

Institute for Public Policy Research



FINDING HOPE

THE FINAL REPORT OF THE
2021/22 IPPR HEALTH AND
CARE WORKFORCE ASSEMBLY

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June 2023

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ABOUT THIS PAPER

This briefing paper advances IPPR's charitable objective of advancing physical and mental health.

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SUMMARY

England's health and care sector is in a deep workforce crisis. This is not because we have less staff overall. Rather, it's because of a growing and sustained mismatch between worker-demand and worker-supply. The demand for workers have increased far quicker than the supply of extra staff: between 2010 and 2019, staff in hospital and community settings grow around 1 per cent per year, compared to 4 per cent average annual increase in outpatient appointments, a five per cent average annual increase in diagnostic activity and an over 3 per cent increase in admissions at major A&E departments. Having grown under a per cent per year since 2010, productivity gains haven't filled the gap - meaning more pressure and work for each individual staff member.

A vicious cycle emerged during austerity and worsened through the pandemic. Without transformational productivity gains, this mismatch between activity and demand means greater workload and pressure on each individual health and care worker. This has combined with a reduction in pay and working conditions, including austerity-era policies like the public sector pay freeze. Combined, this has undermined recruitment and retention – accentuating pressure on individual workers, and making the health and care sector a less desirable and rewarding one to work in.

But we must also acknowledge a British propensity for workforce crises. This isn't the first time the workforce has been in crisis. Indeed, in the time since the NHS' formation, we have experienced many crises. In each case, policymakers have not planned for future trends and demands. Crisis comes as a surprise and solutions tend towards sticking plasters. We need a more long-term and sustainable approach to health and care workforce planning and policy to break this 'feast and famine' model.

There are health and economic justifications to do better. Today, not having a large enough workforce – as well as not having the right people, in the right roles, with the right skills – is the biggest barrier to providing excellent and accessible health and care services. But avoidably poor health outcomes can also undermine national prosperity – as indicated by the UK's record rates of economic inactivity due to sickness. We show that the number of people who are economically inactive due to sickness – long-term or temporary – reached record levels in 2023.

We need a long-term vision for the future – to help support cohesive policy, and to give workers hope. In creating that vision, there are few better sources than workers themselves. In 2021/22, IPPR recruited a workforce assembly – across the NHS, social care, and unpaid care – to define a new vision for health and care work. Together, they convened on five aspirational guiding principles for the future.

1. **Sustainable staffing and recruitment:** including symptom relief for today's crisis – but also a longer-term shift towards long-term planning.
2. **Fairness, hardwired into health and care:** including more equal pay, conditions, and progression, but also freedom from discrimination and prejudice in the workplace.
3. **A shift from antiquated siloes and hierarchies:** and towards a vision of health and care work that is modern, integrated, coordinated, and varied.
4. **The right approach to innovation:** including more innovation, but also more opportunities for workers to have a voice, and to see how the gains of innovation benefit them, as well as patients and taxpayers.
5. **Parity between health and care:** including a fairer deal for social care workers, but also support and sustainability for unpaid carers.

Through assembly deliberations and further research, IPPR have developed these principles into a 10-point policy plan for the future. We contend that these policies would help the UK shift from its historic propensity for crisis, to a more sustainable workforce model – one with far better capacity to meet the challenges, navigate the threats and harness the opportunities the future holds.

OUR 10-POINT PLAN FOR HEALTH AND CARE WORKFORCE POLICY IN ENGLAND

- 1.** A circuit breaker to end the current ‘vicious cycle’ in the health and care workforce – including pay restoration, reform of pay review processes, a substantial increase in social care pay, and a funded retention programme to ‘get the basic right’ on working conditions.
- 2.** Shift from reactive workforce policy to long-term planning, through a long-term workforce projections body and a ‘break glass’ option for that independent body to require the secretary of state or ICS leaders to develop a published workforce plan.
- 3.** Create ‘return to health’ – a scheme that matches people with long-term health conditions, who would like work, with health and social care jobs, facilitated through supported employment programmes.
- 4.** A new health leadership programme, to increase the supply of brilliant, system-level leaders across health and care.
- 5.** A permanent pilot fund to test, evaluate and evidence ‘roles of the future’ – supported by a funded right to lifetime learning and development across health and social care.
- 6.** Increase support for women returning to work after maternity leave – including a ‘comply or explain’ right to flexible working, and a formal review of pay and progression after 12 months, to help tackle the gender pay gap.
- 7.** Hardwire action on prejudice and discrimination within ICSs and make anti-racism a formal consideration of the Care Quality Commission’s ratings.
- 8.** Expand collective bargaining in the social care sector, supported by a new Social Care Council – with powers to negotiate pay, set professional standards and advocate for social care workers.
- 9.** Significantly increase in support for unpaid care, including a legal duty on government to keep unpaid adult care within a set definition of sustainability.
- 10.** Expand the sector’s management workforce to increase capacity to adopt, adapt and spread innovation – and implement new technology and innovation agreements across the sector that outline how those gains will translate into better working conditions (as well as better patient outcomes and cost-efficiency) over time.

1. INTRODUCTION

As recent industrial action across the UK indicates current pressures on the health and care workforce in England are extreme. This is not driven by a simple decline in either headcount or ‘full time equivalent’ (FTE) staff numbers; rather it’s down to a sustained and accelerating mismatch between the rate of growth in workforce numbers, and the rate of growth in healthcare demand as the UK population grows and ages.

Table 1.1 documents this mismatch within the NHS. The acute workforce has grown just one per cent on average each year since 2009/10. This is well below the growth in demand across key service areas, including diagnostic, emergency, and outpatient activity – and under half the rate needed to maintain 2018/19 levels of care by the end of the decade (Bazeer et al 2022). A continued discrepancy in growth in workforce supply and workforce demand underpins estimates that the NHS – even assuming some productivity gains - will be short over 300,000 workers by 2030/31 (ibid).

TABLE 1.1: THERE IS A SUSTAINED MISMATCH IN WORKFORCE DEMAND AND SUPPLY
Average annual growth across key NHS indicators in England and size of acute NHS workforce

Indicator	Compound average annual growth rate
NHS workforce size (workforce-supply), 2010-19 (unless indicated)	
Total HCHS NHS workforce	1.0
Professional qualified clinical staff	1.1
Support to clinical staff	1.8
NHS infrastructure support	-0.3
Senior managers (HCHS settings)	-0.2
Managers (HCHS settings)	-0.0
All managers	-0.1
Doctors	2.0
General practice staff (excluding GPs) (2015–19)	2.5
Fully qualified GPs (2015–19)	1.0
Activity 2010-19 (unless indicated)	
Diagnostic tests	4.7
Outpatient appointments (2010/11–2019/20)	3.6
Outpatient attendances (2010/11–2019/20)	3.2
Finished consultant episodes	2.1
Emergency attendances (major A&Es)	1.8
Emergency attendances (Other A&Es/minor injury units)	3.2
Emergency Attendances (all departments)	2.2
Emergency admissions (major A&Es) (2012/13–2019/20)	3.3
Elective G&A total admissions (2010/11–2018/19)	2.2
GP Referrals (all) (2010/11–2018/19)	2.2

Source: Authors analysis of NHS Data

Note: Data is given until the Covid-19 pandemic. The pandemic has made activity data difficult to compare – given impact on productivity, ways of working and composition of population health need. A fixed relationship between change in activity metrics and workforce demand has been argued for elsewhere (Bazeer et al 2022). Workforce size data is for September in all years.

Had productivity been higher, it might have filled the gap between workforce growth and activity growth. But it has grown under a per cent. This means the remaining shortfall will have been filled in two ways: either lower quality of care, or greater pressure on each individual staff member. Staff surveys and polling data, including IPPR's own, suggest the latter (Patel and Thomas 2021).

Data is less comprehensive in adult social care. However, it indicates a similar mismatch between capacity and demand. In its latest estimates, Skills for Care estimated 165,000 vacancies in adult social care as of 2021/22 (Skills for Care 2022a). Moreover, there has been a steady uptick in both the number of people requesting adult social care from local authorities (and the number being turned down for that support) (Table 1.2). This, in turn, increases the burden on people providing unpaid care. Carers UK data has shown a sharp rise in unpaid carers, with one in five UK adults providing care. These carers are more likely to suffer poor health, financial hardship, unemployment, and inequality – suggesting the burden of informal care is well beyond a sustainable level (Carers UK 2022a).

TABLE 1.2: REQUESTS FOR SOCIAL CARE SUPPORT ARE RISING

Number of requests for social care from local authorities, and number leading to no further action, whole population, England, 2016–21

Year	Requests	No further action
2020/21	1,915,645	544,605
2019/20	1,930,560	530,560
2018/19	1,914,535	504,125
2017/18	1,843,920	463,520
2016/17	1,814,415	495,140

Source: Author's analysis of NHS Digital 2022

Note: Population reduced in 2020/21 due to Covid-19 pandemic, with mortality particularly concentrated on people who draw on – or who might otherwise need – adult social care services. This should contextualise 2020/21 data.

THE CHANGING NATURE OF POPULATION HEALTH

As important as the growth in population health need is the changing nature of those health needs. When the NHS was formed, the nature of illness was far more acute. Heart disease and cancer were, often, either treatable or more immediately fatal, while conditions like tuberculosis (TB) remained major causes of mortality.

In the 21st century, the country's health and care system contends with much greater rates of long-term, multiple health conditions. In some cases, this has been driven by the success of medical science: the average life expectancy of following a cancer diagnosis has risen from one year 50 years ago to nearly six years by 2007 (Macmillan, no date). In other cases, it is driven by the demographic factors – like the ageing population, and the rise of causes of long-term conditions, like obesity.

This changes the nature of the kind of roles and skills the health and care system need. It is likely to require a more generalist workforce – and prioritisation of problem solving over encyclopaedic clinical knowledge (Health Education England 2020). It's like to require more – as the focus of care shifts towards supporting people to live excellent lives with long-term conditions, in the communities and places they live, rather than in hospitals (Thomas & Quilter-Pinner 2020). And it is likely to demand a greater focus on prevention – both primary and secondary – a workforce that has yet to be compellingly designed or created (Wanless 2002).

The composition, allocation, skills and training of the health and care workforce has not changed as quickly as the science or demography of the country. This will accentuate the mismatch in worker-supply and worker-demand.

A VICIOUS CYCLE

As the above indicates – while the pandemic has evidently made things worse – the current workforce crisis cannot be explained by Covid-19 alone. Rather, it can be better understood as a 'vicious cycle', caused and exasperated by the austerity policies that followed the 2008 global financial crash, and now further exacerbated by the lasting impact of the pandemic. There is clear evidence to suggest that austerity driven policy decisions led to health and care work becoming less and less rewarding.

- **Real-terms pay declined:** Following the public sector pay freeze (later cap), Nuffield Trust analysis shows significant and sustained real terms pay cuts across NHS professions, including consultants, junior doctors, nurses and midwives (Rolewicz et al 2022).¹
- **Burnout increased:** Including record high burnout among doctors, according to the 2022 National Training survey (39 per cent) (BMA 2022a).
- **Staff satisfaction declined:** Including a rise in the number of people saying they will leave their role as soon as they can find another job, which now stands at nearly 20 per cent of NHS staff (NHS Staff Survey 2022).

This created challenges with recruitment and retention. As people leave (or don't join) the sector, average workload steadily increased – perpetuating burnout and stress. This pushes more people to leave, either because other sectors are more appealing or because the burnout and stress lead to long-term sickness (see table 1.2). Those left behind face yet more pressure; atrophy of pay and conditions continues; and so, the cycle continues.

¹ In social care, pay has risen – mostly as a result of rises in the national living wage. However, compared to the rest of the economy, pay remains very low across the sector, and lower than in other comparable countries.

THE CONSEQUENCES OF BURNOUT, CHRONIC STRESS, AND POOR WORKING CONDITIONS

Working in health and care is difficult and (wrongly) comes with a personal cost. Healthcare work has been linked to higher rates of suicide than in other professions (Elliott et al 2010); to experiencing greater mental health consequences during ‘health shock’ events like pandemics (Maunder 2004); and to prevalence of depression, anxiety, and chronic stress than the population as a whole (Greenberg 2022, Patel and Thomas 2021). This is additional to the occupational risk that come from working in this sector (for example, infectious disease).

The UK economy has been struggling, in recent years, with the labour market consequences of declining population health – with record numbers of people economically inactive due to long-term sickness (ONS 2022). As the above evidence might make intuitive, the health and care sector has experienced more staff leaving due to long-term sickness than the average sector. Indeed, had the rate of people leaving health and care work due to long-term sickness been the same as a comparable, frontline, and foundational sector (education), we would expect 14,000–16,000 extra qualified staff to be in work today. Had it been the same as in the best performing sector (information and communication), it might be worth 23,000 extra, predominantly frontline staff (see Thomas 2022).

TABLE 1.2. HEALTH AND CARE WORKERS ARE MORE LIKELY THAN MOST TO LEAVE WORK DUE TO LONG-TERM ILLNESS

Number of staff per 1,000 leaving due to long-term sickness by sector 2020–22

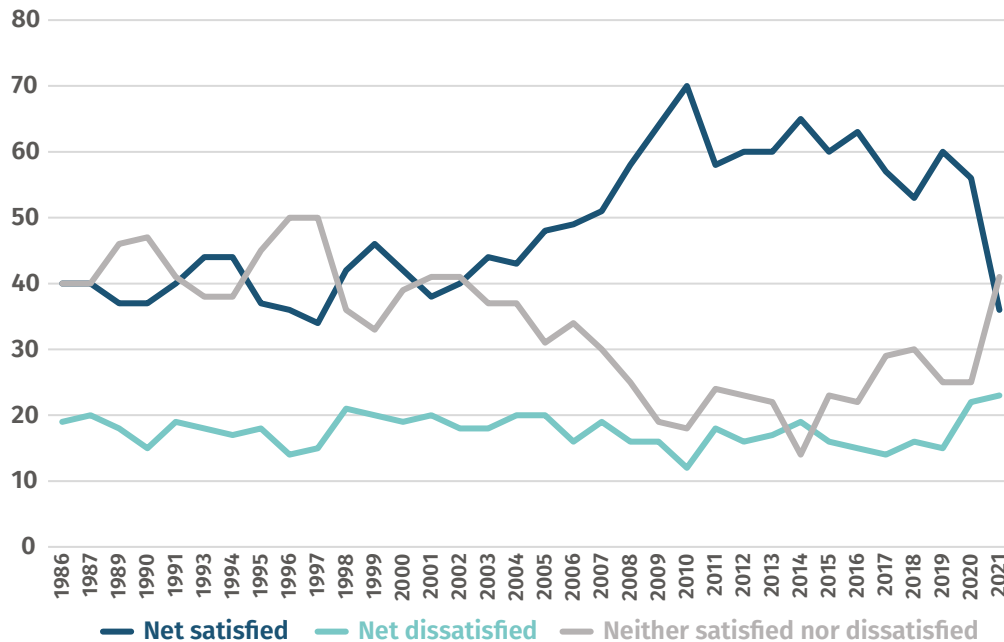
Industry	Long-term sickness rate
Wholesale and retail	10.4
Transportation and storage	10.0
Accommodation and food services	9.2
Human health and social work	7.8
Construction	7.6
Manufacturing	6.8
Education	4.7
Professional, scientific, and technical	3.3
Public administration and defence	3.1
Information and communication	2.8

Source: ONS 2022

This is indicative of the short-sightedness of creating conditions in which the workforce not only cannot thrive, but are also exposed to significant occupational mental and physical health harms. It is also consistent with the NHS' own data on voluntary resignations, which shows a 43 per cent increase in staff leaving NHS roles each quarter due to sickness since the beginning of the Covid-19 pandemic (authors' analysis of NHS Digital 2023).

The consequence of workforce shortages and this vicious cycle are felt not only workers, but by patients and service users too. High staff turnover can lead to poorer continuity of care, lower levels of patient satisfaction and risks both to employees and service users (Rankin and Parkes 2020). Indeed, while research shows strong, continued support for the founding principles of the NHS, actual satisfaction with the reality of NHS services has dropped sharply among the public in recent years.

FIGURE 1.1: SATISFACTION WITH NHS SERVICES HAS DROPPED SHARPLY FROM A 2010 PEAK
 Responses to the question: “All in all, how satisfied or dissatisfied would you be with how the National Health Service is run nowadays?”



Source: Recreated from NatCen 2022

Note: n = 3,112 (in 2021). Methodology change in 2020 – weighting used to minimise impact/maintain year on year comparability.

THE BRITISH PROPENSITY FOR WORKFORCE CRISES

In short, we have arrived at this crisis due to a failure of planning and long-term vision. Instead of calculating how many staff we need – and what kind of roles and skills they’d need to meet future demand and changing epidemiological and demographic realities, and what kind of careers and conditions people need to have long successful careers in the health and care sector – workforce policy over the last decade has instead stripped back both total capacity, and capacity for modernisation.

As the conditions for a sustainable workforce have eroded, and crisis has worsened, policy has focussed on ‘sticking plaster’ short-term recruitment targets – instead of addressing the structural reasons why we fail to train and retain the right number of staff, with the right skills, in the right roles.

This approach is not unique to this government. In fact, the UK seems to have a long-standing propensity to crisis in how workforce planning, and policy are approached – since at least the advent of the NHS. Historically, crises have often hit by surprise, leading to needless consequences for workers and patients alike.

- **1940s:** The creation of the NHS leads to an immediate workforce shortage. This is filled by workers in the Windrush generation.
- **1960s:** Then health secretary Enoch Powell responds to a shortage of doctors and GPs by fronting a sustained international recruitment campaign, focussed on commonwealth countries.
- **1990s:** A shortfall emerges – with particularly acute challenges around the nursing and midwifery workforce – and is solved again through international recruitment efforts – combined with an expansion in training places.

That is, as with NHS funding, health and care workforce planning and policy has operated on a ‘feast and famine’ model. When workforce supply is good – that is, it broadly corresponds to demand – little has been done to adequately plan for the future. This means factors which might cause future shortages are rarely anticipated, and crisis has too often taken us by surprise.

If, historically, when things have gone wrong the safety-net has been international recruitment, then policymakers today will need to face up to the fact it is unlikely to solve the challenges we face today. First, because our workforce crisis persists despite the fact that international recruitment is already at historically high levels:

- international recruitment now delivers over one-third of the nursing workforce (BBC Shared Intelligence Unit 2022)
- international medical graduates joining the workforce (from non-EEA countries) has increased around 500 per cent since 2010, while the number of UK graduates has remained roughly the same (General Medical Council 2022)
- compared to other OECD countries, the UK is particularly reliant on overseas capacity (ibid).

Moreover, where the 1940s, 60s and 90s constituted a national crisis in workforce supply, today’s workforce shortage is global. By 2030, the World Health Organisation estimate a global healthcare worker shortage of 18 million workers (Boniol et al 2022).

In sum, sticking plaster policies and short-term symptom relief for our current workforce crisis are important – but far from the only thing England needs. At least as important are policies that address the structural reasons that stop us training, retaining, and allocating staff in the right way. And it needs to move away from a feast and famine workforce planning model – with a hardwired propensity to crisis – and towards a more long-term, sustainable approach.

2. THE CASE FOR CHANGE

Ambitious, long-term workforce planning can make policymakers nervous, particularly, around the cost implications of reform. However, getting workforce policy right – in the short and the long-term – need not be viewed as a cost to be borne. Indeed, workforce policy can also be framed as one of our most vital instruments in achieving better health; in building the foundations to sustain progress on population health in the decades to come; and in unlocking the prosperity gains that better health offers. This chapter explores the benefits that getting workforce planning right could deliver.

BETTER HEALTH THAT CAN BE SUSTAINED IN THE LONG-TERM

The most important case for change – for addressing the current crisis and mapping out a longer-term vision for the future – remains that it is vital to ensuring a healthier and fairer country. Without the right workforce, working in the right places and teams, people will not be able to get the care they need – whether that’s a GP appointment, fast emergency care, support for a mental health problem within the community, or ongoing support for a long-term condition.

This is only set to be ever more the case in coming decades. Demographic changes in the UK are projected to substantially increase the size of the health and care workforce we need. As the Resolution Foundation’s 2030 enquiry has put it: “the real impact from age-related shifts in the population will come from a huge rise in demand for – and employment of – health and social care workers” (Resolution Foundation 2022). The Health Foundation estimate that – by 2030 – we will need as many as 1.1 million more people in health and social care roles, if we hope to deliver on what people expect from these public services (Rocks et al 2021).

As much as our health will rely on greater numbers of staff, it will also rely on our ability to adapt the role and skill composition of health and care services to future trends.

1. **More time spent in poor health:** Rises in longevity have been faster than rises in healthy life expectancy. More of our lives, on average, are now spent in poor health – necessitating longer-term and more joined-up support.
2. **More people living with multiple conditions:** As the population grows older and lives longer, people are increasingly likely to live with two or more health conditions at once. As other studies have shown, this requires a more personalised, integrated and coordinated approach to care (National Institute for Health Research 2018, Richmond Group 2019)
3. **More people living with chronic conditions:** Medical advances have meant diagnoses that we live longer with illnesses that would otherwise have led to a much shorter life expectancy. One example is a category of cancers that have become ‘treatable but not curable’. As above, this will necessitate a more long-term and coordinated care, as opposed to an acute, hospital led one.

In turn, these shifts are likely to demand very different types of workers and skills to when the NHS was formed in 1948. In terms of settings, it suggests a need for more workers located in the community. In terms of skills, it will necessitate a greater focus on coordination between services, on preventative intervention, and on

long-term support. And in terms of roles, it is likely to necessitate more generalist professionals – who are able to meet complicated and multiple needs holistically.

Long-term vision for health and care work can provide an opportunity to pre-empt this, in the interest of better health – a far superior proposition to waiting for these trends to occur and trying to meet them with a workforce designed for 20th century health and demographic realities.

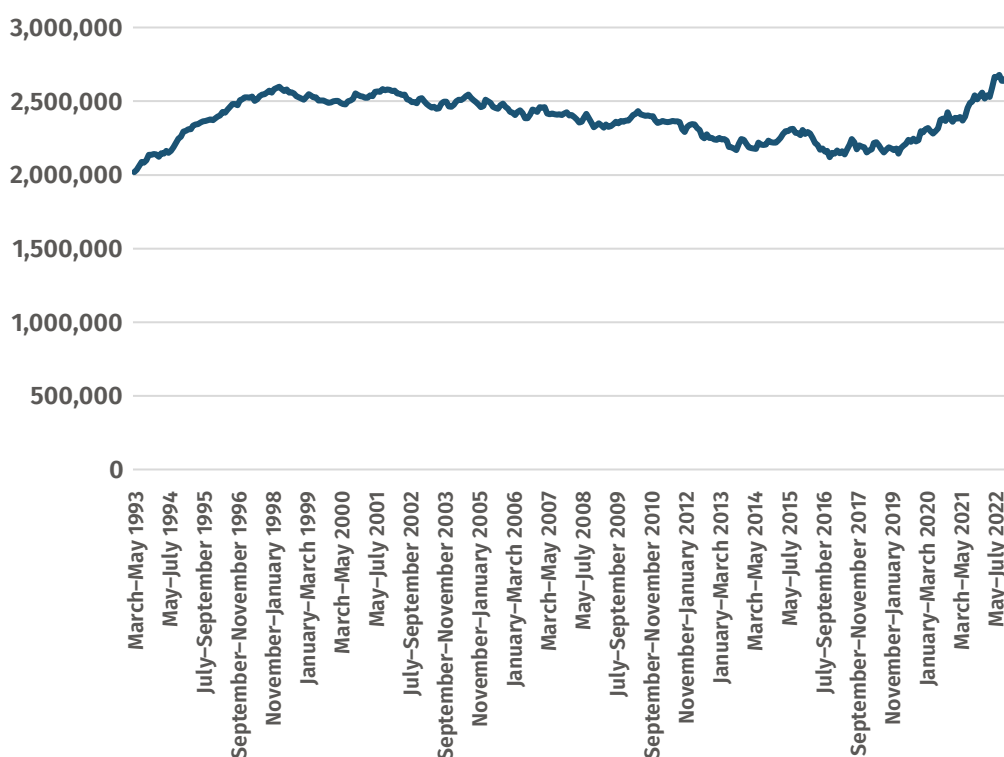
AN OPPORTUNITY TO UNLOCK PROSPERITY

In addition to the morale case for better health, there is also an increasingly strong prosperity case for getting our approach to the health and care workforce right – now and in the future.

There is increasing evidence that poor health is among the biggest breaks on UK economic performance. Evidence from the Northern Health and Science Alliance finds that health explains a third of the productivity gap between the Northern Powerhouse region and the rest of England. While ONS data shows record numbers are involuntarily out of the labour market due primarily to long-term sickness.

FIGURE 2.1: ECONOMIC INACTIVITY DUE SICKNESS HAS RISEN TO RECORD LEVELS

Thousands of people (16–64 years old) economically inactive due primarily to long-term sickness 1993–2022, seasonally adjusted



Source: Authors’ analysis of ONS 2023

For many, this will be down in part or in full due to difficulties in accessing the care they need quickly or consistently – in which workforce shortages play a significant role. Or in other words, there is a clear economic logic to action on challenges around workforce shortage, recruitment, and retention.

As well as supporting economic prospects, long-term health and care workforce policy can also contribute to the fairness of the economy. Regional economic outcomes – or levelling-up – proffer one opportunity. The health and care workforce is not just large, it is distributed across the country. Fairer pay, better working conditions and more job security can boost and equalise the prospects of people working across the whole country, not just in London or the South East. But it also provides an opportunity to support gender and racial justice too.

Longer-term vision on the future of the health and care work will also present more creative opportunities to optimise the relationship between health and care and prosperity further. For example, a shift towards a more integrated model of working help coordinate health and care services - particularly primary care – with work and employment support services. Evaluation of schemes where employment specialists are embedded within healthcare settings have been strong – while there have also been successful pilots of schemes where more novel, generalist healthcare workers (care coordinators) take proactive responsibility for meeting people’s non health needs (employment, housing finances).

3. A NEW, PRINCIPLED, LONG-TERM VISION

The UK stands at a crossroads: either policymakers can choose to continue with the status quo of declining capacity and chronic short-termism – despite the potential cost to both population health and national prosperity. Or they can take this moment as an opportunity to reorientate the future of workforce policy and planning towards a more strategic long-term vision.

Our ability to shift to the latter will rely on our capacity to create a vision for work that excites and motivates workers – and which meets the changing need of patients and public service in years to come. **Put simply, we need to give workers hope – not only now, but for the entirety of their careers in health and care.**

There are few better and untapped resources for creating a hopeful, long-term and strategic vision than workers themselves: people both with ‘skin in the game’ and intimate understanding of how health and care works, of how it must change and react to future challenges or opportunities, and what it would take for them to feel confident in a brighter future.

On this logic, IPPR recruited a workforce assembly to deliberate on principles and ideas that could sit behind a bolder and better vision for the future of the health and care workforce. This included careful considerations of how policymakers and leaders should react to the biggest, immediate challenges – from pay and conditions, to unsustainable work pressures, to challenges around equality and freedom from discrimination.

But importantly, it also included far longer-view thinking. As the nature of health and care work is unlikely to remain static in the coming decades, deliberations were informed by evidence on big shifts, changes, opportunities, and challenges that are likely to have a major impact on the nature of health and care work in the long run.

- **Global workforce shortage:** Including the increasing challenge with workforce policy that overstates the long-term capacity to overly rely on international recruitment models, in the context of increasingly severe global workforce shortages (Britnell 2019).
- **Complex needs:** Including the increasing proportion of people’s lives spent in poor health, the growing prevalence of multiple conditions, and the transition of previously short-term, acute conditions with high mortality into chronic conditions (such as treatable but not curable cancers).
- **Growing insecurity:** Namely, our exposure to global health shocks, such as emerging infectious diseases, AMR, and the health impacts of climate change.
- **The frontiers of science:** Including the innovation and technological advances which will fundamentally change the experience of working in health and care; the kinds of roles and skills needed; and the ways professionals work together.

These are the kind of challenges/opportunities that the UK has struggled to preempt in the past – and which are crucial considerations in shifting from chronic short-termism to a strategic, long-term approach to workforce policy.

COMPOSITION OF THE ASSEMBLY

IPPR began recruitment for the workforce assembly in Spring 2021. Diversity was key to the assembly, which reflected a range of experiences, perspectives, and professions. Recruitment and all assembly sessions were undertaken online, to support accessibility and to ensure capacity to meet government Covid-19 advice.

The assembly was formed of sixteen members, recruited from across the health and care sector (see table 3.1 for their backgrounds). IPPR engaged social research agency NatCen to support the deliberative sessions from June to October 2021. The research was carried out to ethical standards and with ethical approval.

TABLE 3.1: COMPOSITION OF THE IPPR WORKFORCE ASSEMBLY

	Speciality/interest
Doctors, nurses, midwives	Doctors, public health registrar, general practitioner (GP), ST6 doctor in obstetrics and gynaecology, clinical informatician, midwives,
Allied health professionals, clinical support workers	Pharmacist, speech and language therapist, psychotherapist, social prescriber
Carers and people managing their own conditions	Unpaid carers, experts by experience
Social care workers/ NHS support workers	Digital health technology specialists, clinical education fellow, midwife support worker, mental health social worker

Source: Authors' analysis

On the basis of 240 hours of deliberation – combined with literature review, new analysis, and extensive further policy development by IPPR – this report sets out a new vision for the future of health and care on the basis of the assembly's deliberations and puts forward implementable policies through which that vision can be realised.

THE ASSEMBLY'S VISION FOR A SUSTAINABLE, FAIRER, MORE HOPEFUL FUTURE

As well as deliberations on specific policies, the assembly's deliberations converged on four key principles that should define a long-term view on workforce policy and planning. These were themes that the assembly agreed were core to ensuring the sustainability, attractiveness and effectiveness of the health and care workforce – and to ensuring the health and care sector remained one they could still see themselves working in the decades to come.

Principle 1: Sustainable staffing and recruitment

The assembly members wanted to work in a system that took a sustainable, whole-system view of workforce capacity. This is in contrast to the short-term, 'just in time' model of staffing which currently predominates. For the assembly, this meant replacing the crisis-laden 'just in time' approach with a bold (but ultimately pragmatic) shift towards a model with built-in resilience.

In the context of current pressures, and the need to anticipate future trends, this meant:

- addressing challenges around pay, working conditions and burnout
- drawing on international recruitment, and ensuring the UK health and care sector is a competitive place to work
- balancing that with a long-term vision for community-led recruitment strategies
- building generalist skills, to help workers address modern epidemiological and demographic realities.

Principle 2. Fairness hardwired into health and care

To ensure retention and fairness, the assembly wanted health and care work of the future to uphold justice for its workforce, with respect and recognition given to every member for their contribution, alongside a move towards non-hierarchical ways of working.

The workforce assembly highlighted the existence of structural racism, gender inequality and regional inequality. Moving towards a more 'just' workplace meant tackling discrimination in all its forms, as well as striving for parity in pay and recognition. We also heard how an over-reliance on strict hierarchies can make it hard for workers to speak up or whistle blow when faced with, or witness to, various forms of discrimination.

Transparency and protection against under-payment were emphasised as principles to underpin just pay. However, assembly members were clear that parity in recognition is not just about pay and emphasised that pay reform needs to happen alongside improved skills and training offers to support just career pathways.

Principle 3: A shift away from antiquated siloes and hierarchies

An integrated workforce was defined as one with effective coordination and collaboration that enables seamless working between professionals and across disciplines:

Assembly members emphasised that collaboration needs to go beyond senior management and be present in all parts of the workforce. It was acknowledged that integration both within and between health and care is not easy to achieve, nor very well established at present. Social care was seen as particularly fragmented due to the nature of its funding model and the use of private providers.

Localised solutions to integration as part of a national approach was considered important to avoid a 'top down' or 'one size fits all' approach, and to ensure the workforce retains ownership and meets local needs.

Principle 4: The right approach to innovation, with a stake and voice for workers

The assembly agreed that optimising the relationship between work, workforce policy and innovation was crucial in any long-term vision. There is, however, a long way to travel before this is a reality for health and care workers. The assembly presented IT troubles as one of the barriers to – rather than enablers of – high quality care. As one member put it:

“You can only free capacity for higher complexity thinking, freeing up time to have a conversation with the patient on the ward round rather than fighting with the technology on the ward round, if you address [the technology]... the NHS and IT are not good bedfellows.”

The assembly wanted to see more consistency and professionalisation in how innovation was adopted, and change was managed; were frustrated by barriers presented by poor or outdated technology; and wanted to greater say in what change was chosen.

Principle 5: Parity between health and care

A strong conclusion of the assembly was that a sustainable future of health and care work relied on parity between healthcare, social care and unpaid care going forward. The lack of recognition by policymakers for the value of care, and a lack of strategy to support those providing care, was seen as a problem for everyone – and an engine within our propensity for crisis.

In considering parity, we explore specifically how workforce planning and policy can better deliver equal respect and recognition. However, the assembly were also clear that a better approach to adult social care – based on aligning it to the principles of the NHS (free at the point of use, based on need, funded by tax, available for all) was a precondition for this parity. IPPR have discussed and supported this idea elsewhere (Quilter-Pinner and Hochlaf 2019)

These five principles form the basis for the policy shifts we outline in the next part of this report. Our recommendations seek to do two things:

1. addressing the structural drivers of crisis present in the system today, and moving away from the status quo of a sticking plaster approach; but also
2. grapple with the challenge and opportunities of the future, and outline a vision of the workforce that allows us to anticipate the bad and harness the good.

As well as the assembly's extensive deliberations, the recommendations are supported by qualitative research, wide expert interview, a range of IPPR roundtables and discussions, and extensive literature review.

THE FIVE SHIFTS

The five shifts outline policy to deliver a transformative approach to health and care work in England, led by the deliberations of the IPPR workforce assembly. Combined, they form a 10-point plan for a better, more sustainable future for health and care work.

4.

SHIFT ONE: BREAK THE CURRENT 'VICIOUS CYCLE', THEN MOVE TOWARDS LONG-TERM THINKING

Ensuring the health and care sector is a better place to work is a precondition for any solution to our current workforce crisis, and the foundation for any long-term vision for the future of health and care work. If one of the most pressing challenges faced today is a mismatch between workforce supply and demand – driven by poor working conditions and diminishing pay – then making the sector a better one to work in is the basis for ensuring the right levels of recruitment and retention.

This justifies immediate action on recruitment and retention – what we define here as a ‘circuit breaker’ to the vicious cycle sustaining the current workforce crisis.

However, no matter how ambitious, if solutions only focus on the most immediate challenges faced by the workforce today, we are likely to end up in another crisis before long. As such, solutions for today need to go hand in hand with reform for workforce planning – to move us towards greater sustainability in the long-term. We suggest this needs to include both a legal duty to properly plan workforce needs – but also fundamentally more creative, neighbourhood led recruitment pathways into health and care work.

STEP ONE: AN IMMEDIATE CIRCUIT BREAKER

Pay restoration should be an immediate priority

The government accepted the recommendations of the independent NHS Pay Review Body for 2022/23. However, these pay negotiations came before the current pressures of high inflation, rising interest rates, and the wider cost of living crisis. That these have made pay rates inadequate is demonstrated not only by headline real term pay cut figures, but also by the staff welfare offers NHS Trusts are having to now implement. Indicatively, research by NHS Charities Together shows that half of NHS Trusts are providing or actively considering providing food banks (NHS Charities Together 2023).

Alongside longer-term real term pay cuts, working condition challenges and high workload, this has led to industrial action across the NHS. It is important that these strikes are negotiated as quickly as possible. A pay settlement that genuinely addresses cost pressures and historic real-term pay cuts is likely to boost retention, morale and – in turn – productivity. These benefits will be significantly undermined if the resolution is not delivered for all NHS staff and, on this basis, we urge government not to limit negotiation to professions with the greatest public salience (for example, nurses).

As such, we first and foremost recommend the government urgently negotiate a pay settlement to bring strikes across the NHS to an end. IPPR research has previously shown the short-sightedness of artificially suppressing public sector pay, while wider research has shown that public sector pay rises in services like the NHS have lower net-costs than commonly perceived (Stirling and Dromey 2017, London Economics 2021). Even then, as the government’s latest submission to next year’s

pay review body shows² a one-off settlement won't end the fact that the current pay negotiation process tends towards short-sighted, low-ball pay offers. We discuss more fundamental changes to the pay review process in England below.

Of course, negotiating an end to NHS strikes offer little prospect of improving the lot of care workers, who remain among the lowest paid workers in the economy. Retail is a key competitor employer in social care. While in social care the minimum rate for staff over the age of 23 in June 2022 was £9.50 – nine of the 10 largest supermarkets were paying more than this. The lowest was Iceland at £9.50 and the biggest supermarkets such as Aldi, Lidl and Tesco paid £10.10 an hour (Bottery 2022). Similarly, the average care worker pay is paid £1 per hour less than healthcare assistants (HCAs) in the NHS that are new to their roles, and £1.90 below HCA's with more than two years of experience. In comparison care workers with five years' experience only get on average 7p more on average than new care workers (Skills for Care 2022b).

There is clear public support for higher pay for care workers (Thomas and Patel 2021). It is vital for tackling worsening workforce shortages and the longer-term recruitment crisis. As such, we recommend a new minimum sectoral wage should be introduced in social care to above the Real Living Wage at £12 an hour, to help keep pace with inflation and ensure that social care can compete effectively with other low wage sectors such as retail and hospitality. As has been outlined by IPPR and others elsewhere, this could be delivered through commissioning arrangements. Government funding to cover the increase in pay would cost an estimated £1 billion in the first year, declining in each subsequent year.³

The workforce assembly were clear that, as important as pay is, it is not the only thing that matters in making health and care great sectors to work in. Comments from the assembly described an array of relatively 'simple to fix' problems that can undermine the experience of working in health and care roles. These included:

- the cost and availability of parking
- availability of lockers
- availability of water, and capacity to take hydration breaks
- availability of coffee
- quality of staff communication
- availability of hot food for shift workers
- quality of break rooms, staff rooms or messes.

These issues are likely to be far easier and cheaper to fix than the cost of training new staff members to address their impact on retention. On that basis, we make several recommendations.

The means with which wider challenges can be addressed is likely to be different between health and social care. For NHS employees, and the minority of social care workers employed by local authorities, we reiterate previous IPPR recommendations to invest £1 billion in a staff wellbeing fund. This resource should be used to deliver a core set of workforce standards – access to lockers, water, rest rooms – and to ensure that is consistently available across the country (Thomas et al 2022). For independent-sector social care workers, we recommend that the government make working conditions and standards a key consideration in commissioning decisions – in line with previous IPPR recommendations on ethical commissioning (Quilter-Pinner 2019).

2 They recommended a maximum 3.5 per cent rise in pay.

3 Most simply, as the government's national living wage rate increases.

Pay award processes should be reformed, to ensure fairer decisions going forward

Above and beyond pay inequality, recent strike action across NHS professions has exposed the limitations of the NHS pay review process. Problems include the fact that their proposals are often implemented in a limited manner; that they have little capacity to account for changing economic conditions; and that the evidence used in pay decisions is limited. This can lead to policy that has little strategic consideration of the long-term implications for the workforce, for population health or for prosperity. Revisions to this process could include the following.

- **Pay deals should have a ‘force majeure’ clause in favour of workers, whereby the review process is reopened if economic conditions fall outside set parameters.** The recent experience of a significant rise in inflation following a pay decision should lead to the process being rethought. A force majeure clause would allow for more flexibility within the pay review process to adapt to changing economic weather. Moreover, as has been argued by Nuffield Trust (2023), it would also help facilitate a move to longer-term pay negotiations – as a way to free up space for creative, longer-term thinking on pay, without less risk.
- **Pay review body recommendations should not be bound by an affordability envelope:** As it stands, the pay review body is influenced by government remit letters – which stress the importance that recommendations are affordable. However, what is ‘affordable’ is a political decision to be taken by government – and any influence this has on independent pay recommendations reduces transparency on any discrepancy between what is ‘affordable’, and what is needed to meet future demands. We recommend the pay review body limit their enquiries to what pay award is justified by labour market conditions, wider economic context, and by what is necessary to support a sustainable workforce. The government will retain their right to reject these recommendations if they decide they are not affordable, but the political nature of this decision will be more visible and ministers more accountable.

Given that the pay review body does not cover social care, we make separate recommendations on supporting social care workers later in this report (see parity for care chapter).

STEP TWO: DEFINE AND DELIVER SUSTAINABILITY, INCLUDING THROUGH GREATER SELF-SUFFICIENCY

Embed proper and independent workforce planning in law

Both the assembly, and IPPR’s supplementary policy research, highlighted the lack of independent projections of workforce demand and shortage as a problem.

“A lot of the problems which we’ve experienced throughout the pandemic and even pre-pandemic have been to do with the fact there aren’t enough staff across the board in health and social care... And if we can’t increase and oversupply our health and care workforce, then there are big problems... The backlog is not going to be cleared unless we have many more staff... What I liked about making it legally binding [is] that we’ve had a set of governments, from my experience as a GP, promise extra GPs again and again and nothing’s been done about it.”

Since then, NHS England has itself accepted that its workforce planning will need regular forecasts of workforce need to be credible – while the chancellor has committed to “independently verified forecasts for the number of doctors, nurses and other professionals that will be needed in five, 10 and 15 years’ time” (HM Treasury 2022).

This is welcome. However, merely calculating the numbers of staff needed should not be considered a silver bullet in attempts to move to a more long-term and

sustainable approach to workforce policy. The government's planned approach leaves three pertinent risks unanswered.

1. That independent projections have little formal mechanism to force government to act, merely the presence of shortages is not always enough to catalyse decisive action (as the current workforce crisis epitomises).
2. That workforce modelling, alone, will incentivise policymakers to extrapolate existing workforce models into future decades – and miss the opportunity to adapt roles, skills, and ways of working proactively and creatively to the challenges, threats, demands and opportunities of the future.
3. That an ultimately national plan does not give much scope to consider the dynamics of local health and care labour markets. One common problem faced by health and care leaders is competition within the sector, in places where shortfall is particularly pronounced.

To address these risks, we suggest government's workforce planning approach is expanded in four ways.

1. A mechanism should be embedded in legislation to trigger action when (independent projections of) staffing is below – or projected to fall below – thresholds which will endanger patients and staff. For example, an independent adjudicator could be given powers to trigger the secretary of state – together with relevant integrated care systems (ICS) leaders – to present an emergency action plan on workforce within twelve months. As a national level, the plan should be presented to parliament; at the ICS level, the plan should be formally endorsed by the integrated care board at a public meeting – in both cases, to increase transparency and accountability. The same body could further be tasked with verifying whether an ICS has taken reasonable steps to meet workforce planning goals, and whether the government has provided sufficient support to do so. This would help to sharpen incentives to intervene quickly – and pre-emptively – rather than when systems reach breaking point.
2. The body – whether an existing body, like the ONS, or a new 'OBR style' body – should have a remit that goes beyond projections. Specifically, we recommend that the body is funded to take on a What Works function, similar to the Education Endowment Foundation. The focus of this what works function should be identifying, testing, and building the evidence base on innovation in workforce roles. For example, it could explore and test how skill mix can be put to better use; what new skills are most important to the future of the workforce, and how they can best be developed; what 'new' health and care roles are justified, and how they could be rolled out more widely; and what the best levers are to support retention. We discuss our own ideas across these themes in further chapters of this report.
3. Each integrated care system should be required to produce an annual workforce plan and develop a long-term workforce strategy with due regard to independent forecasts, sharing these with the Department of Health and Social Care. A shift to individual providers undertaking workforce planning within integrated care systems would strengthen the broader move towards closer integration, alongside other opportunities to bolster local system resilience, for example economies of scale in local recruitment drives or training schemes.
4. Establish ongoing national-local exchange of data and dialogue on workforce needs. For example, by establishing a national forum of ICS chief executives together with NHS England, the Department of Health and Social Care, HM Treasury and No 10, and requiring that data on local staff need, supply and gaps are made publicly available. Workers and workforce representatives should also be represented. If this is to work – for data returns to be accurate and discussion to be open – this will need to be a forum for supportive, creative, and collective problem-solving, rather than apportioning blame and accountability.

Deliver greater domestic self-sufficiency through neighbourhood level recruitment strategy

International recruitment has offered a huge amount to the health and care sector, not least since the formation of the NHS. Yet, as we have already pointed out, the idea that it can continue to provide a silver bullet to our propensity for workforce crisis is short-sighted, in a period where international recruitment is already high, and where the workforce shortage is increasingly global.⁴

The UK must also think carefully about its reliance on international recruitment from an ethical perspective. Having adopted the WHO's global strategy on human resource for health and code of practice on international recruitment, the UK agreed not only to undertake data-driven analysis to anticipate its future requirements but also to "strive to meet [its] health personnel needs with [its] own human resources for health". The code of practice also restricts nations from actively recruiting from so-called 'red list' countries facing the most pressing workforce shortages, a commitment that is not being upheld by the UK.

This necessitates a fundamental shift in our approach to workforce planning:

- **away** from the current 'lean' workforce model, where the priority is training as few professionals as possible – and on meeting shortfall with an assumption near-limitless international recruitment is theoretically possible
- **towards** a 'workforce plus buffer' model, where we plan for the workforce of the future (both numbers and allocation) and put in place plans to exceed those targets through domestic training, recruitment and retention. Free and open international recruitment should be possible but should not be the basis on which we plan to meet need, nor the only strategy for ensuring workforce resilience.⁵

Self-sufficiency in this context would be "a sustainable stock of domestic health and care workers to meet service requirements", where a 'stock' is a function of inflow, outflow, and existing supply (Little and Buchan 2007).

NHS England's plan to expand apprenticeships, to allow more healthcare workers to train as doctors (by sitting the same exams), and to expand training places are welcome steps in the right direction. Nonetheless, they are unlikely to prove a complete solution. First, because the absolute rise in training places will be – at some point – outpaced by the consistent growth in population health need (workforce-demand). Second, because there is a crisis across the whole workforce, not individual professions: a nurse training to become a doctor eases one shortage but accentuates another.

There are other, untapped routes to increase the pipeline of staff into the NHS. For example, there are nearly 2.6 million people who are now economically inactive in the UK (meaning they are not employed or actively seeking a job) because of long-term sickness. That's the highest level since records began in 1993, and up more than 400,000 since the end of 2019 alone (see Thomas 2022). Overall, there are now a million fewer people in the workforce than if pre-pandemic trends had continued, driven by rising numbers of people aged over 50 or with long-term sickness leaving the workforce. However, there is also a large group of economically inactive who would like to be in work – 581,000 according to the ONS (2022).

4 This both means fewer workers available overall, but also more global competition for those same workers by health and care employers.

5 We acknowledge that exact projections for many professional groups will be difficult and uncertain. However, projecting ranges is plausible – and the buffer model should see a focus on achieving the upper end of necessary workforce-supply projection, rather than the central projection or lower band

We propose that the NHS (with ICSs in the lead), local government and the Department for Work and Pensions come together to establish ‘**Return to Health**’ – a scheme matching people who would like work, but who are barred from it by a long-term health condition, are matched with appropriate supported employment opportunities in the health and care sector.

- Return to Health would offer a supported employment opportunities in the NHS and adult social care for people with long-term health conditions. This would help match people with opportunities to take on a wide range of roles: link workers, social prescribers, peer support/expert by experience roles, manager roles, social care workers, care home managers, infrastructure support roles and similar.
- The scheme should principally focussed on those with a long-term health condition or disability that reduces their capacity to work – including the 600,000 people who are currently economically inactive due primarily to long-term sickness, but who want a job. It should be voluntary, and not participating in the scheme should not lead to benefit sanctions.
- Rather than a nationally prescribed programme, the programme should be made available through local organisations individuals are already in touch with, like local authority job brokerage schemes, housing associations, community groups and health schemes – working closely with integrated care systems.
- In practice, *Return to Health* would see integrated care systems outline a supported employment model for shortage occupations – particularly focusing on (non-medical) roles where specific graduate qualifications aren’t needed.⁶ The model for the ‘supported employment’ type of intervention needed is provided by ‘Individual Placement Support’ or IPS. Its key elements are:
 - a positive culture rooted in the belief that anyone who wants to work can do so
 - employment support integrated with clinical treatment
 - a focus on rapid job-search rather than long periods of generic pre-employment training
 - tailored, long-term support to employees and employers.
- Each placement should last six months to one year and as with similar schemes there would be an offer of a ‘job guarantee’, with placements expected to result in ongoing support or permanent employment.
- This scheme could be comfortably funded from the estimated £2 billion underspend from the government’s Kickstart and Restart schemes, established to tackle long-term unemployment during the pandemic. If such a scheme set out to recruit 15,000 professionals (360 per integrated care systems on average), and assuming a unit cost of £1500 to £3000 based on similar schemes elsewhere, the cost of the scheme would be between £23 million and £45 million.⁷
- This scheme would have several advantages. First, it would increase job opportunities for people with long-term conditions – and who want a job – in a sector that should have a sound understanding of the needs and nature of those health conditions. Secondly, it would constitute a public health intervention: employment, in good jobs, is a determinant of health through the life course. Third, it would deliver across the integrated care system’s four objectives: including tackling inequalities, improving health equality, and building social and economic outcomes. Over time the model could be expanded to other employers and sectors.

6 That is, at lower bands of the AfC pay grade system

7 This does not include additional recruitment/salary costs.

5.

SHIFT TWO: DISRUPT OUTDATED WAYS OF WORKING

The assembly's deliberations identified a range of old siloes and hierarchies that were either no longer needed, or active barriers to progress and evolution. Often, their longevity was down to 'it always having been that way', rather than anything more deliberate. This chapter looks at how some of these can be disrupted, in support of a health and care sector that is more able to evolve, adapt and meet future challenges/opportunities head-on.

MODERNISE HEALTH AND CARE LEADERSHIP

The government's focus on integration has aimed to help coordinate services around people – and to shift from activity-led metrics to outcome lead metrics. However, the assembly noted that leadership within both health and care could be overly focussed on what happened within the walls of the service they lead, rather than what was best for outcomes in the whole population.

This speaks to a wider reality – that real integration won't happen through integration of governance structures alone. It will require a genuine shift in the behaviours and culture of NHS and social care from service-specific-leadership and towards system leadership.

Government has previously accepted the importance of leadership in driving good performance and outcomes – including through the NHS Leadership Academy. The academy has provided the NHS some levers to define the kind of leaders it produces: their values, notions of best practice, and the kind of culture they look to embed. However, evaluations have highlighted problems in the approach to leadership the NHS takes more broadly and that is embedded in the Academy more specifically (see, for example, Edmonstone 2013). Further, wider reviews have concluded there is a crisis in leadership in the health and care sector (see, for example, Naylor 2014). Combined, these bring into question whether we have the means and capacity to consistently develop inspiring, system-orientated leaders across health and care.

We suggest that – either through a new programme or refines to the NHS Leadership Academy – a new 'system level' leadership programme is introduced. The focus of this programme should be two-fold. First, it should integrate detailed and formal study of management as a specialist subject in its own right.

Second, it should focus on providing leaders with opportunities to work across the health and care sector as a whole, to develop their understanding of the wider health and care eco-system before they move into leadership positions. This builds on extensive evidence showing that experience in multiple sectors, including through secondments, makes a significant contribution to the strength of leadership (see, for example, Winninger et al 2010). The success of the programme would be reliant on partnerships, but could include opportunities to spend time in:

- social care
- wider public services
- central government

- life sciences and research organisations
- charity and voluntary sector organisations
- a wide range of healthcare/NHS settings
- membership bodies.

This programme should challenge a common conception in the NHS that clinical expertise is a replacement for strong leadership or management skills. Emerging evidence suggests this idea could be actively harmful – with one recent paper, analysing data from public hospitals in Chile, showing that availability of presence of bespoke management skills account for a significant amount of variation in hospital mortality. Patient composition, level of compensation and availability of performance pay did not explain this relationship. Instead, the benefits came from displacement of “older doctors with no management training in favour of younger CEOs who had studied management... these CEOs improved operating room efficiency and reduced staff turnover” (Otero and Muñoz 2022).

In reality, age is very unlikely to be the causal mechanism behind the link between displacement of existing with new managers. Rather, it is likely that age predicts exposure and formal training in the best management techniques, or management as a specialist discipline. The NHS provides existing leaders little means to continue professional develop, or to keep up with management best practice. As such, while we suggest developing new leaders is one pillar of the new NHS leadership offer, we also suggest existing leaders and managers are given equal access to it as a programme. Existing incentives could help embed this shift – for example, the clinical excellence award – which evidence already suggests rewards the ‘status quo’ way of doing things and may actively obstruct change (see Thomas 2020) – could be reformed to include excellence in management and leadership within its criteria/assessment.

PILOT, EVALUATE AND ROLL-OUT THE ‘ROLES OF THE FUTURE’

We have done little to adapt the kind of roles that make up the health and care workforce – even as population health has shifted towards complicated, long-term, and multiple conditions, and as the nature of innovation and technology have changed best practice and working practices entirely. There is significant opportunity to challenge this mismatch between the stasis of the workforce composition of the health and care sector, and the rapidly changing reality of health need and scientific innovation. Doing so would increase both our capacity to meet need today, and also to shift to meet the challenges of the future (and harness its opportunities).

To that end, we suggest the government launch a series of pilots, exploring the efficacy of high-potential new roles and working models. Based on the deliberations of the assembly, we highlight four – which should be tested for efficacy and, if effective, rolled out nationally.

Innovation specialists

Innovation is changing what’s possible in health and care. Personalised medicine offers the potential to tailor treatment to individuals. Automation can help free up time within the workforce. While Artificial Intelligence and IT are supporting the possibility of a beneficial move towards health and care professionals with a more rounded, generalist skill-set – rather than a focus on an encyclopaedic knowledge in a highly specialised area.

However, this promise is only possible if innovation is skilfully implemented, by people with both the ability to harness it – and to enable others to do so effectively, too. Assembly members were confused as to why health and care often left the work of spread and implementation to clinicians – and while they

felt they should be involved in the process, they also felt that people with bespoke skills in change management, particularly in complex systems, were needed too.

Specialist navigators

As health needs become more complex, more likely to intersect with other non-healthcare needs (e.g., financial, housing, work), and more likely to implicate a wider range of services (not necessarily limited to the public sector), the need to support people navigate the system is growing. Analysis has pointed out the difficulty navigating the NHS, let alone all the services that make up an integrated care system (Davies 2022, Health Education England, no date, Sweeney 2022, AMRC et al, no date).

This can accentuate health inequalities. It is already the case that those with better health literacy get better outcomes, and a reality that levels of health literacy have a social gradient (Fraser et al 2012, Harris et al 2014). If this isn't addressed, we miss both an opportunity to make people's experiences of care better, and tackle well established healthcare and social care inequalities.

We therefore recommend ICSs explore the potential of specialist navigators – with a role in coordinating people across a range of place-based services. Rather than NHS specific coordination, as is currently available in some parts of the country, these navigators should be experts in place-based assets, in the range of services available in a place (from civil society, to the voluntary sector, to the public sector), and in helping people to get access to services that work for them. Similar schemes have been highly successful in Scotland, including the Improving Cancer Journey Programme in Glasgow (Edinburgh Napier University 2020)

Hybrid and portfolio roles

Research, including IPPR research, has shown significant appetite among GPs for 'portfolio careers'. This means a working week where a significant amount of patient-facing work is combined with wider opportunities – for example, spent taking up leadership roles, research or on developing/adapting innovation (Thomas and Quilter-Pinner 2020). Accounts suggest this can have wider benefits, but also help improve retention and job satisfaction.

There is no logical reason – particularly within a longer-term shift towards more integrated and coordinated care – portfolio careers need be the preserve of general practice alone. Indeed, the assembly highlighted both appetite for more hybrid roles, and tangible ideas of where they could be implemented (below). By hybrid roles, we mean opportunities to split the working week across different sites, employers, and settings.

- NHS and schools: Splitting time between healthcare settings and children's NHS settings could be appropriate for a range of nursing roles, mental health roles and allied health professional roles (such as speech and language therapists).
- Community and acute settings: Hybrid roles could be suitable for maternity and nursing staff.
- Clinical roles and clinical research: Could be undertaken more regularly across a range of healthcare professionals, including nurses and doctors.
- Residential care and hospital care: Could sustain hybrid roles for allied health professionals and nurses.

The assembly felt hybrid working could help develop their portfolio of skills, provide variation in their career, support retention and help build empathy/system-level expertise crucial for making integrated care work.

Pilots should cover several, diverse parts of the country – to ensure comprehensive evidence is available for evaluation. Based on health and care unit costs and similar programmes, we estimate running these pilots would cost £20 million per year (PRSSU 2022). Instead of seeing this as one-off spend, we suggest this funding provides permanent capacity to pilot, test and evaluate new workforce models – to support longer-term innovation in the health and care workforce composition.

EMBED A RIGHT TO TRAINING AND LIFELONG LEARNING

The overwhelming majority of the workforce of the 2040s is already in work. Therefore, the major opportunity to shape a workforce fit for the 2040s will come from up-skilling the current workforce, particularly the non-medical workforce. There are several reasons for a ‘right to training and lifelong learning’ to be a major goal for the workforce.

- As we saw above upskilling or retraining may be required to realise the gains made from technological or social innovation in order to re-design jobs, both to improve patient-centred care and improve job quality in low paid health and care roles.
- To create viable career paths for people from different backgrounds or with different abilities and offer more progression opportunities to help boost retention and tackle gender inequality
- To ensure the health and care workforce is ready for the dramatically different health system of the 2040s with skills in genomics, data analytics and AI expected to be in demand (Topol 2021).

We therefore recommend that every nurse, midwife, allied health professional and social care worker is given access to a personal training budget of £2,000, upon reaching their third year in the career. They should have freedom, within the bounds of usual consultation with their manager, to spend this money on developing skills that meet their career aspirations. The budget should not be available to spend on ‘on the job training’, routine continuing professional development or other non-training costs. This is suggested as above and beyond the £1,000 personal training budget allocated by government to support nurses with their revalidation cycle.

Based on extrapolation of similar programme costs, we estimate that this package would have a cost to government of **£1.7 billion**, to cover the existing workforce. A much smaller increase in annual budgets would then be needed to facilitate access to new staff members.

6.

SHIFT THREE: DELIVER A FOUNDATION OF FAIRNESS

The assembly was clear that a stronger approach to fairness was both integral to recruitment and retention today, and to the long-term sustainability of the health and care sector in the future.

Deliberation focussed on the discrepancies in pay and progression faced by women – and the way that health and care work still often isn't optimised for female workers, despite the fact they make up the vast majority of the health and care sector. It also focussed on the discrimination and prejudice faced by ethnic minority staff – both from colleagues and managers, but also patients. This chapter explores new opportunities to help build a stronger basis of fairness in the health and care sector.

SIGNIFICANTLY BOOST SUPPORT FOR WOMEN RETURNING TO WORK

Women make up the majority of the health and care workforce. In the NHS, 77 per cent of the workforce are female (NHS England 2021), while in social care, 82 per cent of workers are female (Skills for Care 2022b). This proportion rises markedly in some professions: over 99 per cent of midwives are women, as are over 88 per cent of nurses and health visitors (Nursing and Midwifery Council 2022).

Despite being the clear majority, women suffer a range of inequalities in health and care work.

- **Pay:** The Independent Review of Gender Pay Gaps in Medicine in England showed wide and persistent discrepancies in pay – including a 24 per cent pay gap for HCHS doctors and a 22 per cent pay gap for clinical academics (Dacre et al 2020). IPPR research has shown a 34 per cent pay gap among GPs (Thomas and Quilter-Pinner 2020b). There is limited data on the gap solely in social care, but TUC analysis shows the pay gap across both the human health and social work sector is 18.3 per cent (TUC 2022).
- **Progression:** Despite making up a majority of the NHS workforce, 44 per cent of NHS chief executives are women (NHS Digital 2018). This is below the 50:50 target set by the regulator in 2016 – and even that, given current workforce composition, lacks ambition (Sealy 2020).
- **Discrimination:** The British Medical Association has found extensive evidence of sexism in the NHS (BMA 2022b). And during Covid-19, female healthcare workers were more likely to be redeployed into high-risk roles for exposure to Covid-19 (Allen 2022). Our literature review did not identify comparable evidence in social care (though the same is likely to hold true).

As the government has acknowledged, the largest barriers to gender equality in pay and progression often arise from the conflict innate in current models of organising work, and unequal caring responsibilities/burden faced by women (see Government Equalities Office 2019). One significant barrier of this type is the 'motherhood penalty'. The assembly highlighted this firmly – as has previous qualitative work on NHS careers (Jones 2019).

Policy in health and care has the means to rectify this. On basis of ideas shared by the assembly, and since developed further, we suggest the following.

Return to work

The government are supporting the pregnancy and maternity discrimination bill introduced in late 2022. This will offer women returning to work enhanced protection from redundancy. However, this is a vital point in tackling gender inequality, and there are opportunities for the health and care sector to go further and faster. We suggest that government introduces a formal pay and progression process for women returning from maternity leave, to be undertaken within a year of return and covering health and care workers in public employment.

This review should have three objectives:

- identifying where women returning to work are at risk of a ‘motherhood penalty’ either in terms of pay and progression, and formally documenting them
- identify proportionate access to further training and skills, in order to help support progression, in discussion and in line with the preferences and priorities of the individual
- formally review pay, with an aim of the process reducing the gender pay gap for that employer and profession. This should be in the context of the size of the gap – and the employer should be held accountable to the extent this process contributes to closing it.

Comply or explain right to flexible work following return to work

The government are also in the process of legislating a ‘day one right to request flexible working’. However, this is a right to request, not to have. As such, it presents further opportunity for the health and care sector to define gold standard. We recommend that that – for the first 1,000 days period – the ‘right to request flexible working’ is shifted to a right to flexible working. In practice, this should be run on a ‘comply or explain’ basis – with a good reason needed to reject flexible working requests, and the expectation the majority are accepted.

A bolder approach to tackling health and discrimination

If the health and care sectors are to recruit and retain more staff from currently under-represented communities, the discrimination and prejudice experienced by many must be eliminated. Previous IPPR research showed that almost a third of health and care staff from minority ethnic backgrounds experienced discrimination or unfair treatment from managers and colleagues (Patel & Thomas 2021). The assembly argued for a zero-tolerance approach to racism and discrimination, but they also felt that the ground for this would need to be prepared with a shared understanding of where discrimination comes from if ‘zero tolerance’ is to be effective. The assembly also argued for greater accountability from NHS senior management for the reduction of incidents of racist discrimination among staff, between health workers, and from the public.

- Integrated care systems have four key objectives: to improve outcomes in population health and healthcare; to tackle inequalities in outcomes, experience and access enhance productivity and value for money and to help the NHS support broader social and economic development. Given the huge challenge faced by the NHS in tackling discrimination and the importance of achieving this not just for a more just system, but for improved recruitment and retention of staff, tackling discrimination should be added as a fifth objective, with an appropriate plan of action and accountability.
- Evidence suggests staff networks are a valuable form of ‘allyship’, representing an opportunity for all staff to understand the perceptions and lived experiences of people from ethnic minority backgrounds. Networks represent an opportunity for all staff to understand the perceptions and lived experiences of people from ethnic minority backgrounds. They play a valuable

role in supporting staff, raising awareness of diversity of experiences and provide important forums for democratic participation in the workplace (Ross et al 2020).

- Relatedly, formal allyship schemes have also shown to be effective (ibid). It can be difficult for people to report their own experiences of discrimination or prejudice. This is particularly true in the health and care sector, where fears of retaliation or detrimental treatment as a result of speaking up are widespread. One charity found that, of the workers who contacted their helpline, 77 per cent had experienced such treatment after speaking up (Thompson 2023). As such, the government should mandate an allyship programme in each health and social care workplace. Similar to wider staff bodies, this should see representative staff provide colleagues with an anonymous route to report their experiences. In turn, 'ally' staff should report back to leaders – providing a safe and legitimate source of feedback on where discrimination is occurring.
- ICSs should play a role in ensuring sufficient staff time can be devoted to the running of groups, and that they have senior sponsorship to be effective. For these networks to thrive, organisations must ensure that staff have protected time to engage in them inside normal working hours and have sufficient, dedicated resources to raise awareness of discrimination and the opportunity for staff to contribute.

We further recommend that Care Quality Commission formally assesses levels of discrimination within their inspections. Specifically, this should mean providing anonymous channels for staff to feedback on their experience of racism at work; assessment of leaders on the basis of creating an anti-racist work environment; and evaluation of NHS trust data covering both ethnicity pay and progression gaps.

7.

SHIFT FOUR: GREATER PARITY FOR CARE WORK

EMBEDDING SECTORAL BARGAINING IN ADULT SOCIAL CARE THROUGH AN ADULT SOCIAL CARE COUNCIL

Several recommendations in this paper will be particularly impactful for social care workers – including on pay and lifelong learning. However, it is also crucial that this plan addresses the structural reasons that social care is undervalued, underpaid and underdeveloped as a sector.

In comparing healthcare and social care, one of the clearest differences between the two is level of representation and collective bargaining. The NHS has highly evolved representation, including professional bodies and trade unions representing both the sector as a whole – and professions specifically. This has supported both better outcomes for staff, as well as the formalisation of professional standards.

By contrast, as IPPR research has shown previously, the social care sector has low levels of union membership and low collective bargaining coverage. While workers in local authority employment are covered – and their pay and conditions are significantly higher on average – they are a significant minority of the social care workforce. This is particularly problematic in a sector like social care – where the prominence of low pay, zero-hour contracts and precarious work undermines negotiating power further.

As IPPR have previously recommended, government could establish a sector council in social care, with responsibility to promote sectoral collective bargaining (Dromey & Hochlaf 2018). It would further provide a forum to bring together unions, employers, government, people who draw on social care and workers to develop agreed minimum standards for employment in the sector.

A LEGAL DUTY TO DEFINE AND PURSUE SUSTAINABLE UNPAID CARE LEVELS

The assembly defined unpaid care work as work. The assembly was united in recognition of the vital role unpaid carers play in society and their communities. There was appetite for greater support for carers – from right to carers leave, to greater support through the social security system. Government could consider the following.

- **Increasing carer's allowance:** In the autumn budget, government confirmed carers allowance would increase with inflation in April 2023. This is welcome – but does not account for the fact carers allowance was already too low, leaving many at risk of financial insecurity, material deprivation and poverty. Carers UK have recommended government increase carer's allowance to the value of 21 hours work a week at the national living wage rate (Carers UK 2022b).⁸

8 This would increase carer's allowance by nearly three times its current rate. Based on latest expenditure data and assuming no behavioural changes from the uplift, this would cost an estimated £5.7 billion in year one (DWP 2023). This is equal to just 10 per cent of the value of adult social care provided by unpaid carers in 2017 (ONS 2017).

- **Expanding carer's leave entitlement:** Challenges balancing work, financial and unpaid care commitments are exacerbated by a lack of carers leave entitlement in the UK. In Poland, employees who provide care for a relative are entitled to two weeks paid leave per year, with financial compensation set at 80 per cent of average earnings. The UK furlough scheme has built our capacity to replicate this scheme, and embedding it is likely to increase carers capacity to remain in employment.

However, as important as they are, such interventions are unlikely to tackle the root causes of unsustainable levels of unpaid care in England today on their own. They alleviate, but don't fully tackle, the root causes of unsustainable unpaid care loads in this country.

- The need for care work is growing across the country. In particular, adult care work is increasing as a result of a growing and ageing population. Indeed, the rising discrepancy between life expectancy and healthy life expectancy – the average person in England can expect to spend nearly two decades in poor health – is indicative of the increasing unpaid care burden
- Unpaid care is hugely valuable but does not need to be remunerated by government. Indeed, the ONS estimated that in 2017, unpaid carers provided social care worth nearly £60 billion (ONS 2017) – over double the government's annual budget for adult social care. This disincentivises government from managing the increase of this labour – or replacing it with state funded care capacity.

Or in other words, the need for care is growing – and that growth looks set to continue. But by default, government are incentivised to allow that burden to fall disproportionately on unpaid carers. Policies that fail to address this dynamic are unlikely to achieve long-term sustainability.

The assembly, and IPPR's subsequent research, did not suggest that the right approach was to attempt to eliminate unpaid care. Indeed, unpaid care often describes desirable, communal interactions between people and their friends, family and loved ones. Instead, the appetite was for unpaid care commitments to be a more sustainable part of our lives.

We therefore recommend that the government sets itself three legal duties on managing the level of unpaid care undertaken across England. For the purposes of this report, we focus on adult care, but the recommendations could be expanded more broadly.

- **Duty 1 (total care):** The average hours of unpaid care for adults undertaken per person should not rise further. Figures on the average amount of adult care provided per person are skewed by the relatively low number of people providing care – full-time carers constitute 8 per cent of the population (ONS 2017). The burden concentrated on a small number of people is relatively high – indicative of a system in which formal care provision does not meet care users or carers needs. Government should seek to reduce the total amount of unpaid care being provided by halting further increase in typical hours of unpaid care work.
- **Duty 2 (distribution of care):** The number of people providing a large amount of care should fall. Survey data suggests around a third of adult carers spent 34 or more hours as an informal carer. This is clearly unsustainable, and is likely to have big wider impacts on the carers wider life (e.g. including finances or work) (Ibid). The government should pledge to bring this number down.
- **Duty 3 (equality of care):** Levels of unpaid care work should be equalised between the genders. As it stands, women do significantly more unpaid labour than men. This is patently unfair, and one of the driving forces of gender-based inequalities in the workplace. Government should focus on

how they can rebalance the distribution of care between men and women, including by offering families more options around formal care provision, and by valuing care work.

Evaluation of the government's progress against this duty could be undertaken by the same body tasked with providing independent workforce projections – and, to build accountability, reported to parliament each year.

UNIVERSAL SOCIAL CARE

Research suggests one of the most effective forms of support for unpaid carers is greater access to formal care (Brimblecombe et al 2018). The introduction of free personal care for those over 65, funded from general taxation as IPPR has recommended previously, would create parity between diseases of old age such as dementia, and diseases like cancer care which are funded free at the point of need by the NHS, while also providing the increase in formal support needed to reduce the total burden of care falling on informal carers (Quilter-Pinner 2019). While we do not cover it in detail here, due to our remit and focus on workforce reform specifically, the IPPR assembly noted achieving this would be a precondition to achieving real parity between the work of healthcare and the work of social care.

8.

SHIFT FIVE: PLANNING FOR INNOVATION

The assembly's deliberations showed the complicated relationship workers often have with technology and innovation. On the one-hand, they could see – and were excited – by the prospect of innovation: from artificial intelligence to gene therapies. On the other, they felt there was a dissonance between the promise and the reality of innovation. Specifically, they pointed towards poorly integrated IT systems, slow computers and inconsistent WIFI as examples of the health and care sector's inconsistent capacity to keep up with the future.

Perhaps most tellingly, many could identify how innovation had made the NHS more cost efficient or patient outcomes better. But, by contrast, few could identify – in the context of increased workload and lower reward – a way that innovation had made their working lives better.

One of the most important features of long-term workforce planning is its potential to build our capacity to harness new opportunities, technologies, and ideas. As such, it is a crucial that a shift to long-term workforce planning and policy considers how best to build interest, engagement, and support for (evidence-led) change. This is the focus of this chapter.

BUILD THE SECTOR'S INNOVATION WORKFORCE AND CAPACITY

This report has already shown the mismatch between clinical workforce-supply and workforce-demand. But, as already show in this report, no workforce category has grown more slowly than NHS infrastructure and support staff (see table 1.1) – including managers and senior managers, the number of which has actually declined year on year through the last decade. These are roles that are likely to be highly relevant to the identification, adoption, and management of change. They are also responsible for keeping services up to date, modern and in working order.

While similarly detailed data does not exist for the social care workforce, Skills for Care data shows that administrative, support and estate roles represent a lower proportion of the total workforce than in the NHS (Skills for Care 2022b).

Overall, this suggests that the health and care sector is under-managed – a conclusion reached elsewhere (Kirkpatrick & Malby 2022). This will inevitably limit its ability to innovate, undertake change successful, and to keep technology up to date. It also increases the burden of bureaucracy – inevitable in an organisation the size of the NHS – that falls on frontline professionals.

Moreover, there is evidence that growing management capacity can have tangible benefits for patients, as well as the wider workforce: a rise in managers from 2 to 3 per cent of the NHS workforce has been associated with a 1 per cent increase in patient satisfaction scores; a 5 per cent increase in hospital efficiency; and a 15 per cent decrease in infection rates. By contrast, using management consultants to make up the deficit was associated with a negative impact on the efficiency of hospital trusts (University of York, no date). Despite this, a lack of in-house management expertise saw the NHS spend over £300 million on external management consultants in 2018/19 (Sturdy et al 2020).

There is limited evidence on what the right level of management would look like in health and care – nor where those managers should be allocated. In this context,

we suggest our previous recommendation of independent workforce projections includes in-depth research and projection of the optimal number and allocation of managers across health and social care. From here, government and employers can set a more evidence-based long-term target for building this vital profession. In the intermediary period, we suggest all NHS Trusts are instructed to recruit management capacity/expertise as a default – and to publish justification for any management consultancy spend of over £100,000 against this expectation.

THE MISSING MANAGERS

As we have already shown, the number of managers in hospital and community settings has actively fallen since 2010. The NHS is one of the most undermanaged health systems in the world – and any comparable business would struggle to maintain productivity and effectiveness with the same management deficit. Properly deployed, they can be transformative in reducing frontline administration burden, facilitating innovation and forming collaboration and partnership.

Quantifying the necessary number of managers is difficult. We can quantify the deficit that has emerged in the last ten years in a few different ways:

- Had manager numbers grown as fast as Health Foundation research (with 2023).
- Had manager numbers grown as fast as (itself insufficient) doctor numbers did over the last decade, we'd expect 7,200 more managers in hospital and community settings.
- And if manager numbers had grown only as fast as the wider HCHS workforce, we'd still expect 4,000 more in relevant settings.

To this end, we suggest this decade has seen the emergence of 10,000 missing managers. That is not to suggest that 10,000 more managers would be enough to solve the current shortage, but would rather undo some of the damage done by policies since around 2010.

IMPLEMENT NEW TECHNOLOGY AGREEMENTS ACROSS HEALTH AND CARE

That the workforce assembly had difficulty identifying how innovation had made their work life better or more manageable – as opposed to how it had supported patient care or sector finances – is worrying. Allowed to continue, this could limit the extent to which workers are advocates for innovation and positive change in their own organisation.

In other sectors, there has been a steady introduction of 'New technology agreements' agreed with employers – often, led by unions in order to safeguard workers interests in relation to the adoption of new technology in the workplace. These agreements are intended to ensure that workers share in the productivity gains from technological innovation. Examples in the UK include the Communication Workers Union's agreements with the Royal Mail Group and in Europe the German transport union reached a Work 4.0 agreement with the Deutsche-Bahn Group (DB AG) (TUC 2021). In the health and care sector, the focus of such agreements should be speeding up the adoption of more innovation, by ensuring the workforce has a vested interest in both adoption and spread of new technologies.

Similar types of agreements offer the opportunity to both build workforce engagement with the latest innovations and ensure greater engagement through a fairer allocation of the benefits of progress between workers, patients and taxpayers. We therefore make the following recommendations.

- We suggest that new technology and innovation agreements (NTIAs) are implemented across health and care, as a negotiation between unions, staff, employers, and government. This should start with a commitment to enshrine principles of quality work in the NHS, ensuring that any change to working practices does not impact on the right to decent, dignified, and well-remunerated work in healthcare.
- This should be followed by a mass consultation exercise within the NHS, modelled on the German Arbeit 2020 process, which aimed to empower local works councils' members to bargain over digitalisation at the workplace level.
- As they mature, NTIAs should set out a formal pathway through which the gains of greater innovation can tangibly improve working conditions across health and care. Optimally, they should outline a way to share the proceeds of productivity-improving innovations with workers. This could be through pay, greater holiday allowance, shorter working hours, or greater access to flexible working. IPPR has recommended similar across the whole economy elsewhere (Roberts et al 2019).
- Consent and negotiation around technology is beneficial to workers and employers alike. For employers, open dialogue about innovations can prevent reactions and disruption further down the line. For workers, a leading role in shaping how and where new technologies are adopted and deployed can enhance productivity impacts, including by identifying opportunities for worker time to be freed up and redeployed on tasks that are uniquely suited to humans.
- In particular, agreements could focus on detailing how productivity gains from innovation will be used to ensure better pay, autonomy and flexible working opportunities in lower-paid health and care roles (including those more likely to be taken up by women and ethnic minority workers).

THE PROMISE OF AUTOMATION

Automation is the archtypal example of an opportunity that, without long-term thinking on workforce, we'll be less able to achieve. It has been estimated that automation could free up staff time worth over £12 billion across the NHS and £6 billion in adult social care (Darzi 2019), while projections have estimated that around 40 per cent of unpaid adult care activities could be automated by 2033 (Lehdonvirta et al 2023).

The value of automation in health and care lies in its capacity to free up 'time to care'. That is, the time savings from automating routine or bureaucratic activities can deliver more time for patient and service-user facing activities; helping improve relationships within the health and care sector and improve long-term condition management.

However, this is demonstrably not happening. Extensive advances in the NHS since its formation – including those we take for granted, like computers and mobile phones – have not radically increased the time doctors feel they have available to interact with patients. Indeed, patient-facing time and continuity of care have both become harder to sustain.

Our proposal of new technology agreements suggests, instead, that automation and wider innovation should create 'time to recover'. By investing a set proportion of productivity savings into annual leave, lower work demands or greater access to flexible working, a clearer relationship can be formed between modernisation of health and care services and working conditions. It is only fair that, as services get better, so should working conditions. In turn, this can deliver a more sustainable and resilient workforce – with tangible benefits for quality, safety, and experience across services.

OUR 10-POINT PLAN

1. A circuit breaker to end the current ‘vicious cycle’ in the health and care workforce – including pay restoration, reform of pay review processes, a substantial increase in social care pay, and a funded retention programme to ‘get the basic right’ on working conditions.
2. Shift from reactive workforce policy to long-term planning, through a long-term workforce projections body and a ‘break glass’ option for that independent body to require the secretary of state or ICS leaders to develop a published workforce plan.
3. Create ‘return to health’ – a scheme that matches people with long-term health conditions, who would like work, with health and social care jobs, facilitated through supported employment programmes.
4. A new health leadership programme, to increase the supply of brilliant, system-level leaders across health and care.
5. A permanent pilot fund to test, evaluate and evidence ‘roles of the future’ – supported by a funded right to lifetime learning and development across health and social care.
6. Increase support for women returning to work after maternity leave – including a ‘comply or explain’ right to flexible working, and a formal review of pay and progression after 12 months, to help tackle the gender pay gap.
7. Hardwire action on prejudice and discrimination within ICSs and make anti-racism a formal consideration of the Care Quality Commission’s ratings.
8. Expand collective bargaining in the social care sector, supported by a new Social Care Council – with powers to negotiate pay, set professional standards and advocate for social care workers.
9. Significantly increase in support for unpaid care, including a legal duty on government to keep unpaid adult care within a set definition of sustainability.
10. Expand the sector’s management workforce to increase capacity to adopt, adapt and spread innovation – and implement new technology and innovation agreements across the sector that outline how those gains will translate into better working conditions (as well as better patient outcomes and cost-efficiency) over time.

REFERENCES

- Allen S (2022) *The she-cession and why the time for equality is now*, blog post, NHS Confederation. <https://www.nhsconfed.org/articles/she-cession-and-why-time-equality-now>
- AMRC, National Voices, NHS Confederation (no date) *Changing care, improving quality*. https://www.nhsconfed.org/system/files/media/Changing-care-improving-quality_0.pdf
- BBC Shared Intelligence Unit (2022) 'Growth in NHS recruits from abroad prompts concern about over-reliance', *BBC News*. <https://www.bbc.co.uk/news/uk-61230287>
- BMA (2022a) 'Morale is at rock bottom', press release. <https://www.bma.org.uk/bma-media-centre/doctors-morale-is-at-rock-bottom-bma-says-in-response-to-the-gmc-national-training-survey>
- BMA (2022b) *Sexism in medicine* <https://www.bma.org.uk/media/4488/sexism-in-medicine-bma-report-august-2021.pdf>
- Boniol M, Kunjumen T, Nair TS et al (2022) 'The global health workforce stock and distribution in 2020 and 2030: a threat to equity and 'universal' health coverage', *BMJ Global Health*, 7:e009316
- Bottery S (2022) 'Odds stacked against it: how social care struggles to compete with supermarkets on pay', blog post, Kings Fund. <https://www.kingsfund.org.uk/blog/2022/08/how-social-care-struggles-compete-supermarkets-pay>
- Carers UK (2022a) 'Key facts and figures about caring', webpage. <https://www.carersuk.org/policy-and-research/key-facts-and-figures/#:~:text=Carers%20UK%20estimates%20that%20the,Petrillo%20and%20Bennett%2C%202022>
- Carers UK (2022b) *Heading for crisis: caught between caring and rising costs*. https://www.carersuk.org/media/x5sfjlbx/heading_for_crisis_report.pdf
- Charlesworth A et al (2023) *Long-term projections of health care funding, bed capacity and workforce needs*, Health Foundation. <https://www.health.org.uk/publications/journal-articles/long-term-projections-of-health-care-funding-bed-capacity-and-workforce-needs>
- Dacre J et al (2020) *Mend the Gap: The independent review into gender pay gaps in medicine in England*, University of Surrey and UCL. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944246/Gender_pay_gap_in_medicine_review.pdf
- Darzi A, Quilter-Pinner H and Kibasi T (2019) *Better health and care for all: A 10 point plan for the 2020s*, IPPR. <https://www.ippr.org/research/publications/better-health-and-care-for-all>
- Davies H (2022) 'If you can't navigate an integrated care system, it isn't a system', blog post, NHS Confederation. <https://www.nhsconfed.org/articles/if-you-cant-navigate-integrated-care-system-it-isnt-system>
- Department for Work & Pensions [DWP] (2022) 'Annual report & accounts 2021-22' https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1091361/annual-report-accounts-2021-22-web-ready.pdf
- Dromey J and Hochlaf D (2018) *Fair care: A workforce strategy for social care*, IPPR. <https://www.ippr.org/research/publications/fair-care>
- Edinburgh Napier University (2020) *Evaluation of Improving the Cancer Journey*. <https://www.napier.ac.uk/~media/worktribe/output-2710068/evaluation-of-improving-the-cancer-journey-final-report.pdf>
- Edmonstone E (2013) 'What is wrong with NHS leadership development', *British Journal of Health Care Management*. https://www.researchgate.net/profile/John-Edmonstone/publication/272467493_What_is_wrong_with_NHS_leadership_development/links/5a44d444aca272d2945c4ca9/What-is-wrong-with-NHS-leadership-development.pdf

- Elliott L, Tan J, Norris S (2010) *The mental health of doctors: a systematic literature review*. <https://www.headsup.org.au/docs/default-source/resources/bl0823-mental-health-of-doctors-report.pdf>
- Greenberg N (2022) *Our moral obligation* KCL <https://www.kcl.ac.uk/news/our-moral-obligation-supporting-the-mental-wellbeing-of-healthcare-workers>
- General Medical Council (2022a) *The state of medical education and practice in the UK: the workforce report 2022*. https://www.gmc-uk.org/-/media/documents/workforce-report-2022---full-report_pdf-94540077.pdf
- General Medical Council (2022b) 'Key stats from the medical register', dataset. <https://data.gmc-uk.org/gmcdata/home/#/reports/The%20Register/Stats/report>
- Health Education England (no date) *Care Navigation: A Competency Framework*. https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf
- Health Education England (2020) *Future Doctor*. <https://www.hee.nhs.uk/our-work/future-doctor>
- Health Foundation (2021) 'Over a million more health and care staff needed in the next decade to meet growing demand for care', news article. https://www.health.org.uk/news-and-comment/news/over-a-million-more-health-and-care-staff-needed-in-the-next-decade?gclid=CjwKCAjw_MqgBhAGEiwAnYOAesJObC-QNaVKS01IjbWfmHmnqdbv2J0aj89fZ7aJFThvRvjycKsZIRoCWE0QAvD_BwE
- Health and Social Care Committee (2022) *Workforce: recruitment, training and retention and health and social care: third report of session 2022–23* <https://committees.parliament.uk/publications/23246/documents/171671/default/>
- HM Treasury (2022) *Autumn Statement 2022*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1118417/CCS1022065440-001_SECURE_HMT_Autumn_Statement_November_2022_Web_accessible_1_.pdf
- Jones L (2019) 'Women's Progression in the Workplace', Government Equalities Office. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/840404/KCL_Main_Report.pdf
- Jung, Dibb and Patel (2021) *Boost it like Biden: Why the UK needs an economic stimulus four times the size currently planned*, IPPR. <https://www.ippr.org/research/publications/boost-it-like-biden>
- King's Fund (2021) *Understanding factors that enabled digital service change in general practice during the Covid-19 pandemic*. <https://www.kingsfund.org.uk/publications/digital-service-change-general-practice-during-covid-19>
- King's Fund (2022) *Interoperability is more than technology*. <https://www.kingsfund.org.uk/publications/digital-interoperability-technology>
- Kirkpatrick I and Malby B (2022) 'Is the NHS over-managed?', long read, *NHS Confederation*. <https://www.nhsconfed.org/long-reads/nhs-overmanaged>
- Kuek A and Hakkennes S (2020) 'Healthcare staff digital literacy levels and their attitudes towards information systems,' *Health Informatics Journal*, 26(1). 10.1177/1460458219839613
- Little L and Buchan J (2007) *Nurse Self Sufficiency/Sustainability in the Global Context*. <https://www.hrresourcecenter.org/node/1766.html>
- London Economics (2021) 'The net exchequer impact of increasing pay for agenda for change staff', blog post. <https://londoneconomics.co.uk/blog/publication/the-net-exchequer-impact-of-increasing-pay-for-agenda-for-change-staff/>
- Macmillan (no date) *Living after diagnosis: median cancer survival times*. <https://www.macmillan.org.uk/documents/aboutus/newsroom/livingaftercancermediancancersurvivaltimes.pdf>
- Maunder R (2004) *The Experience of the 2003 SARS outbreak as a Traumatic Stress among Frontline Healthcare Workers in Toronto: Lessons Learned*, The Royal Society. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1693388/pdf/15306398.pdf>
- NatCen (2022) *British Social Attitudes 33*. https://www.bsa.natcen.ac.uk/media/39062/bsa33_nhs.pdf
- National Institute of Health Research (2018) 'Multi-morbidity predicted to increase in the UK over the next 20 years', article. <https://evidence.nihr.ac.uk/alert/multi-morbidity-predicted-to-increase-in-the-uk-over-the-next-20-years/>

- Naylor R et al (2014) *Ending the crisis in NHS Leadership: A plan for Renewal*. <https://www.hsj.co.uk/Journals/2015/06/12/y/m/e/HSJ-Future-of-NHS-Leadership-inquiry-report-June-2015.pdf>
- NHS Charities Together (2023) 'NHS Charities Support Food Banks for the health workforce', article. <https://nhscharitiestogether.co.uk/over-half-of-nhs-trusts-providing-or-planning-food-banks-for-staff/>
- NHS Digital (2018) 'Narrowing of NHS gender divide but men still the majority in senior roles', news article. <https://digital.nhs.uk/news/2018/narrowing-of-nhs-gender-divide-but-men-still-the-majority-in-senior-roles#:~:text=Analysis%20of%20those%20in%20senior,and%20central%20bodies%20are%20women>
- NHS Digital (2022) 'Adult social care activity and finance report', dataset. <https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report>
- NHS Digital (2023) 'Reasons for leaving', dataset. <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>
- NHS England (2021) 'NHS celebrates the vital role hundreds of thousands of women have played in the pandemic', news article. <https://www.england.nhs.uk/2021/03/nhs-celebrates-the-vital-role-hundreds-of-thousands-of-women-have-played-in-the-pandemic/>
- NHS England (2022) 'A&E Attendances and Emergency Admissions', statistical release. <https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/>
- NHS Staff Survey (2022) 'NHS Staff Survey 2021', survey results. https://public.tableau.com/app/profile/piescc/viz/ST21_national_data_2022-03-30_PIEFH25/Aboutthissurvey
- Nuffield Trust (2023) 'Basis of Negotiation', news article. <https://www.nuffieldtrust.org.uk/news-item/basis-of-negotiation-recommendations-to-improve-the-nhs-pay-review-process>
- Nursing and Midwifery Council (2020) 'Diversity data 2018–2019', dataset. https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/edi/edi-2018-19-data-tables.pdf
- Nursing and Midwifery Council (2022) 'The NMC register 1 April 2021–31 March 2022', dataset. <https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/march-2022/nmc-register-march-2022.pdf>
- OECD (2020) *Who cares? Attracting and retaining care workers for the elderly*. https://www.oecd-ilibrary.org/sites/92c0ef68-en/1/3/4/index.html?itemId=/content/publication/92c0ef68-en&_csp_50980b2bb9059e51e350f213ee338dac&itemIGO=oe&itemContentTypeId=book#section-d1e12891
- OECD (2021) 'Resilient healthcare: number of doctors and nurses', dataset. <https://www.oecd.org/coronavirus/en/data-insights/number-of-medical-doctors-and-nurses>
- ONS (2017) 'Unpaid carers provide social care worth £57 billion', briefing. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/articles/unpaidcarersprovidesocialcareworth57billion/2017-07-10>
- ONS (2022) 'Data on economic inactivity because of long-term sickness', dataset. <https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/datasets/dataoneconomicactivitybecauseoflongtermsickness>
- ONS (2023) 'Economic inactivity by reason (Seasonably adjusted)', dataset. <https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/datasets/economicinactivitybyreasonseasonallyadjustedinac01sa>
- Otero C and Muñoz P (2022) *Managers and Public Hospital Performance*. https://cristobalotero.github.io/files/JMP_CO.pdf
- Patel P and Thomas C (2021) *Recover, reward, renew: A post-pandemic plan for the healthcare workforce*, IPPR. <https://www.ippr.org/research/publications/recover-reward-renew>
- Palmer and Rolewicz (2022) *Deal or no deal: Understanding the effect of the NHS pay settlement on earnings*, Nuffield Trust. <https://www.nuffieldtrust.org.uk/news-item/deal-or-no-deal-understanding-the-effect-of-the-nhs-pay-settlement-on-earnings>

- PSSRU (2022) *Unit costs of health and social care*. <https://www.pssru.ac.uk/project-pages/unit-costs/>
- Quilter-Pinner H (2019) *Ethical care: A bold reform agenda for adult social care*, IPPR. <https://www.ippr.org/research/publications/ethical-care>
- Quilter-Pinner H and Hochlaf D (2019) *Social care: Free at the point of need – The case for free personal care in England*, IPPR. <https://www.ippr.org/research/publications/social-care-free-at-the-point-of-need>
- Quilter-Pinner H, McNeil C and Hochlaf D (2020) *Decades of disruption: New social risks and the future of the welfare state*, IPPR. <https://www.ippr.org/research/publications/decades-of-disruption>
- Resolution Foundation (2022) *Stagnation Nation: Navigating a route to a fairer and more prosperous nation*. <https://economy2030.resolutionfoundation.org/reports/stagnation-nation/>
- Rolewicz L, Dayan M and Palmer B (2022) 'Pay has fallen in real terms for most NHS staff groups since 2010', article, Nuffield Trust. <https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-pay-has-fallen-in-real-terms-for-most-nhs-staff-groups-since-2010#:~:text=Source%3A,%20pay%20fell%20by%208%25.>
- Ross, S Jabbal J, Chauhan K, Maguire D, Randhawa M and Dahir S (2020) *Workforce race inequalities and inclusion in NHS providers*, King's Fund. <https://www.kingsfund.org.uk/publications/workforce-race-inequalities-inclusion-nhs>
- Roberts C, Parkes H, Statham R and Rankin L (2019) *The future is ours: Women, automation and equality in the digital age*, IPPR. <https://www.ippr.org/research/publications/women-automation-and-equality>
- Rocks S et al (2021) *Health and social care funding projections 2021*, Health Foundation. <https://www.health.org.uk/publications/health-and-social-care-funding-projections-2021>
- Sealy R (2020) *The Time is Now*, University of Exeter Business School. https://mcusercontent.com/feeee3bba7c179fd3a7ef554/files/43f71316-2922-4cf4-93fb-fb7193ccf5e5/NHS_WoB_5050_Report_07.09.20_FINAL_VERSION.pdf
- Skills for Care (2022a) *The size and structure of the adult social care sector and workforce in England*. <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-size-and-structure-of-the-adult-social-care-sector-and-workforce-in-England.aspx>
- Skills for Care (2022b) *The state of the adult social care sector and workforce in England*. <https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2022.pdf>
- Stirling A and Dromey J (2017) *Uncapped potential: The fiscal and economic effects of lifting the public sector pay gap*, IPPR. <https://www.ippr.org/research/publications/uncapped-potential>
- Sturdy A, Kirkpatrick I, Reguera N, Blanco-Oliver A and Veronesi G (2020) *The management consultancy effect: Demand inflation and its consequences in the sourcing of external knowledge*, Public Administration. <https://research-information.bris.ac.uk/ws/portalfiles/portal/261780085/padm.12712.pdf>
- Sweeney S (2022) 'The NHS needs to rethink how it communicates', blog post, HSJ. <https://www.hsj.co.uk/patient-safety/the-nhs-needs-to-rethink-how-it-communicates/7033486.article>
- Thomas C and Quilter-Pinner H (2020) 'Mind the GP', blog post, IPPR. <https://www.ippr.org/blog/mind-the-gp>
- Thomas C and Quilter-Pinner H (2020) *Realising the neighbourhood NHS*, IPPR. <https://www.ippr.org/research/publications/realising-the-neighbourhood-nhs>
- Thomas C, Poku-Amanfo E and Patel P (2021) *The State of Health and Care 2022*, IPPR. <https://www.ippr.org/research/publications/state-of-health-and-care-2022>
- Thomas C (2022) *Getting better: Health and the labour market*, IPPR. <https://www.ippr.org/research/publications/getting-better-health-and-labour-market>

- Thompson M (2023) 'Culture of silence as NHS staff are scared to report problems, fearing repercussions', Sky News. <https://news.sky.com/story/culture-of-silence-as-nhs-staff-are-scared-to-report-problems-fearing-repercussions-12798287>
- Tonkin T (2022) 'Burnout hits record high', news article, BMA. <https://www.bma.org.uk/news-and-opinion/burnout-hits-record-high>
- Topol Review (2021) *Preparing the healthcare workforce to deliver the digital future*. <https://topol.hee.nhs.uk/>
- TUC (2021) *Negotiating the future of work: automation and new technology*. <https://www.tuc.org.uk/sites/default/files/2021-12/Negotiating%20Automation%20-%20report.pdf>
- TUC (2022) 'Gender pay gap means women work for free for nearly two months of the year', news article. <https://www.tuc.org.uk/news/gender-pay-gap-means-women-work-free-nearly-two-months-year>
- University of York (no date) 'Managers and management in the NHS', case study. <https://www.york.ac.uk/research/impact/managers-management-nhs/>
- Wanless D (2002) *Securing our future health: taking a long-term view*. <https://www.yearofcare.co.uk/sites/default/files/images/Wanless.pdf>
- Winninger B et al (2010) *Human resources in the public sector: the quest to make government an employer of choice*, Queen's University Centre for the Study of Democracy. https://www.queensu.ca/csdd/sites/csddwww/files/uploaded_files/publications/wps/HR_in_Public_Sector.pdf
- World Health Organisation (2016) *Global strategy on human resources for health: Workforce 2030*. <https://www.who.int/publications/i/item/9789241511131>

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