10 Year Health Plan working group: people

Co-chairs' report

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Introduction

People are not an enabler of change in health and health care. They are, and will be, the change.

Making the 3 big shifts a reality in the NHS means staff - and the wider health and care workforce they work with - doing very different things and in different places. It means staff behaving differently and feeling very differently about their jobs, their colleagues and the citizens they serve and support. It will mean different relationships between clinicians and managers, and different jobs, professions and teams, shaped by the needs of the patient and the citizen in front of them and the needs of the community around them. And that will mean different ways of leading change.

The size, cost and complexity of the NHS workforce means that even small changes become high stakes as they are aggregated across 1.5 million staff into a system that is unusually nationally driven and mediated by multiple powerful interests - including government departments, trades unions, universities, NHS institutions and sectors, regulators, royal colleges and lobby groups. In this context it is difficult to build common purpose, fostering stagnation, making it harder to adapt to changing times and increasingly leaving all concerned unhappy with the prevailing experience of working in the NHS. Because workforce reform is so difficult, NHS reform too often reorganises the architecture instead, without any changes to the employment, culture or experience of those who work in it, with a consequentially minimal impact on the quality, accessibility or productivity of care which is driven primarily by what people do and feel at work.

Today, as a result, far too many staff 'love their work but hate their job' and the biggest challenge for the 10 Year Health Plan (10YHP) will be earning the trust, confidence and the commitment needed for staff to make the changes which will be needed to transform the NHS. That must be a central focus for the early years of the plan, an essential foundation for future transformation. But it also means that the key national players need to recognise their predicament and accept that substantial and radical changes to the model of work in the NHS is a necessity which everyone needs to get behind. While all players passionately want a different future to ensure that the NHS recovers and then thrives, and all recognise that the present is unsustainable, there is a risk that internal institutional logic, loyalties, responsibilities and, at times, protectionism imprison the NHS in the present.

The 3 shifts require a fundamentally different model of care and prevention. But the inertia of the system is powerful, so the 10YHP and new Long Term Workforce Plan need strong counter-gravitational actions to ensure that we achieve them and the changes that many have aspired to over the past 2 decades. The focus needs to be on shift not drift.

The fundamental changes required will take place over 3 timeframes: now (fixing the foundations) next (transition) and later (framework for the future). Actions need to be directionally aligned but also agile and adaptable, so that the decisions we take today take us closer to, not further from, the future we want to create. All 3 phases of change will need to run together, requiring careful planning and leadership to sustain commitment and confidence in the future.

The nature of the change means we shouldn't try and answer everything nationally but set out a framework we can build on together, within which local systems can operate and innovate to best meet the needs of their people. In many cases, this will require fundamental reforms in how we train, employ, regulate and support our staff. But equally in many systems, the future is already out there and there is a wealth of local innovation, inspiration and cutting-edge practice that can be adopted and adapted now to begin to make the changes needed.

In its 7 meetings the members of the people working group discussed a range of substantial and controversial reforms across the whole of workforce policy. In many areas there was substantial consensus and widespread agreement, but in others there were some significant reservations and at times strongly divergent views. At the start of the work, the co-chairs of the group agreed that an attempt to synthesise this spectrum of opinion into a compromise set of recommendations would be at risk of presenting to ministers a report that failed to address some of the most difficult choices that the NHS now faces. While there was largely broad support for the direction of travel and many of the recommendations here had strong support, not all had universal agreement. It is important therefore to be clear that the recommendations in this report, while strongly guided by the rich conversations and debates in the working group, the engagement exercise, and many other discussions with a range of organisations, represent the views of the co-chairs, but not necessarily individual members of the working group.

The size and shape of the workforce

This report does not attempt to set out in a granular way the future size and shape of the future NHS, which will be for the new Long Term Workforce Plan (LTWP) to address, informed by detailed modelling and financial analysis and the needs of systems to deliver the 10YHP so that the workforce is shaped by their service models and plans. Clearly this will need to be significantly different to reflect the scale of change implied by the 3 big shifts, building stronger capacity and capability in community and prevention across the future workforce, and deploying a different mix of skills in teams.

The next LTWP needs to be built on the premise that care won't always be delivered by the employed workforce and recognise the blended nature of care in the 21st century. The bulk of care is already provided by an invisible army of carers. Technology - whether it be

the internet, apps, or smart devices - is increasingly playing an important role in healthcare delivery and supporting citizens to manage their own healthcare. A workforce plan that fails to recognise these core elements of care - the workforce, self-care, informal care and technology - will provide the wrong answer to the wrong question. The real questions are what care needs to be provided, where and how do we best provide that care equitably by deploying the best mix of formal, informal and technological support within the available resources and the changing skill mix of the workforce? The balance between these elements will vary by people, place and disease pathways.

Within this the conception of workforce must be radically different, widening out from the employed and contracted NHS workforce to encompass a wider workforce across neighbourhoods and communities - patients, their families and friends, paid and unpaid carers, volunteers, voluntary workers, the private sector, the social care workforce and beyond. Physical and mental health and ill-health are not bounded by conceptions of sector and the future of accessible, productive and high-quality care depends on extended teams, supported by technology, working in partnership with patients as citizens. Continuity of care, particularly important for people with multiple health problems, across primary, community, acute, mental health and social care will be vital. In the future this cannot be delivered, as some hope to return to, by one doctor over time. Instead, it will be much more about one cross sector team with continuity of care delivered by technology, shared data and AI supporting a distributed team who all know the patient history and have prompting for the right questions and responses at each encounter with individuals, wherever that happens and whoever in the team is doing it. The point of co-ordination team will depend on the particular service model and care pathway in question. Clearly, building public and patient confidence in that very different way of delivering care will be key.

For that to be effective, the recommendations of the equalities vision group to ensure a workforce with the cultural and social competence to understand the realities of individual people’s lives in their neighbourhoods and communities will be critical to ensuring better care, more equitable outcomes and better leadership of all. Staff who get what their patients are saying about their health and their lives don’t waste time on misunderstandings and more quickly get the help that people need to manage their health and their ill-health. Measures to widen social participation in health careers will also be an important dimension of ensuring that NHS staff reflect and understand the diversity and circumstances of the populations that they serve.

The publication of the first Long Term Workforce Plan was welcome, setting out for the first time in the NHS’s history a systematic approach to future workforce needs. Its intention to shift from hospital to community by 6% was within the prevailing mindset, an ambitious aim at the time, but the next plan will need to go much further to transform the service and place it on a sustainable basis. Equally, the productivity assumption of 2% was demanding

within the current conception of service provision, but simply insufficient to address the demographic challenge that healthcare faces. These were drift, not shift, ambitions.

The reality is that we cannot and should not seek to continually grow the workforce in line with forecast activity. It is estimated that unless we bend the curve on demand by shifting towards prevention and find new forms of supply, by 2080 every adult of working age would have to work in the health and care sector[1]. This is neither possible nor desirable. A renewed drive towards the 3 shifts, supported by technologies, co-production, with strengthened leadership and management and shared data should ensure it is possible to deliver much more with less growth than would have otherwise been required.

This can only be delivered by fundamentally changing the future of education and training of our healthcare workforce, the future of their work and the NHS' future leaders, managers and the culture they create. We will need to change who we recruit, what they learn and do, how they learn and work, when and where.

As a result, there are a number of key areas which the next plan will need to revisit. First it is not realistic - in terms of costs of training, costs of employment, the capacity of future labour markets, domestic training capacity, or ethical and practical levels of immigration - to aim for expanding the current 1.5 million staff by a further 800,000 people. Students training to be clinical professionals would make up around one in 6 of all first-year student by 2031 to 2032. The new plan will need to be realistic if it is to be credible.

The first plan also envisaged the consultant workforce growing significantly faster than the GP workforce, where there are already significant shortages. The new plan needs to ensure the balance better reflects the demand assumptions of a shift from hospital to community and treatment to prevention. For existing consultant growth, the mindset on future deployment needs to focus much more on how this key specialist resource can be trained and then deployed in communities so that their expertise is available across all settings at the right time, not simply as the endpoint in an extended and delayed 'patient journey'. Within that doctors and other clinical staff will need a better balance of specialist and generalist skills to enable them to treat patients with multiple conditions effectively.

The new plan also needs to set out how it will expand and fund university and college capacity, placement capacity, teaching capacity and simulated learning environments to deliver any additional workforce.

[1] Based on NHS England modelling extrapolating the size of the workforce from the rate of growth in the NHS Long Term Workforce plan and expected growth of the adult social care workforce.

The growth and productivity assumptions in the LTWP also underpin an overdependence on international supply which is ethically dubious and unsustainable in the long term.

So while delivering the 3 big shifts, a key aim is to reduce the demand for additional staff and the dependence on international recruitment by trying to create contexts for much more productive work. That means:

- regaining the trust of staff by getting the basics right so they are willing to engage with and lead change
- developing and supporting better leadership at all levels - executive, non-executive, managerial and clinical - through a 3 shifts lens - to plan and lead the changes needed
- reshaping and reskilling the workforce with different education, training and career-long development
- reviewing traditional professional role boundaries making them more fluid and permeable across hospital settings, community settings and care contexts, supported by interprofessional education and training
- investment in basic tech hygiene, but also ensuring that procurement of new systems is done with staff so that the change it brings is shaped with clinical realities and drives the changes we want to see
- ensuring contracts and employment models support productivity.

The LTWP largely restricted itself to supply and demand considerations, but while it provided for investment in education and training of additional staff, it did not provide for the cost of employing additional staff. As staff costs already make up the substantial majority of NHS spend, further substantial expansion of the workforce as currently constituted in line with demographic pressures and current productivity assumptions will be unaffordable, and the new plan needs to be aligned with realistic projections for growth in the number of NHS jobs. To build trust with staff that ‘we mean it this time’ any growth in staff in the new plan will need to ensure that the facilities and equipment are in place to ensure any additional staff are trained and deployed productively and in the right places.

The way in which the new LTWP is developed will be as important as its content. While it was developed based on framework 15 and extensive national engagement with stakeholders, at its heart it is a bid for training resources reconciled between NHS England, DHSC and HMT. For the new LTWP to be an effective delivery engine for the new 10YHP, rooted in communities and driving the opportunity and growth missions as well as the health mission, it needs to be rooted in the planning realities, priorities and

ambitions of systems, and partners in local government and education. Following the publication of the 10YHP each integrated care system (ICS) should, as part of the subsequent planning round, set out what they need from the new LTWP to enable the local delivery of its workforce, service and health ambitions. While some 'no regrets' decisions might be needed in the meantime to inform commissioning of any short-term workforce expansion plans, it is important that the new plan is shaped by system and place and the national support and reform needed to enable systems to deliver a different future.

In setting out our thinking on the future of the workforce, the working group considered the issues through some key lenses, which form the structure for the rest of this report:

1. the future of work: the NHS staff standards
2. leadership
3. the future of education and training
4. hospital to community and treatment to prevention
5. analogue to digital
6. anchor systems
7. productivity
8. professionalism

Section 1: the future of work - the staff standards

Currently, we have a transactional model of care and employment. Workforce is viewed as a cost rather than an investment, and employers are incentivised to create as few posts as they need to cover the funded 'activity', and to fill as many of those posts as quickly and cheaply as possible from a range of sources (domestically trained, international recruits and bank and agency - with the latter 2 now the dominant supply). Employees fund 'posts' in organisations rather than investing in people, with life-long learning for life-long careers in the system. This feeds a negative circle that does little to tackle local unemployment, economic inactivity and inequalities in skills or health, and contributes to increased health care demands and reduced economic growth. The NHS is risk averse, so jobs do not offer the flexibility, autonomy, agency, reward, progression, fairness and value that people increasingly seek, fuelling increased sickness and leaver rates, driving up bank and agency, health care costs and unemployment with reduced morale and productivity, so the

NHS struggles to recruit and retain the best people. A low value placed on staff engagement means the basic foundations of good work - good teams, good line management and meaningful appraisal - are woefully inconsistent in practice.

Through the 10 Year Health Plan we should move to a people-based model of care and employment: people are seen as an investment not a cost, so are provided with the skills and employment models to support life-long careers in the health and care system. The NHS is a learning organisation, where everyone learns and everyone teaches, so that everyone leaves with more skills than they joined with. Employers understand not just the physical and mental health needs of their local population but their local labour market and use the twin levers of education and employment to proactively create pipelines that reach into local communities, offering ladders of opportunities in skills and jobs, creating a virtuous circle of behaviour that reduces unemployment, economic inactivity and inequality and improves skills and health, reducing the need for health care and increasing economic growth. The front line is liberated to take risks to innovate and improve and the offer of more flexible, autonomous working with lifelong learning and progression reduces sickness and leaver rates, with improved morale and productivity, and better care for all. Effective teams, good line management, aspirational leadership and proper appraisal are the norm.

Both common sense and a sizeable body of research suggest that healthy and happy staff are an essential precondition for healthy and happy patients. To be effectively patient centred, the NHS needs to be properly people centred.

The NHS staff survey, the NHS Change engagement exercise, industrial unrest: together these paint a challenging and worrying picture in that context. Ultimately, the NHS of today has not modernised its offer to staff or its attitude to staff. Today’s NHS employment model is outdated, with too much emphasis on the way things have always been done, leading to staff feeling undervalued. Fixed, unpredictable shift patterns, and wider cultural and leadership issues lead to staff feeling underappreciated and taken for granted, with outdated attitudes of “you’re lucky to have a job for life” commonplace in some professions. Leadership in some areas fails to acknowledge the inherent stresses of working in health and care, with an insufficient health and wellbeing support offer for staff, and racism, discrimination, harassment and violence are also an everyday occurrence for some staff. All of this means that the trust and goodwill of many staff has been lost, reducing discretionary effort and a willingness to engage with change.

Data on leaver rates, as well as a breadth of academic literature, suggest that overwork, low morale and a lack of flexibility drive people to leave their job in the NHS. Occupational health provision for staff is patchy and career models are limited. In the 2024 NHS Staff Survey, a third of respondents said that they found work emotionally exhausting, and nearly 30% said they did not have enough energy for friends and family during leisure time. In 2024, around 16,000 staff left NHS employment citing work-life balance as

the reason. The experience of black and ethnic minority staff in surveys is consistently poorer than those of white colleagues.

As the offer to staff in other industries has improved in recent years, while the NHS one has been static, the comparisons are becoming more apparent and are felt more keenly by NHS staff. Over the early years of the plan, the restoration of trust - and fostering hope for the future - will be critical to its later success.

NHS England engaged widely with staff to review their experience of work to set out The NHS People Promise. It outlined a set of commitments to seek to ensure that all NHS staff experience a supportive, inclusive, and fulfilling workplace. It was designed to improve the working lives of NHS staff and to create an environment where they can thrive. The core elements of the NHS People Promise are grouped into 7 themes, each of which represents a specific area of focus for fostering a positive workplace culture. These themes are: 1. We are compassionate and inclusive; 2. We are recognised and rewarded; 3. We each have a voice that counts; 4. We are safe and healthy; 5. We are always learning; 6. We work flexibly; and 7. We are a team.

The group were clear that these aims still held true but were also clear that the people promise is, so far, a promise unkept. As part of the work to set out a new Long Term Workforce Plan, NHS England and DHSC should work with the NHS Social Partnership Forum to agree a new suite of Staff Standards, applicable in all settings, and set out a clear timeline for how these standards will progressively over time become an operational reality for staff, with clear milestones, management information and targets to track progress. These will replace the people promise with a core set of standards which all employers will need to meet, and against which their employment practice and culture is assessed. The standards should set out universal and consistent standards on access to nutritious food and drink, rest, health and mental health support and treatment, exercise and fitness. The staff standards should be introduced from April 2026, with quarterly publication of data at employer level.

Flexible working is a core component of the people promise and needs to be a key focus in the development of the staff standards to make it a reality on the ground and give real choice and control to staff. (Where possible, this flexibility should also apply to students as a retention strategy for the future workforce.) There are real and entrenched cultural challenges involved in driving this level of change in a system as large and complex as the NHS: the drag of cultural inertia "we've always done it this way-ism"; fear of being unable to safely and affordably fill shifts in a system with lower management control over deployment; leadership bandwidth in a pressurised system; lack of organisational design and HR capacity and capability; lack of strong social partnership arrangements locally; and the need to "change the engine while flying the plane". To overcome this and identify radical, practical, deliverable routes to achieving this change will require planning and sustained effort. NHS England should commission NHS Employers to set out a blueprint

for giving staff a transformed experience of flexible working, together with an implementation toolkit and guidance on meeting relevant staff standards which will be monitored to ensure delivery and to progressively make the aspiration of more flexible working an easy option for all staff.

Violence is too often a feature NHS staff's experience of work and in some places can too often be accepted as an occupational hazard to be lived with and regretted. The staff standard should set out clear expectations on staff safety and provide for monitoring of progress in reducing violence against staff. There are particular services and settings where violence is more common and these areas will need to prioritise action in this area.

While Care Quality Commission's (CQC's) inspection and ratings regime includes a "Well Led" dimension that seeks to reflect the experience of staff at work, it cannot be right that CQC registered organisations who continue to show unacceptable levels of discrimination, bullying, violence or harassment should receive "Outstanding" or "Good" ratings. CQC should set out explicit quantified thresholds for these elements of staff experience in the staff standards which trigger an automatic "requires improvement" rating for organisational assessments. Putting the regulator's muscle behind staff experience will be an important driver of change and leadership focus which recognises that for people to get behind the patient, employers need to get behind their staff. The Integrated Assurance Framework for the NHS should equally include these elements of staff experience as part of their assessment framework, with organisations falling short excluded from the top 2 segments.

To support this work and the monitoring of progress on implementing the staff standards, an early task for the 10YHP will be to work with the NHS Social Partnership Forum to agree a national set of core staff experience performance indicators at organisational level in all NHS funded services to be published quarterly at organisational level. Too often it has been argued that annual publication of these data is sufficient because change happens so slowly. We are clear that if staff experience becomes a hard measure of trust performance and CQC ratings, and has proper leadership and management attention, that many of the dimensions of staff experience can be rapidly changed. There are many organisations that have shifted the dial on this critical driver of healthcare delivery and patient experience - where there is a culture of complacency, desensitisation, or helplessness this needs to stop.

As part of this work, NHS England, working with the Social Partnership Forum, should agree plans to improve the quality, collection and use of exit interview data. Current information on reasons for leaving the NHS is weak and is key source of information in other industries, providing both local and national intelligence on staff experience.

Working in healthcare is both physically and mentally demanding and impacts on all staff, affecting morale, sickness absence, productivity and retention. NHS England is currently conducting its Staff Access to Treatment Review (STAR) to address this reality of

employment in healthcare. On completion, as part of the new Long Term Workforce Plan, it should set out a clear timeline for the introduction of a comprehensive set of high-quality health and wellbeing and occupational health services for all NHS staff, including services for back conditions and mental health issues that are a significant cause of long-term sickness absence. These services should be available to staff working in acute, mental health, ambulance and primary and community settings. Supporting people who are unable to work because of ill-health back into work is a core component of the 10 Year Health Plan, but keeping people healthy to stay in work is equally important. In a service employing 1.5 million staff, the NHS has a key part to play. Metrics which track the impact of the offer to staff on health and wellbeing, including sickness absence, should be a core element of the new staff standards.

DHSC has a well-established model of national social partnership with trades unions, employers and NHS England and this needs to be strengthened to ensure effective partnership through a substantial period of change. The SPF should assess the extent to which these models are working effectively at regional and local levels and what steps need to be taken to ensure effective social partnership approaches are more consistently adopted. As systems become an increasingly important footprint for workforce activity over the timeline of the plan, DHSC should commission NHS Employers to work with trades unions to ensure strong social partnership fora at ICS level so that strategic decisions at system level can be shaped in partnership with staff representatives.

The NHS Pension Scheme is a generous and valuable part of the NHS employment offer, but modernisation of that offer is needed to better reflect the needs of current and future staff and help retain people in the NHS. Currently, NHS staff have only 2 choices when it comes to their NHS pension saving: opt in or opt out. The amount members contribute is set by scheme regulations, with members paying according to a tiered structure, based on their pensionable pay. As a defined benefit scheme, the pension benefits members accrue, and subsequently receive on retirement, are also set by regulations. This means that NHS staff cannot alter the amount they pay into their pension, unlike workers in private sector, defined contribution schemes. There is no flexibility to choose more pension or more pay.

The government should introduce a new contribution flexibility to the NHS Pension Scheme, to allow members to choose a different amount of pension contribution, and subsequent pension accrual. The model could give staff complete flexibility to choose the level of contributions that suits them, as we move towards more flexible work models. The benefits members accrue would still be defined, although their level of accrual would decrease as pension contributions decreased. Under this model, the employer contribution would still be paid in full. These measures would improve recruitment and retention by making the total reward offer more flexible, decrease opt outs and encouraging some pension saving for staff who would otherwise opt out of the scheme.

There is an important opportunity to shift from a transactional model of HR to a more efficient, effective, productive, and transformational people service - digitalising the employee experience, with automation of processes, virtual assistants, providing deep expertise in HR matters as well as more strategic workforce planning, talent acquisition, talent management and organisational development to create productive performance cultures in motivated teams. Together with proposals to scale up many aspects to system level, NHS England plans for standardisation, scaling up and digitisation are the right ones and need to be a core component of delivering a different future.

The continuing high levels of discrimination apparent in the NHS are a particular cause for concern in NHS culture and the staff standards to measure, manage and monitor progress will need to ensure that race equality, misogyny, sexual violence and harassment and other unacceptable features of inequality and discrimination are as central to leadership concerns as elective recovery and financial balance. The 'inclusion' dimension of the people promise, underpinned by new staff standards needs to rapidly and progressively become a reality for all staff as part of the 10YHP.

Full implementation of the Messenger Review (2022) (see below) will help over time to build the diverse leadership cadre with the capability and confidence to support this work. As part of this effort, to address race equality, NHS England should commission the NHS Race and Health Observatory to provide evidence-based support to NHS organisations, including review of organisational plans, to achieve the national ambitions set out in these recommendations and support delivery of the staff standards. The observatory should provide annual assurance reports to the Department of Health and Social Care and NHS England - outlining progress against the national ambitions. These are:

- eliminate the ethnicity pay and progression gap across the NHS by 2035
- close the ethnicity gap in workplace bullying and harassment, and reduce the overall level of bullying and harassment across the NHS - by 2030
- ensure organisational leadership is reflective of ethnic representation across the workforce - by 2035

The Gender Pay Gap for medicine group should review the gender pay gap for all staff and set out recommendations for reducing unwarranted inequalities over the course of the plan.

The NHS’s current model of setting terms and conditions is a system of national collective bargaining which ensures that much of what happens locally is agreed nationally. Equally, pay is set nationally through a system of independent national pay review bodies. This has a number of advantages, notably national consistency, and a sense that there is a degree of central control over the price of work. It is equally a check on local settlements that

might erode hard won advantages in generous NHS terms and conditions on holidays, sick leave and other benefits. This dispensation also frees local employers from some really very difficult discussions with their staff about pay, terms and conditions and allows them to delegate upwards any concerns about these issues.

While within these national frameworks, local organisations do have considerable flexibility to adapt elements of employment terms in discussion with staff and trades union partners, in practice these are not used extensively. There was no strong consensus among most members of the group for significant changes to this overall framework, but a number of points were raised by some, and by those who fed into our work, about potential other options.

It was proposed for example that non-medical staff working in primary care should be employed on the same terms as agenda for change staff in hospitals, both for equity reasons and for ease of movement between the 2 sectors. Others noted that having different contracts for different staff groups and different contracts for primary care and secondary care staff sustained barriers to a multi-professional and sector-blind approach that makes it harder to build a future in which staff work adaptively in distributed multi-disciplinary teams across boundaries to meet patients' needs more effectively. There are also long-standing issues about the costs of plain and premium time working in some contracts, for example the weekend opt-out for consultants, where collective agreement of new arrangements might be beneficial both to staff and to employers. At the most radical, some saw a single multi-professional contract for all sectors, with a single employer at ICS level enabling easier deployment across a system, not an organisation, as the best means of enabling the 3 big shifts. We recommend that as contracts are negotiated in future over the 10 years of the plan, the considerations of enabling multi-disciplinary working and cross-sector working are a key element of those collective discussions and agreements.

As the model of care changes to deliver the 3 shifts, the delivery mechanisms will need to adapt. No one individual, institution or organisation will be able to deliver the shifts on their own and that includes the NHS. To be realised, the NHS will be reliant on partnering arrangements at all levels from an individual's family and friends, to integrated neighbourhood teams, place, system, regional and national. These coalitions of the willing will involve formal and informal arrangements, contractual, strategic partnering, compacts and emerging new models of collaboration. ICSs and providers will need commissioners skilled in operating across a more blended landscape of delivery models while ensuring the people-centred focus of the 3 shifts remains paramount. The value of outsourcing current NHS-run functions needs careful consideration within that. Taking account of the government's wider commitments on employment rights, the NHS Social Partnership Forum, working with private sector partners, should lead a review of outsourcing in the NHS, including any safeguards, business case and consultation requirements for consideration of outsourcing proposals.

While it offers much more flexibility for staff, agency working is an expensive way of providing care which carries quality and safety risks and needs to end as a routine approach to filling gaps in the workforce. Ideally, national contracts would change to enable flexible working within them, with additional hours paid at comparable rates to bank and much more dynamic payment models such as floating rates giving much greater choice and control to staff.

Section 2: leadership

Leadership is clearly going to be critical for the scale and complexity of change that is needed and to take people with them on that journey. We employ too many people who don't do people in these roles and need a more diverse generation of leaders at all levels who are more relational and less transactional with patients, staff and partner organisations and sectors. The NHS needs a cadre of leaders who "think system" and work naturally across sector boundaries within and out with the NHS - a distributed leadership which is adaptive, operates across and within organisational boundaries and is people and community centred.

A person-centred neighbourhood health service will need to adopt a model of care that is strengths based and relational. One that encourages prevention wherever possible and access to specialist treatment when needed.

This will require a significant cultural shift and cannot be driven by the centre. The strategic ambition, national outcomes and operating framework should be set by ministers but it will be for leaders in all settings, operating within the framework to deliver the cultural change that is needed to transform the NHS and ensure better health outcomes for the nation. The approach to leadership and management will need to empower staff and teams to make the changes to their processes, systems and working practices focused on person-centred care (giving them autonomy), to strengthen competence through team learning and protected time to lead and to promote relational interactions (connectedness). The introduction of professional regulation for NHS managers and the establishment of the College of Executive and Clinical Leadership should reinforce these key elements.

The design work for the future of NHS leadership has already been done by General Sir Gordon Messenger (2022), but its delivery has not been prioritised. It is now critical that its recommendations are delivered so that the systematic talent management of leaders at all levels and in all sectors equips the service with the leaders it needs. NHS England should publish a granular timeline for delivery of the recommendations by August 2025.

In our discussions the group heard a consistent theme of how a national oversight system constrained local leadership bandwidth and how a national pace-setting management style at best inhibited the development of positive relational cultures locally and at worst drive

toxic behaviours, defensiveness and blame. The accountability groups' work needs to be mindful of that risk and the operating model for the future service needs a very careful balance in how it assures performance management. Better boards are critical in that equation. Capable and confident boards are the keepers of the strategy, culture, ethics and mindsets of the organisations and systems that they guide and oversee. As part of the work to set out a delivery plan for the Messenger Review, NHS England should set out a new framework for the recruitment and training of non-executive leaders to enable the board to become a critical centre of power in the new NHS. As with executive leaders they need to think system as much as they think organisation and have sufficient diversity to understand deeply the communities that they serve. The diversity of boards should be monitored and published in annual reports.

While senior leadership is key, the Messenger review has a compelling vision to improve leadership at all levels, both managerial and clinical. Most teams are led by an undervalued group of middle or operational managers who are squeezed between direction and demands from the top and the unhappiness and demands of the bottom. They need to be valued as core leaders, who are the backbone of the NHS, leading the hard, granular realities in actual services of making real change happen. It is equally important to recognise that this is not simply an acute sector issue. In a 3 shifts future, excellent leadership and management is needed across mental health, primary care, ambulance services and community services, not just hospitals.

Clinical leadership and engagement of change will also be vital. While leadership elements are present in clinical curricula, we heard that the capacity to teach, the hidden curriculum and the time devoted to this key dimension of future professional practice was not cutting through. As with team working and cross sectoral experience, leadership needs to be a consistent ethos, not just a module, in clinical training and this needs to be addressed as part of the professional regulators' review of curricula requirements to change the skills and expectations of new graduates. An early task for the College of Clinical and Executive Leadership will be to guide this work.

To increase supply and attract young and able talent, we recommend radical expansion of the graduate trainee scheme as fast as resources permit, refocused on 3 big shifts and system working, and drawing on a broad section of society. All NHS employers and contractors should feel responsible for facilitating the scheme as part of their core business and more locally based funding models for the scheme might facilitate more rapid expansion.

As part of this work, for a report focused on people, an acceleration of the continuing evolution of the HR profession from a largely transactional function to a people function will be vital in managing a large scale and complex set of changes while taking people with them. NHS England's blueprint for HR and organisational development in a digital world and its plans for the future of the profession are robust and are supported by this report.

Section 3: the future of education and training

From a 19th century model of static, front-loaded education for the elite: the pathway to a medical or clinical career often favours the academically gifted, and is heavily front-loaded and roles-based, so that individuals 'qualify' upon graduation, rather than recognising the rapid pace of new knowledge and technology will require constant and adaptive learning of different capabilities and competencies. Learning is largely institution based, focused on specialisms, with the majority of placements (and therefore jobs) acute based, with learning in professional silos rather than multi-disciplinary teams. People on placements feel that they are a pair of hands rather than a person who is a valuable part of a team. Education is seen as a cost rather than an investment, as it is seen as a pre-cursor to competition with work, rather than a core part of everyone's business. The degree of protected time for education varies between different professions and sectors, and individuals often have to learn in their own time or at their own cost, as if it is an optional extra, rather than the foundation of good quality and safe care.

To a 21st century model of life-long, adaptive learning for all: the NHS is a learning organisation, where everyone learns and everyone teaches, so that everyone leaves with more skills than they joined with. Employers understand not just the health needs of their local population but their local labour market and use the twin levers of education and employment to proactively create pathways that reach into local communities, offering ladders of opportunities in skills and jobs, reducing the need for health care and increasing economic growth. Education and training is less rigidly role-based and offers more generalist sets of skills common across a range of different professional roles, with the opportunity to develop relevant competencies, capabilities and confidence throughout their career to reflect changing population needs and scientific and technological developments. Education and training courses are flexible, adaptive, and increasingly hybrid or virtual and multi-disciplinary in nature, so that different professions can learn together in different settings and sectors, as a foundation for integrated and holistic working for the benefit of patients. As part of integrated care, training and experience in primary, community and mental health are as highly valued as training and experience in acute settings.

The working group saw a move from a Victorian educational model to a radically different model for the future as a fourth big shift to enable the future set out in the 4 reports from the vision groups. During the pandemic, NHS England, working with Skills for Health, led a wide-ranging programme of engagement with staff, patients, the public, professional bodies, academia, think tanks and others to develop a long-term strategic vision for the health and social care workforce, called Framework 15. NHS England should now publish this report to inform the new NHS Long Term Workforce Plan.

The framework sets out a strong rationale for the 3 big shifts and the implications for the workforce. It is clear that more of the same will not deliver the future shape of care and

work which people told us they want in the Change NHS engagement exercise. The NHS needs:

- more clinicians and care professionals with generalist skills, able to provide more personal, preventative, and joined up care, supporting flexible, adaptive careers, alongside specialists who maintain enhanced generalist skills

- with a greater focus on skills rather than roles - by expanding the skills (competencies, capabilities and confidence) of existing staff to provide the required activity, rather than automatically creating more or additional roles (which potentially increases the number of people to be referred to increasing the gaps in quality and care)

- able to deploy their skills holistically when and where they are needed - whether that be in peoples' homes; social or health care; community or secondary care and in physical or mental health, prevention, support, or treatment

- supported to develop and adapt in the future - the doubling time of medical knowledge in 1950 was 50 years; now it is just 73 days. We need to move away from a system that focuses on front-loaded training for people to be a particular specialist, to one that supports clinicians to develop and adapt in the future and critically assess knowledge and sources of knowledge, so that the NHS is an organisation where everyone learns and teaches, enabled to do so by technology

Each year, the taxpayer invests £6 billion on educating and training future generations of health professionals. In a world where there are more applicants than places, where there is limited employer influence, there are few incentives for education and training providers to change how they create future generations of NHS staff or to change the social composition of the training population. This needs to change if we are to move at the scale and pace needed to deliver the 3 big shifts.

At present students and trainees are taught in professional silos, but they tell us they want to learn together so that they have the skills to provide joined up patient care. Some members of the group sought to break down the silos and barriers imposed on learners by creating a shared foundation year for doctors, nurses, allied health professionals (AHPs) and social care, as a foundation for multidisciplinary team (MDT) working, while others felt that in practice this would be difficult to implement quickly in practice without very fundamental changes to all the affected curricula. What is clear however, is that all training and education needs to be much more team based and needs to instil a culture of team working and that the new commissioning and regulatory recommendations set out below need to be used to ensure that courses are redesigned to equip graduates with an understanding of how to work in close partnership in teams with other professions to get the best outcomes for their patients. That will mean changing both the formal curricula and the hidden informal curricula which perpetuate unhelpful distinctions and attitudes to other

professions - everyone needs to graduate with an innate sense of respect for their fellow professionals in other disciplines.

These redesigned curricula equally need to equip new graduates for a world in which sector boundaries are increasingly unimportant and with the confidence and capability to operate across boundaries to get the right care quickly for their patients. Over 80% of NHS student and trainee placements are in the acute sector, which means our future clinicians will lack the skills and confidence to work in community and primary care. National processes and incentives prioritise the acute sector, so the LTWP needs to support local systems to drive a significant shift in the number of student and trainee placements in primary and/or community care by reforming tariff and payments. We recommend that NHS England and DHSC reform tariff arrangements urgently to enable financial incentives to drive and support a fundamental shift of training for all clinical staff from hospital to community. The LTWP needs to set out a plan to ensure sufficient training and educator capacity is in place in both education and health provider settings to enable this shift at pace and at scale.

To widen access to health and care careers, develop multi-disciplinary training with community placements where they are needed at pace, we recommend reform of the commissioning process for education and training in healthcare, so that the NHS can directly lever investment rather than negotiating through other parties such as Office For Students. We recommend NHS England and ICSs should have powers to directly commission key courses to ensure that future workforce better meets the needs of patients, employers and local communities. These new mechanisms should be used to help drive growth in medical schools that produce high numbers of graduates who enter general practice, as has happened, for example, in Sunderland.

Doctors working in specialty, associate specialist, and specialist (SAS) and locally employed doctor (LED) roles told us that they don’t get equitable access to training or development opportunities, and that their skills aren’t always used effectively. The dedicated staff working in these roles could play a much greater part in the future of the NHS, working in out of hospital settings as the specialists with enhanced generalist skills to keep people well and support communities. The medical training review should take account of this group of medical staff so that in future they have equitable access to training that supports their development. At a local level, workforce planners should consider how they can use alternative training routes (for example, Certificate of Eligibility for Specialist Registration or Certificate of Eligibility for General Practice Registration) to give SAS and LED doctors quality training that supports them to work in community, primary and neighbourhood health services. In some communities, with a strong local infrastructure, it should be possible to do this now. NHS England should work with a pilot systems to rapidly test this way of working.

Different governments have layered different regulators upon the system at different points in time, and the multiplicity of players in regulation of education make it one of the most heavily regulated sectors in the country, inadvertently stifling innovation. The 3 shifts will require fundamental changes to the current system of regulation, so that it supports and enables the development of our future workforce. Health and education regulation needs to be reshaped at pace so it enables the development of the future and existing workforce in line with the 3 shifts. This should include options to move to a competency-based outcome model (rather than based on theory and practice hours requirements) and enabling greater deployment of simulation, blended learning and hybrid learning, potentially with outcomes and standards backed by nationally set end point assessments for some professions, such as nursing.

A more innovation-friendly regulatory environment, combined with direct commissioning of courses will enable a much more rapid change to the multi-professional and multi-sector curricula we need to see, while also enabling other objectives such as widening social participation to be driven through the education and training system.

In parallel, we recommend for all the health professions, that the professional regulators that oversee the standards of professional training which guide local curricula should review their requirements through the lens of the 10YHP and the 3 shifts. In particular, they need to ensure that all new NHS staff arrive with extensive exposure and experience of community, primary and social care settings as part of their placement-based training, as well as working effectively with other professions in teams as the norm.

We recommend that the new system of commissioning and regulation places student experience - both classroom and placement - at the heart of the quality assurance regime. In growing the education and training system we need to ensure that high attrition rates are addressed to maximise the value of scarce public resources put into health education and training. The unequal experience of education of Black and ethnic minority trainees needs to be addressed as part of this.

Within medicine, the principle is now agreed that specialisation in medicine can no longer be at the expense of continuing generalist capability if we are to meet the needs of an older population with multiple conditions. The review of post-graduate training being led by Prof Sir Chris Whitty and Sir Steve Powis with the Academy of Medical Royal Colleges will be looking in detail at how this is achieved in practice. The substantial time-lag between a doctor starting training and qualifying as a consultant means the impact of curricula and training changes will take time to impact on the workforce. We recommend that on completion of the review NHS England, General Medical College and the royal colleges agree and publish a joint granular timetable for implementation so to ensure that implementation takes place as quickly as possible and that progress can be monitored. The review should seek to release the untapped potential of SAS and LED (‘middle grade’)

doctors by providing access to the same training opportunities and funds, providing a faster increase in senior medical capacity as well as the ability to progress and develop.

While reform of education and training will help to transform the skills, expectations and experience of new joiners, substantial majority of the current workforce will still be working in the NHS in 10 years' time and will need the support and development needed to adapt as the services around them transform to deliver the 3 big shifts. Learning is the bedrock of our health care system: it is the engine that drives developments in science and technology, but our people need time to teach and time to learn so that we can all benefit from new knowledge as it emerges. In the future NHS, everyone learns and everyone teaches everyone who joins the NHS should will leave with more skills than they came with. As ongoing career-long personal and team development and learning will be the norm, protected time for all will need to be built into the how of work - to teach, reflect on practice, learn, adapt and drive continuous improvement in teams. This is a productive investment, not a drag on efficiency.

As skills acquired post-qualification become more important, it is vital that these skills are recognised and become portable around different employers and different sectors, together with other information about core training and barring checks that currently cause delay and friction when staff move. The staff passport which would enable this has been discussed for decades and a number of deadlines for implementation have come and gone. We recommend that it should be implemented for all staff in the next 18 months. The passport should also enable portability of other employment requirements such as DBS checks, to avoid bureaucratic delays and easier movement between employers and sectors. While an urgent priority for NHS staff, the passport should also allow over time for other parts of the extended workforce like volunteers to have portable employment and skills credentials when working as part of extended teams.

Currently the taxpayer shoulders much of the cost of medical training, but other private industries who employ them and benefit commercially from their expertise do not. The government should consider whether there are mechanisms through which all substantial employers of doctors contribute to the costs of training the highly skilled medical professionals that they employ.

Section 4: hospital to community and treatment to prevention

A person-centred neighbourhood health service will need to adopt a model of care that is strengths based and relational. One that encourages prevention wherever possible and access to specialist treatment when needed. This is not the experience of the public, staff or those who work with the NHS today.

The changes described in the preceding sections are intended to equip the NHS workforce with a different set of skills, training and experiences that enable them to work as extended multi-disciplinary teams across sector boundaries that will become increasingly meaningless as digital support and data enables the place of patient encounter to be less significant. Whoever a patient encounters should have the prompts they need to engage with people both on their health and their ill-health, with easy access to specialist support - building on every contact counts. Training and development itself needs to adapt, with much more patient, public and community engagement in the design and delivery of learning so it reflects the realities of people's lives.

While 'vertical integration', multi-disciplinary teams and neighbourhood health may all be familiar concepts to policymakers, for the public a change from a familiar world of the hospital, the family doctor, the district nurse and the care home to a very different model of care will take some considerable effort to assure them that it will be safe and effective and more easy to access. The public will need to be involved in the design of new services if they are to accept them and to use them as policymakers might hope. While a national Change NHS exercise has been invaluable in shaping the design of a new health plan, the local engagement to design and deliver the reality on the ground needs to be sustained and equally inclusive.

What the shifts mean in practice for different specialties will of course vary, with some of the craft specialities in medicine more obviously bound to the hospital rather than the community. But for many others the picture is much more blurred and will be nuanced, redefining the roles of both generalists and specialists in particular areas. We recommend that NHS England works with the royal colleges and systems and patient groups to develop for key pathways and conditions both current best practice in providing specialist care in the community and specialist advice to practitioners in the community, to start to provide a roadmap to a new much more community-based future as a whole.

As the 3 big shifts become a reality, distinctions between primary, secondary and community should become increasingly blurred. Patients' relationships should be with an extended and distributed but coordinated multi-sector and multi-professional team.

With many seeing GPs as the point of leadership in extended multi-disciplinary teams delivering neighbourhood health, there was discussion in the group about whether the future lay in employed GPs rather than the partnership model. Some felt that bringing GPs into the NHS fold would provide the basis for incentivising the shifts and ensuring the capacity in the system is determined by need. Some GPs themselves do now want to work in a partnership model and there are already workarounds emerging in some areas. Others are strongly attached to the partnership model adopted in the founding debates and arguments of the NHS's history. There are choices here as to whether to allow varying patterns to take their natural course, to incentivise particular models or to seek to drive a more consistent national approach.

The importance of 'team' was felt to be particularly undervalued although it is critical to both good care and good jobs. Whatever the industry, meaningful work, an effective team to deliver it and good basic line management is the foundation of good work. The first element of that is self-evident in the NHS but the value placed on the team and good line management was highly inconsistent when it should be the norm. As the 3 shifts depend on multi-disciplinary teams working across traditional sectoral boundaries to wrap the right skills at the right time around people adaptively, a focus on the team and line management will be a critical dimension both of staff engagement and good care. For leaders in all parts of the service, resetting expectations and practice here will be a core element of enabling change.

Far too often, the multi-professional team is inhibited by tribalism, inter and intra professional rivalry, unfounded status assumptions as well as artificial divides between acute, primary and community that are reinforced by different national contracts, employment models and siloed training routes and placements that restrict people's understanding of how best to work together in the interests of their patients. Financial arrangements drive further wedges, offering barriers to collaborative working across sectors and institutions. While professional identity is important and valuable, in making changes to any of the dimensions of workforce considered in this report, whether training, leadership, employment or otherwise, all changes should seek to ensure that individual professional identity is understood in terms of its contribution to effective multi-disciplinary practice in a team to ensure the best care for patients.

Technology will be absolutely critical to the sharing of patient information and shared clinical systems that will be at the core of enabling this new future. The delivery of a ‘one patient record’, a record that is patient centred and not profession centred, should be a clear aim for the next 10 years, allowing the workforce to work more fluidly.

The changes implied by these 2 big shifts also require a change in management information at system and national level to manage and plan the workforce. Even within the current divides between sectors, there is an incomplete and inconsistent set of data that would allow systems to understand what is happening across acute, primary, mental health and community services or workforces in the independent and voluntary sectors and social care. With a quite different skill mix to deliver neighbourhood health and extended teams across NHS sectors, social care and other employers, there needs to be a comprehensive review of the workforce information standard to reset the management information and data available to systems to plan and manage across the whole health economy and more widely. We recommend that NHS England commissions this review, to be completed by the end of year one of the 10YHP and in place by year 2.

For prevention, we support the people dimensions of the first vision group:

Point 1: preventative interventions should be carried out by the most suitable person from the wider health and care professional family and, where possible, by individuals themselves. The people plan should recognise this range of workforce but remember that many interventions require professional skills. Health champions, social prescribers and community health workers are likely to have a role in some elements of delivering preventative interventions.

Point 2: the workforce plan should ensure enough clinical and non-clinical staff are available to provide full population coverage of the following evidence-based prevention interventions:

Retain and scale up services to reach the people who need it most:

- cardiovascular disease prevention
- stop smoking services in care pathways and by referral from GPs
- vaccination coverage up to WHO recommended levels for childhood immunisation
- screening programmes
- diabetes prevention and pathway to remission of type 2

Expand services to provide consistent coverage across the country:

- physical activity within care pathways and during rehabilitation
- alcohol care teams in acute trusts
- fracture liaison clinics
- weight management
- oral health prevention
- perinatal mental health services
- child and adolescent mental health support teams
- access to talking therapies

Point 3: other staff should be skilled so that each interaction with the health service can be an opportunity to offer or request preventative services, making every contact count. The wider health workforce should understand that it is within their responsibility to sensitively address wider health concerns with individuals - and be empowered and resourced to do

so. Healthcare professionals should be equipped with information, knowledge, tools and training on evidence-based prevention interventions and behaviour change to make sure they collaboratively help people and will be able to deliver either digitally or face-to-face.

As discussed earlier, to make the vision groups' recommendations a reality the education, training and development curriculum will need to be designed to facilitate community placements, working in teams and the generalist skills to promote preventive interventions with the populations they serve. The integrated neighbourhood teams will all need to understand the populations they serve - making cultural competency a reality - having the skills to understand the person's story and discern what they are really saying. The vision group recommended a social risk score designed to explore underlying issues and causes. This very practical ability to understand the communities in the neighbourhood they work in and how the population changes over time will be a critical skill for health and care professionals.

Self-care and informal care already play a significant role in our health and care system and will need to play a greater role in the future for a neighbourhood health service to be realised. This means the ongoing conversation with the public started through Change NHS will need to continue. The facility for people to design their own care plan through the NHS App - through conversations with family, friends, volunteers or professionals - should be universal. This will be visible and connected to those who need the information, but also compiled through conversation that considers the person as a whole and things they are worried about.

Section 5: analogue to digital

In discussion the working group used the term 'technology' as shorthand for a broad range of technological, pharmacological, digital and AI innovation.

The point that everyone made from the outset was the importance of getting the basics right in technology. Bad technology such as old hardware, multiple log-ins, slow access, low reliability, poor interoperability, erratic wifi are getting people down, slowing people down and making them feel undervalued. At home most staff have affordable intuitive technology that works wherever they are. When they arrive at work they go back in time. It is not only inefficient and deeply damaging to productivity by wasting time, but it makes people feel undervalued and at time disbelieving that the NHS has the capability to transform through a sustained technological transformation. Many universities are now embracing AI, other learning technologies and learning about health technologies in their on-campus curricula but students' experience of learning in the practice setting often fall short due to poor IT infrastructure and patchy opportunities to see digitally-enabled care delivery. As investment becomes available, getting the basics right in this space should be

high on the list when prioritising spend. It will improve mood and productivity quickly and build confidence that a new future is possible.

That new future will be very different. The bulk of care will be carried out by individuals and their families and carers, increasingly supported by digital technologies. In a future-focused NHS staff will need to recognise patients as active participants in their own care, essential to driving the 3 key shifts. This will need to be supported by:

- providing patients with access to their health information through a 'digital front door' to their healthcare, with intelligent tools such as the NHS App, and digital co-pilots, allowing them to plan their healthcare into their lives rather than their lives around their healthcare

- an NHS and education sector that harnesses technology to support more virtual, hybrid and simulated learning

- work with the third sector to develop digital champions to support members of the community develop digital literacy as part of ‘learn at elbow’ strategy, with health coaches for those who require them to ensure equity of access to information and choice

- co-production (including digital) care to form part of all clinicians training, drawing on best practice in social care and palliative care models to support person-centred care and a new relationship between clinicians and public

- investing in digital competence and confidence at all staff levels to drive technology adoption and effective utilisation, enhancing productivity, safety and satisfaction for both patients and staff. This investment will also help to future-proof the workforce, ensuring a seamless transition to an increasingly digital healthcare landscape. A particular focus must be placed on NHS leaders, equipping them with the knowledge, skills, and confidence required to lead in a digital-first health service.

The group discussed the impact of technology on job security within the NHS. The scale and pace of impact is difficult to assess in such a fast-developing context. The extent of change will vary across different staff groups. In terms of clinical impact, AI-driven radiology and pathology will reduce workloads for radiographers, pathologists, and consultants by automating image analysis. AI-powered chatbots and digital symptom checkers (for example, Babylon, eConsult) will reduce GP appointments for minor issues. Robotic-assisted surgery will improve precision and efficiency, affecting surgeons and surgical teams. AI will assist in tailored treatments, benefiting oncologists, geneticists and other specialists. More virtual consultations and remote monitoring will change traditional patient care delivery. For administrative staff, AI and automation will reduce paperwork, impacting roles such as medical secretaries, administrators and appointment schedulers.

There will be increased demand for digital specialists, cybersecurity experts and AI system managers.

As these changes unfold, altering most jobs and replacing some, thought needs to be given to redeployment, retraining and development of those displaced. While for clinicians, technology will often release more time to care and practise the essential human dimensions of their roles, for others change will be more profound. Planning workforce training and development across an anchor system (see below) will allow a more strategic approach across the whole of the local public sector, as well as voluntary and independent sector partners, to manage change in a way that sustains opportunity and growth in local communities.

Digital literacy and confidence in the workforce will be critical. While tech needs to be intuitive, embedding these skills into curricula is a key enabler of change. We need to change training to include the use of technology, giving staff the digital literacy skills to adopt existing tech-enabled ways of working but also to continue to develop their practice using emerging technologies. Current gaps in digital literacy and confidence are hindering the ability to make the shift from analogue to digital. The new LTWP will also need to set out the specific expertise needed in defined careers in digital, such as clinical informaticians.

This step-change in technology has the potential to enhance self and informal care by putting better information and preventative tools in the hands of the citizens so they are better placed to direct their own care and wellbeing - ‘the digital front door’. The national challenge will be to ensure that as technology and tools rapidly develop, digital inclusion and equity are a key component of design.

Finally, the scale of transformation that technology is bringing is challenging the existing regulatory frameworks and how the risks of technology are balanced against the room needed to innovate. The Care Quality Commission and the Professional Standards Authority should work with professional regulators to review how institutional and professional regulatory regimes need to adapt to enable the rapid but safe deployment of AI and new technologies in a way that sustains both public and staff confidence in the quality of care and the security of data.

Section 5: anchor systems

The NHS was founded to fight one of Beveridge’s “Five Giants” - disease. To sustain its place in the future it has an increasingly important responsibility with its local partners to fight all five giants. The NHS increasingly needs to think less about what society and the economy can do for it and much more about what it can do for society and the economy. To date this discussion has been framed in terms of the NHS being an 'anchor institution'

within its local community. In more deprived areas who continue to struggle to recover from post-industrial decline, the NHS is often the largest employer by far, with the potential to be a major engine of social and economic regeneration.

In its discussions, the working group preferred to adopt an approach of the NHS being a major partner in “Anchor Systems”, working with local government, education, social care and others to use their collective labour market and training power to transform individuals lives by supporting them onto lifelong career ladders; strengthen local communities and build social capital; and in doing so reduce longer term demand for healthcare by delaying and preventing physical and mental ill-health.

We recommend that by the end of the first year of the LTWP, each ICS should develop, in partnership with local government and other key partners such as the voluntary sector and education providers, a 10-year strategy for its role in creating opportunity and growth in the communities it serves. These should have quantified goals for reducing dependence on international recruitment over time and increasing recruitment from deprived areas and socially and socio-economically excluded people. There are already excellent examples of this sort of work across the country, which need to be scale up and spread throughout the NHS so that its substantial presence in the country’s labour market realises its full potential for wider social and economic good.

We recommend that as part of this work, systems consider the potential of health and social care academies to pool resources across sectors to enable this.

We recommend that the current constraints on NHS use of the apprenticeship levy to use apprenticeships to support opportunity are removed, so that the levy can be used to fund backfill of posts and make more widespread use of apprenticeships more financially viable. As part of this work the balance between NHS investment in clinical and entry level apprenticeships should be reviewed in the new LTWP, to ensure that the NHS’s role in an anchor system can be maximised by providing lower threshold entry into NHS careers as a basis for further higher apprenticeships into clinical careers such as nursing associates and registered nurses.

At present the NHS does not have the information it needs to understand how its training capacity and employment power is driving social and economic progress. By the end of year one, there should be national, system and employer level collection and publication of staff employment and recruitment data by socio-economic and vulnerable groups so that progress can be monitored. Similarly, by the end of year one there should be collection and publication of socio-economic and demographic data on healthcare students by training institution. All universities training health students should publish league tables by course, including medical schools, for admission by social class and protected characteristics.

The current NHS jobs and healthcare careers platforms are difficult to navigate and the NHS approach to recruitment generally is outmoded. These should be redesigned and modernised with an aim of widening social participation in NHS careers at their core, both for clinical and non-clinical jobs, adopting best practice in use of technology for recruitment in other industries.

Debt aversion is one of the important factors deterring poorer students from applying to medicine, but there is an urgent need to broaden its social base so that it is better equipped to meet the needs of the communities it serves. Currently, the government provides a small bursary for the fifth year of medical school, which has not been uplifted for many years and does not cover living costs sufficiently. We recommend replacing this bursary with a loan, which would enable it to be increased to cover living costs adequately. The resources made available would then be sufficient to reduce the cost of medical training to the equivalent of a 3-year degree for up to 2,000 students from lower socio-economic backgrounds creating a substantial incentive to change the composition of student cohorts quickly, particularly if combined with quotas on medical schools.

We recommend more widely that the current substantial investment in the learning support fund for all health courses is reviewed to establish whether a better distribution of investment could support widening of social participation in all clinical health careers.

The role of volunteers should also be considered as part of system wide workforce planning. NHS England set up the NHS Volunteering Taskforce in January 2022 to stimulate transformational change in volunteering and strengthen links between volunteer programmes in and outside the NHS in England. This work is important and needs to inform the future vision of the extended place-based team.

Section 6: productivity

Most of the preceding sections in this report consider how best to enable staff to work in partnership with patients without things getting in their way to delivery better care more productively. The first section was about getting the basics right at work so we rebuild trust at work and people are prepared to get behind change and lead it because they think it is doing the right thing. Action on health and wellbeing will help on sickness absence. Allowing flexible working within NHS contracts and banning agency will cut costs. Technology will drive efficiency in a transformational way, as will changing training and development to support staff working differently on prevention and in the community.

While all these measures will support productivity, the word 'productivity' in the NHS has an image problem. Decades of transactional leadership of productivity means that many NHS frontline staff have strong negative feelings about the word, associating it with increased workload, resource constraints and efficiency pressures rather than meaningful

improvements to the way they care for patients. It is seen as a management-driven term and they interpret it as being asked to "do more with less" and with patients receiving poorer care as a result.

True productivity gains should come from better processes, improved technology and adequate staffing, rather than just expecting individuals to work harder. Some staff acknowledge that if productivity is defined as removing inefficiencies, improving processes, and reducing bureaucracy, so that the quality of care is improved and receives more investment, it could be beneficial, but too often the culture, leadership and mindset of organisations' productivity initiatives fail to place productivity at the heart of a quality agenda about good clinical care and as being central to the interests of patients.

This needs to change urgently. Leaders, managers and staff increasingly need to see productivity through a vocational, relational and less transactional lens. Productivity is a core component of modern clinical and professional practice and is central to a set of professional values that seek the best care for patients at the right time and in the best place. Medical and nursing directors, working with clinical staff at all levels and drawing in operational managers need to be the driving force, leading the design and delivery of change. Poorly organised care that wastes time and energy is draining for staff and bad for patients - efficiency, quality of care and good experiences of work are deeply interconnected. We need to organise work better so we stop wasting busy people's time.

Operational managers and the wider non-clinical workforce are as frustrated with bad process, bureaucracy and duplication as clinical staff and have a key role to play in partnership with teams to resolve it. Importantly, patients and carers will have firsthand data on time wasted and the clunkiness and disjointedness and duplication of how work is done.

Future skill-mix will be key to productivity. The health team has continually evolved over the past century with new roles and changing roles to adapt to changing technologies and changing patterns of disease. It will continue to do so and we need teams where each member is able to bring their value to the patient in the most safe, clinically effective and cost-effective way. The new LTWP should maximise the opportunities of new roles and advanced practice, guided by the lessons of the Leng Review on how best to do so.

While there will be AI, technological and pharmacological 'game-changers' on productivity that will transform care, work and the patient experience of health care, significant potential gains lie in a more granular British cycling team accumulation of marginal gains, with improvement science measuring, monitoring and adapting for smaller improvements which mount up. We recommend that improvement science is embedded in clinical, operational and executive training, learning and development to build a collective capability and mindset. Depending on the delivery models, a focus on GIRFT-style redesign of high-volume patient population pathways, potentially driven by a successor to

the Modernisation Agency, could help to drive and support more rapid progress and spread.

Section 7: professionalism and professional regulation

The issue of professions, vocation and professionalism ran through the discussions of the group and the time available did not allow us to do justice to an important powerful dimension of health care - how it works, what it values and what it does. The ethos and values that it instils and nurtures in people are critical safeguards in the system for patients. Professional values and mindset bring out the very best in people to be at their very best in the service of others, driving a sense of individual and collective responsibility to do the right thing. It is why the health professions are so valued and respected by society.

The group also discussed the risks when the powerful sense of belonging, identity and status that professional identity brings could inhibit the changes needed for a multi-professional future. At a time when all professions are under considerable pressure, there is a risk that the unstated hierarchies, protectionism and status anxieties that come with strong professional identity and boundaries become harmful, sometimes toxic. These features of how different professions regard each other and behave towards each other are commonplace day to day realities in health services across the world, but largely accepted as a given.

The measures set out in this report seek to diminish their impact and importance through a focus on teamwork across all our recommendations. But as one commentator said, “The NHS needs a Chief Anthropologist, not a Chief Inspector.” There is a leadership challenge - executive and clinical - to be thoughtful and purposeful about how positive professional instincts are supported and harnessed to deliver the changes need to sustain the NHS into a better future. There is equally a challenge to all, including professional bodies and trades unions, to call out unacceptable behaviour and to give voice to the substantial but sometimes silent majority in a progressive coalition of professionals who want to see change.

This report largely endorses the current proposals to reform the professional regulators of the health professions. In doing so, however, it makes a number of observations:

- the system of 9 different professional regulators strengthens a sense of professional difference and identity rather than a culture of multi-disciplinary working. You would not start from here, but the legislative complexity and risk of moving to a single regulator for 1.5 million are significant. If the current architecture is to be maintained,

reform of each regulator should seek to ensure much more consistent standards and practices across each regulator

- in a safety critical system where human error is inevitable, the professional regulators and the threat of litigation have an unintended consequence of driving defensive practice, over-investigation and additional referrals to specialists for expert opinion. The more that regulators can assure clinicians that they understand the uncertainties of modern clinical practice and the complex clinical risk management that professional judgement is asked to handle at every encounter with a patient, the more they can build confidence in the professions to manage that reality. Many regulators understand this, but it needs sustained attention

- when professionals are the subject of complaints, the regulatory processes need to be human and compassionate both to those who have concerns about professionals and to professionals themselves. GMC have done good work to diminish the inevitable impacts that conflict about care and failings of care bring to all who are involved. This needs to be consistent across all regulators

- the old model of professional regulation - waiting for complaints to arrive and then investigating - needs to change. GMC have for some years been seeking to advance a much more upstream model of regulation that addresses the conditions that drive errors, poor behaviour and complaints and seek to work with system partners to tackle them. All professional regulators need to adopt this mindset, see themselves as part of a wider system, and engage as partners to drive improvement

- in doing so, they need to work with the system to reduce the disproportionate number of referrals to the regulators of ethnic minority staff

- as many of the recommendations above suggest, regulators need to shift their mindsets from one that is simply 'fit to practice' in a technical educational sense endorsed by professional bodies, to one that ensures graduates are 'fit for purpose' for employment and deployment in a 3 shifts future. Employers need a much stronger voice in determining the standards that regulated professionals are required to meet in order to be registered

A number of members of the group raised the issue of private practice by NHS employed doctors and its impact on their responsibilities to their NHS employer and patients. DHSC should commission an independent review of private practice by NHS staff.

Conclusion

The recommendations set out in this report are headline ambitions and those that are adopted for the 10 Year Health Plan will need significant further work to develop the granular policy elements that address in detail their cost, delivery risks, timelines and impacts. However, together they seek to build a very different future and in doing so they challenge all of us who have a stake in the present. But that present is now unsustainable, and patients and staff alike are being let down as a result. That is a rallying call to all players in the system to have the courage to get behind change.

The co-chairs were indebted to the members of the working group, all of whom stepped up to that challenge. Their respect and courtesy in handling disagreement, their appreciation of all the perspectives in the room and their shared will to improve health and care for citizens and improve the working lives of staff showed all the features of the future team the NHS needs to see.

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