

# RECOVER, REWARD, RENEW

## A POST-PANDEMIC PLAN FOR THE HEALTHCARE WORKFORCE

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## Charitable Purpose

The research fulfils IPPR's charitable purpose of advancing health and public services

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## INTRODUCTION

Early in the pandemic, the prime minister, and other world leaders, tended to compare Covid-19 to a war-like event. At the time, IPPR made the case that if Covid-19 was genuinely an episode of this magnitude - and it has the human, social and economic impact to justify the comparison - it must come alongside better support and welfare, not least for those working on health and care frontline (Thomas and Quilter-Pinner 2020). The first world war had 'homes fit for heroes'; the second world war had 'from cradle to grave'; the coronavirus pandemic needs 'care fit for carers'.

One year on, the pandemic situation and the political narrative have shifted. On the former, the development and delivery of Covid-19 vaccines have paved a path out of the pandemic. On the latter, the dominant language has become that of recovery and 'building back better'.

The notion of 'build back better' is welcome to the extent it provides a contrast to the decade of austerity preceding it. Policy in the 2010s had severe consequences for health and care services. It left the UK with too few beds and dangerous levels of hospital occupancy; worse healthcare outcomes than most comparable countries; low uptake of innovative technologies; and very wide of health inequalities (Thomas 2020). 'Building back better' should represent a break from that. It should seek to deliver more resilient health and care services with world leading outcomes for patients and people (Patel et al 2021).

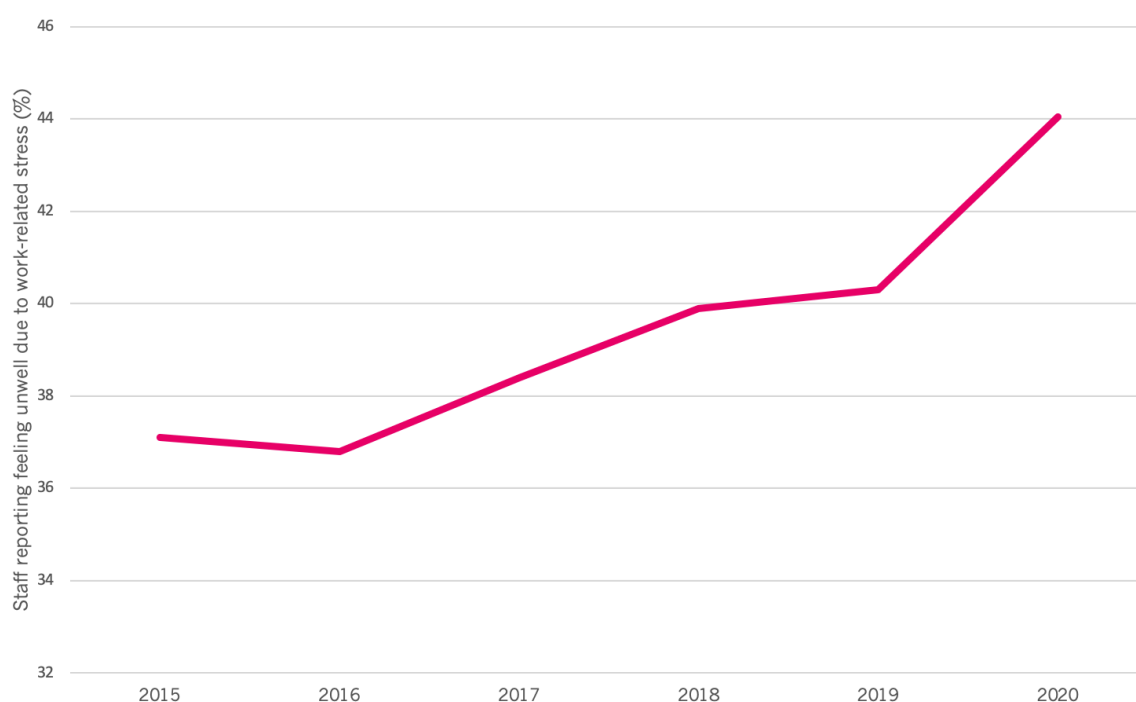
However, the notion of doing 'better' has serious implications for an already stretched workforce. Underinvestment during a decade of austerity has led to growing staffing shortages across the sector. Last year, there were an estimated:

- 85,000 staff shortages across the NHS (Buchan et al 2020)
- 38,000 nurse vacancies in the NHS, of which one quarter are in mental health (ibid)
- 112,000 vacancies across the social care sector, which has a 30.4 per cent annual turnover rate (Skills for Care 2020)

Working in an understaffed system leads to burnout, moral injury and mental health problems among the workforce. The number of NHS staff who report feeling unwell due to work-related stress has been accelerating, reaching almost 600,000 last year (Figure 1). An understaffed and unwell workforce also has serious implications for patient safety, quality of care and access to healthcare services. Put simply, the best way to improve healthcare outcomes for patients in the UK is to ensure a bigger and more sustainable workforce (Patel et al 2021).

## Figure 1: Work-related stress levels in the NHS are accelerating

Per cent of NHS staff who report feeling unwell as a result of work-related stress in the past 12 months



Source: IPPR analysis of NHS Digital 2021

Over the past year, NHS and social care workers have worked under even greater pressures than usual. They have cared for over 450,000 patients admitted to hospital with Covid-19 (UK Coronavirus Dashboard 2021), and many more in care homes and the community. Their ability to adapt and innovate has been remarkable. But now many are exhausted. The plan to 'build back better' will backfire if it is founded on pushing NHS and social care workers to continue to run hot. **The central aim of this paper is to resolve the tension between 'building back better' health and care services and immediate workforce constraints.**

The solution is not to throttle ambition. Few will welcome a 2021 budget, delivered during a pandemic, that made little reference to health or social care. The government will not resolve the tension between 'building back better' and workforce capacity by lessening its ambition to improve health.

Instead, they should pre-empt future workforce challenges. That means a fit-for-purpose plan to support staff who are struggling; to retain those considering leaving; and to attract new people to join the sector. This paper proposes three principles for an effective, immediate-term workforce strategy:

- 1. Recover:** Addressing fatigue, burnout and mental health problems in healthcare workers

2. **Reward:** Realigning contribution and reward in health and care
3. **Renew:** Creating the conditions and opportunities to make the NHS one of the best places to work

Drawing on new IPPR/YouGov polling of 1,006 healthcare professionals (conducted online between 9 and 15 February 2021 and representative of the national healthcare workforce by occupational group), this briefing paper makes the case for why action urgent and recommends policy to recover, reward and renew the health and care workforce.

## A CLEAR DEMAND FOR BETTER

At present, there is little policy in place to ensure a well-staffed and well-supported healthcare workforce after the pandemic. Instead, the government appears to be betting a weak labour market and growing unemployment will mean people stay in their jobs, even if reluctantly. This was made clear by the Department of Health and Social Care's recommendation to independent NHS pay review bodies of a 1 per cent pay rise, reduced from a previously budgeted 2.1 per cent. It is a risky bet for several reasons, not least because it ignores the fact the health and care labour market is international: many will (and already do) simply migrate to work in other countries (Wilson and Simpkin 2020).

Our polling finds very large numbers are actively considering futures outside of the NHS:

- One in four NHS staff say they are more likely to leave their jobs than a year ago
- 29 per cent of nurses and midwives, the occupations with the biggest shortages, say they are more likely to leave the sector than a year ago
- 18 per cent of medical and dental staff, such as doctors, say they are more likely to leave the UK than a year ago, the highest of any healthcare occupational group

This is equivalent to approximately **330,000 NHS workers** (including **100,000 nurses and health visitors** and **8,000 midwives**) saying they are more likely to leave their jobs after working through a year of the pandemic.<sup>1</sup>

In reality, many of these workers will not leave. But a highly dissatisfied and demoralised workforce is very bad news for patients and productivity. Furthermore, even if only a fraction leave, it would significantly compound existing understaffing problems – particularly as those most likely to leave, nurses, are the occupational group with the highest number of shortages. This should ring alarm bells for a government that came into power on bold pledges to boost the NHS workforce.

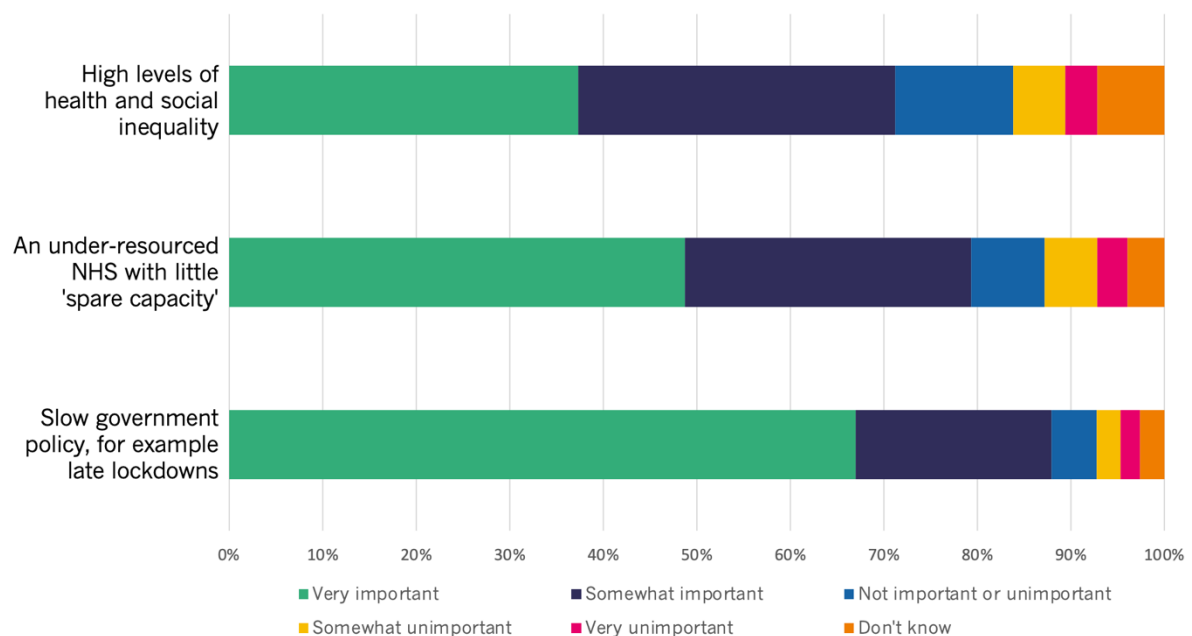
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<sup>1</sup> Based on latest NHS employee statistics from NHS Digital 2021 and IPPR/YouGov polling of a representative sample of NHS workers

Our polling is crystal clear that healthcare workers apportion blame on the government for the difficult working conditions they have endured this past year. Nine in 10 believe slow government action during the pandemic was an important contributor to the UK experiencing the highest Covid-19 death toll in Europe (Figure 2). Healthcare workers are also very clear that years of under-resourcing the NHS and high levels health and social inequalities, both of which deteriorated during austerity, meant the UK was underprepared going into the pandemic.

**Figure 2: Healthcare professionals believe government policy has led to the UK’s poor pandemic performance**

*Per cent who believe the following factors were important, or unimportant, in determining the UK being one of the worst affected countries in Europe by the Covid-19 pandemic*



Source: IPPR/YouGov polling 2021

It comes as no surprise, on this basis, that healthcare workers feel their prospects may be brighter working in other sectors or countries. Yet, if bad policy has created the challenge, then good policy could be the solution. Health and care workers have been calling for more than applause for some time now. Our polling aims to identify what 'more than claps' means. It shows very clear priorities which, if met, could help avoid the pandemic worsening the UK's long-standing health and care workforce crisis.

**Table 1: Healthcare workers want to be better rewarded, have greater flexibility and more chances to progress**

*Most important policy priorities for healthcare workers (per cent selecting each in their top three)*

| Policy priority                          | Per cent |
|--|----------|
| A pay rise                               | 70       |
| Better employee benefits                 | 33       |
| Flexible working hours                   | 29       |
| Fewer administrative tasks               | 22       |
| More career progression opportunities    | 19       |
| More training and learning opportunities | 18       |
| Better mental health support             | 18       |
| More professional autonomy               | 10       |
| Better childcare support                 | 5        |
| Don't know                               | 2        |
| None of the above                        | 6        |

Source: IPPR/YouGov polling 2021

These priorities are reflected in our workforce strategy of **Recover** (flexible working and mental health support), **Reward** (better pay and employee benefits) and **Renew** (more progression and training opportunities).

## RECOVER

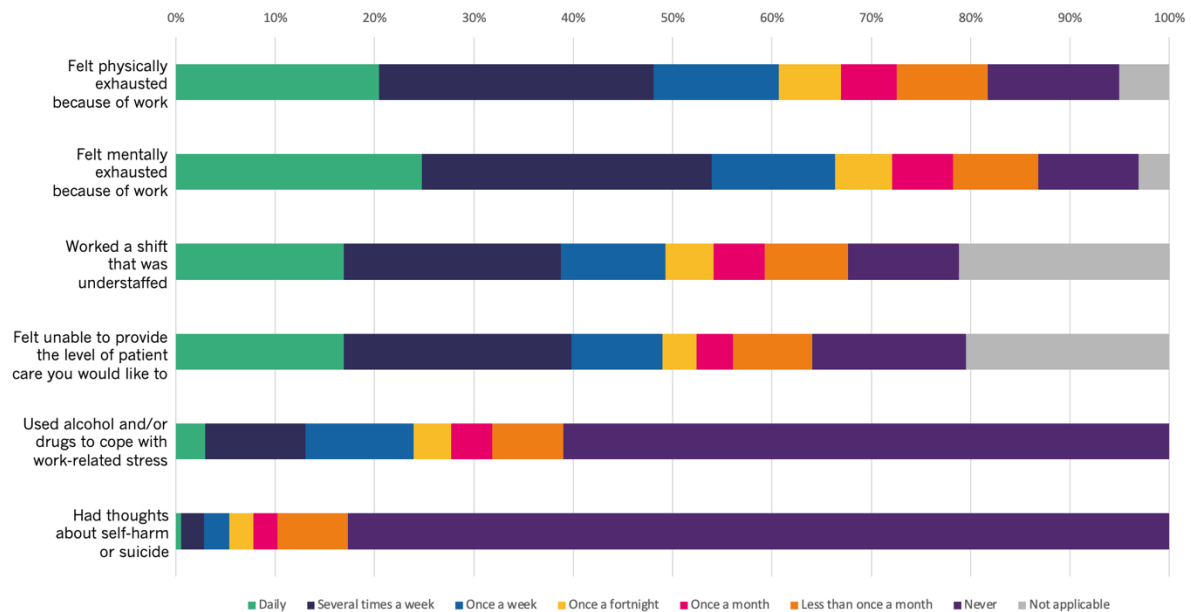
The pandemic radically changed the volume and nature of healthcare workers' roles and responsibilities. On one hand, waves of coronavirus have overwhelmed intensive care units and hospital beds with patients suffering from Covid-19. On the other hand, staff illness and isolation have exacerbated rota shortages, many of which were understaffed well before the pandemic. The result is a mismatch in healthcare demand and supply. IPPR/YouGov polling finds almost half of all healthcare workers report working an understaffed shift once a week or more since the pandemic began (Figure 3).

This has major repercussions for patient safety: 49 per cent report that at least once a week they cannot provide the level of patient care they would like to due to constraints beyond their control, with almost one in five experiencing this daily. Working under such conditions leads to moral injury and mental health problems (Sheather and Fidler 2021). Two thirds (66 per cent) report being mentally exhausted because of work and one in four healthcare workers (24 per cent) use alcohol and/or drugs at least once a week to cope with work-related

stress. Five per cent overall, and 12 per cent of 18 to 34-year-old healthcare workers, have thoughts of self-harm and/or suicide at least once a week.

### Figure 3: Healthcare workers are struggling to cope

Per cent of healthcare workers who report experiencing the following



Source: IPPR/YouGov polling 2021

Policy to help healthcare workers recover is essential for their wellbeing. It is also essential to workforce sustainability, productivity and patient safety.

We recommend:

- Lock in and scale up strengthened mental health support for all staff.** By the second wave of Covid-19, NHS England and NHS Improvement had acted commendably to strengthen mental health support for staff. This was possible because of emergency Covid-19 funding for the NHS during the pandemic. When Covid-19 financing draws to a close, the improved staff mental health services must not go with it. Pressures in healthcare will remain high for years to come and staff need more, not less, support. Comparing IPPR’s April 2020 and February 2021 cross-sectional surveys of healthcare workers suggests the pandemic’s psychological and mental health impacts have worsened as the crisis has gone on (Thomas and Quilter-Pinner 2020). And evidence of the acceleration in work-related stress from the NHS staff survey is unignorable. Staff mental health services should scale up and seek to better focus on inequalities in mental illness across the workforce – our polling finds younger staff (those aged 18 to 34) and low-paid healthcare assistants were the most likely groups to want better mental health support.



- **Guarantee annual leave entitlements for five years and compensate inflexibility.** After a year of working through a pandemic, many need respite. Large numbers of staff have not taken annual leave in the past year and now face it expiring. It would be unacceptable to allow this. At a minimum, accumulated leave in the past year should be guaranteed, made available to take for up to five years and transferrable across all NHS organisations. Even then, the reality is that many will be unable to take their leave entitlement when they would like to. This was a problem well before the pandemic. For example, some hospital departments automatically allocate staff members' annual leave entitlements to avoid rota shortages, meaning staff do not always have a say in when they can take their own leave. This is likely to become a bigger problem now, as workloads remains high but the workforce remains thin. An NHS-wide annual leave inflexibility compensation policy should be developed. This should provide either additional time off in lieu or a pay bonus to staff who are refused annual leave on the dates requested. It would mean that if NHS employers reject annual leave requests, staff hold on to their leave and take it at a different time (as per usual) but also receive a cash or time-off bonus in compensation. Such a scheme would create a strong incentive for employers to give staff greater control of when they take their leave.
- **Make flexible working available to all without conditional requirements.** Clinical rotas in the NHS are rigid and demanding, particularly for junior staff. Inflexible working hours and poor work-life balance is the main reason people leave the NHS (NHS England and NHS Improvement 2020). This falls hardest on women, who bear disproportionate caring responsibilities outside of work, and make up 77 per cent of the NHS workforce. Flexible working refers to where, when and how much people work. There has been a step change in flexible working in the NHS during the pandemic, with more work performed remotely and greater flexibility to accommodate childcare and caring responsibilities. Recent polling for IPPR's State of Health and Care report found NHS leaders believe greater flexible working in the NHS has been one of the most positive shifts to have occurred during the pandemic (Patel et al 2021). Despite progress, flexible working is not consistently available to all occupational groups and often requires a valid reason. NHS employers are shifting to ensure employees can now request flexible working from day one. But to realise 'flexibility by default', a goal of the NHS People Plan, employers will need to go further than that. They will have to proactively design for flexible working arrangements (for example, more self-rostering) and ensure it is consistently available to all staff levels without conditionality. This is especially important to tackle gender inequalities in the NHS; indeed, flexible working would go a long way to addressing the NHS gender pay gap (Timewise 2019). If flexible working does not become the 'new normal' in the NHS, workforce inequalities will entrench further, productivity will stall, and the numbers leaving will rise higher.

## REWARD

Better alignment between contribution and reward is at the heart of addressing the NHS workforce crisis. And better pay is main driver of that alignment. Our polling finds 70 per cent of NHS staff say a pay rise is most important policy priority to them at the current moment (Table 1).

The Department of Health and Social Care's submissions to two NHS pay review bodies (that in turn make recommendations to the government) recommend a 1 per cent pay rise for NHS staff. This is half of the pay rise (2.1 per cent) that had been previously budgeted in the NHS Long Term Plan's funding agreement. It is a post-pandemic public service austerity measure, and out of touch with both public attitudes and the mainstream macroeconomic consensus (Jung et al 2021). Nurses, midwives and most NHS staff who are not doctors are at immediate risk, with their current pay deal set to end in April 2021, and a new deal yet to be drawn up. Most nurses and midwives have experienced a 10 per cent real terms cut to their salary over the last decade and over half report working beyond their contractual hours for no additional pay (NHS Trade Unions evidence submission to the NHS pay review body 2021).

In theory, a pay rise can prevent workforce attrition, boost productivity and drive recruitment into an NHS that is 85,000 staff short. A 1 per cent pay rise risks doing the opposite. The impacts will ultimately be felt by patients, for example the pandemic's elective care backlog may take even longer than the expected five years to address (Patel et al 2021). The recommended 1 per cent pay rise is inadequate in both size and structure. Not only is it too small, but it ignores long-standing gender and race disparities in NHS pay. This should be a chance to change that.

We recommend:

- **A progressive pay rise package for NHS staff.** Healthcare workers we polled said the minimum pay rise they would find acceptable is 5 per cent. Taxpayers are also clear this is where they want their money to go. Separate IPPR/YouGov polling of the UK public finds 50 per cent of people across the country (from a nationally representative sample of 2000 people) want to see nurse and midwife pay increased by 12.5 per cent or more. The political reality is this will not happen, despite strong social and economic justice reasons for doing so. In that context, we propose an average 5 per cent pay rise package that is tilted in favour of low paid staff. This tapered approach will help correct gender and race disparities in the NHS workforce. It would cost an estimated £1.4bn (Patel et al 2021); spending that is not just affordable but would in fact drive a stronger economic recovery after the pandemic (Jung et al 2021).
- **A real living wage guarantee for care workers.** Almost three quarters of care workers are paid less than the living wage, and at least one in four is on a zero-hours contract (Skills for Care 2020). In the first instance, care workers, who are three times more likely to be single parents than the overall workforce (Resolution Foundation, 2020), should receive a living wage guarantee. This is the minimum they should earn providing

essential care services and risking their own health in doing so. This real living wage guarantee can be funded immediately through government wage subsidy, as has been occurring in Scotland, and we estimate it would cost £1 billion for England to do this. In the longer term, the aim should be to raise care worker pay to NHS pay scales, as IPPR has previously proposed.

## RENEW

One in 20 working people in the UK works in the NHS. But only half of the public would encourage a friend or family member to consider working in it (Worsley 2019). The NHS wants to 'become the best place to work' to tackle difficulties in retention and recruitment. That will require significant shifts in long-term health and care workforce strategy, but the first steps should be taken now. We recommend:

- **Expanding workplace benefits for all staff, including meal vouchers, travel costs reimbursement and staff room upgrades.** The pandemic has led to a sea change in workplace benefits available to NHS staff, from free meals to free car parking. But it has also served as a reminder of the basic employee benefits that were not available to those working in the NHS. The precedent has been set but, unfortunately, many of these changes are being reversed. Healthcare professionals we polled put better workplace benefits second only to a pay rise when asked what is most important to them. NHS employers should act to ensure their employees have permanent good access to break room facilities (large numbers do not have access to a staff room), hot meals during shifts and travel cost reimbursement. The small amount of investment this requires will reap large rewards for employers and patients.
- **Introducing a portable health and care competency system to allow staff to work across a range of settings and regions.** The lack of recognition of skills across different trusts, practices and geographies restricts the mobility of health and care workers and exacerbates regional shortages. A national system to certify skills, and make them portable across the country, would help overcome this by providing a nationally recognised certification of competencies and abilities, which can be used towards career progression. It would also help individuals have any skills developed during the pandemic recognised. This is particularly important as 61 per cent of nurses/midwives and 55 per cent of doctors feel the pandemic has had a detrimental impact on their training and professional development.
- **Stronger action to start stamping out institutional racism.** Our polling finds staff from minority ethnic backgrounds were twice as likely (31 per cent) to report experiencing discrimination from their manager or colleagues compared to staff from white ethnic backgrounds (16 per cent). Staff from most minority ethnic backgrounds are over-represented in low-paid NHS jobs and under-represented in leadership jobs. In part,

this is due to unequal access to progression opportunities. Our polling found staff from minority ethnic backgrounds were 50 per cent more likely to say that more career progression opportunities are among the most important things to them now compared to staff from white ethnic backgrounds. Recruitment, training and promotion processes must recognise the institutional racism that exists in the NHS for it to become a fairer place to work. But structural problems cannot be solved with individual solutions, such as anti-racism training for HR personnel. Indeed, a greater role for regulatory bodies such as the Care Quality Commission to monitor and assess workforce inequalities is likely to be helpful, but again not sufficient in itself. Concerted action from local leaders and stronger allyship from white leaders will be required to address placed-based workforce inequalities. Indeed, addressing race disparities in the workforce should be a priority for every Integrated Care System.

## A LONG TERM STRATEGY IS REQUIRED

This paper informs an immediate workforce plan to keep up with ambitions to 'build back better' health and care. However, there is undeniably a need for better and more proactive long-term workforce planning in health and care.

Workforce shortages in the health and care sector are not new. They are driven by expanding services and growing health and care demands. The formation of the NHS in 1948 led to large increases in healthcare demand without sufficient labour to provide it. By 1961, the NHS was the largest employer in the UK, but still there were big shortages, particularly of doctors. The Blair governments confronted further workforce shortages.

Historically, the solution to these workforce shortages has been economic migration. Mass migration from Britain's former colonies in the post-war years is the main reason the NHS was able to develop to such scale. Even Enoch Powell spearheaded an international campaign for overseas doctors to come to work in the NHS. Migrants helped make the NHS and continue to do so today. Over one quarter of doctors working in the NHS today are migrants (NHS Digital 2021).

But there is a growing global shortage of healthcare workers and migration patterns, and migration rules, have changed drastically. The UK cannot rely on labour migrants alone to fill staffing shortages across its health and care sectors. It is time to move from a system of 'treating' workforce crises when they emerge, to preventing them altogether, through a long-term workforce strategy.

To help provide this, IPPR is recruiting a health and care workforce assembly. The idea behind is to pre-empt the challenges of the 2040s, not just the 2020s, and to feed that into more proactive workforce planning. [Applications for assembly members are now open.](#)

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