NHS Confederation

Response to HEE workforce planning call for evidence

September 2021

Prepared by NHS Employers

About

Enclosed is our response to Health Education England's (HEE) call for evidence to inform its long-term workforce planning exercise. It is informed through engagement with network leads and policy leads (mental health, primary care, NHS Employers teams, ICS and policy leads on ICS/systems, digital).

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

In England, our members include acute, mental health, community and ambulance NHS trusts; independent and voluntary sector providers; primary care networks and primary care federations; integrated care systems and clinical commissioning groups.

We also run NHS Employers, which supports the health service in its role as the nation's largest employer. We host the NHS Race and Health Observatory, which is working to tackle ethnic inequalities in health and care. We also host the NHS European Office, which is the conduit for the NHS to engage with the European Union.

Contents

About 2

Demographics and disease 4

Public, People who need care and support, Patient and Carer Expectations 24

Socio-economic and Environmental Factors 30

Staff and Student/Trainee Expectations 48

Science, Digital, Data and Technology (Including Genomics) 64

Service Models and Pandemic Recovery 77

Ambitions 91

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Demographics and disease

Factor A

Age and profile of the workforce

It is essential that close monitoring and observation of the workforce demographics takes place as part of the future planning requirements.

For the purposes of workforce planning, it is important to consider how any demographic changes will impact not just on demand for services, but also supply of staff. Working later in life and supporting an older workforce to stay healthy and in work, is one of the biggest issues that organisations face over the next 15 years and therefore will need to be a key component of workforce planning.

In a report published by the Nuffield Trust in November 2018 (link below), it forecasts the possible demand for future staff, suggesting that the gap between staff needed and the number available could reach almost 250,000 by 2030. Retention of the workforce, especially those in later stage of their career is an essential component of having a functioning workforce plan.

For example, one in three senior leaders in the NHS are over the age of 55. Consultants over the age of 50 now make up 39 per cent of the medical workforce, compared to 31 per cent in 2007.

In the nursing professions almost a third are aged between 45 and 54 and one in six (16.3 per cent) are aged between 55 and 64. In midwifery 40 per cent of midwives are over 45.

Working later in life and supporting an older workforce is one of the biggest issues that organisations face over the next 15 years. The average age of retirement in the UK is 65.1 years for men and 63.9 years for women, in comparison, across the medical workforce it's 59.9 years for men and 58.9 years for women. Our members are making strides to do more to retain staff aged 55 years and over (who comprise over 19 per cent of the NHS workforce). However, it remains a significant factor for the future demand for staff.

The NHS Pension Scheme is a key part of the total reward package that NHS organisations use to attract and retain their workforce. Pension changes made in March 2020, to increase the annual allowance pensions tax threshold, was a welcome concession made by government to support the NHS to recover from the pandemic and to address the issue that disincentivised senior staff from taking on additional work and leadership opportunities. However, our members are still concerned about the impacts of pension taxation on higher earners, such as consultants and senior doctors. Generally, since their introduction, the lifetime allowance and annual allowance limits have been reduced over time, meaning that more pension savers are affected. It's likely this trend will continue, with their being speculation about further cuts to the annual allowance and potentially the removal of higher rate tax relief. In the longer term it may exacerbate issues for higher earners. There is a risk that those affected by pension tax will see the NHS Pension Scheme as being of less value, they may decide to opt out of the scheme and without remedial action, this makes the NHS Pension Scheme and the NHS reward offer potentially less attractive and a weaker tool for recruitment and retention.

The other key issue is affordability of pension contributions for lower earners. Membership levels are lowest at the top and bottom of the salary scale, due to opt outs because of pension tax and opt outs because of affordability. As the scheme moves from a final salary to career average arrangement, a flatter contribution structure, where all employees pay the same level of contribution is more appropriate (compared to the current tiered structure where higher earners pay higher contributions to subsidise lower earners who pay lower contributions). This means, going forward, contribution rates for lower earners may increase, which again could lead more employees to opt out, again potentially making the scheme less attractive and a weaker tool for recruitment and retention.

As the NHS workforce gets older, we may also see the proportion of part-time workers increase. Across the wider economy, there are three times more women aged 50-64 working part-time than men and with 76.7 per cent of the NHS workforce women, it is reasonable to expect this trend to be replicated across the NHS workforce, thus having an impact on the size and shape of the workforce. With a workforce that comprises 77 per cent women, this also means that a large proportion of NHS staff will be experiencing or will experience the menopause. Additional support is needed for this cohort to ensure they can remain at work and their wellbeing is maintained.

It must be noted that much of the data available pre-dates any changes to the workforce that were likely to have occurred because of COVID-19. While we cannot say with certainty whether the pandemic will exacerbate the issues mentioned, it’s likely that these pressures will add a further layer of complexity to the workforce demographic challenges the health and care sector had before the pandemic hit.

What impact do you think this factor(s) will have on workforce number demand?

- Strong demand reducing impact
- Moderate demand reducing impact
- Weak demand reducing impact
- Neutral
- Weak demand increasing impact
- Moderate demand increasing impact
- Strong demand increasing impact

d.5.1.d. What degree of impact do you believe this factor(s) will have on need for new skills?

- Low Impact
- Medium Impact
- High Impact

e.5.1.e. What degree of impact do you believe this factor(s) will have on need for new roles?

- (x) Low Impact
- ( ) Medium Impact
- ( ) High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

- ( ) Low Impact
- ( ) Medium Impact
- ( ) High Impact

In what time horizon will the most significant impact be felt on workforce demand?

- ( ) 0 - 5 years
- (x) 6 - 10 years
- ( ) 11 - 15 years
- ( ) Beyond 15 years

Supporting evidence

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Factor B

Changing needs of the population

Healthcare need or demand is not constant across age groups, for this reason, it is common to consider the impact of demographic changes on the need for health and care services as dependent on two factors: population size and population age structure. A growing and ageing population means the sector will have greater volumes of care needs. This is particularly true of the social care provided to older citizens.

Population health status (alongside reducing health inequalities) is another influencing factor on demand for health and care services. Changes in health status may cause a population to require more or less healthcare, even after changes in population size and age structure are accounted for. It is also the case that many communities have poorer access to healthcare and poorer outcomes. Correcting such inequalities may reduce demand and dependency in the longer term but is likely to require greater intervention in the immediate term.

How these changing needs will evolve over the years to come will have a significant impact on the demand for health and care services and impact the size and shape of the future workforce. Healthcare needs may not be consistent across the country, as we know that health inequalities are more prevalent in certain parts of England. The need for workforce supply may be greater in those areas, where health inequalities lead to ill health or increase the need for additional support to maintain independent living and require more support from a larger health and social care workforce, particularly in primary care and roles related to managing the conditions most associated with health inequalities.

It has been well documented that, over the last few decades, the demand for health and care services has risen dramatically. This, in part, can be attributed to a growing and ageing population, as well as advances in medicine and technology that have enabled a wider range of healthcare services to be provided.

The latest statistics and projections produced by the Office for National Statistics (ONS) show that over the next decade, the population of most areas of England is set to continue growing, particularly in the South and Midlands. The total UK population is projected to pass 70 million by mid-2029 and be 72.9 million in mid-2041. Projections also show the share of people aged 65 years and over will increase almost everywhere. The number of people aged over 85 in the UK is projected to increase to 3.6 million by 2039 and the number of centenarians is projected to rise nearly six-fold, from 14,000 at mid-2014 to 83,000 at mid-2039.

This increase in the numbers of older people means that by mid-2039 more than 1 in 12 of the population is projected to be aged 80 or over. We can anticipate a rise in the number of people with debilitating conditions, including sight and hearing loss and dementia which can be triggered by old age. With the level of demand for health and care services expected to continue to increase, so will the need for staff, particularly with the skills, care and compassion to deal with the increase in care needs for older people. The lack of a long-term strategy for social care is particularly concerning as this will only exacerbate the pressure on health services, it may also impact on the roles required in the NHS and the way in which NHS community services are delivered.

But it is not just life expectancy that has changed, over the past two decades there has been an increase in people living for prolonged periods with multiple long-term health problems. In 2019, there were 5.7 million people over 65 living with a long-term health condition. Projections for the future of long-term conditions are not straightforward. There has been a renewed focus from the healthcare system over recent years on preventative approaches to

treating and referring patients through social prescribing and new roles in primary care such as care/community navigators and link workers. This approach includes action to help people live healthier which could stop thousands developing life threatening or limiting conditions, but it is unclear whether current behavioural trends will continue or reverse. For example, obesity rates could continue to rise, flatten or fall, and the same is true for smoking, physical activity and alcohol consumption.

While those are physical issues, the service is also predicting demand for mental health support to increase above pre-COVID-19 levels and to remain high for some time. Our mental health provider members are seeing patients with more significant needs; a higher proportion of patients are accessing services for the first time; and there are increased Mental Health Act presentations. The number of children and young people needing mental health support was increasing anyway, but the pandemic has increased demand for support for this group. This is impacting on mental health providers but is also being felt across the whole of the NHS, and beyond to local authorities and schools.

The Centre for Mental Health predicts that an additional 500,000 people will require support for their mental health, with the majority requiring support for depression and anxiety. Along with people from a BME background, young people, those living alone, people with lower household income and people with existing mental and physical health conditions are reporting the largest impact on their mental health. A number of systems have already undertaken their own demand modelling work to estimate what the possible increase is likely to be. National work is underway to estimate what the increase in demand is likely to be, to inform the next comprehensive spending review. This work is essential to better understand expected demand and its impact in different areas and on different groups, to determine the services required to meet those needs and what this means for the size and shape of the workforce to deliver those services.

We are also concerned that social care support for working age adults has been forgotten within the broader conversation on care reform. An estimated 1.4 million people have an unmet need for social care. The most recent available figures suggest this represents around 48 per cent of gross current expenditure on social care by local authorities, of which around 10 per cent is on support for mental health.

Adult social services are also facing a deluge of requests for care and support from older people and disabled people of working age as society opens after COVID-19. Survey findings demonstrate that the crisis in social care is not just a crisis in the way older people are supported, with half of adult social care spending focused on help for adults of working age. Some of our members are also reporting an increase in the number of in-patients without family support, which is impacting on the availability of informal care and support, creating problems at the point of hospital discharge.

Many of the determinants of population health status are outside of the health and care sector's direct control. Housing, employment, debt and personal relationships impact on an individual's mental and physical health and ability to recover and stay well. The impact of COVID-19 on these determinants has been significant. If social issues become entrenched for a large section of the population, there is a risk that low level health needs become more serious, and more specialist care will be required from health services.

What impact do you think this factor(s) will have on workforce number demand?

- ○ Strong demand reducing impact
- ○ Moderate demand reducing impact
- ○ Weak demand reducing impact
- ○ Neutral
- ○ Weak demand increasing impact
- ○ Moderate demand increasing impact
- ● Strong demand increasing impact

What degree of impact do you believe this factor(s) will have on need for new skills?

- ○ Low Impact
- ○ Medium Impact
- ● High Impact

What degree of impact do you believe this factor(s) will have on need for new roles?

- ○ Low Impact
- ● Medium Impact

- ○ High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

- ○ Low Impact
- ● Medium Impact
- ○ High Impact

In what time horizon will the most significant impact be felt on workforce demand?

- ○ 0 - 5 years
- ○ 6 - 10 years
- ● 11 - 15 years
- ○ Beyond 15 years

Supporting evidence

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Factor C

Immigration policy and labour market

The health and care sector would not be able to function without its international workforce. For nursing, the planned additional 12,000 nurses from overseas by 2024/25 will contribute towards bridging the long-standing numbers of vacancies – immigration policy is currently structured to support overseas recruitment of many registered health professionals. When the policy has been more restrictive, it has halted the in-flow of supply.

From 1 January 2021, all workers arriving from European Economic Area (EEA) and non-EEA countries have been subject to the same immigration rules. Unlike in the health sector, there are no exceptions made for social care roles, such as care workers. This crucial role has a high number of vacancies and future forecast demand from Skills for Care shows an increased need for these roles. Providers in London and South East are reporting increasing difficulties in properly staffing services, given their previous reliance on labour sourced from the EEA and the continued lack of a long-term plan for social care.

Immigration policy can flex between being open or restrictive.

It needs to be able to respond in an agile way to complement the skills available within the UK labour market and what employers require. It has a history of being slow to respond to changes and

therefore not responsive to employer needs or local workforce plans.

In defining the longer-term view for workforce demand/supply as well as the immediate and medium term need the long-term plan needs to articulate the place of immigration to deliver the plan and be clear how it interfaces with the UK labour market and supports and complements other interventions to meet workforce supply and demand needs in health and social care. This detailed and long terms workforce planning work should be able to inform and shape UK immigration policy.

The Brexit transition period ended on 31 December 2020, since then, aspects of the UK's immigration system have changed. Our members are adapting to a new points-based immigration system introduced to manage migration into the UK. Both EEA and non-EEA citizens are now subject to the same immigration rules, apart from Irish citizens, who are covered by Common Travel Area arrangements and do not need permission to enter or remain in the UK.

Under the new system, there are supportive of our members' ongoing recruitment of healthcare staff from overseas. The Health and Care Visa, launched last year, is a fast-track visa scheme, with a reduced visa fee for health and care workers. There have also been changes to the shortage occupation list, which provides concessions for a number of registered health and care practitioner roles.

As mentioned above, most care workers are not eligible for the Health and Care Visa, and many will fail to meet the salary and skill level thresholds put in place under the new rules. This becomes even more critical with a competitive labour market, low levels of employment across the country and demand from across all sectors to attract workers, leading to increased wages.

Our social care partners in the Cavendish Coalition also report that reductions in immigration to the UK, from the EU and worldwide, is having a current impact on the size of the overall local labour market and – increasing competition for social care providers to recruit.

Social care has approximately 112,000 vacancies predominantly in care worker roles which fall outside the permissions of the immigration system to be able to recruit. As of September 2021, the UK labour market has low levels of unemployment in many parts of the country and lower than forecast. The shortage is nationwide however there are regional variations and reasons for the shortages e.g., remote, and rural providers have a small labour market to recruit from, city and urban providers may have lots of other employers who are competing for the labour and who have flexibility to increase wages in a way local authority funded social care providers may not.

COVID-19 has shone a light on the fragility of the social care system. Social care needs a long term and sustainable funding solution which can help address workforce issues. While this is not in place and the public funded services have less flexibility to increase wages to compete in the labour market, removing the ability for social care to attract new workers from outside the UK through the design of the UK's immigration system places additional pressure on an already fragile sector. The increase in pressure on social care has a direct impact on demand and pressure in health services.

Labour market analysis of ending free movement has also found that up to 160,000 EEA workers who arrived in the UK over the last three years would not have been eligible to live and work here had the new immigration rules been in place. Over time, this could fundamentally change the profile of the EEA workforce participating in the UK labour market, arguably concentrating competition for jobs in higher skilled roles, and leaving labour shortages in sectors that have recruited EEA nationals, such as health and care.

There are also uncertainties surrounding the future of the Mutual Recognition of Professional Qualifications Directive and how any new arrangements following the end of the current transition period will impact on workforce supply flows into the UK, especially for senior doctors.

Professional regulatory bodies are currently working with the government to review future registration requirements for those with qualifications gained in the EEA. This is currently an unquantifiable risk until new arrangements are decided and implemented however the lack of certainty presents an additional risk to be factored into planning.

As the new immigration system beds in, the international workforce supply needs monitoring closely because any gap between supply and demand will in turn drive demand for additional UK based training including through apprenticeship routes as well as undergraduate and postgraduate courses. The health and care sector are already focused on domestic recruitment and retention activity as a priority. Looking at current vacancy data, workforce numbers, number of people available for work in health and care and the training times required for some staff, the domestic market cannot fulfil the sector requirements in the short to medium term.

International recruitment forms a part of the current strategy to increase the workforce in a number of professions including recruiting an additional 12,000 nurses from overseas by 2024/25. This commitment will require an immigration policy that remains supportive of ethical international recruitment if it is to be realised.

The Code of Practice for the international recruitment of health and social care personnel was re-published in February this year. Among other changes, the revised code aligns to the World Health Organisation Workforce Supply and Safeguard List 2020. This saw a reduction of countries not to target for active recruitment from more than 150 to 47. As a result, more than 100 countries are potential new markets for active recruitment.

The impacts of the revised Code of Practice are not yet known. It is also too early to say if the new Health and Care Worker Visa alongside the Immigration Health Surcharge exemption will maintain the UK's status as an attractive place to come to work for non-British nationals. The restrictions on movement necessitated by the COVID-19 pandemic have paused and disrupted some individual's plans to migrate to the UK and we may continue to see some continued disruption to travel in the short term.

c.5.3.c. What impact do you think this factor(s) will have on workforce number demand?

- ○ Strong demand reducing impact
- ● Moderate demand reducing impact
- ○ Weak demand reducing impact
- ○ Neutral
- ○ Weak demand increasing impact
- ○ Moderate demand increasing impact
- ○ Strong demand increasing impact

d.5.3.d. What degree of impact do you believe this factor(s) will have on need for new skills?

- ● Low Impact
- ○ Medium Impact

High Impact

e.5.3.e. What degree of impact do you believe this factor(s) will have on need for new roles?

Low Impact

Medium Impact

High Impact

f.5.3.f. What degree of impact do you believe this factor(s) will have on need for new ways of working?

Low Impact

Medium Impact

High Impact

g.5.3.g. In what time horizon will the most significant impact be felt on workforce demand?

0 - 5 years

6 - 10 years

11 - 15 years

Beyond 15 years

Supporting evidence

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Public, People who need care and support, Patient and Carer Expectations

Factor A

Public expectations post pandemic

Public mood influences policy makers and in particular public mood on the NHS, which surveys have shown has been at the very top of public concern over decades.

The evolution of public perceptions and expectations of health and care services during the COVID-19 crisis has the potential to shape care after the pandemic and must be closely monitored for potential impacts on policy making, which in turn may drive workforce supply and demand.

The sector needs the public's continued patience and understanding, as well as investment from the government to help it adjust post pandemic.

There is also still much more needed to be done to encourage the public to manage and take more accountability for their health and care.

Finally, we know that many communities still experience poorer access, experience, and outcomes in relation to their healthcare. This is seen especially in many ethnic minority communities and in deprived and underserved wards and communities.

The NHS Confederation's membership greatly appreciates the support shown by the public during the pandemic, both the public recognition of the commitment of staff to care for them and being so understanding as usual services were curtailed. The public rightly expects normal services to resume and to receive the care and treatment that has been delayed.

Our members have been committed to resuming services at scale and pace, wherever they safely can, and tackling the service backlog. There has been a delicate balance to be managed between minimising immediate risks to patient safety during a pandemic and mitigating against the longer-term risks associated with delayed treatment.

The pandemic's impact on the capacity of the NHS is still being felt and that is likely to continue for several years. This is particularly the case for mental health, where although the number of people with COVID-19 is going down, the number of patients with mental health care needs is already increasing, especially in children and young people. If the demand modelling is correct, this will continue to increase for the next few years.

The public mood influences policy makers and needs to be monitored closely as a potential driver of policy change. Latest public polling suggests there has not been a huge shift in public opinion on the NHS; satisfaction is a little lower, but there is no sign that pride has diminished and optimism about the future is rising.

However, it remains to be seen how long this public tolerance will last if the rationing of elective care still needs to happen.

Of particular concern to policy makers will be the public's priority placed on the need to improve waiting times post pandemic. The public mood has the potential to dictate the pace of change, particularly as we approach the next general election. For example, this could influence decisions about how waiting lists are tackled; how much virtual care is kept and developed and what forms of new technology should be tried to help improve access to care. This in turn can impact the future size and shape of the workforce.

The NHS needs government investment to support the introduction of new ways of working that will enable it to fully restore services, and the understanding of the public while it adjusts and deals with a large backlog of patients needing care. Public messaging on NHS capacity needs to be honest and realistic. The BMA has estimated that even if the NHS were to run at 110 per cent of its pre-COVID-19 capacity, it could take up to five years to reduce the backlog of elective care in England back down to (already high) 2019 levels.

The commitment of NHS staff to do their best for the public has been demonstrated many times over during the pandemic. Government and national bodies need to support the NHS to manage the realities of recovering services, not set unrealistic targets and impose financial penalties.

The health and care system also needs to invest in increasing health promotion, health prevention and educating the public in managing their own health. This will also mean educating the workforce to ensure they are supporting individuals to take on some responsibility for their health and signposting them to how and where to do this. In addition, the younger generation are used to accessing information when they want it, so the NHS will have to manage these expectations and develop access to health information on a 24/7 basis.

What impact do you think this factor(s) will have on workforce number demand?

- ○ Strong demand reducing impact
- ○ Moderate demand reducing impact
- ○ Weak demand reducing impact
- ○ Neutral
- ○ Weak demand increasing impact
- ● Moderate demand increasing impact
- ○ Strong demand increasing impact

d.8.1.d. What degree of impact do you believe this factor(s) will have on need for new skills?

- ○ Low Impact
- ● Medium Impact
- ○ High Impact

e.8.1.e. What degree of impact do you believe this factor(s) will have on need for new roles?

- ● Low Impact
- ○ Medium Impact

○ High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

○ Low Impact

◉ Medium Impact

○ High Impact

In what time horizon will the most significant impact be felt on workforce demand?

◉ 0 - 5 years

○ 6 - 10 years

○ 11 - 15 years

○ Beyond 15 years

Supporting evidence

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Socio-economic and Environmental Factors

Factor A

Health inequalities

The COVID-19 pandemic has thrown the issue of health inequalities in the UK into sharp focus and exposed the consequences of a long-standing failure to tackle this deep-rooted and multi-faceted problem. The pandemic has had disproportionate health, economic and social impacts on people in lower socio-economic groups and those with minority ethnic backgrounds.

It is imperative for the NHS to deliver a step-change in how it cares for diverse and marginalised communities to make improvements in access, experience, and outcomes. The NHS Race and Health Observatory has been established to particularly address the stark disparities and poorer outcomes for ethnic minority communities.

Designing services to be more inclusive of the diverse needs of communities will have an impact on the size, shape and proximity to the communities served by the workforce, and therefore will need to be a key component of workforce planning. Employers are also increasingly acting to support their role as significant economic actors in their communities, with the ‘Anchor’ movement growing in strength as well as proactive engagement with hitherto under-represented groups. National action is also required though to

ensure that key health professions are inclusive and diverse, and not, for example, drawn predominantly from limited socio-economic groups. Despite the NHS being a universal service, those living in poorer communities and from black and minority ethnic (BME) backgrounds already suffer from poorer health outcomes than the rest of the population.

The COVID-19 pandemic has both highlighted and exacerbated health inequalities. It has

turned the spotlight on troubling differences in health outcomes; on disparities in access, quality, and experience of care; and on the range of social and economic factors that impact on health. Yet health inequalities have been a decades-long issue.

In a survey of NHS Confederation members, almost three-quarters of NHS leaders believe that BME communities continue to have poorer access and outcomes from NHS services, while almost nine in ten leaders believe the NHS must deliver a step change in how it cares for diverse and marginalised communities.

Even before the pandemic, people with learning disabilities and those with serious mental illness were more likely to die prematurely from physical health issues. During the pandemic, people with learning disabilities were more likely to die of COVID-19, and at a younger age than those without a learning disability. There also needs to be a step change in how these people are cared for, which includes addressing physical health issues and social needs, as well as their mental health or learning disability.

If there is to be a serious effort to reduce the level of health inequality, it will require sustained and funded action at national and local level. The NHS Long Term Plan promised extra funding for areas with unmet need and local action to narrow inequalities as part of the government’s ambition for five extra years of healthy life expectancy by 2035. It will require a radical and conscious shift in how service providers engage with communities, co- designing and delivering services in a much more inclusive way which will have consequences for the size, shape and location of the future workforce.

As the success of the vaccination programme in reaching underserved groups demonstrates, reducing health inequalities requires action at the community-level where the demand lies. Through Primary Care Networks (PCNs), primary care has forged links with underserved groups and is delivering tailored initiatives to manage population health. They have also focused on preventative care with PCNs developing creative projects, such as allotments, in partnership with local authorities and the voluntary sector. Addressing health inequalities entails increasing access for underserved groups, ensuring care takes place as close to the population served as possible, and enabling population health management and partnership-working within communities. Moving forward, this will require an increased workforce in primary care.

It also includes addressing workforce inequalities within primary care that result in unequal access, exacerbating health inequalities. Overall, deprived areas are disproportionately affected by workforce shortages and have fewer GPs per 10,000 patients yet, conversely, have a greater number of physician’s associates and pharmacists. The result is unequal access in both number and type

of staff, requiring remedy through targeted interventions to parts of the workforce in deprived areas.

The healthcare sector also has an important role beyond that of just delivering care. One of the important and well-known determinants of health inequalities within society is the availability and nature of employment. Employment is linked to the fundamental causes of health inequality due to the unequal distribution of income, wealth and power. As the largest employer in the country, the NHS has a key role as an anchor institution in helping to tackle inequalities locally in its employment and apprenticeship opportunities.

By opening routes to employment for people who may not have previously considered or been aware of the variety of roles and careers available in the NHS, the sector is helping to ensure the workforce reflects the diversity of local populations. Building a workforce that is more representative on the local area can help to design and deliver inclusive services and respond to patient need, it also helps to grow local workforce supply.

The NHS People Plan explicitly recognises the NHS's responsibility, as an anchor, to support employment opportunities for local communities by creating new job pathways and making the NHS a more inclusive work environment and a better employer for more people. Many of our members are already working alongside local councils, colleges and local enterprise partnerships (LEPs) on initiatives to increase recruitment in their local communities, such as the Kickstart scheme, apprenticeships, traineeships, restart scheme and working with The Prince's Trust. Initiatives like these will be key drivers for workforce supply now and into the future. Furthermore, the expansion of primary care through PCNs and the Additional Roles Reimbursement Scheme is a route of employment and training, for both clinical and non-clinical roles, at the community level.

Co-ordinated national action continues to be required to ensure that access to undergraduate education, as the key gateway to many

careers is diverse and inclusive. Medical Schools have recognised their challenges in relation to social diversity, though progress has been slow since 2015. Similarly certain professions attract fewer applicants from ethnic minority backgrounds.

We say more about the role of the NHS in tackling health inequalities in our published report, 'Health Inequalities: time to act'. We are also pleased to be supporting a major study led by King's College London and City University of London, investigating how discrimination experienced by both patients and healthcare practitioners may generate and perpetuate inequalities in health and health service use.

What impact do you think this factor(s) will have on workforce number demand?

- ( ) Moderate demand reducing impact
- ( ) Weak demand reducing impact
- ( ) Neutral
- ( ) Weak demand increasing impact
- ( ) Moderate demand increasing impact
- ( ) Strong demand increasing impact

What degree of impact do you believe this factor(s) will have on need for new skills?

- ( ) Low Impact

- [x] Medium Impact
- [ ] High Impact

What degree of impact do you believe this factor(s) will have on need for new roles?

- [ ] Low Impact
- [x] Medium Impact
- [ ] High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

- [ ] Low Impact
- [ ] Medium Impact
- [x] High Impact

In what time horizon will the most significant impact be felt on workforce demand?

- [x] 0 - 5 years
- [ ] 6 - 10 years
- [ ] 11 - 15 years
- [ ] Beyond 15 years

Supporting evidence

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Factor B

Governance and regulatory environment

The structures, systems, and processes by which services and health and care organisations are governed can influence the behaviour of individual staff and organisations. It may help drive up quality, and it could also affect willingness to take risks and ability to innovate.

The COVID-19 crisis has required the health and care system to operate differently. Our members transformed clinical practice in days and weeks on a scale that would ordinarily take several months and years.

Change happened at an extraordinary pace in every part of the health and care system, built from the bottom up by leaders who united around the shared challenges presented by the pandemic. This was facilitated, in no small part, by the removal of various bureaucratic stumbling blocks that have previously hindered progress, including in improving patient care. Whatever the governance and regulatory environment looks like for the sector in future, it does create some uncertainty around the size and shape of the future workforce.

The combination of several wider regulatory and legal changes also has the potential to cause uncertainty around workforce supply in the future, this includes the end to transitional arrangements for the recognition of EU professional qualifications (previously mentioned in our response), proposals to reform the regulation of healthcare professionals in the UK and the requirement for social care staff and those entering a care home to be vaccinated.

Finally, a great deal of the policy and planning expertise in relation to workforce (as well as other policy areas) is centralised. An NHS which is focused on system and place will require greater accountability and/or access for that resource to be vested in systems, as vehicles for collaboration for health and social care.

Many of the positive ways of working in response to COVID-19 was based on local public sector and health and care leaders coming together at pace to radically redesign services for their communities. In contrast, and historically, a national response or policy direction can lack pace as we saw with approaches to national guidance, PPE and test, track and trace, the difference makes a strong argument for a less centralised health and care system.

At the same time, the emergency response to COVID-19 has provided a glimpse of how the NHS could be, if duplication in reporting and assurance were stripped away and the system united behind a common cause. Services were transformed in days, rather than years, and frontline clinicians from trusts to primary care were empowered to innovate and redesign services.

The health and care bill introduced on 6 July 2021, provides the opportunity for a new and different regulatory environment. It is the first major piece of primary legislation on health and care in England since the Health and Social Care Act 2012. There is clear consensus across the Confederation’s membership that the future of health and care must be based on collaboration and partnership working at a local level. There is a strong desire to move away from

much of the existing health and care legislation that over-prescribes specific requirements and duties for commissioners, providers and regulators.

The health and care bill is an essential enabler to the integration of healthcare services, however, there are important areas of the bill that we believe need to be amended during the legislative process. If it is to provide a legislative culture and architecture to support partnership working and reduce unnecessary bureaucracy, as is the desire from our members, we need the following.

Greater clarity and checks and balances on the basis upon which the Secretary of State's power to intervene in the NHS will be used.

Provisions for workforce planning to be strengthened, ensuring the NHS has the people it needs to provide high-quality care.

Further clarity from the government on how integrated care system (ICS) partnerships and health and wellbeing boards will work alongside each other.

Greater clarity on whether accountability for quality of care ultimately lies with trusts or systems.

When the governance and regulatory conditions are right, it results in an increase in the pace of decision-making, innovation and improved outcomes for people, patients and communities. But with questions over the future governance and regulatory environment for the sector within the Health and Care Bill, comes uncertainty for the ability to redesign services, new ways of working and demand for new roles and new skills in the years to come.

The government has also recently consulted on potential changes to healthcare professional regulators in 'Regulating Healthcare Professionals, protecting the Public'. The COVID-19 pandemic has required the regulators to act quickly and respond in innovative

ways to cope with rapidly changing circumstances and increased pressures. It has drawn into focus the necessity for a responsive and agile professional regulatory environment. The consultation's proposals are wide-ranging and cover the regulators' key regulatory functions (registration, fitness to practise, and education and training) as well as suggesting changes to their governance and operating frameworks. Proposals also put an onus on regulators to work together to ensure there is consistency and shared processes as appropriate.

The future arrangements and potential increase of autonomy for professional regulators does create some uncertainty about the environment in which healthcare staff will be regulated in the future. Our members are in favour of a professional regulatory environment that can respond to changing workforce models and developments in health and care delivery. Importantly, as new roles are developed and rolled out across the NHS, processes for regulating these new roles must be proportionate and streamlined, with legislation for existing registers to be future proofed to enable the inclusion of new roles or extended permission, e.g., prescribing, in a safe and timely way.

It is expected to be some time before the proposals become reality. The government intends to implement the changes through secondary legislation, starting with the General Medical Council this autumn and with the expectation that this first piece of legislation will come into force in the spring of 2022.

In relation to the questions below re impact on numbers, skills and ways of working – the way the system organises its regulatory architecture and governance regimes has the opportunity to release time to care, enable and facilitate change and innovation and have a positive impact on staff experience.

If it is not fit for purpose, it has the potential to demotivate individuals at all levels and stifle the ability to generate improvement which could lead to an impact on retention.

What impact do you think this factor(s) will have on workforce number demand?

- ○ Strong demand reducing impact
- ○ Moderate demand reducing impact
- ○ Weak demand reducing impact
- ● Neutral
- ○ Weak demand increasing impact
- ○ Moderate demand increasing impact
- ○ Strong demand increasing impact

What degree of impact do you believe this factor(s) will have on need for new skills?

- ○ Low Impact
- ● Medium Impact
- ○ High Impact

What degree of impact do you believe this factor(s) will have on need for new roles?

- ○ Low Impact
- ● Medium Impact

High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

Low Impact

Medium Impact

High Impact

In what time horizon will the most significant impact be felt on workforce demand?

0 - 5 years

6 - 10 years

11 - 15 years

Beyond 15 years

Supporting evidence

NHS Confederation (2020), LEAN, LIGHT AND AGILE GOVERNANCE AND REGULATION IN THE AFTERMATH OF COVID-19. [Online]. https://www.nhsconfed.org/sites/default/files/media/Lean-light-and-agile-Reset_4.pdf

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Factor C

Economy and public funding

The economic conditions for the health and care sector remain challenging. Factors such as the growth and ageing nature of the population, higher incidences of long-term conditions and increased demand continue to put pressure on budgets.

Delivering the future health and care workforce in sufficient numbers and with the skills needed depends greatly on future investment in the workforce and the impact of current interventions, and therefore will need to be a key component of workforce planning.

To create a sustainable workforce in the longer term, and to meet the government's manifesto commitments to recruit more nurses, GPs and other health professionals, more staff need to be educated and trained in the UK.

The introduction of student financial support to help with living costs and additional investment in training places should help, but sustained long-term investment is needed, matched to areas and professions with the greatest needs. A growing reliance on international recruitment has mitigated some of this shortfall in recent years but is not sustainable at present levels.

In recent years there has been a significant focus from the government on reforming the way apprenticeships are delivered and funded in England. As part of these reforms, apprenticeships are now more robust, better structured, and independently assessed to ensure apprentices gain the skills that employers need for their workforce. Our members remain committed to building apprenticeships into their workforce strategies to address skills shortages, as well as a means of attracting new talent, developing

and upskilling existing staff, and retaining their existing workforce. However, concerns have been raised about the level of investment in apprenticeships and their affordability to employers which is creating barriers to their potential.

1 Placement and supervisory capacity

A concerted effort from the NHS to make best use of apprenticeships requires a significant increase in the proportion of learners in the workplace. Our members have highlighted concerns to us regarding the ability and capacity of the service to support an increase in placements and supervision for these learners, in clinical roles which require a large amount of supervision and assessment within the workplace, typically provided by registered healthcare professionals working alongside the apprentice learner.

Concerns have been raised about the difficult balance NHS organisations must strike between providing excellent patient care and having sufficient capacity to support meaningful and high-quality learning in the workplace.

2 Backfill costs

Our members recognise the value of the 20 per cent ‘off-the-job’ training requirement as a key component of an apprenticeship. However, for healthcare-specific standards such as the nursing degree apprenticeship, there is a much larger off-the-job requirement of over 50 per cent. This time is supernumerary and means that when the apprentice is in the workplace, undertaking tasks within their competency and scope of practice, they cannot be considered as part of the workforce or included in safe staffing figures. Employers must provide backfill for this element of their training, which represents a significant cost, in addition to apprentice salary and the supervision and mentoring time required.

3 Infrastructure

For some of our members, the introduction or scale up of apprenticeships in their organisations is a departure from previous practice and therefore requires significant investment to develop the infrastructure required to co-ordinate and support learners in the workplace in greater numbers. Sufficient and stable infrastructure acts as a key enabler of the delivery of high-quality apprenticeships.

In commissioning Health Education England to lead on developing this long-term NHS workforce plan, the government has taken a very important and positive step towards delivering a plan for adequately staffing health and care services. A plan, which responds to the needs of local communities and highlights opportunities for innovation and integration in ways of working. However, there is urgent need for decisive and long-term investment in addressing the chronic staffing issues across health and care.

Our members want to see much greater clarity on the impact that recent interventions, including the expansion of medical schools, the target for 50,000 more nurses and the increased uptake of undergraduate education will have in the years to come. Understanding this will help the NHS to plan more realistically, and better identify the staffing supply and demand gaps that risk the future delivery of the NHS long-term plan.

Research also suggests that a financially challenged country has an impact on worsening health outcomes. The impact of the COVID-19 pandemic on the economy and its influence on our population health is another influencing factor on demand for health and care services. Changes in population health status may cause a population to require more or less healthcare and therefore this should be a key component of workforce planning.

What impact do you think this factor(s) will have on workforce number demand?

- (selected) Strong demand reducing impact
- Moderate demand reducing impact
- Weak demand reducing impact
- Neutral
- Weak demand increasing impact
- Moderate demand increasing impact
- Strong demand increasing impact

What degree of impact do you believe this factor(s) will have on need for new skills?

- (selected) Low Impact
- Medium Impact
- High Impact

What degree of impact do you believe this factor(s) will have on need for new roles?

- (selected) Low Impact
- Medium Impact

- [ ] High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

- [x] Low Impact
- [ ] Medium Impact
- [ ] High Impact

In what time horizon will the most significant impact be felt on workforce demand?

- [x] 0 - 5 years
- [ ] 6 - 10 years
- [ ] 11 - 15 years
- [ ] Beyond 15 years

Supporting evidence

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Staff and Student/Trainee Expectations

Factor A

Expectations of working life: greater control over work/life balance

The annual NHS Staff Survey asks NHS staff in England about their experiences of working for their organisation. The latest survey was conducted between October and November 2020. In total 280 NHS organisations took part, including all 220 trusts in England. The results for 2020 were published on 11 March 2021.

The results bear witness to the sustained pressure on the NHS over the last year. Undertaken during the second wave of the pandemic, the results point to improvements in areas including health and wellbeing, but it highlights that there remains some way to go to improve staff experience. It highlights the need for a renewed focus on tackling work-related stress. The results also show that around a third of staff are considering leaving their jobs, of which nearly one in five are thinking of quitting the health service entirely.

The labour market has also significantly changed during the COVID-19 pandemic, with changing attitudes to work-life having an impact on recruitment and retention.

Results from the biggest survey of NHS staff, published in March 2021 demonstrate the pressures that the NHS has been facing over the past year due to the COVID-19 pandemic. Despite this, there have been improvements in a number of areas, including employer action on health and wellbeing, staff views on feeling equipped to do a job properly, opportunities for flexible working, and opinions on recommending the NHS as a place to work. The overall indicator on staff perception of quality of care remains stable, and staff also felt they were able to provide good quality care.

While the survey points to welcome improvements, challenges remain and will require concerted action in the year ahead and will remain a necessity. Staff from black and minority ethnic (BME) backgrounds continue to have a more negative experience of working in the NHS and have lower confidence in organisations providing equal opportunities. The toll of the pandemic has also seen a rise in work-related stress, with a third of staff considering leaving their jobs and nearly one in five are thinking of leaving the health service entirely. Some of our members are also concerned about the impact on retention of the student workforce who have experienced a pandemic and significant demand pressures early in their careers. This may impact on their choices going forward and their willingness to remain in the NHS.

Growing the workforce is partly dependent on retaining staff already working in the service, especially with so many staff suffering from burnout and significant numbers, particularly nurses, intending to leave. To do this, organisations have a renewed focused on making the NHS a great place to work, a key priority in the NHS People Plan. Examples of this renewed focus include tackling bullying and discrimination, as well as providing an attractive employment offer, including taking steps to create more opportunities to help staff achieve a better work-life balance.

Over recent years, work-life balance has increased as a reason for leaving NHS employment, nearly three times more people cited it in 2019/20 than in 2011/12 according to NHS Digital's leaver data. The extra demands of the pandemic have left staff exhausted and our members are concerned by the many who are re-evaluating their priorities and considering leaving the NHS.

To address this, NHS organisations are stepping up measures to increase the uptake of flexible working, in terms of the time, location and pattern of working. Changes to the NHS Terms and Conditions Handbook are coming into effect in September 2021 that will help to give NHS staff greater choice over their working patterns to encourage staff to continue their careers in health.

The medical workforce has also seen a shift in recent years in how doctors want to train and work. There has been a gradual increase of new initiatives to allow doctors in training to work less than full time (LTFT) and take breaks out of their training, to retain doctors within the NHS workforce who are unable to train on a full-time basis and to promote work/life balance. Most recently there has been an expansion of category three LTFT which means that any doctor in any specialty can request to work LTFT without needing to give a reason. There has also been the introduction of a new out of programme pause, which allows doctors to pause their training to either take a break entirely or work in a different specialty and gain experience elsewhere.

The expectation is more widespread establishment of flexible working across the entire workforce in the future, and therefore that will need to be a key component of workforce planning because of the impact this may have on the size and shape of the workforce.

The COVID-19 pandemic has accelerated changing attitudes to work-life and some of our members are concerned of potential impacts on recruitment and retention in certain geographies. For instance, our provider membership in London has reported that since the COVID-19 pandemic, some 700,000 people have left the

city, and this is impacting on recruitment and retention for those organisations in the inner-city area because staff no longer wish to commute into the city. It could be foreseen that other cities may also see a similar exodus as the options and desire for agile and more flexible working increases.

What impact do you think this factor(s) will have on workforce number demand?

- ○ Strong demand reducing impact
- ○ Moderate demand reducing impact
- ○ Weak demand reducing impact
- ○ Neutral
- ○ Weak demand increasing impact
- ● Moderate demand increasing impact
- ○ Strong demand increasing impact

What degree of impact do you believe this factor(s) will have on need for new skills?

- ● Low Impact
- ○ Medium Impact
- ○ High Impact

What degree of impact do you believe this factor(s) will have on need for new roles?

- (selected) Low Impact
- Medium Impact
- High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

- Low Impact
- Medium Impact
- (selected) High Impact

In what time horizon will the most significant impact be felt on workforce demand?

- (selected) 0 - 5 years
- 6 - 10 years
- 11 - 15 years
- Beyond 15 years

Supporting evidence

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Factor B

Placement capacity and regional variation

The training pipeline of new staff is critical to supply, to replace those leaving, meet increasing demand and cover vacancies. Clinical placements are a pivotal element of healthcare education and the ambition and motivation of our members to meet the proposed increase in students is clear, however there is some apprehension about how additional capacity for placements can be generated.

In addition, there are important issues with regional variation of training capacity for some courses, for example mental health nursing. This can be particularly problematic given that students will likely work in the same region in which they have studied.

Training and placement capacity is a key element to ensuring essential workforce supply, and therefore this will need to be a component of workforce planning.

The NHS is experiencing a unique moment in its history as its value is brought into sharp focus by the COVID-19 pandemic. Healthcare has become a more visible and desired career choice and we can see this through applications to healthcare courses for the 2021/22 academic year which have increased on a large scale. Published UCAS figures have revealed that nursing applications are up 32 per cent, with increased demand from both 18-year-olds and mature students. They have also increased for midwifery and allied health courses in physiotherapy.

Regional distribution for some of these courses is patchy though. For instance, in mental health nursing in 2020 there were only 37

universities with postgraduate and 14 with dual (including mental health) courses. This may be particularly problematic for future workforce supply, given that students will likely work in the same region in which they have studied, the current unbalanced geographical distribution of courses is not ideal.

In 2018, there were three times as many acceptances per 100,000 in the North East of England as the South East, with the latter already struggling with high levels of mental health nursing vacancies. While an increase in applications across healthcare courses is positive, there needs to be an evaluation of how these applications convert through to acceptance of a place and commencement on the course and how they vary by geography/region.

There is also evidence of inequity in the regional distribution of medical students. This needs to be resolved to address underserved populations in the future. There is similar variation in postgraduate training in medicine, though HEE have started initial work to redress this.

Clinical placements are a pivotal element of healthcare education and as such the NHS will have a vital role to play in meeting increased demand. Historically, the number of placements available to host learners for whom practice-based learning is a requirement of their programme has been a barrier to increasing intake levels across the country. Now, the recovery of placement capacity not accessible during the COVID-19 pandemic has further heightened this challenge.

As an essential pipeline for the healthcare workforce, NHS organisations are doing what they can to expand placement capacity as far as possible but there remains a gap between supply and demand. This is regrettable given the now urgent need to upskill and re-skill the domestic workforce. Anecdotally, some universities have reported 1,000 applications for 40 to 50 places on

smaller courses such as paramedic science and radiography. Many healthcare courses are already full for September 2022.

Our members have welcomed the additional investment to increase placement capacity, as well as the steps the Nursing and Midwifery Council has taken to relax some of its requirements during COVID-19. We await the outcomes of their review of programme length and use of technology and simulation which could create more placement capacity in the future.

What is needed is a long-term strategy and continued support to increase placement capacity. Through ICSs there is an opportunity for a joined up and local approach to managing the growth of placements, for example across the NHS, social care, hospices, primary care, independent and private providers, to ensure the availability of clinical placements is not a bottleneck in the training pipeline both now and in the future.

What impact do you think this factor(s) will have on workforce number demand?

- ○ Strong demand reducing impact
- ○ Moderate demand reducing impact
- ○ Weak demand reducing impact
- ○ Neutral
- ○ Weak demand increasing impact
- ● Moderate demand increasing impact
- ○ Strong demand increasing impact

What degree of impact do you believe this factor(s) will have on need for new skills?

- (selected) Low Impact
- Medium Impact
- High Impact

What degree of impact do you believe this factor(s) will have on need for new roles?

- (selected) Low Impact
- Medium Impact
- High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

- Low Impact
- Medium Impact
- (selected) High Impact

In what time horizon will the most significant impact be felt on workforce demand?

- (selected) 0 - 5 years
- 6 - 10 years

- 11 - 15 years
- Beyond 15 years

Supporting evidence

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Factor C

Workforce recovery post pandemic

The NHS workforce was already carrying close to 90,000 vacancies prior to COVID-19, with a further 112,000 vacancies in social care. COVID-19 has shown that the physical and mental health and wellbeing of the workforce is more important than ever. Vacancies lie at the heart of the workload pressures staff face.

Without a healthy workforce, the NHS cannot provide the high quality and effective service that is so essential to helping tackle the backlog of patients requiring care that has built up during the pandemic.

It is expected that many staff will need vital support to deal with the toll the pandemic has had on their health, especially frontline staff who have been faced with traumatic situations on a regular basis for many months now. The success of measures to support staff to remain physically and mentally well is key to the recovery of the health service and building and retaining a resilient workforce for the short, medium and long term.

The pandemic has been without precedent in the demands it has placed on health and care staff across all settings and disciplines, leading to significant levels of stress and anxiety. Staff across the NHS have made significant changes to their way of working throughout this period. Our members recognise that the impact will be felt more significantly by some staff than others. Increased infection, prevention and control measures, the systemic use of personal protective equipment (PPE), and the need to retrain and work outside normal roles have all taken their toll. Our members have reported concerns about the impact of this pressure on staff.

Pre-existing workforce shortages are starting to bite. Colleagues across all parts of the system have mobilised all their resources, including volunteers and students. Current staff stepped up and into other roles; leavers offered to return; and corporate and administrative team colleagues adapted quickly to new ways of working. But as services are restored, pre-existing workforce shortages are starting to show. At the same time, members are keen to ensure that staff who have worked tirelessly for the last few months are able to take a proper break.

Staff burnout is a major concern. Any reductions in productivity will mean a larger workforce is required to deliver the same amount of care. There is a risk of losing thousands of nurses, doctors and other key workers in the longer term unless they are given the time and space to recover from the pandemic. Healthcare staff are not able to undertake a period of decompression in the same way that Armed Forces personnel do after military deployments. Building in time for staff to rest, recuperate and recover remains essential. Some staff will be building up leave that they will need to take, so organisations will need to deploy tailored approaches for local staff that provide the right balance between enabling staff to rest and for managing ongoing demand.

The impact of COVID-19 on the mental wellbeing of staff has been substantial. Mental health services have not yet seen the peak of demand and there are serious concerns over staff burnout, particularly among BME staff who are at greater risk. Our members are concerned about the long-term impact of COVID-19 on the wellbeing of their staff.

There is also the fact that some people are not going to want to carry on full-time within the NHS or perhaps leave entirely and go off to early retirement or something else because the pandemic has been so hard on them, and so the existing workforce crisis is not going to get better in the next few years.

While we are starting to see an increase in applications to degree level courses, this is set against the backdrop of levels of stress and burnout due to the last 18 months, which threatens to increase vacancies. The NHS has close to 90,000 vacant posts, and results from NHS Staff Survey, published in March 2021, show that almost two thirds of NHS staff believe there are not enough people in their organisations to enable them to do their job properly. More than four in ten say they feel unwell as a result of their job, a figure that rises to half of all staff working in frontline COVID care.

An increase in workforce supply across nursing and other key professionals is vital to ensure staff can maintain a healthy work-life balance and organisations can tackle levels of work-related stress and burnout. Vacancies lie at the heart of the workload pressures staff face. Only 40 per cent of staff believe their organisation has enough staff for them to do their job properly. Overlay this with an increase in demand for care, and it is clear the pressure on NHS staff will not subside.

The government has ambitious targets for 50,000 more nurses by the end of this parliament, but failure to act on the issues outlined here will result in this target being missed. The Health Foundation estimates it will require £1 billion of additional investment by 2024 to address supply and vacancy issues.

What impact do you think this factor(s) will have on workforce number demand?

- Strong demand reducing impact
- Moderate demand reducing impact
- Weak demand reducing impact
- Neutral

- ○ Weak demand increasing impact
- ○ Moderate demand increasing impact
- ● Strong demand increasing impact

What degree of impact do you believe this factor(s) will have on need for new skills?

- ● Low Impact
- ○ Medium Impact
- ○ High Impact

What degree of impact do you believe this factor(s) will have on need for new roles?

- ● Low Impact
- ○ Medium Impact
- ○ High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

- ○ Low Impact
- ○ Medium Impact
- ● High Impact

In what time horizon will the most significant impact be felt on workforce demand?

- (selected) 0 - 5 years
- 6 - 10 years
- 11 - 15 years
- Beyond 15 years

Supporting evidence

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Science, Digital, Data and Technology (Including Genomics)

Factor A

Technology enabled care

Technology's pivotal role in health and care can be in no doubt. It is at the core of the NHS Long Term Plan; NHSX wants to drive the largest digital health and social care transformation programme, with more than £1 billion invested annually.

Opportunities to innovate, upscale and deliver digital healthcare are increasing the support the NHS can provide people to maintain their independence and their health and wellbeing. Technology is also enabling people to stay up to date with the latest information relating to their care and treatment plans and access a wide range of healthcare services from their homes. For some NHS organisations, effective use of digital technology is easing demand on services, reducing costs in some areas and supporting professionals to treat patients with the greatest and most urgent needs first. For others, such as primary care, digital technology's contribution is less positive, with remote access driving patient demand and increasing workload.

The COVID-19 pandemic has again evidenced the case for digitally provided services in the future, as social distancing and infection control measures have meant the NHS has seen the benefits of connecting with, and supporting, patients digitally. From the outset, it was clear that technology would have a major role to play in the NHS response to the pandemic. From GP surgeries to outpatient clinics, there has been a significant acceleration of the adoption of new technologies. It has the potential to save lives, enable remote working and provide the information needed to deliver the best possible care for patients.

Achieving this ambition requires substantial investment in the training of healthcare professionals to develop specialist digital skills, as well as the creation of new roles. It also requires a thorough understanding of where and how technology-enabled care enhances both patient and staff outcomes so that it is used to best effect.

The pandemic has encouraged a step change in the use of technology to deliver care. Innovative ways of using technology have, in many areas, helped providers to adapt to the pandemic and increase activity. In primary care for instance, 71 per cent of routine GP consultations were delivered remotely in the four weeks from 16 March 2020 to 12 April 2020, compared with about 26 per cent face-to-face. This reversed the pattern of the same period in 2019, when 71 per cent of GP consultations were face-to-face and 25 per cent were remote. There is also a growing use of artificial intelligence (AI) in diagnostic services. The NHS is still learning about how best to take advantage of this but there are undoubtedly more opportunities to improve services yet to come. Initiatives like the NHS AI Lab are accelerating the adoption of AI in health and care.

Technology enabled care requires the NHS to re-engineer care pathways with the role of technology in mind, including how new

services will be delivered and the impact on the staff involved. The risk of not doing so is high. In primary care for instance, digital access has been superimposed over existing care pathways, resulting in remote consulting increasing overall workload by eight per cent, contributing to general practice being at 'breaking point'. It is feasible to see that almost all areas of the workforce over the next 15 years will be affected by the adoption of digital technologies within the NHS and will need to be trained accordingly. Workforce planners must be alive to the unintended consequences of technology-enabled care, to ensure it does not negatively impact the workforce.

We can expect to see growing demand for knowledge and skills from clinicians, for tasks such as triaging patients based on suitability for remote consultations, analysing data to make the best decisions about care, and verbal and technical skills to coach patients on the use of digital products and to interpret the clinical data that they generate. As well as the creation of new roles.

Addressing skills gaps is not as simple as slotting in a new system and sending staff on a training course. Teams will need the time, space and resources to adapt ways of working and make the most of new technology. As the NHS learns more about the art of the possible it should maintain flexibility to ensure no parts of the community get left behind. For examples of the generic digital skills required across the health workforce and the support needed for teams to make progress, see our Mental Health Network's guide to digital skills (link provided below).

Perhaps most important of all, are the skills the NHS has always relied on to advance care: innovation, problem-solving and a desire to improve the health of our population. An example cited in the BMJ earlier this year highlighted how long surgery waiting lists could be used positively to help prepare people for faster recovery post-operation, whether that's by losing weight or doing preparatory exercises using online services. We know of examples from our mental health members where people on waiting lists are referred

to digital services such as Kooth, as part of their ‘waiting well’ approach. This is an example of where we can use technology to enhance care by providing a new and largely self-administered service.

National workforce strategies must address the workforce, skills and infrastructure needs of the NHS to successfully exploit new and established technologies over the long term. Ensuring the NHS has adequate IT and equipment to make the most of new technologies was also the top priority in a recent survey of NHS staff by The Health Foundation. Ensuring this takes place across the NHS, including primary care, will deliver against health inequalities and population health management. With greater investment in digital skills development across the NHS and the right conditions to encourage innovation, the NHS may unlock a whole raft of achievable innovations that will help improve patient outcomes but will likely have an impact on the size and shape of the future workforce.

It must also be noted that while our members recognise the benefits of technology in supporting staff to do their jobs more easily, there are concerns across the NHS Confederation’s membership about the digital shift and how the increasing use of digital platforms may create and exacerbate health inequalities across different demographics. Many are concerned about those most at risk of being left behind by the digital shift, including the estimated 4.8 million people across the UK who have never used the internet. Others who may face exclusion include those from low-income households and those who do not speak English as a first language. It will be crucial to ensure that there is ongoing evaluation of digital inclusion and literacy at national level. Capital investment will also be needed for intuitive systems which enable equal public access across all communities, and they must be used alongside other points of access such as face to face.

See our Mental Health Network guide to help increase choice and improve access to digital mental health services for further

examples, reflections from individuals who access services about their experiences and challenges, and ways in which our members are supporting their workforce to increase digital skills (link provided below).

For the health and social care workforce, members see the opportunity of technology and digital enhancements to release time to care in clinical roles and corporate functions.

With the workforce supply/demand challenges described through this submission, it will be essential that we support the development of individuals whose current roles may be affected by tech change, to remain in the sector undertaking value added roles and ensuring people receive have access to the necessary training and support to be retained.

What impact do you think this factor(s) will have on workforce number demand?

- (selected) Strong demand reducing impact
- Moderate demand reducing impact
- Weak demand reducing impact
- Neutral
- Weak demand increasing impact
- Moderate demand increasing impact
- Strong demand increasing impact

What degree of impact do you believe this factor(s) will have on need for new skills?

- [ ] Low Impact
- [ ] Medium Impact
- [x] High Impact

What degree of impact do you believe this factor(s) will have on need for new roles?

- [ ] Low Impact
- [ ] Medium Impact
- [x] High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

- [ ] Low Impact
- [ ] Medium Impact
- [x] High Impact

In what time horizon will the most significant impact be felt on workforce demand?

- [ ] 0 - 5 years
- [x] 6 - 10 years

- [ ] 11 - 15 years

- [ ] Beyond 15 years

Supporting evidence

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2.17.2. Factor B

Automation technology

Robotic Process Automation (RPA) is software that uses robots to perform and automate repetitive, time intensive and admin heavy tasks. It allows organisations to offload manual processes and support / free up the workforce. It can provide organisations with immediate productivity gains, reduced operational costs, and the opportunity to increase the quality of patient care and services.

In the wake of technology advancements in response to the COVID-19 pandemic and with the role of technology at the core of the NHS Long Term Plan, we can expect a significant increase in the pace and scale of RPA adoption over the next five to ten years, releasing time for people to spend on other value-added tasks and supporting new ways of working therefore, this needs to be a key component of role design and workforce planning.

Before COVID-19, commentators already believed that that digital innovation offered a route to improved productivity in the face of continued constraints on public spending and demographic pressures. Despite this, RPA adoption has made slow progress across the NHS in the main.

However, in the wake of technology advancements in response to the COVID-19 pandemic and with the role of technology at the core of the NHS Long Term Plan, we can expect significant increase in the pace and scale of RPA adoption, therefore, this needs to be a key component of workforce planning.

RPA allows a wide range of activities to be automated across functions. This enables healthcare staff to spend more of their time on the activities that need human skills, such as direct patient care,

deciding the best course of treatment and devising strategies for improving patient outcomes.

A common place to start for NHS organisations has been corporate-office processes, automating financial and human resources transactional processing, modelling future scenarios and drawing together data to support decision-making, so staff can focus on understanding the impact of decisions. There are possibilities for RPA clinical process support as well, one simple example is the automation of appointment rescheduling, cancellation, and rebooking to save staff time and to reduce the overall waiting times for patients.

NHSX ran a survey in 2020, to understand the challenges and barriers to adoption and scale of automation across health and social care, which revealed interesting findings about the challenges and opportunities to implementing RPA. Analysis of the barriers to adoption highlights two major constraints: finance and the availability of an appropriately skilled workforce.

RPA requires the NHS to redesign processes with the role of automation in mind, including how it will impact on the talent and skills they already have and the talent and skills they need. Substantial investment will be required to ensure staff have the capability and confidence to respond to and adopt new technology and innovation as their roles change as a result, as well as the creation of new roles such as advanced IT and programming skills. Teams will need the time, space and resources to adapt ways of working to make the most of automation technology as the NHS learns more about the art of the possible.

What impact do you think this factor(s) will have on workforce number demand?

○ Strong demand reducing impact

- ( ) Moderate demand reducing impact
- (x) Weak demand reducing impact
- ( ) Neutral
- ( ) Weak demand increasing impact
- ( ) Moderate demand increasing impact
- ( ) Strong demand increasing impact

What degree of impact do you believe this factor(s) will have on need for new skills?

- ( ) Low Impact
- ( ) Medium Impact
- (x) High Impact

What degree of impact do you believe this factor(s) will have on need for new roles?

- ( ) Low Impact
- ( ) Medium Impact
- (x) High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

- ○ Low Impact
- ○ Medium Impact
- ● High Impact

In what time horizon will the most significant impact be felt on workforce demand?

- ● 0 - 5 years
- ○ 6 - 10 years
- ○ 11 - 15 years
- ○ Beyond 15 years

Supporting evidence

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Service Models and Pandemic Recovery

Factor A

Integration and systems working

The health and care system, including NHS, community, primary and local authority services has been on a journey towards more integrated models of delivery, through the introduction of integrated care systems (ICSs) and through place and neighbourhood-based working.

The case for collaborative working in the health and care system has been strengthened by the experience of the COVID-19 pandemic, as the response has rested on different parts of the system working together to address the public health emergency, enable continued provision of essential services and to support people to remain well in their communities.

As the discussions in support of the development of the people plan also showed, there is both the opportunity and the requirement for greater influence for systems over hitherto national dominated workforce planning.

This way of working will affect how and when patients access care and how and where staff provide that care, now and in the future. The existing and future configuration of services needs to be a key component of workforce planning. With workforce being designed around integrated care pathways and the patient.

Over the last few decades, policy makers and workforce planners have been rightly imploring the health and care system to develop its workforces differently, to deal with the demands of a growing and ageing population. This population is presenting with multiple long-term conditions which require the combined involvement of a complex mixture of organisations. The NHS and its public sector partners are making significant progress and working in greater parallel to effectively meet the needs of patients, and the workforce who care for them. This shift is turning the traditional model of healthcare provision on its head, reshaping the way health and care services are provided; how and when patients access care and how and where staff provide that care.

The NHS five year forward view and more recently the NHS Long Term Plan set out a vision of joined-up services and a system built around collaboration rather than competition. ICSs are the main mechanism for implementing these ambitions. Since April 2021, all parts of England have been covered by one of 42 ICSs. Some systems have already been working as ICSs for a number of years, while others have evolved from STPs more recently.

In all cases, the ways of working and governance structures underpinning ICSs remain a work in progress. So too does the organisational development of PCNs which are the enabler of workforce expansion in primary care. At PCN level there is an ambition to expand the primary care workforce by 26,000 by 2024, to increase access to primary care services, improve prevention and keep people out of hospital. The majority of the PCN workforce consists of direct patient care staff, funded by the Additional Roles Reimbursement Scheme (ARRS) but each PCN has the flexibility and autonomy to determine which roles are required to meet the

specific needs of their local populations. The future development of ICSs and PCNs will help shape new ways of delivering services and the size and shape of the workforce.

The future will see services increasingly operate across traditional professional and organisational boundaries to provide co-ordinated care. This will include adapting existing roles to support integrated ways of working, and to develop new roles, such as care/community navigators and social prescribing link workers, as well as further non-clinical roles in primary care. This is already taking place in primary care with ARRS Mental Health Practitioners being employed by the mental health provider yet working in a primary care setting. These roles must be supported by easy administrative, management and HR processes that allow seamless working across professional and organisational boundaries, running in tandem with patients' integrated care pathways.

Multidisciplinary teams represent a specific mechanism for co-ordinating and delivering integrated services, but it is also the whole local workforce, from leaders to frontline workers, within and across all disciplines, specialisms and settings, that need to work in an integrated way. The training, education and development of the workforce will need to ensure that it equips the existing and future workforce for these different models of care. Future development also needs to ensure that there are staff in sufficient numbers, with the right skills and behaviours to provide integrated and community-based care, wherever the patient need is. This requires increasing the out-of-hospital workforce, which it is incumbent on ICSs to support through investing in the primary care workforce via PCNs.

Given the differences in the development of ICSs, the extent to which they will support this expansion of primary care workforce and therefore meet demand, remains uncertain. Furthermore, if out-of-hospital workforce supply is not supported by ICSs and therefore fails to increase, then demand elsewhere in the system will increase.

There is no blueprint for developing an ICS. In contrast to many previous attempts at NHS reform, national NHS bodies have so far adopted a relatively permissive approach, allowing the design and implementation of ICSs to be locally led within a broad national framework. As a result, there are significant differences in the size of systems and the arrangements they have put in place, as well as wide variation in the maturity of partnership working across systems. The advantage is that it enables systems to create arrangements that are suited to their local context and build on the strengths of their existing relationships and local leadership. However, this approach leaves some uncertainty around what the end state of the changes will be, and variation across the country can make these reforms more difficult to understand and plan a national strategy for workforce.

The lack of a long-term strategy for social care is also worrying as this will only exacerbate the pressure on health services. Our social care policy colleagues have reported that the main barrier to working in partnership is the lack of parity in NHS and social care terms and conditions and pay. Until there is some consistency, and an improved career structure that better reflects the skills and importance of care work, the NHS will continue to be the attractive option for people working in health and care and this will mean that social care is going to struggle to meet workforce number demands.

The Health and Care Bill introduced on 6 July 2021 is a significant next step in the attempt to integrate health and care. It is the first major piece of primary legislation on health and care in England since the Health and Social Care Act 2012. There is clear consensus across the Confederation's membership that the future of health and care must be based on collaboration and partnership working at a local level. The Health and Care Bill is an essential enabler to the integration of healthcare services. The legislation is catching up with changes that have been taking place on the ground for many months, if not years in some parts of the country.

Our members report that the main challenges when seeking to plan, develop and deliver new integrated place-based and neighbourhood-level approaches to health and care are current workforce shortages (with primary and secondary care competing for the same clinical ARRS roles), future workforce availability, and resources to support the development of staff to work in the evolving system. This is especially pertinent for small providers that lack HR and/or L&D support functions, such as PCNs. As the bill passes through the legislative process, a greater focus is needed on the health and care workforce. It includes little acknowledgement of the almost 90,000 vacancies in the NHS across England and how to address this. There is only a duty on the Secretary of State to set out how workforce planning responsibilities are to be discharged once every five years. This alone is insufficient and not frequent enough.

If integration between the NHS and local public sector partners is to be successful, clarity and certainty about the future arrangements for social care is also needed. For social care to be an equal partner with the NHS, there must be a long-term plan for social care that sets the priorities for investment and transformation of services and systematically addresses the workforce challenges.

What impact do you think this factor(s) will have on workforce number demand?

- [ ] Strong demand reducing impact
- [ ] Moderate demand reducing impact
- [x] Weak demand reducing impact
- [ ] Neutral
- [ ] Weak demand increasing impact

- ○ Moderate demand increasing impact
- ○ Strong demand increasing impact

What degree of impact do you believe this factor(s) will have on need for new skills?

- ○ Low Impact
- ● Medium Impact
- ○ High Impact

What degree of impact do you believe this factor(s) will have on need for new roles?

- ○ Low Impact
- ● Medium Impact
- ○ High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

- ○ Low Impact
- ○ Medium Impact
- ● High Impact

In what time horizon will the most significant impact be felt on workforce demand?

- [x] 0 - 5 years
- [ ] 6 - 10 years
- [ ] 11 - 15 years
- [ ] Beyond 15 years

Supporting evidence

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Factor B

Pandemic recovery

Managing current and escalating demand, particularly for urgent care across primary and secondary care, reducing the sizeable backlog of elective procedures that has been exacerbated by the pandemic; and continuing to manage the ongoing threat from COVID-19, which requires frontline services to operate with much reduced capacity due to the need for infection prevention and control measures, are major challenges for the NHS.

The NHS Confederation, the Health Foundation and professional organisations e.g., the BMA have all estimated that even if the NHS were to run at a higher percentage capacity than pre-COVID capacity it could take up to several years to reduce the backlog of elective care in England back down to (already high) 2019 levels.

There is also significant additional long-term and 'new' demand as a result of the pandemic. Booster vaccination is likely to be a long term feature of primary and community care, long-covid is emerging as a significant demand on primary and specialist services and the health inequalities so starkly exposed by the pandemic will result in the need for additional services and public health interventions.

All of this is being compounded by the significant staff shortages, close to 90,000 that the NHS is experiencing, with a further 112,000 vacancies in social care. Alongside high levels of staff stress and burnout as a direct impact of the pandemic that threatens to further increase vacancies. This gap between workforce supply and demand is in turn driving demand and additional cost across the health and care sector.

Prior to COVID-19, the NHS was struggling under the weight of demand. Targets were regularly missed (in some places for several

years) and waiting lists were continuing to grow. Winter 2019 was challenging, with declines in many of the operating standards.

Particularly notable was the increasing delay in ambulance handovers and the continuing rise of the four-hour A&E waiting time.

There has been changes in public and patient demands. Now, more than 5.1 million people are waiting for routine hospital care, with over 400,000 waiting for more than a year. Reducing the backlog will take significant investment, innovation from the sector and support from the government and its national bodies. While the situations are different, the experience of clearing waiting lists in the 2000s is instructive. It took seven years to meet the targets set in 2000 – and significant investment.

Last year, the Health Foundation estimated that £7 billion of additional funding was needed to tackle the elective backlog, address rising rates of mental ill-health, support primary care to manage increased patient activity and help ease other pressures resulting from COVID-19 and that HEE would need an increase of upto £900m to support the workforce growth needs. Given the worsening situation, this is likely an underestimate of the challenge faced and the recent report from NHS Confederation and NHS Providers (link below) highlights the additional and miscellaneous workforce costs which providers are faced with.

The NHS is also anticipating significant increases in demand for its services in the next couple of years from new demands on its services:

- Mental health: providers of mental health services are anticipating a 20 per cent increase in demand against a 10-30 per cent decrease in capacity. Our report on mental health, published in August 2020 and inked below, describes this in detail. We are hearing that children and young people's mental health services are seeing an increase in

demand because of the pandemic. There has been a significant increase in referrals to eating disorder services, but we know from our members that there is a serious shortage of consultant psychiatrists specialising in eating disorders, to the extent that it is difficult to even train up additional staff or supervise more junior staff.

- Primary care: practices are experiencing a significant surge in patients while also dealing with a backlog of immunisation and screening programmes, while also caring for patients as they wait for secondary care.

- Community services: widespread concerns about the long-term demand on community services due to patients requiring ongoing treatment and long-term rehabilitation services as part of their COVID -19 recovery.

Financial clarity is essential so that NHS organisations can make key decisions on how many staff they can hire and how much they can invest in their elective capacity to reduce the backlog. For example, the NHS Confederation provider members are telling us that the current uncertainty means they are unable to plan beyond 12-month fixed term contracts for key skilled professionals, meaning they are more likely to go elsewhere, or not apply at all as the roles are not permanent. They are also unable to plan for overseas or large-scale recruitment projects that require additional up-front investment.

The situation is being compounded by the significant workforce shortages, close to 90,000, that the NHS is experiencing and high levels of staff stress and burnout as a direct impact of the pandemic which threatens to further increase NHS vacancies and in turn drive demand. Our members are particularly concerned about clinical colleagues using a post-pandemic period as a point of life reflection, and potentially retiring earlier than planned because the pandemic has been so hard on them. There is a risk that NHS organisations will see increases in turnover, low morale and

performance trajectories not being met, with the only course of action being reactive, rather than being proactive.

This puts in to focus whether organisations are doing enough on longer-term workforce planning. But to do that, they must better understand the risks of the impact of the pandemic on people and plan for what is genuinely needed based on data, demand, capacity and capital requirements, not using existing financial envelopes as the parameters.

The continued lack of a long-term strategy for social care is also worrying as this will only exacerbate the pressure on health services. The last 18 months have exposed deep cracks in the social care sector and exacerbated structural vulnerabilities, with devastating consequences. Social care was already under intense pressure before the onset of the COVID-19 pandemic, with long-term policy failure and funding restrictions as well as staff shortages taking a toll across the country. The COVID-19 pandemic made these problems worse and created some new ones. Mortality rates were catastrophic in care homes, but they also doubled in people with learning disabilities. Many older and disabled people were understandably afraid to allow care workers without adequate personal protective equipment into their home and cancelled or reduced social care packages that they needed. In local communities, day services were suspended with no warning as social distancing regulations were introduced, leaving people without the structure and basic support that they relied on and the cancellation of respite care often left carers with no help at all. There were high levels of loneliness and stress, particularly those who were shielding and who told National Voices that they felt forgotten, abandoned, or dumped. Many people reported losing skills, confidence, and independence.

There must therefore be a long-term plan for social care that sets the priorities for investment and transformation of services and systematically addresses the workforce challenges. To tackle vacancy rates, high turnover and low retention of staff, there are

some fundamental issues on pay and conditions that need addressing alongside the need for an improved career structure and training that better reflects the skills and importance of care work.

What impact do you think this factor(s) will have on workforce number demand?

- ○ Strong demand reducing impact
- ○ Moderate demand reducing impact
- ○ Weak demand reducing impact
- ○ Neutral
- ○ Weak demand increasing impact
- ○ Moderate demand increasing impact
- ● Strong demand increasing impact

What degree of impact do you believe this factor(s) will have on need for new skills?

- ● Low Impact
- ○ Medium Impact
- ○ High Impact

What degree of impact do you believe this factor(s) will have on need for new roles?

- [x] Low Impact
- [ ] Medium Impact
- [ ] High Impact

What degree of impact do you believe this factor(s) will have on need for new ways of working?

- [ ] Low Impact
- [ ] Medium Impact
- [x] High Impact

In what time horizon will the most significant impact be felt on workforce demand?

- [x] 0 - 5 years
- [ ] 6 - 10 years
- [ ] 11 - 15 years
- [ ] Beyond 15 years

Supporting evidence

NHS Confederation (2021): A reckoning: the continuing cost of Covid-19 https://www.nhsconfed.org/publications/reckoning-continuing-cost-covid-19

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The Health Foundation [2020]. Spending Review 2020 Priorities for the NHS, social care and the nation’s health. [Online]. https://www.health.org.uk/publications/long-reads/spending-review-2020

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National Voices (2020). What We Need Now. [Online]. https://www.nationalvoices.org.uk/what%20we%20need%20now

Ambitions

In 15 years' time, what one key thing do you hope to be able to say the health and social care system has achieved for its workforce, including students and trainees?

- We can model health and care workforce needs based on the needs of the communities we serve.
- We retain staff and students because they have had an excellent experience.
- We have eliminated discrimination and exclusion from the NHS and Social Care workforce, including within educational settings.
- We create a working environment that balances employee autonomy and operational efficiency to improve staff experience and increase retention.

18 Smith Square
Westminster
London SW1P 3HZ

020 7799 6666
www.nhsconfed.org
@NHSConfed

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please email **enquiries@nhsconfed.org**

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