

Health Committee – 3 February 2016

Transcript of Item 6 – Health Workforce Recruitment and Retention in London

Dr Onkar Sahota AM (Chair): Can I please welcome Professor Maureen Baker, Chair of the Royal College of General Practitioners (RCGP); Sue Tarr, Operational Manager for the North Central and North East Sectors of the Royal College of Nursing (RCN); Cynthia Davis, a Council Member and Chair of the London Board of the RCN; Dr Fionna Moore, Chief Executive of the London Ambulance Service (LAS); and Mr Danny Mortimer, Chief Executive of NHS (National Health Service) Employers? Thank you very much for coming this morning and for helping us to sort out and get a better understanding of the workforce recruitment and retention in London.

Perhaps, maybe, I can kick off. I may ask questions directed at one particular member, but if somebody has a contribution to make, then do please make the contribution and do not ask to be called upon specifically.

Let me start with you, Professor Baker. What particular sectors of London's health workforce are experiencing recruitment and retention challenges and, from a general practice point of view, where do you think the problems are?

Professor Maureen Baker CBE (Chair, RCGP): We have a national problem with recruitment and retention of general practitioners (GPs). In some respects London is better protected from that, certainly in terms of recruitment, because young doctors want to train in London and they often want to work in London. Compared to other parts of England, London does well, particularly in recruitment into general practice training.

Probably the main area of concern for London, as for many parts of the country, is retention of GPs and particularly GPs in the older demographic, those between 55 and 65, say. That is something I would certainly flag up to the Committee.

General practice, as my College would agree, is not just about GPs, of course. It is a team effort and we also have concerns about recruitment and retention of other members of the practice team, in particular practice nurses and also community nurses and district nurses who are not employed by practices but are very much part of the primary care in the community. The dynamics of the practice nurse and community nurse workforce is not something that we understand, probably, as well as we do for GPs, but we are very much aware that, again, nationally there is a shortage of practice nurses. When we look at the demographics of the practice nurse population, as it were, practice nurses do tend to be older and are coming up to retirement. We worry that there is not a clear path for recruitment into practice nursing and we have some suggestions about that.

There are also additional difficulties for London. The RCGP is very much making the case for building the extended primary care team. We are very supportive of Professor Martin Roland's [CBE, Chair, Primary Care Workforce Commission] report on the primary care workforce that was published at the end of last year. However, in order to have a bigger team, you have to have somewhere to put them. One of the particular difficulties for London is premises and landlocked practices. There is a difficulty in securing new premises or land to build. That is an area that London struggles with. Even if practices can recruit GPs, recruit nurses, recruit pharmacists and recruit support workers, where are they going to put them?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): I would reiterate an awful lot of what you have said, Maureen. We know within the RCN that probably in the last five or six years in particular there has been such a focus on cost improvement and the nursing family, as the largest portion of the health family, has been one that has suffered significantly as a result of that. What we have seen is that a large number of nursing posts have been removed across the whole of the service. Not only that, but the wages that have been paid to the nursing family have been reduced. We have had posts that would have been at a senior level that have been down-banded to work at a more junior level purely to hit cost improvement programmes. That has had an absolutely devastating effect on the nursing family across the whole of London.

What our members are telling us is that London is expensive. To live in London and to travel around London is expensive. A piece of work that is currently underway is to look at where the nursing workforce lives in relation to London. That report will be coming out very shortly. The results, I am sure, will not surprise anybody overly in that the cost of housing in London is such that people are having to move out of London.

What we are also finding is that because of the cost improvement position and the decisions made about six or seven years ago – [at the time] the RCN was extremely vocal in saying, “This is a mistake” – to cut the number of nursing training posts so that we did not have student nurses coming through into the system in preparation for what we know is a large proportion of the registered nursing workforce due to retire. The decisions made around pay and the decisions made around whether you have a registered nurse or a healthcare support worker made quite a significant inroad into whether the nursing workforce stays engaged and stays in London or leaves.

The report that we have just published, which is a follow-up report from 2014, shows that in London we have over 10,000 vacant registered nursing posts, which is absolutely shocking.

Kit Malthouse AM MP: Do you think it was a mistake to make nursing a degree profession?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): No, I do not think it was a mistake to make it a --

Kit Malthouse AM MP: Has that restricted supply of people?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): Yes. Nursing is a very technical profession now. It has changed. When I trained in the early 1970s, it was very different to where we are now. Patients are certainly much sicker when they come into a hospital now than they were 10 or 20 years ago. The nursing workforce has to change and has to morph to meet these technical demands. That is not wrong; that is the right thing because that is what the patient needs.

However, the support network around liberating the registered nurses to deliver the job that they need to do is the bit that is missing in its entirety, whether that is in equipping the healthcare support workers to deliver at a higher level or the conversation that has started and the consultation around whether the old state enrolled nurse is reinvented. That is a conversation that is --

Kit Malthouse AM MP: This is an interesting question as to whether what we now call ‘nurses’, degree-level nurses, are a form of paramedic, really, and what we used to in the old-fashioned days think of as ‘nurses’ have a different kind of qualification that you do not have to go to university to get.

Danny Mortimer (Chief Executive, NHS Employers): If I may, that distinction is not one that we would recognise as employers.

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): No.

Danny Mortimer (Chief Executive, NHS Employers): The move for nursing to be a degree-based profession was decades overdue, frankly.

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): Yes, I would agree.

Cynthia Davis (Council Member and Chair, London Board, RCN): Yes.

Danny Mortimer (Chief Executive, NHS Employers): Nursing, both in my experience in the health service and also – I am the son of a nurse and a midwife – in the experience of my mother, has always been a role where we have asked nurses to carry out quite an extensive range of practice. The fact that a largely female profession was denied a degree-level qualification when peers of mine were doing degrees in all sorts of weird and wonderful things is something of an embarrassment to us.

Also, what we are seeing – to echo Sue's remarks – is a much more complex demand now for nursing skills. Yes, there is a question about how we then mix skills to support the registered nurses and make the best use of their qualifications and experience. Whether it is an acute setting, a mental health setting or children's nursing, nurses absolutely should be degree-qualified. We are not seeing any tail-off in terms of applications for nurse training.

Kit Malthouse AM MP: When it came in as a degree profession, you did not see a drop in numbers?

Danny Mortimer (Chief Executive, NHS Employers): Not at all.

Cynthia Davis (Council Member and Chair, London Board, RCN): No. Speaking as someone who is a lecturer in a university, if anything, there has been an increase in the applications and, therefore, most universities throughout the year have recruitment panels that are running. The absolute bottom-line research says that patients are safer when you have an educated nurse looking after them.

Kit Malthouse AM MP: I understand that. If applications are the same, then, the gap in requirement is caused by demand?

Danny Mortimer (Chief Executive, NHS Employers): Yes. What we saw --

Kit Malthouse AM MP: There is no shortage of people at the moment wanting to do it other than those to fill the growth in demand?

Danny Mortimer (Chief Executive, NHS Employers): We have absolutely seen that growth in demand and the seismic event was the publication of the report into the events at Stafford, Robert Francis's [QC, Chairman, Mid Staffordshire NHS Foundation Trust Public Inquiry] second report. That has driven demand quite dramatically in a very short space of time. Whilst I recognise the critique that nursing commissions were reduced some years ago, that demand for trained nurses increased rapidly in the space of 12 months. Whilst extra places are being commissioned, we will not feel the benefit of those for another two or three years. That is why, particularly for the NHS and particularly in London, the international recruitment piece has been really important. That is why the RCN and we have been arguing so fiercely that nursing should be placed on the shortage occupation list --

Kit Malthouse AM MP: The Government intends to do that.

Danny Mortimer (Chief Executive, NHS Employers): -- as a temporary step.

Dr Onkar Sahota AM (Chair): Let me pick this up about the tension with overseas doctors and nurses. The Government has a policy of denying visas to nurses unless they earn more than £35,000 and have been here serving the NHS for six years: [those who don't] must now leave the country. What do you think the impact of that will be on the nursing shortage in this country?

Kit Malthouse AM MP: They are not doing that now, are they?

Dr Onkar Sahota AM (Chair): Can we ask the expert to answer?

Danny Mortimer (Chief Executive, NHS Employers): The step that has been taken is that nurses have been placed on the shortage occupation list as a temporary measure until the end of this month. That removes both the need for nurses to comply with the salary threshold to stay in the country and also the need for employers to go through a similar salary threshold to get nurses into the country. What both the RCN and we are arguing for is that that move needs to be made permanent.

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): Yes.

Danny Mortimer (Chief Executive, NHS Employers): The Home Secretary [Rt Hon Theresa May MP] has commissioned a review of that question and we very much hope that to tackle the scale of the problem that Sue described nurses will be placed on the shortage occupation list. They will need to be there for the next two or three years to cope with the demand that you have --

Dr Onkar Sahota AM (Chair): Next question: you are a lecturer, right, in nursing? In the applications to join nursing, have you seen any shift at all? Are people very keen to come and do nursing?

Cynthia Davis (Council Member and Chair, London Board, RCN): Certainly. From my experience within our university and from what others are saying, there has not been a decrease. In fact, there are increases in the numbers of applications that have been seen. The screening then removes those people who from a values based recruitment angle we would not find desirable, we feel, to be within nursing --

Dr Onkar Sahota AM (Chair): Sorry. If we are losing nursing bursaries, will that have any impact at all?

Cynthia Davis (Council Member and Chair, London Board, RCN): From speaking with colleagues, my own opinion is that nursing is a profession whereby the students are doing two things: they are gaining the degree and they are also working 2,300 hours within practice and so they are supporting clinical care. Nurses do not have the capacity, like other students, to go out and get a job in addition to working 2,300 hours and attending university. Therefore, on that basis alone, we would say that we would need to see the bursary remain because it is uncertain what the impact will be.

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): Could I also add, Onkar, as well? Putting more students through the system puts a burden on those [qualified nurses] who are already in the system. It should be fantastic; however, those students need to be mentored and they need to have quality mentorship to enable them to maximise their learning so that they are coming through at the other end of their training as really competent practitioners. That has an impact on a service that is already severely in difficulty at the moment.

Cynthia Davis (Council Member and Chair, London Board, RCN): The fact is that universities are competing for placements for students outside to get those 2,300 hours.

Kit Malthouse AM MP: As I understand it, the *quid pro quo* on the bursaries is that they are taking the cap off numbers, are they not?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): Yes.

Kit Malthouse AM MP: It could mean that more people who want to go in and currently cannot are able to?

Cynthia Davis (Council Member and Chair, London Board, RCN): That is the hope but --

Kit Malthouse AM MP: That is the hope. The Government is forecasting 10,000 more pupils [places to study nursing due to the cut] in bursaries. I guess we will have to wait and see.

Cynthia Davis (Council Member and Chair, London Board, RCN): It is uncertain as to what that has been predicated on.

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): We need to also hold on. It is not just as simple as taking the foot off and just let whoever comes through. You need to have the right people. Part of the work that NHS England and the Chief Nurse have been doing is around ensuring that we have the right people come through. What we were finding was that students were coming into nursing and, at the end of their three years, they were unemployable. It is not just as simple as, "OK, open it and we will let everybody in". That would be wonderful, but we need to ensure that the product at the end is what the patients and the public need.

Dr Onkar Sahota AM (Chair): Fionna, this is your opportunity to say something about this from the LAS point of view.

Dr Fionna Moore MBE (Chief Executive, LAS): I would like to talk about two groups of our staff, firstly paramedics and secondly call-handlers. We employ about 1,700 paramedics in the LAS and there is a national shortage of paramedics, which is between about 2,000 and 3,500. We are in competition with other ambulance services for paramedics.

There is an issue about recruiting paramedics because it is moving to a Bachelor of Science (BSc) level qualification, which is absolutely right if you consider the direction that healthcare is going in and the need for our paramedics to be skilled in patient assessment and decision-making. Our paramedics are making decisions out in people's homes that you would not allow band 5 nurses in [accident and] emergency departments (A&Es) to make where they have access to senior help, diagnostics and a much more detailed history of the patient. Paramedics are making really quite mature decisions and they need to have the training and the experience to do that.

We work very closely with four universities around and in London and we are increasing the pipeline for paramedics from 150 paramedics a year to 500. However, if we lose a paramedic, they can leave the service in four weeks and it takes us three years to recruit another one, which is one of the reasons that we have had a very significant gap over the past year to 18 months.

Retaining paramedics has also been an issue because many of our paramedics live outside London because it is expensive to live in London. They do a stressful job, they work long shifts and they are attracted to other ambulance services if they happen to live on that patch. There are also a lot more opportunities for paramedics these days in other areas in the health service, not just in another ambulance service but moving into primary care. The South East Coast Ambulance Service, for example, has seen many of its trainee paramedic practitioners move into primary care. We see people being offered opportunities in A&Es, in urgent care centres or with the Department for Work and Pensions outside the NHS. There are lots of opportunities for paramedics that were never there before and that is leading to a lot more churn. In a service that saw people leave at the rate of 12 to 15 a month, year on year, at one stage we were losing 70 a month. That has now stabilised, fortunately. Therefore, we have an issue with paramedics.

There is the issue about trainee paramedics and bursaries because currently they do not get a bursary and they will rack up a significant debt during their time as a trainee. Like nursing students, they do not have the opportunity to earn because they are out on placements.

The other area that I would like to talk about is the call-handlers in our emergency operations centres, of which we have two in London. We take 1.9 million 999 calls a year and so it is a very busy and very stressful job. Call-handlers are not well paid: they earn between £16,000 and £19,000 a year; they work long shifts. It is a very stressful job. More than 60% of them leave within three years because call-handling is a skill that is very transferable. To work in a [call] centre where you get a commission, you will get a lot better paid. We could do with help both in encouraging people to apply to be call-handlers and also in retaining our staff.

The things that we would look to the London Assembly to help us with is recognising that there is a problem and that London is perhaps special because of the high cost of living, and the pressure that the system is under. It would be great – and it is great – when you recognise the efforts of our staff. They take that really personally.

What could we do to make London a more attractive place to live and to work? Affordable housing would perhaps be really useful; concessions in terms of the congestion charge because most of our staff work antisocial hours and therefore it is difficult for them to use public transport and so they drive; and possibly cheaper travel for support services within the ambulance service.

Dr Onkar Sahota AM (Chair): Fionna, you said that there are of course more opportunities for paramedics. Why is it that they choose to go for those opportunities rather than remain with the service?

Dr Fionna Moore MBE (Chief Executive, LAS): Currently, they are paid band 5 in London. Some of the services elsewhere in the country – notably East of England and South Central, both of which border the LAS – are either paying their paramedics band 6 or moving to paying them band 6. Clearly, that is more attractive. If they were to work in an A&E or in general practice, they would be paid band 6 or possibly even band 7 because of the level of responsibility that they would be taking.

Dr Onkar Sahota AM (Chair): I could understand that because in general practice there is a shortage of recruitment and paramedics would maybe fill the gap there.

Dr Fionna Moore MBE (Chief Executive, LAS): If you were a paramedic and you were working 12-hour shifts out in inclement weather and you had the opportunity to be paid more and be working inside on shorter shifts with better support, what would you choose?

Dr Onkar Sahota AM (Chair): Yes, I understand that.

Andrew Boff AM (Deputy Chair): We all know about the emergency services that over the past few years – many years, actually – the police have had fewer calls and the fire service has had fewer calls but the ambulance service has had considerably more calls. Is there something to be said for unifying the back office perhaps on call-handling amongst the three emergency services?

Dr Fionna Moore MBE (Chief Executive, LAS): On a day-to-day basis, we collaborate really closely with the other blue-light services, as you can imagine. We attend calls together on a day-to-day basis. We are working very closely with the other two emergency services. We now have co-responding projects. We have defibrillators in police cars in three boroughs in London, including Ealing, and the police are co-responding with us on cardiac arrest calls. The London Fire Brigade will be doing that as of this month in four boroughs. We are looking at what back office functions we could share. Currently, there are six control rooms within London. We are looking to see what we could do work more closely with the other emergency services. However, we are an absolutely integral part of the NHS and we are absolutely integral to the way that the health service is going through the Urgent and Emergency Care Review.

Andrew Boff AM (Deputy Chair): Sorry, just briefly on that, last time we did a review from the London Assembly about the LAS, one of the things that we did note in our recommendations was the concern that the police can call directly to dispatch and can summon an ambulance directly. That was a considerable number of calls by the LAS.

It was undertaken that some work would be done. What is the situation now and is it more satisfactory now? It was perceived at the time that some of those calls would not have generated a visit by an ambulance if they had gone through the 999 service.

Dr Fionna Moore MBE (Chief Executive, LAS): That is absolutely true. The police are our second-biggest customer. Healthcare professionals are our biggest customer.

We get about 500 calls from the Metropolitan Police Service a day and they come straight down the computer-aided dispatch (CAD) link, which is the electronic link between their control room and ours. We now have a specific dispatch desk within our control room that manages those calls and has the opportunity to ring back the police officer on the scene. Over 50% of those calls do not get a frontline ambulance response. We can often re-triage that call directly with the patient or with the police officer.

We also have a scheme whereby we have a fast response unit working with the police in 12 of the London boroughs known as the Joint Response Unit. They carry both LAS and police service radios. That manages demand extremely well. Demand from the police is not going to go away, but we manage it much more effectively and safely now than we did.

Andrew Boff AM (Deputy Chair): That is really good. If you do not mind, we will notch that one up as a win for the London Assembly.

Valerie Shawcross CBE AM: I just want to perhaps try to nail some misassumption that people have about the work of the call-handlers. When we say ‘call-handlers’, it is much more than that, is it not? When I used to Chair the London Fire and Emergency Planning Authority, I made a point of observing what went on in all of the different call centres. What struck me was the intense expertise that was being conveyed and used by the call-handlers in order to save lives and preserve people’s conditions while the ambulance was arriving and the advice to the people on the call.

I am almost shocked to hear that people are paid so badly. That has not changed, has it? There is a degree of expertise during the triage process that actually does save lives and preserve people from further damage.

Dr Fionna Moore MBE (Chief Executive, LAS): That is absolutely correct. It is important to realise that we have call-handlers and that the dispatch function of how an ambulance is actually sent is a different part of the control centre, if you like. The calls coming into the control room are handled using a priority dispatch system. There are two approved systems for use in this country. Five ambulance services use the one that we use in London, which is called the Medical Priority Dispatch System. The others use NHS Pathways, which is the system used by 111. Both of those rely on a script and so our call-handlers use a series of scripted questions that they can use either from a series of cards that they work through or through an electronic system, which is what pretty much every ambulance service has. However, the outcome of that series of questions will be a prioritisation and the ability to give post-dispatch instructions and, if necessary, emergency life support. They will talk the person on the scene through how to look after the patient and specifically how to deliver chest compressions.

Valerie Shawcross CBE AM: That is the point I was making. In other emergency services, there is a different skillset. For example, if you listen to a fire brigade emergency call-handler, they are talking people through how to stay safe in a burning building, how to get out or how to protect themselves from [smoke] inhalation. I feel that there might be some assumptions around there that this is just about call-handling.

Dr Fionna Moore MBE (Chief Executive, LAS): It is a very stressful job because they can be talking to somebody who has a very minor complaint and they think, "Why did they ring 999 for this?" The next call could be somebody who is about to deliver a baby and they will talk them through how to do that. The system that we use has quite detailed instructions. Whether it is a normal delivery or whether it is delivering a breech, there are detailed instructions for a call-handler with no clinical knowledge. We know from experience that having call-handlers who have no underlying clinical expertise or experience allows them to use the system more effectively.

Murad Qureshi AM: Dr Moore, you gave us a good analysis of the differences in grades from London and other ambulance services up and down the country. Are you in a position to match those differences with your present budgets?

Dr Fionna Moore MBE (Chief Executive, LAS): Currently, no, but it is something that we are putting into the commissioning discussions for the next year. For us it would be about £8.8 million recurrent to move all of our paramedics to band 6. Of course, that would be fine for the paramedics in the service, but we have almost an equal number of emergency ambulance crew who are on band 4 and moving our paramedics to band 6 will not do anything for them.

Murad Qureshi AM: It has been a long while since I have been involved in local government wage negotiations: is there still an inner London/outer London weighting?

Dr Fionna Moore MBE (Chief Executive, LAS): Yes.

Murad Qureshi AM: Does that make any difference in today's world at all, given what you have said?

Dr Fionna Moore MBE (Chief Executive, LAS): It makes a difference depending on where you are based in London. If you are based at one of the stations - and remember that we work out of 70 sites - approximately half of them get inner London weighting and approximately half of them get outer London.

Murad Qureshi AM: That is still there?

Dr Fionna Moore MBE (Chief Executive, LAS): Yes.

Murad Qureshi AM: OK. I just wanted an update, really.

Dr Onkar Sahota AM (Chair): Professor Baker, I just wanted to pick up. You said that there was no difficulty in getting the GPs to train for general practice in London but --

Professor Maureen Baker CBE (Chair, RCGP): At the moment, as far as I understand, the London Local Education and Training Boards (LETBs) are filling their training places.

Dr Onkar Sahota AM (Chair): OK, but there is a problem with the retention, is there?

Professor Maureen Baker CBE (Chair, RCGP): Yes.

Dr Onkar Sahota AM (Chair): Is that right? When I look through *The BMJ* [formerly the *British Medical Journal*] and other GP magazines, there is a huge vacancy rate there and the practices are having difficulty recruiting salaried doctors and partners. Do you have any view on that? Is that happening? Is that your experience?

Professor Maureen Baker CBE (Chair, RCGP): Yes, that is our experience and it is entirely consistent with the situation across the country. It is often the case that there are a number of factors, as we understand it. Actually, we do believe that more work needs to be done to get under the bonnet, as it were, of the reasons why people leave.

I mentioned already early retirement of doctors in their 50s and early 60s. It is partly that you can retire and the normal pension age is 60. With the changes that have happened in pension arrangements, people are looking to see whether they should retire. There are these things going on at the same time as very intense workload pressures. There is something about how you can retire and the job is really hard and it can seem to some people that there is no relief from this. Therefore, you can see why people do make those decisions.

For younger doctors, though, they are also leaving. What we are finding is that doctors are emigrating, doctors are having career changes and doctors are leaving general practice and going into another branch of medicine. It is a response to the very intense pressures at the moment. There is now a general recognition, I would say, that general practice as a service has been underfunded significantly over the last 10 to 12 years. We have not trained enough GPs. In comparison to 10 years ago, there are something like 70% more consultants in the NHS as opposed to somewhere between 15% and 20% more GPs. Those are headcount figures because GPs in terms of demographics are more likely to be part-time because we have significantly more women. We really struggle with the funding for the service and the workforce for the service and there is pressure, therefore, on the people who remain. Against this lack of resource and insufficient workforce, we have a very significant increase in demand. In 2008 - and these are England figures; I do not have figures specifically for London - across England there were 340 million GP consultations. We estimate that that is now around 370 million. There was a very significant rise in the delivery of consultations within that period of time against a static or falling resource and a failure to increase the workforce. There are very intense pressures, there is huge demand for the service, we have not been funded sufficiently and we do not have enough GPs, nurses or other colleagues to work with this.

Kit Malthouse AM MP: I think I am right in saying that there is a ten-point plan, is there not, to try to solve the problem?

Professor Maureen Baker CBE (Chair, RCGP): Yes.

Kit Malthouse AM MP: How is that going?

Professor Maureen Baker CBE (Chair, RCGP): The ten-point plan came out of the publication of the Five Year Forward View. In my College, we did a review of the Five Year Forward View and we set out a series of actions that we felt needed to be taken for general practice to meet the aspirations of the Five Year Forward View. When discussing these with colleagues in NHS England and other bodies, we realised that a big chunk of those related to workforce. What we then did was to bring together partners. There is us, there is NHS England, there is Health Education England and there is the General Practitioners' Committee of the British Medical Association (BMA). If you like, they are our partner organisations. From this range of measures that needed to be taken, we pulled out the workforce ones and they fit nicely into this ten-point plan. That has now been running for just over a year. We probably had the first partnership group meeting in about January 2015 and so we are just over that.

How is it going? It is certainly moving along and with some bits of it we are really starting to see action. For instance, I long had huge frustrations about the difficulties and the barriers for doctors who were working abroad or who had taken a career break, normally for family reasons, in terms of them picking their careers up again. There is something called the National Performers List. If you had not been in general practice in the NHS for a period of two years, getting back onto the Performers List was hugely bureaucratic and expensive. There were huge barriers. It seemed to be such a waste. We had trained GPs who wanted to work in the United Kingdom (UK) being stopped from doing so.

As an example, one of the items in the ten-point plan is a more effective induction and returners scheme. A lot of work has been put into that. It has improved a lot. We are starting to see somewhere between 100 and 200 GPs in the last year since the revised scheme was delivered starting to come back through. It could still be more streamlined and it could still be more effective. We are still working on that. However, we look at that and we think, "That was worth doing". There is now a clear route and a supported route back into general practice. There is further work to do but we are getting on well there.

There were virtually no practice-based pharmacists a year ago. There was the odd one in the odd practice - not 'odd' peculiar - or there were a few in a few practices doing very well. Some were partners. The evidence that was available from these relatively few situations was very strong. Again, through the ten-point plan working stream and with the close co-operation of the Royal Pharmaceutical Society, a major effort was made to introduce practice-based pharmacists. This was funded to the tune of £30 million by NHS England. That is going very well. The word on the ground both from practices and from pharmacists is that this is really going to happen. If you like, the aspiration for every practice to have a pharmacist and for practice pharmacists to be as routine as practice nurses in a short period of time is well on the way.

However, other parts are not doing so well. We are still struggling with recruitment. We are still struggling to understand the retention issues and the initiatives that can be put in place to really make a difference there. You asked how it is going. It is going well in parts. There has been a lot of work and a lot of input from us and I feel that it is very well worth doing, but there is a lot more to do.

Kit Malthouse AM MP: Can I just ask a wider question about the issue of shortages? Obviously, they will have an impact on patient care. Have there been specific incidents that are of alarm? Has there been a general drop in the standards in London? Are you managing to maintain standards? If so, how?

Professor Maureen Baker CBE (Chair, RCGP): I would say that the service in London and across the country is managing to maintain standards, but it is really difficult. The biggest area of concern for us – and I do not think you have necessarily seen this as much in London – is practice closures. I am not saying that there are not any in London but they tend to be for different reasons.

In other parts of the country, what we have found is, say, a practice that might be very well performing, well regarded and popular with patients. Say it has six GPs and there is one planned retirement, then somebody gets very ill and somebody goes on maternity leave. You can halve within a very short period of time the number of GPs there. The pressure that puts on the remaining doctors, nurses, everyone, the clinicians in that practice, is huge.

Kit Malthouse AM MP: My perception having lived in London for the last 20-odd years or whatever is that the main thing that I have seen, certainly from general practice, is a lengthening in the time that it takes to get an appointment. At the moment where we are in Islington, [waiting times for appointments are] running at about three weeks. Three weeks has a certain informal triage to it because in three weeks' time you are either better or dead, one of the two. I do not mean to be facetious about it, but that seems to be the main thing. Have you seen that lengthening of appointment times, generally?

Professor Maureen Baker CBE (Chair, RCGP): Yes. The first thing to say is that all practices everywhere will see people in an emergency on the same day and they are all set up for that. However, we are aware – very much so – of the long time to get a routine appointment. My colleagues and I are very concerned about that. If you take something like a cough that someone has had for weeks, it is by definition almost not urgent but it is important and really does need to be seen. The concern that we have is then that you increase the length of time before someone is able to be seen for the first appointment. That is a concern for us. It is physically a lack of supply and demand. It is not that the GPs are not there or are off doing other things. It is just that the demand for appointments cannot be met.

Kit Malthouse AM MP: Do you think that there is greater scope in general practice for managing demand better? Lots of practices, as far as I can see, now do seem to be managing patients better. You get a text message saying, "Remember that you have an appointment tomorrow", trying to reduce the number of no-shows, which creates capacity. Also, my perception is that lots of GPs have been quite slow to take up new technology in diagnostics which could improve things. For instance, it is possible that there is a machine now that will take a little blood sample and tell you within four minutes if you have an infection or not. If you do not have an infection, there is not a lot that they can do.

Dr Onkar Sahota AM (Chair): Kit, can we stick to the focus of this, the workforce, rather than looking at information technology (IT)?

Kit Malthouse AM MP: We are. One of my questions is about alcohol demand and so I am now asking about managing demand.

Professor Maureen Baker CBE (Chair, RCGP): If I can come back to the demand thing, I would just say that GPs are the profession in healthcare that adopted technology. That is why GPs all have electronic patient records and, generally, electronic prescriptions. I completely refute that GPs are slow to take up technology.

Kit Malthouse AM MP: OK.

Professor Maureen Baker CBE (Chair, RCGP): In terms of the different ways of managing demand, my College has produced a paper on access, which I am very happy to send to the Committee.

Kit Malthouse AM MP: That would be great.

Professor Maureen Baker CBE (Chair, RCGP): We cover lots of areas in that. If I just give you an example, the practice that I work in is in a market town in Lincolnshire. We use a system called Doctor First. For all requests for appointments, the doctor speaks to the patient, the doctor and the patient decide if they need to be seen or not, they are seen by a doctor or maybe a nurse.

Kit Malthouse AM MP: Yes, that happens here with our practice.

Professor Maureen Baker CBE (Chair, RCGP): Yes. Lots of practices now are moving to these techniques. What I would say is that these work really well in some practices. In the practice I work in in Lincolnshire, it is great. I love working this way. Patients really enjoy it. It is very highly evaluated.

However, in this practice in Lincolnshire, in excess of 99% of patients speak English as a first language and it is very much easier to have a telephone conversation. I think my ambulance colleagues would agree that you [only] have one sense on the telephone: you are just using your hearing. Where you have a significant number of patients who have either poor English or little English, that way of working becomes very much more difficult. I would suggest that in London you have very many practices where probably it is a lot more difficult to use these ways.

Kit Malthouse AM MP: It can be tricky. All right. Thanks very much. From a nursing point of view, have we seen a reduction in the quality of service or greater risk?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): The thing that our members are telling us day in and day out is that they are striving to deliver the best care they can give. I would say that there is not a reduction in the quality of care but that there would be a reduction in the amount of care that people can give. If you are working in an environment - whether in an acute hospital or in the community - and you are working with a reduced number of registered nurses, something has to give. You as one person can only give so much. You are on 12-hour shifts, you have sacrificed your breaks, you do not get a cup of tea during the day and you are giving your all to deliver the best you can to your patients because that is the reason you get up in the morning, but you cannot maintain that *ad infinitum*.

What we see within the service and what is being articulated very regularly to us is that nurses are leaving because they are exhausted. They are leaving and they are going, the same as Fionna [Moore] identified with paramedics. There are hugely transferable skills within nursing that are really attractive to a wide arena. Why would you stay?

Kit Malthouse AM MP: Sorry, just to focus on my question, is it your view, therefore, that the risk in London is rising because of these shortages and that the quality of care is falling?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): The care issue is very complex because what we see, which is different to 10 years ago, is that people generally are sicker now than they were. If you look purely at the community side of things and the community support that used to be in place, if you have a full district nursing team and a full remit of specialist nurses who can go out and enable

people to stay well with long-term conditions in their homes, then their quality of life is better and it takes some pressure off things like the ambulance service, A&Es and the acute services. However, where you have a reduction in the number of registered nurses delivering that care, your patients are going to be sicker. It is not about the quality that the nurses are giving; it is just that there are not enough of them. That will have an impact on your patients, your patients' wellness and their ability to maintain themselves living in their environment at home.

Kit Malthouse AM MP: Obviously, given the critical nature of your service, if quality does drop off, it is all over the front page of the papers.

Dr Fionna Moore MBE (Chief Executive, LAS): That evidence-based journal, *The Evening Standard*: I look at it every day to see whether --

Murad Qureshi AM: Have we got an [*Evening*] *Standard* journalist over there?

Dr Fionna Moore MBE (Chief Executive, LAS): We have had a really difficult time over the past two years, as I think everybody is aware. We continue to prioritise the calls that come into the LAS to ensure that we get to the most seriously ill and injured patients as quickly as we can --

Kit Malthouse AM MP: No, I understand that --

Dr Fionna Moore MBE (Chief Executive, LAS): -- and so the safety of our service has been maintained. However --

Kit Malthouse AM MP: All right. The difficulty with recruitment is not having an impact on safety. Is that what you are saying?

Dr Fionna Moore MBE (Chief Executive, LAS): No, I do not believe it has had an impact on safety, although we have not hit our statutory targets since April 2014 --

Kit Malthouse AM MP: Because of recruitment problems?

Dr Fionna Moore MBE (Chief Executive, LAS): Recruitment is one factor. It is a relatively simple equation with demand and staffing levels or demand and resources. Demand has gone up dramatically. We have seen an increase in our category A demand of 20% in the last two years. What that actually means is that we are getting another 170 category A calls a day at the moment than we did a year ago. Those category A ones are the ones that are immediately life-threatening. We have continued to deliver a safe service to those patients, but I cannot honestly say that we have delivered as high a quality service as we would wish because we prioritise the sickest patients. That inevitably means that patients with lower-priority illnesses and injuries will not get a response as quickly as we would like and we will refer some of them for telephone advice, which is fine. We do an enormous amount of hear-and-treat within our control rooms and 3,500 patients a week either are triaged by clinicians in the control room or are referred to 111 or to A&E.

Kit Malthouse AM MP: All right. Thanks. What are the options to address these various issues in the short-term, Danny?

Danny Mortimer (Chief Executive, NHS Employers): There are a couple of things to say. The first thing to say is that clearly clinical colleagues, most particularly nursing and paramedic colleagues, who are experiencing perhaps the most severe problems in London, are, as you have heard, doing their very best to

make sure that it does not impact on patients. That does have a financial consequence for their organisations and clearly has a consequence on those colleagues as well in terms of the extra effort they are having to put in.

For paramedics, Fionna's [Moore] organisation has done a huge amount in terms of both trying to develop the career structure for paramedics and trying to argue the case to improve the pay and education for paramedics and to make the career more attractive so that they can compete with other organisations. There is also a huge amount, as I am sure you are aware, that they have done in terms of overseas recruitment, particularly from the Antipodes, and that is clearly starting to have some effect.

For other organisations, particularly acute hospitals, they have perhaps more of a problem. It has been in the short term around international recruitment. I will not go back over the points that I made earlier, but that has been an important part of what they have had to do to try to get nursing colleagues in quickly.

There are other things, though, that are going on to make sure that nurses who train in London choose to stay in London. There is an initiative called Capital Nurse, which involves healthcare providers in London and trade union colleagues as well as education providers working together to make sure that the nurses who come to do their degrees here choose to stay in London.

There is a slightly different dynamic for doctors in that London has always trained doctors for the rest of the country and there is a greater concentration of medical schools and postgraduate medical training in London compared to the rest of the country. There are more doctors in London than there are in the rest of the country. There is a slightly different dynamic there.

Those things are all happening and there is urgency. Again, I would repeat the points I made about migration.

Kit Malthouse AM MP: You are certainly giving me the sense that there is a general plan to address those issues in --

Danny Mortimer (Chief Executive, NHS Employers): There is. They are things though - and Fionna [Moore] made the points very well when talking about the ambulance service - that are true for all healthcare staff. The rate of increase in earnings in the healthcare service, along with the rest of the public sector, has been very modest in the last five years --

Kit Malthouse AM MP: -- so, you've all --

Danny Mortimer (Chief Executive, NHS Employers): -- let me finish. Our average earnings for our workforce have gone up by 3% or 4%. The average cost of travel with a zone 1-4 ticket has gone up by 25%. The cost of housing has gone up by in excess of a third. We are seeing our staff struggling to afford to live in London and that, clearly, is something that you have some influence over as an Assembly and that the Mayor has some influence over. We feel that most acutely in the health service along with other public sectors. That rate of increase in the cost of living in London is having an impact now and will have an impact in the future if you and your colleagues do not take some action to help us, particularly around - as Fionna [Moore] rightly said - housing costs and transport costs.

Dr Onkar Sahota AM (Chair): This question was really about the impact on patient care. I just want to tease that out a little bit more. I understand that all of the nurses, doctors and paramedics who work are doing the very best that they can, but here we have a service that is understaffed. Wards have 30 patients in them and there should be eight nurses but they only have five there and two of them are from a locum agency. The patient perception is, "I am not getting the good care that I used to get".

How do you square that up? Here you saying, “We are doing our very best”. Do you think that patient care has suffered over the years or not?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): You are all looking at me. It is not a straightforward answer and I am not a politician and so please forgive me.

Dr Onkar Sahota AM (Chair): We are all politicians here to learn from you. You are the experts.

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): It is a very complex answer. What we are being told and what we are seeing is that the nurses are delivering the life-critical care. It is very much like Fionna [Moore] articulated. The soft-sell stuff is not being done by registered nurses. It would have been. What you are then looking at is that care still needs to be given and so we then have the healthcare support workers who are coming in. It depends on the amount of time, effort and training that you put into the healthcare support workers to equip them to deliver the care that the patients need. I know that as a student nurse I learned some of the best craft of nursing from my healthcare support worker colleagues, but they have been doing this job for a long time, they had invested a lot of time and they were recognised as, really, part of the nursing family.

There is a little disconnect when you are put under pressure around what you need to do as a registered nurse for a much sicker [person]. I keep saying this: the people who are in the service who are being cared for are much sicker than they used to be. We do not have the same aftercare in an acute setting, as I just talked about, that you would have had 15 years ago because the whole thing is about getting people through the system quickly. You have Fionna [Moore] and her wonderful A&E teams - and I am an A&E nurse - bringing people into one part of the service and you have to get them through it. It sounds very hard and very cold, but that is how the business works. As a nurse, you would be looking to provide the best technical care and to look to your teams to provide the best enhanced care to help that patient to get well so that they can then be discharged from hospital into a community setting. There, again, we have exactly the same pressures in that there are not enough district nurses and there are not enough health visitors. Every single nursing component in the system there are not enough of. However, the patients and the patient demand are there.

While it would be absolutely fantastic for me to sit here and say, “Patients have absolutely everything that they need done for them”, we know because our nurses are telling us. It is absolutely shocking when you have somebody who is talking to you about their experience of nursing and they have come away from a 12-hour shift crying because they know they have not been able to do as much for their patients as they know they should do. They have done the technical stuff and they have done the bit that actually saved that patient’s life, but they have not been able to sit on the bed, talk to the patient, hold their hands, reassure them in the same sort of way and explain to them in the same sort of way, “This is what has happened to you. This is what the doctor said”, because the time and the pressures and the demands when they are working short-staffed do not allow them to do that. That is an important point. The technical quality of the care is good, but it is the bits that support around it that is where the patients may not be getting the quality of care that they deserve.

Professor Maureen Baker CBE (Chair, RCGP): There is something really important that I would like to flag up with the Committee that Sue has said several times now about patients being much sicker when they are admitted to the acute sector. That certainly seems to be the case mix that is ending up in the acute sector with the proportion of people who are acutely and severely ill with multiple problems that are difficult to deal with.

However, when you think about why that is, it is because the less acute stuff now is dealt with in the community, whereas 20 years ago people would have been admitted to hospital for what we can look after now in the community between GPs and community nurses. We are holding that in the community and, again, this is increasing the pressure on the primary care teams.

The other thing that is a major underlying difference between now and 20 or 30 years ago, which is actually a great success, is that people are living longer. We have now many more people in their 70s, 80s and beyond. We have many more people who are living with multiple long-term conditions. Thirty years ago, you had a heart attack and died, if you had cancer and died, etc. Nowadays, you are much more likely to survive your heart attack and live with heart disease or be a person who has cancer as a long-term condition. Again, this means that when a severe illness strikes – a severe infection or another cardiac event – that person, compared to the case mix 20 or 30 years ago, is older and does not just have heart disease but has cancer or dementia as well. There is this whole mix. The pressure that puts on the acute system and the ambulance system is very much there. However, there is all of this pressure in the primary care system as well.

The picture, which we are all very proud of – most of us would like to live to be old, thank you very much, and we would quite like to live to be old and well – is a success story, but the consequences and the ways that that impacts on the health service in every sector are really important. Generally, as policymakers and as politicians, we have not quite understood this impact of multimorbidity across the NHS.

By the way, we really need generalists. We need generalists in medicine and in nursing as well as our specialist colleagues. We really need that.

Dr Onkar Sahota AM (Chair): Given that you are seeing more complex patients and that this will have an impact on the workforce also, has the consultation time gone up in general practice?

Professor Maureen Baker CBE (Chair, RCGP): This is another pressure. Most practices working in traditional ways are still doing 10-minute consultations. For a lot of the stuff that used to be done in catch-up time – a pill check or a sore throat – other staff are seeing these people now and so the GPs are seeing the more complex and more difficult and are trying to do that in 10 minutes. There are a number of consequences of that because you cannot do that well in 10 minutes. Either the consultation overruns and you run late, which happens, or you say, “This is what we can do today. You will need to come back”, and you take the next thing on then. That is another reason for more consultations.

Again, there are different ways of working. In the way in which I work, when I book my patient in, the patient and I decide how long they need. Normally I would be giving my patients 20 minutes because I can and that is the way that system works. However, there is no such thing as one size fits all anymore and you have to use the system that works well for your patients in your practice.

You are quite right that this complexity and the way in which we need to deal with this complexity puts another pressure on the way in which we work in general practice.

Andrew Boff AM (Deputy Chair): Perhaps to Mr Mortimer first: could you tell me how dependent London’s health services are on locum and agency staff and which of the services are most affected by that requirement?

Danny Mortimer (Chief Executive, NHS Employers): Forgive me. I do not have the figures immediately to hand but I can let the Committee have them. There is a very high degree of dependency in nursing. The NHS estimates that vacancy rates in nursing are at about 12% and the RCN estimates a slightly higher figure.

Many of those vacancies will be filled by agency locum staff. Whilst I am not minimising what Sue was describing in terms of the gaps that are left, a large part of that vacancy rate is filled by agency and locum. It is probably somewhere around 10% of our nursing workforce across London that comes from agency-type sources.

Andrew Boff AM (Deputy Chair): That is the highest in the country. Is that correct?

Danny Mortimer (Chief Executive, NHS Employers): The spend is the highest in the country. For the proportion of vacancies, there is regional variation around the country but London has one of the highest, yes.

For medicine, it will depend. It depends massively on supply in particular specialities. London, as I have said, is slightly better doctored than other parts of the country anyway, but we are also seeing high degrees of spending in medicine as well as some other professions. We have some particular use of agencies for some of the other professions that support the service and Fionna [Moore] will be able to speak particularly to the LAS in terms of the people it uses.

Some of the issues for agency staff, of course, are around supply. The agency market for nursing and hospital doctors is relatively well developed but it is not as developed for other groups, which creates some of the problems that colleagues have touched on.

Dr Fionna Moore MBE (Chief Executive, LAS): Agency workers are not an issue for frontline ambulance services. We do use some agency staff in our back-office functions. However, for frontline staff, we employ a relatively small proportion of private and voluntary ambulance staff on a daily basis. We use approximately 30 ambulances a day out of a total number of ambulances on the road of around 270 and so it is a very small proportion. We also have our own in-house bank. For example, members of staff who have left us to go to work in primary care, for example, might stay on our bank so that they can maintain their registration, but that is controlled by us.

Andrew Boff AM (Deputy Chair): They can be summoned in to --

Dr Fionna Moore MBE (Chief Executive, LAS): No, they would book shifts with us. We do not summon them in.

Andrew Boff AM (Deputy Chair): You do not call them in? All right.

Danny Mortimer (Chief Executive, NHS Employers): Similar kinds of bank arrangements exist particularly in nursing. Typically, it is either nurses choosing to work extra shifts in their own institutions on top of their permanent hours or it is nurses who want to work flexibly and do not have permanently contracted hours but who then volunteer to do extra shifts.

Andrew Boff AM (Deputy Chair): One could not technically define those people as 'agency staff' or would they be categorised as 'agency staff'?

Danny Mortimer (Chief Executive, NHS Employers): No, we would not define them as 'agency staff'. We would define them as 'bank staff'. They have similar arrangements to what Fionna [Moore] has described.

Andrew Boff AM (Deputy Chair): In any other industry, you would look at a very high level of agency staff as an indication of management not quite getting hold of the situation. Is that the case in the NHS?

Danny Mortimer (Chief Executive, NHS Employers): For nursing, no one anticipated the response that the NHS would have to make to Robert Francis's second Stafford report [Mid Staffordshire NHS Foundation Trust Public Inquiry] and that did drive a significant increase in nursing numbers.

That has been compounded then by the demand issues that my clinical colleagues have expressed to you. Our A&Es now are busier and bigger than they were five years ago; our hospitals are busier and bigger than they were five years ago. With that second category, we should have done better at anticipating that demand. It does feel as if, in terms of that older and more dependent population, we reached a tipping point in the last two or three years that we failed properly to anticipate right across the service.

On the Stafford piece, clearly, the NHS had to respond to what Robert Francis found in Staffordshire. No one could have anticipated that in terms of the nursing numbers that we were commissioning and in terms of the full scale and impact of his recommendations, particularly in terms of the numbers of extra nurses we needed. There is a response now. A significant number of extra nursing places are being commissioned in London for adult nurses and more are being commissioned for mental health nurses, but nurses take three to four years to train.

Andrew Boff AM (Deputy Chair): What about the effect of locums? How is that different in London from anywhere else?

Danny Mortimer (Chief Executive, NHS Employers): The effect?

Andrew Boff AM (Deputy Chair): Of the use of locums. Is there a situation where the use of locums is considerably more or less in London than anywhere else?

Danny Mortimer (Chief Executive, NHS Employers): There is enormous regional variation in terms of the use in different parts of the country. London is of a piece with some other parts of the country in terms of the scale of its demand. Even within London, there is a range of vacancy rates from some organisations - for nurses in particular - where vacancy rates are well below 10% to organisations where vacancy rates may be touching 20%. That obviously drives very different demands for agency staff.

Andrew Boff AM (Deputy Chair): You have mentioned the Mid-Staffordshire Inquiry and I do not think that there is anybody who has said that we should not be addressing the concerns that were in there and, obviously, it does have an effect on nursing recruitment. Are there any other positive reasons for using agency staff, do you think?

Danny Mortimer (Chief Executive, NHS Employers): There are a couple of things that colleagues would observe. There is something about needing to respond flexibly to the more acutely unwell patients. There are patients who are admitted and who need one-to-one care. That could be because of their age, their mental health problems or their particular set of needs. Big organisations cannot always plan to have all of those extra staff available.

Clearly, for a number of our nursing colleagues - and hospital banks offer this and agencies also offer this - there is some control over where they work and how they work. The bank piece has always been a feature for the 25 years that I have worked in the health service and it has always been a very healthy feature of how we have retained an overwhelmingly female workforce. Colleagues have started their families and have not wanted to commit to permanent fulltime work but have been prepared to work flexibly. Bank work has long been a way with which we have retained people. Hopefully, as they have maintained their practice, at the appropriate time they are able to return to more permanent fulltime work.

Andrew Boff AM (Deputy Chair): As you know, the Government has intended to save some money by putting a cap on the amount that an NHS Trust can pay. It aims to save about £380 million on that. However, there has also been some criticism that the introduction of that cap may lead to staff shortages. Do you think that the balance of the cap is right?

Danny Mortimer (Chief Executive, NHS Employers): I would say two things. The cap is a really important step for us to take. We were facing a market that, in some parts of the country and in some parts of London, felt to colleagues as if the vacancy situation they had was being exploited by agencies and the staff who were working through the agencies were not necessarily feeling the benefit of that. It was the agencies that were feeling the benefit in terms of their margins. The NHS had to intervene in the market in that way and that was a positive step.

The second thing, though, is that there is something about our own supply. As we have talked about this morning, the use of agency staff is largely caused by vacancies. It is caused by the shortages we have and the demand we have. That is why, for us, the moves around overseas recruitment are really important because, if we can recruit high-quality nurses from overseas to work alongside my nursing colleagues, it shuts off the demand for agencies in the first place.

There are some other things as well that we need to do about making our own bank arrangements more attractive. We have had some discussions with the BMA recently, for example, about whether there is more we could do to incentivise doctors to choose to work as locums in their own organisations rather than working as locums through agencies in other organisations. I am hopeful that we can do something in that regard as well.

Closing off that demand through filling the vacancies will make the biggest difference and will make more of a difference than the cap.

Andrew Boff AM (Deputy Chair): Actually, I have contradictory advice here; £370 million or £380 million is what they are looking to save. Do you see London as generating a disproportionate amount of those savings because of the pressure on London?

Danny Mortimer (Chief Executive, NHS Employers): Forgive me. I do not have the detail immediately to hand, but I am sure that through colleagues I could let the Committee have it.

Andrew Boff AM (Deputy Chair): You have mentioned overseas recruitment. I should not ask this, but I am going to. Are there problems with the immigration agenda that we have at the moment in terms of recruiting staff?

Danny Mortimer (Chief Executive, NHS Employers): London has had a lot of success recruiting from within the European Union (EU) and recruiting trained nurses to work in our organisations. There is also increasing recruitment of care assistants and Sue [Tarr] has talked about that role within our services.

The problem we have found is that our demand particularly for trained nurses cannot be met from solely within the EU and, therefore, we have to go outside the EU. The Government sets a shortage occupation list. That has not, up until four months ago, included nurses. That it does include nurses then makes life much more straightforward for us. That step by the Government is really welcome and we are very hopeful that when the Home Secretary publishes the results of the review into making that permanent, which should be in the next few weeks, we will have permanence there and we can recruit nurses and keep them.

Andrew Boff AM (Deputy Chair): It is fair to say that without non-EU immigration and employment within the NHS we would not have the NHS that we have now.

Danny Mortimer (Chief Executive, NHS Employers): Yes, I would agree with that. If you look back over the history of the NHS, we have been enriched by colleagues who have come from all parts of the world. My mum came to this country to train to be a nurse and a midwife. Most of the women I grew up around – and it was mainly women – came from Africa, the Caribbean and Ireland. That has been a large feature. Most of the GPs my mum worked with came from the Asian continent. Yes, it has always been a feature of the NHS.

Andrew Boff AM (Deputy Chair): Stick that in 140 characters: we need to tweet that a lot!

You mentioned overseas recruitment. Are there any other ways of resolving what appears to be a problem with agency recruitment or anything else that has been --

Professor Maureen Baker CBE (Chair, RCGP): I mentioned returning to practice for GPs. Across the board, we are rotten at that in the NHS. It seems to me that we invest so much in our workforce and then for various reasons – and people have very good reasons – they leave and we do not have good mechanisms across the board for bringing people back in. It seems to me that that is something – and it will not be quick – that we could do and could focus on for the NHS, allowing people easily to pick up the skills they need, do some refreshing and get back into the workforce. We could be much better at that, in my view.

Danny Mortimer (Chief Executive, NHS Employers): We have had more success with nursing in that area. There are some particular challenges that Maureen has described in terms of the National Performers List that she is seeking to tackle, but one of the responses that the NHS did invest in two years was exactly that kind of return-to-practice scheme for nurses. Again, it is an overwhelmingly female workforce and people stop practising because they have other caring commitments. Once you cease practising for a period of time, you lose your registration as a nurse. We are starting to see the benefit of that as well in a number of settings.

Professor Maureen Baker CBE (Chair, RCGP): Thanks. I was just going to say that one of the things that we want to be taken through as part of our ten-point plan is we would like to see a return-to-nursing course and focused on practice nursing. When you look at the hours and the conditions and the way in which practices are embedded in communities, these should be very attractive jobs for nurses wanting to come back to the workforce. However, most if not all of the return-to-nursing courses are run by or geared towards the acute sector. I would really like to see something set up specifically to bring nurses into practice nursing and indeed community nursing. Again, that is something that we could do relatively quickly. I do not think we would be robbing nurses from any other part of the sector because there are people for whom acute nursing is just not right in their current stage of life but they could do flexible and part-time work in general practice and we would love to have them.

Danny Mortimer (Chief Executive, NHS Employers): That is a great idea.

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): It is. Just building on that, Maureen [Baker], it has to be recognised that one of the first casualties of the cost improvement programme was education, certainly postgraduate education within the health service. What we are being told is that for district nurses, for example, they are unable to be supported to go in to do that specialist qualification. That is replicated throughout the system. If you are looking to try to design a workforce going forward that is going to meet all of these different challenges and different needs, education has to be the key to it. Particularly with the salaries that nurses, doctors and healthcare workers earn, that is not something that should come from them because it is what the service needs.

Building on what Danny [Mortimer] was talking about as well, some of the largest agency costs are to meet needs in specialist fields such as intensive therapy unit (ITU), special care baby units, theatres. We know that in London - and I have been working in London for the last 18 years - throughout that whole period those have been the hard to recruit areas in the acute sector. You now have the primary healthcare sector suffering from the same situation.

Therefore, education investment in the nursing workforce to enable it to deliver care has to be one of the key priorities if you are going to try to look at dealing with some of these vacancy factors and ensure that the people in London get the care they deserve.

Andrew Boff AM (Deputy Chair): If you do not mind, how would that generate more people returning to the health service?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): If you have been invested in and you feel valued as a person, then you are going to come back rather than move on to do something else. This is about the psychology of belonging and being part of a team. If you feel valued, you are going to give. If you do not feel valued, you will go somewhere where you will be valued.

Andrew Boff AM (Deputy Chair): That comes back to the whole agency staff being seen as a test. In not just the NHS but any service you care to look at, whether it is private or not, it is an indicator that its management is not quite where it needs to be in terms of staff.

Cynthia Davis (Council Member and Chair, London Board, RCN): It is an indicator that our workforce planning is not where we need it to be. I was just going to mention that one of the other solutions that is being worked on across some of the Clinical Commissioning Groups is about how we place students with practice nursing so that we are growing the next generation of practice nurses and district nurses. We have been working [on this] with district nursing for many years, but now I am working much more closely with GPs on how we place students within those sectors.

Onkar Sahota AM (Chair): Does that create a problem for practices? Are practices coming forward to accept them? There is a workload issue there, is there not?

Cynthia Davis (Council Member and Chair, London Board, RCN): There is. There are of course, with medical students, a lot of money from the students and so, in terms of the business sense, there is an issue. There is also the issue of how we support those students in practice. There are a lot of issues around it, but it is something that is worthwhile.

Dr Fionna Moore (MBE, Chief Executive, London Ambulance Service): I believe that time for training is really important as a retention strategy for staff. We have certainly found that with our paramedics. One of the reasons that staff have left London to go to other ambulance services is that they are offered more attractive packages in terms of staff development. We have not had the money to do that and it is really difficult to do it on a daily basis. We have a way in which we stand staff down for statutory and mandatory training, which of course is absolutely right and proper but not necessarily as interesting as some of the development work that we would like to do with them. They are working their 12-hour shift or however long their shift is, they come in and pick up their vehicle at the beginning of the shift and they work right the way through. To stand them down for additional development means that they are not on the road to answer calls. We have that competing pressure.

Andrew Boff AM (Deputy Chair): Are you arguing for there being more set time by statute.

Dr Fionna Moore (MBE, Chief Executive, London Ambulance Service): It is essentially funding so that we can stand staff down for additional training and development - over and above the statutory and mandatory stuff.

Andrew Boff AM (Deputy Chair): It is all about money, is it not? We have political arenas full of people arguing about how much money and --

Dr Fionna Moore (MBE, Chief Executive, London Ambulance Service): It is partly about money. We are always looking to be a more efficient and leaner service. We have done that in terms of the amount of hear-and-treat that we now do. What we are finding is that our job cycle time - the amount of time that is spent by crews on the scene with patients - is going up. This is something that is happening nationally, but we are seeing it more in London. It reflects what you have been saying about the high acuity of patients. Our staff are spending longer with patients both because they are sicker but also because they are pacing themselves because of the pressure that they are under.

Andrew Boff AM (Deputy Chair): Thank you very much. That was very interesting.

Murad Qureshi AM: I am just going to ask questions on workloads and the costs of living. We have touched on various areas and so let us try not to repeat ourselves, if you do not mind.

Can I ask Danny [Mortimer]? We have heard from Fionna [Moore], for example, about how staff training is an issue, but are factors like workloads and stress also important in dealing with recruitment and retention in London? How important are they?

Danny Mortimer (Chief Executive, NHS Employers): They are important. I will take a couple of different examples.

If you think about the ambulance service in particular, I do not doubt that it is both the stress of what it is that we ask colleagues to do and respond to and also often the response they get from the public when they do that. The highest rates of violence in the NHS are reported by ambulance staff. Ambulance crews are more likely to suffer physical violence than any other emergency service other than the police. There are things in terms of public behaviour towards our services, particularly our ambulance colleagues, which have a profound impact upon them. Whilst there have been some responses to that - and there is a thing called the Blue Light Programme that runs particularly for police, fire and ambulance that has been funded through LIBOR (London interbank offered rate) [scandal] fines, which is being run by Mind and is a necessary response - there is much more we can do there. I know that the LAS does a huge amount in terms of trying to care for the wellbeing of its staff. However, quite frankly, the public have a responsibility to behave appropriately towards paramedic colleagues, but also we have other healthcare colleagues whether in general practice, A&E or mental health settings where the public bears some responsibility in terms of the added stress they put our people under.

Murad Qureshi AM: Is that any different in London than in other parts of the country? Is that what you are saying?

Danny Mortimer (Chief Executive, NHS Employers): It appears to be a national problem for us, to be fair. However, the rates of violence that are reported by ambulance crews are significant and are disturbing, frankly, in terms of what we see.

Valerie Shawcross CBE AM: They are all alcohol related?

Dr Fionna Moore (MBE, Chief Executive, London Ambulance Service): A significant amount of it is driven by alcohol and, in terms of the volumes that Danny [Mortimer] describes, we are the busiest service and so we are going to see more violence against our staff. We certainly see a very significant amount of calls driven by alcohol and the demand from alcohol-related calls has gone up dramatically over the last five years, particularly in the age group between 21 and 30. You will be aware of some of the campaigns that we have done in combination with the Greater London Authority (GLA) --

Murad Qureshi AM: Yes, before Christmas.

Andrew Boff AM (Deputy Chair): I still think you should charge them. I know. Sorry, Dr Moore. It is just that it really annoys me. I know all the arguments about how you cannot charge someone for an ambulance service, but if they have got themselves incapacitated through booze we have no redress. We cannot go back to them and say, "At least pay for some of this. At least contribute". It really annoys me.

Valerie Shawcross CBE AM: How would you charge drunks?

Murad Qureshi AM: Canada is trying to do some of that with the businesses that throw some of the alcoholics out of nightclubs and the like.

Dr Fionna Moore (MBE, Chief Executive, London Ambulance Service): I suspect trying to get our crews to charge people at the time might be --

Andrew Boff AM (Deputy Chair): With the contactless payment thing, they would not even notice.

Murad Qureshi AM: I knew where that was going. Yes. We have dealt with the alcohol issue in the Health Committee, I understand. There are particular peaks and troughs and it is also geographical. It is not just London *per se*; it is particular areas of London: the West End, Romford and places like that. That obviously causes a lot of stress and workloads.

Can I just hear where the stresses are for nurses more clearly?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): For nurses it will be around workloads and the cost of living. A massive problem is being able to live in London. If you cannot afford to live in London, then at the end of a 12-hour day when you have been on your feet for 12 hours, you are then commuting and you are adding an hour or an hour-and-a-half to either end of your day. Also, the cost of travel, again, is a huge problem.

Cynthia Davis (Council Member and Chair, London Board, RCN): To add to that as well, there is the effect of having done your shift and then the next person coming on is not there and you feel obliged to do a much longer day than you necessarily would choose to do because there is no one to replace you. That is a constant pressure that our members are telling us about and when you go into those departments that is what staff is saying, "No, we feel we need to do it and not because we want to, but we want to make sure the patients are going to be safe and our colleagues are supported". That is an added pressure.

Murad Qureshi AM: We have gone into the cost-of-living area and rightly so. Just in terms of housing, do you have figures for the extent to which nurses may have been priced out of an occupation and renting?

Danny Mortimer (Chief Executive, NHS Employers): The average cost of a house in London now is 11 times the average earnings --

Murad Qureshi AM: Of a nurse?

Danny Mortimer (Chief Executive, NHS Employers): -- of any NHS worker. The figures are distorted slightly of course because our medical colleagues earn far more than the rest of the workforce. We are talking about probably 12 or more times higher than the average earnings of a nurse. As colleagues have rightly touched on, what that means we are seeing is greater and greater distances that people are having to commute, particularly into central London to work at the concentration of hospitals there are in this part of the London. It is that scale of multiplier.

Murad Qureshi AM: What numbers of nurses are privately renting, for example? Has that proportion increased recently or is it much of a muchness?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): I cannot give you details, I am afraid. We have just done some research on the cost of housing whether it is rent or buy. That research is not complete. I am expecting that in March and so it is immanent. I could give you more details, but unfortunately not at the moment.

Murad Qureshi AM: OK. We will look out for them because that would be real examples of the effect of living costs in London on a profession like nursing.

The other issue - living costs you have mentioned - is transport. I was interested by Dr Moore's idea of a congestion charge exemption. That is certainly something that a Mayor could do. I do not remember at the time when the exemptions were first put in place.

Valerie Shawcross CBE AM: Transport for London (TfL) would say that it cannot because of the legal precedent.

Dr Onkar Sahota AM (Chair): TfL is answerable to the Mayor.

Murad Qureshi AM: That is true.

Valerie Shawcross CBE AM: Yes. However, TfL has looked at a variety of requests overtime and the issue was also the precedent for it that, if we give it to this group, then there are these groups and there are teachers and you end up --

Murad Qureshi AM: Yes, I accept that. Was that case made at the --

Danny Mortimer (Chief Executive, NHS Employers): The only comment I would make there is that our workforce typically earns a lot less than teachers. Our workforce includes, particularly, some of the lowest paid workers in London and even our trained nursing colleagues in an acute hospital will be earning on average around £30,000. It is a lot less than some of the other public sector professions. The Mayor and TfL do things - and we would all support that - in terms of our policing colleagues and the access they have to some benefits around transport. We do wonder - given particularly the kinds of shift patterns that we ask many of our staff to work 24 hours a day, seven days a week, 365 days a year - why similar kind of benefits and supports cannot be extended to our workforce. I understand the difficulties and delicacies there in terms of the entire public sector, whether it is congestion charge, but there are other things that have been done around transport for

some public sector workers and there is an argument that could be made for those to be extended to NHS workers as well.

Murad Qureshi AM: Particularly nurses and paramedics?

Danny Mortimer (Chief Executive, NHS Employers): We have nurses and paramedics and GPs represented here, but the NHS family includes many professions and includes people who are not professionals, who do not have a degree-level qualification and who earn relatively small sums of money, as you have been hearing from Fionna [Moore] when she was describing her call-handlers.

As employers – and I am sure my trade union colleagues would support this – we would not make a distinction between different professional groups and also those groups that do not hold a professional qualification. We would say that the NHS workforce needs to be considered in terms of some of these points.

Murad Qureshi AM: I understand that. What I was trying to get at was that there is a difference between GPs' movements and the movements of emergency staff from the paramedics and the nursing. Is there a difference there between them? GPs are calling for many things, but they are not calling for an exemption from congestion charging, are they?

Professor Maureen Baker (CBE, Chair, Royal College of General Practitioners): If you are asking me to get my colleagues an exemption: bear in mind that GPs work in more community-based settings. It is not something I am hearing from my members, but now that we have said this I probably will. The Chair would understand better than I.

Murad Qureshi AM: No, he will do. What we are saying is that there is a case to be made for some very specific employees of the NHS.

Danny Mortimer (Chief Executive, NHS Employers): To express it the other way around, for those of us who have the best employment packages, whether it is senior managers like me or senior medical colleagues, it is perhaps harder to make that case because we do, clearly, earn much more than our colleagues. However, for the vast majority of our workforce, that case can be made and we will be making it during the mayoral campaign.

Murad Qureshi AM: Thank you very much. Hopefully the mayoral candidates will look out for that one.

The other issue we have heard as being of concern for the costs of living is childcare. To what extent is that restricting labour retention and recruitment in the NHS in London? Fionna [Moore] has that been an issue?

Dr Fionna Moore (MBE, Chief Executive, London Ambulance Service): Many of our staff live outside London. It is an issue because of the length of the shifts that they work. If you are working a 6am-to-6pm or 7am-to-7pm shift, that is not the sort of time you can drop your child off with a childminder. Many of our staff are married to colleagues in the ambulance service and so they 'Box and Cox'. What that means is that they might see their children but they do not often see their partner.

Murad Qureshi AM: It is a choice. I am presuming that is the same with the nursing?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): Nursing is predominately a female-based profession and childcare and childcare costs are always going to be a really important dynamic in the decision as to whether you can work and can afford to work or whether from a

practical perspective you can fit it around what is sometimes quite strict parameters around what an employer will and will not do. There is certainly some work to be done around recognising that perhaps it is better to have someone for four hours in a day than to have no one at all. It can be quite difficult for managers sometimes to get their head around that this might be a little bit more difficult for them. Certainly it is a problem. You also must not forget the fact that that childcare is one issue but a lot of us have eldercare.

Murad Qureshi AM: Yes, that is true.

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): That is a demand on your time as well. It is not just predominately about childcare. It is about care for the wider family.

Murad Qureshi AM: You are right and that is picked up in other areas of the economy. Professor, is childcare an issue for costs of living for GPs?

Professor Maureen Baker (CBE, Chair, Royal College of General Practitioners): It is. In medicine we have the highest proportion of female colleagues who are in work. What I am hearing, particularly for colleagues who are in salary posts, is that when they pay their professional fees, when they pay their indemnity - which is a huge issue for GPs in particular -and they pay for childcare, it starts to look like, "Is it worth me working or would I rather spend five or ten years at home with the children?" It is an issue as it is for all parts of the NHS, I expect.

Murad Qureshi AM: Can I finally return to all parts of the NHS? Danny, are there things that hospitals can do about pressures and what-have-you? Employers can make a difference here.

Danny Mortimer (Chief Executive, NHS Employers): Absolutely. We did see in the late 1990s and early 2000s a massive investment in nursery facilities in hospitals. The choice that many of our staff have to make is about the kind of shift work that Fionna [Moore] has described and my nursing colleagues have touched on. They do not want to leave their children in childcare facilities at work because of the kinds of shift patterns they work. We do have fairly good infrastructure now in terms of workplace nurseries in our acute settings. The dynamic is naturally different for people who have much more sites and much more working in the community.

Murad Qureshi AM: Thank you.

Valerie Shawcross CBE AM: The first question is to ask you whether there are future plans in place to make sure the health workforce that we need is there in five to ten years' time. Who is responsible for doing that? Kit [Malthouse] did bring some of that up and so I do not know if there anything else that we need to add about that.

Danny Mortimer (Chief Executive, NHS Employers): There are a couple of things to add very briefly. There was the London Health Commission in the last couple of years and out of that has grown the Healthier London Partnership in terms of our work. We have done some work with GLA colleagues. There is a publication that does set a workforce programme that has just been published yesterday, which is absolutely about tackling the longer-term supply issues and also training issues and as we ask our workforce to work differently in London what we need to do. Particularly in the health service but also working with local authority colleagues to plan our services and plan our training appropriately, there is quite a lot going on in that particular area.

Valerie Shawcross CBE AM: Do you feel it is robust inasmuch as you give other colleagues a chance to critique that? We have talked already about how there are trigger points in the community and things happening in the bigger picture.

Danny Mortimer (Chief Executive, NHS Employers): I am not specifically responsible for that piece of work.

Valerie Shawcross CBE AM: Who is?

Danny Mortimer (Chief Executive, NHS Employers): It is NHS England and Health Education England. I represent employers such as Fionna [Moore] and NHS England in particular commissioned services.

One thing I would say, though, from my experience working in this sector is that the relationship with local authorities has improved in the last five or six years, particularly through the role that the Health and Wellbeing Boards take now in locality. There is much greater scrutiny of what goes on in the health service and also much greater joint working between local authorities, NHS commissioners and providers.

Valerie Shawcross CBE AM: Do you think it is a robust planning system, then?

Danny Mortimer (Chief Executive, NHS Employers): In terms of the workforce, it is getting better.

Valerie Shawcross CBE AM: Wherein lies its weakness?

Danny Mortimer (Chief Executive, NHS Employers): There is an empty seat almost in the conversation that we are having, which is that in the health service we increasingly depend on our colleagues in social care provision. They have the same problems in terms of recruiting nursing colleagues and support work colleagues that we do. They need many of the same responses and in these last few years we have come to a better understanding of the fact that we need to see the problems in the round. It is not just about the statutory provision in the NHS; it is also about the provision that is both paid for by local authorities and also paid for by the public themselves in terms of care homes, domiciliary organisations, charities and nursing homes. That whole sector is absolutely vital to us now. If anything, their problems are more acute than ours are, partly because their economic settlement is so much poorer than ours has been and we are not that happy with our economic settlement. There is a lot to go out there.

Valerie Shawcross CBE AM: How should the workforce be changing in response to that? With the change in demands that are going on with them - multi-illnesses of the older generation, the social behavioural factors - what does the workforce need to look like in terms of dealing with this? Do you need more generalists?

Danny Mortimer (Chief Executive, NHS Employers): Maureen [Baker] has already set out the case for that, but there are also some opportunities to use the practice of our nursing colleagues, for example, in terms of better caring for the population that we have. Again, there is some really innovative work happening in London in terms of how those roles can be developed and work differently, particularly in community settings, to care for the population that Maureen was describing..

Cynthia Davis (Council Member and Chair, London Board, RCN): There are some projects around coming up with the Five Year Forward View, as well as looking at how we match the gaps that there are in terms of nursing skills and the needs out there. We are moving care much more into the community but how do we equip the nurses within the community to cope with that? Therefore, it is looking like more

practitioners working with GPs within district nursing and also looking at specific skills that are needed within acute care as well and developing more practitioners within those areas.

The Government just before Christmas announced the nursing associate role. It is something that we welcome and to see how that is going to be developed to support nursing generally, not just within acute care, but across the piece.

Valerie Shawcross CBE AM: I had not heard about that. Is that like an assistant role? What is it?

Cynthia Davis (Council Member and Chair, London Board, RCN): I suppose in terms of banding it would be somebody who has done a foundation degree and therefore ends up with a band 4 able to support the hands-on delivery of care and some basic decisions but still answerable to a registered nurse. Whether it is in community or in acute care, that is one of the roles that is supportive of bridging the gaps.

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): I would just say that there is something that we also need to do about changing the story, in that the public understands acute care very well but does not necessarily understand primary healthcare very well. It is a really complex environment. As a patient or a member of the public when you are trying to make a decision about what part of the service you need to go to, it is very complex, it is very confusing and I do not think it helps people make the right decisions. Changing the story so that people understand the primary healthcare services better would be good. For us as a nursing profession, it is also about changing that story as well. People tend to focus very much on acute care because that is how it is set up and delivered. Perhaps our nursing colleagues in primary healthcare have not done such a good job about explaining what the role of a district nurse is because going into somebody's home is an absolute privilege, to go in and give them care and to care for somebody, be it end-of-life care or something like that, and to help them and their family to deal with what is a really challenging personal circumstance, and to get some of those stories changing.

Also, there are simple things such as our practice nurse colleagues. According to the Queen's Nursing Institute report that has come out, only about 30% of practice nurses are nurse prescribers. It is about looking at what the service needs to go forward and what we need to do to equip the people to do that. We have started that journey but we do not have a mapped journey out.

Valerie Shawcross CBE AM: Who is responsible for bottoming that journey out and making sure that these necessary modernisations happen?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): It is a shared responsibility. Danny has articulated that very well.

Valerie Shawcross CBE AM: Who leads it?

Danny Mortimer (Chief Executive, NHS Employers): There are a couple of different things to say. Within general practice, Maureen [Baker] and her organisation have played a really important leadership role in terms of encouraging their members to make those kinds of developments. Of course general practices often operate as autonomous organisations, but the ten-point plan and other things that Maureen [Baker] and colleagues are doing is really important. There is also something for the nursing profession itself to embrace some of these opportunities and to present them very positively to their members. We see a huge amount of that happening both through the College and also through the work of the Chief Nursing Officer.

Whilst there is more that can be done in terms of nurse prescribing - which is the example that Sue [Tarr] has been giving - if you look at the growth there has been in nurse prescribing in the last ten years it has been dramatic both in community settings and also in mental health and hospital settings. There is more to do there but it is also a sign of real progress. There is particular work going on in the non-nursing professions - for paramedics and some of the other allied health professionals - where actually there is some very rapid extension of prescribing rights in particular.

Part of what we have to take on board though as employers - the final point - is that many of the most innovative ideas actually exist within our workforce. They exist within our nursing colleagues, our paramedic colleagues or other professional colleagues. Part of our job - and we do have to do it better and I accept that challenge on behalf of my constituents - is to listen to those ideas and move rapidly to implement them. At a national level Health Education England has a particular role to play in terms of making sure education keeps pace with those innovative practices, but we are the ones locally who have to make sure we capture those ideas and get them into practice really quickly.

Valerie Shawcross CBE AM: What about changing and modernising recruitment? You talked about telling a better story. There must be some positive management action that could be taken to improve recruitment?

Sue Tarr (Operational Manager, North Central and North East Sectors, RCN): We will be working very closely with people like Caroline Alexander, the Chief Nurse for London, to actually work with colleagues across the London health environment. The example that Cynthia [Davis] was giving to you about the guaranteed employment scheme that has come out of the Capital Nurse Programme is a fantastic example and opportunity for us.

What needs to then be the follow-up is to have that guaranteed employment across every area of the NHS. You are not just looking at acute care. You can have guaranteed employment into a primary healthcare setting working with a practice nurse. The guaranteed interview scheme and the student training process exposes the students to every element of the healthcare environment. You are not just then focused on acute care; you are exposed to working with district nurses, working with practice nurses and understanding how valuable that is to delivering patient care. That is what I mean by changing the story. It is that guaranteed interview scheme, getting the students in, getting them mentored and supported across the whole of the system rather than what traditionally happened, which was predominately into acute care.

Dr Fionna Moore MBE (Chief Executive, LAS): If I can just give the paramedic point of view, in the short term we will not have enough paramedics being generated within this country. We are increasing the pipeline through our universities. We are going up from 150 to 500. We will be going back to Australia to recruit more Australian paramedics. They have a surplus there. They will not stay forever but they are filling the gap for us and they are of a very high quality.

Going forward, we need to hit people when they are at the ages of 14 to 16 and at school to remind them that becoming a paramedic is something they could think of doing and to channel their A-levels towards university courses in paramedic science. Also, in terms of our London workforce, looking at our trainee emergency ambulance crew, they are people who come into us and we train them up and they work on ambulances. We have now established the LAS Academy so that we can ensure they go through to come paramedics within the LAS through links with higher education. It is becoming a degree qualification by 2021.

There is a lot of work going on also attracting people who have done degrees in other subjects to give them a link to come into the service. Currently to become a paramedic you have to have a degree in paramedic

science. If you do a degree in geography you have to go back to square one to become a paramedic. That is crazy. It is about making it easier for the paramedic workforce.

Going forward, we need to improve career opportunities. We have a very parabolic structure. We have two consultant paramedics in London. We have 24 advanced paramedic practitioners who do some amazing work. Going forward, we have to grow those higher grades - the band 7 and band 8 members of our workforce - to act as role models for people coming through.

Valerie Shawcross CBE AM: There is somewhere to go. I was interested in what you were saying about access to being a paramedic from other areas. One of the things that gives me grief sometimes is when I walk around my constituency and I see bright, intelligent young women working in nail bars. I see bright, intelligent young men --

Murad Qureshi AM: Estate agents!

Valerie Shawcross CBE AM: Yes. You just think that for people who have maybe not made it through their A-levels at school or have not done as well as they wanted to, as they mature, what is the opportunity to have another go? Are there access courses as people mature to get them into roles?

Dr Fionna Moore MBE (Chief Executive, LAS): That is what we would offer to our trainee emergency ambulance crews. They come in. They have a course that is 14 weeks long. They do a blue-light driving course. They are out working on ambulances. We now have the LAS Academy, which will do ramp courses that will enable them to get the skills to go on to undertake a paramedic qualification going forward.

Danny Mortimer (Chief Executive, NHS Employers): I imagine that lay behind one of Mr Malthouse's [AM MP] questions as well before he left earlier. The move to the degree-based nursing profession is the right one. What we have had to do, though, is also to balance that with the fact that what we have typically seen in nursing is access at various stages in people's lives. It often is a second or third career. Often it is a career people choose not necessarily with A-level grades that we would expect in terms of degree entry. Therefore, those access courses and those alternative routes - as with the ambulance service - have been really important to us. We have done a huge amount of work to maintain those.

Valerie Shawcross CBE AM: It is interesting if you compare the recruitment situation, for example in the fire brigade, which is skilful and responsible, and the ambulance service. If they advertise a job in the fire brigade and they are recruiting 100 firefighters, they will have 10,000 applications. A lot of that is because people have decided that they need to get a proper career and proper training but they have not come to that conclusion until they are in their early 20s.

Danny Mortimer (Chief Executive, NHS Employers): We have exactly the same experience.

Valerie Shawcross CBE AM: There is relatively open access in terms of, "If you have the aptitude we will train you and you are in", whereas for so many other careers there is now an educational pathway that does not have enough routes back in.

Danny Mortimer (Chief Executive, NHS Employers): We have been very mindful of that. Whether it is through the apprenticeship route - which includes clinical apprenticeships - or whether it is through other educational routes and non-degree routes, we have tried to maintain that access. It is such a part of how we have recruited our workforce. It is exactly what you described with people making choices slightly later in life

in terms of what they want to do. However, we need people to have that level of educational qualification in terms of degree because of what we ask them to do now for our patients.

Valerie Shawcross CBE AM: Maybe the messaging is about how there are ways back in. It is not as difficult and obscure as it looks from the outside.

Danny Mortimer (Chief Executive, NHS Employers): There is also something there for us about that careers conversation in schools. I went to speak at a school recently about careers in the NHS. The revelatory thing I was able to do for those sixth formers was explain that we did not just recruit doctors, nurses and pharmacists. We recruit other professions as well and there is a massive range of opportunity that we can provide people.

Valerie Shawcross CBE AM: For a young person maybe dropping out of their A-levels or leaving school who has not really thought about it, where would they go to get careers advice about working in the NHS?

Danny Mortimer (Chief Executive, NHS Employers): We run a national service called NHS Careers. We do a huge amount through that. It is online. It is very accessible and has good approval ratings from young people in particular.

The challenge to us is making sure that we have routes such as apprenticeships in particular available to people. What we often find is that if we can get young people in that kind of situation into our workforce, we open them up to the opportunities there may be to progress with us. That has been a really important step for us. There is more we can do but it has been a really positive thing in the last few years.

Valerie Shawcross CBE AM: A quick question to Fionna [Moore]: you talked about ramping up the recruitment, training and all of that. Financially, if you were looking to make a business case with limited money and prevention being better than cure, is there a case for saying, "Let us stop spending quite so much trying to increase supply and do much more to improve retention"?

Dr Fionna Moore MBE (Chief Executive, LAS): Absolutely, that is something we are focusing on. We will have recruited 1,000 new staff from October 2014 by March this year. There is no point in investing all that effort to see them go off and work for South East Coast [Ambulance Service]. It is absolutely focusing on retention. If I ruled the world, which clearly I do not --

Danny Mortimer (Chief Executive, NHS Employers): Yet.

Dr Fionna Moore MBE (Chief Executive, LAS): -- yet, there would be a real benefit in an ambulance service having control over its paramedics but being able to supply them to primary care and to emergency departments on secondment and so that would be a way of developing them. It would be a way of allowing them to develop their skills and knowledge and also to come off the road to work in a different environment for a period of time to see how other people work and then come back into the ambulance service.

Valerie Shawcross CBE AM: You are not allowed to do that at the moment?

Dr Fionna Moore MBE (Chief Executive, LAS): We currently have funding for those people who work on ambulances and work within the ambulance service, not to second them out elsewhere.

Valerie Shawcross CBE AM: There is a business case to be made there?

Dr Fionna Moore MBE (Chief Executive, LAS): Yes. There is a risk of course because – as South East Coast has found – if you send your staff on secondment to work in primary care, they often find that is a really attractive place to work.

Danny Mortimer (Chief Executive, NHS Employers): We have to accept the challenge as well that we have to get better at collaborating with each other rather than competing with each other. As Maureen [Baker] said, it makes sense if we are trying to get women to return to practice to give them opportunities in primary care. That is not stealing nurses away from the hospital; it is in the hospital's interests. It is exactly the same in as being able to rotate paramedics through different settings. We have more to do on that collaborative piece and we would accept that.

Valerie Shawcross CBE AM: Last question: given we need to recruit, train and retain better for our future NHS workforce, what is it that you would be asking the future Mayor to do specifically within his or her ambit to assist?

Danny Mortimer (Chief Executive, NHS Employers): There are two specific asks we would have, which we have all touched on in various ways this morning.

One is to do something about transport costs for NHS workers. We are mindful of the precedence that might set but there is something that needs to be done there given the distance our people have to travel and also the times of day we ask them to travel to care for Londoners.

The second piece is that there has to be a profound intervention in the housing market. It is intolerable for our workforce to have to move further and further out of London in order to be able to afford to work in London. Given the hours and patterns of work we ask them to undertake, it is not just sustainable for us. The others may have things to add as well.

Professor Maureen Baker CBE (Chair, RCGP): I would like to flag what was mentioned very early on: the issue of premises to work from to build primary care teams for the benefit of the wider NHS. That is a particular problem in London. It is very difficult to expand existing premises because they are often landlocked and property prices are so high.

Valerie Shawcross CBE AM: Do you think the NHS makes full use of the potential around the section 106 planning agreements with local authorities?

Professor Maureen Baker CBE (Chair, RCGP): That is absolutely not my area.

Valerie Shawcross CBE AM: It is quite common for a local authority to give a major planning consent for a private development providing there is a community benefit and there is payoff for the community. Very frequently local authorities will give planning consent for a major development, “as long as you rebuild our library”, or, “as long as you add an extension on the local school”.

Danny Mortimer (Chief Executive, NHS Employers): We would probably need to ‘phone a friend’ on that.

Valerie Shawcross CBE AM: Although I have seen a little bit of that with the NHS occasionally --

Danny Mortimer (Chief Executive, NHS Employers): Not that often.

Valerie Shawcross CBE AM: -- I am not conscious that the NHS goes to local authorities and says, "On your section 106 planning gain list, can we have something for a new GP surgery in this area?"

Professor Maureen Baker CBE (Chair, RCGP): That would be extremely helpful, yes.

Valerie Shawcross CBE AM: You just think, "Why is that?"

Andrew Boff AM (Deputy Chair): Can I suggest, Val, that you read the report that the GLA Conservatives released two months ago?

Valerie Shawcross CBE AM: I would not dream of it!

Andrew Boff AM (Deputy Chair): -- raised by Steve O'Connell [AM] on exactly the same issue about the fact that opportunities were missing as a result of not incorporating health requirements into planning.

Valerie Shawcross CBE AM: It is an obvious existing legal mechanism that other parts of the public sector engage with.

Dr Onkar Sahota AM (Chair): One of the issues, of course, Valerie, is that the NHS does not link up with local authorities because of the recurrent costs and also the timeframe within which the NHS having to plan. The population growth always precedes premise issues. The NHS has always been based on, "We have a site there that is sustainable". There is a huge amount of area there.

Valerie Shawcross CBE AM: I would have thought that section 106 would be very susceptible to this because you want to build a specialised design premises and so you would want to do it during a major development.

Danny Mortimer (Chief Executive, NHS Employers): That is a really helpful point. I am sure Maureen [Baker] through her organisation and I through my colleagues - the National Association of Primary Care - will follow that up.

Valerie Shawcross CBE AM: The Mayor also has section 106-type powers as part of his planning consent. He is looking at the really major applications like 500-plus properties, the big super towers and things. He also has it within his power to say, "We want a new GP surgery development on the first floor and you are going to pay for it".

Dr Fionna Moore MBE (Chief Executive, LAS): That could also be very helpful for us because we have a service that is spread over 70 sites, some of which are very small. What we need is to coalesce those sites into much larger ambulance stations.

Dr Onkar Sahota AM (Chair): Also, put GP premises on the same site.

Dr Fionna Moore MBE (Chief Executive, LAS): Yes.

Valerie Shawcross CBE AM: We can add that to your list: assistance with property.

Dr Onkar Sahota AM (Chair): One thing, Professor Baker: you talked about physicians assistants. There is a group looking at these from the United States (US) to expand the capacity of the workforce.

Professor Maureen Baker CBE (Chair, RCGP): In the ten-point plan we are looking to build the primary care team. Physician assistant – ‘physician associate’ is the current term – is a role that we have seen before. You mentioned that it is an established role in the US. It is much more established in the acute setting and where there are bigger teams of people. There may well be opportunities where having a physician associate in the workforce can be beneficial. We are concerned that 10 or 12 years ago when this was tried – we had workforce shortages then – it never really took off. The physician associates who were recruited did not stay. We in the RCGP are keeping an open mind. If practices think these will be good additional roles, then by all means. It is not necessarily something we are pushing. We would like to see more evaluation.

On the other hand, there is a completely new role that we are very keen to explore. The current term for this is ‘medical assistant’, which might not be great because that is confusing with ‘physician assistant’. You might also call them ‘clinical support workers’. Again, this is something they do have in the US. I would call it a cross between a personal assistant and a healthcare assistant, someone who does a lot of administration and some very basic clinical work like blood pressure, temperature and helping patients to undress. Really, their role is to help the doctor make the most use of their time. They are doing all the administration for the doctor. They are looking through the reports. They are looking through the emails. They are doing the phone calls. They are following the doctor around doing the administration.

These roles are starting to be piloted and quite possibly will be coming through the apprenticeship scheme. These are geared at bands 3 and 4 and high school leavers – not degrees – with a relatively short training time. We think that there is the potential to inject a lot of very direct doctor support into the primary care workforce within a short period of time.

We are really quite interested in these roles. In a way, I see them as more doctor-facing than patient-facing. If that frees up more doctor time to see to longer consultations, to have more consultations and to be doing more of the stuff that only the doctor can do, then that seems to potentially be a very valuable addition to the workforce that we could achieve in a short period of time.

Dr Onkar Sahota AM (Chair): They are called ‘medical assistants’?

Professor Maureen Baker CBE (Chair, RCGP): In the US they are called ‘medical assistants’. That is the term we have used. I am not sure it is the best name. We might call them ‘clinical support workers’, for instance. That is the role and concept.

Valerie Shawcross CBE AM: It would be a useful entry-level job as well for newcomers.

Professor Maureen Baker CBE (Chair, RCGP): Indeed. As someone who wants experience of healthcare, you would get very good experience. You would get really good administration skills, organisational skills and good relationship and teamwork skills. You could then go on and develop your career.

The other group of people this would be a great job for are women who want to go back to the workforce after having a family. Again, you could work in your local surgery with very flexible hours and it would be very family friendly. There are lots of opportunities for people within these roles.

Dr Onkar Sahota AM (Chair): Thank you.