Hospice UK's submission of evidence to Health and Social Care Committee's inquiry into the Workforce: recruitment, training and retention in health and social care

January 2022

Hospice UK is the national charity working for those experiencing dying, death and bereavement. We believe that everyone, no matter who they are, where they are or why they are ill, should receive the best possible care at the end of their life.

Hospice UK is informed and guided by its membership of over 200 hospices across the UK. For this reason, we have unique insight into the experiences of, and workforce challenges facing, independent and charitable health and social care providers. This submission includes unpublished data from Hospice UK’s survey of clinical staff working in UK hospices in March-May 2021.

In its submission, Hospice UK outlines current staffing shortages in the palliative and end of life care workforce as well as long-term trends that will lead to further staffing pressures in the coming years. The response also sheds light on specific challenges facing independent and charity sector health and care providers and calls for:

- workforce planning that takes account of the whole system and is not overly focused on NHS providers and acute settings.
- the entire health and social care workforce to receive essential training in supporting people in their last years.
- flexible and attractive palliative care career pathways that allow workers to move across the system.

The palliative and end of life care workforce:

Staffing shortages, pandemic pressure and staff absence due to COVID-19 infection are placing the entire health and care workforce under significant strain. However, the palliative and end of life care workforce faces unique workforce recruitment, training and retention challenges due to the:

- broad spectrum of providers of palliative and end of life care, including hospices, NHS and social care services and the private sector.
- significant proportion of end of life care provided by the generalist workforce.
- increasing and ageing UK population, with more people dying year-on-year and living with life limiting conditions for longer, with more complex symptoms and multiple co-morbidities.
- significant increase in deaths in private homes, accelerated by the pandemic and recently covered by Channel 4 News.

Palliative and end of life care is delivered by a patchwork of different providers, including NHS and non-NHS, independent and charity and private sector. Policymakers often associate end of life care with hospices and the NHS but there were an estimated 1.54 million people working in adult social care in 2020/2021, many of whom will be supporting people with life limiting illnesses.¹ Carers UK also estimates

¹ Skills for Care, The state of the adult social care sector and workforce in England, 2021
that there were 13.6 million unpaid carers at the height of the pandemic, many of whom will have been caring for a dying family member and taking on extra responsibilities as a result of workforce shortages.\(^2\)

Hospice UK’s 2021 survey of clinical staff working in UK hospices found a:

- 11% vacancy rate in community-based and 7% vacancy rate in hospice-based nursing roles in adult hospices (with 16% vacancy rates for hospice-based nursing associate and community-based healthcare assistant roles).
- 11% vacancy rate in community-based and 9% vacancy rate in hospice-based nursing roles in children’s hospices.
- 7% vacancy rate for allied health professionals and other roles in adult hospices.
- 4% vacancy rate for allied health professionals and other roles in children’s hospices.\(^3\)

It is important to note that these vacancies are representative of what is affordable within current funding rather than the level of staffing actually required to meet population need, The survey also found wide variation by area, with vacancy rates higher in some areas than others.

Since this data was collected, between March and May 2021, the sense on the ground is that these figures have increased and workforce shortages in UK hospices and across other providers that deliver palliative and end of life care have worsened.

Shortages across the palliative and end of life care workforce are particularly concerning given the UK’s rising and ageing population and the resulting increase in the number of deaths that will require end of life care. The ONS has projected that the UK population will increase by 3 million between 2018 and 2028 to 69.4 million.\(^4\) More people are also dying year on year, with mortality expected to rise to nearly 800,000 by 2040.\(^5\) The number of people aged 85 and older is also expected increase from 1.6 million in 2016 (2% of the population) to 3.2 million in 2041 (4% of the population).\(^6\) As a result, many more deaths will require complex palliative and end of life care and a highly skilled workforce.

In addition to future longer term trends, the palliative and end of life care workforce is currently responding to the impacts of the pandemic. Research by Age UK found that the pandemic has made it harder for older people to look after their physical health due to reduced opportunities for physical activity and delays in accessing healthcare and treatment.\(^7\) For some, COVID-19 has also exacerbated existing symptoms and problems related to long-term conditions. An increase in the frailty of people with life limiting conditions and their difficulty managing their condition, is increasing the workload of those managing their palliative and end of life care.

Disruption to cancer screenings and routine appointments, as well as a reluctance from the public to attend appointments with their GP, due to the pandemic has resulted in missed diagnoses and late referrals. Macmillan Cancer Support estimates that there are 50,000 missed cancer diagnoses.\(^8\) As a result, end of life care services are finding that the number of patients being referred at a later stage in their condition, requiring more complex care, has increased. As a result, the benefits services can offer for patients are limited because staff are immediately thrust into managing periods of crisis, where

\(^2\) Carers UK, *Unpaid carers pushed to breaking point and may be forced to quit work, warns Carers UK as new figures reveal devastating impact of COVID-19*, October 2021
\(^3\) Hospice UK, *Unpublished 2021 survey of clinical staff working in UK hospices*, 2021
\(^6\) Office of National Statistics, *Living longer: how our population is changing and why it matters*, 2018
\(^7\) Age UK, *Impact of Covid-19 on older people’s mental and physical health: one year on*, 2021
patients have more intense palliative care needs. This is placing further demands on the time and expertise of the specialist workforce.

Prior to the pandemic, there was a shift towards providing end of life care in the community and facilitating more deaths at home. However, pressure to free up hospital beds for COVID-19 patients, in addition to fears of contracting COVID-19, taking up NHS resource and not being able to see loved ones within in-patient settings are among factors that led to a rapid increase in people dying in private homes and care homes during the pandemic.

In February 2022, it is expected that the UK will reach 100,000 excess deaths at home, since the start of the pandemic. Whilst surveys indicate that around 80% of people would prefer to die at home or at their place of residence, Hospice UK is concerned that there is insufficient community care to support this many deaths and that little is currently known about the experiences of these people and their families or the quality of the care they may have received. Hospice UK estimates that almost 67,000 people have died at home during the pandemic without the right end of life care in place.

In response, providers have sought to increase the palliative and end of life care they deliver in the community, placing new demands on district nurses and hospice at home services. For example, Farleigh Hospice in Essex closed its in-patient unit in response to the pandemic and redeployed all of its clinical staff to community facing roles. The increase in deaths at home is also driving a demand for more workers and staff with the ability to manage end of life and palliative care needs in this setting. Between 2019/20 and 2020/21 jobs in domiciliary care in the social care sector increased by 40,000 (7%), illustrating the rise in need for care at home. Hospice UK’s 2021 workforce survey found that an increasing proportion of the hospice workforce is based within the community but growth is still needed.

**Response to inquiry questions:**

1) *What are the main steps that must be taken to recruit the extra staff that are needed across the health and social care sectors in the short, medium and long-term?*
   
   o *What is the best way to ensure that current plans for recruitment, training and retention are able to adapt as models for providing future care change?*

To meet future recruitment and retention needs, it is vital that the workforce feels valued and this is reflected in pay and terms and conditions. Over the course of the pandemic, the health and social care workforce has been working out-of-hours and going the extra mile in order to keep services going. Staff have also needed to upskill to respond to the increased complexity in patient’s conditions, their symptoms and the palliative care they require but often their pay, any support for training and progression and the societal value ascribed to their job remain unchanged.

In order to recruit the staff required to fill current gaps in the palliative and end of life care workforce and meet future need, careers in the sector need to be made more attractive. In addition to fair pay and terms and conditions across the system, including in social care and the charity sector, flexible and desirable palliative care career pathways are needed. Those now entering the health and care workforce are looking for a wide range of experiences across different settings, rather than a place of work for life. However, Hospice UK’s 2021 workforce survey found that a lack of opportunities for career progression within hospices result in an average length of service of just 7 years.

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9 Skills for Care, *The state of the adult social care sector and workforce in England*, 2021
10 Hospice UK, *Unpublished 2021 survey of clinical staff working in UK hospices*, 2021
To recruit more staff to palliative and end of life care, there needs to be a more dynamic approach to workforce planning that offers a clear and flexible career framework, with roles drawn from the full spectrum of palliative and end of life care providers across the entire health and social care system. To attract ambitious talent to palliative and end of life care it is also vital that current work being undertaken to develop a palliative care specialism is accelerated.

In order to deliver personalised care and respond to the increasing number and complexity of deaths, the entire health and care workforce needs to be skilled in providing basic palliative and end of life care. This will free up specialist resource to support and train generalists, as well as provide care to patients with increasingly complex conditions and symptoms. Programmes such as the Gold Standards Framework are designed to upskill the generalist workforce in end of life care. Further investment in community end of life care should also be provided in response to the rapid increase in deaths at home and workplace planning needs to facilitate integrated care provided in the community and coordinated by multiple agencies.

A sustainable funding solution for the charitable hospice sector is crucial to ensuring hospice recruitment and retention can keep pace with care models as they adapt. In order to retain and recruit staff, voluntary and independent sector providers need to be able to offer competitive pay. Hospices and other charitable providers struggle to match NHS Agenda for Change pay, terms and conditions. This is because, on average, excluding emergency Government support in response to COVID-19, hospices receive a third of their funding from Government sources and have to raise £3.1 million of charitable income every single day. A sustainable funding solution for the hospice sector would enable the sector to offer competitive pay, terms and conditions as well as plan services and staffing with more certainty and offer staffing support to NHS and non-NHS providers where necessary.

2) **What is the correct balance between domestic and international recruitment of health and social care workers in the short, medium and long term?**
   - What can the Government do to make it easier for staff to be recruited from countries from which it is ethically acceptable to recruit, with trusted training programmes?

No comment

3) **What changes could be made to the initial and ongoing training of staff in the health and social care sectors in order to help increase the number of staff working in these sectors? In particular:**
   - To what extent is there an adequate system for determining how many doctors, nurses and allied health professionals should be trained to meet long-term need?
   - Do the curriculums for training doctors, nurses, and allied health professionals need updating to ensure that staff have the right mix of skills?
   - Could the training period for doctors be reduced?
   - Should the cap on the number of medical places offered to international and domestic students be removed?

With regard to the system used to determine the number of nurses, doctors and allied health professionals that should be trained to meet long-term need, it is important to be aware that national workforce planning does not currently utilise data from across the whole health and care system to make informed decisions. For example, no consideration is given to workforce needs in the charitable hospice sector. NHS trusts report on their number of vacancies against the agreed staffing establishment but hospices are unable to report on the number of staff they need in the same way or access the Electronic Staff Record. Insufficient data on non-NHS providers, such as hospices, prevents effective workforce planning across the health system.

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11 *The Gold Standards Framework*
and care system. The patchwork of providers delivering palliative and end of life care mean that data on this specific workforce is especially scarce.

With 160,000 more people each year expected to require palliative care by 2040, sufficient staff and volunteer resourcing within the specialist palliative care field is essential. However, this increase in demand cannot be met by specialists alone. All health and care workers across the system need to be properly trained to ensure they are confident in, and capable of, delivering end of life and palliative care. Families caring for loved ones also need support and should have access to training and advice.

The curricula of generalist training programmes often do not prioritise palliative and end of life care. For example, the Care Certificate Standards developed for the social care workforce do not include outcomes focused on end of life care. Where palliative and end of life care does feature in training programmes, it is often not delivered consistently on the ground. The Nursing and Midwifery Standards of proficiency for registered nurses includes outcomes related to palliative and end of life care but Higher Education Institutions often do not translate these standards in a consistent way, resulting in a lot of variation in the training people receive. National Government, the NHS and system partners need to prioritise training for palliative and end of life care and ensure that institutions allocate sufficient time, resource and expertise to deliver this training. Education programmes in end of life and palliative care must also take cultural and linguistically diverse needs of health and care professionals into account.

Education programmes must equip staff with the ability to provide care and support to all irrespective of age, gender, ethnicity and condition, including patients with cognitive disabilities and autism. Currently, the generalist workforce is not equipped to identify when someone might be approaching end of life, particularly if they are from a group often excluded from care. They often also lack the confidence and skillset to speak about death with their patients and adapt their terminology to better communicate with people from different backgrounds to them.

A specific change to training curricula that will exacerbate existing staff shortages within palliative and end of life care is the Shape of Training dual accreditation, with rotations in both general medicine and palliative care. From 2022, the implementation of the Shape of Training dual accreditation will be mandatory, meaning that less people will be working in palliative care at any one time, two trainees will be required per post and trainees will take longer to qualify. There is real worry across the hospice sector that the new Shape of Training dual accreditation will result in changes to the character of palliative medicine and trainees spending less time in hospices. The Royal College of General Practitioners route into the specialist workforce is also now closed, which will likely lead to less palliative medicine consultants.

Training and development opportunities for prospective health and care sector workers often disadvantage non-acute or non-NHS providers. Training for doctors and nurses is orientated around acute care and, as a result, trainees are not taught the skills required in non-acute settings. Higher Education Institutions also tend to favour large acute trusts for student placements because they have the infrastructure to support larger numbers of students. However, this means that hospices, and other non-acute services, miss out on attracting talent and students miss out on the experience these services provide.

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12 BMC Medicine, *At least 42 percent more people will need palliative care in England and Wales by 2040*, 2017
13 Health Education England, Skills for Care and Skills for Health, *The Care Certificate Framework (Standards)*, 2018
14 Nursing and Midwifery Council, *Future nurse: Standards of proficiency for registered nurses*, 2018
15 *Shape of Training: Securing the future of excellent patient care*, 2013
Higher Education Institutions need to be encouraged to seek placement opportunities for students across the entire health and care sector. National Government, the NHS and system partners should also increase opportunities and support for hospices to expand their placement capacity and make better use of apprenticeships, for example by supporting smaller hospices to collaborate on an application for the apprenticeship levy. Hospice UK has been working with Health Education England on a more coordinated approach to placements in hospices but this work needs to be prioritised.

Hospices and other smaller specialist institutions also often miss out on workforce development funding and opportunities to share their expertise and improve the skillset of system colleagues in palliative and end of life care. Leading training hospices, such as LOROS Hospice and Greenwich & Bexley Community Hospice, should be supported and Government should explore whether primary care training hubs could be expanded to include hospices.

A key concern for the hospice sector is a lack of access to the mechanisms and resources available to NHS staff. Equity in access to CPD training, the digital framework for the NHS and other opportunities available to the NHS workforce would help hospices to retain and attract staff. Volunteers, who contribute approximately £200 million to hospices per annum, should also receive equitable access to training, educational resources and support. This must also be accessible with regards to timing, location and cost.

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

An increasing challenge for the delivery of palliative and end of life care and factor in staff leaving the sector is the ageing workforce. Data released in 2014 found that approximately 44% of specialist palliative care nurses are over the age of 50 and Hospice UK’s 2021 workforce survey found that 33% of the clinical workforce in hospices across the UK are aged 55 and over.\(^\text{16}\) In comparison, data from 2017 shows 17% of the NHS nursing workforce is aged over 55.\(^\text{17}\) The retirement of this cohort will lead to further reductions in the palliative and end of life care workforce over the next decade.

There is a clear need to attract staff to palliative and end of life care earlier in their careers and retain them within the specialism. Key to this, as mentioned above, are dynamic career pathways that allow staff to move between different palliative and end of life care services across the health and care sector. Flexible ways of working would also help retain older members of the workforce, and their expertise, within palliative and end of life care by providing them with flexible opportunities to share their knowledge and expertise, succession plan and mentor professionals that are earlier in their careers. The diversity of roles within palliative and end of life care makes the specialism well placed to offer alternative roles for older members of staff or volunteers.

As outlined in above responses, poor pay and terms and conditions, in addition to feeling unvalued and overworked, are driving staff to leave the health and care sector, including palliative and end of life care. Skills for Care found that workers were more likely to leave the social care sector if they were employed on zero-hours contracts.\(^\text{18}\) Staff need to be paid more and offered better terms and conditions for their time and expertise, as well as offered meaningful and valued career pathways, to prevent them from leaving for other careers.

\(^\text{16}\) National Council for Palliative Care, Specialist Palliative Care (SPC) Workforce Survey 2013, 2014 & Hospice UK, Unpublished 2021 survey of clinical staff working in UK hospices, 2021
\(^\text{17}\) National Audit Office, The NHS nursing workforce, 2020
\(^\text{18}\) Skills for Care, The state of the adult social care sector and workforce in England, 2021
Many health and care workers are also burnt out due to the COVID-19 pandemic and the pressure of the last 18 months is likely to lead to many retiring early or changing sector due to exhaustion, exacerbating existing staffing shortages. The high level of excess deaths associated with the pandemic means frontline staff are in need of more bereavement and emotional wellbeing support than ever before. It is vital that accessible mental health support is made available to the entire health and care workforce and that line managers are trained to identify when a staff member or volunteer requires support and signpost them to support services, such as Hospice UK’s 24/7 Just ‘B’ helpline. Just ‘B’ offers emotional wellbeing, bereavement and trauma support nationally to NHS, care sector staff and emergency service workers.19

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

Medical staffing of doctors, nurses and allied health professionals is a significant challenge across palliative and end of life care, including hospices. Whilst hospices take a multidisciplinary approach, medical staffing remains essential. Medical consultants are also an ageing workforce and the numbers of people training are insufficient to meet the need for palliative care services.

The palliative and end of life care sector is in need of a national policy approach to nursing, with national targets and messaging to encourage recruitment. Hospices across the UK employ 12,000 nurses, with 8% of the nursing workforce drawn from bank or agency, which make up a 9,400 full time equivalent nursing establishment, but they are struggling to recruit registered nurses.20 In addition to a national approach to nursing recruitment, there needs to be better communication of opportunities for prospective nurses, such as advertising around the grant offered to nursing undergraduates.

There are also some regional factors. Non-acute services in and around London struggle to recruit nurses due to the CapitalNurse programme, which guarantees prospective nurses a role in a London-based acute trust on graduation. This recruitment challenge is far greater for charity sector services, such as hospices, that struggle to match Agenda for Change pay scales and terms and conditions. In addition to London, service providers also struggle to recruit in more remote or undesirable areas to live in across the UK.

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

The next iteration of the NHS People Plan, and a people plan for the social care sector, need to take a whole system approach to workforce planning and encourage partnership working and integration across services, particularly in palliative and end of life care where there is such a broad spectrum of provision. Since local Integrated Care Systems model their People Plans on the national framework, emphasising partnership working at a national level will also lead to increased collaboration at an ICS and neighbourhood level.

Partnership working across the health and care system is crucial to reducing staffing pressures, as improving knowledge sharing will enable non-medical staff to respond to straightforward palliative and end of life care needs without specialist resource. It will also generate a good skill mix by encouraging knowledge sharing between system partners. London Ambulance Service’s work with St Christopher’s Community Nursing Team to ensure they provide dignified, compassionate and respectful end of life care is a great example of successful knowledge sharing and partnership working.21 St Christopher’s Hospice

19 Just ‘B’, 20 Hospice UK, Unpublished 2021 survey of clinical staff working in UK hospices, 2021 21 St Christopher’s, London Ambulance and St Christopher’s Online Learning, 2021
has also provided remote on-call consultant medical support to Ardgowan Hospice in Scotland in response to their recruitment challenges.\textsuperscript{22}

National plans need to continue to prioritise creating an inclusive workplace with a workforce that represents societal diversity. Hospice UK’s report \textit{Equality in hospice and end of life care: challenges and change} highlights how diversity in the workforce increases access to care for typically excluded groups.\textsuperscript{23} Efforts to improve diversity should apply as much to leadership positions as frontline roles across the health and care system.

7) \textit{To what extent are the contractual and employment models used in the health and social care sectors fit for the purpose of attracting, training, and retaining the right numbers of staff with the right skills?}

Current disparity in terms and conditions of employment between palliative and end of life care providers in the voluntary sector and the NHS mean that hospices and other charities in this space are struggling to attract and retain high quality staff. It also drives the dis-integration of the workforce meeting palliative and end of life care needs. Non-NHS providers, including hospices, find it very difficult to match the NHS Agenda for Change pay scales, and to mirror NHS terms and conditions. This is compounded by (albeit welcome) increases in NHS pay, which drive significant cost increases among non-NHS providers such as charitable hospices. Hospice UK’s 2021 workforce survey found that only 66\% of hospices were mirroring Agenda for Change pay grades.\textsuperscript{24}

Standardising NHS pay and terms and conditions across the system would bankrupt small organisations that cannot match them, including many hospices. However the current disparity in what services can offer, prevents hospices and other not-for-profit services from fully contributing to their local ICS systems in a meaningful way. A sustainable funding solution for the charitable hospice sector is necessary to ensure they are able to recruit and retain skilled workers.

8) \textit{What is the role of integrated care systems in ensuring that local health and care organisations attract and retain staff with the right mix of skills?}

Integrated Care Systems have a key role to play promoting integrated working across their footprint. An integrated approach to care could be as simple as ensuring generalist care home staff or primary care services are able to call a palliative care consultant or nurse for advice and support, or as complex as arranging for nurses and other allied health professionals to complete a training rotation in palliative care services.

In order to deliver personalised palliative and end of life care, integrated, locally focused teams consisting of hospice, hospital, primary care and district nursing workforce must work together across the system at a primary care network level. Integrated Care Systems are too high level to drive this activity but they can promote and foster this collaboration and integration of services at a local neighbourhood level by removing some of the practical barriers to integration.

Hospices, which operate at a neighbourhood level, have significant expertise in palliative and end of life care as well as a deep understanding of their local communities. By valuing hospices as equal partners within the system and involving them in local planning and practice, Integrated Care Systems can benefit

\textsuperscript{22} BMJ Supportive and Palliative Care, \textit{A tale of two hospices: the development of a unique service model of hospice consultant support}, 2021
\textsuperscript{23} Hospice UK, \textit{Equality in hospice and end of life care: challenges and change}, 2021
\textsuperscript{24} Hospice UK, \textit{Unpublished 2021 survey of clinical staff working in UK hospices}, 2021
from their expertise in planning and strategy. They can also ensure generalist staff within their area can draw upon the specialist skills within hospices and utilise any training or support they offer as well as fully embed hospices as local providers in their neighbourhoods caring for their local communities. Hospices often struggle to engage with partners at multiple levels, including the neighbourhood level where they operate and the strategic level where workforce planning takes place. Therefore ICS’s need to take the initiative to reach out to these smaller organisations to facilitate their contribution.

Integrated Care Systems also have an important role in assessing population need and ensuring services are able to respond to the palliative and end of life care need present in their local communities.