet the commitment without staff having sufficient training, improved interoperability of systems and long-term funding in digital transformation.[236] We did not receive any evidence about if this commitment allow staff to increase the amount of time they can spend with patients, however evidence from our stakeholder roundtables

232 Stakeholder roundtable
233 Diabetes UK (EPW0044)
234 Royal College of Paediatric and Child Health, Annual report 2020–21: care processes and outcomes, April 2022
235 Stakeholder roundtable
236 NHS Providers (EPW0011); Academy of Medical Royal Colleges Trainee Doctors' Group (EPW0023)

suggest that there is the potential for technology introductions to have an impact on staff wellbeing, and greater consideration needs to be taken on the ways that technology may alter working practices:

> *" … It's difficult, because with the introduction of technology, sometimes there can be blurred lines. So your work commitments might spill into your personal commitments, because of the technology that you were using which could lead to higher stress."*[237]

> *"[…] it's interesting that there's a correlation within the pledge that increasing technology will increase time with patients, and then increase the numbers of patients that people can see. I'm not sure how they've come to that conclusion. I think that shows a distinct lack of understanding about what technology brings to the clinical area, and in actual fact it can, in many cases, take very valuable and experienced clinical time away and reduce the number of patients that you can see."*[238]

Interim findings from a QNI survey show that staff feel that technology can be impersonal, as it is not always well designed and acts as a barrier to interacting with patients. Respondents stated that there was often replication of work due to system design. The interim findings also showed that another aspect to consider in terms is the ergonomic issues it can cause for staff. This includes having to carry heavy laptops and working in cars, which could have a negative impact on musculoskeletal health.[239]

Through our evaluation, we have found that there is a lack of understanding of what action is needed to meet this commitment, and a poor understanding of technological impacts on working practices and outputs, which may be why there seem to have been little progress on meeting this commitment nationally. Therefore, we conclude that the appropriateness of this commitment is rated as inadequate.

237 Stakeholder roundtable
238 Stakeholder roundtable
239 Queen's Nursing Institute (EPW0089)

3 Wellbeing at work

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
"Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services."	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
"Reduce bullying rates in the NHS which are far too high."	Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate
"Listen to the views of social care staff to learn how we can better support them – individually and collectively."	Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate

In this section we provide an assessment of the Government's commitments focusing on ensuring the wellbeing of social care and NHS staff. Three commitments were selected for this policy area:

"Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services."[240]

and

"Reduce bullying rates in the NHS which are far too high."[241]

and

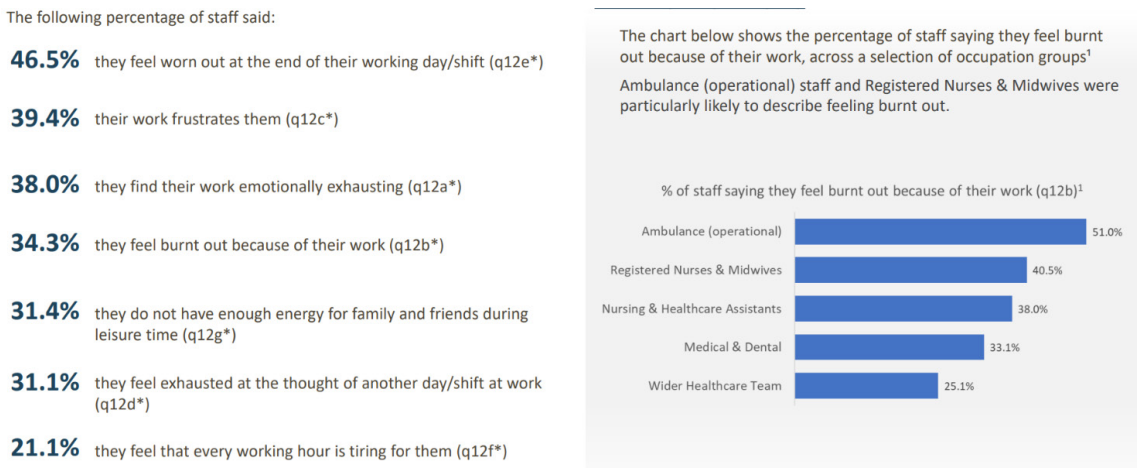
"Listen to the views of social care staff to learn how we can better support them– individually and collectively."[242]

Staff wellbeing is vital for a well-functioning health and care system. In its response to our evaluation, the Government states that "it is imperative that we look after the NHS workforce and continue to prioritise their safety, health and wellbeing".[243] On its website the NHS states that "the NHS can only achieve the extraordinary things for patients that it does if the safety, health and wellbeing of our people is recognised as a key priority".[244]

240 The Conservative and Unionist Party Manifesto 2017, p. 68
241 The Conservative and Unionist Party Manifesto 2017, p. 68
242 Department of Health and Social Care, Adult Social Care: Quality Matters overview, July 2017, p.8
243 Department of Health and Social Care (EPW0062)
244 NHS, "Support Available of Our NHS People", Accessed 130622

Similarly, the Government's White Paper 'People at the Heart of Social Care', highlights that the quality of social care can directly improve individuals' quality of life, and that the social care workforce is a core component of that.[245] However, the NHS Staff Survey 2021 shows that almost half the workforce (43%) did not agree that their organisation takes positive action on health and well-being.[246]

Figure 7: Wellbeing statistics from the NHS Staff Survey 2021



Source: NHS Staff survey 2021[247]

Other worrying statistics from the 2021 survey are displayed in Figure 7 above, including that 34.3% of respondents stated that they feel burnt out because of their work and 31.1% who said that they feel exhausted at the thought of another day/shift at work.[248] There is no corresponding staff survey concerning wellbeing run for staff in social care settings, which Hospice UK states in their written submission makes it "exceptionally challenging" to collect and analyse the views of social care staff and to better understand how to improve support for them. However, Hospice UK goes on to state that the "fragmented and independent nature" of social care makes it difficult to collect consistent data across the system and creating ways to listen to voices.[249] Dr Carolyn Downs pointed to research done collecting feedback from social care staff, which seemed to suggest that negative opinions of social care staff were downplayed.[250]

The Covid-19 pandemic has further increased the demand on services, and the pressures on staff. A recent study of the UK's health and social care workforce found that during November 2021-February 2022, respondents reported working more overtime since the start of the pandemic with 60% reporting feeling overwhelmed by increased pressures. This study also found that those staff who were experiencing high levels of stress and

245 Department of Health and Social Care, People at the heart of care: Adult social care reform white paper, 2021, p.26
246 NHS, NHS Staff Survey 2021, March 2022
247 NHS, NHS Staff Survey 2021, March 2022
248 NHS, NHS Staff Survey 2021, March 2022
249 Hospice UK (EPW0053)
250 Dr Carolyn Downs (EPW0001)

burnout were more likely to consider changing their employer.[251] Another study surveying social care workers found that 81% of respondents stated that the amount of time their jobs made them feel tense, uneasy, or worried had grown since the onset of the pandemic.[252]

The commitments we have selected in this chapter refer to the mental and physical health support NHS staff receive, and the consultation and support of social care staff, ensuring they feel supported in their professional roles. However, as has become clear to us during the course of our evaluations to date, workforce pressures, including continued recruitment and retention challenges, have a negative impact on the success of Government commitments. There was a broad consensus in the evidence that wellbeing services or consultation of staff cannot counteract unsustainable workforce pressures caused by patient and people in receipt of social care demand surpassing workforce capacity. A reasonable workload, time to rest and recover and adequate renumeration for the work done were a few things cited as important aspects of ensuring staff wellbeing. The quality and availability of wellbeing services aimed at improving staff wellbeing becomes almost obsolete if staff are overworked to the point that they do not have time to access them. There is also a risk that wellbeing services just treat the symptoms (such as stress and burn out) rather than the workload causing much of the poor wellbeing to begin with.

Commitment 1: "Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services."

Overall Commitment Rating and Overview of the new services for NHS employees commitment: Requires improvement

Some of the evidence we received indicated there had been an increase in the number of wellbeing services offered, and pointed to positive local initiatives aimed at improving staff wellbeing.[253] Stakeholders recognised initiatives like the NHS Civility and Respect Toolkit,[254] and the Government referred to a "national package of support" in place for NHS staff which includes mental health and wellbeing hubs, and to specialised support for staff who had experienced trauma.[255] These system-wide mental health and wellbeing hubs were accessed 62,000 times between February 2021 and March 2022.[256] The 2020 NHS People Plan highlights staff health and wellbeing, support for flexible working, improved culture and leadership and tackling inequalities as a focus in retaining NHS staff.[257] The NHS Operational Guidance in 2021/22 and 2022/23 instructs leaders across the NHS to consider the health and wellbeing of staff as a strategic priority.[258]

251 Health and social care workers' quality of working life and coping while working during the COVID-19 pandemic: Findings from a UK Survey, May 2022, p.42
252 PSSRU, COVID-19 and the Wellbeing of the Adult Social Care Workforce: Evidence from the UK, December 2020, p.10
253 For example: NHS Confederation (EPW0048); Academy of Medical Royal Colleges Trainee Doctors' Group (EPW0023); Medical Protection Society (EPW0021)
254 NHS Confederation (EPW0048)
255 Hospice UK (EPW0053)
256 Department of Health and Social Care (EPW0062)
257 NHS, We Are the NHS: People Plan 2020/21 – action for us all, July 2020, p.17
258 Department of Health and Social Care (EPW0062)

Although stakeholders welcomed wellbeing services, many were hesitant about whether they would achieve positive impacts if staff were not also given a manageable workload.[259] The Royal College of Physicians and Surgeons of Glasgow told us that the Covid-19 pandemic had focused political and public debates on the wellbeing on the workforce and stated that problems are primarily the result of "chronic excessive workloads" which they argue have been intensified by the Covid-19 pandemic.[260] Similarly, the Academy of Medical Royal Colleges Trainee Doctors' Group stated that the resumption of many NHS services and the current backlog was leading to increased levels of burnout in the trainee workforce.[261] The Royal College of Nursing pointed to their 2020 staff survey which showed that a major reason why nurses choose to leave the profession is increased stress levels, which many of their respondents testified to be much higher now compared to before the pandemic.[262]

Was the commitment met overall (or on track?)

Rating: Requires improvement

The pandemic put a significant strain on the healthcare workforce, and we heard numerous testimonies from a workforce who have gone above and beyond for too long, leading to burnout and diminishing morale.[263] The Covid-19 pandemic has had a significant impact on the mental health and wellbeing of staff who have been under substantial pressure, whilst experiencing the same challenges as the rest of the population in terms of being isolated from family and friends and disruption to day-to-day life. Initiatives were developed to support staff, including psychological first aid training and online peer support.[264] In its response, the Government recognised that there is an opportunity to learn from schemes and types of support initiated during the Covid-19 pandemic which worked well. One of the participants during our roundtable discussions told us that they thought there was good access to mental health support during the Covid-19 pandemic, which they largely attributed to the fact that psychologists could be redeployed to support staff. However, they said that the support had not continued post-Covid when everyone was back to their "normal-day job", catching up on backlog of patients. They also indicated a shift to app-based support which they did not think was as effective, especially considering that people now would have less time to access it, concluding:

> *"So I think there was a promising start during Covid-19, because there was just a little bit more capacity in the system counterintuitively, but it's not gone back to where it was. I accept that the intention is good, but I'm not sure that the reality lives up to it."*[265]

259 For example: Royal College of Anaesthetists (EPW0017); Chartered Society of Physiotherapy (EPW0058)
260 Royal College of Physicians and Surgeons of Glasgow (EPW0015)
261 Academy of Medical Royal Colleges Trainee Doctors' Group (EPW0023)
262 Royal College of Nursing (EPW0039)
263 For example: Faculty of Sexual and Reproductive Healthcare (EPW0029); British Association of Dermatologists (EPW0030); Royal College of Physicians (EPW0031); Royal College of Pathologists (EPW0034); Royal College of Nursing (EPW0039); Hospice UK (EPW0053); Royal College of Radiologists (EPW0056); Chartered Society of Physiotherapy (EPW0058); Academy of Medical Royal Colleges Trainee Doctors' Group (EPW0023)
264 Parliamentary Office of Science and Technology, Mental health impacts on Covid-19 on NHS healthcare staff, 2020
265 Stakeholder roundtable

An initiative aimed at improving staff wellbeing is the wellbeing guardians, which was introduced following the 2019 NHS Staff and Learners' Mental Wellbeing Review. The wellbeing guardian's role "is likely to vary" in different organisations as national guidelines set out that the role should be adapted after the specific organisational need. It "should" however be someone who can "independently challenge senior organisational leaders" and are expected to sit within a Non-Executive Director's portfolio.[266] In a letter to the Expert Panel, the then Secretary of State told us that 93% of NHS provider trusts have reported having a wellbeing guardian in post.[267] Considering the impact of this initiative, the then Secretary of State states that having a wellbeing guardian in each NHS organisation is "pivotal" as part of the Covid-19 recovery, and in working towards an "organisational culture where staff are being cared for and enabling them to pass that care on to patients and service users". In addition to this, the letter sets out that an early indicator of wellbeing guardians having an impact is the "increased discussion of wellbeing/wellbeing guardians" in board papers. UNISON questioned whether the wellbeing guardian role would be taken up across trusts, as some NHS settings (such as primary care) do not have Non-Executive Directors.[268] The letter from the then Secretary of State addresses this point, stating that further work is needed to "increase the reach" of wellbeing guardians at a system level, such as primary care.[269]

However, the majority of evidence we heard argued that wellbeing services have little impact when the staff are over-worked, and that this had been the case even before the pandemic.[270] We therefore considered that the commitment overall 'Requires Improvement'.

266 NHS, Wellbeing Guardians, Accessed 150622

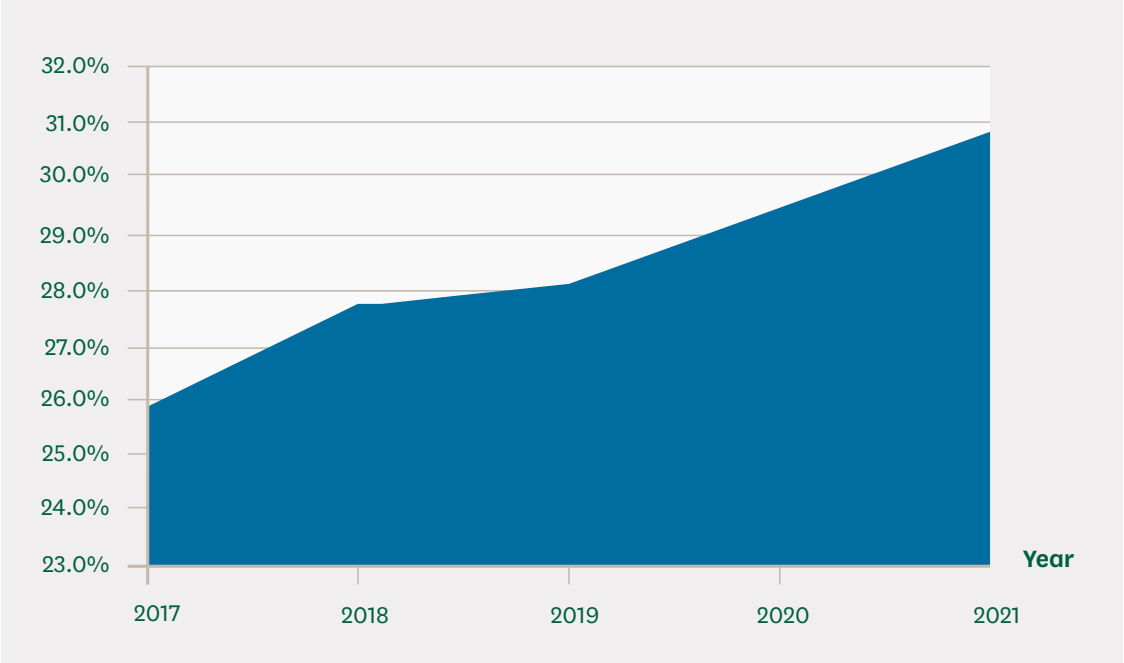
267 Letter from the then Secretary of State for Health and Social Care Sajid Javid to Professor Dame Jane Dacre, 20 June 2022

268 UNISON (EPW0047)

269 Letter from the then Secretary of State for Health and Social Care Sajid Javid to Professor Dame Jane Dacre, 20 June 2022

270 For example: Royal College of Anaesthetists (EPW0017); Royal College of Physicians and Surgeons of Glasgow (EPW0015)

Figure 8: Staff stated to have experienced musculoskeletal problems as a result of work activities



Data source: NHS Staff Survey 2021[271]

Musculoskeletal (MSK) conditions affect joints, bones and muscles, and can also include autoimmune diseases and back pain. According to the NHS there are over 200 MSK conditions, which affect 1 in 4 of the adult population. MSK conditions are also associated with a large number of co-morbidities (additional diagnoses) such as diabetes, depression and obesity.[272] The work carried out by NHS staff is often physically demanding. The British Society of Echocardiography (BSE) stated that MSK injuries were prevalent in the echocardiography workforce due to close patient contact.[273]

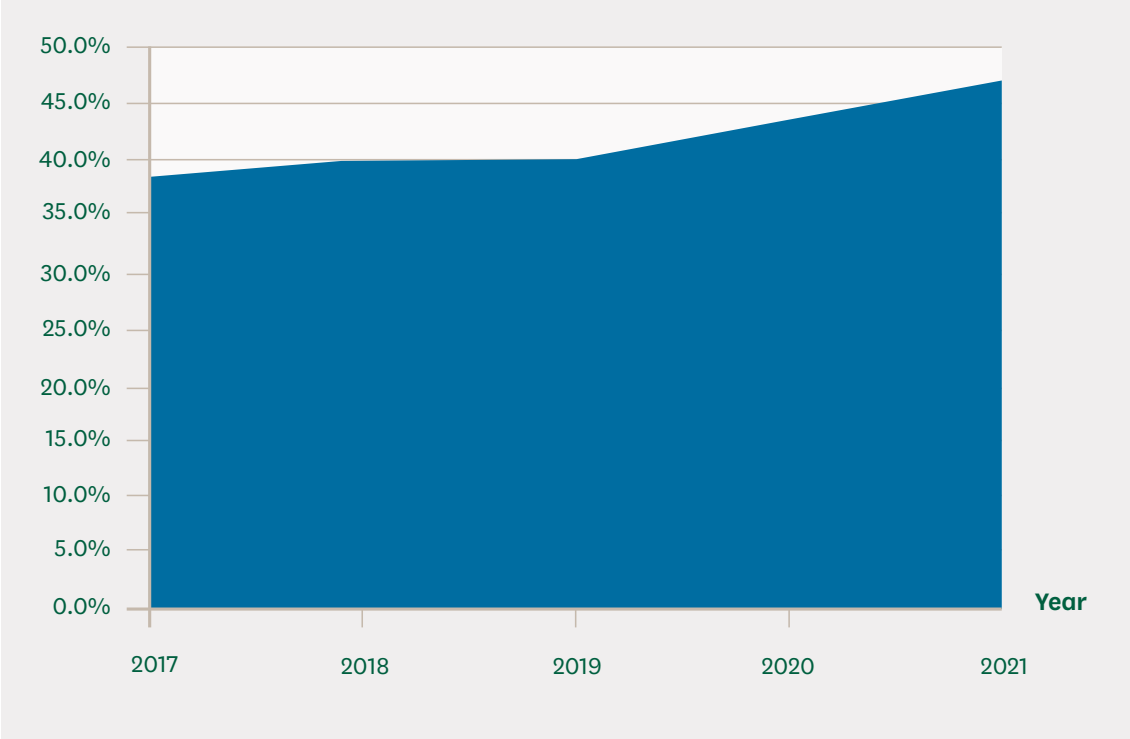
In the Government's response, they set out that the NHS Health and Wellbeing framework has a section devoted to physical health with an emphasis on MSK, and that a national Commissioning for Quality and Innovation incentive scheme promoting workplace health (including MSK) will be introduced in 2022/23.[274] However, an increasing number of NHS staff are suffering from MSK related injuries. In the last 12 months, 30.8% of NHS staff experienced musculoskeletal problems as a result of work activities. As illustrated in Figure 8 this number has been rising steadily since 2017, when it was 25.8%.[275]

In a letter to the Expert Panel, the then Secretary of State told us that although it is possible to say how many "contacts" there have been from health and social care staff to the 40 mental health and wellbeing hubs (62,000 between February 2021 and March 2022), it is not possible to say how many of these were MSK services specific. However, based on a request from the Department to one occupational health service covering three trusts,

271 NHS, NHS Staff survey 2021, March 2022
272 NHS, Musculoskeletal conditions, Accessed 140622
273 British Society of Echocardiography (EPW0066)
274 Department of Health and Social Care (EPW0062)
275 NHS, NHS Staff survey 2021, March 2022

their records show that MSK referrals have remained broadly unchanged from 2019/20 to 2021/22. This statement was however caveated with a line stating that this may not be representative of the national picture.[276]

Figure 9: Staff stated to have felt unwell as a result of work-related stress



Data source: NHS Staff Survey 2021[277]

Nearly half (46.8%) of staff responding to the survey stated that they have felt unwell because of work-related stress. This percentage has increased in the last 4-year period and is now 8% higher than in 2017.[278] The most frequently reported reason for sickness absence, and accounting for over 593,228 full time equivalent days lost, is anxiety, stress, depression and other psychiatric illnesses, and accounts for 23.7% of all sickness absence in December 2021. This has decreased slightly since November 2021 when the figure was 25.7%.[279]

The General Medical Council's annual survey 2021, which surveys both trainee doctors and those training them, found that a third of trainees who responded felt burnt out to high or very high degree because of their work, compared to around a quarter in previous years. The survey also found that three in five trainees always or often felt worn out at the end of a working day. However, this percentage was considerably higher amongst GP trainees, where 71% said they were always or often worn out at the end of the day. The survey also found that 25% of trainers felt burnt out to a high or very high degree, which is two percentage points higher than in 2019. Encouragingly, however, the majority of trainees participating in the survey felt supported and valued at work.[280]

276 Letter from the then Secretary of State for Health and Social Care Sajid Javid to Professor Dame Jane Dacre, 20 June 2022
277 NHS, NHS Staff survey 2021, March 2022
278 NHS, NHS Staff survey 2021, March 2022
279 NHS Digital, NHS Sickness Absence Rates, October 2021 to December 2021, Provisional Statistics, April 2022
280 General Medical Council, National Training Survey 2021, July 2021

The General Medical Council's state of medical education and practice barometer survey 2021 presented some concerning findings:

- over the last year three in ten (30%) felt unable to cope with their workload at least once a week,
- doctors felt more burnt out in 2021 than they did in 2020, and
- almost one in five doctors (17%) reported having taken a leave of absence due to stress over the last year. This is a higher proportion than reported having done so in 2020 (14%) and 2019 (12%).[281]

Table 6: Quarterly sickness absence rates October-December from 2017 to 2021

	England	London	South West of England	South East of England	Midlands	East of England	North West	North East and Yorkshire
2017	**4.43%**	3.65%	4.37%	4.17%	4.74%	4.33%	5.07%	4.83%
2018	**4.44%**	3.73%	4.46%	4.11%	4.76%	4.36%	5.14%	4.72%
2019	**4.73%**	3.98%	4.69%	4.36%	5.10%	4.51%	5.52%	5.06%
2020	**4.84%**	3.96%	4.47%	4.48%	5.17%	4.52%	5.96%	5.46%
2021	**5.81%**	5.28%	5.53%	5.23%	6.07%	5.66%	6.88%	6.40%

Source: NHS Digital, NHS Sickness Absence Rates, October 2021 to December 2021, Provisional Statistics, April 2022[282]

The most up to date quarterly sickness absence rates statistics are from October-December 2021. Comparing those to the four previous October-December quarters, rates have increased (illustrated above in Table 6). In 2017 the rates were 4.4% across England, and in 2021 it was 5.8%, however there are regional differences. Sickness rates have been consistently higher in the North West of England, which recorded a 6.9% sickness absence rate in the October-December quarter 2021, compared to a 5.2% absence rate in the South East of England during the same time period.[283]

In conclusion, our assessment of the Government's progress against this commitment is "Requires Improvement". The Government is making progress on ensuring there are adequate services for NHS staff, but data collected clearly indicates that more work needs to be done to ensure that staff have access to the support that they need. We are encouraged by the Government response which indicates an understanding that more work needs to be done:

> *"While much is being done, we are not complacent and both Ministers and NHSEI continue to seek to understand what further action will help support staff in keeping well and feeling supported while doing the difficult jobs that they do."*[284]

The sickness absence rates (often due to mental health, stress or musculoskeletal problems), and the NHS staff survey results, and much of the evidence we have received suggests there

281 General Medical Council, The state of medical education and practice barometer survey 2021, December 2021
282 NHS Digital, NHS Sickness Absence Rates, October 2021 to December 2021, Provisional Statistics, April 2022
283 NHS Digital, NHS Sickness Absence Rates, October 2021 to December 2021, Provisional Statistics, April 2022
284 Department of Health and Social Care (EPW0062)

is still a lot to be done to meet this commitment. This commitment mentions ensuring there is "quicker access" to support, and the evidence seems to suggest that despite improvements and investment, demand is quickly surpassing the capacity of support services. The Government states that it is making wellbeing of staff a strategic priority through introduction of frameworks and policies, and that it is providing various services to support staff wellbeing. However, unsustainable workloads leave staff stressed and burnt-out, and means they do not have time to access services to improve their wellbeing. The Royal College of Physicians concluded:

> *"We often hear from members that they are offered wellbeing or yoga classes for free, but to be attended in their own time. When consultants are working on average 11% more than they are contracted for, that is simply not enough."*[285]

Was the commitment effectively funded (or resourced?)

Rating: Requires improvement

According to the Government response we received, £43 million was invested in wellbeing hubs and national staff mental health offer in 2021/22 and a further £15 million was invested into 14 healthcare systems across all seven regions to "enable them to develop tailored health and wellbeing offers which meet the needs of their local workforce". In their response, the Government state that the currently available support and the mental health hubs will continue to be available to staff in 2022/23.[286]

Some stakeholders expressed concerns regarding how to access funding for wellbeing support and whether specific interventions and schemes would have dedicated funding attached to it. Many stakeholders also called for assurances that wellbeing support put in place during the Covid-19 pandemic should be made permanent.[287] However, most of the submissions cited a lack of investment in expansion of the workforce as the key issue hindering improvement of the wellbeing of NHS staff.[288]

NHS Providers emphasised that there needs to be continued investment in staff health and wellbeing, and that although many trusts are increasing local support, more centralised support is needed to address what is characterised as a "growing issue". This support should take the additional stress caused by rising costs of living into account, and recommended that:

> *"Ensuring there is flexibility to use funding on the interventions that have the greatest impact is essential and prioritising short- and longer-term evaluation as part of funding plans to ensure this happens."*[289]

Hospice UK also emphasised the need for specially tailored support to help staff who, through the pandemic, have witnessed a high number of excess deaths:

285 Royal College of Physicians (EPW0031)
286 Department of Health and Social Care (EPW0062)
287 For example: Faculty of Sexual and Reproductive Healthcare (EPW0029); NHS Providers (EPW0011); UNISON (EPW0047); The Royal College of Physicians and Surgeons of Glasgow (EPW0015)
288 For example: Royal College of Anaesthetists (EPW0017); Royal College of Physicians (EPW0031)
289 NHS Providers (EPW0011)

> "*Whilst Government and NHSEI support for Our Frontline was hugely welcome, there is still significant unmet need for bereavement and mental wellbeing support for health and care workers, including those working in palliative and end of life care. Many health and care staff are still living with trauma, grief and burnout created or accelerated by the pandemic and require additional support.*"[290]

We were encouraged by some of the evidence we received which indicated that funding for staff wellbeing support is available, but there is uncertainty of what this support will look like going forward. As highlighted earlier in this chapter, the worrying statistics indicating NHS staff are feeling stressed and burnt-out and suffer from MSK conditions because of their job, suggests to us that more needs to be done and further investment is required. This therefore leads us to conclude that the funding aspect of this commitment "Requires Improvement".

Did the commitment achieve positive impacts for patients and people in receipt of social care?

Rating: Requires improvement

There was consensus in the evidence we received that staff who feel well supported and are less stressed provide better care. It was also clear that failure to look after staff put patients at risk.[291] The Society of Occupational Medicine (SOM) stated in their submission that occupational health has an important role in protecting staff from MSK related injuries. They identified early intervention through advice or management as key in helping to reduce absence rates and to facilitate a quicker return to work following an injury. By managing MSK injuries in time, the SOM argues that cost savings can be made in ensuring conditions do not worsen or lead to mental health issues often resulting in staff is away from work for a longer period.[292]
On its website, the NHS states that:

> "*The NHS achieves extraordinary things for patients, but this is only possible if the safety, health and wellbeing of our people is recognised as a key priority. If we don't look after ourselves and our colleagues, we cannot deliver safe, high quality patient care.*"[293]

The evidence we have received suggests that workforce shortages are contributing to extra pressure, impacting the wellbeing of staff and their ability to provide care. The Royal College of Nursing stated that 67.6% of respondents in a membership recent survey felt that too much pressure at work had impacted on the quality of care they were able to provide for patients.[294] Similarly, Macmillan Cancer Support also stated that long-term staffing shortages across several areas of cancer care are impacting on patient care.[295]

290 Hospice UK (EPW0053)
291 For example: Royal College of Physicians (EPW0031); Royal College of Surgeons of Edinburgh (EPW0038); Royal College of Radiologists (EPW0056); Chartered Society of Physiotherapy (EPW0058)
292 Society of Occupational Medicine (EPW0036)
293 NHS, Supporting our NHS people, accessed 150622
294 Royal College of Nursing (EPW0039)
295 Macmillan Cancer Support (EPW0049)

The General Medical Council's 'The state of medical education and practice barometer' survey 2021 found that over half (59%) of the respondents at high risk of burnout had difficulty providing patient care at least once a week, compared to those at very low risk of burnout (9%). Furthermore, almost three in ten (29%) doctors reported that they had witnessed a situation in the last year where they believed a patient's care had been compromised. This was especially likely to have happened amongst respondents who were GPs (41%) and specialists (37%). Staff witnessing compromise to patient safety or care was more strongly associated with them being at high risk of burnout (49%) and high workloads. The same survey showed that nearly half, 47%, of the respondents who stated that they were 'struggling' with their workload.[296] During our roundtable, one of the participants told us that issues with wellbeing are often connected to services being overstretched:

> *"Moral injury gets talked about in terms of the fact that you feel like you're not providing a good enough service to patients, and that will contribute to burnout."*[297]

The rating for this commitment's positive impact on patients and people in receipt of social care is "Requires Improvement". This takes into account the potential for the commitment to have a positive impact, but recognises the work still needs to be done in regard to staff wellbeing before this positive impact can be fully realised. A well-staffed workforce with access to timely wellbeing support would positively impact on patients and people in receipt of social care. In direct contrast, staff who do not have timely access to wellbeing support and are working under unsustainable pressure and struggling to cope with their workload will continue to experience burn out and report poor wellbeing. The Royal College of Aestheticians conclude:

> *"This commitment did not focus on addressing the fundamental daily stresses and workload issues that clinicians face. While provision of mental health apps may be helpful in some cases, it is better to address the root causes of mental health problems rather than try to mitigate them once they emerge."*[298]

Was it an appropriate commitment?

Rating: Requires improvement

Considering the evidence, we have received in regard to this commitment, stakeholder consensus suggests that although the commitment itself was positive, the unsustainable workload experienced by many NHS professionals is both a major cause of stress and injury, and a barrier to accessing wellbeing services available. The Chartered Institute of Physiotherapy argued that more should be done to tackle the root causes of stress and ill health in the physiotherapy workplace, rather than relying on the individuals' resilience.[299] In her evidence to our evaluation, Dr Emma Hayward similarly pointed out that it would be better to seek to prevent injuries, rather than promising to treat them once they have occurred:

296 General Medical Council, The state of medical education and practice barometer survey 2021, December 2021
297 Stakeholder roundtable
298 Royal College of Anaesthetists (EPW0017)
299 Chartered Society of Physiotherapy (EPW0058)

> *"This is a laudable aim but does not acknowledge the role of the working environment in creating the problems in the first place."*[300]

The commitment sets out that it will introduce "new services", but some stakeholders questioned why the focus was not on improving the existing offer and ensuring the "essential wellbeing support" was available to staff.[301] Hospice UK stated that:

> *"[…] there has been a lack of initiative and meaningful work to assess the mental health needs of the health and care workforce. Whilst the Government can meet this commitment by introducing new, or faster access to, mental health services, an assessment of the level of need for such services and the funding and provision required to meet this need is essential to achieving meaningful improvement for staff."*[302]

In addition to this, stakeholders criticised the commitment's aim of introducing services, whilst not also setting out the structure or mechanism enabling staff to access them.[303] The British Medical Association pointed to its Covid-19 Tracker which found that 56% of respondents had not had access to NHS wellbeing support services provided by their employer or a third party during the pandemic.[304] The Medical Protection Society considered the commitment to be a step in the right direction, but concluded that it is too broad and does not go far enough in addressing healthcare mental health effectively. They said that the commitment is "high level" which makes it challenging to assess whether it is ambitious enough.[305] The lack of a time frame for what "quicker" access to services would mean in practice, was also something which some stakeholders criticised.[306]

Considering the evidence presented throughout this chapter, we conclude that the appropriateness of this commitment "Requires Improvement". In the context in which the NHS workforce has found itself in the last 5 years, the introduction of new services to support NHS staff is not as urgent as ensuring all staff have manageable workloads to prevent them feeling stressed or burnt-out in the first place. In addition to this the commitment is quite broad on what it seeks to achieve and provides no definition for what "quicker" access means.

Commitment 2: "Reduce bullying rates in the NHS which are far too high"

Overall Commitment Rating and Overview of the reducing bullying in the NHS commitment: Inadequate

Bullying and harassment of NHS staff is something which the Government has attempted to tackle for a long time, and which is set out in several strategies and policies. The NHS

300 Dr Emma Hayward (EPW0002)
301 Professor Jennifer Hunt (EPW0004)
302 Hospice UK (EPW0053)
303 Royal College of Physicians (EPW0031); Chartered Society of Physiotherapy (EPW0058)
304 British Medical Association (EPW0042)
305 Medical Protection Society (EPW0021)
306 Royal College of Surgeons of Edinburgh (EPW0038); Dr Emma Hayward (EPW0002); Medical Protection Society (EPW0021)

Long Term Plan,[307] the NHS People Plan 2020/21[308] and the NHS People Promise[309] all make commitments to address the issue, and to ensure the wellbeing of NHS staff. The NHS People Promise states:

> *"We do not tolerate any form of discrimination, bullying or violence."*[310]

NHSE/I has launched an NHS Civility and Respect programme which draws on the Vanderbilt Model of Professional Behaviour, which the toolkit identifies as "research on compassionate leadership and the function of teams to guide organisations to a new way of thinking, focus for action and the crucial link back to improved patient care".[311] According to the Government response, the NHS Civility and Respect programme seeks to tackle bullying and harassment in the NHS by promoting cultures of civility and respect through the establishment of positive working environments.[312] In a letter to the Expert Panel, the then Secretary of State told us that the toolkit has been shared with 10,000 NHS colleagues over the past 15 months.[313]

Our evaluation of this commitment has, however, led us to rate it as 'Inadequate'. The commitment we chose was specific to bullying and did not explicitly mention abuse. However, as the NHS staff survey asks whether staff have experienced bullying, harassment or abuse, we have decided to include figures and analysis of incidents of abuse of staff. In our view, violence is included within the term abuse. Further, analysis of the NHS Staff survey shows that the impact of violent attacks on staff is significant. Violent attacks contribute to 46.8% of staff feeling unwell as a result of work-related stress in the last 12 months, with 31.1% thinking about leaving the organisation.[314] New policies and strategies have been introduced, bullying, violence and harassment rates have remained on similar or worse levels. Certain parts of the health system have especially concerning levels of experiences of bullying, violence and harassment, such as ambulance trusts and nursing. In addition to this, recent reports point out that racial abuse and mistreatment led to some doctors leaving the profession. Furthermore, consistently worse experiences of staff from an ethnic minority background compared to their White colleagues are clear indicators that this commitment has not been met. We will address inequalities in more detail in Chapter 4.

Was the commitment met overall (or on track)?

Rating: Inadequate

In its response, the Government states that bullying and harassment in the NHS remains a concern which has an impact on staff wellbeing, engagement and patient care. The response refers to the NHSE/I's NHS Civility and Respect programme. This programme, the Government states, takes a preventative approach employing "practical resources" such as toolkits and online training. Through this programme, the Government states it

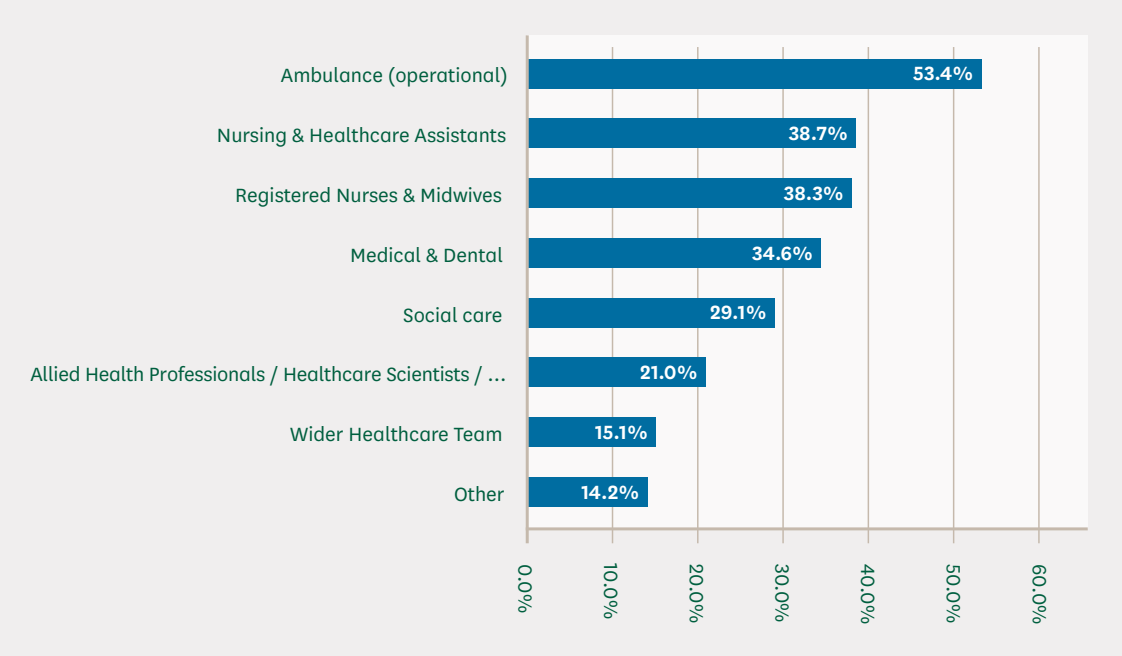
307 NHS, The NHS Long Term Plan, January 2019
308 NHS, The NHS People Plan 2020/21, July 2020
309 NHS, Our NHS People Promise, Accessed 150622
310 NHS, Our NHS People Promise, Accessed 150622
311 NHS, Supporting our staff – a toolkit to promote cultures of civility and respect, Accessed 150622
312 Department of Health and Social Care (EPW0062)
313 Letter from the then Secretary of State for Health and Social Care Sajid Javid to Professor Dame Jane Dacre, 20 June 2022
314 NHS, Violence prevention and safety, Accessed 290622

provides employers with evidence-based approaches to "raise awareness of what bullying looks like in the NHS" and how to reduce it. The Government response also refers to the NHS People Plan, which in turn sets out that "employers are responsible for preventing and tackling bullying, harassment and abuse against staff, and for creating a culture of civility and respect" and refers to the introduction of the Civility and Respect programme.[315] The response does not set out whether the Government assess that the commitment to have been met, and although it considers staff wellbeing and impact on patient care, it does not link a reduction in rates of bullying and harassment to improved retention of staff.

According to the NHS Staff Survey 2021 27.5% of respondents experienced at least one incident of harassment, bullying or abuse in the last 12 months. This has increased slightly since the 2020 survey (26.8%) but is lower than in 2018/19 (28.7%). Worryingly, less than half of those who have experienced bullying report it. According to the NHS Staff Survey 2021, only 48.7% state that they or a colleague reported the incident. This percentage is at a similar level to 2019 (48.6%) and 2020 (48.4%).[316] Analysis presented by Dr Wen Wang, Professor Roger Seifert and Professor Mickael Thelwall concludes that:

> *"[…] there has been no sign of significant improvement, and if anything, bullying in the NHS has become worse in some trusts".*[317]

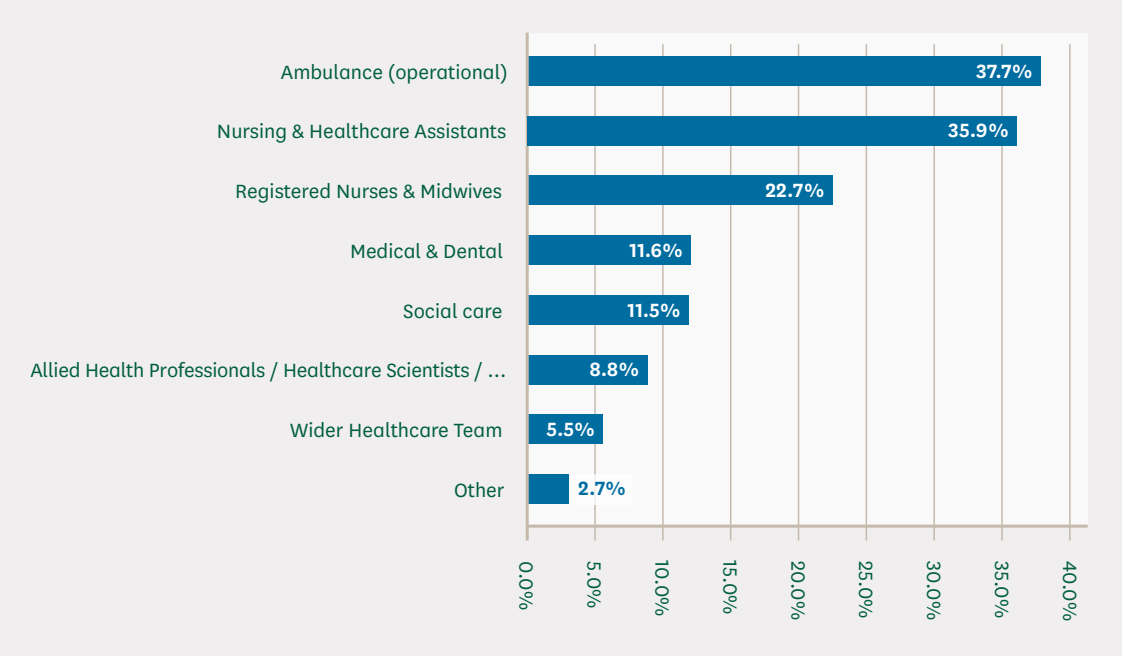
Figure 10: Staff who stated that they have experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public at least once in the last 12 months by occupation subgroup (NHS Staff Survey data 2021)[318]



As illustrated in Figure 10 above, more than half of all respondents working in the ambulance service reported experiencing harassment, bullying or abuse at work from patients or people in receipt of social care, their relatives or members of the public in the last 12 months. Rates are also high amongst nursing and health care assistants (38.7%), and registered nurses and midwives (38.3%).

315 Department of Health and Social Care (EPW0062)
316 NHS, NHS Staff Survey 2021, March 2022
317 Dr Wen Wang, Professor Roger Seifert, and Professor Mickael Thelwall (EPW0020)
318 NHS, NHS Staff Survey 2021, March 2022

Figure 11: Staff who stated that they have experienced physical violence at work from patients / service users, their relatives or other members of the public at least once in the last 12 months by occupation subgroup (NHS Staff Survey data 2021)[319]



Similar to the figures on bullying, ambulance staff are also overrepresented in the statistics of staff who in the past 12 months experienced physical violence at work, from patients or people in receipt of social care, their relatives or other members of the public. 37.7% of ambulance staff respondents reported having experienced this in the past 12 months. In 2021 the mental health charity Mind surveyed almost 4000 ambulance staff. The survey showed that 77% of staff felt that their mental health had worsened since the start of the coronavirus pandemic.[320] In February 2022 the Association of Ambulance Chief Executives launched a national campaign titled '#WorkWithoutFear' to highlight the abuse faced by the ambulance workforce (on average 32 ambulance staff are attacked or abused every day), and the profound impact it has on wellbeing. Daren Mochrie, Chair stated that:

> *"[…] Alcohol is the most prominent factor in assaults against ambulance staff, followed by drugs and people in mental health crisis. Race and sexuality have also increased as exacerbating factors in these assaults."*[321]

Nursing and healthcare assistants also reported being subject to physical violence, at very similar levels to ambulance staff (35.9%). The Royal College of Nursing (RCN) told us in their written submission:

> *"In 2021 the RCNs member hotline received 2,495 enquiries where bullying was raised. On average, this is just over 200 calls per month from members who have witnessed and/or experienced bullying in their workplace. In the*

319 NHS, NHS Staff Survey 2021, March 2022
320 MIND, Mind survey reveals toll of pandemic on ambulance workers' mental health, March 2021
321 Association of Ambulance Chief Executives, #WorkWithoutFear, February 2022

> *same year, 287 members who accessed RCN counselling (out of a total of 1367) reported that bullying and harassment was a significant issue for them, and 63 of those members revealed they had suffered violence or assault".*[322]

A common theme in the evidence we received was that good management and management structures are critical tools in tackling bullying, and of the importance of a caring and supportive environment.[323] In their written evidence Dr Wen Wang, Professor Roger Seifert and Professor Mickael Thelwall suggested that bullying by managers set a harmful precedent can be replicated by colleagues, and "augmented by the public".[324] The 'Health and social care review: leadership for a collaborative and inclusive future', also called the 'Messenger Review" reported in June 2022. It was led by General Sir Gordon Messenger and Dame Linda Pollard and investigated leadership across health and social care in England. The report concluded that:

> *"The sense of constant demands from above, including from politicians, creates an institutional instinct, particularly in the healthcare sector, to look upwards to furnish the needs of the hierarchy rather than downwards to the needs of the service-user. These pressures inevitably have an impact on behaviours in the workplace, and we have encountered too many reports to ignore of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance. We experienced very little dissent on this characterisation; indeed, most have encouraged us to call it out for what it is."*[325]

The review pointed to the NHS Staff Surveys which it argued testified to the normalisation of discrimination, bullying and blame cultures across the system.[326] The Government stated that it accepted the recommendations by the Messenger Review in full, and in response to the review the then Secretary of State for Health and Social Care Rt Hon Sajid Javid stated:

> *"The findings in this report are stark: it shows examples of great leadership but also where we need to urgently improve. We must only accept the highest standards in health and care–culture and leadership can be the difference between life and death. I fully support these recommendations for the biggest shake-up of leadership in decades. We must now urgently take them forward, to ensure we have the kind of leadership patients and staff deserve, right across the country."*[327]

In its response, the Government suggests that the 0.8% reduction of staff experiencing harassment, bullying or abuse from managers in the latest NHS staff survey compared to

322 Royal College of Nursing (EPW0039)

323 For example: Dr Wen Wang, Professor Roger Seifert and Professor Mickael Thelwall (EPW0020); Royal College of Pathologists (EPW0034); Royal College of Surgeons of Edinburgh (EPW0038); Royal College of Midwives (EPW0061); Royal College of Physicians and Surgeons of Glasgow (EPW0015)

324 Dr Wen Wang, Professor Roger Seifert and Professor Mickael Thelwall (EPW0020)

325 Health and social care review: leadership for a collaborative and inclusive future, Leadership for a collaborative and inclusive future, June 2022

326 Health and social care review: leadership for a collaborative and inclusive future, Leadership for a collaborative and inclusive future, June 2022

327 Department of Health and Social Care, Biggest shake-up in health and social care leadership in a generation to improve patient care, 8 June 2022

the previous one, is a "step in right direction".[328] However, we were very concerned about the overrepresentation of certain groups of staff in experiencing bullying, harassment, and physical violence at work. This includes staff from an ethnic minority background,[329] and staff living with a disability and colleagues identifying as part of the LGBTQ+ community.[330] We will discuss this inequality in treatment of staff in Chapter 4 on inequalities.

In conclusion, rates of bullying and harassment remain high in the NHS workforce and much of the evidence we have received suggest that current efforts by the Government have a limited impact in addressing this. Stakeholders agreed that the work environment is vital in helping to address poor behaviour. Poor culture amongst staff and unsustainable workloads will inevitably lead to staff being overworked and taking it out on other staff. An attempt to address workplace culture, and environment, is essential in tackling bullying rates. Organisations should be working towards a workplace where staff are well looked after, and where speaking up when subjected to poor behaviour is welcomed and encouraged. As much is yet to be done in order to tackle rates of bullying in the NHS, we conclude that the rating for whether this commitment is met or on track to be met is 'Inadequate'.

Was the commitment effectively funded (or resourced?)

Rating: Inadequate

The NHS has estimated that bullying "costs" the organisation £2 billion pounds every year.[331] The Government states that the investment in the NHS Civility and Respect programme is part of "an overall comprehensive package of investment" made through the People Plan to enhance staff experience and well-being. The NHS Civility and Respect programme offers "toolkits, online training and other practical resources and evidence-based approaches made available to employers to raise awareness of what bullying looks like in the NHS and consider how to reduce it." The Government's response goes on to state that:

> *"Improving workforce experience and reducing bullying and harassment can reduce staff sickness absence and the significant cost attached to bullying."*[332]

Much of the evidence we have received seems to indicate that poor behaviour such as bullying often stems from poor management and workplace cultures, and an underfunded workforce leading to overstretched teams. The Royal College of Midwives concluded:

> *"Individuals are responsible for their own behaviour, of course, but bullying rates are also fuelled by group and territorial conflicts, and by local culture and leadership."*[333]

Similarly pointing to the importance of a healthy work environment, the British Medical Association concluded:

328 Department of Health and Social Care (EPW0062)
329 NHS, NHS Workforce Race Equality Standard, March 2022
330 NHS Providers (EPW0011)
331 NHS, Civility and Respect, Accessed 290622
332 Department of Health and Social Care (EPW0062)
333 Royal College of Midwives (EPW0061)

> *"The underlying environmental factors that are likely to fuel such behaviour in the NHS must be addressed. It is unsurprising that a system with such a strong focus on finance and targets translates into pressures on staff and bullying down the line."*[334]

The Royal College of Surgeons of Edinburgh pointed out that "it is not possible to legislate for culture change", and was hesitant to the effect of the commitment without an understanding of the Government's plan to ensure there are support systems for assisting local leadership to lead cultural change.[335] NHS Confederation furthermore pointed to the link between adequate staffing and a good working environment, concluding that "central government intervention to tackle a critical shortage" in workforce would "go a long way" in tackling bullying.[336]

The question of whether this commitment is effectively funded leads back to ensuring there are structures in place to encourage a good work environment, where staff display good behaviour and are aware of where to turn to, and importantly feel able to do so, if they experience harassment or bullying. Evidence seemed to indicate that strengthening management structures and developing the leadership within an organisation is a vital first step in tackling bullying rates. There was also agreement amongst stakeholders that although initiatives to tackle bullying and harassment are welcome, they will only have limited impact as long as staff are dealing with unsustainable workloads and staff shortages within their teams. The Government's investment in the NHS Civility and Respect programme is a welcome step, but the evidence we have received seems to suggest that one of the major factors behind high bullying rates are systematic challenges which impact on staff behaviour. Until there is adequate funding to address these issues, and substantive investment in the workforce, we worry that current initiatives will have a limited effect on tackling bullying rates. We therefore conclude the rating for adequate funding of this commitment is 'Inadequate'.

Did the commitment achieve positive impacts for patients and people in receipt of social care?

Rating: Requires improvement

Poor behaviour amongst, and treatment of, staff can have a detrimental effect on patient care.[337] A study observing 24 Neonatal Intensive Care Unit (NICU) teams found that rudeness in staff teams treating patients explained nearly 12% of the variance in diagnostic and procedural performance.[338] The Ockenden review, published in March 2022, identified bullying and undermining in teams as one of the reasons for the poor maternity services at the Shrewsbury and Telford Hospital NHS Trust causing the preventable death of many mothers and babies.[339] The Point of Care Foundation's review Behind Closed Doors found that:

334 British Medical Association (EPW0042)
335 Royal College of Surgeons of Edinburgh (EPW0038)
336 NHS Providers (EPW0011)
337 Villafranca et al, Disruptive behaviour in the perioperative setting, Canadian Journal of Anaesthesia (November 2017) Vol. 64, p.128
338 Riskin A., et al, "The Impact of Rudeness on Medical Team Performance: A Randomized Trial", Paediatrics (September 2015), Vol. 136, p.1
339 Ockenden Review, Final findings, conclusions and essential actions from the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust, March 2022

> *"Patient safety and the quality of the care the patient receives are dependent on the members of staff who interact with the patients being psychologically and emotionally, as well as physically, present with the patient and the family, and able to be responsive and engaged with colleagues. If staff are under sustained pressure and feel unable to offer patients the care they believe each patient needs, they suffer so-called 'moral distress' and their sensitivity to stress and burnout is heightened."*[340]

Bullying and harassment also has a negative impact on staff retention, which ultimately leads to a disruption in patient care due to gaps in the workforce. The Nuffield Trust stated, in their submission, that workforce retention along with staff welfare and patient safety is being challenged by rising pressures in the NHS.[341] The Royal College of Anaesthetists concluded that many NHS employees struggle to maintain good mental health and wellbeing which in turn they cited as the "key factor" hindering retention in the anaesthesia workforce with adverse impact on patients.[342] The British Medical Associations 'Racism in Medicine' report showed that many doctors consider leaving or have left their jobs because of racial discrimination. Shockingly, almost a quarter of respondents (23%) said they had considered leaving a job because of racial discrimination and a further 9% stated that they had left a job because of it.[343]

While workforce shortages are a major factor in bullying and harassment rates in the NHS, there is much that could be done related to good management that has not been achieved. We are encouraged by the recent tools, programmes and initiatives introduced by the Government to tackle bullying rates. However, we remain convinced that safe patient care will be at risk as long as staff are experiencing bullying and harassment while caring for patients and people in receipt of social care. Ineffective management of bullying and harassment incidents combined with increased workload exacerbate poor behaviour within staff teams, which inevitably impacts patient care either due to staff leaving the profession or through poor quality care provided.

Was it an appropriate commitment?

Rating: Requires improvement

The Nuffield Trust argued, in their submission, that the data collected in NHS staff survey on experiences of bullying and harassment is not detailed enough to provide properly targeted approaches. They call for an intersectional understanding of staff experience, which would be possible through more granular level data.[344] Stakeholders suggest that approaches to tackle bullying should be developed with staff to avoid "one-size fits all" approach,[345] and scrutinised to identify hotspots and worrying trends.[346] The Government's response states that:

340 Point of Care Foundation, Behind Closed Doors, July 2017
341 Nuffield Trust (EPW0051)
342 Royal College of Anaesthetists (EPW0017)
343 British Medical Association, Racism in Medicine, June 2022
344 Nuffield Trust (EPW0051)
345 NHS Providers (EPW0011)
346 Royal College of Nursing (EPW0039)

> "*NHSEI is working with ICSs/Trusts in all seven regions to support them to adopt the NHS Civility and Respect Framework to drive continuous improvement and positive culture change.*"[347]

However, the evidence submitted by Dr Wen Wang, Professor Roger Seifert and Professor Mickael Thelwall suggests that in order to ensure staff understand how harmful bullying is, incentives need to be put in place.[348] The Society of Occupational Medicine pointed to a lack of understanding of and training for managers to deal with the elevated level of stress experienced by staff.[349] The NHS Staff Survey 2021 results showed that less than of half of staff who had experienced harassment, bullying or abuse said that they or a colleague reported it.[350] The British Medical Association's report 'Racism in Medicine' found that 71% of respondents who had personally experienced an incident of racism did not report it.[351]

Generally, stakeholders were positive towards the commitment pledging to tackle bullying rates in the NHS, but as NHS Providers sets out, regional efforts are affected by the wider context of backlog and high staff vacancy rates putting an increasing pressure on NHS services.[352] Several participants during our stakeholder roundtable brought up workforce pressures as one of the issues causing poor behaviour amongst staff. One the participants told us:

> *"[…] the majority of workplaces that are deemed to have a lot of bullying, actually comes from the fact that they are working in incredibly stressful clinical environments. They're under resourced and they are not in a healthy environment. So I think a lot of the bullying that we see in the NHS actually speaks much more of the system, and being under overwhelming pressure, rather than particular individuals, albeit they are responsible for their behaviours.*"[353]

The Royal College of Midwives pointed to the need to look after staff's general welfare in tackling bullying rates:

> *"Staff who are tired, overwhelmed, hungry and thirsty, worried about getting home in time for their children, who do not feel heard or respected or appreciated, are more vulnerable to both bullying and being bullied. Government can take effective action on bullying if it focuses on the fundamentals: fair pay, decent working conditions, safe staffing levels.*"[354]

Our evaluation of the appropriateness of this commitment is that it requires improvement. Bullying and harassment rates are different depending on staff group, trust and background of the staff member and a blunt commitment to reduce bullying rates overall risks overlooking the different causes for bullying in different staff groups. Evidence also seems to suggest that a lot of bad behaviour could be avoided if staff have manageable workloads and have their general wellbeing looked after, including being effectively supported by

347 Department of Health and Social Care (EPW0062)
348 Dr Wen Wang, Professor Roger Seifert and Professor Mickael Thelwall (EPW0020)
349 Society of Occupational Medicine (EPW0036)
350 NHS, NHS Staff Survey 2021, March 2022
351 British Medical Association, Racism in Medicine, June 2022
352 NHS Providers (EPW0011)
353 Stakeholder roundtable
354 Royal College of Midwives (EPW0061)

management and structures that facilitates reporting and addresses bullying in a timely manner. To conclude, the commitment is too vague in setting out what needs to be done to tackling bullying, and regarding where the principial responsibility of ensuring those practical steps are taken, should lie. A national toolkit may risk suggesting solutions which does not adequately take the local contexts in to account, overlooking issues around management and other structural issues which will inevitably hinder progress. We therefore consider the general character of the commitment as well-meaning, but that it in practice fall short in tackling bullying rates in the NHS.

Commitment 3: "Listen to the views of social care staff to learn how we can better support them –individually and collectively"

Overall Commitment Rating and Overview of the listening to the views of social care staff commitment: Inadequate

The social care workforce is large, with an estimated 1.54 million people employed in England. Adult social care staff are mainly employed by profit making and non-profit making agencies, as well as local authorities, and by individual direct payment recipients and other people using their own funds to pay for support and care.[355]

Dr Carolyn Downs, a senior lecturer based at Lancaster University Management School, concludes that:

> *"The large number of providers and relatively small size of the organisations makes central planning or integration of care with the NHS extremely challenging for all involved."*[356]

In their submission, the Disabilities Trust told us about the challenges in setting a common standard for staff wellbeing in the workforce sector:

> *"There are an estimated 17,700 different organisations providing care in the sector. Just like healthcare workers, social care workers frequently treat patients at their most vulnerable. However, unlike the NHS where top-down policies set out standards and support for workforce health, there is currently no unifying guidance for the social care sector."*[357]

As not all social care is delivered or commissioned through local authorities it is challenging for the Government to know exactly who makes up the workforce.[358] In December 2021, the Department of Health and Social Care published a report titled 'Adult social care workforce survey', which set out the analysis of the capacity tracker[359]. This survey had 9000 responses, representing a response rate of 27% of all Care Quality Commission (CQC)-registered care homes and 44% of all CQC-registered domiciliary care providers.[360] The survey of 9000 of social care settings concluded that respondents to the survey reported an increase in challenges in the 4 key areas of recruiting staff,

355 Skills for Care, The state of the adult social care sector and workforce in England, October 2021
356 Dr Carolyn Downs (EPW0001)
357 Disabilities Trust (EPW0014)
358 Homecare Association (EPW0026)
359 NHS, Capacity Tracker, Accessed 170622
360 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021

retaining staff, morale and accessing agency staff, over the last 6 months.[361] The survey focusing on workforce capacity and numbers, is different to the NHS Staff Survey which includes questions on staff wellbeing, safety and welfare amongst other things.

We found it difficult to find evidence of ways in which the Government sought the views of the social care workforce, apart from the consultation for the 'People at Heart of Social Care' and references to "ongoing engagement" by the then Secretary of State which was not specified or evidenced. We heard testimonies from a sector in a workforce crisis following years of low pay and poor working conditions, and recently due to the pressures of Covid-19 and mandatory vaccinations. This led us to conclude that the Government's progress on this commitment to listen to the views of and work to better support social care staff, is 'Inadequate'.

Was the commitment met overall (or on track?)

Rating: Inadequate

Stakeholders were broadly positive regarding the commitment to listen to social care staff and take their views in to account. However, understanding and collecting the views of the social care workforce is challenging. The Government response does not set out how the Government is practically planning on engaging with the social care sector following the engagement with 200 stakeholders for the social care White paper, but state that they "continue to engage with people and organisations across the sector".[362] Although Government engagement with the sector in connection with the creation of the social care White Paper was widely considered a positive step,[363] some stakeholders, like the Homecare Association, argued that wider consultation was not systemic and only included a fraction of the workforce.[364]

Table 7: Responses to "Compared to April 2021, how would you describe the current level of workforce challenges in your service or location for … ?"

Question	More challenging	About the same	Less challenging	Response rate (with number
Retaining staff	70.3%	25.0%	4.5%	98% (8765)
Recruiting staff	81.9%	15.1%	2.5%	97% (8677)
Maintaining morale	70.6%	24.5%	4.4%	98% (8735)
Accessing agency staff	77.9%	16.6%	2.4%	58% (5238)

Source: Adult social care workforce survey: December 2021 report[365]

361 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021
362 Department of Health and Social Care (EPW0062)
363 Anchor (EPW0016); National Care Forum (EPW0033); Dr Carolyn Downs (EPW0001); NHS Confederation (EPW0048)
364 Homecare Association (EPW0026)
365 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021

In the social care workforce survey previously mentioned in this chapter, over 80% of respondents said it had become increasingly more challenging to recruit staff, and 70.3% reported that it was more challenging to retain the staff they had (as outlined in Table 7 above).[366]

In the evidence we received, stakeholders also pointed to the lack of support for social care staff during the Covid-19 pandemic.[367] Care England argued that the pandemic exacerbated many of the wellbeing challenges encountered by the sector, and emphasised the expanded role of the social care sector due to withdrawal of NHS community support in the beginning of the pandemic.[368] The Association of Directors of Adult Social Services (ADASS) stated that during the pandemic, access to personal protective equipment (PPE) supply was not the same in the social care sector, as in the NHS and that lack of parity with NHS staff made social care staff feel "underappreciated and an afterthought".[369] National Care Forum similarly stated:

> *"Social care workers were ignored by policymakers during the first few months of the pandemic, with very little support in terms of PPE, testing or access to clinical support. Financial and wellbeing support, when it did come, often came too late and was insufficient."*[370]

The Care Workers Charity told us:

> *"Policy decisions impacting the adult social care workforce, from temporary vaccine mandates to unlawful hospital discharges, have failed to take into account the views of those on the frontline often resulting in confusion and impacting their ability to provide quality of care. Managers were more likely to hear about changes to guidance for visiting care homes from BBC Breakfast than they were from the DHSC, demonstrating a complete lack of regard for the wellbeing and resilience of this essential workforce".*[371]

However, it is clear from the evidence we have received, that issues faced by the social care sector were widespread before the pandemic. Low pay and poor conditions were frequently cited by stakeholders. One participant during our roundtables told us:

> *"I don't think they do listen to frontline staff views. They might watch a documentary and feel a bit sad about stuff, but no, I don't. I think the perception of the public, and the perception of politicians is not dissimilar really, and unless they're involved in social care, or they have relatives having social care, I don't think they care enough. So no, I don't think they do listen to social care."*[372]

The Government response refers to the work done during the formulation of the White Paper, consultation with the Chief Nurse and Chief Social Worker and the engagement

366 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021

367 For example: Association of Directors of Adult Social Services (EPW0028); Care England (EPW0003); National Care Forum (EPW0033)

368 Care England (EPW0003)

369 Association of Directors of Adult Social Services (EPW0028)

370 National Care Forum (EPW0033)

371 Care Workers' Charity (EPW0025)

372 Stakeholder roundtable

the Secretary of State carries out in meeting with stakeholders. There is no attempt to gather the views of the social care workforce nationally, tracking rates of welfare and experience of staff as is the case for the NHS through the NHS Staff Survey. This we suggest, does not meet the commitment to listen to the views of social care staff, nor does it indicate that feedback from listening to staff has led to better support being provided. Based on the evidence we have received, the feeling on the ground is not of a workforce listened to and supported.[373] Many stakeholders, and the Government's own survey of the workforce, shows that recruiting and retaining staff is becoming increasingly difficult which partly is due to poor conditions. A failure to properly listen to the experience of staff and recognising the underlying factors of these poor conditions and responding to their concerns has led us to conclude that Government progress on meeting this target was 'Inadequate'.

Was the commitment effectively funded (or resourced?)

Rating: Inadequate

In its response, the Government states that "this commitment requires no additional funding".[374] The National Care Forum stated "we note with concern that the same £500m set aside for other elements of workforce reform, is also expected to cover this."[375] However, as stakeholders frequently pointed out, many staff in the social care sector feel underpaid and underappreciated. Care England argues that staff burnout is "fundamentally intertwined" with issues of reward and pay.[376] NHS Providers told us that:

> *"The cost-of-living crisis is further exacerbating this trend as the low pay offered to social care workers by providers means working in other sectors like retail - where high number of vacancies are available and hours tend to be more predictable–are more attractive."*[377]

ADASS argued that a main reason for much of the retention issue is because an increasing need for social care being met by a "smaller pot of Government funding".[378] Evidence indicated that social care needed to have similar top-down policies regarding support for the workforce, as currently there is no unifying guidance for the social care sector.[379] ADASS stated:

> *"The workforce crisis in social care is not a result of the pandemic (though the pandemic and wider labour market issues worsened it), it is the consequence of many years of underinvestment in adult social care by successive Governments from all sides of the political divide."*[380]

Due to the absence of dedicated funding for this commitment, and the evidence we have heard pointing to many of the issues in sector being driven by lack of funding for and

373 For example: Mortimer Society (EPW0012); Methodist Homes (EPW0035); Centre for Care (EPW0037); Royal College of Nursing (EPW0039)
374 Department of Health and Social Care (EPW0062)
375 National Care Forum (EPW0033)
376 Care England (EPW0003)
377 NHS Confederation (EPW0048)
378 Association of Directors of Adult Social Services (EPW0028)
379 Disabilities Trust (EPW0014)
380 Association of Directors of Adult Social Services (EPW0028)

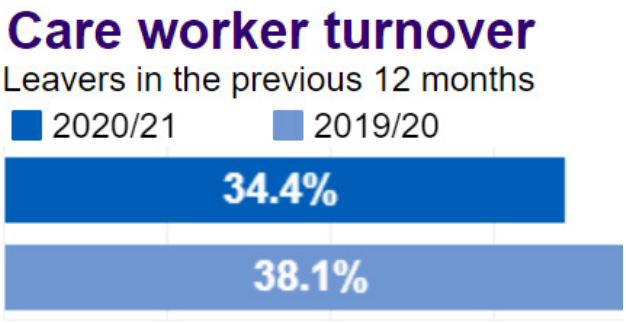
remuneration of staff, we conclude that funding for this commitment is 'Inadequate'. The failure to address the poor pay and conditions in the social care workforce is in itself, a clear sign of the Government not engaging, listening and responding to the views of staff.

Did the commitment achieve positive impacts for patients and people in receipt of social care?

Rating: Requires improvement

Skills for Care's most recent evaluation estimates that on average, 6.8% of roles in adult social care were vacant in 2020/21. This is equivalent to 105,000 vacancies being advertised on an average day.[381]

Figure 12: Care worker turnover in the previous 12-month period



Source: Skills for Care[382]

Stakeholders told us that job dissatisfaction amongst staff is often due to not feeling listened to.[383] We heard evidence of social care employers struggling to recruit and retain staff who would leave the profession for better pay and conditions in the NHS, or sectors like hospitality.[384] Care England also pointed to the adult social care bonus payment to social care staff in Wales and Scotland due to increased levels of risk as a result of working during the Covid-19 pandemic, which was not paid to social care staff in England.[385] In the Adult social care workforce survey in 2021, the most frequently cited reason for difficulties to recruit and retain staff was that pay and working conditions in the care sector were uncompetitive, when compared to outside sectors. Another reason cited specific to care homes was the vaccination as a condition of employment.[386] A stakeholder at our roundtable told us:

> *"[…] the wages we're paying care workers is actually comparable with Aldi, and other supermarkets. So people are thinking, 'why do I need to work these really odd hours, and sometimes have physical and verbal abuse thrown at me, when I can get the same money stacking shelves- and get staff discount.' And we're up against all sectors, as all industries are saying that there is not*

381 Skills for Care, The state of the adult social care sector and workforce in England, October 2021
382 Skills for Care, The state of the adult social care sector and workforce in England, October 2021
383 Association of Directors of Adult Social Services (EPW0028); Disabilities Trust (EPW0014); Sense (EPW0050)
384 Care England (EPW0003); Disabilities Trust (EPW0014); Care Workers' Charity (EPW0025); Methodist Homes (EPW0035)
385 Care England (EPW0003)
386 Department of Health and Social Care, Adult social care workforce survey: December 2021 report, December 2021

> *enough staff to go round. Tomorrow I'm doing a job fair, and there's about 50 employees going, and the target is to get two applications. So a senior manager like myself, and my colleague, will be standing there all day hoping that at least two people come along because, as I say, we've got 4000 vacancies."*[387]

In their evidence, Sense (a national disability charity) stated:

> *"However, it is important to note that low morale in the sector cannot be tackled in isolation. While the Government's proposals for initiatives to provide wellbeing and mental health support is positive, the root cause of low morale amongst care workers is often linked to pay and conditions, limited prospects for career advancement, and stress brought about by the workforce crisis. Without addressing these issues, it will be impossible to significantly improve wellbeing at work."*[388]

ADASS carried out a survey of their members, who include all Directors of social care from local authorities. The survey asked questions regarding homecare hours delivered or undelivered in a quarter and assessed the monthly number of people waiting for assessments, care and support or a direct payment to begin, or a review of their care plans. In a report titled 'Waiting for Care and Support', ADASS provided the following analysis of this survey:

- Almost 170,000 hours a week of home care could not be delivered because of shortage of care workers during the first three months of 2022.
- More than six in 10 councils that responded (61%) said that they are having to prioritise assessments and are only able to respond to people where abuse or neglect is highlighted, for hospital discharge or after a temporary period of residential care to support recovery and reablement.
- 506,131 people were waiting for assessments, reviews, and/or care support to begin.
- There has been a 16% increase in the numbers of hours of home care that have been delivered since Spring 2021.[389]

In its response the Government states that it is on track to meet this commitment:

> "*We are planning the delivery of the workforce reform work, set out in the People at the Heart of Care White Paper, with stakeholders from across the sector, including the Workforce Advisory Group, the National Care Forum, Skills for Care and the Care Quality Commission. We are working collaboratively with the Chief Nurse and the Chief Social Worker to inform our policies as well as engaging with the groups of staff they represent, such as the Nursing Advisory Group and the Principle Social Worker network, to hear their views. The Secretary of State undertakes regular engagement with stakeholders, including representatives of providers, local authorities, trade unions and people with lived experience, where pay and terms and conditions*

387 Stakeholder roundtable
388 Sense (EPW0050)
389 Association of Directors of Adult Social Services, Waiting for Care and Support, May 2022

> *are discussed. Our engagement continues to take a range of forms including roundtable discussions, bilateral conversations, in-depth workshops and larger conference events."*[390]

This commitment, if met, has the opportunity to improve staff wellbeing and therefore improve care for those in receipt of social care. However, we heard no evidence which suggested that the social care workforce feels listened to or supported. There were no mechanisms set in place to collect staff views systematically or regularly, and no clear indication of how these views would lead to actionable interventions. Emotional stress and lack of opportunities to be listened to and taken seriously combined with poor pay and poor working conditions drive staff to leave the profession or leads to burnout for those who stay, both of which has an inevitable knock-on effect on people in receipt of social care. Our conclusion is therefore that in order to ensure there is a positive impact for people in receipt of social care, this commitment 'Requires Improvement'.

Was it an appropriate commitment?

Rating: Requires improvement

Stakeholders judged the commitment to be vague, arguing that consultation with staff needs to be sustainable, and accompanied by long-term mechanisms for taking action.[391] The Royal College of Nursing similarly criticised the lack of "ongoing feedback loops and communication channels" set up by the Government to achieve this commitment.[392] Hospice UK concluded that:

> *"Furthermore, for there to be meaningful improvement for care workers and their beneficiaries there needed to be pre-planned resource available for responding to any concerns raised by the workforce. Listening to the views of staff is important but it cannot be translated into meaningful improvements for the workforce if there is no commitment to using this data to drive change."*[393]

Sense concluded that the commitment is too vague to evaluate, and argues that without addressing the "root cause" of low morale amongst those working in social care (which it states is often linked to pay, conditions, limited career options and stress), it will be "impossible" to make major improvements to wellbeing at work.[394] In addition, findings from the Lapis and Helpcare research projects suggest that the Government is not intervening to help the recruitment and retention "crisis" in the social care workforce:

> *"The highly fragmented social care sector is not able to develop comprehensive solutions–largely because co-operative working across the sector is discouraged by the market in care, meaning providers are naturally in competition with each other."*[395]

In summary, the social care workforce is large and fragmented between thousands of employers. Although the Government has committed to listen to the workforce, no efforts

390 Department of Health and Social Care (EPW0062)
391 Royal College of Nursing (EPW0039); Dr Carolyn Downs (EPW0001); Centre for Care (EPW0037)
392 Royal College of Nursing (EPW0039)
393 Hospice UK (EPW0053)
394 Sense (EPW0050)
395 Dr Carolyn Downs (EPW0001)

have been made to map out the workforce to have a clear picture of who it needs to consult, nor has an effort been made to systematically survey it. In evaluating the appropriateness of this commitment, we conclude that the rating is 'Requires improvement'.

4 Inequalities

Inequalities exist in various forms throughout society, and the health and social care sector and its workforce is no exception. What became clear to us as we undertook our evaluation is that specific to the health and social care workforce are common themes of inequalities which we will address in this chapter. This is not an exhaustive list of inequalities, but those which we have chosen to focus on in relation to the health and care workforce. These common themes were:

- The poor experience and treatment of ethnic minority staff, and staff identifying as LGBTQ+ or living with a disability working in the NHS and social care.
- Gender[396] and how it affects the pay, status, development, and treatment of staff in the health and social care sector.
- A lack of parity between the NHS and social care workforces, hindering integration of services and leading to staff leaving social care for better pay and conditions in the NHS or in other sectors.

There is a distinct difference between the two sectors, much due to the common employer for health care staff (the NHS), and the fragmented delivery model for social care (local authorities, private companies, agencies etc.) We will explore this disparity at the end of this chapter.

We are very concerned about the experiences of ethnic minority staff in the health and social care workforce. Issues of inequality cut across the three areas of planning for the workforce, building a skilled workforce and wellbeing at work, which we focused on in our evaluation. The majority of the evidence we received highlighted disparities between ethnic minority staff and White staff's experience and treatment in the health and social care workforce.[397] As of 31 March 2021, 22.4% (309,532) of staff working in NHS trusts in England were from a black and minority ethnic background. This is an increase from 19.1% in 2018.[398] Ethnic minority staff were similarly estimated to make up a fifth of the social care workforce in 2020–2021 (although this estimation only covers local authority and independent sector). Black staff form 12% of the adult social care workforce, but just 3% of the general population.[399]

396 When we mention gender in this chapter, we assume the definition used in the sources we quote.
397 For example: Prostate Cancer UK (EPW0032), British Medical Association (EPW0042); Nuffield Trust (EPW0051)
398 NHS, Workforce Race Equality Standard 2021, April 2022
399 Skills for Care, The state of the adult social care sector and workforce in England, 2021

Figure 13: Workforce Race Equality Standard (WRES) indicators for NHS trusts in England: 2016–2021

WRES indicator			Year					
			2016	2017	2018	2019	2020	2021
1	Percentage of BME staff	Overall	17.7% *	18.1% *	19.1%	19.9%	21.1%	22.4%
		VSM	5.4% *	5.3% *	6.9%	7.6%	7.9%	9.2%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		1.57	1.60	1.45	1.46	1.61	1.61
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.56	1.37	1.24	1.22	1.16	1.14
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		1.11	1.22	1.15	1.15	1.14	1.14
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	29.1%	28.4%	28.5%	29.7%	30.3%	28.9%
		White	28.1%	27.5%	27.7%	27.8%	27.9%	25.9%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	27.0%	26.0%	27.9%	29.3%	28.4%	28.8%
		White	24.0%	23.0%	23.4%	24.4%	23.6%	23.2%
7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	BME	73.4%	73.2%	71.9%	69.9%	71.2%	69.2%
		White	88.3%	87.8%	86.8%	86.3%	86.9%	87.3%
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	14.0%	14.5%	15.0%	15.3%	14.5%	16.7%
		White	6.1%	6.1%	6.6%	6.4%	6.0%	6.2%
9	BME board membership		7.1%	7.0%	7.4%	8.4%	10.0%	12.6%

Source: NHS, Workforce Race Equality Standard 2021, April 2022[400]

The above figure from the NHS Workforce Race Equality Standard (WRES) shows how things have, or have not, changed regarding workforce race equality in the NHS. The WRES data is collected through submissions by individual NHS trust and Clinical Commissioning Groups (CCGs) via the NHS Digital Strategic Data Collection Service (SDCS). All trusts and CCGs completed the surveys. There are many things which we would like to pick out from this, but in particular:

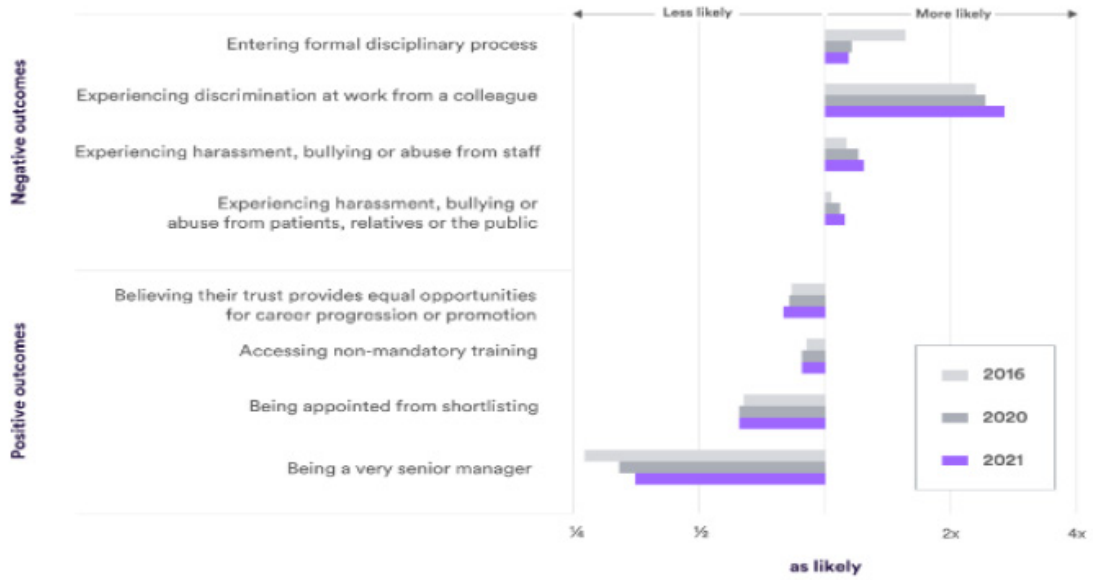
- For 72.3% of trusts a higher proportion of ethnic minority staff compared to White staff experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- Experiences of bullying and harassment from the public amongst White staff has declined from 28.1% in 2016 to 25.9% in 2021, whilst for Black and minority ethnic staff it has largely remained the same since 2016 (29.1% in 2016 to 28.9% in 2021).
- The percentage of ethnic minority staff believing that their trust provides equal opportunities for career progression and promotion decreased from 73.4% in 2016 to 69.2% in 2021.
- Staff stating that they have personally experienced discrimination at work from a manager or colleague amongst respondents from an ethnic minority background has increased from 14% in 2016 to 16.7% in 2021, making it almost 10% higher amongst ethnic minority staff compared to white staff (6.2% in 2021).[401]

The British Medical Association ran a Racism in Medicine Survey between October to December 2021 and invited all doctors and medical students in the UK, from all ethnic backgrounds, to participate. The survey found that 76% of respondents experienced racism at least once in the last two years, with 17% stating that they had been experiencing these racist incidents on a regular basis. The report found low levels of reporting of racist abuse

400 NHS, Workforce Race Equality Standard 2021, April 2022
401 NHS, Workforce Race Equality Standard 2021, April 2022

- with 71% of respondents who experienced racism choosing not to report it to anyone due to fear that it would have a negative impact on them.[402] A Human Rights Commission report on the treatment of lower paid ethnic minority workers in health and social care presented some very worrying findings. 18% of ethnic minority staff in all pay bands across the NHS reported experiencing discrimination from patients or other members of the public, compared to 4.6% of White staff.[403]

Figure 14: Different career experiences for Black and minority ethnic staff compared with White Staff



Source: Nuffield Trust (EPW0051)

In their analysis, the Nuffield Trust pointed out that there are "stark differences in the wellbeing of some staff groups". Specifically, the Nuffield Trust highlights that those from a Black or a minority ethnic background have worse day to-day work experiences.[404] The NHS Workforce Race Equality Standard found that white applicants to jobs in the NHS were 1.61 times more likely to be appointed from shortlisting compared to ethnic minority applicants; this is the same number as it was in 2020. This statistic has remained broadly the same over the past six years.[405] The Equality and Human Rights Commission also found that several lower-paid ethnic minority workers and other contributors reported a lack of training opportunities, particularly in social care.[406] In their 2020 survey on issues facing the ethnic minority workforce and the impact of Covid-19, Skills for Care found that racism was identified as a major challenge by respondents. This included institutional systemic racism from and within organisations, management and peers, as well as racism from people in receipt of care. Respondents also cited progression and representation linked to racism, as barriers to progressing in their organisations.[407]

402 British Medical Association, Racism in Medicine, June 2022
403 Equality and Human Rights Commission, Experiences from health and social care: the treatment of lower-paid ethnic minority workers, June 2022
404 Nuffield Trust (EPW0051)
405 NHS, Workforce Race Equality Standard 2021, April 2022
406 Equality and Human Rights Commission, Experiences from health and social care: the treatment of lower-paid ethnic minority workers, June 2022
407 Skills for Care, Investigating the issues facing the BAME workforce and the impact of COVID-19, December 2020

An analysis of a UNISON union members' survey cited in the Equality and Human Rights report, shows that between March and December 2020, 67% of Black workers in bands 1 and 2 reported having worked in Covid-19 wards, compared with 51% of their White colleagues in the same pay bands.[408] The Office for National Statistics analysis looking at the time period between 8 December 2020 (the start of the vaccination programme) and 12 June 2021 (the approximate end of the second wave of the Covid-19 pandemic), shows that people from all ethnic minority groups (except the Chinese group and women in the "White other ethnic group") were more likely to die from Covid-19, compared to the White population. In connection with the publication of these statistics Vahé Nafilyan, Senior statistician at the Office for National Statistics, concluded:

> *"Today's analysis shows that since the vaccination programme began, the risk of death from Covid-19 has continued to be higher in most ethnic minority groups than in the White British ethnic group. As already highlighted in our analyses of earlier periods, these differences in mortality are largely explained by socio-demographic and economic factors and health. For the first time, we show that the lower vaccination coverage in some ethnic groups also contributes to the elevated risk of Covid-19 death, particularly in the Black African and Black Caribbean groups."*[409]

The Equality and Human Rights report also highlighted different patterns of employment between minority ethnic staff and White staff. Analysis carried out by Skills for Care found that ethnic minority care workers in the independent care sector were more likely to be employed on a zero-hours contract than other staff. This contrast was especially stark in the homecare staff group, where 71% of minority ethnic staff were on zero-hours contracts compared to 59% of White British workers. The Equality and Human Rights Commission concludes that this results in a "two-tier" workforce, and that minority ethnic staff including migrants tend to be over-represented in lower paid roles. The situation is similar in the health care sector, where many of the lower-paid roles such as cleaning staff and catering staff are outsourced through private companies rather than being employed directly by the NHS. the Equality and Human Rights Commission reports that the latter leads to workers feeling isolated and detached from their workplace, and in many circumstances means they are paid less and have worse conditions than those employed by the NHS.[410]

Another aspect of inequality which is vital to consider in relation to the health and social care workforce is gender. In the social care workforce 8 out of 10 staff are women.[411] This is very similar to the health workforce, where 76.7% of staff are women.[412] The overrepresentation of women in the social workforce is something which an article by Atkinson et al. concludes reinforces the perceptions of the profession's low status.[413] Palmer and Eveline argue that care work has traditionally, and is to this day, often something which is performed by women in the family. This in turn affects the way care work is

408 Equality and Human Rights Commission, Experiences from health and social care: the treatment of lower-paid ethnic minority workers, June 2022

409 Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups, June 2020

410 Equality and Human Rights Commission, Experiences from health and social care: the treatment of lower-paid ethnic minority workers, June 2022

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

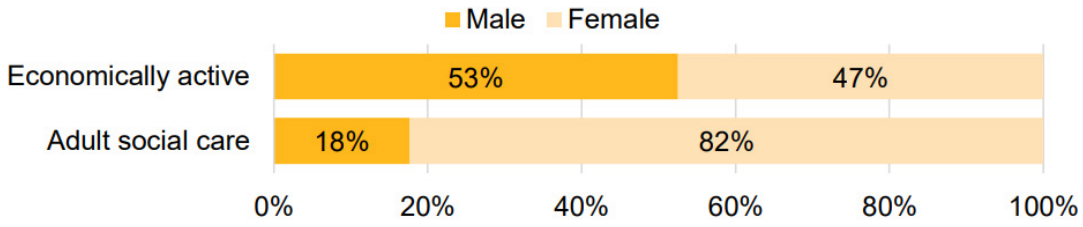
412 NHS Digital, Equality and Diversity in NHS Trusts and CCGs March 2022, June 2022

413 Atkinson, C., Crozier, S. and Lewis, Factors that affect the recruitment and retention of domiciliary care workers, Government Social Research, Welsh Government. (2016)

considered and has a knock-on effect the perception and status of paid care work.[414] Jobs and roles that have an increasing female workforce are often attached to lower wages.[415] In her evidence to our evaluation, Dr Carolyn Downs concludes that:

> *"[…] the care sector comprises a largely female and older workforce paying a care premium (through low wages, low status and compromised mental and physical health) which arguably should be borne more widely".*[416]

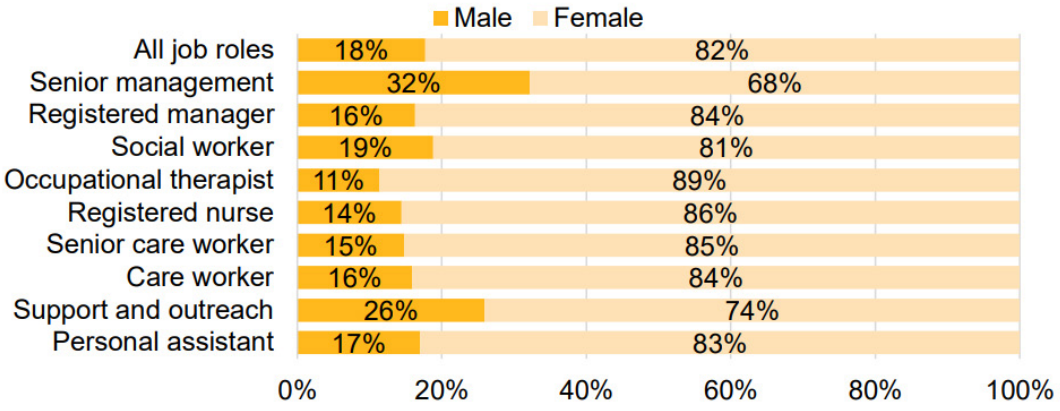
Figure 15: Estimated gender breakdown of the adult social care workforce and the economically active population



Source: Skills for Care, The state of the adult social care sector and workforce in England, 2021

As illustrated in figure 15, although the economically active general population is almost split equally between female and male, the social care workforce is predominantly female.[417]

Figure 16: Estimated proportional gender split in the adult social care workforce by selected job roles, 2020/21



Source: Skills for Care, The state of the adult social care sector and workforce in England, 2021

As illustrated in figure 16, there is not a significant variation of gender between professional roles within the social care workforce, although women are less likely to be in managerial roles (79%), and especially when it comes to senior management roles (68%) compared to other roles. Skills for Care's analysis of workforce data from the Adult Social Care-Workforce Data Set in 2020/21 shows that there were no substantial differences

414 Palmer, E. and Eveline, J., "Sustaining Low Pay in Aged Care", Gender, Work and Organization (2012), Vol. 19, pp 257–258

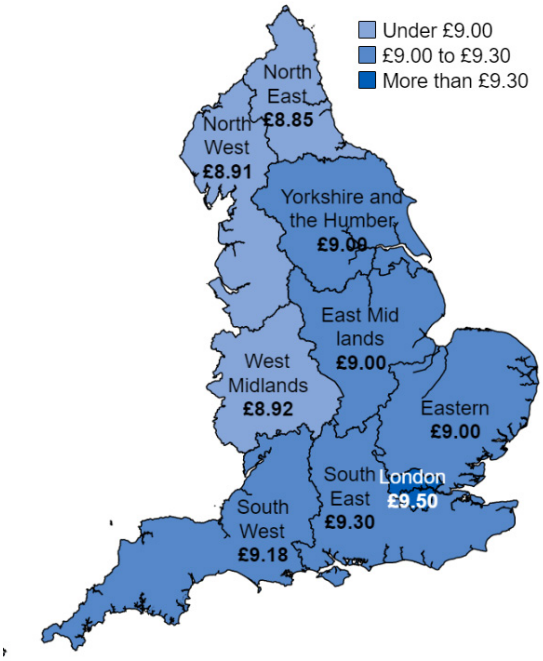
415 Geordan Shannon et al, "Feminisation of the health workforce and wage conditions of health professions: an exploratory analysis", Human Resources for Health (2019), vol 17, p. 1; C. Atkinson and R. Lucas, Policy and Gender In Adult Social Care Work, Public Administration, Vol. 91

416 Dr Carolyn Downs (EPW0001)

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

in pay according to the gender or ethnicity of care workers after accounting for their geographic location, sector, service type and experience. However, analysis also showed that proportionally more males and more white people were in senior roles compared to front line roles.[418]

Figure 17: Median care worker pay by region (Independent care sector worker pay 2020/21)



Source: Skills for Care, Pay in the adult social care sector, March 2022

The median hourly rate of pay in the independent care sector is £9.01. According to Skills for Care, 71% of care workers in the independent sector are paid below the Real Living Wage.[419] Pay was repeatedly brought up as a barrier to recruitment and rendition of the social care workforce.[420]

In the NHS, 77% of the staff are female, which is a lower percentage compared to the social care workforce, but still notably higher than the economically active population (47%).[421] The higher percentage of a female workforce in the NHS is set to continue. The Council of Deans, which represents faculties predominantly focused on nursing, midwifery and allied health professional students' education and research stated that healthcare courses (for nurses, midwives and allied health professionals) remain overwhelmingly taken by female students (83.7%).[422] Within nursing, 89.3% on the professional register are women.[423] However, research in the International Journal of Nursing Studies indicates that despite

418 Skills for Care, The state of the adult social care sector and workforce in England, 2021
419 Skills for Care, Pay in the adult social care sector, March 2022
420 For example: NHS Confederation (EPW0048); Sense (EPW0050); Nuffield Trust (EPW0051); Dr Carolyn Downs (EPW0001); Care England (EPW0003); Mortimer Society (EPW0012)
421 NHS Employers, Gender In the NHS, May 2019 n
422 Council of Deans of Health (EPW0065)
423 NMC, The NMC Register 1 April 2021–31 March 2022, March 2022

nursing being a female dominated profession, women are disadvantaged in terms of career progression and pay, as men are over-represented in senior positions compared to their overall proportion in the nursing workforce.[424]

There are disparities between professions regarding support for caring responsibilities. In 2020, additional funds were made available to the NHS Induction and Refreshers scheme to help GPs who were interested in coming back to the NHS access financial support worth up to £2000 for each child, to assist with caring responsibilities during a return programme.[425] General practice nurses can only access £1,000 for childcare, travel, and book costs overall during a return to practice course.[426] Both schemes are supported by Health Education England.

The 'Mend the Gap Report' from 2020 highlights that a large gender pay gap still persists in medicine, across specialities and sectors, even when working hours are taken into consideration .[427] Within medicine, a Royal College of Physicians (RCP) 2020 census showed that 62% of consultants were men and 38% women, and that although the number of women in the workforce is increasing, women are more likely to work less than full time (43% of women aged 35–44 years old, and only 4% of men). The RCP therefore concludes that there is a need to "train many more doctors than the number of full-time equivalent doctors we will need in the future".[428] Statements made during our stakeholder roundtable further highlighted that more women working less than full time needs to be considered:

> *"In dental training more than 50% are female- there is probably a predominance of females entering into dental training. This can affect whole time equivalents going forward because of other responsibilities, largely family responsibilities."*[429]

Evidence from our stakeholder roundtable suggested that more initiatives are needed to support people with caring responsibilities to get through training programmes, so to improve retention rates:

> *"[…] women are far more likely to drop out of training programmes than men, and we need to do something about those critical years of training. It may need some extra funding for, say, people with parental duties, to get through those bottlenecks because otherwise we're losing them. You recruit people and then the retention just falls off."*[430]

The Covid-19 pandemic has further entrenched the challenges that women face regarding additional caring responsibilities outside of work. Recent survey data collected between February-March 2021 by the NHS Confederation Health and Care Women Leaders Network reports that the pandemic has caused notable shifts in caring responsibilities outside work.[431] The number of additional hours per week of non-work caring

424 Geoffrey Punshon et al, "Nursing pay by gender distribution in the UK - does the Glass Escalator still exist?", International Journal of Nursing Studies, vol 93 (2019), pp 21–29

425 NHS England, Childcare costs for doctors to be covered in drive to boost GP numbers, July 2020

426 NHS Health Careers, Return to general practice nursing, accessed 29 June 2022

427 Department of Health and Social Care, Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England, December 2020

428 Royal College of Physicians (EPW0031)

429 Stakeholder roundtable

430 Stakeholder roundtable

431 Health and Care Women Leaders Network, COVID-19 and the female health and care workforce survey, May 2021

responsibilities taken on by women compared to the start of the pandemic was 12.81 hours.[432] The increasing additional hours per week of non-work caring responsibilities was associated with reduced working hours, which the report highlights has serious implications for career progression opportunities.[433]

The 2020 RCP census also found that women consultants were more likely to report feeling undermined (40%) or witnessing undermining (39%) than men (31% and 32%).[434] Evidence from our stakeholder roundtable similarly suggested that women face discrimination in the workplace:

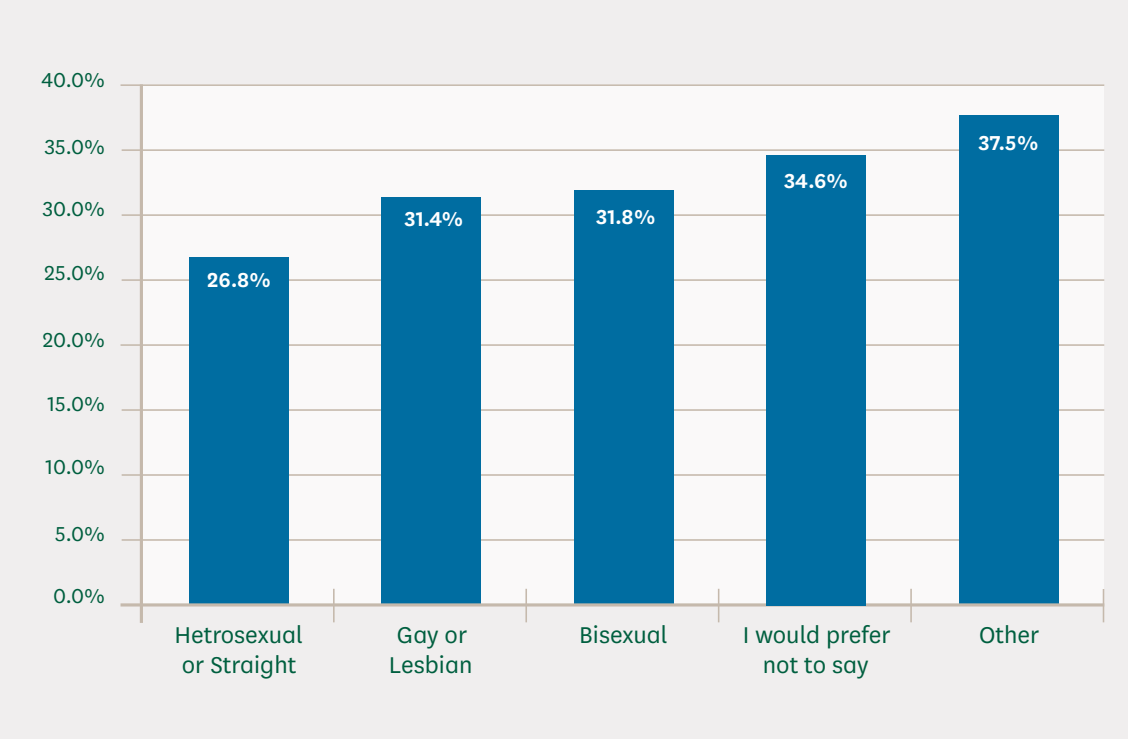
> *"The Medical Women's Federation has found that people say things to women who are just back from maternity leave that just makes them not want to carry on, and it's that low-level stuff that we need to deal with and not just walk past."*[435]

The Health and Care Women Leaders Network report further highlight that the physical and emotional wellbeing of women in the healthcare workforce had seen a marked deterioration, which promoted increasing worries about a large number of the workforce leaving roles because of untenable pressures caused by the pandemic.[436]

Furthermore, some of the evidence we received pointed to specific issues amongst staff identifying as LGBTQ+.[437] The General Medical Council's 'Completing the picture report' found that doctors identifying as LGBTQ+ more commonly reported mental health problems.[438]

432 Health and Care Women Leaders Network, COVID-19 and the female health and care workforce survey, May 2021
433 Health and Care Women Leaders Network, COVID-19 and the female health and care workforce survey, May 2021
434 Royal College of Physicians (EPW0031)
435 Stakeholder roundtable
436 Health and Care Women Leaders Network, COVID-19 and the female health and care workforce survey, May 2021
437 For example: NHS Providers (EPW0011); Marie Curie (EPW0060); Royal College of Physicians (EPW0031)
438 General Medical Council, Completing the Picture, October 2021

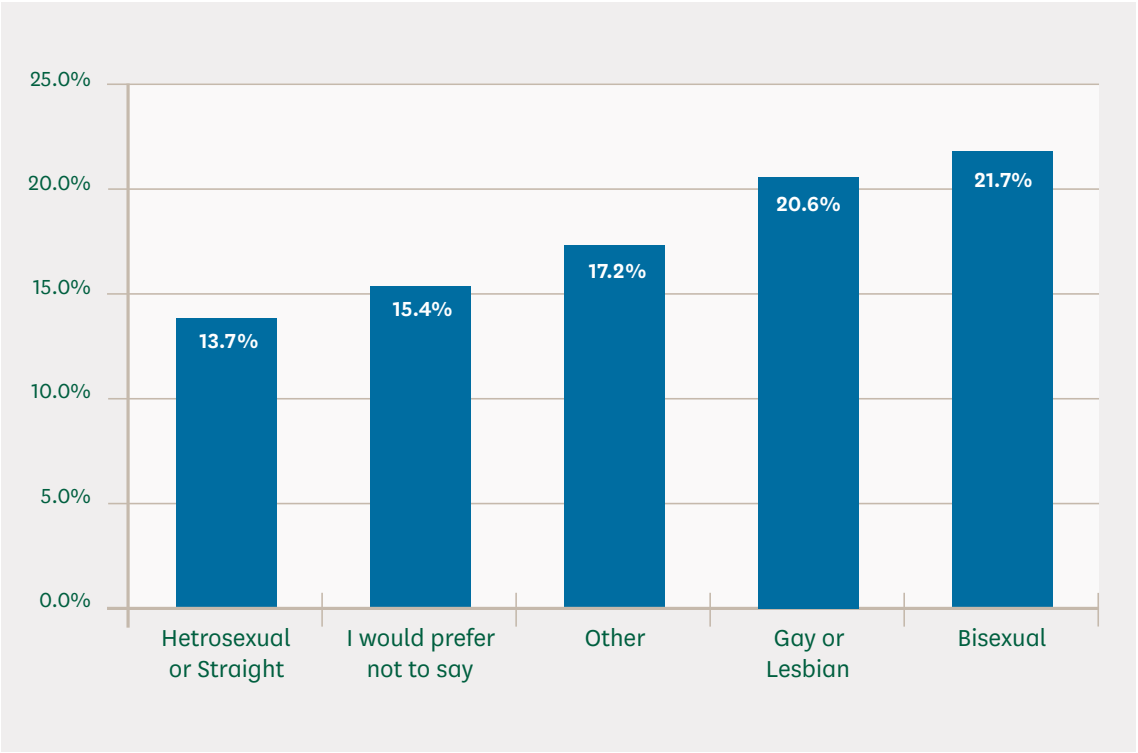
Figure 18: Staff who stated that they have experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public at least once in the last 12 months by sexual orientation subgroup (NHS Staff Survey data 2021)[439]



Of the medical staff who stated their sexual orientation, staff who were gay, lesbian or bisexual were more likely to have experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public at least once in the last 12 months.[440]

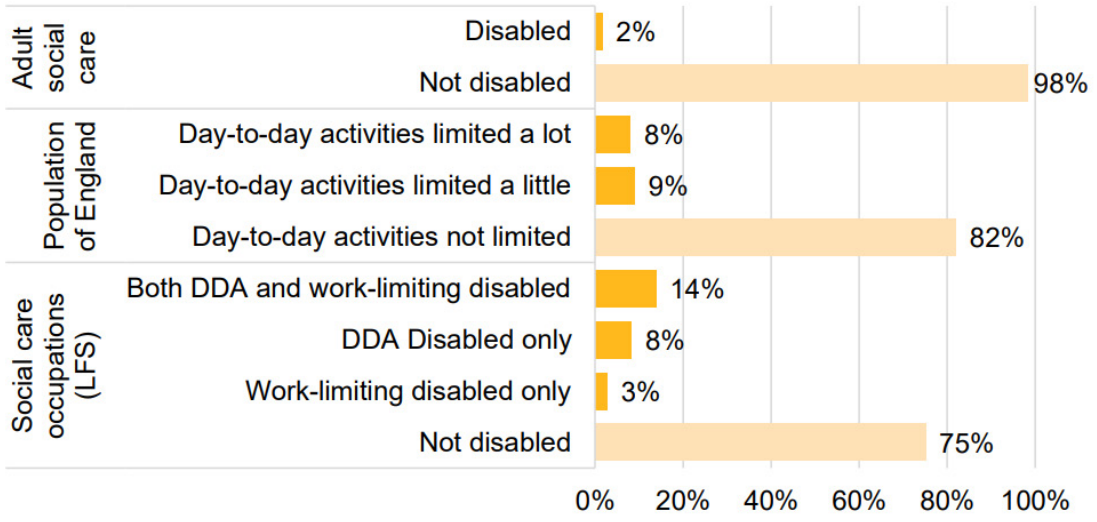
439 NHS, Workforce Race Equality Standard 2021, April 2022
440 NHS, Workforce Race Equality Standard 2021, April 2022

Figure 19: Staff who stated that they have experienced physical violence at work from patients / service users, their relatives or other members of the public at least once in the last 12 months by sexual orientation subgroup (NHS Staff Survey data 2021)[441]



The NHS Staff survey data also show that staff who identify as gay, lesbian or bisexual were more likely to have experienced physical violence at work from patients, their relatives or other members of the public, as set out in Figures 18 and 19.[442]

Figure 20: Estimated proportion of the adult social care workforce, population of England and economically active population by disability status



Source: Skills for Care, The state of the adult social care sector and workforce in England[443]

441 NHS, Workforce Race Equality Standard 2021, April 2022
442 NHS, Workforce Race Equality Standard 2021, April 2022
443 Skills for Care, The state of the adult social care sector and workforce in England, 2021

Skills for Care estimates that about 1.7% of the workforce in local authorities and independent sector live with a disability.[444] Little is known about this section of the workforce and more could be done to consider the impact of disability on turnover and how employers could support disabled people to join and remain in social care services.

Figure 21: WDES 2021–Harassment, bullying or abuse 2016–2020

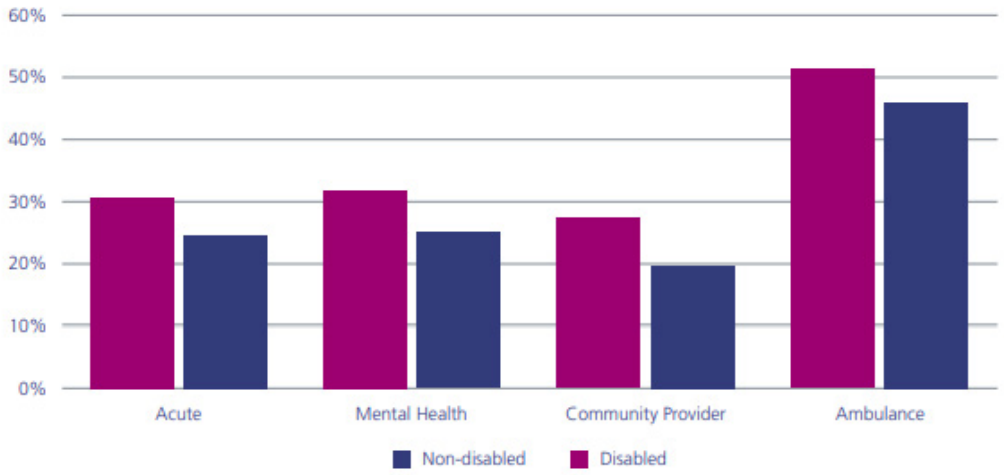
Year	From public (4a)		From manager (4b)		From colleagues (4c)	
	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
2016	33.6%	27.0%	19.8%	11.4%	24.9%	16.1%
2017	33.3%	27.0%	19.5%	11.3%	25.0%	16.3%
2018	34.1%	27.1%	19.4%	11.5%	26.4%	17.2%
2019	34.2%	27.4%	18.5%	10.8%	26.3%	17.3%
2020	31.9%	25.5%	18.5%	10.6%	25.6%	16.7%

Source: Workforce Disability Equality Standard (2021)

3.7% of the NHS workforce states that they live with a disability according to the NHS Workforce Disability Equality Standard 2021, which is an increase of 0.3% since the previous year.[445] According to a General Medical Council's report, disabled doctors were more likely to report bullying as a more important factor in why they left the profession.[446] Worryingly, disabled staff are over-represented in statistics of staff who have experienced harassment, bullying or abuse (as shown in figure 21 above). Incidents of harassment, bullying or abuse from managers towards disabled staff has remained consistent over the past five years at around 19%.[447]

444 Skills for Care, The state of the adult social care sector and workforce in England, 2021
445 Skills for Care, The state of the adult social care sector and workforce in England, 2021
446 General Medical Council, Completing the Picture, October 2021
447 NHS, Workforce Disability Equality Standard, May 2022

Figure 22: WDES 2021 - harassment, bullying or abuse by trust type



Source: Workforce Disability Equality Standard (2021)

As discussed in chapter 3, staff in ambulance trusts are more likely to experience harassment, bullying and abuse. This is also the case for disabled staff when considering the statistics by trust type (as shown above in figure 22). The difference between the amount of harassment, bullying or abuse experienced by disabled staff and non-disabled staff has remained consistently higher over the last five years.[448]

Parity between health and social care sectors

In addition to protected characteristics (such as gender and ethnicity), based on the evidence submitted to us, structural differences were evident between the health and social care sectors. The perception of a lack of parity between the health and social care sector was especially prevalent in the evidence we received from stakeholders in the social care sector, and across several health and care settings.[449] Guidance, support and pay and conditions were repeatedly pointed to as areas where there was inequality between the two sectors. Sense stated that the low rates paid by local authorities make it difficult for providers to offer competitive pay and conditions, such as in the NHS or in retail and hospitality sectors.[450] MHA stated that comparable roles to social care staff in the health services, such as a Band 3 Health Care Assistants, are paid around £4,000 a year more than social care staff on minimum wage. They added that NHS staff also benefit from better pension arrangements and sickness policy benefits.[451] Care England argued that the Health and Social Care Levy will push the social care sector further into financial instability, unless providers are able to offset the increase. Their estimate of the impact on the sector, for both employers and employees, is £600 million per year. In the NHS however, the Government is recompensing these extra National Insurance (NI) employer contributions. Care England concluded:

448 NHS, Workforce Disability Equality Standard, May 2022
449 For example: Care England (EPW0003); Anchor (EPW0016); Association of Directors of Adult Social Services (EPW0028); Methodist Homes (EPW0035); Royal College of Nursing (EPW0039); Sense (EPW0050); British Dental Association (EPW0052)
450 Sense (EPW0050)
451 Methodist Homes (EPW0035)

> *"[…] adult social care and the NHS are two sides of the same coin and they need parity. This lack of parity only undermines the Government's ambition of providing a better infrastructure for adult social care staff."*[452]

However, stakeholders did not only point to worse pay and conditions as examples of disparity between the sectors, recognition and reward were also frequently cited.[453] The Association of Directors of Adult Social Services (ADASS) stated:

> *"Social Care Nurses feel unrecognised and undervalued compared to the public support offered to NHS nursing staff."*[454]

In conclusion, any commitments set for the workforce will fall short in meeting their targets as long as the experience and treatment of staff from ethnic minority backgrounds, staff identifying as LGBTQ+ or staff living with a disability continues to be disproportionality poor. Both the social and health care workforces are predominantly female, and the way in which we value work carried out by staff in these sectors does not stand in parity with the incredible work that they carry out. Many stakeholders from the social care sector testified to the "low status" assigned to social care work, and the effect this has on recruitment, retention, and wellbeing of the workforce. A running theme throughout this evaluation has also been regarding the disparity between health and social care workforce, which unless addressed and mitigated, will be a major barrier in growing the social care workforce and encouraging integration or closer working between the two sectors.

452 Care England (EPW0003)

453 For example: Mortimer Society (EPW0012); The Disabilities Trust (EPW0014); Association of Directors of Adult Social Services (EPW0028)

454 Association of Directors of Adult Social Services (EPW0028)

Annex A: Anchor statements for CQC-style ratings

Rating	Was the commitment met overall/Is the commitment on track to be met?	Was the commitment effectively funded?	Did the commitment achieve a positive impact for patients?	Was it an appropriate commitment?
Outstanding	The commitment was fully met/there is a high degree of confidence that the commitment will be met	The commitment was fully funded with no shortfall	Patients and stakeholders agree that the impact was positive	Evidence confirms appropriateness of the commitment
Good	The commitment was met but there were some minor gaps, or is likely to be met within a short time after the deadline date/it is likely that the commitment will be met, but some outstanding issues will need to be addressed to ensure that is the case	The commitment was effectively funded, with minor shortfalls	The majority of patients and stakeholders agree that the impact was positive	Evidence suggests the commitment was appropriate overall, with some caveats
Requires improvement	The commitment has not been met and substantive additional steps will need to be taken to ensure that it is met within a reasonable time/the commitment will only be met if substantive additional steps are taken	The commitment was ineffectively funded	A minority of patients and stakeholders agree that the impact was positive	Evidence suggests the commitment needs to be modified
Inadequate	The commitment has not been met and very significant additional steps will need to be taken to ensure that it is met within a reasonable time/the commitment will only be met if very significant additional steps are taken	Significant funding shortfalls prevented the commitment being met	Most patients and stakeholders did not agree there was a positive impact for patients	Evidence suggests the commitment was not appropriate

Annex B: Published written submissions

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

1 Dr Carolyn Downs (EPW0001)

2 Dr Emma Hayward (EPW0002)

3 Care England (EPW0003)

4 Professor Jennifer Hunt (EPW0004)

5 Dr Liz Brewster, Dr Michael Lambert, Dr Luigi Sedda, Dr Euan Lawson, Mr Barry Rowlingson, Dr Cliff Shelton and Professor Jo Rycroft Malone (EPW0007)

6 Relatives and Residents Association (EPW0008)

7 British Thoracic Society (EPW0009)

8 NHS Providers (EPW0011)

9 Mortimer Society (EPW0012)

10 Disabilities Trust (EPW0014)

11 Royal College of Physicians and Surgeons of Glasgow (EPW0015)

12 Anchor (EPW0016)

13 Royal College of Anaesthetists (EPW0017)

14 Faculty of Intensive Care Medicine (EPW0018)

15 General Medical Council (EPW0019)

16 Dr Wen Wang, Professor Roger Seifert and Professor Mickael Thelwall (EPW0020)

17 Medical Protection Society (EPW0021)

18 Professor Rachel Jenkins (EPW0022)

19 Academy of Medical Royal Colleges Trainee Doctors' Group (EPW0023)

20 Royal College of Speech and Language Therapists (EPW0024)

21 Care Workers' Charity (EPW0025)

22 The Homecare Association (EPW0026)

23 Association of the British Pharmaceutical Industry (EPW0027)

24 Association of Directors of Adult Social Services (EPW0028)

25 Faculty of Sexual and Reproductive Healthcare (EPW0029)

26 British Association of Dermatologists (EPW0030)

27 Royal College of Physicians (EPW0031)

28 Prostate Cancer UK (EPW0032)

29 National Care Forum (EPW0033)

30 Royal College of Pathologists (EPW0034)

31 Methodist Homes (EPW0035)

32 Society of Occupational Medicine (EPW0036)

33 Centre for Care, University of Sheffield (EPW0037)

34 Royal College of Surgeons of Edinburgh (EPW0038)

35 Royal College of Nursing (EPW0039)
36 Association of Dental Groups (EPW0040)
37 Dr Rachel Sumner and Dr Elaine Kinsella (EPW0041)
38 British Medical Association (EPW0042)
39 Cancer Research UK (EPW0043)
40 Diabetes UK (EPW0044)
41 British Society of Haematology (EPW0045)
42 British Infection Association (EPW0046)
43 UNISON (EPW0047)
44 NHS Confederation (EPW0048)
45 Macmillan Cancer Support (EPW0049)
46 Sense (EPW0050)
47 Nuffield Trust (EPW0051)
48 British Dental Association (EPW0052)
49 Hospice UK (EPW0053)
50 Professor Kath Checkland, Dr Jonathan Hammond, Dr Sharon Spooner, Dr Lynsey Warwick-Giles and Dr Jon Gibson (EPW0054)
51 Company Chemists' Association (EPW0055)
52 Royal College of Radiologists (EPW0056)
53 Collaboration for the Advancement of Medical Education Research (EPW0057)
54 Chartered Society of Physiotherapy (EPW0058)
55 Royal College of General Practitioners (EPW0059)
56 Marie Curie (EPW0060)
57 Royal College of Midwives (EPW0061)
58 Department of Health and Social Care (EPW0062)
59 Council of Deans of Health (EPW0065)
60 British Society of Echocardiography (EPW0066)
61 Practice Management Network (EPW0067)
62 British Psychological Society (EPW0069)
63 British Society for Rheumatology (EPW0070)
64 Papworth Trust (EPW0071)
65 Anonymous (EPW0072)
66 Peter Wilson (EPW0073)
67 Robert Johnstone (EPW0074)
68 Scarlett McNally (EPW0075)
69 Nuffield Trust (EPW0088)
70 Queen's Nursing Institute (EPW0089)

Annex C: Transcripts

Roundtables 5 May 2022:

- Group 1 (EPW0076)
- Group 2 (EPW0077)
- Group 3 (EPW0078)
- Group 4 (EPW0079)
- Group 5 (EPW0080)
- Feedback session (EPW0087)

Roundtables 11 May 2022:

- Group 1 (EPW0081)
- Group 2 (EPW0082)
- Group 3 (EPW0083)
- Group 4 (EPW0084)
- Group 5 (EPW0085)
- Group 6 (EPW0086)