
Closing the gap

Key areas for action on the health and care workforce

Jake Beech, Simon Bottery, Anita Charlesworth,
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1. Introduction

When the National Health Service (NHS) was first established in 1948, it was supported by a workforce of around 144,000 people. Now, 70 years later, the NHS is the largest employer in England, with around 1.1 million full-time equivalent (FTE) staff in hospital and community services (**NHS Digital 2018b**).¹ These people are the health system's greatest asset. Without its many different staff – including doctors, nurses, scientists, porters, clerks and therapists – there would be no health service.

And yet right now, the NHS workforce is struggling to cope. In November 2018, The Health Foundation, The King's Fund and the Nuffield Trust jointly published a briefing in advance of *The NHS Long Term Plan* (**NHS England 2019c**), highlighting the scale of workforce challenges facing the health service and the threat they pose to the delivery and quality of care over the next 10 years (**Health Foundation et al 2018**). In it we showed that NHS hospitals and mental health and community providers are currently reporting a shortage of more than 100,000 FTE staff (representing one in eleven posts) (**NHS Improvement 2018b**), severely affecting some key groups. One of the greatest challenges lies in nursing, with 41,000 nurse vacancies² (one in eight posts) (**NHS Improvement 2018b**), but there are also problems in medicine, particularly in some specialties – eg, core psychiatry training is now on the Migration Advisory Committee's list of occupations experiencing a shortage of staff – and geographical areas, as well as some allied health professions. These pressures also extend beyond NHS trusts, with serious staffing issues in general practice.

The adult social care sector is also under pressure and facing many of the same issues as the NHS. There are 1.1 million FTE jobs in adult social care (**Skills for Care 2018a**), and vacancies are rising, currently totalling 110,000, with around one in ten social worker and one in eleven care worker roles being vacant (**Skills for Care 2018a**). There is also a registered nurse vacancy rate of 12 per cent in adult social care, implying around 5,000 nursing vacancies in this sector as well (**Skills for Care 2018a**).

The current level of vacancies looks set to worsen. Concerns about Brexit appear to have created additional risks in both the short and medium term. Already a net inflow of nurses from the European Union (EU) into the NHS has turned into a net outflow; between July 2017 and July 2018, 1,584 more EU nurses and health visitors left their roles in the NHS than joined (**NHS Digital 2018d**). Further, the government's efforts to increase the number

¹ These figures exclude staff working in primary care or the voluntary and independent sectors.

² Our November 2018 briefing referenced more than 36,000 nurse vacancies based on data published by NHS Improvement. In our modelling for this report we refer to 32,500 nurse vacancies. This figure comes from applying the nursing vacancy rate from NHS Improvement data to the nursing establishment data published separately by NHS Digital. We have used NHS Digital data on the nursing establishment because these are classed as official statistics and are consistent with other sources whereas the staff numbers collected by NHS Improvement are reported as management information.

of nurses and allied health professionals in training by up to 10,000 (by removing the NHS bursary for students starting courses from August 2017 – see Chapter 2 for more detail) ([Health Education England 2017a](#)) have so far not been successful; in fact, the number of placed English applicants for nurse undergraduate training in 2018 was 4 per cent lower than in 2016 ([UCAS 2017, 2018a](#)).³

In addition to these vacancies, staff in post face other challenges. The 2018 NHS Staff Survey showed that 12.8 per cent of staff reported experiencing discrimination at work during the previous 12 months and around one in six did not believe that their organisation provided equal opportunities for career progression or promotion ([NHS England 2019c](#)). And in terms of progression, while the NHS has made progress in addressing unwarranted inequalities, there is evidence that disparities still exist, resulting in pay gaps. For example, the estimated median basic FTE pay gap between men and women in 2017 was 8.6 per cent in favour of men and was significantly worse for women in some ethnic groups.

Workforce challenges are currently the biggest threat facing the health service and are already having significant consequences for both patients and staff. As the Care Quality Commission (CQC) stated in its recent report on the state of health and social care in England: 'Workforce problems have a direct impact on people's care' ([Care Quality Commission 2018](#)). The latest GP Patient Survey shows clearly that patients have problems accessing general practice, with more than a third of patients struggling to get an appointment when they need one ([NHS England and Ipsos MORI 2018](#)). For services provided by NHS trusts, performance against key waiting times standards has been in decline since 2012/13, with patients experiencing longer waits for both A&E and planned care. Mental health services are also under pressure – for example, national data published in November 2018 found that 675 patients in acute need were admitted to mental health units outside their local area ([NHS Digital 2019b](#)), a practice that the government has committed to eliminate by 2020/21. In the longer term, if substantial staff shortages continue, we could see waiting lists continue to grow and a further deterioration in care quality, potentially undermining the future sustainability of services.

As we set out in our November 2018 briefing, the scale of the workforce challenges currently facing the health service pose a threat to the delivery and quality of care over the next 10 years. We also urged national leaders to use the long-term plan as an opportunity to address these issues. The long-term plan was published in January, setting out far-reaching commitments to improve health outcomes and quality of care. The plan rightly recognises that the NHS can only achieve these outcomes if it has enough staff with the right skills and they are given adequate support to work effectively. However, it acknowledges that conditions currently fall far short of this, with 'our staff... feeling the strain' ([NHS England 2019c](#)).

³ This figure is based on applicants permanently living in England, accepting a place at any university within the UK, using the latest available data for comparison ([UCAS 2017, 2018a](#)).

To address this, the plan outlines a number of measures, including proposals to increase staff numbers through training and recruitment. It also proposes to make the NHS a better place to work, so that more staff stay and feel able to make better use of their skills and experience. It sets out some immediate actions, to be overseen by NHS Improvement and a newly established, cross-sector national workforce group, with membership from across the health sector, including representatives from our three organisations. The group will explore other actions, to be set out in an 'interim' workforce implementation plan in April 2019 and finalised in a 'full' plan following the Spending Review later this year. Wider changes are deferred until after the 2019 Spending Review, when the budget for training, education and continuing professional development (CPD) is set, alongside decisions on capital investment, public health and social care funding over the rest of this parliament.

The plan has already been followed by ambitious goals in the new GP contract, which plans for many more physiotherapists and pharmacists to be brought in, and in the Topol Review on training staff to use new digital technologies ([Health Education England 2019d](#)).

Scope of this report

Our report lays out a set of high-impact interventions that, if put into action now, could help to ameliorate the current workforce crisis. We focus on the areas where severe national problems are having an immediate impact – in particular, nursing and general practice. Our recommendations do not amount to a full workforce strategy for the future or a plan for the NHS; this would be an enormous task, taking several years and that is the job of system leaders. In relation to the NHS, we focus on five main opportunities:

- training new staff, specifically nurses
- pay
- helping the NHS become an employer of choice for health care workers, improving the career offer and ensuring that staff from all backgrounds are treated fairly
- the right teams with the right skills
- international recruitment.

In order to assess how many health care workers the NHS can secure through these actions and whether it will be enough, we project the potential demand for staff in the future. This is based on estimates of the size and age of the population, the rising burden of chronic disease, and ambitions for the quality and range of services which are in line with planned growth in spending. We then model the impact of our recommendations on the gap between supply and demand for nurses in NHS hospitals, mental health providers, community trusts and GPs.

The NHS long-term plan and associated workforce implementation plan are concerned with the NHS, and so this is our focus. However, the NHS has a close inter-relationship with social care and there are strong connections between the two workforces, with a flow of workers between the two sectors and day-to-day, side-by-side collaboration in care. While the fundamental structural differences between the two sectors mean

they cannot currently be treated as one sector, the deep links between them necessitate workforce strategies that cover both. We therefore also, albeit in less detail, look at measures needed to improve recruitment and retention in social care.

Approach and methodology

The report itself is structured along the five 'opportunity' areas we outlined earlier. These are: training new staff; pay; the NHS as a good employer; the right teams with the right skills; and international recruitment. In addition, we set out our modelling analysis in Chapter 7 and in the final chapter we look at the implications of the interrelations between health care and social care in terms of staffing.

The report has been produced as a collection of policy analyses by experts from the three think tanks. Each analysis has named authors and although they are inter-linked (for example, they all draw on our modelling exercise), each can be read as a standalone document.

The purpose of this report is to make policy-level recommendations for national bodies that are designed to support progress towards the objectives that have been set for the NHS over the next 5–10 years in *The NHS Long Term Plan*. The recommendations will, however, also be of interest to those leading on workforce issues at local and regional levels. In each chapter, we have estimated cost implications of our recommendations for HEE budget which will be set as part of the 2019 Spending Review.

In developing our recommendations we have drawn on published literature and data. We have also spoken to national and professional leaders. Further, in September 2018 we held a roundtable, which brought together 55 participants from a range of organisations, including national statutory bodies, voluntary sector organisations, professional regulators, academia, trade unions and NHS provider organisations.

The modelling exercise that underpins this report provides new insights. When looking at the NHS, we have focused on the workforce employed directly by NHS hospitals, mental health and community providers and general practice. We have based our analysis on data available from NHS Digital and NHS Improvement, who in turn focus on the workforce employed by the NHS and the contracted professions, including general practice. We have used this data to project forward the potential supply of key workforce groups using an approach that is consistent with the approach that Health Education England takes.

This approach starts with the stock of current staff in key groups and potential flows in and out of NHS employment, but it does not capture the demand and supply of health care workers across the economy as a whole (as well as working in the NHS, nurses, for example, can be employed in the private sector, in social care and by charities). Our starting point for nurses is one of shortage (based on the vacancy rate as produced by NHS Improvement and staffing data from NHS Digital). This is not intended to act as a precise estimate of vacant posts from a human resources perspective: this method

approximates a gap between supply and demand for staff in a way that we can project forward, which we refer to as 'vacancies'. We have taken a similar approach for GPs based on data from NHS Digital.

Our modelling is assumption-driven and involves little empirical analysis of incentive effects (for example, how much pay changes recruitment or retention). Improving these models and, more fundamentally, our understanding of the relationships underlying the data is critical to good workforce planning. Our quantitative work should therefore be seen as indicative, reflecting the art of the possible rather than the state of the art.

We have also modelled the number of nurses and GPs that are expected to join and leave the NHS over both the next five years (to 2023/24) and ten years (to 2028/29). This has allowed us to produce estimates that include the effect of our recommendations in this report on these staff groups. This helps to show what can be done to close the gap between the supply of and demand for staff and has helped to guide our understanding of which areas are the most important to focus on. In particular, our modelling shows how the effects of our recommendations combine and the cumulative impact they could have.

We hope that this report will be of use to everyone involved in planning and supporting the NHS workforce. In certain instances, solutions go well beyond the remit of the NHS and will require policy engagement with government – in some cases because delivering them will require significant financial investment, and in others because they will require political support and leadership.

2. Supply of new staff: education and training

Billy Palmer and Nina Hemmings, Nuffield Trust

Key messages

- The training of new staff is a key route to supplying the staff that the NHS needs, but it requires significant financial investment and is not a quick fix for short-term staff shortages. For example, it requires more than £500,000 investment and 14 years to train a hospital consultant ([Curtis and Burns 2018](#)).¹ In this context, the trend of falling national funding for education and training should be reversed immediately. *The NHS Long Term Plan* ([NHS England 2019c](#)) proposes a range of targets and measures to improve the supply of staff, including increased funding for clinical placements during training, more apprenticeships and a new online nursing degree. While the ambition of the plan is welcome, some of the suggested measures remain either untested or, as yet, unfunded.
- Certainly, the status quo looks unlikely to provide a sufficient supply of staff to meet demand in the long term. Action to improve the size and efficiency of the training pipeline, backed by appropriate levels of funding for education and training in the 2019 Spending Review, is urgently needed if the ambitions in the plan are to be delivered. Doing so will require better co-ordination, at all levels, between the many parties involved. Success will also depend, in part, on the ability of the new NHS Improvement-led national workforce implementation plan steering group to set a precedent for more positive collaborative working.
- The government's expected increase in nursing and allied health professional training posts as a result of changes to how these courses are funded has not yet materialised. In fact, the number of placed applicants for undergraduate nursing was 4 per cent lower in 2018 than in 2016.² Progress in expanding the quicker, postgraduate training route has also stalled. The long-term plan proposes an online nursing degree from 2020 at a reduced cost to students, alongside exploring 'earn and learn' support premiums to students on more flexible undergraduate degrees in mental health or learning disability nursing, who are also predominantly mature, with the aim of having an additional 4,000 people in training by 2023/24. However, the response from the sector has included scepticism that these measures are sufficient given the scale of the staff shortages. Further research is urgently needed to understand

¹ Note that this covers both the student's and the taxpayer's investment.

² This figure is based on applicants permanently living in England, accepting a place at any university within the UK, using the latest available data for comparison ([UCAS 2017, 2018a](#)).

the decisions that both prospective students and providers of training make and, in particular, the impact of the removal of NHS bursaries.

- Action is needed to ensure the funding and availability of clinical placements are not a bottleneck in the training pipeline, in particular for nursing. The long-term plan proposes funding for 50 per cent more nursing placements from 2020/21. Any expansion in clinical placements should be done in a way that exposes students to a more appropriate mix of settings at more appropriate times during their training, to positively affect their experiences and future career choices. However, it is worth noting that the intended expansion in clinical placements in 2017 was not realised. The ability to support clinical placements is particularly challenging when, for example, services are already under pressure. The allocation of funding for clinical placements should be rebalanced to deliver optimal value for money; providers receive around 10 times more funding for some medical placements per year than for a nurse placement and there has also been a particular lack of transparency on where medical placement funding goes.
- Focusing on reducing attrition during training could significantly improve the situation for the student, the NHS and the taxpayer. Despite a policy push to reduce attrition, levels appear to have remained worryingly high with, for example, an estimated one in four potential consultants quitting training before reaching the senior doctor role. In nursing, of UK students who began a three-year degree due to finish in 2017, a quarter (24 per cent) left or suspended their studies. We heard that meeting living costs during nursing training is a significant pressure on students and may be contributing to students leaving their training. While the long-term plan proposes a focus on such attrition, it is light on detail.
- We recommend that commissioners of undergraduate and postgraduate medical, nursing and allied health professional courses and placements set conditions on the quality, success and balance of the training, taking into account variation between institutions. This must be informed by accurate monitoring of attrition. In the context of the challenge of meeting living costs for some students, some of the savings that have been made by removing NHS bursaries should be reinvested into the training of nurses and potentially other under-pressure professions. Given the scale of the challenge, we recommend this includes covering tuition fees for postgraduate student nurses and offering 'cost of living grants' for all nursing degrees in recognition of the time spent on clinical placements. We propose that this is set at around £5,200 a year thus providing an income for those with the maximum maintenance loan equivalent to the national living wage. In addition to this, we propose that the number of students studying nursing as a postgraduate is substantially expanded and, therefore, recommend that they are exempt from tuition fees.
- More needs to be done to ensure apprenticeships can help to solve key workforce shortages. To date, the model has been delayed and numbers are low; only around 300 had started nursing degree apprenticeships in the year to July 2018 ([Department for Education 2019a](#)). Although potentially a significant route for widening participation and advancing social mobility, some more intensive apprenticeship routes appear financially unviable for providers. We recommend that the government revisits proposals by NHS

Employers and the Education Select Committee to increase the maximum funding level and flexibility in how it is used, and to improve regional co-ordination including between health and social care settings. In addition, there have been other promising initiatives between higher education institutions and NHS trusts to recruit trainees locally, which could be replicated elsewhere.

Introduction

The training pipeline of new staff is critical, to replace those leaving, meet increasing demand and cover vacancies. At any one time, there are around 140,000 students in training and education to become clinicians and a further 50,000 junior doctors in postgraduate medical education in England (**Health Education England 2018f; National Audit Office 2016**). The total investment and time taken to train staff is often substantial – typically around £70,000 and three years for an undergraduate nurse and more than £500,000 and 14 years for a hospital consultant (**Curtis and Burns 2018**). Centrally, Health Education England (HEE) is expecting to spend £4.0 billion on training places in 2018–19 (**Health Education England 2018b**).

The management of the training pipeline is both important and complex. The balance between different staffing groups will affect future workforce composition and the make-up of teams, while the location and setting of training may influence students' choice of specialty, and geographical location, of work. Moreover, the content and quality of training, and experiences during clinical placements, will determine – at least in part – the skills of clinicians and their likelihood of working in the NHS.

This chapter covers recent developments in the supply of new staff and key ways for managing it. In particular, we cover three key areas:

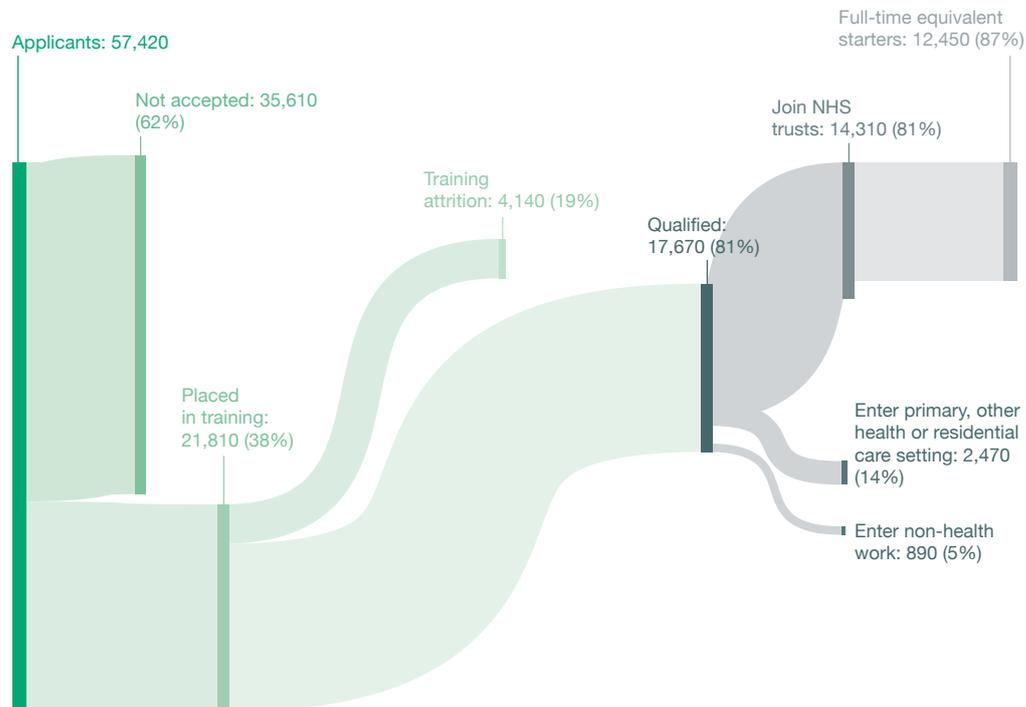
- the commissioning and funding of training posts
- the rates at which training posts are filled, completed and result in an NHS employee
- the apprenticeship scheme.

Other routes to supplying staff – including international recruitment, 'return to practice' and the development of existing staff – are covered in Chapters 3, 5 and 6 respectively. In Chapter 8 we cover implications for social care – a setting in which most staff in England are not registered professionals and therefore do not require as structured a training pipeline.

The challenges are clear, with current numbers emerging from training in many specialties and regions insufficient to meet demand. As we discuss below, this is, in part, due to a failure to scale up training numbers but also due to the 'leaky' nature of the pipeline, with one estimate suggesting that out of every 100 adult nurse training places commissioned, only 58 full-time equivalent (FTE) staff enter the NHS (**NHS Pay Review Body 2018**). While data on this is limited, our own exploratory analysis found a similar ratio,³ as demonstrated below with the estimated attrition and participation levels for the cohort of students who began their nursing course in the autumn of 2014 (see Figure 2.1).

³ Our indicative figures suggested that from 21,810 people placed in training there were around 12,450 FTE starters, suggesting a ratio of 57 FTEs per 100 training places. However, due to limitations in the available data, these figures should be treated with caution.

Figure 2.1: Undergraduate nurse training pipeline, represented with estimates for students starting in 2014



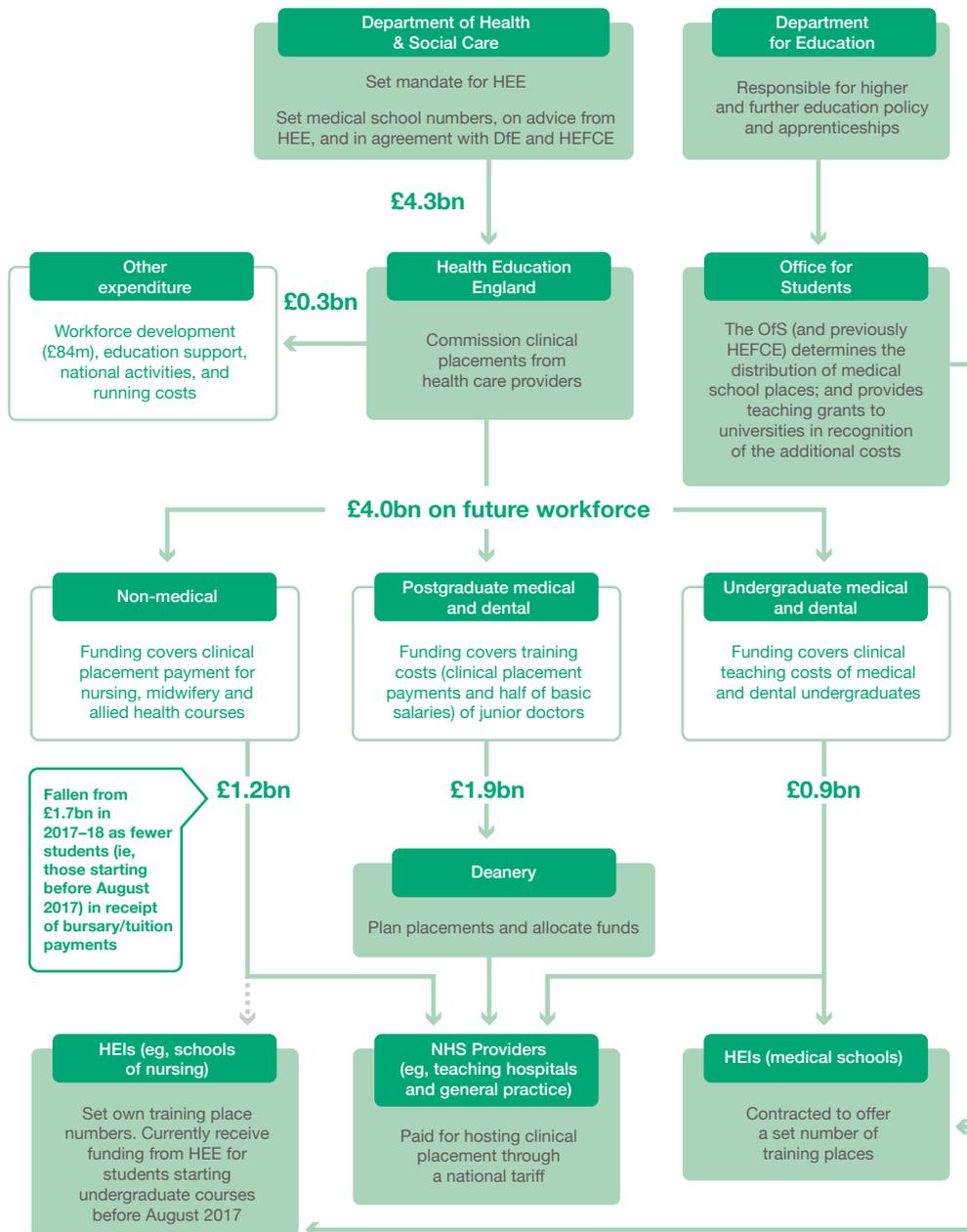
Notes: The pipeline is for those students starting their degree at an English provider in 2014 and therefore joining the NHS in 2017 at the earliest. Our estimate for training attrition is the proportion of students accepting a place on a nursing course who do not qualify with a nursing degree; other existing estimates may be based on an alternative definition. Due to limitations in the underlying data, these figures should be treated with caution and are presented for indicative purposes only and rounded to the nearest 10.

Source: Nuffield Trust analysis of data from HEE, the NHS Pay Review Body and UCAS.

Commissioning and funding training

The responsibilities for training new staff fall on a range of different organisations. While the Department of Health and Social Care is ultimately accountable for both the health and social care workforce (**Department of Health and Social Care 2018a**), HEE is responsible for providing leadership for and oversight of workforce planning, education and training. HEE has intervened at the national level to make small adjustments to the training places it commissions to reflect national priorities and emerging pressures, including increasing people's opportunities to train in the emerging physician associate role. However, it has been criticised for failing to be sufficiently proactive in changing training numbers in response to possible over – and under-supply, although this may be a result – in part – of its decreasing budget (**National Audit Office 2016**). National funding for education and training has fallen over time, from 5 per cent of total health spending in 2006/07 to just over 3 per cent in 2018/19 – the equivalent of a £2 billion shortfall – which

Figure 2.2: National funding of the future workforce, 2018–19



Notes: HEE = Health Education England; HEFCE = Higher Education Funding Council for England; HEI = higher education institutions; DfE = Department for Education; OfS = Office for Students. To aid presentation, not all funding flows – such as loans for students – are included. All figures are in 2018/19 prices.

Source: Higher Education Funding Council for England (HEFCE).

has reduced its ability to shape the training pipeline nationally.⁴ *The NHS Long Term Plan (NHS England 2019c)* notes that HEE's budget will be set in the 2019 Spending Review and, therefore, the level agreed will influence, for example, the budget for continuing professional development and the potential to expand medical school places. As discussed below, the change in funding arrangements for nursing and allied health subjects has also removed national control over the number of training places offered for these professions. The training itself is primarily delivered by higher education institutions and NHS providers who host both clinical placements and the junior doctors completing their postgraduate medical training (see Figure 2.2). This fragmentation results in a system where lines of accountability at both the national and local levels are opaque and confusing.

The availability of clinical placements can be a bottleneck, while their funding may unduly incentivise providers to plan to use some staff over others, even if this would create a less-than-optimal workforce composition in the long term. There may be scope to expand placement capacity by using a wider range of providers and doing so in a way that exposes students to a more appropriate mix of settings at more appropriate times during their training, to positively affect their experiences and future career choices. However, the ability to support clinical placements is particularly challenging when services are already under pressure and budget cuts mean there are insufficient trainers (also known as facilitators) available within clinical services to supervise placements. This situation may continue if bodies wait until the national budget covering some of this education support – which has decreased in recent years – is agreed in the 2019 Spending Review before acting to support growth in the number of trainers available. While timely funding for continuing professional development is critical, other rate-limiting factors include workload demands and staffing shortages, which play a role in restricting opportunities to train (*Royal College of Nursing 2017*). A 2018 survey suggested that 92 per cent of general practitioners (GPs) considered that clinical workload was 'not always dealt with appropriately to make sure that trainees are not adversely affected' (*General Medical Council 2018b*, p 38).

HEE currently funds providers to cover the direct costs of training, including staff teaching time, during clinical placements.⁵ However, there are huge differences in funding levels between staff groups, with providers receiving around 10 times more for some medical placements each year (up to £44,000) than for nurse placements (up to £4,000; *Department of Health 2017a*).⁶ In addition, for junior doctors only, HEE funds half of basic salary costs. These levels are set nationally and so local areas have little ability to direct funding to address particular bottlenecks. There is also a lack of transparency on where the funding for medical placements goes and it has been suggested in the past that it is 'too often used to fund research' (*Walsh et al 2014*, p 493).

4 Extrapolated from trends set out in a report by the National Audit Office (2016) and recent HEE and Department of Health and Social Care budget data. Total health spending in the National Audit Office's estimates appears to be based on the total Departmental Expenditure Limit (DEL).

5 Note that funding to cover existing staff to be facilitators (trainers) comes from the continuing professional development budget, discussed in the previous paragraph.

6 These amounts may be increased by up to 30% (in the case of University College London Hospitals NHS Foundation Trust) to account for local cost pressures; this adjustment is known as the 'market forces factor'. These figures exclude the salary reimbursement for junior doctors.

Deciding on the number of training places to commission is inherently challenging, requiring forecasts on the future demand for, and supply of, staff. In particular, factors outside the control of the NHS as well as unexpected events within the NHS can have a huge impact, as can the volume of applications, which can also vary ([Health Foundation 2018](#); [Buchan et al 2017a](#)). During our interviews with stakeholders, we heard views that this may not have been helped by a failure, in many areas, of higher education institutions, commissioners of training and the NHS to work appropriately closely at all levels. *The NHS Long Term Plan* ([NHS England 2019c](#)) signals an intent for 'local workforce action boards' – responsible for supporting regional workforce plans – to 'become more accountable' to health and social care employers, but it remains unclear what effect this will have on planning. History suggests it may also take time for any new body taking responsibility for workforce planning to do so well; for instance, two-thirds of the sustainability and transformation plans (STPs) produced in 2016 contained no detailed workforce plan ([Boyle et al 2017](#)). That said, there are positive examples of universities and health care providers – such as University of Bradford and Mid Yorkshire Hospitals NHS Trust – collaborating to set up new locally focused nurse training courses with the intention of attracting local applicants using, for example, job guarantees, to increase the supply of nurses ([University of Bradford 2017](#)).

The lack of co-ordination has made predicting training capacity and increasing supply more challenging. The plan also has the welcome ambition to commission a review of NHS workforce data, which we hope will lead to the availability of more information to support planning. Certainly, at present, the lack of information on staffing in some care settings is a major barrier to modelling the supply and demand for some groups. The NHS Staff and Learners' Mental Wellbeing Commission, led by Sir Keith Pearson, has also pointed to the need for greater co-ordination between health care providers 'such as GP practices, hospitals, and care home operators' on a local sustainability and transformation partnership or integrated care system footprint, to co-ordinate schools' work experience ([Health Education England 2019c](#), p 26).

Recommendation

We are concerned by the lack of co-ordination between the many parties involved in supplying new staff. We recommend that, in all areas and at all levels, higher education institutions, commissioners of training and the NHS work as partners. As part of a more co-ordinated local system, these bodies should, in particular, consider the feasibility of replicating existing promising initiatives between higher education institutions and NHS trusts to recruit trainees locally. This will require clearer accountabilities throughout the entire system.

The NHS Long Term Plan aims to 'ensure a sustainable overall balance between supply and demand across all staff groups' ([NHS England 2019c](#), p 79). Yet to date, forecasts have tended to overestimate the supply of, and underestimate the demand for, staff. This pervasive optimism bias is, in part, due to local workforce plans – themselves a fundamental driver for national commissioning decisions – being linked to agreed financial plans, which

tend to overstate likely cost reductions and therefore lead to underestimates of future staff numbers (**Palmer and Imison 2018**). In light of this, it is worth acknowledging that the long-term plan makes it clear that NHS Improvement, which historically has had a focus on financial performance, 'now has lead responsibility for the NHS workforce' (**NHS England 2019c**, p 78). However, the role and expected influence of the Department of Health and Social Care remain unclear.

The implications of an undersupply of staff are not the same as those for an oversupply in the context of the English health system and, at the national level, there has also been little assessment of the implications of undersupply for service delivery (**Charlesworth and Lafond 2018**). This issue of workforce undersupply spans across the NHS, local authorities and the independent sector. Although an oversupply of some types of labour could conceivably add to cost pressures by increasing demand for health care services and the cost of training staff is high, undersupply and poor labour planning can lead to unintended consequences and hidden costs. These include additional spending on agency staff, lower productivity and system inefficiency. The fixation on preventing oversupply has contributed to significant undersupply across numerous professions (**Centre for Workforce Intelligence 2014**). For example, the UK had around 29 nursing graduates per 100,000 population in 2014, considerably less than the average of almost 50 per 100,000 for countries of the Organisation for Economic Co-operation and Development (OECD) (**Buchan et al 2017a**).

In recognition of these factors, it would be prudent for policy-makers and planners to plan for a degree of oversupply for some critical professions, including nurses and groups for which the risk of undersupply are particularly high. The risk to individuals of unemployment following their nurse training seems low given the global picture of nursing shortages, England's continued reliance on international recruitment and the attractiveness of many of the skills of registered nurses to other sectors. Action has been taken to support an adequate supply of doctors with a phased 25 per cent expansion in the number of medical students from 2018, at an estimated cost of £280 million a year (in 2018–19 prices) (**Department of Health 2017b**), and there is potential to grow this further depending on the level set for HEE's budget in the 2019 Spending Review. Yet ways to increase commissions for other staff groups are far more limited.

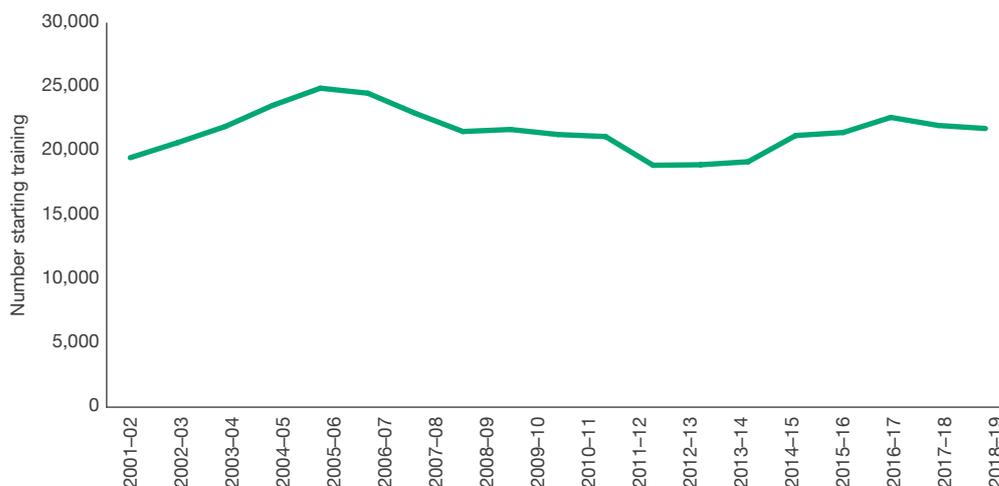
Commissioning of nurse and allied health professional training

Since August 2017, nurses and allied health professionals have had to pay for their undergraduate training. Previously, HEE spent around £1.2 billion (in 2018/19 prices) annually on bursaries (non-repayable grants) to around 58,000 nursing and midwifery students and 19,000 allied health students who were studying at that time (**Department of Health 2016a**). Under the new arrangements, students are expected to pay in the region of £28,000 in tuition fees for their degree in addition to covering living costs, but they are able to take out student loans.⁷ The government's intention was to remove the

⁷ There have also been changes in the funding arrangements for maintenance costs.

cap on numbers caused by the limited national budget available to fund places, which was claimed would result in an expected increase in up to 10,000 posts on nursing, midwifery and allied health profession courses by 2020 (Osborne 2015). This level of increase would, for nursing specifically, in fact put us back above the level achieved in 2004 (see Figure 2.3). That said, the commitment in *The NHS Long Term Plan* to provide funding for up to a 50 per cent increase in clinical placements from 2020/21 suggests a greater ambition (NHS England 2019c).

Figure 2.3: Trend in numbers starting nurse training, 2001–02 to 2018–19



Notes: Due to difficulties in accessing trend data, this figure is based on English students placed at any university within the UK rather than all students at English providers (as quoted elsewhere in this chapter).

Sources: UCAS (2018a) and Hansard (2015).

In the event, the expected increases have yet to materialise. While there was a 17 per cent increase in the number of physiotherapy student places in 2017, the first year of implementing the reforms (Chartered Society of Physiotherapy 2018), nurse undergraduate training numbers fell by 4 per cent in England between 2016 and 2018 (see Table 2.1). In fact, the number of nurse degree starters in 2018 was around 3,000 fewer than in 2004 but higher than at the low point around the start of this decade. In comparison, there have been increases in the number of nurse students in Scotland and Wales where the bursary arrangements have been retained (see Table 2.1). That said, the exact influence of bursaries – and their removal – on student numbers is still unclear as many other factors will influence the trend, including for example a demographic drop in the number of 18-year-olds (Buchan et al 2019). Further research is urgently needed to understand the decisions that both prospective students and providers of training make. The latest data suggests that there was a small (4 per cent) increase in the number of English students applying for undergraduate degree nurse courses by the January 2019 deadline compared with last year, although numbers remain more than a third below 2016 levels (UCAS 2019a).

Table 2.1: Comparison of tuition and maintenance costs a year for undergraduate nurse students in 2018

	Living costs	Tuition fees	Placed nurse applicants in 2018 compared with 2016 (2012)
England (pre-2017)	Bursary of £1,000 with up to £3,200 extra means-tested support	None (bursary)	<i>n/a</i>
England	Loan of up to £8,430 (£11,002 in London)	Up to £9,250	-4% (+15%)
Scotland	Bursary of up to £6,578 but no maintenance loan	None (bursary)	+14% (+28%)
Wales	Bursary of up to £4,567 with maintenance loan of up to £4,000	None (bursary) on condition that students commit to working in Wales for two years after graduation	+10% (+49%)
Northern Ireland	Bursary of up to £5,165 but no maintenance loan	None (bursary)	-1% (+110%)

Note: Placed nurse applicant figures for each nation of the UK are based on the individual's country of permanent residence and their acceptance of a nursing degree place at any university across the UK, using the latest publicly available data for comparison.

Sources: Compiled from various literature, including Scottish Government (2018), UCAS (2017, 2018a) and UNISON (2017).

The fall in opportunities for, and interest in, nurse training has been more dramatic for some courses, regions and demographics than others. For example, over the course of 2017, the first year of the implementation of the funding changes, the number of students accepted on to undergraduate children's nursing courses increased by 6 per cent while for learning disability nursing it fell by 38 per cent to just 350 acceptances (Health Education England 2018e).⁸ This is, in part, due to the effect of the demographic of applicants, with applications from mature students in England having fallen at a higher rate than those from younger students (UCAS 2019b), resulting in fewer being placed on a course (see Figure 2.4). Mature students are more likely to specialise in learning disability and mental health nursing with, for example, respectively around 56 per cent and 60 per cent of students enrolling on these specialisms aged 25 and over compared with respectively 46 per cent and 27 per cent of students enrolling for adult and child nursing aged 25 and over (HESA 2015–16, cited in House of Commons Health Committee 2018). These specialisms currently face particular shortages, and *The NHS Long Term Plan* proposes exploring 'earn and learn' support premiums for undergraduate mental health and learning disability nursing students, with a target of 4,000 more people in training by 2023/24 (NHS England 2019c). However, the Council of Deans of Health, which represents the relevant university faculties, has noted concerns that such piecemeal solutions could 'create unintended consequences by encouraging students to delay study or diverting students from adult nursing or other health care careers' (Council of Deans of Health 2018, unpaginated).

⁸ Data provided by HEE based on UCAS analysis.

Figure 2.4: Percentage-point change in nurse applicants in 2018 compared with previous years, by age and gender



Note: These trends are based on English students accepting a place at any university within the UK, 28 days after A-Level results day.

Source: UCAS (2018b).

The NHS Long Term Plan commits to establishing an online nursing degree from 2020, which it claims will be offered at a lower cost than current courses (NHS England 2019c). While making training more accessible and widening participation are crucial, it will be imperative that education providers and regulators maintain the quality of newly qualified nurses. As the Royal College of Nursing has highlighted in response to the long-term plan, 'nursing degrees demand both academic and practical skills... and entry standards are rigorous because they have to be' (Royal College of Nursing 2019, unpaginated).

Progress in expanding the postgraduate training route, which can be a valuable additional supply of clinicians, has also stalled. Postgraduate courses are typically quicker to complete than undergraduate ones and the Department of Health noted that those completing them 'bring valuable qualities to the health care student population and... workforce' (2016b). While the number of postgraduate places is currently relatively small – around 2,500 students across nursing, midwifery and allied health professions in England (Hansard 2018) – there is scope for expanding this route; education providers have estimated that many of these postgraduate courses could expand by around 50 per cent if more funding was available (Royal College of Nursing 2018a). However, since September 2018, students on postgraduate nursing and allied health profession courses have had to pay tuition fees.⁹ This is not consistent with the approach either to the postgraduate training of senior health care science roles – for example in genomics and imaging – who are paid during training (Health Education England 2019b), or in the education and social care sectors where schemes such as 'Teach First' and 'Think Ahead' cover training fees, bursaries and a basic salary. Investing in the postgraduate route

⁹ Transitional arrangements were in place for 2017–18 (Department of Health 2016b).

has the potential to be an efficient and economic part of the solution to increase the supply of new staff and should be done in the context of promoting the attractiveness of careers in health care.

In May 2018, the Department of Health and Social Care announced £10 million for one-off £10,000 'golden hellos' for hard-to-recruit postgraduate nursing programmes starting in 2018–19, although there have been significant delays in the implementation of the scheme (**Ford 2018; Hansard 2018**). The Royal College of Nursing has suggested that there must be investment to grow the postgraduate route, suggesting that these students receive a maintenance grant of £10,000 a year for the two years of study in addition to having their fees fully covered (**Royal College of Nursing 2018b, 2018c**).

Recommendation

Given that the expected increases in the number of nurses in training have not yet materialised, the Secretary of State for Health and Social Care should urgently seek to increase the supply of nurses and other under-pressure professions. This will likely require influencing prospective students, higher education institutions and providers of clinical placements. However, given the scale of the challenge, we recommend this includes the following:

- **Student funding.** The savings from the removal of NHS bursaries being reinvested, including both reinstating funding to cover tuition fees for postgraduate nursing courses, which usually take only two years to complete, and offering 'cost of living grants' of around £5,200 a year for undergraduate and postgraduate nursing students in recognition of the time spent on clinical placements.¹⁰ These measures would, for example, cost up to some £640 million a year, depending on the numbers entering training.
- **Placement-provider funding.** National bodies urgently resetting the level and balance of funding for clinical placements and salary support for clinicians in education and training to encourage an expansion in the number of clinical placements where they are currently proving to be a bottleneck. This could potentially involve a shift of funding from medical to nursing and other non-medical training if appropriate.

Location of training

The location of training places is important as many students take up work near where they trained. For example, a quarter (24 per cent) of all licensed doctors who qualified in England live within 10 miles of the medical school where they qualified (**General Medical Council 2018a**). The responsibilities determining the location of training are mixed: the new Office for Students – a non-departmental public body of the Department for Education,

¹⁰ This level of funding would mean that, with a maintenance loan of up to £8,430 (£11,002 for London) for full-time students not living with their parents, they are able to receive up to the national living wage level after income tax and National Insurance contributions for 21- to 24-year-olds (£13,593).

which took on the responsibilities of the HEFCE – determines the distribution of medical school places, while HEE determines the distribution of clinical placements. As it is now left to the market, there is limited central control over the distribution of most nursing and allied health care training posts. It is therefore imperative that national, regional and local health bodies take the initiative to work closely with higher education institutions to ensure that the supply of staff meets the needs of all areas of the country. Similarly, there is potential to better balance the content of training and specialty and the setting of placements to influence students' career choices. For example, the proportion of doctors completing foundation training in 2017 and being appointed to GP training ranged from 2 per cent for graduates of Oxford University to 57 per cent for graduates of the Lancaster School of Health and Medicine ([UK Foundation Programme 2018](#)).

Given this, of the 1,500 additional medical places announced by government in 2016, it is encouraging that the allocation of 1,000 of these new medical student places was partly based on which medical schools' curriculum encourages students to choose shortage specialties and produces graduates in geographical areas where there are relatively fewer doctors ([Health Education England 2017b](#)). To this end, five new medical schools are being created with the explicit intention of encouraging doctors to train and remain in areas with particular medical staff shortages ([Health Education England 2018c](#)). *The NHS Long Term Plan* indicates that the national workforce implementation plan steering group will examine greater contestability in the allocation of medical school places, intended to ensure that courses are delivering graduates who meet the needs of the NHS ([NHS England 2019c](#)). Until recently there have been only limited changes in the geographical distribution of training places and scope remains to better use these means to address specific staff shortages ([National Audit Office 2016](#)). This may require increased exposure to primary and community care, potentially supported by local training hubs¹¹ and a move to 'at scale' working in general practice to create better support infrastructure.

Delivering value from training

Attrition during training represents a significant waste of resources for the individual, the NHS and the taxpayer. Reducing it has been a recent priority. The Department of Health and Social Care set HEE a target to reduce avoidable attrition from training programmes by 50 per cent by 2017 and launched the NHS Staff and Learners' Mental Wellbeing Commission to investigate the mental wellbeing of staff and those in training. Its review highlighted the financial and wellbeing impacts of clinical placements and rotations, and called for the appointment of an NHS workforce wellbeing guardian in every NHS organisation ([Health Education England 2019c](#)). HEE also established the Reducing Pre-registration Attrition and Improving Retention project (RePAIR) to address the mandated requirement to reduce unnecessary attrition ([Health Education England 2018h](#)). Their research found that finances are 'by far the most significant concern for students in all years of study' ([2018g](#), p 48) and the number one factor cited by students for the high drop-out rate (attrition) during training. However, there is yet to be a sufficiently comprehensive and

¹¹ Now known as 'community education provider networks', these are networks of local education providers and other relevant partners who have joined together to plan and deliver education and training for health and social care workers in their local area.

sustained effort to address all the key reasons for people leaving their courses. And scope for further reductions in attrition remains, with parliament recommending close monitoring of attrition rates, with universities and NHS providers held to account for investigating and addressing the causes (**House of Commons Health Committee 2018**). Given this, it is concerning that data on attrition remains inadequate and, indeed, we still do not have a standard accepted measure of it. Despite progress in some areas, as outlined below, the extent to which the avoidable attrition target was achieved is unclear as the Department of Health and Social Care did not define 'avoidable attrition' and existing data is neither sufficient nor readily available. *The NHS Long Term Plan* sets out the expectation that the new national workforce implementation plan steering group will seek to reduce attrition from training (**NHS England 2019c**) but, in order to learn from past mistakes and ensure action to address the identified reasons for attrition, policy-makers will need to put in place a clear and consistent process for defining and monitoring it.

Attrition during nurse training

Based on the limited available data, attrition in nursing and similar courses appears to remain high. Of UK nursing students who began a three-year degree due to finish in 2017, a quarter (24 per cent) left or suspended their studies, representing a loss of more than 4,000 students (**Health Foundation 2018**).¹² Within this, attrition varies from 9 per cent to 45 per cent between providers¹³ and can also differ considerably between specialisms too.¹⁴ We heard from key stakeholders that student experience and quality of placement are factors and that meeting living costs during training is also contributing to some students giving up their training. This is a particular problem as clinical placements, which account for up to half of nurses' training, can contribute to higher costs for students while also restricting any opportunity to work outside of their training to support themselves financially. This may also disproportionately affect some groups, including mature students. That said, our analysis suggests that, compared with courses ending in 2012, the attrition rate for those ending in 2017 reduced significantly for mental health, children's and adult nursing, but it rose for learning disability nursing.¹⁵ Of course, issues around attrition are not just limited to nursing courses.

¹² Data obtained by Nursing Standard and The Health Foundation. This attrition figure differs from that shown in Figure 2.1 as it includes, for example, those who suspended their studies.

¹³ Variation data is from a different source and time period from the national attrition figure quoted: Jones-Berry S (2017), cited in Buchan *et al* (2019).

¹⁴ Based on cohorts completing in academic years 2013/14 and 2014/15, attrition varied from 29 per cent to 39 per cent in children's and learning disability nursing, respectively (**Health Education England 2018h**).

¹⁵ Analysis of HEE RePAIR data (**Health Education England 2018g**), comparing the cohort expected to complete training in 2011/12 with the cohort expected to complete in 2016/17. Our analysis of this data suggests that attrition rates reduced by about a third for mental health and children's nursing, and 45 per cent for adult nursing, but rose by 8 per cent for learning disability nursing.

Converting medical school places to senior doctors

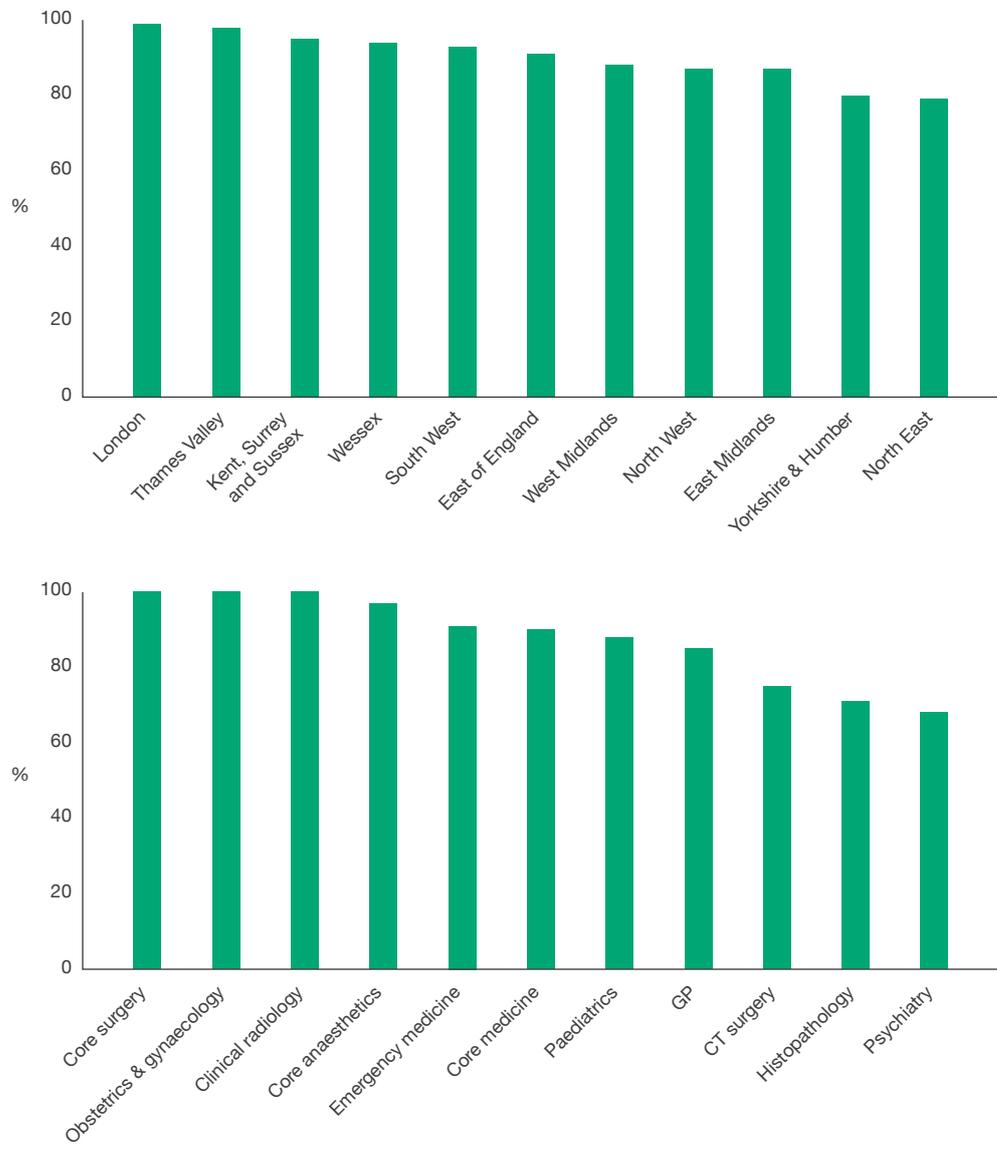
Even when training places are offered, there are challenges in ensuring that they are taken up. For doctors, there is very high demand for studying medicine at university, with more than 10 applications for each place (**Medical Schools Council 2018**). However, approximately one in ten specialty postgraduate medical training posts go unfilled (**Health Education England 2018f**). This varies considerably by specialty and geographical location. For example, one in five posts in the North East in 2015–17 (21 per cent) and a third of core psychiatry posts in 2017 (32 per cent) went unfilled (see Figure 2.5). The NHS Staff and Learners' Mental Wellbeing Commission has identified a range of factors affecting doctors during this transition, including increased clinical responsibility, reported unrealistic workloads, long working hours and inadequate staffing levels (**Health Education England 2019c**). For non-medical undergraduate courses, HEE has acknowledged that certain courses are struggling to be filled, such as podiatry and therapeutic radiography (**Health Education England 2017b**).

Given the very high costs of training doctors, reducing attrition in this area is particularly important. The way people are choosing to undertake training has changed and the NHS and the training pathways need to be flexible to accommodate this. The proportion of doctors completing their foundation training who progressed directly into specialty training in the UK has steadily declined over the past eight years, falling from 71 per cent in 2011 to 38 per cent in 2018 (**UK Foundation Programme 2019**). Many will rejoin a training route; however, for those finishing foundation training in 2014, one in four (24 per cent) had not started further training after three years. The NHS Staff and Learners' Mental Wellbeing Commission has advised that higher education institutions and NHS placement providers should 'proactively provide support for the transition stresses that students may face at course commencement, entering each clinical placement and on taking up their first graduate role' (**Health Education England 2019c**, p 43). Attrition rates also vary by gender and specialty with, for example, attrition rates for women in surgery training varying from 22 per cent to 75 per cent (**Hampton et al 2016**). Figure 2.6 sets out indicative levels of attrition throughout the course of training a new GP. The Royal College of Physicians recently estimated a 'loss' of one in four people from medical school to an appointment as a consultant (**Royal College of Physicians 2018a**), although it should be noted that not all doctors wish to continue into specialist training.

Recommendation

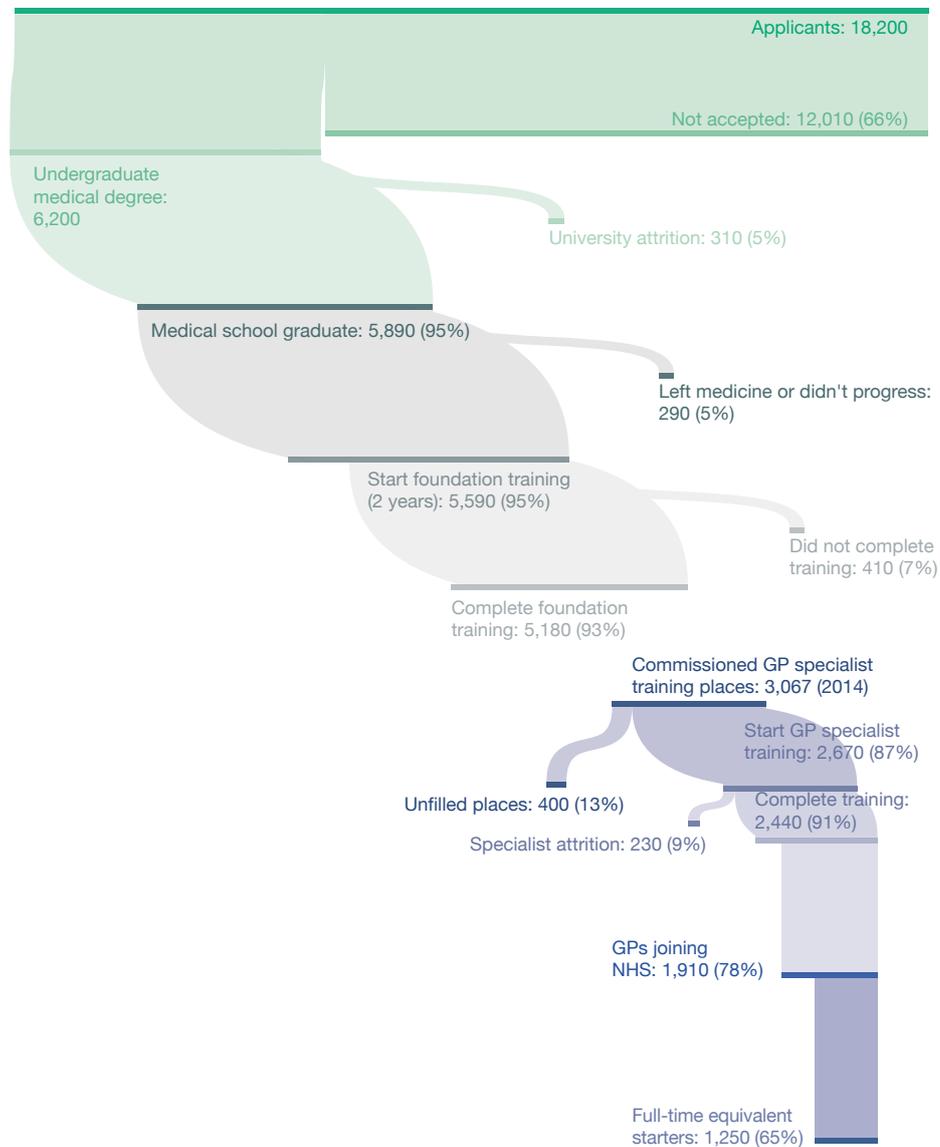
Taking comprehensive action to reduce attrition in training and increase students' participation in NHS services on qualifying could lead to improved value for the time and money invested in training and education by increasing the number of people joining the NHS workforce. Specifically, commissioners of undergraduate and postgraduate medical, nursing and allied health profession courses and placements should set conditions on the quality, success and balance of the training. Nationally, HEE – as the single largest funder – should consider issuing guidance to inform this. This must be informed by accurate monitoring of the level of, variations in and reasons for people not completing the training.

Figure 2.5: Fill rate for medical post-foundation training posts, by region (2015–17) and specialty (2017)



Source: Health Education England (2018a).

Figure 2.6: GP training pathway, represented with estimates for doctors starting their GP specialist training places in 2014



Notes: Figures are for the cohort who started specialist training in 2014 and, therefore, are likely to have started medical school in 2007 at the latest and joined the NHS in 2017 at the earliest. Due to limitations in the underlying data, these figures should be treated with caution and are presented for indicative purposes only. A significant number of doctors join the cohort during the training pathway, including non-UK medics at the start of foundation training. For simplicity we only capture this inflow at the stage of starting specialty training, which is depicted by the break in the figure above at this stage.

Source: Nuffield Trust analysis of data from the General Medical Council, the National Audit Office, the Royal College of General Practitioners, UCAS and the UK Foundation Programme.

Participation in NHS services on qualifying

Too many people are choosing not to work in the NHS on completing their training. *The NHS Long Term Plan* seeks to address this, in part, by offering a five-year NHS job guarantee for nurses and midwives within the region they qualify (**NHS England 2019c**). Either way, national workforce planners need to account for the demand for staff in all sectors, including the independent sector, if they are going to deliver a sufficient number of new staff. Efforts to do so are constrained by a lack of information; NHS Digital publishes statistics on the workforce employed by independent health care providers but they are limited and do not represent the entire workforce employed across the whole of this sector. In addition, general practices, local authorities and private and third sector providers have also regularly not provided workforce plans to inform regional and national planning (**National Audit Office 2016**). While most medics (99 per cent) and other health professionals (96 per cent) entered employment or undertook further studies in 2016–17 after completing their degrees, participation in public clinical services appears much lower, particularly for some groups, as illustrated below.

- While 81 per cent of nurse graduates joined the hospital sector, 4 per cent joined primary care and 2 per cent joined residential care, a large number went on to 'other health' (8 per cent) and non-health (5 per cent) activities (**NHS Pay Review Body 2018**).
- Participation in public clinical services among graduates from other Agenda for Change¹⁶ related health degrees was lower, with over two-fifths (42 per cent) of graduates going on to 'non-health activities'.
- The number of new doctors (aged under 30 and who qualified in the UK) joining the General Medical Council register annually has fallen, from 6,868 in 2014 to 6,579 in 2018 (**General Medical Council 2018a**). Data also suggests that joiners to the GP workforce aged under 40 in the year to March 2018 were contracted to work the equivalent of two-thirds of a FTE post on average (**NHS Digital 2018a**).

Apprenticeships

The promotion of apprenticeships across the economy is a key government policy, and has significant implications. In health and social care, around 420,000 people started apprenticeships in the six years to 2017 (**Health Education England 2017b**). Social care alone holds the largest market share of all sectors, with 19 per cent of all apprenticeships in 2016/17 (92,000 starts) (**Skills for Care 2018b, 2018c**). That said, given the need to understand progress, the lack of available data on apprenticeships in these settings and where people move on to after they have completed their apprenticeship is concerning.

The policy has changed over time with, since 2017, all large UK employers being required to contribute 0.5 per cent of their pay bill towards the cost of apprenticeships (**NHS Pay Review Body 2018**).¹⁷ Smaller employers – such as many GPs and small social care organisations – who do not make payments into the apprenticeship levy can still access it to pay 90 per cent

¹⁶ Agenda for Change is the national pay system for NHS staff, excluding doctors, dentists and very senior managers.

¹⁷ Large employers being defined as having a pay bill of more than £3 million.

of their apprentices' training and assessment costs. As at 2017, the NHS alone was expected to contribute £200 million a year to the levy and, to recoup this, the NHS would need 27,500 apprentices annually (**NHS Pay Review Body 2018**; **Department for Education 2017**). In the three months to October 2018, 5,270 people had started as levy-supported, 'health and science route' apprentices, although this figure includes any apprentices hosted by other large employers outside of the NHS, such as pharmaceutical companies (**Department for Education 2019a**). From April 2019, levy-paying employers will be able to transfer a quarter of the value of their annual levy fund to another employer (**NHS Employers 2018a**). However, there is currently limited regional co-ordination on the use of the levy, including between organisations and sectors (**Fox et al 2017**).

By offering paid employment and protected learning time to work towards a qualification, apprenticeships have the potential to support wider participation and career progression. The programme is popular with older entrants and attracts people from diverse backgrounds (**Skills for Care 2018b**). In addition, apprenticeships represent a key way for some NHS and social care employers to maximise recruitment from their local labour economies and offer a clear career progression from support worker through to degree or postgraduate level (**NHS Employers 2018c**).¹⁸ Apprenticeships also provide career development for existing staff, with NHS trusts intending to spend 80 per cent of their levy on internal staff (**BPP University 2018**).

Despite the potential, apprenticeships have yet to represent a route to solve key workforce shortages. The apprenticeship model has also been delayed; in late 2016, the government announced support for up to 1,000 nurse degree apprenticeships each year, yet the first start was not until September 2017 (**Health Education England 2017b**) and, in the year leading to July 2018, only around 300 had started (**Department for Education 2019b**). More recently, *The NHS Long Term Plan* reiterated the bold ambitions for apprenticeships, suggesting that 7,500 new nursing associates will start in 2019 (a 50 per cent increase on the ambition for 5000 starting in 2018; **NHS England 2019c**). There were 2,975 people starting nursing associate apprenticeships in the 17 months to December 2018 (**Department for Education 2019b**). However, the long-term plan also accepts that the terms of the levy may need to change if the NHS is to provide opportunities to more clinical staff in the future. The ambitious expectations for nurse associate apprenticeships suggest that they could eventually deliver around 2,400 additional qualified nurses each year from 2021, although there is a large degree of uncertainty over whether this level can be achieved (**House of Commons Health Committee 2018**). Employers also continue to face difficulties, particularly as the levy:

- cannot be used to cover backfill costs when apprentices are on training – despite, for example, in the region of 60 per cent of nursing degree apprenticeships being off-the-job training
- does not cover training for those supervising, assessing and mentoring apprentices
- will be redistributed to other sectors if unused by NHS employers after two years

¹⁸ For example, eligible applicants to the nursing degree apprenticeship include health care assistants, local school and college students, and assistant practitioners.

- is capped per course, making some more-intensive apprenticeship routes financially unviable – for example, it would cost a trust around £140,000 over and above the levy for a nurse apprenticeship (the highest funding band only offers up to £27,000) compared with no cost for undergraduate nursing (see Table 2.2).

Table 2.2: Estimated cost of nurse training

Nursing course	Years	Cost to student	Cost to NHS trust
Undergraduate	3	Around £28,000 in tuition fees ^a	£0 ^b
Apprenticeship	4 ^c	£0 – instead paid a salary of around £20,000 a year ^d	Around £140,000

Notes:

- This figure excludes wider costs of training (eg, living costs) but also does not account for the 'loans subsidy' for those graduates who do not fully repay the loans taken to cover their tuition fees.
- Trusts have costs in providing mentoring and supervision during clinical placements although they receive funding for hosting these.
- There is an intention that some people with prior learning may be able to complete a nurse degree apprenticeship in fewer than four years.
- This figure has been calculated as a spot salary based on NHS Employers' interim pay guidance ([House of Commons Education Committee 2018](#)). As there are no formal agreements in place at the moment, pay offers are determined locally, with reference to NHS Staff Council guidance ([2017](#)).

The government review of the apprenticeship programme has been postponed from 2018 to 2020. To improve apprenticeship quality rather than quantity, the House of Commons Education Committee ([2018](#)), the Royal College of Nursing ([2018d](#)) and The Confederation of British Industry ([2018](#)) have published recommendations to address the immediate challenges. In particular, the House of Commons Education Committee ([2018](#)) recommends allowing NHS employers to use their apprenticeship levy to cover backfill costs¹⁹ and that the Institute for Apprenticeships considers increasing the funding band for nursing degree apprenticeships. In this context, we are concerned that the government's response to the Education Committee does not adequately set out suitable alternatives to address the immediate challenges ([House of Commons Education Committee 2019](#)), and so we are recommending that the government revisits these issues. Certainly, some action will need to be taken to ensure that this can become a serious and viable training route for all providers that would benefit.

¹⁹ For apprentices who are required by the Nursing and Midwifery Council to be supernumerary for more than 20 per cent of their contracted hours.

Recommendation

While apprenticeships will not be a quick fix for some of the fundamental workforce challenges, they can support social mobility and widen participation particularly from the local workforce. They therefore need to become a serious and viable training route. To make this happen, we recommend – based on proposals by NHS Employers and the Education Select Committee – that the Institute for Apprenticeships considers an increase in the maximum funding level, more flexibility on how the apprenticeship levy is used (including covering backfill costs) while protecting learning time, and greater regional co-ordination including between health and social care settings.

Conclusion

Recurring over-optimism and a lack of proactive intervention have meant that the training pipeline has repeatedly failed to deliver the right number of staff in the right places. Health and social care need to be attractive employers to ensure a sufficient number of applications and they need to provide high-quality training in the right specialties and locations to meet the demand for staff. A common theme is that financial incentives – whether for prospective students, universities or health and care providers – are not aligned in a way that will deliver the considerable increase in the supply of staff that is needed. *The NHS Long Term Plan* proposes a range of targets and measures to improve supply ([NHS England 2019c](#)) – and the ambition is welcome – but many remain untested or, as yet, unfunded. In this chapter we have therefore identified a number of areas of promise that – alongside reviewing the funding arrangements – should be investigated further, including local collaborations to tap into the local workforce, and increasing and improving the training offer in primary and community care.

As part of our work, we explored the potential effect and costs of adopting the key recommendations outlined in the chapter. These estimates on the potential supply of newly trained staff focus on two key groups: nurses in hospital and community services and GPs. To do so, we compared the potential effect of taking urgent action on training new staff, including adopting the key recommendations outlined in this chapter, to the likely supply if nothing changes. Our forecasts suggest that acting decisively now could provide around 10,000 more newly trained adult nurses by 2024 (with a combined 89,100 newly trained staff joining over the period compared to 79,100 in our baseline scenario) and 54,400 by 2029.²⁰ For GPs, we estimate in the region of 500 more in our best-case scenario by 2024 (with 8,000 as opposed to 7,500 newly trained GPs joining over that period) and more than 2,000 by 2029.²¹

²⁰ These figures are based on there being 164,300 nurses in our baseline scenario compared with 218,700 nurses in the best-case scenario by 2029.

²¹ These figures are based on there being 15,200 GPs in our baseline scenario compared with 17,200 GPs in our best-case scenario by 2029.

We have estimated the costs of implementing our recommendations. Limitations to existing information on training costs and uncertainty over the future number of students mean that it is not possible to cost these scenarios precisely. However, our exploratory analysis to estimate the possible central costs of supporting our recommendations suggests that they could be up to around £710 million a year (in 2018/19 prices). They include placement costs, other supplementary funding, loans subsidy, tuition fees and the proposed cost-of-living grants for nursing degrees. They also include costs for extra placement fees and salary support for GPs in training – reaching £69 million a year (see Table 2.3). Some of our recommendations do not have overall cost implications.

Table 2.3: Estimated additional cost of training recommendations (2018/19 prices)

Funding body	2019/20	2020/21	2021/22	2022/23	2023/24
For nurses					
HEE	Up to £360 million	Up to £410 million	Up to £500 million	Up to £550 million	Up to £560 million
Office for Students, Department for Education or Student Loans Company	–	–	Up to £50 million	Up to £70 million	Up to £80 million
For GPs					
HEE	£16 million	£39 million	£62 million	£69 million	£69 million

Notes: The figures presented are broad estimates to give an indication of the scale of funding required. In particular, costs will be lower if the intended increases in training numbers are not achieved. We have had to make a number of assumptions, including, for the nursing costings, that some of the central costs are for English domiciles only and that funding is already available for 10,000 additional clinical placements since this is an existing commitment (although that also covers midwifery and allied health professionals, meaning that the actual costs could be slightly higher). Our figures for GPs show the maximum level which includes both placement fees and salary contribution to cover the additional GP specialty training places. A lower cost will be accrued if, for example, places are filled by reducing specialty training for non-GP medical routes.

3. Pay and reward: ensuring pay policy supports recruitment and retention

Ben Gershlick and Anita Charlesworth, The Health Foundation

Key messages

- Pay is the biggest single cost in delivering health care, and as a result is often one of the first ways in which costs are contained. However, this will have implications for the attractiveness of working in the NHS, and for the morale and retention of the staff already working in the NHS. Pay in the NHS has been capped or frozen since 2010/11, as in much of the public sector, resulting in the real-terms value of a nurse's starting salary being reduced by almost 10 per cent between 2010/11 and 2017/18. However, a new pay deal was agreed in 2018, which ends the 1 per cent cap on pay increases, at least until 2020/21, with a 6 per cent pay increase in a nurse's starting salary over and above inflation.
- Pay must continue to at least keep up with inflation after this point, but it must also keep up with pay growth in the rest of the economy. While the current pay deal may help in terms of retention and morale among staff, this can quickly be undone by pay rises that are below inflation and below increases in whole-economy earnings once it ends.
- Pay rises in the NHS need to be targeted – focusing on occupations and specialties with hard-to-fill vacancies. We recommend that this becomes part of the Pay Review Body process. There are an existing and growing number of occupations and specialties in shortage. Financial incentives alone will not solve the pernicious lack of supply for shortage areas in the NHS. However, as part of the pay review process, targeted increases, loan write-offs and 'golden hellos' should all be looked at. To prevent the piece-meal implementation of targeted pay rises the Pay Review Body should be tasked with providing a coherent recruitment and retention-driven framework for these decisions for these occupations. As well as using the existing national capability and pay determination system in a more targeted way, more needs to be done to understand why local pay flexibilities are not being used.
- *The NHS Long Term Plan* sets out a future of 'genuinely integrated', joined-up, fluid working between acute and primary care and health and social care ([NHS England 2019c](#), p 6). While pay and terms and conditions cannot make this

happen, they can be a barrier to it. Understanding the challenges will not be straightforward. Therefore, we recommend that the NHS Pay Review Body looks into this issue and identifies any areas that will require further harmonisation in order to allow local areas to make progress towards the ambitions in *The NHS Long Term Plan*.

- There clearly remain considerable issues with inequality progression opportunities in the NHS, resulting in pay gaps and impacting on the pay and experiences of staff, including female and black and minority ethnic staff. It is also inconsistent with the values of the NHS. This has been a persistent inequity and action should be urgently taken at all levels of the system to understand the causes of and solutions to it.
- While local organisations make employment decisions locally, the Department of Health and Social Care sets national pay policy – it sets the remit for the NHS Pay Review Body and then makes a decision on its recommendations. As a result, *The NHS Long Term Plan* – led by NHS England and NHS Improvement – did not address any of the fundamental challenges for the pay system over the next five to ten years. With regard to the review of the gender pay gap for doctors, the long-term plan rightly points out that the issue is much broader and commits to a new 'chief people officer' to 'consider what more we need to do' (**NHS England 2019c**, p 87). While the NHS is constrained in its ability to set pay policy, it is not powerless, and the long-term plan could have done much more to set out the ambition and vision for how the NHS will use its pay and benefits levers to improve equality, retention and morale.

Introduction

The NHS is a labour-intensive sector. More than £50 billion is spent on the pay bill for NHS trusts (**Department of Health and Social Care 2019a**) – more than on defence and international development combined – and around two-thirds of NHS providers' spending is on staff costs. This reflects the nature of the work: hospitals, primary care and social care are primarily systems that are centred on people caring for people. It also means that any changes to pay need to be understood in the context of the wider finances of the NHS, as even a 1 per cent uplift in pay increases spending by more than £500 million. Therefore, it is important to make good decisions about pay, with a thorough understanding of the impact of pay increases on staff morale, recruitment and retention.

It is impossible to disconnect NHS pay from NHS funding. At a time of NHS funding constraints and austerity, NHS pay is inevitably a target for control. However, if sustained over a period of time, this is likely to demoralise staff as they see their pay rates fall behind others and their earnings eroded by inflation. This in turn will lead to increasing pressure for 'catch up' awards to be above inflation. This is exactly what happened repeatedly in the NHS in the 1950s, 1960s and 1970s – and was one of the reasons for establishing the NHS Pay Review Body in the early 1980s (**Buchan et al 2017a**). (The role of the NHS Pay Review Body is to make recommendations on the remuneration of Agenda

for Change staff,¹ but in doing so to have a number of considerations, including the need to recruit, retain and motivate suitably able and qualified staff; regional/local variations in labour markets and their effects on the recruitment and retention of staff; and the funds available to the health departments: **NHS Pay Review Body 2018.**)

In particular this chapter addresses the opportunity to be more flexible and targeted with pay, using a range of specific pay and non-pay measures, such as wider terms and conditions to address existing shortages and problem areas for recruitment and retention, as set out in Chapter 8, it is important not to think about NHS or social care pay in isolation, instead understanding them together – in terms of both the overlapping staff between the two sectors and their place in the wider labour market, especially in local areas. This is also across other sectors, including the voluntary, community, and private sectors.

Role of pay as an incentive

A lot of people who choose to work in the NHS or social care do so partly because of some intrinsic motivation. The NHS is a source of pride for a significant number of people across the UK, and many people go into the care sector with the desire to 'do good' (**While and Blackman 1998**). But this does not mean that the people who work in the NHS are a limitless well of goodwill, which can be drawn from without adequately compensating them. It also does not mean that NHS staff are immune to being demoralised by a real-terms reduction in pay. In the 2017 NHS Staff Survey, the number of staff either satisfied or very satisfied with their level of pay has dropped 6 per cent between 2016 and 2017 to 31 per cent. This was its lowest level in 10 years (**NHS England 2018d**).

One survey found that 56 per cent of a sample of trusts think that the NHS pay squeeze has had 'some impact' on recruitment and retention and 11 per cent a 'significant impact' (**The Smith Institute 2015**). The number of people citing a 'better rewards package' as their reason for leaving their role has increased by 87 per cent since 2011/12, in particular among ambulance staff, although this is lower than the growth in the number of people citing 'work-life balance', and has stayed stable as a percentage of all cited reasons over the period (**NHS Pay Review Body 2018**). This underlines the fact that pay alone cannot solve problems such as workload, bullying and a lack of career progression. But as the NHS Pay Review Body states, the total reward package 'can have a significant influence on retention. The financial and other elements of the package can impact on specific aspects of the employee experience for individuals' (**NHS Pay Review Body 2018**, p 83).

Recent trends in pay

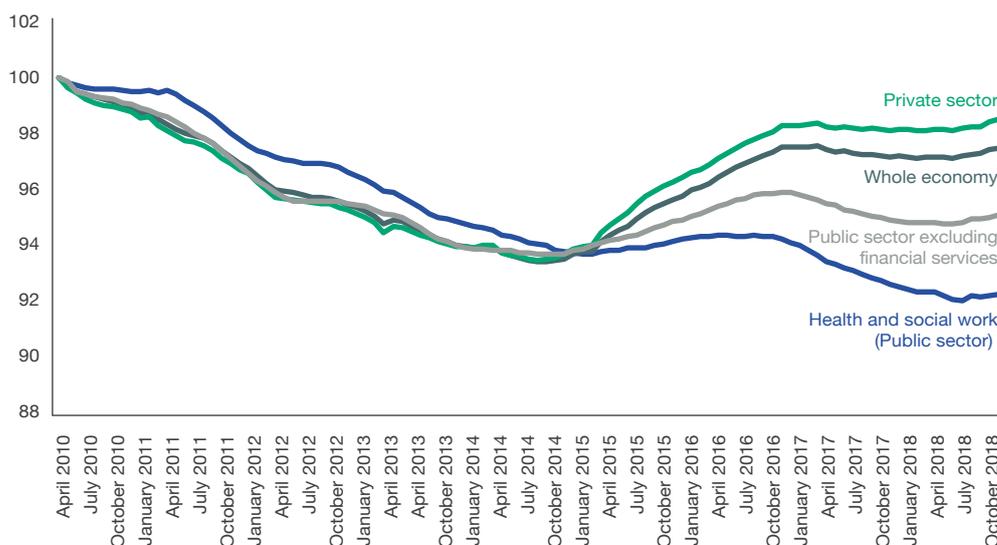
In an effort to constrain costs, staff pay was capped or frozen from 2010/11 up until 2017/18. The result was that the real-terms value of a nurse's starting salary reduced by almost 10 per cent between 2010/11 and 2017/18 (compared to the Consumer Price Index; **Office for Budget Responsibility 2018**). This resulted in a relative decline in the

¹ This covers most staff who work in the NHS, including for example nurses and support staff, but not doctors, dentists or very senior managers.

purchasing power of new NHS staff and it is also likely to have made the NHS a less attractive career option. An NHS Pay Review Body report found that 'NHS recruitment, retention, motivation, earnings and patient experience across the country are indeed linked to NHS pay relative to local private sector pay' (NHS Pay Review Body 2012, p x). This is a period – during the recession and in the period of austerity that followed – when wages were falling across a number of jobs. This can be seen in Figure 3.1, with pay across the economy falling by around 6 per cent between 2009/10 and 2014/15. There is some evidence, however, that wages outside of health and social care have risen in recent years.

However, it is important to note that while pay scales have fallen in real terms, this may not be the experience of individual members of staff, and that the pay system provides some protection against large pay cuts. Recent research suggests that NHS nurses and nursing auxiliaries were relatively protected from the impact of the recession and austerity compared with comparable staff groups such as private nurses (Bryson and Forth 2017). For them, staff salaries on average increased over the period 2005–15 in real terms, whereas for comparable non-NHS staff they fell. This is consistent with other evidence (Department of Health and Social Care 2018c). This is not necessarily surprising – the Agenda for Change pay system has built-in pay progression, and the NHS Pay Review Body can protect against big cuts to wages for NHS staff, in particular cash-terms cuts. However, the falling real value of the NHS pay scale, combined with the fact that many staff progress to the top of a pay scale, can cause mixed experience of pay increases across different staff. NHS staff are also not constrained to doing comparable roles elsewhere, and may respond to pay increases in other industries.

Figure 3.1: Change in real earnings of staff in different sectors, UK, 12-month rolling average, 2010 = 100



Source: Monthly Wages and Salaries Survey, Office for National Statistics. Earnings show total pay including bonuses and arrears.

In July 2018, a new pay deal was agreed for Agenda for Change staff across the NHS until 2020/21. This covers most staff in the NHS – except for doctors, dentists and very senior managers – and the deal represented the biggest change to NHS staff pay since the pay cap and freeze was introduced. The size of the increase varies by spine point, but if staff progress through spine points via pay progression, the increases could in cash terms be between 4.5 per cent (for those previously earning £100,000) and 29.0 per cent (for those previously earning £32,000). This means that almost all staff are likely to receive real-terms pay increases between 2017/18 and 2020/21, including the roughly half who are at the top of their bands.

This will be a welcome increase to staff salaries, and may help to improve recruitment and retention. The 2018 staff survey saw an improvement in the percentage of staff satisfied with their level of pay, perhaps linked to the new pay deal.

After the pay deal

The pay deal provides a return to growth for NHS real wages until 2021. However, the positive impact this may have on relative staff wages, morale and retention can quickly become undone. If this period of real pay growth ends in 2021/22 rather than becoming the new 'normal', then any impact will not last long. A new pay deal for after this period will need to be nuanced and targeted in the approach it takes and how it uses pay as an incentive, as we discuss below.

The deal must maintain growth at least in line with inflation for all staff. The current deal provides this – with the lower end of growth for some staff of 6.5 per cent being roughly in line with expected inflation. This would be equivalent to growth of 2 per cent a year from 2021/22 onwards by the latest projections for Consumer Price Index inflation from the Office for Budget Responsibility ([Office for Budget Responsibility 2018](#)). However, as set out above, it is important not just that NHS staff's pay grows in line with the cost of living but also that it keeps up with pay in other areas of the economy. The current political and economic climate means that there is considerable uncertainty about what this will be in five, let alone 10, years' time but current projections from the Office for Budget Responsibility are for earnings growth to be 1.2pp above inflation from 2021/22 onwards ([Office for Budget Responsibility 2018](#)).

This is what any new pay deal will need to provide if the NHS is going to avoid the morale, recruitment and retention challenges that come with becoming a relatively less well-paid career option. The next two years of sufficient pay increases cannot be the exception rather than the norm.

Recommendation

Pay in the NHS should continue to rise in real terms after the end of the current pay deal for all staff, and should rise in line with wider economy earnings to ensure that as few staff as possible feel undervalued, leave the NHS or never join in the first place, due to poor remuneration.

Importance of pay for the lowest-paid staff

The 2018 pay deal was a targeted increase, with the biggest increases focusing not on the highest earners but on those below Band 8 (which in 2018/19 starts at £42,000). The deal includes increasing minimum basic pay in the NHS to 'ensure the NHS in England retains a competitive market advantage in the jobs market for staff employed at this level' ([NHS Staff Council 2018](#), p 6).

By not targeting increases at the higher pay bands, the NHS Staff Council has clearly understood the potential issues in the competition for staff at this lower end of the labour market. This competition is caused by a number of factors, including question marks over future immigration rates, a low unemployment rate and an increasing national minimum wage.

But this is not the only area where the NHS will face challenges. There are existing and growing shortage occupations and specialties covered by the Agenda for Change remit, which have not been targeted as part of the pay deal. For example, there have been reductions in the number of staff working in mental health nursing (-11 per cent from September 2010 to 2018) and learning disability nursing (-37 per cent). At the same time, there have been reductions in the number of nursing students starting mental health and learning disability courses in 2017, partly due to a wider reduction in the number of mature students studying nursing.

Pay flexibility and other financial incentives

Financial incentives alone will not solve the pernicious lack of supply of staff for shortage areas in the NHS. However, as set out in Chapter 2, more can be done to target these areas. Pay supplements, loan write-offs and 'golden hellos' should all be explored to encourage staff to join and stay in these shortage areas. There is a precedent for this already in the NHS, with a £10,000 golden hello for district nurses being introduced, although there are some remaining issues with implementation ([Thomas 2018](#)).

If the policy priority is to use pay as a lever to enable and implement local change and additional workforce flexibilities, then it should first be noted that the current flexibilities in the NHS pay system are not being used to full effect. Local management capacity does not currently exist in all NHS trusts to handle local pay determination effectively (this was a factor in the failure of NHS 'local pay' reforms in the 1990s) and pay strategy should be integrated in an overall workforce development strategy, rather than determined in isolation ([Buchan et al 2017b](#)).

This is not a reason to further centralise pay determination (if it is possible to centralise it further), but instead to understand why the use of recruitment and retention premia is low and declining, what the local capability gaps are and how to best take a holistic approach to pay rather than just focusing on basic pay increases. Part of this will involve using the existing national capability and pay determination system in a more targeted way.

There is some evidence that the supply of substantive staff is amenable to targeted interventions in this area – most recently there are lessons that should be reviewed from how agency and locum price caps have worked, which could inform future pay policy.

Pay flexibility has traditionally been underused in the NHS, and allowing more national and local targeting of pay supplements or enhancements to particular shortage roles, identified by the NHS Pay Review Body, could help to correct the result of some of the current failures in workforce planning. Any options should not be taken lightly or without due process, but the NHS must use all tools at its disposal to improve supply, morale and retention in these important shortage roles.

To prevent the piecemeal implementation of targeted pay rises the Pay Review Board should be tasked with providing a coherent recruitment and retention-driven framework for these decisions for these occupations.

Recommendation

The Pay Review Body identifies shortage occupations and recommends the appropriate structure and amounts of pay premia, loan write-offs and 'golden hellos'. To prevent the piecemeal implementation of targeted pay rises the Pay Review Body should be tasked with providing a coherent recruitment and retention-driven framework for these decisions for these occupations. There also needs to be an examination of why local flexibility has not been used more with pay, and how areas can be supported to respond to their own shortages of certain staff.

Progression and pay gaps

One area where pay and progression must be taken more seriously is ensuring that NHS staff are paid fairly. This should not be done in an instrumental way to improve recruitment, but because it is the right thing to do. As set out in Chapter 5, black and minority ethnic staff continue to be underrepresented in the upper tiers of the NHS, resulting in lower earnings for these staff. This is also true when it comes to gender. A recent paper shows that, within nursing, men are overrepresented at senior bands and attain higher grades faster than women ([Punshon *et al* 2019](#)).

Since 2018, large organisations have been required to publish data on their gender pay gaps – the difference in the average hourly wage of all men and women in their workforce. In 2017, data for directly employed NHS staff in the English health service – 77 per cent of whom are women and 23 per cent of whom are men – shows that the estimated median basic full-time equivalent (FTE) pay gap between men and women was 8.6 per cent in favour of men. This was equivalent to an earnings gap of £207 a month ([Appleby and Schlepper 2018](#)). The gap was significantly greater for women in certain ethnic groups. Asian/Asian British and Chinese women experienced the largest gender pay

gap at 21.3 per cent and 20.9 per cent respectively, followed by those of mixed ethnicity (13.5 per cent), white women (6.1 per cent) and women of any other ethnic background (2.1 per cent). Only for black/Black British staff was the gender pay gap in favour of women (2.2 per cent). While the overall ethnic basic pay gap was 5.2 per cent in favour of people from black and minority ethnic groups, this conceals significant negative differences within different staff groups. For Asian/Asian British managers (including senior managers) and nurses the pay gap was 10.8 per cent and 8.5 per cent respectively in favour of white staff ([Health Foundation et al 2018](#)).

Recommendation

There clearly remain considerable issues with inequality in pay and progression opportunities in the NHS. This has a negative impact on the pay and experiences of staff, including female and black and minority ethnic staff, and is inconsistent with the values of the NHS. This has been a persistent inequity and action should be urgently taken at all levels of the system – led and supported by NHS England – to understand the causes of and solutions for it.

Pay harmonisation across sectors

The NHS Long Term Plan sets out a vision of integrated and fluid working across the health system and between health and social care ([NHS England 2019c](#)). It is one of 'the "triple integration" of primary and specialist care, physical and mental health services, and health with social care' (p 10); of 'genuinely integrated teams of GPs, community health and social care staff' (p 6); of 'expanded teams across groups of neighbouring GP practices who work together... and with local NHS, social care and voluntary services' (p 34); and 'flexible teams working across primary care and local hospitals, developed to meet local needs, including GPs, allied health professionals (AHPs), district nurses, mental health nurses, therapists and reablement teams' (p 14).

For a number reasons, many of them good reasons around flows of finances or the mechanism for the employment of staff, there is a disconnect between pay and terms and conditions between these different areas.

Clearly the future of health is not in these silos but in joint working. With more of health and social care focusing on supporting people to manage their chronic conditions – complex patients with a range of acute and less-acute needs – this flexibility needs to be reflected in the way the NHS employs its staff. A result of this might be more opportunities for staff to move between acute, primary and social care.

But trying to do too much too soon is likely to do more harm than good. In particular, the goal of harmonisation should not be to provide crude, inflexible and identical rates of pay across all sectors – it is important not to homogenise pay arrangements for a diverse group of workers in health and social care. Rather, in the first instance,

harmonisation should be focused on understanding the barriers to joint working – licences, training and so on – and looking at what can be done centrally or regionally to allow staff to work across organisations more easily. And even within organisations, such as within the contractor professions in primary care, which can encourage competition rather than co-operation, for instance between GPs and pharmacies.

For example, staff needing to redo basic training when moving between care sectors can be inefficient compared with having accredited training schemes. But looking over a longer horizon, more thought needs to go into what the publicly funded health and social care system's offer is to staff, and whether or not that involves guaranteed and consistent levels of pay, training and portability.

Pay and terms and conditions cannot make integrated, fluid working happen, but they can be a barrier to it. If this is the future of health and care provision, then pay and terms and conditions need to be taken seriously. This will not be straightforward and we are recommending more analysis goes into these barriers before changes are made.

Recommendation

We recommend that the Department of Health and Social Care asks the NHS Pay Review Body to look into potential ways in which pay and terms and conditions could be a roadblock to working in a more joined-up way.

Conclusion

Pay is not the main reason why people choose to work in health or social care, nor is it the main reason why people leave the NHS. But it is a mechanism that, if used sensibly, can help to attract people into health and social care, and motivate them to stay there. Over the past decade, the real-terms value of the NHS's Agenda for Change pay scale has been falling, while financially distressed social care providers have struggled to compete with other sectors.

For the NHS, it is important that its pay bands do not return to the real-terms reductions they have experienced since 2010. But pay must also retain its relative value by rising in line with earnings in the wider economy. While the current pay deal may help with staff recruitment, retention and morale, this can quickly be undone by below-inflation pay rises once it ends.

The NHS has shortages in specific areas among Agenda for Change staff. There are currently not enough nurses either able to or choosing to work in mental health and learning disability nursing. Targeted pay and non-pay financial incentives can help to attract people to these areas, but also financially support people who would otherwise not have the means to train.

The NHS needs to be more forward-looking when thinking about pay and reward conditions. Currently these can act as barriers to joint working across health and social care, and primary and acute care. If the future is as set out in *The NHS Long Term Plan* (NHS England 2019c), then part of the challenge will be working towards some harmonisation in this area, where local providers and areas are supported nationally to solve the challenges they identify.

4. A good employer: making the NHS a better place to work and build a career

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Key messages

- The NHS needs to focus on becoming a better employer. This must be an ongoing ambition for the NHS, reflected in every aspect of the NHS as a good place to work and to build a career. In this chapter we do not discuss the full range of actions that the NHS could and should take to become a better employer. Instead, we focus on the things that need immediate action. These include areas that cannot be ignored (such as diversity and inclusivity) and actions that can be undertaken now to improve the supply and retention of staff.
- The single most malleable and powerful influence on the culture of modern organisations is leadership. It is 'the way we do things around here'. Culture powerfully shapes how people deliver care, manage their work, interact with patients, colleagues and carers, develop and improve ways of delivering services. A greater understanding of the impact of leadership on culture is required across the NHS, in addition to specific actions on leadership, culture and talent management, which will be included in the forthcoming workforce implementation plan that was promised in *The NHS Long Term Plan (NHS England 2019c)*. The national arm's length bodies need to deliver on their pledges to change their behaviour and approaches.
- One area where the NHS has failed its staff is in its treatment of diversity and equality in employment and career opportunities. More than a quarter of black and minority ethnic staff do not believe that their organisation provides equal opportunities for career progression or promotion. Black and minority ethnic staff are also more likely to enter the formal disciplinary process compared with white staff. While the NHS has made progress in addressing inequalities in pay, evidence shows that disparities still exist (as set out in Chapter 4).
- Staff at the beginning of their career do not always have the required level of management support, in particular during transitions to roles with increased levels of responsibility. This can result in problems in their level of engagement and mental wellbeing, and in turn may make them more likely to leave the NHS. There needs to be

a greater understanding of the generational shift that is occurring in the workforce and the implications this may have for meeting the needs of staff. More needs to be done to support new staff, including continuing professional development and ensuring that staffing levels do not lead to an over-reliance on newly qualified staff. A key part of this will be giving less-senior staff clearer progression pathways.

- For staff towards the later stages of their career, there could be untapped potential through more flexible working and reduced participation. These staff would often like to continue to work, but the rigid structure of NHS employment and rostering means that there can be an 'all-or-nothing' approach, with long shifts and undesirable work-life balance.
- There are also unresolved issues with regard to pensions policy. The Department of Health and Social Care and HM Treasury need to provide clarity about and more flexibility in the NHS Pension Scheme to support people to manage their pension benefits.
- The NHS needs an explicit statement of the universal 'offer' to staff – including, but not limited to, their legal rights. The form of this should be explored with staff side representatives and employers but may be in the form of a compact covering not just fair treatment for all staff with protected characteristics but also what staff can expect from the NHS in terms of equal pay and opportunity, CPD, streamlining, supervision (especially in early career and during key transitions), work-life balance, proper appraisal, and non-financial benefits. This will require national leadership from NHS Improvement and NHS England both in terms of what this national offer is, and how they will support local employers to achieve it.
- Retention is largely a result of other aspects of people's experience in work. It is directly related to the leadership and culture of the organisation. People leave because they feel overworked, underpaid, poorly treated, unable to deliver good care, unable to progress, or some combination of all these things. And so it is important to understand how all these factors influence people's desire to stay in the NHS.
- There are, however, some areas where a particular focus is likely to have an impact on retention rates. An ongoing NHS Improvement retention programme has some early positive findings. Its evidence suggests that often this is the result of a more rigorous understanding of an organisation's data, leading to more targeted approaches to retention, and promoting better awareness and sustained implementation of existing policies, possible career pathways or opportunities.
- Many staff who leave the NHS may be open to returning to the service at some point. 'Return to practice' is a promising route to help staff re-enter the NHS, which has historically been targeted at nurses. Employers' expectations for return to practice are low. However, it has been much more successful in the past, suggesting that current targets underplay its potential. We recommend that a full review of return to practice is carried out to understand whether expectations are correctly calibrated and how schemes can be improved.

- The NHS needs to understand its role as part of a wider labour market and how it can work better in partnership with social care rather than competing with social care for staff. Given the ambitions in the long-term plan for greater integration between health and care, this should be embraced.
- *The NHS Long Term Plan (NHS England 2019c)* recognises the importance of retention to having an adequate supply of staff and includes a commitment to extend NHS Improvement's Retention Collaborative programme, which commits to improving staff retention by at least 2 per cent by 2025. This is an ambitious but achievable target. The challenge will be spreading the results across all trusts and sustaining the improvement, in particular after the 'quick wins' and in the context of an increasingly stretched NHS.

Introduction

The NHS as a good employer

Stepping up recruitment is not the only way to ensure the NHS has enough staff, and efforts to increase recruitment will be undermined if these staff are not joining a supportive environment that they want to stay in. In 2017/18, one in nine (135,000) staff left the NHS (*NHS Digital 2019c*), highlighting the scope to boost the workforce by improving retention.

Happy, motivated staff who enjoy their job are less likely to leave. This also brings other benefits. The link between staff engagement and patient experience is well established – more engaged staff provide better, safer care and are less likely to be absent (*West and Dawson 2012*). This also offers an opportunity to reduce costs – the average direct and indirect costs of replacing a member of staff in the NHS is £30,000 (*Oxford Economics 2014*).

This underlines the importance of being a good employer and treating staff well. Yet evidence suggests the NHS is falling short on this. Findings from the 2018 NHS staff survey (*NHS England 2019b*) reinforce this:

- 1 in 8 (13 per cent) of staff experienced harassment, bullying or abuse from staff in the previous 12 months
- 1 in 8 (13 per cent) experienced discrimination at work in the previous 12 months
- almost half (46 per cent) disagree that there are enough staff at their organisation to do their job properly
- nearly 2 in 5 (40 per cent) felt unwell due to work-related stress in the previous 12 months.

Nevertheless, there are grounds for optimism. Nearly three-quarters of staff (74 per cent) are often or always enthusiastic about their job and more than 4 in 5 (81 per cent) are satisfied with the care they provide to patients. The significant variation between NHS

organisations in staff engagement and attrition rates also suggests that improvement is feasible; there are examples of good practice that can be spread. The NHS should be ambitious about this.

If the NHS is to become a better employer, then this mission must permeate everything it does. In particular, there are a number of areas that NHS organisations (and the NHS as a whole) can and should focus on: compassionate and inclusive leadership, culture, internal communications, the work environment, employee engagement, flexible working, job satisfaction, training and development and ensuring sufficient organisational development support.

These are all important but we do not examine them all in this chapter. Rather, we look at a range of actions that the NHS should always focus on, such as equality and diversity, and pragmatic immediate actions that the NHS can take to encourage staff to stay in the NHS by becoming a better employer. This includes being a fairer and more equal employer, improving work-life balance for staff and providing more flexibility, and supporting staff better at the beginning and end of their career.

In this chapter, we set out six ways in which the NHS should channel that ambition and make progress in the short term:

- staff retention
- equal opportunities and diversity
- work/life balance
- support for staff at the beginning and end of their careers
- return-to-practice schemes
- enabling leadership at national and local levels.

Retention

The NHS should become a better employer for multiple reasons – including the intrinsic moral obligation to treat staff well, as well as instrumental benefits such as possible improved productivity. But a key result of this would be that staff are more likely to want to stay working in the NHS. Over the next five years, one of the few ways to reduce the gap between the number of staff working in the health service and the number that are required is improving retention. If it is possible to reduce the number of people choosing to leave the service then that can make a significant difference. It cannot be done overnight but is much faster and less expensive than recruiting or training more people. It is important to do both.

However, there are two more important reasons to focus on retention. First, with retention comes continuity – for both patients and other members of staff. Second, retention is a symptom of other things. People leave their jobs for a reason, and it is important to understand what those reasons are in order to be a better employer and be able to improve the experience and morale of people working in the NHS.

This second point is the most important. In other chapters of this report we look at some of the challenges and opportunities in terms of international recruitment, pay, skill mix and training new staff. These are the contexts in which staff operate when they decide to leave their job. Focusing on these areas, and making improvements in them, will lead to bigger benefits for retaining staff than focusing on retention alone.

Below we look at some of the specific challenges in retaining staff, but action to address them should be taken in the context of the wider set of reforms needed to improve the experience of staff working in the NHS – set out elsewhere in this report.

The scale of the retention challenge

Improved retention is necessary for greater workforce stability and availability, and improved access to quality care. And as the retirement age is increasing for many staff in the NHS, and in broader society, policies will need to focus on supporting the health and wellbeing of the health care workforce so that they can stay in work for longer. This is especially true as many staff are retiring early and more can be done to support them to work until retirement age.

Around one in nine staff – 135,000 people – left the NHS in 2017/18. Retention of NHS staff has – by most measures – deteriorated in recent years, although it has shown some signs of stabilising in the last year ([Buchan et al 2019](#)).

The problem of retention has been particularly marked with nurses. According to data from NHS Digital the number of nurses and health visitors leaving the NHS increased by 25 per cent from 2012 to 2018, from 27,300 to 34,100, although there is some indication that it has stabilised recently. There are now roughly as many nurses leaving each year as there are nursing vacancies. Another, broader measure is that the number of joiners to the Nursing and Midwifery Council register was less than the number of leavers in 2017 – meaning a reduction in the number of nurses licensed to practise in the UK.

Staff are often leaving their roles to work elsewhere in the NHS, with 40 per cent of nurses and health visitors leaving their organisation but staying in the NHS in 2017/18. While this is not as great a concern as people leaving the NHS as a whole, churn is an issue for health care providers. The average stability index¹ for NHS trusts (not including doctors in training) has decreased from 88 per cent to 85 per cent since 2010/11 ([Buchan et al 2017b](#)). Within this there is large variation between different regions and between trusts, with the average stability index at NHS trusts ranging from above 90 per cent to below 75 per cent.

¹ The average stability index shows the percentage of staff at the beginning of a given year who are still in their role at the end of that year.

Equal opportunities and diversity

One area where the NHS has failed its staff is in its treatment of equality and diversity in employment and career opportunities. The latest *NHS workforce race equality standard* report shows that a quarter of black and minority ethnic NHS staff do not believe that their organisation provides equal opportunities for career progression or promotion (**NHS Workforce Race Equality Standard 2019**). Also that black and minority ethnic staff are more likely to enter the formal disciplinary process compared with white staff and are much more likely to report personally experiencing discrimination at work (from a manager, team leader or other colleagues) within the past 12 months (in 2017, 15 per cent of black and minority ethnic staff compared with 6.6 per cent of white staff). The report also shows an increase in the number of black and minority ethnic staff in the NHS workforce since 2017; however, they are underrepresented at senior Agenda for Change pay bands. A total of 121 trusts (52 per cent of all trusts²) have no black and minority ethnic representation in the 'very senior manager' pay band (**NHS Equality and Diversity Council 2019**).

While the percentage of black and minority ethnic staff in NHS trusts and CCGs in Band 8a to very senior manager level has increased from 9.7 per cent to 11.2 per cent between 2016 and 2018, this is barely faster than growth in black and minority ethnic representation in the workforce as a whole, meaning the percentage of black and minority ethnic staff in these grades is still 7.7 percentage points lower than in the wider workforce.

These issues are not confined to just black and minority ethnic staff. For example, staff with disabilities report very high levels of discrimination; levels of reported discrimination in the NHS are higher against people with disabilities than against people in any of the other 'protected characteristics' groups (**West et al 2015**).

This issue exists in all areas of the health and care system and must be addressed at every level. As set out in Chapter 4, while the NHS has made progress in addressing inequalities in pay, evidence shows that disparities still exist. Inequalities are also reflected in clinical excellence awards, where black and minority ethnic doctors are underrepresented in applications (**Stevenson and Rao 2014**). In Chapter 2 on the supply of new staff from education and training, it is clear that the current support offer for nurses in training discriminates against those without the means to support themselves financially. Furthermore, the inflexibility of NHS employment can create issues for those with children or caring responsibilities, forcing them out.

Since April 2015 the Workforce Race Equality Standard (WRES) has been mandated through the NHS standard contract, and providers and commissioners are expected to show progress against a number of indicators of workforce equality. A number of NHS organisations have made progress and are providing visible and high-impact leadership on these issues, but across the NHS as a whole progress is not as rapid as it needs to be and there is considerable variation.

² Includes acute, mental health, ambulance and community provider trusts.

But the work by the WRES team has also encouraged and surfaced good practice. In Greater Manchester, for example, public sector employers (including NHS organisations, local authorities and others) have signed a collective commitment to make progress on race inequality. This commitment includes three outcomes indicators – including that black and minority ethnic applicants will be just as likely to be appointed from shortlisting as white applicants within three years, and that there will be a 10 per cent minimum shift in black and minority ethnic representation into more senior grades in organisations, taking into account an organisation's starting position.

Recommendation

The workforce implementation plan should map the good practice examples of local action to tackle racial discrimination, harassment, exclusion and lack of progression in the NHS. It should put in place a nationally led programme, building on the WRES, to learn from the best of these initiatives and support NHS trusts to adapt and adopt successful approaches so that all NHS organisations have concrete action plans to tackle race inequality in the NHS.

Tackling these issues is not easy and they often reflect wider structural issues in society, but the NHS can and must do more to ensure that it is a fair, equitable employer. An employer that attempts to provide equal access for equal need should also provide equal opportunities for equal ability. Part of this should involve greater clarity to staff about what their rights are and greater accountability when discrimination takes place. This can be done through existing routes but may require a 'compact' between the NHS and its staff, which sets out the expectations of NHS employers and the NHS's commitment to reducing the inequalities described here.

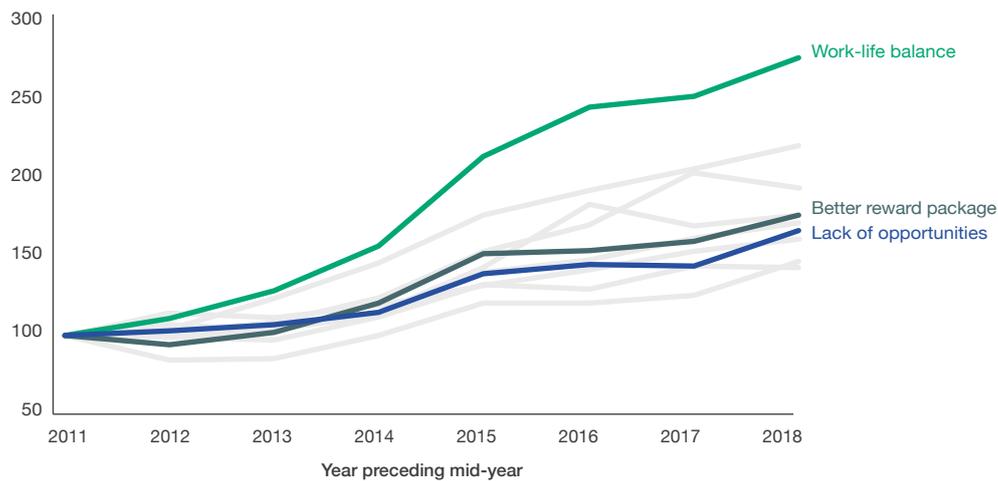
Work–life balance

The reasons why someone chooses to leave their job is a complex, personal decision, which can be the result of a number of things – such as work–life balance, pay, morale and job prospects. Over recent years, work–life balance in particular has increased as a reported driver, with NHS Digital data suggesting that more than two-and-a-half times as many people cited it as a reason for leaving the NHS at the beginning of 2018/19 than in 2011/12 (see Figure 4.1). While this is partly accounted for by more nurses leaving and increased data availability, it has grown from representing 18 per cent of stated voluntary reasons for leaving, to 26 per cent, where we have information. However, the limitation of this analysis is that the most common reason for leaving is reported as 'other/unknown'.

This lack of good-quality routinely collected information is compounded by the fact that research is limited in this area. A recent comprehensive review found that 'the evidence is not as definitive as previously presented from individual reviews. Further research is required, of rigorous research design, whether quantitative or qualitative, particularly against the outcome of actual turnover as opposed to intention to leave' (Halter *et al* 2017, p 824).

However, the review did identify nurse stress and dissatisfaction as important individual factors, and managerial style and supervisory support as important organisational factors ([Halter et al 2017](#)).

Figure 4.1: Reasons for leaving the organisation, 2011 to 2019 (2011/12 = 100)



Source: NHS Digital, NHS Hospital & Community Health Service (HCHS) workforce statistics.

Of respondents to a Nursing and Midwifery Council survey on why they left the nursing register (for a reason other than retirement), 44 per cent cited working conditions, including workload and staffing levels ([Nursing and Midwifery Council 2017](#)). This was higher than disillusionment with the quality of care provided to patients (27 per cent) and poor pay and benefits (16 per cent). Flexibility and work–life balance are therefore likely to be important areas to focus on, but not the only ones.

Despite greater awareness of the importance of safe staffing levels and the workload of staff (see Chapter 5), supply has failed to keep up with demand. This is partly because demand has risen, but also because supply has failed to keep up. This is concerning as half of staff in the 2017 NHS Staff Survey said that current staffing levels were insufficient to allow them to do their job properly ([NHS England 2018d](#)).

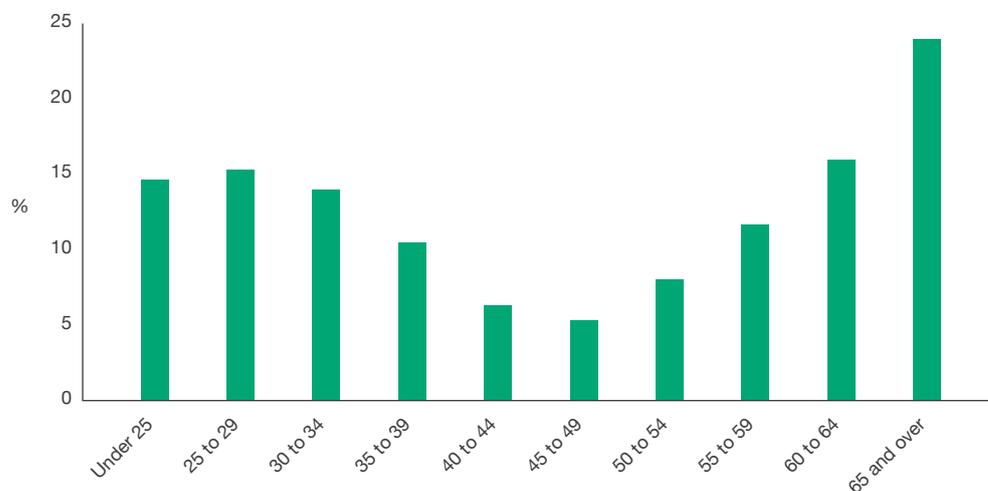
Worsening retention is not just a problem because it reduces the number of staff in the NHS, it can also decrease continuity for other staff, it can result in increased costs for providers as they have to recruit and train more staff and it can add a lack of stability in the lives of the staff themselves. There is a lack of good human resources data on the reasons why staff are leaving the NHS and where they are going. While it is important to understand this better, the data points to clear and worsening issues with workload and work–life balance. These must be addressed – not just to retain staff, but also to be a fair and supportive workplace for staff.

Support for staff at the beginning and end of their career

While the problems caused by workload are a major reason for leaving across people's careers, these issues can be most acute for staff at either end of their career path. Newly qualified nurses and doctors are undertaking roles with significant responsibility in the complex, at times 'sink-or-swim', environment of a stretched NHS. For staff towards the end of their career they may have significant experience but want to reduce their hours or focus on particular parts of their work in order to continue to work up to and beyond retirement age in a way that is consistent with the rest of their lives.

The rate of nurses leaving the NHS is 'J-shaped' over the age groups: relatively high among the youngest staff before decreasing and then rising sharply towards retirement age. This is likely to always be true. However, it shows that the biggest opportunity for decreasing the number of people leaving the NHS is likely to be in flattening the J by focusing on staff in the 25–29 age group in particular (which has the highest absolute numbers of leavers) and looking at ways of keeping staff working in the NHS as they approach retirement age, even if it is less than full-time.

Figure 4.2: Leaver rates from the NHS for nurses and health visitors, by age group, 2017/18



Source: NHS Digital.

As shown by the number of people citing work–life balance or workload as their reason for leaving the NHS, flexibility will be incredibly important. While the opportunities to improve retention rates may be highest among staff at either end of their career, the duty of the NHS to be a good employer exists throughout. The NHS employs a diverse group of people, including parents with child care responsibilities, people with caring responsibilities and people having to work multiple jobs. It is important that the NHS offers a career that is open to these people and provides the flexibility to respond to the needs and expectations of today's workforce. This requires leaders and managers to be better

at enabling staff's views to be heard and to engage with staff and be more flexible in their approaches to managing individuals and teams. All NHS organisations will have flexible work policies but the actual take-up varies hugely.

The Department of Health and Social Care and NHS Improvement have commissioned NHS Employers to run network sessions, including on new starters, on flexibility (including supporting experienced staff) and on development and career planning. Work should build on what is being learnt as part of these networks, rather than start from scratch (**NHS Employers undated**).

Support for recently qualified staff

Significant loss of senior, more-experienced staff can increase pressure on younger, less-experienced staff. This loss is one of many reasons why less-experienced staff do not always have the required level of support – particularly during transitions and the period following their preceptorship (a period of support and learning for newly registered nurses, with time protected in their first year of qualified practice). This can result in problems in their engagement and mental wellbeing, and in turn makes them more likely to leave the NHS (**Michie and Williams 2003**). Part of this will be helped using targeted interventions, but it will also require additional funding for continuing professional development.

As set out in Chapter 6, we are recommending that CPD funding returns to previous levels as a percentage of health spending, and this will allow NHS organisations to support these newly qualified staff better in terms of both their professional development and that of their managers. Some trusts have tried to do more to support recently qualified staff and staff in transitions. An example of this is Mid Yorkshire Hospitals NHS Trust, where they offer 'career crossroads clinics' where nurses at career crossroads can talk about training courses, secondments or sideways transfers (**Mid Yorkshire Hospitals NHS Trust 2017**). They also have a badge system for graduate nurses – where fresher nurses wear a blue badge to encourage colleagues to offer them more support.

More focus needs to be on supporting staff at the beginning and end of their career, particularly at transition points. For newly qualified staff this means increasing support beyond their preceptorship and making sure that there are adequate numbers of senior staff and sufficient CPD funding, to allow them to continue to learn in a safe environment.

Pensions policy

It is also important to focus on how to retain staff towards the end of their careers. Changes in pensions policy can influence patterns of work and rates of voluntary early retirement. Before recent changes to annual and lifetime allowances were introduced, few NHS staff would be likely to exceed tax thresholds, but this has now changed, particularly for senior medical staff.

The proportion of GPs who have taken voluntary early retirement has risen from 33 per cent to 62 per cent of all retirements since 2011/12 (**Review Body on Doctors'**

and Dentists' Remuneration 2018). The Review Body on Doctors' and Dentists' Remuneration clearly states that it remains 'concerned that changes to the ways in which benefits accrued as part of the NHS pension scheme are taxed may be having some impact' (**Review Body on Doctors' and Dentists' Remuneration 2018**, p 44).

For both hospital doctors and GPs, the combination of changes to the NHS pension scheme and lowering the thresholds of the pensions annual and lifetime allowances appears to have incentivised experienced doctors to retire early or to reduce their working hours. While some of these will 'retire to return', this requires them being re-employed, which is itself an inefficiency. NHS Employers report that membership levels of the NHS pension scheme for doctors have fallen by 1.4 percentage points from October 2011 to June 2018, potentially due to the impact of pension tax allowances. They also report that some trusts are struggling to recruit for higher earning roles as employees are worried that they may exceed the allowance (**NHS Employers 2019**).

Changes to tax thresholds are not set by the NHS. HM Treasury, working with the Department for Health and Social Care, could do more to provide clarity in this complex policy area and could investigate ways in which more flexibility could be introduced in the NHS pension scheme. In the most recent GP contract, there is a strong recommendation that the government should create a new partial pension option for the NHS, similar to that available in the local government pension scheme.

Senior staff can provide a huge amount of experience and expertise. With ongoing issues of morale, staffing levels, workload and pay, the workforce is already under immense pressure. When staff want to stay and work in the NHS but choose not to due to personal finances, that is a loss to the NHS and should be avoided.

Furthermore, this flexibility needs to be extended to other working arrangements. Currently, senior staff – if they want to be directly employed by a trust – can be faced with an 'all-or-nothing' choice due to the nature of the shift-working arrangements in operation. This can lead to staff choosing to leave.

Trusts should be supported to explore ways of encouraging staff to stay in work through providing additional flexibility while remaining substantively employed. This will require engagement and exploration with the Department of Health and Social Care and HM Treasury. Options explored should include a '50:50 option' where members pay half the contribution rate in return for half the benefit (a feature of the Local Government Pension Scheme), an option to only opt in to the life assurance element of the scheme, and a pensionable pay cap (**NHS Employers 2019**).

Recommendation

More work needs to go into encouraging staff approaching retirement to stay in the NHS rather than leave through offering more flexibility and different options for reduced participation, as well as doing more to support staff against external financial changes such as in pensions.

Leadership

The single most malleable and powerful influence on the culture of modern organisations is leadership. It is 'the way we do things around here'. Every interaction, by every member of staff, every day, influences the extent to which there are cultures of high-quality and compassionate care. Leadership and culture are essential issues to address in any consideration of workforce retention to make the NHS a great place to work.

The NHS Long Term Plan acknowledges that the ability of the NHS to deliver high-quality care and meet the complex challenges it faces will depend on 'great leadership' at all levels of the health and care system (**NHS England 2019c**, p 89). While the vision is for leadership that is both compassionate and diverse, the current assessment is that, while this is present in some parts of the NHS, it is 'not yet commonplace' (**NHS England 2019c**, p 89).

Evidence and experience from high-performing health systems demonstrates that compassionate, inclusive leadership enables teams to deliver better patient care and value for money while also delivering continuous improvements to population health. The measures on leadership outlined in the long-term plan should contribute to a better leadership culture, with more support for leaders and a stronger pipeline of leaders for the future. However, shifting the culture to where it needs to be will take time, along with investment and relentless commitment from leaders at every level of the system in their everyday practice. National NHS bodies will need to rapidly adopt new leadership approaches to support this.

All of these actions will build on existing recommendations in the national strategic framework, *Developing people – improving care*, which was published in December 2016. However, there are many actions within this framework that have not yet been implemented.

Finally, there is now a series of national reports (see, for example: **NHS Improvement 2016**; **Kerr 2018**; **Kark and Russell 2019**; **Health Education England 2019d**) which includes recommendations relating to leadership and culture. This presents local leaders with a prioritisation challenge in terms of the sheer number of recommendations. The national workforce implementation group can play a helpful role in highlighting which of these recommendations are priorities.

Recommendation

The national bodies – led by NHS Improvement and Health Education England – should recommit to a revised set of actions (to be implemented within 12 months) against the national strategic framework on improvement and leadership development, *Developing people – improving care*. This should include demonstrable action by the national bodies on changing their leadership approaches and developing compassionate and inclusive leadership.

The workforce implementation group should undertake a prioritisation exercise of the many recommendations relating to leadership and culture now in existence to support NHS employers to understand where to focus their attentions first.

The NHS offer to staff

The universal NHS 'offer' to staff is currently unclear. It is set out in the NHS Constitution with some important high-level commitments, underpinned by legal protections, but it is lacking in some areas (NHS 2015). Detail is missing around what staff can expect when it comes to continuing professional development, their ability to move between NHS (and social care) organisations as well as to general practice and non-NHS providers, the progression of their career, and their guarantee of being treated well and fairly. Currently this information is spread across the NHS Constitution, the Agenda for Change staff handbook and each individual organisation's human resources policies and practices. Staff may also look to their professional regulators for an understanding of their rights and responsibilities in their profession. This leads to a lack of clarity for NHS staff, and a lack of accountability for their careers.

In 2018 HEE established the Pearson Commission on the mental wellbeing of NHS staff and learners; the report was published in February 2019 (Health Education England 2019b) and contains 33 recommendations in three groups to address NHS culture, the mental wellbeing of NHS staff and those learning in the NHS, and the support the NHS provides to them. This is an important report, and adds to the growing number of documents setting out the support required for NHS staff.

More work needs to be done to bring these things together and make clear what the national guarantee is to NHS staff. This needs to be as well as, rather than instead of, directly supporting organisations to help them take care of their staff. But this must also take into consideration staff not directly employed by the NHS – to non-NHS staff and GPs providing patient care. If the health of the population is linked to the health of the workforce, then it is vital that all staff providing care are treated fairly and with dignity and respect. Simply codifying the offer will not be enough, and it will need to be matched by making real progress on treating people fairly, paying people properly and having an adequate supply of staff.

Recommendation

The NHS needs an explicit statement of the universal 'offer' to staff – including, but not limited to, their legal rights. The form of this should be explored with staff – side representatives and employers, but may be in the form of a compact covering not just fair treatment for all staff with protected characteristics but also what staff can expect from the NHS in terms of equal pay and opportunity, CPD, streamlining, supervision (especially in early career and during key transitions), work-life balance, proper appraisal, and non-financial benefits. This will require national leadership from NHS Improvement and NHS England both in terms of what this national offer is, and how they will support local employers to achieve it.

Opportunities to improve retention

Most progress in retaining staff is likely to come through being a better employer, an employer people do not want to leave. However, there is some evidence that progress can be made by focusing on retention as a route to understanding staff experience and engagement better. Emerging evidence from NHS Improvement's retention programme suggests that through data analysis, board engagement and focus, improvements can be made in trusts' retention rates. This work is 'a targeted, clinically-led, direct support model to support trusts improve their turnover rates' as well as various learning resources and improvement guides. It has directly supported 110 NHS trusts, and 71 per cent of the first cohort of trusts have seen an improvement in their turnover rate ([NHS Improvement 2018c](#)).

As part of this programme, NHS Improvement has identified some case studies where trusts have improved staff turnover dramatically, such as Yeovil District Hospital. In this example, promoting flexible working and staff development through a range of measures was associated with an improvement in nursing turnover from 23 per cent to 17 per cent in one year ([NHS Employers and NHS Improvement 2018](#)).

Emerging themes from NHS Improvement's retention programme

There is no silver bullet, but there are actions that all trusts can take, which starts by understanding your own workforce and leaver data and what it is telling them.

We have seen that successful staff retention programmes include many of these elements, which you can tailor to your local situation:

- knowing workforce data inside out and building a plan based on the insights this data offers, including those gleaned from consistently doing exit interviews and holding staff focus groups
- supporting new starters and the newly qualified, expanding preceptorship programmes and offering pastoral support from more experienced staff
- offering a range of flexible working options for all staff to support their work-life balance and life needs (ie caring or childcare)
- mapping out career pathways so that staff can visualise early how to progress their career in the trust, as well as promoting roles and opportunities through career clinics and online support
- effective staff engagement, including finding ways to acknowledge and reward values-driven behaviours
- supporting staff health and wellbeing
- employing innovative employment practices and trying new things, such as fast track/one stop recruitment events, 'itchy feet' conversations as a preventive measure, and new models of 'retire and return'.

Source: NHS Improvement ([2018c](#)), unpaginated.

While it is still early days for the programme, and too soon for a conclusive evaluation, early evidence is promising and suggests that there is scope for improvement in this area. Often this is not the result of more policies and programmes but rather a better awareness and sustained implementation of existing policies, possible career pathways or opportunities.

Overall for the first cohort, average turnover for nurses reduced by 1 per cent. While this is leavers from the trust rather than from the NHS, it suggests that the NHS as a whole should be able to make improvements in the retention rate, even in a challenging environment.

The best single year of improvement in the overall NHS nurse and health visitor leaver rate since 2010/11 was 0.4pp.³ If the NHS adopts some of these best-practice methods of understanding and reducing retention, especially if combined with improvements in the quality of work elsewhere, as set out in other chapters of this report, this improvement rate may be achievable on a more sustained basis. While this equates to reducing the leaver rate by more than a third over the next 10 years – a significant improvement – this is not so low that there is no natural flow out of the workforce.

The long-term plan commits to extending this support to all NHS employers. This is welcome, and this support for employers to understand and diagnose their ability to retain staff should not be underestimated as an important part of the solution to improving retention both within a provider and across the NHS.

Return to practice

Many staff leave the NHS for personal reasons and then wish to return later in life (**Kent 2015**). Returning nurses can be supplied more rapidly and are cheaper than training new pre-registration nurses. Pre-retirement leavers also have valuable experience and their return can reinforce other workforce equality initiatives.

The NHS has previously successfully exploited return to practice as a source of staff. A centrally funded programme from 1999 to 2004 resulted in 18,500 former nurses and midwives returning to work. However, after 2004, responsibility for return-to-practice programmes was devolved to local organisations (**Health Education England 2014a**).

The National Audit Office has estimated that between 2010 and 2014 around 4,800 nurses in the UK completed return-to-practice courses (**National Audit Office 2016**), approximately four times less than the number achieved in the early 2000s.

Following an overhaul in 2014, regional return-to-practice programmes were brought together under HEE and became centrally funded again, and between 2014 and 2018, more than 3,000 nurses completed a return-to-practice course (**Health Education England 2018i**).

³ Between 2011/12 and 2012/13.

How does the NHS currently do return to practice?

At present there are two key return-to-practice programmes being run out of HEE: one targeting nurses, the other targeting allied health professionals. For these programmes, HEE covers some of the costs to the applicant and the organisation providing the course, including some out-of-pocket expenses.

Returning a nurse to the register costs around £2,000, compared with around £79,000⁴ for training a new nurse ([National Audit Office 2016](#)).

There is also a refresher scheme for GPs, run by HEE in partnership with the British Medical Association, NHS England and the Royal College of General Practitioners, which covers basic training costs for returning GPs and provides a bursary of £3,500 a month. The scheme supports GPs to pass different assessments that are required to renew General Medical Council registration and be included on the NHS medical performers list.

Current barriers to return to practice

Employers we spoke to did not perceive return to practice as a worthwhile initiative, due to the relatively small number of people applying for programmes. Consequently, they put less effort into it than other recruitment routes. Broader challenges to retention – including pressure on staff and poor work–life balance – reinforce the difficulty of recruiting them back. This is a vicious cycle.

These barriers are underpinned by the national bodies' lack of ambition for return to practice. For the allied health professional scheme, funding was provided for 300 returners. The target was reached and now this programme is set to end. A recent nursing scheme set a working target of just 500 recruited returners ([Sawbridge and Brown 2015](#)). But 500 returners represented a significant reduction from the actual numbers of returners achieved in previous years. This target has now been increased to 1,000 nurses a year ([Health Education England 2018h](#)) – an upgrade in ambition – but it is still not adequately built on an understanding of what can realistically be achieved locally.

Reviews of the literature have found that 70 to 80 per cent of nurses who start a return-to-practice course go on to complete it ([Health Education England 2014a](#)). Additional dropout can occur where those who complete a course do not go on to take up employment. Providers we spoke to said that even those who do take up employment often choose to take up part-time roles instead of full-time ones. As a result, one returner who undertakes a return-to-practice course does not equal one full-time staff member back in the workforce.

The Nursing and Midwifery Council is running a consultation in order to review its approach to return to practice, which includes the standards for academic programmes, and considering the possibility of using a test of competence or self-declaration as alternatives ([Nursing and Midwifery Council 2018c](#)). University funding and study bursaries are other ways of increasing the uptake of courses ([Sawbridge and Brown 2015](#)).

⁴ The comparison with training a new nurse should be made with caution. The figure of £79,000 includes costs to the trainee as well as to the health service – the costs to the taxpayer are lower.

Finding eligible returners

There is little evidence on what makes an effective return-to-practice scheme. Previous successful initiatives were not evaluated to our knowledge and there is very little published data on the success of these schemes. This means that appropriate expectations about the opportunities for return to practice are hard to gauge.

Despite these challenges, the opportunities for attracting back trained and experienced staff should not be ignored. Return-to-practice schemes succeeded in the past partly when they were taken seriously. If local organisations were supported more robustly, and national investment for return to practice more forthcoming, return to practice could be a real opportunity to attract experienced staff back to the NHS. Given the current staff shortages in the NHS, a stronger and more ambitious national programme on return to practice is therefore worth further consideration.

Recommendation

We recommend that HEE leads a full review of return-to-practice schemes to understand what works and what is realistic. Unnecessary barriers should be removed where possible. Return to practice should be considered part of the drive for equal employment opportunities and should be conducted at a level that supports economies of scale. Steps should be taken to improve the NHS's ability to find people who are eligible for schemes and encouraging them to participate.

Conclusion

If the NHS are going to have enough staff over the next 10 years it is not enough simply to focus on recruitment of new staff. Instead, it is important to also focus on the staff currently working in health care.

Retention is a product of the system as a whole, such as staff experience of training and how it prepares them for their career, changes in workforce composition and the opportunities for career development that come with it, the amount staff are paid and what that says about how they are valued, and whether they are surrounded by enough staff to feel supported and that they can do their job well. And so while it is necessary to understand retention and specific interventions to improve it, it is much more important to focus on the system as a whole. If you are able to make improvements in training, workforce composition, pay, and staff numbers then fewer people will want to leave the NHS, and more will want to join. If you do not have sufficient numbers of staff then you will also struggle to retain the staff you have.

Perhaps more importantly, staff leave for a reason. Understanding the impact of things like lack of work-life balance, bullying, low morale, and low pay will help not only to reduce turnover but also to improve the experience and engagement of all staff.

Meanwhile, the continuing inequalities in pay and career progression by gender, race, ethnicity and occupation across the NHS must be addressed if the NHS is to become a great employer.

By taking these issues seriously, including paying greater attention to leadership and culture, the NHS will be better able to make the most of the staff they have and keep them. Improvement in these areas should also help to encourage staff to return to practice and make the NHS somewhere staff want to work.

When undertaken sensibly, changes in workforce composition can provide staff with different opportunities for progression and can promise a more varied and interesting career, especially if combined with increases in funding for continuous professional development. Sustained increases in pay, combined with greater flexibility and a targeting of staff groups that are hard to recruit and retain, can help to keep staff working in the NHS. Training the right staff, and preparing them well for their careers, can improve retention rates among newly qualified staff – a time when many people choose to leave the NHS. Finally, having enough staff working in the NHS means that staff will not feel overstretched and will be able to provide the level of care they aspire to deliver, limiting the number of people who leave due to being disillusioned with their ability to help.

Early evidence from NHS Improvement's retention programme suggests improvements in turnover for nurses. While some of this improvement may relate to people who would otherwise have left the trust but not the NHS, it does suggest that the NHS as a whole could achieve an improvement in its leaver rate over the next five to ten years.

5. Workforce redesign: the right teams with the right skills and technological support

Candace Imison, Nuffield Trust; and Jake Beech, Helen McKenna and Richard Murray, The King's Fund

Key messages

- Medical and technological advances alongside changing patient needs mean that workforce policies need to move beyond a narrow focus on workforce shortages to ensure 'the right mix of health workers, with the right skills, and providing services in the right places, to better respond to changing patient need' (**Organisation for Economic Co-operation and Development 2016**, p 13). All frontline staff will need to acquire new skills and adopt new ways of working to support changing models of care. This will increasingly mean a blurring of traditional boundaries both between and within sectors with staff being equipped for more 'boundary spanning' working, particularly with social care. Teamworking will be the norm.
- Team-based approaches, changes in practice and the use of technology have the potential to improve the quality of and access to care in all settings and reduce pressure on staff. In this chapter we look particularly at primary care – a setting where our modelling (see Chapter 7) shows that growth in demand cannot be met if we rely solely on an increase in the number of GPs, even with the national efforts to expand GP supply. This year, we estimate the NHS in England has 2,500 fewer full-time equivalent (FTE) GPs than it needs, with our projections suggesting that this gap could increase to 7,000 FTEs within five years if current trends continue. These projections, of course, do not take account of the growing expectations of general practice as underlined in *The NHS Long Term Plan* (**NHS England 2019c**). Unless action is taken, shortages of this scale represent a fundamental threat to the sustainability of primary care in England. We believe that the most effective way to address the projected gap between supply and demand is, while expanding the number of GPs as much as possible, to make much greater use of an expanded multidisciplinary team. Both approaches carry risks.
- We make recommendations to maximise the opportunities offered by pharmacists, physiotherapists and support staff due to the large size of their current workforces, relatively strong future supply (at least at a national level) and the significant amounts of work currently done by GPs and other staff in general practice that these roles can take on. There is also strong evidence that nursing can make a major contribution

to the wider primary care team, and emerging evidence for paramedics, but given the current constraints on their supply (see also Chapter 2), we have not factored them into our modelling for GPs in Chapter 7. Also, as 90 per cent of adults with mental health issues are supported primarily in primary care there is a pressing need to explore new ways of meeting these needs. Expanding the team in primary care is not just about meeting demand – it is also about improving quality and widening the offer of primary care. There should be no 'one size fits all' solution to team composition. It will need to reflect both the local supply of staff and local health care need. Critically it is also about reducing unsustainable pressure on GPs and other practice staff to help both recruitment and retention (see also Chapter 5).

- The recent changes to the GP contract, including funding for 20,000 additional staff, will encourage a more multidisciplinary approach in primary care. However, achieving workforce change of the order we anticipate will be a significant undertaking. As well as this funding for additional staff, it will also require investment in primary care capability development and infrastructure. Expanding the primary care team will require flexibility around employment models, and significant investment in primary care estate will also be needed. These issues underline the challenges and consequent risks in meeting the demands on general practice and the importance of addressing them. We welcome the substantial recurrent cash allocations designed to support the development of primary care networks.
- In this chapter we also look at wider considerations such as safe staffing. Safe staffing levels are a complex but important issue. Any change in practice should be evidence-based and requires a strong governance framework to protect patient safety. For example, there should be no dilution of professional nursing skills in an inpatient setting. There should be further development and evaluation of the National Quality Board's safe staffing tools in all settings.
- Having the right team with the right skills can require new or extended roles. Our recommendations engage with the wide range of opportunities for nurses and allied health professionals to acquire additional skills to deliver more patient-focused care and take on some activities traditionally undertaken by other staff, including doctors. In the interests of patients and the public, Health Education England (HEE) and professional regulators should actively and co-operatively support the ability of non-medical staff to safely undertake advanced clinical roles and extend their scope of practice (eg, to prescribe and work with increasing clinical autonomy). This would build on current initiatives to credential staff and the national framework for advanced clinical practice but also aim at the formal regulation and licensing of physician associates and other advanced clinical practitioners, including nurses and allied health professionals.
- To ensure that the future workforce is equipped with the right skills, staff and technology, there needs to be a step change in the capability and capacity of local systems to deliver more effective and efficient care through service improvement. This should be underpinned by evidence-based workforce redesign and the adoption of new technologies. *The NHS Long Term Plan* recognises the importance of investing in continuing professional development and its ability to 'deliver a high return on

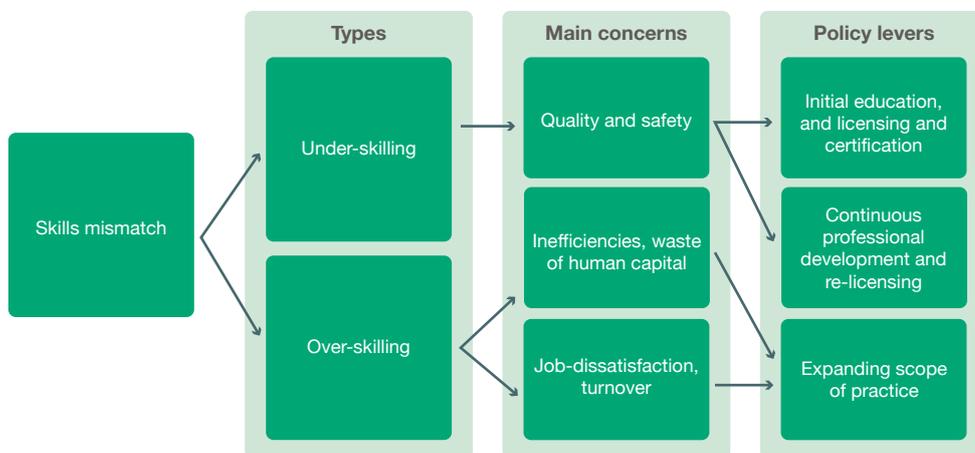
investment' (NHS England 2019c, p 85). The plan commits to HEE increasing the proportion of its total budget spent on workforce development. We argue that the recent cuts to the workforce development budget should be reversed at the least, returning the budget to the equivalent of its 2013/14 figure.

Introduction

The case for change

So far in this report, we have focused on how to secure the supply of the health and care workforce. However, changing patient needs, alongside medical and technological advances, will require all frontline staff to acquire new skills and adopt new ways of working over the next 10 years. In a recent report, the Organisation for Economic Co-operation and Development argued that workforce policies should move beyond a narrow focus on workforce shortages to ensure 'the right mix of health workers, with the right skills, and providing services in the right places, to better respond to changing patient need' (Organisation for Economic Co-operation and Development 2016, p 13). It cited compelling evidence that the skills of the current health care workforce are poorly aligned to patient need. Under-skilling creates quality and safety issues while over-skilling is inefficient and lowers morale (see Figure 5.1).

Figure 5.1: Impact of the skills mismatch in the health sector



Source: Organisation for Economic Co-operation and Development (2016).

The need to adapt the workforce to changing patient needs, as well as significant financial pressures and growing problems with recruitment and retention, are fuelling policy interest and local innovation in workforce development. Traditional workforce planning has focused on the training pipeline, but it also requires significant investment in skills development and role redesign in the current workforce, to address both the current and future skills mismatch. For example, the growing number of patients with multiple health and social care needs necessitates roles that cross current professional and sector boundaries and manage patient needs holistically. Yet the central investment in ongoing training and development for existing staff has been cut by two-thirds

since 2013/14.¹ *The NHS Long Term Plan* contains a welcome commitment for HEE to increase the proportion of its total budget spent on workforce development, but with no specifics on how much this will be until the Spending Review provides clarity later this year. In this chapter we lay out how workforce redesign can both improve care and offer some solutions to current workforce challenges.

Overview

In the remainder of this chapter we first look at technology and safe staffing – both vital considerations for any changes to workforce composition and design and important context. We then go on to explore the high-level opportunities offered by role enhancement and enlargement in the professional and support workforce as well as the barriers and enablers to them.

We explore in depth the opportunities for workforce redesign within primary care. We believe that these offer the most realistic solutions to current workforce challenges in this sector and will enable more patient-focused care. We focus on primary care both as an example of what is possible and because this is where the evidence has led us to believe that short- to medium-term opportunities are strongest. There are also significant opportunities in community and mental health services but the evidence and solutions are less clear. This chapter is not intended to be comprehensive.

We then go on to discuss the key barriers to change that need to be tackled and enablers, in both primary care and the wider workforce, before setting out the key challenges for expanding teams in primary care.

Technology and the workforce

Technology and the workforce who use it are interdependent. Deriving the full benefits from information technology in health care relies on the necessary investment in continuous staff development and service transformation. Making the full use of scarce clinical skills requires technology that supports and empowers staff in their work.

The implementation of technology frequently results in declining productivity in the early stages, the so-called 'productivity paradox', with gains only realised in the longer term ([Wachter 2015](#)). Evidence from the United States also demonstrates the significant risk of burnout for clinical staff from poorly designed and implemented electronic health records ([Shanafelt et al 2016](#)). A common problem in implementation is a lack of appreciation of the service and workforce redesign required for the full benefits to be achieved ([Greenhalgh et al 2018](#)). Some digital innovations, such as symptom checkers, if poorly designed or lacking in rigorous clinical evaluation, can put patients at risk and increase the load on health systems ([Fraser et al 2018](#)).

¹ Calculated from Health Education England ([2014b](#)) and Health Education England ([2018k](#)).

If the benefits are to be realised, the right skills and capabilities in staff and management are needed ([Wachter 2016](#)). Analytical skills will be particularly important. The current deficit in analysts and analytical capability undermines the potential benefits of the data that is collected ([Bardsley 2016](#)).

The NHS Long Term Plan sets out a positive vision for the future potential of technology:

In ten years' time, we expect the existing model of care to look markedly different. The NHS will offer a 'digital first' option for most, allowing for longer and richer face-to-face consultations with clinicians where patients want or need it. Primary care and outpatient services will have changed to a model of tiered escalation depending on need. Senior clinicians will be supported by digital tools, freeing trainees' time to learn. When ill, people will be increasingly cared for in their own home, with the option for their physiology to be effortlessly monitored by wearable devices. People will be helped to stay well, to recognise important symptoms early, and to manage their own health, guided by digital tools.

[NHS England 2019c](#), p 92

The Topol Review further expands this vision:

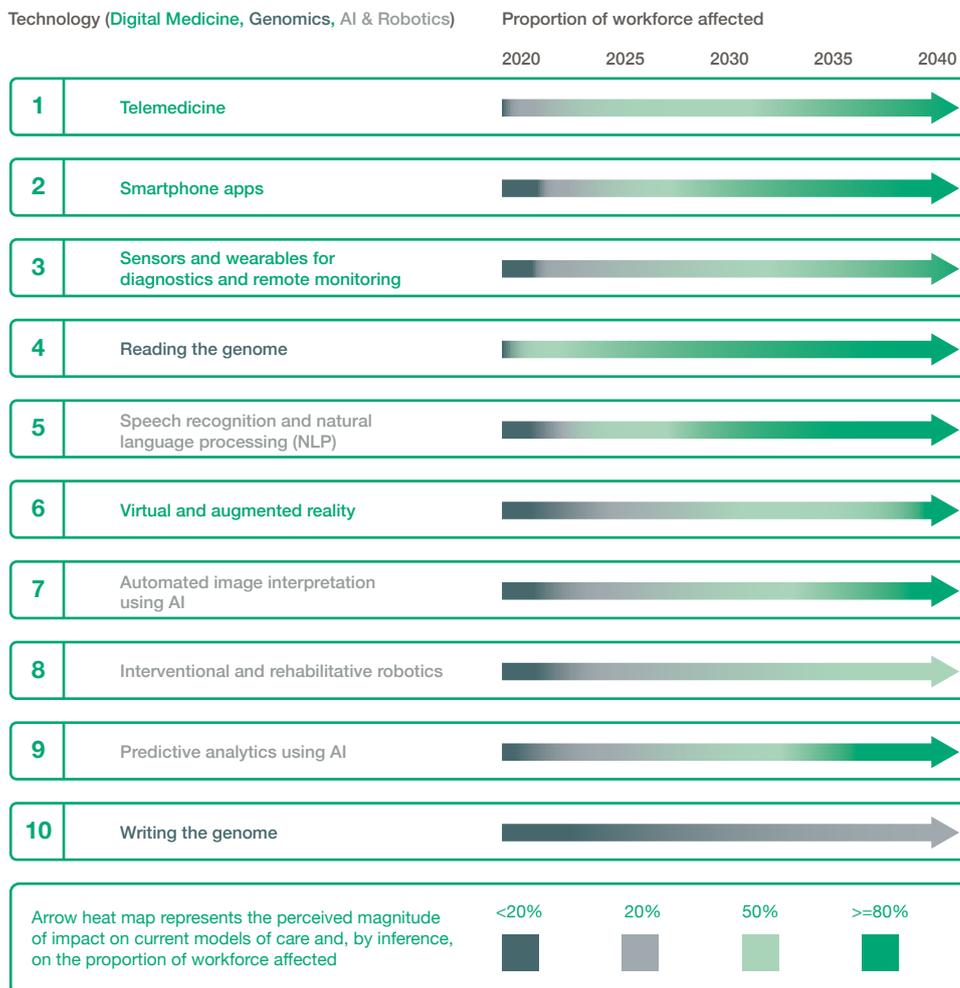
We are at a unique juncture in the history of medicine, with the convergence of genomics, biosensors, the electronic patient record and smartphone apps, all superimposed on a digital infrastructure, with artificial intelligence to make sense of the overwhelming amount of data created. This remarkably powerful set of information technologies provides the capacity to understand, from a medical standpoint, the uniqueness of each individual – and the promise to deliver healthcare on a far more rational, efficient and tailored basis.

[Health Education England 2019d](#), p 6

The Topol Review has estimated when these trends will affect the future workforce (see Figure 5.2). Within 10 years, at least half of the trends will be having a significant impact on the way staff work. The cumulative impact is immense. Nearly all clinical staff will need to be able to interpret and communicate genomic findings, and all staff will require digital skills. This is a huge skilling and reskilling task for the NHS.

The Topol Review has made recommendations on the training and skills that clinical staff need to make the best use of artificial intelligence, robotics, genomics and digital medicine ([Health Education England 2019d](#)). This involves changes to professional regulatory requirements and academic curricula, as well as providing training to current staff and cultivating a culture of lifelong learning. There will be a need for a whole new cadre of clinical and analytics staff to analyse and interpret the growing body of clinical and other data and drive service improvement. The findings from the review report underline the scale of the current and future workforce development challenges that the NHS faces if it is to benefit fully from technological advances.

Figure 5.2: Technological advances affecting health care and the magnitude of disruption



Source: Health Education England (2019c, p 27).

Safe staffing

Safe staffing levels are a complex but important issue. Research shows that not having enough fully trained nurses in a hospital can lead to increased patient mortality. Aiken *et al* found that an increase in a nurse's workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7 per cent, meanwhile every 10 per cent increase in the number of bachelor's degree nurses was associated with a decrease in this likelihood by 7 per cent (Aiken *et al* 2014). This is one of a number of major studies that have demonstrated that higher numbers of registered nurses on hospital wards are associated with improved clinical outcomes; conversely there is some evidence that higher numbers of health care assistants produce worse clinical outcomes (Griffiths *et al* 2017). But the environment also plays a part. One study found that 'lowering the

patient-to-nurse ratios markedly improves patient outcomes in hospitals with good work environments, slightly improves them in hospitals with average environments, and has no effect in hospitals with poor environments' ([Aiken et al 2011](#), p 1048).

Safe staffing is not limited to the acute sector. Workforce issues are also one of the biggest challenges to delivering the vital changes needed for mental health ([All-Party Parliamentary Group on Mental Health 2018](#)). Existing shortages in mental health medical staff and nurses are severe, with 10 per cent of consultant psychiatrist posts ([Royal College of Psychiatrists 2017](#)) and 12.8 per cent of mental health nursing posts² unfilled ([NHS Improvement 2018b](#)). In the case of community learning disability nursing, the number of FTE nurses employed by the NHS fell by 23 per cent between September 2010 and September 2018³ ([NHS Digital 2018c](#)). The recent Carter Review highlighted large variation in service and staffing models in both mental health and community services and a need to establish best practice focused on providing safe and effective care ([NHS Improvement 2018a](#)). In primary care, the level of nurse staffing is positively associated with improvements in chronic disease management. But there is also evidence (similar to the experience in acute care) that organisational factors can outweigh this and mitigate the impact of low nurse staffing levels ([Griffiths et al 2011](#)).

The National Quality Board has produced some useful guidance on safe staffing, including guidance on the deployment of nursing associates ([National Quality Board 2016](#)). But the NHS must do more to understand and encourage safe staffing ([Buchan et al 2017b](#)). Different providers across the system are using different methods, but little information is available on the relative advantages and disadvantages of these methods, or their effectiveness. In addition, the training for staff and managers in their application and interpretation is often inadequate. There will not be a 'one-size-fits-all' solution. It is only through better understanding the experience of other countries, listening to staff and exploring the tools and approaches that are available that sensible steps forward can be made.

Recommendation

We recommend that the National Quality Board further develops and evaluates safe staffing tools for the full range of settings: acute, community, mental health and primary care. These tools should evolve to reflect the team and multidisciplinary nature of the delivery of health care, including the new roles such as the nursing and physician associate.

² Data only covers mental health nursing posts that would be employed by NHS trusts or directly by clinical commissioning groups.

³ Figure includes full-time equivalent staff in hospital and community services in the NHS in England. This excludes staff working in primary care or voluntary and independent sectors.

How the workforce is changing

Role enhancement in the professional workforce – advanced practice

Over the past 10 years, there has been a significant increase in the number of new and extended professional roles, particularly for nurses, and allied health professionals including occupational therapists, physiotherapists and paramedics. The biggest growth has been in advanced practice roles in all settings, including acute, mental health and primary care. In 2017,⁴ the NHS employed 30,000 FTE staff with the job title 'specialist nurse practitioner'. There are also more than 3,000 FTE advanced nurse practitioners and just under 11,400 FTE nurses working in general practice (see Figure 5.5 later in this chapter). There is considerable variation and confusion around job roles and titles, particularly in nursing. Recent research found 595 job titles in use in 17,960 specialist nursing posts (Leary *et al* 2017).

A new role, with the potential to work autonomously at an advanced level, is the physician associate. The role first emerged in the United States where there were 102,000 physician associates practising in 2016. This is expected to grow to 184,000 by 2030 (Auerbach *et al* 2018). The experience in the United States suggests that the role can take on a significant proportion of primary care activity (Green *et al* 2013). A physician associate is defined as a dependent practitioner, who works for and with doctors, undertaking a range of clinical tasks that traditionally doctors would have done. Physician associates usually have a biosciences degree and are trained on a two-year postgraduate degree programme. They can perform a range of clinical tasks, releasing junior and senior doctors' time, and help support continuity of care for patients (Royal College of Physicians 2018b). The role is not currently regulated in England but the government has committed to doing so. This will be necessary for the role to achieve its full potential. However, the numbers in England are small. In 2017, it was estimated that there were just under 600 qualified physician associates in the UK. In February 2018, NHS Digital recorded just 27 physician associates in NHS trusts⁵ (NHS Digital 2018e). But the total number is expected to grow to up to 3,200 by 2020 (Royal College of Physicians 2017). This compares with a total junior doctor workforce of just over 55,000 and a consultant workforce of 47,000 FTEs (NHS Digital 2018c).

There is good evidence that nurses and others in advanced practice roles can help to deliver more patient-focused care and undertake activities traditionally done by other staff, including doctors (Imison *et al* 2016b). Nurse practitioners now account for 19 per cent of the primary care workforce in the United States (Green *et al* 2013). A recent six-country review of advanced nursing roles found that they were growing at between three and nine times the rate of doctors (Maier and Buchan 2018). In hospital settings, advanced practice roles offer opportunities to improve clinical continuity; provide mentoring and training for less-experienced staff; and offer a rewarding, clinically facing career option for experienced staff (Imison *et al* 2016b).

⁴ Calendar year.

⁵ Figure includes full-time equivalent staff in hospital and community services in the NHS in England. This excludes staff working in primary care or voluntary and independent sectors.

In community settings, professionals working together through fully integrated teams across traditional boundaries can ensure that the skills and assets across different sectors are used effectively and fragmented care is avoided (Charles *et al* 2018). It is increasingly being recognised that the best use of certain professional groups may not be solely in providing direct care but also in co-ordinating and leading in community teams. This is a key potential role for district nurses, but there is an urgent need to reverse the recent significant decline in their numbers – there was a 43 per cent drop in the number of FTE district nurses between September 2009 and September 2018 (NHS Digital 2018c).⁶ Occupational therapists are also well-placed to train, upskill and supervise others to deliver joined-up, person-centred care (Royal College of Occupational Therapists 2017). *The NHS Long Term Plan* confirms that the potential of allied health professionals (such as occupational therapists) will continue to be explored (NHS England 2019c), in part through the ongoing 'AHPs into Action' initiative (NHS England 2017a).

With the high degree of variation in community care models, routes for sharing best practice around staff composition and the support to implement workforce redesign are critical.

The UK is a comparative outlier by not separately registering advanced nursing roles, although the Royal College of Nursing has a voluntary credentialing process for nurses with advanced skills. The International Council of Nurses believes that all nurse practitioner and advanced nurse practitioner roles should be formally registered and that not doing so risks a lack of role clarity and has safety implications (Schober 2018).

Recommendation

In the interests of patients and staff, we recommend that the Department of Health and Social Care and the professional regulators give consideration to more formal national regulation of advanced practice. In addition, there is an urgent need for the government to introduce legislation to support the regulation of physician associates to enable them to prescribe and achieve their full potential in the clinical workforce.

Role enhancement in the support workforce

There are considerable opportunities to develop staff in clinical support roles, including new roles to help patients navigate the system more effectively and to take more responsibility for their own care (Gilbert 2016). However, many of the innovations in this area have stayed relatively small scale and some of the interesting new roles have grown relatively slowly. Importantly, these roles help to span traditional divides between sectors. Meanwhile, *The NHS Long Term Plan* notes that '1,000 trained social prescribing link workers will be in place by the end of 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then' (NHS England 2019c, p 25).

⁶ Figure includes full-time equivalent staff in hospital and community services in the NHS in England. This excludes staff working in primary care or voluntary and independent sectors.

The nursing associate role, regulated by the Nursing and Midwifery Council, aims to bridge the skills gap between the 286,000 FTE registered nurses and 320,000 FTE health care support workers in NHS trusts (**NHS Digital 2018c**). The hope is that nursing associates will deliver hands-on care, freeing up registered nurses to do more advanced tasks. The role also provides the support workforce a career ladder to nursing. There are currently 2,000 nursing associate trainees in England, with ambitions to grow the number of nursing associates significantly (**Health Education England 2018d**). *The NHS Long Term Plan* anticipates 7,500 new nursing associates starting in 2019 (**NHS England 2019c**). An early evaluation of the role has shown a generally positive perception of the impact of the role on patient care and enthusiasm for people to undertake it, but it can face professional resistance, not helped by a frequent lack of role clarity (**Traverse 2018**).

The severity of the workforce gaps in nursing makes changes to staff composition – in particular greater use of support staff – seem like an attractive option. But, as discussed earlier, the evidence on safe staffing would caution against any staffing solution that dilutes nursing skill mix in an inpatient setting. However, there is also good evidence that nurses spend a considerable portion of their time on tasks that other staff could undertake, including administrative duties, medication management and personal care. There is emerging evidence that ward administrators and pharmacy technicians can release significant portions of nursing time (**van den Oetelaar et al 2018; Hendrich et al 2008**). There is also some evidence that nursing associates can safely undertake some of the personal care duties that traditionally nurses have undertaken, but that their capacity to do so is often hindered if their role is not clearly demarcated (**Kessler et al 2014**).

It is hoped that the new nursing associates will enhance the quality of hands-on care offered by the support workforce and release registered nurses to focus on more complex tasks and work 'to the top of their licence'. However, some argue that nurses often undertake complex patient assessment while doing routine tasks (**Needleman 2017**). Even if the number of nursing associates grows as anticipated in *The NHS Long Term Plan* (**NHS England 2019c**), in the short to medium term they will be far outnumbered by the number of registered nurses.

Better support for people with mental health problems requires the skill development of 'physical' health staff to meet mental health needs and vice versa. Initiatives such as 'Equally Well' are leading progress in this area (**Centre for Mental Health et al 2018**). Band 4 associate practitioner roles are showing promise in ensuring that physical health needs are met in mental health inpatient settings (**Imison et al 2016b**). Nursing associates may also have a role to play particularly in providing physical health support as supply increases and their role in mental settings is clarified.

Table 5.1 provides a summary of advanced, enhanced and expanding roles.

Table 5.1: Summary of advanced, enhanced and expanding roles

Role	Description	Regulation and national standards for practice	Agenda for Change pay band
Health care assistant	Clinical support staff member who takes on tasks often previously undertaken by nurses – for example, in primary care, routine health checks	No	2–4
Medical assistant	Takes on a range of support functions in primary care, including health coach, care co-ordinator, referral co-ordinator, administrative assistant and receptionist (role originates in the United States)	No	3–4
Nursing associate	Provides hands-on care to patients, with the aim of releasing qualified nursing time for more complex tasks	Yes	4
Care navigator	Helps to identify and signpost people to available services, acting as a link worker, usually based in a multidisciplinary team (no universal definition)	No HEE competency framework	3–6
Physician associate	A dependent practitioner, who works for and with doctors, undertaking a range of clinical tasks that would traditionally have been undertaken by a doctor	No but government commitment to do so Own professional body sets standards	7
Advanced nurse practitioner	A nurse with a high degree of expertise and experience who is able to diagnose and manage health care problems in their specialist area or refer to an appropriate specialist if needed	Through their original professional registration and could be credentialed	7–8
Advanced allied health professional	An allied health professional with a high degree of expertise and experience who is able to diagnose and manage health care problems in their specialist area or refer to an appropriate specialist if needed	Through their original professional registration and could be credentialed. Some professions have regulatory barriers to independent prescribing	7–8
Advanced clinical practitioner	Educated to Masters level and takes on expanded roles and scope of practice caring for patients – comes from a range of professional backgrounds such as nursing, pharmacy, paramedics or occupational therapy	Through their original professional registration and could be credentialed	7–8

General practice and primary care

Issues and scale of the challenge

Workforce shortages are contributing to a well-publicised crisis in general practice. This year, the NHS in England has 2,500 fewer FTE GPs than it needs, with our projections suggesting that this gap could increase to 7,000 FTEs within five years if current trends continue. These projections do not take account of the growing expectations of general practice as underlined in *The NHS Long Term Plan (NHS England 2019c)*, which will add additional pressure. Unless action is taken, shortages of this scale represent a fundamental threat to the sustainability of primary care in England.

The numbers of GP–patient contacts are growing substantially – between 2010/11 and 2014/15, the number of face-to-face consultations increased by 13 per cent and the number of telephone consultations by 63 per cent ([Baird et al 2016](#)). The ambition in the 2016 *General practice forward view* to achieve an additional 5,000 GPs in general practice by 2020 ([NHS England 2016](#)) has so far failed to deliver, with fewer GPs in post now than at the outset of the plan ([Royal College of General Practitioners 2018](#)). The GP workforce is also ageing, with 23 per cent of GPs aged 55 or over as of September 2018 ([NHS Digital 2018b](#)). Practice nursing, while generally stable, is also facing problems, including an ageing workforce – 37.4 per cent of all practice nurses are over the age of 55 and 16.2 per cent are over the age of 60 ([NHS Digital 2018b](#)). There are also issues with their recruitment – the Royal College of General Practitioners states that 71 per cent of those involved in recruiting practice nurses in the last year reported that it was 'difficult' ([Royal College of General Practitioners 2018](#)).

This coincides with increasing complexity and intensity of the work done in primary care, such as supporting a growing burden of chronic disease – this creates new workforce demands ([Maier and Buchan 2018](#)). The impact of this on staffing has been substantial, with ongoing pressures and high workload in general practice contributing to problems in the recruitment and retention of staff ([Department of Health and Social Care 2018b](#)). In addition, improving access in primary care may itself increase activity. The current difficulties that patients experience in accessing general practice may well have suppressed some demand and this may bounce back once access begins to improve. This should be a short-term effect as the service adjusts to meet underlying demand but will need monitoring as new models of care roll out.

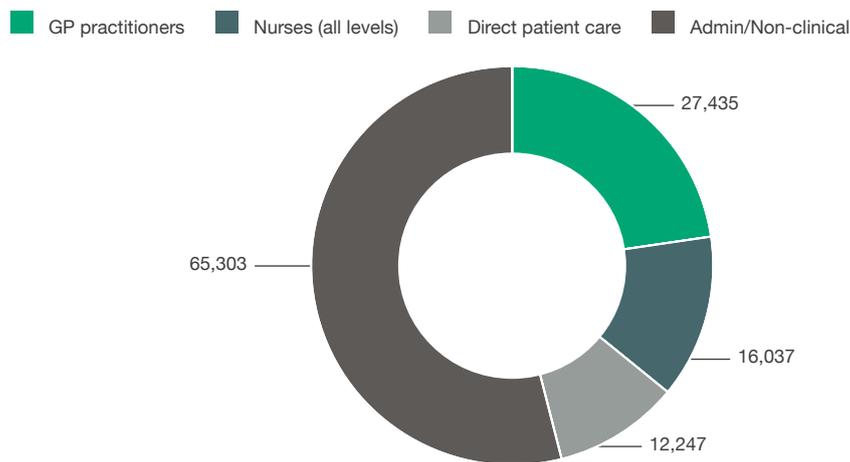
Opportunities to address the challenges in primary care

Both in the UK and internationally, there is a shift away from 'doctor-driven' to team-based ways of working within primary care ([Baird et al 2018](#)). In these models, non-medical staff are not there to be 'delegated' to but to form part of a wider and enriched health care team with a different skill mix ([Freund et al 2015](#)). There is little evidence that these models are any less costly and they require skilful implementation for the full benefits to be achieved ([Nelson et al 2018](#)). There is a growing consensus that team-based approaches, changes in practice, better use of technology and better and expanded use of non-medical staff have the potential to help offset the increase in demand for services while improving access to and the quality of care ([Auerbach et al 2013](#); [Bodenheimer and Smith 2013](#); [Green et al 2013](#)). This move to a team-based approach is further supported by the recent changes to the GP contract ([British Medical Association and NHS England 2019](#)) and funding for the new primary care networks. We welcome NHS England making funding available for 20,000 new staff in general practice through recent changes to the GP contract to enable expansion of the primary care team.

Internationally, it is now common to include physiotherapists, nurse practitioners, pharmacists, social workers and psychiatric nurses within the extended primary care team ([Groenewegen et al 2015](#)). Initial data from a new NHS Digital data collection suggests that in England, almost half of appointments in general practice are already taken by non-medical staff ([NHS Digital 2019a](#)). As well as reducing the burden on GPs, patients are more likely to get the care they need ([Schottenfeld et al 2016](#)).

Figure 5.3 provides a high-level overview of the current FTE staffing levels in primary care in England.

Figure 5.3: FTE general practice staff: England, September 2018

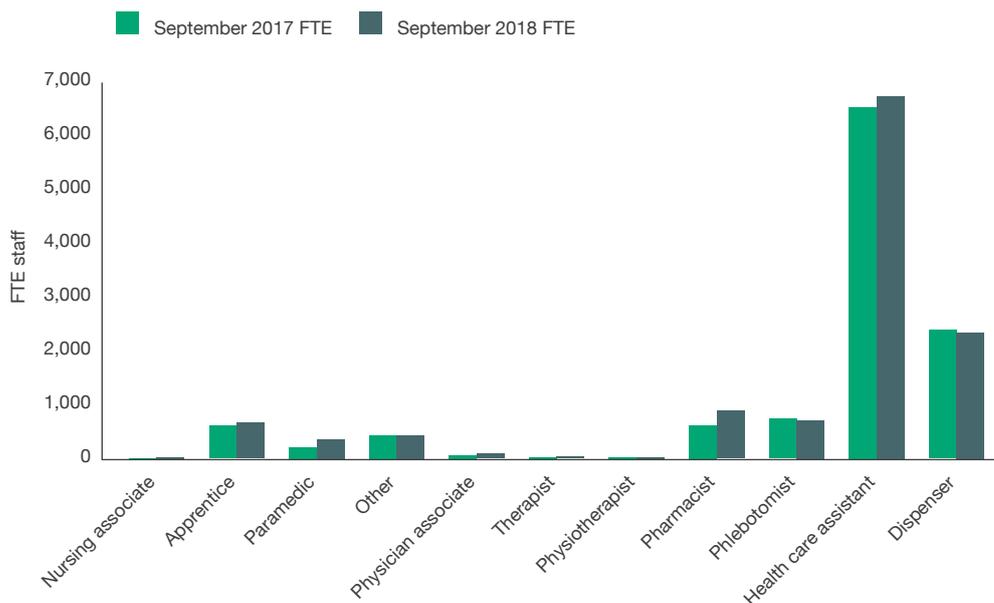


Note: 'GP practitioners' excludes locums, retainers and registrars.

Source: [NHS Digital 2018b](#).

A detailed breakdown of the FTE direct patient care workforce (which excludes GPs and nurses) in primary care is given in Figure 5.4.

Figure 5.4: FTE direct patient care workforce in primary care, by role, September 2017 and September 2018



Source: [NHS Digital 2018b](#).

The *NHS Long Term Plan* has the ambition of using the new primary care networks, alongside a significant increase in funding, to expand the range of clinical and non-clinical staff working alongside GPs (**NHS England 2019c**). The proposed increase in integration that this funding will deliver has the aim of creating expanded community multidisciplinary teams that are aligned with the primary care networks. The teams themselves will comprise 'a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and AHPs [allied health professionals] such as physiotherapists and podiatrists/chiropractors, joined by social care and the voluntary sector' (**NHS England 2019c**, p 14). Overall, the long-term plan envisages 'fully integrated community-based health care' (p 15), entirely blurring the lines between community services and primary care. The plan also confirms that the forthcoming workforce implementation plan will build on the *Forward View for General Practice* (**NHS England 2016**) to create the 'skill mix to relieve pressure on GPs' (p 83) in particular.

In the rest of this section we quantify the potential opportunities to grow other staff groups in general practice to help bridge the primary care workforce gap, reduce staff workload and expand patient access to appropriate care in the primary care setting. These strategies would run alongside national efforts to expand the number of GPs. We have quantified the opportunities in terms of FTE GPs. However, this should not necessarily be taken as a like-for-like direct substitution of staff but a reflection of GP time and capacity across the sector freed up through expanding the primary care team.

We focus below on pharmacists, physiotherapists and support staff because of the large size of their current workforces, relatively strong future supply (at least at a national level) and the substantial work currently done by GPs, nurses and other staff in general practice that these roles can take on. However, expansion of the primary care team should not be limited to these professions. Many others, including other allied health professions and mental health staff, will have a growing role in primary care teams in the future.

The estimates presented in this chapter represent what we believe to be the full effect of the opportunities to expand the primary care team. In our modelling chapter (Chapter 7) we make additional allowances for unmet demand when considering their cumulative effect.

Our work suggests that over a 10-year timeframe, there is a plausible scenario under which a more multidisciplinary approach in primary care would be able to meet demand. However, this comes with significant challenges, which will require urgent attention if this approach is to succeed. These are described more fully in our discussion of barriers and challenges towards the end of this chapter.

Physiotherapists in general practice

An estimated 20 per cent (**Chartered Society of Physiotherapy 2017**) to 30 per cent (**NHS England 2019c**) of a GP's caseload is related to musculoskeletal issues. A physiotherapist can deal with most of these cases effectively without the patient needing to see a GP (**Chartered Society of Physiotherapy 2017**). As independent practitioners, physiotherapists can take direct referrals, undertake musculoskeletal assessments, manage a wide array of musculoskeletal issues and provide rehabilitation and reablement support (**NHS 2017**). Since 2014, physiotherapists are also able to obtain independent prescribing

rights in their field (**Chartered Society of Physiotherapy 2018**). Collectively, these factors enable physiotherapists to act as a first – often only – point of contact for patients who would currently visit a GP for musculoskeletal problems and they may also prevent or delay onward referral to hospital.

There are currently around 43,000 registered physiotherapists in England, with around a quarter of them operating at advanced practice level.⁷ Current figures suggest a strong pipeline for the profession, with a 40 per cent increase in pre-registration training places between 2015/16 and 2018/19, low attrition rates and high translation rates of students into practice.⁸

Situating physiotherapy in general practice can help to optimise referral pathways, foster collaboration and skill sharing, and enable patient access, but this is not always possible with current pressures on the general practice estate. The Chartered Society of Physiotherapy, the British Medical Association and the Royal College of General Practitioners have offered implementation guidance for first-contact physiotherapy posts in general practice to help address practical issues such as these and to build musculoskeletal pathways in primary care (**Chartered Society of Physiotherapy et al 2018**).

The NHS Long Term Plan reaffirms NHS England's commitment to improving direct and first-contact access to musculoskeletal practitioners (**NHS England 2019c**). The plan confirms that 98 per cent of sustainability and transformation partnerships have pilots for first-contact programmes and 55 per cent of pilots are reportedly already under way. The plan also commits to expanding the number of physiotherapists working in primary care networks specifically. These commitments need ambition: less than a fifth of GPs currently rate their access to physiotherapists as 'good' (**Royal College of General Practitioners 2018**).

Our modelling has explored the potential demand for GPs if other staff were deployed in general practice. We estimate that if there were an additional 6,000 physiotherapists working in general practice by 2028/29, this would absorb 10 per cent of future demand for GPs. This is approximately equivalent to one physiotherapist per 10,000 patients in general practice. Our calculation assumes that half of the musculoskeletal workload (20 per cent of GP demand) would be transferred to physiotherapists and that physiotherapist sessions would be twice as long as a GP appointment. Rather than replacing GPs, this estimate aims to capture the amount of GP time that moving appropriate tasks to physiotherapists would recover. We recognise that the evidence base in this area is limited and implementation needs to be informed by the current pilot schemes. This expansion will require careful pathway and service redesign, learning from the pilots, and consideration of the need for physiotherapists to have advanced practice skills to exploit their full potential to save GPs' time.

⁷ This estimate of physiotherapists operating at advanced practice level is based on the number of physiotherapists working in the NHS at band 7 or above.

⁸ Chartered Society of Physiotherapy analysis of data from the Higher Education Statistics Agency (HESA).

Clinical pharmacists in general practice

There are currently more than 55,000 registered pharmacists⁹ in Great Britain, working in a range of settings (**General Pharmaceutical Council 2018**), and often supported by their own wider teams, particularly pharmacy technicians. The majority work in community pharmacy and large provider settings, particularly hospitals.

There are 11,700 community pharmacies in England,¹⁰ a sector with extensive reach and an established high-street presence in most areas. Community pharmacy often acts as a widely accessible point of appropriate care, with a proven track record of adding value to the health system (**PricewaterhouseCoopers 2016**). It has previously been identified as a sector where the clinical skills of the pharmacists are underused, and where there is potential to enable the delivery of more patient-facing clinical work as part of the primary care multidisciplinary team (**Royal Pharmaceutical Society 2013**). *The NHS Long Term Plan* suggests that this will be explored further (**NHS England 2019c**).

A growing number of pharmacists are now working directly within general practice. Current estimates put this figure at just under 900 (0.03 per GP) (see Figure 5.4). As experts in medicines, these clinical pharmacists are able to manage repeat prescriptions, conduct medication reviews, ensure that medicines are being used appropriately and safely, support patients with long-term conditions and provide health and social care advice and support. They are also taking on the role of independent prescribers, with 11 per cent of all registered pharmacists having the capacity to independently prescribe (**Robinson 2018**). With substantial amounts of time being released through even routine activity such as prescribing support (**Maskrey et al 2018**), pharmacists are well-placed for making an impact. Acceptance and support for their role are also reportedly high among existing primary care staff (**Royal College of General Practitioners 2018**), with pharmacists being seen as valued and valuable members of the primary care team.

Roll-out through NHS England's current Clinical Pharmacists in General Practice programme is aiming to deliver one pharmacist per 30,000 patients by 2020 through the tapered co-funding of posts (**NHS England undated**). As of September 2018, 1,834 doctors' surgeries in England covering 15 million patients now have some access to clinical pharmacists. Recent reductions in eligibility criteria within the programme now allow practices to apply for this central support if they aim to have one FTE pharmacist per 15,000 patients, down from the initial 30,000 patients (**NHS England 2017b**). Independent evaluation of the pilot of the programme suggests a strong, positive effect from pharmacists working at a ratio of one FTE pharmacist per 30,000 patients or fewer (**Mann et al 2018**). Most of the pilot sites within the evaluation opted to work at levels closer to one pharmacist per 15,000 patients (or even fewer) and qualitative feedback suggested that working at higher ratios would compromise patient care and the ability of pharmacists to integrate and work in the practice team. Some parts of the country are already looking to reach one pharmacist per 10,000 patients. Initial targets should therefore aim for at least one FTE pharmacist per 15,000 patients nationally. *The NHS Long Term*

⁹ Headcount figure of registrants.

¹⁰ A PSNC (Pharmaceutical Services Negotiating Committee) reported figure.

Plan commits to continue to increase the number of clinical pharmacists, and primary care networks are to use a part of the new funding announced in the long-term plan to do this ([NHS England 2019c](#)).

As there is an overlap between pharmacists working in general practice and those working in independent community pharmacies, ongoing learning from evaluations within the programme should underpin the future development of staffing ratios in individual practices and look to inform the balance between pharmacists based in general practice and those working in other settings. The sharing of summary care records between settings can facilitate this and enable more joined-up care. Also, community pharmacy has its own estate, which opens additional possibilities for where services across a joined-up primary care team can be delivered.

General practice workforce statistics show that around 900 FTE pharmacists are already employed in practices. As we modelled for physiotherapists, we estimate that if this number were expanded by an additional 3,100 by 2023/24 (reaching approximately one FTE per 15,000 patients), this would reduce the demand for GPs by approximately 1,600 FTE GPs and allow patients greater access to the specialist skills of pharmacists. This figure should be taken as a lower limit to what can be achieved – we believe that there is scope for significantly greater expansion. Part of the uncertainty about any upper estimate of the appropriate number of pharmacists arises because there is an overlap between pharmacists in general practice and pharmacists working in community pharmacies as part of the wider primary care team. Again, this estimate aims to capture the amount of GP time that pharmacists can recover – reducing GPs' workload and allowing them to undertake more activity that requires their unique skill set. In addition, a clear and well-supported route for early-career pharmacists to establish a career in general practice is required.

Clinical and other support staff in general practice

International models make significantly more use of support staff to carry out health assessments, perform routine tests and help people to monitor their conditions and look after their health ([Baird et al 2018](#)). In the United States, which is also facing shortages in primary care doctors, the role of medical assistant is one of the fastest-growing occupations. Flexibility has been a key factor, with staff in this role being trained to take on a range of support functions, including health coach, care co-ordinator, referral co-ordinator and receptionist. In some cases they have also acquired more clinically orientated skills and become, for example, a phlebotomist or diagnostic technician ([Chapman and Blash 2017](#)). Medical assistants are frequently recruited from the local community and their linguistic and cultural concordance with patients is seen to be a huge asset ([Chapman and Blash 2017](#)). A recent analysis of the staffing of GP practices in the 'Comprehensive Primary Care Initiative' in the United States provides an interesting comparison to the current position in England. While these practices had a similar ratio of administrative staff to GPs (1:2), they had considerably more clinical staff, with a ratio of 2.5 other clinical staff per GP, compared with the English ratio of 0.9 other clinical staff per GP ([Peikes et al 2014](#)). The practices also made significantly more use of clinical support staff, particularly medical assistants.

In England, health care assistants are becoming increasingly important and prominent members of the general practice team. Many more practices are employing them to take on routine tasks that previously practice nurses carried out (Dale and Vail 2010). They can improve patient access, reduce waiting times and enable more highly qualified staff to concentrate on patients with more complex needs (Bosley and Dale 2008).

Significant investment in training, mentorship and support is required, with support staff having clearly demarcated roles (Bosley and Dale 2008). If the number of support staff in general practice was significantly expanded, with the appropriate investment in training and support, they could take on a proportion of the work that currently general practice nursing staff do. This in turn could release nurses' time to develop and take on roles that would release GPs' capacity (see our calculations below).

A key element of the support required in general practice is administration. GPs spend an estimated 11 per cent of their time on administrative tasks. An equivalent of 1,600 FTE GPs could be freed up if 50 per cent of this work was transferred to administrative staff (Primary Care Workforce Commission 2015). Support for up-skilling general practice administrative staff and the development of new roles such as GP assistants, that are currently being piloted (Health Education England 2018a), will have a role in making the most of clinical staff time. Administrative support is also important for advanced nursing roles. Modelling from the United States showed that providing two nurse practitioners with a dedicated assistant enabled primary care settings to increase the number of patients they could see by 40 per cent (Liu et al 2014).

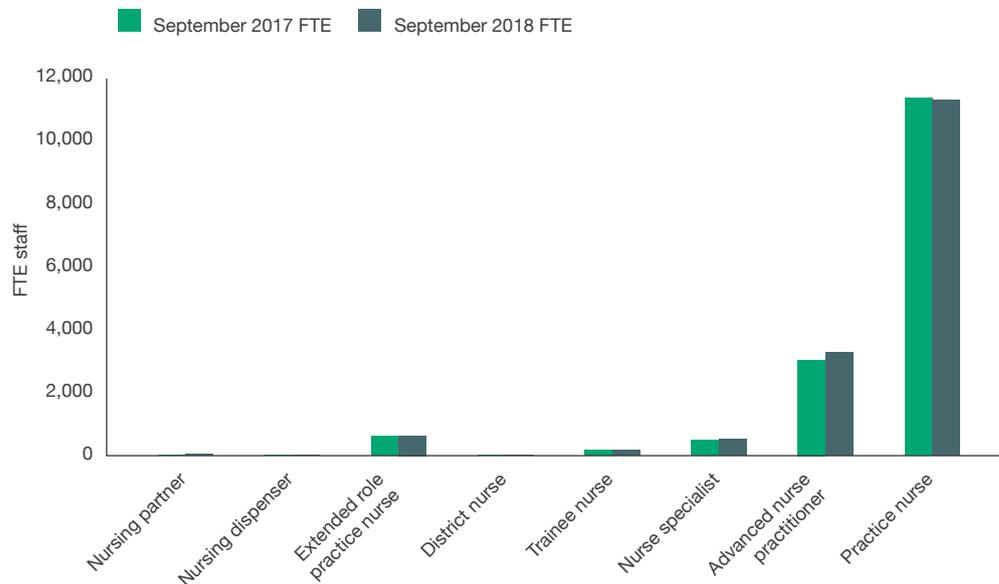
Using the Primary Care Workforce Commission's figures, we estimate that 1,600 FTE GPs could be released through the recruitment of additional administrative support to free capacity. The evidence also shows that additional support staff recruited to general practice to undertake functions such as care co-ordinator, referral co-ordinator, phlebotomist or diagnostic technician could release both nurses' and GPs' time. We have made a conservative estimate that an extra 1,400 FTE GPs could be released through this additional support route.

Nursing staff in general practice

Nurses are a core part of the primary care team, with growing numbers of nurses in advanced practice roles (see Figure 5.5). Higher levels of nurse staffing are associated with improved clinical outcomes (Griffiths et al 2011).

There is growing scope for advanced nursing practice in primary care. There is considerable evidence that nurse-led care delivers equivalent or better-quality care across a large range of outcome measures (Maier and Buchan 2018) and that nurses are able to undertake a significant proportion of primary care activity (Maier et al 2016). Indeed, a number of European health systems are expanding nurses' roles to increase their clinical autonomy in the management of long-term conditions and so that they can take on work that historically doctors did (Jakab et al 2018). In the UK, Cuckoo Lane Practice in London is one example of this type of working where advanced nurse practitioners take a central role in both the clinical work and leadership of the practice, with the practice having been rated outstanding by the Care Quality Commission (Cuckoo Lane Practice 2018).

Figure 5.5: FTE nursing staff in primary care, by role, September 2017 and September 2018



Source: [NHS Digital 2018b](#).

The recruitment and development of more nurses in primary care could release significant GP capacity and improve the quality of care. However, given the constraints on the nursing pipeline, exacerbated by the age profile of nurses in primary care, our modelling on the future GP workforce includes no assumptions that there will be any further shift in work between GPs and primary care nurses. Elements of the training pipeline for nurses are discussed in Chapter 2.

Support for mental health problems

Primary care has a pivotal role in supporting and promoting mental as well as physical health. It is estimated that 90 per cent of adults with mental health issues are supported primarily in primary care ([Mental Health Taskforce 2016](#)). The *Forward View for General Practice* has promised 3,000 more mental health therapists in primary care by 2020/21 ([NHS England 2016](#)) and NHS England has recently offered guidance for situating them within general practice ([NHS England 2018b](#)). Evaluation from 37 sites involved in integrating mental health therapists into primary care through the Improving Access to Psychological Therapies (IAPT) programme is ongoing, although early evidence suggests that savings are possible through moderating demand for physical care ([Gammie 2017](#)). This builds on positive international evaluations of models that combine physical and mental health provision in primary care ([AIMS Center undated](#)). The *NHS Long Term Plan* has signalled NHS England's continuing intention to expand the IAPT service, with a focus on those with long-term conditions ([NHS England 2019c](#)). It also suggests that the forthcoming workforce implementation plan will explore how roles such as counsellors can be integrated further into general practice.

There has also been growing interest across England in the use of non-clinical staff to deliver a more holistic approach to care involving a mental health component, for example by including employment specialists and housing and benefits advisers in primary care teams ([Newbigging et al 2018](#)). The use of social prescribing and related approaches to connect people with resources in their local community is also demonstrating positive results in some parts of the country; for example, evidence from the 'Vanguards' programme supports the use of 'wellbeing co-ordinators' in integrated community teams ([Naylor et al 2017](#)). These again show the importance of holistic care that spans traditional boundaries.

Although an agreed model (including the optimal type, range and number of staff) for mental health provision in primary care is currently lacking, it is already clear that there is a pressing need to explore ways of delivering services that differ from the status quo. We therefore recommend that national bodies support large-scale pilots in general practice, similar to those being delivered via NHS England's Clinical Pharmacists in General Practice programme, combined with rapid evaluation to look at their impact.

Recommendation

As the majority of adults with mental health issues are supported primarily in primary care, there is a pressing requirement to explore new ways of meeting these needs with a wider group of staff. We recommend the introduction of large-scale pilots in general practice aimed at exploring different models, similar to the pilots being delivered via NHS England's Clinical Pharmacists in General Practice programme.

Paramedics

A growing number of practices are training and employing paramedics in advanced practice roles to help manage patients with urgent care needs. This could involve:

- 'same-day' home visits for patients who cannot attend the practice
- seeing and treating urgent or emergency patients
- concentrating on care home activity
- running clinics for selected patient groups.

There is some limited evidence that paramedics in general practice can help to avoid hospital admissions and are valued by both GPs and patients ([Evans et al 2014](#)). But there is little evidence on cost-effectiveness; as well as the initial training, paramedics require GP supervision ([Imison et al 2016b](#)). HEE has been piloting a model whereby specialist and advanced paramedics are deployed in rotation across a variety of settings, including primary and community-based care, as well as within the ambulance service ([Health Education England 2018g](#)). The hope is that this will be attractive to paramedics and support retention across sectors. From 2021/22, arrangements under the new GP contract will support greater numbers of paramedics to work within primary care networks. The contract framework has suggested that it is only at this point when enough paramedics will come out of training to prevent a net transfer

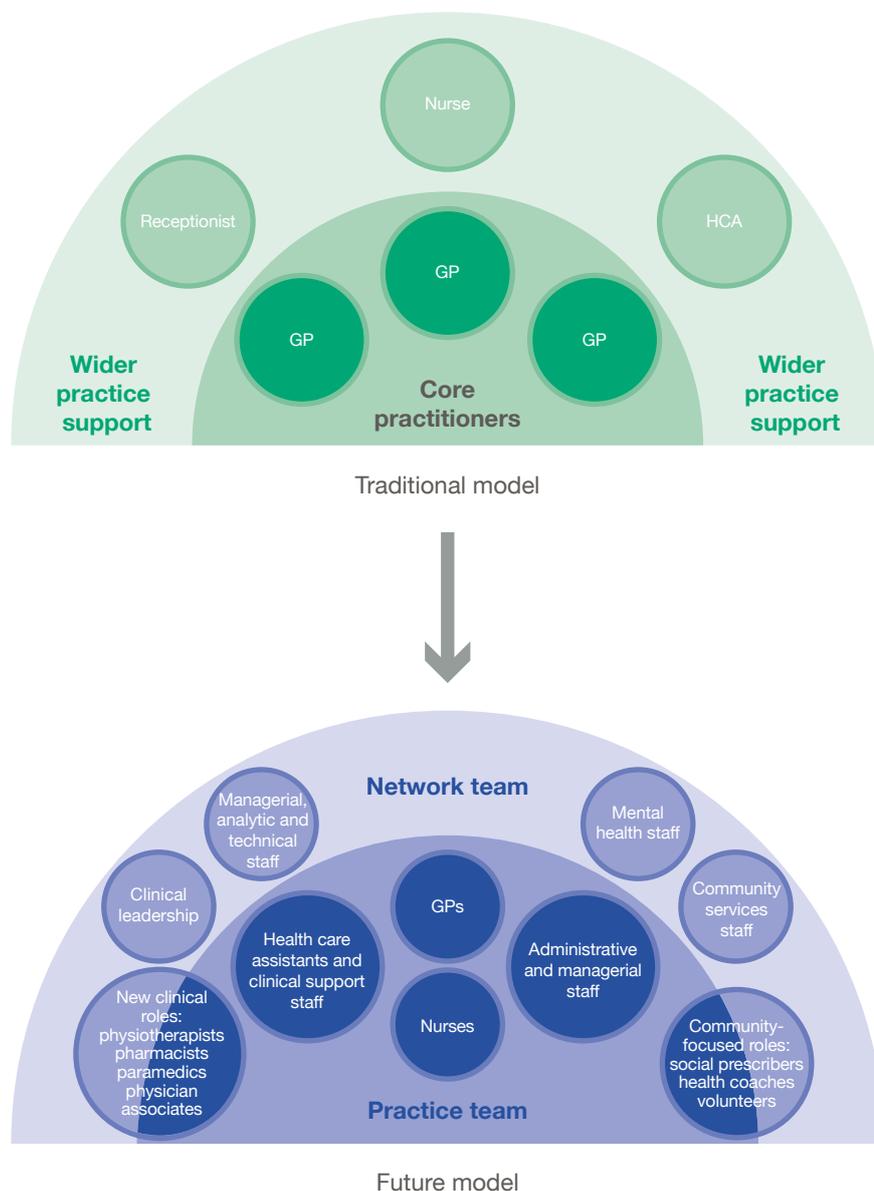
from the ambulance service. As there is a national shortage of paramedics, that limits the potential of this role in the short term, but if supply issues are addressed, it may offer opportunities for the medium term onwards.

The future model for primary care

There are significant opportunities to develop a much richer variety of roles in primary care. This was captured by the future vision for primary care that the Primary Care Workforce Commission set out in 2015.

Figure 5.6 shows how the model of primary care will develop as multidisciplinary teams expand.

Figure 5.6: The changing workforce model in primary care



Primary care practices will include a wider range of disciplines. As well as GPs, nurses and administrative support, primary care teams may include health care assistants, physician associates, paramedics, allied health professionals, social workers and others. Pharmacists will increasingly become a core part of the general practice team.

Primary Care Workforce Commission 2015, p 12

But different areas will have different patient needs, different abilities to recruit clinical staff and different workforce pressures. So there will be no one right model for the future primary care team and in the future the composition of teams will vary across England.

Changing the composition of the primary care team will also require significant changes to patient pathways and ways of working. These will be challenging to deliver, as we explore below.

Recommendation

NHS England, Health Education England and primary care networks should ensure best use of the primary care workforce is made through inclusive and ambitious changes in multidisciplinary teamworking with one possible route shown in our modelling. We welcome announcements in *The NHS Long Term Plan* and GP contract to achieve an expanded primary care team, including the recruitment of 20,000 additional staff. Investment in estate, support for workforce redesign, and flexible employment models are all needed if the full potential of these additional staff are to be realised.

Barriers and enablers to workforce redesign

Pathway and workforce redesign capacity

Some of the greatest opportunities for workforce redesign come from close alignment to pathway redesign and new models of care. One example is the Calderdale Framework, which provides a systematic approach to reviewing the capabilities within a team and staff roles in order to streamline services and provide more client-centred care (Smith and Duffy 2010). This can not only support greater role flexibility and sustainability but also the more efficient and effective use of resources (Patterson *et al* 2015; Nancarrow *et al* 2012). HEE has developed an online, interactive workforce transformation tool called 'HEE Star'¹¹ to support trusts that are looking for workforce solutions but, in our view, staff will need support and development to help them make use of this tool and undertake successful workforce redesign.

The Nuffield Trust report on reshaping the workforce (Imison *et al* 2016b) identified 10 lessons for organisations seeking to redesign their workforce (see the box below). Core to these are the skills needed for workforce redesign.

¹¹ See www.hee.nhs.uk/our-work/hee-star

10 lessons for workforce redesign

1. Be realistic about the time and capacity needed to support change.
2. Create a receptive culture for change.
3. Support transformation with a strong communication and change management strategy.
4. Build roles on a detailed understanding of the work, staff skills and patient needs.
5. Invest in the team, not just the role.
6. Ensure robust triage mechanisms.
7. Develop and invest in a training capability.
8. Build sustainability for new and extended roles.
9. Evaluate change.
10. Adopt a systematic approach to workforce development and change.

Investment in workforce development

As our earlier discussion demonstrates, all of the opportunities from workforce redesign and the associated technological support we have described rely on skilful implementation. Staff need to be trained. Investment in team and organisational development needs to be made. Allowance needs to be made for paying the backfill costs. The recent cuts to the HEE budget to support workforce development, which goes towards continuing professional development for staff, present a major challenge to progress, as does the lack of local workforce redesign capability. The current budget of £84 million¹² is woefully inadequate to deliver the scale of change needed and should be increased to at least its 2013/14 equivalent value (corresponding to a budget of £330 million in 2023/24). See our costings section at the end of this chapter for further detail. We would emphasise that even this amount is still comparatively small for a workforce of 1.4 million people with significant training needs. Further implications for the HEE budget from our other recommendations in this report are discussed in Chapter 7.

Clarity of role

A consistent theme that has emerged – in both extending roles and creating entirely new ones – is that clarity of purpose and a defined, safe remit are essential (Ross *et al* 2018). These are especially important where working across traditional boundaries, such as health and social care, can create uncertainty. For some roles, formalisation and regulation may be appropriate. For many others, clear local or national guidance will be immensely valuable if the roles are to unlock their potential. This is happening with examples such as the recently published HEE framework for 'advanced clinical practice', which codifies expectations with a view to informing staff training and development as well as governance arrangements (Health Education England *et al* 2017), but a similar approach is needed for other levels of the workforce where new roles are planned or developing.

¹² Sourced from Health Education England (2018j). In-year budget movements now mean the workforce development budget is currently £114 million (Health Education England 2019a). This reflects funding being reallocated or recharacterised from the 'future workforce' budget, largely to support specific programmes.

Regulation

There are problems with the current regulatory framework. The absence of protected titles or a clear national competence framework, particularly for many of the new support roles, opens up clinical governance risks, and is likely to inhibit roles' portability and sustainability. Regulation is also an important enabler for embedding advanced practice roles (**Maier et al 2017**). The government and the regulatory bodies have generally been slow to adapt and change to support local innovation. In a welcome move, *The NHS Long Term Plan* commits to expanding multi-professional credentialing to enable 'clinicians to develop new capabilities formally recognised in specific areas of competence' (**NHS England 2019c**, p 86). For example, in stroke services a new credentialing programme for hospital consultants, from a variety of relevant disciplines, will enable them to be trained and 'credentialed' to offer mechanical thrombectomy. The long-term plan's aim is to develop credentials for mental health, cardiovascular disease, the ageing population, the prevention of harm and cancer by 2020.

Supply of alternative staff

While there are significant opportunities for non-medical staff with advanced clinical skills to provide some care that doctors currently provide, this requires a buoyant supply of these alternative staff. The number of physician associates is still relatively small and the growing gaps in the nursing workforce present a challenge to the pipeline of nurses with advanced skills.

Technology

Finally, as we described at the outset, technology is a key enabler to workforce redesign and requires the necessary investment in staff development and service improvement.

Challenges for expanding teams in primary care

Capacity to do workforce redesign in general practice

In the case of general practice, most GPs work in partnerships and not in large organisations and so lack a significant infrastructure. They are, in addition, already facing challenging workloads with little development support on offer. While the local HEE training hubs have been helpful (**Health Education England 2017c**), they have been constrained by the cuts to workforce budgets, alongside local variation in capacity. On top of this, if practices are expected to recruit and retain new professional staff and develop new career opportunities for them, progress is likely to be slow at best. Instead, to move at pace in areas where the evidence clearly points to the need to bring in new staff such as physiotherapists and additional pharmacists, the NHS needs to look to establish a mixed model of employment and support that can then be tailored to meet local needs. The new GP contract allows for this flexibility, but it will remain a challenge to deliver at pace. Recent planning guidance states that clinical commissioning groups will be required to provide substantial recurrent cash allocations for the developing development and maintenance of the new primary care networks (**NHS England 2019a**) (see below) and clearly, workforce redesign is an important priority for this funding.

Models of employment for new staff

The NHS Long Term Plan (NHS England 2019c) has announced that individual practices will now enter into a network contract with other local practices as an extension of their existing contract, together covering between 30,000 and 50,000 patients (NHS England 2019c). The plan states that primary care networks will share a single designated fund through which resources for the whole network will flow. It is expected that these networks will be the route through which significant new investment will be channelled to create integrated primary and community care services. However, serious challenges persist with this model for facilitating workforce redesign. Primary care networks cannot employ staff directly themselves, and instead, can only aim to channel funding towards others that can. In some parts of the England, this may cause problems. More widely, networks are likely to face issues, particularly in the short term, related to their status as a contracting arrangement rather than a distinct 'body' with appropriate executive functions representing the whole network. They may also face challenges with indemnity and accountability if clear structures are not present for relationships between practices and with other organisations.

Over time, these networks and federations of practices may offer another way for of bringing in new staff to general practice, using the benefits of scale. Subject to their legal status, integrated care systems may be able to directly employ staff as local systems mature, supporting new posts directly as health boards have done in Scotland (Scottish Government 2017). The move toward this model in Scotland is certainly an opportunity for learning that can be applied to services in England.

In the shorter term, a mixed model of employment will be needed that includes: NHS trusts; federations or networks; voluntary, community and social enterprise organisations; and lead practices. The recent GP contract framework allows new staff brought in to general practice through the 'additional roles reimbursement scheme' to be employed by other providers as long as both organisations agree (British Medical Association and NHS England 2019).¹³ It is likely that in many areas this will mean looking to NHS providers to employ and host staff on behalf of general practice and it is possible that this will end up as the permanent model. But we need further evidence on what works before ruling out any approach and must recognise the operational challenge of moving from the current model of general practice to wider, multidisciplinary teams that provide an attractive career to staff, both clinical and non-clinical. Pharmacists have been brought directly into general practice using a greater degree of central funding. This model continues to offer opportunities to grow certain staff groups at pace. For physiotherapists (and other staff like them), employment by community and acute trusts (which take on human resources, backfill, pensions and clinical supervision and enable staff to stay on Agenda for Change contracts), and which then provide staff to general practice, is often appropriate. In all cases, the funding allocated in *The NHS Long Term Plan* to support and develop primary and community care (NHS England 2019c) should be used in a versatile way and make use of existing NHS bodies (and beyond) to enable successful employment arrangements.

¹³ Section 1.31 of 'Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan'. British Medical Association and NHS England (2019).

Teamworking and an attractive career

The model of employment in primary care must ensure an attractive career structure in these new roles and allow the potential for developing flexible and portfolio careers. This can pose challenges for those working across community pharmacy, general practice and NHS trusts due to variation in remuneration, and terms and conditions and the huge difference in scale of the organisations involved.

Whatever the appropriate route of implementation, posts in general practice must always be firmly embedded within the team to build the relationships and trust needed for high-quality care ([Baird et al 2018](#)) and not 'parachuted' in on top of existing general practice staff. To achieve this, support for general practice must also include organisational development and assistance in building these teams.

The general practice estate

The general practice estate is also a potential barrier to moving forwards. Being located in the same place is an important aspect of team-based care. However, the British Medical Association reports that seven out of ten GPs in England feel that their facilities are too small to deliver extra or additional services to patients, while four out of ten GPs say that their practice currently does not have adequate facilities to deliver services to patients ([British Medical Association 2014](#)). A review of GP premises has been commissioned to find solutions to problems with the current general practice estate. This review is being undertaken in part due to concerns around how policy barriers are limiting the efficient and effective use of the estate – including how reimbursement works between care providers and how risk and liability are shared ([NHS England 2018a](#)). Due consideration must be given to the ease with which general practice (and other parts of the NHS's estate seeing similar 'mixed use') can be expected to co-locate professionals in the same place as teams expand. Significant investment in the primary care estate will be needed.

Recommendation

The Department of Health and Social Care and Health Education England should support a step change in the capacity and capability available within organisations and across local systems to implement evidence-based workforce redesign and equip their staff with the skills for a digital future. The current workforce development budget of £84 million should be increased at the very least to the equivalent of its 2013/14 value – approximately equal to £330 million in 2023/24.

Conclusion

Workforce redesign and fully exploiting the opportunities offered by new technologies present significant opportunities to improve care for patients, reduce the workload of clinical staff and help to bridge the forecast gap between demand for health care and the workforce available to meet that demand, but will be hard to deliver.

In primary care, the availability (at least at the national level) of pharmacists and physiotherapists presents a good opportunity to broaden the primary care team, improve patient access and reduce GPs' workload. Similarly, expansion of both clinical and administrative support staff can free up capacity in the wider team. Involving IAPT therapists as well as non-clinical staff such as employment specialists and housing and benefits advisers in the wider team also creates opportunities to improve care for patients and potentially moderate demand. There are opportunities for many different professional groups to increase their role in primary care teams in addition to those discussed in this chapter, with the aim of not only coping with demand but also increasing access to appropriate types of care for patients. However, general practice will need significant support with workforce and service redesign to make use of these additional staff, especially where this is to happen quickly. This includes flexibility around staff employment models. There will be different solutions in different places.

In acute hospitals, there are considerable opportunities for nurses and a range of allied health professionals equipped with advanced clinical and diagnostic skills, including physician associates, to safely take on many of the functions that traditionally doctors took on. Technology can facilitate and support these opportunities in both the acute sector and other settings.

A major barrier for new roles and unregistered workers taking on more duties is a lack of clarity about what can be expected of them and what tasks are safe to delegate. To make the most of these types of worker, there should be a structured approach to the development of the roles, setting out clear boundaries and expectations. This should be either at the local or the national level, depending on what is most appropriate in the context of local service design. All new roles should be built around a clear, articulated vision for their place in the multidisciplinary team. This will require significant resources and capability if we are to move from the current variable and piecemeal approach to deliver systemic change in the health and care workforce.

Costings

We have estimated the additional cost of implementing our recommendations for this chapter in the table below. We note that some of the cost of implementing workforce redesign will fall under recently announced funding allocations. We welcome NHS England's commitment to funding for around 20,000 additional staff, including pharmacists and physiotherapists, as part of the new GP contract. Additionally, recent planning guidance for clinical commissioning groups ([NHS England 2019b](#)) requires that recurrent funding in cash is made available for developing and maintaining local primary care networks, which are an important source of funding for workforce and

service redesign. Our recommendations require these sources of funding to be used to secure change at pace and scale but do not include them in our estimates below as they are not an additional cost to the system.¹⁴

Table 5.1: Uplift in the HEE workforce development budget needed

	2019/20	2020/21	2021/22	2022/23	2023/24
Uplift in the HEE workforce development budget needed	£210 million	£220 million	£230 million	£240 million	£250 million

¹⁴ This uplift represents the difference between the 2018/19 HEE workforce development budget of £84 million and the total if returned to the equivalent percentage of Department of Health and Social Care's resource departmental expenditure limit (RDEL) this budget had in 2013/14. As shown in the table, this figure then grows in line with the real-terms NHS England RDEL up to 2023/24. Figures rounded to the nearest £10 million.

6. Supply of new staff: international recruitment

Harry Evans, Helen McKenna and Pinchas Kahtan, The King's Fund

Key messages

- International staff make up 13 per cent of the NHS hospital and community services workforce. We recognise the invaluable role that they play in providing high-quality health care in England.
- International staff are the only realistic short-term lever for dealing with current widespread vacancies. *The NHS Long Term Plan* has committed to reaching 5 per cent nursing vacancies by 2028 ([NHS England 2019c](#)). We do not think it is desirable to operate with extensive vacancies for so many years, and we instead believe that NHS England should be aiming to meet this 5 per cent target by 2023/24. Our modelling (see Chapter 7) suggests that the only way of achieving this is to employ staff from other countries. After 2023/24, international recruitment can decrease, as domestically trained staff enter the workforce. By 2028/29, we believe that international recruitment can return to current levels, encouraging cultural exchange, but not overreliance.
- We recommend that the NHS delivers a step change in the ethical recruitment of international nurses, with a view to recruiting an average of 5,000 international full-time nurses a year to 2023/24 into the NHS in England – higher than currently, but a level achieved in the past.
- We recommend that these efforts are supported by a nationally funded, regionally led programme, underpinned by effective and ethical practice. Existing initiatives, such as the Medical Training Initiative, should be expanded rapidly to scale up international recruitment in the short term. We estimate that the cost of this infrastructure, given savings at scale, will be around £10 million a year for the next five years (in 2018/19 prices).
- There are challenges that are preventing international recruitment from being used to full advantage, including complexities in language restrictions and recognition of international qualifications. Further action is needed from professional regulators and the Royal Colleges to make the process easier.

- We recommend that regulators are supported to effectively review their processes, ensuring that the processes are streamlined and standardised for international recruits. The review should look at language-testing requirements to ensure that they are proportionate, as *The NHS Long Term Plan* has suggested (**NHS England 2019c**).
- Other barriers to international recruitment include the costs that newly recruited migrants and employers face. One example of this is the health surcharge, which newly recruited non-EEA staff have to pay if they want access to NHS services. The Royal College of Physicians estimates that these immigration-system-related costs are £4,409 (in 2018/19 prices) over three years (**Goddard 2018**). We anticipate that these costs may also apply to EU health workers post-Brexit.
- We recommend that national bodies meet these costs. This should remove a disincentive for both people seeking employment in the NHS and employers.
- The challenges in securing visas for international staff have been significantly mitigated by removing doctors and nurses from the visa cap. However, there are still barriers in the visa process for many medical specialties. The Home Office has only guaranteed the existing health professional visa salary exemptions to January 2021 (**Collins 2019**). Visa barriers are excessive for some allied health professionals, who find it very difficult to come and work in the NHS. Brexit may extend these challenges to health workers in countries of the European Economic Area¹ (EEA) too.
- We recommend that all registered health professionals, not just doctors and nurses, are exempted from current restrictions on visas. The government's recent proposals for a post-Brexit immigration system (**Home Office 2018b**) do not, by themselves, provide for this eventuality. This means that action will need to be taken to add health professionals to the 'shortage occupation list', with a salary exemption guaranteed beyond January 2021.

Introduction

In recent years, historic shortfalls in training numbers mean that employers are increasingly looking to where they can find other sources of staff. Today's significant vacancies must be filled urgently to maintain patient safety and prevent waiting lists from deteriorating further. Educating and training more staff to address the shortfalls can take years (see Chapter 2 for an exploration of training) and so the NHS needs to consider other sources of trained staff in the short term.

In this chapter we examine one of these alternatives for finding trained workers: international recruitment. 'Return to practice' – another way of attracting trained staff – is explored in Chapter 5.

¹ In this chapter we usually refer to EEA migrants to encompass those in the EU and EEA together.

International recruitment

The English NHS is already supported by a skilled, international workforce. In June 2018, 13 per cent of hospital and community sector staff in England reported a non-British nationality (**Baker 2018**). Of these, 6 per cent reported an EEA nationality – over 63,000 staff. Of nurses, the largest staff group, 9 per cent had a non-EEA nationality and 7 per cent had an EEA nationality.

Past history

In the past, the UK has relied heavily on the recruitment of health staff from other countries. It was an important source of workforce growth in the early 2000s. In 2001/02, 16,000 nurses and midwives joined the Nursing and Midwifery Council register from outside the UK² (**Buchan 2009**). Of those 16,000, we estimate that around 8,000 nurses started full-time equivalent (FTE) roles in the NHS in England. In the same year, more international nurses than UK-trained nurses joined the register (**Health Foundation 2017**).

Successful recruitment during this period was driven through national targets, supported by a strong national and regional infrastructure. There were teams at national and regional levels working directly with employers to recruit large numbers of staff from overseas. This made use of economies of scale in a way that individual organisations could not (**Buchan 2009**). The Department of Health provided support with obtaining references, work permits and assistance with relocation (**Department of Health undated**). Government was also able to negotiate deals with other governments to ensure that source countries were bought in and aware of recruitment drives.

International recruitment then fell away again before 2010 as lower NHS funding reduced the number of posts and more restrictive immigration policies made it difficult to bring such staff in from outside the EEA. This change was also in response to more domestically trained staff entering the workforce.

In **2013**, the final report of the Francis Inquiry into Mid Staffordshire NHS Foundation Trust was published. The inquiry recommended that the National Institute for Health and Care Excellence (NICE) should produce evidence-based guidance on safe levels of staffing. Safe staffing guidelines and increasing vacancy rates signalled to employers that it was necessary to increase staffing levels and they began to look internationally again (**Lintern 2014**). These new staff initially came largely from the EEA (facilitated by its policy on the freedom of movement and economic factors in other European countries), while restrictive immigration controls made non-EEA immigration difficult.

² To practise in the UK, nurses and doctors must register with the Nursing and Midwifery Council or the General Medical Council respectively. However, registration figures are not equivalent to the number of full-time staff joining the English NHS. We have estimated how historic Nursing and Midwifery Council registrations equate to English full-time NHS nurses, but the most reliable way of using these numbers is to report on total international Nursing and Midwifery Council and General Medical Council registrants. Unless otherwise stated, international joiner figures in this section relate to new registrants in all of the UK.

But in 2015, in response to growing alarm over registered nurse shortages, the Home Office added nurses to the UK's 'shortage occupation list',³ lifting many immigration restrictions for non-EEA nurses (**Migration Advisory Committee 2016**).

Current position

Relaxation of these restrictions has led to the growth in non-EEA nurse registrants seen since 2015, but Brexit may be part of a corresponding fall in EEA joiners. The latest Nursing and Midwifery Council register numbers show that 2,724 non-EEA nurses joined the register in 2017/18, compared with 805 EEA nurses (**Nursing and Midwifery Council 2018b**). However, even with both EEA and non-EEA registrants taken into account, these figures are considerably below the peak of around 16,000 international registrations in 2001/02.

This suggests that there is scope for expanding our international recruitment efforts to support the NHS workforce in the short term. *The NHS Long Term Plan* recognises this, calling for a 'step change' in international recruitment in the short term, until long-term measures to boost supply begin to deliver (**NHS England 2019c**). To support this, the workforce implementation plan will lay out new 'national arrangements' to provide support to local NHS organisations recruiting internationally.

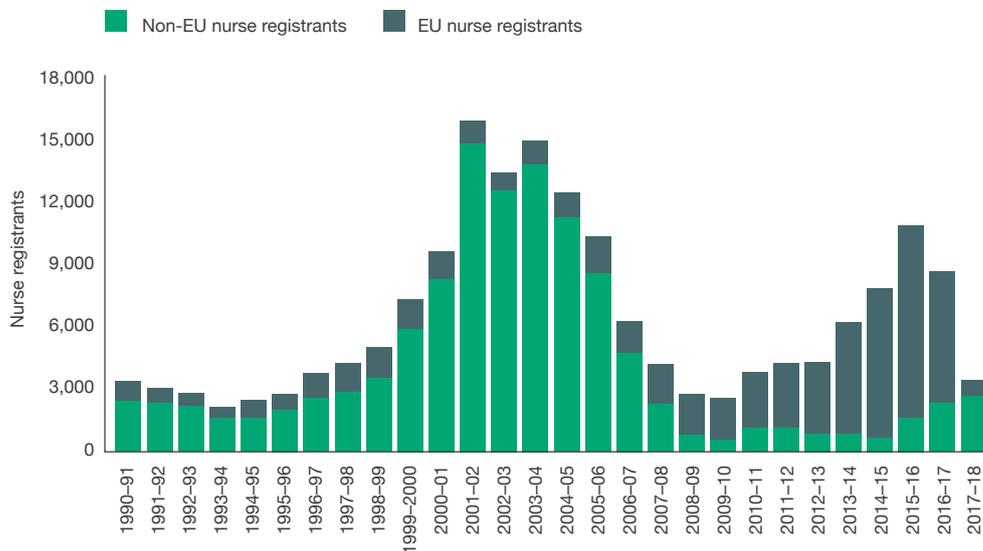
Figure 6.1 shows the number of EU and non-EU nurse registrations with the NMC since 1990/91. This is registrations for all of the UK and includes individuals who go on to work in other sectors, such as social care. For consistency, this figure uses 'EU' as a definition, instead of EEA which came into existence in 1994.

International recruitment is easier for certain staff groups that are prevalent internationally, such as nurses working in acute settings. Looking internationally is more challenging for some specialties (**Priebe 2004**), general practitioners (GPs) (**Rimmer 2017a**) and community nurses (**Lucas 2015**). This tends to be because of severe shortages in these professions outside the United Kingdom or a lack of equivalence between roles.

Some international recruitment efforts have come unstuck due to challenges and complexities in hiring some staff groups from overseas. One example is the international GP recruitment programme. *General practice forward view* aimed to recruit an additional 5,000 GPs between 2016 and 2020 (**NHS England 2016**). To support this, an NHS England-led programme was developed, initially aiming to recruit at least 2,000 international GPs between 2017 and 2020. The programme supports GP practices in underserved areas to find new recruits from the EEA and Australia.

³ The shortage occupation list is a list of occupations where there are not enough resident workers to fill vacancies. It is reviewed regularly by the Migration Advisory Committee. Visas for occupations on the list are not subject to the same restrictions as visas for other occupations. For more detail, see the box entitled 'Tier 2 visas' later in this chapter.

Figure 6.1: Number of EU and non-EU nurse registrations, UK, 1990/91 to 2017/18



Source: [Health Foundation undated](#).

This has proved more challenging than expected and the programme only managed to recruit 85 GPs in its first year ([Osborne 2018](#)). The programme has found that there is a long lead-in time for recruiting GPs overseas, but more may be entering the workforce as the number of applications has been increasing ([NHS England 2018c](#)).

International recruitment of GPs has been more successful in the past. Non-EEA and EEA General Medical Council registrants in the UK rose 6 per cent between 2006 and 2007, compared with flat growth between 2016 and 2017 ([General Medical Council 2017](#)). Interviewees suggested that current efforts are being hampered, in part, by the lack of attractiveness of the NHS to international GPs and problems over the equivalence of qualifications and training.

The learning from the international GP recruitment programme highlights how challenging and difficult recruiting internationally can be. It also demonstrates that international recruitment should not be relied on for all staff groups.

How does the NHS currently do international recruitment?

There are different ways in which the NHS recruits internationally, but they generally fall into two categories. First, there are 'train-and-return schemes' where international health workers are brought over to the UK temporarily, usually for two to three years, and are provided with learning as they work. Second, there is the active recruitment of permanent staff, which is also common in the NHS. With this kind of recruitment there is no time limit for roles, unless imposed by visa restrictions, and otherwise it is like recruiting domestically trained staff.

Train-and-return schemes

Train-and-return schemes vary in size and scope and often have some national co-ordination. The Medical Training Initiative, a national example of such a scheme, is allocated 1,000 visas a year (see the box below) ([Academy of Medical Royal Colleges 2018](#)). Health Education England (HEE) has also started its own programme, aiming to work with local NHS organisations to attract 5,500 international nurses over an unclear timescale ([Lind 2017](#)).

The Medical Training Initiative (MTI)

The Medical Training Initiative brings doctors from overseas into the NHS for a fixed period. It was initially set up to attract a small number of doctors from developing countries, ensuring that cultural exchange was maintained while the numbers of international medical graduates in the NHS fell ([Trewby 2008](#)).

The programme, run by the Academy of Medical Royal Colleges, works with trusts to find suitable placements. Placements last a maximum of two years, and doctors must wait five years before applying for further MTI placements ([Academy of Medical Royal Colleges 2017](#)). The programme provides training and education to participants, tailored to their needs. Successful applicants are brought in on tier 5 visas, which are reserved for short-term exchange migrants, and it is made clear that the scheme should not be a route to permanent residence.

The programme has expanded greatly since its first year ([Trewby 2008](#)). The focus for the MTI is on cultural exchange and the sharing of international learning in the NHS. But it can provide a route for recruiting to areas with a high number of medical vacancies. *The NHS Long Term Plan* flagged the MTI as a potential means of encouraging international trainees to learn and work in the NHS ([NHS England 2019c](#)).

An early attempt at train-and-return was HEE signing a memorandum of understanding with Apollo Hospitals in India. The intention was to bring over doctors on a rolling basis for three years. While this programme initially brought over emergency medicine doctors, HEE also hoped to attract 400 GPs ([Wickware 2017](#)). As with the specific international GP recruitment programme, it is not clear that this programme had an impact on the GP workforce.

More recent efforts to create other train-and-return schemes for doctors and nurses, with a regional focus, have attracted larger numbers of recruits. Of particular note is a scheme in Greater Manchester, initially in Wrightington, Wigan and Leigh NHS Foundation Trust ([Rimmer 2017b](#)). In 2018, the programme brought in 90 doctors from India and other countries on a temporary basis while they study for a postgraduate qualification. There are plans to expand this further to other local trusts and also expand it into nursing.

A key emphasis of train-and-return programmes is that individuals return with new skills and experience ([Rimmer 2017b](#)). Many clinicians value the learning and prestige that come from working in another system, and as they return to their country of origin this causes less disruption to the source country's workforce. However, concerns have been raised that ensuring the return of staff to the source country can be difficult ([Karan et al 2016](#)).

With increasing interest in using train-and-return schemes in nursing, it is important that new schemes are evaluated. Evaluations should particularly assess whether nurses benefit from these schemes and, in turn, whether the source countries benefit from their participation.

Active recruitment of permanent staff

There are many examples of individual trusts bringing groups of qualified nurses permanently over to the UK and retaining them at their organisation ([Sandhu 2018](#); [Handley 2015](#)). James Paget University Hospitals NHS Foundation Trust has successfully recruited nurses from Portugal ([Handley 2015](#)), while King's College Hospital NHS Foundation Trust has been recruiting internationally for some years and has helped other trusts to do the same ([Osborne 2014](#)).

Successful trusts report having heavy involvement in the recruitment process, with some managing most of the recruitment visit themselves instead of using commercial recruiters. Attrition of staff can be managed through investing time and resources in making the visa and relocation process easy.

Thinking early about the retention and wellbeing of international staff is also important as a means of demonstrating attractiveness to new recruits. Research has shown that orientation and mentoring programmes are effective means of supporting international recruits in their new surroundings ([Kehoe et al 2016](#); [Ohr et al 2014](#)). The NHS still struggles with discrimination of international workers and so cultural awareness in the receiving organisation is crucial ([Kehoe et al 2016](#)). Ensuring that staff from different backgrounds are supported is explored in diversity themes throughout this report, especially in the section on retention in Chapter 5.

Yeovil District Hospital case study

Yeovil District Hospital NHS Foundation Trust has been recruiting nurses from Dubai and the Philippines successfully for the past two years. The trust does not outsource its recruitment and it is able to give applicants an honest picture of Yeovil and the surrounding areas. This has helped to ensure retention as the trust is able to select staff who are attracted to the particular qualities of the local area (Sandhu 2018).

The trust has been supporting 12 other trusts in achieving the same aims, recruiting on their behalf while sharing best practice and knowledge with them. The sharing of best practice has not only included recruitment advice but also focused on keeping in touch with recruits before they make the journey to the UK. The trust has also provided advice on how to settle staff rapidly and compassionately into trusts and the local area. The assisted trusts have included both acute and community trusts.

Challenges to international recruitment

Despite existing good practice from some organisations, some have had poor experiences of recruiting from overseas. There are many different factors that can influence success in overseas recruitment. Rural areas may be more difficult to recruit to (Somper 2018) and staff in some sectors are specifically difficult to find internationally (see the section entitled 'Current position' earlier in this chapter). Propensity to recruit internationally may also be affected by organisational factors, such as finances or having the skills and confidence to look internationally (Marangozov *et al* 2018).

In this section, we do not go into organisational challenges specifically, but rather address the system issues that we have identified that may be having an impact on a range of international recruitment efforts. However, we recognise that the reality for many local NHS organisations is that international recruitment has been difficult for reasons other than the small number listed here.

Visa restrictions

Visa restrictions have made it difficult for non-EEA workers to come and work in the NHS. Some of these restrictions have recently been relaxed (Collins 2018), a change that the Home Secretary, Sajid Javid, has said he has no plans to reverse (Grierson 2018). However, many medical specialties remain off the shortage occupation list, which means there are additional hurdles for recruiting these specialties despite this change.

Specialties that are currently in crisis, such as child and adolescent psychiatry (Royal College of Psychiatrists 2018), are still required to go through processes to prove there are no local candidates available. Navigating these processes requires dedicated resources from NHS organisations. Smaller organisations, such as GP practices, could be put off from attempting to look internationally.

Tier 2 visas

Most staff who join the NHS from overseas do so on a tier 2 visa. Tier 2 visas are for workers who have an offer of employment and a certificate of sponsorship from their prospective employer. There is an annual cap of 20,700 certificates of sponsorship available and they are allocated based on a points system. Points towards certificates of sponsorship are allocated in the following order of priority: first, roles recognised on the shortage occupation list, then PhD-level occupations, then new graduates and then on the basis of salary. A £30,000 salary floor prevents some poorer-paid applicants from entering the UK. However, some professions on the shortage occupation list have a lower salary floor, such as nurses and paramedics due to nationally set pay scales ([Home Office 2018a](#)). The Home Office has confirmed that the salary exemption for professions on the shortage occupation list will be extended to January 2021, when it will be reviewed ([Collins 2019](#)).

Nurses and a limited number of medical specialties have been on the shortage occupation list, but in July 2018, the Home Office removed all doctors and all nurses from the tier 2 cap ([Collins 2018](#)). This has made employing international doctors and nurses much easier. However, medical specialties that are not on the shortage occupation list⁴ are still required to pass a resident labour market test (RLMT), requiring any vacancy to be posted domestically for 28 days before being filled internationally. The test can be satisfied at a national level for national programmes. The shortage occupation list is currently under review, with the Migration Advisory Committee due to report its recommendations for changes to the Home Office in the spring of this year.

Some allied health professionals are not helped by these changes and the salary threshold makes international recruitment very difficult for these groups. These challenges are likely to be exacerbated by Brexit. The government published its post-Brexit immigration system proposals in December 2018 ([Home Office 2018b](#)), which are to:

- treat migrants from EEA countries the same as non-EEA migrants
- remove the tier 2 visa cap, which currently restricts the numbers of skilled professionals that can enter the UK in a given year
- keep the salary floor of £30,000
- lower the qualification floor to Regulated Qualifications Framework level 3 (RQF-3) (A-Level or equivalent)
- abolish the resident labour market test.

A summary of the tier 2 visa system, how it applies to different health professionals and the implications of the government's proposals can be found in Table 6.1.

⁴ A small number of medical specialties are on the list, such as old-age psychiatrists and emergency medicine consultants and non-consultants. Child and adolescent psychiatrists, neurologists and most junior doctors are all groups of doctors currently not on the list.

Regulatory considerations

Beyond visa restrictions, there are many additional hurdles for employers and migrants to jump. Some potential applicants perceive regulators' language requirements to be 'arbitrary' ([Allan and Westwood 2016](#)). In 2017, 35 per cent of surveyed EU nurses being placed in the UK reported that language testing was the biggest barrier to joining the NHS ([HCL Workforce Solutions 2017](#)). Only 15 per cent cited Brexit as a barrier. This demonstrates how important a factor language testing can be for an international health worker deciding where to practise.

In 2018, the General Medical Council and the Nursing and Midwifery Council made progress in simplifying and reducing language requirements, while attempting to maintain safety and the quality of doctors and nurses ([Nursing and Midwifery Council 2018a](#); [Parkin and Bate 2018](#)). Despite improvements, interviewees told us that language levels that regulators require are still some of the highest in the world.

While there is automatic recognition of some EEA qualifications, non-EEA qualifications are treated differently. This means that non-EEA applicants undertake individual assessments before they can complete their applications. Automatic recognition of qualifications and experience from a wider range of countries could facilitate speedier and less burdensome movement of trained staff.

As *The NHS Long Term Plan* has noted, progress has been made in simplifying regulatory processes ([NHS England 2019c](#)). However, there is more work to be done this year to understand whether language restrictions are proportionate. The impacts of changes to language testing should be monitored – both for safety and to understand whether the new testing arrangements are working for employers. If international recruitment is to be boosted, there will need to be corresponding support provided for regulators.

Recommendation

Ensure that regulators have the support to standardise and streamline their processes for international recruits. Government should support professional regulators to review processes and understand where time savings can be made to ensure that successful international applicants can get into post as soon as is safe. Existing positive efforts in terms of automatic recognition of qualifications and finding more appropriate language testing should be redoubled.

Brexit

The sharp decline in the number of nurses joining the NHS from the EEA may be exacerbated by the increased friction caused by the end of the free movement of people from the EU. A recent report projected that Brexit could lead to an additional shortage of between 5,000 and 10,000 nurses by the end of the transition period ([Dolton et al 2018](#)).

One of the challenges is that new recognition of European qualifications will need to be managed. Currently, there is an automatic recognition of EEA clinical qualifications, but it is unclear how this will change after Brexit.

On the other hand, the total number of General Medical Council registrants from the EEA seems to be holding up, rising 0.3 per cent in 2016/17 and a further 0.8 per cent in 2017/18 (**General Medical Council 2018a**). It remains to be seen whether this growth will continue after Brexit, especially given the visa issues described below.

There are associated costs for NHS organisations that will need to be met once the visa system applies to EEA migrants after Brexit. Currently, employers cover the costs of applying for a certificate of sponsorship and an immigration skills charge. Migrants pay for their visa and immigration health surcharge, although employers are now sometimes paying this to lower the barriers to migration. The Royal College of Physicians estimates that the total cost per health worker for three years is £4,409 (2018/19 prices), covered between the individual and the employing organisation. These are costs that currently the NHS may have to bear when the UK leaves the EU/EEA.

Recommendation

Pay the costs associated with migrating to work in the NHS from central funding.

The financial barriers to working in the NHS should be removed for both the migrant and the NHS organisation. Given the need for international recruitment to increase in the short term, the disincentive of cost should be removed from the equation. Currently, the cost will apply to EEA migrants after Brexit as well as non-EEA migrants. In line with the Royal College of Physician's estimate, we assume that this cost will be an average of £4,409 per recruit for three years.

The NHS Long Term Plan recognises some of the progress that has been made in the visa system, but indicates a desire to do more across government to ensure that the post-Brexit immigration system works for the NHS (**NHS England 2019c**).

Table 6.1 summarises the current visa situation for different staff groups and how this is likely to change given the government's recent post-Brexit immigration system proposals (**Home Office 2018b**). It contains granular recommendations for what needs to change to support future international recruitment as the UK leaves the EU/EEA. Social care is addressed in the table, but more detail is provided in Chapter 8. See the box entitled 'Tier 2 visas' earlier in this chapter for details on the tier 2 visa system and the government's proposals for how it might change after Brexit.

Table 6.1: Summary of the impact of tier 2 visas on different staff groups in the current situation, the government's recommendations for after Brexit, and our recommendations

Staff group	Current situation (for non-EEA migrants)	Government's proposals post-Brexit (applies to EEA and non-EEA migrants)	Our recommendations
Registered nurses	On the shortage occupation list (SOL), granted a salary-limit exemption (to be reviewed in January 2021) and removed from the tier 2 visa cap (fewest barriers to entry).	The removal of the tier 2 visa cap formalises the current exemption for nurses. Salary floor of £30,000 would have a big impact on nurses if they are not kept on the SOL with a salary exemption.	Ensure that nurses stay on the SOL when it is reviewed this year and that their exemption from the salary floor is maintained after January 2021.
Medical practitioners on the SOL (eg, old-age psychiatrists and emergency doctors)	On the SOL and removed from the tier 2 visa cap.	The removal of the tier 2 visa cap formalises the current exemption for doctors.	These practitioners should be looked at in the SOL review to understand whether they will be affected by the salary floor. Some junior medical practitioners may be beneath the salary floor and it should be investigated whether other routes such as the Medical Training Initiative might be most appropriate for recruiting these groups.
Medical practitioners not on the SOL (eg, child and adolescent psychiatrists and neurologists)	Removal from the tier 2 cap makes recruitment easier. But the resident labour market test (RLMT) requires vacancies to be advertised domestically for 28 days, making it difficult to recruit rapidly and at scale.	The government has proposed removing the annual cap on tier 2 visas and removing the RLMT. Some junior medical practitioners will be below the £30,000 salary floor.	Adopt the government's proposals. Review whether other routes for junior medical practitioners, such as the Medical Training Initiative, are sufficient to guarantee an inflow of junior international medical graduates.
Allied health professionals (AHPs) on the SOL (eg, paramedics)	AHPs on the SOL are subject to the annual cap, but being on the list puts them in a very good position to be approved for working in the NHS. The SOL also gives AHPs a salary exemption until January 2021.	The government's proposals remove the cap on tier 2 visas, making it easier for this group to join the NHS. The salary floor of £30,000 would have a big impact on this group if they are not kept on the SOL with salary exemptions.	Ensure that AHPs remain on the SOL when it is reviewed, with a salary exemption after January 2021.
Allied health professionals (AHPs) not on the SOL (eg, occupational therapists)	Unless these AHPs have excellent salary prospects and a PhD, they are unlikely to reach the number of points they need to gain a visa. Many of them are under the £30,000 salary floor needed for a tier 2 visa.	The government's proposals remove the cap on tier 2 visas, making it easier for highly paid or educated AHPs to join the NHS. However, the salary floor would limit the migration of these AHPs substantially.	Add these AHPs to the SOL and exempt them from the salary floor. Even if these AHPs are not in shortage, or there is not evidence of this yet, they will be needed to complement health professionals that are (see Chapter 6).

Social care – care workers (see Chapter 8)	Due to the £30,000 salary floor and the required qualification level (degree level or above), tier 2 visas are out of reach for this staff group.	The government's proposals do not recommend exempting social care or creating a separate scheme for care workers. The government proposes the allocation of transitional, 12-month visas to allow migration for sectors such as social care in the short term.	Boost pay and conditions for social care staff (see Chapter 4). If this is not achieved, a specific international scheme for social care will need to be explored and piloted. A 12-month visa scheme is unlikely to be attractive to either migrants or social care providers (Hemmings and Curry 2018).
Social care – managerial staff (see Chapter 8)	Some managers will exceed the salary floor, but these roles do not have the advanced qualification threshold needed for visa consideration.	The government's proposals would lower the qualifications threshold needed for social care managers to be considered for a tier 2 visa. The removal of the tier 2 visa floor would make it easier to employ social care managers, although the salary floor may still have an impact on the chances of some social care managers.	In the short term, social care managers should be added to this year's review of the SOL. A salary exemption should be considered given the numbers of social care managers earning less than £30,000 a year.

Recommendation

Extend existing visa salary exemptions to all registered health care staff, and these exemptions need to be extended beyond January 2021. All health care professions should be added to the shortage occupation list. The Department of Health and Social Care and the Home Office should ensure that visas are available swiftly, as and when they are needed. The visa process for NHS organisations should be revisited to ensure that ethical international recruitment is as easy as domestic recruitment.

Cost

There are other costs associated with recruiting internationally. Cost estimates for a trust to recruit from overseas vary: between £2,100 and £12,800 for a nurse (in 2018/19 prices) (**National Audit Office 2016**). This variation will be due to the international recruitment approach used, the country of origin of the recruit and whether an external agency is used, alongside other factors.

This is considerably cheaper than educating and training a new nurse, which costs the system and nursing student an estimated £70,000 (**Curtis and Burns 2018**).⁵ But as employers do not meet the costs of educating new nurses but do typically meet the costs of international recruitment, they may be reluctant to consider international recruitment, particularly in areas where recruitment might be more costly.

⁵ This estimate is in 2018/19 prices and includes the tuition costs, infrastructure costs (such as libraries), costs or benefits from clinical placement activities, and lost production costs during the period of training where the member of staff is away from their post.

Challenges to international recruitment in the longer term and ethical considerations

Global shortages are a longer-term issue for international recruitment. The World Health Organization has projected that, by 2030, all World Health Organization countries could experience shortfalls of about 50,000 midwives, 750,000 doctors and 1.1 million nurses (**World Health Organization 2016**). There are also legitimate ethical concerns about expanding our international recruitment policies. The global shortage of health workers means that developing countries are at risk of a brain-drain to developed countries. Voluntary ethical codes exist to establish principles for the ethical recruitment of health workers (see the box below). While positive, these codes have not eliminated unethical recruitment practices (**Bourgeault et al 2016**).

Train-and-return schemes are sometimes seen as beneficial for the source country, as they provide different experiences and training, as well as returning individuals to their source country. However, the benefit of these schemes to the source country has been doubted, especially where the opportunity costs include losing medical professionals in shortage (**Khan 2004**).

Government-to-government agreements are one way of mitigating these risks, such as that between the UK and India, which restricts recruitment from states that receive Department for International Development aid (**Jayaweera 2015**). However, the success of these agreements is dependent on governments adequately understanding the complex impacts of health worker migration in developing countries. Governments should also ensure that they consult professional groups as they begin developing international agreements. VSO International has recommended redirecting aid to build resilience in international workforces that the UK benefits from (**Voluntary Service Overseas 2010**).

An international recruitment programme should be designed in conjunction with both professional regulators and international governments to ensure that they are sustainable. Given the issues with the international workforce, in the longer term, the government should think about its role in the international workforce and consider how the skills of domestically trained staff can be exported to support the resilience of other countries' workforces.

Resources to ensure ethical international recruitment

Any attempts to actively recruit internationally should be alive to the risks to the source country. This is especially the case when considering recruitment from developing countries, but should be a consideration whenever recruitment from overseas is being explored.

The World Health Organization's 'Global Code of Practice' and its accompanying user guide are a starting point for ensuring positive international recruitment practice ([World Health Organization 2010](#)). The code provides practical guidance on ethical practice, as well as setting out actions for member states to address the underlying causes of migration in developing countries. The code provides guidance on the fair treatment of migrant health workers.

In 2004, the Department of Health developed a UK-specific code of practice for international recruitment, which sets out ethical principles for UK health care organisations and approved recruitment agencies ([Department of Health 2004](#)). It also contains best-practice benchmarks for organisations to monitor their recruitment practices against. NHS Employers supports adherence to the UK's code and maintains a list of recruitment agencies that adhere to it ([NHS Employers 2018b](#)).

Conclusion

Ethical international recruitment holds potential for providing short-term relief for the NHS by plugging existing and pressing gaps in the workforce. However, this must be part of a wider system plan for solving the workforce crisis; a plan that makes a commitment to increasing domestic training, recruitment and retention.

International recruitment has been very effective in the past, for example when the government's recruitment drive attracted around 8,000 international full-time nurses into the NHS in England in a single year (2001/02). There is considerable scope, therefore, for the government to expand its international recruitment efforts.

The NHS Long Term Plan sets a target of reducing nursing vacancy rates to 5 per cent by 2028. We feel that operating for so many years with high levels of vacancies is undesirable, and that the NHS should aim to reach this 5 per cent target by 2023/24. Our modelling shows that achieving this target by 2023/24 will require in the region of 5,000 international nurses a year.⁶ These attempts must adhere to the robust ethical codes highlighted above. We recognise that this will be challenging to achieve. Today's context is different from the early 2000s, but previous efforts were able to scale up international recruitment very quickly.

A robust infrastructure for recruiting internationally should focus on making the most of economies of scale, while still remaining tuned in to local needs. It is essential that some national co-ordination can take place to address some of the localised issues

⁶ See Chapter 7 for how the international recruitment target fits alongside other staff sources.

that organisations have experienced, such as challenges in terms of drop-out rates and visa issues. There is plenty of good practice to develop and existing initiatives, such as the Medical Training Initiative and local initiatives, could be built on relatively rapidly. Lessons can be learnt from recent recruitment drives for GPs, which demonstrate the challenges of recruiting some staff groups internationally (Rimmer 2017a). New national arrangements should be more realistic about the opportunities for difficult-to-recruit staff groups.

However, the existing good work risks being undone through a combination of visa restrictions and Brexit. Coming to work in the NHS is still not as easy as it should be, and for EEA migrants it is about to get more difficult.

Finally, the opportunities as a result of international recruitment and return to practice can be multiplied if considered alongside other levers presented in this report. For example, rethinking skill mix becomes easier when considered alongside international recruitment. For instance, occupational therapists can play an important role in supporting mental health services, an area with severe staff shortages. However, visas are difficult to obtain as occupational therapists are not on the shortage occupation list, despite evidence of them being in shortage. This highlights the importance of a co-ordinated architecture to workforce planning.

Table 6.2 summarises the opportunities and key challenges around international recruitment.

Table 6.2: Opportunities and challenges around international recruitment

Key opportunities	Key challenges
International recruitment is the only realistic short-term lever for helping to bridge immediate shortfalls in staff.	International recruitment as currently implemented only works for some staff groups (such as registered nurses in hospital settings) and not others (such as staff in primary care).
Some approaches are based on non-EEA staff being brought in for a short period of time, and being provided with training, before returning to their home country.	Global workforce shortages mean that active recruitment should be ethically underpinned and carried out in a way that does not have a disproportionate impact on the source country.
Whitehall and regulators appear to be more willing recently to rethink approaches to international recruitment, with some improvements to visas and the professional registration process.	Obtaining a visa remains a challenge for prospective recruits in key areas. Brexit threatens to immediately exacerbate this, with social care needing urgent attention.
International recruits are already qualified and bring different experiences and knowledge into the NHS.	The NHS has work to do to ensure that all international staff are welcomed into the NHS and that their skills are used effectively.

Recommendation

NHS England and Health Education England should establish a regionally led but nationally funded and co-ordinated programme of ethical international recruitment.

Local and regional organisations should work together to understand local need for international recruits and ensure that recruitment is regionally led. National bodies should co-ordinate elements of the recruitment, such as visa processing, and make the most of economies of scale. National bodies need to grow existing national schemes for doctors and nurses to come to the NHS, like the Medical Training Initiative. There should be robust evaluation of these schemes to understand their impact on domestic and international health workforces. Regions should be compensated for international recruitment through existing funding routes, to ensure that international recruitment costs employers no more than employing domestically.

Recommendation

The NHS needs to aim to recruit an average of 5,000 full-time, international nurses a year, if it is to achieve a 5 per cent vacancy rate target for nurses by 2023/24.

Achieving this will be challenging, but it is essential if immediate vacancies are to be addressed. National bodies and regions should share best practice to understand how new recruits can be supported and take an active role in ensuring that recruitment is being done ethically and with the authorisation of non-UK governments.

Costings of recommendations

The recommendations in this chapter should be seen as necessary costs in providing a properly staffed NHS. In this section we give a rough idea of how much they could cost. This is not intended to be definitive, but demonstrates by how much the budget HEE might need to increase to fill vacancies.

We estimate that the cost of a nationally funded programme to support international recruitment would be around £11 million a year (in 2018/19 prices) up to 2023/24 (see Table 6.3). This is estimated using the lower per-head recruitment cost of nurses that was cited in the 'cost' subsection earlier in this chapter (£2,100) and multiplying by our average target of 5,000 nurses a year by 2023/24. Scaling efficiencies should be expected. Other recommendations do not have cost implications or are covered by additional revenue expected from new staff (such as regulator registration fees).

The national bodies also need to meet the costs of migrants coming to work in the NHS. This includes paying for the costs of going through the visa system and paying for the immigration health surcharge. The Royal College of Physicians has estimated this cost to be £4,409 per recruit (in 2018/19 prices) over three years (**Goddard 2018**).

We have assumed that this cost is split equally across the three years, and applied it to the average number of 5,000 nurses that these estimates assume. We estimate that the costs associated with the tier 2 visa system would be £7.5 million a year (in 2018/19 prices) up to 2023/24 (see Table 6.3). Given that some of these costs are currently already being met by providers (such as the skills surcharge), this funding is not entirely a new requirement, but we would now expect there to be a national budget for it.⁷

Table 6.3: Estimated additional cost of international recruitment policy measures to increase the supply of nurses (£million, 2018/19 prices)

	2019/20	2020/21	2021/22	2022/23	2023/24
International recruitment programme (HEE)	10	10	10	10	10
Costs associated with the tier 2 visa system (HEE)	10	10	10	10	10

Note: Numbers are rounded to the nearest 10 million.

⁷ For simplicity and so that the scale of these proposals can be viewed in the context of wider budgets, we have assumed these costs will be met by HEE. However, we accept that it may be more appropriate for international recruitment funding to be provided by NHS England and NHS Improvement.

7. Closing the gap: modelling the impact of reform and funding on nursing and GP shortages

Anita Charlesworth and Ben Gershlick, The Health Foundation

In this report we have outlined a series of policy proposals to address England's health and social care workforce shortages. Our projections of the potential number of health care workers in the next decade suggest that, on current trends, the gap between the number of staff needed and the number available for the hospital and community health service workforce could grow to 250,000. If some of the problems with recruitment and retention continue on their recent downward trajectory, the gap could be as much as 350,000 ([Health Foundation et al 2018](#)).

We have explored what these different policy interventions might imply for the gap between demand and supply for two staff groups:

- hospital and community health service nurses employed in NHS acute, community and mental health providers
- general practitioners (GPs).¹

We focus on these two groups for this quantitative analysis as they both face staffing shortages. Following the publication of *The NHS Long Term Plan*, NHS Improvement is leading the development of an NHS workforce implementation plan, with an interim report due in the spring of 2019 and a final report due following the 2019 Spending Review ([NHS England 2019c](#)). This plan should clearly set out more comprehensively than we can how the proposed policy and delivery activities will reduce the scale of the workforce gap across all staff groups. Health workforce modelling aims to project the balance between supply and demand for different categories of health workers, in both the short and longer term. Our projections of workforce supply and demand are based on recent trends in training numbers, recruitment and retention. The Organisation for Economic Co-operation and Development has reviewed workforce planning across member countries ([Ono et al 2013](#)). It concludes that while modelling has inherent uncertainties and cannot be an exact science, it is nevertheless important to underpin effective workforce policy.

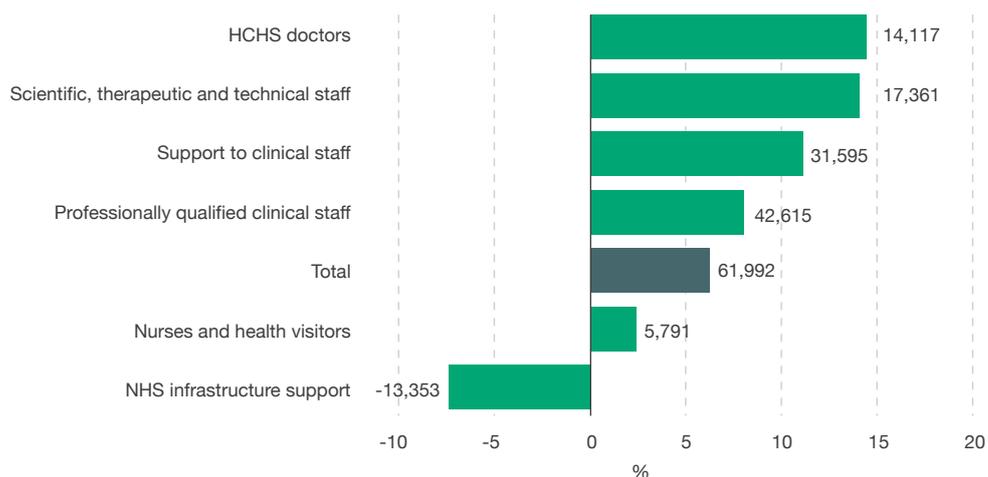
¹ This excludes health visitors, midwives and nurses employed in primary care. GP figures relate to GPs excluding registrars, trainees and locums.

Health care workforce modelling is important given the time and cost involved in training health care professionals. With tight budget constraints, it is needed not just to guide training decisions on the number and mix of health care professionals, but also to inform decisions on service delivery as patterns of need change. Workforce models involve a series of assumptions about how the various supply-side and demand-side factors affecting health workers might evolve in the future. The NHS in England needs to improve the quality and transparency of these models at national and local levels. It also needs to broaden their scope, to explicitly incorporate changing economic and health service delivery contexts and improve the underlying evidence on key issues. This will ensure that workforce models are more relevant for assessing the impact of alternative policy options and future scenarios. As our projections reflect the limitations of current modelling approaches, they should be seen as a guide to the scale of the future challenges and the potential contribution of different groups of staff.

Nurses in NHS trusts

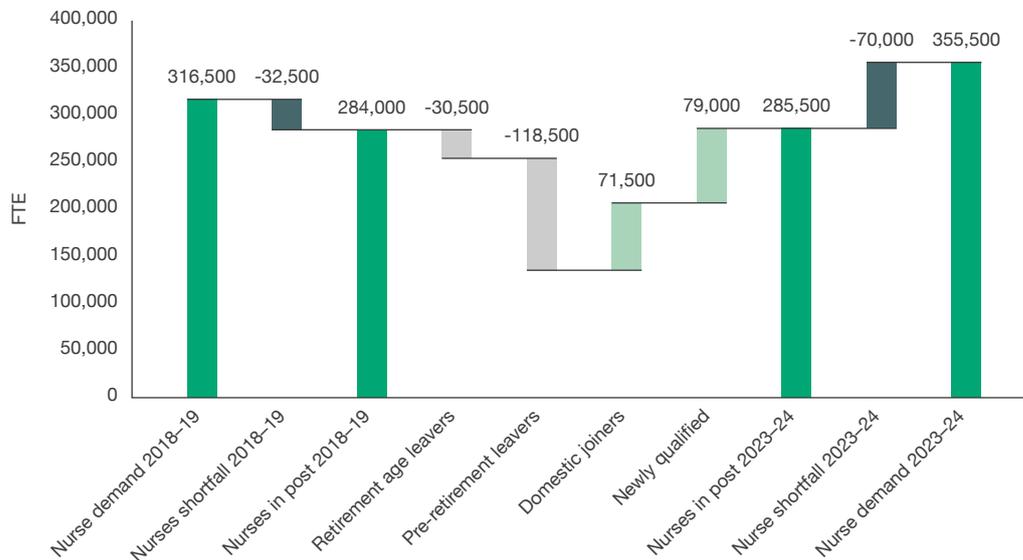
Nurses account for more than a quarter of all the full-time equivalent (FTE) staff in the NHS but around 40 per cent of the current staff shortages in hospital, mental health and community health services. Although the number of FTE staff employed in NHS trusts has increased since 2010, the mix of staff employed has changed significantly. Figure 7.1 shows the absolute and percentage change in different staff groups between 2010 and 2018 (FTE). While the numbers of hospital doctors and clinical support staff have increased, the number of nurses has been broadly flat despite growing demand for care.

Figure 7.1: Percentage and absolute change in selected staff group numbers, FTE, September 2010 to September 2018



Source: NHS Digital. NHS Workforce Statistics – November 2018.
HCHS = Hospital and community health services.

Figure 7.2: Nursing demand and supply projections for England based on current trends, 2018/19 to 2023/24



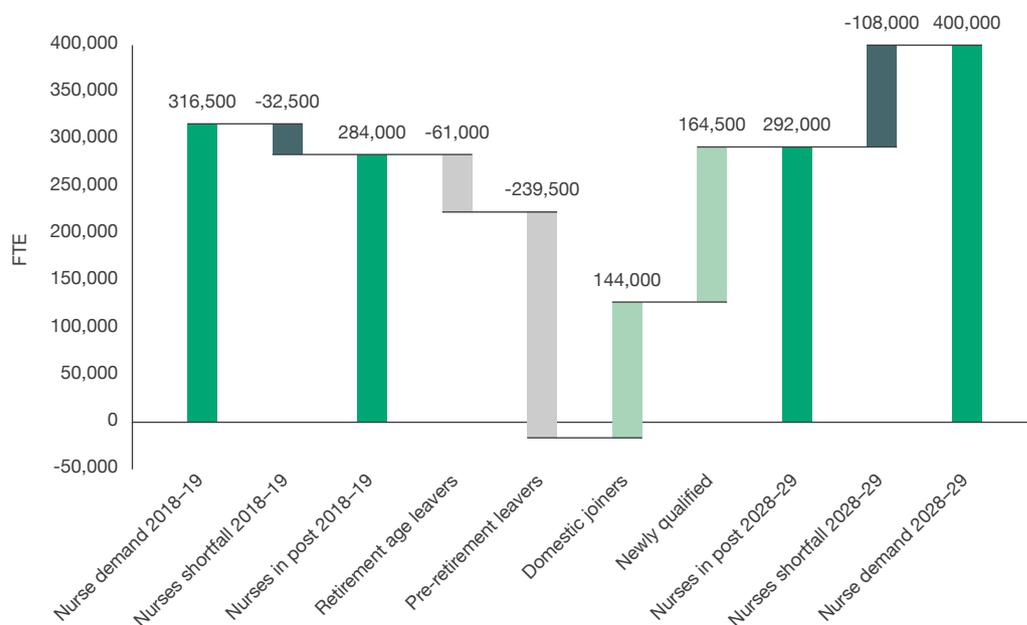
Source: Modelling based on various sources.

Figure 7.2 shows how the demand for nurses and the supply of FTE nurses are projected to change between 2018/19 and 2023/24. This is the period covered by the Prime Minister's announcement of an additional £20.5 billion real-terms funding growth for NHS England.

This year, we estimate the nurse staffing shortfall to be 32,500 FTE nurses, and the number of nurses in post by the end of the financial year to be 284,000 FTE.² If current trends continue, the number of nurses leaving the NHS will be similar to the number expected to join – either following initial training or on return to the NHS from other roles or a period out of the labour market. The pipeline of newly qualified staff is struggling to keep up with the pace at which staff are leaving and demand for health care is growing. As a result, the staffing shortfall would almost double to 70,000 FTE nurses in five years' time without international recruitment. Staff shortages are an important capacity constraint for the NHS, resulting in longer waits for both accident and emergency (A&E) and planned care. The NHS also manages some of the impact of staffing shortages by using agency staff and encouraging the nurses it has to work more hours to cover unfilled posts via their bank arrangements. This means that temporary staffing arrangements provide cover for most of the gap but the result is unstable staffing. Our analysis found an association between less-stable staffing and lower productivity performance across NHS acute hospitals.

² Our November briefing referenced more than 36,000 nurse vacancies. NHS Improvement released more recent data that same month which showed around 41,000 vacancies. In our modelling we use NHS Improvement's vacancy rate but adjust this to be consistent with NHS Digital workforce data (which are Official Statistics) which gives the 32,500 vacancies we refer to elsewhere.

Figure 7.3: Nursing demand and supply projections for England based on current trends, 2018/19 to 2028/29



Source: Modelling based on various sources.

Figure 7.3 shows the impact of these trends over the next decade as a whole. Our projections show that the gap between the projected demand for nurses in NHS trusts and supply would grow to over 100,000 FTE staff in 2028/29. The volume of staff leaving pre-retirement is simply too great for training and recruitment strategies to fill the resulting vacancies.

Reducing the nursing gap

In this report, we have looked at potential policy options to increase the number of nurses joining the NHS, both from initial training and other sources, and at measures to aid retention.

We have proposed measures that would see England progressively narrow and then eliminate nurse staffing shortages. This would shift the balance of nurse staffing in NHS trusts towards domestic recruitment, reducing the reliance on overseas-trained nurses. Our analysis suggests that, in the long term, with concerted action now, it might be possible to eliminate nurse staffing shortages by 2028/29. Figure 7.4 shows how nursing supply might be brought into balance or modestly exceed the demand for nurses from NHS trusts. It is based on a significant expansion in the number of people training to qualify as a registered nurse but also on reform to nurse training and NHS employment so that a much greater proportion of those who start nurse training, complete the training and go on to work in the NHS. We estimate that action on these measures, as set out in

Chapter 2, could result in an extra 54,000 nurses joining the NHS from nursing degrees and apprenticeships by 2028/29, compared with current trends (see Figure 7.3). This would require action in the following areas.

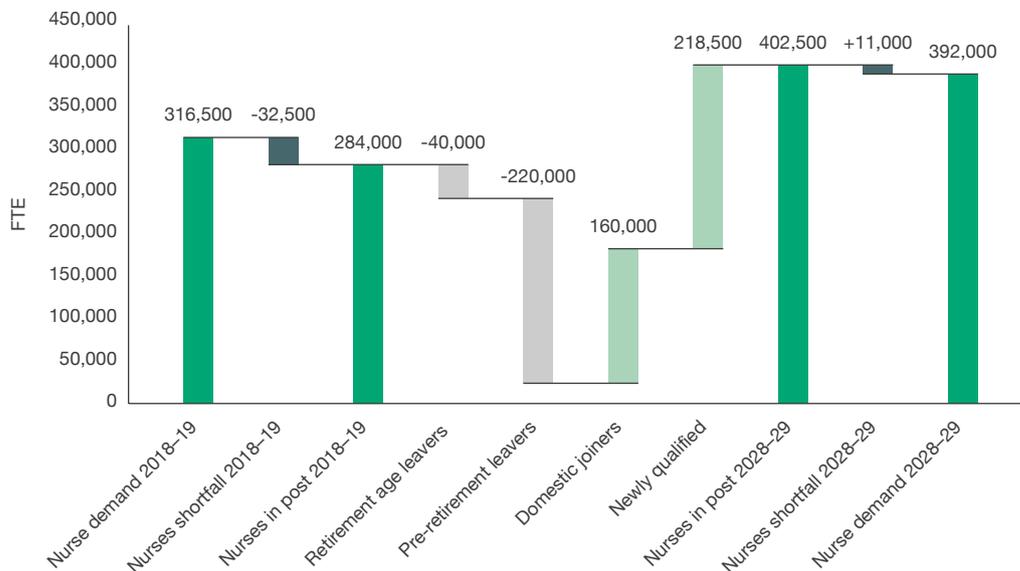
- Incentives for people to train as a nurse need to be improved. For example, we suggest that 'cost of living grants' of around £5,200 a year are introduced in addition to the standard package of student finance for tuition fees and maintenance costs.³ Time on placement in a clinical setting is a vital part of student nurse training but it does mean that it is much harder for nursing students to support themselves through university by working part-time.
- The routes into nursing need to be further diversified, with a doubling of the numbers training to be a nurse as a postgraduate after completing a first degree in a different subject – this is the most common route into professions such as teaching and social work.
- The number of students who do not complete their studies, or on completion choose not to work in the NHS, needs to be significantly reduced, by investing more to ensure the quality of support while nursing students are undertaking clinical placements and diversifying the range of settings in which students undertake placements, with more emphasis on experience in primary care, mental health and community services.

But relying solely on increasing the number of newly qualified staff is neither realistic nor efficient. In this report we have set out the range of measures that will be needed to attract and retain staff who are already qualified nurses, including:

- ensuring that NHS pay is competitive
- becoming a consistently good employer for staff from all backgrounds and across different settings
- offering much more support in the early years post-qualification (so-called 'preceptorships') when many nurses leave the NHS
- offering career pathways and good-quality opportunities for continuous professional development
- developing new roles.

³ This level of funding would mean that, with the maintenance loan of up to £8,430 (£11,002 for London) for full-time students not living with their parents, they are able to receive up to the national living wage level after income tax and National Insurance for 21- to 24-year-olds (£13,593).

Figure 7.4: Nursing demand and supply projections for England based on policy action to increase the supply of nurses, 2018/19 to 2028/29



Source: Modelling based on various sources.

These measures are all essential. Taken together, they could bring the number leaving the NHS before retirement age and the number joining after a period of time out of the NHS substantially closer together.

Our work also suggests that new technology and productivity improvements could have a modest impact on the number of nurses needed, reducing demand by 8,000 FTE staff by 2028/29.

Table 7.1 summarises our proposed policy changes and the estimated impact that underpins our projections.

Taken together, over the next 10 years these measures could result in the NHS having a potential pool of nursing staff that exceeds demand. It is prudent to plan for such an oversupply as there is considerable uncertainty about the potential impact of individual measures, external factors may change and nurses' skill set is attractive to employers, so if modest oversupply were achieved, the risk of nurses being unemployed would be very low.

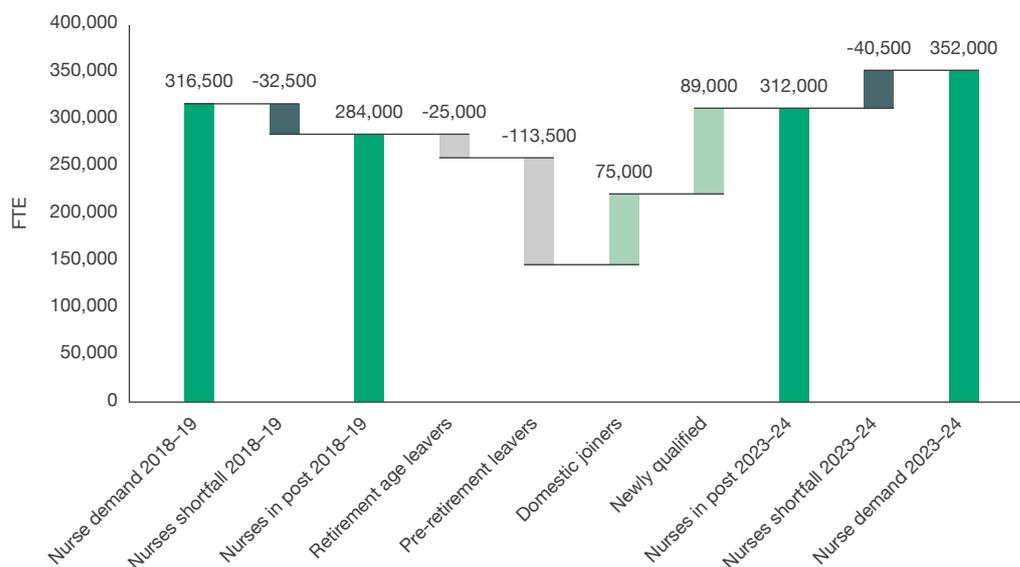
There are many positive reasons for nursing staff working in different countries, including the transfer of knowledge, but our projections suggest that, with systematic action to increase training, recruitment and retention, in the longer term the NHS would not have to be reliant on overseas trained staff to meet demand.

Table 7.1: Policy action to increase domestic nursing supply and moderate the demand for nurses

	Current trends	Policy action	Policy impact
Nurses leaving at retirement age	2.1% of nurses leave each year	Consistently implement bundle of organisational level interventions to be a good employer, including additional flexibility for staff	The number of FTE leavers over 55 decreases by more than 50% over the period, reflecting staff choosing to work longer due to flexibility
Nurses leaving the NHS before retirement age	8.4% of nurses leave the NHS each year under the age of 55 – the equivalent of 23,000 FTE nurses in 2018/19	Ensure that pay is competitive by increasing it in line with average earnings beyond the current Agenda for Change deal Increase investment in education and training for existing staff Consistently implement a bundle of organisational-level interventions to be a good employer	The leaver rate falls to 7.1% of nurses a year by 2023/24 and to 5.9% by 2028/29
Nurses joining the NHS from initial training	Around 14,000 newly qualified FTE nurses joined the NHS from initial training in 2017/18 – without action, this is expected to grow to 17,000 by 2023/24 and then stay at this level until 2028/29	Provide better financial support and improve placement quality to reduce attrition so that more nurses complete their training (numbers) Rebalance clinical placement funding to ensure appropriate reimbursements for providers to offer an increased number of placements Introduce a new NHS 'cost of living grant' for nurses of around £5,200 a year	The number of undergraduate nurses from England starting training increases from 22,575 in 2017/18 to 27,259 in 2023/24 The improved pay following the Agenda for Change deal, better experience during training and improved support in nurses' early careers through preceptorship encourage more nurses to join the NHS on qualification The number of newly qualified nurses joining the NHS rises to 23,000 in 2023/24 and grows to a steady state of 26,000 a year from 2025 onwards The number of postgraduate nurse training places triples from 1,667 in 2017/18 to 5,000 in 2022/23 and beyond
Nurses rejoining the NHS after working elsewhere or taking time out of the labour market	Those rejoining amount to 5% of the nursing workforce – the equivalent of 14,000 FTE nurses in 2018/19	No specific action	Those rejoining amount to 5% of the nursing workforce
Reduced demand due to technology	Technology has no impact on the staffing requirement for nurses in the hospital and community sector	Have e-rostering and reduce patients' length of stay in hospital with improved vital signs monitoring and better working between hospitals and the community	1% fewer staff FTE required by 2023/24, 2% fewer by 2028/29 By 2028, technology is enabling staff to work to the top of their licence, with clinical decision support and technology helping to optimise care pathways

But while our work suggests that the NHS has the potential to match demand with supply from domestically trained staff in a decade's time, the short-term picture is much more challenging. Figure 7.5 shows how the gap between demand and supply for nurses might change over the next five years as a result of the concerted policy actions set out in this report. This analysis suggests that the NHS might be able to stop the workforce shortfall deteriorating substantially, keeping it to 40,500 FTE posts.

Figure 7.5: Nursing demand and supply projections for England based on policy action to increase the supply of nurses, 2018/19 to 2023/24



Source: Modelling based on various sources.

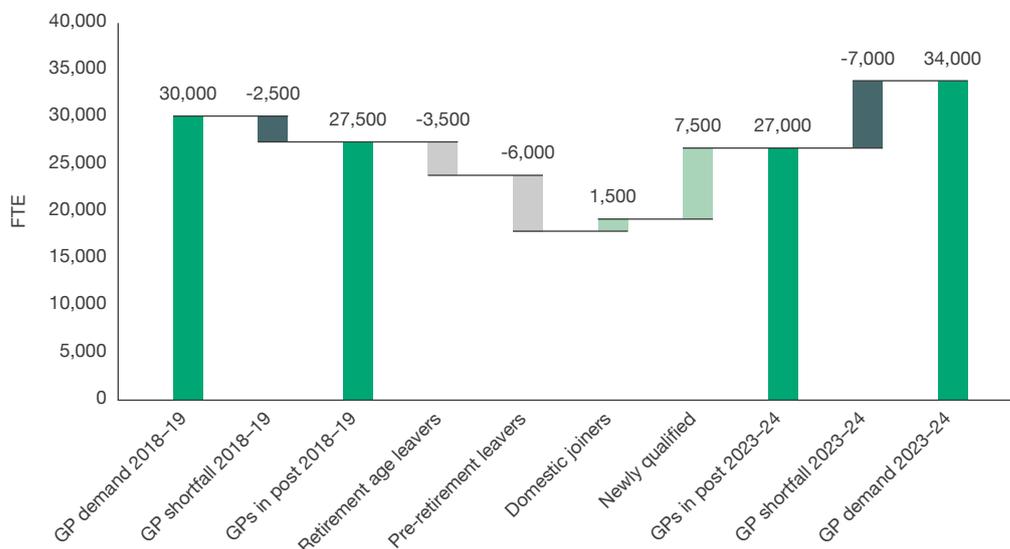
This means that if nurse staffing shortages aren't to act as a major break on the delivery of *The NHS Long Term Plan*, NHS trusts will need to maintain a high level of international recruitment. We estimate that in the early 2000s, around 8,000 FTE nurses were recruited into the NHS each year. In 2017/18 the figure was just 1,600. If the NHS can increase international recruitment to an annual average of 5,000 FTE NHS nurses over the next five years it could half the projected staffing shortage over the next five years. To achieve this would require international recruitment efforts to be ramped up over the next couple of years, with work done to ensure that ethical frameworks are adhered to, and some EU migration to continue after Brexit. *The NHS Long Term Plan* aims to achieve a 5 per cent nursing vacancy level by 2028 – a delay that we think is undesirable.

The outlook for GPs

The gap between GP demand and supply has been growing over recent years. The NHS has had a target to increase the number of FTE GPs by 5,000 between 2014 and 2020 ([NHS England 2016](#)). The actual position is of falling numbers of GPs, with 6 per cent fewer FTE GPs in September 2018 than in 2015.⁴ And this year we estimate the NHS in England has approximately 2,500 fewer FTE GPs than needed. Our projections suggest that on current trends this gap would increase to 7,000 FTE GPs in five years' time. This does not directly take into account the policy implications of *The NHS Long Term Plan* and other measures aiming to shift more care to primary care (and the growing expectation of general practice as a result). Figure 7.6 shows the contribution of different trends to the growing gap. Figure 7.7 sets out the gap after a decade, when the shortfall would increase to 11,500 FTE GPs. This represents a fundamental threat to the sustainability of primary care in England.

The government is expanding, and filling, training places (3,250 people started GP training last year compared with 2,769 in 2015/16). But the length of training means that it will take between five and ten years for these trainees to substantively add to the supply of GPs. In the meantime, the number of GPs retiring and the number leaving before retirement age are substantial and many newly qualified GPs are electing to work fewer hours.

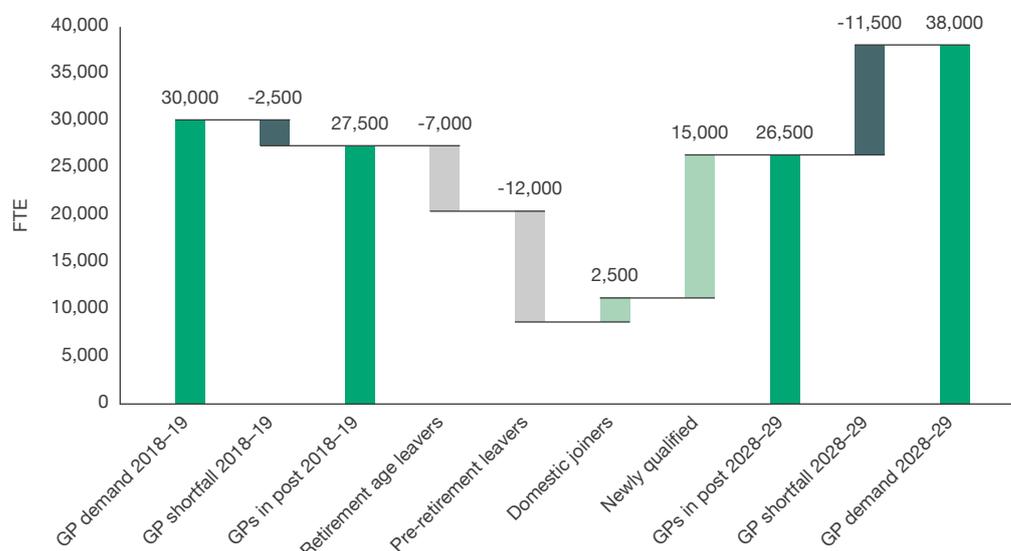
Figure 7.6: GP demand and supply projections for England based on current trends, 2018/19 to 2023/24



Source: Modelling based on various sources.

⁴ Data from NHS Digital's General and Personal Medical Services statistics. Excludes registrars, GP retainers and locums.

Figure 7.7: GP demand and supply projections for England based on current trends, 2018/19 to 2028/29



Source: Modelling based on various sources.

Balancing supply and demand in primary care with policy action

A student starting medical school in 2019/20 will not finish their GP training by 2028/29. These long training lead times mean that the supply of GPs is less amenable to policy action over the next decade than the supply of nurses. Recognising this constraint, we identify two important ways to increase supply. First, for GP training, the policy shift is to increase general practice specialty training places to 3,905 over two years to 2020/21 compared to the government's current planned policy of 3,250 (with an uplift in 2025/26 and 2026/27 to reflect the already planned increase in the number of people entering medical school from this year onwards). Second, we anticipate our policy actions – including reducing pressure on GPs through an increased supply of other staff such as physiotherapists and pharmacists, as well as a greater supply of GPs coming through training – will reduce the rate of GPs leaving. This improvement is a modest decrease in the leaver rate of two percentage points over the period, partly to reflect the range of reasons that staff choose to leave the career. The net impact of these two changes is that the current reduction in GP numbers is reversed by 2021/22, and supply of GPs starts to increase.

But even with this action the result is that the supply of FTE GPs would be 7,500 fewer than projected demand in 2028/29 based on current service models (see Figure 7.9). While it is not possible to substitute the fundamental role that GPs have in primary care, it is possible to substitute some of the tasks they undertake. The move towards multi-professional teams working in primary care, using both existing established professionals as well as new staff roles, makes it possible to offer patients greater access to high-quality care from the appropriate professional. Figure 7.9 shows that the NHS will need a very substantial shift towards multi-professional team-based general practice if it is to meet patient demand. This will need to be implemented consistently across the English NHS in order to stabilise

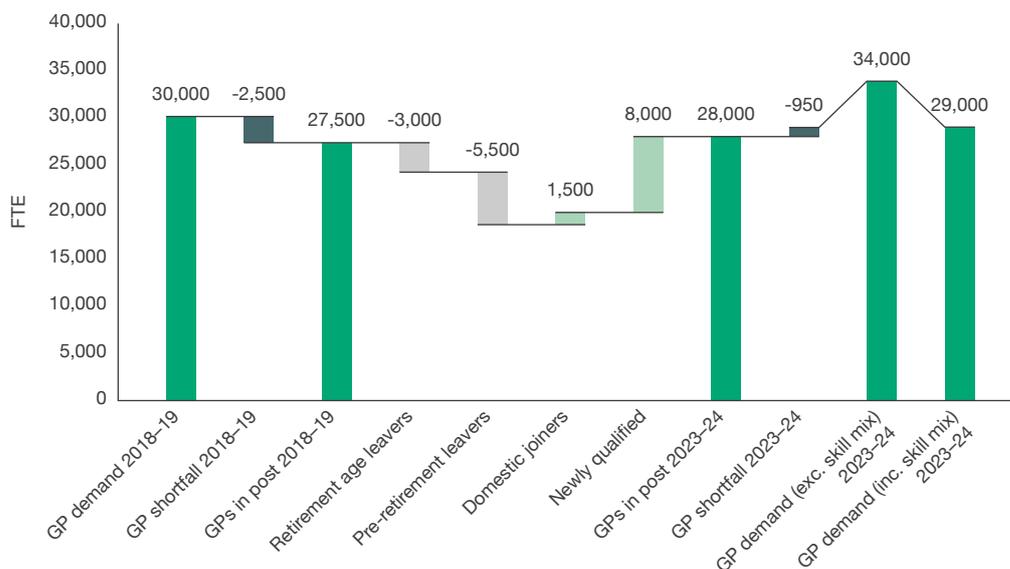
demand for GPs. As Chapter 6 outlines, this would involve a team of pharmacists, physiotherapists, nurses and mental health professionals and access to wider skill sets and services through social prescribing. Drawing on these other staff groups also has the added benefit of meeting some of the unmet demand for primary care, and as the practices make these changes there may well be a feedback loop meaning the amount of GP time they free up is slightly less than expected, while still substantial. We allow a buffer for this surfacing of currently unmet demand by reducing the size of our skill mix changes by 10 per cent compared to what our analysis in Chapter 5 suggests is possible.

Our projections suggest that the English NHS would need 3,100 more FTE pharmacists by 2023/24 and 6,000 more FTE physiotherapists by 2028/29 to be working in general practice over the next decade, as well as increases in the number of administrative and clinical support staff.

NHS England has committed to funding for around 20,000 additional staff, including pharmacists and physiotherapists, as part of the new GP contract. Additionally, recent planning guidance for CCGs requires recurrent funding in cash to be made available for developing and maintaining local primary care networks which is an important source of funding for workforce and service redesign.

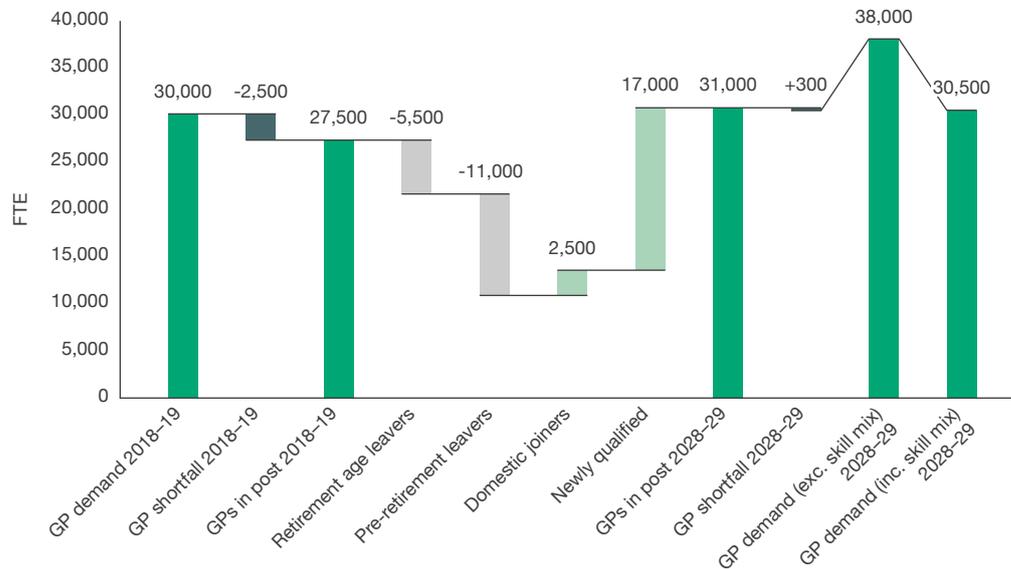
While the lack of current supply constraints on the two key professions – physiotherapists and pharmacists – at the national level means that action could lead to changes being made at pace (and indeed, is well-advanced for pharmacists), this will require a major focus on organisational and team development to provide support to help implement these models quickly and consistently. Beyond just resources, it will also need flexibility over the employment model for new staff so that these careers are attractive and competitive.

Figure 7.8: GP demand and supply projections for England based on policy action to moderate the demand for GPs and increase supply, 2018/19 to 2023/24



Source: Modelling based on various sources.

Figure 7.9: GP demand and supply projections for England based on policy action to moderate demand for GPs and increase supply, 2018/19 to 2028/29



Source: Modelling based on various sources.

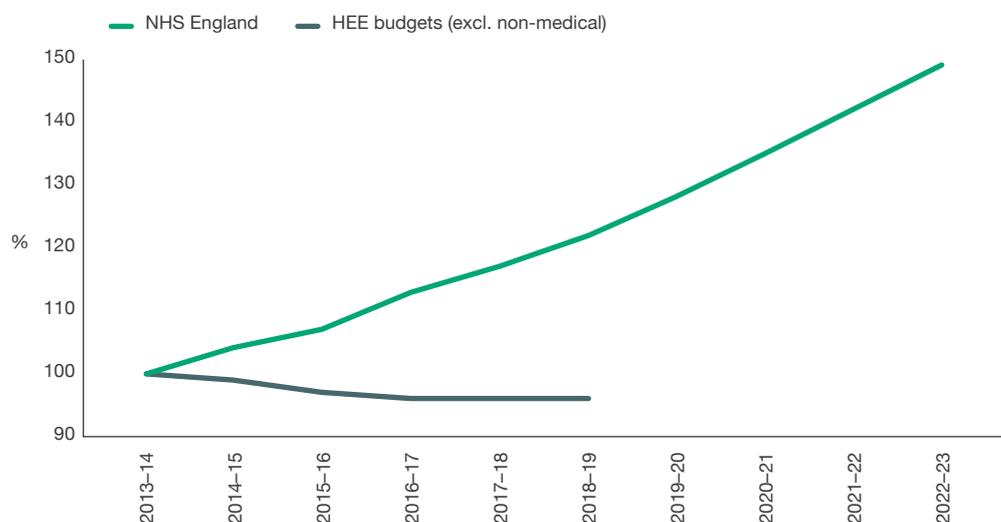
Implications for the HEE Budget in Spending Review 2019

Many of the policy actions set out in this report will require additional funding. The Prime Minister's announcement of additional funding for the NHS linked to *The NHS Long Term Plan* was for the NHS England Budget ([Department of Health and Social Care et al 2018](#)). This excludes central funding for education and training which is managed by Health Education England. The Health Education England budget for the next five years will be determined as part of this year's Spending Review led by the Treasury. HEE's budget in 2018/19 is £4.3 billion, this is £1 billion less in real terms than the budget it received in 2013/14 (£5.3 billion) when it was founded as part of the Health and Social Care Act. Figure 7.10 shows how central funding for workforce training and education through the HEE budget has been diverging from spending on frontline NHS services via the NHS England Budget.

We have produced high-level indicative costings for the policy actions in this report. The cost estimates exclude the nursing and GP pay bill as this is within the core budget of NHS England and the Prime Minister's funding commitment reflected the need to employ more staff and maintain pay. We estimate that the specific new policy measures outlined in the report would add around £900 million in real terms to the annual budget for Health Education England by 2023/24 (Table 7.2). This is in addition to any cost pressures for policies which have already been announced and implemented by DHSC and the NHS but whose full effect has yet to work through the training and education system. For nursing, there may be some exchequer costs through the student loan scheme which we have not assessed. Our estimates of the costs of delivering

more GPs through training are subject to assumptions about how the additional training places will be filled and funded. Our figures account for the placement fees for the additional GP specialty training places. Other factors might increase these costs (eg, employment costs as HEE contributes toward the salary of junior doctors, although we are recommending that this funding level should be revisited) or lower costs (eg, if the places are filled by reducing specialty training for non-GP medical routes). Our estimates of additional costs for workforce development are based on HEE's initial budgets.

Figure 7.10: Relative budget changes since 2013–14 for NHS England and HEE (compared with 2013–14 as Index =1)



Clinical budgets (previously referenced as non-medical) have been excluded as they are significantly impacted by the policy changes in respect of commissioning undergraduate places and bursaries which are now funded through student loans.

Source: Health Education England (2019d).

In addition to the additional spending we also propose reprioritisation of HEE's training budget to shift some of the funding for undergraduate medical clinical placements (funding per placement is currently up to £44,000 per student per year) to nurse clinical placements (funding per placement is currently up to £4,000 per student per year). Our analysis does not include the cost of existing policy commitments such as the expansion of medical student training numbers, which is working its way through the system and has yet to reach steady state.

Table 7.2: Estimated additional funding pressures for Health Education England resulting from the specific new policy measures to reduce the gap between demand and supply for NHS nurses and GPs (£million, 2018/19 prices)

	2019/20	2020/21	2021/22	2022/23	2023/24
Workforce development	£210	£220	£230	£240	£250
International recruitment ⁵	£10	£10	£10	£10	£10
Costs associated with tier 2 visa system	£10	£10	£10	£10	£10
Cost of living grants for nurses	£320	£350	£390	£410	£420
Other funding support for nurses (tuition fees for postgraduates, placement costs)	£40	£60	£110	£130	£140
Additional specialty training places for GPs	£20	£40	£60	£70	£70
Total additional cost	£610	£690	£810	£870	£900
HEE budget requirement	£4,920	£5,000	£5,120	£5,180	£5,210

Conclusion

In our November 2018 briefing in advance of *The NHS Long Term Plan*, we projected that the gap between the demand for health care workers from NHS trusts and the potential supply of staff could grow to between 250,000 and 350,000 FTE staff ([Health Foundation et al 2018](#)). This is a threat to patient access and quality of care and a major risk to the deliverability of *The NHS Long Term Plan*. But work is under way, led by the national NHS bodies, to develop a workforce implementation plan to address these challenges. We have used aggregate workforce modelling techniques to explore how workforce shortages among two key professional groups – nurses in NHS trusts and GPs – might be tackled.

Our projections of nurse staffing suggest that without a significant scaling up on ethical international recruitment it will not be possible to reduce shortages over the next five years. Ethical recruitment of international nurses will be essential if nursing shortages are not to act as a major break on the ambitions to improve care set out in the long-term plan for the NHS. But even if successful, politicians and system leaders need to be realistic about the pace at which changes to services can be implemented, given the workforce constraints. This will have an impact on the staff that are employed in the NHS, and the system needs to place a priority on high-quality management and support for nurses in the NHS. In the longer term, with additional investment in the HEE budget in the 2019 Spending Review, it may be possible to increase the potential supply of nurses so that England has a modest oversupply by 2028/29. This should be the goal of policy.

⁵ We have assumed international recruitment costs will be met by HEE for simplicity and so the scale of these proposals can be viewed in the context of wider budgets. However, we accept that it may be more appropriate for international recruitment funding to be provided by NHS England and NHS Improvement.

Our analysis suggests that current efforts to increase the number of GPs are essential but they are in no way sufficient to ensure there is sufficient capacity in general practice to meet rising demand.

To bring nursing and GP demand and supply into balance over the next decade, the 2019 Spending Review would need to restore the real-terms value of the HEE budget to broadly the level in 2013/14 when it was established – an increase of £900 million in 2023/24.

Our report is also not intended to contain a comprehensive set of opportunities – other policy interventions may be possible and where identified, should be implemented alongside our recommendations. It is possible these could result in gains that could reduce the gap further. The projections of nurse and GP levels in this report are very high level and reflect the limitations of existing data and techniques. As highlighted in the report on health workforce planning by the Organisation for Economic Co-operation and Development ([Ono et al 2013](#)), high-quality modelling to inform and underpin workforce planning and strategy across the full range of policy levers (training, recruitment, retention, skills and teamworking) is important given the cost and importance of workforce decisions. The forthcoming workforce implementation plan needs to include plans to improve the skills, capability and use of such modelling across the NHS.

8. Social care: pay, recruitment and retention

Simon Bottery and Harry Evans, The King's Fund;
and Anita Charlesworth, The Health Foundation

Key messages

- Social care is by no means the junior partner to the NHS in workforce terms. There are some 1.1 million full-time equivalent (FTE) employees working in social care, and some important overlaps between the two. However, unlike the NHS, the sector is mostly made up of workers who are not professionally regulated (although they are still skilled).
- As a major employer, typically providing better pay, terms and conditions than social care can afford, the NHS has a significant potential 'gravitational pull' on the social care workforce. We recommend that NHS England supports local systems to plan their workforce collaboratively with social care. Integrated care systems and sustainability and transformation partnerships must fully include social care in workforce planning.
- The social care sector has a major and growing problem with recruitment and retention, a significant cause of which is poor pay and conditions. While there are actions that individual employers can take to improve recruitment, low pay is a fundamental issue that cash-strapped social care providers and local authorities are currently not in any position to solve.
- We recommend that funding for the sector is comprehensively addressed in the 2019 Spending Review. In the longer term, the wider funding system will need to be reformed. The government has promised a Green Paper on social care and it should seriously address the challenges in the workforce and accept the Migration Advisory Committee's diagnosis of a workforce crisis.
- These issues could soon be compounded by the UK's departure from the EU. Even small losses in workforce numbers would seriously compromise the social care sector, particularly in areas such as London. The current proposal of a 12-month, 'low-skilled' visa is far less appropriate for social care than for other sectors of the economy. We are recommending that the government designs a visa system that works for social care.

There are important similarities and overlaps between aspects of the health care workforce and those of the social care workforce. The most obvious link is the role of registered nurses, of whom there are an estimated 42,000¹ in the adult social care sector (**Skills for Care 2018a**), largely working in nursing homes, compared with 320,000 nurses in the NHS (**NHS Digital 2018c**).² There are also 3,000 occupational therapists in the social care sector (**Skills for Care 2018a**).

There are also similarities – and a flow of individuals – between some other job roles, particularly between the health care assistant role in the NHS and that of care worker in social care. And NHS staff and those in social care will often in practice be working together, jointly providing direct care to individual members of the public, working as part of multidisciplinary teams to co-ordinate care or collaborating as managers to ensure that systems and processes between health and social care operate smoothly.

Social care is by no means the junior partner in this relationship and nowhere is this clearer than in employment numbers – there are 1.1 million FTE jobs in social care in England (**Skills for Care 2018a**), about the same as in the NHS. The sector accounts for around 6 per cent of total employment in the UK and contributes £46.2 billion to the economy (**ICF Consulting 2018**).

Yet there are also major differences and inequalities between the NHS and social care, particularly in terms of workforce and industry structure. It is therefore more accurate to think of health and social care as two interconnected sectors, themselves part of a wider overall labour market, than as a single sector.

In social care, only around 5 per cent of roles are regulated professionals – nurses, occupational therapists, social workers and allied health professionals (**Skills for Care 2018d**). By far the most common job title in adult social care is 'care worker', accounting for more than half of all jobs, and there are also around 145,000 'personal assistants' who are directly employed by people paying for their own care or holding social care personal budgets. Direct care roles account for 76 per cent of all jobs in social care and only around half of the staff carrying out these roles have qualifications at level 2 or above (**Skills for Care 2018c**). However, the sector and its workers bridle at the idea that it is a 'low-skill' industry, despite earning below the £30,000 salary floor for 'skilled' migration (see Table 6.1 on visas in Chapter 6). A less-contentious way of thinking about social care is as a sector that requires no formal qualifications to enter but which requires that staff develop significant skills, often during employment, in order to do their job well.

The organisations employing staff are typically very different from those in the NHS, not least because they are so small. Of the 21,200 social care providers, nearly half (46 per cent) employ just one to four staff (**Skills for Care 2018c**). Only 6 per cent of social care providers employ more than 100 staff. Nor are the organisations typically in the public sector. More than three-quarters of roles are in the private or voluntary

1 In other chapters of this report we refer to full-time equivalent roles; however, in this chapter we are using Skills for Care data, which refers to 'posts' or 'roles'. This data also includes social care staff who are funded privately.
 2 This figure refers to nurses and health visitors (headcount) working in hospital and community health services.

sector. Local authorities employ 7 per cent of staff while the NHS has around 95,000 adult social care roles – including nearly 70,000 health care assistants and more than 17,000 occupational therapists ([Skills for Care 2018c](#)).

A further significant difference is that a large (although hard to precisely quantify) percentage of social care staff work with people who pay for their own care ('self-funders') rather than having it publicly funded. An important consequence of this is that providers who are catering for such clients are typically able to charge higher fees than the rates that local authorities pay for clients receiving publicly funded care. The Competition and Markets Authority found that the average fee paid by self-funders in care homes was 41 per cent higher than that paid by local authorities ([Competition and Markets Authority 2017](#)).

Pay

Even more than in the NHS, poor pay, terms and conditions are an area of ongoing concern in social care. According to data from Skills for Care for 2017, a quarter of the workforce were on a zero-hours contract (335,000 jobs). It is a low-pay industry and has been identified as such since the Low Pay Commission's first report in 1998 ([Low Pay Commission 1998](#)).

The Low Pay Commission has flagged social care as a sector of concern, in particular as minimum wage non-compliance has been prevalent in the past ([HM Revenue and Customs 2013](#)). Some estimates place the level of frontline care jobs paying below the minimum wage at between 9.2 per cent and 12.9 per cent ([Gardiner 2015](#)) – before the recent increases in the national living wage. Social care is characterised by having a high 'bite' of the minimum wage. This is the ratio of the minimum wage to the median wage in the sector – and it means that there tends to be a lot of staff whose pay is close to the minimum wage. Skills for Care reports that before the national living wage, care worker hourly rates increased by around £0.13 (1.9 per cent) a year, but the launch of the national living wage in 2016 saw the average hourly rate increase by 2.7 per cent, then by 5.2 per cent in the following year ([Skills for Care 2018c](#)).

Skills for Care also reports that there is currently no evidence of the national living wage having a large impact on recruitment and retention in the adult social care sector ([Skills for Care 2018c](#)). This is partly because recruitment and retention are affected differently by increases in pay across providers, where there tends to be little effect ([Hafner et al 2017](#)), rather than between providers, where there is more evidence of an effect in social care ([National Institute of Economic and Social Research 2018](#)).

As a major employer, typically providing better pay, terms and conditions than social care can afford, the NHS can have a significant potential 'gravitational pull' on the social care workforce. Health care assistant roles in hospitals and other roles that require few qualifications on entry can be extremely attractive to staff working in social care. A further key area of concern is registered nurses: the care home industry body Care England told the Migration Advisory Committee of the 'significant challenges' in retaining and recruiting registered nurses, 'particularly as a consequence of competition with the NHS's' ([Care England 2015](#), p 2). Even in 2015, Care England pointed to a 16 per cent decrease

in the number of registered nurses within the social care sector since 2012, which it said was 'adding further and increasing pressures upon both providers and commissioners in supporting a sustainable market going forward' ([Care England 2015](#), p 2).

This attraction of workers to the NHS over the care sector is likely to increase as a consequence of the recent NHS pay deal. For instance, NHS pay at the bottom of Band 7 as of last year was £31,696 – similar to average pay for a registered nurse in social care. If Band 7 nurses in the NHS have a cumulative pay increase of 29 per cent over the next three years, then this may increase the number of people leaving social care to go to the NHS, or who choose to join the NHS instead of social care. Nursing pay is discussed further in Chapter 3.

The NHS exists as part of a local labour market and so local social care providers who try to match NHS pay increases will put more cost pressure on already financially distressed social care providers. One estimate puts the cost of social care staff receiving a similar pay uplift as NHS workers at £3 billion ([Association of Directors of Adult Social Services 2018](#)). Our own estimate suggests this may be lower, closer to £1.7 billion once you map current social care staff to equivalent current pay rates in the NHS. While this is a significant cost, it is hard to see how social care providers can recruit and retain staff when salaries are rising higher in competitor labour markets.

This raises the need for collaboration on workforce planning between the NHS and the care sector, both nationally and regionally. Interesting local initiatives exist to support this. One example is the Lincolnshire Talent Academy, which has developed a common shared goal of recruiting local talented staff across NHS, social care and the third sector. Greater involvement of local authorities in integrated care systems and sustainability and transformation partnerships could provide a basis for more joined-up thinking on the workforce.

Recommendation

We recommend that NHS England supports local areas to develop workforce strategies that cross health and social care, paying attention to interdependencies between the two. Sustainability and transformation partnerships and integrated care systems should explore initiatives such as the Lincolnshire Talent Academy, and similar bodies in Derbyshire and elsewhere.

Recruitment and retention

Finding and retaining staff is a critical issue in social care. There are now 110,000 vacancies, most of which are for direct care roles but with particularly high vacancy rates for registered managers (11.8 per cent) ([Skills for Care 2018c](#)). There are also higher-than-average vacancy rates for the two roles with the most direct crossover to the NHS – occupational therapists (9 per cent) and registered nurses, who have the highest vacancy rate in social care at 12.3 per cent.

The Migration Advisory Committee's analysis of the social care sector articulates numerous challenges for the social care workforce:

There are signs that the sector is struggling to recruit and retain workers at the moment. Numbers from Skills for Care show that vacancy rates for social workers have increased from 7.6 per cent in 2012/13 to 10.8 per cent in 2016/17. Vacancy rates have also increased for care workers from 7.1 per cent in 2012/13 to 7.7 per cent in 2016/17. These vacancy rates are much higher than the national average of 2.7 per cent in July 2018. With record levels of employment in the UK, increasing vacancy rates and an expanding and ageing population, the social care sector could come under tremendous pressure if these positions cannot be filled.

[Migration Advisory Committee 2018](#), p 88

A consultation by Skills for Care found that social care providers faced the following challenges in terms of recruitment ([Skills for Care 2018b](#)):

- a perception of low pay (80 per cent)
- not enough people are applying for vacancies (70 per cent)
- a perception of poor terms and conditions of employment (69 per cent)
- poor public perception of adult social care locally (61 per cent)
- a lack of awareness of different roles (56 per cent)
- candidates' expectations do not match the reality of the work (40 per cent)
- applicants do not have a genuine interest in the roles (33 per cent) or lack the right values (27 per cent).

This demonstrates that while attracting staff with pay could be an important factor in filling vacancies, there are also significant recruitment and retention issues to be tackled by a sector that may need to find an additional 650,000 staff by 2035 ([Skills for Care 2018c](#)). As well as pay and conditions, public perception and the status of the sector will need to change.

There is an opportunity to improve the recruitment performance of the social care sector not just through the development of employer skills but also through wider campaigns to change the image of adult social care as a sector in which to work. The current national recruitment campaign will be a valuable source of experience about how best to achieve this ([Department of Health and Social Care undated](#)).

Recommendation

There should be robust evaluation by the Department of Health and Social Care and Skills for Care of the social care recruitment marketing campaign to understand how best to improve the image of the sector and enhance recruitment. As well as assessing the impact of the campaign in overall numbers, this should seek to understand how the perception of social care roles can be improved.

Retaining staff is also a problem. Almost a third of social care staff leave their job each year and, while we do not have comparable data between the NHS and social care, this looks to be roughly double the rate experienced in the NHS. This rate has increased year on year, from 23 per cent in 2012/13 to 31 per cent in 2017/18 – equivalent to 1,000 people leaving their job every day ([Skills for Care 2018c](#)). Even the region with the lowest leaver rate now (London) has a higher rate than the region with the highest rate in 2012/13 (the South West).

Although data on where social care staff move on to when they leave their job is limited, the data we do have suggests that the largest non-social care destination for social care staff that left their job in 2017/18 and went immediately to another was not retail or something similar but in fact the health sector. This was the destination for 14 per cent of leavers ([Skills for Care 2018a](#)). The NHS is able to offer career pathways and the prestige that comes with opportunities in 'licensed' professions. Many NHS staff are also represented by strong and active national trade unions and professional associations.

International recruitment and Brexit

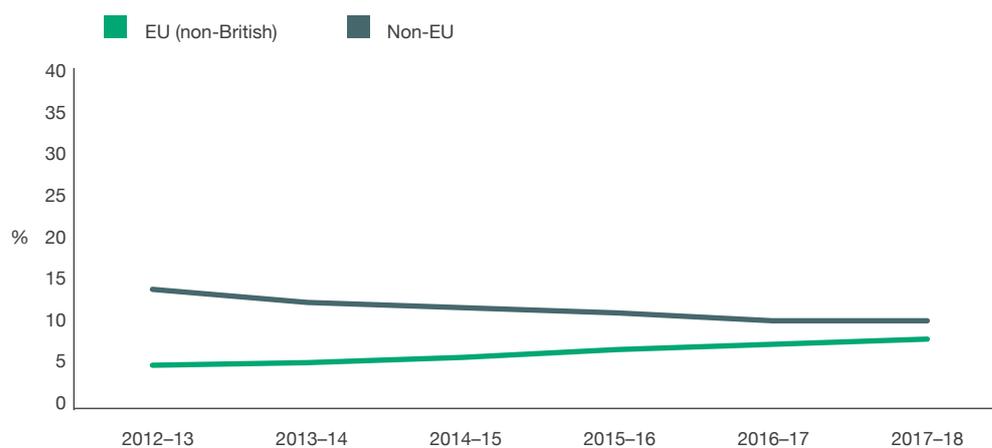
Against this background of difficulties in both recruitment and retention, social care has benefited from the bigger pool of relatively low-skilled workers able to work in the UK since the enlargement of the EU in the early 2010s. Some, but not all, of these migrant workers have experience in social care and related areas and have been willing and able to take on roles in a sector that remains unattractive to a UK workforce.

A recent report has argued that the contribution of nationals from the European Economic Area (EEA) is even greater to social care than it is to the NHS ([Dolton et al 2018](#)). In social care, 18 per cent of the current total workforce were born outside of the UK, with 8 per cent from other EU³ countries and 10 per cent from outside the EU ([Skills for Care 2018c](#)). The figures vary greatly between areas: 96 per cent of the social care workforce in the North East have British nationality, compared with just 61 per cent in London.

³ In this chapter, we refer to 'EU' migration instead of 'EEA' migration as in Chapter 6. This is due to Skills for Care using 'EU' in their workforce estimates, which we rely on here.

The pattern for the migration of care workers – the largest part of the social care workforce – has followed a similar pattern to the nursing workforce. Numbers of care workers from the EU have grown as a proportion of the overall workforce since 2012/13, while non-EU care workers have declined (see Figure 8.1). After years of limited migration from outside of the EU, the numbers of EU care workers had begun to catch up.

Figure 8.1: Care workers by nationality as a proportion of the total, England



Source: Skills for Care (2018b).

As well as care workers, there are around 4,700 EU managerial staff in the English social care workforce, 4 per cent of all care managers (Skills for Care 2018c). While they do not make up a large part of the workforce, the number of EU care managers has grown by nearly 1,800 since 2012/13.

Brexit appears so far to have had little effect on these trends, according to Skills for Care (Skills for Care 2018c). A large proportion of new starters in 2017/18 were from the EU. Nonetheless, restrictions on the free movement of people between the UK and EU countries when the UK leaves the EU will put the social care workforce at risk. Yet the government's recent proposals for an immigration system after Brexit do not create a specific entry route for social care (Home Office 2018b) and more than 90 per cent of care workers – including those from the EU – earn well below the proposed £30,000 salary threshold required to obtain a visa after Brexit (Skills for Care 2018c).

The proposed visa scheme would be unlikely even to help the recruitment of managers in social care, where the vacancy rate is estimated to be around 6 per cent (rising to 12 per cent for registered managers) (Skills for Care 2018c). Even managers often do not earn above the £30,000 proposed salary floor (and nor do they necessarily have the formal qualifications needed to be considered for a tier 2 visa).

The government has suggested that care workers may benefit from a transitional 12-month visa scheme. However, this is a much less attractive approach in social care than in other industries such as construction and agriculture. This is because the nature of the role requires consistency of provision and puts a premium on long-term

relationships between individual care workers and people who use care services. In addition, turnover of staff in social care is already too high and could be worsened by limiting migrant workers to 12-month visas.

Given that the changes to recruitment and retention will take some time to implement, the sector will need a short-term solution for the social care workforce for when the UK leaves the EU, which must be more tailored to the sector than the current solution of 12-month visas for 'low-skilled' workers suggested by the Home Office.

Recommendation

We recommend that the government goes back to the drawing board to design a sector-specific visa route that works for social care.

In its recent report, the Migration Advisory Committee recognises that Brexit seriously threatens the social care workforce (**Migration Advisory Committee 2018**). It argues that the sector needs a policy wider than just migration policy to fix its many problems and that, without it, migrant workers will continue to be needed:

The sector's problems are not primarily migration-related. A sustainable funding model, paying competitive wages to UK residents, would alleviate many of the recruitment and retention issues. Unless working in social care becomes more desirable to UK workers, chiefly through higher wages, migrant workers will be necessary to continue delivering these services. The factors that make working in social care unattractive for UK residents are also likely to make it unattractive to migrants who may look to change sector at the first opportunity even if hired to work in social care.

Migration Advisory Committee 2018, p 90

Recommendation

We recommend that the government develops a comprehensive plan for social care funding in the 2019 Spending Review and, in the longer term, reforms adult social care funding that reflects the need for better pay and conditions in social care.

The upcoming social care Green Paper could play a pivotal role in laying the groundwork for this.

Conclusion

Resolving the deep-set workforce issues within social care will not be straightforward and requires action at all levels. The following are by no means a comprehensive series of proposals but the development of them should be part of the upcoming Green Paper on adult social care.

There are individual actions that employers can take: more than a quarter (28 per cent) of independent sector employers in adult social care have an annual staff turnover rate of less than 10 per cent (**Skills for Care 2018c**). Skills for Care has found that employers who have values-based recruitment can attract better-performing staff and can lower the cost of recruitment and training. Employers who are more successful in recruitment and who have lower turnover rates say that the reasons for their performance include honesty about the realities of the role (**Skills for Care 2018c**).

Nonetheless, the sector's problems cannot be resolved simply by better recruitment practice. We agree with the Migration Advisory Committee that the basic underlying problem with recruitment and retention for social care is the poor pay, terms and conditions for workers in this sector, in turn caused by the difficulty in finding a sustainable funding model. The only sustainable solution to social care's workforce challenges over the next 10 years is for government to increase funding for adult social care and ensure that a significant proportion of this funding goes to improving the pay, terms and conditions for social care staff. Unless and until this happens, however, there is an urgent need to consider an international recruitment option that works for the social care sector.

9. Next steps and conclusion

The NHS Long-Term Plan recognises that over the past decade workforce growth has not kept up with the demands on the service and that the NHS now needs a comprehensive workforce plan to tackle staffing shortages, improve working lives and better utilise the talents and skills of the million plus people who work in the health service. Few disagree that the workforce is the make-or-break issue for the NHS over the coming years.

Over the past decade, day-to-day spending pressures have crowded out investment in the workforce. This must stop; this short-termism has not served patients, staff or taxpayers. The government has committed to a new pay deal for NHS staff and will be spending £20.5 billion more on NHS services by 2023/24. These are important and substantial first steps. But to tackle the current pressures in the workforce, much more action is needed, including more investment in training new staff and more support for the development and retention of existing staff. The health service cannot afford the government continuing to view education and training as an overhead cost to be minimised. There needs to be a fundamental shift in thinking to plan for 'over-supply' of key groups. If this were done and education and training budgets were increased, broadly back to the funding level in 2013/14, our analysis shows that the NHS has the chance to be self-sufficient – in nurses at least – in a decade's time. But this won't happen without investment, policy action and managerial focus now and sustained across the coming years.

In some other areas the management of staffing shortages requires even more radical action. The government has had a target to increase the number of GPs by 5,000 since 2016 ([NHS England 2016](#)). It is clear that this is not achievable. Over the next decade and across the NHS primary care will need to move to a wider team-based model in all parts of the country. Transforming primary care to a team model, shifting to train for over-supply, paying people competitive wages and investing in all staff so that they have rewarding jobs with terms and conditions which reflect modern life is critical to closing the staffing gap and delivering high-quality care.

But for the next five years we need to be realistic about what can be achieved – turning around the NHS's staffing problems will not be quick. For the next few years the NHS can only maintain services by recruiting and retaining enough staff internationally. A positive culture and supportive immigration policy is essential alongside having NHS organisations that are ready to be good employers and help people settle. Even with this, the workforce constraints will inevitably shape and constrain the speed at which health services can be transformed and quality of care improved in areas such as cancer and mental health.

There are no silver bullets for the workforce; addressing staff shortages requires consistent and concerted action across the system on pay, training, retention and job roles. While it is possible to point to individual policy failures in the past that have contributed to the current depth of the workforce shortages, the cause of our current problems goes deeper; workforce has not been a policy priority, responsibility for it is fragmented nationally and locally, the information the NHS needs to understand and plan its workforce is poor and the NHS has not invested in the leadership capability and skills needed to manage the workforce effectively. The NHS workforce implementation plan needs therefore to address not just specific policy areas but also the roles, responsibilities, skills and capabilities needed across the system for more effective workforce planning.

Finally, a key part of good workforce planning and policy needs to include thinking through how the NHS can work much more effectively with partners outside the strict confines of the health service. The past few years have clearly shown that good health depends not just on the NHS but also on the social care system; and an effective training pipeline of skilled staff requires strong partnership with further education institutions and universities, especially if we want to broaden the opportunities to ensure that the NHS has a diverse staff group that properly reflects the society it serves. There are a number of actions that can be taken to improve recruitment and retention in social care. However, workforce challenges in this sector partly have their basis in the poor pay, terms and conditions for social care workers. This can only be addressed by government, first through additional funding in the 2019 Spending Review, and in the longer term through comprehensive reform of adult social care funding.

10. Full table of recommendations

In this report we set out a series of policy options to address staffing shortages in the NHS as a contribution to the work under way to ensure that hospitals, mental health and community providers and general practice have the workforce they need to deliver the vision outlined in *The NHS Long-Term Plan*.

This is not a comprehensive programme and there are many important aspects of workforce policy we have not addressed, including, for example, geographical inequalities. As explained previously, our focus is narrowly on the staff directly employed in NHS providers and general practice. However, national workforce policy needs to be more comprehensive, understanding the NHS's role in the wider health and care sector.

Our policy recommendations are based on the current evidence but in many areas this is limited, so many of our recommendations are not based on as robust an evidence base as we would wish. The problem is that the workforce issues are too acute and too critical to wait for better information and research. But this does mean that the workforce implementation plan currently in development needs to consider carefully its approach to assessing and learning about the impact of policies as they are implemented. Real-time, rapid evaluation will be essential and in some areas there may be a case for phased introduction that allows for robust research evidence to be gathered in parallel.

In developing these recommendations, we have sought to identify who we believe should be responsible for implementation. However, in some cases, solutions go well beyond the remit of the NHS and will require policy engagement with government – either because delivering them will require significant additional financial investment, or because successful implementation will require strong political support and leadership.

Recommendation

Supply of new staff: education and training	Actor responsible for implementation
<p>1. In all areas and at all levels, higher education institutions (HEIs), commissioners of training and the NHS need to work as partners. As part of a more co-ordinated local system, these bodies should, in particular, consider the feasibility of replicating existing promising initiatives between HEIs and NHS trusts to recruit trainees locally. This will also require clearer accountabilities throughout the entire system.</p>	<ul style="list-style-type: none"> • HEE • Higher education institutions • NHS trusts and other providers
<p>2. The Secretary of State should urgently seek to increase the supply of nurses and other under-pressure professions. This will likely require influencing prospective students, higher education institutions (HEIs) and providers of clinical placements. However, given the scale of the challenge, we recommend this includes:</p> <ul style="list-style-type: none"> • student funding – reinvesting the savings from removing NHS bursaries, including both reinstating funding to cover tuition fees for postgraduate nursing courses, which usually take only two years to complete, and offering 'cost of living grants' of around £5,200 a year for undergraduate and postgraduate nursing degrees in recognition of the time spent on clinical placements.¹ These measures would, for example, cost some £640 million a year depending on the numbers entering training. • placement-provider funding – national bodies urgently resetting the level and balance of funding for clinical placements and salary support for clinicians in education and training to encourage an expansion in the number of clinical placements where they are currently proving to be a bottleneck. This could potentially involve a shift of funding from medical to nursing and other non-medical training if appropriate. 	<ul style="list-style-type: none"> • Secretary of State • HEE • Deaneries
<p>3. Commissioners of undergraduate and postgraduate medical, nursing and AHP courses and placements should set conditions on the quality, success and balance of the training. Nationally, HEE – as the single largest funder – should consider issuing guidance to inform this. This must be informed by accurate monitoring of the level of, variations in, and reasons for, people not completing the training.</p>	<ul style="list-style-type: none"> • HEE • Deaneries
<p>4. To ensure apprenticeships become a serious and viable training route, we recommend – based on proposals by NHS Employers and the Education Select Committee – an increase in the maximum funding level, and that the government to consider more flexibility on how the levy is used (including covering backfill costs) while protecting learning time, and regional co-ordination including between health and social care settings.</p>	<ul style="list-style-type: none"> • Department for Education
Pay and reward: ensuring pay policy supports recruitment and retention	Actor responsible for implementation
<p>1. We recommend that in the NHS should continue to rise in real terms after the end of the current pay deal for all staff, and should rise in-line with wider economy earnings to ensure that as few staff as possible feel undervalued, leave the NHS or never join in the first place due to poor remuneration.</p>	<ul style="list-style-type: none"> • Department of Health and Social Care
<p>2. We recommend that the Department of Health and Social Care should ask the Pay Review Body to identify shortage occupations and recommend the appropriate structure and amounts of financial incentives such as pay premia, loan write-offs and golden hellos where this would be beneficial. To prevent the piecemeal implementation of targeted pay rises, the Pay Review Body should be tasked with providing a coherent recruitment and retention-driven framework for these decisions for these occupations. There also needs to be an examination of why local flexibility has not been used more with pay, and how areas can be supported to respond to their own shortages of certain staff.</p>	<ul style="list-style-type: none"> • Department of Health and Social Care • Pay Review Body

1 This level of funding would mean that, with the maintenance loan of up to £8,430 (£11,002 for London) for full-time students not living with their parents, they are able to receive up to the national living wage level after income tax and National Insurance for 21–24-year-olds (£13,593).

3. There remain considerable issues with inequality in pay and progression opportunities in the NHS. This negatively impacts the pay and experience of staff including women and BME staff, and is inconsistent with the values of the NHS. This has been a persistent inequity and action should be urgently taken at all levels – led and supported by NHS England – of the system to understand the causes of and solutions for this.

- All levels

4. We recommend the Department of Health and Social Care should ask the NHS Pay Review Body to look into potential ways in which pay and terms and conditions could be a roadblock to working in a more joined-up way and how any barriers can be overcome.

- Department of Health and Social Care
- Pay Review Body

A good employer: making the NHS a better place to work and build a career

Actor responsible for implementation

1. The NHS needs an explicit statement of the universal ‘offer’ to staff – including, but not limited to, their legal rights. The form of this should be explored with staff side representatives and employers, but may be in the form of a compact covering not just fair treatment for all staff with protected characteristics but also what staff can expect from the NHS in terms of equal pay and opportunity, CPD, streamlining, supervision (especially in early career and during key transitions), work-life balance, proper appraisal, and non-financial benefits. This will require national leadership from NHS Improvement and NHS England both in terms of what this national offer is, and how they will support local employers to achieve it.

- Department of Health and Social Care

2. We recommend that the workforce implementation plan maps the good practice examples of local action to tackle racial discrimination, harassment, exclusion and lack of progression in the NHS. It should build on Workforce Race Equality Standard (WRES), to learn from the best of local initiatives and support NHS trusts to adapt and adopt successful approaches so that all NHS organisations have concrete action plans to tackle race inequality in the NHS.

- WIP

3. More focus needs to be on supporting staff at the beginning and end of their career, particularly at transition points. For newly qualified staff this means increasing support beyond their preceptorship and making sure that there are adequate numbers of senior staff and sufficient CPD funding. For staff approaching retirement this means encouraging staff to stay in the NHS rather than leave through offering more flexibility and options for reduced participation, as well as doing more to support staff against external financial changes such as in pensions.

- HEE
- NHS Improvement
- Department of Health and Social Care

4. We recommend a full review of return-to-practice schemes to understand what works and what is realistic. Unnecessary barriers should be removed where possible. Steps should be taken to improve the NHS’s ability to find people who are eligible for schemes and encourage them to participate.

- HEE

5. The national bodies should recommit to a revised set of actions (to be implemented within 12 months) against the national strategic framework on improvement and leadership development, Developing People – Improving Care. This should include demonstrable action by the national bodies on changing their leadership approaches and developing compassionate and inclusive leadership.

- National bodies

6. A series of national reports have been published, each containing recommendations on leadership and culture. We recommend that the workforce implementation group undertakes a prioritisation exercise of the many recommendations now in existence to support NHS employers to understand where to focus their attentions first.

- Workforce implementation group

Workforce redesign: the right teams with the right skills and technological support	Actor responsible for implementation
<p>1. Support a step change in the capacity and capability available within organisations and across local systems to implement evidence-based workforce redesign and equip their staff with the skills for a digital future. The current workforce development budget of £84 million should be increased at the very least to the equivalent of its 2013/14 value – approximately equal to £330 million in 2023/24.</p>	<ul style="list-style-type: none"> • HEE • Department of Health and Social Care
<p>2. Best use of the primary care workforce should be made through inclusive and ambitious changes in multidisciplinary teamworking with one possible route shown in our modelling. We welcome announcements in the long-term plan and GP contract to achieve an expanded primary care team, including the recruitment of 20,000 additional staff. Investment in estate, support for workforce redesign, and flexible employment models are all needed if the full potential of these additional staff is to be realised.</p>	<ul style="list-style-type: none"> • NHS England • HEE • Primary care networks
<p>3. In the interests of patients and staff, consideration should be given to more formal national regulation of advanced practice roles. There is an urgent need to introduce legislation to support the regulation of physician associates to enable them to prescribe and achieve their full potential in the clinical workforce.</p>	<ul style="list-style-type: none"> • HEE • Clinical regulators
<p>4. To deliver better and more efficient management of mental health in primary care, national bodies should support large-scale pilots in general practice. This should be aimed at exploring different models and involving a wider group of staff.</p>	<ul style="list-style-type: none"> • NHS England • HEE
<p>5. We recommend that the National Quality Board develops and evaluates safe staffing tools – for the full range of settings; acute, community, mental health and primary care. These tools should evolve to reflect the team and multidisciplinary nature of delivery of health care.</p>	<ul style="list-style-type: none"> • National Quality Board
Supply of new staff: international recruitment	Actor responsible for implementation
<p>1. NHS England and Health Education England should establish a regionally led but nationally funded and co-ordinated programme of ethical international recruitment. Local and regional organisations should work together to understand local need for international recruits and ensure that recruitment is regionally led. National bodies should co-ordinate elements of the recruitment, such as visa processing, and make the most of economies of scale. National bodies need to grow existing national schemes for doctors and nurses to come to the NHS, like the Medical Training Initiative. There should be robust evaluation of these schemes to understand their impact on domestic and international health workforces. Regions should be compensated for international recruitment through existing funding routes, to ensure that international recruitment costs employers no more than employing domestically.</p>	<ul style="list-style-type: none"> • NHS England • NHS Improvement • Health Education England
<p>2. The NHS needs to aim to recruit an average of 5,000 full-time, international nurses a year, if it is to achieve a 5 per cent vacancy rate target for nurses by 2023/24. Achieving this will be challenging, but it is essential if immediate vacancies are to be addressed. National bodies and regions should share best practice to understand how new recruits can be supported and take an active role in ensuring that recruitment is being done ethically and with the authorisation of non-UK governments.</p>	<ul style="list-style-type: none"> • NHS England • NHS Improvement • Health Education England
<p>3. Expand existing visa salary exemptions to all registered health care staff and these exemptions need to be extended beyond January 2021. All health care professions should be added to the shortage occupation list. The Department of Health and Social Care and the Home Office should ensure that visas are available swiftly, as and when they are needed. The visa process for NHS organisations should be revisited to ensure that ethical international recruitment is as easy as domestic recruitment.</p>	<ul style="list-style-type: none"> • Department of Health and Social Care • Home Office

4. Ensure that regulators have the support to standardise and streamline their processes for international recruits. The government should support professional regulators to review processes and understand where time savings can be made to ensure that successful international applicants can get into post as soon as is safe. Existing positive efforts in terms of automatic recognition of qualifications and finding more appropriate language testing should be redoubled.

- Professional regulators
- Department of Health and Social Care

5. Pay the costs associated with migrating to work in the NHS from central funding. The financial barriers to working in the NHS should be removed for both the migrant and the NHS organisation. Given the need for international recruitment to increase in the short term, the disincentive of cost should be removed from the equation. Currently, the cost will apply to European Economic Area (EEA) migrants after Brexit as well as non-EEA migrants. In line with the Royal College of Physicians' estimate, we assume that this cost will be an average of £4,409 per recruit for three years.

- NHS England
- NHS Improvement

Social care: pay, recruitment and retention in social care

Actor responsible for implementation

<p>1. NHS England should support local areas to develop workforce strategies that cross health and social care, paying attention to the interdependencies between the two sectors.</p>	<ul style="list-style-type: none"> • NHS England
<p>2. There should be robust evaluation of social care recruitment marketing campaigns to understand how best to improve the image of the sector and enhance recruitment.</p>	<ul style="list-style-type: none"> • Department of Health and Social Care and Skills for Care
<p>3. The government needs to develop a comprehensive plan for social care funding in the 2019 Spending Review, and in the longer term through more fundamental reform of adult social care funding that reflects the need for better pay and conditions in social care.</p>	<ul style="list-style-type: none"> • Ministry of Housing, Communities and Local Government • Department of Health and Social Care
<p>4. The government should go back to the drawing board to design a sector-specific visa route that works to support the social care sector to continue to benefit from international migration.</p>	<ul style="list-style-type: none"> • Department of Health and Social Care • Ministry of Housing, Communities and Local Government • Home Office



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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.

Nuffield Trust

The Nuffield Trust is an independent health think tank. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

The King's Fund

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible health and care is available to all.