

**Written submission to the Health and
Social Care Committee –
Workforce: recruitment, training and
retention in health and social care
(January 2022)**



**palliative,
neurological
and bereavement
support**

About Sue Ryder

Sue Ryder supports people through the most difficult times of their lives. For over 65 years our doctors, nurses and carers have given people the compassion and expert care they need to help them live the best life they possibly can.

We take the time to understand what's important to people and give them choice and control over their care. This might be providing care for someone at the end of their life, in our hospices or at home. Or helping someone manage their grief when they've lost a loved one. Or providing specialist care, rehabilitation or support to someone with a neurological condition.

We want to provide more care for more people when it really matters. We see a future where our palliative and neurological care reaches more communities; where we can help more people begin to cope with bereavement; and where everyone can access the quality of care they deserve.

Across the UK we have seven hospice services including Inpatient and community palliative care services, and four specialist neurological centres. Our centres employ 1,061 Sue Ryder Nurses and Nursing Assistants¹. We also provide bereavement support via our Online Bereavement Community and Online Bereavement Counselling, in addition to that provided by our family support teams in our hospices.

This response sets out our experiences and reflections on the Workforce: recruitment, training and retention in health and social care call for evidence by the Health and Social Care Committee.

¹ There when it matters- How we made an impact 2020-21. September 2021. <https://www.sueryder.org/sites/default/files/2021-11/07320%20-%20Sue%20Ryder%20Impact%20Report%2032pp%20A4%20lo%20res.pdf>

Executive summary

There has been a need for a strategic, integrated, long-term workforce plan for the wider health sector for a long time. The Government must plan for the workforce as a whole system across health and social care, including for charitable providers of essential services. It must consider all parts of the system as equal players, so that one area is not favoured more than another and it should address the need to value our health and social care workforce better as a society.

Hospice sector

We know how important receiving high-quality end-of-life care is, and our workforce continues to provide that. 99% of people cared for by our hospice teams would recommend our care to friends and family², but without it patients would be putting significant extra demand on the NHS and social care services. The pandemic exposed how the hospice sector is hanging by a financial thread.

Without an increase to statutory funding for the hospice sector, measures such as the recent announcement of a pay increase for doctors and nurses working in the NHS and changes to the National Minimum Wage and National Living Wage, all impact on our ability as an employer to remain in line with the NHS, as we are challenged to stretch our statutory funding even further, in order to retain and recruit staff.

Training and recruitment

We need to ensure there is a robust and fit for purpose pipeline of trainees across all disciplines - including nursing, medical, allied health professionals and carers. This is critical for the short, medium and long term.

We encourage the Government to look at the following areas:

- Review the reasons stated for staff leaving the sector and include steps to make changes to prevent future leavers in a whole system workforce plan.
- Review why healthcare university students are dropping out and take relevant steps to reduce the dropout rate.
- Conduct research as to why people are not choosing health and social care roles as career options and commit to addressing these issues.
- Review processes to ensure all health and social care roles on the list of those that can be employed from another country can be done so efficiently and affordably.
- Focus current recruitment efforts on return to nursing applicants and staff who have retired or are due to retire.
- Review the rules regarding the NHS pension scheme. If the rules on how many hours can be worked whilst drawing an NHS pension were relaxed, more retired staff may be attracted back into the system as they would be able to work limited hours, without negatively impacting their pension.

We believe consideration should be given to focusing on community based planning and recruitment, particularly as local population health needs assessments are undertaken as a key aspect of Integrated Care System (ICS) strategic planning. We are in a staffing crisis and

² There when it matters- How we made an impact 2020-21. September 2021. <https://www.sueryder.org/sites/default/files/2021-11/07320%20-%20Sue%20Ryder%20Impact%20Report%2032pp%20A4%20lo%20res.pdf>

need to make stronger links between health and care providers and the community, and should be more proactive in recruiting young and disadvantaged people.

Domestic and international recruitment

We believe that the balance of domestic and international recruitment of staff needs to be flexible. Where there are shortages that cannot be filled from existing healthcare professionals, or will not be filled in the near future through the pipeline of professionals who are in training, action needs to be taken.

The addition of care workers and home carers to being eligible for the Health and Care Worker Visa, and the roles added to the Shortage Occupation List (SOL) is a positive step to providing more options for roles to be filled, however this threshold is higher than a full time National Living Wage salary, which is the level of pay many of these roles will be advertised at as providers are unable to be more competitive on pay due to funding. This should be reviewed to be of benefit across the health and care sector.

We also want to see the Government create parity across the training programmes that exist within countries that are ethically acceptable to recruit from and the UK. This would allow for better understanding of what the gaps are in foreign qualifications (if any) and what necessary interventions are needed before individuals are able to work here.

Changes to the initial and ongoing training of staff

Sue Ryder would welcome a number of initiatives:

- Extending the Government's Continued Professional Development (CPD) allowance (£1,000 over three years) for individual NHS Registered Nurses or Therapists to Registered Nurses or Therapists who are employed by the hospices/independent sector.
- Making initial training more financially accessible for both young and mature learners.
- Improving existing pathways across the whole system to help balance growth in clinical expertise with the expectation of leadership.

It is important for staff who are training to experience rotation within different services, working alongside different disciplines. Sue Ryder would welcome the development and implementation of a system where, for example, training rotations for nursing degrees could be experienced across the whole health and care system, including NHS Trusts and other charitable health organisations.

Reasons for driving staff out of the sector

It is unsustainable for our health and social care workforce to feel exhausted and underpaid, and as a population we are seeing the impact of this. These issues must be tackled by the Government head on and we must ensure that health and care workers across the whole health sector feel valued. To help the health and social care workforce feel more valued the Government should explore areas such as:

- Enabling parity of pay across all services within the health and care sector, so that pay is not dependent on which part of the sector the role is in, and increases in pay are reflected across the system;
- Collaborations with housing companies - to offer affordable housing cost options;
- Reduced travel costs nationally for staff (or students) in the sector;
- Relocation budgets to encourage staff in hard to recruit areas;

- Childcare support measures for all staff across the health and care sector, as shift work is particularly demanding on families.

NHS People Plan, and a people plan for the social care sector

Fundamentally, the NHS People Plan and a people plan for the social care sector should not be viewed separately, nor developed independently of one another. A whole sector approach must be taken, including a focus on the independent healthcare sector. Workforce planning must be developed in line with projected population demand across all vital health services (not just NHS and social care).

Contractual and employment models

We have outlined a number of areas for consideration including:

- **Flexible working** - roles in the health and care sector no longer align with how people want to live their lives. As more of the population are working remotely - hybrid working becomes more of the norm.
- **Contract perception** - a zero hour contract offers no guarantee of work or financial security. This type of contract coupled with a culture of commissioning care by 15 minutes - as some Local Government organisations have moved towards to manage their budget - is not conducive to 'good quality care' and it doesn't attract people into the profession. The health sector must be adequately funded to avoid this type of commissioning and the Government should take steps to tackle this view.
- **NHS agenda for change** - the independent sector is contracted to provide vital health services that the NHS would otherwise have to provide, yet it is difficult to keep pace with increases in other parts of the system as statutory funding does not respond to NHS increases. Any statutory funding for NHS contracted care such as palliative services should be increased in line with any NHS pay increases.
- **Travel** - the Government could go further to support those who work in health and care to access the transport they need to undertake their job, whether that is through supporting the initial outlay for a vehicle, improving transport links and subsidising public transport costs, or reducing the burden of new charges that can apply to owning a vehicle.
- **Carers** are vital in providing care to a huge part of society. The Government could explore with expert organisations in the field, the role of carers as partners in healthcare. For example, exploring how carers could 'join' the social care workforce on their terms, as many carers reluctantly give up their role when needing to receive an income.

Role of Integrated Care Systems

Integrated Care Systems (ICSs) must work with service providers to understand the demographics and demand for services in their footprint. By doing this the ICSs will be better equipped to plan and commission the appropriate types and levels of service needed, as well as identifying any gaps, to make longer term plans for both services and the workforce. For example, we know that the number of people receiving palliative care services is set to increase by 55% over the next ten years³. We need to ensure we have a well-resourced workforce in place to deal with this predicted rise in demand.

³ London Economics commissioned by Sue Ryder, Modelling demand and costs for palliative care services in England, 2021 – www.sueryder.org/hospicefunding

Our response

What are the main steps that must be taken to recruit the extra staff that are needed across the health and social care sectors in the short, medium and long-term?

There has been a need for a strategic, integrated, long-term workforce plan for the wider health sector for a long time. However, the pandemic has demonstrated just how stark this need is and how reliant we are on a strong workforce across the NHS, hospice and social care sectors. There needs to be an overarching approach encompassing all of the health and care system; planning for the NHS in isolation will only create more problems in the future, especially if social care services and other providers, such as independent hospice services, collapse.

The Government must plan for the workforce as a whole system across health and social care. It must consider all parts of the system as equal players, so that one area is not favoured more than another. There are immense pressures across all health and care services, and the independent hospice sector is no different. We have seen challenges recruiting across all roles and geographical locations where we offer services.

A whole system workforce plan is crucial. The Secretary of State for Health and Social Care said in his recent evidence to the Health and Social Care Select Committee that 'we need a much longer-term approach' to workforce planning⁴, and the Health and Care Bill could provide a critical opportunity for this. The current proposed duty on the Secretary of State to publish a report on workforce planning once every Parliament is too infrequent. The duty as it is currently proposed will not show whether we are training enough people to deliver health and care services both now and in the future. If the amendment (Clause 35) which has been laid is accepted, it will ensure there is a duty on Government to train adequate numbers of healthcare professionals to keep up with projected population growth over 5, 10, 15, 20 years.

There has long been a shortage of staff for independent palliative services and community based care, but at Sue Ryder we have felt this even more now because:

- There has been a focus on filling shortages in acute services during the pandemic
- Health professionals are leaving the sector due to burnout - with some staff opting to take early retirement where possible
- Remuneration for health services is lower than other sectors and lower skilled jobs elsewhere are able to pay more. Where staff remain in the health sector there has been an inflationary effect on remuneration in order to fill shortages, which is particularly difficult for providers who receive a fixed statutory amount for services
- The sector is now feeling the effect of the removal of nurses' bursaries which was available to support nursing staff through training
- Nurses who trained in the European Union (EU) now have to go through the same processes as overseas nurses, this is impacting the numbers of nurses from the EU coming to work in the UK, which is compounding the issue of shortage of available staff
- Anecdotally, agencies that we would use are struggling to find nursing staff who are available for work, so our usual mitigations to fill staff roles, even on a temporary basis, are at times impossible which puts services at risk.

⁴ Health and Social Care Committee - Oral evidence: Clearing the backlog caused by the pandemic. 2 November 2021
<https://committees.parliament.uk/oralevidence/2942/html/>

Whilst the requirement for health and care staff to be vaccinated against Covid-19 is important for protecting patients it has had a small, but not insignificant, impact on the numbers of staff health providers can keep within their service. With shortages across all health services at record highs, even losing one member of staff can sometimes be detrimental to service provision. It is also possible that the requirement for staff to be vaccinated will further impact the numbers of people considering a role in a care profession and the Government should consider how to further incentivise this cohort of people to get vaccinated.

Training and recruitment

We need to ensure there is a robust and fit for purpose pipeline of trainees across all disciplines - including nursing, medical, allied health professionals and carers. This is critical for the short, medium and long term.

We need to see an increase in the number of university courses/places across all roles in health and social care, and support for universities to recruit to healthcare programmes. As well as diversification of the routes into all healthcare professions, and programmes for career development for specific roles; for example, nursing assistant to registered nurse, physiotherapist assistant practitioner to physiotherapist. These career development opportunities should be available across the country and have the required financial support attached, particularly for mature students who cannot access Student Finance. We would also welcome a review of Health Education England's (HEE) application for additional funding support for some Healthcare Apprenticeships widened to include non-NHS organisations (such as our hospices).

We would encourage the Government to take the following steps to aid recruitment and retention:

- Review processes to ensure all health and social care roles on the list of those that can be employed from another country can be done so efficiently and affordably.
- Focus current recruitment efforts on return to nursing applicants and staff who have retired or are due to retire.
- Review the rules regarding the NHS pension scheme. If the rules on how many hours can be worked whilst drawing an NHS pension were relaxed, more retired staff may be attracted back into the system as they would be able to work limited hours, without negatively impacting their pension.
- Review the reasons stated for staff leaving the sector and include steps to make changes to prevent future leavers in a whole system workforce plan.
- Review why healthcare university students are dropping out and take relevant steps to reduce the dropout rate.
- Conduct research as to why people are not choosing health and social care roles as career options and commit to addressing these issues.
- Consider enabling career breaks and easing the current 'return to practice' approach - where for example a nurse's registration lapses if they have not met the minimum practice hours required for registration with the Nursing and Midwifery Council (NMC). If these hours haven't been completed they also will have to complete an approved Return to Practice (RTP) programme. Explore how a keeping in touch model could allow fatigued staff to maintain a relationship with healthcare and recover, which will help staff back into roles by removing the perception of loss of experience, aiding both the system and practitioner.
- National drive to encourage more people to Return to Practice.

Hospice sector

We know how important receiving high-quality end-of-life care is, and our workforce continues to provide that. 99% of people cared for by our hospice teams would recommend our care to friends and family⁵, but without it patients would be putting significant extra demand on the NHS and social care services. The pandemic exposed how the **hospice sector is hanging by a financial thread**. It highlighted that the provision of essential end of life care is too heavily dependent on the generosity of the public and that a sustainable statutory funding solution is needed for the longer-term. Without this solution, hospices will not be able to keep pace with demand⁶ and in some cases hospices will be forced to close. Without palliative and end of life care services, patients and their families will miss out on vital specialist care and as a consequence the NHS and social care system will see substantially increased demand for their already stretched services.

Without an increase to statutory funding for the hospice sector, measures such as the recent announcement of a pay increase for doctors and nurses working in the NHS and changes to the National Minimum Wage and National Living Wage, all impact on our ability as an employer to be in line with the NHS, as we are challenged to stretch our statutory funding even further, in order to retain and recruit staff. With the absence of an increase to statutory funding for palliative care services to match these increases, the voluntary sector's ability to keep our services adequately staffed is damaged. This is why it is critical that a whole sector approach to the health and social care workforce should be taken when the Government is making decisions about what the workforce needs to continue to operate.

Sue Ryder is **calling for the Government to increase funding to the palliative care sector from 37% to 70%** - without it there is a serious risk the sector will collapse.

What is the best way to ensure that current plans for recruitment, training and retention are able to adapt as models for providing future care change?

Consideration should be given to focusing on community based planning and recruitment, particularly as local population health needs assessments are undertaken as a key aspect of Integrated Care System (ICS) strategic planning. We are in a staffing crisis and need to make stronger links between health and care providers and the community, and should be more proactive in recruiting young and disadvantaged people.

Where trends in current and future demand for different services are identified in each ICS, the ICS should work with the parts of the community - e.g. job centres, schools, colleges and youth organisations - to profile the importance of the healthcare professions in their community, that they could go on to have a career in.

As part of this, young and disadvantaged people should be incentivised to join these professions, which can only be done through a full review of the cultural and financial value

⁵ There when it matters- How we made an impact 2020-21. September 2021. <https://www.sueryder.org/sites/default/files/2021-11/07320%20-%20Sue%20Ryder%20Impact%20Report%2032pp%20A4%20lo%20res.pdf>

⁶ Demand for palliative care services is projected to rise from 245,000 in 2021/22 to between 271,000 and 379,000 in 2030/31. (London Economics. 2021. Modelling demand and costs for palliative care services in England: A final report for Sue Ryder. Available at: https://www.sueryder.org/sites/default/files/2021-03/Modelling_Demand_and_Costs_for_Palliative_Care_Services_in_England%20%281%29.pdf)

placed on healthcare workers, and by making substantial improvements to their experience of the sector from training through to retirement.

Identifying population health needs and translating this into population benefit through recruitment planning will strengthen the workforce in harder to recruit places, as well as strengthening communities and providing individuals with accessible opportunities. But, this must be made attainable for those from disadvantaged backgrounds where the cost of training to be a health professional can prevent them from applying.

What is the correct balance between domestic and international recruitment of health and social care workers in the short, medium and long term?

We believe that the balance of domestic and international recruitment of staff needs to be flexible. Where there are shortages that cannot be filled from existing healthcare professionals, or will not be filled in the near future through the pipeline of professionals who are in training, action needs to be taken. The Government needs to ensure there are adequate levels of care staff from amongst the UK population, but if levels are too low, our international recruitment policy should be able to respond to this and adapt on an on-going basis. However, this should be additional to domestic programmes of recruitment, not instead of.

The recent Government announcement⁷ that care workers and home carers have been made eligible for the Health and Care Worker Visa, and the roles added to the Shortage Occupation List (SOL) is a positive step to providing more options for roles to be filled⁸. However, the policy sets the minimum salary at £20,408 per annum. **This threshold is higher than a full time National Living Wage salary, which is the level of pay many of these roles will be advertised at as providers are unable to be more competitive on pay due to funding.** The Migration Advisory Committee has acknowledged this, stating in their 2021 yearly report that *“MAC recognises that this is not a solution that will work for all employers in the sector (...) We also recognise that many care worker jobs pay significantly below the rate of £10.10 per hour.”*⁹

To ensure there are adequate numbers of UK non-specialist health and care workers in the medium to longer term, the Government should be investing in a programme of recruitment, training and retention for these roles, placing new value on these roles.

In the short term, to ensure a positive impact is had from the addition of care workers and home carers to the SOL, we believe that the threshold for this visa should be set at the National Living Wage level and/or flexibilities be added to the visa to ensure any overtime worked can count towards the minimum salary.

⁷ Biggest visa boost for social care as Health and Care Visa scheme expanded (24 December 2021)
<https://www.gov.uk/government/news/biggest-visa-boost-for-social-care-as-health-and-care-visa-scheme-expanded>

⁸ Migration Advisory Committee Annual Report. December 2021.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1040877/2021_Annual_Report_combined_FINAL_v3.pdf

⁹ Migration Advisory Committee Annual Report. December 2021.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1040877/2021_Annual_Report_combined_FINAL_v3.pdf

What can the Government do to make it easier for staff to be recruited from countries from which it is ethically acceptable to recruit, with trusted training programmes?

We want to see the **Government create parity across the training programmes** that exist within countries that are ethically acceptable to recruit from and the UK. This would allow for better understanding of what the gaps are in foreign qualifications (if any) and what necessary interventions are needed before individuals are able to work here.

Following Brexit, nurses who trained in the EU now have to go through the same processes as overseas nurses to be qualified to work. This is impacting the numbers of nurses from the EU coming to work in the UK, which is compounding the shortage of available staff. This reinforces the importance of better recognition of comparable qualifications from different countries around the world. Addressing this would help to speed up recruitment to work in the UK.

The Government should look to provide support to smaller organisations in their recruitment for international health professionals. 'On the job' training in a UK health setting whilst individuals are waiting to undertake necessary exams that would allow full transfer of international to UK qualification requires substantial support - including accommodation and pastoral style care. This process usually takes around 12 months in total and can create significant loyalty from an individual to an organisation for having provided this. NHS Trusts can provide this support at scale and take large numbers of international nurses, however it is difficult for smaller organisations like Sue Ryder to provide this due to the cost and staff resource. As a result, this closes another route to recruitment.

Additionally, agency fees to support bringing staff across from abroad can equate to around £10,000 per nurse. Again the NHS can recruit at such scale that they are able to circumvent much of this cost by having in house support services. However, smaller health and care providers face these very high costs and need help to make this process less expensive.

We would like to see the Government develop national programmes to recruit ethically in the following ways:

- Lead building and maintaining relationships with relevant countries in defining appropriate and ethical recruitment arrangements (e.g qualifications, necessary additional training, role availability),
- Allow smaller providers (such as Sue Ryder) access to the expertise and knowledge required to recruit internationally and place individuals appropriately, across the health and care sector,
- Monitor the impact of international recruitment on the respective countries' infrastructure to inform future recruitment drives,
- Enable collaborative recruitment programmes that offer placements with non-NHS providers - such as the hospice sector - as this would widen the offer to a border range of professionals,
- Develop stronger ethical pathways with countries (Government approved) where reciprocal experience based secondments could be offered - this will help to retain staff working in health and social care and build greater cultural learning.

What changes could be made to the initial and ongoing training of staff in the health and social care sectors in order to help increase the number of staff working in these sectors?

Sue Ryder would welcome a number of initiatives to encourage an increase in staff numbers:

- **Extending the Government's Continued Professional Development (CPD) allowance** (£1,000 over three years) for individual NHS Registered Nurses or Therapists to Registered Nurses or Therapists who are employed by the hospices/independent sector.
- Making initial training more financially accessible for both young and mature learners.
- **Improving existing pathways across the whole system** to help balance growth in clinical expertise with the expectation of leadership. This could be done by building opportunities for shared learning across the system, giving leaders the opportunity to experience the wider system, not just acute or community, and across the sectors. Having posts that rotate between sectors and having secondments would help to achieve this. However there is often no pay parity between the NHS, private and charity sector so there would need to be a mechanism in terms of funding provision to address this and allow for rotation between sectors and secondments. We believe this would strengthen an ICS, and develop system thinkers of the future through wider experience. For an organisation like Sue Ryder who are relatively small, it can be challenging to accommodate all staff's career aspirations at times, as staff reach a certain level (e.g. senior nurses) internal opportunities are not always available like they would be in the NHS.

To what extent is there an adequate system for determining how many doctors, nurses and allied health professionals should be trained to meet long-term need?

We do not believe there is an adequate system in place to determine the number of staff that should be trained to meet long-term needs.

Workforce is the biggest challenge facing the health and care sector, yet we have no clarity on how many staff we need to deliver care. The draft Health and Care Bill currently places a duty on the Secretary of State to publish a report describing the system in place for assessing and meeting workforce needs. We accept that this will help with some workforce planning, however there is no indication of whether enough people are entering training to meet demand now and in the future. As outlined above, the proposed amendment to the Health and Care Bill would mean the Secretary of State will be required to publish workforce projections in line with population growth, and the Government will be held accountable for not responding to this with policy that ensures necessary numbers are trained in time.

Additionally, Sue Ryder believes that pharmacists - who are taking increased responsibility and providing more services within their community - should be included in a long-term workforce plan and within shortage projections published by the Secretary of State. In order for pharmacies to continue to deliver the service they do under the current model, the numbers of pharmacists must be considered alongside the population need.

Do the curriculums for training doctors, nurses, and allied health professionals need updating to ensure that staff have the right mix of skills?

It is important for staff who are training to experience rotation within different services, working alongside different disciplines. This is particularly true for those undertaking nursing degree apprenticeships. However, organisations such as specialist palliative care providers cannot

offer enough variation in experience alone to satisfy the full NMC requirements by themselves, meaning it is difficult to take on trainee nurses and to attract them to choose a career in specialist palliative care due to lack of exposure during training. This is not the same in many areas of the NHS where staff can be rotated between many different departments, or as we know in some areas, a Memorandum of Understanding was established across an ICS, including services in the community, to share placements for learners to gain full experiences required.

Sue Ryder would welcome the development and implementation of a system where training rotations for nursing degrees could be experienced across the whole health and care system, including NHS Trusts and other charitable health organisations. Not only would this tackle the problem of organisations not being able to take on nurses doing their apprenticeship degree, it would also allow nurses to gain really valuable experience in a different environment than can be provided by the NHS.

Could the training period for doctors be reduced?

Sue Ryder doesn't believe the training period should be reduced.

Should the cap on the number of medical places offered to international and domestic students be removed?

As previously highlighted Sue Ryder believes there should be an increase in the number of university courses/places across all roles in health and social care in line with accurate future workforce projections. The removal of the cap on the number of medical places offered to international and domestic students should be considered if we are in a position where places are not being filled.

What are the principal factors driving staff to leave the health and social care sectors and what could be done to address them?

As referred to earlier in the submission, burnout due to long hours and staff shortages - particularly over the past two years where the pressure on health and social care staff has been relentless - as well as, lack of recognition and levels of remuneration are common reasons for staff leaving the health sector. It is also widely documented that many health and social care staff are nearing retirement age. It is therefore possible that Covid-19 and burnout may have driven many to retire earlier than they would have otherwise, which has exacerbated the workforce shortages further. **It is unsustainable for our health and social care workforce to feel exhausted and underpaid, and as a population we are seeing the impact of this.** These issues must be tackled by the Government head on and **we must ensure that health and care workers across the whole health sector feel valued.** As we mentioned earlier in our response, focusing on alleviating these issues in one area such as the NHS will be to the detriment of other services.

To help the health and social care workforce feel more valued the Government should explore areas such as:

- Enabling parity of pay across all services within the health and care sector, so that pay is not dependent on which part of the sector the role is in, and increases in pay are reflected across the system;
- Collaborations with housing companies - to offer affordable housing cost options;

- Reduced travel costs nationally for staff (or students) in the sector;
- Relocation budgets to encourage staff in hard to recruit areas;
- Childcare support measures for all staff across the health and care sector, as shift work is particularly demanding on families.

Another commonly cited reason health and social care staff leave the sector is because they don't have enough time to actively care for patients and this is largely the reason they chose their profession. Regular changes to governance, data collection and accountabilities all require staff time, usually in the form of training programmes and increased paperwork. Whilst an accurate record of care that is delivered is of paramount importance, the Department for Health and Social Care and NHS England should review how data and governance information is collected across the system and streamline this as much as possible to avoid repetition. This is particularly true since we entered the pandemic and requests for information from different agencies and stakeholders have increased. We need to ensure that we protect health and social care staff time to undertake the most important part of their role - providing high quality care.

Are there specific roles, and/or geographical locations, where recruitment and retention are a particular problem and what could be done to address this?

At Sue Ryder we find some of our services are particularly impacted by location. A number of our services are in rural areas of England, or areas that are hard to reach as they are not located on public transport routes. This isn't exclusive to us, for example we know that in Aberdeen the NHS has had to shuttle staff into the area to fill hospital vacancies. Additionally, as organisations move to a more community centred model of care, where technology allows us to deliver increasing services within people's homes, transport again becomes a blocker to being able to move our teams around where they are needed.

Furthermore, affordability of transport and housing may prevent staff looking for roles in certain areas. This is particularly acute when services are located near an area where inner and outer area weighting can apply. For example, staff can opt to work in a similar role which involves them travelling in one direction (maybe 30 mins) and earning more per hour, versus working in a service which is potentially closer to them and earning significantly less per year.

The Government could go further to support those who work in health and care to access the transport they need to undertake their job, whether that is through supporting the initial outlay for a vehicle, improving transport links, or reducing the burden of new charges that can apply to owning a vehicle.

In addition to this, as previously mentioned, strengthening recruitment pipelines within communities would help in the medium to longer term.

What should be in the next iteration of the NHS People Plan, and a people plan for the social care sector, to address the recruitment, training and retention of staff?

Fundamentally, we believe the NHS People Plan and a people plan for the social care sector should not be viewed separately, nor developed independently of one another. A whole sector approach must be taken, including a focus on the independent healthcare sector.

Workforce planning must be developed in line with projected population demand across all vital health services (not just NHS and social care). This should also address training and

remuneration so that the whole ecosystem of the healthcare workforce can continue to function well.

Staff must feel valued in their role and by society. We need to see clear performance reviews with dialogue and feedback, alongside staff being rewarded fairly and recognised for their contribution.

Practical interventions that should be encompassed within the next iteration of the NHS Plan and people plan for the social care sector to address recruitment, training and retention could include:

- Development of new flexible pathways for a range of roles across the whole sector.
- Better financial support for mature students who need to pay for their own training and often can't afford to get through this period.
- Availability of childcare options for key workers to assist them with shift work patterns. This is sometimes available within large hospitals, but is less available to the wider health and care workforce who also work shifts.
- Flexibility in shift patterns for people with caring responsibilities to remove barriers.

[To what extent are the contractual and employment models used in the health and social care sectors fit for the purpose of attracting, training, and retaining the right numbers of staff with the right skills?](#)

Flexible working

The pandemic has highlighted that roles that we predominantly see in the health and care sector no longer align with how people want to live their lives. This is particularly true as more of the population are working remotely, and hybrid working becomes more of the norm. This is likely to lead to a better work-life balance for those who are working in non-caring roles.

Additionally, a large percentage of caring roles will follow a shift pattern which is particularly difficult for families, but as the sector already has significant shortages in its pool of available staff it means it is difficult to explore new models like shift sharing, or providing term-time hours contracts.

Childcare support measures would be one way to make the working patterns for health and care staff more attractive.

Contract perception in care sector

Furthermore, zero hours contracts have become publicly synonymous with care roles. A zero hour contract offers no guarantee of work or financial security. This type of contract coupled with a culture of commissioning care by 15 minutes - as some Local Government organisations have moved towards to manage their budget - is not conducive to 'good quality care' and it doesn't attract people into the profession. The health sector must be adequately funded to avoid this type of commissioning and the Government should take steps to tackle this view.

NHS agenda for change

The NHS agenda for change sets out pay scales for all health staff. The NHS also increases pay by 2% year on year for all staff (when not in a pay freeze). The independent sector is contracted to provide vital health services that the NHS would otherwise have to provide, yet it is difficult to keep pace with increases in other parts of the system as statutory funding does not respond to NHS increases. Any statutory funding for NHS contracted care such as palliative services should be increased in line with any NHS pay increases.

Minimal regulation on the pay that agencies can give to casual staff means it is difficult to attract staff to become 'bank' staff (casual staff who want to work every now and then). As a result, the cost of staff shortages continues to increase as agency pay is not in line with the NHS agenda for change pay scales.

Travel

Expectations to travel can be an issue. For example, it is expensive to run a car, but many areas where health and care staff are needed are rural or have poor transport links. Whilst Sue Ryder has an expenses policy that supports staff who need to travel for work, the expectation to be able to get around makes recruitment in areas outside cities more difficult. We are looking at introducing a shuttle bus to help tackle this at one of our services. The Government could go further to support those who work in health and care to access the transport they need to undertake their job, whether that is through supporting the initial outlay for a vehicle, improving transport links and subsidising public transport costs, or reducing the burden of new charges that can apply to owning a vehicle.

Carers

Carers are vital in providing care to a huge part of society. The Government could explore with expert organisations in the field the role of carers as partners in healthcare. For example, exploring how carers could 'join' the social care workforce on their terms e.g. providing paid support for arranged hours - which allows the carer to maintain their vital and skilled involvement with the person they care for and to use these skills to earn additional income. Many carers reluctantly give up their role when needing to receive an income.

What is the role of integrated care systems in ensuring that local health and care organisations attract and retain staff with the right mix of skills?

Integrated Care Systems (ICSs) must **work with service providers to understand the demographics and demand for services in their footprint**. By doing this the ICSs will be better equipped to plan and commission the appropriate types and levels of service needed, as well as identifying any gaps, to make longer term plans for both services and the workforce. For example, we know that the number of people receiving palliative care services is set to increase by 55% over the next ten years¹⁰. We need to ensure we have **a well-resourced workforce in place to deal with this predicted rise in demand**.

ICSs must take responsibility in their areas to commission services at a rate that allows providers to not only deliver services but also to allow for attractive packages for recruitment and retention of staff. **Providers need to be resourced appropriately** for the service they are commissioned for, which includes making it possible for them to give competitive remuneration.

HEE funding has been allocated to support all Service Requirements across the ICS to deliver the care required. This training included non-medical prescribing training, Continuing Professional Development courses and Clinical Apprenticeships. Independent services, such as Sue Ryder, should be allocated some of this funding to help to support their work to train, recruit and retain staff. Independent services should have a say in how ICSs use and allocate

¹⁰ London Economics commissioned by Sue Ryder, Modelling demand and costs for palliative care services in England, 2021 – www.sue Ryder.org/hospicefunding

this money to ensure that it is able to benefit staff training and retention across the health and social care sector.

ICSs should **consider enabling the movement of staff between providers across the ICS** - which would allow opportunities for shared learning across the services, helping staff development, aiding retention and helping to fill shortages. The coordination and facilitation of such a programme would provide rich learning opportunities and enhance the workforce; however, a centralised resource would need to be in place as this could not be coordinated by individual providers.