
The health care workforce in England

Make or break?

November 2018

Summary

In advance of the publication of the NHS long-term plan, this briefing highlights the scale of workforce challenges now facing the health service and the threat this poses to the delivery and quality of care over the next 10 years. It sets out the reasons why the long-term plan and supporting workforce strategy must address the urgent and mounting challenges facing the health care workforce.

This briefing will be followed in the coming weeks by a more in-depth report that explores five key levers available nationally and locally that could help ameliorate the workforce crisis affecting both health and social care.

Key messages

- The workforce challenges in the NHS in England now present a greater threat to health services than the funding challenges.
- Across NHS trusts there is a shortage of more than 100,000 staff. Based on current trends, we project that the gap between staff needed and the number available could reach almost 250,000 by 2030. If the emerging trend of staff leaving the workforce early continues and the pipeline of newly trained staff and international recruits does not rise sufficiently, this number could be more than 350,000 by 2030.
- The current shortages are due to a number of factors, including the fragmentation of responsibility for workforce issues at a national level; poor workforce planning; cuts in funding for training places; restrictive immigration policies exacerbated by Brexit; and worryingly high numbers of doctors and nurses leaving their jobs early.
- Central investment in education and training has dropped from 5% of health spending in 2006/7 to 3% in 2018/19. Had the previous share of health spending been maintained, investment would be £2bn higher.
- Current workforce shortages are taking a significant toll on the health and wellbeing of staff. There is also evidence of discrimination and inequalities in pay and career progression, which must be addressed.
- If substantial staff shortages continue, they could lead to growing waiting lists, deteriorating care quality and the risk that some of the £20.5bn secured for NHS front-line services will go unspent: even if commissioners have the resources to commission additional activity, health care providers may not have the staff to deliver it.
- NHS leaders will shortly publish a long-term plan setting out their ambitions for the health service in the context of the recent funding settlement. The plan must be clearly linked to a strategy to address the workforce crisis, otherwise it will simply be a wish list rather than a credible path to a sustainable future for the health service.
- Given the scale of the challenge and emerging global shortages of health professionals, a credible workforce strategy will need to plan for a degree of oversupply of NHS staff.
- The long-term plan and a supporting workforce strategy will need to pass five key tests. The tests require a funded and credible strategy to:
 1. address workforce shortages in the short term
 2. address workforce shortages in the long term
 3. support new ways of working
 4. address race and gender inequalities in pay and progression
 5. strengthen workforce and service planning at all levels of the system.
- Many of the same issues are affecting the social care workforce: for example, vacancies in adult social care are rising, currently totalling 110,000, with around 1 in 10 social worker and 1 in 11 care worker roles unfilled. Any strategy for shoring up the NHS workforce cannot be viewed in isolation from the need to invest in and support the social care workforce.

Introduction

NHS leaders will shortly publish a long-term plan, which will set out their ambitions for the health service in the context of the recent funding settlement. We also await the outcome from the consultation on the draft national workforce strategy published by Health Education England in December 2017,¹ as well as the green paper on the future of social care, which should contain important detail on the equally critical and fundamentally connected issue of the social care workforce.

This briefing highlights the scale of the NHS workforce challenges and the threat this poses to the delivery and quality of care. It sets out the reasons why the long-term plan and a supporting workforce strategy must address the urgent and mounting challenges facing the health care workforce. We believe these challenges now present a greater threat to NHS services than the funding challenges.

It is important to note that our commentary in this briefing is directed towards action needed by the NHS, as our focus here is on the workforce requirements linked to the NHS's long-term plan. But this should not in any way detract from the message that urgent action is required in social care: the two systems are critically interdependent.

Indeed, our work suggests that there needs to be a more coherent national system to develop and oversee workforce strategy and ensure its alignment with the changing models of delivery of health and social care. We cannot continue with siloed working between hospitals, primary care and social care, and an effective approach to the workforce needs to look at the requirements of all these sectors holistically.

A coherent and holistic strategy will not only look at the training of the future workforce, but will also consider how to mobilise the talents of the current workforce – using the full range of policy options, including financial and non-financial incentives. Moreover, as many health and care staff work for non-NHS providers, a credible workforce strategy must look beyond those employed by the NHS: the failure to consider the workforce needs of health and care services as a whole is one factor that has contributed to shortages.

This briefing will be followed in the coming weeks by a more in-depth report that explores five key levers available nationally and locally that could help ameliorate the workforce crisis. These levers are: training; international recruitment; better employment practice; pay and conditions; and maximising the potential of staff through better use of existing skills, enhancing those skills and redesigning roles.

We will explore the opportunities offered by each of these levers and will recommend a number of high-impact interventions. The report will also explore the issues in social care in more depth than we are able to here.

¹ Health Education England (2017) HEE launches plan to 'future-proof' NHS and care workforce. www.hee.nhs.uk/news-blogs-events/news/hee-launches-plan-future-proof-nhs-care-workforce

Context

The size of the workforce

Some 1.2 million full-time equivalent (FTE) staff work in the NHS, 1.1 million work in adult social care² and at least a further 46,000 work for independent health care providers.³ Together, they make up around 1 in 10 of the total workforce in England.

Yet the UK has a low number of doctors and nurses per head of population compared with other countries. In the UK there is one doctor for every 356 people, compared with one for every 277 people on average across comparable countries.⁴ The NHS has a lower-than-average number of staff for all professional groups except midwives.

Workforce strategy, or lack of it

There are severe shortages of key groups of essential staff, including nurses, many types of doctors, allied health professionals and care staff. In 2017/18, NHS trusts spent £5.5bn on temporary staff⁵ to cover vacancies and other short-term absences, accounting for over 10% of total pay costs.⁶ An ageing population with a growing burden of frailty and chronic disease means that there are also significant gaps between workforce skills and population needs.

These issues have steadily mounted in recent years and the NHS has been unable to recruit the staff it needs. This is because of an incoherent approach to the NHS workforce at a national level; poor workforce planning; inadequate funding for training places; restrictive immigration policies that have been exacerbated by Brexit; frozen or capped pay increases; and worryingly high numbers of doctors and nurses leaving their jobs before retirement. There is a real risk that this picture could be replicated across the NHS workforce as a whole. In key areas such as nursing and general practice, we are potentially reaching a tipping point whereby shortages make the working life of staff so difficult that this risks undermining efforts to remedy the crisis.

There is no credible overarching strategy in place to address these problems. Indeed, the central investment in education and training has dropped from 5% in 2006/7 to just over 3% of total health spending in 2018/19. This is £2bn lower than it would have been

2 Skills for Care (2018) *The state of the adult social care sector and workforce in England: executive summary*. www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf

3 NHS Digital (2018) *Healthcare Workforce Statistics – March 2018*. digital.nhs.uk/data-and-information/publications/statistical/healthcare-workforce-statistics/march-2018-experimental/content. (Independent provider workforce based on those organisations that provided data to NHS Digital or whose data could be extracted from the electronic staff record.)

4 Dayan M, Ward D, Gardner T and Kelly E (2018) *How good is the NHS?* www.kingsfund.org.uk/sites/default/files/2018-06/NHS_at_70_how_good_is_the_NHS.pdf

5 All financial figures in this document are in 2018/19 prices using the Office for Budget Responsibility's October 2018 deflators unless otherwise specified.

6 NHS Improvement (2018) *Performance of the NHS provider sector for the year ended 31 March 2018*. improvement.nhs.uk/documents/2852/Quarter_4_2017-18_performance_report.pdf

if spending had grown in line with the rest of health spending.^{7,8} As a recent House of Lords Committee noted, the lack of a credible workforce strategy “represents the biggest internal threat to the sustainability of the NHS”.⁹

Additional NHS funding

NHS England’s funding is now planned to increase by an annual average of 3.4% over the next five years – an increase of £20.5bn in 2023/24.^{10,11} This is in line with the 3.3% that has been estimated as the minimum increase needed to maintain quality and access to care given the growing and ageing population and rising burden of chronic disease. It is higher than the 1.4% per year funding increases for the Department of Health and Social Care’s budget since the financial crisis, but lower than the long-run average of 3.7%.¹²

But even before the increase in funding was announced, the NHS could not recruit the staff it needed. The widespread difficulties with recruiting and retaining staff could lead to growing waiting lists, deteriorating care quality, and to other planned improvements failing to materialise. This presents a real risk that that some of the £20.5bn secured for NHS front-line services will go unspent: even if commissioners have the resources to commission additional activity, health care providers may not have the staff to deliver it.

The long-term plan: an opportunity for change

The long-term plan must give clear direction about where to invest the new funding to meet changing needs, address the capacity constraints and put in place or set in train the long-term changes that are needed to ensure that, in 10 years’ time, the health system delivers both high-quality care and value for money to the taxpayer. None of this can be achieved without major changes to the health care workforce. A plan that does not have these issues at its heart will simply be a wish list, not a credible path to a sustainable future.

We now set out some of the key workforce challenges faced by the NHS and outline the five key tests we believe the long-term plan and a supporting workforce strategy must satisfy if the plan is to achieve its ambitions. We then highlight the scale of the challenges faced by social care, which are equally urgent.

7 National Audit Office (2016) *Managing the supply of NHS clinical staff in England*. www.nao.org.uk/wp-content/uploads/2016/02/Managing-the-supply-of-NHS-clinical-staff-in-England.pdf

8 Health Education England (2018) HEE Board Meeting – 16 October 2018. www.hee.nhs.uk/about/how-we-work/board-meetings-papers/hee-board-meeting-16-october-2018

9 House of Lords [Select Committee on the Long-term Sustainability of the NHS] (2017) *The long-term sustainability of the NHS and adult social care*. Report of session 2016–17. publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf

10 UK Government (2018) NHS Funding Settlement, 19 June 2018. assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/717765/nhs-settlement-numbers.pdf

11 While higher-than-expected inflation may have changed the possible front-loading of this amount, the Autumn Budget makes clear that the increase over the five years will be 3.4% in real terms.

12 Institute for Fiscal Studies and the Health Foundation (2018) *Securing the future: funding health and social care to the 2030s*. www.ifs.org.uk/publications/12999

Five key tests for the NHS long-term plan and supporting workforce strategies

Test 1: Is there a funded and credible strategy to address the immediate workforce shortages – including addressing forecast critical shortages in job specialties and specific geographic areas?

There are significant staff shortages across the NHS. There are over 100,000 vacancies across NHS trusts (1 in 11 posts) with the vast majority of these vacancies filled by bank or agency staff.¹³ In addition, the staff that are in post are under increasing stress: the latest NHS staff survey showed that 38% of staff had felt unwell during the previous 12 months due to work-related stress.¹⁴

One of the greatest challenges lies in nursing. One in eight posts is vacant, with 36,000 nurse vacancies in the NHS. There are worrying increases in numbers of nurses leaving the NHS, particularly at younger ages: in 2016/17, 5,000 more nurses left NHS employment than in 2011/12.¹⁵ Had the rate remained at 2012 levels through to 2017, there would have been 16,000 more nurses working in the NHS – almost half the currently vacant nurse posts filled.¹⁶

Brexit has created additional risks in both the short and medium term. Already, a net inflow of nurses from the EU into the NHS has turned into a net outflow: between July 2017 and July 2018, 1,584 more EU nurses and health visitors left their roles in the NHS than joined.¹⁷

Finally, a reduced cohort of young people leaving school and the loss of bursaries for nursing places has seen the number of applicants for nursing courses decline, with an 18% drop (11,750 fewer applicants) between 2016 and 2017 – the biggest fall in nursing applicants on record.¹⁸ The anticipated expansion in the nursing training pipeline of 10,000 additional nurses has not materialised.¹⁹

There are also challenges in medicine, particularly in some specialties and geographical areas. GP practices are struggling to recruit and retain doctors such that the number of GPs has fallen in recent years.²⁰ Similar issues are faced in psychiatry, and core psychiatry

13 NHS Improvement (2018) Performance of the NHS provider sector for the quarter ended 30 June 2018. improvement.nhs.uk/resources/quarterly-performance-nhs-provider-sector-quarter-1-201819

14 NHS Survey Coordination Centre (2018) Results from the 2017 staff survey. www.nhsstaffsurveys.com/Page/1064/Latest-Results/2017-Results

15 Health Education England (2017) *Facing the facts, shaping the future*. www.hee.nhs.uk/our-work/workforce-strategy

16 Health Education England (2017) *Facing the facts, shaping the future*. www.hee.nhs.uk/our-work/workforce-strategy

17 NHS Digital (2018) Nurse and Health Visitor joiners and leavers from the NHS_AH2359. digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/nurse-and-health-visitor-joiners-and-leavers-from-the-nhs_ah2359

18 UCAS (2017) *End of cycle report 2017: patterns by subject*. www.ucas.com/file/136531/download?token=A0UpZoEd

19 Health Education England (2018) Education funding reforms. www.hee.nhs.uk/our-work/education-funding-reforms

20 House of Commons Committee of Public Accounts (2016) *Access to general practice in England*. Twenty-eighth Report of Session 2015–16. publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/673/673.pdf

training is now on the Migration Advisory Committee shortage occupation list.²¹ A recent survey by the Royal College of Physicians²² found that 53% of consultants and 68% of trainees said that there were ‘frequently’ or ‘often’ gaps in hospital medical cover that raised significant patient safety issues.

As the Care Quality Commission highlighted in their recent *State of care* report, workforce shortages are having a direct impact on the quality of people’s care.²³ These shortages must be addressed.

Action needed

In the short term, it is critical that there is concerted action to improve retention and active support for international recruitment. While NHS Improvement is actively engaging with trusts on improving retention from a national perspective, the local picture is variable. Moreover, international recruitment of health professionals has been constrained by a restrictive immigration policy compounded by Brexit, lack of national coordination, and a number of regulatory hurdles from some professional bodies. Addressing these issues will be key to addressing the immediate workforce challenges.

Test 2: Is there a funded and credible long-term strategy to deliver a sustainable workforce over the next 10 years?

Our projections suggest that without significant remedial action, the current gaps in the NHS workforce will increase significantly and undermine the future sustainability of services.

Given the ageing population, increasing dependency ratios and a growing burden of chronic diseases and multimorbidity, demand for health care services will grow. In order to keep up with these pressures alone, the Institute for Fiscal Studies and the Health Foundation calculate that acute activity in England would need to increase by 40%, and health spending would need to rise by 3.3% per year on average.²⁴

If current models of care and staffing continue, this would see the need for health care workers in the NHS increase to over 1.5 million FTE staff. Current estimates of trends in supply suggest that available staff will not increase by anywhere near that rate. Our projections²⁵ estimate that by 2030, the gap between supply of and demand for staff employed by NHS trusts could increase to almost 250,000 FTE posts.

21 Royal College of Psychiatrists (no date) Shortage occupation list: core psychiatry training. www.rcpsych.ac.uk/traininpsychiatry/internationalmedicalgraduate/shortageoccupationlist.aspx

22 Royal College of Physicians (2018) *Focus on physicians: 2017–18 census*. www.rcplondon.ac.uk/projects/outputs/focus-physicians-2017-18-census-uk-consultants-and-higher-specialty-trainees

23 Care Quality Commission (2018) *The state of health care and adult social care in England 2017/18*. www.cqc.org.uk/sites/default/files/20171011_stateofcare1718_report.pdf

24 Institute for Fiscal Studies and the Health Foundation (2018) *Securing the future: funding health and social care to the 2030s*. www.ifs.org.uk/publications/12994

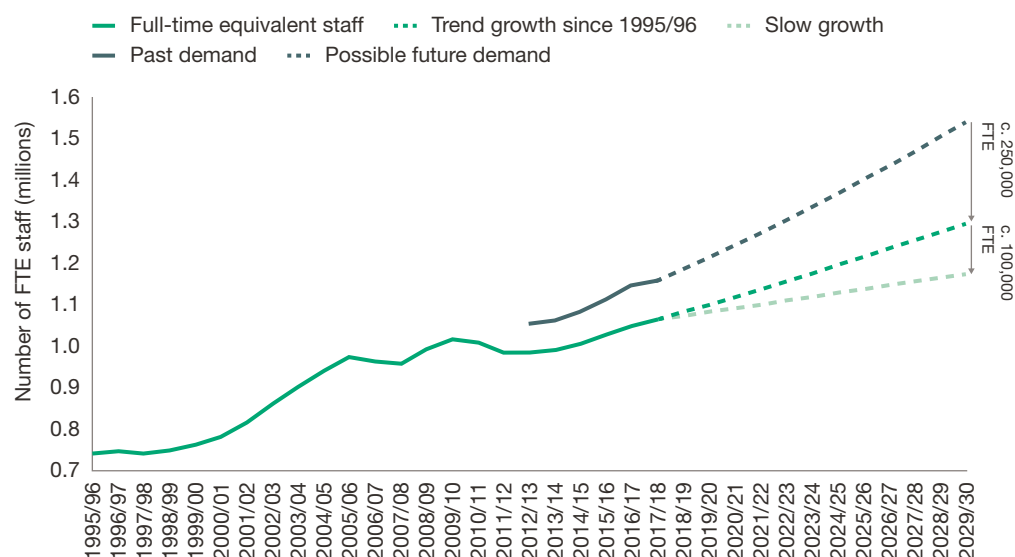
25 Health Foundation projections, based on workforce data from NHS Digital and Health Education England. These projections are for Hospital and Community Health Services (HCHS) staff working in NHS organisations and do not include staff working in primary care, including GPs and practice nurses.

This position could be further exacerbated if the emerging trends of clinical staff leaving the NHS well before retirement age continue and international migration is unable to support the short-term gaps. The nursing workforce is also ageing: nearly a third of qualified nursing, midwifery and health visiting staff are over 50 years old, with one in three expected to retire in the next 10 years.²⁶

While international recruitment is a useful short-term fix, it is not a long-term solution, and there are ethical concerns about taking trained workers from developing countries. The World Health Organization has projected workforce demand across 31 of its member countries, with the results suggesting that by 2030 all countries could experience shortfalls of about 50,000 midwives, 1.1 million nurses and 750,000 doctors.²⁷ As with all such projections the results must be treated with some caution, but they are consistent with other evidence of rapid global growth in demand for health care professionals, which is increasing at a faster rate than supply.

If the emerging trend of staff leaving the workforce early continues and the pipeline of newly trained staff and international recruits does not rise sufficiently, this suggests a worst-case scenario of a shortage of more than 350,000 FTE staff in NHS trusts by 2030, according to our projections (see Figure 1).

Figure 1: Future supply of and demand for NHS staff



Source: Health Foundation projections, based on workforce data from NHS Digital and Health Education England.

Gaps of this size will require significant action over and above that suggested for addressing shortages in the short term. The domestic training pipeline will need to secure adequate numbers of clinical staff to meet growing needs, with allowance

²⁶ Institute for Employment Studies (2016) *The labour market for nurses in the UK and its relationship to the demand for, and supply of, international nurses in the NHS*. www.employment-studies.co.uk/system/files/resources/files/mac0716.pdf

²⁷ World Health Organization (2016) *Global strategy on human resources for health: Workforce 2030*. www.who.int/hrh/resources/global_strategy_workforce2030_14_print.pdf

for a worst-case scenario. Traditionally, the NHS has been keen to avoid an oversupply of clinical professionals, and has relied on overseas migration to fill workforce gaps. But in the context of major global workforce shortages, it would be prudent to plan for a degree of oversupply.

The government has increased numbers in the pipeline for doctors and we are now slightly above the OECD average for doctors in training. But numbers of nurses in training are low by international standards – half that of the United States or Australia – and the promised 10,000 increase, as mentioned previously, is not yet evident.

Action needed

The priority, then, should be to expand the number of student nurses and look beyond traditional routes to maximise the opportunities offered through alternative routes, such as apprenticeships, and under-represented groups. Achieving the necessary level of expansion will require the government to review and improve the targeted incentives on offer, financial and otherwise, to students entering the profession, and to employers looking to become more directly involved in supporting education opportunities.

Test 3: Is there a funded and credible strategy to support new ways of working across the health care workforce?

Rapidly changing patient needs, alongside medical and technological advances, will require all frontline staff to acquire new skills and adopt new ways of working over the next 10 years. But at present the NHS struggles to make full use of the capabilities of its staff and new technologies, and progress is far, far too slow.

For example, access to and effectiveness of primary and secondary care could be significantly improved through enhanced contributions from nurses and allied health professionals working in advanced roles as part of multidisciplinary teams alongside doctors and other staff. This would also help to achieve better workload balance, with staff contributing at the optimum level of their skill set.²⁸

This is already happening in isolation in some parts of the system, but it needs to happen at greater scale and pace. For example, pharmacists can take on medication reviews and some elements of long-term condition management. Likewise, with musculoskeletal conditions making up around a fifth of the GP workload, enabling patients to self-refer to a physiotherapist has been shown to be a safe, cost-effective alternative.²⁹ One estimate suggests that up to a quarter of a GP's overall time could be saved through new ways of working, with greater use of other staff.³⁰

Technological developments, including the widespread use of digital tools and intelligent devices, also have significant implications for the roles and functions of the health workforce. The long-term plan needs to focus clearly on the mechanisms for adoption and deployment of new technologies and their implications for the workforce. Staff need

28 Imison C, Castle-Clarke S and Watson R (2016) *Reshaping the workforce to deliver the care patients need*. www.nuffieldtrust.org.uk/research/reshaping-the-workforce-to-deliver-the-care-patients-need

29 Chartered Society of Physiotherapy (2016) *Physiotherapy in primary care – summary briefing*. www.csp.org.uk/professional-clinical/improvement-and-innovation/primary-care/physiotherapy-primary-care-summary

30 Bodenheimer T and Smith M (2013) 'Primary care: proposed solutions to the physician shortage without training more physicians', *Health Affairs*, November. www.healthaffairs.org/doi/10.1377/hlthaff.2013.0234

to be equipped with new technologies and the necessary digital skills and be supported to work differently to maximise the potential benefits. At present, this is only taking place in a piecemeal way. It is largely being left to individual organisations, leading to patchy implementation and adoption and limiting the scope for realising the benefits at scale.

Action needed

The central investment in ongoing training and development for existing staff is now a third of its 2014/15 value.³¹ The £84m dedicated nationally to workforce development in the NHS³² in 2018/19 is wholly inadequate to equip this huge workforce with the skills and capabilities it needs to be as productive as possible.

A significant uplift in investment is required to deliver a step-change in capabilities at local level. But solutions are about more than money. In primary care in particular there needs to be greater support to equip staff with the time and space to develop new skills and ways of working.

Test 4: Is there a credible strategy for addressing inequalities in recruitment, pay and career progression by gender, ethnicity and occupation?

The 2017 NHS staff survey showed that one in eight staff had experienced discrimination at work during the past 12 months and one in six did not believe that their organisation provided equal opportunities for career progression or promotion.³³ While the NHS has made progress in addressing unwarranted inequalities in pay, there is evidence that disparities still exist.³⁴

In 2017, for directly employed NHS staff in the health service in England – 77% of whom are women and 23% men – the estimated median basic FTE pay gap between men and women was 8.6% in favour of men.

The gap is significantly worse for women in some ethnic groups. Asian/Asian British and Chinese women experience the largest gender pay gap at 21.3% and 20.9%, respectively, followed by those of mixed ethnicity (13.5%), white women (6.1%) and women of any other ethnic background (2.1%). The gender pay gap only favours women in the case of black/black British staff (2.2%).³⁵

There are also significant ethnicity pay gaps within some major staff groups. For Asian/Asian British managers (including senior managers) and nurses, the pay gap in favour of white staff is 10.8% and 8.5%, respectively.³⁶

31 Health Education England (2015) Annual Report and Accounts 2014/15. assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/445316/Annual_Report_HR_web_without_signatures.pdf

32 Health Education England (2018) Finance report, 2018/19, Month 5. www.hee.nhs.uk/about/how-we-work/board-meetings-papers/hee-board-meeting-16-october-2018

33 NHS Survey Coordination Centre (2018) NHS Staff Survey 2017: National Briefing. www.nhsstaffsurveys.com/Caches/Files/P3088_ST17_National%20briefing_v5.1_LB_RC_FR_20180419.pdf

34 Analysis by the Nuffield Trust – in production.

35 Schleppe L and Appleby J (2018) 'The gender pay gap in the English NHS: how does it vary by ethnicity?' www.nuffieldtrust.org.uk/news-item/the-gender-pay-gap-in-the-english-nhs-how-does-it-vary-by-ethnicity

36 Analysis by the Nuffield Trust – in production.

Action needed

A complex array of factors drive differences in earnings, and more research will be needed to understand them. But we know that under-representation at senior levels of any group of staff is not beneficial for organisations. Many studies have shown that a motivated, engaged and valued workforce helps deliver high-quality patient care, increased patient satisfaction and better patient safety.³⁷ Addressing gender, race and other inequalities must be a key feature of national and local workforce strategies. This must be accompanied by a commitment to inclusive leadership and developing cultures that engage staff and result in high-quality, compassionate care.

Test 5: Is there a plan to strengthen workforce and service planning at all levels of the system, including alignment of the institutional accountabilities and responsibilities for these?

A litmus test for the credibility of the long-term plan is whether it addresses the workforce implications of the proposals it contains in addition to estimating the staff needed to meet rising demand. Service leaders have acknowledged that proposals will only be deliverable if the workforce required to deliver them is put in place. For example, long-standing objectives to reach parity of esteem between physical and mental health will fail if the NHS cannot overcome the existing deep shortages in mental health staffing.

NHS history is sadly littered with examples of policy ambitions that were not underpinned by robust workforce strategies – the most notable being the desire to shift care out of hospitals. Despite the overarching policy commitment to move care away from hospital and towards primary care,³⁸ in the period from 2006 to 2014 the number of hospital consultants increased by almost a third (32%) compared with just a 5% increase in GP numbers.³⁹ This trend has been exacerbated over the period since 2014, during which the number of GPs has actually fallen. Meanwhile the number of nurses in community services has fallen by around 14% since 2009, and the number of district nurses has declined by 45% over the same period.⁴⁰ Unsurprisingly, the anticipated shift has not taken place.

Action needed

Alongside specific policy changes and investment, the long-term plan needs to establish a new system and approach to workforce issues. At the heart of this should be a much more coherent and transparent national-level approach to workforce planning and strategy across the health and care system. Health Education England and NHS Improvement recently announced plans to work together more closely. This may help, but falls short of what is really required, which is a stable platform for workforce policy and planning, based on a strategic approach, agreed and coordinated responsibilities and allocated functions.

37 Faculty of Medical Leadership and Management, Center for Creative Leadership and The King's Fund (2015) *Leadership and leadership development in health care: the evidence base*. www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf

38 Department of Health (2006) *Our health, our care, our say: a new direction for community services*. assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf

39 Nuffield Trust (2018) *Doomed to repeat? Lessons from the history of NHS reform*. www.nuffieldtrust.org.uk/files/2018-10/learning-from-history-web.pdf

40 Dayan M and Palmer W (2018) 'What's really going on with nursing outside hospital?' www.nuffieldtrust.org.uk/news-item/what-s-really-going-on-with-nursing-outside-hospital

The social care workforce

The five tests for the long-term plan mean this briefing has focused on staff required for the health service. However, any strategy for shoring up the NHS workforce cannot be viewed in isolation from the challenges facing the social care workforce.

Indeed, many of the challenges we identify for the NHS are equally pressing in social care, so any strategy addressing one must also look at solutions for the other. For example, the number of vacancies in adult social care is rising, currently totalling 110,000, with around 1 in 10 social worker and 1 in 11 care worker roles unfilled. Nearly one in three staff employed in adult social care left their job in 2017/18. Like the NHS, there appears to be a particularly pressing problem in nursing: there is a registered nurse vacancy rate of 12% in adult social care, implying around 5,000 nursing vacancies.⁴¹

Recruitment and retention is a key issue in social care and appears to be directly linked to pay and conditions. The Migration Advisory Committee has highlighted that one basic underlying problem with recruitment and retention for social care is the poor terms and conditions offered to workers in this sector, which is in turn caused by the difficulty of finding a sustainable funding model.

If social care pay and terms and conditions are not addressed, it is almost impossible to see how the sector can recruit and retain enough staff without a 'low-skilled' migration route for EU or other international social care workers. Projections suggest that 320,000 more social care staff will be required by 2029/30.⁴²

Finally, the issues we have highlighted regarding gender and ethnicity pay gaps also require attention in social care. Men hold 34% of senior managerial roles compared with 18% of roles in the social care workforce as a whole.⁴³ The great majority of care workers (84%) are women, and for these workers the median hourly rate is only 39p higher than the National Living Wage.

Twenty-one per cent of the social care workforce have a black, Asian and minority ethnic (BAME) background, a greater proportion than the national average. However, representation at the management level is lower than in the wider social care workforce, with just 14% of registered managers and 17% of senior managers having a BAME background.⁴⁴

⁴¹ Skills for Care (2018) *The state of the adult social care sector and workforce in England*. www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf

⁴² Projection model used in Institute for Fiscal Studies and the Health Foundation (2018) *Securing the future: funding health and social care to the 2030s*. www.ifs.org.uk/publications/12994

⁴³ Skills for Care (2018) *The state of the adult social care sector and workforce in England*. www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf

⁴⁴ Skills for Care (2018) *The state of the adult social care sector and workforce in England*. www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf

Conclusion

Securing the right number of staff with the right skills requires a sustained policy and leadership focus with reform to national and local structures. But it also needs significantly more investment.

The approach needs to be long term and should address both supply and demand. Many people choose to work in health care for careers, not jobs. Effective workforce planning needs to involve a much wider group of perspectives than just NHS bodies. It needs to be transparent, realistic and publicly accountable so that planning decisions are not totally driven by short-term service affordability constraints.

It will need stronger collaboration between the education, health and social care sectors; other national authorities; and the private sector to improve the match between health professional education and the realities of health service delivery. Though we have focused here on the national position, delivering change on the ground will require greatly enhanced capacity and capability at the regional level.

The workforce issues we have highlighted are acute and systemic. Solving them will not be easy and the long-term plan will fail without credible plans to address them. But the case is not hopeless: our forthcoming report will examine some of the measures that local and national bodies can implement over the short and long term to secure the health and social care workforce of the future.

The Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care.

Nuffield Trust

The Nuffield Trust is an independent health think tank. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

The King's Fund

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible health and care is available to all.