Theme 1: We can make a significant difference to our ability to recruit and retain staff by making the NHS a better place to work

a. Have we captured the key areas we need to focus on in 2019/20 to make the NHS a better place to work? Is anything missing or less of a priority?

The general consensus is that the key areas have been captured and it is good to see reference to the NHS as an employer “singular” and hope future plans sell the benefits of a well promoted single brand with significant career opportunities and flexibility to move between Trusts (supported by the streamlining work). It is also reassuring to see the impact of the Pensions Policy on retention considered, although from a Mental Health perspective in particular, it would be good to see recognition that the pressures are driven by a combination of pension taxation, Mental Health Officer status now reaching maturity, a limited resource pipeline and a cap on agency feeds that makes securing locums more challenging. A challenge for mental health and Learning disability services is violence, bullying and harassment from service users and carers and given the nature of these services this needs careful consideration and support.

Additional focus could be given to positive action if we are to get the changes we need to see around equality, diversity and inclusion. Also the final plan could do with some detailed analysis on the projected size of the NHS workforce (keeping in mind age profile of current workforce) compared with numbers of expected school/university leavers and current/anticipated career aspirations. This will help identify what work needs to be done at entry to create the “sustainable pipeline” referred to in the letter.

b. We are keen to ensure that this workstream is relevant to all parts of the NHS, are there specific actions we should consider to ensure we capture the needs of staff working in the community and primary care?

Specific actions could include:
- Support working in integrated teams and OD resourcing to enable this
- Develop model career pathways and routes, case studies.
- Invest in CPD monies
- Community focused apprenticeship programmes

Consideration could be given to combining the inclusion agenda with delivering care at home and finding a way to enable community staff to work in the community they live within and therefore opening up career opportunities to groups who previously didn’t have access (eg might not have a car)

We also need to think about the needs of an ageing workforce many of whom will need to continue to work for longer and what that means in terms of flexible careers as well as flexible working.

c. What more can we do nationally to create the right conditions for success?
HR Benchmarking has resulted in HR capacity being eroded particularly in areas like training and organisation development, equality and diversity - crucial areas supporting the transformation agenda. This needs to be rethought if we are going to build in the capacity to deliver the skills and change agenda.

Decisions regarding commissioning of public health services switching to Local Authorities without ring fencing has had a detrimental impact due to the cuts Local Authorities have had to make. This has eroded quality, access and - impacted negatively on the workforce.

Within the concept of thinking about a single employer ‘brand’, there is the opportunity to raise the profile of Mental Health and Learning Disabilities, perhaps a public campaign combining anti-stigma work with a message around a rewarding environment to work within. At place level there are examples of rotational placements across disciplines, making Mental Health and LD experience part of each core training programme, therefore further raising awareness. For those individuals who do not choose to go into Mental Health or LD as a career, this will still help equip them to more effectively manage dual diagnosis health issues.

Mental Health is disproportionately impacted by the current tariff uplifts which assume a standardised pay to non pay split across acute and mental health trusts. The Mental Health cost envelope has a disproportionately higher ratio of pay to non pay than acute trusts therefore the current tariff agreements create greater financial pressure for Mental Health Trusts, whose agenda for pay uplifts are not fully funded, which is contrary to supporting the health and wellbeing agenda.

With regards to workforce systems; common procurement across the system could help unblock barriers and support streamlining e.g. DBS system.

**Theme 2: If our workforce plan is to succeed we must start by making real changes to improve the leadership culture in the NHS**

a. Do you agree that improving the leadership culture in the NHS is critical if we are to address our workforce challenges? If so, have we got the right immediate actions to create the conditions for local systems and organisations to improve? Is anything missing or less of a priority?

General agreement and in support of proposed actions with the caveat that Chief Executives operate within a Trust that has its own value set and any “leadership compact” should be sensitive to this.

There is a sense that parity of esteem still hasn’t been fully embedded so whilst the language is around left shift and no health without mental health, the system and consultations are still acute dominated at both national and ICS level with mental health services engagement sometimes being an afterthought.

It is important that NHSI/NHSE model the right leadership behaviours if this is going to be truly embedded throughout the NHS.
Theme 3: Although there are workforce shortages in a number of professions, disciplines and regions, the biggest single challenge we currently face nationally is in the nursing and midwifery profession

a. Do you agree that our highest priority for further investment is nursing and midwifery?

Certainly agree it is one of the highest priorities but Mental Health and LD psychiatry is also a concern particularly in geographically isolated areas and there needs to be recognition that a small number of vacancies can have a significant impact on the ability to deliver a high quality service. There needs to be a review of the centralisation of recruitment and the impact that has had on attracting people to these areas and specialities.

Any investment needs to also enable placement capacity at organisational level.

b. Are these the right actions in the short to medium term and is this the right direction of travel? Have we missed anything critical?

Generally agree and great to see the expansion of clinical placements; although more detail on how this will work in practice in terms of engagement with Trusts would be helpful. Other than a targeted approach to 15-17 year olds there is little detail about what else is happening to encourage students onto the courses in the first place (particularly since the end of bursaries).

It is recognised that the most significant shortages are in mental health, LD and community nursing but our experience would say that 15-17 year olds are not the typical target audience to currently be attracted into Mental Health and LD services. There is opportunity to utilise our carers networks and skill sets to encourage individuals into these careers but we need to be flexible and recognise that if successful engagement happens this will not necessarily mean lots of additional colleges places. Rather we need to consider more flexible means of upskilling/re-skilling such as apprenticeships as picked up in Theme 4.

Placement capacity is an issue that cannot be ignored. Support to services to develop supervision capacity and capability and creative solutions are going to be important. Solutions like looking at collective recruitment for some posts (eg PWPs?) over a bigger footprint and/or rotating between organisations in the patch could be useful.

In consideration of the number of individuals due to retire with MHO status, could more be done to incentivise these experienced staff to stay in employment for longer. An incentivised retire and return initiative perhaps.
Theme 4: To deliver on the vision of 21st century care set out in the LTP will not simply require ‘more of the same’ but a different skill mix, new types of roles and different ways of working

a. Are these the right actions in the short to medium term and is this the right direction of travel?

These are the right actions in the short to medium term and the right direction of travel. The introduction of new roles feels critical and it is reassuring to hear the view that this needs to be accelerated. More guidance and shared learning relating to the introduction of such roles would be very welcome as this is being worked through at individual Trust level at the moment which is no doubt causing much duplication of effort and missed opportunities. However in relation to the digital agenda and in thinking about the new and exciting elements of VR, artificial intelligence etc. we need to be mindful about the baseline position and the digital “literacy” levels and training needs of the workforce and also the work with the universities required to deliver a workforce that can thrive in this environment in the short, medium and longer term.

b. What other actions could we take to transform the skill mix of our workforce and enable new ways of working?

Actions could include:

- Flexible employment models and contracts.
- Investment in CPD
- Case studies capture around blended roles
- Flexibility in the apprenticeship levy as lobbied for nationally
- Acknowledge and seek to measure / support the current and potential role of the unpaid caring workforce and the third sector in delivery of the Long Term Plan

In relation to the digital agenda, introducing the concept of upward coaching in this area could be beneficial but the hierarchical nature of the NHS currently discourages this to arise organically. A more targeted approach is likely needed.

Theme 5: We must look again at respective roles and responsibilities for workforce across the national bodies and their regional teams, ICSs, and local employers, to ensure we are doing the right things at the right level

a. Do you agree we should devolve more responsibility for workforce to regions and STPs/ICSs?

Broadly agree with devolution of responsibility assuring the support mentioned is tangible. Workforce planning cannot continue to focus on reconciling the monies with the staff in post. However the ICS footprint might not be the right unit of measure for every geography ie some may better suit place based plans (particularly where there is integrated working between health and care sectors at place level). A stronger statement on devolution would be helpful.
b. What activities would best be done at STP/ICSs level, and what enablers are required to make this a reality?

Investment in workforce planning expertise, consideration of social care staff workforce information/data accessibility and understanding including primary care workforce data. Clarity and certainty regarding HEE monies beyond the short term to enable proper investment and longer term planning would be beneficial. There is a need to ensure mature entries to training are encouraged and supported.

In terms of ICS level, this is where budgets should be devolved to for CPD and working with education providers on numbers of placements etc for the professional programmes. The benefits of having CPD monies at ICS level gives greater leverage to invest strategically which then gives more efficient use of the resource. E.g. commission once for a programme for all our staff across the ICS in mental health to be Trained in for eg CBT therapy rather than ad hoc individual approach which is what tends to happen. Also, giving more control over rewarding for local impact so decisions are taken by individuals who see and understand individual contributions and the local market.