WORKFORCE CHALLENGE PARTNERS
Challenge to Change

NHS
East of England
Clinical Senate

Redesigning the Future Workforce

What have we learned about the current and future workforce challenges?

May 2024

Contents

Clinical Senate Workforce Paper

1. Introduction

1.1. A workshop on Redesigning the Future Workforce was undertaken in January 2023 as part of the Clinical Senates development sessions in order to stimulate discussion on what actions we should take to address the workforce challenges in the region now and for the future.

1.2. Anna Morgan MBE and Sudeep Dhillon from Workforce Challenge Partners (WCP) facilitated the workshop and used materials based on research, strategy development and practical workforce transformation they have been involved in over the last five years both within the region and in other regions.

1.3. Since the development day the NHS Long Term Workforce Plan was published (on 30 June 2023) setting out how the NHS will address existing and future workforce challenges. The focus is on recruiting and retaining thousands more staff over a 15-year period, and working in new ways to improve staff experience and patient care. The plan sets out the strategic direction over the long term as well as short- to medium-term actions to be undertaken locally, regionally, and nationally. Those actions fall into three priority areas:

- **Train:** Substantially growing the number of doctors, nurses, pharmacists, allied health professionals and support staff. This is underpinned by a £2.4 billion funding commitment.
- **Retain:** A renewed focus and major drive on retention, with better opportunities for career development and improved flexible working options. This comes alongside reforms to the pension scheme, with an aim to retain 130,000 staff working in the NHS for longer.
- **Reform:** Working differently and delivering training in new ways. Advances in technology and treatments will be explored and implemented to help the NHS modernise and meet future requirements.

1.4. The plan aims to increase the total number of NHS staff through an unprecedented expansion in recruitment and significant improvement in retention, so the NHS keeps more existing staff in post.

1.5. Routes into the NHS will change through the development of apprenticeships and reform of professional education and training. The plan also aims to deliver productivity improvements through making the most effective use of emerging technologies such as artificial intelligence. It also signals a shift from reliance on international recruitment to a largely domestic recruitment model.

1.6. The long term workforce plan is positive and ambitious, it gives systems some much needed direction on which to enhance their own workforce ambitions.

2. Summary of workforce challenges

2.1 What's the problem with workforce from a national perspective?

2.1.1 The national workforce crisis is well documented and in focus with a plethora of papers from national bodies translating the impact on various professional groups across health and social care. In a nutshell, health and social care are losing skills at a fast rate, skills that are hard to replace easily or quickly and this trend is set to continue into the future. People are either retiring or leaving health and care, and there is a lack of flexibility to support different ways of working to attract a new workforce. Staff do not feel valued, they feel overwhelmed, and unsupported. Leaders are said to be exhausted and lacking in the time, knowledge, confidence and training to look after their teams as they would like, or to pursue more flexible alternatives.

2.1.2 There is a chronic lack of investment in the right support and development for managers, and policies are seen to be too rigid. The NHS in particular has created too many specialists, therefore not enough generalists to deal with demand. Service structures are outdated with a lack of ability to support progression though the roles and bandings, this is further exacerbated by a lack of robust policies for talent management.

2.1.3 Traditionally the NHS has not been good at modernising at pace or preparing for the future in relation to digital disruption, or in responding to changes in consumer behaviours. Proactive workforce transformation has improved with the support of funding and expertise from Health Education England (HEE now NHSE) although workforce planning at organisational level is still inadequate. Before the recent drive from HEE there was a historical lack of leadership for workforce, workforce planning and infrastructure to build and access the right data sets for workforce. Sharing of information to inform transformation is minimal which means that at a system level there is a lack of collaboration to support sustainable workforce solutions for the long term.

2.1.4 To address population needs we urgently need to grow the health and care workforce to meet both the current and the future demand driven by an ageing population, co-morbidities, backlog of care and impacts of long Covid. In the next decade the NHS workforce needs to grow by 40% and social care by 55% to meet demand therefore systems need to be more future focused and proactive in growing the right workforce models.

- **Overview of National Vacancies (as at Sept 2022)**

2.2.1 **Health Vacancies –**

- NHS England vacancy rate was **9.7%**
- NHS hospitals, mental health and community services **133,446 FTE staff.**
- **47,496 FTE** vacancies are in **nursing** accounting for a third of all vacancies.

2.2.2 **Primary Care –**

- *General practice vacancy data was not available at time of writing*. To address shortages of GPs and nursing plus ongoing increased demand, active growth of multidisciplinary teams via Additional Roles Reimbursement Scheme (ARRS) 26,000 roles was seen as part of a solution. However, this has shifted existing workforce from other sectors into primary care, creating additional shortages and workforce challenges. Forecast shortfall of around **1 in 4 GP** and general practice nurse posts by 2030/31.

2.2.3 **Care Sector Vacancies –**

- Adult Social Care **165,000** number of vacant posts increased by **55,000 (52%)** between 2020/21 and 2021/22. Forecast: if adult social care workforce grows proportionally to the projected number of people aged 65 and over in the population then the number of posts in adult social care will increase by 27% (480,000 posts) to around 2.27 million filled posts by 2035.

2.2.4 **VCSE –**

- Key partners in delivering health and care. Require longer-term sustainable funding to recovery from Covid and support services and grow VCSE paid and unpaid workforce.

3. Regional Position

3.1. **Age profile:** The proportion of staff aged under 25 for both health and care has been low, in some systems 6% for secondary care and 5% for primary care, in coming years the next wave of 18-24 years will increase. Those aged 55 and over take up the highest proportion of 29% (general practice), 28% social care and 16.4% in secondary care.

3.2. **Growing our own:** 80% apprenticeships are for developing existing workforce, >50% are for level 5 and above apprenticeships. At the same time, we need to have a pipe line of younger workforce coming into health and care roles. Regional investment to make this happen and ensure that apprenticeships are systematically moving into roles is key.

3.3. **Diminishing workforce:** Vacancies, sickness, retirements, and supply continue to be ongoing challenges which have worsened in some areas. Demand will go up further over the next 10 years and this will require a different workforce model.

3.4. **Retention:** With low morale, leavers, burnout/sickness – at times more people are leaving than joining.

3.5. **Positive and inclusive culture:** A number of high priority (EDI) areas for improvement within the systems include e.g. harassment, bullying or abuse from staff in last 12 months against BME staff. It is critical to address this now and linked to International Recruitment (IR) being successful in the long-term, a number ICSs across EoE actively involved in IR, high priority area.

3.6. **Overview of Regional Vacancies**

3.6.1 **Health –**

- NHS Staff in Post (Region FTE) 118,629
- In last 12 months (Sept 2022 data) - New Starters 2,365; and Leavers 1,403
- Region Vacancy Rate: 9.2%
- Region Turnover Rate: 9.8%
- Region Absence Rate: 5.8%

3.6.2 **Care Sector –**

- Filled posts at 2021/22 were 193,000 (FTE filled posts 174,000) for Eastern region
- Eastern vacancy rates for adult social care 11.3%
- Eastern turnover rate 32%
- 28% of staff are aged 55 and over
- 20% workers are BAME ethnicity
- 81% of workers are British nationality
- 42% of workers with a relevant social care qualification
- 82% female: 18% male

Data source: NHS Digital 2022 – 23 Q2 & ESR latest available data, E Portal HEE Skills for care – adult social care sector and workforce in Eastern 2021/22

3.7. **Total vacancies across health over 11,800 excluding primary care, and 17,500 for adult social care sector.**

4. Why do we need to take action now?

4.1. As already highlighted significant workforce challenges have been evident for a long time and very little changes have been made at the scale and pace required. Some positive changes were seen through Covid with the 'Halo' effect which did accelerate new ways to deliver care, these may not have been sustained post-Covid.

4.2. Demand will increase by 40% over the next 10 years and workforce challenges will worsen if no real transformational changes are made now. Systems need to grow more generic capability to address complex health and care needs. Alongside this, consideration needs to be given in how we address the shrinking pool of registrant's taking opportunities to utilise their skills to support the growth of a new workforce.

4.3. There are lots of opportunities to work together to change workforce models for the future across systems, we need more engagement with workforce and other key stakeholders at all levels to make this happen. Other countries have similar problems and are adopting different workforce models and engaging more with the local

communities, we need to learn more from these global examples. Many of these ideas are captured in Mark Britnells book on *Solving the Global Workforce Crisis in Healthcare*.

4.4. We know we have an ageing workforce**,** with insufficient younger entrants. However, there will be a 'bulge' in 18-year-old population over next few years, and an expected increase of 25% in 2030. We need to influence and attract this age group now.

4.5. In order to grow our own workforce, there needs to be substantial and continuous investment in apprenticeships. Significant investment has already been made for level 5, and whilst it's important to develop our existing staff, we need to invest more in level 2, 3, and 4 apprenticeships to create the pipeline now and for the future. Investing more in apprenticeships at level 2 – 4 would help to provide opportunities for people who didn't get the attainment at school/college therefore limiting their traditional choices. System investment is required to make this happen and we need to plan to have apprentices moving into roles once they have completed their programme.

4.6. The diminishing workforce across health and care is impacting on staff well-being, and patient/resident care and flow within the system. We need to prioritise growth in the domestic workforce supply, getting the balance between domestic and international recruits right. Retention of our staff and building an inclusive and positive culture is key.

4.7. The data shows that a lot of effort goes into recruitment with a small net gain. This picture was very similar across health and care.

5. In summary what does this mean at a local level?

- Growing the workforce to increase more level 2, 3, 4 apprenticeships, alongside more targeted recruitment encouraging local people, and people new to health and care.
- Grow the number of generalists, implement new roles/models of care, recruiting more people with general skills that can adapt, develop, and learn at work, more flexibility in employment more future focused.
- Enhance the role of registrants to support growth in the workforce in order to maximise the impact of this valuable resource.
- Systems need to develop sustainable robust and granular level workforce plans.
- More emphasis on training, education, and supervision, appropriate to meet needs of the population, supporting different generations, and embracing new technology.

6. New models & new roles –

6.1. There are many new roles emerging and we have highlighted three new **apprenticeship roles** that will have a significant impact on health, social care and primary care now and in the future. These are the Nursing Associate, Physician Associate and the Anaesthesia Associate roles. There are plans set out in the NHS Long Term Workforce Plan to increase the numbers and autonomy of these roles. **These roles provide a key stepping stone, for those who want to progress their careers, towards becoming a Registrant in the future**. An overview of these roles is summarised below.

6.2. The **Nursing Associate Role (NA) –** is a generic nursing role (covering four fields of nursing: Adults, Children, Learning Disabilities and Mental Health) in England that bridges the gap between healthcare/care support workers and registered nurses. NAs are members of the nursing team, who have gained a Nursing Associate Foundation Degree awarded by a Nursing and Midwifery Council (NMC). The NA role is regulated by the Nursing and Midwifery Council (NMC). The NMC sets out the

standards of proficiency which every NA must meet in order to become registered. The role has been introduced to help build the capacity of the nursing workforce and the delivery of high-quality care while supporting nurses and wider multidisciplinary teams to focus on more complex clinical duties. NAs are a vital part of our 'grow our own' strategy to build the workforce across Health and Social Care. The long-term plan aims to increase training places to **10,500 by 2031/32.**

6.3. **Physician Associates (PAs)** – are medically trained, generalist healthcare professionals, who work alongside doctors and provide medical care as an integral part of the multidisciplinary team. PAs are practitioners who can work autonomously, but always under the supervision of a fully trained and experienced doctor. They bring new talent and add to the skill mix within teams, providing a stable, generalist section of the workforce. The long-term plan aims to increase the PA training places to over **1,500 by 2031/32**. The aim is to work with partners to ensure new roles are appropriately regulated to use their full scope of practice, freeing up the time of other clinicians as much as possible, for example, by bringing anaesthesia and physician associates in scope of General Medical Council (GMC) registration by the end of 2024 with the potential to give them prescribing rights in the future. To continue growing as a profession, PAs will need more opportunities for education and training, including on-the-job clinical learning and formalised training in specific skills for their area of clinical practice. Winning the hearts and minds of the breadth of professionals in the wider NHS will be essential in supporting this role to become embedded in clinical practice, opportunities for leadership and in contributing to professional support in education, training and career development.

6.4. **Anaesthesia Associates (AAs)** – formerly known as physician assistants (anaesthesia), were introduced in 2004 and the role is now established within many NHS hospitals. AAs are trained, skilled practitioners that work within the anaesthetic team under the supervision of an autonomously practicing anaesthetist, such as a consultant or SAS doctor. AAs are a part of the Medical Associate Professions (MAPs), alongside physician's associates and surgical care practitioners.

7. How can we get there?

7.1. Two new concepts were presented for discussion that aims to help organisations in the journey to transform the workforce.

7.2. **Ripple Framework (see diagram in appendix 1)** – The Ripple Workforce Framework illustrates where we should put our effort and energy now in order to make a dramatic difference to our current and future workforce across health and social care. This framework (five ripples) offers both a descriptive and visual representation of how we can achieve the system change we need by focusing on the ambition at the centre, which then stimulates a cascade of actions which increase over time.

7.2.1 Building Capacity

- This describes the need to have a ***systematic way to build capacity*** in our health and social care organisations. This involves working in partnership to recruit from our local communities, holding live recruitment events, supported by tailored marketing, use of academies, tapping into schools and colleges and universities, using local groups to raise the profile of health and care careers. ***Building the pipeline*** of the level 2, 3, 4 entrants is key. Providing good recruitment processes with ongoing pastoral support and career conversations is needed.

7.2.2 Building Capability

- This is about changing the skill mix recognising that it takes between 3 to 8 years to train registrants. In addition to investing in building our registrant pool we need to embrace the opportunities that skill-mix brings. For example, broadly, the highest numbers of staff in the clinical workforce in healthcare are band 5 and above. The smallest numbers are seen in bands 2, 3 and 4. If we addressed

these ratios, investing more in bands 2 to 4 then we would have more people. Given the right support they could work differently, at the same time develop their careers, helping to address quality and demand issues. The role of registrants needs to change, they would have a greater role in providing supervision, coaching, mentoring, and support to the workforce, alongside empowering our patients and carers as an extension of the workforce. Registrants will need training, education, coaching, supervision and mentoring to support this shift, we are calling this a Growth and Leadership model (see appendix 2).

7.2.3 **Building Competence**

- The next ripple relies on HEIs to support our health and care organisations with the **training and education needed for a modern workforce**.

7.2.4 **Building Career Structures**

- The next ripple is about **changing the shape of services** to make room for a new workforce, creating the career structures we need from entry level upwards, across clinical and support services. The way services look now only allows for what we already have, not what we want and need in future. This will require a different approach to workforce planning.

7.2.5 **Building Infrastructure**

- Finally, we **need systems and processes** across health and care that are as aligned as we can make them so that we fully embrace a 'One Workforce' culture. This was seen in an example during COVID in N&W. A health and social care group that agreed an MOU to enable people to work seamlessly across health and care sectors. LA staff were enabled to work in the hospitals and health teams were enabled to work in social care. These initiatives are possible, it takes an **agreed vision, commitment, leadership, and the courage to try new approaches to delivery**. There is potential now to develop this concept further with the **Digital Staff Passport (DSP)** mentioned in this document below.

7.3. **Growth & Leadership Model –** As mentioned above, part of building capability relies on registrants working differently in the future. Ultimately this is about moving to a model of Growth & Leadership that is built on a principle of the registrant spending around 60% of time focusing on activities **that nurture** others such as; on the job support, training, education, coaching, mentoring, and supervision; 30% of a registrants time will be on **delivering advanced skills** in direct care such as; primary assessment, diagnostics, specialist interventions, prescribing and evaluation of care; and 10% should be focused on **nurturing self** through training, researching, coaching, shadowing, mentoring and supervision.

7.3.1 The percentages of time spent on these activities can be flexible depending on the nature of the registrant's role, however it is important to aim to get to this shift over time so that we develop an empowered new workforce fit for the future. As already mentioned, this model will require support from HEIs, and significant engagement with registrants to shape this concept further so that it is aligned appropriately to each service/speciality.

8. What were the clinical senate's initial reactions to the discussion?

8.1. **Summary of reactions included:**

- People were not surprised by the workforce challenges, agreeing that they are not new concerns, recognising that we don't have a workforce plan to address these.
- The lack of net gain from recruitment was seen as a concern and a question was raised about whether we have a clear demand picture.

- Some thought it was consistent with what we hear across the country and that its great that we are thinking creatively about how to take early action.
- Retention was a concern.
- Not surprised, agree need to use staff skills better.
- Very concerning. The NA role sounds as though it has massive potential to liberate other staff for more specialist activities.
- Feeling that the position was precarious, staffing remains inconsistent and that there are unwarranted variations in care.
- Sounds very promising, is it easy for a NA to progress to a fully registered nurse? Not much mention of doctors?
- NA sounds like a great idea.
- This was consistent with what was heard across the country, it was great thinking creatively about how to take early action.
- Cadet idea is brilliant too.
- Some great ideas to a complex issue, see these issues at provider level. The challenge is getting from system working and processing these ideas down to the level where patient care is happening.
- Some data would suggest we also have a historical deficit in terms of numbers of staff versus demand which leaves East of England more vulnerable now than before. Is this something you have seen and if so, what is the added impact on the ambitions here?
- Very tricky to navigate as investment is needed.
- Need to rely on communities and families more.
- Workforce planning and modernisation of roles to attract young workforce.
- Do we have a clear demand position?
- How can we learn from other industries like Amazon and Tesco? The skill mix is not the same but how do they keep their supply chain intact; we don't hear a lot about backlogs in successful industries.
- Workforce planning should start from understanding Population health need and demand; how does the demand translate to workforce required to meet the health needs of our population?
- Is there evidence that nursing associates reduce referrals to GP and secondary care?
- With the negative press re NHS the employer brand is being affected such that attracting new blood will be difficult.

8.2. **Follow-up reactions:**

In a follow-up discussion, a senior medical practitioner highlighted the current crisis stemming from resource shortages, which pose significant challenges to both individuals and teams. To address these issues effectively, several key strategies should be implemented:

8.2.1 **Enhanced Focus on Leadership Development:**

- **Training for New Team Leaders**: Equip emerging leaders with the skills necessary to guide their teams effectively. This includes comprehensive training in management, decision-making, and change management.
- **Ongoing Leadership Programs**: Establish continuous leadership development programs tailored for primary care professionals to ensure they are well-prepared to handle evolving challenges.

8.2.2 **Mentorship Programs:**

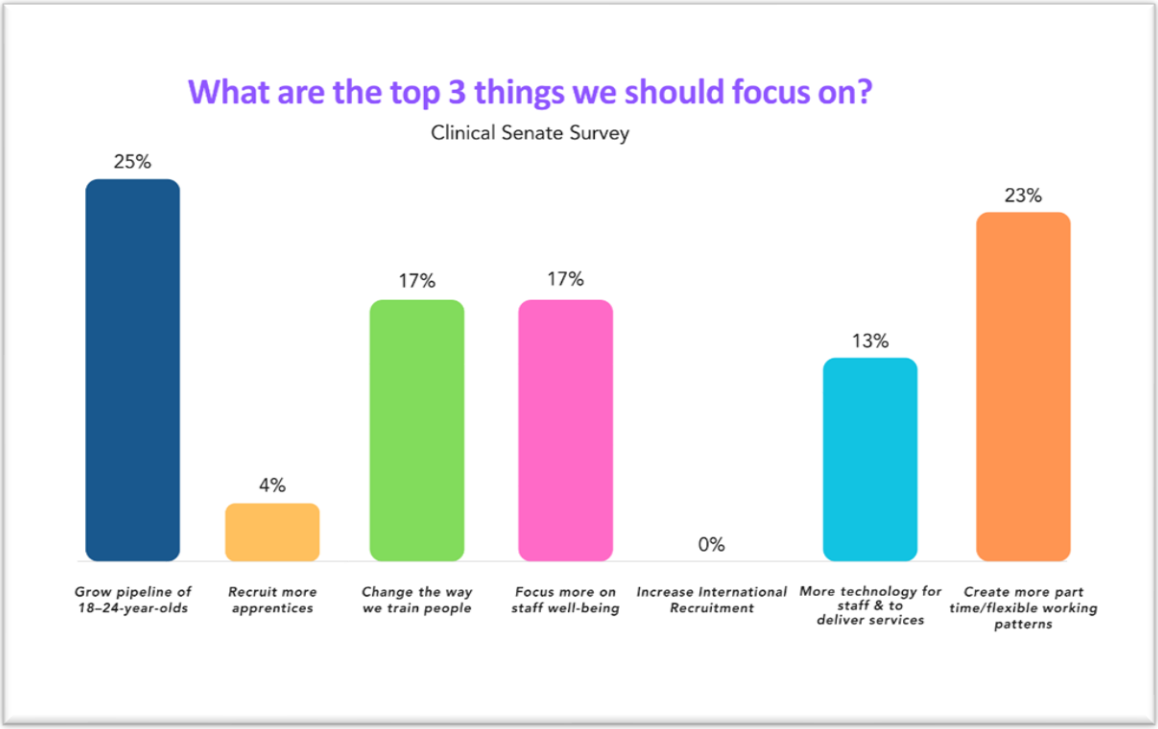
- **Support for Emerging Leaders**: Create mentorship initiatives that pair new leaders with experienced mentors. This support system can provide valuable guidance and foster leadership growth.

8.2.3 **Promotion of Team-Based Care Models:**

- **Interdisciplinary Collaboration**: Encourage collaboration among physicians, nurses, pharmacists, and other healthcare professionals. This team-based approach ensures that patient care is coordinated and comprehensive.
- **Effective Communication**: Foster open and effective communication across different levels of care and specialties. This is crucial for ensuring that all team members are aligned and working towards common patient care goals.

By implementing these strategies, healthcare organisations can better navigate the current resource challenges and enhance the effectiveness of their teams, ultimately leading to improved patient care outcomes.

8.3. **We asked the Senate to consider the Top 3 things to focus on, the results are as follows:**



The top three results were:

a) Grow pipeline of 18-24 year olds;
b) Create more part-time/flexible working patterns; and jointly
c) Change the way we train people and focus more on staff wellbeing.

8.4. **Where should we put our focus?**

- Getting the basics right - access to food, parking, lockers etc.
- Technology so less time writing in records.
- Career progression.
- Definitely free parking.
- Virtual Care.
- Better Career Counselling.
- Reduce specialisation increase generalist.
- Schools and Outpatient Clinics.
- More fluidity of roles across health and social care so people can have a diverse career whilst staying in health.

- Being creative with secondments and fellowships opportunities.
- Offer of Portfolio careers for all staff groups.
- Flexible working.
- Digitalisation.
- Valuing staff contributions and investing L&D opportunities.
- Support with social housing, pay review, better onboarding for international recruits, celebrating successes, childcare on site in school holidays.
- Flexibility across the working life, support for child care, travel and access.
- Slightly out of our hands until the pay situation is improved, in our gift - to improve working conditions - free parking, free meals at work (banks in London do this) anything that will help staff with current pressures.
- Offer of Portfolio careers for all staff groups.
- Better retention- pension tax resolution, more incentives and flexibility for the older workforce, career progression for all, ensure everyone at every level has training development and progression opportunities.
- Embedding values more across ICBs and a sense of pride, hopefully supporting retention.
- True talent management and make it easy for people to gain and develop extra skills.
- Supply more Scholarships, sign a contract to say you will work for the NHS for say two years after finished qualification.
- Retention: help staff feel supported. Flexibility for work patterns and to include major life events especially children. (As a trainee doctor I missed my brother's wedding and much of children's early days) Professional development pathways.
- Invest in PNAs, PMAs and clinical supervision.
- Effective supervision, meaningful appraisals and CPD.
- Needs to filter to all managers as not all managers are supportive.
- Retain senior staff; incentivise caring rather than non-patient facing roles.
- More detailed and in-depth Manager training to ensure they know how to support their staff and understand the work life balance and differences in ages of staff and what their needs are for e.g. young parents to Menopausal women.
- Recruitment campaigns similar to army showing the exciting sides of working in health - I.e. robotics and prevention / population work.
- NHS needs a clear joined up attraction strategy.

8.5. **What are your initial reactions to the Ripple Workforce Framework?**

- Primary Care Exclusion
- Bottom-up engagement is key. A lot of colleagues on the frontline won't know there are People Strategies and know of the wealth of training and development courses they can access let alone all the different roles and career pathways open to them.
- Makes good common sense but unclear how this works in partnership with other pieces of work currently underway that cross over i.e. retention, overhauling recruitment etc.
- Good framework, however, also need to ensure there is flexibility so not reliant on people having a career / job pathway for life as people may come and go into health workforce from other industries.

8.6. **What might help embed this framework at organisational, system, and regional level?**

- Work passports - i.e. mandatory training, DBS
- Better engagement with pipelines - schools, colleges and universities (not just health departments but all departments)
- Training opportunities at system level not organisation - more rotational opportunities.

- Real opportunity at an organisational level to have meaningful alignment to values, pride, and legacy of working within your local community (help with retention).

8.7. **Feedback from group discussion activities**

8.6.1 **One thing you want the room to know that came from this exercise?**

- Some positive ideas to take forward, more true system working – recruitment, mandatory training, support and development.
- Change is necessary and the quicker the better. Ripple structure brings about a good pathway for new recruits to the NHS.
- Agree, we need some pace, incentives need to be there to encourage organisations to change.

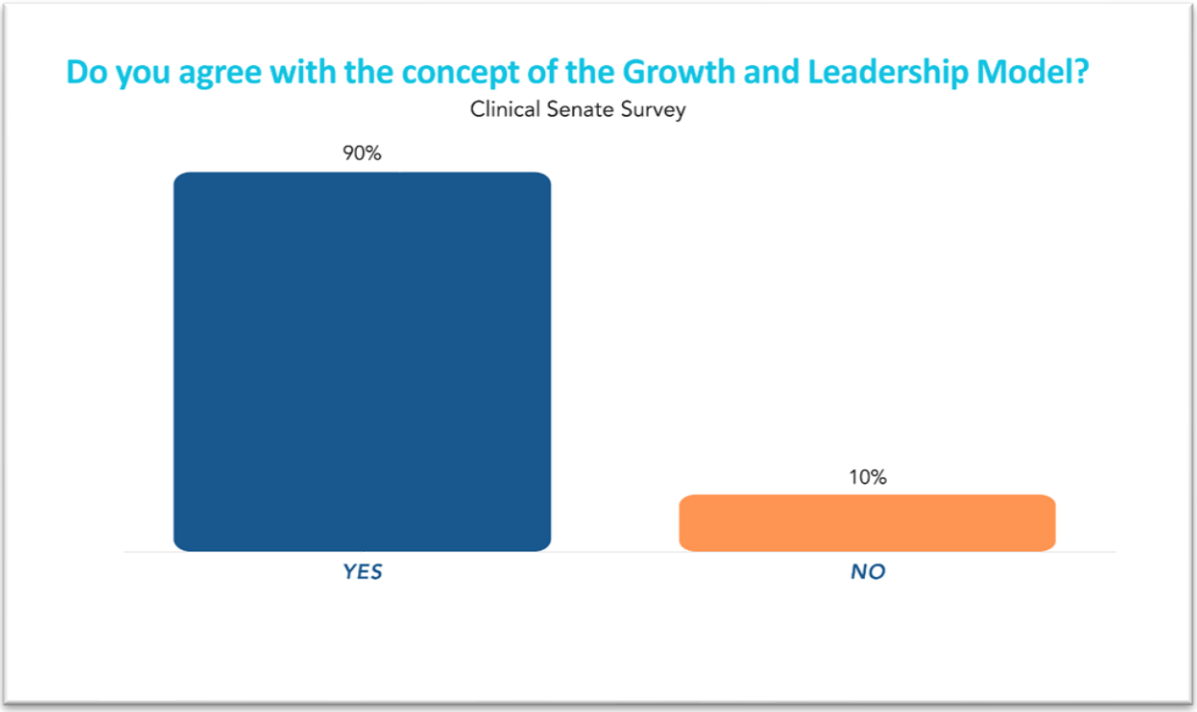
8.6.2 **What are your initial thoughts on the Growth & Leadership Model?**

- We have Professional Nurse and Midwifery advocates who support clinical supervision. We need more!!
- Makes sense to me, a challenge is that some individuals are much naturally adept at coaching, mentoring and training, another challenge is freeing up the time. Do wards need to be plus one in terms of numbers but different skill mix?
- Need sufficient protected time to do supervision and support.
- Don't think it could be rolled out at scale due to the operational pressures.
- Great idea but this is a massive cultural shift to work across boundaries. What do we need to do to grow confidence in this way of working and to accelerate pace of change?
- Looks a bit like a consultant job plan. If you think of teaching on ward rounds and in clinic as nurturing.
- Think there is a big difference between leadership, mentorship, and supervision. Carers quite often go into their career and are not always keen to take on the responsibilities of being a mentor but are probably fantastic at teaching 'on the job'.
- This will be tricky to operationalise initially as investment is required to release time to nurture.
- What are the current divisions of working in terms of mentoring, doing and self-development?
- It is a good way forward. It is all about getting workforce on board to do the mentoring, support and listening.
- A few test sites make sense, could really shape a broader roll out.
- Can see this as essential but we need sufficient support, additional registrant capacity to enable this. This is something that could be provided at system level.
- Need time to devote to skilling up in coaching and tutoring and providing supervision. For nurses they get pulled into the numbers all the time which means any other work is sidelined., suspect the same for other professions in healthcare.
- 'Teaching people to teach' will be a big challenge, and essential. Being good at stuff doesn't means you can necessarily teach that stuff.
- Needs piloting and mentor training. Also look at good models internationally.
- We need to increase flexibility. Many medics to pursue their careers make huge sacrifices from the perspective of their families, the price to do a training programme reduces personal flexibility and can often live many miles from and either travel long distances daily or stay away from their family, we need to make this better for his staff groups as well as others.
- Analyse the barriers to demonstrate that this is a realistic approach.

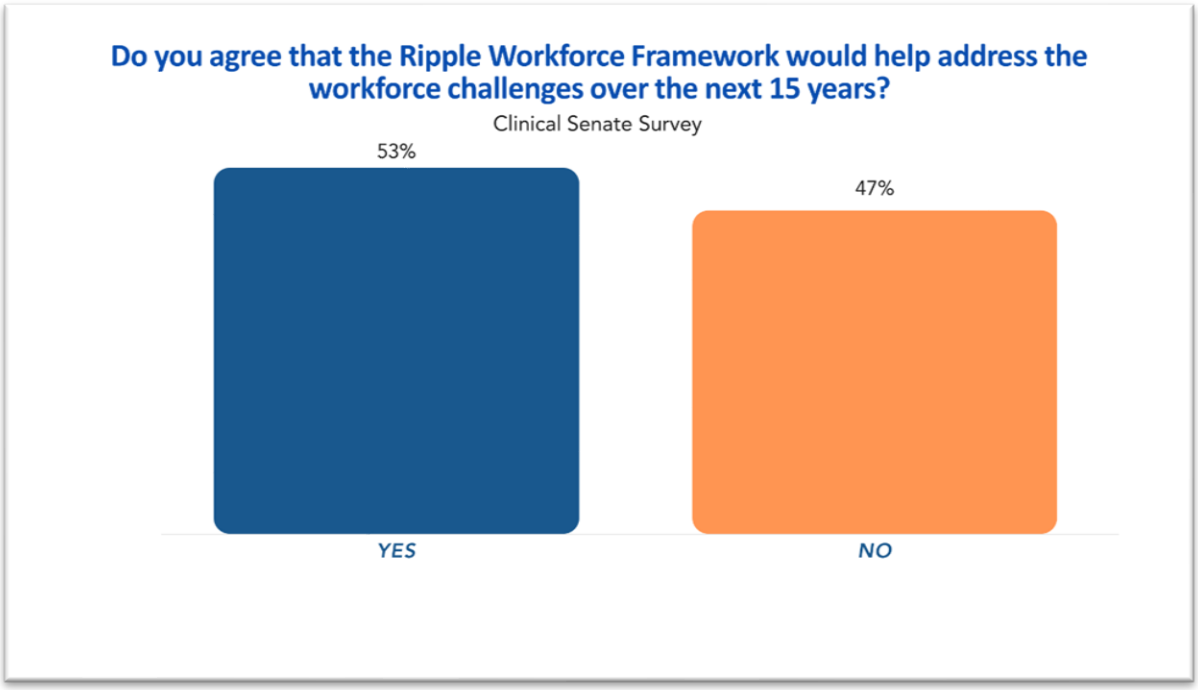
8.6.3 **What can you do in your role to influence people's thinking around our workforce challenges and opportunities?**

- Promote flexibility and long-term career planning.
- Take back to our own systems, ask for the evidence, and work up plans.
- A lot of this work in multiple groups.

- Pilot projects which are evaluated and developing an evidence base. Then spread good practice.
- Senate needs to promote the importance to people of flexibility and retention, and the potential effect on finances of reducing turnover.
- Senate should produce a document summarising all the good ideas we have heard today.
- More visibility and promotion of the opportunities and programmes available.
- Case studies as examples.
- Focus on challenges in workforce in MSE. Encourage different ways of doing things to promote staff wellbeing and retention.
- Influence and advocate as the senate.
- Link with system groups.
- Clinical senate could write a response with clear recommendations for systems.
- Talk about and influence younger people to encourage them in to Nursing Associate roles. Talk about a progressive career structure.
- Develop cross sector roles.



90% of the clinical senate in attendance agreed with the concept of the Growth and Leadership Model.



Over 50% of the clinical senate in attendance agreed that the Ripple Workforce Framework would help address the workforce challenges over the next 15 years.

8.6.4 **Any comments, feedback on where to go next from today's session?**

- Consider how the initiatives would be implemented at system level.
- Organisation buy in crucial. Simplification of processes in NHS is very hard, we love red tape and are super risk averse.
- Maybe, we need to see pilot sites and the outcomes in practice to ensure this is the best use of resources in a time when there is a massive financial squeeze.
- A solution that is co-created with clinical leadership and HR/ Operations has more chance of success than a theoretical framework.
- Not aligned as a System - especially re who holds the finances.
- People might be saying no as these initiatives will take time to get off the ground, so the next 5 years minimum certainly look rocky.
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- We need a rigorous understanding of demand to measure the workforce gap.
- Think we just need to go for it and write about the good examples and get people on board.
- Need greater spend of GDP on demands of health and social care.
- Think it is a good framework, will organisations really buy-in? Will they move quickly enough, will they work as systems.
- IT systems, understanding of talent management, barriers in the way. It's all so slow.
- Different staff groups will need different approaches… so not one size fits all. Needs to be nuanced.
- Need a system approach to workforce. Still have some areas that are restricted by money.
- Is there something about systems coming together to support each other to deliver this so at system level and supra system thinking about working together across the region?

9. Recommendations

9.1. Clinical Senate to influence at regional and system levels around workforce transformation initiatives.

9.2. Align the national NHS Digital Staff Passport (DSP) programme to support workforce transformation including the education and training programmes. Supporting staff movement so they can work within and across organisations more seamlessly. Having a similar approach to support education, training, and development of staff to support retention.

9.3. Expand engagement with professional networks around the Growth and Leadership model and Ripple Workforce Framework. Share findings via the Clinical Senate programme.

9.4. Proactive workforce transformation initiatives at regional and system level for the younger generations to maximise the opportunities of the bulge of 18 to 25 years expected in 2030.

9.5. Develop training opportunities at system level including rotational opportunities.

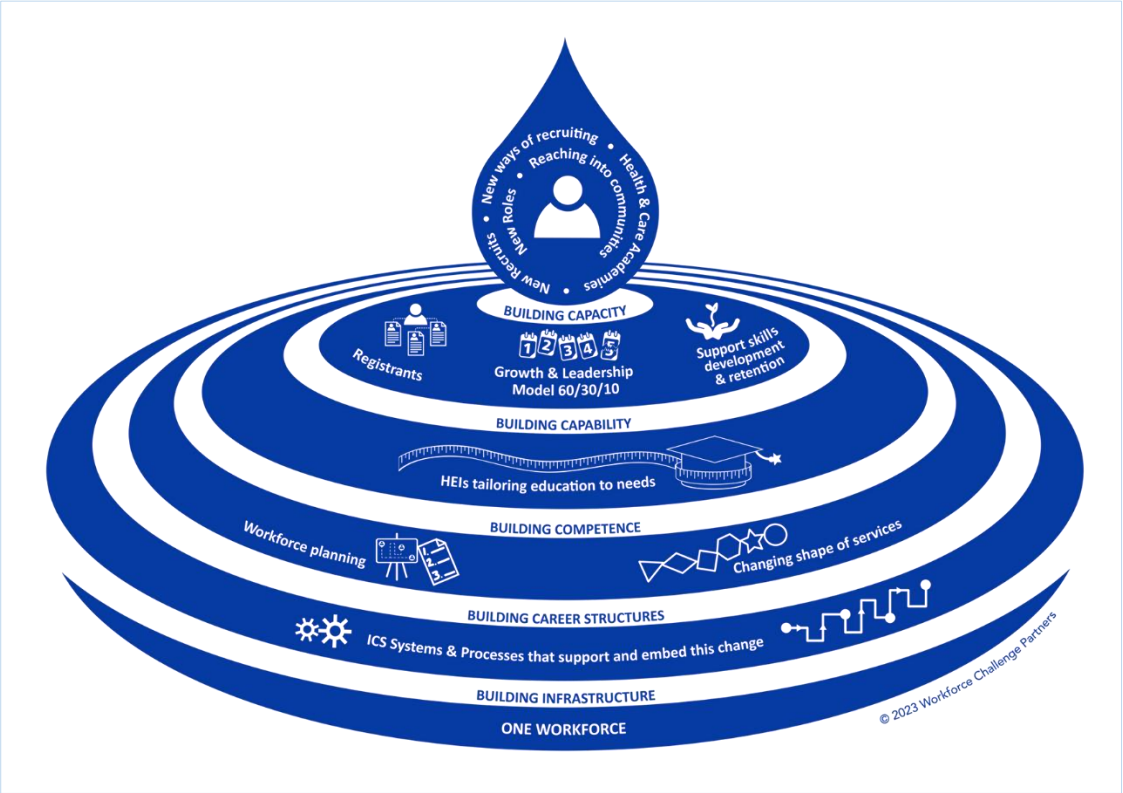
9.6. Develop robust real time data intelligence on current and future demands for health and care at regional level, linking this with system level data/intelligence to influence the relevant changes required at HEI level.

9.7. Share best practice examples of where shape of services have changed and the impact this has had on staff and patient care. Developing test sites to support roll out.

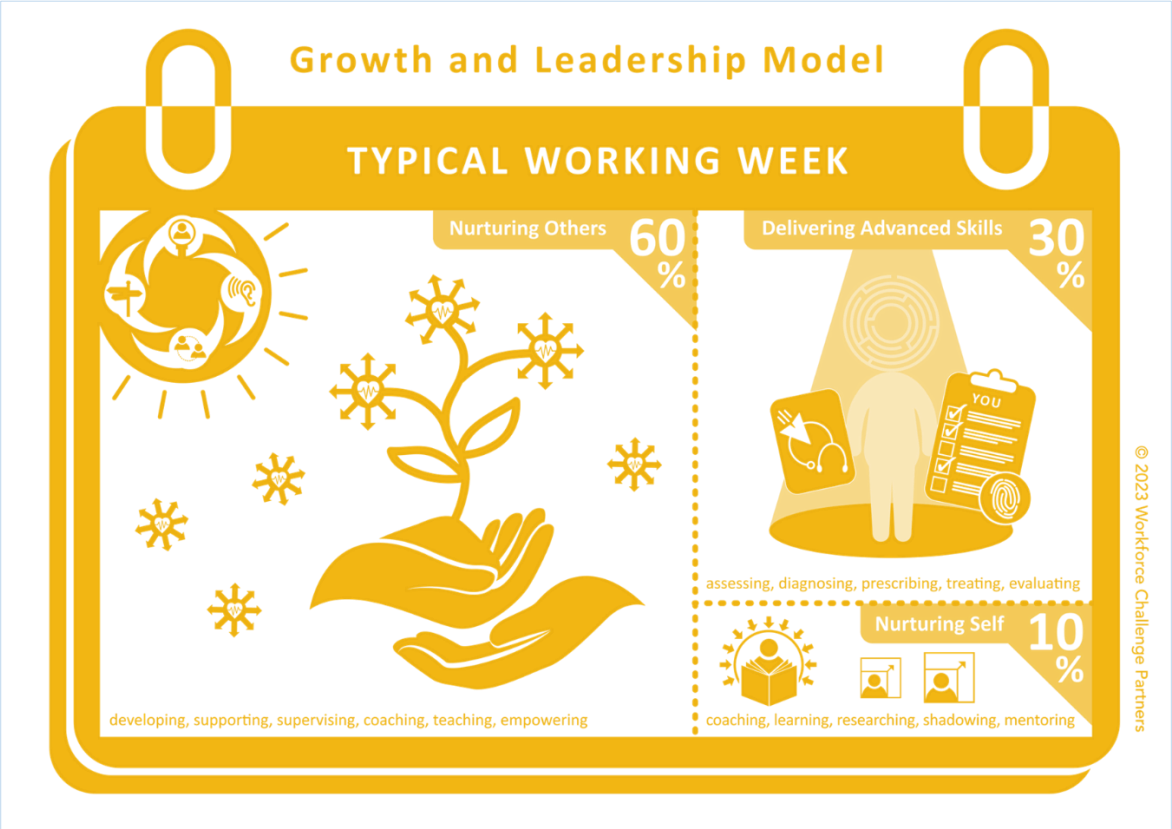
9.8. Align coaching, mentoring and supervision programmes at system and regional level to support consistency and share best practice examples.

9.9. Clinical senate to actively promote the importance of flexibility and retention, and how long-term investment is required to reduce turnover of staff. Include new flexibility models for medical workforce in training to support retention and reduce attrition from training programmes.

Appendix 1: Ripple Model



Appendix 2: Growth and Leadership Model 60/30/10



Shifting the role of registrants' forms part of the Growth & Leadership model utilising a 60/30/10 principle, shown here.

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