Written evidence submitted by The Nuffield Trust (EPW0051)

Nuffield Trust submission

The Nuffield Trust is an independent think tank which uses research and policy analysis to improve health care in the UK. As requested by the Committee, this submission presents our views on the primary commitments for the NHS and social care workforce which the Expert Panel is now evaluating. It looks in turn at each of the three policy areas within which the Panel are considering DHSC commitments in this crucial area.

Planning the workforce

Commitment: Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs.

Ill-defined targets

It is apparent that the health service does not have as many staff as it needs to meet demand. This problem has gradually built over many years. As the 2019 NHS Long Term Plan itself put it: 'over the past decade, workforce growth has not kept up with the increasing demands on the NHS'.[i] It is therefore important to define and monitor commitments made that relate to workforce growth as a means to provide transparency and to hold government to account on their pledges made to the public.

However, health and social care workforce commitments made by the government have rarely been explicitly defined and measured. Exactly how the headline commitment given above is defined is unclear - though it would be difficult to make a case that it is currently being met - and imprecision extends even to more quantifiable and specific targets. For instance, we do not know whether the ambition for an additional 6,000 doctors in general practice by 2024 includes doctors in training.

One exception to this lack of clarity is the case of the commitment for 50,000 more nurses; that said, clarity on how this is defined only emerged over two years after the commitment was made.[ii] As far as we can ascertain, there has never been any indication about how the remaining commitments are supposed to be measured.

Gaming the targets

Where targets have been defined, it appears the government have made some rather advantageous assumptions. For instance, the baseline figures being used to monitor progress on nurse numbers are for September 2019, some two months before the publication of the manifesto commitment. This matters because newly qualified students typically enter the labour market in the autumn. Indeed, nurse numbers increased by around 4,800 between September and December 2019 when the general election occurred, which represents a useful head-start.

Another caveat to the way government is monitoring progress on nurses is the exclusion of health visitors. These are registered nurses or midwives who have additional training in community public health nursing.[iii] Their numbers have fallen by over 700 in the two years since the 2019 general election. Of course, opinions on what is the best way to define and monitor a measure but there is

also a risk in trying to inflate perceptions of progress in a way which might run contrary to the experiences of those working in the health service.

Meaningful impact

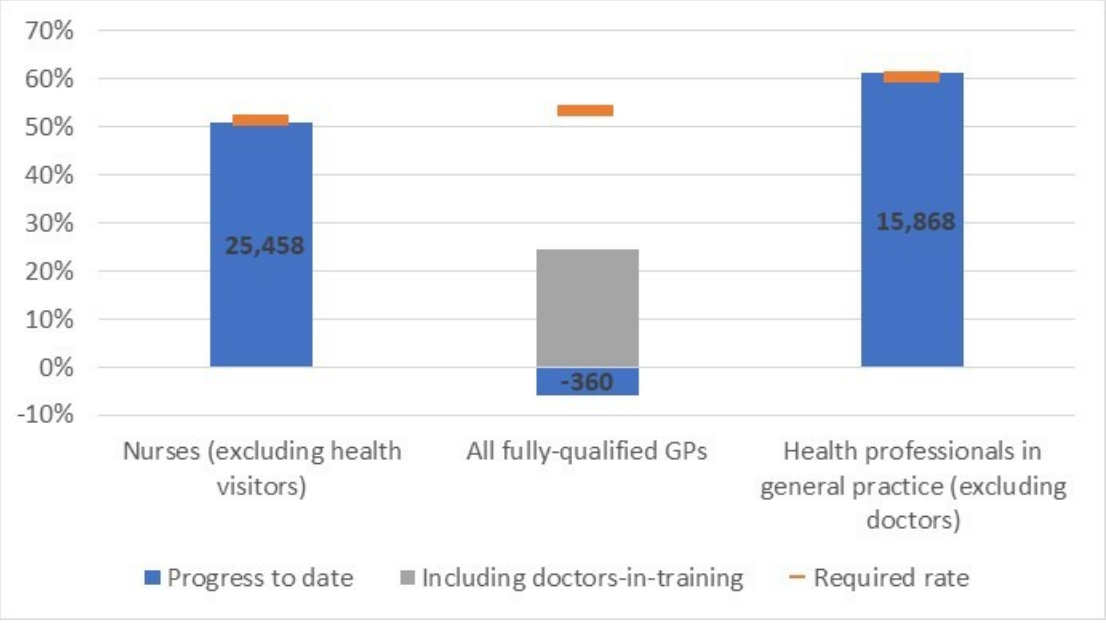
Whether or not some of the workforce targets set by government will make a meaningful difference is unclear. Increasing the number of medical school places or people starting nursing associate apprenticeships does not directly determine additional capacity for the NHS. One evaluation of the nursing associates training programme found an attrition rate of 16%, which should be considered when taking account of those starting training courses.[iv]

There is a risk that the piecemeal commitments around numbers within specific staff groups means that the mix and balance between professions is overlooked. There are lessons from history on this. Between 2009/10 and 2015/16 the number of consultants rose by 4.1% per year, but activity by just 1.7%, so representing a 2.3% fall in consultant 'productivity'. Researchers have suggested this was in part due to failure to also increase the wider health care team who work with consultants, including nurses and clinical support staff.[v] Failure to manage skill mix is bad for staff, bad for patients, and bad for the taxpayer. With this is mind, it is frustrating that some key mechanisms that influence mix of professions – such as employers being reimbursed part or all of basic salaries of doctors in training – are not actively reviewed.

Progress to date

Notwithstanding the uncertainty about how some of the measures are intended to be monitored, making some assumptions about how they are defined, it appears that there has been some positive progress.

Figure 1: Progress on NHS workforce manifesto commitments



Notes: Data for nurses to February 2022 whereas to March 2022 for general practice staff. Non-medical general practice workforce includes those employed by Primary Care Networks (PCNs) and directly by practices; we have had to make assumptions on missing PCN data to estimate a total

figure. Baseline figures are December 2019 except for non-medical health professions in general practice, which uses a baseline figure of March 2019. Column labels are estimates.

Nursing

In the two years since the 2019 general election, the number of nurses working in hospital and community services or general practice has increased by 22,129 or just over 7 per cent. This is impressive and historically high without being totally unprecedented: in the two years to September 2002, the numbers of qualified nursing staff increased by around 24,300.

GPs

Meanwhile, the number of fully qualified, full-time equivalent GPs has decreased by 360 since the 2019 election. Even when including GPs in training – which the Secretary of State for Health and Social Care did in a recent social media post[vi] – the increase in the number of GPs that we would expect to see at this point is still not sufficient.

Other general practice staff

The 2019 manifesto commitment built on an existing target on health professionals in general practice and, by the time of the election, there were already around in the region of 3,000 additional staff working in the sector compared to a March 2019 baseline. The number of full-time equivalent staff employed in general practice and primary care networks has since estimated to have increased by over 13,000 suggesting that the government appear to be broadly on track.

Nursing associates

The government target to train 7,500 nursing associates in 2019 was set by then-Secretary of State for Health Jeremy Hunt[vii]; the timeframe then shifted to by the end of March 2020.[viii] The number of nursing associate apprenticeship starts between January 2019 and March 2020 totalled 5,407 – below the target of 7,500[ix]. We measured this progress using apprenticeships data published by the Department for Education.[x]

Medical placements

Another target set by the previous government in 2017 was to expand the number of undergraduate medical places by 1,500. According to UCAS data, over 2,000 more students were placed at medical schools for the 2018-19 and the 2019-20 intakes, which exceeds the original government target. However, caution must be used when interpreting UCAS data against this target because it also includes dentistry students, as well as medical students placed in schools across the UK (as opposed to England only).

Variation by setting and geography

Meeting a national target provides limited assurance about whether regional and local staffing levels are sufficient. This is a particular risk where there are significant existing imbalances, with GPs being a clear example of this.[xi] There is a risk that focussing on national, high-level targets will increase these disparities further, which in turn can widen the gap in patient access and quality of care between regions.

The same argument can be applied to certain specialties or care settings. For example, while the overall increase in nurse numbers is welcome, numbers in general practice and learning disability services have actually fallen. Similarly, there are also regional variations with the North East and Yorkshire seeing the lowest growth and South East leading the pack.

Social care numbers overlooked

These commitments on employed staff cover much of the primary care workforce and over a quarter of hospital staff. However, social care staff numbers are not covered in any of these measures. The number of filled posts in the adult social care workforce is estimated to have fallen by around 52,000 (4.5%) between March 2021 and February 2022.[xii] In comparison the NHS hospital and community workforce grew by 25,900 (1.9%) over that same period.

Workforce planning

We are concerned about the lack of a workforce strategy which might give assurance that the overall commitment will be delivered in future. There has been no adult social care workforce strategy for over a decade.[xiii] For nearly a year, work has been ongoing to produce a new long-term strategy framework for the health workforce. Judging from the predecessor framework, this is unlikely to be a detailed workforce strategy which instead will be published at best only later in 2022, in response to the Secretary of State's commitment made in March to have a "proper long term workforce plan".[xiv] With a workforce facing burnout from efforts over the Covid-19 pandemic and the prospect of a step-change in activity to attempt to make headway into the huge waiting lists, managing the NHS workforce could hardly ever have been as important.

Given workforce projections carry much uncertainty it is not a case of whether there will be a mismatch between the demand for, and supply of, staff but rather the direction and size of it. To date, workforce planning appears to have failed to recognise this and, as a result, the strategy has been insufficiently agile. In particular, workforce planning has been hindered by, for example:

- inconsistencies between workforce ambitions and funding available, including the allocations to Health Education England
- limited understanding of the capacity and cost of different mechanisms to manage the workforce numbers;
- poor alignment of funding, resources and accountability across the bodies responsible, with a lack of leadership by the Department of Health and Social Care for the adult social care workforce;
- a failure to appropriately balance risks of over- and under-supply; and
- funding arrangements which are not promoting the most cost-effective skill mix and can create bottlenecks in expanding the supply of staff.

Building a skilled workforce

Commitment: Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead.

Commitment: £1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities.

Commitment: Greater access to digital tools and data among community and ambulance staff, supporting moves towards prevention and support (paraphrased).

Digital skills

The government committed to spending £1 billion extra every year for more social care staff and better infrastructure and technology. Both spending reviews in 2019 and 2020 delivered £1 billion. However, this and an additional central grant of £300 million in 2020 were split equally between adult and children's social care, alongside increases to the Adult Social Care precept.[xv.xvi] Arguably the £1 billion committed by government in 2019 and 2020 has been used to stabilise social care services rather than as strategic investment into addressing the workforce recruitment and retention crisis, or into improved estates or technology. While it is difficult to quantify exactly how much money has been spent on social care staff, more recently, some £500 million has been allocated from the Health and Social Care Levy to the wellbeing and professional development of the social care workforce.

Research has shown that building the digital skills of the social care workforce can be hugely valuable.[xvii] The wider use of digital technology for care during the covid-19 pandemic makes this even more relevant to improving the standard of care.

Typically, opportunities for career progression in social care are not as abundant as those seen in the NHS. Coupled with poorer working conditions, this has led to low recruitment and retention rates. Providing opportunities to use new technologies and practice new skills in this sector can lead to increased job satisfaction and help with progressing employees' career aims.

To deliver meaningful change, the government should be focusing on the potential to create a pay and progression framework for social care staff, rewarding them with acquiring new skills and reducing staff turnover. However, there needs to be significant consultation and buy-in from stakeholders across the health and social care sectors, with careful planning, management and collaboration.

Professionalisation

There have been increasingly urgent calls for care workers to be 'professionalised' in England, following steps taken in other countries to register and regulate staff, improve pay, progression, training, and working terms and conditions. However, England appears to be lagging behind counterparts in the UK and further afield.

Our research suggests that statutory registration and regulation is seen by many as a first step towards professionalisation of unregulated care workers.[xviiixix,xx] . The Department for Work and

Pensions' *In-Work Progression Commission* recommended that a central body be established in England for care workers, to manage and certify training and ongoing professional skills development, help set out a clear progression pathway for low-paid workers, and transform perceptions of care as a profession.[xxi]

We are concerned that action to address the social care workforce crisis pales in comparison to the measures adopted in other countries - such as in Scotland, where hourly pay has increased to £10.50 per hour, equivalent to NHS Agenda for Change band 3. Social care is at risk of system failure if urgent action is not taken now to alleviate unsustainable workforce pressures.

Wellbeing at work

Commitment: Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services.

Commitment: Reduce bullying rates in the NHS which are far too high.

Commitment: Listen to the views of social care staff to learn how we can better support them – individually and collectively.

Each of these commitments is difficult to precisely define, but the available evidence suggests that negative experiences around safety and wellbeing at work remain stubbornly high. In the 2021 NHS staff survey, more than one-in-four of the workforce (27.5%) reported experiencing at least one incident of harassment, bullying or abuse from patients / service users, their relatives or other members of the public in the previous 12 months.[xxii] This is similar to previous years (28.7% in 2018/19 and 26.8% in 2020). Around one-in-nine (11.6%) reported experiencing such treatment from their manager and around one-in-five (18.7%) from other colleagues. The proportion of staff saying they felt unwell as a result of work-related stress has increased for four consecutive years, rising from 38% in 2017 to 47% in 2021.

There has been a significant rise in mental health issues among NHS staff since the Covid-19 pandemic began, at a time where many were placed under extreme pressure to deliver care. The government had already committed to introducing new mental health services for staff, which is needed more than ever to improve morale and retention. Staff mental health and wellbeing hubs have been set up across the country to provide quicker access to treatment where needed.[xxiii] However, we have yet to see that these are being evaluated and staff wellbeing – particularly for groups that were specifically at risk during the pandemic – sufficiently monitored. Wales, Scotland and Northern Ireland also offered bonus payments to reward the hard work of the health and social care workforce during the pandemic, which intended to reduce the rate of those leaving. No such payment was offered in England.

Leavers

While the proportion of staff leaving the NHS and social care appeared to have fallen at the start of the pandemic, the numbers now exiting these services are on the rise and the indications are that the situation could get worse. [xxiv]

Workforce retention – alongside staff welfare and patient safety – are all being challenged by rising pressure in the NHS.[xxv] This represents a significant risk to the NHS given the ceiling for domestic supply of some key professions into health and social care is already largely set for the short term. Those starting an undergraduate nursing or social work degree this year will likely not graduate within this parliament, with the election scheduled for May 2024.[xxvi]

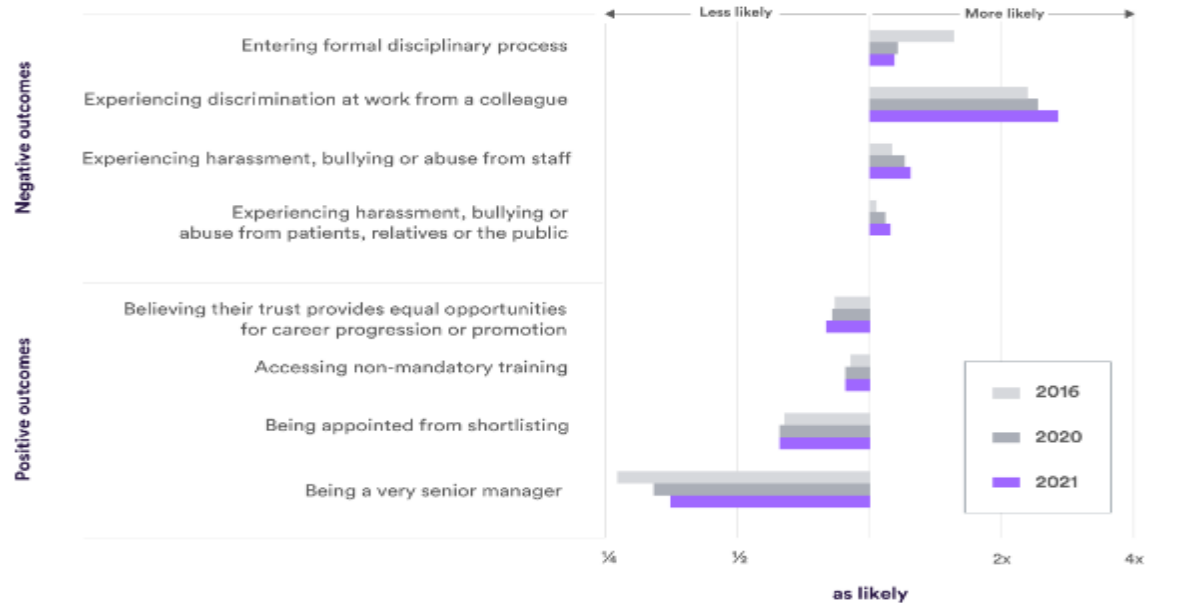
The majority (between two-thirds and four-fifths) of doctors considering retiring, leaving the medical profession, reducing hours or taking a career break cite current demands of the role adversely impacting wellbeing as a reason. The picture is also concerning for nurses, with a survey of those leaving their register in the year to June 2020 suggesting that – as in previous years – too much pressure (alongside retirement and personal circumstances) was a common reason for leaving.[xxvii] Workplace culture, a new option for this latest iteration of the survey, was the fourth most common. In social care, a survey of almost 9,000 adult social care settings found that some of the top reasons given by both domiciliary care and care home providers were better pay outside the care sector, better hours and working conditions outside the care sector, and feeling burnt out/stress.[xxviii] It is notable that there is no central social care staff survey, equivalent to the NHS staff survey, and therefore no central route for government to collect and listen to the voices and experiences of individual social care staff working across all settings.

Yet, while we have a rough idea, our understanding of the numbers leaving, and the reasons for this, is still limited. This represents a huge missed opportunity for services to learn about how to better retain staff, including the potential implications for diversity, equality and inclusion given that the levels leaving – and the reasons for doing so – vary between staff groups.[xxix] A recent national report did recommend organisations and integrated care systems should "understand why people leave the NHS and take system action to address the causes".[xxx] Our view is that this should of course be extended to social care. Such an understanding would also help ensure there is not undue competition for limited staff between services and settings. [xxxi]

The wellbeing of staff from different groups

There appear to be stark differences in the wellbeing of some staff groups. For instance, those from a Black and those from a minority ethnic background (over one-in-five of NHS staff) have worse day-to-day work experiences – including being more likely to experience harassment, bullying or abuse from either colleagues or others. They also face more challenges in progressing their careers (see figure below). In particular, those from minority ethnic backgrounds are well over twice as likely to personally experience discrimination at work from a manager or other colleague (16.7% compared to 6.2% for White ethnicity) and substantially less likely than White applicants to be appointed from a recruitment shortlist.

Figure 2: Different career experiences for Black and minority ethnic staff compared with White staff



Source: www.nuffieldtrust.org.uk/chart/different-career-experiences-for-black-and-minority-ethnic-staff-compared-with-white-staff

The NHS appears to be particularly failing some specific groups too. For example, when looking at more detailed data, those with Bangladeshi, African, or White and Black African ethnicities appeared to have lower success rates at interview.[xxxii] There are also stark disparities when looking at other characteristics with, for example, the likelihood of Sikhs, Muslims and Hindus being shortlisted or appointed all significantly below the average.

We recently reported on the practical conditions necessary to improve the situation, including sufficient information and data; clarity on what works; and sufficient resources and clear responsibilities to implement and evaluate. Our recommendations sought to address, for example:

- the lack of understanding and consistency around data and information systems. This would support a more detailed analysis of variation by sub-groups within the protected characteristics, taking into account the effect of intersectionality.

- the variation and lack of transparency around the resources (budget and staff) NHS trusts have put towards improving equality and diversity.

- the lack of a single accessible repository for evidence-based solutions.

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