Health Foundation response to Health Education England's call for evidence on its *Long-Term Strategic Framework for Health and Social Care Workforce Planning*

September 2021

About the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

1.0 Drivers of change over the next 15 years

Over the next fifteen years, many factors will influence the delivery of health and social care and the health care workforce. Our submission focuses on a selection of key factors. We draw on our analysis of the workforce policy implications of these factors, and on our expertise in improvement approaches to enable change in health care delivery. The Health Foundation's Shaping Health Futures programme has also developed its 'COVID-19 horizon scan' to map trends across society, technology, the environment, the economy and politics that will affect health and social care in the future, and the impact of the pandemic on these trends. Separate to this submission, the horizon scan will be shared with HEE and will also be useful in the development of HEE's long term strategic framework for workforce planning.

1.1 Demographics and disease

Factor A. People's changing health and care needs

The UK population is projected to grow by 3 million people from mid 2018 to mid 2028. The proportion aged 85 years and over is projected to almost double by 2043. Demographic changes will have major implications for NHS and social care workforce demand (see section 2).

The burden of disease is also increasing. The proportion of people with multiple long term conditions is projected to double between 2015 and 2035. The implications for services and the workforce will be uneven. The older population is not equally spread across the UK, and those in deprived areas are more likely than others to have multiple conditions, at younger ages. The number of people needing care because of a disability is also likely to grow in the coming years: the proportion of younger adults (aged 18 to 64) reporting a disability increased from 14% in 2007/08 to 18% in 2017/18, and the number of people with severe learning disabilities is projected to rise by 34% between 2017 and 2027. Pre-existing physical and mental health conditions, and disabilities, made people more vulnerable to severe outcomes from COVID-19. The future impacts of long COVID are also not yet fully understood.

Initiatives to improve treatment for people with multiple conditions include virtual clinics and co-located services to avoid multiple visits to outpatient departments. But whatever new models are advanced to care for those with multiple conditions in the future, the most important service is still likely to be general practice. People with multiple conditions attend general practice more than any other NHS service. Practices – especially those in more-deprived areas – will therefore require additional resources and staff (see section 2.0).

The increasing prevalence of disabilities will also impact health and social care training needs. Currently, learning disability nursing courses struggle to attract and retain students, and are becoming financially unsustainable. The learning disability nursing workforce significantly declined in size and increased in age over the past decade. And not enough other health and care staff understand the needs of people with learning disabilities and autism. Skills for Care data suggest that only 9% of social care staff receive any learning disability training. Government has committed to introducing mandatory learning disability and autism training for all health and social care staff. Providing support and care to growing numbers of people with learning disabilities will require further progress on this commitment and in addressing supply problems in the specialist workforce.

Relevant Health Foundation work

- Understanding the health care needs of people with multiple health conditions
- Building the NHS nursing workforce in England: Workforce pressure points
- Social care for adults aged 18–64
- What action is required to make NHS workforce shortages a thing of the past?
- Multimorbidity, deprivation and consultation length

Factor B. Migration

Migrant workers have long been vital to the UK's health and care workforce. And over the past decade, the health and social care system has relied heavily on international staff – migration accounted for almost half of total workforce growth between 2009/10 and 2018/19.

The longer-term picture of migration is uncertain and likely to continue to be affected by Brexit, national immigration policy, economic conditions, and uncertainty over travel restrictions. The post-Brexit immigration system includes an NHS visa, but severely limits the potential for international recruitment into social care. COVID-19 caused significant decreases in population movement globally, impacting the UK health and care workforce. For example, there was a sharp reduction in new registrations from nurses from outside the EEA between March and April 2020 (from 1,348 to 35). And there is a growing shortage of health care workers globally: a shortfall of 18 million health workers is projected by 2030.

The impact of any future reductions in international recruitment into health and care would be uneven, as proportions of non-British staff vary by role and region in social care and the NHS. According to Skills for Care, non-British nationals undertake 16% of all social care jobs in the UK, 27% of social care jobs in London, and 35% of social care nursing jobs.

Ethical international recruitment of NHS and social care professionals will continue to be important to ensure enough staff – enabled by supportive national immigration policy and regional coordination to account for different local need for international recruits. To meet the government's target to increase NHS nurses by 50,000 by 2024/25 alone, the NHS will need around 5,000 international recruits every year. But the health and social care system also

needs a long-term, national strategy to recruit, train and retain staff in the UK, and support sustainable workforce growth.

Understanding the impact of changing numbers of people moving in and out of the UK on health care workforce demand is difficult. Research is limited on how and when immigrants use NHS and social care services, but available evidence suggests people born outside the UK use fewer services than others and immigration has not reduced health care quality.

Relevant Health Foundation work

- Building the NHS nursing workforce in England: Workforce pressure points
- Closing the gap: Key areas for action on the health and care workforce
- Thinking local and global: exploring the UK's reliance on international nurses and the impact of COVID-19
- Immigration and the NHS: the evidence
- Labour market change and the international mobility of health workers

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

Also see section 1.5 on public and staff attitudes towards technology in health care.

Factor A. Person-centred care

Person-centred care – where staff work in partnership with people who use health care services – is a long-term aim and current priority in UK health policy. Person-centred care can equip people with the knowledge, skills and confidence to better manage their health and care (sometimes known as 'patient activation'). There is evidence of its potential, in certain circumstances, to improve health outcomes, increase satisfaction with care, and contribute to wider social outcomes. As our forthcoming report on productivity outlines, greater patient involvement can also lead to more efficient use of staff time and resources – for example, as some health care activity may shift from staff to patient. And supporting people to better manage their conditions could reduce some avoidable use of health services.

Realising policy aims to personalise care will require changes to service delivery, and to staff roles and ways of working. Realising the Value, a programme led by Nesta and the Health Foundation, sets out some of the ways in which staff need to work differently to put people at the heart of health, including enabling health and care professionals and the wider workforce to understand and work in person and community-centred ways. There are implications for undergraduate and postgraduate curriculum and training, as well as continuing professional development. Staff need skills and confidence to work differently, including in shared decision making, supported self-management, and similar approaches.

Relevant Health Foundation work

- Long read on improvement approaches to increase productivity, and how to make them happen (forthcoming, autumn 2021)
- Realising the Value: Ten actions to put people and communities at the heart of health and wellbeing
- At the heart of health: realising the value of people and communities
- Briefing: Reducing emergency admissions: unlocking the potential of people to better manage their long-term conditions

1.3 Socio-economic and Environmental Factors

Factor A. Health inequalities

Going into the pandemic, there had been a decade of widening health inequalities in England. Improvements to life expectancy had stalled and declined for the poorest 10% of women. People in poorer areas were spending more of their shorter lives in ill health.

COVID-19 exposed and exacerbated existing health inequalities. Some groups – including young people, disabled people, people from ethnic minority communities and care home residents – have been disproportionately affected by the negative health impacts of the virus and government restrictions. COVID-19 mortality rates in England were more than twice as high for people from the most deprived 10% of local areas compared with people from the least deprived.

If current trends continue, health inequalities will widen further and the health needs among certain population groups and in areas of high deprivation will rise. This would increase demand on the health care workforce – including in general practice, the part of the NHS that the public interacts with the most. But currently, access to high-quality general practice is itself inequitable. Practices in areas of high deprivation are underfunded and under-doctored, with implications for patient care. These practices are more likely to receive lower CQC ratings, and their patients have shorter GP consultations on average. Considering this, the equitable distribution of the GP workforce should be a priority for workforce planning, at a national and ICS level. Action to boost GP recruitment and retention should be targeted at areas of high need – increasing overall capacity will not necessarily improve distribution.

Addressing health inequalities requires whole government action, but health and social care workforce planning can also play an important role. As an anchor institution, the NHS can improve health through its influence on social and economic conditions across the country, including through the way it employs people. Helping young people into employment, targeting recruitment in deprived areas, and working alongside communities to develop skills and training programmes for newly unemployed adults for entry into the NHS workforce, can have a significant impact on local communities and tackling health inequalities. As local health systems take greater responsibility for developing workforce plans, there is an opportunity for Integrated Care Systems to advance anchor strategies and develop joint approaches with local partners to improve employment prospects for local people.

<u>Relevant Health Foundation work</u>

- Health Equity in England: The Marmot Review 10 Years On
- Unequal pandemic, fairer recovery: The COVID-19 impact inquiry report
- ‘Levelling up’ general practice in England: What should the government prioritise?
- Building healthier communities: the role of the NHS as an anchor institution
- Anchors in a storm. Lessons from anchor action during Covid-19
- Working paper on the health and wellbeing of lower paid NHS staff (forthcoming, autumn 2021)
- Analysis of national policies since 1990 to address the inverse care law in general practice in England (forthcoming, winter 2021)

Factor B. Climate change
As highlighted by the latest IPCC report, acting on climate change is urgent, and the health and care system has a key role to play in minimising climate change and responding to its effects – both of which will have implications for the future workforce.

To minimise the NHS's contribution to climate change, NHS England is implementing a strategy to reach 'net zero' greenhouse gas emissions by 2045. Achieving net zero will require whole-system transformation, with every staff member involved in the adoption of more sustainable health care practices. This will include, but is not limited to:

- implementing new care models, such as increasing use of remote monitoring
- changes to care practices and prescribing behaviours
- changes to how staff commute and travel for work.

As the strategy recognises, staff will need to be 'upskilled' to implement the measures required to achieve net zero. While staff surveys show overwhelming support for the NHS's ambition to be more environmentally sustainable, there is a gap in the knowledge and skills for sustainable health care. And the future workforce will be required to communicate sustainability issues and environmentally-driven changes to patients – to explain to patients the relative environmental impact of different treatments as part of shared decision making, for example. Public awareness and attitudes towards sustainable health care (explored in our forthcoming polling) will have implications for how staff communicate these issues.

A certain amount of climate change is already inevitable. In the UK, more frequent extreme weather events will alter the pattern of health care demand and may affect the infrastructure needed to deliver services. The health and social care workforce will need to be equipped with the competencies to prepare for and manage the health-related risks and impacts of environmental change (which will vary by role and location), including in emergency situations. For example, an estimated 90% of hospital wards are vulnerable to overheating, placing service users at risk. The scale of overheating in social care facilities is unknown, but research has identified a lack of staff awareness as a barrier to effective heat management in care homes.

Relevant Health Foundation work

- Public polling on climate change, health and sustainable health care (forthcoming, October 2021)

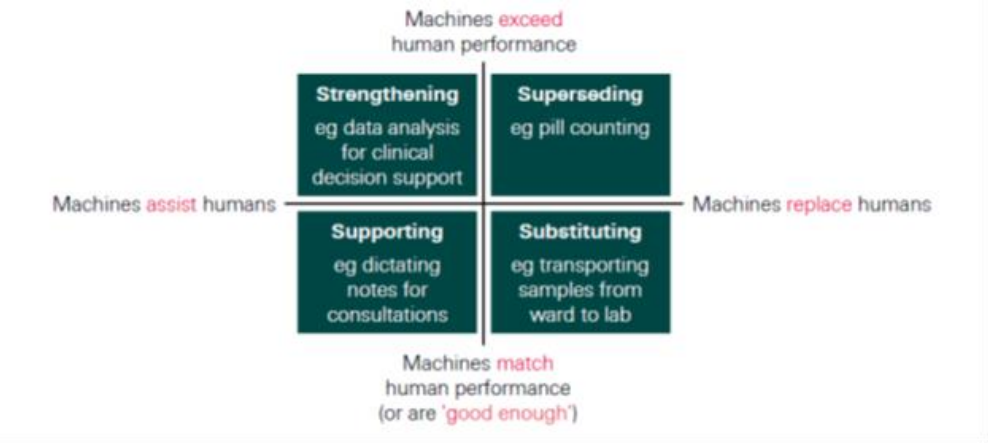
1.4 Staff and Student/Trainee Expectations

The Health Foundation is not responding to this section.

1.5 Science, Digital, Data and Technology (including Genomics)

Factor A: Potential impact of AI and automation
There are different modes of automation, which can be described as supporting, substituting, strengthening and superseding (see Figure 1). Our analysis and Oxford University research suggest that automation and AI in health care will in many cases assist workers in their roles, rather than replace them. Many tasks and roles in health care are not wholly automatable. For instance, the Oxford study found that while 44% of all administrative work in general practice could be either mostly or completely automated, no single full-time role could be entirely automated. Human agency is also an important factor in health care – so even where tasks could be automated, it does not necessarily follow that they should be.

Figure 1. Modes of automation



Source: Switched on: How do we get the best out of automation and AI in health care? Health Foundation 2021

Automation and AI have the potential to improve the quality of health care work and the quality of care. For example, automation could be used to remove some of the burden of repetitive, everyday tasks, allowing staff to focus on activities where they add most value.

Where automation and AI are primarily deployed in a supportive capacity, existing roles may evolve in response. For example, the Oxford study found that many of the responsibilities of GP receptionists are potentially automatable, such as processing prescriptions. Automating these types of task could allow the receptionist role to shift to more face-to-face interaction with patients, focusing on aspects of patient management such as coordinating care and helping patients navigate the system. In addition, robotics, which can be coupled with automation and AI, can perform tasks that require significant strength – alone or in combination with a human. This could help reduce the risk of injury and extend careers, particularly for staff who have to lift patients or heavy items, such as healthcare assistants and porters.

While AI systems could ultimately become better than humans at performing diagnostic tasks, they will not be able to cover all medical cases. So the partnership between doctor and machine is likely to be more beneficial than either of them working alone. Automation and AI will likely also create new roles, for example to ensure technologies are used appropriately.

Given how new automation and AI are, their future impacts on the health and care workforce are uncertain. How they affect workforce demand and supply will depend partly on how national bodies, such as NHSX, and the health care professions respond to the opportunities these technologies present. So HEE must work with others to understand what automation and AI will mean for the workforce, and how to plan for the future.

<u>Relevant Health Foundation work</u>

- Switched on: How do we get the best out of automation and AI in health care?
- The health care workforce in England: Make or break?
- The Future of Healthcare: Computerisation, Automation and General Practice Services (Oxford Study)

Factor B: The use of technology to improve the quality of work for health and social care staff
Increasing the use of technology in health and social care offers the opportunity to improve the quality of work for staff in several ways. As a result, this may improve job satisfaction and retention, as well as make working in health and social care more attractive.

The burden of administrative work is currently significant and contributes to a chronic excessive workload, which in turn is associated with low morale, burn out and poor retention. The use of technologies like AI and robotic process automation to undertake administrative tasks – such as letter work, referrals and processing test results – has the potential to alleviate some of the pressure this workload creates. A recent Health Foundation poll showed that many NHS staff are optimistic about the impact automation and AI could have on healthcare work, with 45% of staff agreeing that the primary impact of automation and AI would be positive for health care workers, improving the quality of work (compared to 36% of staff thought that the primary impact would be negative.)

During the pandemic, changes to how health and social care staff work have also illustrated the potential for greater use of technology to improve their jobs. For example, communications and remote monitoring technologies could allow a greater proportion of staff to work more flexibly and reduce commuting. Video conferencing and collaborative software make team working and patient interactions possible from home or other locations. Asynchronous remote consultations can also give clinicians greater flexibility as to when they work. Asynchronous consultations have also been shown to improve workflow efficiency, which is associated with an improved quality of working life.

HEE will need to work with professional bodies to evaluate the impact of technology-enabled working seen in the NHS over the past 18 months on job satisfaction, retention and recruitment, to help understand expectations of work in the future. There is also learning to be drawn from other sectors, including the knowledge economy, where some of the largest shifts in how people work and where they work have occurred in recent years.

Relevant Health Foundation work

- Switched on: How do we get the best out of automation and AI in health care?
- Reshaping secondary care consultations after COVID-19: the role of asynchronous consultation methods
- Working paper on the health and wellbeing of lower paid NHS staff (forthcoming, autumn 2021)

1.6 Service Models and Pandemic Recovery

Factor A. Pandemic recovery (elective care and waiting lists)
The pandemic has caused huge disruption to elective care, cancer screening and treatment, and community and other services. In the first wave, hospitals cancelled or postponed non-urgent services to care for COVID-19 patients. Performance against the 18-week target for non-urgent operations – at a record low before COVID-19 – has worsened. By June 2021, 5.4 million people were waiting for routine treatment – up from 4.4 million in January 2020. There may also be six million 'missing patients' yet to be referred for elective care.

The impact of pauses to NHS screening programmes is uncertain but there are concerns that progress on cancer survival, for example, may stall or even reverse. Delivering earlier diagnosis, resuming clinical trials and building personalised support for cancer patients will need investment to address shortages in staff and diagnostic capacity. An estimated 41,000 more clinical staff above planned increases will be needed by 2029 to improve services.

The backlog of unmet need will likely increase further and waiting time standards will fall. The extent and duration of the decline in performance is less certain. To support recovery, the NHS has introduced pathway changes (such as community diagnostic and surgical hubs) which, if maintained, will have implications for workforce planning. But additional investment and staff is also needed. Even before the pandemic, meeting the 18-week standard for referred patients and clearing backlogs would have required more staff to treat an extra 500,000 patients a year for 4 years. Without significant additional capacity, addressing the backlog of unmet need risks causing stress and burnout among NHS staff. As NHS leaders have warned, pushing too hard could lead to staff leaving the service.

Workforce planning must also account for the pandemic's unequal impact. Access to elective treatment fell further in the most deprived areas of England during 2020. And although the backlog is likely to be a highly visible priority for the NHS and its workforce, it must not come at the expense of interventions to prevent disease and reduce inequalities.

COVID-19 has also had a sustained impact on adult social care, which will likely also impact the NHS. The pandemic has exposed longstanding policy failures in the sector, and made some problems worse, such as unmet need. To fix social care, government must enact fundamental reform, including action to increase pay and improve staff terms and conditions.

Relevant Health Foundation work

- Returning NHS waiting times to 18 weeks for routine treatment: the scale of the challenge pre-COVID-19
- Longer waits, missing patients and catching up
- Elective care in England: Assessing the impact of COVID-19 in 2020 and where next
- The NHS Long Term Plan and COVID-19: Assessing progress and the pandemic's impact (forthcoming, September 2021)
- Further analysis of the pandemic's impact on elective care, including work to understand the reduction in completed treatment pathways, the difference in pathways started, and how these vary by geographical area and by deprivation (forthcoming, September 2021)
- Long read on improvement approaches to increase productivity, and how to make them happen (forthcoming, autumn 2021)

Factor B: Workforce and skill mix

Chronic staff shortages and changing health needs mean the NHS must think differently about how staff work. Traditional workforce models have resulted in highly trained staff sometimes performing tasks that do not make the best use of their time and skills. Skill mix changes enable other staff with appropriate training (in new or existing roles) to take on such tasks – freeing up higher band staff and enabling other staff to maximise and develop their skills – and also offer the opportunity to expand the range of skills within teams. For example, there is evidence that pharmacists and nurses playing a greater role in managing diabetes and cardiovascular disease in primary care can be cost effective and improve key outcomes.

Changes to the balance and mix of staff involved in delivering care has implications for workforce planning, affecting the numbers of different kinds of staff needed in the future (for example, see section 2 for our projections of the numbers of additional pharmacists and physiotherapists needed). But effective implementation of skill mix models also requires support for staff to work in different ways. An evidence review commissioned for our forthcoming report found that the evidence on such workforce models is mixed – their potential to improve productivity is dependent on the context of care, the nature of role changes and how successfully they are implemented. For example, in some cases, nurses taking on some of the responsibilities of doctors led to tasks taking more time and increased referrals.

Making the most of the skills of the health care workforce requires organisation-level action to improve multidisciplinary working, work organisation and job design. At a national level, regulatory frameworks must enable safe skill mix changes. And to make the most of the potential for skill mix change, more investment is needed in the skills and training of lower band staff, who play an important part in skill mix models and currently have limited opportunities for career progression or pay increases.

Relevant Health Foundation work

- Long read on improvement approaches to increase productivity, and how to make them happen (forthcoming, autumn 2021)
- Rapid evidence review of team-based approaches to working and productivity conducted by the Institute for Employment Studies (available on request)
- Working paper on the health and wellbeing of lower paid NHS staff (forthcoming, autumn 2021)

Factor C: Designing pathways and ways of working to get the most out of digital technology

The pandemic saw the rapid rollout of established and newer forms of technology in the NHS, including video conferencing, remote monitoring devices and smartphone apps. The response has shown the potential for technology to change care delivery in the longer term. But success in building on this recent progress will partly depend on how well new technologies fit into organisations' processes and workflows, as well as wider social and institutional factors. Fitting new technology into a specific organisational context often involves the redesign of treatment pathways, the creation of new roles, and the evolution of new ways of working. This can be a challenge and is a recurring theme of evaluations of health technology interventions.

In addition to organisation-level action, national bodies including HEE will also have a role to play in successfully implementing technologies in health and social care. For example, working with NHSX and others, HEE could develop guidance on how pathways and related ways of working need to change to accommodate new technologies, setting out what good redesign looks like. HEE could also explore what skills and knowledge are required by staff working in the NHS to undertake this work successfully. There may also be a need for HEE to consider the impact of work reorganisation on job quality and support appropriate role development for those significantly affected by the adoption of new technologies.

Relevant Health Foundation work

- Realising the benefits of technology in healthcare: key factors for successful implementation

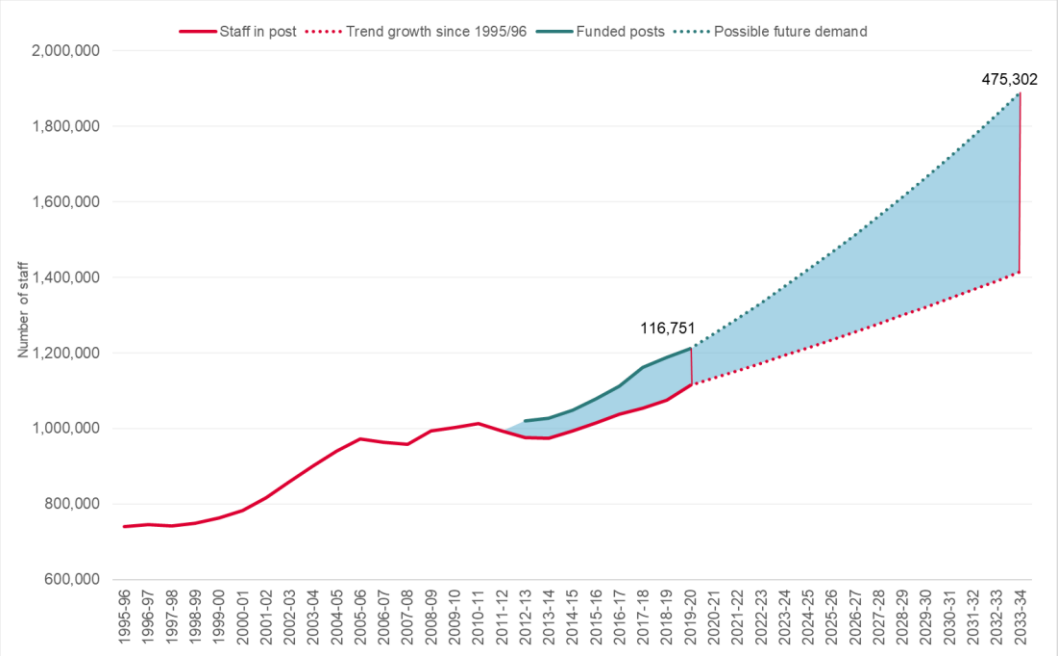
2.0 Demand and supply gaps over the next 15 years

Summary of Health Foundation analysis of workforce shortages and projections

Last year, the Health Foundation projected that the NHS would face a workforce shortfall of over 115,000 FTE in 2020/21 – this is projected to double over the next five years and to exceed **475,000 FTE staff by 2033/34** (see Figure 2 and Table 1). **This does not account for any potential impacts of the COVID-19 pandemic, which will take more time to quantify and understand.** This assumes that the number of staff in post follows the updated average annual growth (of 1.7% a year between 1995/96 and 2019/20), and that the demand for staff grows in line with health care activity.

NHS staff numbers in England have increased at a faster rate in more recent years. FTE staff numbers increased by 3.7% in the year to February 2020 and by 3.1% in the year to May 2021. But demand is likely to have increased due to the COVID-19 pandemic.

Figure 2: Projected supply of and demand for NHS staff, 1995/96 to 2033/34



Source: Health Foundation analysis of NHS Digital and HEE data • Note: projections are for Hospital and Community Health Services (HCHS) staff in NHS organisations and do not include primary care staff, including GPs and practice nurses. Projections do not account for COVID-19 impacts.

Our analysis last year built on a 2018 report by the Health Foundation and the IFS, *Securing the Future*. In this report, we also estimated that beyond simply keeping pace with expected activity growth – in order to meet rising expectations for the quality and range of care provided and for services to adopt new technological advances – the NHS in England would require workforce growth of 3.2% a year over the next 15 years. This implies a requirement of a projected 179,000 additional FTE staff by 2023/24, rising to **639,000 additional FTE**

staff by 2033/34 in this 'modernised scenario'.[1] This would include 171,000 extra nurses and health visitors and 343,000 extra professionally qualified clinical staff.

Table 1: Projections of NHS and social care workforce requirements (2020 – 2035)

Year	Estimated/ projected number of funded NHS staff posts (FTE)	Estimated/ projected NHS workforce shortfall relative to activity growth (FTE)	Skills for Care estimates/ projections of adult social care jobs
2020*	1,250,376	116,751	1,650,000
2025	1,465,716	231,280	1,800,000
2030	1,718,142	373,930	2,000,000
2034/35**	1,890,011	475,302	2,170,000

Source: Health Foundation analysis of NHS Digital and HEE data and Skills for Care analysis. • Note: NHS projections are for Hospital and Community Health Services (HCHS) staff in NHS organisations and do not include primary care staff, including GPs and practice nurses. Projections do not account for COVID-19 impacts.

* NHS estimates are for 2020/21 and Skills for Care estimates are for 2019/20.

** NHS estimates are for 2033/34 and Skills for Care estimates are for 2035.

UCAS data show 6,000 more people began undergraduate nursing degrees in 2020 than in 2019 (a 26% increase). 11,950 more started degrees in medicine, dentistry and allied subjects. Government must commit to maintaining recent increases in nursing, allied health professional and medical undergraduate places. The 2018 multiyear settlement for health services did not include funding for education and training. HEE's budget should rise by between £580m and £900m from 2019/20 to 2023/24, for increased spending on workforce development, clinical placement expansion, Continuing Professional Development, nurse and GP training (especially for the cancer and mental health workforces) and international recruitment.

Nursing

Nursing is the key area of workforce shortages in the NHS in England – registered nurses account for one in four FTE jobs in the NHS hospital and community health services but one in two vacancies. In 2019, our report *Closing the Gap* looked at nurse and GP supply and concluded that the NHS in England faced **a shortfall of 108,000 FTE nurses by 2028/29,** not accounting for fluctuations in international recruitment. This is because existing trends suggest that the number of nurses leaving the NHS will substantially exceed those joining domestically – either following initial training or on return after a period out of the NHS.

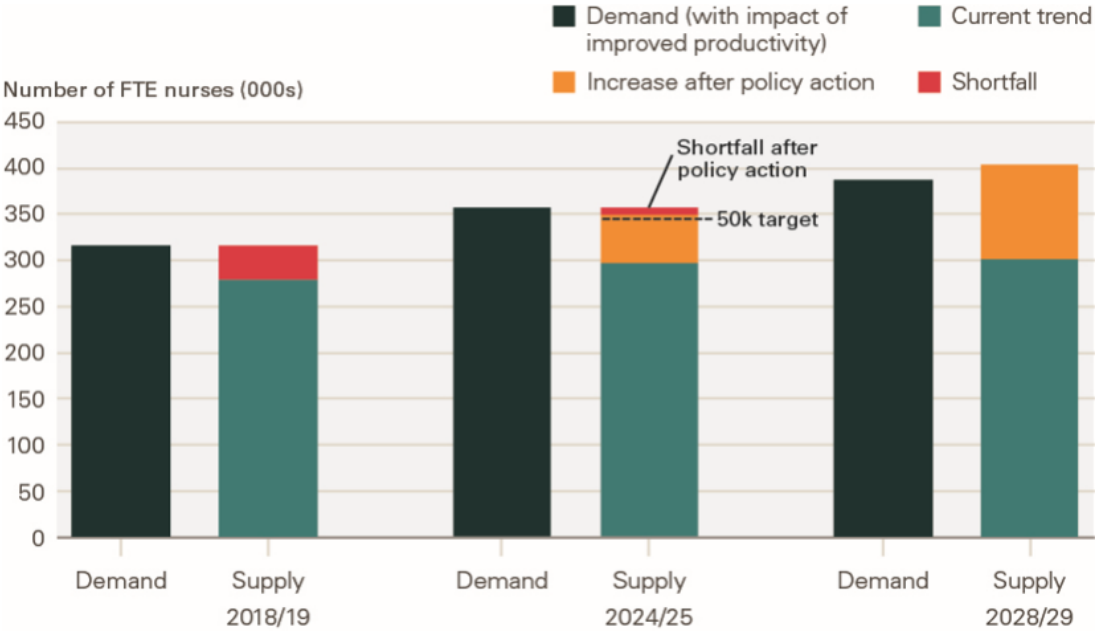
Closing the Gap found that the projected NHS nurse staffing gap could half if 5,000 more nurses started training a year by 2021 and the student attrition rate reduced by a third, with more nurses joining the NHS after qualification. The NHS would also need an additional

[1] The corresponding numbers from our updated analysis based on February 2020 data are: a requirement of a projected 188,000 additional FTE staff by 2023/24, rising to 656,000 additional FTE staff by 2033/34 in the 'modernised scenario'.

5,000 internationally recruited nurses a year up to 2023/24 to reduce registered nursing vacancy rates from over 11% in 2019/20 to 5% by 2023/24. In a best-case scenario of sustained growth in the numbers of nurses educated and employed by the NHS, along with reduced student attrition rates and better retainment, the supply of nurses in England could broadly match demand from around 2028/29 onwards – 'increase after policy action'.

Last year, *Workforce pressure points* updated this analysis, focusing on the government's 2019 general election target to hire 50,000 additional NHS nurses by the end of the parliament (only possible with sustained investment and policy action on domestic supply, including much better retention). Figure 2 shows the (largely unchanged) results of the updated 'best' case scenario. Increasing the number of nurses in the NHS by 50,000 would mean that nursing growth matches future demand growth, reducing the pre-existing nursing shortfall to around 8,000 FTE nurses by 2024/25. If the expansion in nurse training in the 'increase after policy action' is sustained and retention rates improve, it would be possible to close the nursing workforce gap over this decade and achieve a small excess of supply.

Figure 2: Nursing demand and supply projections for England based on policy action to increase the supply of nurses, 2018/19 to 2028/29



Source: Health Foundation analysis of NHS Digital, UCAS and NMC data. • Note: chart shows demand after the impact of improved productivity, included in our 'increase after policy action' but not 'current trend' scenarios. So, demand is lower (by 4,000 in 2024/25 and 8,000 in 2028/29) than in our 'current trends' scenario. Data are updated to June 2020 but we do not account for COVID-19 impacts.

GPs

Our analysis of GP supply in *Closing the Gap* found that even with a major focus on increasing the number of trainees, the number of GPs in the NHS would fall substantially short of demand and of the NHS Long Term Plan target of a net increase of 5,000 GPs. If staffing trends continued, the NHS in England would face a shortfall of 7,000 FTE GPs in 2023/24 and the shortfall would increase to 11,500 FTE GPs by 2028/29. This shortfall is likely to vary across regions and local areas, with Health Foundation research showing that there are fewer GPs per head of need adjusted population in deprived areas than in affluent ones.

Even assuming ambitious policy intervention, our projections suggest that there will be only an extra 650 FTE GPs working in general practice by 2023/24 and an extra 3,500 FTE GPs by 2028/29. This is largely due to long lead times in GP training and no anticipated improvement in the rate at which GPs leave training or join the NHS following training. Closing the gap in demand will require ambitious changes to the primary care workforce's composition, leveraging the skills of a wider team. Our projections estimate that by 2023/24, 3,100 more FTE pharmacists would need to be working in general practice and by 2028/29, 6,000 more FTE physiotherapists, plus increases in administrative and clinical support staff.

Social care demand and supply

Workforce shortages in adult social care, which employs around 1.5 million people in 1.65 million jobs in England, are even greater than in the NHS. The social care vacancy rate rose from 4.4% in 2012/13 to 7.3% in 2019/20, and the sector has an estimated 112,000 vacancies at any one time. *Securing the Future* projected that 458,000 additional FTE social care staff would be needed in England by 2033/34 to meet the expected growth in demand – based on PSSRU modelling projections of activity growth of 2.2% a year in social care up to 2033/34. These projections are consistent with Skills for Care analysis suggesting that if the social care workforce in England grows in proportion to the number of people over 64, the required number of social care jobs will increase by 480,000 (29%) by 2035 (Table 1). Projections do not account for changes in demand for care due to COVID-19. Data suggest a slight decline in vacancy rates since the pandemic. It is uncertain whether this will persist.

<u>REAL Centre modelling</u>

The REAL Centre is a new unit at the Health Foundation, working to produce independent projections and analysis to support the long term sustainability of health and social care in the UK. As part of this work, it is currently developing a set of health and social care demand and supply projection models, incorporating evidence on need, costs, and workforce supply.

Nurse supply model

In 2019, the REAL Centre commissioned Decision Analysis Services Ltd (DAS) to develop a nurse supply model. Due for completion in September 2021, this project aims to enable projections of the future nursing workforce supply in England under alternative policy scenarios over a five to twenty year timeframe. We are keen to engage with HEE and others on this from September. For more information, see Nurse supply model: progress so far.

Adult social care model

The REAL Centre recently appointed a supplier to develop a model to project long term adult social care demand, workforce supply and output (eg number of care packages or hours of client facing care delivered). This starts in September 2021 and should take two years.