Health and Care Bill – ensuring we have enough staff to meet demand

Clause 35 currently places a duty on the Secretary of State to publish a report describing the system in place for assessing and meeting workforce needs. While this will bring some clarity to the *system* of workforce planning, **we still will not know whether we are training enough people to meet demand now and in future.** Workforce is the biggest challenge facing health and care services, yet the bill does not bring clarity on how many staff we need to deliver care.

A coalition of almost 90 health and care organisations has been calling for the **bill to be amended to mandate independent assessments of current and future workforce numbers to be published regularly.** We are encouraging peers to speak in support of the amendment tabled by Baroness Cumberlege, Lord Hunt of King's Heath, Baroness Brinton and Lord Stevens of Birmingham when debated in committee which would mandate these assessments.

Government has so far dismissed amendments on workforce projections on the basis that 'Framework 15', commissioned by the Department of Health and Social Care (DHSC), will look at the drivers of workforce supply and demand and *'help to ensure'* we have the right numbers of staff. **But Framework 15 was first published in 2014, last updated in 2017, and yet there is no agreed, publicly available assessment of workforce numbers now nor into the future.** The findings of the Framework 15 consultation could be fed into the assessments the amendment asks for so that they take account of changing drivers, **but we do not believe that the Framework alone will not solve the ongoing data gap on health and care staffing numbers to inform strategic workforce planning decisions at all levels.**

Government has also pointed to 'record numbers of doctors and nurses in training'. More staff in training is always welcome but we do not know if this record number is enough for the NHS to provide care and meet future demand. We will only know that by modelling future health need and projecting staff numbers required to meet it. **All successful organisations rely on long-term workforce planning to meet demand - the NHS and social care are no exception.**

The Prime Minister said in his session with the liaison committee in 2021 that he would 'look at' the amendment, and the Secretary of State for Health and Social Care told the health and social care select committee in November 2021 that 'we need a much longer-term approach' to workforce planning. **We hope progress will be made on including regular workforce projections in the bill given the strong cross-party and sector support.**

It takes time to train skilled health and care staff – we need to act now if we want to feel the benefit in future. According to the Royal College of Physicians' census, 48% of advertised consultant posts went unfilled in 2020 – mostly (49%) due to a lack of any applicants. There are 39,813 FTE registered nurse vacancies in the NHS in England, equating to a vacancy rate of 10.5%, and the Royal College of Nursing expects 52,000 nurses to retire in the next few years. Skills for Care estimate that 6.8% of roles in adult social care were vacant in 2020/21 with the number of filled posts falling for the first time since March 2021. The BMA estimates we are 50,000 doctors short based on comparison with OECD nations, and the Health Foundation has estimated we need 488,000 more healthcare staff in the next decade.

Regular, independent public workforce projection data will not solve the workforce crisis. But having a collective national picture of the health and care staff numbers needed now and in future to meet demand will provide the strongest foundations to take long-term strategic long-term decisions about funding, regional and specialty shortages, skill mix and underpin a long-term workforce strategy. We hope peers will consider supporting this amendment.

What should an amendment on workforce planning aim to do?

The coalition of almost 90 health organisations represents service users and patients, doctors, nurses, and health and care employers and providers in the NHS and the voluntary sector. This broad spectrum of the health and care sector

is clear that the data gap on how many staff we need in future must be resolved to put the NHS and care workforce back on sustainable footing. **The amendment tabled by Baroness Cumberlege would achieve this, helping to close the data gap and strengthen accountability and transparency on workforce planning.**

The coalition believes any other amendment or clause tabled for this purpose needs to meet the following principles:

1. Assessments must be national to ensure a collective understanding of current and future workforce numbers across health and care.
2. Assessments must be independent and laid in a report to parliament.
3. Assessments must include projections for staff across health, social care and public health.
4. Assessments must include staff **numbers** as follows:
    a. Numbers of staff at the time of publication.
    b. Numbers in 5, 10 and 20 years' time based on current trajectory.
    c. Numbers needed in 5, 10 and 20 years' time based on the projected health and care needs of the population over the same time frames.
5. Demand must be modelled on demographic changes in the patient population, demographic changes in health and care staff (eg. rise in part-time working),rising role of technology, changes to cost of healthcare, new and emerging patient pathways and evidence-based treatments and expected rise in certain health conditions.
6. A role for NHS and health and care stakeholders to share intel that impacts staffing supply and demand.
7. Published at regular intervals that are more frequent than every 5 years to enable the system to plan. The coalition recommends the assessments are done every 2 years.

Why do we need an amendment?

All successful organisations rely on long-term workforce planning to ensure they can meet demand and the NHS and social care system are no exception. The non-legislative approach that has been taken so far has not worked.

Health Education England's refresh of Framework 15

The DHSC commissioned HEE to refresh 'Framework 15' ahead of Second Reading in the Commons in July 2021. Framework 15 will, as the Minister Lord Kamall said, provide *"a framework for the health and regulated social care workforce...*[and] *look at the key drivers of workforce supply".* Greater clarity on these changing drivers is welcome, but the current **Framework 15 was first published in 2014, last updated in 2017, and yet we have no agreed, publicly available assessment of workforce numbers now nor into the future.** We do not believe Framework 15 will provide ongoing assessments of health and care workforce numbers to know if we are training enough people now to meet future patient demand. Its findings could be fed into regular published assessments of the future health and care numbers so they take account of changing drivers, but **the Framework alone will not solve the data gap on staffing numbers to inform strategic workforce planning decisions at all levels.**

Merging HEE into NHS England/Improvement

The Minister also cited the recent announcement on HEE merging with NHS England/Improvement (NHSEI) which he said would '*help to ensure that workforce is placed at the centre of NHS strategy*'. HEE merging with NHSEI could help to ensure this, but it will not necessarily lead to regularly published numbers of current and future workforce numbers based on projected health and care need.

Local responsibility for workforce planning

Integrated Care Boards (ICBs) will be given responsibility – set out in draft guidance – to develop system wide plans to address current and future workforce supply locally and to undertake supply/demand planning based on population

health needs. A local only approach would not increase government accountability or transparency on workforce planning, and would fail to ensure a collective understanding of current and future workforce numbers across health and care. ICBs also do not have access to the levers that government does, such being able to increase training places or change immigration policies, that are required to take action to fill current and future staffing gaps. **Locally driven assessments have a place but should come alongside a national picture and direction of travel.**

How does this amendment work?

"After section 1G of the National Health Service Act 2006 (but before the italic heading after it) insert—

1GA Secretary of State's duty to report on workforce systems

(1) The Secretary of State must, at least once every two years, lay a report to parliament describing the system in place for assessing and meeting the workforce needs of the health, social care and public health services in England.

(2) This report must include

a) an independently verified assessment of health, social care and public health workforce numbers, current at the time of report publication and the projected supply for the following 5, 10 and 20 years

b) an independently verified assessment of future health, social care and public health workforce numbers based on the projected health and care needs of the population for the following 5, 10 and 20 years, consistent with the Office for Budget Responsibility long-term fiscal projections

(3) NHS England and Health Education England must assist in the preparation of a report under this section.

(4) The organisations listed in subsection (3) must consult with health and care employers, providers, trade unions, royal colleges, universities and any other persons deemed necessary for the preparation of this report, taking full account of workforce intelligence, evidence and plans from local organisations and partners within integrated care boards."

Explanatory notes

This amendment would require published assessments every 2 years of the workforce numbers required to deliver the work that the Office for Budget Responsibility estimates will be carried out in future, based on projected demographic changes, the growing prevalence of certain health conditions and likely impact of technology.

2(a) sets out current workforce numbers at the time of publication, and what those numbers will look like over the next 5, 10 and 20 years on current projections. 2(b) then sets out what numbers will need to be over the same time period to keep pace with demand consistent with the projected health and care needs of the population.

The Bill currently says HEE and NHSE must only assist in the preparation of reports 'if required to do so by the Secretary of State'. Subsections 3 and 4 propose that they must be consulted because of their overview of the system, and that a wider group including health and care employers are consulted because of their involvement in workforce planning.

Why OBR?

The Office for Budget Responsibility (OBR) predicts likely healthcare spending by projecting healthcare activity, taking into account demographic changes and other factors such as the changing cost of healthcare, impact of technology and rising prevalence of certain health conditions. This amendment asks for the published assessments of future health

and care staff numbers to be *consistent* with those OBR projections and the assumptions tied up in them. **It is a way to understand how many staff will be needed to deliver the work that the OBR estimates we will carry out in future.**

Why every 2 years?

A workforce planning document that is only published at a maximum of every 5 years – as is currently proposed – will not be sufficiently responsive to potential societal shifts or unexpected external events.

The repeal of the Fixed Term Parliament Act means that governments are no longer guaranteed five-year terms, which could lead to inconsistent reporting periods. **To enable the system to plan, reporting periods should be consistent and regular.** A 2-year reporting cycle should allow government and others sufficient time to begin action in response to the projected numbers, without leaving too long between cycles that the figures are fundamentally different.

Why 5, 10 and 20 years?

Projecting over these regular time periods means we can take account of changes across the health and care workforce and the wider population. For example, 56% of medical trainees entering the NHS are interested in working part-time - this will have significant implications for workforce planning in 10 years, when they begin to qualify as consultants. It's also estimated that in the next decade 41% of consultants will retire (taking a mean retirement age of 62.4 yrs).

The patient population is changing too. The ONS estimates that by 2040 there will be over 17 million UK residents aged 65 and above, meaning 24% of the population may potentially require geriatric care. Assessment of current workforce data, alongside sophisticated projections for the immediate, medium and long term are critical for population health, including prevention and tackling health inequalities. The pandemic has demonstrated how unforeseen events can have significant impacts that change over time. This range of time periods means workforce planning can respond to immediate changes, while considering long-term shifts in the ageing population and environmental factors.

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